

The development of a laughter therapy program

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BACKGROUND

In early November 2000, a newspaper article was brought to our attention at the Aged Care Rehabilitation Unit (ACRU). The article outlined details of a laughter therapy group being conducted in the north of Tasmania by the Northern field officer of Arthritis Tasmania and a community health social worker. It generated a lot of interest and I opted to look into it further as a possibility for group work at ACRU.

At the same time, a volunteer with clown doctoring skills made contact with ACRU via Volunteering Tasmania. Conversations with colleagues in the Southern Community Health Social Work Team revealed knowledge of yogic laughter therapy exercises and programs, with a number of colleagues expressing interest in program development and facilitation. Volunteer Jody Kingston and myself visited the Northern laughter program to experience first hand, laughter therapy in action. This took place in late April 2001. It was an inspiring experience and upon return to Hobart, a number of meetings between ACRU and community health social work staff led to the decision to pilot three, six week programs in three different settings. These were to be based in a rural, outer metropolitan and an inner city setting.

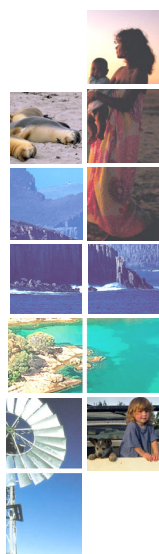
AIMS

The aims of the laughter therapy program were:

- to break down the barriers of social isolation and concomitant depression
- to expose people to a light-hearted but effective way of enhancing their sense of well-being
- to encourage and empower people to actively participate in their health care
- to incorporate the known benefits of laughter therapy into a program structure designed to enhance the health and well-being of those participating.

In our multi-disciplinary clinical work at ACRU and in our social work practice in the community, we are very aware of the health ramifications of social isolation in people's lives. More often than not, varying degrees of depression are a corollary to this. We anticipated that laughter therapy had much to offer in helping to reduce the impacts of isolation and depression. This was based upon the fact that the literature on laughter therapy emphasises its benefits for psychosomatic disorders, anxieties and depression, due to its positive role as a natural anti-stress measure.

Laughter brings people together and impacts favourably on interpersonal relationships. It helps people overcome social reserve and minimises inhibitions that



otherwise may prevent involvement with the wider community. It is a great adjunct to confidence boosting. There is a general consensus in the literature, (Kataria, www.laughteryoga.org/open.htm; Cameron-Hill and Yates, 2000; Thorsen and Powell, 1997) that people who actively utilised humour in their day-to-day life dealings, tended to have stronger and more useful coping mechanisms combined with a greater degree of psychological health. It was envisaged that laughter therapy would be an alternative, but light-hearted way to encourage and empower people to feel more able to take control of their life in general and health needs in particular.

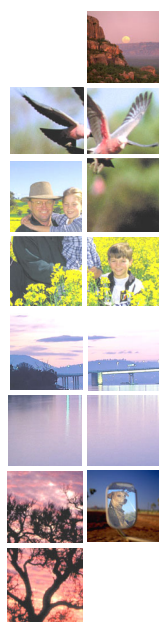
We were also interested, where possible, to advocate the inclusion of laughter therapy programs into existing or future care plans for people. The laughter therapy group was offered as an option to ACRU clients at the point where the need for intensive clinical individualised input was lessening. It was considered that the group social experience would be of advantage in terms of increasing confidence in social situations and re-building a sense of well-being and control over one's own health needs. Those coming into the community based programs were largely self-referring and were people seeking new and innovative ways to increase their sense of well-being and to find natural ways to improve their health situation.

METHOD

A quite comprehensive literature review was conducted pre program. It was extremely enlightening to discover the wealth of information available regarding the health benefits of laughter. We were particularly pleased to locate the work of Indian Doctor Madan Kataria (Kataria, M. www.laughteryoga.org/open.htm) and the development of his yogic laughter exercises via his School of Laughter Yoga. This coincided with a segment on his work being included in the John Cleese series, Face which featured on Australian TV around June 2001. This further motivated us in the development of the pilot program and increased our sense of certainty that laughter therapy did have a place in promoting health and well-being in the general community.

