CANCER MAY CAUSE SARCASM:
THE USE OF SARCASM DURING ONCOLOGY INTERVIEWS

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by

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DEDICATION

This thesis is dedicated to all those who have been affected by cancer—the patients, families, friends, loved ones and physicians. I would also like to dedicate this to all my fellow sarcastic souls who make the world a little bit more interesting.
Sarcasm: Intellect on the offensive.

- Anonymous
ABSTRACT OF THE THESIS

Cancer May Cause Sarcasm: The Use of Sarcasm during Oncology Interviews
by Alyssa M. Strom
Master of Arts in Communication
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Cancer is ubiquitous in today’s society. Patients fighting cancer, as well as their families, endure a large amount of stress while combating the disease. Coping mechanisms are important during cancer management because they aid in stress reduction. Sarcasm, a potential method of coping, is examined in this study in an attempt to gain a clearer understanding of its intricacies and effectiveness in a medical, institutional setting. Employing conversation analytic methods, the sarcastic communication strategies engaged in by both doctors and patients during oncology interviews are assessed from an oral and nonverbal perspective. This is done in an effort to gain a greater understanding about the use of sarcasm in medical settings and the way doctors and patients effectively and ineffectively interact with one another.
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CHAPTER 1

THE STATE AND FATE OF SARCASTIC STUDY

The prevalence of sarcasm in society is undeniable. It is a form of wit that began its existence in early Greco-Roman literature (Jensson, 1999), and has evolved to a form of humor found among various venues in modern day life. Sarcasm is defined here as a type of, “verbal irony [that] can be defined as expressions in which the intended meaning of the words is different from or the direct opposite of their usual sense” (Cheang & Pell, 2008, p. 366).

Proving the pervasiveness of sarcasm, one study found that 56% of people regularly use sarcasm when conversing with a close friend (Rockwell, 2006). The same study also found that 26% of the time sarcasm is used with someone being met for the first time (Rockwell, 2006). This statistic supports the possibility that medical patients may attempt to establish a more immediate relationship with their doctors during patient-doctor interviews by using sarcasm, which has been found to be a marker of solidarity and evidence of rapport in some institutional interactions (Nelms, 2001). A lack of acknowledgement from doctors regarding patients attempt at dry humor, a reason for sarcasm put forth by Martin (2007), may leave those patients feeling dissatisfied with the interaction.

Most of the American population has had one or more experiences with being the patient of some type of doctor. Many who have been patients seem able to classify the exchange between themselves and the doctor as “good” or “bad.” For example, a Consumer Reports article posited that of the 70,000 people they asked, over 51% thought their health
care interactions had room for improvement ("How is your doctor," 1995). According to the 2003 and 2005 Health Information National Trends Surveys (HINTS) of over 5,000 respondents, about 11.5% of patients say their physician only sometimes or never explained things to them in a way they could understand, and about 10% indicated their physicians only sometimes or never respected the patient (National Cancer Institute [NCI], n.d.). In the 2007 data, in response to the question "How often did doctors, nurses, or other health professionals give the attention you needed to your feelings and emotion" 24% indicated only sometimes or never (NCI, n.d.). In response to the item: "How often did they make sure you understood the things you needed to do to take care of your health?" 13% indicated sometimes or never (NCI, n.d.). In response to the item "How often did they help you deal with feelings of uncertainty about your health or health care?" almost 25% indicated only sometimes or never (NCI, n.d.).

Also, research by Arora and colleagues (Chang, Arora, Lev-Ari, D’Arcy, & Keysar, 2010; Hinami, Farnan, Meltzer & Arora, 2009), implies that in shift change handoffs of service conversations, as many as 13-18% are incomplete, and “unsuccessful” as often as 60% of the time. This indicates a high level of substantive inaccuracy and much less rapport (Chang et al., 2010; Hinami et al., 2009). Additionally, a large scale study by Žebiene et al. (2008) found that especially after a year or in a first consultation, patients and physicians have disagreements about their communication in as much as 26% of such consultations.

One possible reason for this dissatisfaction is that patients feel doctors are not responding to them as individuals. Doctors’ over-reliance on the biomedical model, which focuses healing on only the biological symptoms, can devalue the unique human aspect of each patient (Engel, 1977). It is proposed that a more holistic, psychosocial approach to
treating patients would be beneficial (Engel, 1977). Evidence of a need to address patient emotions is put forth in a study conducted by Bantum and Owen (2009). When something personal and not directly related to the medical issue at hand is raised in a medical interview, doctors were revealed as attentive but only minimally receptive to patients’ lifeworld disclosures and demonstrations. … [There is] a tendency for doctors to provide neither reassurance nor commentary on patients’ contributions, essentially working to close down and move a way from patients’ emotional concerns. (Beach, Easter, Good, & Pigeron, 2005, p. 906)

This idea is further supported by Ackerson and Viswanath (2009), who suggest that addressing the social framework may be an effective device for eliminating communication disparities.

The need to feel supported by a doctor is invaluably important when going through cancer treatment. Families and friends of the diagnosed, as well as the diagnosed him- or herself, are shuffled from doctor to doctor as a treatment plan is developed to defeat the cancer. The strain this puts on the family, and especially the cancer patient, is intense. It is important that some marked effort be made to ease the hardship for those having to spend such a large percentage of time engaging in institutional interaction with doctors due to keeping appointments for chemotherapy, monthly checkups, surgeries, and gene therapy. Spending time involved in such interaction can detract from time that would otherwise be spent employing stress-relieving activities. This effort becomes especially paramount when taking into consideration that those people are already undergoing a significant amount of suffering as a function of the cancer itself.

The use of humor, self-expression, and the ability to connect with a doctor are ways that cancer patients and their families can begin to reduce the amount of stress caused by the disease (Rockwell & Theriot, 2001; Visser & Hoog, 2008). The reduction of stress may, in turn, aid in both healing and coping (Garland, Carlson, Cook, Lansdell, & Speca, 2007;
Krasner, 2004). In an effort to gain further insight on the topic of sarcasm as it is employed in oncology interviews, this paper will evaluate several instances of such.

The rest of chapter one will examine the state of research and literature available regarding sarcasm in general as well as its relationship to cancer and the field of medicine. Following that, the need for more research on interactional sarcasm will be discussed. An overview of the foundations of conversation analysis (CA) will be conducted and an explanation of the dataset will be put forth. Finally, research questions will be posited. A forecast of the remaining chapters will occur at the end of this, chapter one.

SEARCHING FOR MEANING IN THE SARCASM LITERATURE

Research on sarcasm has extensively explored the rhetorical and linguistic aspects of sarcasm (Clark & Gerrig, 1984; Jorgensen, Miller, & Sperber, 1984; Kreuz & Glucksberg, 1989; Sperber, 1984). Recently, there has been some additional research on the demographics of people who employ sarcasm as a regular method of communication (Gibbs, 2000; Rockwell, 2001, 2003; Rockwell & Theriot, 2001). One’s ability to recognize sarcasm has been examined in the field of communication (Clark & Gerrig, 1984; Gerrig & Goldvarg, 2000; Ivanko, Pexman, & Olineck, 2004; Jorgensen et al., 1984; Kaufer, 1981; Kreuz & Glucksberg, 1989; Slugoski & Turnbull, 1988; Sperber, 1984; Williams, 1984) and the personality characteristics of those who prefer and dislike sarcasm have also been researched (Keirsey, 1998).

An analysis conducted by Partington (2006) posits that sarcasm, while closely related to irony, tends to be more “overtly aggressive” and have a more “obvious victim” (p. 215). Most other analyses of sarcasm relate it, almost synonymously, with sardonic use of language and irony. For example, Gioria (1991, 1995; Gioria, Fein, & Schwartz, 1998) posits
that both ironic and sarcastic statements are cognitively processed in the same manner. In order for a message to be processed and understood as coherent in one’s mind, it must be considered relevant to the conversation at hand (Gioria, 1991, 1995; Gioria et al., 1998). Once relevance has been determined, cognitive processes check that the amount of disclosure occurring in the statement is either the same as in previous statements or slightly more (Gioria, 1991, 1995; Gioria et al., 1998). The graded increase in information shared with another conversant indicates a natural progression of social penetration (Altman & Taylor, 1973). When a statement is not in line with the expected amount of informational disclosure, one’s secondary cognitive function of “implicature,” a type of mental filling in the blank, is triggered to recognize the then potentially humorous incongruity of the statement (Martin, 2007, p. 99).

Sarcasm as a Coping Mechanism

Beyond Gioria (1991, 1995) and Gioria et al.’s (1998) theory that ironic and sarcastic statements are cognitively processed in the same way, the cognitive-phenomenological model of psychological stress is related to why cancer patients may use sarcasm (Lazarus & Folkman, 1984). Lazarus and Folkman’s theory states that a person categorizes events based on the significance personally associated with those events. The person then experiences an amount of stress believed appropriate for an occurrence of that importance (Lazarus & Folkman, 1984).

Several studies have examined the stress and strain experienced by cancer patients and their families (Ambrosi & Preziosi, 2009; Beaudoin & Tao, 2008; Czaja, Manfredi, & Price, 2003; Hilton, 1988; Neumann et al., 2007; Weber & Solomon, 2008). An indication that coping mechanisms are made use of to deal with that stress and strain has been identified
in studies examining patient-doctor interaction. Those studies, however, have limitations. For example, Ambrosi and Preziosi’s publication is presented from only a biomedical perspective, causing it to reach only a limited number of consumers. The research methods utilized in Beaudoin and Tao’s study, as well as Czaja et al.’s study, rely primarily on self-report, which can be affected by lack of adequate participant recall, as well as the social desirability bias. Neumann et al.’s study deals with an environmentally limited demographic. Weber and Solomon’s study relies solely on computer mediated communication and focuses exclusively on breast cancer patients, another limited demographic. Finally, Hilton (1988) also focuses only on breast cancer patients. Hilton found that one type of coping mechanism used in several instances by women diagnosed with breast cancer is called “buffering the situation” (Hilton, 1988, p. 226). Humor is a method of buffering the situation (Hilton, 1988) and sarcasm as mentioned previously, is a potential form of humor (Martin, 2007).

Humor, while certainly related to sarcasm, will not be specifically investigated in this paper. Humor encompasses too broad a social activity to be adequately delved into during this study (see, e.g. Du Pré, 1998). This paper’s purpose is to investigate the serious nature of sarcasm. Sarcasm’s construction as a humorous phenomenon is addressed in this paper only as a means of reducing patient stress. The primary interest of this paper is to view the dialectic nature of potentially humorous sarcasm as serious.

**Nonverbal Sarcasm**

Sarcasm will is often constructed through the nonverbal use of voice to communicate irony. In research by Bryant and Fox Tree, (2005), sound clips were taken from radio broadcasts and altered for use in an experiment. While the study found that irony and sarcasm are not detected through tone of voice, it was found that context, as well as other
nonverbal cues like loudness and rate, did contribute to people’s ability to perceive such communicative phenomena (Bryant & Fox Tree, 2005). The findings of Bryant and Fox Tree’s study were supported by the results of Rockwell’s (2000) study of vocal cues involved with sarcasm.

Research has also investigated the influence of nonverbal features of speech and gestures on the comprehension of conversation, including the communication of affiliation (Yang, 2007), foreshadowing of upcoming topics in interaction (Streeck, 2009), and the course of computer-mediated interactions (Derks, Bos, & Grumbkow, 2008). Even the nonverbal aspects of computer mediated communication (CMC) have been considered by communication scholars (Derks et al., 2008).

Some research has been conducted on nonverbal methods of communication in institutional settings. These institutional experiences of nonverbal communication range from an examination of that used by writing tutors (Thomspoon, 2009) to an examination of gestures used by auction bidders (Heath & Luff, 2007). For example, Koschmann, LeBaron, Goodwin, Zemel, and Dunnington (2007) found the glossing practices, which are ways of summarizing content and skipping over explicit details, of surgeons are extensively used when teaching up-and-coming surgeons. Research has examined the coordination of conversation between the patient and doctor from the perspective of ending the medical interview (Heath, 1985) as well as from the perspective of turn-taking in talk (Duggan & Bradshaw, 2008). The specific ability of medical students to pick up on nonverbal cues has also been studied by Hall, Roter, Blanch, and Frankel (2009).
SUMMARY OF SARCASM’S CURRENT STATE

Significant work has been started in an effort to aid in understanding the use of, and purposes for, sarcasm. Based on the publication dates held by most of the cited research in the literature review, it is clear that the in depth study of sarcasm is in its infancy. When surveying all the research found on sarcasm and its uses, it becomes clear that real-life, interactional studies of the sarcasm phenomena are severely lacking. As the study of sarcasm matures, it is necessary to push the envelope and attempt to engage in studies that may be more difficult to obtain materials for, as well as studies that focus on more and more specific demographics. This attempt to push sarcastic studies forward is made evident through research conducted by Beck, Ragan, and Du Pré (1997) and Kotthoff (2003).

