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Laughing Through the Pain: An Analysis of Dark Humor in Trauma-and-Crisis-Centered Occupations

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Laughing Through the Pain:

An Analysis of Dark Humor in Trauma-and-Crisis-Centered Occupations

by

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Abstract

The use of dark, or "black" humor by professionals in trauma-and-crisis-centered occupations is common, with fields such as healthcare, crime, emergency response, and social work reporting frequent use of dark humor on the job. Using a literature review approach, peer-review articles were examined to understand the function that dark humor plays in trauma-and-crisis-centered fields. The findings suggest that dark humor acts as a coping mechanism, and contributes to various group dynamics between colleagues. The literature was also reviewed for the effects that dark humor has on patients or people in contact with trauma-and-crisis personnel. While some preliminary findings point to a relevant connection between humor, bias, and prejudice, the research in this area is scant and in need of further investigation. This review contributes to the literature by analyzing the most salient explanations behind why and how dark humor is used by professionals working in trauma-and-crisis-centered fields, and then offers a new direction for this research which considers the potential consequences dark humor may have on the institutions and communities being served. The population of interest is also expanded in this review, as trauma-and-crisis-centered field refers to a larger body of occupations that deal with death and trauma, but that may not be emergency services. Recommendations for the future include education about ethical concerns surrounding dark humor, positive behavior modeling from senior staff, and further investigation into how dark humor interacts with one's biases and prejudices, and in turn, patient quality-and-quantity of care.

Keywords: Gallows humor, dark humor, emergency services, coping, occupational stress

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Occupations

Introduction

Professionals working in careers involving death, crises, and trauma face many occupational stressors, and are at risk for increased negative mental and emotional outcomes (Johnson et al. 2005; Rocha et al. 2020). This population–which I will be referring to as trauma-and-crisis personnel–has a unique familiarity with suffering, including the smells, textures, and emotional labor associated with trauma and death, setting their occupational context apart from others. While one might assume that the nature of these jobs evokes a serious work environment, trauma-and-crisis personnel, such as emergency nurses and physicians (Rowe & Regehr, 2010), firefighters (Sliter et al. 2014), paramedics (Scott, 2007), crime scene investigators (Vivona, 2014), and social workers (Sullivan, 2000) often fill their long days with dark, or "black" humor. The function that dark humor plays in these occupational contexts varies in the literature, and it has been suggested to be a method of coping (Bouchard, 2016; Parsons et al. 2001; Rowe & Regehr, 2010; Watson, 2011), as well as an expression of group dynamics between coworkers, and between worker and patient (Rowe & Regehr, 2010; Vivona, 2014; Watson, 2011; Wear et al. 2006). Some consideration of humor's relationship with physiological health has also been explored, with mixed results (Martin, 2002). In this thesis, I will briefly review the theoretical explanations behind humor, and then follow with a review of the literature on the use of dark humor in trauma-and-crisis-centered fields, as well as its impact on the individuals and communities these fields serve. I am using the term *trauma-and-crisis-centered field* to refer to occupations in which there is a frequent and expected exposure to trauma, crises, or death. Some articles on humor in this population use the term *emergency service personnel* (Rowe & Regehr,

2010; Scott, 2007), however, for the scope of this paper I will be including occupations that are exposed to trauma and death, but that may not fit under the description of emergency services, such as crime scene investigators and social workers, in an attempt to broaden the range of occupations being researched.

Theoretical Background of Humor

Humor as a construct is challenging to narrow down to a single definition or theory. Many researchers grapple with this by applying different humor theories to different situations when attempting to explain individual or group humor, such as why we joke when we are under stress (Maxwell, 2003), or why joking with coworkers may prevent burnout and strengthen work relationships (Plester, 2009). Over the last few centuries, the mystery behind our amusement has been investigated by curious psychologists, sociologists, and philosophers, and born from this curiosity are three core theories of humor that have withstood the test of time: Freud's relief theory, and the philosophical theories of superiority and incongruity (Atkinson, 2006).

Much of Sigmund Freud's work examined the theory behind humor (Freud, 1905; Freud, 1928). Freud not only labels humor a defense mechanism, like repression and denial, but goes one step further, hailing it "the highest of these defensive processes" (Freud, 1905, p. 168-169). Freud puts humor on a pedestal because it requires we face our threats head-on (Freud, 1905). In order to make light of something aversive for our own benefit, we must first be cognizant of its danger, thus, Freud saw humor as an admirable defense, saying, "[humor] signifies the triumph not only of the ego, but also of the pleasure principle, which is strong enough to assert itself here in the face of the adverse real circumstances" (Freud, 1928, p.2).

Along with Herbert Spencer, Sigmund Freud helped popularize the Relief Theory of humor, which views humor as a means of personal relief from energy trapped within the nervous

system (Atkinson, 2006). The theory itself has been slightly reworked from the 18th and 19th

centuries as society has expanded its understanding of how the human body and the nervous

system work (Morreall, 2020). Today, this theory is understood as relief from nervous tension or

stress through the physiological act of laughing (Morreall, 2020).

       Another key humor theory, known as Superiority Theory, was promoted by philosophers

Plato, Aristotle, and Thomas Hobbs, and dominated the 18th century (Atkinson, 2006). This

theory assumes that we assert ourselves over others when we joke with the goal of

communicating our superiority–we belittle *the other* to acknowledge our own higher standing

(Atkinson, 2006).

       Supported by philosophers like Immanuel Kant and Soren Kierkegaard, the dominant

theory of humor today is Incongruity Theory (Morreall, 2020), which posits that we find things

humorous when an expectation is set and then defied (Atkinson, 2006). When we expect a

situation to go one way, and then it goes somewhere entirely different, the incongruity–and

namely, absurdity–of the situation is believed to mediate humor (Morreall, 2020).

