LAUGHING AT DEATH: THE FORMS AND FUNCTIONS OF HUMOR IN ILLNESS

TRAUMA NARRATIVES

Thesis

Submitted to

The College of Arts and Sciences of the

UNIVERSITY OF DAYTON

In Partial Fulfillment of the Requirements for

The Degree of

Master of Arts in Communication

By

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December, 2010
LAUGHING AT DEATH: THE FORMS AND FUNCTIONS OF HUMOR IN ILLNESS

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ABSTRACT

LAUGHING AT DEATH: THE FORMS AND FUNCTIONS OF HUMOR IN ILLNESS TRAUMA NARRATIVES

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This thesis attempts to demonstrate that public storytelling and memoirs – if crafted and shared effectively – may elicit beneficial private/intrapersonal and public/interpersonal functions, and might be utilized as effective media for the formulation and dissemination of humorous health narratives. Through the study of three illness trauma narratives that utilize humor, this thesis analyzes the forms in which productive humor was employed throughout the process of narrative construction, and the information the humorous aspects of the narrative product expresses to audiences about the illness experience. More specifically, this thesis attempts to demonstrate that the integration of humor with health narratives can effectively call attention to health issues such as REM sleep behavior disorder, severe drug addiction, and cancer.
ACKNOWLEDGMENTS

My most special thanks are in order to Dr. Teresa Thompson, my advisor and friend, for putting an inordinate amount of time and effort into the development of this thesis. Her encouragement, motivation, and – most importantly – patience were tantamount to the formulation of a theoretical basis for research and an analysis of these texts. Most importantly, without Teri’s initial support, introduction into the fascinating and broad world of communication research, and genuine mentorship, I would not be blessed with the many amazing opportunities I have experienced, am experiencing, and will experience. She has truly changed my life and I will never forget it.

I would also like to express my appreciation to everyone who has helped me with this work. The advice and ideas of my committee members – Dr. James Robinson, Dr. Kathy Watters, and Dr. Lou Cusella – have been invaluable and will continue to shape the development of this research. My fellow graduate teaching assistants Carrie Scherer, Pat Fries, Kathryn Lecklider, Sara Hoyt, Brittany Waag, and Rania Shakkour, and part-time instructor Jeff Geers have also provided me with essential feedback and support during my time at the University of Dayton.

Finally, I’d like to thank my family for putting up with me for two hellish summer months during the development of this thesis. That they did not deadlock me in the basement during this process speaks to their infinite patience and love. And to anyone who invested their precious time to read this work from front to back, please go outside.
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INTRODUCTION

This thesis seeks to analyze the social construction of illness as it relates to the productive and receptive functions and purposes of humor in stories about one’s health. Three pre-existing narratives which utilize humor in the recounting of one’s experiences with illness – a one-person show, a stand-up routine, and a memoir – will be analyzed as case studies through qualitative narrative, rhetorical, and phenomenological methodology to determine how the author’s ability to craft humor from extremely serious and possibly traumatic and dehumanizing proceedings has impacted their portrayal or moralization of the illness. Additionally, this analysis will seek to understand whether the story’s construction and dissemination may have served a therapeutic function for the author, such as allowing them to reestablish a sense of their own identity and empowerment lost to a faceless, perhaps serious, likely humbling illness.

These narratives will also be studied to determine their educational and stigma-reducing value (namely, their ability to enlighten the public regarding issues about which they may know little and create affinity through humanization and the “reimagining” of stereotypical sufferers of an illness). Past health communication research suggests that the use of humor has many benefits among audiences, such as enhancing recall, attention, and persuasiveness, which can be used to advance knowledge and salience of health issues through entertaining and approachable channels (Compton, 2006).
Three stories were selected based on their perceived effectiveness in telling a coherent, well-crafted, truthful, and – most importantly – genuinely humorous, personal, and heartfelt story. Fisher’s (1984) description of narrative rationality was used as a guide. Readers will be provided with three case studies analyzing the perceived effective use of humor in recounting traumatic experiences. These will be meant as guides for possible replication and instruction on how humorous health narratives have been written, and as an argument for the heuristic value of humorous health narratives as a new area of further study in qualitative and quantitative health communication research. Analyzed health conditions will include REM sleep behavior disorder, drug addiction, recovery from third-degree burns, and cervical cancer.

The author will propose that public storytelling and memoirs – if done effectively – can elicit beneficial private/intrapersonal and public/interpersonal functions, and could be utilized as effective media for the formulation and dissemination of humorous health narratives. The following literature review will examine the value, relevance, and development of narrative production/analysis and productive/receptive humor in health communication research, and will attempt to provide a rationale for their integration.
CHAPTER I

Review of Literature

Narrative Approaches to Health Communication Scholarship

“Storytelling...is a mode of coming to know ourselves...Stories are devices which shape agents and events into some intelligible pattern. They weld actors to their actions and doers to their deeds.”

-Churchill and Churchill (1982, p. 74)

What is Narrative?

From both a productive storytelling and receptive audience standpoint, narratives possess the power to characterize and potentially transform our perceptions of the world (Eisenberg, Baglia, & Pynes, 2006). Narrative scholar Walter Fisher (1984) said that human beings are rational and inherent storytellers; that is, we make sense of the world through the social sharing of ongoing, action-oriented stories – as conflicts with plot, characters, beginnings, middles, and ends – from which we choose, and thus consequently, recreate our lives. Narration is viewed by Fisher (1984) as symbolic actions – words and exploits, for example – that have sequence and meaning for those who live, share, or interpret them. Furthermore, Lablov (1972) defines narrative as “one method of recapitulating past experience by matching a verbal sequence of clauses to the sequence of events which [it is inferred] actually occurred” (p. 359-360). Narratives reflect our personal views of the world and our rationale for why things happen in certain ways. Telling stories about one’s life is the most common way of communicating and understanding individually-constructed ideas of the realities one experiences.
According to narrative theory (Fisher, 1984) humans participate in their lives through the formulation of value judgments. Our practice of constantly re-creating stories requires an author – a person who tells the story – and co-authors – people who receive the story and the audience that participates in the creation of meaning for the story. The social, cultural, historical, situational, personal, and relational forces in a person’s life influence plots, themes, and texts that the storytellers creatively reflect, negotiate, and retell, making meaning and value judgments as they do so. The narrative construction of meaning organizes seemingly meaningless, random events into larger, significant structures that are symbolically represented as stories (Eggly, 2002).

For instance, you will often notice a great disparity in terms of how some event actually occurred (A man catches a minnow on his tenth cast of the day – “story lived”) and how the event is formulated into a narrative based on one’s own interpretation and retelling of the event (A man catches a 20-pound catfish during a driving rainstorm on his final cast of the day – “story told”) that exposes the storyteller’s view of themselves, a situation, or the world. This person might have a negative view of himself, sensing he is an inconsequential speck in an ever-expanding universe, and perceives that society is less than impressed with his existence. Therefore, he may feel the need to exaggerate to gain at least a semblance of acceptance from his audience.

Fisher (1984) believes that narratives serve a reciprocal function for listeners – namely, to witness the worldview of others. He reminds audiences that all stories are not equally good, and that anyone with common sense is capable of making a judgment about whether or not to accept a tale’s merits based on its narrative rationality. Its dimensions are two-fold: First, we analyze the story’s coherence, or how probable an account sounds
to its hearer. This gauges whether the people and events the narrative depicts seem to hang together as an organic, consistent whole. Audiences tend to recognize a specific set of expectations about what makes up a story – a particular sequence of events, sensible causal relationships between important elements, and a distinct framework that includes some things while excluding others. If these rules are utilized, a hearer may be more likely to be convinced that the narrator has not left out important details or skewed facts, and has additionally considered other plausible interpretations of the event. We also tend to judge coherence based on other stories we have heard that deal with the same themes.

The most important factor in a story’s unity and believability tends to be the reliable depiction of its characters. We are often more suspicious of stories that portray characters who act “uncharacteristically,” rather than through a continuity of thought, motive, and action (Fisher, 1984).

Second, a story gains narrative fidelity when it rings true with hearers’ experiences, strikes a responsive chord in the life of the listener, and provides “good reasons” (p. 7) to guide future actions and decisions in various contexts. Humans create and apply these good reasons to fit specific situations according to norms or rules dictated by their history, culture, personal integrity, and experience. According to this logic, audiences are concerned with values embedded in narrative messages, the relevance of those values to decisions made, the consequence of adhering to those values, their overlap with the worldview of the audience, and their conformity with what audience members believe to be an ideal measure of behavior. People tend to prefer stories that advance what they view to be truthful and humane – things like wisdom, beauty, courage, and justice (Fisher, 1984).
Fisher (1984) contends that humans must choose among all the stories the world has to offer in order to create a good life for themselves. Consequently, when we judge a story to have fidelity, we are accepting the possibility that those values will influence our future beliefs and actions. Fisher (1984) believes a good story can be a powerful method of persuasion. When we buy into a story, we consequently buy into the type of character we feel we should be.

Narratives may appear as individual stories; an accumulation of individual stories that form family, group, or organizational narratives; or as socially constructed stories or master narratives developed from and existing within the larger culture (Sharf, Harter, Yamasaki, & Haidet, in press). Master narratives “underlie, reflect, and perpetuate predominant cultural values and assumptions about how the world is constituted and how society functions (Sharf, et al, in press, pp. 8-9). For example, these stories provide the commonly-accepted depiction of what it means to live with cancer, or that most individuals from the Midwestern U.S. are blue-collar simpletons. Narratives purposely shape historical understandings of the events to which they refer and may also have a direct impact on actions and choices in the moment (Sharf, 2005).

As easily seen, narratives do not exist by themselves in a vacuum, nor are they preserved there. Stories often overlap, reinforce, indirectly contradict, or actively confront or resist one another in ways that shape our perceptions and understandings of the world – viewpoints related to health, morality, and various groups of people, for instance. Sharf (2005) refers to the “exponential power” (p. 341) of narrative, a concept she would eventually coin “intertextuality” (Sharf, et al, in press, p. 9), in discussing the
process by which discrete narrative meanings influence and build on one another to create a newly-derived significance not expected or implied in pre-existing stories.

More specifically, previously-told stories might be recollected and recreated in entirely different situations and contexts, achieving influence in ways that were not anticipated by the original storytellers. For instance, Sharf and colleagues (in press) described how a teenage girl with cancer coping with her newly-altered identity by swapping stories with another girl undergoing similar difficulties. Her mother, as well, found enhanced meaning of the illness experience by participating in a cancer story-sharing website. Sharf (2005) herself noted how significant her friends’ tales of surgery gone awry and the struggle to have healthy babies were in providing her with social support and guidance when she needed to make an important health decision.

Narrative Analysis

Fisher (1987) argues that the study of narratives brings us closer to understanding human communication and action, because it allows us to understand the reasons humans use for selecting certain stories over others in explaining their worldview. Revealing the underlying meaning of a story also allows scholars the opportunity to understand what is perceived by storytellers to be normal or ordinary as well as extraordinary or abnormal (Eggly, 2002). Narratives facilitate both a referential function by describing a specific past event, and an evaluative function by reflecting an author’s perspective or point of view (Lablov, 1972).

Lablov’s (1972) model of narrative structure states that, in order to meet the criteria of a narrative, stories must possess an internal structure of six components: (a) abstract, which foreshadows the story through a short summary; (b) orientation, detailing
the time, place, and people involved; (c) complicating action, in which the clauses relate the temporal sequence of the event; (d) evaluation, involving the narrator describing the significance of the event or point of the story; (e) result, which concludes the story; and (f) a coda, which returns the author’s perspective or orientation back to the present. Van Dijk (1997) uses slightly different terms to express a similar conceptualization of narrative structure: setting the scene, developing the characters, presenting a crisis, and resolving that crisis.

Polanyi (1985) expands upon Lablov’s model of narrative structure by incorporating linguistic and social contexts – namely, through discursive interaction between speaker and recipient. He believes that the purpose of telling a story is “to make a point, to transmit a message – often some sort of moral evaluation or implied critical judgment – about the world the teller shares with other people” (p. 21).

According to Polanyi (1985), meaning emerges from social interaction. More specifically, narratives are constructed by all members of the conversation in which the narrative occurs. Therefore, it is the responsibility of the teller to (a) tell a topically coherent story in which an event produces a meaningful change, (b) tell a story on a narratable topic worth building a prolonged telling around, (c) introduce the story so that it connects with the conversation, (d) structure the story so that it distinguishes appropriately between states and action or events, (e) start at the beginning of the story and move forward, and (f) evaluate states and events so that the point becomes clear. The recipient must simultaneously (a) listen or provide a reason not to listen, (b) refrain from not supporting the telling of the story through obstructive turn taking, and (c) demonstrate understanding of the point (Polanyi, 1985).
In her analysis of medical patient-provider interactions, Eggly (2002) determined that narrative is not always simply the relaying of a strict chronological sequence of events by one speaker with the support or facilitation of a listener. Rather, the story is co-created through the social interaction of the participants. In this context, the patient and their caregiver use dialogue to co-construct a chronological sequence of initially disordered events that describe a meaningful experience – perhaps a nasty fall or worsening symptoms of the flu. Narratives also emerge through the co-constructed repetition and elaboration of key events, and the co-constructed interpretation of the meaning of key events (Eggly, 2002).

Regardless of whether a narrative is developed through interactive discourse or by oneself (i.e., journaling) stories should be subjected to a more specific analysis than coherency of plot structure. Cherry and Smith (1993) identified nine different types of loneliness experienced by men with AIDS through an analysis of their first-person narratives. Their methodology focused on the meaning of story selection and story content, including plot, characterization, and cues for interpretation.

*Included/Excluded Content*

Cherry and Smith (1993) first looked for stories that the narrator chose or neglected to tell. They argue that included content is perhaps the most significant part of the experience for the storyteller, while that which is omitted reveals what people, events, and values are of least importance to them. For example, the complete omission of a subject’s family from his or her delineated experience often sheds a deeper light on what the teller has already discussed.
**Plot**

For Cherry and Smith (1993), an analysis of plot involves the identification of two elements: the episodes through which the plot unfolds and the plot lines or themes across episodes. An episode is “an event experienced by the narrator, at least loosely bounded by time…they tell what happened, who did what, who said what, and what that all meant to the narrator” (p. 186). Episodes embody actions that drive stories, and can often be found by asking the hypothetical question, “What happened?” (p. 186).

If a story contains more than one episode, they are unified by a plot line or theme. Cherry and Smith (1993) believe that the plot line will usually be offered openly by the narrator through the explicit or implicit logic that leads the episodes to be linked – typically through chronology. However those stories that deviate from temporality are often explained as such: “Oh, I forgot to tell you. That also happened this other time”; “Here’s another example of what I was telling you earlier” (p. 186). The nature of plot reveals how narrators view the world and their place in it. Because the plot draws together the actions depicted in the episodes, some elements will be noticeably highlighted or glossed over.

Cherry and Smith (1993) seek to answer several questions through analysis of a narrative’s plot (episodes and themes/plot lines): “Is this story one of triumph or defeat, comfort or despair, justice or injustice, humor or seriousness? Is it a beginning or an ending? What or who wins, loses, is changed, is unchanged, is rewarded or punished? Is this story typical or atypical of the narrator’s experiential world, desired world, or feared world? What actions have been depicted and what do they reveal? What values justify or condemn the actions being depicted?” (p. 186).
Characterization

The people included in a storyteller’s episodes carry out the actions that move the story forward. By depicting characters in various roles possessing various characteristics, authors are able to develop and assign positive and negative qualities to them. Thus, heroes, villains, victims, and innocent bystanders, among many other character types, frequently run rampant as depictions of the people who populate an author’s worldview (Sharf & Vanderford, 2003). Inanimate objects can even come alive and gain voice through personification. The representation of character contributes further to a story’s meaning by revealing how the narrator regards the personalities in his or her life.

When studying characterization, Cherry and Smith (1993) ask the following questions: “Who are the characters included and not included in the story and why? Which characterizations are elaborated and which remain vague and why? What attributes are ascribed to each character and how does the narrator regard each attribute? What role does the character play in the plot and in relation to other characters? How do the depictions of plot and character reveal the values, beliefs, attitudes, hopes, fears, explanatory frames, and expectations of the storyteller?” (p. 187).

Cues for Interpretation

If a narrator does not offer a straightforward prompt preceding or following a story to guide audiences in their interpretation of the meaning behind plotted episodes, then how will we ever know what a storyteller is really getting at? Narrators frequently provide interpretive cues through the use of metaphor to describe plot, action, characters, and emotions. Other forms of figurative language, particularly hyperbole, understatement, irony, and sarcasm, are also emphasized by Cherry and Smith (1993) for
their ability to suggest the meaning and emotional force an episode has for the narrator. Verbal storytellers have another interpretive weapon that must be diffused: nonverbal cues, such as gestures and paralanguage. The tiniest shrug of the shoulders, flick of an eyebrow, sigh, or vocal fluctuation can elicit an entirely different interpretation than the literal meaning of a message.

Consider this statement as it appears on the page: “Of course, my wife loves it when I surprise her at work!” We take it as literally as it appears, right? This guy’s wife genuinely appreciates his attempts to visit during business hours. Now imagine an individual saying it like this, with a roll of the eyes and an exaggerated, exasperated wave of the arms: “Of course, my wife looooooooves it when I surprise her at work!” We sense the sarcasm and embellishment rather handily. This poor guy has clearly had a few bad experiences (at least) when “impinging” upon his wife’s attempts to work. Along with figurative language, nonverbal indicators offer significant interpretive cues a narrative analyst must consider when searching for the backstage meaning of an episode or a series of episodes (Cherry & Smith, 1993).

But what does the process of narrative criticism look like? How is it conducted? One particularly influential study – which analyzed individual texts that co-mingled to create a transformative, continuous organizational/master narrative – has provided researchers with an exceptionally well-developed model of narrative analysis.

Critique of “Toughlove” Parental Support Group Narrative

Narrative analysis was utilized proficiently by Hollihan and Riley (1989) in their study of the collective use of storytelling by participants in a support group for parents of delinquent teens called “Toughlove.” The authors were able to observe how members are
acculturated into the Toughlove philosophy of using strict discipline and ultimatums to control “problem children,” and how this philosophy guides their lives. At Toughlove, it is not the parents who have failed or are failing, it is their children. Therefore, highly-disciplined child rearing practices must be utilized in an attempt to stop unruly teens from controlling households, to rid parents of guilt, and to enable families to lead a normal family life. Like Alcoholics Anonymous, Toughlove emphasizes an open-forum support system in which individual stories ultimately coalesce and develop into one shared group story that stands the test of time to become the “Toughlove philosophy.” The authors were able to characterize individual stories and the newly-accepted grand narrative fiction through four prevalent themes (Hollihan & Riley, 1989).

First, researchers found that individual tales were interwoven to explain the “good reasons” for abandoning and eventually condemning the predominant rival story – the modern approach to child-rearing frequently characterized as “TLC” (p. 274) or tender loving care. Parents found narrative fidelity in the call for a return to traditional values because it resonated with stories from the parents’ youth – like “being taken to the woodshed,” (p. 275) as one parent illustrated it. The security and comfort of their nostalgic perceptions of the past, and the respect and fear they felt of their own parents, was destroyed by modern parenting. Parents therefore characterized themselves as essentially good people who were misled into becoming victims through their estrangement from the “old-fashioned” values among which they were raised. The Toughlove narrative also possessed fidelity for these parents because it confirmed their self-perceptions and absolved them of their guilt and failures. They were simply too permissive with their child and not as tough as their own parents had been. Blame,
therefore, was shifted onto the shoulders of their disobedient and abusive offspring, the real “failures” and “villains” (p. 275) of this story.

According to Hollihan and Riley (1989), these parents discovered that no one else understood life with delinquent children except other parents in similar circumstances. This accounts for the narrative fiction’s second and third themes. The parents identified child service professionals as secondary “villains” (p. 275) of the Toughlove story because they were too quick to blame them for the failures of their offspring. They also were viewed as highly vocal proponents of the rival story, that of modern parenthood. To Toughlove parents, this narrative lacked coherence and fidelity because it placed at least partial blame on the parents for their child’s conduct and reflected an unrealistic approach to raising children – one which simply resulted in providing teens with an excuse to continue misbehaving (Hollihan & Riley, 1989).

Other external factors were also disdained and vilified: the media, the permissiveness of society, their child’s friends, and the lack of discipline in schools. As a result, the Toughlove narrative viewed “the system” (p. 276) as being pro-child, and that parents could best cope with their problem teen by depending on, and supporting, each other. The police and juvenile system were frequently described through individual stories as being both materially and symbolically anti-parent. However, the Toughlove narrative served to remind parents that they had formed their own social services system, a support group that could step over or defeat the system if necessary (Hollihan & Riley, 1989).

Finally, through the Toughlove narrative parents were also offered a course of action in dealing with their out-of-control child. This involved setting “bottom lines”
(p. 277), essentially ultimatums or rules their child had to obey if they wanted to continue to live with their family. The group constantly stressed and reinforced the notion that bottom lines must be enforced, no matter what; if children don’t obey, good riddance. The master narrative held that it is better to kick problem children out of the house than to have to endure the disruptions and trouble they caused in the home. Numerous parents also exclaimed that their child was now behaving much differently as a result of the Toughlove program. This theme helped to facilitate narrative fidelity by providing parents with a course of action that showed their child who was in charge, fulfilling their nostalgia for “old-fashioned” social order, and allowing their family to lead normal lives after the delinquent youth was either reformed or estranged (Hollihan & Riley, 1989).

Narrative analysis allows researchers to gauge how individual and shared stories give insight into people’s beliefs, actions, and worldviews, and into the process by which they attempt to characterize and potentially transform their lives. For various reasons explained below, health communication is a discipline that is frequently analyzed as a hotspot for the facilitation of narrative development as a process and narrative product as a communal forum for narrative analysis.

**The Social Construction of Health and Prevalent Health-Related Ideological Themes**

Sharing narratives from a health perspective may serve numerous powerful functions for storytellers suffering from a serious illness. Because Western medicine has long been dominated by the establishment of a solitary biomedical, objective voice, it often neglects to consider that each and every person has a different worldview and awareness of illness. Like anything else, matters of health are not immune to the social construction of reality, which is marked by an ongoing tension between commonly
accepted knowledge and personal understanding. This dialectic is mediated through linguistic expression among people and communities, and shaped and recorded as history. Communication, therefore, is the process that produces and reproduces shared meaning, and reality is co-constructed and reinforced through our interactions with others (Sharf & Vanderford, 2003).

According to Kline (2003), critical scholars in the field of health communication seek to identify dominant cultural ideologies constituted, maintained, and perpetuated by health-related discourse, particularly as they are disseminated through the media. These researchers believe the domain of healthcare has been claimed by an elite collective of medical professionals, so much so that most people forget that such practices are relatively contemporary in relation to history. As a result, most alternative, lay, or folk remedies – which humankind has relied upon far longer than Western medicine – are largely ignored by the mass media. The more we become entrenched in the biomedical paradigm, the more we are convinced of its “timeless truth” as the only way to solve a medical problem (Kline, 2003).

Consequently, most medical issues in clinical settings are treated with scientific detachment and institutional empiricism, often regarding the organic, measurable construction of disease. The perspective of science in medical decision making and understanding is considerably important; however, it should not be considered the be all and end all of creating shared meaning in health-related matters. Rather, the empirical generalities of science must be juxtaposed equally with the individual illness experience (Sharf, et al, in press). However, according to the biomedical perspective, a malignant
brain tumor is a malignant brain tumor whether it is festering in the head of a Muslim or a Buddhist, a Latino or a Slovak.

Meanwhile, subjective language regarding the internal, non-verifiable experience of illness and the moral, spiritual, and social meanings of human suffering often go by the wayside. In reality, people throughout the world perceive health and illness differently based on wholly incongruent cultural values, social norms, and culturally-shared rules of interpretation. To some cultures, such as the Hmong, epilepsy isn’t simply a brain disorder, but an invasion of the body by evil spirits that need to be exorcised. This is the voice of the lifeworld, separate from academic textbooks, faceless biological malfunctions, and one-size-fits-all treatment methods (Sharf & Vanderford, 2003).

Interestingly, according to Bury (2001), before the rise of the biomedical model of illness in the understanding of disease – attributed to the development of the modern hospital and the laboratory during the mid and late 19th century – the ability of the doctor to take an accurate, detailed, and holistic history from the patient was paramount. In the absence of fundamental and decisive anatomical or physiological expertise, the ability to diagnose and make prognoses was highly touted. This process shed light on the patient’s wider environment in which he or she lived. Instead of simply recording physical symptoms and bodily disorders, physicians strove for information about the patient’s circumstances and lifestyle, and his or her moral values and beliefs. Doctors were thus expected to attend to patients’ narratives and develop treatment regimens accordingly, often resulting in an intimate patient-provider relationship (Bury, 2001).

The validation of science resulted in the role of the patient’s narrative becoming progressively diminished. The study and treatment of disease became relocated within the
human body, only to be understood by medical experts, and not through individual experience. The task of the doctor, therefore, developed into translating pieces of information about the objective signs and symptoms of disease into a definitive diagnosis that linked the disease to specific biological causes and outcomes – “disease as individual pathology” (Bury, 2001, p. 266). The rapid development of medical and surgical treatments and procedures beginning in the 1940s exacerbated and reinforced the trend of medical professionals holding most of the power over what is and what is not considered illness. Because their subjective accounts were virtually irrelevant, and illness sequestered from everyday life by professional medicine, patients were rendered passive (Bury, 2001).

Sharf (1990) identified most modern medical interviews as rhetorical situations in which patients and physicians shape their discourse in attempts to persuade the other to take action and cooperate. In an analysis of a narrative co-constructed by a patient and his doctor, Sharf (1990) observed the use of anecdotes, examples, and personal beliefs by the patient in the itemized recounting of his health problems. Meanwhile, the doctor told his story in an accounting style, offering biological explanations and often reprimanding the patient for his shortcomings in maintaining his health. Both participants essentially address the same topics, but their stories conflict in many ways. As a result, there is little room for agreement about the nature of the patient’s problem or its resolution (Sharf, 1990).

However, Bury (2001) notes that the more recent considerations of various illnesses as “degenerative” and “chronic” have resulted in the line between the distinctively medical and the everyday experience becoming blurred. This can be
attributed to an increased emphasis placed on quality of life issues and the development of a more personalized patient-provider relationship due to the long-term nature of and treatment regimens associated with these disorders. Bury (2001) also notes that the rise of primary care has brought with it a resurgence of patient-provider familiarity and intimacy. Medical authority has also been diminished by the enormous availability of information about illness available to patients through the media, the internet, and alternate forms of health care (Bury, 2001).