The only analysis of sarcasm that could be located that uses CA as a method of research was conducted in the context of gynecological exams (Beck et al., 1997). The very nature of such research makes the applicability of the study limited to females only. While sarcasm was not explicitly mentioned, transcribed instances do occur and were discussed, exposing sarcasm as a method used by patients to assuage the awkward situation put forth by such an involuntarily intimate experience as a pap-smear (Beck et al., 1997).

A study conducted by Kotthoff (2003) did not use CA, however, it is the only other study to examine naturally occurring instances of sarcasm as opposed to examples specifically constructed for use during a survey or experiment. Kotthoff, using interactional sociolinguistics, found that most responses to sarcastic assertions are treated with a literal response that does not disregard the ironic nature of the statement. The literal response instead promotes a playful banter between conversants. While Kotthoff’s study is certainly relevant, CA may have provided different results and will be discussed next in an effort to explain why it is the ideal method to examine interactional sarcasm.
CONVERSATION ANALYSIS

The method of analysis used to breakdown the meaning of conversations between Patients (P#) and Doctors (D#) for this study is conversation analysis. According to Beach (2009), “conversation analysis (CA) is a primary mode of inquiry for understanding how people talk with one another in everyday casual encounters” (p. 87). CA is a methodology that focuses primarily on mundane topics of conversation (Heritage, 1984); those that would occur whether they were being tape recorded or not (LeBaron, Mandelbaum, & Glenn, 2003). Some examination of institutional interactions has also been involved in the corpus of CA knowledge (Heritage & Drew, 1992).

CA focuses both on the actual utterances and words used by speakers, as well as the give and take of social interaction between communicators (LeBaron et al., 2003). The primary source for any scholar engaging in CA is the actual audio or video recording (Beach, 2009, p. 35). While CA began as the study of transcribed conversations, the concept of analyzing video and audio recordings is not a new one. The idea to study the nonverbal aspects of interaction through such recordings was posited by Sacks (1992) as early as 1964. Birdwhistell (1970), another early savant of nonverbal dealings, published an entire book of essays speaking to the importance of interactional kinesics, which examines body movement and positioning.

Video recordings of real time interactions were first studied through ethnography in the field of sociology (Heath, 1986). Having unlimited access to so much detail was too much to analyze through an ethnographic lens, but CA is well-suited to scrutinize such minute detail (Heath, 1986). As explained by Heath (1986), video recordings provide access to, “moment by moment interactional coordination of body movement and speech between [specifically] doctors and patients” (p. 5). The ability to analyze a conversation at a frame by
frame level of detail allows an exacerbation of the opportunity for researchers to grasp the perspectives of participants (Heath, 1986). Video, in addition to its rewind-ability, provides a simple way to share raw data with other scholars in the scientific community (Heath, 1986). While it can be difficult to obtain recordings of real-life interaction, the benefits far outweigh the hardships. Strides in making video cameras smaller, more affordable, and user friendly have aided in the increased ability to use video recording as a data collection method and will continue to aid in increasing the prevalence of such studies.

A study conducted by Heath (1989) used video recordings to examine how patients communicated pain to their doctors. The study found that patients express pain through “embodiment,” not just verbal explanation (Heath, 1989, p. 121). Doing so allows patients to clue doctors in the actual suffering caused by the pain (Heath, 1989). The body is used, essentially, as a conduit through which a patient’s suffering can be demonstrated to the doctor (Heath, 2002). Another study using video recordings to analyze talk and nonverbal actions found that in a medical setting, patients often contradict their bravery in speech with nonverbal exhibitions of fear (Beach, Easter, Good, & Pigeron, 2005).

Some studies have used the visual aspect of CA to examine how doctors control the conversation in medical interviews (Robinson, 1998; Ruusuvuori, 2001). Specifically, the orientation of doctors to both patients and the medical records of patients are inspected through video recordings (Robinson, 1998; Ruusuvuori, 2001). The studies found that orientation is often used by doctors to start and stop the flow of information coming from the patient (Robinson, 1998; Ruusuvuori, 2001). The orientation of a doctor’s legs, as opposed to his or her head, was found to be indicative of how involved the doctor was in active listening (Robinson, 1998).
Issues such as gestural glossing (Koschmann et al., 2007), attending to tearful displays (Beach & Dixson, 2001), managing a patient’s quavering voice (Beach & LeBaron, 2002) and recognizing nonverbal acts of ostension during a surgical procedure (Koschmann, 2003) are all areas of research that nonverbal conversational analysis has been able to address because of the ability to review, over and over again, the recorded instances of real-time human interaction. The analysis engaged in for this paper is based on video recordings that were then transcribed. The transcriptions, as well as images captured from the video, are used to aid in reader understanding of this paper’s conducted examination.

**DATA FROM SDCL: 10 SEPARATE INTERVIEWS**

The data examined for this paper were gained from The San Diego Conversation Library (SDCL). Specifically, 10 separate patient-doctor interviews were examined. The video recordings of the interviews were obtained as part of an ongoing study focusing on patient-doctor interaction taking place in San Diego County, California. The study focuses on interactions between cancer patients and the doctors they are seeing for counseling or treatment.

All interviews examined capture medical interviews occurring between a patient and oncology doctor who are seeing each other for the first time. Although the patients have already been diagnosed with cancer, none had previously spoken with the doctor seen in these particular recordings. The videos were taken at what is now the Moores Cancer Center at the University of California at San Diego in La Jolla, California (formerly Thornton Hospital) in the early 2000s. The data was collected as part of a National Institute of Health (NIH) and National Cancer Institute (NCI) grant. The study received full clearance from the Institutional Review Boards (IRBs) at both San Diego State University and the University of
California at San Diego. The interviews range from 11 minutes and 37 seconds to 51 minutes and 21 seconds. All interviews were recorded by a video camera that remained on its stationary stand throughout the entire interview. All recorded participants signed consent forms agreeing to be recorded and allowing for those recordings to be utilized during academic research.

**Research Questions**

Based on the existing data that has been collected and the materials being examined in the present study, the following research questions are posed:

- **RQ1**: How do patients and doctors display sarcasm during oncology interviews?
- **RQ2**: How do patients and doctors use sarcasm in similar and different ways?
- **RQ3**: When patients display sarcasm, how do doctors respond?
- **RQ4**: When doctors display sarcasm, how do patients respond?
- **RQ5**: What are the primary interactional environments through which sarcasm is communicatively negotiated during oncology interviews?

**Forecast of Following Chapters**

Now that the relevance, need for, and purpose of this study have been made clear, the analysis of data will begin. In Chapter 2, verbally exemplified sarcasm will be examined. The evaluation of transcripts exposes three apparent instances of sarcastic speech: patient initiated sarcasm, sarcasm used to enable collaborative play, and doctor initiated sarcasm. A breakdown of the effectiveness of each type of sarcastic display will occur.

Chapter 3 will provide an arena to observe the nonverbal actions that occur in conjunction with sarcastic remarks. Specifically, the uses of paralanguage, facial expression, and kinesic positioning will be addressed. Still frames extracted from video recordings will be included to aid in reader understanding of some important nonverbal occurrences.
Finally, Chapter 4 will discuss what the oral and nonverbal analyses revealed in relation to the five specific research questions posed. Strengths and weakness of this study will also be discussed. The chapter will close with a discussion of where future research may want to focus in an attempt to better understand the uses of sarcasm as it pertains to medical interaction.
CHAPTER 2

SARCASM EXHIBITED VERBALLY

This chapter proposes that sarcasm is employed by many cancer patients, and encouraged by some doctors, as a coping mechanism. In an effort to gain further insight on the specific topic of sarcasm as it is employed in oncology interviews, this chapter will evaluate several instances of sarcasm in patient-doctor interaction using conversation analytic methods. In this study, from this point forward, sarcastic instances will be understood as non-literal utterances that are occasionally obviously aggressive (Partington, 2006). Sarcasm will also be understood as existing on a continuum from markedly sarcastic to vaguely sarcastic (see Figure 1). The idea of sarcasm existing on a scale is supported by Rockwell’s (2000) reference to sarcasm’s degree of severity. Additionally, a study conducted by Bryant and Fox Tree (2005) found that participants differentiated among phrases based on the amount of irony and sarcasm perceived in them. Those phrases with a large amount of sarcastic intent were referred to as “dripping with sarcasm” (Bryant & Fox Tree, 2005, p. 267).

![The sarcastic continuum.](image)

**Figure 1. The sarcastic continuum.**

**ANALYSIS OF INTERVIEWS**

The collection of sarcastic instances that has been developed for this study exhibits three recurring themes. The first theme, patient initiated sarcasm, is observed and discussed
in the first five excerpts of this chapter. The next theme, patients and doctors playing at sarcasm together, is examined in Excerpts 6, 7, and 8. Finally, sarcasm initiated by the doctor will be examined in the last four excerpts.

**PATIENT INITIATED ACTION OF SARCASTIC MOMENTS**

1) **NCI D2-P5: 19**

   1. D: ...If your mother spent forty years having intense hot flashes that [weren’t] tolerable
   3. D: You’re probably not the best candidate for that study. I. I. And I have noticed.
   4. P: She went to the north pole and wore shorts.
   5. D: And I have. I have noticed that it does tend to be familial. That. That you share a lot of genes with your mother and it does tend to be predictive.

Excerpt 1 provides an example of a disattended patient initiated action (PIA). Although the patient is sharing a “joke” (Excerpt 1, Line 5) with the doctor, the doctor does not acknowledge the attempt at humor made by the patient. The patient’s “joke” is sarcastic because it is obviously non-literal. While it is unlikely that the patient’s mother ever went to the North Pole, the idea that she wore shorts there is even more implausible because the North Pole is very cold.

The doctor, in Excerpt 1 seems more interested in completing a preformulated sentence than listening to the patient, as evident by the continual stop and start speech pattern employed by the doctor. The stop and start speech pattern used by the doctor, in this instance, serves to erase what the patient said. The doctor treats the patient’s comment as though it never happened. As explained by Alvarez (2002), the patient’s comment registers with the doctor as, “…distracting and threaten[ing to] the context, which in turn may be treated by [doctors] with active disattention so that the main line of activity can continue” (p. 91). The
doctor’s disattention shows and unwillingness, or inability, to move away from the specific
task of acquiring a complete medical history for the patient. This apparent lack of flexibility
is an occurrence commonly associated with the biomedical model.

The limited response provided by the doctor to the patient’s PIA portrays him as
inattentive and focused primarily on his own concerns, not the concerns of the patient. While
it is understandable that the doctor is busy and has certain information he must obtain
through the interview, it is unfortunate that he chooses to pay little heed to the patient’s PIA.
The asymmetry in patient-doctor interaction is not only expected, it is necessary. There are
ways, however, that the doctor can attend to PIAs and still maintain his dominant position in
the conversation. As explained by ten Have (1991), “although the initiative for the encounter
is primarily the patient’s, this task distribution involves quite ‘natural’ interactional
dominance by the physician, enacted through questioning, investigating, and decision-
making behavior, generally complying with the doctor’s orders and suggestions” (p. 139).

It was originally thought that patients act extremely passive when involved in a
patient-doctor interview. It has recently been found, however, that patients will initiate
actions when they have a specific concern or question. When doctors use conversational
styles that allow the patient to take a more active role (such as partnership-building), patients
tend to initiate more actions (Street, Gordon, Ward, Krupat, & Kravits, 2005). It is believed
that these PIAs are more common in cancer patients than in any other type of patient because
there are so many unknowns and variations with that particular disease (Street et al., 2005).

Research has also indicated that patients who have higher levels of education are
more likely to assert themselves in patient-doctor interaction (Street et al., 2005). Finally,
Street and his colleagues found that white patients are generally more forward in patient-
doctor situations than are non-white patients. Robinson (2003) proposes that the type of visit occurring has a significant impact on the amount of patient participation. None of the medical interviews examined in this paper are from diagnostic visits, but they are the “acute,” as in “initial,” visits between patients and doctors, as patients had previously been seen by a different doctor. The “acute” nature of the visits occurring in these analyzed interviews is, according to Robinson, a significant factor in the asymmetry between patient and doctor initiated topics.

