Exploring the perceptions of nursing students and nursing academic lecturers on the use of gallows humour in the clinical setting.

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Abstract

Past research on gallows humour in a healthcare context has generally focused on justifying its use by healthcare professionals during stressful situations as a temporary relief from the tragedy that is occurring. Some previous research takes the alternate view that the use of gallows humour, regardless of the reason, is unacceptable in any situation. Most research has focused on the response of nurses and doctors with a small amount looking at the perceptions of medical students.

There is currently no research that reflects how undergraduate nurses view the use of gallows humour in the clinical environment or how they deal with their feelings relating to gallows humour. In fact there is little literature that examines how nursing students cope with the tragedy that can occur in the clinical area or how nursing educators can help student nurses cope with the stressors they experience in clinical placements.

This research aims to investigate the perceptions of students enrolled in any of the three years of an undergraduate nursing degree programme. The research was also triangulated as it correspondingly included the nurse lecturers who are in charge of the teaching and learning for students. The purpose behind including lecturers was to compare their results with students and determine if there were differences in perception between those with a vast amount of clinical experience as compared to those who were just beginning.

The research is informed by pragmatism, which considers views from two perspectives, in this case students and nurse lecturers. Given the differences in clinical experience between participants, pragmatism gives the research a more balanced overview of the perspectives of nurses in the clinical area.

Data was collected using an online questionnaire. Although the questions for each group were broadly similar there were slight differences incorporated to accommodate the differences in clinical experience. Responses from 55 students and 10 lecturers were considered. A thematic analysis revealed some similarities between students and lecturers in that some students agreed with the nurse lecturers that gallows humour is not offensive if used appropriately for stress relief and coping.
The biggest differences came between students. Generally older students believed they were more able to speak up if offended by the humour used whereas younger students did not feel like speaking up was an option for them. However students in year three, the final year of the degree programme, felt less empowered to speak out regarding gallows humour if offended. These students felt that speaking up would make them stand out for negative reasons which they considered could impact on their chances of securing employment once they pass and become registered.

These findings can contribute to the current literature by adding perspectives from both nursing students and nurse lecturers with clinical experience, something that was missing from the current literature. This research also highlighted some issues student nurses have with the use gallows humour. The research also highlighted how students in their last year of undergraduate nursing school feel especially vulnerable in regards to the clinical experience and how important they think it is for them to be seen positively. This was the major factor determining whether or not students felt they would speak up if offended by the use of gallows humour.
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# Table of Contents

Preface .................................................................................................................. 1
Positioning the researcher ..................................................................................... 1

1. Introduction ........................................................................................................ 2
   1.1 Thesis introduction ...................................................................................... 2
   1.2 Background to the research ....................................................................... 4
   1.3 Research question and aims ....................................................................... 5
   1.4 Overview of results .................................................................................... 6

2. Literature review ................................................................................................ 7
   2.1 Chapter introduction .................................................................................. 7
   2.2 How the literature review was conducted ................................................. 7
   2.3 Defining gallows humour .......................................................................... 9
   2.4 Theories of gallows humour ..................................................................... 11
   2.5 Relief theory ............................................................................................. 11
   2.6 Superiority theory .................................................................................... 12
   2.7 No one theory works completely .............................................................. 14
   2.8 Inappropriate humour: jokes and nicknames .......................................... 15
   2.9 The functions of humour .......................................................................... 16
   2.10 Positive and negative side effects of the function of humour ................. 18
   2.11 Stress, compassion fatigue and the caring professions ......................... 20
   2.12 Gallows humour as a coping mechanism .............................................. 22
   2.13 Gallows humour in other settings ......................................................... 25
   2.14 Ethics of gallows humour ........................................................................ 26
   2.15 Chapter summary .................................................................................... 30

3. Methods ............................................................................................................. 31
   3.1 Chapter introduction.................................................................................. 31
   3.2 Ethical considerations .............................................................................. 33
   3.3 Methodology ............................................................................................ 35
   3.4 Research design ....................................................................................... 37
   3.5 Questionnaire design .............................................................................. 39
   3.6 Questionnaire development ..................................................................... 39
   3.7 Piloting questionnaires ............................................................................ 41
   3.8 Participants ............................................................................................... 43
   3.9 Recruitment .............................................................................................. 44
   3.10 Data collection ......................................................................................... 45
   3.11 Data analysis ............................................................................................ 46
   3.12 Chapter summary .................................................................................... 47

4. Results ............................................................................................................... 48
   4.1 Introduction ............................................................................................... 48
   4.2 Response and completion rates: Students ................................................. 48
   4.3 Socio-demographic information .................................................................. 50
   4.4 Qualitative understanding of gallows humour and thematic analysis ....... 51
   4.5 Speaking up if offended ............................................................................ 52
   4.6 Responses by students who have not heard gallows humour ................... 58
   4.7 Speaking up if gallows humour is inappropriate ...................................... 63
   4.8 Ethics of gallows humour ........................................................................ 64
   4.9 Gallows humour as ethical if not heard by patients and family ............... 70
   4.10 Student results summary ....................................................................... 70
Table of Figures and Tables

FIGURE 1: FLOW CHART OF LITERATURE SEARCHES .............................................................................. 9
FIGURE 2: STUDENT RESPONSES PER QUESTION .................................................................................. 49
FIGURE 3: RESPONDENTS’ ETHNICITY ...................................................................................................... 50
FIGURE 4: STUDENT AGE/YEAR PROFILE ................................................................................................ 51
TABLE 1: NUMBER OF STUDENTS WHO HAD OR MAY HAVE HEARD GALLOWS HUMOUR ......................... 53
FIGURE 5: COMPARISON OF ABILITY TO SPEAK UP ACCORDING TO AGE GROUP AND YEAR ENROLLED ........ 56
FIGURE 6: ANTICIPATED REACTIONS IF HEARD GALLOWS HUMOUR ....................................................... 59
FIGURE 7: REACTIONS ANTICIPATED FOR STUDENTS WHO HAD NOT HEARD GALLOWS HUMOUR .............. 61
FIGURE 8: HYPOTHETICALLY: SPEAKING UP IF GALLOWS HUMOUR WAS INAPPROPRIATE ....................... 63
FIGURE 9: IS GALLOWS HUMOUR ETHICAL? .............................................................................................. 65
FIGURE 10: DO YOU THINK GALLOWS HUMOUR IS AN ACCEPTABLE FORM OF COPING? ....................... 66
FIGURE 11: HUMOUR AS ACCEPTABLE ACCORDING TO YEAR ENROLLED .................................................. 67
FIGURE 12: ETHICAL IF USED FOR COPING ACCORDING TO AGE GROUP .................................................. 69
TABLE 2: STUDENTS UNDERSTANDING OF GALLOWS HUMOUR .............................................................. 71
TABLE 3: ALTERNATE WORDS USED TO DESCRIBE GALLOWS HUMOUR .................................................. 71
TABLE 4: REASONS WHY STUDENTS WILL/NOT SPEAK UP ......................................................................... 71
FIGURE 13: LECTURERS’ YEARS OF TEACHING AND CLINICAL EXPERIENCE ............................................. 73
FIGURE 14: LECTURERS’ ETHNICITY .......................................................................................................... 74
FIGURE 15: IS GALLOWS HUMOUR USED BY HEALTHCARE PROFESSIONALS ETHICAL? ....................... 78
FIGURE 16: IS GALLOWS HUMOUR AN ACCEPTABLE FORM OF COPING? .................................................. 80
FIGURE 17: GALLOWS HUMOUR ETHICAL IF NOT HEARD BY PATIENTS AND FAMILIES .......................... 80
TABLE 5: SUMMARY OF LECTURERS’ DESCRIPTIVE ANSWERS .............................................................. 81
Preface

Positioning the researcher

I am a Registered nurse with 13 years of clinical experience followed by 10 years of experience teaching in an undergraduate-nursing programme where I currently work as a senior nurse lecturer. During my clinical career I often encountered the use of gallows humour. Sometimes my colleagues would initiate it and at other times I would do so. While I do not remember the content of the gallows humour used, I do remember it was always at difficult times, often when there were serious consequences for the patient we were caring for. Thinking back, gallows humour just seemed to happen, no one really thought about it, sometimes we laughed and sometimes we did not. I honestly cannot recall if it helped but it was used often enough that I thought it must serve some purpose.

When I started teaching undergraduate nurses, I began to understand that student nurses often did not see things the way seasoned professionals did. This came as a result of a discussion with a second year student who was offended at what was being said in an operating theatre when things were not going well. It became clear that the healthcare professionals were using gallows humour. I understood why this was happening, but the student struggled. We talked about it and I tried to explain why gallows humour was used but to no avail. For her this was just completely offensive and how could people who care enough to become healthcare professionals be so callous. As time moved on I had a few other students with the same reaction and also some students who were able to see beyond what was said and comprehend some of the nuances of using gallows humour. However, I always remembered that first student, her response, how appalled she was and how I did not really understand her perspective as well as I could have. This is what led me to this research.
1. Introduction

1.1 Thesis introduction

If you have ever worked in healthcare, then chances are you have encountered gallows humour. Gallows humour is a type of humour that historically has been used during times of tragedy in order to cope with what is occurring (Parsons, Kinsman, Bosk, Sankar, & Ubel, 2001). Gallows humour is used in situations which are considered hopeless or grave but not necessarily funny (Watson, 2014), where the stakes are often high and people are seriously ill or injured and may even die, and helps healthcare professionals cope with what is happening (Moran & Massam, 1997). Healthcare professionals, who confront the life and death experiences of patients they are caring for, commonly use gallows humour (Christopher, 2015).

The phenomenon of gallows humour (also known as black humour) has been around for a very long time (Morreal, 2013). It can be defined as: “a style of humour that treats serious, frightening or painful experiences such as illness, trauma and even death in a light-hearted way” (Obrdlik, 1942; Watson, 2011). Gallows humour gets its name allegedly from a time when people were sent to the gallows for their crimes. Often on the way some form of humour would occur and relieve some of the tension experienced in these moments. Many theorists, including Socrates and Plato, both ancient philosophers, and Freud, a psychoanalyst, have discussed the use of gallows humour and the ethics of its use, and attempted to define why people use it (Bardon, 2006). All have contributed to the theories that today provide different perspectives that may help us to better understand why gallows humour is used during stressful times.

The use of gallows humour is ubiquitous and often makes its appearance when people need to cope with difficult experiences. It is often used by very different people to get through some very difficult times: by prisoners of war; people in concentration camps; and commonly today by people working as police, fire fighters, doctors and nurses (Frankl, 2004; Samson & Gross, 2012). Using gallows humour is largely attributed to an effort to cope with extremely difficult situations and the stress and anguish that accompany such incidents (Nahas, 1998; Olin, 2016; Tremayne, 2013; Vivona, 2014). For example it is well documented that police officers, paramedics and fire fighters will use gallows humour when dealing with tragic events either during the time they are at the scene or shortly after in a debrief (Coughlin, 2002; Moran &
Therefore it should be no surprise that gallows humour is often used by healthcare professionals (Rowe & Regehr, 2010; Watson, 2014) in the course of their working lives to cope with what they encounter.

While people often have their own opinions regarding the use of gallows humour, several theories have been developed to explain why it occurs during difficult situations. These include relief theory, incongruity theory and superiority theory (Charman, 2013; McCreaddie & Payne, 2014; Robbins & Vandree, 2009; Storey, 2014). Each has its own philosophical take on why gallows humour makes an appearance during serious situations. Two theories most obviously related to gallows humour are relief theory and superiority theory. Relief theory sees humour in general as relieving tensions in order to cope (Kulka, 2007; Morreall, 1998; Wilkins, Eisenbraun, 2009). Relief theory was first looked at by Freud and Spencer and viewed the use of gallows humour as a way of getting relief from the difficulties experienced in very tense situations. Superiority theory, which is the oldest of the theories and was first considered by Plato, Aristotle and later Hobbes, attributes using humour in difficult times to make us feel superior to the person in the difficult situation which in turn provides some relief from any difficult feelings one may be having (Morreall, 2009). A third theory of humour, incongruity theory (which is associated with Kant) can be identified, but it is not described here, as its explanatory power (Morreall, 2009) with respect to gallows humour appears rather limited.

Having theories is helpful in providing a basis for understanding why humour may occur in such serious situations. However it is also important to have evidence that explores how those who are actually involved in caring for those people in difficult situations feel about the use and appropriateness of gallows humour. There is a lot of research that looks at the perspective of healthcare professionals working in clinical areas, particularly doctors, paramedics and (somewhat fewer) nursing professionals (Dean & Major, 2008; Wear, Aultman, Zarconi, & Varley, 2009; Wooten, 1996). However, there is a paucity of research that looks at the views of nursing students, who by the very nature of being in clinical areas will at some point no doubt be exposed to the use of gallows humour. This research therefore focuses on the perceptions of nursing students currently enrolled in an undergraduate-nursing programme.
As nursing lecturers are pivotal to students’ education it is important to gain their perspective of gallows humour as well. Nursing lecturers work closely in clinical settings with students and are often the first person students will report to should something occur that has made them uncomfortable. Therefore gaining an understanding of any similarities and differences in the perception of gallows humour that may exist between the two groups strengthens the research and brings a more complete understanding of the various perceptions of the use of gallows humour.

In the literature some of the discussions and research involved nurses (Dean & Major, 2008; Wear, Aultman, Zarconi & Varley, 2009; Wooten, 1996), however there is no research that looks specifically at nursing students or those involved in their education. As gallows humour is commonly used in clinical arrears and nursing students are in these areas there is a chance that they will be exposed to the use of gallows humour. It is important to gain some insight into how they view the use of gallows humour, especially as it can be contentious and has the ability to offend some (Bennett, 2003; Coughlin et al., 2002; Morreall, 2009; Perks, 2012). Consequently, understanding how students and lecturers view the use of gallows humour will not only add to the literature but also help lecturers and nurses in general help students understand the use of gallows humour and guide them through how they are feeling about its use.

1.2 Background to the research

Working in healthcare today can be a very stressful job (Rowe, 2010; van Wormer; Boes, 1997; Watson, 2014). External pressures such as budget restraints and cutbacks, coupled with the day-to-day stress of trying to help people who are sick and may well die, can be tremendously difficult to handle (Chinery, 2007; Rowe, 2010; Sobel, 2006; Watson, 2014). Health professionals are exposed to a high degree of tragedy, grief and loss whether expected or unpredicted (Chinery, 2007; Watson, 2014). Exposure to such life changing events can contribute to elevated experiences of stress and tension and have the potential to lead to burnout and consequently poor health if not addressed appropriately (Chinery, 2007). It is therefore important for people working in such high stress areas that they have effective coping mechanisms and find ways to manage stress.
1.3 Research question and aims

The question that formed the basis for this research is: How do students and academic staff perceive the use of gallows humour in the clinical setting? During their clinical experiences student nurses are exposed to the use of gallows humour, yet there currently is no research that examines their views of gallows humour used in clinical settings. Nursing lecturers, unlike students, have a tremendous amount of clinical experience and therefore are more likely to have experienced or even used gallows humour in the course of their clinical work.

While there is some literature regarding registered nurses and gallows humour it was limited when compared with other healthcare professionals. Authors Bennett, 2003; Buxman, 2008; Kuipera, Kuipers, & Kuipera, 2012; McCreadie & Wiggins, 2008; Strudwick, Mackay, & Hicks, 2012 have published articles regarding nurses and the use of gallows humour. As a result this research aims to provide insight into the views of nursing students and triangulate this with the views of their lecturers in order to gain a deeper understanding of gallows humour. With this in mind, the aims of this research are to:

1. Understand how nursing students and academic nursing staff perceive the use of gallows humour in the clinical environment;
2. Explore whether nursing students and academic staff see gallows humour as justifiable; and if so under what circumstances
3. Assess under what circumstances gallows humour is justifiable.

This research employs an exploratory, descriptive approach using open- and closed-ended questionnaires for each group of participants. The research focused on nursing students and nursing lecturers who have direct contact with students during clinical learning experiences in order to gain an understanding of their perceptions of the use of gallows humour. This research will not only add to the literature but it is hoped it will also give some insight into the perception of gallows humour and better understand why students and lecturers perceive it the way they do.
1.4 Overview of results

The research showed that students were divided on the appropriateness of gallows humour in the clinical environment. Even where it was clear that the unwritten rules were followed, such as ensuring patients and their families couldn’t hear it and the humour being about the situation not the person, one in five students felt that the humour was unethical. Another third of students gave a neutral response, indicating that it could depend on the context. The lecturers were more accepting in these situations.

Common themes arising from that majority in both sets of responses were that:

1. Context is important, it matters where and when gallows humour is used;
2. Gallows humour is ethical when used in the right context and not in front of patients or their family members; and
3. Gallows humour is an acceptable form of coping or way of managing or relieving stress in the moment of serious incidents so that people can carry on with their work.

For lecturers, the research suggests that they were unaware that students felt any distress when they heard gallows humour. It is not clear whether this is due to students’ not feeling distress or just not talking about it nor displaying any distress signals. This thesis did not therefore reach a conclusion as to how lecturers can respond if students are distressed, beyond the support they already provide in their clinical visits. This could provide an interesting area for further, more focused exploration.

The research produced some other interesting results which haven’t been explored in depth in this thesis but could provide a basis for future study. The themes that emerged were:

1. Some students were offended by the use of gallows humour but felt powerless to speak up, particularly students in their final year of study who were concerned about the impact that speaking up might have on their chances for future employment;
2. Older students were more comfortable than younger students about speaking up if they thought the gallows humour was inappropriate; and
3. Both lecturers’ and students’ responses yielded comments regarding culture and ethnicity and how they might impact on the person’s perception of gallows humour.
2. Literature review

2.1 Chapter introduction

This chapter examines the literature relating to gallows humour and its use during difficult times. It starts with the functions of humour and then looks at ethical considerations of the use of gallows humour and the kinds of jokes considered to be unethical. This is followed by some ideas about what it means when humour is negative and the kinds of effect negative humour can have when used.

Due to the complexity of the use of gallows humour and the propensity of people working in the healthcare professions to use gallows humour to cope with difficult situations, it can be awkward to discuss the topic in a logical way. To address this problem this literature review is organised under the following themes:

A. Humour:
   • Defining humour and its function especially in relation to its use in the clinical environment.
   • The inappropriate use of humour and the positive and negative effects of humour.

B. Gallows humour:
   • The theories used to explain why gallows humour is used
   • The ethics of its use.

C. Stress:
   • Gallows humour as a coping mechanism
   • The use of gallows humour to survive in extreme circumstances

2.2 How the literature review was conducted

A limited literature review was undertaken initially in order to gain ethics approval and ensure that there was something this research project could add to the existing literature. This initial search revealed that gallows humour is a complicated phenomenon. As a result it was decided to conduct the literature review in stages. During the initial literature review for ethics approval it was noted that including the words sick or black that are sometimes used in place of gallows produced results that did not relate to humour. For this reason the terms sick and black were omitted in this literature search.
During the literature search some words were truncated. The term nurse was truncated to nurs* in order to capture the different forms the word can take such as nurses, nursing or nurse and similarly medicine was truncated to med*. Gallows humour was searched as a phrase and humour was truncated to hum*, as depending on where you are in the world it can be spelled humor or humour.

The first search used the key terms gallows hum* AND nurs*, this resulted in 3974 pieces of work. When the keyword students was added the number was reduced to 394. Following this stress AND coping were added giving the search 169 results. The final addition was compassion fatigue and this reduced the number to thirty-two.

A similar search was conducted using the key terms gallows hum* AND paramedics AND stress AND coping. This resulted in seventy-two pieces of work. As in the first search the word students was added and this reduced the number to eleven. It was noted that many of the results were the same as the articles found using nurse instead of paramedics. The flow chart below illustrates the iterative searches conducted.

A final search using the same key words as above and substituting med* for nurs* yield 217 results. Adding students to this search reduced the number to 109 and again many of the same articles appeared in this search as in the previous ones. This search is also illustrated in the flow chart below.
The main finding of this literature review is that gallows humour is used in order to help people cope with the difficult situations healthcare professionals encounter in the course of their daily work. It is a quick remedy in the heat of the moment that allows a person some kind of distance, giving them a chance to refocus and then carry on with the work at hand. It also found that while many people believe gallows humour to be ethical they also believe that where and when gallows humour is used as well as who is around to hear it is important. There seems to be a kind of unwritten rule that it is never used in front of patients, family members or friends of the patient.

2.3 Defining gallows humour

Humour it seems is ubiquitous, we encounter it in an enormous number of situations and in many forms. The difficulty when studying any form of humour is the complexity of defining what it is; the many forms humour can take further complicates this. Humour can take the
form of puns, riddles, exaggerations, mimicry and sarcasm (Kulka, 2007) among others. Further complicating a definition is the fact that humour also has social and contextual factors (Hull, Tosun, & Vaid, 2017).

One form humour can take is what is known as gallows humour. Definitions of gallows humour take various forms. For example, gallows humour has been defined as a type of humour that is used to make jokes or humorous comments about hopeless or worrying situations such as death and illness (Cambridge Dictionary; Oxford Dictionaries). It is recognised that it has been used historically during times of tragedy in order to cope (Moran & Massam, 1997; Parsons, Kinsman, Bosk, Ubel, 2001; Watson, 2011). Watson (2011) explains gallows humour as a kind of humour that treats otherwise frightening, painful or serious matters in a light-hearted way, arguing that events which are life threatening, disastrous or terrifying are perfect fodder for this particular kind of joking. Others note that gallows humour often arises often arises from the misfortunes of others and involves taboo subjects such as illness, injury, tragedy and death (Strudwick, Mackay, & Hicks, 2012; Watson, 2014). This definition can and probably should be extended to include that it is also a type of humour that is grim, macabre and can be scatological in nature (Buxman, 2008; Strudwick et al., 2012).

Taken together, the elements of a definition of gallows humour seem to include aspects related to its nature, aspects related to its setting, and aspects related to its purpose. Very simply stated, its nature is shared with humour in general. This will be further discussed below under theories of humour. The setting includes situations which are considered hopeless or grave but not necessarily inherently funny (Watson, 2011). Its purpose includes its use as a coping mechanism for healthcare professionals who confront the difficult life and death experiences of patients they are caring for (Watson, 2011).

A further complication is that humor is always situated in a broader context that sometimes requires a lot of external knowledge to fully understand it. This is especially true for gallows humour in a clinical setting, where when trying to share the joke, a sense of “you had to be there” happens outside of the original context and those not present during the initial joke just may not understand it. Despite the difficulty with defining humour, one thing that remains consistent is the theories that attempt to explain why humour exists and why we use it.
2.4 Theories of gallows humour

While there are several theories that explain humour, the two most written about in relation to gallows humour used by healthcare professionals are relief theory and superiority theory. Both theories have deep roots and connections to philosophers such as Kant, Plato and even the father of psychoanalysis, Freud (Bardon, 2006). These theories point to the use of humour as a conduit for the release of stress and tension associated with a situation or the day to day stress of caring for people who are ill (Bardon, 2006; Wilkins, & Eisenbraun, 2009). Each of the many theories in existence encapsulates only one view on why some people find humour in situations and others may not (Raskin, 1979) and each only explains one aspect of humour. While each theory may have merit, no single theory completely explains why humour is used but almost all point to the notion of relief from a tense situation as a function of gallows humour, if not humour in general.