       While these three popular theories have maintained their relevance for centuries

(Atkinson, 2006), recent research by McGraw & Warren (2010) proposes the Benign Violation

Hypothesis, which attempts to better explain which conditions are conducive to humor and

laughter. This hypothesis names three conditions that must be present for something to be

appraised as funny. First, there must be a violation. A violation can take many forms, for

example, poking fun at the atypical, or breaking social and moral norms. According to McGraw

& Warren (2010), if something defies or alters a person's worldview or expectation, then it can

be considered a violation. The second condition states that it must also be benign. Perhaps the

violation breaks one norm, but does not break a competing, relevant norm. A violation may also

be considered benign if the person is psychologically distant from it–that is, the situation seems unrealistic or unlikely to impact them. The last condition according to this hypothesis states that the appraisal of something as both a violation and as benign must occur simultaneously. The presence of these three conditions together is theorized to set the stage for humor (McGraw & Warren, 2010).

We can apply the Benign Violation hypothesis to the context of trauma-and-crisis-centered occupations, such as emergency and ICU nurses. Hospitals see violations on a regular basis–gunshot wounds, gangrene tissue, and suicide attempts are just a few examples. At first glance these situations do not seem benign at all, and the injuries themselves are not. There is arguably nothing benign about the very real suffering of patients, but according to the Benign Violation Hypothesis, both the interaction of competing norms and psychological distancing can mediate benignity (McGraw & Warren, 2010). Emergency nurses have been known to psychologically and emotionally distance themselves from patients in order to both protect their mental health, and increase focus on the task at hand during a crisis situation (Bouchard, 2016; Wanzer et al., 2005). The interaction of competing norms also applies, because despite the larger social norms that police our reactions to death (Harris, 2009), people can follow the different social norms of various groups and institutions based on who is around them (Gross & Vostroknutov, 2022), and it is not atypical for nurses and doctors to use dark humor with each other on the clock (Wanzer et al., 2005; Wear et al., 2009). The combination of violations and simultaneous benign appraisals suggest that the application of Benign Violations Hypothesis may be a fitting theory behind humor in trauma-and-crisis-centered fields.

Dark Humor

Dark humor, or "black humor," is a form of comedy that makes light of the morbid, unpleasant, and taboo (Britannica, 2023). It goes by various names to reflect its particular style, such as cynical (Dharamsi et al. 2010; Rowe & Regehr, 2010), derogatory or disparaging (Bartolo et al. 2021; Parson et al. 2001), and gallows (Maxwell, 2003; Obrdlik, 1942; Watson, 2011). Since different styles of dark humor tend to bleed together and may be used interchangeably, the Merriam Webster dictionary can provide some guidance on a few main types:

Cynical refers to a distrust of people, and the belief that "humans are motivated primarily by self-interest" (Merriam-Webster, 2023). Cynical humor often involves sarcastic or ironic quips.

Derogatory means "expressing of a low opinion," and to "detract from the character…of something" (Merriam-Webster, 2023). Derogatory humor–also commonly referred to as *disparaging* humor–involves belittling or humiliating an individual or group (Bartolo et al. 2021). This humor tends to mask underlying prejudiced attitudes, since the premise of "it's only a joke" acts as a socially acceptable justification for its content (Koszałkowska & Wróbel, 2019).

Gallows Humor "makes fun of a life-threatening, disastrous, or terrifying situation" (Merriam-Webster, 2023). The term *gallows* refers to both the structure in which a person is hanged, and the act of hanging itself (Merriam-Webster, 2023). Fittingly, gallows humor often arises in response to an awareness of our own mortality (Hackney, 2011; Ostrower, 2015), and according to Freud's defense mechanism paradigm, gallows humor serves as a defense against the uncomfortable or frightening reality of death (Freud, 1928). Historically, these dark jokes have been weaponized by the oppressed as acts of resistance or as a means of raising one's spirits

(Ostrower, 2015; Ostrower, 1942). During the Nazi invasion and occupation of Czechoslovakia, gallows humor was alive and thriving among Czechs who saw their country pillaged, and their parents, children, and neighbors sent to concentration camps (Obrdlik, 1942). After spending 9 months in Czechoslovakia following the invasion, Obrdlik (1942) found that a good joke changed pessimists to optimists, and claims that "[gallows humor] is an unmistakable index of good moral and of the spirit of resistance of the oppressed peoples" (p.712). Thus, gallows humor created a space for itself among vulnerable people. Those who were persecuted joked to cope, and it was the most painful, despondent circumstances in which the darkest jokes had the power to lift spirits and fuel hope (Obrdlik, 1942; Ostrower, 2015). Even outside the extreme circumstances of war, gallows humor is a common response to death, and often finds itself somewhere in the grieving process. In a recent qualitative study of 424 grieving participants whose conversations with each other over dinner were recorded and scored, gallows humor was the second-most frequently used communication style (Lambert South et al., 2022).

Dark humor continues to be prevalent in trauma-and-crisis-centered fields (Sliter et al. 2015; Craun & Borke, 2015; Vivona, 2014; Evans et al. 2013), with much of the research in this area focusing specifically on healthcare occupations (Feudtner et al. 1997; Rowe & Regehr, 2010; Wear et al. 2006; Wear et al. 2009). Dark and derogatory hospital humor was highlighted early on through Samuel Shem's popular novel, *House of God,* which satirizes the dehumanization of patients by medical students and residents, namely through the use of medical slang and derogatory jokes (Shem, 1985). Nearly 15 years later, Feudtner et al. (1997) found dark humor in the hospital to be highly prevalent, with 98% of medical students across 6 medical schools in Pennsylvania reporting to have heard a resident or attending physician make dark jokes about a patient.

In addition to reviewing the literature on the function of dark humor among professionals working in trauma-and-crisis-centered fields, I will dedicate the second portion of this thesis to a review and analysis of the literature on the impact that dark humor may have on patients, specifically in the context of the medical field due to a lack of available literature for non-medical trauma-and-crisis-centered occupations. I will then suggest areas for further research where the current literature is lacking. By taking into account both the function and consequences of dark humor in trauma-and-crisis-centered fields for both professional and patient, as well as expanding the populations of interest to include non-emergency personnel, I hope to provide a thorough review of the literature, and encourage new directions for future research moving forward.

Dark Humor as a Coping Mechanism

Why use Dark Humor?

Out of the many types of coping mechanisms that someone exposed to trauma or death could use, dark humor is a popular choice (Lambert et al. 2022; Fuedtner et al. 1994; Rowe & Regehr, 2010). It is worth briefly exploring a few possible explanations behind why dark humor could act as a coping mechanism.