To review, Excerpt 1 shows a patient exhibiting an obvious instance of sarcasm to which the doctor does not respond at all. The next excerpt, like Excerpt 1, provides an example of a patient using sarcasm. Both instances of patient initiated sarcasm are meant to provide the doctors with additional information. The patient in Excerpt 1 pokes fun at someone else through her use of sarcasm. The patient in Excerpt 2, however, uses himself as the brunt of his sarcastic comment.

2) **NCI D5-P2: 4**

1. D: No leaking?
2. P: No I don’t have any – I never even I uh to this day I don’t have any breasts
3. bleeding or enlargement. I don’t have – I lost all my hair. **I look like** =
4. D: Yeah.
5. P: = **like like a (eunuch) or whatever.** Um (.) uh (.) I can’t get an erection, cuz that’s
6. the (Flomax) and the other stuff.
7. D: Yeah.

Similar to PIAs, patients occasionally will provide doctors with extended responses that include sarcasm (Perakyla, 1998). Extended responses are defined by Perakyla as, “turns of talk that follow the doctors’ diagnostic statements and in which the patients do something more than just acknowledge the diagnosis” (p. 219). An extended response can be seen in
Lines 2, 3 and 5 of Excerpt 2. When the patient follows his initial answer to the doctor’s question with additional information, the extra sentences are an extended response. Specifically, the extended response is adding to a prior answer provided by the patient of “No I don’t have any —.” Although this statement is not made in response to a diagnosis given by the doctor, it can still be considered an extended response because it goes beyond answering the doctor’s prior question, which was, “No leaking?” (in reference to symptoms of prostate cancer).

The sarcastic portion of Excerpt 2 is bolded in Lines 3 and 5. It is clear that the patient’s statement “I look like = like a (eunuch) or whatever” is not literal and therefore sarcastic. The fact that the statement is not literal is known because he is referring to his lack of pubic hair as cause for making him look like a eunuch. A eunuch is actually a man who has been castrated, which is not what happened to this particular patient because he had prostate cancer, not testicular cancer. There is, however, a grain of truth in the patient’s statement because, due to castration at an early age, eunuchs do not develop pubic hair.

The sarcastic comment made by the patient in Line 5 of Excerpt 2 is an example of an imbedded instance. The patient makes the sarcastic comment about looking like a eunuch, but then continues to list other medical symptoms sans sarcasm. The imbedded nature of this instance obligates the doctor to make a choice regarding to which part of the patient’s utterance he will respond. The fact that the sarcasm is imbedded may be why the doctor did not respond to the patient’s attempt at “humor.”

The fact that doctors are innately regarded as intelligent is often taken into consideration when using sarcasm during patient-doctor interactions. The example in Excerpt 2, for instance, takes for granted the fact that the doctor knows what a eunuch is, otherwise
he would not understand the patient’s reference. In the next excerpt, Excerpt 3, the patient
takes for granted the doctor’s innate knowledge of foreign word origins.

3) **NCI D3-P3: 7**

1. D: Are you Greek?
2. P: [Yeah] I’m Greek.
4. P: **Uh with this ah last name?**
5. D: Yes right. Huh huh huh huh. Um and um (.) eh (.) never smoked tobacco?

Another example of an extended response can be seen in Line 4 of Excerpt 3. The
original question was posed by a doctor during a medical interview, but is more of a personal
question than a question attempting to establish a medical history. The question posited by
the doctor in Line 1 of Excerpt 3 is, “Are you Greek?” In Line 2, the patient answers the
question directly. In Line 4, however, the patient goes further and uses a sarcastic remark to
extend her response to what she seems to consider the doctor’s incredulous question. The
sarcasm manifests itself in the sense that the patient is asking the question “Uh with this last
name?” but is backhandedly attacking the doctor’s intelligence, as was discussed earlier as a
distinction between irony and sarcasm (Partington, 2006). The patient’s last name is
something similar to Papadopulus and the patient has a relatively thick Greek accent.

As one may recall, a patient’s extension of acknowledgement was previously termed
a PIA. An extended response can be the same as a PIA because in both cases, the patient is
offering some information not specifically asked for by the doctor. A PIA, however, is not
necessarily an extended response. The PIA in Excerpt 1 is an example of such an occurrence.
There, the patient is not extending her response to anything; she is simply initiating a
comment of her own accord. Another example of a PIA can be seen in Excerpt 4.
4) NCI D1-P1: 5

1. P: I keep copies hehe.
2. D: Uh hm, keep multiple copies, so okay. [Then I]
3. P: [That’s a] professional patient, would you say.
4. D2: Yeah.
5. P: Oh, that’s sound terrible.

A common practice among doctors is to use repetition in an attempt to understand just what their patients are saying (Couper-Kuhlen, 1996). When a patient initiated action (PIA) of sarcasm occurs, doctors seem to revert to a pattern of communication that is the opposite of that repetitive nature. For example, in Line 1 of Excerpt 4, the patient utters an initial PIA that can be seen in bold. To the patient’s “I keep copies hehe,” the doctor responds with repetition, as is the primary mode of operation for many of today’s medical interviewers. Repetition is often used to seek clarification and express empathy, both of which allow for a more certain comprehension of the patients position. For example, “physicians [who] seldom demonstrate empathetic behavior, [leave] patients not feeling understood” (Lee, Rosenberg, & Moloho, 1998, p. 335).

A marked shortage of attention and support is exhibited by the doctor after the patient’s second PIA, occurring on Lines 3 and 4 of Excerpt 4. To the patient’s sarcastic, “[That’s a] professional patient wouldn’t you say,” the primary doctor responds only minimally. The patient’s utterance is known to be sarcasm because the patient refers to herself as a “professional patient,” a profession that, in reality, does not exist. The patient treats her actions of keeping records as proficient and competent. She presents that proficiency as a skill one can learn from being a frequent patient. The patient’s comment also comes across as bragging. Bragging about being a frequent patient is not something one
would expect to hear from another person. As Martin (2007) states, sarcasm is often perceived when what one says is not in line with the expected response or comment.

The only acknowledgement of the patient’s attempt at humor and face-saving comes in the form of a “Yeah” on Line 5 of Excerpt 4 that was uttered by the secondary doctor in the room (denoted as D2 in the transcription). The “hehe” that followed the patient’s admittance of keeping copies of her medical records with her (Line 1, Excerpt 4) is suggestive of the embarrassment felt at having revealed such a truth. The laughter indicates a delicate moment (Beach, 2009; Haakana, 2001). It is known that laughter can be used to help protect “face” and forced laughter following an admission is indicative of laughter for face-saving purposes (Kovarsky, Curran, & Nichols, 2009). That knowledge, coupled with the fact that the patient openly criticizes her own statements of disclosure (Line 6, Excerpt 4) show that the patient is feeling uncomfortable, if not embarrassed. The patient, through her laughter, marks her use of sarcasm as a possible delicate situation.

The secondary doctor’s “Yeah” in Line 5 of Excerpt 4 can be likened to a rejection of the patient’s sarcasm. The patient’s response (on Line 6 of Excerpt 4) to that rejection is an expression that what she, the patient, just said was terrible. Indicating that her sarcastic comment was terrible reveals that she, the patient, is not sure if her cancer is really something she should be joking about. In the midst of her sarcasm, the patient seems to be looking for attention.

In summary, this instance exhibits a patient putting forth a sarcastic comment for the sake of levity and attention. The patient’s initiation of sarcastic humor is not picked up by the doctors. The patient then attempts to assuage the situation by dealing with the consequences, such as a need to save face.
The next excerpt being examined (Excerpt 5) involves another instance of a patient offering a sarcastic take on trouble. The patient in Excerpt 5 asserts fear using sarcasm, which, as mentioned previously, is a face saver (Martin, 2007). As in all the excerpts thus far, the patient is the initiator of sarcasm in Excerpt 5.

5) **NCI D3-P5: 26**

1. F: Mmm.
2. P: *Your fingernails don’t fall off, do they? Heh heh heh.*
3. D: No. No, they turn many colors and get bumpy, and stuff like that.
4. P: Yeah.
5. D: But that grows out.
6. P: Yeah

((Patient and doctor have been talking about the impacts of chemotherapy; F is friend.))

The patient’s question in Line 2 of Excerpt 5 is offered up as an unlikely possibility, but is treated, and delicately so, as something worth double checking. The patient’s method of asking the question is deemed sarcastic because it is blatantly forceful toward herself. She does not bother with any leading questions, but instead gets right to the point about which she desires information. Sarcasm, as discussed in Chapter 1, is identifiable as “overtly aggressive” (Partington, 2006, p. 216).

The laughter that follows the patient’s questions is inserted not because it would be truly humorous to lose all her fingernails, but because she is nervous as to what the answer will be. This nervousness has to do with the lack of information displayed by the patient regarding cancer and how that manifests itself in uttered sarcasm. The patient’s use of sarcasm is not blatant. Her question in Line 2 of Excerpt 5, when placed on the sarcastic spectrum (see Figure 1), falls closer to the “sarcastic in nature” end. Through this excerpt it is clear that sarcasm can be used to manifest something implausible in a delicate manner.
In Excerpt 5 sarcasm is observed as a vehicle for attaining more information from the doctor. Sarcasm can be used for other reasons as well. All of the excerpts discussed in Chapter 2 so far have dealt with patients initiating sarcasm. It is important to keep in mind that while a patient can exhibit sarcasm that falls somewhere on the continuum shown in Figure 1, so too can doctors respond to that sarcasm on a continuum. While the doctors in the excerpts examined in the previous section provided minimal responses to the patient’s sarcasm, some doctors, as will be shown in the next section, engage in sarcastic play with their patients.

**COLLABORATION AND PLAY**

Collaboration and play are common practices during any type of storytelling. Providing a medical history, depending on how the questions from the doctor are framed, can be likened to telling a story. Collaboration and play as specifically related to sarcasm are examined in the following excerpts.

6) **NCI D5-P1: 14-15**

1. P: Right. I just, you know, I’ve gone through a lot of you know different things in my life, I’m not afraid of anything, I’m not afraid of dying, you know. But when it comes to blisters all over my body and there’s no way to do anything but stand (.)
2. D: *Was she – was she reading the book of (Job) to you?* [$Heh heh heh$]
3. W: [$Heh heh heh$]
4. P: *Yeah, it was like the (pestilence) had come to – to take me away*. And so I would, I would dearly like not to have to go through that again.
5. D: Yeah.
6. P: Even if I have to take forty milligrams of Prednisone and blow up like the Michelan Tire Man you know.
7. D: $Heh heh heh$
Sarcasm can be seen at two instances in Excerpt 6. The initial instance is put forth by the doctor in Line 6. The doctor’s comment has an obvious victim, which is an indicator of sarcasm (Partington, 2006). The victim in this case is the patient. The patient is a victim because the doctor is making fun of the patient’s hyperbolically vivid description of boils. The next instance of sarcasm in Excerpt 6 is uttered by the patient in Line 8 in response to the doctor’s initial use of sarcasm. The patient’s response has been deemed sarcastic because of its non-literal nature. It would be highly unlikely that the pestilence, a biblical phenomenon, over took the patient.

The collaborative efforts used to build the sarcastic and fictional scenario transcribed in Excerpt 6 (above) are not unique to sarcasm or medical encounters. Sacks proposed a theory in 1972 stating that stories are, “...sequenced objects articulating with the particular context in which they are told” (Jefferson, 1978, p. 219). The first step in the sequence referred to by Sacks is when the patient begins to discuss his extreme fear of and dislike for blisters all over his body (Excerpt 6, Line 1). At this point in the interaction, the patient is not trying to tell a story, but tell his troubles. The doctor, for reasons unbeknownst to observers, decides to posit a popular reference at a break in the patient’s “troubles telling” (Beach, 2000). Because the reference was to a book in the Bible, it was a safe bet that the association made between the patient and Job would not be terribly offensive. Also, it established a common framework for all who were about to hear the story, increasing relevance and, therefore, interest (Goodwin, 1990).

Once the reference has been posited, the doctor proceeds to laugh at his own wit, thus encouraging others to laugh along with him (Haakana, 2002). The patient’s wife (W) laughs with the doctor, confirming that the “joke” was not offensive (Jefferson, 1978). To keep the
“joke” going, the patient then adds to the fictional idea of being tested by God and a pestilence. The “joke” ends in Line 12 of Excerpt 6 when the patient makes a sarcastic reference to an ailment he had mentioned to the doctor earlier in the interview. At this point, the story that was begun by the doctor has been taken over by the patient in an effort to reclaim face that was lost by being compared to the biblical, Job. This reappointment of story-teller is a fairly common phenomenon in collaborative storytelling (Jefferson, 1978).