2.5 Relief theory

Relief theory was developed in the mid-1800s and was picked up and further explored by Freud (Charman, 2013; Mccreadie & Payne, 2014; Robbins & Vandree, 2009; Storey, 2014). In about 1860 English philosopher Herbert Spencer indicated that humour and any associated laughter resulted in the release of built up energy and feelings one may have suppressed (Hawkins, 2008). This theory is closely related to what science was thinking at the time concerning how the nervous system worked. During this time it was believed that within the nervous system were gases and liquids known as animal spirits that connected to nerves. These nerves were in turn connected to the brain, sensory organs and muscles by a complex series of tubes, whereby pressure known as emotional excitement builds up and needs to be released (Morreall, 2009). Spencer believed that the body’s emotions take the form of nervous energy and once this energy reached a certain level, people release their emotions like anger in order to find relief. In terms of gallows humour, this relief is found through the use of joking and any associated laughter that may occur (Morreall, 2009). While today we have a much different understanding of how the nervous system works, we still acknowledge a need for humans to find release from stressful and tense situations as demonstrated in the literature.

The famed psychoanalyst Freud contributed to relief theory in that he believed telling a joke in stressful and tense conditions can be liberating, Freud thought it was better to release the
tension by telling a joke than it was to demonstrate the aggression one may be feeling (Mathew & Vijayalakshmi, 2017). The humour produces a feeling of pleasure (Watson, 2015) and it is this pleasure that reduces the stress and relieves the tension that may have built up (Mills, 2011; Watson, 2015; Wilkins & Eisenbraun, 2009) which is the essence of relief theory.

This theory suggests that humour, which includes gallows humour, gives people the opportunity to be able to deal with the pressure and intensity of emotions felt when providing care for people (Bardon, 2005; Watson, 2011). Relief theory explains that the laughter is a result of the release of nervous or emotional tension experienced in tragic or trying circumstances encountered by health professionals in the clinical environment (Wilkins & Eisenbraun, 2009). Humour provides relief from the strain and allows people to remove themselves mentally and emotionally, even if only briefly, so that they can carry on (Smuts, 2010; Watson, 2014; Wilkins & Eisenbraun, 2009). While gallows humour may evoke laughter, the real purpose is not to laugh but to help people cope by providing temporary relief. Gallows humour can also foster the strength to continue whereas otherwise the pressure could cause excessive stress and make continuing difficult (Watson, 2011).

Gallows humour offers people a protection from the raw experience of tragedy occurring around them, and the feelings they are experiencing, by providing a sense of relief. Using gallows humour releases the stress by easing the unbearable horror witnessed and the sense of helplessness experienced (Rowe & Regehr, 2010).

2.6 Superiority theory

Superiority theory has its roots in philosophy of the 18th century and also includes the musings of ancient philosophers such as Aristotle, Plato and (in the 17th century) Hobbes (Charman, 2013; McCreaddie & Payne, 2014; Storey, 2014). Superiority theory, which is also sometimes referred to as hostility humour, is the oldest of the theories. For superiority theory, the humour results from providing a sense of superiority (Morreall, 1998). There may also be a major crossover with relief theory, as it may be said that the amusement comes from the sense there is relief that we did not make the mistake or suffer the misfortune of the person being joked about (Coughlin III, 2002; Jones & Wheaton, 1997). It is believed this happens because people have an innate predisposition to protect themselves (Hall, 2005).
The purpose of humour according to superiority theory is to make us feel better or superior by finding humour in the misfortunes of others. Hobbes truly believed that the purpose of humour was to ridicule (Banas, Dunbar, Rodriguez & Liu, 2017; Jones & Wheaton, 1997; Morreall, 1998) and believed that humour comes from a sudden sense that we are superior to others (Coughlin III, 2002).

Superiority theory and the kind of joking it involves is created from a power difference and superiority over others. According to Mills (2011) this is powerful in that it has the potential to lead to disturbing behaviour, as there is always a person who holds the power over someone else. Power can lead people to do and say things they may not otherwise say, especially if they were not usually in a position of power. Superiority theory is often linked to jokes that involve negative stereotypes involving gender and marginalized racial or ethnic groups and so forth (Olin, 2016; Vivona, 2013). These jokes are often worrying as they can be symptomatic of larger problems such as racism, sexism or homophobia, and are generally considered to be wrong (Anderson, 2015).

There is also the troublesome behaviour of someone excusing an offensive joke, as “It’s just a joke”, especially when the joke has not been well received. The terms “just joking” or “it was just a joke” are an attempt to alleviate any offence perceived or tensions arising from a failed joke (Haugh, 2016; Skalicky, Berger & Bell, 2015). Superiority theory identifies more strongly the moral hazard of gallows humour due to the nature of the inherent power structure being emphasised, or epitomised, by the jokes.

On a more positive note, superiority theory is also often used to explain why jokes exist in places like concentration camps as the humour gives people a feeling of superiority in order to resist the oppression they are experiencing (Friederichs, 2015). An example is Viktor Frankl who used humour in a way that helped wrest power back from his oppressors, in effect saying you can abuse, break and kill me, but you do not control the essence of me and I am superior to you in that sense.

Craun & Bourke's (2015) indicate that police officers working in the area of child sexual abuse often make jokes about the perpetrators of the sexual assault. This example of joking may indicate a link to superiority theory, whereby perhaps those who are working in this area feel superior to the perpetrators of child sexual assault and the officers find some relief in that
feeling of superiority. Jokes linked to superiority theory often have elements of clear winners and losers (Vivona, 2013) and in this instance police officers are the clear winners. Furthermore superiority theory has strong link to hostility (Olin, 2016) and it would not be a stretch to imagine those involved in seeking out perpetrators would hold some hostility towards them.

Whatever the theory used to explain the use of gallows humour, the claimed underlying benefit is that it aids the healthcare professional in coping with the reality of what is happening and enables them to carry on. Moreover both relief and superiority theory, while differing in how they describe aspects of using humour, have a link to providing relief in difficult situations.

2.7 No one theory works completely

The theories are perhaps as complex as humour itself in that no one really seems to understand why we find humour in tragic or difficult circumstances. The question that arises is this: can a single theory really explain why humour is used during times when it is seemingly a humourless situation? The answer to this is, yes kind of and no not completely.

Each theory has merit in explaining why people engage in humour however each theory only describes one aspect of humour and why people find amusement (Olin, 2016). For example relief theory, as Olin (2016) notes, does not offer an explanation as to why humour can occur or why jokes occur spontaneously. Likewise, superiority theory has no explanation for the amusement of puns or logical jokes (Olin, 2016). However in many instances they do seem to share the common element of giving people in difficult situations the ability to cope by providing relief.

No healthcare professional actually finds suffering and death funny and the frustration of not being able to help is often a painful experience for them. However, regardless of the theory used to explain the use of humour in jobs where people are regularly exposed to human tragedy, adversity and suffering, there are some commonalities in what using humour provides. Regardless of the role or reason humour is used, many authors believe humour used in stressful situations replaces the negative feelings with ones that are a bit more positive which gives people caught in the situation a chance to cope with what has occurred (Perks, 2012). Positive
emotions help provide a psychological buffer and create a distance from the stress (Kuipera, 2012).

It is likely that there is some overlapping of the theories (Perks, 2012; Raskin, 1979) and combining theories such as relief and superiority theory may more adequately explain why humour occurs in situations where you may think it unlikely. However different the theories are the one thing the theories agree on is that the experience of humour is fundamentally rewarding and provides the possibility to change how one is feeling, whether that be satisfaction, comfort or relief (Hull et al., 2017).

2.8 Inappropriate humour: jokes and nicknames

No theory of humour can explain or excuse bad behaviour and attitudes. The practice of giving slang names to people who have experienced some kind of injury or accident, whether at their own hands or not, is a common practice in healthcare. However there are inherent dangers with this kind of humour as it is seen as aggressive, can be used to tease and/or bully and may be cruel and negative (Abel, 2016). It may on the surface look like this kind of humour is linked to superiority theory since the intention of humour in these situations is not to find relief but purely to mock the misfortunes of others and there is no link to any kind of relief.

A language has developed in healthcare which uses nicknames to describe human suffering witnessed by healthcare professionals and while this language maybe connected to gallows humour in that people might see humour in it, there is also a danger in using what may be seen as derogatory terms. To outsiders, those not involved in healthcare, using such terms can be seen as hurtful and demeaning, and the healthcare professional seen as insensitive and uncaring (Gordon, 1983).

It is easy to see why these terms are seen by some as uncaring as they include things like “crispy critter” for someone experiencing severe burns (Gordon, 1983) or “GOMER” (Get Out Of My ER). “GOMER” is a derogatory term coined by Samuel Shem in the 1978 book The House of God that often refers to older, fragile people who may be confused, those who have dementia coupled with complicated co-morbidities, or people who may seem less deserving of care than some others (Smith, 2004). The difficulty with humour that poke fun at people and their
situations is that it can easily be seen as aggressive or hurtful, especially as it is often targeted at minority groups or vulnerable people (Martin, 2007; Morreall, 2009). While we might like to think that healthcare professionals have moved beyond the attitudes of the 1970s and are showing more sensitivity, this is sadly not the case. In a recent study conducted with third year medical students, a majority of them had experienced the negative humour associated with slang and derogatory jokes directed toward patients (Tariq et al., 2016). Often the derogatory comments were directed at people who are seen as somehow responsible for their health predicament, people who are non-compliant, obese or made bad healthcare decisions (Piemonte, 2015; Tariq et al., 2016) and using these terms for such patients was considered somehow more acceptable than if it were an accident that brought them into the hospital.

Even if this kind of humour did offer coping benefits, one has to question the ethics of making fun of or putting down people in need of care. This kind of gallows humour or joking is seen as humiliating and disrespectful and has the power to decrease the level of perceived professionalism compared with what is expected of those caring for people (Berk, 2015). There is one study that looks at ethical issues as seen by nursing students, in which one of the top things students viewed as unethical was when they heard R.N.’s laughing and making jokes at the expense of patients or, at times, colleagues (Sinclair et al, 2013). It is possible nursing students find gallows humour offensive and unprofessional and this brand of humour will only add to that view. It is this type of information that this research hopes to uncover.

2.9 The functions of humour

The literature on humour, including gallows humour, strongly identifies that humour performs important functions in the lives of people. Those functions are coping, reframing, communicating, expressing hostility, and building group cohesion (Kahn, 2018; Morreall, 2009). This may explain why people in professions that come close to human tragedy and suffering often use gallows humour.

Humour can be found in such serious situations as death, dying and human suffering. Sometimes it is helpful or entertaining, depending on the reason it is needed, and sometimes it can be distracting or harmful. Having said that, humour in its many forms is widely accepted as a tool that can provide relief, create distance from a painful or difficult situation and allow
people to cope with what is happening (Craun & Bourke, 2015; Watson, 2015; Watson, 2014). Humour can offer a different way of communicating; through humour one can gain insights and alternative perceptions of a shared reality that assist one to cope with the situation at hand. With humour people can decrease their social distance as humour can help create familiarity and reduce anxiety (Coser, 1959). It is this social aspect of humour that requires it to be studied in terms of the social context in which it arises (Obrdlik, 1942) and for this research, the social arena is the clinical setting. Humour according to Obrdlik (1942) is a social phenomenon that serves a specific purpose. In the tragic and difficult situations that occur in a clinical environment gallows humour often arises and potentially serves to help the healthcare professional cope with the situation at hand.

A common function of humour is its ability to provide a mechanism for coping in tough, emotional times. Humour lightens the load and provides a bit of relief so that one can carry on with the matters at hand (Watson, 2011; Watson, 2015). Humour helps ease tensions and can be found at such sombre events as funerals (Vivona, 2013), tragic occurrences in healthcare settings, (Bennett, 2003b; Coughlin, 2002; Rowe & Regehr, 2010; Watson, 2011) and amongst fire fighters, police officers and paramedics as they work at scenes of crimes and accidents (Bennett, 2003; Coughlin III, 2002; Rowe & Regehr, 2010; Watson, 2014). Humour used at the right time can help alleviate some of this negative emotion and its harmful effects (Fredrickson & Levenson, 1998; Samson & Gross, 2012).

Humour enables people to reframe a difficult situation in order to look at it in a different way (Kahn, 2018; Rowe & Regehr, 2010; Vivona, 2014). This reframing gives them a bit of distance from the intense emotions, which may in turn help people to cope. Reframing, also known as cognitive reappraisal, allows a person to move away from negative feelings for a brief moment and substitute them with something a bit more positive. Cognitive reappraisal helps provide perspective by creating distance and the relief comes by making the situation somehow feel less threatening and more manageable (Kuiper, 2012; Lefcourt et al., 1995; Rowe & Regehr, 2010). Reducing the threat may also help people maintain their professionalism, by creating a barrier between them and what is happening. This hopefully helps the carer to be more objective and effective in what they are doing (Dean & Major, 2008).
It also helps distance the professional from the patient’s family and friends whose emotions may be running high (Dean & Major, 2008) which otherwise no doubt can have an effect on the health carers’ ability to provide the necessary care. Humour if used appropriately can help disrupt tensions and refocus on what needs to be done (Dean & Major, 2008; Rowe & Regehr, 2010; Scott, 2007). This occurs because people generally cannot have negative and positive thoughts at the very same time (Lefcourt et al., 1995).

2.10 Positive and negative side effects of the function of humour

While humour has some clear functions there also seem to be some things that can occur as a kind of side effect as a result of using humour. Working in groups or teams is an important aspect of working in healthcare; rarely do healthcare professionals work in isolation. According to some research, humour can help a team bond and become cohesive (Bennett, 2003; Duncan & Feisal, 1989; Rowe & Regehr, 2010; Tanay, Wiseman, Roberts & Ream, 2014; Vivona, 2014). While perhaps not considered a direct function of using humour, it can help in improving morale (Bennett, 2003) and creating a positive culture and work environment (Duncan & Feisal, 1989; Kuiper, 2012; Vivona, 2014).

One way of understanding how some of these indirect side effects may come about is to recognise the presence of two perspectives in the context in which humour is used. The first perspective is that of the person who is being humourous and the second, that of the audience to which the humour is directed, or who witness the humour. For maximum effect these two perspectives should line up. People need to be ready to hear and appreciate the humour or the positive effects of humour will not be experienced, and unwanted side-effects may be more pronounced.

With humour, the timing of its delivery is also absolutely critical to its success (Davidhizar & Bowen, 1992). As humour is extremely subjective in nature (Tanay et al., 2014) not all people see humour in the same manner, it depends on many things. At the height of a crisis, when tensions and anxieties are high, some people may not appreciate humour. In fact they may very well find it to be distracting by decreasing concentration. People may consider humour at this time to be even offensive especially as some people find it distasteful to use humour in association with illness, injury and death (Davidhizar & Bowen, 1992). For some people there
is no time for humour when another life is hanging in the balance. Instead the humour may be better received and appreciated more once the crisis subsides (Davidhizar & Bowen, 1992).

People need to be in a certain place physically and emotionally in order to appreciate the intention of the humour. When this happens humour has positive effects on people and how they may be feeling. Humour can have drastically different effects on people and likewise can be helpful or harmful in some situations (Davidhizar & Bowen, 1992; Samson & Gross, 2012).

Whatever the reason humour is being used or the intention of its use, when it is effective it can have many positive outcomes for people. It is considered an effective method for coping in difficult situations. The positive effects of humour can result in 1) lightening an atmosphere heavy with high emotions which potentially have the ability to overwhelm, 2) enhancing the ability to carry on which can be beneficial when working in areas associated with high levels of stress and patients needing care, and 3) helping reduce levels of anxiety and tension for healthcare professionals (Samson & Gross, 2012; Watson, 2011). The negative emotions created when working in healthcare, where things do not always go the way you intended, can have a huge impact on healthcare professionals and ineffective coping or lack of relief, even if temporary, can lead to exhaustion and burnout, impacts that have been well documented.

Gallows humour has the ability to create positive and negative effects. For some the positive effect results in more effective coping in a situation that is trying and helps them separate themselves so that they can carry on. For those who see no place for the use of gallows humour in patient care, the effects can be negative since for them what is said is always offensive. The literature overwhelmingly indicates that for most people gallows humour is positive however, at the same time, when using gallows humour it is important that it adhere to unwritten rules and stay away from those topics that are ethically questionable to joke about (Benetar, 2014; Tanay et al., 2014)

Sometimes what starts out to be humour as coping can lead to what is known as negative humour. Negative humour is related to self-defeating attitudes and psychological distress which can in turn lead to serious consequences such as depression and anxiety, have negative effects on relationships, and be considered as maladaptive coping (Kuiper, 2012; Martin, 2007; Olin, 2016). Negative humour can often occur when, despite all of their experience, a health professional has no control over what is happening, becomes frustrated, possibly angry, and
uses humour inappropriately. Moreover, negative humour can be alienating, is often associated with jokes that are maleficent in nature (Anderson, 2015; Mesmer-Magnus, Glew, & Viswesvaran, 2012) and can signal that the professional may not be coping (Buxman, 2008).

Gallows humour is not without controversy. Arguably its use may in some circumstances reflect a lack of ability to cope with stress and trauma. For example, the manager of a radiology department viewed the use of gallows humour as a way to gauge how colleagues were coping with traumatic situations and if its use became too frequent, assessed this as a sign of poor coping and possibly a cry for help (Strudwick et al., 2012). Likewise people who work in the area dealing with childhood sexual offences rarely make jokes about the children and when they do this it is a concern that the person is no longer coping well (Craun & Bourke, 2014).

There is debate on whether or not this kind of coping reflects a heightened or decreased sensitivity to the tragic circumstances occurring (Moran, 2002; Moran & Massam, 1997). Making jokes or laughing in such situations may be considered by some to be showing inadequate sensitivity (Benetar, 2014). From this perspective, rather than being a tool to relieve stress and avoid compassion fatigue, gallows humour may instead be symptomatic of that very condition. Piemonte (2015) contends gallows humour may make a situation feel better temporarily but does nothing to help with coping in the long term and sensitivity can be easily forgotten (McCreadie & Wiggins, 2009). It is too easy to allow a cloak of cynicism and humour to protect you from the raw and painful feelings encountered when dealing with the suffering of illness or the life and death issues that are common and every day in patient care and may lead to poor coping ability in the longer term for some. It is important to find effective coping mechanisms as poor coping can not only lead to burnout but also result in ineffective and possibly destructive coping habits such as the use of drugs and alcohol (Lemaire & Wallace, 2010).

2.11 Stress, compassion fatigue and the caring professions

There is no debating that those who work in healthcare have to deal with the many tragic circumstances life sometimes throws at people. As a result, there is a need to find ways to cope in order to continue to function effectively in their roles. There are multiple ways people cope with the human trauma they deal with; some are healthy and others not so much. One of the most common ways to deal with stress in both the short and longer term is the use of humour.
The day-to-day work of people in healthcare can create high levels of stress, due in part to situations such as the need to always be ready to deal with what may happen, patients who are seriously ill or injured, and frequent exposure to trauma and suffering (Van Wormer, & Boes, 1997; Parsons, Kinsman, Bosk, Sankar, & Ubel, 2001; Rowe & Regehr, 2010). This coupled with factors such as insufficient funding, high workloads, long shifts and the impact of shift work on biorhythms, diet and sleep, along with the high demands and complex nature of illness and trauma, can have a serious impact on the mental, emotional and physical well-being of the healthcare professional (Hunsaker, Chen, Maughan, & Heaston, 2015; Nolte, Downing, Temane, & Hastings-Tolsma, 2017). These effects include compassion fatigue and burn out (Dehghan-Nayeri, Ghaffari, & Shali, 2015; Wooten, 1992).

Compassion fatigue results when a healthcare professional experiences emotional, physical and spiritual exhaustion as a result of caring for those who are ill or who experience trauma and is considered to be a negative side effect of caring linked to loss of empathy (Hamilton, Tran, & Jamieson, 2016; Hunsaker et al., 2015). Those in the caring professions such as medicine, nursing and social work are particularly at risk for compassion fatigue (Harr, 2013). An equally troubling repercussion of daily exposure to illness and trauma is burnout, which is a feeling of hopelessness and loss of empathy, and as a result healthcare professionals have difficulty carrying out the responsibilities of their jobs (Hunsaker et al., 2015). While burnout may seem remarkably similar to compassion fatigue it is not linked to empathy but rather the day-to-day grind of the stressful jobs (Hunsaker et al., 2015). Both compassion fatigue and burnout can lead a healthcare professional to feeling depressed, apathetic, detached and ineffective at their job (Hunsaker et al., 2015; Harr, 2013) and as a consequence can have serious effects on their ability to care (Hunsaker et al., 2015). Therefore, it is very important that those working in caring professions and regularly exposed to illness and trauma develop effective ways of coping.

The day-to-day grind of caring for people who are sick or injured can take its toll on the people who are caring for them. The use of gallows humour is an attempt to find ways to deal with very challenging and emotionally difficult situations, such that even in serious or grim situations jokes exist (Olin, 2016). While people laugh when gallows humour is used, it is not the feel-good humour we generally associate with laughing (Watson, 2011) especially when you consider the context in which the humour occurs and the subject matter being joked about. Instead it is a kind of humour that helps relieve stress when situations are painful and tragic.
(Morreall, 2009) to try to make sense of what has happened (Buxman, 2008; Chinery, 2007; McCreadie, Watson, 2011; Wiggins, 2009).

2.12 Gallows humour as a coping mechanism

Support for the use of gallows humour overwhelmingly points to its use as a coping mechanism, reflecting that the closer one comes to tragedy and death the darker the humour gets (Buxman, 2008). It is used not only by healthcare professionals but also by fire-fighters, police officers and paramedics, in other words people whose jobs require them to come face to face with tragedy and suffering on the frontline. Therefore, this literature review includes articles and studies of the use of gallows humour that goes beyond the clinical environment.

One article features often and is frequently commented on in literature reviews on gallows humour and its use in healthcare. That article is “Gallows Humor in Medicine”, written in 2011 by Katie Watson, a Professor of Medical Humanities in Bioethics at Northwestern University and a contributor to the world’s first bioethics research institute (The Hasting Centre, n.d.). In her article Watson teases out several themes that are common in gallows humour literature.

Watson describes a situation where three emergency room residents ordered a pizza, the pizza did not arrive, and the residents were wondering about it when a person with a gunshot wound was brought into the emergency room (E.R.). The injured person did not have a pulse or a blood pressure. The young doctors realised that the injured person was the man who usually delivered their pizza and it became apparent that he was mugged, robbed and shot while on his way to them. Despite the young doctors’ best efforts, the injured man died (Watson, 2014). Following their efforts to save him, one of the three doctors remarked, “how much should we tip him”? After laughing at the joke, the residents ate their pizza (Watson, 2014). Years later one of the doctors involved asked Watson, was it wrong to laugh? Watson’s article is her response to the question.