One of the reasons why humor might be used as a coping mechanism is because of its hypothesized relationship to our psychological well being. For example, some research suggests that the use of humor is linked to higher self-esteem (Kuiper & Martin, 1993; Martin et al. 1993), and an increased hardiness and resiliency when facing adverse life events (Kuier, 2010; Martin et al. 1993). Research also supports the idea that humor facilitates positive affective states while decreasing negative ones (Martin et al. 1993; Samson et al. 2014). Not only this, but it is thought that humor does this more effectively than serious reappraisal, so laughing or joking may make

us feel happier quicker, and to a higher degree than seriously reappraising an event (Samson et al. 2014). One study (Samson et al. 2014) showed university students 80 pictures from the International Affective Picture System (IAPS) depicting random objects and people. The students were told to either write a humorous response to the pictures, or a serious one, and they were also asked to rate how positive or negative they felt while looking at the pictures. The results showed that humorous coping was more effective at decreasing negative feelings and increasing positive ones in the short term, and it was also more effective at decreasing negative feelings in the long term compared to serious reappraisal. All of these positive outcomes suggest humor is a useful tool for coping, so why is *dark* humor specifically, which deals with the morbid and tragic, so popular?

Terror Management Theory (TMT) is a social psychology model which posits that because humans have an advanced cognitive understanding of our own mortality, we seek out psychological mechanisms to help us cope with the fear or anxiousness related to our impending deaths (Hackney, 2011). This theory relates to trauma-and-crisis-centered fields due to their frequent exposures to death (Scott, 2007; Vivona, 2014), and it may provide insight into why dark humor is used to cope. Hackney (2011) examined the connection between dark humor and TMT on 93 undergraduates, who were randomly assigned to either a *mortality salience*, or control group. The study found that when asked to rate the "funniness" of three comic strips varying in terror management (neutral to dark humor), the participants who had been made aware of their mortality rated the darkest comic strip as the funniest, while there were no differences in ratings within the control group. In a different study, Morgan et al. (2019) measured trait coping humor in 556 adults, and found that those who use humor to cope are less affected by mortality salience, or existential anxiety. Since dark humor seems to be useful for

coping with one's thoughts and fears about death, this might explain why many trauma-and-crisis personnel utilize it during their work day.

Coping with Occupational Stressors

Trauma-and-crisis-centered fields are considered high-stress environments (Rowe & Regehr, 2010; Johnson et al. 2005), with research highlighting low job satisfaction and poor health outcomes for workers in these occupations (Gandi et al. 2011; Johnson et al. 2005; Myren et al. 2013; Rocha et al. 2020). Information about 26 "high-demand" occupations pulled from a database of 25,000 people found that firefighters ranked third worst in psychological health (Johnson et al, 2005). Nurses may also experience poor psychological health outcomes, with another study finding that out of a population of 248 emergency nurses, 1 in 3 suffer from depression and anxiety, and 87% had experienced at least one traumatic event within the past 6 months (Adriaenssens et al., 2012). This finding is unsurprising, since research shows that the prevalence of PTSD symptoms is higher in emergency nurses (12%) than in the general population (6.8%) (Laposa & Alden, 2003; NIH, n.d.).

Low job satisfaction is also a common problem within trauma-and-crisis-centered occupations. In the same study of 26 "high-demand" jobs, paramedics ranked second in low job satisfaction, while police and medical personnel ranked third and eighth, respectively (Johnson et al. 2005). Research shows that job satisfaction is linked to burnout, suggesting that occupations that frequently rank the lowest on job satisfaction, are likely to report higher levels of burnout (Myren et al. 2013; Rocha et al. 2020). This is especially problematic for trauma-and-crisis-centered occupations, because burnout is further linked to absenteeism (Poncet et al. 2007; Rocha et al. 2020), somatic complaints (von Känel et al. 2020), and poorer job performance (Lemonaki et al. 2021). It has been suggested that workers are particularly at risk for developing

burnout when they feel they cannot adequately cope with the conditions of their job (Rocha et al. 2020). This could be where dark humor comes into play.

For trauma-and-crisis personnel, occupational stressors may look specifically like long shifts, demanding workloads, exhaustion, and frustration (Parsons et at. 2001). In the medical field, young residents may face the brunt of these stressors due to both their tiresome working conditions, and their coming to terms with the less-than-ideal reality of working in medicine (Andre, 1992). Dark humor is thus used to cope with these occupational stressors and mitigate burnout (Bouchard, 2016). Even medical students, whose perceptions of their senior's dark humor is mixed, and sometimes even disapproving (Fuedtner et al. 1994; Parsons et al. 2001), reveal an empathic understanding that their joking is a coping mechanism for "chronic sleep deprivation" and "demanding workloads" (Parsons et al. 2001, p.546).

Some have gone as far as to suggest that dark humor is a form of "compensatory nourishment" for these professionals who are constantly deprived of physiological needs such as sleep, and who are overworked and frustrated by both the limitations of medicine and the patients they cannot help (Watson, 2011). It could be that after working 12 hour shifts in a high-stress environment, and taking responsibility for not only the physical healing of patients, but also the emotional labor of knowing their trauma, that humor acts as a psychological snack bar or energy drink, giving the exhausted worker the push they need to go on. Without this push, trauma-and-crisis personnel risk becoming overwhelmed by not only burdensome occupational stressors, but negative emotional states as well (Rowe & Regehr, 2010; Wanzer et al. 2005; Watson, 2011; Wormer & Boes, 1997).

Coping with Negative Emotional States

Dark humor is often used in trauma-and-crisis-centered fields to cope specifically with the negative emotional outcomes influenced by working so close to trauma and death (Rowe & Regehr, 2010; Wanzer et al. 2005; Watson, 2011; Wormer & Boes, 1997). Interviews with medical personnel reveal a need to cope with sadness, hurt, and frustration (Parsons et al. 2001; Wear et al. 2009), as well as compassion fatigue (Bouchard, 2016; Hooper et al. 2010). In Bouchard (2016), nurses expressed compassion fatigue due to not knowing how their patients fare after being released from their care. One nurse shared that she would "go home wondering" if her patients survived, without ever being able to know for certain. Nurses also reported the witnessing of grief as the largest contributor to compassion fatigue (Bouchard, 2016). Experiencing not only the patient's death, but the family's grieving is particularly difficult, and was explained as an event that you take home with you. Nurses in this study preferred to use gallows humor rather than talking about the serious emotional events, claiming, "it's funny to us, but it's not funny" (p. 43), with another nurse adding, "they use humor to cover up all of their hurt" (Bouchard, 2016, p.43).

