The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred), and no references, tables, or figures. Send material to the column editor, Francine Cournos, M.D., at the New York State Psychiatric Institute, 1051 Riverside Drive, Unit 112, New York, New York 10032.

The Humor Group: More Than a Joke

There is much theoretical and empirical support for the belief that humor is good for you. Laughter can mitigate pain, enhance immunologic function, promote general physical health, improve mental functioning, attenuate stress, narrow interpersonal distance, and create a common language. These advantages can in turn enhance social health, facilitate relationships and rapport, augment the psychotherapeutic process, enhance group cohesion, promote communication, and help caregivers cope with the demands of their work.

Based on the proposition that humor can catalyze therapeutic change, a unique treatment modality called "the humor group" deliberately uses humor as the focal point of treatment. The group was initially designed to give nursing students in a 16-week clinical rotation at a state forensic psychiatric hospital practice in leading a group and in using humor therapeutically. The intention was to provide patients with a mirthful place of respite and help students and patients transcend negative stereotypes arising from their disparate sociocultural backgrounds by sharing laughter.

The original humor group began in March 1994 and ended in March 1998, when changes in the curriculum of the affiliated nursing program led to discontinuation of the hospital as a training site. By the time the group concluded, ten completed cycles—a sequence of group encounters that took place over a six- to eight-week period—had been offered, each encompassing six to eight one-hour sessions. A total of 66 sessions were held, involving 129 patients and 64 nursing students.

After completing a two-hour class on therapeutic applications of humor, each student planned and led one session under the supervision of the instructor. To help them function as effective leaders and to enhance the likelihood that they would share constructive humor, each session followed a specific format.

First, a "call for rules" opened each session with a discussion of the group guidelines, which centered on being respectful of other participants. Then, because group membership was open, each week's session included an introduction, which was conducted in a playful manner and set a jovial tone for group interaction. The sharing of yarns during the "call for jokes" served as a springboard for more spontaneous humor, provided an incentive to prepare ahead of time, and gave shyer participants a concrete focus.

Next, a "humorous activity" engaged members in a variety of games, songs, dances, skits, or relays that emphasized cooperation. This activity was followed by a discussion that encouraged members to share concerns and plan for future sessions and was a safeguard against humor's divisive or destructive potential. Finally, there was an "enlightenment" component, which often took the form of an instant replay of some funny group occurrence and ended the session on an upbeat note.

After each session, a debriefing was held in which the students and the instructor critiqued the group process and developed strategies for improvement.

A comprehensive evaluation of the initial humor group was conducted in 1999 to explore the impact of the group on patients' well-being. Analysis of data collected over the group's four-year duration—including patient and student questionnaires instituted as an ongoing means of group assessment, attendance lists, patient records, and student and instructor notes—and interviews conducted with 13 patients revealed several themes suggestive of the group's therapeutic value. The participants viewed the group as a place in which to develop a sense of connection, improve communication and social skills, learn to manage thoughts or feelings, get new perspective, reduce stress and enhance coping, find respite and relaxation, and laugh with others at oneself.

Humor is not a panacea, and neither was the humor group. Although the patients found it beneficial, none of them claimed that the group was a cure-all or the only helpful therapy. Nonetheless, patients' experience in the group debunked a prevalent belief that treatment always has to be provided in a serious manner. Clinicians often perceive therapy as a collaborative, helpful venture, yet many patients in the group construed therapy as coercive or frightening. The humor group sought to cultivate humor in their lives, which was a goal that the members shared. They liked its subtle route to change and found its focus on positive emotions unique.

The original structure and format of the humor group have guided two subsequent efforts to introduce humor's healing potential in other settings. In the fall of 2000 and the spring of 2001, nursing students offered similar groups to male and female inpatients and outpatients who were receiving psychiatric care at a Department of Veterans Affairs hospital. Nursing students are currently leading a humor group with elderly and disabled residents of a low-income housing project. Both endeavors lend credence to the age-old adage that laughter is the best medicine and the current assertion that the original humor group was more than a joke.

Pamela Minden, Ph.D., R.N.

Dr. Minden is associate professor of nursing at Edgewood College, 1000 Edgewood College Drive, Madison, Wisconsin 53711 (e-mail, pminden@edgewood.edu).