After all, those working in healthcare, whether R.N.s, doctors or paramedics, are witness to some of the most frightening life-threatening situations, chockfull of tension and stress, on a daily basis. According to Watson (2011), gallows humour is a more acceptable manner of expression than, say, throwing things or yelling at people. It is somehow more “ok” to make jokes than to express self-doubt or grief, something that is a common theme in many theories.
regarding the use of gallows humour (Scott, 2007; Wanzer, Booth-Butterfield, & Booth-Butterfield, 2005). The thinking is that if the healthcare professional is more detached when tragedy occurs they appear more competent, rather than breaking down which would be intrusive and could interfere with patient care (Scott, 2007; Wanzer et al., 2005; K. Watson, 2011). This is especially important as life threatening and tragic events occur frequently in this kind of work (Rowe & Regehr, 2010). In this manner humour functions as a coping mechanism.

This view is echoed in articles that discuss the use of gallows humour by first responders during the 9/11 attacks in 2001 in the United States of America (who say if you didn’t laugh you would cry) as well as by healthcare professionals who encounter sudden death through the course of their work in areas such as an emergency department or intensive care units (Scott, 2007; Wanzer et al., 2005; Zolten, 1988). Some authors believe laughing and crying are closely associated and that laughing keeps you from crying (Jones & Wheaton, 1997; Zolten, 1988) as the humour used tries to disrupt the negative emotion felt, through making jokes.

Interestingly, nurses working in palliative care settings also discussed a thin line between laughing and crying. When they talk about death and dying, laughter and crying often occur together during those conversations, even with patients (Jones & Wheaton, 1997). Both forms of expression have the same effect of relieving tension (Rowe & Regehr, 2010) but the use of humour was seen as more acceptable and beneficial than crying (Watson, 2014) although it may not always be gallows humour that is used. Humour allows the healthcare professional to care for the sick and injured despite what has occurred and the role they played in these circumstances (Rowe & Regehr, 2010). Crying on the other hand would likely render the professional unable to complete their duties and may also have a negative impact on patients and their families, although there can be some argument that using gallows humour and crying may share the same function as both allow for some release of emotion.

As for Watson (2011), she believes that for doctors (and an assumption can be made here extending to all healthcare professionals) viewing gallows humour as unprofessional reflects a lack of understanding of the value of humour for people working in these situations. In fact, her belief is that it is the very use of gallows humour in the short term that enables the healthcare professional to get through those difficult moments and keeps them from not being able to perform their job.
There is a view that when it comes to coping with the demands of the job it is whatever gets you through that counts as long as you follow a few ethical “rules” (Vivona, 2014; Watson, 2011). Watson (2015) believes there are some tacit yet important rules one needs to abide by when using gallows humour, the most common of which is that the humour is always shared “backstage” and nowhere else (Charman, 2013; Parsons et al., 2001; Watson, 2011). Backstage brings the obvious reference to behind-the-scenes in the performing arts, where there is frantic activity that is not apparent to the audience in front of the stage and which if the audience did see, it would both distract and detract from their enjoyment of the performance. In the context of healthcare, backstage refers to the inner circle of those intimately involved in dealing with the stressful of traumatic event but excludes the patient and their family (the audience) who should only see the professionals acting in the performance of their duties. Those who are not usually backstage should not be exposed to this kind of humour and joking as they would not understand the use of gallows humour as a coping mechanism and may also find it offensive.

What authors are saying is that using gallows humour can be insulting to the family and loved ones of the person who is ill, as this is a loved one who is suffering and the pain is very real and personal to them. What would they think if they heard what was said, would they be offended or would they see the humour? And if the answer is that it would offend those not part of the inner circle, particularly the family of the patient, perhaps it is more harmful than helpful.

Watson (2011) posits she does not mind if doctors joke about what they are dealing with, but she has had the time to reflect about gallows humour and contemplate the positive benefits when it is used, however people suffering as a result of the crisis may not see it the same way. There are often a lot people backstage who are not deeply involved in what is going on and as a result they may not understand just how difficult the situation is for both the patients and the healthcare team. At such times there is incredible tension and sometimes the humour used eases that tension just a little bit, making it easier to do their jobs. Of course, no patient’s family member wants to hear what is said as there is a large chance they may find it offensive. But, one suspects, neither would they want a healthcare professional struggling with the emotions and tensions of the situations. Perhaps that is the rub of gallows humour.
Humour also functions as a means of communicating in difficult times (Duncan & Feisal, 1989; Kahn, 2018; Vivona, 2014). Humour has a way of disarming defences and allowing people to admit they may need help (Kahn, 2018). Using humour can be a low-profile way of saying “I need some help dealing with this”. While humour may be considered a positive way to communicate, it also involves a risk that the signal of distress may be misinterpreted due to humour down-playing the difficulties and leading to an assumption that no help is needed (Kahn, 2018) with potentially catastrophic consequences to all involved.

2.13 Gallows humour in other settings

While Benetar (2014) believes that it is unethical to make jokes about the Holocaust or the people who suffered unimaginably, there are numerous examples of survivors who talk about how humour and making jokes is something that those incarcerated used to help them survive extreme cruelty and abuse. Humour is often used in situations where people are held captive and oppressed. This humour can be powerful and possibly liberating as it is targeted at their oppressors (Benatar, 2014) and, like gallows humour used in healthcare to cope, so too is this used to cope with the situation at hand. An example is prisoners of war (POWs) who often used humour to poke fun at those keeping them imprisoned as this gave the POWs a sense of power and mastery over those that held them captive (Samson & Gross, 2012). Likewise Viktor Frankl and other Holocaust survivors were known to make jokes at the expense of the German SS who imprisoned them (Frankl, 2004). POWs and people detained in the concentration camps of World War II were powerless and poking fun at their captors made the situation less threatening by cognitively reappraising the situation even if only briefly.

The holocaust during World War II produced an inconceivable amount of suffering and death. Viktor Frankl, who survived three years in a Nazi concentration camp, wrote about his experiences (Frankl, 2004; Lampland & Nadkarni, 2016). Given the scale of death and pain suffered it would be easy to think that among those imprisoned in concentration camps humour did not exist, but for Frankl humour brought temporary relief so that he could get through the horror (Frankl, 2004). For Frankl, finding things to laugh at helped give him a sense of meaning and purpose in life and he believed contributed to his survival (Frankl, 2004) He was not trivialising the situation, he was simply trying to find ways to survive where many did not.
Gallows humour may be seen as necessary for survival at times when survival is threatened (Friederichs, 2015). In such situations it is seen as a mechanism of self-protection and allows people an emotional escape from their cruel situation (Obrdlik, 1942). Interestingly Obrdlik (1942) compares using humour in this situation as analogous to having hope, since with hope what feels unbearable can somehow become bearable and it gives people something more positive to hold onto.

2.14 Ethics of gallows humour

It has been suggested in the previous sections that gallows humour may have an important function as a coping mechanism in a trying, difficult, or tragic situation. However, this does not amount to a full justification for its use, for, as has also been recognised, it may have unintended side effects. Moreover, an ethical evaluation needs to go beyond good and bad consequences to take into account other ethical issues. This section considers all these aspects of an ethical analysis of the use of gallows humour.

The effects of stress and the impact it can have on patient care is well documented (Samson & Gross, 2012; Watson, 2011). Some authors such as Watson (2011) indicate that the use of gallows humour can be justified if and only if it is used in the context of coping and it is not used to make fun of patients (Watson, 2011). The intention of gallows humour, while not included in the definition, is to not to be cruel but rather to find some relief. If this is so then gallows humour perhaps makes a contribution to patient care in that coping hopefully allows the healthcare professional to carry on doing their job effectively. In doing so a healthcare professional may be seen as performing their job in a non-maleficent manner, with non-maleficence being defined as doing no harm (Sinclair, 2013).

Van Wormer and Boes (1997) maintain that gallows humour is a suitable reaction to the trauma and stress involved. It may be essential to the psychological survival of working in environments fraught with emotion, tension and trauma as it is a chance to let off steam, lighten the situation, make it less serious and somehow less threatening (Bennett, 2003; Coughlin, 2002; Kuipera, 2012; Rowe & Regeh, 2010; van Wormer & Boes, 1997). Having such a release will positively contribute to patient care.
Freud in his psychoanalytical view saw humour as a relatively benevolent way of expressing “socially unacceptable impulses” (Ford, Ferguson, Brooks & Hagadone, 2004). Interestingly this is what some of the literature says about the use of gallows humour by healthcare professionals and front line emergency professionals, whereby it is more appropriate to use humour than it is to be seen to get angry, throw things or even cry (Buxman, 2008; Rowe & Regehr, 2010; Wanzer & Booth-Butterfield, 2005).

While there are some who see the value in using gallows humour and justify its use when certain rules are met (Rowe & Regehr, 2010; Watson, 2011) there are others who completely disagree with this thinking. Some do not see it as acceptable even with boundaries for its use (Piemonte, 2015). While initially Piemonte (2015) saw merit in Watson’s argument that gallows humour was acceptable in certain situations in order to cope and continue with the job, Piemonte (2015) comes to the conclusion that healthcare professionals need to find a better way to cope than using jokes when others are suffering and dying. Gallows humour for Piemonte (2015) is unacceptable even if the humour helps the healthcare professional, as the joking trivialises what is a painful time for friends and family (Piemonte, 2015) and this for her is wrong.

However it is important to remember here that the jokes are not made directly about the patient nor are they delivered in order to trivialise a situation, they are made to cope with the gruesome reality of what is happening. Piemonte (2015) does not seem to recognise that healthcare professionals do understand the pain and this is exactly why the jokes are occurring. They too are feeling pain but because they need to continue their work they need something to mitigate the pain briefly to carry on, which is exactly the point Watson (2011) is trying to make.

This is a bit like the law of double effect in medicine. This is a doctrine in ethics that looks at the intention of acts of caring in difficult or potential ethical situations (Wholihan & Olson, 2017) such as giving high doses of medications to people suffering pain near the end of their lives. As an example of what the doctrine of double effect says, if a medication is given with the right intention, that is to relieve pain, and the person dies shortly afterwards, there is no wrongdoing as the intention was beneficent, that is to help relieve suffering not to expedite
death. The intention\(^1\) is important, and healthcare professionals using gallows humour have no intention of being hurtful or trivialising the event. Rather, their intention is primarily to get through a very difficult time without breaking down. If this is not the intention, then this is a red flag for poor coping.

Piemonte (2015) believes that instead of using humour to cope in the short–term, healthcare professionals including students need to become more comfortable with suffering and death (Piemonte, 2015). This can be accomplished through reflection on experiences so that the healthcare professional becomes more comfortable with the unpredictable aspects of caring for people in challenging circumstances. But the difficulty here is that this takes a great amount of time and happens later, after the crisis, when one has time to reflect and review it.

Nonetheless, what Piemonte (2015) says may hold some truth. In order to cope with stress and tragedy, healthcare professionals may indeed need more in their arsenal than just using gallows humour. However she does not provide any suggestions on what healthcare professionals can do in the moment when things seem overwhelming and possibly unbearable, when something you have been a part of is so tragic it can be agonizing, especially if you are unable to change what happened. Sometimes in the heat of the moment when the tension is so thick, what is needed is temporary relief so that you can get through, a bit of short-term coping. Yes, Piemonte is critical of Watson’s belief that gallows humour is a useful tool in the short-term but what she is not acknowledging is that the joking quickly and efficiently serves a purpose. That is using humour quickly changes the narrative (in the individual’s head) and permits short term coping until another form of coping can be accessed (Abel, 2016).

While some may justify the use of gallows humour in relation to its contribution to patient care, there are some who believe that the use of gallows humour can never be justified. For them it is harsh and not appropriate under any circumstances. This is in part due to the risks of people hearing the humour who were not meant to hear and the inherent offensiveness of the humour especially in trying times. Morreal (2013) considers the use of gallows humour to be an

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\(^1\) Understanding intent is a slippery slope as it is difficult even for the teller, let alone the listener, to really know what the intention is for many jokes, especially when a joke has failed and the comment “it’s just a joke” pops up. Arguably, since you can’t see inside the joker’s head, perhaps you can infer their intent from the nature and content of the joke itself and the circumstances in which it occurs. If it prompts this type of comment, it is likely that the intent behind it would be questionable at best. This is an interesting issue but one that is not explored here due to the limitations of a Master’s thesis.
unacceptable tool for relieving stress, as there are some who may find it offensive. Williams (2013) supports the argument that the use of gallows humour is not acceptable and cannot be justified as a coping method even in light of burnout and compassion fatigue as there are more effective, less offensive ways to cope.

Gallows humour can also be viewed as an insensitive response to what has happened (Berger, Coulehan, Belling, 2004). Some research indicates that groups such as medical students, while they can understand why people use gallows humour, still find it ethically challenging (Parsons, Kinsman, Bosk, Ubel, 2001). In part this is due to what medical students view as being an outsider rather than a key player in the situation, they are not yet part of the of the backstage group (Parsons, Kinsman, Bosk, Ubel, 2001; Wear, Aultman, Varley, Zarconi, 2006). They cannot justify using gallows humour as they are not close enough to the tragedy (Wooten, 1992). As a result, they have a tendency to be less cynical and more idealistic and therefore find it difficult to reconcile the use of gallows humour in light of what has occurred for the patient (Parsons, Kinsman, Bosk, Ubel, 2001). As nursing students are in a similar situation to medical students, it is possible they may have a similar reaction to the use of gallows humour.

Another difficulty is that while people may share the experience, there is room for different individual interpretation of the jokes, which can lead to people seeing the jokes as unethical (Parsons et al. 2001). As noted earlier, humour is at least in part contextual and is also shaped by the individual’s frame of reference, established by their life’s experiences not just the immediate situation. It is impossible to predict how a person may respond to the humour used regardless of position or experience (Rowe & Regehr, 2010), which may be borne out by the research with nursing lecturers and students. Gallows humour is wide open to interpretation and may not be well received by some people.

Some of the difficulty with the ethics of gallows humour is that it is often aimed at the circumstances surrounding the ill fortunes of a patient and it is unethical to poke fun at the suffering of the patients being cared for (Strudwick, Mackay, & Hicks, 2012). What is not said about gallows humour here is that boundaries between the situation and the patient can be and often are blurry. This might contribute to the misunderstanding and offence that arises from the use of gallows humour. For some using gallows humour is considered distasteful as it reinforces a power imbalance between the teller of the joke and the butt of the joke, except
of course if the teller is disempowered, such as prisoners of war (POWs). However for some, despite the intention, the joke is still harmful in some manner (Lefcourt, Davidson, Prkachin & Mills, 1997).

However, humour does not occur in a vacuum, rather, it arises within social constructs and across cultures (Dehghan-Nayeri et al., 2015). This makes the phenomenon incredibly complex and wide open for different understanding and interpretation depending on the individual’s perspective. This is the reason why it has so much potential to cause offence and why this research looks at the ethics of humour as well as peoples’ perception of gallows humour.

2.15 Chapter summary

The funny thing about humour is that is difficult to define as it depends on so many different things. It is however agreed that humour, especially gallows humour, helps with social cohesion, stress relief, coping and generally helps people feel better just when they seem to need it the most.

Regardless of the reasons humour is used or the underlying theories that attempt to explain it, the one consensus is that experiencing humour is fundamentally satisfying and a range of feelings including comfort and relief may be experienced (Hull et al., 2017). There are many forms of humour and they share this purpose.

There can be no doubt working in healthcare is difficult and stressful and requires both long term and short term coping strategies. While not all people agree with its use, gallows humour offers a way to cope with the gruesome, painful and tragic situations people encounter in the moment. For the most part gallows humour helps healthcare professionals find a way to cope and manage their way through the immediate events so that they are able to continue with their work.

This chapter explored the complexities of the use of gallows humour, the theories that exist to explain its use and how gallows humour can be useful for some and yet offensive for other. Chapter three will discuss the methods used to conduct the research for this thesis.
3. Methods

3.1 Chapter introduction

The purpose of this chapter is to provide a description of the methodology employed in this thesis in order to answer the research question: How do students and academic staff perceive the use of gallows humour in the clinical setting? The chapter will include a description of the mixed methodology design employed, the philosophical underpinning of mixed methodology and the rationale for using this approach. Following this will be a description of the participants, how they were recruited and how data collection was managed.

The literature review uncovered some discussions and research that looked at the use of gallows humour involving nurses working in clinical areas, however there was no research that looked specifically at nursing students or those involved in their education. As gallows humour is commonly used it is likely student nurses will be exposed to it and that lecturers may also have varying experiences with its use. It is important to gain some insight into how students and lecturers view the use of gallows humour, especially as gallows humour can be contentious and may be offensive to some people. Consequently, understanding how students and lecturers view the use of gallows humour will add to the literature.

By reflecting on clinical practice through research, we are better able to understand how we behave in certain situations that may have an impact not only on patient care but also, as in the case of this research, an impact on the mental well-being of students and practitioners. It is important to understand how lecturers and students perceive gallows humour, as they will no doubt encounter its use. Some, like the student I described in the Preface, may struggle with the use of gallows humour.

With a pragmatic philosophy and combining methods, this research seeks to gain a better understanding of the perceptions of students and lecturers with regards to gallows humour and quantify how frequently different perceptions might occur. This would give a more balanced view of the phenomena of gallows humour as experienced by these two groups.
Nurse lecturers spend a lot of time in the clinical area with students. During clinical visits students often debrief with nurse lecturers about events they have experienced, and this can include discussions about gallows humour. In addition to this, lecturers have their own experiences of the use of gallows humour and it is possible there is a difference between how students and lecturers view its use. If a student is offended and a lecturer is not, the lecturer needs to have some understanding as to why the student is feeling the way they are and help guide them through this. As students are neophytes it may well be easy for them to misinterpret why the humour is being used and lead them to question what is happening. It is possible that for students the use of gallows humour can appear to be harsh and cruel (Piemonte, 2015).

The philosophical paradigm supporting this duality of views is pragmatism, which is widely accepted as an appropriate basis for selecting a mixed method research approach (Cresswell, Plano, Clark, 2017). Pragmatism has a view of reality from two perspectives. One perspective is consistent with a quantitative approach in that it has a positivist or post-positivist view of reality, which believes that reality can be measured and understood (Cameron, 2011). The second perspective holds that there is no one truth, but instead there are many different explanations of reality and this reflects a qualitative approach to research (Cameron, 2011). Pragmatism values the subjective and objective views each method contributes to answering the question (Cresswell, Plano, Clark, 2017). By combining both methods, pragmatists believe there will be a better outcome from the research process as it gives a more accurate approach by avoiding the deficiencies of each method (Plano Clark, 2017).

It is important that those involved in their education have an awareness of how students feel, as it may differ from their own perception. It is likely that student nurses engaged in clinical learning experiences, even in their undergraduate years, will be exposed at some point to the use of gallows humour. It is beneficial to have a better understanding of how they view the use of gallows humour so that those responsible for their education are better equipped to deal with the students’ understanding and reactions.
3.2 Ethical considerations

This research was challenging, as there is potential for a conflict of interest due to the position of the researcher relative to students and colleagues who were possible respondents. Students in particular are most at risk due to the fiduciary relationship between students and those responsible for their education (Ferguson, Yonge, & Myrick, 2004). The fiduciary relationship creates unequal power levels between teachers and students therefore it is important that those who hold the greater amount of power do what they can to protect those who are less powerful (Lemmens & Singer, 1998). As result it was important for the researcher to take numerous steps to ensure that students felt comfortable to agree or refuse to participate in this research. This includes how the processes of recruitment and consent were handled, as well as ensuring how students could remain anonymous to the researcher throughout the entire research process.

This research explored the perceptions of student nurses and nurse lecturers in relation to the use of gallows humour. As the researcher is familiar with some of the students and nurse lectures it was important to minimise the potential risks inherent in this research. To do this the following steps were taken:

1. As the researcher is involved with students from the Bachelor of Nursing (BN) programme, a neutral person who works in another programme and has no contact with these students conducted the recruitment;
2. Recruitment of lecturers was done through email sent by an administrator of the programme;
3. Nursing lectures and students had an anonymous link through which they could access the questionnaires;
4. Consent was assumed by participation as a signed consent could potentially identify participants;
5. Nursing lecturers and students were made aware that this research was completely voluntary, and they were free to drop out of the research at any time simply by not completing the questionnaire; and
6. Students were not told who was conducting the research to avoid any potentially feeling undue pressure.
There are elements of the research process that are vulnerable to ethical issues. These include recruitment, informed and voluntary consent and data collection, maintaining a participant’s right to withdraw at any time in the research, ensuring a participant’s right to be anonymous where possible and protecting confidentiality (Miller, Rosenstein, DeRenzon, 1998). In order to reduce the risk of encountering ethical issues it is important to design the research in such a way that strategies can be developed in order to manage risks and hopefully reduce the potential for harm (Miller, Rosenstein, DeRenzon, 1998). The importance of minimising the risk of harm in any research cannot be overstated. It is extremely important that all research has respect for participants and is non-maleficent in its intent. However, this is especially true of this research as the researcher is involved with teaching many of the potential student participants and works alongside many of the potential nursing lecturer participants.

As there is always the potential for students to feel or perceive pressure to participate it is crucial that the entire process is handled ethically and steps be taken to mitigate this in some way (Edwards & Chalmers, 2002). Therefore it was essential that potential participants had little to no contact with the researcher during the recruitment. This was made very clear by the ethics boards at both Whitireia NZ and Otago University. The researcher was not to directly recruit the students she is currently teaching or will be teaching in the future; rather this was to be done by a neutral person. Therefore, the person chosen to recruit students in the BN programme was someone who had no contact with or teaching responsibility for undergraduate students at Whitireia NZ. A person who does not teach undergraduate nursing students was chosen as it was thought this would hopefully reduce the pressure to participate as well. During recruitment, the researcher had no contact with students immediately before, during or shortly after recruitment occurred. For Year three students, recruitment took place on a day the researcher had no teaching or contact with students as this is the group she was currently teaching.

There were no similar requirements from either board of ethics for the recruitment of colleagues. However, the researcher and her supervisors made the decision that recruitment would be best handled by a neutral person through email that also provided colleagues with an anonymous link to the questionnaire. An administrator from the Health Administration team sent an email with the participant information sheet and an anonymous link to the research questionnaire to each member of the nursing faculty.
3.3 Methodology

Historically, research in healthcare has principally been conducted using one of two methods, quantitative or qualitative, depending on what was being researched. Quantitative methods are designed to be deductive in nature with the intent being to test a hypothesis (Lederman & Lederman, 2013). A qualitative approach has an entirely different style in that it is inductive in nature and its purpose is to generate a hypothesis (Lederman & Lederman, 2013). Quantitative research is etic in its approach (Lederman & Lederman, 2013) meaning its perspective rests with what the researcher thinks is important. On the other hand, qualitative research is emic with regards to its methodological approach (Lederman & Lederman, 2013). How people think and perceive their world, how they explain things and what has meaning to them is very important in qualitative research. Despite their differences in approach it is possible to combine the methods for research projects.