Another example of sarcasm in storytelling can be seen in Excerpt 7.

7) **NCI D5-P3: 18**

1. P: Yeah it was – it was a pretty miserable uh – you know we find out about the match
2. um and I’m trying to finish my dissertation and then we find out that I have
3. cancer. And then the next day after I’d met with ( ) and he told me basically well
4. yeah we need to do an (archeectomy), the next day I had to get my dissertation out
5. to all my committee members and it’s just.
6. D: Yeah.
7. W: This has been [(quite the few weeks)].
8. P:      [ $heh heh heh heh  ]. So it’s been um (.)
10. P: It’s been a little [stress].
11. W:           [Yeah.]
12. D: Just a little stress.

A similar pattern of story telling turns can be seen in Excerpt 7. Sarcasm is seen here in Lines 9, 10, and 12. The phrase “a little stress” that was uttered by the doctor, then the patient, and then the doctor again, is sarcastic because of its non-literal nature. Based on the situation described by the patient in Lines 1 through 5 of Excerpt 7, the patient is experiencing far more than a little stress. The collaboration in this situation begins when the doctor responds with a sympathetically sarcastic remark in Line 9 of Excerpt 7 to a “trouble’s
telling” instance provided by the patient. The patient then adds to the story in Line 10 of Excerpt 7. The decision to collaborate could be a result of several different constructs such as the demeanor of each patient or the cognitive clarity with which each patient was processing at the time the collaborations were occurring.

Except 7 is an excellent example of the use of repetition in interaction. The phrase “a little stress” is repeated three times in less than 20 seconds and is uttered by both the patient and the doctor. The repeats exhibited above are considered “near copy” repeats because they do not take the shape of an exact lexical replica (Couper-Kuhlen, 1996). The purpose of the repeat in this particular situation appears to be two-fold: confirmation and claim to epistemic authority (Stivers, 2005).

Stivers explains that the person in a conversation who makes an initial assertion claims epistemic authority regarding knowledge of that statement. This idea is similar to the idea of establishing a storyteller, as discussed in conjunction with Excerpt 6. In Excerpt 7 the doctor makes the initial claim about how stressed the patient must have been while trying to complete his doctoral dissertation and deal with his cancer diagnosis. The patient’s repeat of the doctor’s assertion is an attempt to reclaim epistemic authority regarding the stress he felt, that the doctor could sympathize with, at best. The repeat made by the patient is also an agreement with the doctor because the patient did, in fact, feel stressed. The doctor’s final repeat of the phrase in line 12 shows that he accepts the patient’s reclamation of epistemic authority regarding the patient’s stress. This negotiation of epistemic authority has been found to matter to a majority of conversational participants (Stivers, 2005) and is therefore important in this situation.
Excerpts 6 and 7 both involve collaborative sarcasm. They both, also, involve the doctor making the initial sarcastic comment. In the next excerpt, Excerpt 8, collaborative play through sarcasm happens again, but is initiated by the patient and picked up on by the doctor.

8) NCI D3-P5: 11

1. P: [Okay, ha ha ha. **With my luck.**]
2. D: [Ha ha ha. Yeah right, right.] **And chances are it might come** [back for you. Ha ha ha.]
3. P:                   
4. P: [Ha ha ha.]

Prior to Excerpt 8 the patient and doctor were talking about a potential situation that, if it occurred, would require the patient to need a round of chemotherapy. The patient is expressing, in Line 1 of Excerpt 8, that the worst case scenario is what would likely happen to her. The lack of seriousness regarding that expression is evidenced by the patient’s laughter (Norrick, 1993). The lack of alignment with an expected response to hearing such news is interpreted as sarcasm (Martin, 2007).

The laughter and sarcasm initiated by the patient alert the doctor to the acceptability of such remarks and responses. Shared laughter is a way to increase immediacy between two people and is a way of connecting and sharing agreement on a level beyond that which can occur lexically (Glenn, 1991). The patient’s laughter in Line 1 of Excerpt 8 is an example of current speaker initiation of two party shared laughter (Glenn, 1991). The doctor took the process of identifying with the patient a step further and chose to engage in collaborative sarcasm as well as the shared laughter. The patient’s continued laughter in Line 4 of Excerpt 8 demonstrates that the patient accepts the doctor’s move to identify on a deeper level with the patient.
Excerpt 8 is also an example of two people working together to formulate an “imaginary” situation. Each contributes something to the potential scenario, but both participants understand that the scenario being constructed is only a possibility. These types of instances are referred to as inviting collaboration (Beach, 2000). The patient and doctor are, together, constructing a “worst case” scenario together, but, through the use of sarcasm, are keeping the discussion light hearted.

As was made clear through the analyses of the four stories above, storytelling has certain components that allow for effective delivery. This idea of a formulaic quality for conversations and stories is related to the fundamental basis of CA. As quoted by Sacks (1970) in his lecture “On Doing ‘Being Ordinary,’” “The idea [of CA] is to take singular sequences of conversation and tear them apart in such a way as to find rules, techniques, procedures, methods, maxims...that can be used to generate the orderly features we find in the conversations we examine” (p. 413). In his 1984 “Notes on Methodology,” Sacks says that the patterns found in conversations are a result of machinery. That machinery is the human attempt at correctness approaching the ability to predict how a conversation will unfold (Sacks, 1984). He says that it is as though the conversations were created by a machine (Sacks, 1984). Sacks (1984) uses “machine” for his metaphor because, unless a machine malfunctions, the resulting product should look or sound exactly as the machine inventor intended.

Up until this point, the sarcastic remarks have been either introduced by the patient, or are a collaborative effort between the patient and doctor. While the occurrence of doctor initiated sarcasm may not fit intuitively into the biomedical model, some doctors do engage
in such action. The excerpts in the following section are examples of doctors as the primary patrons of sarcasm.

**DOCTORS “DOING ‘BEING SARCASTIC’”**

9) **NCI D1-P3: 16**

1. D: But of course, any trauma that depending on [how is] could potentially=  
2. P: [Sure.]  
3. D: = cause a [problem.]  
4. P: [Yeah.] Uh hm.  
5. D: So, uh, uh, yeah, maybe you don’t wanna be catcher for six months or so  

In Line 5 of Excerpt 9, the doctor makes a sarcastic remark about some limitations the patient faces as far as physical activity during his cancer treatment. The bold text in Line 5 of Excerpt 9 denotes the sarcastic portion found in the passage. Here, the doctor’s use of “maybe” is the primary sarcastic remark. The doctor actually the thinks the patient should *definitely* not play the position of catcher for six months. The doctor’s recommendation of staying away from catching for the softball team is made because it would be beneficial for the patient. However, the doctor is of the opinion that the instruction to not play the position of catcher during cancer treatment to be self-evident. The “maybe” was included in the statement to overtly poke fun at the patient’s naivety, as is the nature of sarcasm.

In Excerpt 9, the doctor’s sarcasm is attended to in a minimal way through the patient’s wife’s (W) laughter (Line 6). Just as doctors attend to patient sarcasm through varying degrees of acknowledgement, so too can patients attend to doctor sarcasm through varying degrees of acknowledgement. The next excerpt, Excerpt 10, exhibits a patient acknowledging the doctor’s sarcastic remark, but showing no indication that she knows it is sarcastic.
10) NCI D1-P6: 11

1. D: Yeah, that they’ll, they’ll kick you out and show you where the laboratory to
2. get your blood [drawn is,] but it’s right on your way out the door, uh=
3. P: [Oh, I see.]

Excerpt 10 is another instance of sarcasm as used by the doctor, but not responded to by the patient. The doctor mentions that some one in the hospital will be “kick[ing] out” the patient and sending them to another area of the hospital. The non-literal nature of that statement explains why it has been labeled as sarcasm. Obviously, the patient does not think she is going to be kicked by hospital personal because UCSD’s Moores Cancer Center is a high-class establishment. What the patient does not seem to understand, however, is why the doctor chose to use sarcasm at the particular time and in the particular way she did. This confusion is evidenced by the patient’s failure to acknowledge the doctor’s attempt at humor. Another failed attempt at humor by a doctor can be seen in Excerpt 11.

11) NCI D10-P5: 12

1. D: Yeah, yeah, this squishy part is more from the radiation. I think, right, the
2. swelling.
3. P: Yeah
4. D: It does wonders for your skin, doesn’t it. [Ha ha.]
5. P: [Yeah.]

In this third instance of doctor posited sarcasm, the doctor makes a joke about radiation in Line 4 of Excerpt 11. The joke is known to be sarcastic because of its non-literal quality. Radiation, in reality, is horrible for one’s skin. It can cause symptoms such as rashes and swelling.

While the patient does not come across as offended by the comment, he does not seem to find it humorous either, as evidenced by his monosyllabic response. It is possible that the doctor is so used to the ravage radiation executes on human skin that seeing it is
nothing special for him. The cancer patient, however, has likely never had to deal with the horrible radiation burns left on one’s skin after going through radiation treatment and may, therefore, be more sensitive to others noticing his imperfections caused by radiation. That theory, of course, is primarily speculative because there is now way of knowing the thoughts going on in a person’s head without asking them directly.

The final excerpt examined in this chapter deals again with doctor initiated sarcasm. The instance of sarcasm in Excerpt 12 is acknowledged by the patient’s wife (W). However, unlike in other excerpts, the wife checks with the doctor about whether or not he was being serious.

12) **NCI D5-P1: 16-17**

1. P: So uh those are the things that I need to talk to the surgeon about.
2. D: Yeah. ()
3. P: Okay. (.) When would you like to start the uh – following [the] –
5. P: Yeah. I agree with that.

((skip 1 page and 22 Lines))

28. W: You jokingly said we should’ve started this in December. I mean, it’s not ( ) this too late to do anything about it.
29. D: No, I’m just saying but it’s sort of spiraled on at a slow pace so far, It’s time to get moving.

One potential pitfall associated with the use of sarcasm in dire situations like cancer treatment is the inability for some people to detect sarcasm. In Excerpt 12 the doctor makes a sarcastic remark regarding when a cancer patient should have started treatment. The sarcastic statement is in bold print on Lines 4 and 5 in Excerpt 12. Because the interpretation of sarcasm involves one’s ability to determine what statements do and do not make sense in a given context, sarcastic statements about cancer can be difficult. While the doctors are
familiar with protocol and normal occurrences involving cancer, many patients and their families are not. This lack of knowledge regarding cancer makes it difficult for one to determine if what a doctor says is so ridiculous it has to be sarcastic, especially if there is a “deadpan” delivery.

Such an instance as the hypothetical described above occurred and is exemplified by Excerpt 12. The comment regarding treatment that was made by the doctor was meant to be interpreted by the patient and his wife (W) to mean that treatment should be scheduled for as soon as possible. Because the doctor said treatment should have started at a time that had already passed, the patient’s wife felt the need to ask whether or not the doctor was joking about that. Had the wife been more familiar with cancer herself, she would have realized that a few months of treatment would not make a significant difference in saving the life of her husband, simply because the particular type of cancer he has is slowly progressing.

The examination of the 12 excerpts above has revealed that sarcasm can be initiated by either patients or doctors. Additionally, this chapter exposed the fact that patients and doctors can sometimes “play” at sarcasm together. Chapter 2 identified sarcasm only on an oral level. The next chapter, Chapter 3, will examine the ways patients and doctors exhibit sarcasm on a nonverbal level among the same 12 excerpts just discussed.
CHAPTER 3

NONVERBAL SARCASM

This chapter explores the nonverbal communicative instances that occur in conjunction with the delivery of sarcasm by patients and doctors. The same excerpts that were discussed in Chapter 2 are revisited and discussed from a nonverbal perspective. Very few studies have examined the nonverbal communicative methods used when delivering sarcasm, which is why this chapter is exploratory in nature.

Each of the following 12 excerpts is given its own section for analysis. When feasible, freeze frame images are included for visual reference. When an image is not included as part of the analysis, that is an indication that the purveyor of sarcasm in that instance was not visible to the camera. The chapter will conclude with a summary of the sarcastic nonverbal patterns found.