Health Ideology in Nonmedical Contexts

Discourse regarding health is no longer relegated solely to medical forums and the individual experience. Modern illness sufferers are also subjected to many disease-related connotations which originate from, and hold relevance in, nonmedical spheres of life. Sharf and Vanderford (2003) argue that language is capable of shaping the identities of people suffering from various diseases in problematic ways. Cancer, for instance, is often explained through socially-acquired knowledge as “a dreaded disease, a curse, or a punishment” (Cherry & Smith, p. 189). Subsequently, cancer has become a metaphor for HIV. Both health issues, in fact, have long been the targets of pervading war and plague metaphors. The body is invaded by a disease, and it is medicine and doctors’ duty to surround, attack, and conquer the enemy. This perception dehumanizes cancer and HIV patients by making them feel like numbers instead of people (Cherry & Smith, 1993). Both AIDS and cancer have long mustered up a fear that stigmatizes those who have the diseases.

Cancer metaphors also seem to be a particularly rife method of discourse in politics. The Bush Administration often expressed its commitment to keeping malignant
terrorist cells from growing inside the United States. The disease has also been related to the Nixon Administration’s Watergate coverup and President Clinton’s extramarital affairs which led to his impeachment trial before the U.S. Senate. These examples reflect how the voices of medicine and of the lifeworld can become commingled within everyday discourse (Sharf & Vanderford, 2003).

To further this point, Kline’s (2003) analysis of a prevalent medicalization ideology coursing through mass mediated portrayals of health issues argues that medicine and the frequent labeling of individuals as “healthy” and “ill” are becoming more and more relevant to an ever-increasing part of human existence. Normal bodily processes, like menopause and PMS, are sometimes portrayed as illnesses or health problems. Kline (2003) points to disseminated pharmaceutical literature which depicts menopausal women as happy and healthy. Because these images are being used to sell hormone treatments, their depiction is a comment on the pathological state of menopause, one which requires treatment (Kline, 2003).

Another ideology, which Kline (2003) dubs individual versus societal orientation, targets responsibility for the cause and cure of health problems toward the individual. This process of “victim blaming” can be seen in the media’s frequent focus on two controllable risk factors – diet and reproduction – when discussing the causes of breast cancer. This view takes prevalence over uncontrollable risk factors such as family history, age, and age of onset of menses and menopause. Women, therefore, are inherently responsible for their own battle with breast cancer because they had not previously made the “proper” dietary and reproductive choices. Focusing attention on the
individual takes attention away from other, more productive ways of approaching health issues, like defining, preventing, diagnosing, and treating the disorder (Kline, 2003).

Additionally, Kline’s (2003) perception of the moralization of disease holds that society often judges a person’s character and moral health based on their physical health, as mentioned above. The media, for instance, frequently provide meanings and attributions to certain diseases, which result in the social creation and reinforcement of stereotypes and stigmatisms toward an illness or an illness sufferer. Cancer might be associated with “the forfeiture of the moral self by the invasion of an evil predator,” a heart attack described as an “objective, morally neutral event,” and HIV/AIDS portrayed as “morally repugnant,” for instance (Kline, 2003, p. 571). By characterizing HIV/AIDS as an “invasive, alien, and murderous entity,” a stigma is placed on those who actually have it (Kline, 2003, p. 571). When ill individuals acquire identities that set them apart from others, these differences can lead to isolation and negatively affect the outcome of their treatment (O’Hair, Scannell, & Thompson, 2005).

Although these symbolic portrayals of the illness experience are often accepted by the public as being natural and inevitable, such depictions and connotations of medical issues have the power to mold health beliefs and behaviors, clinical judgments, and organizational routines. For example, the Reagan Administration’s decision to treat the AIDS crisis as a political problem about which they chose to remain silent kept the matter from becoming a social issue during Reagan’s first term. Because AIDS was viewed largely as a “gay man’s disease” that could only be contracted through homosexual male intercourse, the public at large was not receiving proper education on possible avenues of infection, safe sex, responsible needle use, and so on. It was not until former Surgeon
General C. Everett Koop’s report on AIDS in 1986 that the socio-political climate was altered enough to warrant the treatment of AIDS as a public health crisis (Kline, 2003). The ideology and social construction of medical issues may contribute considerably to the suffering of people with serious illnesses (Sharf & Vanderford, 2003).

**Illness Narration as “Process” and “Product”**

Illness narratives challenge the voice of medicine as the primary means of understanding health and disease. Sharf and Vanderford (2003) define illness narratives as “Individual stories of sickness that serve multiple functions for the teller and sometimes have the power to influence others as well” (p. 26). Likewise, Fisher (1984) noted that, “Any story, any form of rhetorical communication, not only says something about the world, it also implies an audience, persons who conceive of themselves in very specific ways” (p. 14).

Sunwolf, Frey, and Keranen (2005) believe interactive illness storytelling to be a method of “co-healing” (p. 250) for both tellers and listeners. Accordingly, Anderson and Martin (2003) argue that narratives can be viewed as both a “process” and a “product” (p. 140). First, through the process of crafting and sharing their experiences of illness, narrators often discover more about themselves. The formulation of narrative can help authors understand how an illness has affected their roles, relationships, and identity, and how their personal attitudes have been impacted by social, organizational, ethnocultural, and familial influences.

For instance, if a young individual has been told his whole life that having severe asthma and astigmatism makes him “a nerd” or “a wimp,” he might not portray himself in the most flattering, confident light. He would likely gain deeper insight into the impact
his social relationships have had on his perception of identity as an illness sufferer and his resulting purpose in life. This knowledge may contribute to a greater feeling of control and legitimacy in dealing with his illness. Thus, narrative as a process can be viewed as a method of sensemaking, agency, identity, and decision-making for storytellers (Sharf & Vanderford, 2003). These functions may occur whether the narrative is developed individually; co-constructed with a family member, interviewer, or medical professional; or co-constructed as an organization.

As a product for individuals who had no direct impact on a story’s formulation, narratives may help other sufferers gain deeper meaning from their own journeys with illness and allow non-sufferers to gain personal insight on the illness experience that could be contrary to their preconceived notions (Anderson & Martin, 2003). Audiences gain a richer, more multifaceted understanding of illness than if they had simply read objective information from a biology book. For example, a Hmong woman with epilepsy who is resistant to standard medical treatment due to her traditional beliefs would have the opportunity to provide her possibly befuddled caretakers with an organized expression of her worldview. Her narrative could provide a different perspective and voice to the patient-provider relationship by showing that her cultural upbringing has impacted her perception of the illness experience. By incorporating her personalized experience of epilepsy, the woman’s doctor can subsequently help co-create a new narrative through discourse that invokes a treatment plan and enhances her understanding of biological processes.

A huge majority of people around the world will never contract HIV or AIDS during their lifetimes, or even be acquainted with someone living with the condition.
Non-sufferers know its biological effects on the human body, but how will they ever be able to apply a human or psychosocial context to a distant ailment if they are not provided with first-hand accounts of its impact? Look at the recent prevalence of memoirs written by individuals on their deathbeds – Randy Pausch’s *The Last Lecture*, Patrick Swayze’s and Lisa Niemi’s *The Time of My Life* – stories with plots that span from beginnings and middles to ends. These collections allow authors to give value to their experiences on their own terms, and enable others not yet faced with their own mortality to gain insight into the experience (Anderson & Martin, 2003).

*Illness Narratives as “Process” – The Private, Organizational, and Social Functions of Creating Stories*

Sharf and Vanderford (2003) relay four socially-constructed functions of health-related storytelling that assist narrators in clarifying the values of the illness experience. These include (1) making sense of health and disease, (2) asserting control in the midst of physical and psychological losses, (3) transforming identities and social roles as a result of an altered health status, and (4) assisting in making decisions about one’s health (Sharf & Vanderford, 2003). Much of the following literature supporting the notion that crafting and sharing narratives can be a beneficial practice for individual, organizational, and social storytellers relates to these functions.

**Narrative as Sensemaking**

Encouraging illness sufferers to share their experiences in a unique light through the use of familiar literary devices such as plot, character, scene, setting, motive, metaphor, personification, analogy, rising/falling action, climax, and point of view enable patients to ascribe meaning to their illnesses. These devices also allow sufferers to shape
their possibly random and disorganized perceptions of the world into accessible, easily-digested descriptions with all loose strings tied (Sharf & Vanderford, 2003).

Pennebaker (2000) believes that humans actively seek to understand the world around them. If we feel pain or witness something out of the ordinary, we try to learn the cause of it. Once we understand how and why an event has occurred, we become more prepared to deal with it if it happens again. Naturally, we will be far more motivated to learn about and examine events that have significant positive or negative consequences than about common or predictable events that don’t directly impact us. In attempting to understand this experience, we will ask ourselves why it happened and how we can cope with it (Pennebaker, 2000). A narrative’s sensemaking function, then, enables writers to create unified meanings of unexpected and random events, people, and actions as they assemble structured accounts of what they experienced. This allows sufferers to establish links with seemingly unrelated story elements to create some sort of understandable pattern, paving the way for the ascription of meaning, interpretation of events, and justification of actions.

Storytellers may overlook or repress the significance of events and links in real time that are likely to become more impactful after authors remove themselves from the experience and arrange the pieces in retrospect. Patients may be better able to deal with chaotic or confusing conditions by stepping outside – or reframing – the experience by recalling the events in hindsight as observers or bystanders of their past experiences. From her own experience, Sharf (2005) realized that it can be extremely difficult to be a coherent, potentially impactful storyteller in the midst of an ordeal. The construction of an illness narrative requires the acquisition of perspective, obtained through the passage
of time, feedback from a listener, *the use of humor*, or some other experience that enables the author to reflect on the events in question, even as they are being lived (Sharf, 2005).

As previously mentioned, we make sense of situations as guided largely by our notions of personal, social, and cultural identity. Storytelling encourages a deeper, more linear form of thinking than simply allowing unfettered experiences to float around freely and without context or perspective in one’s head. Perspective is seemingly inseparable from the sensemaking process (Sharf & Vanderford, 2003).

A patient’s suffering may also be diminished because a reason for the illness experience can be established through the formulation of a narrative. Sharf and Vanderford (2003) note that the voicing of an illness experience in story form is an act of healing and agency in and of itself. Many illnesses or disabilities are completely unavoidable; however, narratives allow an author to assume accountability for him- or herself (and perhaps others in similar circumstances) by simply providing reasons for the person’s illness experience. The ways in which authors account for the contributory factors of disease may provide scenarios of innocent and culpable victims, careless perpetrators, or factors of nature or probability beyond human control. The act of assigning responsibility or blame allows the narrator a certain degree of agency (Sharf & Vanderford, 2003).

Although a serious diagnosis or the incident of life-threatening illness may often be anticipated by researchers to be the most important issues for a sufferer to write or talk about, Pennebaker (in press) notes that traumatic experiences regularly bring to the fore other important events in a person’s life. Thus, illness sufferers’ narratives may focus
more on some other trauma that may have occurred years before – the death of a loved one or abuse by a parent, for instance.

Bostico and Thompson (2005) studied the use of narratives by 10 bereaved parents and their subsequent ability to understand, organize, and manage the powerful effects of loss and their emotions of grief. These parents were shown to be adept at determining good reasons for events and situations to promote a good life for themselves and for those they love. By attempting to construct plausible stories of their bereavement experience, while simultaneously integrating details into a whole, parents were able to see patterns and understand connections that might not have been apparent to them before. Bostico and Thompson (2005) also recognized the parents’ personal growth, decision making, and sensemaking development through the deconstruction of their stories.

Mehl-Madrona (2008) analyzed the life stories of 47 cancer patients who sought traditional aboriginal healers for help and survived at least five years past treatment. After comparing these stories to 50 cancer patients who also worked with aboriginal healers but died within that same time frame, Mehl-Madrona (2008) observed several discrepant qualities between the two groups. The survivors seemed more present-centered, forgiving, disconnected from their past, and humorous than those who succumbed to their illness. They were also able to advance more plausible theories to themselves and to their community about why they healed, were graced with more supportive communities, underwent more change in identity, and experienced more spiritual change. The author argues that these attributes may be qualities of the “states of mind” that are most attuned with “miracle cures” (p. 502).
The Health Benefits and Therapeutic Potential of Narrative

The act of constructing stories is a natural human process that helps individuals to understand their experiences and themselves. But according to Pennebaker (2000), when people put their emotional upheavals into words, their physical and mental health also improves markedly. In a study by Pennebaker and Beall (1986), students wrote about the most traumatic experiences of their life over four consecutive days for 15 minutes each day without stopping, and without regard to spelling, grammar, or sentence structure. The control group was asked to describe objects and events dispassionately. Those in the experimental condition wrote an average of 340 words during each 15 minute session, covering a wide array of traumatic topics such as rape, family violence, suicide attempts, and drug problems.

The researchers expressed surprise that participants seemed to intuitively know how to put their life experiences into remarkably coherent narratives with few spelling or grammatical errors. Despite the fact that many cried, 98% of participants reported that they found the writing to be extremely valuable and meaningful (Pennebaker & Beall, 1986). The respondents’ respective emotional states immediately after writing were shown to be influenced by how participants felt prior to writing: the better they felt before, the worse they felt after, and vice versa. However, two weeks after the studies, experimental volunteers reported long-term improvements in both mood and indicators of well-being (Pennebaker & Beall, 1986).

Most interestingly, among relatively healthy samples, participants who had written about their thoughts and feelings significantly reduced their trips to the doctor after the study compared to control participants (Pennebaker & Beall, 1986). Later
experimental respondents have also been shown to possess improved immune system
functioning, achievement of better grades, better work attendance, and faster acquisition
of a new job. These results have been shown to generalize across most individual,
educational, linguistic, and cultural differences, and are independent of social feedback
(Pennebaker, 1997).

McGuire, Greenberg, and Gervirtz (2005) found that one month after participants
talked or wrote about deeply personal topics, they exhibited lower systolic and diastolic
blood pressure than before the experiment. Three months later, their diastolic numbers
remained lower than baseline levels (McGuire, et al, 2005). Health benefits were also
found in an expressive writing study examining those suffering from asthma and
rheumatoid arthritis (Smyth, Stone, Hurewitz, & Kaell, 1999).

However, translating traumatic experiences into language – and not into dance,
music, or art alone – is necessary for physical and mental health improvement (Krantz &
Pennebaker, 1995). Concordantly, Pennebaker, Mayne, and Francis (1997) analyzed the
language that individuals use in writing about traumatic experiences, and determined that
essays from those whose health subsequently improved were more self-reflective,
emotionally open, and thoughtful. Further, the more storytellers used positive emotion
words (happy, laugh) or moderate amounts of negative emotion words (sad, angry), the
better their subsequent health. Additionally, both very high and very low levels of
negative emotion words correlated with poorer health, most likely because these authors
are poor at being able to identify and label their emotional states, or neurotically ponder
their negative emotions in exhaustive detail without achieving closure.
Meanwhile, the increase in the use of causal words (*because, reason*) and insight words (*understand, realize*) over the course of writing was also strongly associated with improved health (Pennebaker, et al, 1997). However, contrary to the authors’ assumptions, the increasing use of causal and insight words does not reflect the building of a good and coherent narrative. “Good stories” were recognized as narratives which maintain clear beginnings, middles, and ends; reflect a moral or a message; are intriguing, interesting, insightful, and titillating to readers; are products of the writing process being taken seriously by the author; demonstrate the author’s mental health; depict the author as possessing positive and emotionally meaningful relationships with others; offer a reflection of the author’s growth or change over the course of writing; focus on multiple episodes and/or themes throughout the writing process; and allow the offer to gain insight without appearing overly conflicted (Graybeal, Sexton, & Pennebaker, 2002, p. 575). It is important to note that those entering the study with a coherent story about the experience already in place did not benefit from writing. The actual *construction* of a narrative, then, seemed to be critical in reaching understanding or knowledge (Pennebaker, et al, 1997).

An explanation for the positive effects of journaling could be Pennebaker’s (2000; in press) belief that the act of converting emotions and traumas into words changes the way the person organizes and thinks about the negative experience. Pennebaker (in press) compares this to the application of digital technology (language) to an analog signal (emotion and the emotional experience). Part of the distress caused by the trauma does not simply lie in the events, but in the person’s emotional reactions to them. Therefore, if an emotion or experience remains in analog form, it cannot be understood or conceptually tied to an event. By integrating thoughts and feelings – or translating distress into
language – the person can then construct a more cognizant and coherent narrative of the experience. This allows the event to be summarized, distorted, and stored in the memory as a more understandable, one-dimensional abstract that is much easier to forget or move past (Pennebaker, 2000; in press).

To demonstrate this, Crow and Pennebaker (1997) studied how 76 students thought and talked about the Persian Gulf War during the time it was underway and in the months following its completion. Two-and-a-half years later, the researchers found that those people who were initially most upset about the war and talked the most about it had the poorest memory of the proceedings after 30 months. Crow and Pennebaker (1997) believe these individuals were able to construct a coherent, simplified narrative about the event, and were easily able to move beyond it after the war since they had no reason to rehearse or relive the experience.

Pennebaker (2000) has found that after writing about traumatic experiences, people generally devote less cognitive energy to their distress. Thus, individuals begin talking more to their friends, laughing more, and using more positive emotions in their daily language. This can play a huge role in the development of social support. However, keeping an important secret can be psychologically and biologically taxing, can block the natural cognitive work of coming to terms with an experience, and can distance the secret-keeper from family and friends (Pennebaker, 2000). Inhibition, or constraining thoughts, feelings, or behaviors linked to an emotional upheaval, could exacerbate stress and thereby increase the risk of illness and other stress-related disturbances (Pennebaker, in press). Not talking about a traumatic experience is associated with a breakdown of one’s social network, a decrease in working memory, sleep disruptions, alcohol and drug
abuse, and an increased risk of additional traumatic experiences (Pennebaker, in press). Letting go and talking about these experiences, should, in theory, reduce the stress of inhibition and short circuit this negative process.

**Narrative as Asserting Control**

O’Hair and his co-writers (2005, p. 425) state that the acquisition of agency “provides choice for patients within the patient-health care contexts, empowering individuals to exert control over their health care.” Sharf and Vanderford (2003) argue that narratives allow ill individuals to regain their voice and perception of control, which are often lost in the frequently demeaning process of sickness and treatment. Living with a severe and/or chronic disorder is almost always accompanied by at least a small loss in a sufferer’s sense of autonomy. These feelings can exacerbate a patient’s sense of pain and helplessness, particularly among those who are used to frequently working, socializing, or participating in a wide range of activities.

Rather than continuing to possess sole control over their life and future, many patients must also become increasingly reliant on family caregivers, medication schedules, and health care providers. For instance, certain sufferers may lose bladder and bowel control during the course of their illness. Many women undergoing treatment for breast cancer receive mastectomies. Epilepsy too is often accompanied by a list of physical restrictions which may lead to the diminishment of social relationships. Physiological losses – like the removal of a testicle due to cancer – can, of course, have emotional repercussions such as shame, embarrassment, and frustration (Sharf & Vanderford, 2003).
Assuming an inherently passive patient role is typically associated with a long-term or serious illness experience. If nothing else, patients lose a sense of certainty about – and control over – what is to come in their lives, with their perception of a “taken for granted” future rich in sustained health shaken to the core by their turbulent descent into disorder and loss. Even though a cancer patient may currently be in remission, the patient has no idea if or when the condition will worsen once again. But instead of simply remaining a name on a clipboard at the foot of a hospital bed, powerless to a slew of medical professionals and a future filled with uncertainty, narrators can reclaim their individuality and assert themselves as agents by describing how an illness has altered them as a person.

Sufferers are able to place their own changing relationships, interactions, roles, identities, emotions, losses, and personal growth into a dramatic story with a beginning (pre-disorder, for example), middle (diagnosis), and end (disorder or post-disorder). Creating a chronological order of previously unexplainable events can help project that control – once unsure – into the future (Sharf & Vanderford, 2003). Keely and Kellas (2005) believe that lessons learned through the narrative formulation of past events can impact both the present telling of that story and future events.

The act of ordering and predicting the future, and allowing the narrator to be a major character in his or her own story, is a denial of the dominance of disorder and unpredictability over one’s life, and thereby an act of control. Being able to plan how death occurs, for example, is the ultimate measure of control assertion. A study by Anderson and Martin (2003) observed a woman suffering with cancer who felt it necessary to write out her last words to her husband and son as a confrontation of her
own mortality. In doing so, she was able to grasp onto the control she so much wanted – and previously lacked. According to Sharf and Vanderford (2003), “Narrative form puts the ‘I’ back into a person’s understanding of his or her life. Rather than silently comply with the initiatives and orders of others, the patient-narrator asserts him/herself as an agent” (p. 21). The act of narration also allows authors to emphasize how the illness has influenced and emphasized who that agent is (Sharf & Vanderford, 2003).

O’Hair and his fellow researchers (2005) propose that the construction of illness narratives by cancer patients helps to negotiate and renegotiate threats to storytellers’ identity, relationships with close others, and aspects of the cancer-care environment. Patient agency can be achieved through narrative because it provides an outlet for cancer sufferers’ strength and voice within the story. Narratives also enable cancer patients to grapple with multiple stressors that impinge upon their psyche, allowing them to adapt to the illness experience psychologically, emotionally, and communicatively. This leads to personal growth, which becomes a desirable outcome that empowers the patient (O’Hair, et al, 2005).

When co-constructed openly and equally, illness narratives can also provide legitimacy to the often unacknowledged expertise of patients and encourage a more egalitarian perspective during medical interactions. Effective clinical practice relies on narratives to facilitate treatment, build relationships with patients, and attempt to understand what it means to be sick and well (Sharf, et al, in press). Eggly (2002) emphasizes the important role of both patients and providers in creating medical narratives through the co-constructed chronology, elaboration, and interpretation of key events. By actively promoting the elicitation and collaborative understanding of patients’
stories as a primary history-taking tool, physicians demonstrate that illness is not an objective phenomenon over which medicine has unique ownership or expertise. Instead, illness becomes an interpretive experience that requires a personalized method of treatment (Eggly, 2002).

Narrative as Transforming Identity

Formulating stories also allow sufferers to reshape their identities, either in enabling ways, or conversely, with an emphasis placed on loss, trauma, or impairment (Sharf & Vanderford, 2003). Chronic and/or severe illness often disrupts a person’s previously established self-image and lifestyle through dramatic changes in health, social roles, physical appearance, bodily functions, relationships, social circles, and the realization that a crisis may have lasting implications. According to O’Hair and his colleagues (2005, p. 417) “Individuals constantly reconfigure the past and future as part of an emergent present, and both the memories of the past and expectations of the future are symbolically organized and constructed to provide a congruent self-perception. Narrative identity reflects a person’s life through a sequence of experiences, expectations, and memory categorized into a triad of past, present, and future.”

When individuals face the possibility of death associated with a critical illness, attitudes change, questions are asked, and emotions heighten, not only for the patient but also for family and friends (Anderson & Martin, 2003). Recovery from such medical issues may not be possible through a physical cure. Instead, healing may require the creation of a revised life story with an altered identity capable of thriving despite debilitation, pain, or a future filled with uncertainty (Sharf & Vanderford, 2003). An individual suffering from a stigmatizing disorder like HIV may, for instance,
subsequently view him- or herself as “a person living with a chronic illness,” rather than “a person dying of a terminal illness” after successfully formulating an individual narrative (Sharf & Vanderford, 2003, p. 23). Each time a person’s story is told, identities are altered, changed, discovered, or abandoned (Anderson & Martin, 2003).

Severe medical issues frequently interrupt the plans sufferers make for themselves. But narratives may allow a person’s newly-modified identity to reflect the creation of a self who can overcome their present circumstances. Sharf and Vanderford (2003) also note that many narrators apply essential personal resources and expertise to the illness experience – like the use and appreciation of humor – in order to derive deeper insights. Overall, the storytelling process allows for various facets of one’s identity to be expressed, and can reveal a person’s essential character through their struggles to adapt, persist, and thrive (Sharf & Vanderford, 2003).

Seagal and Pennebaker (1997) discovered that writing about being a member of a stigmatized group raises one’s level of collective self esteem. People who had a visible stigmatized identity, such as being overweight or Latino, benefitted more from writing about being a member of the general population rather than identifying themselves with members of their in-group. In contrast, members of a non-visible stigmatized identity, such as homosexual or cancer sufferer, found it more helpful to write about being a member of that group. Both of these groups reported experiencing more difficulty in writing their accounts than people who were in other writing conditions, but they also reported more long-lasting benefits and felt less sad and depressed a month later (Seagal & Pennebaker, 1997).
An individual’s identity can indeed alter the stories they tell of the illness experience. For instance, people who feel victimized may neglect to fully disclose the details of their story because evasion helps them to deal with their feelings of stigmatization. Conversely, those who deem themselves to be “warriors” in a battle against cancer (Anderson & Martin, 2003, p. 135) may feel that telling more people about their illness will help in their fight to conquer the disease. The validation or dismissal of a narrative by a storyteller’s audience may also shape the context for future disclosure (Anderson & Martin, 2003). O’Hair and his colleagues (2005) demonstrated a possible difference in how males and females renegotiate their identity after it is threatened by cancer. While females often allow the illness to take on a positive meaning in order to create and sustain a contented self, male patients have been shown to use their illness as a crutch so that he no longer has to keep up a persona of invincibility (O’Hair, et al, 2005).

Anderson and Martin (2003) investigated the narratives of couples who lived through life-changing events following a cancer diagnosis. In particular, the authors studied the family units’ similarities and differences in perceptions about the illness experience, the sensemaking that arose, the moments of strained communication, and reflective feelings about the experience. They found that these families, cancer patients included, often fluctuate between a maze of different identities – such as a sick patient, a victim, a warrior, or a survivor – throughout the course of their illness. In fact, the narratives presented in this study showed that identity composition and re-composition are a continuous, multifaceted process that occurs among all members of a family, not simply the ill individual. Through family communication and the shared experience of illness, survivor identities and renewal of self develop (Anderson & Martin, 2003).
For example, one family whose members were open about their illness experience with one another and others outside of their immediate family found it easier to communicate about their feelings in general. The mother suffering from cancer needed to be nurtured and comforted, while her husband needed her to share her feelings and be strong for him. Both parents felt the need to protect their son from information about his mother’s illness. Although there were times when they could not align themselves with these expectations, the ability of these family members to break down their communication barricades allowed them to realize that they needed each other more than previously thought. The development of a survivor identity, however, does not mark the end of the illness journey; a person can easily revert back to being a victim one day or a warrior the next (Anderson & Martin, 2003).

Keely and Kellas (2005) found that talking about the final conversations (FC) one has held with loved ones on their deathbed serves as a therapeutic means of making sense and coming to terms with the passing. FC narratives enable authors to learn about, grapple with, and confirm their own identities by making statements about themselves and the roles they assumed in response to the situation, recounting statements from the dying person that confirmed or redefined the storyteller’s identity, and explaining how the experience has changed their self-perception and subsequent actions (Keely & Kellas, 2005).