Mixed methods research allows for a deeper understanding of the complexity of the phenomenon (Fetterman, 2008; Lederman & Lederman, 2013). When looking at how participants feel about a phenomenon the emic position is important in order to understand, interpret, and represent their perspective as accurately as possible. The emic position allows the researcher to see that how people interpret their world is affected by who they are and where they come from. This shapes their perspective and how they see the world as they are describing their perspective. By combining an emic and etic approach the researcher is able to gain the inside lived perspective of the nurses and students in clinical settings and back this up by allowing the researcher to step back and analyse the data and its meaning, which is what Fetterman (2013) explains is the purpose of combining both perspectives. The two distinct methodologies are an amalgamation of approaches that offers an understanding that is more thorough than if a single approach is used (Cresswell, 2006). This is particularly true when the concept is new or may not be well understood (Cresswell, 2006) as is the case with gallows humour and students.

This study employed a mixed method approach. Mixed methods research occurs when the researcher collects both kinds of data in a single research project (Cresswell, Plano Clark, 2017). Mixed methods allow the researcher to collect information and have access to different facets of the same social phenomenon (Creswell & Clark, 2011). This approach was considered appropriate as each method independently has limitations but together the combined strengths
not only minimises the limitations but can add depth and breadth to the work (Foss, Ellefsen, 2002; Palinkas et al., 2015; Tashakkori & Creswell, 2007). For example, quantitative methods enable researchers to explore the breadth of issues relating to a particular phenomenon, meanwhile qualitative approaches enable the research to gain in-depth knowledge of the circumstances and context in which individuals experience a phenomenon (Tashakkori & Creswell, 2007). The holistic approach of qualitative methods allows the researcher the flexibility to examine the lived experience of the participants, which is particularly important for increasing the understanding of how student nurses react to the use of gallows humour coupled with the quantitative approach, which will look at how often something may occur.

Each method has its own assumptions. By way of example, qualitative research will not make assumptions about meaning from influences outside a situation, whereas quantitative research will make assumptions about outside factors that have the potential to influence an outcome (Lederman & Lederman, 2013). It would be difficult to make assumptions around how people perceive the use of gallows humour as there are so many factors that influence not only its use but also how people will view its use. Therefore, it was important to look at the use of gallows humour from multiple perspectives in order to try to explain and interpret what participants were saying and feeling and how common these feelings were in the group. This would give the research a well-rounded understanding of the use of gallows humour in the clinical setting, which is one of the many benefits of combining methods.

Given the aim of this research, which is to explore how participants viewed gallows humour, this research had a convergent parallel design. This is where both qualitative and quantitative data sets are collected at the same time but are treated equally, independent analysis of each data set occurs, and results are compared or related in order to provide an interpretation (Alavi, Archibald, McMaster, Lopez, & Cleary, 2018; Cresswell, Plano Clark, 2017; Halcomb, Hickman, 2015). The purpose is to gather different but complimentary data in order to obtain the best possible understanding of the chosen research topic. Mixing at the interpretation phase is the last step in the research process. Here the researcher in a discussion will make conclusions and/or inferences from what was learned (Alavi et al., 2018; Cresswell, Plano Clark, 2017).

To conduct this research an online questionnaire was developed. Several questions had a Part A, which consisted of closed-ended questions in the form of “yes/ no/ maybe” options, and a Part B which allowed students to explain their choices. Multiple choice questions (where
participants were given a set of predetermined answers) and Likert rating scale questions were also included. The Likert and multiple-choice questions provided the quantitative component of the research as they spoke to the frequency and allowed the researcher to quantify certain reactions to gallows humour. These questions were often followed up by Part B, which allowed participants to give a more in-depth perspective that will add to the richness of the data collected. The qualitative component consisted of questions that explore the perceptions of gallows humour for both sets of participants. This research allowed participants to provide narratives which allows researchers to better understand the phenomenon from participants’ perspectives (Whitehead & Schneider, 2012). This method allows the researcher to develop subjective meanings of the experience and look for categories of ideas occurring in the different groups (Cresswell, Plano, Clark, 2017).

3.4 Research design

Research designs are the processes researchers use in order to develop a professional knowledge base in professions where complex phenomenon exist (Teddlie & Tashakkori, 2012). Research design helps the researcher establish a foundation that directs the collection and analysis of data and assesses variables that may affect outcomes (Cameron, 2011; Teddlie & Tashakkori, 2012). The purpose of research design is to map how a piece of research will be lead (Halcomb, Hickman, 2015). Research design essentially gives researchers a road map to conduct and complete a piece of research.

This research employed two questionnaires using both qualitative and quantitative questions to explore the perceptions of the use of gallows humour of students and lecturers respectively. A questionnaire was chosen as this approach facilitates the collection of standardized and comparable information from a sizeable number of people (Taylor, Kermode & Roberts, 2006). Questionnaires also allow the researcher the ability to use both qualitative and quantitative methods to collect data by designing precise questions when investigating the phenomenon of interest.

When research is conducted with participants known to the researcher, increasing ways to maintain anonymity and decrease the possibility of coercion both real or perceived are extremely important (Ferguson et al., 2004; Palinkas et al., 2015). As the researcher has contact
with some students either currently or in the future and works alongside some of the faculty who would be recruited, the use of focus groups and interviews were not considered an appropriate option, as the researcher would be immediately able to identify participants. Complicating this would be the potential for participants to feel pressure to participate should the researcher know them. Therefore, a questionnaire delivered anonymously online reduces some of the perceived coercion and pressure.

Another advantage (and especially important to this research) is that questionnaires allow respondents to remain anonymous (Blaxter, Hughes, Tight, 2010; Taylor, Kermode, Roberts, 2006). An online questionnaire that protected anonymity of participants would hopefully mean students and lecturers felt freer to answer questions in a manner that was true and honest about how they feel regarding the use of gallows humour.

A further advantage of questionnaires is they are quick and easy to administer and convenient for participants (Taylor, Kermode, Roberts, 2006). This was considered to be important to the researcher as both nursing students and those involved in teaching them have little spare time and would be more likely to participate if they understood that participation would be brief.

Advantages also include the reduction of researcher bias by eradicating the possibility of the researcher influencing answers with verbal and non-verbal cues. These kinds of cues can lead a respondent to answer a question in a particular way (Taylor, Kermode, Roberts, 2006). This was especially important due to the researcher’s current or future relationship with students and the working relationship with nurse lecturers. It was important to eliminate as much bias and undue influence as possible in order to gain a true picture.

Unfortunately, questionnaires are also known to have some disadvantages including poor response rates, participant unreliability due to misinterpreting question(s) and incomplete questionnaires (Taylor, Kermode, Roberts, 2006). Not all of these disadvantages can be eliminated however with the piloting of a questionnaire the possibility of misinterpretation can be minimised (Blaxter, Hughes, Tight, 2010; Jain, Dubey, & Jain, 2016). Piloting allows the researcher to strengthen the validity of questions by ensuring that participants will answer questions correctly through making questions less open to misinterpretation. The answers that test respondents give will hopefully be the ones the researcher is seeking and if not the questionnaire can be edited and refined (Castro, Kellison, Boyd, & Kopak, 2010).
In this research, two electronic questionnaires were developed and piloted. Each questionnaire was developed with both groups of participants in mind. While some questions in each questionnaire were similar, they were also some that were different. The questionnaire for students looked directly at whether or not they had directly experienced the use of gallows humour and how they felt regarding its use. The lecturers’ questionnaire included not only this information but also looked at their experience of gallows humour while working with students.

3.5 Questionnaire design

An electronic questionnaire for both sets of participants was designed following the literature review. Through the literature review, themes were identified and aspects concerning the research were considered when developing the questionnaires. Each questionnaire contained a number of questions across several sections. A preliminary section required participants to submit some demographic information. For students this included ethnicity, age group and the year they are enrolled in. For nurse lecturers this included ethnicity, age group, number of years of clinical experience and number of years of teaching experience.

For subsequent sections, questions consisted of multiple choice where more than one response could be chosen, yes/no/maybe answers and open-ended questions. Most of the multiple choice and yes/no/maybe questions were followed by an opportunity to explain which fits with a mixed methodology that seeks to gain more insight into the phenomenon experienced (see Appendix C and D). Each set of questionnaires also contained Likert scale questions, which were aimed at exploring the depth of how much nurses and students considered different aspects of gallows humour to be ethical.

3.6 Questionnaire development

The questionnaires for both students and lectures were remarkably similar with only minor differences. This was done intentionally in order to see if there were differences in the perception of gallows humour between students and lecturers.

The questionnaire for this research was comprised of 19 closed- and open-ended questions in total across four sections. For lecturers, the first section following the demographic questions
sought to collect information on the experiences of gallows humour while working as an R.N. in a clinical setting, since lecturers come to undergraduate education after having many years of clinical nursing experience. For students, this section focused on their experiences during clinical placements, which they undertake several times each year during the undergraduate programme.

The first key question in both questionnaires (following the preliminary demographics) asks both sets of participants to explain their understanding of gallows humour. Despite a definition being given in the information sheet and directions for taking the questionnaire it was still important to establish their understanding of what gallows humour is, as this could be different for different people.

The second question was a Yes/No/Maybe question asking if, while working clinically, they had heard gallows humour being used. For students this was reworded to ask if they had heard gallows humour in the clinical setting. This was followed by part B that allowed respondents to explain what was heard. This part of the question was optional but gave the participants an opportunity to expand on what they heard.

The third question and final question in this section for both questionnaires was a multiple-choice question that gave respondents eight choices, exploring how they may have responded to the use of gallows humour while working clinically. Respondents were allowed more than one choice, as it is possible to have many different reactions at the same time. This question also had a part B that asked respondents to explain their choice(s).

If respondents indicated that they had not heard gallows humour used in a clinical setting they were directed to Section two of the questionnaire. This section contained questions that were similar to section one but reworded to ask about how they think they might respond if they were to hear gallows humour used in the clinical setting. This section was included as there is a possibility that nurses were not exposed to the use of gallows humour although this was thought to be unlikely as the literature indicates that gallows humour is a frequent occurrence. This section included a question about being offended by what they heard. For lecturers this was followed up with a “please explain” question. For students the follow up question differed in that it asks if they felt they were able to speak up if offended.
Section three of the staff questionnaire looked at lecturers’ experience with students. This section contained two Yes/No questions that asked lecturers if students had discussed gallows humour with them and whether or not they felt students were offended. There was not the opportunity to explain their answers, as it would be extremely difficult and probably speculative for lecturers to explain why students may have been offended. Section three for students was designed for those students who have not experienced gallows humour. Students in this section were asked if they heard gallows humour being used would they be offended, followed by a “please explain”.

Section four explored the ethical perceptions of nurse lecturers regarding the use of gallows humour. This section contained three Likert type questions, which ranked answers from 1 strongly agree to 5 strongly disagree. The first question asked both sets of participants if they thought gallows humour was an acceptable form of coping. The second question asked if they thought gallows humour was ethical if used as a form of coping. The third question asked if gallows humour is ethical provided patients or family members do not hear it, followed by an opportunity to explain their answer. See Appendix C and D for the full set of questions.

3.7 Piloting questionnaires

In order for a questionnaire to valid and reliable it is important to have it tested prior to using with research participants (Castro et al., 2010; Jain et al., 2016). It is valuable to test questions so that the researcher knows whether or not the wording is correct and will elicit the kind of answers being sought (Castro et al., 2010). Piloting ensures consistency of the questionnaire and more importantly that participants understand what is being asked of them and whether or not all participants interpret the question in the same manner (Jain et al., 2016; Whitehead & Schneider, 2012). In order to strengthen the reliability and validity of the questionnaires, nurses in the field of nursing education piloted the questionnaire. Once the initial questionnaires for students and lecturers were developed, they were given to four different nurses to pilot. The pilot was conducted to ensure the final questions accurately reflected the information sought.

Content validity is the logical evaluation and judgement of whether the instrument adequately reflects the content of what is being researched (Whitehead & Schneider, 2012). For this research this meant that during the development phase of the questionnaire the wording was
reviewed and considered suitable for participants. Excessive jargon and technical terms were avoided to ensure ease of reading especially for those students who are not fluent in English.

Pilot participants were asked to complete the survey and provide feedback to the researcher regarding the wording of questions, whether or not they were clear and understandable, and whether or not completing the questionnaire was true to the timing suggested by the researcher. Reliability in research is an important concept in that its goal is to ensure the extent that a questionnaire is capable of producing the same results if it is repeated with other group (Jain et al., 2016).

The students’ questionnaire was piloted by four R. N’s, including one who was a recent graduate of the BN programme at Whitireia NZ, one who was Pasifika and one who identifies as Māori. Pilot participants were chosen for several reasons. Potential research participants included Māori and Pasifika; therefore it was important to have Māori and Pasifika professionals pilot the questionnaire. A number of potential participants have English as an additional language (EAL) and it was important that the questionnaire was written in a manner that these students would clearly understand what was being asked. Some lecturers work closely with EAL students and have a good understanding of the impact that wording can have on an EAL student’s ability to interpret questions.

Four nurse lecturers who were not eligible to participate in the research piloted the lecturers’ questionnaire. All have previous clinical experience in various areas and are currently working in tertiary education facilities providing nursing education in some capacity with undergraduate or postgraduate students. They also have experience writing questions for exams and assignments and understand the importance of the accuracy of the wording in questions in order to elicit the kind of answer required.

For the most part, pilot participants indicated that questions were worded appropriately and, apart from some minor additions or deletion of words for more clarity, very few changes were made to either of the questionnaires. The estimated time to complete the questionnaire, at approximately 10-15 minutes, was confirmed to be accurate.
3.8 Participants

This research employed purposive sampling in order to gain participants. Purposive sampling refers to a method of sampling that involves deliberate decisions regarding who is eligible to participate in the research (Palinkas et al., 2015). These participants are sought due to their knowledge about or experience with the phenomenon (Palinkas et al., 2015). Included in these decisions are considerations about who participates, where and how the research is conducted (Blaxter, Hughes & Tight, 2010; Payls, 2008). Purposive sampling allows the researcher to choose a group that most suits their research needs. Purposive sampling contributes to depth of information in that participants are able to provide details through the qualitative aspects in mixed methodology (Palinkas et al., 2015). Furthermore, identifying a research population through purposive sampling adds breadth in that the research is generalizable as it represents a particular population (Palinkas et al., 2015). The purpose is to find the correct population who can answer specific questions in order to examine why people may feel the way they do about a certain phenomenon. The aim of purposive sampling is to gain a group that will give a true picture of how they regard the phenomenon. This research was purposive in recruitment in a deliberate attempt to gain representative samples of student nurses and lecturers.

For this study the sample group included students enrolled during 2018 in years one, two and three of the BN and year two of the Bachelor of Nursing Pacific (BNP) at Whitireia NZ. Participant criteria differed for students and lectures. In order to be eligible to participate in this research as a student, they had to be enrolled in a nursing degree programme and had at least one clinical learning experience, also known as clinical placement, in a hospital or community setting. There was no requirement on whether or not students had any experience of gallows humour.

Criteria for nurse lecturers differed slightly. All nurse lecturers were required to have at least one year of teaching experience however there was no specific criteria regarding clinical experience as this is a given in their roles.
3.9 Recruitment

Prior to recruitment commencing, the programme leaders of the BN, BNP and Bachelor of Nursing Māori (BNM) offered at Whitireia NZ were contacted and consent to approach students was granted. Unfortunately, due to the timing of recruitment, timetabling and clinical commitments, not all students in all three programmes could be recruited although this was the initial intention of the researcher. However, those who could be recruited represent a good cross section of the make-up of the ethnicities represented at Whitireia NZ, including Māori and Pasifika students.

Recruitment for this research had special requirements. While informed consent and participants rights are very important issues for all research it was even more important for this research due to the relationship of the researcher to some of the potential participants. Several steps were taken in the research design and recruitment process in order to minimise some of the risks involved in recruiting participants known to the researcher, such as those around anonymity and consent.

Recruitment of students enrolled in the BN programme who have the greatest amount of current and future contact with the researcher were recruited by a senior lecturer in the Master of Clinical Practice programme offered at Whitireia NZ. This lecturer has no contact or teaching responsibilities in the delivery of undergraduate nursing at Whitireia NZ. It was agreed between the researcher and the recruiter that a script be written to guide her through the research. The recruiter was also given the abstract to read and a chance to ask the researcher any questions regarding the research project. The recruitment of students occurred within the same week at different times.

The recruiter had paper copies of the information sheet with her should students want to read it before considering participation. They were also told that the information sheet was attached to the online questionnaire for them to read. The consent process was also explained to the students, as there was no “official” consent form to sign.

In order to protect the anonymity of participants, consent was obtained online in the questionnaire. The information sheet (see Appendix A) contained a statement explaining that there was no consent to sign and that filling out the questionnaire would imply consent. This
meant there was complete anonymity throughout as the researcher had no way of tracking who was participating now or in the future and there were no signatures to identify.

Once students were recruited, electronic versions of the information sheet were placed on Moodle, an online learning platform used by all nursing programmes at Whitireia NZ for learning and communication with students. Each year of the nursing programmes offered at Whitireia NZ hosts their own Moodle page. Permission was sought from and granted by team leaders and Programme managers to have the research information and a link on each Moodle page. This manner of accessing the questionnaire also gave the student participants an added layer of anonymity.

Once student recruitment was completed, recruitment of nurse lecturers took place. This was done through an email invitation that was sent to faculty in the undergraduate programme. This email was composed by the researcher and sent by a member of the Health Administration team so that there was no contact between the researcher and the potential participants in order to avoid bias and/or undue pressure. The email included the information sheet (Appendix B) and an anonymous link to the appropriate questionnaire, which was hosted on Qualtrics.

3.10 Data collection

Student data was collected first. Students were able to access the questionnaire via an anonymous link on their Moodle page [web-based learning platform]. The information on the Moodle page included a brief introduction to the research, the information sheet and an anonymous link and QR code. Once recruitment was complete, access to the research remained open for two weeks. Students were reminded of the research at the beginning of the second week through a message on Moodle posted by a member of the teaching team in the relevant year and programme.

The timing of the research was such that year one students had experienced at least one clinical learning experience. For these students this experience was in residential care facilities that also included a hospital wing. Year two and year students had by this time multiple experiences in both hospital and community settings.
Data collection for nurse lecturers was done through an email from Health Administration at Whitireia NZ. The email included an introduction to the research with an anonymous link and the information sheet as an attachment. Once this was done no further emails were sent to the nurse lecturers.

The questionnaires were hosted on Qualtrics®. Qualtrics® is a private research platform in the form of software that allows for the hosting of research questionnaires. Access to Qualtrics® was gained through a corporate account at Otago University through which this research project was being completed. Qualtrics® allows for anonymity by providing anonymous links and QR coded for easy access by participants. Qualtrics® only recorded IP addresses so that it was possible to check if a person had attempted the questionnaire more than once.

3.11 Data analysis

This research was conducted using a convergent parallel design, a form of mixed methods research that sees both qualitative and quantitative data collected at the same time and the mixing occurring at the analysis stage. Descriptive statistical analysis was used in order to describe and summarise data so that it is presented in a more meaningful manner. With this in mind the quantitative data was analysed and described using percentages in order to be able to account for how often a feeling or perception occurred.

Demographics for students included age, year of study and ethnicity. For lecturers this included ethnicity, years of clinical experience and years of teaching experience. This was collected in order to determine the number of respondents in each category and provide percentages and see if any patterns developed in corresponding categories.

Qualitative data, which, existed in the form of open-ended questions, provided an opportunity for participants to explore thoughts on some of the questions asked. As this data is unstructured it was analysed using thematic analysis in order to evaluate and determine any patterns and themes evolving. Reports were generated using Qualtrics® analyse tab and exported to Microsoft® excel for further analysis.
The researcher reviewed the responses numerous times in order to be familiar with the data. Qualtrics® analysis software was used to generate the most commonly used words and to label responses into broad categories using excel, applying colour to differentiate themes. The data was again reviewed, and the broad categories and themes were further defined and named. As the research was anonymous, the data and its meaning could not be verified by participants therefore the data was reviewed for explicit meaning as implied meaning is impossible to determine in this instance.

3.12 Chapter summary

This chapter provided a detailed description of the methods chosen to conduct this research. The approach to data collection and analysis was outlined. Ethical considerations especially with regards to the relationship of the participants were discussed and recruitment in light of this relationship was outlined. Chapter four will present the results from both questionnaires.
4. Results

4.1 Introduction

In this chapter the results from both student and lecturer questionnaires are presented. Descriptive data along with charts and graphs are used to present the demographic and results for several of the questions asked.

The analysis uses descriptive statistics to compare groups and results and commentary is used to elaborate on quantitative data. Data will also be analysed by comparing student responses according to the year enrolled and age group categories where appropriate. As previously outlined, this research is two pronged. The first results presented focus on how nursing students respond to the use of gallows humour in clinical situations. This is followed by the results obtained from the nurse lecturers.

In order to better demonstrate results some quotations from participants are used. Where this occurs the quotations from the participants’ answers appear in italics along with the year of the programme that they are enrolled in. No other identifying features are used as none were gathered in order to maintain anonymity of the respondents. The statements are quoted verbatim and there have been no corrections for grammatical or spelling errors.

4.2 Response and completion rates: Students

For this research there were 170 potential participants of which 66 submitted responses, making a response rate of 39%. In the returned responses 11 were less than 50% complete, making an initial completion rate of 83% for those participating, and these incomplete responses have been excluded from the results. Of the remaining 55 respondents (representing 32% of potential participants) five dropped out after answering 65% of the questionnaire, or as far as question 7B. A decision was made to include the responses of these five as the answered questions had students explain their perceptions and this was deemed important. From question 8A to completion at question 11, 50 respondents completed the survey with the exception of the elaboration or “B” questions (as described below), which means a final completion rate of 76%.
In Figure 2 below it is noted that responses for question 3B, 6A, B and 7A, B appear to have lower responses than other questions. However, question 3B was an option for students to add an answer that was not included in the list provided at 3A. In this case only 10 students went on to add further information. Students were only directed to Question 6 and 7 if they had not heard gallows humour in the clinical setting. These questions are similar to Questions 4 and 5 except that they asked students to anticipate their reactions, see Appendix C. Those who had heard gallows humour were directed to a different part of the questionnaire.

![Number of student respondents per question](image)

**FIGURE 2: STUDENT RESPONSES PER QUESTION**

At question 4, which asked students to indicate where they had heard gallows humour, three participants either chose not to answer or described a non-clinical setting where they had heard it, with the remaining 37 respondents describing the clinical situation where gallows humour was heard.

In answer to question 5A, which asked students if they felt that gallows humour was inappropriate did they speak up, 37 participants responded, with three additional students indicating by subsequent question responses that they did not answer 5A because they did not feel the gallows humour they heard was inappropriate. Question 5B asked the participants to
explain their answer and 39 students responded. This is explored further in the analysis of the responses.