The three pilot sites were identified. Three geographically different sites were chosen, one rural, one outer metropolitan, and one inner city. Facilitators were found for all groups. Five social workers and two volunteers were involved. It was felt necessary to train the facilitators, as none felt particularly adept to take the groups. At this point theory felt significantly more comfortable than practice. We were very fortunate in having our actor/ clown doctor volunteer who conducted two training sessions for all nominated facilitators. This proved to be vital to the success of the programs as it taught ways to overcome inhibition and self-consciousness so that an atmosphere open to humour could be created.

Program content was finalised. Weekly themes were used to structure the program like kids, seaside, outer space, and animals. Jokes, funny videos, yogic laughter exercises and games were included. Props such as wigs, masks, balloons, videos, joke books, hats etc were purchased or found and placed in a mobile laughter box which did the rounds of the groups. Dates were finalised and advertised and flyers distributed. The first program opened at ACRU on 17 July 2001 followed by Kingston and then, Ouse.



PROGRAM CONTENT

During the pilot program, content covered introduction to the concept of laughter therapy and recognised health benefits, contraindications, development of group rules. This was followed by other housekeeping matters including, initiation and completion of evaluation procedures, relaxation exercises, games, excerpts from humorous videos, jokes, stories, yogic laughter exercises. A tea break was taken mid session.

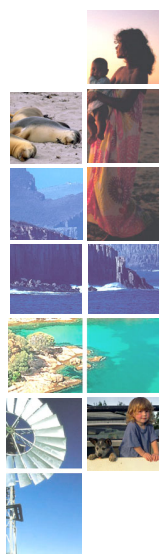
It became apparent early in the pilot that there had to be adequate structure and material on hand to maintain the momentum of the energy generated by the group. By doing so, the positive benefits being experienced by people were enhanced. A good supply of jokes were found and copied from many sources, for example the net, joke books, and Readers Digest. Humorous videos were located in video shops, in private collections, and the ABC shop. Games were found and adapted from party books for children and from the imagination of facilitators and participants. Dr Madan Kataria's yogic laughter exercises quickly became a desired component by the participants and facilitators alike.

Since the pilots, the program structure has been progressively refined. Today's program still incorporates those original components but the yogic laughter exercises, which were used in a more ad hoc fashion then have been formalised in a chanting format of some twenty minutes. It features in both the first and second halves of each session. Typical two hourly sessions would now open with general greeting and, "how are you" as people arrive, followed by:

- a gentle relaxation exercise period with some deep breathing
- a laughter chanting session
- a round of jokes or a game or two
- morning tea (always sumptuous and long enough to enhance the social dynamic)
- an excerpt from a humorous video
- a round of riddles, knock-knock or jokes
- a laughter chanting session followed by positive affirmations for the well-being of the group
- then, thank you's, expressions of enjoyment and confirmation of next week's attendance accompanied by cheery good byes.

EVALUATION OF PILOT GROUPS

We thought it important to evaluate each pilot program as well as attempting to cross evaluate the three groups. The entrance criteria for all groups were uniform – that of social isolation, feelings of being emotionally challenged, and/or having complex medical problems. The format and evaluative tools were uniform across all groups. The age range of participants varied across the groups. To assess for possible quality of life changes we used the Dartmouth Coop project charts, 1987. These were



administered in week one and week four. Participants were asked to answer two questions in week one. The first was motivational, “why were you attracted to the group” and the second related to expectation, “how could laughter benefit you”.

In week six, participants were asked to comment on whether they felt their expectation had been met and to further comment on any other outcome – expected or not expected.

We were conscious of the need to minimise any sense of intrusiveness. We felt the simple tools used would provide us with adequate feedback as to the efficacy of the program and whether it could be expanded into an ongoing program. Through the six-week pilot, facilitators were making note of participants commentary, positive and negative, and actively encouraged them to share any benefits they felt with the group.

RESULTS

Both Kingston and ACRU core group members showed a more positive outlook on life. Even those participants who were variable in attendance testified to a sense of improved well-being as a result of attending the groups.