These nurse's self-awareness when acknowledging dark humor as a funny tool to mask their deeper hurt is also seen in other trauma-and-crisis-centered occupations (Scott, 2007). In a series of interviews with police officers, a traffic officer talked about using humor to cope after a man burned to death in his car following a road incident. During the debrief, they joked about him "getting knocked off for having no rubber on his tyres." The officer acknowledged the desire to cope after witnessing such a horrific event, further admitting, "it was terrible" (Scott, 2007, p. 355).

The fact that professionals in trauma-and-crisis-centered occupations may be clearly aware of the shocking and distasteful nature of their jokes while simultaneously leaning on them for emotional protection is a predicament directly related to their specific occupational context. This self-awareness also alludes to worker's mixed approval over the use of dark humor to cope, even if they themselves are telling the jokes. Sullivan (2000) examined the self-perceptions of 65 social workers and their use of gallows humor on the job, and found that while 15% felt that dark humor is "vital" to releasing tension at work, another 20% admitted to using dark humor despite having mixed feelings about it. Interviews with police officers also indicated contradictory feelings towards this coping mechanism (Evans et al. 2013). On one hand, officers reported using dark humor to cope with traumatic and stressful work incidents because they perceived opening up to their coworkers or asking for help as weak. On the other hand, officers simultaneously recognized that masking their hurt is unhealthy, and reported advising rookies against it (Evans et al. 2013).

Medical students also express mixed attitudes towards dark humor, particularly from the mouths of their seniors (Feudtner et al. 1994; Parsons et al. 2001). As a population, medical students provide a unique perspective because they occupy a space somewhere between the in-group and the out-group. For them, the medical context is still somewhat novel, but their first-hand experience grants them more insight than the average layperson. This could perhaps facilitate an internal struggle between an insider's acceptance of dark humor and an outsider's disgust with it.

Despite individual worker's varied responses to dark humor, some professionals say that dark humor and joking are seen as a measure of wellbeing and positive coping among coworkers, whereas an absence of humor indicates a problem with the emotional state of the team (Vivona,

2014). This has been reported by crime scene investigators, who are no strangers to the deceased. Semi-structured interviews with crime scene investigators reveal stories of digging through garbage bags for body parts, identifying victims who have been burned beyond recognition, and the smell of human decomposition (Vivona, 2014). One CSI team leader emphasized that if a new recruit could not handle the team's joking about their work's conditions, then the recruit was "probably not going to work out" (Vivona, 2014, p.134). In this sense, introducing a new employee to the dark humor used within a trauma-and-crisis-centered field may indicate to their coworkers how well that employee is estimated or perceived to function long-term with the requirements of the job.

Dark Humor as a Protective Mechanism

A rookie CSI's ability to successfully integrate into the team's joking culture may be of significance, not just because dark humor is thought to be a coping mechanism for negative emotional states like sadness and grief, but because due to the stressful nature of their jobs and contact with victims of crime, CSIs and forensic scientists are vulnerable to developing vicarious trauma and secondary stress (Slack, 2020). Not alone in their risk, other types of professionals in trauma-and-crisis-centered fields are also vulnerable to the development of vicarious trauma (Burruss et al. 2018; Regehr & Cadell, 1999; Regehr et al. 2002; Slack, 2020), secondary stress (Craun & Bourke, 2014; Regehr & Cadell, 1999; Regehr et al. 2002), and even post-traumatic stress (Alexander & Klein, 2001; Evans et al. 2013; McCammon et al. 1987; Sliter et al, 2014).

Vicarious trauma (VT) results from exposure to traumatic materials by-way-of other people who experienced the trauma first-hand, and manifests as negative changes in the way the professional views themselves, other people, and the world itself (Slack, 2020). Secondary-traumatic stress (STS) is almost symptomatically identical to PTSD, but occurs when the person

is exposed to the trauma and suffering of another person (Baird & Kracen, 2006; Slack, 2020). In short, trauma-and-crisis workers interact with victims, whose trauma can psychologically harm the worker, causing symptoms like sleep disturbances, intrusive imagery of the traumatic events, and a general negative outlook on life (Regehr & Cadell, 1999; Regehr et al. 2002).

When it comes to preventing these negative stress outcomes, research shows that dark humor may act as a buffer, decreasing the severity of symptoms (Sliter et al. 20014) and aiding the person in coping with them (Alexander & Klein, 2001; Dangermond et al. 2022). While traumatic events significantly predict signs of burnout and PTSD, coping humor has been shown to minimize the chances that traumatic stress symptoms develop in firefighters (Sliter et al. 2014). This suggests that the onset of PTSD or other negative stress outcomes may be avoided when humor is used to cope. Other emergency services also utilize dark humor to protect against stress symptoms (Alexander & Klein, 2001). In a study on ambulance personnel, one-third reported burnout and post-traumatic stress symptoms, but 71% of the study's participants reported using dark humor to cope with these symptoms (Alexander & Klein, 2001). These findings suggest that even if negative stress outcomes develop, dark humor may still benefit the worker by providing a means to cope with symptoms.

While trauma-and-crisis personnel may make jokes about patients and victims as a protective mechanism, research suggests that the characteristics of the patient or victim plays an important role in whether the use of dark humor actually decreases the risk of stress disorders. Internet Crimes Against Children (ICAC) task force members are at a high risk for developing secondary-traumatic stress as a result of their regular exposure to other people's–specifically children's–victimization (Craun & Bourke, 2015). An initial study of 500 ICAC personnel found that while lighthearted humor is significantly linked to lower STS symptoms, gallows humor is

inversely linked to higher STS symptoms (Craun & Bourke, 2014). However, a follow-up study made the further distinction that increased STS symptoms are only discovered among personnel whose jokes pertain to victims. There was no relationship between higher STS symptoms and the use of dark humor against perpetrators. This finding is interesting, because all of the victims within an ICAC context are children, which are commonly considered by trauma-and-crisis personnel as off-limits to joke about (Dangermond et al. 2022; Evans et al. 2013; Vivona, 2014; Wear et al. 2006; Wear et al. 2009). If a task force member suddenly begins violating a norm regarding who can and can't be joked about, we might start to wonder if there is a greater cause for concern related to their mental and emotional well-being.