For questions 8A, 9A and 10A the response rate was 100% amongst the 50 remaining participants. As with earlier questions, 8B, 9B and 10B allowed students a further chance to elaborate on their answers to part A of each question if they chose and as a result there are small dips in the response rates. An additional question, 8C, asked students who they thought they would speak to however it was later decided that this question was not relevant to the research question and the response data has not been included.

4.3 Socio-demographic information

Figure 3 sets out information about the self-reported ethnicities of the student respondents. Of the 55 respondents the majority, at 64%, identified as New Zealand European. For this question students were allowed to select more than one ethnicity if appropriate, these are included in the multiple ethnicities category.

![Student ethnicities](image)

**Figure 3: Respondents’ ethnicity**

Figure 4 sets out the age/year profile of the student respondents. The age group 18 - 20 had 16 respondents, which represented 29% of all students who responded. The majority of students
in this age bracket were enrolled in year one. The category 21 - 29 had the highest number of respondents with 18, which represents 33% of respondents. The majority of these students were in year three. These two age group categories also represent the majority of students enrolled in nursing at Whitireia NZ, so the sample is broadly consistent with the age demographic of this population. After these two groups the number of respondents in each age group drops noticeably.

![Participants by age and year enrolled](image)

**Figure 4: Student Age/Year Profile**

4.4 Qualitative understanding of gallows humour and thematic analysis

Early in the questionnaire students were asked to explain what they understood gallows humour to be. This question garnered responses indicating many of the students believe that gallows humour is a type of humour people use that made light of, or pokes fun at, difficult, hopeless situations like death, serious illness or injury.

**Making light of difficult situations:**

**Year three student:** “Dark humour”, making light of an unfortunate situation through humour

**Year one student:** Gallows humour is a form of humour that somewhat 'makes light' of more serious topics.
In addition many students also described that they thought the purpose of gallows was to help people cope or deal with the serious situations they encounter on a regular basis. The following statements by students are indicative:

**Humour as a coping mechanism:**
- **Year two student:** Humour often used, as a coping mechanism to deal with challenging, traumatic, or frightening situations usually not joked about.
- **Year one student:** It is being able to laugh in stressful and serious situations so you can deal with them and cope

**Gallows humour is offensive:**
A few students believed the content used in gallows humour could potentially be offensive to some people. This accurately sums up what students indicated gallows humour to be:
- **Year one student:** Humour/jokes involving content some might find disturbing/offensive/inappropriate
- **Year three student:** Black humour. People who joke about people’s situations. May not always be appropriate or professional

### 4.5 Speaking up if offended

Forty students (73% of respondents completing 65% or more of the survey) indicated that they have or may have heard gallows humour in the clinical setting. Two students in year one and five in year three make up the total of seven students (13%) who indicated they “maybe” heard gallows humour, while 33 (60%) said yes, they had heard it.

The proportion of respondents who thought that they had or may have heard gallows humour increases according to their years in the programme, with 55% (11 of 20 students) in year one indicating that they had or may have heard gallows humour, 82% (nine of 11) in year two and 83% (20 of 24) in year three. This is consistent with expectations that those students who have
completed more clinical placements are more likely to have heard gallows humours because of their greater exposure to situations where they might hear it.

**Table 1: Number of students who had or may have heard gallows humour.**

<table>
<thead>
<tr>
<th>Age</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-20</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>21-29</td>
<td>1</td>
<td>3</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>30-39</td>
<td>-</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>40-49</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>50+</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Prefer not to disclose</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>9</td>
<td>20</td>
<td>40</td>
</tr>
</tbody>
</table>

These 40 students were then asked in question five if they felt the gallows humour they heard was inappropriate, did they feel able to speak up. There was a small difference between the percentage of those who felt they could speak and those who felt they could not. Of the 40 participants who answered this question, 23 (57%) felt they were able to speak up and 17 (43%) felt they were not able to do this or that they did not need to speak up.

This question also asked students to explain their answer. For some the inability to speak came from how they were treated by preceptors or they felt it was not the place of a student to speak up.

The following quotes from students demonstrate some of the reasons why students felt they could not speak up:

**Gallows humour as an expression of feelings:**

*Year three student:* I wouldn't have ‘spoken’ up about it, as I am only a student and wouldn’t want to be placed as that student who takes offence to everything or that I take a place that I am better than the other staff members. I feel this is a way staff ‘copes’ with a lot of the things they are seeing while working in a hospital setting as only some wards I have noticed use gallows humour.
**Year three student:** Did not want to cause a scene. Everyone has their own sense of humour. It would depend on what was said if I was to react.

The following two students felt that gallows humour is simply a means of expression and did not feel the need to speak up.

**Year two student:** I didn't feel the need to say anything. It wasn't my place and also I wasn't offended. It is a way of expressing yourself. I don't think it's something to be offended over.

**Year three student:** Different people have different understanding. I respect people's way of talking.

**Feeling powerless as students:**
For some students the inability to speak up was about what they feel their place as students to be, not wanting to draw attention to themselves and feeling powerless. Others felt they might be judged or categorised in manner that would be unfavourable to them.

**Year three student:** In the situation among a group of nurses I felt uncomfortable speaking up. Time and place, would not want to be talked about behind closed doors.

**Year one student:** I felt powerless. Not in any state to speak up.

For those students who did not feel the need to speak up it appeared from their answers in Part B to be about coping with the ugliness of tragedy and death. However students often couched this with limits such as not making fun of patients or their family members. It was only acceptable if the humour was shared between health professionals. Protecting patients from the brutal nature of gallows humour appeared to be important for the nursing students who have encountered its use in a clinical setting.

**Year one student:** I feel it’s a way of dealing with what we encounter in day-to-day working life. It’s a way to get through it rather than feeling sad/depressed/angry at death and other bad outcomes, we make jokes and laugh to lift us back up. Not at the
When looking at whether or not students felt they could speak up according to age group and year enrolled, some interesting themes emerged (see Figure 5). Years one and two had quite similar percentages of students who indicated that, if offended, they would speak up. Of the 11 Year one participants who answered this question, 72% (n=8) answered that they would speak up. Of the nine Year two students 78% (n=7) indicated the same. The latter represented the highest percentage of students who felt enabled to speak up if the humour was inappropriate. Year three sees a big difference since of the 20 students who answered the question only 40% (n=8) of students felt they were able to speak up if they felt the gallows humour used was inappropriate. This is discussed in the following chapter.

All of the 17 students who felt unable to speak up were younger than 40, with more than half (71%) of these being in year three (n=12). Of the three groups under the age of 40, students in the age ranges 18-20 and 30-39 were almost evenly split, with 45% (five respondents out of 11) and 50% (two of four) respectively indicating they did not feel able to speak up. However, 67% (10 of 15) of students in the 21-29 age group felt they would not speak up even if they felt the gallows humour used were inappropriate.

When broken down further by age and year enrolled, in year one and the age group 18-20 67% (four out of six) felt able to speak up if the humour was inappropriate. The proportion of students in the 18-20-age category in year two is 50% (one of two) and in year three 33% (one of three) who felt able to speak up if they felt what they heard was inappropriate.

For the next group of 21-29, only one student in year one and three in year two answered the question. Of these four students, only one, in year two, felt able to speak up. In year three, of the 11 students in this demographic who responded to the question, only three, or 27%, thought they would speak up.

For the age group 30-39, year one did not have any respondents and year two had only one, who said yes they could speak up if they felt what they heard was inappropriate. In year three for this age group, one student out of three respondents indicated they would speak up. For the
remaining age groups across all years, 100% of respondents (n =10) said they would speak up if they felt that what they heard was inappropriate.

More generally when students are grouped into under 30 and over 30 years of age we see the biggest difference in whether or not a student will speak up. In the age group over 30 85% (11) indicated they would speak up as opposed to those under 30 where 39% indicated they would speak up if offended by what they heard. From these numbers it seems that older students are more confident to speak up.

![Ability to speak up according to age and year enrolled](image)

**Figure 5: Comparison of ability to speak up according to age group and year enrolled**

The following student sums up nicely what the other “yes” respondents were saying:

**Year one student:** I would speak up if I felt the humour was nasty or inappropriate. I think it is necessary sometimes to relieve tension in a situation where stress levels are high and the events occurring are stressful and really upsetting, people need a release valve so they do not feel overwhelmed.

In year two, nine students (16% of all respondents) said that they have or may have heard gallows humour. Of these seven felt they could speak up and two felt they could not. Both age categories 18-20 and 21-29 had one each who felt they could not speak up, with the younger
group having one student and the older group two who could speak up. Of the remaining four respondents, all felt they could speak up, one in the 30-39-age category and three in the 40-49-age category.

Two of those year two students who felt they could speak up indicated that it would depend on how others reacted to the humour as well as whether or not they felt what they heard was inappropriate. For them, if others seemed to take offence or the humour was insensitive then speaking up was an option. The appropriateness of the humour mattered.

For those in year two who felt they could not speak up, one felt those using the humour (R.N.’s) were senior and it was being used to lighten the situation and cope with what was happening.

**Year two student:** The people using the gallows humour were more senior than me (a nursing student). As long as the gallows humour is clearly a joke and making light of a situation, rather than making fun of a person then I would be able to see the humour and recognise it as a coping mechanism of a serious situation.

These two students felt like they did not have the power to speak up, as they are students.

The results for year one students are similar. Of the 11 (28% of all respondents) who said they had heard gallows humour, eight (73%) said they could speak up, three (27%) said they couldn’t. One of these students was made to feel inferior and could not speak up even though offended by what was felt to be inappropriate use of humour.

**Year one student:** The nurse had made me feel like I was already less than her so I felt too anxious to say anything else. Offended as I feel it’s inappropriate

In year three, five students felt they were unable to speak up because they were students and it is not their place to speak up. The theme of “not speaking up as just a student” comes up more in year three than the other years.

**Year three student:** If it was a between health professionals, as a student I wouldn't feel comfortable saying anything I would just ignore it

Of those students who felt they would speak up if they felt what they heard was inappropriate this seemed to come down to feeling empowered, a sense of confidence or boundaries.
**Year one student:** Because I have confidence that if something is inappropriate I will pull someone up on it.

**Year two student:** Because I know how to assert myself and know where to draw the line.

**Year three student:** I will always speak up if something is inappropriate.

Some students in year two and three did not feel the need to speak up, as they believe that this kind of humour either appealed to them or that generally they just thought they knew how to react to a joke.

**Year two student:** not easily offended, I know how to take a joke.

**Year three student:** I didn’t find it inappropriate. I find black and dark humour funny.

### 4.6 Responses by students who have not heard gallows humour

Of the respondents, 15 had not heard gallows humour in the clinical setting. If students answered that they had not heard gallows humour in the clinical setting they were directed to questions 6A, B and 7A, B. The first of these questions asked students if they did hear gallows humour, how did they think they might feel. They could choose from not offended, offended or would not care. The majority of these students, eleven (or 73%) indicated that they would not be offended, three (20%) would be offended and one (7%) said they would not care. See Figure 6 below.
For those who indicated that they would not be offended, it came down to matters similar to those who have heard gallows humour in that they understood it to be a way to cope with the terrible reality of tragic events that can happen in healthcare, but also understood that its use may offend some and so when and where it was used is important. For example:

**Year three student:** For me gallows humour is a way to manage the stress that can be involved in nursing. I can see that it might offend some people, but I don't find it personally so. However there is a time and a place for it and I think there's a need to be careful in the clinical environment. Clients and families might not understand the element of stress release.

Some students also felt that gallows humour was similar to their own sense of humour and would probably find it to be funny:

**Year two student:** Because it probably relates to my type of humour. It would depend on how it was used and I would not think it appropriate if it caused offence to the patient.

This group of students also felt that context was important for the use of gallows humour as well as who was there to hear the humour. Students did not indicate exactly for whom they thought gallows humour was appropriate.

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**Figure 6: Anticipated Reactions if Heard Gallows Humour**

<table>
<thead>
<tr>
<th>Anticipated reaction</th>
<th>Number of students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not offended</td>
<td>12</td>
</tr>
<tr>
<td>Offended</td>
<td>2</td>
</tr>
<tr>
<td>Wouldn't care</td>
<td>1</td>
</tr>
</tbody>
</table>
**Year one student:** If the gallows humour was said in a context where any humour was appropriate, then I would not be offended. It comes down to the context of the environment and people involved.

Interestingly even though this group of students had not come across the use of gallows humour they felt that if gallows humour was used as a way to cope with the stress of the job, then it was appropriate. They also indicated that even if used for coping they understood how this kind of humour maybe offensive. This is the same as students who have heard gallows humour in the clinical setting.

There were three students who felt that they would be offended if they heard gallows humour, one from each of the years in nursing school. Two of these were in the age group 21-29 and one in the age group 30-39. Of these students, one thought that gallows humour was just not professional and would upset patients and families:

**Year one student:** I don't think it is very professional. Depending on the individuality of the health consumer, it might be appropriate but I feel in most cases would be upsetting to patient and or family especially in helpless situations.

One student was clear that using gallows humour for whatever reason is disrespectful and that there could be other ways to relieve the tension:

**Year two student:** I just think it’s a form of disrespect towards the other person. No matter that way anyone will try to explain his or her reasoning's for this, it will always be unacceptable in my view. There are surely other ways a person can go about lightening the mood.

While the final student in this category indicated they would be offended their response was similar to those who had experienced gallows humour and were not offended. This student felt that sometimes it may be appropriate and that it was really dependent on the situation:

**Year three student:** It really depends on the intention of the person using gallows humour. I don’t think that gallows humour is always appropriate in the clinical setting but it really depends. Case by case situation I think.
The students who had not heard gallows humour in a clinical setting were asked to anticipate what kind of reaction they might have to hearing gallows humour. They were given multiple choices as well as an opportunity to add an answer should they have a reaction not listed. See Appendix C, question 7A. Mostly students chose multiple reactions, which gives the appearance that there is an increased number of responses. Five of the 15, or 33% of respondents, chose embarrassed as a reaction. Only one chose this as a singular choice while the others had a combination of embarrassed with anger or laughing, or no reaction. See Figure 7 below.

Of these students who said they would be offended, one student felt that the laughter might occur as a result of being surprised or nervous.

**Year one student:** I might laugh out of shock or nervousness. I would feel embarrassed if I did not have any control over my reaction and how it affects others. I would be angry as generally don't think it is appropriate, unless patient has similar humour.

The above student also seemed to think that gallows humour occurs between a patient and the healthcare professional and this would only be ok if the patient had a similar sense of humour.
Similarly the student below also thought that it would be inappropriate with patients however did not state whether or not this would be ok if the patient had initiated gallows humour. This occurred in several other answers with both students who have heard gallows humour and those who have not.

**Year three student:** I wouldn’t have any reaction unless I really felt that what was said was completely inappropriate and made the patient uncomfortable.

The final student in this category had very strong feelings about the inappropriateness of gallows humour and why they felt as though this absolutely should not be used in the clinical setting:

**Year two student:** I feel it is a form of disrespect. I think you should never say anything about someone unless it is something you are willing to say to their face. If you can’t say it to their face then don’t say it all - no matter the context.

Of these three students who felt they would be offended, two indicated that they would maybe feel comfortable speaking up. One student indicates that speaking up, as a student, was always difficult. This also echoes what students who have heard gallows humour felt as well.

**Year three student:** As a student it’s really hard to speak up about something that’s bothering you because of the power relationship that exist. I like to think that I could speak up if I were hear gallows humour but I’m not entirely sure whether I could. This is why I went with maybe.

Another student felt they would speak up depending on what was said and what context it was used in. The final student who has consistently said that gallows humour is offensive and inappropriate even if used for coping would definitely speak up.

**Year two student:** I would speak up about it because it is my right to not be forced into a situation that is going to make me feel very uncomfortable. If people talk like that then at least show me some respect and not do it when I am there. All I can do is share how I feel about this and ask that it not be used around me.
This student had very clear ideas about how inappropriate this kind of humour was and justifies speaking up in the next question that asks whom they would say something to. This student felt that speaking was important as they felt it was a way to make change.

4.7 Speaking up if gallows humour is inappropriate

The third and final section in this questionnaire was designed for all students to participate. It is at this point that five respondents exited the questionnaire.

Question eight asked students if they were to hear gallows humour and they felt it was inappropriate, would they feel they could speak up (see Appendix C Question 8). This may seem to be a repetitive question (similar to 5A) however not all those who heard gallows humour thought what they heard was inappropriate.

The number of yes responses went up considerably when compared to the number who said they would speak up if they were offended by gallows humour (Question 5A). There are two possible explanations for this. The first is that Question 8 involved everyone regardless of experience of gallows humour in a clinical setting, and the second reason may be about feeling the humour was inappropriate but not necessarily being offended by it. Figure 8 below represents the yes, no and maybe answers by all students who responded to this question.

![Figure 8: Hypothetically: Speaking up if gallows humour was inappropriate](image)

Not all students from Question 5A and B who heard gallows humour and said they felt like they could speak out answered the same way in Question 8A and B. Five of these students
indicated maybe for question 8A and B, which is different from their answer in question 5A and B. For this particular group of students, speaking up was reliant on the context and the situation in which the gallows humour occurs. For these students, if they felt comfortable in a setting then they may speak up but were also very aware of the power balance between students and nurses and this may prohibit them from speaking up.

There were two different reasons students gave for feeling they would not be able to speak up. The first reason was that for some they felt like they are just students and it is not their place to speak up even if offended. The second reason students gave was that they had concerns that speaking up may have a negative impact on how they were viewed and consequently any reference they may get in the future. This was especially true for students in the third and final year who spend a lot of time in clinical areas and rely on nurses for references for job applications.

**Year three student:** I wouldn’t want the older nurses to think I was just going to nark on everything that they said and I wouldn’t want my placement to be impacted because the “nursing” staff then decided they didn’t like me impacting on references, my name and how welcome I feel in the ward.

For some those students who indicated they would speak up, this was reliant on the relationship they had developed with the nurses they were working with. If it was a positive supportive relationship then students indicated they would feel comfortable to speak up.

**Year two student:** If I were comfortable with the people in the clinical setting I would speak up, depending on the power and the position that the person has in said clinical setting.

### 4.8 Ethics of gallows humour

Questions 9A and 11 asked directly about the ethics of gallows humour. Question 10 asked students if gallows humour was justified if it was used to cope with stress. All of these questions were Likert scale questions with the same rating scale used in Question 9.
Question 9 asked participants regardless of their experience with gallows humour to rank whether or not they felt the use of gallows humour by healthcare professionals was ethical. Fifty students answered this question. Of these, three or 6% strongly agreed, thirteen or 26% agreed, twenty-one or 42% students neither agreed nor disagreed, nine or 18% disagreed and four or 8% strongly disagreed. Figure 9 presents the numbers of these student responses regarding the ethics of gallows humour.

Of the three students who strongly agreed that gallows humour was ethical, one felt that even though gallows humour is ethical healthcare professionals still have a responsibility to behave in front of patients and family members. One student felt that as long as the humour was “tasteful” they would not have any problem with it.

Question 10A explained that according to the literature gallows humour helps people cope in difficult situations. This explanation was followed by asking participants if they thought using gallows humour was acceptable form of coping and required them to rank their answer using the same Likert scale as the previous questions.

Of the fifty students who responded to this 36 (72%) either strongly agreed or agreed that gallows humour, as a coping mechanism is ethical, eight (16%) neither agreed nor disagreed, 6 (12%) either strongly disagreed or disagreed. See Figure 10.
A high percentage, 72% of students who responded, either strongly agreed or agreed that gallows humour is ethical as long as it is used as a form of coping, while only 12% strongly disagreed or disagreed about this. Eight students, or 16%, neither agreed nor disagreed with the proposition. The following discusses respondents according to the year in which they are enrolled. See Figure 10 above.

When looking at the year in which respondents are enrolled there is very little difference in the numbers between the years, with the majority of respondents in each year group agreeing that the use of gallows humour to cope was ethical. Year three looks to have more who agree but they also had more respondents for this question. See Figure 11.
Many of the year three students stated that nursing is a stressful profession and there needed to be a way to cope, as stress can be unhealthy.

*Year three student:* It is method of managing stress in what can be a very stressful career. Better to manage the stress than let it build up, which would not be healthy.

However there was one year three student that felt it was probably not the best way to cope but did not think it would cause any harm.

*Year three student:* Probably not the best coping mechanism but doesn’t hurt.

Other students felt it was possibly ethical dependent on the context of its use, which is the same justification used in question 9A and 9B.

*Year three student:* I agree but it also does once again depend on the situation that it is being used. And also the people involved in the situation. And the frequency it's used and to what extent.

There were eleven respondents who were enrolled in year two. Most of these students fell between strongly agree, agree and neither agree or disagree. In these three categories there were 10 (91%) respondents who agreed and only one who strongly agreed. Students believed
that using gallows humour was not harmful and a safer way to cope. The following student sums up what many in the year two group believed about coping with the stress of the job.

**Year two student:** *Humour is known to relieve stress so it is safer than some other things people may use eg. alcohol, eating junk food.*

The year two students were also quick to point out that the humour was only ethical if it did not occur in front of patients or their family.

**Year two student:** *It is what it is ... people are human and coping mechanisms come in various forms. It probably isn’t ethical or culturally safe but if health care professionals are sensitive to those around them ie not in-front of patients or family and not hurtful then I think its ok.*

**Year two student:** *I do agree to some extent, but I don’t think it should be used around patients in a compromising situation.*

For the one student who strongly disagreed with the ethics of gallows humour for coping, they believed that they had their own ethics, that this differed from the majority and that if you cannot say something in front of your patients and their families then perhaps it just should not be said.

**Year two student:** *Society has deemed that it’s acceptable therefore the masses agree. I am not one who is part of the mass. I think for myself and have my own ethical beliefs and values.*

There were sixteen students enrolled in year one who responded to this question. Year one students had similar results to year three students in that the majority of students strongly agreed or agreed that gallows humour is ethical if used for coping. Of these 16, seven (64%) strongly agreed and five (31%) agreed. Together this represented 75% of the year one students who responded to this question and 24% of all respondents.

**Year one student:** *I think it is appropriate among staff to help lighten the mood and make work more enjoyable. I don’t think it’s appropriate among patients.*
**Year one student:** I think humour in any form is a great coping mechanism and can really help people who are struggling. (Note this student does not indicate if they are speaking about the healthcare professionals or patients).

The following discusses question 10A and 10B according to age of respondents. See Figure 12.

![Ethical if used for coping according to age group](image)

**Figure 12: Ethical if used for coping according to age group.**

The student questionnaire asked students if they believed that gallows humour was ethical if used for coping. This was analysed according to the age groups of the students. Across all age groups 72% of all respondents agreed.

The age group who had the largest amount of respondents who either strongly agreed or agreed that gallows humour was ethical is used for coping was in the 18-20 year old group. Within in this age group 92% respondents agreed.

The remaining age groups were reasonably consistent with those who strongly agreed or agreed with gallows humour as ethical for coping. The age group 21-29 were slightly higher at 13/18 or 72%, whereas the age groups 30-39 and 40-49 came in at 6/9 or 67% in each group.
For those students who neither agreed nor disagreed that gallows humour was ethical if used for coping the lowest percentage was in the age group 18-20 at 8%. Among the remaining age groups both 21-29 and 40-49 had 22% and the age group 30-39 had 16% who neither agreed nor disagreed that gallows humour was ethical when used for coping.