FC narratives also assist storytellers in reconstructing relational identity with their deceased loved one by portraying their relationship as unique or important, describing how the dying process in some way strengthened the relationship, and confirming the overall reality or characteristic of the relationship. This type of FC storytelling can also
empower people to utilize past communication with their loved ones as a way of beginning to make sense of their loss and death in general, thereby initiating the healing process. Finally, participants articulated clear lessons about the importance of communication that occurs at the end of life and their communication with loved ones in the present (Keely & Kellas, 2005).

**Narrative as Warranting Decisions**

Narratives may also be effective in revealing storytellers’ values, judgments, or reasons for actions, especially those involved in the medical decision-making process. According to Sharf and Vanderford (2003), “Stories function to justify decisions already made and determine future decisions. Understanding a patient’s story is key to understanding his or her decisions” (p. 26). Because narratives often reflect the shortcomings of healthcare, or the functions and applications of medicine that run counter to one’s own ideological perspectives, personal accounts reveal the way storytellers feel the world should operate; this is often contrasted with the way things actually occur in the story.

Providing the illness experience with a narrative arc can portray, and possibly critique, how one came to a decision through the interweaving of virtue, morality, reason, attitude, and rationalization. Health decisions related to treatment, adaptation, and coping are often made based on the meanings patients give to their symptoms, and their experiences with illness and physicians in general (Sharf & Vanderford, 2003). Narratives provide writers and audiences with a cognitive road map of the decision-making process, complete with detours, accidents, and u-turns.
As mentioned above, when more than one person is involved in a healthcare decision, the co-constructing or overlapping of separate narratives is often utilized to elicit a clear conclusion. If narrators are able to accurately describe where they as patients are coming from, for instance, and providers as co-interactants in a medical consultation are given the same opportunity, their negotiated story might be more beneficial in arriving at a care management plan acceptable to both parties. Well-crafted narratives place interactions in a context that could expose an unbalanced sense of power between participants, and detail the positives and negatives of each party’s approach to making decisions (Sharf & Vanderford, 2003).

Eisenberg and colleagues (2006) provide support for the rationale that constructing narratives can potentially result in the transformation of an environment through characterization and sensemaking processes that impact subsequent decisions. The researchers provided an open forum among employees of an urban hospital emergency room to share their individual experiences of disorder at work. The dialogic process encouraged the ER staff to acknowledge and understand each other’s ways of viewing the world and to include this awareness in the co-construction of a new organizational narrative – eventually delivered to hospital administration (Eisenberg, et al, 2006).

Both ER staff and the researchers of the study were able to focus on a revisable story and better understand a world filled with multiple sensemaking frameworks and voices by thinking through the narratives. Their ability to raise awareness of alternate ways to describe what was happening in the ER gave voice to those employees whose perspectives were once marginalized. It also resulted in significant decisions regarding
the hiring of an additional patient advocate and several patient-greeters, and the facilitation of timelier physician communication with patients, among many other changes (Eisenberg, et al, 2006).

**Narrative as “Product” – Prevalent Forms, Themes, and Communal Functions of Texts about the Illness Experience**

While the formulation of the illness experience through story may provide a powerful and multifaceted function for authors, Sharf and Vanderford (2003) argue that voluntarily making the private public also serves a communal role in providing a primary, personalized opportunity for scholars, medical professionals, and others not directly involved in the storytelling “process” to learn about illness. By examining how tellers construct stories and describe themselves in relation to other characters, actions, and events, audiences can learn how they create meaning from their experiences (Cherry & Smith, 1993). The dissemination of these story “products” can also help individuals with common difficulties provide support to one another, and allow them to become more perceptive of issues they may have been unaware of or are attempting to deal with themselves.

Those suffering from stigmatizing, serious, or chronic illnesses, for instance, can view tangible, real-world examples of how others were successful (or unsuccessful) in coping with similar difficulties and making medical decisions. This can result in a newfound sense of guidance and empowerment for audience members, and the replacement of social isolation with social support (Sharf & Vanderford, 2003). Stories about an individual’s experience with cancer, for example, can help other sufferers experience their own journeys with the disease and determine the supportive relationships
central to their own healing processes. Audiences can subsequently understand cancer as a survivable, chronic disease rather than a death sentence (Sharf, et al, in press). The narratives of others open up opportunities for understanding and participating in our own health care with greater direction and freedom (Anderson & Martin, 2003). They can also be conduits for transforming audiences, shaping their understandings, feelings, attitudes, and even behaviors in particular ways (Sharf, et al, in press).

Adelman and Frey (1997) discuss the roles various modes of storytelling play in the spiritual, material and communal sustenance of residents living in Bonaventure House, a facility for people with AIDS. Stories served to help initiate incoming members, prepare established residents for the deaths of others, create private boundaries and cooperation, and balance a sense of normality with a continuous sense of crisis and loss. Narratives also functioned in positively reframing grief and fear with celebration and continuity, namely through the use of stories about departed residents (Adelman & Frey, 1997).

As narratives create a sense of community, they also function to reinforce or to challenge dominant ideologies (Thompson & Bostico, 2009) and contrast widely ascribed master narratives (Sharf, et al, in press). Narratives have been shown to be effective in raising public awareness about specific issues inherent in experience of illness, and serve as highly-recognizable discourses for health advocacy, public education, social activism, and policy change (Sharf & Vanderford, 2003). Health care providers, for instance, may receive advice on how to treat future patients with similar afflictions. Little-known or overlooked medical issues can gain legitimacy in social and political realms if suffering and debilitation is given a human face. The accumulation of personal stories serves to
illustrate the extent and proximity of the problem in a way that generalized statistics cannot. Challenging prevailing assumptions and conventional representations of illness can contribute to the formation of health-based communities (Sharf, et al, in press; Sharf & Vanderford, 2003).

Berkley-Patton, Goggin, Liston, Bradley-Ewing, and Neville (2009) demonstrated the effectiveness of narrative in promoting health-seeking behaviors. By utilizing role-model stories, “which employ culturally tailored narratives to depict experiences of an individual modeling health-risk reduction behaviors” (p. 199), the research team was able to develop a campaign to increase minorities’ engagement in HIV/AIDS health and related services in a nonthreatening, engaging, culturally-identifying, and value-driven manner (Berkley-Patton, et al, 2009).

Through focus groups and interviews with community members and HIV-positive minorities, the authors were able to identify thematic issues with which respondents claimed to most struggle in their pursuit of effective health administration – namely, the maintenance of routine medical care and medication adherence practices. The final narrative product, disseminated throughout low-income areas of Kansas City, depicts an African American female who struggles with keeping her doctor’s appointments and taking her HIV medications. “The role model story depicts how she moves beyond ambivalence and (a) makes a commitment to keep doctor appointments and take medications, (b) develops trust in her doctor, (c) gains support, and (d) enjoys some of her favorite pastimes due to her improved health” (Berkley-Patton, et al, p. 204).
Illness Narrative Form, Structure, and Prevalent Themes

Bury (2001) suggests the consideration of three broad forms of storytelling as a framework for analyzing illness narratives. “Contingent narratives” (p. 268) ontologically address beliefs about the origins of disease, its emerging symptoms, the causes of an illness episode, and the direct effects of illness on the body, self, others, and everyday life in general. Concepts of illness and disease in this realm can be divided into two types: on one end of the spectrum is the “categorical view of illness” (p. 269), based on the objective, biological separation of the normal healthy state and the pathological. The course of the disease is viewed as being relatively clear-cut. The “spectral view of illness” (p. 269), conversely, holds that the difference between disease and illness is a matter of social or personal perspective. Bury (2001) notes that a great deal of overlap is often observed in the use of categorical and spectral views, particularly in personal narratives. The occurrence of illness often leads to both a greater re-examination of personal, familial, and work-related issues, and a growing familiarity with current medical thought about the particular issue. Thus, contingent narratives often draw on different types of expert knowledge – that of the individual and that of medicine. Aspects of normalization, coping, and strategic management of chronic illness figure prominently in these types of narratives. However, these reflections do not offer a great deal in terms of plot structure or drama (Bury, 2001).

“Moral narratives” (p. 274), meanwhile, include an evaluative dimension of the links between the personal and the social. These provide accounts of (and help to bring about) changes between the person, the illness, and social identity, and help to reestablish the moral status of the individual. This moralization can either be positive or negative:
one can pride oneself on renewal and change, or place a great emphasis on shame and being flawed.

“Core narratives” (p. 277) reveal connections between the lay person’s experiences and deeper cultural levels of meaning attached to suffering and illness. These stories essentially take a contingent or moral narrative and mix in plot structure, themes, and genres. According to Bury (2001), the construction and presentation of narratives occur within frameworks of cultural settings which provide specific forms of language, clichés, motifs, references, and other linguistic elements which foster and constrain what is said and how it is disseminated. More simply, through core narratives, people can both account for events and give shape to them in terms of the ways in which they feel they relate to self and others. The author points to several prevalent sub-forms or genres in which a narrative that seeks to reconstruct identity and interaction with others can operate – epic/heroic, tragic, comic/ironic, disembodied/romantic, and didactic. He also draws a distinction between “progressive,” “regressive,” and “stable” (p. 280) narratives based on the direction of causal linkages between the story’s episodes. While progressive stories seek to move toward an author’s valued goals, regressive tales move away from such goals, and stable narratives eventually get there, but tend to ruminate upon a sequence of events more ontologically and inertly, without great movement, character development, or drama (Bury, 2001).

Frank’s (1995) analysis of the narratives of “wounded storytellers” revealed three common types of tales about illness. Restitution stories depict happy endings in the storytellers’ experience as instances of health being restored. Health problems, therefore, can be remedied and the body can return to normalcy. Quest narratives demonstrate how
everyone involved in a story is able to “meet suffering head on; they accept the illness and seek to use it” (p. 115). Characters are portrayed as growing stronger through dealing with troubles and adversity. Chaos narratives, however, result in an author portraying an illness as a series of random events that are not well connected to one other. Often this involves a plotline in which all seems to go uncontrollably awry, with no guarantee of getting better (Frank, 1995). Because closure is not obtained and uncertainty remains, coping becomes much more difficult (Sharf, 2005).

Sharf’s (2005) analysis of her own story in which she fired her surgeon for commandeering the medical relationship identified another theme prevalent in illness narratives: cautionary tales, likely similar to Bury’s (2001) didactic genre. These are “stories with a moral imperative of sorts that invites audiences to consider what not to do, how to look for danger signs of an unworkable relationship earlier on, and how to get out of the mire” (p. 340). Sharf (2005) also classified the contrasting plot themes of “engagement” (p. 341), a sense that one holds sway over the course of one’s own experience of illness and health-seeking behavior, and “fatalism” (p. 341), a perception that the destiny of one’s illness is predetermined and unchangeable.

Ellingson and Buzzanell (1999) found that women with breast cancer tend to utilize a more nonlinear, unfolding narrative structure that weaves together many different subplots, themes, and characters. Their stories in this experiment also seemed to lack a discernable beginning or end, and very few were complete or step-by-step, plot-driven accounts in the traditional sense. Breast cancer patients often did not start at the beginning of a story, but instead jumped to the part that interested them the most. These women frequently incorporated various aspects of their lives into stories in great detail
because they saw these experiences as being closely related to each other and to their illness and recovery. Female patients’ descriptions of their doctors also had the tendency to be expressed through stories that describe their concrete actions, rather than simply listing abstract characteristics (Ellingson & Buzzanell, 1999).

Young and Rodriguez (2006) analyzed the narratives of elderly veterans to determine their perceptions of and preferences for end-of-life care. Researchers identified the presence of a subtext – the goals and values driving the narrative – and a context – life experiences that filter and shape the current interpretation (i.e. actual or anticipated outcomes) – within the production of a narrative or advance directive text. One respondent used the story of his wife’s death to share his own need to maintain control in decisions about his health care. This was determined by his tendency to use first-person “I” language to indicate control and agency in telling his story. However, his use of “you” or “we” in the narrative indicates where his perception of control over his health care is tenuous or nonexistent. The researchers also identified three themes that the respondents negotiated in relation to end-of-life care and life-sustaining treatment situations: quality versus quantity of life, benefits versus costs (thought of in terms of their impact not only on the individual but on family and society), and control versus lack of control (often contextualized by assigning the ultimate power over one’s health to God) (Young & Rodriguez, 2006).

Caplan, Haslett, and Burleson (2005) examined journals written by 41 older adults coping with significant losses, like the death of a spouse, to determine how these individuals thought about and described their experiences. Through content analysis, the researchers concluded that overall participants shifted from a primarily factual mode –
often detailing what the loss was and how it occurred to set the scene and sequence events – to more of a focus on the impact of the loss on their lives. This was achieved through expressive statements ranging from depression and desolation to optimism and moving ahead, and descriptions of whether they were successful or unsuccessful in handling new tasks. Three themes also became visible: themes of loss, themes of feeling, and themes of coping (Caplan, et al, 2005).

**Narrative Portrayal of Particular Health Issues and Health Problems**

Cherry and Smith (1993) identified nine different types of loneliness in men with AIDS: Social isolation (from society, engendered by the institution of medicine, and the results of social isolation on the individual), emotional isolation (resulting from transformation of the body; from friends, family, and intimates; and building new relationships in the wake of emotional isolation), and existential loneliness (as it relates to faith and religion; in the face of death; and the newfound appreciation of the purity of nature and the quest for meaning in life) (Cherry & Smith, 1993).

Many of these AIDS sufferers utilized metaphor and comparisons to describe their experience of stigmatization and separation from a society which advanced an overzealous rejection of their disorder: “us versus them” (p. 188); being cut off from society by an “impassable wall” (p. 189) and “a glass house” (p. 194); feeling like “the boy in the bubble” (p. 194); AIDS as a “homosexual disease,” “the revenge of God” (p. 198), and “the wasting syndrome” (p. 196); being judged as “the lowlife of society” (p. 193) and a “freak” (p. 194); medical interactions as “business transactions in which information is given in exchange for money” (p. 191); diagnosis as “a hammer on the head,” “hand grenade in the stomach,” and “total devastation” (p. 191); having a body
like “a car that can’t be fixed” (p. 195); doctors as being “cold” (p. 191); and the label of “full blown AIDS” as “a death sentence” that makes patients feel like “less of a person” (p. 192). HIV patients also frequently likened their experiences to those of cancer patients – as the recipients of a dreaded disease, a curse, or a punishment (Cherry & Smith, 1993).

Ellingson and Buzzanell (1999) studied women’s narratives of their breast cancer treatment to uncover conceptualizations of patient satisfaction with medical interactions. Patients described satisfaction as a negotiated dialectical process of both needing to be cared for and needing to be active participants in their treatment. They also wanted their doctors to identify with and understand the context of their lives – family, work, and friends – as being intimately connected to themselves, their treatment, and their recovery. Satisfaction was also deemed an ongoing dynamic process in which continuous revisions of self and the medical relationship were prevalent. These women felt they needed to be respected as an intelligent and autonomous being, cared for as an individual, and reassured of the physicians’ expertise. They also enjoyed using a “feminine communication style” (p. 172) with their physicians that placed an emphasis on equality, relationships, support for others, and concrete details. Also, each woman negotiated communication satisfaction in her relationship with her physician according to her own needs, identity, and empirical viewpoint (Ellingson & Buzzanell, 1999).

Wareing (2005) found that men experience a broad range of phenomena while living with a benign prostate condition, which most participants viewed as an inevitable result of ageing. Their experiences included feelings of profound embarrassment, fear, revulsion, and humor, and the recognition that their condition requires an adjustment of lifestyle to manage and contain their symptoms (Wareing, 2005).
Broussard’s (2005) analysis of the narratives of 13 actively bulimic women revealed four prevalent themes of the illness experience. Because the practices of bulimic women are typically carried out in secret, these women often expressed isolation. Their narratives also reflected a sense of living in fear, because binging and purging are regarded as abnormal and the women were fearful of others discovering their practices. They also feared living without bulimia because it had become a significant part of their identity, and because they were terrified of gaining weight. They also demonstrated an internal struggle which fed the compulsion to eat, and often resulted in guilt. Self-induced vomiting allowed these women to both get rid of their fullness and erase guilt (Broussard, 2005).

Summary

Although narratives can, and often are, co-constructed in conversation, the analytic aspect of this thesis is primarily interested in first-person written or verbalized accounts individuals assemble by themselves, about themselves, and intended for both themselves and others. Our authors have certainly been influenced by interactive discourse in the creation of their narratives – among many, many other societal, historical, and relational factors – but the end products we intend to analyze are pre-arranged and pre-organized personal linguistic narratives about one’s own illness experience. Think of it as private journaling one intentionally decides to share with a wider audience.

These narratives also share a similar structure in that they demonstrate core forms of storytelling with either progressive or regressive dimensions (Bury, 2001). They all possess varying degrees of rising action/movement/drama, character development,
figurative language, and are not stable or stringently ruminative in nature. However, a more significant similarity involves the authors’ choice to tell their story of past or present traumas through the utilization of humor and/or irony. This thesis intends to analyze the ramifications of these decisions – namely, how is humor employed in these stories and why does it resonate with audiences?

**Relevance of Humor in Health Communication Research: Contexts, Forms, and Functions**

“One of the significant things about serious illness is that it separates you from that which gave you hope and strength and makes you someone else. The word support comes from two words: to hold from underneath and to carry. Humor itself or people who use humor as a therapeutic tool use it not necessarily to make someone feel better but to give support — to give people the freedom to be able to see the resources they have in order to obtain the answers they need.”

-Hospital Chaplain in Francis, Monahan, and Berger (1999, p. 155)

Imagine being escorted to the examination room at your family practitioner’s office. You’ve had the stomach flu for several days, and feel completely terrible. The medical assistant who’s taking your blood pressure looks up at you and says, “Hey, did you hear researchers have discovered that diarrhea is hereditary? Yeah, it runs in your jeans!” You’d almost certainly not be amused at that moment (and likely be forced to bite your tongue to keep from saying, “Oh my God, I don’t care! Where the fuck is the doctor?”). Aside from being quite lame, the joke itself is an example of contrived humor, defined by its hypothetical situation and mentally rehearsed delivery. The punchline is only funny in relation to the set-up (if then), and will not make sense out of context. Each time a person is told that same joke, the less humorous (and likely more annoying) the joke may become.

The description of the entire situation, however, marked by its placement of an ill-timed cornball joke told by an overzealous caregiver to a crummy-feeling patient who is
in no mood, would likely elicit laughter if shared with others. This is an example of situational humor, which refers to “statements and actions relative to the experience of a lifeworld situation” (duPre, 1998, p. 50). Spontaneous occurrences are often funnier – and funnier longer – than the repeated retelling of the same self-contextual joke. We might be quite fond of recalling the time “That person checking my blood pressure told me a stupid joke when I was in serious danger of puking in their face and I wanted to scream.” We’re able to relate much more to the story than the joke itself because it portrays an environment which we recognize; we can place ourselves in the shoes of the patient, and can feel their irritation like it was our own. Along the same lines, conversational humor, verbal play, or “joking around” can be defined as playful banter relevant to a situation. This type of communication might utilize humorous puns, comical expressions and actions, exaggerations, absurdities, and colorful compliments (duPre, 1998). If situational humor is our perception and description of an event that occurred in the past, conversational humor is the “playing around” that might occur in real time between, say, a dentist and his or her patient during an ongoing interaction.

The humor described and portrayed in both the literature review and case study portions of this thesis occurred, for the most part, spontaneously. More specifically, it is situational or conversational in nature, as opposed to the contrived “setup-punchline-repeat” patterns of many stand-up comedians. As supported by an analysis of the following literature, Francis, Monahan, and Berger (1999) define humor intended to manage emotions as, “(1) A culturally-based sensitivity to context, including the status of the actors present as well as the setting and timing, (2) which strengthens or restores the feeling norms of the situation and creates amusement in the self and others,
(3) generating positive emotions among members of an interacting group by bonding them and/or reducing an external threat, (4) often at the expense of some excluded person(s), event(s), or objects(s), and (5) must be recognized by at least two participants in the interaction” (p. 171).

**Conceptual Frameworks**

**Humor Orientation**

Because simply comparing the inclinations of Alan Greenspan to Will Ferrell would not be considered quality scientific research, Booth-Butterfield and Booth-Butterfield (1991) advanced empirical evidence that funny individuals – namely, those who appreciate, recognize, and enact humor frequently, spontaneously, and successfully across a variety of situations – possess a communication trait known as humor orientation. This explains why some individuals are more adept at regularly eliciting laughter through actions, jokes, stories, riddles, and puns, and why some – like the droning economics teacher in *Ferris Bueller’s Day Off* (1986) (“Bueller?...Bueller?”) – often avoid initiating humor attempts and do not try to interact by making others laugh. Funny people were shown to utilize and welcome humor primarily as a means of eliciting positive responses from conversational partners, sustaining communication, and creating social relationships (Booth-Butterfield & Booth-Butterfield, 1991). However, much like the author of this thesis, many individuals who do not often display the most spontaneous humor production capabilities may still make for enthusiastic humor receivers.

Further research (Wanzer, Booth-Butterfield, & Booth-Butterfield, 1995) determined that people with higher self-reported humor scores tend to be more competent communicators overall. First and foremost, high humor oriented participants were
perceived to be funnier than those with low humor orientation both by participant-
observers and by independent coders who listened to audiotapes. Since participants in the
high and low groupings delivered the same content, their skilled behavioral enactments
clearly produced the humorous responses.

High humor orientation was also shown to be associated with greater
communication flexibility. This is considered the ability to recognize diverse
communication situations and the emotional states of receivers accurately and adapt
one’s behaviors accordingly. More specifically, individuals with a high predisposition to
humor are often able to manage a wider variety of interactions – like those perhaps
marked with frustration or awkwardness – and a greater number of receivers through the
effective use (and, sometimes, restraint) of humor. It also helps that those with high
humor scores tend to report a stronger need for creating positive impressions in their
receivers, and claim to laugh in a greater number of situations. These individuals are
more likely to be aware of their own emotions (like stress, happiness, and
embarrassment) and perhaps use humor as a response to or method of coping with these
feelings more regularly (Wanzer et al, 1995).

High humor oriented individuals also tend to be less lonely than those with low
humor orientation, suggesting that these individuals have a sufficient network of
relationships to satisfy them on an interpersonal level (Wanzer, Booth-Butterfield, &
Booth-Butterfield, 1996). Of course, being pleasant to be around and having many close
friends and family members can aid dramatically in the receipt of social support in times
of great need. Likewise, the higher an individual’s humor score, the more acquaintances
tend to rank him or her as humorous, and the more attractive that person becomes. Highly
verbally aggressive individuals who ranked high in humor scores also do not tend to feel lonely, but were perceived by acquaintances to be less socially attractive. This could be attributed to the fact that when people who are verbally aggressive do enact humor, it tends to be directed at others and not at themselves (Wanzer et al, 1996).

More specifically related to the topic of this thesis, multiple studies (Wanzer, Booth-Butterfield, & Booth-Butterfield, 2005; Booth-Butterfield, Wanzer, Weil, & Krezmien, 2010; Wanzer, Sparks, & Frymier, in press) have shown that those with high humor orientation tend to enact various patterns of inducing laughter in both themselves and others as a method of coping while under duress, and are less likely to perceive humor as inappropriate during negative health care events (Durbin & Booth-Butterfield, Under Consideration). Because the use of humorous coping communication over time often results in more frequent laughter and smiling – which in turn produces more consistently positive affective states – humor oriented individuals also tend to be more emotionally expressive and confident in their uses of humor (Wanzer et al., 2005) and demonstrate more effective coping efficacy during difficult situations, like the death of a loved one (Booth-Butterfield et al., 2010). This can lead to fewer psychological and physiological problems (Booth-Butterfield et al., 2010) and greater job and life satisfaction (Wanzer et al., 2005; Wanzer et al., in press).

Humor Relief Theory

Freud’s (1905; 1928) psychoanalytic humor relief theory states that laughter can be cathartic, and results when individuals are freed from social and psychological inhibitions. The act of making jokes and mocking social institutions can assist individuals in demonstrating their own power over forces of marginalization – both on a personal and
societal level. For example, the act of ridiculing a dominant system of healthcare focused more on biomedicine, diagnosis, and paternalism than on a patient’s individual perspective and value as a human being can help reverse the typical power dynamic and relieve hegemony. This can result in a greater sense of personal self-worth if jokes are told on an individual level – by patients among other patients or with family members – or, if parody occurs on a widespread societal level, the possible implementation of a more collaborative health care system in which patients and providers become co-agents in health.

Freud (1905; 1928) believed that humor might provide people with an outlet to approach topics with which they are having difficulty coping. As a result, concepts like death become safe to laugh about. This also explains “dirty” or “blue” jokes: people are often able to find humor in subjects that are otherwise taboo, perhaps because they’re not entirely sure how else to articulate their conceptualization of the issue. Freud (1905; 1928) also advanced the perception that even “innocent” jokes are an opportunity to overcome the adult inhibition against “play.” Joking frees individuals from the restrictions of logic and practicality.

**Transactional Theory of Emotion and Coping**

More evidence of a possible relationship between humor and coping can be found in Folkman and Lazarus’s (1988) transactional theory of emotion and coping. This holds that the ways people cope with a stressful event can make a significant difference in their subsequent and ongoing emotional states. When we are faced with difficult situations, our appraisal of the context and how best to handle the situation often results in the generation of various emotional responses which are labeled as either positive or
negative. The authors believe these emotions impact our coping processes, which in turn alter our relationships with other individuals and the surrounding environment in either positive or negative ways. The altered person-environment relationship and associated affective states are then reappraised, which leads to a change in our overall emotional quality and intensity. Taken this way, coping clearly serves as a mediating factor of the emotional response (Folkman & Lazarus, 1988).

Wanzer and her colleagues (2005) have supported this theory with evidence that humor oriented nurses’ appraisal of their job is often moderated by their use of humor as a coping method, which ultimately leads to greater job satisfaction. Similarly, aging adults who frequently use humor also cope better with stress. This has been shown to result in greater life satisfaction and more consistently positive emotional states (Wanzer et al, in press).

Arousal Relief Theory

But why do we often immediately feel better after a good laugh, particularly when we are stressed? The buildup of nervous energy generated, say, because of the discomfort associated with a gynecological exam may be released through the use of humor, Berlyne’s (1969) arousal relief theory states. Unless this emotional arousal is extreme, it can be viewed as pleasurable and laughter provoking, and may necessitate relief or venting if someone enters a situation with nervous energy ready to be released. The buildup of a well-told joke, for example, can be associated with the inducement of arousal beyond its optimal level of pleasure. This relief, and an associated pleasurable level of mirth, most likely occurs due to a resolution or reduction in arousal – achieved in this case through laughter brought on by a punch line (Berlyne, 1969).
However, duPre (1998) notes that empirical evidence has often struggled to find a relief component associated with humor, most likely because researchers often operationalize humorous themes or sources that are not associated with the main cause of a participant’s arousal. So, for instance, people believed to be sexually excited, nervous, or anxious would be shown *Looney Tunes* cartoons or Steve Martin stand-up routines as an attempt to experience significant relief through laughter. But, if a participant is not producing or receiving humor that is pertinent to the main source of arousal, the theory may not be directly applicable. Nevertheless, it is likely that situation-pertinent humor is repeatedly employed as a coping strategy by individuals in stressful conditions, because its use usually leads to “relief” and a positive affective reappraisal. Interestingly, DuPre (1998) states that expectation deviation can be appropriately substituted for “arousal” to align arousal relief theory with Surprise-Liberation Theory (discussed below).