EXPLORING EXCERPT 1

1) **NCI D2-P5: 19**

1. D: ...If your mother spent forty years having intense hot flashes that [weren’t] tolerable
3. D: You’re probably not the best candidate for that study. I. I. And I have noticed.
4. P: She went to the north pole and wore shorts. Ha ha.

6. D: And I have. I have noticed that it does tend to be familial. That. That you share a
7. lot of genes with your mother and it does tend to be predictive.

Line 5 of Excerpt 1 was qualified as sarcastic due to its non-literal nature in Chapter 1. The paralinguistic expressions involved with the patient’s delivery of the sarcastic phrase entail an increase in volume and more marked annunciation. Greater loudness was found by Rockwell (2000) to be commonly associated with a listener’s perception of sarcasm. Increased volume is often associated with the expression of emotion, so finding that volume is also associated with sarcastic expression is not surprising.

The patient’s use of annunciation during her delivery of the sarcastic sentence was also a notable implementation of paralanguage. Annunciation is a common practice when one wishes to emphasize something (Erickson, Fujimura, & Pardo, 1998). The patient in Excerpt 1 is emphasizing her mother’s extreme hot flashes during menopause in an effort to alert the doctor that she, the patient, will likely be susceptible to hot flashes that result as a potential side effect of cancer treatment.

The patient in Excerpt 1 also uses kinesic nonverbals during her sarcastic addition to the conversation. The patient makes a downward hand waving motion toward the doctor at two separate instances. The first occurs when she says the word “pole” and the second occurs when she says the word “shorts.” An image of the first hand waving motion can be seen in Figure 2.

Those two words are the basis of the patient’s sarcastic remark. For that reason, they are emphasized with the hand gesture just mentioned. This type of emphasis is referred to as a multitemescale dynamical interaction, meaning that the words being emphasized and the gestures aiding in that emphasis are occurring at the same time (Tilsen, 2009).

A final nonverbal occurrence was noticed during the patient’s sarcastic utterance in Excerpt 1. That occurrence was the patient leaning in toward the doctor at the point in the
sentence when she said “north.” The leaning in resulted in a proximity reduction (Chapman, 1975). Reducing proximity is often enacted to increase intimacy (Chapman, 1975). To make the increase in intimacy more tolerable for both parties, laughter is can be engaged in (Chapman, 1975), as is the case in Excerpt 1. The nonverbal communicative actions that occur along with the patient in Excerpt 2 will be examined next.

**EXPLORING EXCERPT 2**

2) **NCI D5-P2: 4**

1. D: No leaking?
2. P: No I don’t have any – I never even I uh to this day I don’t have any breasts
3. bleeding or enlargement. I don’t have – I lost all my hair. **I look like** =

4. D: Yeah.
5. P: = **like like a (eunuch) or whatever**. Um (. ) uh (. ) I can’t get an erection, cuz that’s
6. the (Flomax) and the other stuff.

7. D: Yeah.

In the bolded portions of Lines 3 and 5 of Excerpt 2, the patient engages in sarcasm through the use of a non-literal statement, as was determined in Chapter 2. Throughout the patient’s sarcastic statement his paralanguage differs from how it comes across during the rest of the medical interview. The difference occurs in the sense that the patient speaks faster and more quietly while engaging in sarcasm. This alteration in volume and tempo is related to the patient’s shifting of frames (Buchbinder, 2008; Goffman, 1981). In the case of Excerpt 2, the patient shifts from the frame of literal speech to the frame of non-literal speech, or sarcasm. When the patient utters the phrase “I look like,” he concurrently gestures up and down to himself with both hands and looks down at himself, which can be seen in Figure 3.

![Figure 3. Patient gesturing down his body with both hands.](image)

Those gestures and the head movement serve as gestural embodiments of suffering. The idea that patients demonstrate their medical issues through gestures and movement is explained by Heath (2002). Research further explains that patient’s gestures, “...enliven, if only momentarily, different parts of the body and provide a dramatic display of the symptoms and suffering incurred by the patient” (Heath, 2002, p. 601).
Based on discourse coherence, the patient has established a pattern of gesturing to the subjects about which he is talking (Lascarides & Stone, 2009). He gestured to the areas of his body that had lost hair when mentioning hair loss. His gesture away from himself when uttering the word “eunuch” indicates that he does not consider himself a eunuch. The gesture away from himself also acts as a distancing mechanism. Similar to the idea of relational distancing when a relationship becomes unwanted (Helgeson, Shaver, & Dyer, 1987), the patient uses gesture to put space between his actual person and the image of himself as a eunuch.

The patient in Excerpt 2 uses a final kinesic movement during his sarcastic statement when he says the word “whatever” in Line 5. The kinesic movement is dropping his head toward his right shoulder. Head movement during speech has been noted as an indication of stress (Hadar, Steiner, Grant, & Rose, 1983). The patient’s choice to drop his head while uttering the word “whatever” may indicate that the whole ordeal of losing all his body hair was stressful. Kinesic movements also occur during the patient’s sarcastic question in Excerpt 3.

**EXPLORING EXCERPT 3**

3) NCI D3-P3: 7

1. D: Are you Greek?
2. P: [Yeah] I’m Greek.
4. P: **Uh with this ah last name?**

![Gestures with left hand toward medical records and raises eyebrows briefly (see Figure 4)](image1)

![Gestures with left hand toward herself and raises eyebrows briefly](image2)
5. D: Yes right. Huh huh huh huh. Um and um (. ) eh (. ) never smoked tobacco?

The patient in Excerpt 3 engages in sarcasm during Line 4, as determined in Chapter 2. The patient lowers her volume when saying the sarcastic comment. This change in volume from the rest of the medical interview is an indication of frame change (Buchbinder, 2008; Goffman, 1981). As mentioned in the analysis of Excerpt 2, a frame change can occur when a person switches from a literal frame to a non-literal, or sarcastic, frame. The patient’s quietness during her sarcastic remark may also be an indication of the timidity she experiences when poking fun at the doctor, who is the superior in a medical interview (Page & Balloun, 1978).

During the history-taking portion of the medical interview, which is the phase at which Excerpt 3 occurs, it is common for the medical records to be a focal point for the doctor (Byrne & Long, 1976). The medical records can act as a reference for where to take the interview next, and as a place to take notes (Byrne & Long, 1976). The patient’s gesturing to the medical records during her sarcastic remark is an indication that she thinks the medical record is, indeed, a central part of the interview. Gesturing is found to be an indication of importance in a study by Lascarides and Stone (2009).

Multitimescale dynamical interaction occurs during Line 4 of Excerpt 3 when the patient raises her eyebrows in time with gesturing toward the medical records and then herself (Tilsen, 2009). An image of the patient gesturing to the medical records with raised eyebrows can be seen in Figure 4. As discussed in the analysis of Excerpt 1, multitimescale dynamical interaction aids in emphasizing a point (Tilsen, 2009). In this situation, it emphasizes that the patient thinks her last name is obviously Greek. Looking at the patient’s raised eyebrows on their own also reveals some information. Raised eyebrows have been found to convey questioning (Coerts, 1992) and surprise (Eckman, 1993), both of which are
likely felt by the patient during her sarcastic comment. A facial expression exhibited by the patient in Excerpt 2 can also be seen in conjunction with sarcasm.

**EXPLORING EXCERPT 4**

4) **NCI D1-P1: 5**

1. P: I keep copies hehe.
2. D: Uh hm, keep multiple copies, so okay. [Then I]
3. P: [That’s a] professional patient, would you say.
4. you say.
5. D2: Yeah.
6. P: Oh, that’s sound terrible.

![Makes a disgusted face as though tasting something bad (see Figure 5)]

The sarcastic phrase uttered on Lines 3 and 4 of Excerpt 4 was classified as such in Chapter 2 due to the non-literal nature of referring to one’s self as a “professional patient.” In terms of the paralanguage used by the patient during her sarcastic utterance, the only
noticeable difference between how she usually sounds and how she sounds during her sarcastic phrase is the rate of speech. Compared to how she speaks throughout the rest of the interview, the sarcastic comment is spoken much more quickly. This change in tempo indicates a frame change (Buchbinder, 2008; Goffman, 1981), as discussed in conjunction with both Excerpts 2 and 3. During this instance of sarcasm the patient is indicating a shift in the frame of literal speech to the frame of non-literal speech, which is also the case in Excerpts 2 and 3.

One other notable nonverbal occurrence was observed in the video that corresponds to Excerpt 4. When the patient says the phrase, “Oh, that’s sound terrible.” in Line 6, she makes a markedly disgusted face. While the comment in Line 6 is not in and of itself sarcastic, it is in direct reference to the sarcastic comment she made in Lines 3 and 4. Because of the comments direct association with sarcasm, it will be discussed.

To display disgust the patient altered her facial expression by closing her eyes and pulling down the edges of her mouth, as can be seen in Figure 5.

![Figure 5. Patient displaying disgust through downward facial movements.](image)

When one’s eyes are closed the ability to make eye contact with the person to whom one is talking is made impossible. A study conducted by Monk and Gale (2002) indicates that
when a person makes less eye contact it often means they are less concerned with their conversational partner, or partners, fully grasping what is being said. In the case of Excerpt 4, the patient could be unconcerned with the doctors’ understanding what she said because she was saying it primarily to herself.

Regarding the patient’s mouth movement as a type of kinesic expression, the pulling down of facial muscles has been linked to negative feelings (Rockwell, 2000). That explanation would make sense in the situation occurring on Line 6 of Excerpt 4 because the word “terrible,” which is a negative word, is being said. Another interesting point is that sarcasm is more often associated with mouth movement than any other facial expression (Rockwell, 2001). Mouth movement occurs during sarcasm in Excerpt 5 as well.

**EXPLORING EXCERPT 5**

5) **NCI D3-P5: 26**

1. F: Mmm.
2. P: Your fingernails don’t fall off, do they? Heh heh heh.

| Looks down at right hand’s fingernails and makes a disgusted face by pulling the upper lip up to reveal teeth (see Figure 6) |
| Shakes both legs while crossed |

3. D: No. No, they turn many colors and get bumpy, and stuff like that.
4. P: Yeah.
5. D: But that grows out.
6. P: Yeah

The sarcastic comment bolded in Line 2 of Excerpt 5 was determined to be sarcastic in Chapter 2 because of its clearly aggressive nature (Partington, 2006). Here, the nonverbal
signals displayed by the patient distinguish it as sarcastic as well. Similar to the other excerpts examined thus far, a frame change is indicated by the patient in Excerpt 5 as well (Buchbinder, 2008; Goffman, 1981). She indicates a shift in frame from literal to non-literal through an increase in tempo and a decrease in volume. The increase and decrease are noticeable in comparison to the way she talks throughout the rest of her medical interview.

The patient’s laughter, which directly follows her sarcastic comment in Line 2, is louder than the volume used by the patient to communicate throughout the rest of the interview. Because it is placed right next to the sarcastic comment that was spoken with reduced volume compared to the patient’s established speaking volume, the laughter comes across as markedly louder. Forced laughter is often excessively loud (Zweyer, Velker, & Ruch, 2004), so it is possible that the patient’s laughter is not organically occurring. A reason for this could be to boost her mood after having just thought of losing her fingernails. Forced laughter has been found to better the moods of people who engage in such behavior (Foley, Matheis, & Schaefer, 2002).

While uttering the sarcastic comment, the patient looks down at the fingernails on her right hand while making a disgusted face when she utters the word “fingernails” in Line 2 of Excerpt 5. An image of this facial expression can be seen in Figure 6. To describe her face more specifically, the patient pulls her upper lip up further to expose her teeth. The facial expression could be likened to a sneer, which is an expression commonly associated with sarcastic delivery (Rockwell, 2000). As was discussed in Excerpt 4, the downward movement of facial elements is indicative of negative feelings (Rockwell, 2000), which could be why the patient chose to look down at her fingernails as opposed to bringing her fingernails up to her face to look at them.
The kinesic movement of leg shaking while laughing, displayed by the patient in Excerpt 5, may have been an attempt to emphasize her laughter. Body movement has been linked to emphasis in conversation (Bull & Connelly, 1985). It makes sense that the patient would want to emphasize her laughter because she is looking to the doctor to provide an answer that would make her sarcastic question about losing her fingernails sound silly. In the next excerpt, Excerpt 6, the nonverbal communicative methods will be examined as exhibited by the doctor as well as the patient.