Dark Humor and the Group

Who can we make fun of?

While children are often reported by trauma-and-crisis-centered personnel to be off-limits, they are not the only group that is considered "protected." Medical students report never making fun of cancer, terminal illness, or pregnancy loss (Wear et al. 2006). Outside of the medical field, police officers also frown upon making jokes about child victims (Evans et al. 2013), and CSIs agree, adding that victims who are personal acquaintances with a coworker are also left alone (Vivona, 2014). These accounts from trauma-and-crisis personnel allude to an unspoken moral code that dictates which kinds of victims or situations are deemed acceptable to joke about. To understand this code, it may be helpful to understand social norms.

A social norm can be understood as a kind of social contract for appropriate social behavior between individuals within a group (Cialdini & Trost, 1998). Sherif (1936) describes this as the "customs, traditions, standards, rules, values, fashions, and all other criteria of conduct which are standardized as a consequence of the contact of individuals" (p.3). One thing we can

take from this is a possible explanation behind the unwritten, unspoken "moral code" which may socially prohibit the use of dark humor against certain groups of people, due to its perceived inappropriateness or insensitivity. If sparing these chosen groups from jest is a social norm, the consequences for violating it could be unpleasant, causing feelings of guilt or shame, and creating interpersonal tension and judgment (Van Kleef et al. 2015).

If groups such as children, the terminally ill, or cancer patients are off-limits, then who are considered acceptable targets of dark humor? In focus groups, medical students frequently cited patients that are "at fault" for their conditions as targets of cynical and derogatory jokes (Wear et al. 2006). This category included obese patients, drug-users, people involved in criminal activity such as reckless driving, and anyone who is considered generally noncompliant (Wear et al. 2006). Whether or not these patients are actually culpable for their arguably nuanced situations, they are often deemed responsible by medical staff, and thus, branded as socially acceptable targets to make fun of (Wear et al. 2006). These patient profiles share in common the concept of deviance, which refers to the breaking of social norms (Goode, 2015). Deviance includes both minor social violations, such as dressing outside of a dress code or inappropriate eye contact with others, as well as more extreme violations, such as violent crime (Goode, 2015). People who are overweight (Maddox et al. 1968), people with substance-use disorders (Meier, 2014), criminals (Meier, 2014), and general rule breakers (Meier, 2014) are all examples of what society labels deviant, and if a patient is perceived as deviant by healthcare personnel, they may be considered acceptable targets of dark humor.

Group Power Dynamics

Along with social norms, dark humor interacts with the group by-way-of power dynamics. The interaction of group power dynamics between both the less-experienced and the

senior staff, as well as between professionals and patients, provide additional insight into how

dark humor functions within trauma-and-crisis-centered fields.

Some researchers use the *intergenerational transmission model* to explain cynical and

derogatory humor as learned behavior that is passed down by senior staff (Coombs et al. 1993;

Wear et al. 2006). Hospital culture is quick to socialize students and interns (Coombs et al. 1993;

Wear et al. 2006), and soon enough medical students pick up on the unspoken rules that dictate

under which conditions dark humor is to be used within the group. For example, medical

students report that it is common for an attending or resident to initiate dark humor in front of

students, but it is rare for a medical student to initiate dark humor in front of any senior staff

above them (Wear et al. 2006). Additionally, a group made up entirely of medical students is free

to share dark jokes amongst themselves, due to their equal standing (Wear et al. 2006).

A student's participation in the joking, regardless of their personal opinions about dark

humor, could also be influenced by a power dynamic between senior staff and themselves. Some

medical students report feeling uncomfortable with their senior's dark humor, but admit to

joining in and laughing along due to the fact that their mentors are figures of authority whom

they look up to (Parsons et al. 2001; Feudtner et al. 1994; Wear et al. 2006). Despite expressing

empathy for their patient's situation, they go along with the joke because it is facilitated by a

person with seniority.

A less common perspective on group power dynamics and dark humor is the concept of

relative power, and "joking up" (Watson, 2011). In this interpretation of power dynamics, it is

deemed socially acceptable for a person of less power to make fun of a person with more power

(joking up), whereas individuals with more relative power are not socially allowed to joke about

people with less power (joking down) (Watson, 2011). One might assume that dark humor

directed at patients is an example of the socially unacceptable "joking down," but a different

perspective suggests that we take into account relative power. Medical professionals are in a

position of privilege and authority compared to their patients, but some suggest that the patient

holds relative power over their providers by inadvertently denying them of their physiological

needs, such as sleep (Watson, 2011), or by threatening the physicians "sense of accomplishment

or need to be liked" (Andre, 1992, p.149). In the medical field, Watson (2011) alludes to a right-

of-passage that doctors must experience before being allowed to use dark humor. This came

about after a senior psychiatrist told a young doctor that they had not yet earned the right to joke

about patients, because the young doctor had not been in the field long enough (Watson, 2011).

Since he had not truly "suffered" the difficult and emotional working conditions of the hospital,

he could have been perceived to have more relative power over his patients, making his dark

humor less appropriate. The more seasoned psychiatrist has been presumably worn down by the

working conditions of the hospital (and perhaps, the greater context of working in a trauma-and-

crisis-centered field), so according to Watson (2011), their relative power would have decreased,

giving them more authority to joke. Overall, this perspective would benefit from additional

research and investigation, as it has not been discussed very much in the literature, however, it

still raises interesting questions about the interaction between dark humor and relative power

among professionals in trauma-and-crisis-centered fields.