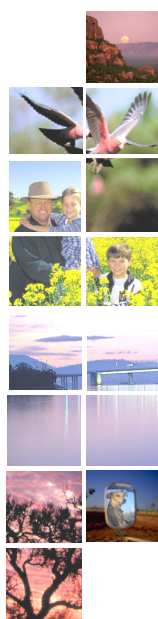
In terms of self reporting, written commentary contained statements such as:

- a positive change in their outlook on life
- a positive physiological change due to stress reduction
- a reduction in loneliness
- I’m happier to go home
- I seem more happy since coming
- It’s been great to meet new people
- I see the funny side of things
- I am certain it has helped me to relax.

ACRU and Kingston participants, by and large, attended the group for friendship and company, to forget about pain and health related problems, for relaxation purposes and to feel happier and lighter about life.

The Ouse laughter group, conducted mid week, was situated in a rural setting with some participants travelling significant distances to take part. Facilitators who picked up participants on the way found the journey just as enjoyable as the session. In regards to the laughter group, the magic for Ouse overwhelmingly was that of sharing company and breaking down rural isolation. One respondent summed it up by saying “this keeps me going ‘til at least Sunday”.

Following the completion of the pilots in September 2001, the Ouse group continued once a month to the end of 2001 as did ACRU which continued fortnightly. The Kingston group ceased due to the lack of an ongoing facilitator. In 2002, The ACRU group reformed on a weekly basis and has been growing in its popularity. Community



health social work and nursing established a group on the Eastern Shore of Hobart. A group was established at Oatlands, in the Southern Midlands District of the state by myself as a community health social worker. This group runs fortnightly.

FURTHER DEVELOPMENTS

In the post pilot period, there has been increasing awareness of the health benefits of laughter due to increased media attention. It is not unusual now to hear the virtues of laughter therapy being extolled on radio, to read about it in newspaper, healthy lifestyle supplements and in mainstream magazines or to tune into television programs on the subject. I have had the pleasure of talking about our own programs on ABC radio, community FM radio and contributing to newspaper articles.

Each time programs have been featured in the media, we have fielded many requests to do introductory sessions for a multitude of differing organisations, government, private and consumer based. We have also been asked to establish and facilitate new groups. To meet this need, we are developing a training program for facilitators based around a half-day workshop. The aim is to give sufficient knowledge, know-how and skill to potential facilitators in order for them to feel confident enough to take the plunge into the world of laughter therapy.

We have also packaged all the knowledge we have gained over the past two years into a Laughter Therapy Action Kit. The aim of the kit is to take any person or organisation through the process of establishing and running a laughter therapy program, step by step.

CONCLUSION

Across the past two years, with our ongoing involvement in developing the laughter therapy program at ACRU and transporting it out into a variety of settings, particularly rural settings, we have become convinced of its power to impact favourably on the quality of life of all those involved.

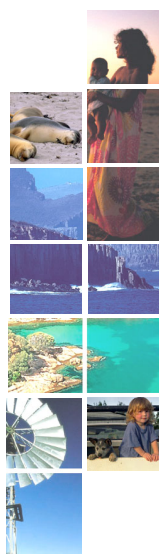
Laughter is a natural attribute and ability that we all possess and it enables us to tap into our own healing powers, both physiological and psychological. When practised regularly, it has a positive cumulative effect on our attitudes and perspectives.

Laughing is good for you.

ACKNOWLEDGMENTS

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A special thanks to all the wonderful participants who kept the show on the road by rolling out the barrel of laughter week after week and who were continually supportive and encouraging of the program.



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PRESENTERS

Robyn Bishop qualified in 1976 with a BA in Social Geography and Political Science/Public Policy (Tas) and later qualified with a postgraduate BA in Social Work (Tas) in 1980.

The majority of Robyn's social work practice since 1981 has been in acute hospital, outpatient and community health settings. Robyn has specialist knowledge and skills in the area of health service provision and program development for older Australians. Robyn currently provides a social work service to clients of the Aged Care Rehabilitation Unit in Hobart and to the residents of the Southern Midlands District (a large rural district) as a member of the Southern Community Health social work team.