Interestingly the age 18-20 did not have anyone who strongly disagreed or disagreed that gallows humour is ethical if used for coping. The remaining groups had very small numbers of people who strongly disagreed or disagreed.

The numbers for this study are small and it is difficult to know whether or not the percentages would hold if there were more participants but from what was uncovered in the study the majority of student participants seem to believe that when used for coping gallows humour is considered to be ethical. This mirrors what the literature also revealed.

4.9 Gallows humour as ethical if not heard by patients and family

Question eleven asked students if they considered gallows humour to be ethical if patients or their family does not hear it. For this question there was no opportunity to explain the answer, although it has been noted that many students believe in the ethics of gallows humour if others do not hear it, which also includes patients and family members.

For this question, 44% of the fifty respondents either strongly agreed or agreed, while 43% neither agreed nor disagreed with the premise of gallows humour being ethical if not heard by patients or family. A total 22% of students felt that gallows humour is still not ethical regardless of whether or not it is heard by patients and family.

4.10 Student results summary

In this section of this chapter the results from the student surveys were presented. Themes emerged such as the context of where gallows humour is used is important and humour is ethical is used for coping and not used in front of patients or family. The most interesting and unexpected themes that emerged were that students in their third year of study were more reluctant to speak up if offended than the other years, and that students over the age of 40 were
more likely to speak up than younger students. The three tables below summarise students understanding of gallows humour, the alternative words they used to describe what gallows humour is, and the reasons students gave for speaking up or not speaking up. The findings will be discussed further in the next chapter.

**Table 2: Students understanding of gallows humour**

<table>
<thead>
<tr>
<th>Students’ understanding of gallows humour</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Making light of a situation</td>
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<tr>
<td>- A coping mechanism</td>
</tr>
<tr>
<td>- The ability to look at something, others would see as &quot;inappropriate medically&quot; and be able to see it in a funny sense to help you mentally cope</td>
</tr>
<tr>
<td>- Humour in desperate/hopeless situations</td>
</tr>
<tr>
<td>- Jokes others may find offensive</td>
</tr>
<tr>
<td>- Jokes about something serious like death/illness</td>
</tr>
<tr>
<td>- Inappropriate jokes due to situation jokes occur</td>
</tr>
<tr>
<td>- Humour that takes the seriousness out of tragic situations</td>
</tr>
<tr>
<td>- Jokes about things not normally laughed at such death</td>
</tr>
<tr>
<td>- A away to let emotions</td>
</tr>
<tr>
<td>- A way to detach from the seriousness of the situation</td>
</tr>
</tbody>
</table>

**Table 3: Alternate words used to describe gallows humour.**

<table>
<thead>
<tr>
<th>Alternate words to describe gallows humour</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Morbid humour</td>
</tr>
<tr>
<td>- Dark humour</td>
</tr>
<tr>
<td>- Black humour</td>
</tr>
<tr>
<td>- Ironic humour</td>
</tr>
<tr>
<td>- Dry humour</td>
</tr>
<tr>
<td>- Dirty humour</td>
</tr>
<tr>
<td>- Sarcastic humour</td>
</tr>
<tr>
<td>- Cynical humour</td>
</tr>
</tbody>
</table>

**Table 4: Reasons why students will/not speak up**
Students reasons for not speaking up

- Felt powerless
- Am just a student so not my place
- Did not want to get labelled
- Was worried it would affect my reference

Students reasons for speaking up

- Felt it was inappropriate to the situation
- Saw it as a way of coping with the situation happening
- I know when to speak up
- Felt supported so if offended I could speak up
- I felt what was said was disrespectful

The next part of this chapter will deal with the results of the surveys from nurse lecturers.

4.11 Nurse lecturers questionnaire results

Following a section on gathering demographic information, the lecturers’ questionnaire was set up in three parts. The first part identified their understanding of gallows humour and then asked if they had experienced gallows humour while working clinically. Yes and no answers were set up so that selection of one of them brought them to different subsequent parts of the questionnaire similar to the student questionnaire.

Nurse lecturers had a slightly different questionnaire from students. The questions that were similar were whether or not they heard gallows humour while working clinically and (if so) whether or not they were offended by what they heard; whether they thought gallows humour used by healthcare professionals to be ethical; and if, as the literature generally suggests, when gallows humour is used to cope with stress is it acceptable?

The differences in the lecturers’ questionnaire dealt with their experiences with students’ experience of gallows humour and their perception of whether or not they felt students were offended. Lecturers were also asked to describe the circumstances where they felt gallows humour was justified.
The first part of the analysis deals with the closed-ended questions that were presented in a Likert form to participants. However, note that some questions used a Likert scale and included a section for participants to elaborate on their answers. Following on from this will be the presentation of the themes that evolved during analysis.

4.12 Demographic completion rates for nurse lecturers

For this research there were 16 potential participants of which 10 submitted responses, making a response rate of 63%. In the lecturers’ questionnaire all questions were completely answered. Of the 10 who responded, eight had 20 plus years and two had 11-20 years of experience working in clinical areas. See Figure 13.

When looking at teaching experience it is more varied (see Figure 13). The highest number of respondents (four) had 6-10 years of experience, this represented 40% of respondents.

![Figure 13: Lecturers’ years of teaching and clinical experience.](image)

Of these respondents, the two with 11-20 years of clinical experience also had 6-10 years of teaching experience. The remaining group all had 20 plus years of clinical experience but varying amounts of teaching experience.

The demographic information included participants’ ethnicity, see Figure 14. Participants were given a list to choose from and also had the opportunity to add an ethnicity if theirs did not
appear. Further to this they were also able to choose multiple ethnicities, as people will often identify with more than one. The largest proportion of participants was New Zealand European at 50%. The remaining 50% was divided evenly with all other identified ethnicities.

![Ethnicity Pie Chart]

**FIGURE 14: LECTURERS’ ETHNICITY**

### 4.13 Understanding of gallows humour

Like students, nurse lecturers were asked to explain their understanding of gallows humour, (see Appendix D question 1). All ten participants answered this question and indicated they did understand what gallows humour was. Five of the lecturers indicated that gallows humour was used to lighten serious situations and that often these situations are not about something you would normally laugh at. Others stated that gallows humour was a combination of lightening the atmosphere and being something used to cope. One lecturer expressed that gallows humour was an “inappropriate response to someone’s tragedy”. The remaining respondent believed that gallows humour was used to address or manage painful or socially taboo topics.
4.14 Gallows humour in the clinical setting

Question 2 asked lecturers if they had heard gallows humour in the clinical setting while they were practicing. All ten participants responded yes to hearing gallows humour in the clinical setting. This was followed by Question 3, which offered respondents an opportunity to explain what they heard. Only three (30%) of the respondents provided an actual example of what was heard. One (10%) indicated that too much time had passed to remember what was said. One did not provide a text answer. The remaining five respondents gave an example of the kind of situations where they thought gallows humour would appear, such as with bowel movements and other bodily functions, and echoed what was said earlier about gallows humour being used during challenging times.

One respondent explained that gallows humour was a quip or a remark that was not appropriate or professional. Another respondent thought that while gallows humour was used in tragic times to lighten ‘very difficult’ situations, it is never acceptable in front of patients or their families. Of the 10 respondents six indicated that gallows humour was a fairly common occurrence during their clinical work.

One respondent who identified as Samoan indicated that they had heard gallows humour in the clinical setting and relayed that they could not remember what was said but remembered not understanding the joke because of the English/European context. It turns out for this participant that because of the stated English/European context an explanation was often needed when jokes were made. Once that occurred it was felt there was a delayed understanding of the joke, however being offended was not what was felt, rather an “odd curiosity” about why people thought it was funny.
4.15 Response to gallows humour

In question 3 nurse lecturers were also asked to identify their reactions to the use of gallows humour. Respondents were given a list of reactions; see Appendix D. Respondents were able to choose as many reactions from the list as they saw fit and as needed. This resulted in several different combinations of reactions chosen. For this question only 8/10 respondents provided an answer. Lecturers also had the ability to add any reactions that were not listed. This was followed by an opportunity to explain their responses.

Six of the respondents included the choice laughed in their answers. Of these six, five also indicated they thought that what was said was funny. The combinations of answers varied among the eight respondents. By way of example the combinations included:

- Laughed
- Thought it funny, laughed
- Laughed, felt angry, ignored it
- Thought it funny, laughed, felt offended, felt embarrassed, did not care

For question 3, respondents were given a chance to explain their choices. Five respondents went on to explain that their response depended on the situation, what was said and who was around to hear it. One respondent explained that there were times when they laughed even if they did not want to, but gave no further explanation. Another respondent believed that they would feel offended if the humour was aimed at patients, nevertheless they also indicated that if the joke were about the situation they would be more likely to find it funny. They also indicated that they at times felt embarrassed to find the jokes funny but did not explain this further.

Seven, or 70%, of the lecturers believe that the context and who was present when gallows humour was used was important. For the most part lecturers considered gallows humour to be acceptable if it was not said in front of patients. Lecturers also felt that the joking about situations was acceptable, however what was not acceptable was to joke about the patients themselves.
One respondent indicated that sometimes what was happening was so challenging and it was the humour that helped get them through. However they also felt that the context of what was said and where it was said was important. This respondent also cautioned that what one person finds funny another might not as words can have multiple meanings and can be taken in different ways. This theme also emerged in the literature review.

One nurse lecturer said that as a novice R.N. they felt embarrassed and that they thought the use of gallows humour was a strange reaction to the situation. However as they gained more experience in the clinical setting they felt they had a better understanding of why it is used.

4.16 Encountering students who heard gallows humour

In question 4 and 5 nurse lecturers were asked if they had students talk to them about gallows humour and did the lecturer think the student was offended by the gallows humour (see appendix D). Seven respondents indicated that yes they had students who have spoken to them. Of these four indicated that they believed the student to be offended by the gallows humour and three indicated they did not think the students were offended.

4.17 Gallows humour as ethical

Like the students, nurse lecturers were asked if they thought gallows humour was ethical. For this question the Likert scale used for students was also used. See Appendix D, question 8. For this question, seven or 70% of the respondents felt that gallows humour was ethical. Of the remaining lecturers, two or 20% neither agreed nor disagreed about gallows humour being ethical and one or 10% indicated no they thought gallows humour was unethical. This is shown in Figure 15.
There was one respondent who disagreed that gallows humour is ethical. For this person it was about the situation, if the humour was between two colleagues and did not affect anyone else then perhaps it could be ethical. This was the same person who earlier indicated that they sometimes were embarrassed that they laughed at the gallows humour. Unfortunately they did not explain this any further but perhaps the difficulty for the respondent was they found what was said to be funny despite feeling that using gallows humour was unethical.

For those who neither agreed nor disagreed one indicated that humanity is flawed but did not go on to explain what they meant by this. The other respondent felt the question was subjective and that gallows humour could be ethical or unethical, it really depended on the situation, and what was said.

Of the respondents who said they strongly agreed or agreed that gallows humour was ethical, one believed ethics is a grey area. However if the humour was used in difficult or challenging situations to alleviate stress it was acceptable. Nevertheless the content and the intent of what was said was important, in that especially if it provided an outlet that alleviates the healthcare professionals’ stress and allows them to move on then it is ethical. Another respondent believed that it was ethical if used in the staff room, at debriefings or at staff meetings.

Interestingly, with this question on the Likert scale there seemed to be strong differences in opinion with regards to the ethics of gallows humour used by healthcare professionals. However, when this is examined further all of the lecturers indicate that there are ‘unwritten
rules” about when and where to use gallows humour and that the context, intent, subject and audience have an impact on whether it is ethical. This correlates with the literature review which also indicated that the “unwritten rules” when using gallows humour was important.

4.18 Is there a time gallows humour can be justified

In question 9 participants were asked if there was a time they could think of when gallows humour was justified. The answers given in this section by students closely reflected what was said about justifying gallows humour in the literature review. Students believed gallows humour was justified if it was used for coping and relieving stress as it gave people a bit of time to remove themselves from the stress and reframe the situation before carrying on. Not doing so was believed to possibly have an effect on clinical judgement.

While students justified the use of gallows humour for coping they also indicated that it needed to be in front of appropriate people and at the right time in order to justify it. This way of thinking not reflects what was said in the literature but is also closely related to what is said in order for gallows humour to be ethical.

4.19 Is gallows humour an ethical form of coping?

Nurse lecturers were also asked if they thought gallows humour was an acceptable form of coping (see Figure 16). See appendix D question 10. When the answers strongly agreed and agreed are combined this represents 70% of the respondents. Following this 20% neither agreed nor disagreed that gallows humour is an acceptable form of coping. Only 10% of respondents disagreed that gallows humour is acceptable as a coping mechanism. For this question respondents were not given an opportunity to explain their answer.
4.20 Gallows humour as ethical if not heard by patients and families

Similar to the student questionnaire, nurse lecturers were asked if they thought gallows humour was ethical as long as patients and their family did not hear it, see Appendix D question 11. See Figure 17 for results.

Half of the participants said either definitely yes (n = 2, 20%) or yes (n = 3, 30%) to this question. Respondents were also given the opportunity to explain their answer.

For those who agree that gallows humour is ethical as long as patients and family do not hear it, one believed this because of its ability to relieve stress. One respondent felt that this is not a black and white situation and it really depends on the circumstances. They believed that it
depended on the context the humour occurred in and the intent of the humour. Another indicated that gallows humour needed to be used with caution in areas where patients and families could hear. However they also believed that when used correctly with patients and their family, using gallows humour could help open communication especially on difficult topics. The final respondent in this category believed that it was ethical if it did not cross a line such as jokes about culture, peoples’ beliefs or including racism.

For those that were neutral on the issue, one believed that it depended on the situation but some topics are off limits, such as racism and homophobia. The other respondent believed that it is ethical only as a form of coping but never in front of patients and family unless they are contributing. However they also indicated that there is no right or wrong answer, it really depended on the situation.

Interestingly, however differently the participants answered the Likert scale, they actually all broadly agreed gallows humour is ethical but referenced this with “it depends” and went on to explain the circumstances using gallows humour depended upon. There was only one exception to this, the respondent who that believed gallows humour was unethical regardless of the circumstances.

**TABLE 5: SUMMARY OF LECTURERS’ DESCRIPTIVE ANSWERS**

<table>
<thead>
<tr>
<th>Lecturers’ understanding of gallows humour</th>
<th>When is gallows humour ethical?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- It lightens serious situations</td>
<td>- If the context or intent is appropriate</td>
</tr>
<tr>
<td>- It is something you would not normally laugh at</td>
<td>- Humanity is flawed</td>
</tr>
<tr>
<td>- Something used to cope</td>
<td>- If it is used appropriately between colleagues</td>
</tr>
<tr>
<td>- An inappropriate response to someone’s tragedy</td>
<td>- It is a grey area, depends on context</td>
</tr>
<tr>
<td>- Used to address painful or socially taboo topics</td>
<td>- If not used in front of friends and family</td>
</tr>
<tr>
<td></td>
<td>- Under no circumstances is gallows humour ethical</td>
</tr>
</tbody>
</table>
4.21 Chapter summary

In this chapter the results from nursing lecturers’ and students’ questionnaires have been presented. Results and themes have been highlighted and are elaborated on in the following chapter. On the whole there were many similarities in the results between the two participant groups, but some small differences, which are also discussed, in the next chapter.

The key themes that emerged from this section included: the importance of context when using gallows humour, generally gallows humour is recognised and accepted as a form of coping for both lecturers and students, and that gallows humour is ethical depending on the context and some ‘unwritten rules’, including that it not be used in front patients their family or friends. These themes generally aligned with what was found in the literature review, with any differences also discussed in the following chapter.

Additional themes emerged that were not integral to the research question. These included that students in their final year of training and younger students were less likely to speak up when they were offended by gallows humour than students in their first or second year, and more mature students. Another was that ethnicity may also have a significant impact on the individual’s perception of the acceptability of gallows humour. These themes are discussed generally but not explored in depth.
5. Discussion

5.1 Chapter introduction

In this chapter, a discussion of the key findings of both questionnaires will be presented. Where possible the results from lecturers and students questionnaires are compared and discussed in terms of not only the literature but also in terms of similarities and/or differences that were found between the two groups.

5.2 Demographic information

Demographic information was collected for this research. For students this included age, ethnicity and the year in which they are enrolled. For lecturers this included ethnicity, number of years spent working clinically and the number of years spent working in undergraduate nursing education. The demographic results were unremarkable in both instances and are only discussed briefly in terms of ethnicity.

This information was collected as it was thought to be important since all factors could have an impact on how participants see the use of gallows humour. This was especially important for students as they have such limited clinical experience so far in their careers and tend to be younger than the lecturers.

Although the demographic information did yield some differences in responses with regards to age and year enrolled among particular student groups. There were some interesting comments made in terms of ethnicity and how culture can impact on how a person perceives the use of gallows humour.

While ethnicity was part of the demographic information collected, it featured only once in each of the students’ and lecturers’ questionnaires and although it does come up occasionally in the literature it was not discussed in the literature review. It is important to discuss briefly here as Whitireia NZ has a focus on cultural safety and is unique in that it offers three nursing programmes, two of which are geared to specific ethnicities found throughout New Zealand and the South Pacific.
It is unfortunate that the BNM students were unable to participate in the research when it occurred, as it was the intention to include them in the study. However students from year two in the BNP programme did take the opportunity and this is partly why some discussion of ethnicity, in particular Samoan culture, is important.

When permission was granted to approach BNP students I had a lengthy discussion with a colleague teaching in the BNP programme. She had concerns that this cohort of students would struggle with the concept of gallows humour in a European context. Her concerns were due to a function of humour in Samoan comedy known as fale aitu. In Samoan culture humour is important and this concept of fale aitu exists in comedy shows and can be seen on stage or on television and used as a form of entertainment. It is a long-standing brand of humour in Samoan culture which involves a performance of parody that pokes fun at people in positions of authority (Simpson, 2005). Fale aitu is believed to exist in order to allow the everyday person a brief moment to laugh at the authorities that influence their lives (Simpson, 2005). Fale aitu is literally a performance art in satirical comedy (Donnell, 2014). Although there may be some amount of spontaneity, fale aitu is generally scripted and rehearsed (Donnell, 2014). This differs from gallows humour, which is usually spontaneous and occurs in the heat of the moment. Fale aitu is aimed at specific topics that can be serious and the purpose is to make people laugh and feel better.

Much like gallows humour in the healthcare professional context, in fale aitu it is the circumstances of tragedy of everyday work that is joked about. The BNP lecturer felt it was important I understand this concept prior to recruiting her students. One respondent to the student questionnaire, who identifies as Samoan and has experienced gallows humour in the clinical setting, indicated that they did not find the use of gallows humour to be offensive. They attributed this to their understanding of how dark humour was used for comedy within their cultural context (though they did not name fale aitu). While the student liked dark humour, they were also quick to point out that some content of the jokes had the potential to be contentious.
**Year two student:** In a Samoan sense, dark humour is expressed as comedy. Sure, subjects of conversation are controversial but I find it entertaining.

It seems as a culture Samoan people are exposed on some level to a form of dark humour and for the Year two BNP student this may have had an impact on how gallows humour was viewed and accepted.

5.3 Students’ understanding of gallows humour

For this research participants were provided the following definition:

“Gallows humour (also known as black humour) is a style of humour that treats serious, frightening or painful experiences such as illness, trauma and even death in a light-hearted way” (Obrdlik, 1942; Watson, 2011).

In order not to influence the participants’ answers, this definition makes no mention of the purpose of gallows humour or why it is used in difficult situations. Participants were encouraged to read the definition prior to starting the questionnaire so that they had some idea about the kind of questionnaire they were responding to.

Participants were then asked to explain their understanding of gallows humour. This yielded a host of explanations. Most related to humour that makes light of serious situations, while some attempted to explain what gallows humour is by using alternative words such as cynical humour, black humour and dark humour. However most students went beyond a simple explanation of what gallows humour is and explained the purpose of gallows humour in terms of coping with difficult situations. Students demonstrate an understanding of just how difficult it can be working in situations where people are suffering in very difficult situations and acknowledged the need to find some way of coping.

Also included in students’ understanding were alternative words that they used to explain what gallows humour is, words such as dark humour or sarcastic humour. Table 3 at page 72 provides a summary of the alternative words students used for gallows humour.
The literature also revealed that the terms dark, black and/or cynical humour are sometimes used as alternative terms for gallows humour. Gallows humour, as the literature review indicates, is an old term originating from humour around deaths occurring on the gallows (for example, hanging), which for the most part do not exist in the modern era, and it is likely that words such as black and dark are used as modern substitutes.

Cynical humour in the literature relates to sarcasm and negative humour and occurs when the jokes and laughs are aimed at others (Capps, 2006; Hall, 2005; Hawkins, 2008). This is in contrast to what is said to be important and ethical when using gallows humour, which is that laughing at others is not an accepted form of gallows humour but is an indicator of something more sinister such as burnout (Craun & Bourke, 2015). While appropriate use of gallows humour is effective for coping, using cynical, sarcastic or negative humour is an indicator of poor coping even when used in the context of gallows humour. It is a fine line and making jokes about the people personally involved in the tragic situation is considered indicative of ineffective coping (Craun & Bourke, 2015; Hawkins, 2008).

Other terms such as sarcastic, ironic and dirty humour indicate forms of humour that may be used in the context of gallows humour but are not necessarily gallows humour. The use of alternate words by students may indicate some confusion around what gallows humour really is and just how difficult it is to define.

5.4 Gallows humour and having a sense of humour

What people find funny is largely subjective and, as stated previously, dependent on a multitude of things. Just as defining humour is difficult, so is defining what we mean by a ‘sense of humour’. For some authors, a sense of humour is viewed as a personal characteristic and involves the ability to laugh a certain situations or at oneself and people can have varying degrees of sense of humour (Moran & Massam, 1997). Some people find humour in things more readily than others and having a sense of humour in some instances may contribute to how humour is used and may affect the perception of the use of gallows humour.
Having a sense of humour does not decrease stress per se but it gives people some ability to cope with what is occurring (Moran & Massam, 1997). While the literature does not indicate that having a sense of humour is needed to appreciate the gallows humour and benefit from its positive effects, it may help. The literature review did not reveal any information on what it meant to have a sense of humour and how this may relate to the perception of gallows humour. Having a sense of humour was a theme that occurred with student participants. Many student participants felt they related to gallows humour and indicated that they would not be offended upon hearing it. Student participants indicated this was due to gallows humour being closely related to their sense of humour.

Having a sense of humour is noted to help improve one’s mood, boost immunity, decrease depression, anxiety and stress (Mesmer-Magnus et al., 2012). When discussing gallows humour in relation to their sense of humour students made no mention of the effects of humour on their mood or stress levels. While students signalled that they like gallows humour because its suits their sense of humour this might be better viewed as they appreciate a dark sense of humour, as this is what gallows humour tends to lend itself to.