In-Group Belonging

The use of dark humor in trauma-and-crisis-centered fields is also thought to be a

function of in-group belonging (Rowe & Regehr, 2010). A sense of in-group belonging is

important for trauma-and-crisis personnel because feeling like one is a part of the in-group is

associated with lower levels of occupational stress (Rose & Unnithan, 2015), and increased

resiliency (Scarf et al. 2016).

One way that members of a group can show in-group belonging is through special

language, such as slang (Coombs et al. 1993). Using specialized slang or jargon creates what has

been referred to as a "restricted code" (Rowe & Regehr, 2010), separating the insider from the

outsider. In the case of trauma-and-crisis-centered fields–particularly the medical field–this

restricted code can embody a derogatory or insensitive style of jest, such as describing dead

bodies as "crispy critters," "greenies" or "veggies" (Rowe & Regehr, 2010; Scott, 2007). Samuel

Shem's satiric novel, *House of God*, is a popular example of medical students using derogatory

slang and dark humor to describe patients in ways that would horrify non-medical personnel

(Shem, 1985).

Some suggest that this linguistic code fosters an "us vs. them" mentality, which facilitates

a sense of exclusivity among the in-group (the providers) against the out-group (their patients)

(Rowe & Regehr, 2010; Watson, 2011). Others point out that in-group dynamics can also be

applied to different hospital departments (Wear et al. 2006). Using the analogy of a "language

game," Wear et al (2006) explains how medical staff in a particular department are considered

the players, and the game only works if all the players know the rules–if they belong to the in-

group. If one member is ignorant of the code, it affects the whole team. A strong in-group

increases efficiency within the team (Watson, 2011).

Slang also plays an important role in forming intra-group bonds, which can aid teams

both during and after crisis situations (Moran & Roth, 2013). Since dark humor cannot be shared

with people outside of trauma-and-crisis-centered fields without risk of seriously offending the

recipient, the function of in-group belonging may provide trauma-and-crisis personnel a way to

cope with dark humor within a context that is more accepting. Among doctors, the use of

medical slang is at its highest during the internship years (Coombs et al. 1993), during which

residents work especially long hours, and experience high levels of occupational stress (Ebrahimi

et al. 2018). Since a "restricted code" fosters team unity and camaraderie (Rowe & Regehr,

2010), it may function to aid individual coping and resiliency by way of strengthening the in-

group.

Humor and Physiological Health

Another possible function of dark humor has to do with the connection between humor

and health. Dating back to biblical times, it has been thought that humor positively impacts our

physiological health (Martin, 2002). Modern empirical research, however, offers mixed results.

Whether it be reducing negative physiological symptoms through laughs, or protecting against

the development of them, an extensive review of the literature on humor's supposed link to

health reveals four theoretical mechanisms through which humor has been hypothesized to

benefit our health (Martin, 2002).

The first mechanism suggests that the physiological changes in the body that occur when

we laugh are beneficial to our overall health. For example, some researchers claim that laughter

relieves muscle tension, increases our immunity, and stimulates circulation (Martin, 2002). The

second mechanism claims that when we laugh, we experience a positive emotional state, which

is thought to increase pain tolerance and reverse the effects of poor cardiovascular outcomes

associated with negative mental states (Martin, 2002). The third argues that laughter helps us

cope with stress, which in turn reduces the risk of high blood pressure and poor immune

functioning, and the fourth mechanism suggests that humor indirectly benefits our physical

health by increasing our social support. This model predicts that people who laugh a lot are more

likely to attract other people, resulting in a larger social support system that can then aid them during times of turmoil (Martin, 2002).

This literature review's findings showed that even though there are many studies on humor and physiological health, the results are generally less than idealistic. While a few studies found a significant positive relationship between humor and immunity through increases in T-cells and NK cells (Berk et al. 1989; Berk et al. 2001), others found no such relationship (Kamei et al. 1997). Additionally, out of all the studies investigating humor and immune function, every single one was reported to lack "adequate controls and manipulation checks" (Martin, 2001, p.509). Blood pressure (White & Camarena, 1989), and life longevity (Friedman et al. 1993; Rotten, 1992) failed to show any connection to humor, however, pain tolerance was significantly linked to humor (Cogan et al. 1987; Weisenburg et al. 1995) with the caveat that researchers are unsure if it is the physical laughter or the feelings of amusement that interact with perceptions of pain (Martin, 2001).

While the methodology was strong in pain tolerance studies, further research should be conducted to clarify the exact conditions in which humor may help with pain. It has also been pointed out that some studies on humor and health lack controls which examine negative emotional states, like sadness or fear, and many studies have low replicability (Martin, 2001). Overall, better methodology is needed in this research to understand if health benefits contribute to the functionality of dark humor in trauma-and-crisis-centered fields.

The Effects of Dark Humor

Much of the literature on dark humor in trauma-and-crisis-centered fields dedicates itself to investigating the function of this humor for the workers (Moran & Roth, 2013; Rowe & Regehr, 2010; Scott, 2007; Sullivan, 2000). The next section of this thesis will shine a light on

another perspective, which peers into the effects of this humor on the institutions, and patients

they interact with.

On the Institution

The introduction of medical students into the medical institution is a defining period in

which the next generation of bright-eyed newbies are rigorously socialized to hospital culture

(Vaidyanathan, 2015). During and after medical school, it has been argued that students learn to

see patients as bodies, and patient's bodies as systems (Andre, 1992). Good & Good (1989)

claim that to a non-professional, a person includes a personality, but to a medical doctor, a

person can become "a thing of compartments, tubes, electrical system" (p.306). This dramatic

change in perspective has been described by researchers as traumatic (Piemonte, 2015), and

some have sought to put a name to this period of assimilation. Thus, the term "ethical erosion" is

used to describe the negative ethical changes and challenges that medical students experience

once they enter the hospital and begin their clinical clerkships (Feudtner et al. 1994). The

prevalence of self-perceived ethical erosion among clinical clerks has been reportedly high, with

61% having witnessed unethical behavior from their seniors, 67% feeling guilty about something

they did during their clerkship, and 62% admitting to feeling that "at least some of their ethical

principles had been eroded or lost" (Feudtner et al.1994, p. 670). Among the ethical dilemmas

mentioned, derogatory humor was a key concern, with clinical clerks even referencing pressure

to joke about patients under anesthesia (Feudtner et al. 1994).