**Relational Communication and Meta-Humorous Interaction Theory**

Bateson (1969) states that in an effort to reduce ambiguity inherent in the delivery and receipt of messages, people constantly offer clues about how their actions and utterances are to be interpreted. A raise of the eyebrow, gentle touch on the arm, or drop in vocal inflection can dramatically alter the way a typically straightforward utterance is interpreted. A favorite episode of *Seinfeld* sees George Costanza develop an unfortunate eye-winking habit after accidentally squirting grapefruit juice in his eye. As a result, the seemingly innocuous statement of “Have a nice massage” takes on adulterous undertones when the message is delivered to Costanza’s boss with his wife in the room, all thanks to an ill-timed wink. In this case, relational cues are misinterpreted by one of Costanza’s receivers.
Achieving mutual understanding often requires communication about one’s own communication, and how the message is relevant to the situation and relationship of the interactants. According to Bateson (1969), this collaborative process of metacommunicative cuing acts as a subtle guide to interpretation and contributes to the “frame” or context of an interaction. This makes the achievement of mutually-managed understanding possible. DuPre (1998) lists slightly raised eyebrows, exaggerated facial expressions, and idiosyncratic word choice as typical metacommunicative “humor cues,” or clues a message producer sends to a receiver to express that an utterance or action should be interpreted as “playful” rather than “serious.”

Bethea, Travis, and Pecchioni (2000) have worked to extend arousal relief theory by incorporating relational elements with the coping and relief functions of humor. Through the employment of meta-humorous interaction theory (MetaHIT) the authors determined that the use of humor while conveying sensitive and personal information to health care providers is often a signal that something of deeper meaning is at play. More specifically, if an individual’s humorous account of a stressful experience lacks a phrase that indicates closure and is laced with heavy sighs amidst chuckles, it may indicate that the topic being discussed is an area of unresolved conflict or concern. Just because an individual uses humor to convey a sensitive situation and does not specifically state that he or she is having difficulty does not mean that they are not simultaneously sending metacommunicative signals that express distress and a need of assistance.

**Surprise-Liberation Theory of Humor**

A large portion of this thesis will attempt to support the notion that recounting difficult and personal health situations through the use of humorous storytelling could
have positive ramifications for both the author and his or her audience. But first we must consider what makes something funny. How do serious illness sufferers find humor amidst such troubling situations? Why do those who listen to their stories laugh along with them, rather than solely feel sadness and pity? Does this use of humor make elements of a story more memorable and enhance mutual understanding of the illness experience between sufferers and non-sufferers?

Booth-Butterfield and Booth-Butterfield (1991, p. 205) define the communication of humor as, “Intentional verbal and nonverbal messages which elicit laughter, chuckling, and other forms of spontaneous behavior taken to mean pleasure, delight, and/or surprise in the targeted receiver.” But this seems to be an entirely oversimplified encapsulation of the principals of humor perception and its associated functions.

DuPre (1998) assumes a phenomenological perspective in describing her Surprise-Liberation Theory of Humor, reminding us that funniness is a phenomenon not sufficiently explained by the presence of outside influences or even by our own physical demonstrations – like laughter. Think of it this way: We often chuckle at things we don’t necessarily think are funny to be polite and allow a lame joke-telling interactant to save face. Some of us also come across times in which we strain every muscle in our body to keep from letting forth a gut-busting spew of giggles, because, say, we’re at a very small Catholic service and the priest just tripped on his robes and face-planted on the altar. Phenomenology also argues that taken-for-granted notions obscure the essential nature of phenomena – like the tacit perception that comedians and jokes are funny, and funerals are not. Although various social cues may enhance humor perception, funny is not adequately defined by the things that trigger it (DuPre, 1998).
So, instead of supporting the notion that particular entities which exist outside of our consciousness – a sitcom, for instance – cause the incarnate reaction of funniness, duPre (1998) argues that whether a thing is funny or not is determined by our awareness and perception of it, rather than the thing itself. More specifically, funniness is derived from the pleasurable realization that things are different than one had believed them to be.

Several elements impact this: First, funniness depends on one’s commitment or orientation to an expected outcome, and one’s willingness to see that “expectation” violated. We often “expect” doctors to be rigid and professional, firefighters to be strong and brave, grandmothers to be sweet and innocent, and war to be hell. Expectancies are most likely affected by our perceptions of self, others, and the situation. Our perspectives of course can change, thereby retrospectively reconstituting our awareness of an event. A memory can be funny when viewed from one angle and upsetting from another. An embarrassing situation could be considered much more hilarious when we look back on it than when it actually occurred. Regardless, we identify people and things by what we “expect” of them relative to ourselves. Therefore, defining others also results in us defining ourselves. We eventually become trapped in a spiraling web of our own biases.

Secondly, in order to consider something funny we must encounter a surprising deviation from our expectancies. DuPre (1998) describes a funny and unexpected incident in which she witnessed her high school teacher – whom she previously viewed as dignified, authoritative, and infallible – slip ungracefully on a wet leaf. Her “expectations” of her teacher as an omnipotent leader – and herself as a less-powerful follower – were violated, allowing her prejudices to become visible (if not completely
banished). This revelation, she notes, was “funny and liberating” (p. 52) from the confines of her own “expectations.”

DuPre (1998) states that the final stipulation in the pursuit of humor is the perception of the deviation as being a pleasurable liberation. When expectations are particularly threatening, such as in relatively tense or stressful medical situations, the unexpected is often a profound and exhilarating relief. We may be poised to have our “expectations” violated. The author notes that the common perception that hospital settings are not places of humor may, paradoxically, make incidents in those settings seem funnier. To find something funny is to experience a reprieve from serious consideration of it, and enable oneself to disengage somewhat from an orientation. This is why many who attend the calling hours or funerals of extreme loved ones report “laughing to keep from crying” (duPre, p. 53). Likewise, experiencing one’s restricting prejudices being disposed at the drop of a hat can also be a relief (“That scary shadow in my room was just the stupid cat all along!”).

A patient in an incredibly rigid, procedural, and highly emotional medical routine would likely consider a small surprise to be quite unexpected and comical, such as if a persistently professional and cold doctor unwittingly smeared black ink from his pen onto his face. The level to which we attribute a surprise to be profound affects how funny it is. Memories of an incredibly humorous event are much less likely to be eradicated than a “knock knock” joke because they directly relate to “expectations” of our natural attitude – to which we are moderately committed – and are not based on contrivances (duPre, 1998).
My grandma, who suffered from colorectal cancer, often joked that she wanted to write a *Seinfeld* episode about Elaine sitting in a waiting room before an intestinal x-ray, struggling not to laugh as the women she conversed with unwittingly sported chalky-white barium swallow moustaches. Clearly, this was inspired by personal experience. My grandma’s ability to find a humorous twist amidst the quiet tension of a waiting room could have provided a temporary respite from the uncertain status of her condition – and the test results to follow. DuPre (1998) agrees that humor is a persuasive signal that things “are not so bad” (p. 62). The author also observed several AIDS patients in their last days of life making more dramatic efforts than usual to be funny. Meanwhile, their caregivers seemed too committed to their own feelings of seriousness or too wary of offending the patient to initiate much humor themselves.

The amount of liberation we might feel is of course impacted by how committed we are to the assumptions being challenged. DuPre (1998) notes that people possess an upper and lower threshold beyond which a surprise is unfunny. When a deeply held and cherished assumption is challenged – such as witnessing an off-color comment about abortion – or when you’re the one who falls awkwardly in front of a crowd, it might not seem so funny. People who are weakly committed to a prejudice would likely not care if it is being challenged. Depending on one’s perceived stake in the expected outcome, sudden anomaly can be liberating, threatening, trivial, or funny. But when one’s fears and anxiety are within a certain threshold, relief may be particularly exhilarating. DuPre (1998) considers our society’s frequent joking about AIDS, sex, and race to be a reflection on what we consider to be most distressing. Humor provides liberation from
our commitment to these topics as serious, threatening issues. Viewing things as ridiculous allows us to not consider them as menacing, at least for a few minutes.

**Productive and Receptive Humor’s Impact on Coping Effectiveness, Social Support, and Overall Wellness**

When one mentions the roles and functions of humor in health care settings, many of our minds may float to the sappy mirth and merriment of the film *Patch Adams* (1998), in which eternal jester-slash-medical student Robin Williams addresses his patients’ emotional needs and life satisfaction through the use of humor. The real “Patch” Adams’ red clown noses and bedpan shoes were an affront to the callous, arms-length medical and scientific community during the 1970s, yet revolutionary and appreciated enough as an alternative form of medicine to, well, warrant a dutiful biopic from Universal Pictures.

Just as the general public may often associate their perception of humor in medicine with the exposure of illness sufferers to humorous stimuli (e.g., movies, jokes, rubber chickens, etc.), it seems that many health communication scholars have historically tended to focus mostly on the behavioral, cognitive, and affective ramifications of being the *recipient* of humorous messages. Meanwhile, the impact of *producing* humor on emotion-focused coping effectiveness and social support in everyday interaction has not received much research attention (Lehman, Burke, Martin, Sultan, & Czech, 2001; Wanzer et al., in press). Although a great deal of anecdotal evidence abounds, empirical support is comparatively small and sometimes equivocal.

For example, Lehman, et al (2001) asked test subjects to write humorous narratives in relation to a spontaneously stressful event – the viewing of nature films which depicted predatory animals hunting prey. Subjects who were deemed more
successful at producing humorous narratives showed significantly greater stress moderation after writing as compared to before. However, these changes were not significantly different from those who wrote non-humorous intellectual narratives or no narratives at all. The significant difference found between high and low humorous narrative producers could have been accounted for in terms of an author’s success or non-success at completing the experimental task. However, the researchers found that individuals can effectively be primed to produce successful humor during stressful situations (Lehman, et al, 2001).

Particularly in the case of severe illness, medical interactions between patients and health care providers can be racked with tension and distress. Not only do threats of negative consequences, discomfort, debilitation, and possibly death frequently abound in such meetings, but patients must also endure the awkwardness and embarrassment of nudity, physical examinations, and the discussion of intimate details and personal shortcomings. Most likely due to its propensity for generating serious discussions, Francis and colleagues (1999) sought to investigate the role of humor in medical interactions through personal interviews with 22 health care providers. They found that the presence of humor in these encounters functions as forms of interpersonal emotional management and social support, and that its use varies depending on the status of the actors in the situation and the timing and place of the interaction.

When patients interact with providers, for instance, humor can function as an expression of anger or frustration with the providers, treatment, or illness. A nurse from the Neonatal Intensive Care Unit (NICU) described how a mother of a baby who had been kept in NICU for nearly five months dressed her child in camouflage, tied a piece of
black ribbon around his head, and stated “He’s a little Rambo baby and he’s going to break out of here and escape!” (p. 164). Although everyone involved had a good laugh at the notion of an infant plotting his liberation from his sterile prison, the mother’s anger and frustration is unmistakable. Her method of expressing her growing desperation was perhaps more face-saving and persuasive than sparking anger or conflict in return.

More frequently, patients use humor with providers as an attempt to deny or distance the threat of diagnosis or impending treatment. Denial can function as a form of supportive defense, preventing the inherent anxiety from becoming overwhelming and allowing the patient to adjust to an uncomfortable reality. Laughing keeps people from having to think about what’s going on. Distancing oneself from the stressor can help patients put the situation in perspective, allowing them to make rational decisions about options and making the possible damage to self deniable. One patient who had horrible luck with her illness employed a running joke that she always prepared for the worst possible outcome, even saying while scheduling for surgery, “I know the chance of dying is really small, but with my luck, I’ll be the one person who dies from ‘routine’ anesthesia” (p. 164). Providers often consider it a positive sign when patients are able to use humor in this way. However, some patients may rely too heavily on jokes to avoid painful topics that need to be discussed (Francis et al, 1999).

DuPre (1998) also notes that laughter is one of the most common responses to humiliating accidents, and is helpful in reducing embarrassment in medical situations. Using jokes to manage face-threatening situations is commonly achieved by a patient downplaying the somberness of losing one’s dignity, and reframing the incident as affiliative and unserious instead. Many patients have also been shown to introduce verbal
play, or joking around, into medical exchanges by responding to habitual questions in unanticipated ways (duPre, 1998). Verbal play provides a means of exerting energy, experimenting, and encouraging/displaying greater intimacy through the reduction of patients’ alienation in medical settings. Laughter is also a form of positive stress – or eustress – and may possibly enhance the body’s immune, cardiac, and respiratory systems, as well as alleviate pain and improve mental and physical health. This may be because productive humor has, again, been shown to serve as a buffer for anxiety, anger, fear, and embarrassment (duPre, 1998).

Coles (1989), a physician-researcher, reinforces this notion: “I am still constantly surprised at the ability of my [elderly patients] to laugh at their problems, to separate themselves, as it were...that’s the beauty of humor. It allows us to express our deepest concerns, our passions and our doubts while asserting control over those feelings – no matter what our age” (p. 85). Richman (1995), a psychotherapist, reported that the anxiety of many of his suicidal patients was quickly relieved by laughing at stressful subjects. He credits humor with enabling certain patients to refrain from causing self-inflicted harm. Elderly patients were also more likely to build enjoyable bonds between themselves and others through the use of humorous storytelling (Richman, 1995).

While both the humorous expression of anger and frustration and the utilization of distance and denial by patients can be seen as forms of creating space from something potentially threatening – either an illness or a provider – providers’ use of humor with patients is typically an attempt to build rapport, to calm and reassure by validating and normalizing feelings, or to reduce embarrassment. Humor can also be a method of chastising patients for noncompliance with treatment regimens without alienating them.
(Francis et al, 1999). DuPre (1998) agrees that people in a variety of cultures joke with one another to foster relationships, vent emotions, and exert social control. She suggests that humor can help reduce social distance by allowing caregivers to dispel the stiff formality and traditional paternalism of medical institutions and provide grounds for a more codependent relationship.

The use of humor in long-term patient-provider relationships has also been shown to increase affinity and social intimacy among both parties (DuPre, 1998). Humor makes statements more memorable and attention-grabbing, an important notion considering DuPre’s (1998) point that most caregivers spend a good percentage of their time teaching patients. One physician cautioned a patient, “Don’t lift anything heavier than a peanut butter and jelly sandwich. And then it depends on how much peanut butter is on it!” (p. 27).

If the statuses of the interactants are similar – as in the case of breast cancer sufferers within a support group – humor likely functions to emphasize the similarity of status, share and normalize experiences and feelings, and reinforce a sense of group cohesion, often at the exclusion of out-group members (Francis, et al, 1999). A chemotherapy patient who wore a wig with an attached hat once expressed her membership in the club of cancer patients by saying to a non-ill hat admirer, “Well, I’d let you try it on, but the problem is that my hair comes with it” (p. 168). As the butt of the joke, the hat admirer is clearly excluded from a common bond that only cancer patients share.

Johnson (2002) argues that many women coping with a breast cancer diagnosis feel a strong need to laugh at themselves and life so that they may relax, take their lowest
moments less seriously, and maintain their will to survive. The sharing of one’s stories and humorous experiences with those who have had the same issues also allows sufferers to be themselves, feel more comfortable, and see the absurdity in what they are going through. Additionally, humor in this context is often found to be evolutionary. Many women initially find difficulty employing laughter when their diagnosis is still relatively fresh, but over time they are more likely to find humor in situations where they wouldn’t have before. The use of humor also may help sufferers understand themselves better and develop a greater concern regarding the wellbeing of others. By helping family and friends cope with the diagnosis, or assisting fellow support group members who are suffering from their own illness, these women often find greater meaning and purpose in their lives. Additionally, when their nurses use humor, breast cancer sufferers report the development of deeper relationships built on trust and sensitivity, and feel their situation is “more bearable” (p. 693).

Wanzer et al. (in press) studied the ways in which age, humor production, and coping could impact overall life-satisfaction among older adults. High humor oriented individuals were shown to be more likely to use humor as a means of coping with difficult situations and demonstrate higher levels of coping efficacy, which led to increased reports of overall life satisfaction. The authors also discovered variations in humor use, type, and appreciation among adults of different generations. Participants under 50 years of age scored significantly higher in humor orientation than both the “younger-old” (ages 50-74) and the “older-old” (75 and older) participants. Adults over 50 ranked notably lower in humor orientation than college-age participants in past research, whose scores were relatively similar to those in the younger than 50 group. The
researchers surmise that as individuals age, their use of humorous behaviors (jokes, stories, anecdotes, contrived or planned humor) could differ dramatically from younger generations due to subtle barriers that are physical (declines in memory, hearing, and/or sight) and psychological (losses of confidence in humor, depression, or anxiety) in nature (Wanzer et al., in press).

Another study delves into the role receptive and productive humor plays in managing grief during the bereavement process (Booth-Butterfield et al., 2010). Humor oriented individuals were again shown to be effective at coping during extraordinarily difficult situations – in this case, the death of a loved one – which led to a lower incidence of physiological and psychological symptoms like eating and digestive problems, lack of concentration, and narcolepsy. In comparison to women, men were shown to possess higher levels of humor orientation, coping efficacy, and use of communication to cope specifically with bereavement, and fewer negative psychological and psychological effects post death. Interestingly, individuals who believed that the employment of humor during bereavement situations was intrapersonally or interpersonally inappropriate – namely, that it would result in disappointment, guilt about one’s own response pattern, and a lack of social support from others – often experienced greater coping difficulty and an increase in grief symptoms. Humor, instead, should be viewed as a healthy and innate coping tool, rather than as a disrespectful gesture toward the deceased. The natural generation and receipt of humor in difficult circumstances contributes to better overall functioning and resilience (Booth-Butterfield et al., 2010).

Humor may also provide a more comfortable means of conveying socially taboo, sensitive, awkward, and embarrassing topics to others, and can help provide a face-saving
rationale for why individuals thought, felt, or acted in a particular way. Bethea and colleagues (2000) interviewed individuals who provided long-term care to frail elderly family members to determine if their use of humor when relaying information about personal caregiving situations (mainly in the form of narrative responses) would result in relief – as Berlyne’s (1969) theory of humor relief suggests – or whether their laughter instead masked a difficult story that delivered no positive effects.

The authors labeled this function of nonrelief as coping, noticed in responses that were more open-ended and ineffective in providing both the listener and respondent with a sense of satisfaction. For example, a coping anecdote might end with a caregiver alluding to their “just having to deal with” (p. 366) an aspect of the situation – despite the fact that the interviewee might have smiled or chuckled their way through their difficult or severe story. Humorous relief accounts, in contrast, would conclude with a phrase that indicated closure and a sense of pleasure from recalling difficult events in a positive manner (Bethea et al., 2000).

Eighty-six percent of respondents used humor (smiles, jokes, and punch lines) at some point during the interview to help them deal with the anxiety and discomfort of providing care for a loved one. Their responses consisted of cognitive (e.g., conveying a decline in care recipients’ mental or physical functioning), affective (e.g., relaying embarrassing social situations caused by the recipient), and behavioral (e.g. describing difficulties in administering medication or caregivers’ attempts to relieve their own daily stress) response patterns. The cognitive relief category was divided into positive relief and painful relief categories, differentiated by the presence of residual pain or discomfort with humor relief closure. The authors argue that humorous metacommunication cues
should not be overlooked in determining whether a storyteller’s humor-laced account signals an area of relief or unresolved conflict and concern, without respondents explicitly mentioning so (Bethea et al., 2000).

However, the use of humor during negative health care situations may result in adverse effects among those on the receiving end. Durbin and Booth-Butterfield (under consideration) determined that health professionals use humor for the benefit of others (i.e. to comfort patients and their loved ones) over 66% of the time, twice as often as they do for themselves (i.e. to avoid a malpractice lawsuit) when medical procedures go wrong. But low humor oriented individuals are much more likely to report these forms of humor as more inappropriate than those high in humor orientation. The authors believe this perception is intensified when a patient experiences a negative health care event, despite one’s level of humor orientation. The reception of improper humor (among 42% of respondents) led to higher levels of anxiety, which can also result in more problems for the patient. Patients high in humor orientation were shown to perceive their health care practitioner as being more qualified. However, because these patients expect their provider to be professional and act in a serious manner during a negative health care event, they tend to be less satisfied when he or she utilizes either appropriate or inappropriate humor under unsettling conditions (Durbin & Booth-Butterfield, under consideration).

Employees of health care organizations have also received a good deal of research attention in an attempt to analyze the forms and functions of humor among individuals consistently exposed to distressing environments. Kosenko and Rintamaki (in press) interviewed HIV care providers from five AIDS Service Organizations (ASOs) to
examine the use of humorous coping strategies among professional colleagues to combat chronic work-related stress and burnout. Participants felt humor is inherent to the culture of HIV care, and openly utilized multiple forms or genres of comedy without much regard for conventional workplace boundaries. Given that sexual behavior is frequently linked to HIV, a great deal of humor revolved around sexual behavior, like joking openly about large dildos and chastity-belts. Likewise, many clients and HIV caregivers are gay, and ASOs serve as a “safe place” for gay individuals to express themselves, so gay humor was also frequently employed.

Other forms of humor include gallows jokes (also described as “black,” “gross,” “sick,” and “twisted,” p. 9) about serious issues like illness, side-effects from medication, bodily fluids, bodily functions, or death. One provider said, “When you’re sitting there talking to a client about a problem, you can’t go ‘ewww’…I think making jokes and laughing about it just releases that stress and, with some of this stuff, you just have to talk about it or it gets bottled up inside. The only way to let it out is to be humorous about it” (p. 10). ASO providers also employed empathetic humor to show understanding and camaraderie for colleagues regarding sources of shared stress and challenges inherent to HIV care (like overly needy clients), and teasing colleagues through sarcasm.

The authors determined that humor serves both adaptive and maladaptive functions among professional HIV care providers. It has been shown to boost morale and facilitate solidarity among colleagues, and provide a release valve for stress. This is especially helpful when providers are overwhelmed by caseload volume, faced with difficult tasks (like talking with patients about sexual health and behavior), forced to be firm with clients without creating a rift in their relationship, dealing with demanding and
self-insufficient clients, and maintaining a professional distance from a client’s suffering or death by balancing dispassion with emotional involvement. Maladaptive functions, however, include emotional masking as a defense mechanism, indirectly addressing conflict that required more direct discussion, and exacerbating conflict by impairing productivity and providing less than optimal care for clients. Individuals also have the potential to become offended (especially if clients overhear some of the more colorful conversations), and workplace solidarity may become undermined by the formation of cliques among those who appreciate humor more than others (Kosenko & Rintamaki, in press).

Wanzer et al. (2005) determined that nurses tend to use humor most often during situations involving day-to-day patient care responsibilities, under stressful or overwhelming conditions, and regarding work relationships. Most of their humor (almost 75%) takes the form of witty word-play or clever language (like saying “code brown” for patient cleanups, or recounting embarrassing stories about themselves to demonstrate empathy to patients); general expressions of friendliness, enthusiasm, happiness, and optimism to make light of situations and to establish warm banter; and low humor through acting stupid, silly, or absurd (like pretending to drop a patient being carted to another room or asking a purposely dim question). The authors note that, like HIV care providers, humor is utilized as a method for nurses to cope with difficult situations and remain effective in their jobs. Also, the use of humor in situations that involves routine patient care – like helping stroke victims learn to feed themselves again – may help the patient avoid embarrassment or discomfort.
Higher humor oriented nurses are also more confident and accomplished about their use of humor, are more emotionally expressive of their emotions in general, and demonstrate higher job satisfaction. Emotionally expressive individuals with high humor orientation tend to be successful in recognizing and modifying emotions like tension and negative affect into laughter. The authors argue that individuals who believe their humorous enactments have made those around them feel better experience higher coping efficacy and job satisfaction, because they feel more productive and tend to focus themselves on others rather than on their own internal distress. However, researchers have been unable to demonstrate a link between emotional expressivity and coping efficacy (Wanzer et al., 2005).

**Forms and Functions of Humor in Various Medical Settings**

Perhaps the most comprehensive study of the use of humor among patients and medical providers comes from duPre (1998), who analyzed seven health care settings through ethnographic, speech act, ethnomethodologic, and conversational analytic methodologies. She determined that humor use is actually a sophisticated way of organizing and influencing social transactions. Her examination of an outpatient physical therapy department, a breast care center, and a family practice doctor’s office demonstrates that “joking around,” despite sometimes differing in tone and topic, seems to serve the same functions in a variety of settings. This includes providing a socially acceptable way to mitigate embarrassment, soften or sidestep complaints, display identification, solicit feedback, and good-naturedly insist on compliance with unpopular treatment regimens. It seems likely that humor use in patient-provider interactions is
affected by the length and nature of treatment, status differences, goals, and privacy (duPre, 1998).

**Outpatient Physical Therapy Unit**

DuPre (1998) classifies the use of humor in the physical therapy unit as bold, public, and candid. Certainly, the fact that the department is a relatively open space in which multiple patients and therapists often interact with one another impacts the tone of this humor somewhat. However, the nature of physical therapy typically requires that patients and providers work closely under trying circumstances – for instance, to recover from a serious and painful injury – over a lengthy period of time. The author argues that this often forces physical therapy patients and caregivers to get to know each other better than other interactants in most medical routines, and allows each party to shed their initially stiff decorum more quickly. Because of the need for rigorous and uncomfortable treatment, humor seems to function as a means of alleviating the tension between helping one recover from an ailment, and causing them to feel pain in the process. It also allows both parties to negotiate their uncertain relationship without losing face – a favorable or desired image of self (duPre, 1998).

For instance, if a patient exclaims during a particularly rough procedure, “Ouch, that hurts too badly! I want to quit!” his or her “brave and cooperative face” as a committed patient may be threatened, along with the therapist’s “caring and helpful” face (p. 76). However, if a patient says to a therapist in a humorous manner, “You might be the devil!” the event can be interpreted as joking around – or what duPre (1998) calls a “laughter-coated complaint” (p. 167) – and thus the impropriety of griping is softened. Conversational analysis reveals that the flagging of complaints as laughable is often
achieved through the use of idiosyncratic wording, delayed placement, and suggestive feedback (duPre, 1998). Meanwhile, the therapist may register and react to the patient’s playful expression of pain (either by assuaging the grievance or explaining why he or she will not change the circumstances) without becoming defensive or tipping the precarious balance between helping and hurting. Humorous complaints help both parties remain committed to an amicable partnership as co-agents in the healing process – one that isn’t marred by griping or being accused.