**Exploring Excerpt 6**

6) **NCI D5-P1: 14-15**

1. P: Right. I just, you know, I’ve gone through a lot of you know different things in my life, I’m not afraid of anything, I’m not afraid of dying, you know. But when it comes to blisters all over my body and there’s no way to do anything but stand (.)
2. 
3. 
4. erect with your legs spread apart because the – the twenty-five centimeters blisters
5. between your thighs are like (.) just –
6. D: *Was she – was she reading the book of (Job) to you?* [$Heh heh heh$]
7. W: [$Heh heh heh$]
8. P: Yeah, it was like the (pestilence) had come to – to take me away. And so I

Excessive blinking throughout

Left hand moves to side (see Figure 7)

9. would, I would dearly like not to have to go through that again.
10. D: Yeah.
11. P: Even if I have to take forty milligrams of Prednisone and blow up like the
12. Michelan Tire Man you know.
13. D: $Heh heh heh$

On Line 6 of Excerpt 6 the doctor initiates the first instance of sarcasm for this excerpt. As determined in Chapter 2, the doctor’s question is sarcastic because it is obviously aggressive and interpreted as non-literal (Partington, 2006). Because the doctor is not visible in the video recording from which Excerpt 6 was taken, only his paraverbal activities can be discussed. The only noticeable difference between the doctor’s method of speech throughout the rest of the medical interview and the instance of his spoken sarcasm is the rate at which he speaks. During his sarcastic question, the doctor speaks more slowly than his established normal rate. The delivery of sarcasm, as previously mentioned, is linked to a reduction in speech speed (Rockwell, 2000).

The patient’s sarcastic response to the doctor’s sarcastic question involves both paralanguage and kinesic aspects. Paralinguistically, the patient increases his rate of speech when uttering the sarcastic sentence in Line 8 of Excerpt 6 until he reaches the word “pestilence,” at which point he slows again to the rate of speech he established as “normal” for him during the rest of the medical interview. The increase in speech rate may have been do to conversational momentum, which is an increase in rate of speech that occurs when two people are “playing” at a story together (Arnott, Newell, & Alm, 1992). The slowing in
speech that occurred when the patient reached the word “pestilence” could be an attempt to emphasize the sarcastic nature of the word in the sense that the patient knew he was not actually experiencing the pestilence, but something else unpleasant (Rockwell, 2000).

With regards to kinesic movement, the patient uses a gesture when he says the word “pestilence.” The gesture involves the patient moving his left arm up and to the left, as seen in Figure 7. As previously discussed, gestures and body movement can be used to place emphasis on a certain part of the conversation (Bull & Connelly, 1985). That notion would support the idea that the patient’s change in speech rate was also an attempt to emphasize the word “pestilence.”

Figure 7. Patient gesturing to the left with his left hand.

Throughout the entire sarcastic comment in Line 8 of Excerpt 6, the patient displays excessive blinking, relative to his blinking throughout the rest of the medical interview. A study conducted by Riemer (1955) linked excessive blinking to pronounced hostility. Sarcasm is sometimes viewed as an aggressive method of communication (Partington, 2006) so excessive blinking as an indication of that aggression or hostility would make sense.
While no excessive blinking occurs in Excerpt 7, several other instances of nonverbal communication do and are examined next.

**Exploring Excerpt 7**

7) NCI D5-P3: 18

1. P: Yeah it was – it was a pretty miserable uh – you know we find out about the match
2. um and I’m trying to finish my dissertation and then we find out that I have
3. cancer. And then the next day after I’d met with ( ) and he told me basically well
4. yeah we need to do an (archectomy), the next day I had to get my dissertation out
5. to all my committee members and it’s just.
6. D: Yeah.
7. W: This has been [(quite the few weeks)].
8. P:        [ Sheh heh heh heh ]. So it’s been um (.)

10. P: It’s been a little [stress].

11. W:          [Yeah.]
12. D: Just a little stress.

The doctor’s initial sarcastic comment on Line 9 of Excerpt 7 is spoken more slowly than the rate established by the doctor as normal for him through out the rest of the medical interview. That comment, as well as the other bolded instances in Excerpt 7, were established as sarcastic in Chapter 2 because of their non-literal nature. As discussed in conjunction with previous excerpts, a slowing in speech rate can indicate the use of sarcasm (Rockwell, 2000).
While the doctor paralinguistically slows his speech, he also engages in the kinesic action of rocking in his chair. As mentioned previously, body movement of any type can be meant to emphasize the words being said in conjunction with that movement (Bull & Connelly, 1985). Body rocking is a self-stimulatory behavior often engaged in to soothe oneself (Smith & Van Houten, 1996). The doctor may be in need of soothing because he has taken a chance in being the person to initiate sarcasm during a serious point in the medical interview.

The patient’s engagement in sarcasm occurs in Line 10 of Excerpt 7. During his sarcastic comment the patient speaks more quietly than he does throughout the rest of his medical interview. As previously discussed, a change in voice volume can indicate a shift in frames (Buchbinder, 2008; Goffman, 1981). As is the case with other examined excerpts of sarcasm, the patient in Excerpt 7 is moving from the literal to the non-literal frame during his quietness.

The patient looks down and away from the doctor when he utters his sarcastic comment in Line 10 of Excerpt 7, as can be seen in Figure 8.

Figure 8. Image of patient looking away from the doctor and down.
Looking down, as mentioned previously, can indicate a general downward movement of the facial muscles, which has been linked to negative emotion like that commonly expressed through sarcasm (Rockwell, 2000). Looking away is indicative of the desire for a turn exchange. In the situation occurring in Excerpt 7, the patient’s look away may indicate that he wishes to be done discussing the stressful time in his life when he was diagnosed with cancer and faced with distributing his doctoral dissertation. Looking away has also been indicated as more common during a sarcastic utterance than a sincere one (Williams, Burns, & Harmon, 2009).

The patient’s final kinesic communication during his sarcastic comment is exhibited through manipulating a pen that he holds in his right hand. Object manipulation during conversation has been linked with submissiveness (Gifford, 1991). The idea that the patient is taking a secondary seat during the sarcastic play going on in Excerpt 7 because he did not initiate the sarcasm, would go along with the idea of submissiveness. While no object manipulation occurs in the next excerpt, several instances of kinesic nonverbal communication do, and are discussed in the following section.

**EXPLORING EXCERPT 8**

8) NCI D3-P5: 11

1. P: [Okay, ha ha ha. With my luck.]

Moves around in chair, nods head, gestures to the air with both hands, and rolls eyes (see Figure 9)
2. D: [Ha ha ha. Yeah right, right.] **And chances are it might come** [back for you]. Ha

![Looks away from patient toward the medical records and gestures toward the patient with left hand (see Figure 10)]

3. ha ha.]

4. P: [Ha ha ha.]

The sarcasm found in Excerpt 8 is denoted through bold print and is established as sarcasm in Chapter 2 because of its aggressive and non-literal nature. The patient is the first to initiate sarcasm in Excerpt 8 on Line 1. During her sarcastic comment the patient uses several nonverbal methods of communication including body movement, gesture, and facial expression. The patient’s body movement involves moving around in her chair. As previously discussed, body motion during speech can indicate an attempt at emphasis (Bull & Connelly, 1985). The patient nods her head up and down repeatedly when uttering her sarcastic phrase. This motion is also an attempt at emphasis (Bull & Connelly, 1985), possibly enacted to alert the doctor that she, the patient, is being sarcastic. Head nodding is commonly seen as a nonverbal sign of agreement (Kleck, 1970), which, in this case, could be interpreted as the patient agreeing with her self regarding her bad luck.

The gesture made by the patient during her sarcastic comment in Line 1 of Excerpt 8 is not directed to anything in particular, as can be seen in Figure 9.

It is similar to one throwing his or her hands up in the air in an exasperated manner (Arth-Pendley & Cummings, 2002). The patient’s choice to use the movement of her arms at this particular instance may be another way she is placing emphasis on the sarcasm she is uses during her statement of “with my luck” (Bull & Connelly, 1985). Finally, the patient
Figure 9. Image of patient making an exasperated gesture with both hands.

rolls her eyes during her sarcastic comment. A study by Rockwell (2000) found that eye rolling is commonly linked with sarcastic utterances.

The doctor’s sarcastic comment occurs in Line 2 of Excerpt 8. While uttering her sarcastic comment, the doctor engages in volume variation. This occurs when she becomes quieter at the point of saying the word “it.” Vocal variation has been associated with sarcasm (Cheang & Pell, 2008). The doctor looks away from the patient and toward her medical records when she comes to the word “it” in her sentence. Medical records have been linked to a reduction in eye contact with patients (McGrath, Arar, & Pugh, 2007), which may account for why the doctor looks away from the patient during her sarcastic statement.

Along with varying her volume and looking away from the patient, the doctor gestures to the patient when she says the word “it.” The gesture can be seen in Figure 10 and may mean that the doctor considers the patient important because, as discussed earlier, gesturing can indicate importance (Lascarides & Stone, 2009).
The gesture could also be an attempt to add emphasis to the sarcasm being engaged in by the doctor at that time (Bull & Connelly, 1985). In the following excerpt no gestures are discussed, but several other nonverbal instances of communication are examined.

**Exploring Excerpt 9**

9)  NCI D1-P3: 16

1. D: But of course, any trauma that depending on [how is] could potentially=
2. P: [Sure.]
3. D: = cause a [problem.]
4. P: [Yeah.] Uh hm.
5. D: So, uh, uh, yeah, maybe you don’t wanna be catcher for months or so


The doctor in Excerpt 9 engages in sarcasm, as established in Chapter 2, on Line 5. The doctor gives a “deadpan” (Rockwell, 2000, p. 485) delivery by keeping a strait face during the telling of his sarcastic joke up until he utters the word “six.” Such a delivery
method is commonly associated with sarcasm (Rockwell, 2000). The doctor’s downward gaze is analogous with the idea that facial muscles pull downward during the delivery of sarcasm (Rockwell, 2000).

The doctor uses the positioning of his smile half way through his statement to aid in the delivery of his sarcastic joke. The positioning of the punch line of a joke has been found to be more effective in eliciting the desired response of laughter than the actual perceived humor of the joke itself (Pickering et al., 2009). The smile, which reveals itself when the doctor says the word “six,” serves as the punch line in this situation because it alerts the listeners that the doctor’s statement is a joke. The doctor looks toward the family of the cancer patient when he smiles in an attempt to gain their response to his joke. Gaze can be an indication of turn in conversation (Craig & Gallagher, 1982). The doctor’s gaze and smile can be seen in Figure 11.

![Figure 11. Image of doctor smiling and directing his gaze toward the patient’s wife and daughter.](image)

The doctor’s paralanguage during his sarcastic remark involves speaking at a faster rate and lower volume than what he established as normal for him throughout the rest of the medical interview. As discussed previously, a change in volume and rate can indicate a
change in frame (Buchbinder, 2008; Goffman, 1981). The doctor’s frame changed from literal and serious to joking and non-literal during his sarcastic remark.

The doctor rocks back and forth on his feet while delivering his sarcastic remark. As discussed previously, rocking is a self-stimulatory behavior that aids in soothing (Smith & Van Houten, 1996). The doctor may be engaging in a soothing behavior because he is unsure of the appropriateness of his initiation of sarcasm during an otherwise serious situation. The final nonverbal behavior exhibited by the doctor during his sarcastic comment is the position of his hands in his pockets. Having one’s hands in his or her pockets can indicate dominance (Schwartz, Tesser, & Powell, 1982), which the doctor also displays through standing (Marsh, Yu, Schechter, & Blair, 2009) while the patient and the patient’s family are all sitting. The next excerpt examines the nonverbal communication practices of a doctor engaging in sarcasm as well.

**Exploring Excerpt 10**

10) **NCI D1-P6: 11**

1. D: Yeah, that they’ll, they’ll kick you out and show you where the laboratory to

   

   - Gestures with right hand to where the patient will go for the laboratory test and has left hand in pocket (see Figure 12)

   

2. get your blood [drawn is,] but it’s right on your way out the door, uh=

3. P: [Oh, I see.]

   The sarcastic phrase uttered by the doctor in Excerpt 10 is established as sarcastic in Chapter 2 due to its blatantly aggressive and non-literal nature. Because the doctor changes his vocal rate, an indication of frame change becomes noticeable. Frame change is often indicated by a shift in vocal delivery (Buchbinder, 2008; Goffman, 1981). The frame change
in this situation, as with many previously examined excerpts, indicates a change from a literal to a non-literal frame.

The doctor uses his right arm to make a gesture indicating the location of the lab to which the patient needs to go. The gesture can be seen in Figure 12.

![Image of the doctor gesturing to the lab he wants the patient to find.](image)

Figure 12. Image of the doctor gesturing to the lab he wants the patient to find.