Crisis Intervention Services in Juvenile Detention Centers

The prevalence of mental disorders among juvenile detainees is estimated to be as high as 60 percent, and reports suggest that adolescents who are detained have a three- to fourfold risk of suicide. The transfer of juveniles who commit serious offenses to the adult legal system and the problems of overwhelmed child care agencies appear to have precipitated a shift in the composition of populations in juvenile detention centers. Adolescents are often detained for minor legal charges that occur in the context of severe behavioral problems and family stress. We report on a collaborative venture between a state juvenile justice system and the psychiatry department of a medical school for assessing and intervening with acutely distressed youths.

The program was implemented for short-term juvenile detention centers where youths are held pending adjudication of their cases, usually for two to four weeks. The high turnover in such centers means that the staff are less familiar with individual youths and thus makes the need to assess suicide risk compelling. During admission, youths complete a self-report suicide scale that is integrated into the standard intake protocol. Detention center staff are trained to administer and score this instrument and to probe for information specifically pertaining to psychiatric history, including suicidal ideation and intent. Because suicide watch status becomes part of the computerized record as an incident report, information on concerns about suicide risk during previous detentions is available. Detainees are automatically placed on suicide watch if any risk factor is identified during intake, and they remain under watch until evaluated by the mental health consultant.

A licensed mental health consultant from the psychiatry department—usually a psychologist or a social worker—is on-site at each detention center for three hours a day, five days a week. The consultant's role is to determine severity of symptoms, to facilitate psychiatric hospitalization when indicated, and to make referrals to a consulting psychiatrist, who is on-site for three hours on one day of each week at each site. The psychiatrist evaluates and monitors ongoing psychotropic medication prescribed before admission. Because adequate follow-up is requisite for good care, psychiatrists typically do not initiate medication except when acutely indicated, in which case an inpatient referral is usually called for.

Detention center staff undergo intensive training by a nurse practitioner in medication administration and documentation. Standard administration times are adjusted to avoid scheduled dosing during shift changes. The consulting psychiatrist is on call to approve medications for newly admitted youths and to advise staff how best to respond to adverse reactions or other acute situations. For behavioral concerns, the mental health consultant is usually contacted first, whereas the consulting psychiatrist is contacted for medication concerns.

Case managers are employed by the detention centers to monitor the well-being of detained youths. They conduct psychosocial assessments, including detailed social, legal, medical, and psychiatric histories, by using standardized forms and make disposition recommendations to the court. They work closely with the mental health consultant to triage youths who need further assessment. The level of observation that youths are assigned to receive is tailored to the degree of risk: suicide alert (15-minute checks), suicide watch (four-minute checks), and constant observation (continual direct observation by an assigned staff member). In most cases, youths who receive constant observation are in acute enough distress to warrant psychiatric hospitalization. In these instances, the mental health consultant contacts the admissions office of a local hospital to arrange precertification from the appropriate third-party payer.

The most common inpatient interventions include assessment, stabilization, and medication evaluation. Concerns about disposition, dangerousness, and severity of legal charges frequently need to be addressed during the referral process. Our program provides outreach and education to hospitals that accept referrals to prepare hospital staff to effectively manage these youths and develop appropriate policies—for example, keeping youths on a locked unit. Hospitalization policies and procedures are approved by superior court.

As a general rule, the mental health consultants do not communicate directly with the court. Other mental health professionals are contracted by the detention centers for forensic evaluations. After a hospitalization, the mental health consultant facilitates communication between the hospital clinician and the detention center case managers (after appropriate consents are obtained), and the case manager brings the information to all parties in the court when appropriate and relevant. These boundaries have proven essential to ensuring that the efforts of the mental health consultants are focused on the immediate needs of the youth.

This collaborative program has been in operation for several years. The program recognizes the mental health needs of adolescents in detention centers and has increased staff awareness of suicide and psychiatric problems. The clinical assessments help to address behavioral problems during detention and help case managers to make disposition recommendations. Several hospitalizations occur each month, demonstrating the need for this service, and detention center staff have become more interested in mental health education and training as the program has matured.

Charles A. Sanislow, Ph.D.
John Chapman, Psy.D.
Thomas H. McGlashan, M.D.

Dr. Sanislow and Dr. McGlashan are affiliated with the department of psychiatry at Yale University School of Medicine in New Haven, Connecticut. Dr. Chapman is with the Court Support Services Division of the State of Connecticut Judicial Branch in Hartford. Send correspondence to Dr. Sanislow at the Yale University School of Medicine, Department of Psychiatry, P.O. Box 208098, New Haven, Connecticut 06520-8098 (e-mail, charles.sanislow@yale.edu).