As a result, most of the humor in this environment typically involves exaggerated topics such as “torture,” “slave-driving,” “pain,” and the juxtaposed perception of therapy as being “luxurious” (p. 81-82). Sometimes these patients and therapists even undergo elaborate rituals of playfully pretending to be angry or indifferent with one another. Humor is seemingly everywhere in this context, and its functions are clearly multifaceted. Patients may use it to soften complaints, and providers to discourage them. It also serves in motivating patients through lavish praise and encouragement, as a method for patients to boast about completing their exercises or feeling better without appearing cocky, and providing an opportunity to make amends for a perceived mistreatment or oversight (duPre, 1998).

DuPre (1998) observed that interactants in inpatient and outpatient physical therapy units, as well as hospital surgical, pediatric, orthopedic, and general medicine departments typically utilize a “code of compassion” (p. 132) to regulate their use of humor through tacit agreements about its appropriateness. This unspoken set of moral orders suggests that patients and caregivers in these contexts may consider it compassionate to humorously dispute (or “rile up”) one’s behavior if it will result in that
person becoming more cooperative or attentive. Again, because this code is often featured in long-term symbiotic medical relationships, its use is primarily bold, persuasive, and collectivistic. The code of compassion functions in encouraging patients to cooperate by enabling them to see that short-term discomforts can turn into long-term benefits, and allowing both parties to display a sense of intimacy and familiarity that is not steeped in medical decorum. Patients may also initiate joking around sequences to campaign for more individualized attention, and caregivers might seek to lift a patients’ spirits when they sense that they are nervous or uncomfortable (duPre, 1998). The code of compassion, then, is typically employed for the purposes of increasing affiliation between two parties and reducing social distance. It generates and reinforces the notion that “we’re in this together.”

**Breast Care Center**

In contrast, duPre (1998) describes the breast care center as “luxuriously intimate” (p. 89) and its patient-caregiver transactions as private, dyadic, and brief. It’s important to note that these are not long-standing, familiar relationships like in the physical therapy unit, but more like single-exposure encounters that may or may not be repeated in the future. When patients return, they could very easily have a different technician guiding them through a procedure, for instance. Likewise, humor is utilized much more quietly and subtly than in the physical therapy ward. Caregivers tend to joke about innocuous things like room temperature and procedures, and generally wait to see how a patient will react when deciding whether to laugh or to proceed seriously.

Because its visitors are typically affluent, asymptomatic females (average age of 50) simply fulfilling their annual mammogram appointment, the breast center’s patients
assume the role of voluntary client. The caregivers strive to pamper and respect their patrons as best they can to ensure that their experience isn’t any more awkward or embarrassing than it has to be. The staff’s insistence on decorum and dignity is considered important both as a means of generating repeat and word-of-mouth business and encouraging healthy breast monitoring practices (duPre, 1998).

The patients’ use of humor, meanwhile, is much bolder than their caregivers’. As women stand nude from the waist up, they frequently make humorous remarks about the size of their breasts and the “squeezing” aspects of the examination. These statements emulate the “torture” humor of the physical therapy department, and are a means of alleviating the physical discomfort and awkwardness of the exam. Patients also utilize discreet humor to solicit feedback about the legitimacy of their fears or discomfort by expressing their apprehension while laughing and speaking in exaggerating tones. One patient demonstrated the seemingly facetious concern that her breast implants might burst from the pressure of the compression device, while another jokingly stated that she was scared the machine’s automatic compression might go haywire. The exaggerated delivery of these statements allows patients to seek and receive information without losing face by seeming overly weak or disagreeable. Caregivers can choose to respond in a serious, assuring manner (as in the case of the first example) or through more playful means (like simply laughing it off, as seen in the second example) to suggest their perception of the threat’s severity and how they plan to react. Again, like the physical therapy department, the use of humor helps to regulate the dialectic between helping and hurting (duPre, 1998).
Humor is also used by patients to bide for a lighter, more affiliative tone from their providers. For instance, women who did not seem self-conscious made jokes about their breasts seemingly out of concern for putting their caregiver at ease. Patients also use humor to “forgive” the technician for seeming hesitant or apologetic. The author notes that conversations tend to become more relaxed, conversational, and humorous after patients interject humor into the proceedings. Joking around seems to function as an effective icebreaker in this context, and helps to establish a more intimate and comfortable exchange. In this context, relationship-building is more likely to be initiated by the patient. As it appears, humor does not seem to greatly interrupt the flow of events, but often changes, or reframes, the tone of what follows it (duPre, 1998).

For example, duPre (1998) describes how a previously preoccupied and impersonal technician became more attentive and humorous after an elderly patient elicited laughter by presenting her bare breasts in an exaggerated, unself-conscious manner. Her single use of humor served as a persuasive suggestion to treat the possibly somber and threatening situation as a playful, flippant one. Interestingly, the patient portrayed a detached “commentator” role in describing her breasts as “they’s” (p. 160). DuPre (1998) believes that humorous self-commentary allows an individual to portray a persona not directly reflective of what she calls the “naked I” (p. 161). The patient may actually maintain a hidden level of self-consciousness about her breasts, but the use of animation and exaggeration seems to help distance and diminish a person’s vulnerability to humiliating episodes. According to Goffman (1974), “Instead of stating a view outright, the individual tends to attribute it to a character who happens to be himself, but
one he has been careful to withdraw from in one regard or another” (p. 551). Through these measures, both parties may collaboratively organize and interpret the experience.

Ambiguous humor is also effective in allowing caregivers to acknowledge a patient’s grievance while treating it as if it were a less-than-serious topic. Caregivers can either anticipate or respond to a patient’s complaints in a way that reframes the whole conversation in a more positive manner – namely, by discouraging patients from voicing (or continuing to voice) negative reactions. For instance, caregivers responded to various patients’ gripes (“It’s hot in here!”) by utilizing humorous statements that reframed their complaints into accomplishments (“Worked up a sweat on that one, huh?”) (p. 98). The patient is essentially told that she feels discomfort because she’s doing so well. Meanwhile, the technician’s insistence that the procedure be carried out is softened (duPre, 1998).

**Family Practice Doctor’s Office**

Communication in the family practice doctor’s office is similar to that of the breast care center in its dyadic, quiet, and brief nature. However, laughter and humor are less visible, and are often employed during instances which don’t seem particularly funny. Patients, for example, sometimes chuckle their way through their concerns, hardships, or descriptions of symptoms. This “brave laughter” (p. 104) is a way for patients to demonstrate their adversity without feeling like they’re complaining. The physician does not typically treat these instances as funny, but instead expresses empathy and concern in a serious manner to help the patient feel okay about complaining – even going so far as to suggest patients are putting on a brave face by minimizing their expression of discomfort.
DuPre (1998) also notes that these patient-provider interactions are not marked as distinctly with a helping-hurting dynamic, because the physician typically asks her nurses to administer injections and perpetrate most other discomforts. Because her patients’ gripes and “brave laughter” do not directly implicate her, and consequently threaten her face as a compassionate caregiver, the physician takes the role of a sincere and sympathetic listener who understands their troubles (by saying “No fun!”) and has experience in suffering through similar predicaments, like childbirth (“Me too!”) (p. 107). Humor seems to express commonality between the physician and her parents. However, duPre (1998) says that this insistence on minimizing status difference through reciprocal self-disclosure is rather atypical in this context.

Overall, shared laughter (when it does occur) and humor is utilized to express mutual identification in this setting, and is often used to comment on matters unrelated to the medical exam – like mutual friends and changing diapers. However, when an intimate procedure such as a gynecological exam is performed, humor does focus on the awkward and uncomfortable aspects of the procedure. The provider, again, responds in ways that display empathy, and support the notion that sometimes the situation is funny or absurd rather than solemn and hostile. Like in the breast center and physical therapy unit, humor serves to mitigate embarrassment and discomfort by functioning as a safety valve for nervous energy (duPre, 1998).

In the breast center and physician’s office, a “code of dignity” (p. 122) guides communication to ensure that individual well-being is given preference over conformity to collectivistic goals. More specifically, providers in the analyzed settings attempt to display that the patients’ individual expectations are just as important as adherence to
strict medical routines. This involves creating a less threatening environment by
communicating a feeling of camaraderie or empathy with patients, and consciously
avoiding technical jargon and clinical terms so that patients feel like active participants in
the medical process.

More importantly, clinicians in these settings often strive to avoid becoming an
adversary by attempting to uphold the notion that being healthy outweighs the
discomforts associated with being forced to undergo an uncomfortable examination. The
notion that practitioners are hurting patients – but helping more – is maintained by
reframing complaints as compliments, and being encouraging, empathetic, and
congratulatory. This allows the caregiver to acknowledge the patient’s situation while
simultaneously showing that the violation is really “not that bad.” Patients are displayed
as being brave and dignified for undergoing an uncomfortable procedure or bearing life’s

Additionally, providers in these settings are shown to cater as much as possible to
patients’ wishes. This involves not offending with unfortunately-placed humor attempts,
and encouraging participatory decision making. By showing respect for patients’ feelings
and preferences, providers are able to adhere to a code that preserves individuality.
Patients also attempt to make light of face-threatening situations to maintain their dignity,
and because it seems to be more comfortable for them than stoically enduring their
discomfort. Transactions tend to be more humanized and less robotic if patients are able
to inject humor into the proceedings. Finally, practitioners adept at humor find ways to
congratulate patients for taking care of themselves and performing admirably during the
exam (duPre, 1998).
Clearly the use and reception of humor can hold major sway upon the form and function of an interaction. But what role does humor serve when it is intended to speak to the masses? Namely, how does humor shape the general public’s discernment of health issues when it is disseminated through mass communication?

**Mediated Humor’s Role in Perceptions of Health Issues among the General Public**

Although communication scholars have previously examined mediated health messages, Compton (2006) was the first to approach late-night comedy programming – and perhaps comedy intended purely for entertainment – from a health communication perspective. His textual analysis revealed prominent themes in how late-night comics approached the well publicized cardiac care of Vice President Dick Cheney in monologues between 2000 and 2004. Not only have the media been shown to shape attitudes among audiences, including perceptions regarding health issues, but approaching serious topics with humor may make the messages more impactful.

The medical community and the Bush administration portrayed Cheney as a poster child for cardiac care that could inform, inspire, and educate the public. However, late-night comedians often suggested that the vice president was frail, weak, destined to frequent hospitalizations, and near death. As a result, this ridicule also mocked heart patients and cardiac care in general.

Seven main themes or topics were identified in late-night jokes about Cheney: ability, pacemaker, diet, activity, frailty, frequency of attacks, and hospitalization. After Cheney’s fourth heart attack in November 2000, doctors claimed he would “leave the hospital in better health than when he arrived.” Yet, Jay Leno said that Cheney wanted “four more years, which is pretty good. Unfortunately, his doctors are only giving him
two more years.” In July 2001, Cheney received a state-of-the-art “pacemaker plus” capable of altering his heart rate and preventing ventricular fibrillation. Doctors hoped media coverage would help “demystify” the device. But Leno and David Letterman often compared it to common machines like icemakers and TiVo, which simplified its sophistication and countered doctors’ attempts to publicize the advanced technology of cardiac care.

Although Cheney purportedly made immediate changes to his behavior in response to his diagnosed heart problems, he quickly became a poster boy for unhealthy eating habits. This caused Cheney to assume the stigma of unabashedly contributing to his own cardiac problems, thereby hindering his perception as a model heart patient. Conan O’Brien joked about Homeland Security’s color-coded advisory system stating, “The highest warning is red, which means that Dick Cheney is about to eat a mozzarella stick.” Cheney planned no reduction in his workload, yet many jokes differed in the perspective they would take. When making fun of former President Clinton’s extramarital affairs, Cheney was portrayed as being too weak to have sex or partake in any strenuous activity. Yet, when compared to President Bush’s frequent breaks and vacations, Cheney was viewed as much more active, with mentions of his hunting trips and hardnosed political work. This view was more consistent with statements offered by Cheney, his doctors, and the administration.

Despite claims of his vitality, late-night comics painted a picture of a man marred by frailty and weakness. They also greatly exaggerated the frequency of his heart attacks (four, as of spring 2004), with Leno offering, “The man’s had 18 heart attacks in three weeks!” and O’Brien reporting that, “Dick Cheney is fine after having his tenth heart
attack.” The hospital was portrayed as a second home for the vice president by late-night programs, contrasting the idea that he was living a relatively normal life as a recovering heart patient. O’Brien said, “Dick Cheney was given a clean bill of health after a checkup. Doctors say that if he keeps to his diet he’ll be in good shape for his checkup in two days.”

Although late night comedians advanced relatively negative portrayals of individuals with heart disease, Compton (2006) suggests that humorous mediated treatments of cardiac problems and procedures could be advantageous. He mentions that the use of humor has many benefits among audiences, such as enhancing recall, attention, and persuasiveness, which can be used to advance knowledge of health issues. This may be particularly promising when disseminating messages that are crafted to elicit a change in behavior (like a humorous public service campaign from the American Cancer Society about screening for colorectal cancer). But for humor utilized for little more than entertainment to be effective in promoting responsible health attitudes and behaviors, additional information would need to be included (see the structure of NPR’s segment of *All Things Considered* as discussed in Chapter 3).

Although late-night comics ridiculed Cheney’s “pacemaker plus” and did not provide an accurate description of the device, Compton (2006) surmises that public awareness was likely still increased regarding cardiac care. Additionally, word-of-mouth behavior may spread this awareness beyond those who actually heard the jokes. The author suggests that news media report portions of monologue material and connect them with legitimate news stories as a way to inspire a more insightful deliberation on health.
This would allow ridicule to work in conjunction with effective health communication to both gain the attention of viewers and provide accurate, useful information.

While Compton (2006) is somewhat of a pioneer in his line of humorous mediated health communication research, a considerable amount of analysis has been conducted on the effectiveness of humor in anti-alcohol abuse campaigns targeting college-aged audiences. Despite the fact that humorous and nonfictional illness narratives are not typically employed as an element of health-based campaigns (nor will the author of this thesis specifically attempt to make a case for their inclusion), authors of narratives often call their audience to action regarding matters of health – whether it be Birbiglia’s insistence that “denial can kill” (see Chapter 3), or Pryor’s warning regarding the sneaky ease of developing a cocaine addiction (see Chapter 4).

Literature on the use of humor in intentionally persuasive health messages can provide scholars with a general understanding of the direct impact comedic appeals may have on individuals’ perceptions and behavior regarding various health issues. Adamle and Missik (2007) found that community directors in Hispanic neighborhoods often produce audionovelas, which utilize a sound-only variation of the popular Hispanic telenovela soap opera format, for the dissemination of entertaining health education messages among Hispanic communities. These typically incorporate culturally-based humor into the proceedings, like reflecting the Hispanic tendency to make jokes about negative events as a method of resiliency, to enhance the audience’s likelihood of learning (Adamle & Missik, 2007).

Lee and Chen (2004) believe humorous appeals tend to create positive mood and lower audiences’ defensive reactions toward a message that may advocate a change in
lifestyle. Skalski, Tamborini, Glazer, and Smith (2009) found that humor in persuasive media messages can heighten perceived credibility of the message and promote feelings of involvement and immersion in the media environment.

Anyone who has ever watched a televised sporting event has certainly witnessed at least a few legitimately funny beer advertisements that urge consumers to “Please Drink Responsibly!” Lee and Chen (2004), however, believe these messages are quite ineffective in preventing heavy alcohol consumption, and serve merely as the gestures of “concerned” citizens that do not serve much purpose beyond promoting a brand. “Please Drink Responsibly!” is an example of a positive slogan in humorous counter-alcohol abuse advertisements. When compared to negative slogans (like “Don’t be Stupid!” or “Don’t do this to Your Body!”), positive slogans have considerably less impact on moderate and heavy drinkers’ interest in the ads.

Moderate drinkers exposed to negative slogans reported higher perceived risk of excessive drinking in the ads (i.e. were more likely to respond to the statement, “The ads scared me about the dangers of drinking,” p. 14), greater perception of the dangers of excessive drinking (“I consider myself to be at risk of getting alcohol-related injuries,” p. 14), and more concern over upsetting significant others. The ads also increased moderate drinkers’ intention to drink less. However, heavy drinkers responded more favorably to positive slogans as they related to perceived risk of excessive drinking in the ads and risk perception of excessive drinking. Negative slogans actually reduced heavy drinkers’ concern about upsetting their significant others, while neither slogan type changed their intention to stop drinking (Lee & Chen, 2004). Those formulating health narratives intent
on impacting audience behavior may want to pay considerable attention to their use of positive and negative calls to action to maximize the effectiveness of their message.

Lee and Shin (2006) compared the employment of fear and humor appeals among individuals with high and low risk-taking tendencies. They determined that fear messages generated more interest and perceived danger of excessive drinking regardless of risk-taking tendency. But humor appeals were better liked by rebellious risk-takers. Skin conductance tests also revealed that participants’ physiological responses toward humor messages actually elicited more arousal than fear messages, despite participants’ self-reports indicating the opposite (Lee & Shin, 2006). The results of this study could have implications for high-risk individuals exposed to Richard Pryor’s humorous cocaine freebasing narrative in Chapter 4.

Lee (in press) determined that the use of self-efficacy statements (i.e. “You Are in Control of the Situation!”) in humorous anti-alcohol abuse television messages aimed at highly rebellious college students significantly increased participants’ intentions to change their behavior and perceived risks of drinking, and lowered their expectancies of positive drinking consequences. However, high-risk individuals reported less fear of the danger associated with drinking and lower confidence in their ability to refuse drinks than those who received no self-efficacy message. Less rebellious participants were found to like the ads more than those in the non-self-efficacy condition. Despite the fact that the findings are based on the participants’ short-term responses right after they watched the ads, the author advances the notion that it may be beneficial to appeal to highly rebellious targets’ sense of self-efficacy in non-threatening manners, like humor (Lee, in press).
Layton, Campo, and Oprescu (in press) determined that variation in an audience’s humor styles can also impact positive and negative reactions toward humorous anti-binge drinking campaigns, and can even be related to alcohol consumption. The authors enacted a poster-based anti-“extreme drinking” campaign that poked fun at individuals who exhibited extreme behaviors (like sporting a large number of tattoos), and thus drew upon college students’ desire to fit in and adjust their behavior to campus norms. The heaviest drinkers again maintained the most resistant attitudes and motivations in response to the campaign. Interestingly, those who were shown to utilize primarily aggressive forms of humor (i.e. teasing to build self rather than fostering relationships with others) were linked most closely with alcohol consumption and unwillingness to change behavior.

Individuals with affiliative and self-enhancing humor predispositions were also considerably less likely to find humor in and be motivated by the campaign than those with self-defeating humor. Like the campaign, this form of humor is somewhat maladaptive to self with the intention of reinforcing social norms. Perhaps most intriguing is the authors’ notion that certain humor styles can relate to various health behaviors more effectively than others. Clearly, heavy drinkers of an aggressive humor type would still be highly unlikely to identify with a responsible drinking campaign even if it utilized aggressive humor messages (Layton et al., in press). This study may explain why those who most often demonstrate self-disparaging forms of humor may identify more with the absurd behavior, general awkwardness, and vulnerability found in Birbiglia’s narrative (Chapter 3).
**Research Questions**

The purpose of this study is to analyze the narratives of three humorous individuals to determine if the recounting of difficult and personal health situations through the use of humorous storytelling could have positive ramifications for both the author and his or her audience. More specifically, this thesis seeks to determine how productive humor is employed throughout the process of narrative construction, and what the humorous aspects of the narrative product express to audiences about the illness experience. Namely, does the use of humor function effectively in calling attention to certain health issues?

This thesis will attempt to answer four broad questions:

1. Do the following case studies meet the requirements of narrative? How do the authors utilize plot, themes, subtext, characterization, and cues for interpretation?
2. How do the authors characterize or portray their traumatic experience through humor? Do they seem to make sense of their illness, reclaim a lost sense of control, demonstrate a change in identity, justify or critique their decisions, and proclaim a sense of community?
3. What makes these narratives funny? How does humor function to emphasize or increase mutual understanding of the illness experience between sufferers and non-sufferers? Does humor provide for the narrative’s most “transformational” or “compelling” moments?
4. If humor and narratives are both shown to be beneficial for those who produce them, why not encourage their affiliation?
CHAPTER II

Methods

When people experience seismic shifts in their lives as a result of trauma or distress, it would probably be safe to assume that their most initial thoughts would not be, “Well…I have cancer. But at least this might make for a funny story one day!” or “What? You’re firing me? After 20 years? It’s a damn good thing I don’t have a pen or paper with me, buddy, because I would write you one hell of a humorous job termination narrative right here and now.” We don’t function like this – not without the bestowment of cognitive distance, anyway. It usually takes time to remove oneself from a situation enough to attempt to make sense of it all or put it in perspective (Sharf, 2005). Sometimes, this sensemaking results in the ability to see the absurdity or irony of a situation. We might even be able to laugh about it a little in retrospect. The process of openly mocking or poking fun at something threatening – even at oneself – enables individuals to treat a scary, menacing, or irregular perception as being less than serious (duPre, 1998). Like Daffy Duck smashing Hitler on the head with a mallet in a 1943 Looney Tunes cartoon, buffoonery is a natural human response to things that frighten us. Freud (1905; 1928) and duPre (1998) both note that we can experience a release from self- or socially-imposed marginalization by effectively crafting humor from negative events. Along with the passage of time, laughter creates a sense of distance between oneself and the event (duPre, 1998).
Laughing about something that was, or still is, terrible to experience certainly is not always easy, even for people who are inherently humorous, and especially if they are still mired within an ordeal. But this ability to reframe a perception can have major ramifications on an individual’s success or failure in achieving perspective. Only when perspective is gained does Sharf (2005) believe we can attach language to our emotions through the formulation and sharing of coherent and organized verbal or written stories. Through the corralling and conscious structuring of the disparate events which make up a traumatic experience, an author is subsequently able to simplify or boil down their future recollection of the occurrence (Pennebaker, 2000). Cognitive simplification leads to a diminished expulsion of mental energy and anguish, because authors no longer feel the need to repeatedly ask “Why?” or struggle to search for causal linkages between the emotions they experience and the events that occurred. Transforming a multifaceted, complex experience into a one-dimensional perspective (i.e. “My marriage ended because I’m an alcoholic”) enables one to move past a distressing occurrence much more easily. Once we come to terms with an event, we no longer feel the need to talk or write about it as deeply or as frequently (Crow & Pennebaker, 1997).

The release of cognitive energy allows individuals to begin to open up and laugh more with their friends, and use more positive emotions in their daily language. This can play a huge role in the development of social support, which is of significant importance to those suffering or recovering from an illness (Pennebaker, 2000). However, humor might serve to enhance this social benefit of storytelling. When exposed to a narrative, potential audiences may find themselves laughing with an author because they are able to identify their own values, fears, and feelings of empathy within the tale. Humor also
enables users to become more endearing to others (Wanzer, et al, 2006). When discussing their various struggles with medical issues, authors may be resistant to the idea of appearing whinney or cowardly. Humor has been shown to provide users with a route that enables them to complain and openly express fear or inferiority in socially acceptable, and perhaps socially attractive, ways (duPre, 1998).

The more an individual laughs with others about a traumatic experience, the more distance he or she is likely to experience from the event, and so begins the cycle again. When cognitive distance is achieved through the passage of time and/or the newfound ability to laugh at the ridiculousness of a situation, many individuals with a propensity for humor would likely benefit from telling funny stories related to the past, present, and future ramifications of a traumatic illness or event. As viewed in the following case studies, three professional writer-comedians who have experienced various forms of distress related to personal health issues demonstrate this notion.

This thesis seeks to analyze the private and public functions of constructing and sharing stories about tragic events that arise from illness through the employment of situational humor. Three pre-existing, individually-constructed stories were selected to determine what these tales communicate to audiences about the illness experience, and how humor functions in the pursuit of mutual understanding between sufferers and non-suffers. If determined to be effective and compelling, these case studies can potentially serve as model examples of successfully-constructed and disseminated illness trauma narratives that proficiently utilize situational humor.
Chapters 3, 4, and 5 will delve into the illness experiences of three professional writer-comedians as they characterize and potentially transform their perceptions of health and the world at large. The focus in Chapter 3 is placed on Mike Birbiglia (b. 1978) a storytelling comedian who suffers from a rare sleepwalking disorder that culminated in an event which almost cost him his life. A 12-minute excerpt of Birbiglia’s live one-person stage show *Sleepwalk with Me* was featured on National Public Radio’s *This American Life* program in August 2008, and accessed via audio podcast.

Richard Pryor’s (b. 1940 – d. 2005) bombastic and highly inappropriate presence cannot be ignored in Chapter 4, as his story of drug addiction is placed under the microscope. Pryor’s live 1982 concert film *Richard Pryor: Live on the Sunset Strip* marked his first appearance on-stage since suffering third degree burns after a cocaine freebasing accident. Yet, the comedian refrains from delving into a somehow-hilarious recitation of the traumatic incident and his experience with drugs until minute 52. The film is available for streaming through Google Videos.

Julia Sweeney (b. 1959) is probably best-known for her androgynous character “Pat” on *Saturday Night Live*, but her 1998 memoir *God Said, ‘Ha!’*, which describes cancer’s devastating effects on her family, will be analyzed in Chapter 5. While watching her brother suffer with lymphoma, Sweeney was diagnosed with cervical cancer. Sweeney’s book, which originated as an acclaimed one-woman Broadway show, is equal parts candid, moving, and, of course, hilarious.
Analysis

Three humorous case studies which characterize Birbiglia, Pryor, and Sweeney’s experiences of illness and brushes with near death were examined through narrative, rhetorical, and phenomenological methodology. Taken broadly, this analysis will examine plot structure, episodes or themes, and subtextual issues.

Plot Structure

First, it was determined if these stories met the structural requirements of a compelling personal, non-interactive narrative, as advanced by Lablov (1972). As such, they must possess an internal structure consisting of an abstract, orientation, complicating action, evaluation, result, and coda. Plot was accounted for in terms of its linear, chronological, temporal nature or its tendency to unfold randomly and include numerous subplots (as seen in Ellingson & Buzzanell, 1999). In keeping with the narrative analysis of Cherry and Smith (1993), elements of the story which are noticeably excluded were also accounted for.

Episodes or Themes

Episodes, or thematically-linked groupings of episodes, were identified and compared within each case study (Cherry & Smith, 1993). Examination of each episode or theme attempted to unveil the authors’ demonstrations of Sharf and Vanderford’s (2003) socially-constructed functions of health-related storytelling. Narrators were considered successful in clarifying the values of the illness experience through clear demonstration of the following abilities: (1) making sense of health and disease, (2) asserting control in the midst of physical and psychological losses, (3) transforming identities and social roles as a result of an altered health status, (4) assisting in making
decisions about one’s health, and (5) building community (Sharf & Vanderford, 2003). Identification of the presence of these functions was achieved through an analysis of characterization, interpretive cues, and the author’s attempts to craft situational humor from initially serious proceedings.