### 5.5 Gallows humour as way of coping

The literature review completed for this research indicated that generally healthcare professionals used gallows humour to find relief from the tension that comes with the responsibility of caring for people in difficult and serious situations (Frankl, 2004; Rowe & Regehr, 2010; Vivona, 2013; Watson, 2011). The need to cope is vital when caring for patients and it would seem that the majority of students also view the use of gallows humour in this manner. The majority of students who either condone or justified the use of gallows humour did so in relation to coping.

If students had heard gallows humour in the clinical setting they generally felt its use was an acceptable form of coping even if they did not like what they heard. For those students who have not yet encountered the use of gallows humour the majority had the same response as those who have heard gallows humour. Students in all three years seemed to understand how
difficult it can be to care for sick or severely injured people, given the intensity of the emotion in a room and that the healthcare professional has their own feelings to deal with.

Most students accepted the need to release the tension. Nevertheless students did feel the need to couch this within their own set of rules, including that as long as patients or their family do not hear it, it appears to be more acceptable. For patients and family this kind of humour about their situation would often be offensive and possibly it disparages their suffering. This is a major theme that emerges in the results from participants and the literature.

Humour does seem to find its way into very serious situations but in reality there can be very little that is funny about some of what healthcare professionals cope with. There is something intangible about what a joke can do in those very difficult moments in patient care. For some this seems to be the release they need in order to carry on. A short break from the intensity of the moment seems to give people enough time to refocus in order to continue. In fact some authors believe gallows humour is more professional than some other forms of emotional expression such as becoming angry or throwing things (Buxman, 2008; Rowe & Regehr, 2010; Wanzer et al., 2005). However there were some students for whom, no matter the difficulty of the situation, gallows humour was not an acceptable form of coping as they felt it was disrespectful to patients. There are also those in the literature who would agree with how the students felt. These authors also felt gallows humour was disrespectful and had no place in the clinical setting (Strudwick et al., 2012).

There appeared to be no difference in the understanding of gallows humour based on the participant’s age or the year in which they were enrolled. Most students regardless of age or year enrolled generally believed that gallows humour was a form of humour used to cope in difficult situations.

The expressed perceptions of students concurred with much of what the literature revealed. One of the biggest concepts to come out of the literature review was that gallows humour is used during stressful times in order to cope, i.e. relief theory, which indicates that the joke allows people to briefly remove themselves emotionally from the situation in order to cope. There were a multitude of authors who explained that the benefit of gallows humour relates to its ability to allow people to refocus, even if temporarily, which seems to promote coping (Buxman, 2008; van Wormer, & Boes, 1997; McCreadie, Wiggins, 2009; Morreall, 2009;
Watson, 2015; Watson, 2011). These stressful times often involve death and illness that reflects what the student responses referred to.

Results from student participants also indicate that for the most part they believed that gallows humour was a chance at relief from the tension and/or negative feelings being experienced. Students believed gallows humour allows professionals to let out emotions, reduce the seriousness and assist with coping. They also point out that while gallows humour may help with coping it may also be offensive to others.

5.6 Appropriateness of gallows humour

The majority of students have experienced some form of gallows humour in the clinical setting. Most of what they heard was between other healthcare professionals, mainly R.N.’s, which is to be expected, as this is whom they are working most closely with. The majority of students in this group indicated that they did not feel what they heard was inappropriate and again coping is the major reason why.

Students would be offended if gallows humour is used inappropriately or in front of people who should not hear it, such as patients and family members. The importance of gallows humour occurring in the presence of the right people is a theme for both the students and one that occurred in the literature review. This theme comes up again when students discuss the ethics of using gallows humour, as many students believed that gallows humour was ethical depending on who hears it.

The difficulty of course is that there is no way to predict how even how those present may respond to the humour voiced. Even those who are seasoned professionals, who likely have experienced gallows humour throughout their career, may find some gallows humour unpalatable. While generally the purpose of gallows humour is not to cause harm or have malevolent intentions, the very content which the humour is derived from lends itself to misinterpretation and this alone can have the ability to offend.
5.7 Gallows humour is not professional

Several students, regardless of whether or not they have heard gallows humour, felt the use of gallows humour even to cope was not acceptable professional behaviour and that there are better ways to cope. Although not a big focus, this is consistent with some of the literature explored. It is not clear if, much like the medical students described in the literature review, this group of students feel those using gallows humour are setting a poor example, but it is clear they think it is unacceptable. These participants believed that gallows humour was disrespectful of the patient and felt there must be alternative, more respectful ways to cope with distressing situations.

It is important to remember that students, regardless of the year they were enrolled, have had limited clinical experience and are viewing the use of gallows humour from an outsider’s perspective. Medical students felt that they could not really understand or justify the use of gallows humour as they were not close enough to what was happening or often not involved in the direct care of patients in life threatening situations where gallows humour is more likely to be used (Tariq et al., 2016). This is likely the experience of the student nurses as well.

Of note, one student mentions that nursing is a caring profession and is unable to reconcile gallows humour in light of this. This is consistent with the views of Piemonte (2015) who felt strongly that gallows humour has no place in caring for patients as laughing at the suffering of patients is not only dismissive but it also belittles the pain and suffering patients are experiencing. There is no doubt that to some gallows humour appears harsh and disrespectful. It is often stated that gallows humour needs to remain behind closed doors in the company of only those involved. Keeping gallows humour backstage and not letting others be party to it makes it almost seem taboo. However people are aware that it occurs and many accept it as a coping mechanism.

How nurses act and give care, and how people perceive nursing behaviour, is all part of the cloak of professionalism. Nurses are judged by what they say and do, regardless of the purpose, so it is necessary to keep some of what they do from those they care for in order to maintain that respect. This does not necessarily mean the use of gallows humour is unprofessional but rather it is professional, as the nurse knows the boundaries and what ought to and ought not to
be said in front of patients. Having said this there are some patients who do use gallows humour in relation to their own situation.

5.8 Gallows humour and the ability to speak up

Both the literature and the results from the research make it fairly clear that using gallows humour in the context of coping is acceptable as long as it adheres to some unwritten rules, such as not being used in front of patients and their families. In spite of this there is also the chance that using gallows humour can be offensive or viewed as inappropriate to some who are close enough to hear it and this was important to explore from a student perspective.

As this research sought to gain the students’ perspective it was important to explore how they felt about gallows humour. Students who have experienced gallows humour were asked early in the questionnaire if they had heard gallows humour in a clinical setting. Students who had not heard gallows humour were then directed to another part of the questionnaire designed for them. For those who had heard gallows humour, they were then asked if they felt what they heard was inappropriate and if so did they feel they could speak out.

A question further on in the questionnaire was directed at all students regardless of their experience with gallows humour. They were asked if they were to hear gallows humour and they felt it to be inappropriate, would they speak up. While these two questions seem similar it was necessary to explore as taking offence and thinking something is inappropriate are not necessarily the same thing. Furthermore not all students have experienced gallows humour yet and it was important to get their perspective on how they thought they might respond.

For those who have heard gallows humour, asking this question again in a hypothetical situation looks at gallows humour in a more general sense rather than looking at specific incidents in their clinical experience. This hopefully gives a more in-depth view of the student experience and perspective.
Participants who have heard gallows humour in the clinical setting and felt it was inappropriate provided a range of responses. These included yes they felt empowered especially if the humour involved poking fun at patients, or no they were unable to speak up due to their position as a student. For some students, feeling unable to speak up was due to how they were treated by the R.N they were working with. If they did not have a comfortable relationship with their preceptor they were unlikely to speak up.

Although students are in the clinical areas for a brief amount of time, it is important for the relationships with healthcare professionals especially R.N.s to be positive. Relationships that are positive and supportive help foster good self-esteem, confidence, resilience and a feeling of connectedness with the team (Levett-jones & Lathlean, 2009). When students are not treated well and do not feel like they are part of the team they are unlikely to speak up when they see behaviour that they are uncomfortable with. In fact they are more likely to comply with what others are doing and if no one is speaking up this is what students are most likely to do (Cornish, & Jones, 2010; Levett-Jones & Lathlean, 2009).

According to the literature, for gallows humour to be considered ethical and professional it ought not to be used by healthcare professionals to make fun of people as this is considered to be harmful (Oczkowski, 2015). This seems to be where both students and clinicians draw a line on gallows humour.

A key aim of nursing education is to develop the student’s sense of professionalism. Nursing has fought hard to gain and maintain its reputation as a credible and respected profession with unique responsibilities and skills that play a crucial role in patient care. Professions are required to have occupational knowledge and skills (Bisholt, 2012). Nursing is now considered to be a profession as it has educational pathways and regulating bodies (Westwood & Rhodes, 2013). At Whitireia NZ the concept of professionalism is introduced in year one and continues to be developed throughout the three years. Early on, student nurses are trained to have a sense of what it means to be professional and for some participating in the questionnaire; this is reflected in what they consider to be professional behaviour.

Part of the process of nursing school is to socialise students into the nursing profession. This socialisation takes place within both the classroom and the clinical learning areas. Nursing students spend an increasing amount of time in clinical experiences as they move through
nursing school. At Whitireia NZ the time spent in clinical areas starts off with four-week clinical experiences and advances to nine weeks in their third year. During the clinical experiences, regardless of the length of time of each stint, it is important for students to build good relationships with those they are working with, particularly with the R.N.s, as this is whom they work with most closely.

Building positive working relations helps foster a positive sense of self-esteem, increase confidence and gives students a sense of connectedness (Levett-Jones & Lathlean, 2009), all of which has an effect on a student’s ability to speak up when they encounter something that they feel uncomfortable with (Bradbury-Jones & Alcock, 2010; Cornish & Jones, 2010). It became evident in this research that when a student felt connected and part of the team they had the confidence, or felt that they would have the confidence, to speak up if offended by the use of gallows humour. Those students who had good relationships and felt part of the team also felt they would speak up if they thought they needed to.

As educators we believe it is important to empower students so that they feel confident in what they are doing. It is also important to the nursing profession as empowerment can help foster a healthy self-esteem (Bradbury-Jones, Sambrook, & Irvine, 2007) which is essential to good mental health and the ability to deal with stressful situations. However, despite the education, students often feel disempowered when R.N.s behave negatively towards them and experience difficulty challenging issues they are concerned about (Bradbury-Jones et al., 2007).

In this research there were some students who did not feel comfortable enough to speak up. For some of them this was the result of how they were treated by R.N.s, which left them feeling powerless. One student even stated that they felt powerless and unable to speak up while another student had experienced belittlement by the R.N. they were working with. This treatment left them feeling inferior to the R.N. and not able to speak up.
Actions that demean a person and make someone feel inferior are symptomatic of bullying (Sinclair, 2013). This is a hot topic currently in the nursing profession and elsewhere. Unfortunately students often experience bullying by the R.N.s they working with in clinical areas (Walker & Clendon, 2012). In their national survey of nursing students, Walker and Clendon (2012) describe behaviour that includes “intentional threatening, demeaning or intimidating behaviour causing harm, manipulation or coercion” as bullying. This kind of behaviour towards students who already feel vulnerable is not going to help them feel safe and can make it very difficult for them speak out in situations where they feel like they ought to.

Bullying is an all too frequent occurrence that needs to be addressed so that not only students but also all health care professionals feel empowered speak up when the need arises. Until this occurs students will not be able to have a feeling of belongingness and will continue to feel unable to speak up when they see or hear something they do not agree with. In this instance it is hearing gallows humour, however the problem is concerning when students feel unable to speak up about a potentially harmful situation.

The issue of whether or not to speak up is explored again later in the survey. This question was repeated so that it could capture the thoughts of all participants and check if speaking was situational or part of how students conduct their practice. This time all students are asked if they were to experience gallows humour, would they speak up if they felt it was inappropriate. There was a slight difference in those who indicated they previously felt they could speak up when they heard gallows humour. For most of those students who had previously heard gallows humour and felt they could speak up, they were consistent in confirming their ability to speak up should they think the humour was inappropriate. For some this was about feeling empowered to do so as their experience with preceptors and lecturers had always been supportive. However others indicated that they felt confident regardless of the situation and would have no difficulty speaking up if they felt a situation warranted it.

Others felt that they could speak up if they had a good relationship with the R.N they were working with. These students previously said yes they felt comfortable speaking up but when asked again they indicated maybe. Speaking was dependent on how comfortable they felt and whether or not they had a good relationship with the R.N. How students are treated and the relationship seems to play a big role in a students’ confidence to voice their concerns over something happening. What is problematic here is that for those students who feel unable to
voice concerns about what they see as inappropriate, it is possible that they are unable to voice concerns when other perhaps more serious situations occur that could possibly have a direct impact on a patient’s wellbeing.

The only students who indicated no both times said it was a mix of feeling it was not their place as a student, and of not wanting to cause a problem, particularly between them and their preceptors. Students feel like there is a kind of hierarchy in healthcare and these particular individuals seem to think they are on the lower end of the hierarchy and view R.N.s and physicians as superior, which impacts on their ability to speak up. Of course there is a hierarchy especially within the student – preceptor relationship. Nurses hold a great deal of power over students as they can have a direct impact on their passing or failing. Coupled with this is the importance of the clinical learning experience for students in progressing through the programme. Students have a lot riding on what happens in these clinical experiences as their performance is graded. Their eligibility to continue depends a lot on what preceptors and R.N.s in clinical areas have to say. Speaking up for them must feel very risky.

For the students who said they would not speak up, they felt it was not their place (as students) to speak up or that speaking up would create a negative image of who they are. Interestingly all students who indicated ‘no’ (they would not speak up) in this section were in their third and final year of nursing school. At Whitireia NZ, third year students spend a total of seventeen weeks in the clinical environment across the two semesters. This includes an eleven-week clinical learning experience in the second and last semester of their undergraduate education. Anecdotally, when working with students in their third year, lecturers often hear students refer to the clinical learning experiences as a very long job interview, especially during the later experience. Theoretically this is perhaps true as throughout the clinical learning experiences students in New Zealand need obtain references for the job application process, which includes both written and oral feedback.

All of this can have a huge impact on employment prospects and students are rightly concerned about how they are viewed, so there is little wonder that some students would be reluctant to speak up in situations which they may find offensive or inappropriate. Students in third year are in a difficult place, they are the students closest to registration and there is so much pressure on them to behave more like R.N.s and yet so much rides on how they are perceived. Students indicated they did not want to be seen as making waves that could lead to them receiving
negative feedback. The students in this research echo the nursing students in the research conducted by Levett-Jones and Lathlean (2009), who were described as “not wanting to rock the boat” as they felt this would reflect badly on them and they would receive poor feedback. As with the Levett-Jones research, the reluctance to speak up is also well documented in a New Zealand study where nursing students expressed the inability to speak up for the same reasons (Sinclair, 2013).

The results of this research highlighted three students currently in year three who answered no to speaking up in both questions. Two of these students indicated that it was not their place to speak up as students or they feared negative consequences if they did speak up. This is in contradiction to research that found year three students generally felt less powerless in uncomfortable situations as they had learned how to process the situations through their years at nursing school (Sinclair, 2013).

This is a much smaller piece of research and it is possible this is an anomaly in terms of how empowered third year students feel. This research is unable to explain why more students in year three, especially in the age group 21-29, felt unable to speak than in other years, especially as it did not seek to find out this information and therefore did not ask any questions in relation to students feeling powerless. It can only be speculated that students were feeling the pressure of making a good impression and securing jobs and felt speaking up may jeopardise this. However what is interesting, and a bit concerning, is that the Sinclair research was conducted in 2013 and, while there is some change, students continue to feel disempowered as indicated by some of the results in this research.

An emerging theme that is concerning is that some students lacked the capacity to speak up as they felt they were ‘just a student’. Whether this was related to how they were treated by R.N.s or this was how they see themselves in the nomenclature of healthcare professionals, it speaks to how disempowered students felt in clinical areas and how they considered that their voice is not important. Even more frightening is that “I am just a student” is not far from “I am just a nurse”. Both statements seriously devalue the work and contribution nursing students and R.N.s make to healthcare. Both statements are also a failure of nursing education and a profession that often struggles to recognise the value of their work, education and the unique perspective nurses bring to health and patient care.
5.9 Ethics of using gallows humour

Students were asked if they thought the use of gallows humour was ethical and were able to choose from strongly agree to strong disagree on a Likert scale. For those who strongly/agreed again the responses were about who hears it and where it is said. This is a reoccurring theme in this research and within the literature. This speaks to the contentious nature of gallows humour and the potential to cause offence, which is what students indicate when asked to explain, they are aware that there may be some people in the room who are offended by gallows humour for whatever reason.

Even more important for students was the belief that gallows humour was not voiced in front of patients and their families. Students are acutely aware that the humour is used among healthcare professionals to cope and that there were appropriate times for this to occur. To use gallows humour in front of patients and families crosses the line; students understood this, in spite of limited clinical time.

5.10 Lecturers’ discussion

Lecturers were included in this research for various reasons; they have a great amount of teaching and clinical experience and have probably had exposure to gallows humour. The purpose was to triangulate the research in order to have a wider understanding on the phenomena. Including lecturers meant that the perspective of students and R.N.s could be compared and see whether similarities or contrasts existed between the two groups.

5.11 Lecturers’ understanding of gallows humour

Like students, lecturers were asked to explain their understanding of gallows humour. Lecturers were a bit more vague in their description of gallows humour, mostly indicating that it was a form of humour used during stressful times. A few lecturers did point out the usefulness of gallows humour for coping but this seemed to be a lesser focus of their understanding.
There was one lecturer who indicated that they did not know what gallows humour was until it was explained to them. Once it was explained, they understood but later indicated that they struggled when they heard gallows humour in a Western context as for this participant it differs from a Samoan context. It is difficult to attribute this to anything in particular as it differs somewhat from what the students were saying. The lecturer does explain that they understood why the humour was occurring but would not use gallows humour in difficult situations. Nevertheless the lecturer did state they understood why people would want to make difficult situations lighter. Either way we again see how culture can impact a person’s perception of the use of gallows humour and also that we cannot predict peoples’ reactions to gallows humour based on their culture.

Even in a small study of this size it does seem that ethnicity, or perhaps more accurately culture, can have some impact on the understanding of what gallows humour is, especially in relation to the results from the lecturers’ perspective. However it is difficult to make any kind of generalisation from this, as it is a small study. Furthermore the study was conducted in a Western context, where a majority of the participants in both cohorts identified as being from a Western ethnicity such as European, and potentially reflects Western views of gallows humour.

5.12 Context is important

While context and culture is important in understanding the humour, gallows humour also relies on many different social and contextual factors (Tapley, 2013). The other respondents indicated that context in terms of who is around to hear the humour or where the gallows humour is used was important in understanding gallows humour and made no comment on culture. Context for the remaining participants was about who heard the humour and where it took place. Like the students, lecturers were careful to point out that not all people ought to be exposed to gallows humour. This could be due to the fact that not all people have the same experiences in life, rather we are multifaceted, growing up in a myriad of different cultures and circumstances, all of which will have an effect on how individually we may perceive gallows humour. Understanding of humour and this includes gallows humour is dependent on many things such as previous history, friendships and where you sit in the taxonomy of work hierarchy, as well as place, timing and subject manner (Dehghan-Nayeri et al., 2015).
Understanding is also dependent on who is available to hear the jokes; those not involved in healthcare may not understand the humour used backstage by healthcare professionals. Not everyone in the room will understand or appreciate the use of gallows humour, which makes context so important. Both students and lecturers made it very clear that patients and families should not hear the gallows humour used by healthcare professionals even in coping. Patients and families could very well be offended by what is said.

The literature review found that from a healthcare perspective the closer you are to the event the more you might understand and accept the use of gallows humour. For lecturers there was a clear understanding of its use as long as parameters were followed. While this was true for some students, not all agreed. Like the medical students discussed in the literature review, the nursing students may not yet be close enough to the care of the patient to really understand just how very difficult it is, although they can imagine. On the other hand lecturers have had a vast amount of experience with the pain trauma and illness brings and how it feels when all that you do does not necessarily mean a good outcome.

5.13 Gallows humour as offensive

Like the students, the lecturers were asked if they were offended by the use of gallows humour. Most indicated that no they were not generally offended by gallows humour and understood why it was sometimes needed. Perhaps this can be attributed to the amount of clinical experience the lecturers have had and therefore also have an understanding of the difficulty in managing emotions in times of great stress.

Nevertheless lecturers like many of the students were quick to point out that gallows humour was only acceptable if patients or family did not hear it relating to the potential offensive nature of gallows humour. The difference between students and lecturers when discussing the ethics of gallows humour was that students generally indicated that gallows humour should not be used in front of patient and families ever. However lecturers indicated that there were appropriate times to use gallows humour with patients and family. For lecturers the issue of using gallows humour with patients and families was less black and white.
Some lecturers knew that patients and families themselves would use gallows humour at different times in their healthcare journey. Like healthcare professionals this is done in order to cope with trying situations. The use of gallows humour among patients and families was well documented in the literature, although not extensively explored in this research due to the limitations of a master’s thesis. However it does make some sense that both patients and their families would use gallows humour during stressful times. There is nothing that dictates how people should cope with trying situations and the relief theory of humour makes sense for all involved not just the healthcare professional.

5.14 Chapter summary

In this chapter the results from both nursing lecturers’ and students’ questionnaires has been discussed. The results from both are compared where possible and any similarities or differences between lecturers and students were discussed.

For nursing lecturers and students the appropriateness and ethics of the use of gallows humour depended on some unwritten rules that mirrored what the literature review also highlighted. These unwritten rules largely rested with the context of the use of gallows humour.

An important theme that developed was the context of the humour, where it is said and who is around to hear it. The context of the humour was important to both lecturers and students and both understood that if the context was not right there was huge potential for the gallows humour to be offensive and this was supported in the literature review.

The largest theme identified in the research, which directly reflects what the literature says, was that healthcare professionals used gallows humour in order to cope with difficult aspects of the job. Participants understood just how difficult the job of being a nurse was and the need to cope. While not all participants agreed with the use of gallows humour, participants generally accepted that using gallows humour was a form of coping. This also reflects what was found in the literature review, especially in terms of relief theory, which is the theory of gallows humour that is alluded to most frequently in the results.
5.15 Thematic Analysis

For this research several themes emerged in both the student participant group and the lecturers group, some themes such as not using gallows humour in front of patients and family were shared between groups and some were exclusive to the group such as students feeling powerless to speak up.

The biggest common theme that emerged was that for gallows humour to be ethical it had to meet some “unwritten rules”, the rules were the same for each group. These rules were if gallows humour is used it had to be for coping in difficult situations and not for making fun of or ridiculing patients. This is an interesting theme as the nature of gallows humour often mocks the situation as in the pizza deliveryman in Watson’s 2011 article. This mocking could look to some as it is making fun of someone and the situation they find themselves in.

This theme closely links with the next theme, which is that gallows humour is not to be used in front of patients or their family. Both students and nurse lecturers expressed that it is very important that gallows humour not be used in front of patients of their family. As noted in this thesis gallows humour has the ability to offend, it can appear off hand a callous and for patients and family this may seem cruel and uncaring.