The doctor’s choice to use a gesture at this moment may be an attempt to place emphasis on the sarcastic nature of his comment about “kicking” the patient out. As previously mentioned, body movement can aid in emphasizing important parts of speech (Bull & Connelly, 1985). The gesture may also be an indication of how important it is for the patient to go to the lab. Lascarides and Stone (2009) conducted a study that found people tend to gesture to, or about, objects and ideas they feel are important.

The doctor, during his sarcastic statement, has his left hand in his pant’s pocket. As discussed earlier, having one’s hand in a pocket can be an indication of dominance (Schwartz et al., 1982). The doctor is the dominant person in a medical interview because the doctor is the one asking the questions, so asserting his or her dominance nonverbally would make sense. In the next excerpt, no kinesic nonverbal communication is discussed in conjunction with sarcasm, but paralanguage is examined.
EXPLORING EXCERPT 11

11) NCI D10-P5: 12

1. D: Yeah, yeah, this squishy part is more from the radiation. I think, right, the
2. swelling.
3. P: Yeah
4. D: It does wonders for your skin, doesn’t it. [Ha ha.]
5. P: [Yeah.]

The sarcastic comment made by the doctor in Line 4 of Excerpt 11 was established as such in Chapter 2 because of its non-literal nature. The doctor, when engaging in sarcasm, speaks more quickly and at a higher volume. The doctor’s alteration in voice projection is an indication of frame shifting. Frame shifting, as mentioned before, is often indicated by a variation in vocal delivery (Buchbinder, 2008; Goffman, 1981). The doctor is shifting from literal to a non-literal frame in the situation transcribed in Excerpt 11.

The only other noticeable nonverbal communication being engaged in by the doctor when she uses sarcasm is the shift in her tone of voice from up to down. Vocal pitch shifts have been linked with irony and sarcasm by Cheang and Pell (2008). A change in voice pitch is linked with other attitude states as well (Banse & Scherer, 1996; Bänzinger & Scherer, 2005), so its indication of sarcasm is not surprising. The final excerpt, which is examined next, will also look only at paralanguage in regard to sarcastic delivery.

EXPLORING EXCERPT 12

12) NCI D5-P1: 16-17

1. P: So uh those are the things that I need to talk to the surgeon about.
2. D: Yeah. (.)
3. P: Okay. (.) When would you like to start the uh – following [the] –
4. D: [Oh] December. Last
5. December probably.

28. W: You jokingly said we should’ve started this in December. I mean, it’s not ( ) this too late to do anything about it.

29. D: No, I’m just saying but it’s sort of spiraled on at a slow pace so far, It’s time to get moving.

Sarcasm, as determined in Chapter 2, can be seen in excerpt 12 on Lines 4 and 5 as delivered by the doctor. The doctor maintains a much slower rate of speech during his conveyance of sarcasm than he maintains throughout the rest of the medical interview. As discussed in conjunction with other excerpts, sarcasm is often delivered at a slower rate than other types of speech.

**SUMMATION OF EXPLORATIONS**

Based on the examination of the previous 12 excerpts, only one pattern is noticeable throughout. The only indication that a person is engaging in sarcasm that was observed in most instances was some type of alteration in vocal delivery. Some people became louder when delivering a sarcastic comment, but some other people became quieter. Some people spoke more quickly when saying something sarcastic, while others spoke more slowly. The implications of these findings will be discussed in Chapter 4.
CHAPTER 4

CONCLUDING REMARKS

Through an analysis of video recordings and transcriptions, this study was designed to: (1) examine how patients and doctors display sarcasm, (2) explore how patients and doctors use sarcasm in parallel and diverse ways, (3) determine how doctors respond when patients initiate sarcasm, (4) determine how patients respond when doctors initiate sarcasm, and (5) explain what the circumstances under which sarcasm is negotiated during oncology interviews. This study concludes by reviewing the topics discussed in the previous three chapters, discussing the findings promoted by the study’s research questions, examining limitations of the study, and providing ideas for future research.

OVERVIEW OF THE SARCASTIC STUDY

A review of the existing literature revealed that sarcasm is a growing area of communication research that is still in its infancy. Sarcasm as a method of communication, however, is known to be prevalent (Rockwell, 2006). Sarcasm is much more than just a method of communication. It can be described as a series of nuances sometimes used to handle delicate situations. Sometimes sarcasm is marked and obviously noted, while other times it is hard to determine if a person is using sarcasm at all. The idea that the use of sarcasm is a possibility during medical interaction is supported by previous research indicating that sarcasm serves as a method for creating immediacy (Nelms, 2001), which is desirable in a patient-doctor relationship. Sarcasm, as determined by this study, can also be passive aggressive and used to establish rapport.
The literature review conducted in Chapter 1 revealed patient-doctor interaction as a burgeoning topic of investigation. A research focus has been established on trying to move patient-doctor interaction toward a more psychosocial implementation, as opposed to the relatively impersonal biomedical model most often relied on in the medical field (Engel, 1977). The delicate moments brought up by patients through sarcasm during medical interviews are more helpful to both patients and doctors when addressed. Addressing such an instance aids in facilitating a more satisfying medical experience for patients (Bantum & Owen, 2009).

Sarcasm’s stress reducing qualities during cancer treatment, the prevalence of sarcasm in society, and the pervasiveness of cancer in the world were proposed as the rationales for this study. Both humor and self-expression are linked by previous research to stress reduction and to sarcasm (Martin, 2007; Rockwell & Theriot, 2001). The importance of stress reduction during cancer treatment is posited by several studies as well (Garland et al., 2007; Krasner, 2004).

The method employed for this study is CA, which focuses on the organizing details of human interactions. Attending to these details aids in the study of somewhat fleeting instances of sarcasm. Additionally, CA allows for the examination of real-time interactions between people both verbally and nonverbally (Heath, 1986). Finally, there is a deficit of sarcasm research within CA. The findings from this study can provide new insights to aid in contributing to that deficit.

Spoken instances of sarcasm were examined in the second chapter of this study. The data analysis was divided into sections that dealt with patient enacted sarcasm, sarcastic play
between patients and doctors, and doctor enacted sarcasm. The level of sarcasm displayed in each excerpt was interpreted from an oral perspective.

The nonverbal aspects of sarcastic instances were scrutinized during the third chapter of this study. An attempt was made to determine and identify what embodied practices of communication are used by both patients and doctors during the enactment of sarcasm through the examination of visual elements. The dearth of conclusive studies examining the nonverbal aspects of sarcastic delivery lends itself to the importance of that examination. A summary of those findings, as well as the findings determined through analysis in the second chapter will be discussed next.

**SUMMARY OF THE FINDINGS BASED ON PROPOSED RESEARCH QUESTIONS**

This study has revealed that the use of sarcasm in medical interviews is relevant due to the fact that 10 out of 12 interviews contained at least one instance of sarcasm each. The analysis of those sarcastic instances has brought to light some ways in which patients and doctors make use of sarcasm during oncology interviews. Occurrences of both failed sarcasm and successful sarcasm examined during this study have aided in the understanding of the perceived appropriateness of sarcasm during oncology interviews. The findings are discussed in further detail in the next section.

**Research Question #1: Display of Sarcasm**

Patients and doctors display sarcasm through the use of non-literal speech. Non-literal sarcasm implies that the words being said by the purveyor of sarcasm are not what the purveyor actually means. Sometimes what was said was the polar opposite of what was meant. Other times, however, there was a grain of literality in what was said.
This idea that sarcasm can involve saying the complete opposite of what was meant as well as saying something slightly different than what was meant applies to the sarcastic continuum discussed at the beginning of the second chapter. The sarcastic continuum implies that sarcasm exists in degrees and can range from “markedly sarcastic” to “vaguely sarcastic.” Sarcastic comments that are the polar opposite of what was meant would fall closer to “markedly sarcastic,” while sarcastic comments that contain a grain of truth would be closer to the “vaguely sarcastic” end of the spectrum.

Sarcasm was also engaged in as a method of clearly aggressive communication, established as a use for sarcasm in a study conducted by Partington (2006). The use of sarcasm for this reason was less frequently found in the excerpts examined for this study. It is unclear why patients and doctors use this type of sarcasm as opposed to the non-literal sarcasm also observed. It is possible that they believe it will have more of an effect on their listeners because it can be more obvious. Explicitly aggressive sarcasm, similar to non-literal sarcasm, exists on a spectrum as well (Partington, 2006). Instances that pose aggressive questions seem to fall closer to the “vaguely sarcastic” end of the spectrum. Instances that could be taken as insulting, however, fall closer to the “markedly sarcastic” end of the spectrum.

There was no common nonverbal element that occurred during all instances of sarcasm examined in this study (see Table 1). The nonverbal element that most frequently occurred during the delivery of sarcasm was a change in vocal delivery either through volume or rate. Some people delivered their sarcastic comments more quietly, while others delivered their sarcastic comments more loudly. Some people spoke more quickly and some people spoke more slowly. Some people that did alter their volume did not alter their speech
| Excerpt 1: D2-P5 | P | x | | X | x |
| Excerpt 2: D5-P2 | P | x | x | | X | x |
| Excerpt 3: D3-P3 | P | x | | x | X |
| Excerpt 4: D1-P1 | P | | x | x |
| Excerpt 5: D3-P5 | P | x | x | x | x |
| Excerpt 6: D5-P1 | D | x | | -- | -- | -- |
| Excerpt 6: D5-P1 | P | | x | x | X |
| Excerpt 7: D5-P3 | D | x | | -- | x |
| Excerpt 7: D5-P3 | P | x | | x | x |
| Excerpt 8: D3-P5 | P | | x | X | x |
| Excerpt 8: D3-P5 | D | x | | x | X |
| Excerpt 9: D1-P3 | D | x | x | x |
| Excerpt 10: D1-P6 | D | x | | -- | X | x |
| Excerpt 11: D10-P5 | D | x | x | | -- | -- | -- |
| Excerpt 12: D5-P1 | D | x | | -- | -- | -- |

**Table 1. Nonverbal Occurrences during Sarcastic Delivery**

<table>
<thead>
<tr>
<th>VOCAL ALTERATIONS</th>
<th>Patient (P) or Doctor (D)</th>
<th>Louder</th>
<th>Quieter</th>
<th>Slower</th>
<th>Faster</th>
<th>Facial Expression and/or Eye Movement</th>
<th>Gesture</th>
<th>Other Kinesic Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excerpt 1: D2-P5</td>
<td>P</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Excerpt 2: D5-P2</td>
<td>P</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>X</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Excerpt 3: D3-P3</td>
<td>P</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excerpt 4: D1-P1</td>
<td>P</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excerpt 5: D3-P5</td>
<td>P</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excerpt 6: D5-P1</td>
<td>D</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Excerpt 6: D5-P1</td>
<td>P</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excerpt 7: D5-P3</td>
<td>D</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>--</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Excerpt 7: D5-P3</td>
<td>P</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excerpt 8: D3-P5</td>
<td>P</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excerpt 8: D3-P5</td>
<td>D</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excerpt 9: D1-P3</td>
<td>D</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excerpt 10: D1-P6</td>
<td>D</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>--</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Excerpt 11: D10-P5</td>
<td>D</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Excerpt 12: D5-P1</td>
<td>D</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Note. “x” indicates that such an instance occurred during the delivery of sarcasm. “—“ indicates that the information was not available due to a lack of visibility.

rate at all. Only one person who engaged in sarcasm and was examined during this study did not engage in any vocal alteration during the engagement in sarcastic speech.

Through the illustration of Table 1, it can be observed that sarcastic speech was more often quieter than louder as compared to the rest of the patient or doctor’s speech. Also, it is clear through Table 1 that sarcastic phrases were more frequently said at a faster rate, as
opposed to a slower rate, than the established “normal” rate of speech throughout the rest of the interview that was not sarcastic. Those findings are in direct opposition to a study conducted by Rockwell (2000), which found sarcasm was usually slower and louder than the rest of a person’s speech.

As made evident in Table 1, it was common for those engaging in sarcastic delivery to make use of both paralinguistic and kinesic nonverbal communication. Due to the lack of visibility during some sarcastic instances, however, it is not known whether kinesic communication was engaged in by all who made use of sarcasm. No real pattern was established as far as the type of kinesic communication one uses during the delivery of sarcasm. It did seem that when people used facial expressions and gaze during the use of sarcasm, they tended to move their muscles in a downward motion, but this was not always the case.