Characterization

The people included in a storyteller’s episodes carry out the actions that propel the narrative forward. Their representation also demonstrates how the narrators regard the personalities in their lives. This analysis asked the question, “How do the depictions of plot and character reveal the values, beliefs, attitudes, hopes, fears, explanatory frames, and expectations of the storyteller?” (Smith & Cherry, 1993, p. 187). As such, whether these characters reflected the qualities of heroes, villains, victims, or innocent bystanders was also considered (Sharf & Vanderford, 2003). It was especially important for this analysis to determine how the author demonstrated a change in his or her own character from the beginning of a story to its ending. A special eye was kept out for the use of personification to describe character. Additionally, the researcher also analyzed whether an author utilized humorous self-commentary to portray a persona not directly reflective of his or her “naked I” (duPre, 1998, p. 161), or true self-conscious sense of identity.

Interpretive Cues

Inspired by Smith and Cherry (1993), this analysis attempted to identify instances of figurative language in determining how the author intended for aspects of their episodes to be interpreted. Particularly, cues such as metaphor, hyperbole, understatement, irony, and sarcasm were analyzed to understand their role in the function of successful humor employment. Depending on whether the story was written or told
verbally, analysis of additional interpretive cues varied. Verbal stories provided a forum for the study of nonverbal cues such as gestures, facial expressions, and paralanguage. In examining the tales of comic performers, the significance of nonverbal cues was analyzed through Bethea, Travis, and Pecchioni’s (2000) meta-humorous interaction theory (MetaHIT) to determine if their humorous account of a stressful experience showcased phrases or nonverbal cues that indicated closure. Potentially visible humor cues or comedic expressions – clues a message producer sends to express that an utterance or action should be interpreted as playful and not serious – include slightly raised eyebrows, exaggerated facial expressions, idiosyncratic word choice, impersonations, charades, and mocking behaviors (duPre, 1998).

**Instances of Situational Humor**

These episodes were examined further to determine why instances of situational humor can be successfully perceived as funny by both audiences and storytellers. Utilizing duPre’s (1998) phenomenological surprise-liberation theory, this analysis attempted to identify the initial expectations (or, commitments/orientations) of storytellers and audiences, a surprising deviation from those expectations that reveal possible prejudices, and a pleasurable liberation from that expectation. Particularly when the expectations of audiences and tellers are threatening, as the case often seems to be in episodes involving illness, writers and audience members frequently experience an unexpectedly profound or exhilarating relief. Again, to find something funny or ridiculous is to (temporarily) experience a reprieve from serious consideration of its menace, and to allow one to achieve disengagement from an initial orientation. Because
commitment is positively correlated with liberation, this analysis considered violated thresholds as one explanation for instances of failed situational humor (duPre, 1998).

This analysis also questioned whether these instances of situational humor could provide audiences with good reasons to buy into the storyteller’s overall theme or tale. Particularly significant was the consideration of whether the employment of situational humor offered the narratives a more compelling and approachable dimension than if they were told in a more straightforward, non-humorous fashion. Fisher’s (1984) description of narrative rationality guided this analysis in an attempt to determine how probable these accounts sound to hearers, and if these episodes provide good reasons to guide audiences’ future actions and decisions.

Subtextual Themes

In addition to a story’s context, Young and Rodriguez (2006) identified the presence of subtext, or the goals and values that drive the narrative. Whether the authors move toward or away from these goals and values during their story will also be accounted for by looking at Bury’s (2001) descriptions of progressive and regressive core narratives. An attempt to determine whether the authors employ a more engaged or fatalistic view of the illness experience will shed light on their perception of agency (or lack thereof) in the face of distress (Sharf, 2005). The author’s propensity for delineating a more categorical or spectral perspective of illness will also be taken into account, in addition to the storytellers’ ability to commingle their biomedical and expressive worldviews (Bury, 2001). This analysis will then attempt to determine if the narratives can accurately be labeled as chaos, restitution, quest, or cautionary tales (Sharf, 2005;
Frank, 1995). A definition of the authors’ overall moralization of their illness will also be elicited according to Sharf and Vanderford’s (2003) thematic observations.
CHAPTER III

Mike Birbiglia’s Secret Public Sleepwalking Disorder

Nick Iannarino: “Was it tough for you to turn such personal, serious stuff about yourself into comedy?”

Mike Birbiglia: “It’s definitely sticky, the subject, sometimes, because it bleeds into my life a little bit. Sleepwalking is still something I wrestle with. It usually takes about a year or so to figure out whether or not something will make a good story. You need the perspective of time, and it’s been about four years since that incident happened. But the more distance I get from it, the more I’m able to make comedy from it. The laughter helps. If there were no laughter, it would be much more painful, I think” (Iannarino, 2008).

- Interview with Mike Birbiglia, September 8, 2008

Introduction

Listening to a Mike Birbiglia stand-up routine is painful. Not in a “This is so terrible I want to gouge my eyes out,” Carrot Top- or Larry the Cable Guy-type way. Rather, you can’t believe that one man has the capacity to say and do the wrong thing at the wrong time as often as Birbiglia. Plus, your stomach totally kills from laughing so hard.

Take, for instance, the time Birbiglia moved his bed into a new apartment complex. A woman held the door, remarking that she wasn’t worried to let him in because a rapist wouldn’t have a bed like his. “What I should have said was nothing,” he said. “But what I did say was ‘You’d be surprised.’”

Rather than winging one-liners at audiences, Birbiglia has enjoyed enormous success sharing excruciatingly true and often awkward stories about his life, whether they’re written as entries in his famed “Secret Public Journal” blog, or performed on his three Comedy Central specials and two live albums. His most recent work, the one-
person stage show *Sleepwalk with Me* – which ended its off-Broadway run in June 2009 after a whopping 198 performances – received unfathomably stellar reviews from fans and critics (*Sleepwalk*, 2009). A large portion of the show draws from Birbiglia’s real-life difficulties with sleepwalking, which came to a head during a scary incident in 2005 that nearly killed him.

Like his comic predecessors Richard Pryor and Bill Cosby, Birbiglia often employs honest, intimate, and personal stories about his life to generate laughter from audiences, and, just as importantly, from himself. This case study seeks to analyze Birbiglia’s representation of sleepwalking disorders in a performance on NPR’s *This American Life*, particularly as it relates to the function and purpose of humor in health narratives. Birbiglia’s material is an example of how stand-up comedy (or public storytelling that incorporates humor) can be utilized as an effective medium for the formulation and dissemination of health narratives. Through the writing and repeated retelling of his illness narrative, and, more specifically, his ability to craft humor from the proceedings, Birbiglia’s storytelling serves two important functions: to reconstruct, characterize, and maintain a sense of his own wellbeing – namely, to aid in his recovery from several traumatic experiences – and to educate the public about an issue they may not take seriously.

**REM Behavior Disorder**

Normal sleep is divided into two distinct states: non-rapid eye movement (NREM) and rapid eye movement (REM) sleep. According to WebMD (2007), REM sleep usually represents about 20-25% of a person’s total sleep period, and is characterized by the occurrence of rapid eye movement, irregular breathing, rising blood
pressure, and loss of muscle tone (which results in virtual paralysis). The brain, however, remains highly active; the electrical activity recorded in the brain during REM sleep is similar to that which is recorded during wakefulness. Not surprisingly, REM sleep is usually associated with dreaming. This process occurs 4-5 times during a normal 8-to-9-hour sleep period, and may range from less than 10 minutes to more than 60 minutes in duration. In a normal night’s sleep, REM occurs every 90 minutes (WebMD, 2007).

A person living with REM sleep behavior disorder (RBD) must contend with the incompleteness or absence of the paralysis that normally occurs during REM sleep. RBD is characterized by the “acting out” of dreams that are often vivid, intense, and violent – usually nightmarish in nature, with the dreamer being chased or attacked by something or someone (Mayo Clinic, 2009). According to WebMD (2007), dream-enacted behaviors include talking, yelling, punching, kicking, sitting, jumping out of bed, arm-flailing, and grabbing.

The disorder is much more common in men than in women and usually begins in middle age or later, though it can occur earlier. The exact incidence and prevalence of RBD are unknown, but the Mayo Clinic (2009) reports that it treats more than 100 people with the disorder annually. A study by Olson, Boeve, and Silber (2000) reported that out of 93 RBD patients, 87% were male and the mean age of the disorder’s onset was 60.9 years (with ages ranging from 36-84). In addition, 32% of the patients had injured themselves while sleeping, and 64% had assaulted their spouses or partners (Olson, Boeve, & Silber, 2000).

The exact cause of the disorder is unknown, although it may occur in association with various degenerative neurological conditions such as Parkinson’s disease, multiple
system atrophy, or Lewy body dementia (Mayo Clinic, 2009). RBD often precedes the development of these conditions by several years. WebMD (2007) reports that in one study, 38% of patients diagnosed with RBD subsequently developed Parkinson’s disease within an average time of 12-13 years from the onset of RBD symptoms. RBD can be controlled through the use of clonazepam, a tranquilizer considered to be the best medication option, or melatonin, a dietary supplement. Physical safeguards, like moving any objects that could cause injury away from the bedside, and lifestyle modifications, such as preventing sleep deprivation and avoiding excessive amounts of alcohol, are also encouraged (Mayo Clinic, 2009). Unfortunately for RBD sufferer Mike Birbiglia, it is quite rare for hotel rooms to be without windows…

**Mike Birbiglia on NPR’s This American Life**

In the fall of 2008, Birbiglia set off on the nationwide “Sleep While Standing” tour, intended as promotion and practice for his off-Broadway one-person stage show, *Sleepwalk with Me*. To clarify, the most typical differences between a stand-up set and a one-person show involve narrative arc and continuity. While a stand-up set may contain a series of unassociated stories scattered amidst a smattering of comedic bits and jokes, one-person shows usually present a large, solitary story comprised of thematically-linked episodes held together by an overarching plot. More simply, legitimate one-person shows are typically structured as a series of related stories that ultimately comprise one bigger story. In contrast, a 60-minute stand-up set could cover material as varied as bacon, bed sheet threat count, the Pope, manatees, oatmeal, gay cats, and feeding Subway to a duck. It is important to note that one-person shows can, and often do, mix subplots and other anecdotes into the proceedings from time to time. These elements, however, relate
somehow to the overall coherency and development of the primary narrative. Like stand-up, there tends to be no “fourth wall” in place between one-person narrators and their audiences. Because these forms of entertainment typically require the active involvement of listeners, performers often directly and spontaneously address the audience in some fashion – through the acknowledgement of applause or horrified gasps at a story’s impending, foreshadowed doom (to which Birbiglia often replies in mock agreement, “I know…I’m in the future also”), or unscripted back-and-forth with listeners, for example.

Like many patients recovering from a less-than-pleasant medical experience, Birbiglia has crafted his struggles with RBD into an illness narrative – one that infuses humor into the proceedings nearly every step of the way. Birbiglia has repeatedly stressed the importance of retrospective sensemaking to his own psychological well-being (see quote on p. 100). During his 2008 Comedy Central special *What I Should Have Said Was Nothing – Tales from My Secret Public Journal Live in Concert* (1998), Birbiglia states, “A few years ago my therapist suggested I keep a journal of all the crazy things that were going on in my life, so that I could keep things in perspective.” The comic claimed his ability to open up enabled him to find the humor in these once-troubling experiences – so he continued writing as a therapeutic measure.

Birbiglia eventually realized that others might also enjoy his stories, so he began recording them in a blog and sending them out to his mailing list. Beginning with *What I Should Have Said Was Nothing*, Birbiglia also attempted to mix true and embarrassing tales from his life into his comedy act, alongside the rather impersonal, surface-level jokes with which he had established himself – absurdist bits like his comparison of George W. Bush to a fun-loving but irresponsible party guest named Wiffleball Tony,
and a deconstruction of the slang term “cracka.” Sleepwalk is, of course, a one-person show that tells a unique story about Birbiglia’s maturation as a young adult built entirely around his RBD narrative.

On September 18, 2009, Birbiglia performed an abridged version of Sleepwalk mixed with some of his older stand-up material at the Victoria Theater in Dayton, which the author of this thesis attended. As of now, no taped specials of Sleepwalk or Birbiglia’s fall 2008 tour have aired on television or been released on DVD. However, his first book – Sleepwalk with Me and Other Painfully True Stories – which contains many of the tales from his one-person show and “Secret Public Journal,” will hit bookshelves in October 2010.

Birbiglia is also a frequent contributor to National Public Radio’s This American Life, a weekly program broadcast on more than 500 stations to about 1.7 million listeners (This American Life, 2010). Each week, the show selects a particular theme – first dates, for instance – and allows everyday people the opportunity to share their true stories related to the topic. An episode which aired in August 2008 titled “Fear of Sleep” features a taped 12-minute excerpt from one of Birbiglia’s performances at The Moth, a famous New York City storytelling organization. This segment highlights the emotional and thematic core of Birbiglia’s one-person show, and a portion of the material this author viewed live.

Sleepwalk is all about instances in Birbiglia’s life that exemplify his inability to confront his personal fear of relationships, honesty, and maturation. While the excerpt that aired on NPR streamlines Birbiglia’s sleepwalking narrative into one extended, self-contained, and uninterrupted story, the authentic performance of Sleepwalk fragmented
this tale, utilizing it as the basic thematic framework for the entirety of the author’s 90-minute one-person show. His tale of the sleepwalking experience was broken up into smaller stories, almost like little checkpoints that connected the larger narrative of his life, family, old girlfriends, and eventual maturation back to its most prominent theme—his difficulties with RBD.

This case study will provide an analysis of Birbiglia’s appearance on *This American Life* as a potential example of a model illness trauma narrative that utilizes humorous public storytelling to tremendous effect. Unfortunately, this examination will miss out on an authentic demonstration of Birbiglia’s comedic movements and gestures, a dimension of humor that has been proven as significant to the overall comedic experience. Wanzer and her colleagues (1995) determined that audience members who receive humorous messages from a comedic presentation in person judged these attempts as significantly funnier than those who listened to the same material on tape. The authors attributed these findings to the fact that humor was communicated to listeners through multiple channels which provided both auditory and visual cues. Humorous nonverbal behaviors such as facial expressions, gestures, and body movements clearly enhanced the performer’s funniness ratings (Wanzer et al, 1995).

Nevertheless, in an attempt to capture the entirety of Birbiglia’s comedic repertoire, this analysis will describe the extent of Birbiglia’s humorous gestures and body movements as they are recalled from his previous performance in Dayton.

**Plot**

Mike Birbiglia’s sleepwalking story fulfills the structural requirements of narrative as advanced by Lablov (1972). It utilizes a rather straightforward plot arc with
episodes separated by chronological temporality, and incorporates the standard literary elements of exposition, rising action, climax, falling action, and resolution.

Abstract

Act I of “Fear of Sleep,” titled “Stranger in the Night,” begins with a poem – Raymond Carver’s The Scratch, read by the male co-host of NPR’s This American Life (2008).

I woke up with a spot of blood
over my eye. A scratch
halfway across my forehead.
But I’m sleeping alone these days.
Why on earth would a man raise his hand
against himself, even in sleep?
It’s this and similar questions
I’m trying to answer this morning.
As I study my face in the window.

Orientation

We cut from the studio to what sounds like a small, crowded venue. Birbiglia tells the audience that he began walking in his sleep seven years earlier, at age 23. It began with recurring dreams involving an insect-like jackal hovering above the bed he shared with his girlfriend, Abby. Birbiglia says that at least once nearly every night he would jump on top of his bed and strike a karate pose in his sleep (“I never took karate, but I had books from Book Fair”), before screaming out his girlfriend’s name and warning of her the impending threat (“Abby! There’s a jackal in the room!”). Abby had apparently gotten so used to Birbiglia’s outlandish behavior that she eventually gained the ability to talk him down while remaining asleep. (Abby’s practice of repeating, “It’s okay, Michael, go back to sleep” would always result in an intensely-delivered response of “Abby, are you sure?!”). Birbiglia says he would lie back down knowing there was still a
jackal hovering above him. “And that’s trust,” he jokes of his relationship with Abby. Birbiglia shows us how ridiculous it must have appeared to an outsider in the middle of the night through his hysterical body movements, zoned-out facial expressions, and wild gestures – from his most intense, focused karate stance to skeptically and extremely cautiously letting his guard down.

Some time later, Birbiglia had a dream he was in the Olympics “for some arbitrary event like dustbusting.” He stood on the third place podium feeling pretty good about himself (“I’m new to the sport”) until the judges suddenly decided he actually came in first place. He moved over to the tallest podium, but it started to wobble uncontrollably as he mounted it. He lost his balance and began to fall. Birbiglia woke up as he was tumbling off the top of the bookcase in his living room. He landed hard on the floor on top of his TiVo, which smashed into pieces. He was disoriented “like one of those stories where people black out drinking and wake up in Idaho and don’t know where they are. And they’re like ‘Oh noooo…Hardees!’ or whatever’s there. But it was in my own living room. I was like ‘Oh noooo…TiVo pieces!’” Birbiglia went back to bed. When Abby woke him in the morning, she said, “Michael, what happened…to the TiVo?” He said, “I got first place…and it’s a long story.”

At this point, clearly somewhat put off by his late night living room swan dive, Birbiglia thought to himself, ““Maybe I should see a doctor.”” But then he thought, ““Maybe I’ll eat dinner.’ That seemed more convenient.”” Lots of people, including his parents – his dad is an M.D. – told him he needed to see a doctor. ““I remember saying, ‘I’m really busy,’ and thinking, ‘These people are crazy…They don’t know how busy I am.’”” Birbiglia never went to a physician, but he did purchase a book by an author named
Dr. Dement (“Which is not the most calming name for a sleep doctor”) called The Promise of Sleep. The book said that several hours before bed he should turn off the news, his cell phone, the Internet, and his computer, and refrain from eating big meals.

In the sleep disorder section of the book he spotted an ailment that resembled his own symptoms – REM behavior disorder. People who suffer from this disorder are deficient in dopamine, a chemical released from the brain that paralyzes the body when a person falls asleep “so that you don’t do what’s in your brain.” Once again, Birbiglia thought to himself, “‘Maybe I have this.’ And then I thought, ‘Maybe I’ll eat dinner.’” He continued putting off seeing a doctor.

Complication

Rising Action

In 2004, Birbiglia was on tour in Walla Walla, Washington. He stayed overnight at a LaQuinta Inn and notes that people always correct him on his inability to pronounce the company’s name correctly (“Lah-keeenta”). “That’s not fair,” he says. “You can’t force me to speak Spanish.” He sets the scene for this episode with more pronunciation jokes: “I’m at Lah-keeenta Inn in Why-yah Why-yah, Washeeengton…” Birbiglia says he fell asleep watching the news that night, which had showcased a story about war “or something chaotic.” He began to dream that there was a guided missile headed toward his room, which was all of a sudden packed with military personnel. Birbiglia jumped out of bed and asked, “What’s the plan?!” An officer responds, “It’s come to our attention the missile coordinates are set specifically…on you.”
Climax

Birbiglia continues: “And I thought, ‘That’s very bad, because I don’t have a plan for that one.’ So I decided to jump out the window…in my dream…and, as it turns out, in my life.” He notes that there are two important details to this story: “One, I was on the second floor of Lah-keeenta Inn. And two…the window was closed. So I jumped through a window like...The Hulk. And I say that because that’s how I described it at the emergency room. What’s remarkable is that people with this disorder are capable of doing things they can’t do in their everyday life. It’s like blacking out drinking where you don’t feel any pain or inhibition. I jumped through a second story window and I landed on the front lawn of the hotel. I took a spill, I got back up…and I kept running. And I’m running, and I’m slowly realizing, ‘I’m on the front lawn of Lah-keeenta Inn in Why-yah Why-yah, Washeengton…in my underwear…bleeding.’ And I’m like, ‘Ohhh noooooo.’”

Falling Action

The audience is howling. “And it was one of those rare moments in your life where in retrospect you’re like, ‘What the hell?’ and at the same time you’re like, ‘I guess I’ll walk to the front desk and explain what happened.’ Fortunately, the person working at the front desk was mildly retarded, and I say fortunately because he was completely unfazed by what had just happened. It’s three in the morning. The phones are ringing off the hook from people staying at the hotel who just saw the guy jump out the window screaming. I’m bleeding in my underwear. And I say, ‘Hello,’ because, as it turns out, you have to start somewhere. ‘I’m staying at the hotel’ – credibility – ‘I had an incident wherein I jumped out of my window. I am bleeding and I need to go to a hospital.’ And
I’ll never forget his reaction, because he just goes, ‘Huh huh.’ And I thought, ‘This is the best possible reaction I could receive at this juncture.’”

Birbiglia drove himself to the hospital. He says he had to explain the situation three separate times to the front desk, a nurse, and a doctor – “‘I’m The Hulk,’ ‘I’m The Hulk,’ I’m The Hulk,”’ he mimics. The ER doctor worked on him until 5:30 a.m. Birbiglia ended up with 30 stitches in his arms and legs. He said the doctor told him, “You should be dead” (“And I was like, ‘No, you should.’ I zinged him”). Birbiglia drove back to the hotel and checked out. “I paid for the window, like any good window-jumper would.” He notes that he dished out $300 to replace the glass, and $49 for the room.

Result

“I went back to New York and did what I should have done in the first place when I saw the jackal: went to a doctor who specializes in sleepwalk disorders. So now when I go to bed at night I take a very strong pill, and I sleep in a sleeping bag up to my neck, and I wear mittens so I can’t open the sleeping bag.” His ability to act out this process is gut-bustlingly hilarious in person. He looks absolutely ridiculous. Birbiglia, standing rigidly as if he were sleeping vertically in a tight sleeping bag has his eyes closed, mouth open, arms bent upward and harnessed at the elbow, and hands dangling in the air in front of him. He begins to mock his thrashing, yet constricted nocturnal movements, alternating between gentle, calming, settled motions and violent, battering attempts to unleash his body from the bag and run amuck in the night. Slowly, he begins to relax and drift back to sleep.
Evaluation

Birbiglia concludes on a relatively serious and poignant note. “So in closing, I think that if it weren’t for denial I wouldn’t be a comedian, because to be a comedian you have to go on stage those first few years and bomb, and then walk off stage and think, ‘That went great.’ Because otherwise you would never get on stage the next night. You would just think, ‘Well, I guess human beings don’t like me.’ But sometimes denial can kill you.” We hear applause, and fade out to the studio.

Coda

The male co-host of This American Life then says, “If you have a sleep disorder of the sort we’ve been talking about so far today, there is very effective treatment. See a doctor. There’s a little pill called clonazepam that helps most cases, as Birbiglia said.”

Additional Note Regarding Overall Context

Birbiglia also devotes part of Sleepwalk to a similarly funny/scary story about the removal of a malignant tumor from his bladder during his freshman year of college. After urinating blood at a rest stop on his first drive home from Georgetown University, Birbiglia visited the doctor, who told him that a large mass was spotted in his bladder. “Whenever they find something, it's never anything good like, "We found something in your bladder, and iiiiiit's… season tickets to the Yankees!" he says. Birbiglia also notes that the invasive procedure the doctor used to examine his bladder involved a camera attached to a rod the size of his microphone stand – which he holds up for everyone to see. “I think the funniest thing that can happen to a hypochondriac is to have cancer, because it confirms every fear you've ever had in your life. You're like, ‘See? I told you! Remember when I thought I had rickets? I was probably right about that too. There's
gonna be a lot of changes around here!” Similar narrative analyses could be utilized to study this aspect of Sleepwalk or as further evidence of Birbiglia’s integration of humor and illness trauma narratives. More importantly for the purposes of this thesis, Birbiglia cites the aftermath of this incident as the beginning of his struggles with RBD.

**Themes**

Through an analysis of Birbiglia’s narrative, three themes become prevalent: Sleepwalking as liberation, sleepwalking as surrendering control, and learning lessons from sleepwalking.

**The 64-Slices-of-American-Cheese Effect: Sleepwalking as Liberation**

Viewed through multiple lenses, society’s perception of and reaction to sleepwalking and sleepwalkers is inherently dualistic in nature. A favorite episode of The Simpsons involves a semi-conscious Homer shuffling to the kitchen in the middle of the night and polishing off 64 slices of individually-wrapped American cheese before dawn. This portrayal encapsulates the funny and somewhat embarrassing side of sleepwalking – the one people do not view as a legitimate problem. In this context, sleepwalking is demonstrated as an opportunity for sufferers to “experience” life without inhibition and regard for basic social decorum and dignity. One would not be likely to sit in their kitchen in their underwear and eat an entire block of cheese until dawn in a normal cognitive state – unless that person is Homer Simpson, of course.

Adhering to “The 64-Slices-of-American-Cheese Effect,” Birbiglia uses metaphor to initially liken the experience of sleepwalking to blacking-out while drinking, a state of being society and the media, rightly or wrongly, often views as hilarious (see: the film The Hangover). This perception is particularly prevalent among college students, a
respectable quotient of Birbiglia’s audience. But why are drunken tales so frequently valued as hilarious anecdotes to share the morning after an epic kegger? Simple: As analyzed through duPre’s (1998) surprise-liberation theory, the persona-diverging behavior we sometimes engage in while getting “hammered” is often humorous because it goes against whatever expectations we have of ourselves or others.

For instance, if we are a meek, unassuming guy during the day, but a tabletop-dancing sex hound after guzzling vodka at our roommate’s 1980’s-themed party, this night will likely be valued by our friends as a liberating deviation from our norm of tentativeness and drudgery. Of course, our propensity for treating a night of debauchery fondly all depends on what our thresholds allow. If we are normally nice people and turn into disparaging jerks, destructive property damagers, drooling lobotomy patients, or brainless daredevils when we drink – or in the previous example, if we have a girlfriend, a big exam the next day, or act that way every weekend night – then we have a problem. These actions are not nearly as funny as they are sad, disgraceful, and socially undesirable. As we grow older, our responsibilities increase, and we no longer live in an environment that supports the practice of consistent drinking (i.e. college), our thresholds become smaller and more rigid – and this behavior becomes less and less acceptable. We can no longer use alcohol as an excuse to act like an idiot: “Yeah, I was so hammered last night I passed out on a park bench downtown by myself. My wife is going to kill me.”

The notion of losing all judgment and inhibition and unconsciously immersing oneself in the most random and persona-diverging behavior is also sometimes embarrassing and threatening to one’s sense of dignity. This may be an additional reason why binge drinking is often rationalized as such: “Although my life may temporarily be
in disarray, my hair smells like puke, and my mouth tastes like a landfill, I must have had
a whole bunch of fun in getting here!” According to duPre (1998) humor is frequently
employed as a method for saving face and diffusing humiliation from a situation.
Portraying oneself as being “in on the joke” allows one to laugh with others, rather than
being laughed at when acting without regard for social conventions and human
rationality.