Even though there are researchers who defend (Rowe & Regehr, 2010), and even

encourage gallows humor and "backstage" joking in the hospital (Watson, 2011), there are others

who challenge it (Aultman, 2009; Dharamsi et al. 2010; Piemonte, 2015). It has been suggested

that a mentor's use of gallows humor in the hospital not only sets a bad example for trainees, but

that it can even be traumatic for them (Piemonte, 2015). This may be due to the fact that gallows

humor is part of a "hidden curriculum" (Piemonte, 2015); it is not explicitly taught to medical

students, rather, it is perhaps something that is thrust upon them in the training environment,

providing a taste of life in the hospital as it really is, not what medical school ethics taught them

it would be. Clinician Jerald Kay's (1990) term, "traumatic deidealization," further describes the

"disillusionment" that is created when medical students are appraised by their mentors based on

the strict ethical standards that said mentors do not abide by themselves (Kay, 1990; Piemonte,

2015, p. 379).

In addition to the harm dark humor may bring to medical students, others argue that

derogatory and cynical humor undermines medical education, professional interactions between

coworkers, and the overall culture of the hospital (Aultman, 2009). We can, of course, empathize

with the doctors, nurses, and paramedics who find themselves in chronically stressful situations,

face-to-face with human suffering, however, Aultman (2009) claims that these conditions still do

not make cynical or derogatory humor moral. Trauma-and-crisis personnel are asked to sit in the

incongruity of being regular people as well as professionals who face death, illness, and gross

bodily fluids time and time again, yet, while it is important to remember that these professionals

also share in common with their patients the human condition, those in their care are still entitled

to humane and ethical treatment.

On the Patient

Some researchers point out the harm that dark humor may pose to patients, arguing that

even if the targets of derogatory and cynical humor are not physically injured by the verbal

attack, they may still face unforeseen consequences (Aultman, 2009). This could be because dark

jokes can reflect and encourage real-life stereotypes and prejudiced attitudes (Ford et al. 2017;

Hodson & MacInnis, 2016). The reinforcement and normalization of certain stereotypes could manifest in harmful ways, as reported by concerned psychiatric residents who worry that their jokes could create preconceived notions about their patients, with one resident stating that the jokes have the potential to "cloud their judgment" (Wear et al. 2009). If the culture of humor in a hospital interferes with healthcare provider's perceptions of their stigmatized patients, such as those receiving psychiatric care (da Silva et al. 2020), it is arguably cause for concern.

It has also been suggested that social distance may play a part in dark humor within trauma-and-crisis-centered fields, assuming our social distance from a particular context determines, in part, if we laugh or help (Dharamsi et al. 2010). This potential relationship still needs to be thoroughly researched, but if there is a connection between who we socially distance from, and who we make fun of, it could have relevant implications for groups of stigmatized patients, since stigma also influences who we socially distance ourselves from (Albrecht et al. 1982; Jorm & Oh, 2009; Turner et al. 2022).

Stigma involves having negative attitudes toward specific aspects of a person which carry a perceived "mental, physical, or social deficiency" (APA Dictionary of Psychology, n.d.), while prejudice refers to a preconceived judgment or opinion (Merriam-Webster, 2023). Humor has the potential to contribute to prejudiced attitudes towards stigmatized and marginalized communities, as seen in a study that examined whether or not exposure to derogatory jokes impacts participant's feelings towards the jokes targets (Hodson & MacInnis, 2016). Despite controlling for pre-prejudiced attitudes, Canadian participants showed increased negative prejudice towards Mexicans after exposure to derogatory jokes about them. This suggests that even if we claim to not share the beliefs expressed in a dark joke, humor has the power to influence our attitudes towards the people we joke about. In trauma-and-crisis-centered

occupations, these findings are particularly pressing, because prejudiced attitudes against stigmatized patient populations may impact the quality and quantity of care that these populations receive (Smedley et al. 2003).

Another study empirically tested if our humor preferences, that is, what we find funny, are determined by what we think is true (Lynch, 2010). The results supported the hypothesis that we laugh more when a joke aligns with our implicit biases. Despite there being limited research addressing humor and implicit bias, the findings from Lynch (2010) raise questions about if trauma-and-crisis personnel's implicit biases could be interacting with their use of dark humor about certain populations.

Implicit biases are unconscious, and develop from recurring exposure to stereotypes about groups of people (Chapman et al. 2013). Physicians have the same amount of implicit bias as the larger public body (Maina et al. 2018), but these biases run the additional risk of impacting their patient's quality and quantity of care (Cooper et al. 2012; Smedley et al. 2003; Todd et al. 1993). Furthermore, we tend to have negative implicit biases against marginalized communities and individuals (Baah et al. 2019; Schwartz et al. 2003; Smedley et al. 2003), meaning that implicit bias among healthcare professionals could contribute to larger health inequities (Baah et al. 2019; Johnson, 2020). For example, even death discriminates. Research shows that the perceived social value of patients being resuscitated affects how long, and with how much effort they are resuscitated (Sudnow, 1967; Timmermans, 1998). Older patients may be worked on for far less time than younger patients, and patients who are perceived to be "at fault" for their condition or of lower value to society, such as those with substance-use disorders, are also more likely to end up biologically dead after being deemed "socially dead" (Timmermans, 1998).

Questions about how dark humor might interact with our implicit biases and prejudices need to be empirically explored to a greater extent, since the literature is extremely limited. The findings from Lynch (2010), and Hodson and MacInnis (2016) give reason to suggest that a relationship exists, and more importantly, the research on the impact of healthcare personnel's implicit biases on marginalized patient's quality and quantity of care give urgent reason to investigate how dark humor in the hospital might contribute. This issue should be granted more attention in the social sciences, and since much of the current literature focuses on the medical field, other trauma-and-crisis-centered occupations should also be considered moving forward.