In summation, patients and doctors do something different, from a nonverbal perspective, when engaging in sarcasm. A person can determine that sarcasm is being engaged in by another when that person engages in a nonverbal activity that was not previously being enacted by that person. Due to the vagueness of this conclusion, much more research needs to be conducted regarding the nonverbal delivery of sarcasm in a medical interview setting.

**Research Question #2: Patient and Doctor Similarity and Difference**

Patients and doctors seem to be very similar in their verbal enactment of sarcastic speech. For example, both patients and doctors make use of non-literal sarcasm, as well as explicitly aggressive sarcasm (Partington, 2006). Also, both patients and doctors ask questions through their sarcastic engagement, as well as make declarative sarcastic
statements. When engaging in sarcasm both patients and doctors intermittently used it as a means to potentially establish rapport. This is evident through the use of leading questions and expectant gazes.

**Verbal Differences**

When patients enacted sarcastic displays, they were sometimes expressing uncertainty. For example, some patients requested more information through their sarcastic questions. Doctors, on the other hand occasionally used sarcasm as a way to deliver bad news. One instance of this occurred when a doctor informed a patient, through sarcasm, that he needed to begin treatment right away because the cancer he was diagnosed with was moving aggressively.

**Nonverbal Similarities**

Both patients and doctors use kinesic and paralinguistic nonverbal communication activities in conjunction with the delivery of sarcasm. Both tend to speak more quietly while being sarcastic, as determined in this study. Also, both patients and doctors in this study tend to speak more quickly than usual when engaging in sarcasm.

**Nonverbal Differences**

Doctors are the only people who, when engaging in sarcasm, also used nonverbal communication strategies commonly associated with dominance. Examples of this included having hands in pockets and standing erect while others were sitting. The doctors that engaged in these types of dominant behaviors were all male, which is interesting.

Another difference between patients and doctors regarding the use of sarcasm was that doctors were the only people who engaged in deadpan delivery among the instances examined for this study. Deadpan delivery involves maintaining a straight face and serious
tone of voice when saying a sarcastic phrase or asking a sarcastic question. No patients were observed using deadpan delivery during this study; possibly because they wanted to make sure the doctors knew they were being sarcastic. It could be linked to the respect patients usually feel they must show doctors, who are their medical superiors.

**Research Question #3: Patient Sarcasm and Doctor Response**

During one instance of patient sarcasm, the doctor responded by adding to the sarcastic line of commentary with more sarcasm. The sarcastic addition made by the doctor to the patient’s initiated sarcasm is labeled in the second chapter as “sarcastic play.” The only other two instances of sarcastic play were initiated by doctors and responded to by patients.

During the other five instances of patient initiated sarcasm, the doctors reacted with a range of responses. For example, some doctors completely ignored the sarcasm enacted by the patient. One doctor went so far as to ignore it and then repeat exactly the same sentence he had said prior to the patient’s sarcastic comment, causing it to appear as though he attempted to erase the patient’s comment.

One doctor recognized the patient’s attempt to lighten the mood in the medical office by laughing at her patient’s sarcastic remark. The same doctor, when engaged in a medical interview with a different patient, seemed to not notice her patient’s sarcasm at all and responded as though the sarcastic question was a standard, unaggressive question. Other doctors responded minimally with a one word acknowledgement such as “yeah,” which seemed to be the most common because it was observed twice among the excerpts examined for this study. The one word acknowledgements do not reveal whether or not the doctor recognizes that the patient is employing sarcasm, which would be interesting and helpful to
know in regard to how effective sarcasm is during medical interviews and how perceptive doctors are regarding the recognition of enacted sarcasm.

**Research Question #4: Doctor Sarcasm and Patient Response**

The only instance of sarcasm clearly backfiring as a method of effective communication occurred when a doctor initiated the sarcasm. During this occasion, the doctor sarcastically said the patient needed to begin treatment at a time that had already past. The wife of the patient, who was present during the medical interview, brought up the doctors remark later on in the medical interview to make sure he was joking, do to the fear he inspired in her through is apparently inappropriate statement.

The instance of failed sarcasm poses the question: is it appropriate to use sarcasm when discussing life and death matters? Because successful sarcasm relies on the listener’s ability to separate the sarcastic from the literal, a certain amount of knowledge regarding the subject about which sarcastic comments are being made is necessary. The listener needs to be knowledgeable enough about the subject sarcasm is being used to discuss to know when the statement made by a person is clearly not literal. Otherwise, the statement comes off as only obviously aggressive, which can cause additional stress for the cancer patient and/or his or her family (Partington, 2006). The use of sarcasm during medical interviews should be only for the purpose of stress reduction. Precautions should be taken to specifically avoid adding to the stress of those dealing with cancer.

When doctors initiated sarcasm, it was more common for play to occur than when the patient initiated sarcasm. While there were only three total instances of patients and doctors playing at sarcasm together, two of those three involved doctor initiated sarcasm. One possible reason for sarcastic play being more successful when initiated by doctors is a sense
of requirement felt by the patient to “humor” the doctor’s attempt at humor. This idea is similar to a need felt by some people to laugh at the jokes of their superiors, regardless of the actual humorousness of the joke (Coser, 1959).

**Research Question #5: Primary Interactional Environments for Sarcasm**

An engagement in sarcastic play, or sarcasm that was acknowledged with laughter, tended to occur when the patient and doctor were of the same perceived sex. This occurrence’s validity is supported by a study regarding the effectiveness of teacher humor in the classroom (Bryant, Comisky, Crane, & Zillmann, 1980). The study found that a teacher’s humor tends to be regarded more positively by students who are the same sex as the teacher (Bryant et al., 1980). Along those same lines, it appears as though sarcasm is more effective when the purveyor and receptor are the same sex.

One interview from which an excerpt was taken for this study suggests that establishing some common ground between the patient and doctor makes for a more successful engagement in sarcasm. In this study, a successful engagement in sarcasm is considered the ability to employ sarcastic play. The interview during which such immediacy was established involved the patient and doctor determining that both had previously served in the Navy. The transcription during which that determination occurred is not included in the transcriptions from Chapter 2 or 3 because the situation involved no sarcasm.

A study conducted by Jacucci, Oulasvirta, Salovaara, and Sarvas (2005) links immediacy to shared experience. The idea that the common ground aids in the facilitation of successful sarcasm could also be related to the theory of attraction, which posits that people are attracted to those who are similar to them (Byrne, 1961). Perceived attitudinal similarity
can cause people to be more interpersonally attracted to one another (Byrne, 1961), which is a situation in which playful banter can more easily occur.

One other environment that seems to be necessary for sarcasm to occur, based on the findings of this study, is a high level of comfort with the English language. Two medical interviews were examined in which no instances of sarcasm were found. For that reason, they were not included in the analysis occurring in Chapter 2 and 3. One of those interviews was with a man who spoke only broken English. According to a study regarding the procurement of proficiency in learning a second language, those who are not yet completely comfortable with the language may misinterpret sarcasm because, “learners’ sociopragmatic knowledge is not yet sufficiently developed for them to make contextually appropriate choices of strategies and linguistic forms” (Kasper & Schmidt, 1996, p. 157).

While one woman who did engage in sarcasm claimed Greek as her native language, she seemed to have a firm grasp on the intricacies of the English language. Another interesting cultural finding regarding sarcasm is that individualistic people are more sarcastic than collectivistic people (Rockwell & Theriot, 2001). Such a finding suggests that the man who engaged in no sarcasm during his medical interview may not have found sarcasm to be culturally relevant for him. Sarcasm is not a culturally universal form of communication. The ambiguity regarding the environments among which sarcasm thrives is reason for more research on the topic of sarcasm in medical situations.

**LIMITATIONS**

The primary limitation experienced by this study was the lack of consistency in camera placement during the medical interviews. The video cameras were placed at different locations in the room and aimed at the place patients and doctors were expected to be
interacting. During some medical interviews, the patient and doctor did not sit in the location at which the camera was pointed. During other medical interviews the patient and doctor stayed in the location at which the camera was pointed only briefly, and then moved to a different part of the room, often the examination table. Because no one was manning the camera during the interview, the angle of the camera did not vary.

In order to aid in the elimination of this limitation for future studies, it has been suggested that the camera be placed on a tall pole so that it sits in the upper corner of the room and allows all areas of the room to be visible on the recording. Placing the camera high up like that would eliminate the need for patients or doctors to have to reposition it during the interview, a requirement that would likely prove burdensome to both the patient and doctor. Were the camera placed up high, as suggested, it would also prevent patients and doctors from covering the lens, whether purposely or inadvertently.

When the entirety of each medical interview is recorded visually by the camcorders placed in the medical offices, the use of kinesic communication by all individuals involved in the interview will be more easily identifiable. In this study, a few doctors were not at all visible during their enactments of sarcasm, which made analysis of their kinesic communication at those times impossible. Having access to such images will allow for a more complete, and potentially conclusive, study of the nonverbal communication associated with the enactment of sarcasm during medical interaction.

Another limitation incurred by this study was the lack of a standardized measure when listening for vocal variations. Some studies, like one conducted by Bryant and Fox Tree 2005), make use of a standardized mechanism when analyzing vocal speed and volume. This study relies solely on one researcher’s interpretation, allowing for more error than a
standardized measure would. Along with the development of a standardized measure of vocal speed and volume, an increase in knowledge regarding the incarnation of sarcasm would be beneficial. This study provided only a suggestive and exploratory analysis of embodied action, which leaves room for additional research.

A final limitation associated with this study was the limited number of medical interviews that were examined. As is common with conversation analysis, the generalizability of this study is limited due to a focus on only 12 interviews. The implications derived from this study, however, far out weigh the limitations.

**FORECAST OF FUTURE RESEARCH**

While different demographics and their correlation with sarcasm have been studied, none have been evaluated with the method of CA. Such an investigation would prove beneficial, as the majority of the studies that have been done thus far focus on hypothetical situations involving sarcasm or example phrases that fail to capture the true essence of sarcasm in use. Other areas of medicine and society can benefit from these sarcasm studies using CA as a method because real time examination is more credible than hypothetical research.

Further studies of sarcastic interaction may benefit from adding a vertical dimension to the sarcastic continuum discussed in Chapter 2. The dimension would be a vertical, double-sided arrow that goes from “insulting” to “questioning” and refers to the victim of the sarcastic remark, as opposed to the type of sarcasm employed. The model can be seen in Figure 13. Adding such a dimension would allow for a more specific classification of the type of sarcasm employed by both patients and doctors. The addition of such a dimension would also aid in the further development of a consistent language to discuss matters
Figure 13. A model of sarcasm with a vertical dimension examining identification of the victim.

involved with sarcasm. The development of such a language will aid in specificity and clarity when sarcasm is the focus of research.

During future studies of medical interaction and sarcasm, it would be interesting to examine the effect bringing someone with you may have on the use of communicative techniques. It is a common practice for cancer patients to take a friend or family member with them when seeing a doctor, as it is always helpful to have an extra pair of ears when be barraged with medical information. In this study, all but one instance of patient initiated sarcasm was enacted while there was at least one other person in the room. It is possible that patients are more comfortable using sarcasm and other types of humor when they have a “friend” there, as sarcasm is most often used with established acquaintances (Rockwell, 2006).

An examination of the way patients and doctors respond to sarcasm from nonverbal perspective would also be an interesting study. For example, do patients exhibit nonverbal
signs associated with offense when faced with doctor sarcasm? In this study, the nonverbal communicative aspects associated only with sarcastic enactments were examined.

On a final note, the data collected from this study can contribute to the possible training of both current and future doctors regarding successful communicative practices. It is known that effective communication techniques can be learned by those in the medical field (Baile, Kudelka, & Beale, 1999; Fallowfield, Lipkin, & Hall, 1998; Maguire, 1988, 1990; Maguire, Booth, Elliot, & Jones, 1996; Parle, Maguire, & Heaven, 1997; Pigeron, 2003). If doctors learn to better interpret patients’ use of sarcasm, the satisfaction felt by cancer patient’s after engaging in a medical interview will likely improve.

When conducting initial research, more references to sarcasm were located than expected. One of the most unique internet locations relating to sarcasm that was found was the Sarcasm Society’s website. Their slogan is “Like we need your support.” Clearly, with so many popular culture references, sarcasm is a significant part of today’s society. So is cancer, unfortunately. The correlation between them deserves to be further examined. The assistance provided by sarcasm to patients and families dealing with cancer is worth researching. Doing being sarcastic means a person is tough and he or she is not going to take cancer lying down.
REFERENCES