Birbiglia associates the randomness of his sleep-climbing to the top of his family
room bookcase with a person who got really drunk and ended up at a Hardees fast food
restaurant (the gold-standard of lapses in judgment) in Idaho (total randomness). So long
as the behavior is not replicated often enough to truly endanger others or to lose complete
control as a functioning adult, getting blackout drunk could carry a certain level of
spontaneity and attractiveness, a welcome respite from the drudgery of the everyday
experience. What’s the fun in being moral and straight-laced all the time? Cut loose a
little bit! At the very least, this behavior makes for a fun story. Essentially, an individual
is able to live out a fantasy – one that reinforces the notion of invincibility – performing
some action one never would in a normal cognitive state.

The dualistic nature of sleepwalking also encompasses a sleepwalker’s
inheritance of a “split personality.” Right off the bat, Birbiglia implicitly demonstrates a
major difference between “Conscious Mike” and “Sleeping Mike.” Conscious Mike is
characterized as a mild-mannered man-child who always seems to say the wrong things
at the wrong time. He doesn’t know karate, but has read books about it from book fair.
When he dreams of rising to fame and glory at the Olympics, it is because he won a
dustbusting competition. Birbiglia’s previous material asserts that Conscious Mike’s
favorite foods are English muffin pizza and hot chocolate, and that he once unwittingly mocked a man he did not know was blind by attempting to shake his hand – in the middle of his Major League Baseball Writers’ Lifetime Achievement Award acceptance speech.

Sleeping Mike, meanwhile, wrestles with imaginary insect-like jackals and spontaneously climbs to the top of the living room bookcase. Needless to say, he demonstrates random, irrational behavior that would most likely not be carried out in a normal cognitive state. But despite falling from a height tall enough to smash a TiVo box into a million pieces, and threatening violence in a room which holds his sleeping girlfriend, Birbiglia does not yet explicitly emphasize the pressingly dangerous side of sleepwalking or an alternate aspect of his subconscious that is inherently malicious or completely out-of-control. Even after undertaking research on the subject, borne certainly out at least some concern over his condition, enabled him to put a name to the experience (RBD), Birbiglia expresses his belief that Sleeping Mike can be controlled on his own. This is demonstrated by the initial justification of his decision to not see a doctor.

Throughout this theme, Sleeping Mike can be characterized as a newfound drinking buddy one might really like to hang out with, because he or she is fun and liberating – an initially invigorating variation from the norm also personified in classic literature like The Strange Case of Dr. Jekyll and Mr. Hyde, and films such as The Wolfman, The Nutty Professor, Fight Club, and Youth in Revolt. The drinking buddy pushes this person to do things the person normally is not able to do on his or her own. Slowly, though, this person may begin to have doubts about the relationship. His or her friend’s drinking and deviancy becomes more reckless and intense, often culminating in both parties becoming mixed up in illicit behavior. Eventually, the drinking buddy slides
completely off the deep end, framing the more straight-laced individual with a crime he or she did not commit. This person’s once-liberating friend turns into a villain, a predator that must be vanquished in order to once again live virtuously. For now, however, Conscious Mike is wary of, but not overly concerned with, Sleeping Mike.

Although Birbiglia’s girlfriend Abby serves a major role in other areas of the *Sleepwalk* one-person show, she is relegated to innocent bystander status during “The Jackal” and “The TiVo” episodes – her only appearances in the RBD narrative. Through no fault of her own, Abby must deal with the consequences of Birbiglia’s nightly hallucinations. However, she also maintains the incredibly important agent role of talking Birbiglia down from his karate stance to a more calm and restful position. It is not clear whether she understands how dangerous the byproducts of this disorder could be to her or to her boyfriend.

*The Promise of Sleep: The Beginnings of Birbiglia’s Sensemaking Process*

Birbiglia’s ability to backtrack seven years to discuss his initial succession of reoccurring jackal-haunted dreams and his concordant sleepwalking performances demonstrates his propensity for making sense of his overall experience with RBD. As newly-christened mile markers along Birbiglia’s sprawling sleepwalking journey, individual experiences like “The Jackal” and “The TiVo” are linked together, retrospectively transformed, and assigned value and significance. These events are changed from isolated “Hm, that was weird. I must have eaten too much Indian food last night before I went to bed. Oh well” incidents, to major episodes within a considerably larger story. Thus, authors are able to identify clear beginnings and endings, establish causal linkages and trends, provide legitimate reasons for the occurrence of peculiar
incidents, and facilitate the recollection of other events the narrator previously dismissed as insignificant.

After tumbling from his bookcase, it is clear that Birbiglia engages in some sort of initial retrospective sensemaking/narrative-building process as he peruses through Dr. Dement’s book. He comes to this preliminary conclusion: “Man, these are clear indications that I have RBD. And it might be getting worse. There’s now a legitimate reason this stuff was happening. I wasn’t just losing my mind or overly stressed. And it also explains that other time I walked in my sleep I just remembered. I should probably see a doctor. I’ll eat dinner instead.” Clearly, Birbiglia had not yet come to a complete understanding of his disorder. It would take a considerably more serious event to push him to fully comprehend the ramifications of his sleepwalking habits.

*Why Is This Theme Funny and Compelling?*

Birbiglia’s demarcations of his first two brushes with sleepwalking can effectively be described as a pair of drunken stories with positive ramifications. These types of tales are prominently disseminated through the media and often hold significance in the worldviews of many young people. As such, if these nights of debauchery do not surpass individual thresholds for lack of social inhibition, they are often valued and treated as humorous. Similarly, Birbiglia’s brushes with “The Jackal” and “The TiVo” can be considered humorous and compelling because they are clearly not the actions of a man in a normal cognitive state.

The inherent liberation and expunged inhibition of sleepwalking (and drinking) implies that individuals can achieve or envision *anything*. In *The Hangover*, audiences laugh at a scene following a raucous bachelor party in which a luxury hotel suite contains
the charred remains of a chair, a live chicken, and a full-grown Bengal tiger belonging to
former boxer Mike Tyson. It is the random placement of objects that do not belong in a
hotel room – and those that would likely only be transported there in a delirious state –
that makes this scene funny. Similarly, listeners laugh at Birbiglia due to the incredibly
arbitrary and capricious nature of his dreams (a hovering insect-like jackal, winning a
gold medal in dustbusting) and his concordant bodily actions (striking an exaggerated
karate pose on top of his bed, teetering on the edge of his living room bookshelf).

The audience certainly winces a bit at Birbiglia’s living room tumble – he could
have broken his neck, after all – but since he is presently standing on his own in one
piece, listeners know that everything is presumably okay. However, a large focus should
also be placed on how Birbiglia was able to present this moderately troubling information
to such humorous effect. Simply by treating his situation as patently ridiculous and
something to laugh about, Birbiglia’s experience just seems to lend itself to humorous
retellings. He mocks himself through an over-exaggerated impression of his ridiculous
after-hours karate sessions. He utilizes the familiar metaphor of blacking out while
drinking and winding up at a Hardees in Idaho to allow anyone who has never walked in
their sleep to compare it with something they likely have experienced. Birbiglia also
smiles or laughs to himself numerous times throughout the proceedings as if to tell his
audience, “Yeah, this was an embarrassing experience, and it could have been a whole lot
worse. But I am okay. Go ahead – laugh.” Certainly, if Birbiglia had utilized a more
straightforward, serious storytelling style rife with sighs and frowns, and without the use
of overly-exaggerated impressions, figurative language, or other humor cues, the
audience’s reaction might have been much different.
Additionally, the perception that individuals do not often go into such detail in delineating potentially embarrassing information makes Birbiglia’s open and honest demarcation to thousands of individuals at a time all the funnier. The audience’s perception that topics such as these are not things an individual would normally tell complete strangers – or that humor would not be employed throughout the proceedings – is rebuked, and that notion becomes refreshingly pleasurable to listeners. Thus, Birbiglia’s release of potentially embarrassing information is rewarded with empathy and social attraction.

**The Hulk Who’s Had One Too Many: Sleepwalking as Losing Control**

Like the negative effects of heavy social drinking (i.e. alcohol poisoning, car accidents, accidental pregnancies, etc), there are not as many media portrayals representing the dangers of sleepwalking as there are its goofy aspects. But the reality is that, like binge drinking, suffering from a sleep disorder can result in an individual becoming a real danger to oneself and others if instances of sleepwalking all allowed to become more frequent and more intense. A sleepwalker is at the same time completely vulnerable and totally dangerous. Individuals suffering from sleep disorders must contend with the reality that they are forking over control of their bodies for eight hours each night. Literally anything can happen. The Raymond Carver poem the producers of This American Life selected to accompany Birbiglia’s piece encapsulates this theme nicely: “Why on earth would a man/raise his hand against himself, even in sleep?” Again, Birbiglia relates sleepwalking to binge drinking, but this time he mentions that “you don’t feel any pain or inhibition” – typical signs of being in control over one’s body, especially when the body needs the mind to pay attention the most.
The juxtaposition of the image of Birbiglia – as an awkward, mild-mannered, and scrawny man of average height – bursting through a plate glass window like The Hulk – an enormous creature of god-like power and endless rage – reinforces this notion. Whenever Bruce Banner became angry, he lost complete control of himself and turned into a gigantic green monster. Birbiglia’s moralization of sleepwalking is the forfeiture of the moral self by the invasion of an evil predator (Kline, 2003). At night, he becomes a different person – Conscious Mike transforms into Sleeping Mike. As the disorder continues to go untreated, Birbiglia loses more and more of himself. As such, This American Life’s title is appropriate for Birbiglia’s story: “Stranger in the Night.”

Why is This Theme Funny and Compelling?

What is different for Birbiglia this time around is his tendency to use metaphor and humorous self-commentary to separate himself from his “naked I” (duPre, 1998). Suffering a near-death experience is obviously unsettling, and when it occurs in an almost surreal fashion in a public forum it is potentially embarrassing. Birbiglia repeatedly refers to himself as “The Hulk” to medical professionals and “a window-jumper” to audiences to achieve distance from the incident.

It is completely shocking that sleepwalking can result in consequences that severe, that there is that much inherent danger in acting out dreams. But despite his dire circumstances, Birbiglia’s story does not sway into an overwhelming sense of pathos or fearful spectacle. Instead, the audience is endlessly entertained, and able to laugh with Birbiglia’s feelings of embarrassment, danger, and relief because of his deft ability to mock himself through self-deprecation. By appearances alone, Birbiglia is not The Hulk.
Nevertheless, Birbiglia’s use of disparate metaphor and imagery allows audiences to picture his unconscious, pasty, short, and scrawny body thrashing in bed, slowly turning green, bursting through his window, hitting the ground, and – like an unstoppable superhuman force – getting up and continuing to sprint...by himself, still scrawny, on a hotel front lawn at 3:00 a.m. Birbiglia is also sure to note the irony in his having to pay six times more for the window than he did for the room. Taken out of a humorous context, this could be a horrifying story. But Birbiglia’s presentation gives audiences permission to literally laugh at his experience of near death – and, perhaps, demonstrates to them that it is possible to find the humor in their own brush with death one day.

Birbiglia is also successful in enabling audiences to place themselves in his shoes, and in those of the witnesses to the incident and its aftermath. He essentially asks the question, “What would you do if you were bleeding in your underwear in the middle of the night and had to notify the front desk about what happened?” What is funny is Birbiglia’s casual, almost business-like perception of the interaction. He just jumped through a window, but is concerned more about demonstrating his credibility by pointing out that he is staying in the hotel. It is also a surprising deviation from the norm that the attendant did not act with alarm, but instead seemed “mildly retarded,” and gave an indifferent shrug of his shoulders. Additionally, the doctor’s grim statement of “You should be dead” brought about an unexpected reaction from Birbiglia: “‘No, you should’...I zinged him!” As seen in duPre (1998), Birbiglia felt the need to interject humor into an otherwise sterile medical interaction. The recounting of this incident, additionally, assisted in the development of this episode’s humor.
Denial and the Sleeping Bag Shackles: Learning Lessons from Sleepwalking

Through the use of narrative, Birbiglia is also provided an opportunity to critique his decision-making process in initially neglecting to receive treatment. Though he became a bit concerned after his Tivo tumble, and despite the fact that his attempts to seek information about sleepwalking resulted in his stumbling across an exact description of his symptoms, Birbiglia ignored the advice of his MD father to see a doctor, and did not adhere to the preventative measures recommended by Dr. Dement. Because he was “in denial” – a positive trait when attempting to hack it as a comedian – and “busy,” Birbiglia attempted to justify his belief that he could harness “Sleeping Mike.”

The statement “Maybe I should see a doctor. Maybe I’ll eat dinner” can be considered funny because Birbiglia valued stubbornness and convenience to such a large extent, despite experiencing incredibly abnormal, and potentially devastating, circumstances. His excuses are hysterically weak in this context. It is important to note that the night Birbiglia jumped through the window, he fell asleep to a news program that featured a story about war – blatantly ignoring the warnings of The Promise of Sleep. Birbiglia’s critique of himself as a negative role model and the final comments by the co-host of This American Life are clearly a call to action for those suffering from sleep disorders to seek help before it is too late. Birbiglia’s ability to attribute a reason for the consequences of his disorder, and apply it to a context which affects his everyday life – that he was “in denial,” which is essential for a comedian to succeed, but could result in death – demonstrates that he was able to achieve closure through the formulation of his experience.
Not only is Birbiglia still currently recovering from a series of traumatic and embarrassing events, he is also adjusting to a new life as a “person with a disorder.” Aside from being forced to change his lifestyle in order to prevent another window-jumping incident, Birbiglia may also be questioning whether showing signs of RBD at such a young age (23 years old – far removed from the average onset age of 60) is especially problematic. Is this a manifestation of something more serious down the road? Do I have a greater chance of eventually developing Parkinson’s or dementia? Even when preventative measures are utilized, it is clear that Birbiglia will forever possess a slightly bifurcated identity – “Conscious Mike” and a newly-controlled “Sleeping Mike.”

Why is This Theme Funny and Compelling?

Analyzing Birbiglia’s RBD narrative in psychological health and face-saving terms calls immediate attention to his reaction toward his necessary changes in lifestyle. It is clear, in a painfully hilarious way, that Birbiglia, a grown man, has lost a bit of his dignity by being forced to restrain himself within a sleeping bag. What grown, now-married man must strap himself down each night – in his own bed, no less? To add insult to injury, he must also sport mittens so that he does not unzip the bag and escape. Yet, calling to mind the image of a restless Birbiglia struggling with all his might to subconsciously escape from his confines (which he performs with deft comic touch – like the karate pose he strikes in the face of the imaginary jackal), evokes feelings of empathy rather than puzzlement and awkward distaste. No matter how odd it appears, Birbiglia’s use of a sleeping bag is his own unique method of asserting control over his RBD. Each night, for the good of himself and of society, he traps The Hulk within the confines of an impenetrable nylon pouch. It is actually incredibly endearing.
Like every other story he tells, Birbiglia takes the most ridiculous aspects of his
life – stuff that some people might be absolutely horrified to share – and uses it to make
fun of himself for us, the audience. It is clear that the sleeping bag simply fits his created
persona: Because he is always so self-deprecating, it makes sense in the grand scheme of
things. A person of such good-natured social awkwardness would be so strange as to
package his flailing limbs in a sleeping bag at night, or subconsciously fear that he might
actually have to take a crack at a hovering, malicious jackal. Birbiglia is open and
completely vulnerable – the audience gets to know him – it is an intimate experience.
Empathy creates social support in the form of mutual laughter, which Birbiglia has
received in endless supply over the past two years. And social support/affiliation, of
course, aids in the healing process.

Birbiglia’s use of humor also enables him to call greater attention to a serious
disorder about which most people know little. Again, Birbiglia repeatedly provides his
listeners with concrete, mutually understandable examples of the fear and adrenaline
associated with handing over control of one’s body in the middle of the night.
Sleepwalking may thus be perceived as more serious than one initially thought, and
listeners may subsequently be able to empathize with friends who suffer from a sleeping
disorder. As a result, Birbiglia’s story is both shocking and unique. He does use a bit of
sensationalism to gain audience attention (for instance, picking only his most shocking
and oddball sleepwalking behaviors). This could result in individuals with even the
mildest sleeping disorders becoming overly fearful that they too will jump through a
window.
Interestingly, during his nationwide “Sleep While Standing” tour, Birbiglia and his team set up a “video confession” booth in the theater lobby to allow audience members to record their own humorous sleepwalking stories after the show. Some of these stories were later posted on Birbiglia’s website. Clearly, Birbiglia’s narrative may have resulted in a greater overall audience awareness and education of RBD and sleepwalking in general.

**Subtextual Issues**

The primary goal and value of Birbiglia’s illness trauma narrative is the reacquisition of a sense of control by coming to terms with denial. As Birbiglia’s ability to control “Sleeping Mike” on his own becomes increasingly compromised, his narrative takes on a regressive and chaotic form, culminating in his “Hulk out” experience. But from the moment he seeks medical treatment for his gashes and ultimately decides to visit a sleep professional in New York, Birbiglia tells a progressive restitution narrative. His health problems can be remedied and the body can return to a sense of normalcy – to a degree. Ultimately, though, his story takes on the dynamics of a cautionary tale by urging listeners to take sleeping disorders seriously before it is too late.

**Biomedical vs. Interpretive Perspectives**

Because RBD is not a particularly well-known illness, Birbiglia’s decision to intertwine clinical information and a more personalized view of his sleepwalking experience is significant in allowing audiences to gain and retain information through the dissemination of his narrative. In addition to comparing his sleepwalking experience to being unconsciously drunk, Birbiglia cites biomedical information from *The Promise of Sleep* when discussing the ramifications of dopamine deficiency. He also discusses Dr.
Dement’s suggestions for restful sleep – namely, by ridding himself of any sensory-amplifying technology and huge meals several hours before bed.

**Engagement vs. Fatalism**

Through close examination of his narrative, one gets the sense that Birbiglia feels he holds sway over the course of his experience of illness and health-seeking behavior. RBD, while not completely curable, is controllable through medication and preventative measures. Though Birbiglia is essentially renting his body out to another user as he sleeps, his decision to see a medical professional can ultimately allow himself to be placed behind the wheel again for good. For now, Birbiglia holds compete and total engagement over his illness experience – it is simply a matter of whether or not he wants to employ it. It will be interesting to note whether the supposed degenerative nature of RBD as a precursor for something more serious down the road will cause Birbiglia’s sense of engagement to slide into fatalism territory.

Overall, Birbiglia’s RBD narrative can be viewed as an effective model for the implementation of humor into the formulation of one’s medical experience, and is a prime example of the positive effects of humorous storytelling on both the author and his or her intended audience in the face of a traumatic illness experience.
CHAPTER IV

Burnt Up: Richard Pryor and the Pipe

“The last twenty minutes is one of the most remarkable marriages of comedy and truth I have ever seen. He talks with great honesty about his drug addiction, his accident, and how his life has changed since he stopped using drugs...Watching Richard Pryor Live on the Sunset Strip, a breathtaking performance by a man who came within a hair of killing himself with drugs, was like a gift, as if Pryor had come back from the dead to perform in his own one-man memory of himself. It is good we still have him. He is better than ever.”

- Film Critic Roger Ebert’s (1982) review of Richard Pryor: Live on the Sunset Strip

Introduction

In June 1980, superstar actor and comedian Richard Pryor suffered third degree burns across the upper half of his body at his suburban Los Angeles home. Rumors raged that Pryor, an open and unrepentant user of drugs and alcohol, had been the victim of a cocaine-freebasing mishap. Two years after the incident, in 1982’s concert film Richard Pryor Live on the Sunset Strip, Pryor himself perpetuated these rumors, recounting – in an open and somehow hilarious manner – his battles with addiction and the drug-infused accident that brought him within inches of his life.

But the “accident,” he later admitted to Barbara Walters during a television interview in 1986, had really been a macabre suicide attempt through self-immolation. In a cocaine-fueled haze after freebasing for three straight days, Pryor doused himself with a bottle of 151-proof rum and flicked his lighter. He then ran from his home and down the street until he was subdued by police. Pryor spent six weeks in recovery at a burn center. “I was crazy,” he said of his drug-related psychosis, and his drug addiction was so strong
he “couldn’t stop for five minutes” (Esckilsen, 1994). Cooper (2002) says Pryor attempted to take his own life out of despair for being unable to kick his addiction.

*Sunset Strip* was the first time Pryor had been back on stage since setting himself on fire. Although the details of what *directly* instigated the incident vary, Pryor utilized *Sunset Strip* – and more specifically, humorous storytelling – as an opportunity to discuss and typify the severity of his addiction and the slow, painful process of recovering from third-degree burns. But unlike Mike Birbiglia, Pryor was a global superstar at the time of his brush with death. Because his frequent drug use and hospitalization were widely publicized, Pryor’s audience was doubly aware of his vulnerability, and, naturally, steeped in preconceived notions. Mike Birbiglia did not ask to develop RBD. The public is much less forgiving (and prone to finger-pointing), however, when it comes to drug addiction. For a comedian who had always projected utter confidence in his material and had cashed in on a hip, countercultural image for years, presenting an illness trauma narrative detailing human frailty and self-destruction was bold, and likely as stressful as it was therapeutic and liberating. *Sunset Strip* also facilitated and maintained public discussion about the dangers of freebasing, which received national media coverage following the incident in 1980.

**Plot**

A giant elephant looms tall behind Richard Pryor on stage at the Hollywood Palladium during the first hour of *Live on the Sunset Strip* (1982). “I got so fuckin’ nervous myself today, I forgot what the fuck I did [for a living],” he mentions during the opening minutes. It’s a shaky start; he’s not, at first, the supremely confident, cocky Richard Pryor of his earlier comedy specials. But Pryor eventually gets the ball rolling:
His one-man vignettes about working with Youngstown, Ohio mobsters as a teenager and observing the wildlife in a Kenyan jungle are some of his most classic bits.

Pryor’s freebasing and burn-recovery narrative does not possess the same stringent literary organization and straightforward chronology as Birbiglia’s tale. Pryor’s story seems to jump back and forth in time until he mentions the first time he ever freebased. From there, it adheres to a more forward-moving momentum, but with little emphasis placed on attempting to integrate rising action. Whereas Birbiglia tries to build energy toward his window-jumping climax, Pryor tells audiences from the start of his narrative that he “burnt up in his own house,” thus diminishing much of the tension associated with approaching an unexpected result. This method was most likely employed because Pryor was a much bigger star than Birbiglia, and his brush with death was already well-publicized. Pryor also seems to introduce his discussion of the actual “burnt up” incident rather out-of-the-blue, and does not offer many details of how it occurred.

Because of its rather unorganized presentation, and inclusion of several spontaneous and improvised asides – typical of Pryor’s unrestricted live comedy – Pryor’s narrative appears much more free-wheeling and impulsive than Birbiglia’s story, and does not seem to have been crafted or oriented as methodically. This is not a knock against Pryor, but an observation that Birbiglia had to be especially proficient in tying the disparate elements of his story together with a bow because it was a part of a much larger story which required a great deal of preparation. One can argue that Pryor’s story had not been shared or practiced as often as Birbiglia’s had at the time of their recordings.
Abstract

Pryor does not explicitly mention being “burnt up” until minute 52 of Sunset Strip, and even then, it’s not Pryor himself that brings it up. After stating that “all Italian people are not in the Mafia...most of them work for the Mafia, but they’re all not in the Mafia,” members of the audience begin clamoring for Pryor to “Do the Mudbone routine!” Mudbone is a recurring character in many of Pryor’s stand-up shows, and perhaps his most famous creation. A wino philosopher born in Tupelo, Mississippi, Mudbone imparts his cracked wisdom upon the audience in the form of free-wheeling monologues usually revolving around his ludicrous life experiences. Pryor reluctantly agrees, stating that “This is the last time Mudbone will be seen anywhere.” He sits on a stool and begins to improvise: “You know, now, I knownt that boy [Pryor]. See, he[‘s] fucked up. That fire got on his ass and it fucked him up upstairs. Fried up what little brains he had.” Mudbone later says of Pryor, “Don’t let him get none of that powder in his nose. That’s like tryin’ to talk to a baboon’s ass. I talked to the boy seven days and seven nights. He was still on the same subject: ‘Where can I get some more?’”

Mudbone concludes his rambling, six-minute take on life’s mysteries by stating, “The point I’m tryin’ to make is that there is no point to be made. That’s all it is. There ain’t no point to it. ‘Cause you didn’t ask to come to this motherfucker and you sure can’t choose how to leave, ‘cause you don’t know when you’re gonna go. So don’t take this shit sad. You better have some fun, and plenty of it. ‘Cause when this shit over and you ask for a recharge, it’s too late. So all I can say is keep some sunshine on your face.”
Orientation

Pryor begins speaking about his tenuous relationship with an old friend, a dope dealer who started poking fun at him for the “burnt up rings” around his neck. “And it hit me, because I had never thought of myself like that. ‘Cause I said, ‘Yeah, I’ve been burnt up’...Most people I meet, I act like I ain’t burnt up, they do too.” He imitates the inquisitive looks shot at him by people who saw his scars but never overtly brought up the incident. “People would say, ‘Nice tattoo you have...all over your body.’”

Pryor then puts himself in the place of his audience, who, bear in mind, certainly already knew about the incident. “I guess you all say, ‘Fuck all that, how’d you burn up? How’d you burn up in your own house, motherfucker?’” He claims that the stories they’ve heard about “‘Basin’ this, and ether that” are untrue. Pryor proceeds to tell them “the truth” about the incident: Not that it was (allegedly) a suicide attempt by self-immolation (one inspired by a deep, drug-infused despair), but an accident involving his ritualistic nighttime snack of milk and cookies. “One night I had some low fat milk and some pasteurized, and I mixed them together, and I dipped my cookie and the shit blew up! I mean the damndest thing I’ve ever heard of in my life. Medical history was made.”

Pryor alludes to the fact that he believed his chances of setting himself on fire while freebasing were roughly the equivalent of his milk and cookies causing him to erupt in flames. “All the people you’ve ever heard of freebasing, have you ever heard of anybody blowing up? Why me? Ten million motherfuckers freebase, I gotta blow up.” He said he should have known that something bad was going to happen to him, because the first time he ever freebased he accidentally set his bed on fire. (He imitates his
response to a friend who pointed this out, slowly and blankly as if he were stoned:

“Whaaaaaat? The bedddd’s on fire?”

He then says that addiction to cocaine is “a weird disease.” “If any of you people out there are doing it, I know you ain’t going to believe this, but if you’ve been doing longer than two weeks, you’re a junkie. I’m telling you, and I’m telling you so you’ll know it. And I know you’ll tell yourself, ‘I ain’t no fuckin’ junkie, not gonna hook me,’ but you cannot stop if you wanted to. You’ll go home tonight and say ‘Watch me.’ You will not be able to. If you got the shit there, you will do it.” He humorously imitates the process of setting his pipe down and being unable to walk away from it. “One time it looked like I had an appendage on my hand, was a pipe.”