Both groups also agreed that gallows humour in the clinical environment is used as a coping mechanism during difficult times, which many people do not encounter. Healthcare professionals are inundated with human suffering and tragedy and the need to cope in manner that allows them to continue patient care is extremely important not only to their careers but to the patients that rely on them for care. There was a general sense from what was said by participants that if the use of gallows humour helped you cope and helped get you through s that you can continue helping people then is was acceptable. This is heavily supported in literature, authors Craun & Bourke, 2014; Kuiper, Kuipers, & Kuipera, 2012; Rowe & Regehr, 2010; Storey, 2014; Watson, 2011. There seems to be something in the momentary space created that allows people to regroup, reframe their mind-set and then carry on. Buxman, 2008; Hall, 2005; Moran & Massam, 1997; Rowe, 2010 all point to the significance of reframing to help people cope when involved in tragic or difficult situations in particular healthcare professionals.
There were some differences in themes that emerged for both groups. For students the theme that emerged was that for some students there was an inability to speak up and feeling powerless. In part feeling powerless is due to the hierarchy in healthcare (Parsons, Kinsman, Bosk, Sankar, & Ubel, 2001) it seems clear that students involved in this research felt the effects of this hierarchy as students felt that as they were ‘just students” it was not their place to speak up if offended or that they were too junior to be able to say anything. Nurse lecturers as one might probably expect felt confident enough to speak up (they would be of course much higher up on the hierarchy) if they needed to but did not as they felt the gallows humour was appropriate.

Sadly the students also feared repercussions if they were to speak up when offended by gallows humour and this was especially evident in the third and final year of nursing school. There is no illusion that there is a lot riding on clinical performance in nursing school, which is graded not only by nurse lecturers but also by nursing preceptors in the clinical area. Getting a job after completing nursing school requires getting a reference from a nurse from their last clinical learning experience. So there is little doubt that students expressing unwillingness to speak up if offended were worried it would reflect badly on them and they would end up with a poor reference. It appears these students did not feel safe or supported in speaking up.

Conversely the biggest group who indicated they would speak up if offended were year one and two where there is no requirement for a reference for a job. However it is important to note that for these students who did speak it was due in part because they felt like the nurse they were working with supported them and they felt safe to do so.
6. Conclusion, limitations and future considerations

6.1 Conclusion

The phenomenon of gallows humour has existed for centuries and continues to be studied in the modern-day era. It is no wonder that gallows humour has been studied extensively; it is at once both fascinating and confusing phenomenon even for theorists. It is difficult to understand laughing and making jokes in the face of tragedy, the two somehow seem incompatible and yet that is exactly what can happen.

Being involved on a routine basis with the sometimes tragic and difficult events that can happen to people can take its toll on healthcare professionals. It is therefore important that healthcare professionals not only find ways to manage and cope with the situation and the emotions they may experience as a result. As the literature review indicates one such manner of coping is to use gallows humour.

This research has shown that there are at least two distinct theories that attempt to explain why people use gallows humour in difficult times. Relief theory, which first appeared in the late 1800s and then is revisited by Freud, postulates that gallows humour is used in an attempt to gain relief from the seriousness of what is happening. Superiority theory, espoused by Kant and Schopenhauer, believes people make jokes in order to feel superior, not necessarily superior to those experiencing the tragedy but rather superior to the situation. In a connection to relief theory, this may reflect relief that it is not happening to them.

Each theory in its own way attempts to explain gallows humour however after an extensive literature for this thesis the one that seems to fit best in terms of healthcare is relief theory. Watson (2011) makes it very clear that gallows humour is used to cope so that the healthcare professionals can carry on with their work. The results from this research would indicate both students and lecturers agreed with gallows humour as a strategy for coping and recognised just how stressful nursing can be.

While the use of gallows humour is mostly supported in the literature it is not without controversy. Some think it is actually an indication of poor coping while others believe that due to its nature and content for joking that gallows humour is actually unethical. The result of
this research also indicates that students are divided on the appropriateness of the use of gallows humour. While many believed that gallows humour was ethical as long it followed some boundaries, there were others who simply could not justify the use of gallows humour in any situation and felt its use even with boundaries was unethical. Lecturers seemed more accepting of gallows humour when certain boundaries were maintained, these being mostly not to use gallows humour around patients and their families.

What is clear from the literature review and results from both surveys is that while the use of gallows humour is pervasive in healthcare, it can be contentious as not all people will understand it or why people make jokes in tragic situations. However, what stands out is that on some level for some people it helps them cope with their jobs and the horror they are often witness to. And yes, to some it may seem cruel but in the heat of the moment when nothing else seems to be working a brief joke helps refocus people and allow them temporarily to release the tension and pressure experienced in order to be able to continue to care for people.

This research sought to explore the views of nursing students and nurse lecturers with regards to the use of gallows humour in the clinical setting. Views among the students were varied; some were not comfortable with the gallows humour even as a coping mechanism and saw it as disrespectful, while the majority saw the use of gallows humour as an acceptable form of coping. No nurse lecture expressed discomfort with its use and in fact most advocated the use of gallows humour in order to get through difficult situations, having experienced the use of gallows humour during the course of their clinical.

Those students who accepted the use of gallows humour as a coping mechanism and all of the nurse lecturers indicated that its use is only ethical if not used in front of patients or family members. However those students who disagreed with the use of gallows humour were unable to justify the ethics of its use under any circumstances. As nurse lecturers have more clinical experience and most likely have been more exposed to the horrors of humour suffering it is possible they better understand the coping that is needed in the moment in order to get through these situations. Whatever the belief regarding the use of gallows humour in the clinical setting, students and nurse lecturers mirrored the results found in the literature review both in their views of the ‘unwritten rules” regarding when gallows humour ought to be used and who it ought to be used with. Likewise those who disagreed with its use for whatever reason echoed
the concerns found in the literature review in that they saw it as disrespectful and depersonalising for patients and family.

6.2 Limitations

A potential limitation of this research is that it may not be representative of the wider nursing student population or nurse lecturers due to the small number of participants. A larger sample would have added to the data and contributed a more reliable and powerful sample for statistical analysis.

Another limitation is generalisability, with this cohort of participants being from one tertiary education provider in New Zealand. The findings are from two of the nursing programmes within one institution and may have characteristics similar to other programmes within New Zealand, however there is no claim that the findings of this study would be true for any other programme or institution although it is possible that students at other institutions may have similar reactions.

Upon reflection it may have been useful to know which clinical areas students heard gallows humour and which clinical areas nursing lecturers had worked in. In the literature review authors such as Watson (2011), Buxman (2008) and Rowe and Regehr (2010) all mention using gallows humour in relation to specific environments, that being mostly emergency or intensive care.

6.3 Future recommendations

This research was conducted as an exploratory descriptive study. The next logical step would be to repeat the study with a wider base of students and lecturers from other institutions in order to fully examine the perceptions of nursing lecturers and students. Additionally it would be good to extend the research to include all students in the healthcare industry who work with patients. It would be interesting to see how perceptions compared among all students.

The literature review suggested that medical students were often offended by the use of gallows humour but felt powerless to speak up as they were outsiders, not close enough to the situation
and they also felt it was not their place to speak up. This features in the results to some degree with nursing students. Potential for further research would be to explore this concept further which would be useful not only in terms of gallows humour but in clinical situations in general as there could be other times where students felt powerless to speak up.

While demographic information was collected it was not explored at any great length. The results in both the nursing lecturers’ and students’ questionnaire yield a few comments regarding culture and its possible impact on the perception of gallows humour. Further exploration of the perceptions of gallows humour among a larger group of lecturers and students ought to include a more in-depth investigation of the impact demographic factors, especially culture, play in people’s perception of gallows humour. This is also true for the age group divisions as there were clear differences between the age group 21-29 and the ability to speak up from the other age groups.
Reference List


Summary: Retrieved from https://www.nzno.org.nz/LinkClick.aspx?fileticket=4cZcUEPcmHuw%3D&portalid=0.


Appendix A: Information sheet for student participants

My name is Shelley Winters, I am an RN currently working as a nurse lecturer at Whitireia NZ. This research will explore the views of student nurses and nurse lecturers’ on the use of gallows humour in the clinical setting.

Thank you for showing interest in participating in this questionnaire. Your participation is entirely voluntary. By agreeing below and responding to the questionnaire it will be implied that you have given your consent. The questionnaire will take approximately fifteen minutes to complete.

The purpose of this research is to gain insight into how student nurses perceive the use of gallows humour (black) humour in the clinical setting and explore whether or not students think the use of gallows humour is justified in certain situations.

In order to participate in this research it is important that you have an understanding of what gallows humour is, therefore a definition has been provided. Please read this definition and ensure you understand what gallows humour is before agreeing to participate.

**DEFINITION:** Gallows humour also known as black humour. It is a brand of humour that treats serious, frightening, or painful experiences such as illness, trauma and even death in a light hearted or humorous way (Obrdlik, 1942; Watson, 2011).

This research is being conducted as part fulfilment of a Master’s Degree in Health Science endorsed in Bioethics at the University of Otago.

*How do students and academic staff perceive the use of gallows humour in the clinical setting?*
What Type of Participants is being sought?

This research is recruiting participants from the all three Bachelor of Nursing Programmes at Whitireia NZ and the academic staff who have also worked as nurses in the clinical setting.

In order to participate as a nursing student you must be currently enrolled and have experienced at least one clinical placement so far during your education at Whitireia NZ.

In order to participate as a nursing lecturer who must be teaching undergraduate nursing and follow students in the clinical setting.

What will Participants be asked to do?

Should you agree to this project, you will be asked to participate in a questionnaire that will take approximately 15 minutes to complete.

Please be aware that you decide to take part in the project your anonymity will be protected and nothing you say will be traceable back to you.

In order to protect your anonymity an official consent form is not available. Taking part in the questionnaire and ticking the “agree” box in the questionnaire will imply consent.
What Data or Information will be collected and What Use will be made of it?

When completing the questionnaire you will remain completely anonymous and you will not be asked for any identifying information. You will be asked for your ethnicity, age and which programme you are enrolled in. The information collected from this research will be used for the completion of a Master’s thesis. However, in the future it may also be used for publications and conference presentations.

The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand).

The only people who will have access to this research are Shelley Winters, and her supervisors Associate Professor Neil Pickering and Professor Grant Gillett of Otago University. Electronic data will be locked in a password-protected computer at Whitireia NZ. Hard copies of any data will be stored in a locked secure cabinet based at Faculty of Health, Whitireia Polytechnic.

After the information you proved has been transcribed it will destroyed however the data retrieved may be kept for up to 5 years.

Should you agree to participate you will be able to receive a copy of the report and be invited to attend a short presentation once the research is complete.

This project involves completing a questionnaire. The area of questioning will explore your experience and views of gallows humour, and how you feel about the use of gallows humour. The University of Otago Human Ethics Committee is aware of the areas to be explored in the questionnaire and the Committee has been able to review the precise questions to be used.

Can Participants Change their Mind and Withdraw from the Project?

Due to the nature of the research design once you have completed the questionnaire it will be impossible to withdraw from the research, as it will be impossible to identify with questionnaire is yours.
What if Participants have any Questions?
If you have any questions about our project, either now or in the future, please feel free to contact either:

**Shelley Winters**
Whitireia NZ School of Health  
Telephone: 237-3100 extn. 4201  
Email Address: shelley.winters@whitireia.ac.nz

**Dr Neil Pickering**
Department of Bioethics, University of Otago  
University Telephone Number: - 64 3 471 6126  
Email Address: neil.pickering@otago.ac.nz

**Dr Lynley Anderson**
Department of Bioethics, University of Otago  
University Telephone Number: - 64 3 471 6132  
Email Address: lynley.anderson@otago.ac.nz

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph +643 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix B: Information sheet for lecturer participants

How do students and academic staff perceive the use of gallows humour in the clinical setting?

My name is Shelley Winters, I am an RN currently working as a nurse lecturer at Whitireia NZ. This research will explore the views of student nurses and nurse lecturers’ on the use of gallows humour in the clinical setting.

The purpose of this research is to gain insight into how student nurses perceive the use of gallows humour (black) humour in the clinical setting and explore whether or not students think the use of gallows humour is justified in certain situations.

This research is being conducted as part fulfilment of a Master’s Degree in Health Science endorsed in Bioethics at the University of Otago.

What Type of Participants is being sought?

This research is recruiting participants from the all three Bachelor of Nursing Programmes at Whitireia NZ and the academic staff who have also worked as nurses in the clinical setting.

In order to participate as a nursing lecturer who must be teaching undergraduate nursing and follow students in the clinical setting.

What will Participants be asked to do?

Should you agree to this project, you will be asked to participate in a questionnaire that will take approximately 15 minutes to complete.
Please be aware that you decide to take part in the project your anonymity will be protected and nothing you say will be traceable back to you.

In order to protect your anonymity an official consent form is not available. Taking part in the online questionnaire and ticking the “agree” box in the questionnaire will imply consent.

**What Data or Information will be collected and What Use will be made of it?**

When completing the questionnaire you will remain completely anonymous and you will not be asked for any identifying information.

You will be asked for your ethnicity, age and years of experience.

The information collected from this research will be used for the completion of a Master’s thesis. However, in the future it may also be used for publications and conference presentations.

The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand).

The only people who will have access to this research are Shelley Winters, and her supervisors Associate Professor Neil Pickering and Professor Grant Gillett of Otago University.

Electronic data will be locked in a password-protected computer at Whitireia NZ.

After the information you provided has been transcribed it will destroyed however the data retrieved may be kept for up to 5 years.

Should you agree to participate you will be able to receive a copy of the report and be invited to attend a short presentation once the research is complete.

This project involves completing a questionnaire. The area of questioning will explore your experience and views of gallows humour, and how you feel about the use of gallows humour in a clinical setting. The University of Otago Human Ethics Committee is aware of the areas to be explored in the questionnaire and the Committee has been able to review the precise questions to be used.
Can Participants Change their Mind and Withdraw from the Project?

Due to the nature of the research design and in the interest of protecting your identity, once you have completed the questionnaire it will not be possible to withdraw from the research, as it will be impossible to identify with questionnaire is yours.

What if Participants have any Questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:

**Shelley Winters**  
Whitireia NZ School of Health  
Telephone: 237-3100 extn. 4201  
Email Address: shelley.winters@whitireia.ac.nz

**Neil Pickering**  
Department of Bioethics, University of Otago  
University Telephone Number: - 64 3 471 6126  
Email Address: neil.pickering@otago.ac.nz

**Lynley Anderson** Department of Bioethics, University of Otago  
University Telephone Number: - 64 3 471 6127  
Email Address: grant.gillett@otago.ac.nz

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph +643 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix C: Student Questionnaire

Exploring the perceptions of nursing students and nursing academic lecturer’s perceptions of the use of gallows humour in the clinical setting.

Thank you for showing interest in participating in this questionnaire. Your participation is entirely voluntary. By agreeing below and responding to the questionnaire it will be implied that you have given your consent. The questionnaire will take approximately fifteen minutes to complete.

Please tick to confirm that you have read the information sheet for participants and understand what the research is about.

I agree

Section One
Some information about you.
Which ethnic group do you identify with? Select all, which apply to you.

☐ New Zealand European

☐ Māori

☐ Samoan

☐ Cook Island Māori

☐ Other please state:

☐ Prefer not to disclose
Which age group you are in?
☐ 18-20
☐ 21-29
☐ 30-39
☐ 40-49
☐ 50+
☐ Prefer not to disclose

Which year are you currently enrolled in?
☐ Year 1
☐ Year 2
☐ Year 3

Section Two

QUESTION 1
Explain what you think gallows humour is.

QUESTION 2
Have you heard gallows humour used while in the clinical setting?
☐ Yes
☐ No
Maybe, I’m not sure if what I heard was gallows humour

If you answered NO please go to SECTION 3 QUESTION 5
If you answered YES or MAYBE go to QUESTION 3
QUESTION 3A
If you answered YES or MAYBE to Question 2 – When I heard gallows humour I:
Please indicate which of the following are true for you (it maybe more than one).
☐ laughed
☐ felt angry
☐ felt embarrassed
☐ ignored it
☐ didn’t feel any reaction
☐ didn’t know where to look
☐ didn’t care

QUESTION 3B
Any other feelings?

QUESTION 4
In what context did you hear gallows humour used (for example: between a nurse and a doctor on an oncology ward)? Please explain.

QUESTION 5A
If you felt the gallows humour you heard was inappropriate, did you feel able to speak up about it?
☐ Yes
☐ No

QUESTION 5B
Please explain
Section Three
THIS SECTION IS ONLY FOR THOSE WHO HAVE NOT HEARD
GALLOWS HUMOUR IN THE CLINICAL SETTING
QUESTION 6A
If you were to hear gallows humour in the clinical setting, how do you think you
might feel?
☐ Offended
☐ Not offended
☐ Wouldn’t care

QUESTION 6B
Please explain your choice from the previous question
QUESTION 7A
“If I heard gallows humour in the clinical setting I would”:

(It can be more than one).

☐ laugh
☐ feel angry
☐ feel embarrassed
☐ probably not have any reaction
☐ ignore it

QUESTION 7B
Please explain your choice from the previous question.

Section Four
This section is for all students to answer

QUESTION 8A
If you were to hear gallows humour in the clinical setting and felt it was inappropriate, do you feel you could speak up about it?

☐ Yes
☐ No
☐ Maybe

QUESTION 8B
Please explain your choice from above.

QUESTION 8C
If you were to speak up or tell someone how you felt, who would it be? Please explain.
QUESTION 9A
This section is for ALL students.

Regardless of your experience with gallows humour, on a scale of 1-5 with 1 being strongly agree and 5 being strongly disagree: Do you consider the use of gallows humour by healthcare professionals to be ethical?

<table>
<thead>
<tr>
<th>Strongly agree disagree</th>
<th>Neither agree or disagree</th>
<th>Strongly disagree</th>
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QUESTION 9B
Please explain your choice above.

QUESTION 10A
Academic literature indicates that gallows humour may help people cope with stress. Do you think this is an acceptable form of coping?

<table>
<thead>
<tr>
<th>Definitely Yes</th>
<th>Neither yes or no</th>
<th>Definitely No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

QUESTION 10B
Please explain why you chose this response.

QUESTION 11:
On a scale of 1 - 5, with one being strongly agree and 5 being strongly disagree.

Would you agree that the use of gallows humour is ethical as long as patients or their family do not hear it?

<table>
<thead>
<tr>
<th>Strongly agree disagree</th>
<th>Neither agree or disagree</th>
<th>Strongly disagree</th>
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<td></td>
<td></td>
<td>5</td>
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</tbody>
</table>
Appendix D: Academic staff questionnaire

Exploring the perceptions of nursing students and nursing academic lecturer’s perceptions of the use of gallows humour in the clinical setting.

Thank you for showing interest in participating in this questionnaire. Your participation is entirely voluntary. By agreeing below and responding to the questionnaire it will be implied that you have given your consent. The questionnaire will take approximately fifteen minutes to complete.

In order to participate in this research it is important that you have an understanding of what gallows humour is, therefore a definition has been provided. Please read this definition and ensure you understand what gallows humour is before agreeing to participate.

DEFINITION:
Gallows humour also known as black humour; is a style of humour that treats serious, frightening, or painful experiences such as illness, trauma and even death in a light hearted or humourous way (Obrdlik, 1942; Watson, 2011).

In order to ensure anonymity there is no consent form to sign. It will be assumed that by ticking the “I agree” box below that you have granted consent and are happy to participate in this research.

Please tick to confirm that you have read the information sheet for participants, understand what the research is about and consent to participate.

☐ I agree
☐ I have read the information sheet
This questionnaire has 12 questions arranged in 4 sections. Some sections are compulsory, and some sections are for only some, depending on previous answers. You do not have to answer all the questions, but the more you can answer, the richer the data will be and the more meaningful the research. Thank you in advance for your participation.

Section One
Some information about you.

Which ethnic group do you belong to? Select all, which apply to you.

☐ New Zealand European
☐ Māori
☐ Samoan
☐ Cook Island Māori
☐ Tongan
☐ Other please Pacific Island, please state:
☐ Chinese
☐ Indian
☐ Prefer not to disclose

How many years of clinical experience do you have?
☐ 5-10 years
☐ 11- 20 years
☐ 20+ years

How many years of clinical teaching do you have?
☐ 1-5 years
☐ 6-10 years
☐ 10-15 years
☐ 16- 20 years
☐ 20+
Section Two

QUESTION 1

During the recruitment process for this research and at the beginning of this questionnaire, gallows humour was explained to you. Do you think you have a clear idea of what it is?

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<tr>
<th>Very clear</th>
<th>Not clear</th>
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QUESTION 2

When you were practicing clinically, did you hear gallows humour being used?

☐ Yes
☐ No
☐ Maybe, I’m not sure if what I heard was gallows humour

If you answered NO please go to SECTION 3 QUESTION 6.
If you answered YES or MAYBE please describe what you have heard.

QUESTION 3

When I heard gallows humour I…
Please indicate which of the following are true for you (it may be more than one).

☐ laughed
☐ felt offended
☐ felt angry
☐ felt embarrassed
☐ ignored it
☐ didn’t feel any reaction
☐ didn’t know where to look
☐ didn’t care

Please explain
QUESTION 4

While working clinically with students have they ever discussed the use of gallows humour with you?

☐ Yes
☐ No

QUESTION 5

If you answered Yes to question 4 do think the student was offended with the use of gallows humour in the clinical setting?

☐ Yes
☐ No

PLEASE GO TO SECTION 4 QUESTION 7
Section Three
The next two questions are for those who have not heard gallows humour used in the clinical setting.

QUESTION 6

If you did hear gallows humour being used in the clinical setting, do you think you might find it offensive?

☐ Yes
☐ No
☐ Maybe

Please explain your answer
QUESTION 7

“If I did hear gallows humour in the clinical setting I might”:

(\text{It may well be more than one}).

☐ laugh
☐ feel angry
☐ feel embarrassed
☐ ignore it
☐ not feel any reaction
☐ might not know where to look
☐ wouldn’t care
☐ am not sure how I would react

Please explain your choice

Section Four

QUESTION 8

This section is for all participants

Regardless of your experience with gallows humour, on a scale of 1-5 with 1 being strongly agree and 5 being strongly disagree: Do you consider the use of gallows humour by healthcare professionals to be ethical?

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<tr>
<th>Strongly agree</th>
<th>Strongly disagree</th>
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Please explain why.

QUESTION 9

Can you think of a situation where you consider that the use of gallows humour would be justified?

☐ Yes
☐ No

Please explain why you chose this response.
QUESTION 10
Academic literature indicates gallows humour may help people cope with stress. Do you think this is an acceptable form of coping?

<table>
<thead>
<tr>
<th>Definitely, yes</th>
<th>Definitely, no</th>
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</table>

Please explain why you chose this response.

QUESTION 11
Would you consider the use of gallows humour ethical as long as patients or family members do not hear it?

<table>
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<tr>
<th>Definitely, yes</th>
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Please explain.

You have completed this questionnaire. Many thanks for your participation I really appreciate you taking time to answer this for me.