Discussion

We can't ignore the clear evidence that dark humor plays a vital role in helping trauma-and-crisis personnel cope with the conditions of their occupational context. An outsider cannot really grasp what it is like to consistently face the pain, suffering and (sometimes violent) deaths of other people, as well as taking on the emotional labor of consoling. In addition to this, the high-stress, fast-paced environment of many trauma-and-crisis-centered occupations leave little room for workers to breathe and recover after experiencing other people's suffering. A joke, in this instance, can be a quick and efficient way to pick oneself up again and get ready to care for the next person who needs them.

On the other hand, as important as it is to show compassion for the workers in these fields when they use humor that is perceived as socially unacceptable or offensive behind the scenes, we must not forget to show compassion to the individuals being joked about. Just because someone is hurting, it does not give them free reign to hurt others, and there is a delicate line that must be walked when deciding if dark humor would cause more harm than good in any given scenario. One factor that should be considered are the implications that dark humor could have

for already stigmatized groups of people, who are often the targets of jokes made by professionals. One should ask themselves how a dark joke could alter the care that is given, even subconsciously, by reinforcing implicit biases and stereotypes about certain patients. Recall the psychiatric resident who worried that jokes targeting their patients would foster preconceived notions about patients and their disorders (Wear et al. 2009). This is an area of research that should be given more attention. Despite the literature that supports a relationship between healthcare provider's implicit biases and prejudices with the quality and quantity of care that their marginalized patients receive, as well as the newer, less explored evidence that suggests a possible link between humor and our biases and prejudices, there is currently inadequate research to conclude whether or not dark humor used by trauma-and-crisis personnel has negative consequences for the people they serve.

Recommendations

Given the prevalence of dark humor in trauma-and-crisis-centered fields, specifically in healthcare, a few different recommendations have been made for how to practice good ethics. To start, medical students already take ethics courses, but it has been suggested that they would benefit from education that openly raises the issue of dark humor (Rowe & Regehr, 2010), rather than leaving students to learn about it more implicitly, through immersion into the hospital culture. As mentioned previously, dark humor in the hospital has been called a "hidden curriculum" (Piemonte, 2015), so rather than being discussed formally in an educational setting, medical students are expected to pick it up and learn the social rules of dark humor in their particular hospital on their own. One might ask if failure to properly prepare students for very prevalent, morally gray situations like this could lead to inconsistencies within and between

healthcare settings over if or how dark humor can be used. Perhaps it is worth including a discussion on dark humor practices during training to increase transparency.

While this transparency may start important conversations, it is still worth questioning how salient those lessons remain in the real world, i.e the clinical setting. Through the power of socialization, one might wonder if the biggest obstacle preventing medical students from appropriately coping with or without humor is their direct observation of dark humor and cynicism from residents and attending doctors. Piemonte (2015) argues exactly this, suggesting that the largest influence on a medical student's transition into their career is not school lectures or textbook chapters, but by the way in which they are socialized by other healthcare providers in a clinical environment. Nurses and doctors who make witty, but dehumanizing and inappropriate remarks about those in their care are the role models and teachers of the next generation of professionals. Even in other trauma-and-crisis-centered occupations, like CSIs and police officers, experienced employees and team leaders introduce and sometimes even encourage the use of dark humor among their rookies (Scott, 2007; Vivona, 2014). Thus, if dark humor is deemed inappropriate for professionals in trauma-and-crisis-centered fields, or perhaps even harmful to their working environment or the people in their care, then the biggest adjustments may need to come from those with more seniority.

Finally, there should be greater clarification between different types of dark humor when researching and discussing it in these occupational contexts. As one attending doctor explains it in Wear et al. (2009), the difference between gallows and derogatory humor is "the difference between whistling as you go through the graveyard and kicking over the gravestones" (pp.39). In my literature search, different types of dark humor were sometimes used interchangeably, and some were used while others were excluded for no explicitly stated reason. As mentioned in the

beginning of this paper, subcategories of dark humor have their own defining characteristics and definitions, which could impact which jokes are more acceptable than others. Gallows humor in response to losing a patient despite resuscitation efforts, for example, is characteristically different from derogating humor that makes fun of a patient's weight or substance-use disorder. While one might aid the worker to continue on with their day after a traumatic loss, the other targets characteristics of the patient for no obvious benefit to the worker–it is just a pass to be mean. Due to the variations of dark humor, future studies should consider differentiating between types of dark humor and their individual contributions and consequences within trauma-and-crisis-centered fields. The understanding gained from this may aid in determining if there are types of dark humor which are more fitted to be used for coping in professional settings, and others which are not.

Limitations

The biggest limitation to writing this thesis was the limited amount of research available, especially in regards to the second section of this paper which examines the potential effects of dark humor. Dark humor in the emergency services (and now, trauma-and-crisis-centered fields) is a niche subject area, and many studies focus exclusively on careers within the medical field, leaving a gap in the literature for other trauma-and-crisis-centered occupations related to the legal, social work, and some emergency response fields. Thus, we are unable to develop a more detailed and comprehensive picture of how dark humor is used in the working lives of professionals in these other fields.

Another limitation of this paper was the amalgamation of different styles of dark humor, which mirrors the greater literature of this subject. As previously noted, there is an important distinction between derogating and gallows humor, and between other types as well. However,

there is not enough distinction in the research, nor enough studies in general to review the

literature with only one style of dark humor in mind.

Conclusion

How do we show compassion for both the suffering of patients, and the doctors who treat

them? For the grieving of families, and the officers who must deliver this grief? There is much

more to learn about the potential impacts of dark humor in trauma-and-crisis-centered fields, but

if one thing is clear so far, it is the important and versatile functions that these jokes perform in

such difficult occupational contexts. Moving forward, we must continue to broaden the literature

to include more careers outside of the medical field that face death and trauma, and we should

take a closer look at how humor may interact with our biases and prejudices, which may in-turn

have implications for dark humor and the quality and quantity of care that communities receive.

Finally, we should distinguish between styles of dark comedy for future study, because using

gallows humor to quickly recover and refocus after a traumatic event is dissimilar to cracking a

demeaning joke about a patient under different circumstances. Whether it helps with coping,

creates a sense of group belonging, or benefits one's physiological health, both the prevalence

and the potential implications of dark humor in trauma-and-crisis-centered occupations suggests

that this is an important area of research that should call the attention of social scientists,

scholars, and anybody in need of trauma-and-crisis services.

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