Pryor begins to use a soft, comforting, positive voice to personify his pipe. “This pipe used to tell me when to go to bed. Pipe would say, ‘Time to get up. Time for some smoke, Rich. Come on now, we’re not gonna do anything today. Fuck all your appointments, me and you just gonna hang out in this room together.’ And I’d get mad and frustrated, people didn’t understand me. The pipe’d say ‘Come on in the room with me, I’ve gotcha covered. I know how you feel, Rich, I understand. Just light me up, hold me for a couple days and we’ll talk it over.”

Pryor was still in denial a year later (despite alluding to the fact that his cheeks were essentially drawn in and lips puckered almost permanently): “I was drawin’ up, fucked up, and out of my mind. But I’m not hooked. And people tryin’ to help me, I’d say, ‘You’re just meddlin’ in my mutha-fuckin’ business! You just think because I’m having a good – leave me the fuck alone!’ And I’m smokin’ my shit, because my pipe would say, ‘I understand, Rich, they don’t know. It’s your life; they don’t have a right to
fuck with you. Where were they when you needed them? Come on in here with me because I love ya.”

The pipe’s malevolence wasn’t apparent to Pryor until later. “‘You let me get a little low yesterday,’” it began to say. “‘I don’t like that. Now don’t let me get low again or I’m gonna hurt ya! You promise? Keep me full at all times, okay? Come on, Rich, you can do it. ‘Cause I understand.’” He said that he was so addled with drugs so frequently that even dope dealers began to cut him off. “‘I’m sorry, brother. I can’t see you do it to yourself,’” they would say. “Dope dealers don’t give a fuck about nothing usually...Said, ‘No, motherfucker, you killin’ yourself!’” Pryor says, “What?!” in mock disbelief, and states that you could sooner “get free food in a Chinese restaurant” than have a dope dealer refuse to sell to you. They suggested he simply take up snorting again, and he would acquiesce: “‘Just give me enough for the weekend, I’m gonna snort.’ ‘Okay, how much you want?’ A kilo,” he says menacingly, lowering his voice as if an insatiable demon within couldn’t resist the opportunity to speak up.

Despite this, Pryor says he still didn’t know he was a junkie. “I weigh about 103. I look like [He puckers his face again]. Ain’t been out my room in eight weeks. Funk is my shadow.” Finally, Pryor’s wife called his friend, actor and NFL Hall of Famer Jim Brown, and asked him to come over. Upon hearing the news, Pryor screamed to himself, “FUCK Jim Brown! I’ll show Jim Brown. I’m the man, I don’t give a fuck. Nobody afraid of Jim Brown here!” He acts out hearing the doorbell and nervously scrambling to get his pipe, all the while exuding mock defiance and bravery in the face of an intervention with the incredibly intimidating Brown.
Pryor’s pipe fed into his motivation: “‘Come on, Rich. Me and you, we’ll show Jim, don’t worry about it. Shit, Jim don’t scare nobody. That’s right, Rich.’” Brown walked into the room, and Pryor starts hitting his pipe like it is the greatest thing in the world. He cannot help but look terrified. “‘Hey Jim,’” he says casually in between ridiculously exaggerated drags. “‘How ya doin, brah?’” Brown asks him if he wants to go roller skating or for a ride. Pryor acts like Brown is crazy; he’s clearly preoccupied and content with his pipe. (Pryor acts out the ridiculous process of hitting and gesturing toward the pipe nervously in front of Brown for close to 30 seconds). Brown simply asks, “‘Whatcha gonna do?’” Pryor responds, “‘What do you mean?’” “‘Whatcha gonna do...about that shit?’ ‘What? Um, I’m doin’ what I wanna do [Pryor sounds terrified].’ ‘You know, I ain’t afraid of you, you know. You ain’t no movie star to me. I ain’t scared of you, motherfucker, I’m your friend. Whatcha gonna do? You gonna get well, or you gonna end our friendship? Whatcha gonna do?’”

The pipe said, “‘Don’t listen. He tryin to fuck with you, Rich.’” Pryor begins to defend himself: “‘Jim, I am a man.’” Brown replies, “‘There ain’t no doubt about that. But whatcha gonna do?’” He followed Pryor down the hall, repeating the words “‘Whatcha gonna do?’” despite the comedian’s pleas for him to stop and leave him alone. He admits that Brown almost got him to go to a hospital, but he made the mistake of briefly having to go home. That gave Pryor enough of a window to listen to the pipe once again: “‘Hey, Rich. Jim’s gone,’” it whispered. Pryor says that no matter how many times a person with a cocaine addiction breaks their pipe they go out immediately to buy a new one. “This addiction, it’s a monster. It’s pitiful.” He pretends to scavenge the floor of his
house looking for something, anything, else (a piece of a log) to smoke. “I wonder how my sleeve would taste?”

**Complicating Action**

Finally, Pryor found a solution. Unfortunately, it almost cost him his life. Out of the blue, and matter-of-factly, Pryor says, “When that fire hits your ass, that will sober your ass up quick! I mean, I was standing there on fire and something said, ‘Why, that’s a pretty blue. You know what? That looks like...FIIIIIIIIIRRRE!’ Fire is inspirational. They should use it in the Olympics, because I did the 100-yard dash in 4.3. And you know somethin’ I found out? When you’re on fire and running down the street, people will get out of your way...except for one old drunk. He was goin,’ ‘Hey, buddy, can I get a light? Just a little off the sleeve?’”

Pryor portrays a doctor’s reaction when he arrived at the hospital: A horrified, high-pitched gasp, arms waving above his head, and a “Holy shit...Why don’t we get some coleslaw and serve this up?” Pryor says he was lying there in the hospital “with tubes and shit up my nose, and an IV in my arm,” and a man came in to his room wanting an autograph. “I mean, steam and shit was still comin’ off me.” He imitates the man obliviously attempting to speak with him and casually using his hand to fan the smoke away from his toasted body. “Come on, Rich, let me have this last autograph.”

**Result**

Pryor says that Brown visited him every day while he was in the burn ward “getting well.” Pryor was able to gain strength from his visits because Brown has “never been hurt, so I can’t show no pain. I’ve gotta show my strength and try to get well.” (Pryor says that “fire jumped on Jim once.” He said, “Hey,” and brushed it away.) “And I
was doin’ real good, because nature is wonderful. When you burn up, your skin goes to
sleep, because nature says, ‘I can’t deal with it!’ So you don’t feel shit for about three
days until your nerves wake up. I didn’t know that. I figured, ‘I ain’t feelin’ nothin’,
everything’s fine.’’

Pryor discusses his puzzlement at the individuals on the medical staff that treated
him: “They’re unique people, [those] who work with burnt people, because I don’t know
if I could work with no motherfuckin’ burnt up. Put some butter on ‘em, and say, ‘That’s
it.’” Every day one of his nurses would enthusiastically inform Pryor that he would get a
bath in a few days: “We’re gonna wash you, Rich, we’re gonna wash you down, and
you’re gonna feel great!” Pryor was baffled, and a bit annoyed, by the nurse’s emphasis
and enthusiasm on the subject. He was left wondering what the big deal was. “I should
have known something was wrong, because this motherfucker would come every day
with this, ‘Don’t worry, now, we’re gonna put you in the tub, and it’s gonna be alright,
don’t worry.’ And I said, ‘I’m not worried, motherfucker. Put my ass in the tub.’”

Finally, the day arrived, and Pryor sits on the stage steps to emulate resting in the
tub. Pryor portrays the feeling of having his skin rubbed by a sponge by making a high
pitched squealing sound – like a harsh riff on a violin or nails running slowly down a
chalkboard. His minute-long, mostly non-verbal reaction is priceless as he pretends to
do everything in his power not to cry out in agony at the top of his lungs. “Don’t...don’t
wash me no more,” he whimpers and sobs quietly. He is absolutely defeated. “Not even
my little finger. No...no...no you will not...Don’t wash me no motherfuckin’ more...And
if you do, I will bite you, you motherfuckin’...I don’t care if I die, don’t you wash me no
more.” “But they were wonderful,” he says of the staff in the end.
Evaluation

“You find God quick when they find your ass dead,” Pryor says. He was bandaged up watching TV one night in the hospital, and the news reported that he had died five minutes earlier. He mocks his attempts to scream “Nooooo!” through the bandages covering his mouth. Pryor briefly mentions the stigma surrounding drug addiction. “I thank God every day,” he said. “I say, ‘God, thank you for not burning my dick. Because most people said, ‘You’ve been punished by God!’ I said, ‘No! If God wanted to punish my ass, He’d have burnt my dick. Now that’s some punishment. Because when that fire hit my ass, my dick went to work. It said, ‘EMERGENCY! Piss, cum, do something! Keep the fire off the balls!’”

Coda

Pryor asks an audience member to give him a light for his cigarette. Before striking a match, members of the audience scream, “Don’t do it!” Pryor laughs and says, “Say, watch out.” His energy level immediately drops; he appears incredibly relaxed.

“Listen, ya’ll have been wonderful to come and share this with us, and I think everyone connected with the...,” his voice trails off. “It’s been a pleasure for me to do this and get up here, and I thank you very much. I want to say ya’ll gave me a lot of love when I was not feeling well, and I really appreciate it...Also, ya’ll did some nasty-ass jokes on my ass too. Oh yeah, ya’ll didn’t think I saw some of these, since you loooove me so much. I remember this one.” He strikes a match and moves it from left to right across his face.

“What’s that? Richard Pryor runnin’ down the street.” Aretha Franklin’s “Respect” plays as the closing credits roll.
Themes

Through an analysis of Pryor’s narrative, three themes become prevalent: drug addiction as desperation and depletion of control, drug addiction as culminating in an inevitable brush with death, and the physical and emotional agony of recovery.

The Pipe: Drug Addiction as Desperation and Helplessness

Pryor most significantly exemplifies his experience of drug addiction through the use of personification to demonstrate his increasingly intimate relationship with his pipe. Pryor also relays a pervading sense of helplessness and desperation underlying the jokes he cracks regarding his insatiable freebasing habit and its impact on his life. Pryor is successful in advancing the notion that the more addicted to cocaine he became, the more an inanimate object began taking on human characteristics and holding over him a physical, persuasive, and destructive influence.

Like Birbiglia, Pryor’s moralization of his drug abuse can be characterized as the forfeiture of the moral self by the invasion of an evil predator (Kline 2003). Somewhat similarly, this predator pretended to be a friend who would always soothe and understand Pryor, providing support and telling him exactly what he wanted to hear – even calling him “Rich” in the process. Yet, the pipe slowly claimed more and more of Pryor’s moral self every single time he hung with it. Its opinion immediately took precedent above those of his real friends. By threatening violence, the pipe’s presence also enabled Pryor to justify his decisions to blow off all his responsibilities, ignore Jim Brown’s intimidating pleas for help, and continue using at all costs. Thus, Pryor is describing the “ultimate enabler” to his illicit behavior – a friend who seduced him with comfort and empathy, but was actually pointing a gun at him from its coat pocket since day one. It
should be noted that, unlike Birbiglia, Pryor had a hand in the creation of the predator by choosing to do drugs in the first place.

It is also quite interesting that Pryor utilized the very first words coming from the mouth of an alter-ego – Mudbone – to introduce the subject of his drug addiction and brush with death. It was almost as if the subject was on the tip of his tongue the entire show, but he had no idea how to approach it himself. But the second Pryor realized that someone else could poke fun at him – an idea planted into his head by the audience members who requested to see the character – everything began to spill out. Through the remarkable use of extemporization, Pryor is spontaneously characterized by Mudbone as being “fucked up,” a single-minded coke-hound who is only capable of discussing how he can acquire more drugs. Mudbone also emphasizes the importance of living life to the fullest, because it could end at any second. Through Mudbone, Pryor employs a distancing agent to initially separate the dreaded drug addiction and immolation topic from a sense of his “naked I” (duPre, 1998).

Pryor’s comparison of his character to that of Jim Brown also demonstrates his frequently self-detrimental perception of himself as an addict. While Brown has allegedly never felt pain or weakness for a second in his life, Pryor is comparatively sniveling, weak, helpless, and cowardly. Yet, Pryor characterizes addiction as “a weird disease,” which classifies his belief that it is a serious, tangible, physical ailment shared by many. To a degree, Pryor is retrospectively able to exert meaning for his experience and concordantly alleviate some of the blame he has placed on himself for becoming powerless to drugs. Sharf and Vanderford (2003, p. 14) define disease as “organic malfunctions and pathological processes whose signs and symptoms typically can be
observed and quantitatively assessed.” Pryor also offers a warning to current and potential users by mentioning how incredibly easy it is to get hooked – claiming that, despite one’s sense of invincibility, it takes no longer than two weeks of casual usage to become “a junkie.” He also references his own past denial of his addiction and calls cocaine dependency a “monster” and “pitiful.”

Outside of Jim Brown and a quick mention of his wife, Pryor does not include a great human presence within his freebasing episodes. Cocaine addiction, to Pryor, is characterized as a disease of isolation. Pryor would go into his room with his pipe for days at a time, emerging for nothing. The more the world seemed to close in around Pryor when friends and associates questioned him about his drug use, the more he retreated to his sanctuary to be consoled. Like Birbiglia, Pryor characterizes his illness as a private battle for control over his mind and body waged between his rapidly-diminishing moral self and an increasingly evil predator.

Why is This Theme Funny and Compelling?

Like Birbiglia, Pryor’s ability to utilize effective humor cues meant to poke fun at himself enables audiences to understand that it is okay to laugh at portrayals of his increasingly desperate behavior. Pryor mocks his slow, stoned response to being informed he had set the bed on fire by decreasing his rate of speech, utilizing a droning vocal tone, and blinking vapidly. His insatiable need for drugs is characterized by a low, demonic voice. Pryor humorously imitates his ritual of setting his pipe down and being completely unable to walk away from it, and portrays his ridiculous faux defiance and sense of cool in the face of an intervening Jim Brown. Multiple times, Pryor draws his cheeks in and puckers his lips, informing the audience that his mouth might as well have
been permanently kept in that position. He also pretends to search desperately across the floor after breaking his pipe to find something, anything, he could use instead. Pryor was so hooked he was willing to smoke his own sleeve. Even crack dealers refused to sell to him. Pryor’s ability to describe what he experienced in a unique fashion allows non-users to better understand the difficulties of overcoming drug addiction – particularly by entertainingly imitating elements of his addiction experience through humorous gestures, facial expressions, and body movements.

**Burnt Up: Drug Addiction as an Inevitable Brush with Death**

Pryor’s “burnt up” narrative represents his ability to be morbid about his traumatic experience, and allows him to reframe the physical agony he endured, as well as the embarrassment of receiving national media attention by somehow managing to set himself on fire. Pryor’s description of his freebasing habits up to this point makes it seem inevitable that something horrible will happen to him. But again, by publicly and tastelessly mocking the experience, Pryor is able to distance himself from his severe injuries and close call with death. At the same time, he demonstrates his power over aspects of his life with which he had trouble coping. In keeping with Freud (1905; 1928), Pryor may be able to find humor through this subject because he is not entirely sure how else to articulate his viewpoint of the issue.

Pryor knows that everyone in the audience is aware of his unrepentant drug use and the fire incident. As such, he juxtaposes aspects of his troubled personal life with an extremely innocent, childlike pastime by comically claiming that “the true” reason he was set aflame was due to an unfortunate milk and cookies explosion. Ah yes, one of *those*. Because it was delivered near the beginning of the freebasing narrative after the
Mudbone impression, this joke served to poke fun at the audience, their preconceived notions of the events leading up to the incident, and their perception of the giant elephant in the room. It also simultaneously allowed Pryor to find a way to introduce the topic without the help of an alter-ego and without losing face.

The incident was also labeled a freak accident – a one-in-ten-million chance, about as likely as having a midnight snack blow up in someone’s face. Thus, his classification may have allowed him to achieve distance from the incident and alleviate a sense of responsibility over its occurrence. It was simply a matter of fate. Yet, Pryor is also able to recall a seemingly disparate episode in which he set his bed on fire while freebasing. Perhaps after all, he should have known something horrible could occur. Despite this knowledge, the strength of Pryor’s addiction, his inability to drop the pipe, and his concordant denial created a perfect storm which sent him down an inevitable and inescapable path toward some type of self-destruction. Lighting himself on fire was a freak accident that he could no longer avoid, because he had long ago set the events in motion: “You cannot stop if you wanted to.”

Why is This Theme Funny and Compelling?

Pryor demonstrates that fire can “sober your ass up quick”: “Why that’s a pretty blue…” The audience cannot believe Pryor is making such morbid jokes at his own expense, and in such an animated, over-exaggerated manner. Pryor refers to the Olympic-quality speed at which he tore down the street after setting himself on fire. He impersonates a doctor who treated him, shrieking and throwing his arms above his head when he sees Pryor’s wounds. Clearly, this did not happen, but it is a funny image because doctors have “seen it all” and seem to maintain their professionalism at all costs.
Pryor’s injuries were embellished as being so bad (“Steam and shit was still comin’ off me”) his doctor completely lost it, even saying “Why don’t we get some coleslaw and serve this up?” as if Pryor came into the hospital on a bed of lettuce and an apple in his mouth.

Pryor creates such a sense of collective intimacy and closure regarding his experience that the audience feels comfortable cracking jokes at his expense the second he wraps up his story. When Pryor attempts to light a cigarette on-stage, members of his audience scream “Don’t do it!” He also openly, honestly, and spontaneously closes his set with a “nasty-ass joke” he allegedly heard from someone else as he lights a match, moves it horizontally across his face, and claims that it’s “Richard Pryor running down the street!” Again, Pryor is able to demonstrate that he understands the incident from multiple viewpoints: his own and his audience’s.

Pryor also jokes about the insensitivity expressed to him by some members of society in the wake of his accident: He imitates a fan who oblivious to seek an autograph from Pryor as he lies in bed with tubes up his nose (“Come on, Rich, let me have this last autograph”), and cracks that even if one is running down the street engulfed in flames, an old drunk will still ask for a light (“Just a little off the sleeve?”)

It is also interesting to note the language Pryor frequently uses to characterize the incident: Being “burnt up.” Pryor calls on his trademark dynamism and almost lyrical flow of words to increase engagement. To write the words on the page is to lose out on Pryor’s fantastic rhythm of language.
“I Ain’t Dead Yet, Motherfucker!” – The Physical and Emotional Agony of Recovery

Pryor also toys with the notion that it took him quite some time to emotionally come to terms with suffering such intense burns, because most people – except for a pissed off dope dealer – refused to overtly acknowledge the presence of, and reason for, his wounds. Clearly, by describing his marks as “burnt up rings” and as a full-body tattoo, he is self-conscious about their existence. However, Pryor is able to identify with those in the burn ward – albeit, not in a necessarily positive way – by wondering how his medical staff could work with people who suffered similar injuries. Pryor refers to himself in noun form as “(a) motherfuckin’ burnt up,” and gives credit to his staff for being so positive around his fellow burn victims, because he views them basically as lost causes: “Put some butter on ‘em, and say, ‘That’s it.’”

Pryor also claims to have found God as a result of his near-death experience. He notes that if he were really being punished by God, as some had claimed, then He would have burned “his dick.” Although Pryor believes that losing his masculinity is a fate worse than death, the real value of this statement in a health context is that Pryor has witnessed people express the notion that the horrible things that happen to drug addicts are actually a form of punishment from God. Similar sentiments have historically been expressed toward those living with AIDS and cancer, as if they had done something immoral, corrupt, or crazy in their life to deserve their illness (“Well, they had it coming”). People’s individuality, even their humanity, is overshadowed by this discrediting characteristic. Pryor’s ability to poke fun at himself is an attempt to reclaim it. Because much of his immediate audience had grown up with him, Pryor was successful in putting a face to drug addiction.
It is also incredibly interesting from a metacommunicative standpoint that Pryor ends his set by smoking a cigarette. Not only does it clearly bring to mind the relaxing practice of smoking after sex, but Pryor’s energy levels dropped significantly after sharing his narrative, and he appeared much calmer, perhaps indicating a sense of closure. The scholars who developed MetaHIT might characterize this as a “humorous relief narrative” (Bethea et al., 2000). Clearly his behaviors do not hinder the argument that his storytelling method was therapeutic.

*Why is This Theme Funny and Compelling?*

One instance of rising action in the recovery narrative involves the episode in which Pryor is overzealously prepared for his bath by a nurse. Both Pryor and the audience find it a little strange that his caregiver repeatedly places so much emphasis on how great a sponge bath will feel, and that it should not be something to worry about. Pryor’s skin was in a state of numbness (“asleep”), so he could not conceptualize any negative ramifications of being washed. But it is clear that a single touch from the sponge, normally a source of comfort and refreshment, was one of the most painful experiences of his life. Obviously the nurse, knowing how painful the procedure was, wanted to spare Pryor any trepidation. Pryor’s ability to demonstrate a sense of crippling pain through screeching sounds effects, muffled whimpers, and exaggerated gestures and facial expressions makes for a much more memorable, entertaining, and compelling experience than simply saying to audiences, “I had a sponge bath and it hurt really, really badly.” The audience simultaneously gains the ability to become a witness to Pryor’s suffering: He was in such pain that even the softest touch of a sponge left him begging for mercy.
The listener also quickly finds the irony in witnessing the report of one’s own death through the media. Pryor’s futile attempts to scream “Noooo!” through his bandages is hysterical because no one can hear him disprove the news report, as if even the hospital staff caring for him would believe everything they hear on television. This experience seemed to solidify the severity of the “burnt up” incident for Pryor, as if he needed another reason to attempt to clean up his act.

**Impact on Public Discussion of Freebasing Community**

*Sunset Strip* was Pryor’s most widely-seen theatrical concert film release, grossing $36.3 million on 1,277 screens over an 11-week span and finishing first at the box office after its first weekend (Box Office Mojo, 2009). Cooper (2002) states that media coverage of Pryor’s incident in 1980 greatly contributed to a change in public perception regarding cocaine use. Headlines included “Free Base: What It Is and Why It’s Dangerous” (*Los Angeles Herald Examiner*, 1980) and “Freebasing: A Highly Dangerous High” (*Philadelphia Daily News*, 1980). News stories featured freebase paraphernalia as reports about the occurrence and the “new” drug practice were told. Sales in cocaine freebase kits and chemicals for freebase preparation were reported to have declined for two weeks following the Pryor incident. It was also surmised that user demand increased for dealers to convert cocaine powder to freebase in advance, to avoid the danger and hassle associated with preparing the product themselves (Cooper, 2002). Certainly, Pryor’s health narrative further educated the public about recognizing the signs of drug addiction and knowing just how incredibly addictive (and dangerous) freebase is. Pryor certainly knows better than most.
**Subtextual Issues**

The primary goals and values of Pryor’s illness trauma narrative are the reacquisition of a sense of control by coming to terms with denial of one’s addiction, and achieving redemption of the moral self by enduring tragedy. While Pryor allows more and more of himself to be taken by the pipe, his freebasing episodes employ a regressive and chaotic form, peaking during the “burnt up” incident. Pryor portrays his addiction as a series of random events that are not well connected to one other. All events in Pryor’s life seem to go uncontrollably off-kilter, with no guarantee of becoming better. Once Pryor begins to receive treatment for his burns – and concordantly stops freebasing – he starts to utilize a progressive restitution narrative, because despite experiencing a great sense of physical and emotional trauma, Pryor’s body is given the opportunity to heal and detoxify. At least in form, Pryor’s tale includes somewhat of a happy ending. His story also takes on the dynamics of a cautionary tale by urging listeners to consider how truly easy it is to become hooked to cocaine, and how horrible of an experience addiction was for him.

*Biomedical vs. Interpretive Perspectives*

Pryor’s intention is not to set out and explain the biological, clinical aspects of addiction, or to specifically describe the procedures he endured while in the burn ward. Mainly, he sticks to his own experience of addiction and recovery, and allows others to explain exactly what the act of freebasing entails, and why his newly-burned skin “fell asleep” for several days after the incident. While freebasing may not have been a universally well-known method for consuming cocaine in 1982, the overall concept of addiction had long been described and accepted throughout society. Thus, Pryor may not
have felt it necessary to explain the biological reasons for his desperate need to smoke. Additionally, this information is simply not as crucial to the overall storyline as the clinical background of RBD is in order to fully understand Birbiglia’s plight. RBD is a disorder with which considerably fewer people are familiar.

Engagement vs. Fatalism

As previously mentioned, one gets the sense that Pryor felt completely powerless to his addiction. The pipe had a firm hold on him, and approaching Pryor about the topic seemed to send him spiraling deeper. He had absolutely no control over his own life, and none of his friends – including Jim Brown – were able to help him. It appeared as if his addiction was destined to culminate in a predetermined and inescapable tragedy. Indeed, it took a forced, long-term hospitalization for third-degree burns for Pryor to become clean.

Because of their differences in persona – Pryor the brash, hip, and cocky social commentator, Birbiglia the loveable, awkward, doughy goofball – vulnerability seems a much larger concern for Pryor. Perhaps that was why he characterizes his drug-inspired suicide attempt as an “accident” that directly involved drugs. Maybe it was hard enough for him to even admit he had a drug problem at that time to begin with. Maybe he needed four more years to reach a point in which he would benefit from taking it further.

In 1986, Pryor wrote, directed, produced, and starred in *Jo Jo Dancer, Your Life is Calling*, a fictional but autobiographical comedy about the rise and self-destruction of a famous comedian who sets himself on fire in a harrowing, drug-fueled despair, and must re-examine his life while lying unconscious in a burn ward. Pryor would also later make comedy out of personal tragedy by joking about his experience with multiple sclerosis up
until his death in 2005. Pryor also shared a humorous narrative about suffering a major heart attack in 1979’s *Richard Pryor: Live in Concert*. 
CHAPTER V

Shangri-Lost: Julia Sweeney and the “International House of Cancer”

“God may have swept aside her life plan with a wave and a chuckle, but, as her exquisite memoir recounts, Sweeney survived – by joining in on the laughter.”

- The Columbus Dispatch (Sweeney, 1997, “Praise”)

Introduction

Actress, comedian, writer, and Saturday Night Live veteran Julia Sweeney is known by many as the creator of “Pat,” a slovenly, nerdy, bespectacled, nasally-voiced anomaly just bulbous enough that one cannot tell whether he/she is a man or woman. The one-joke premise typically resulted in surrounding characters crafting intricate plans to determine Pat’s sex. But in the mid-nineties, several months after she left SNL for good, Sweeney and her family were touched by a stream of tragic circumstances. Following the ordeal, Sweeney shared her initial conceptualization of the experience in a series of serio-comic performances at a comedy club in Los Angeles. Eventually, Sweeney combined the stories into a one-person stage show – God Said, “Ha!” – which played in San Francisco before moving to Broadway in 1996 to much popular and critical acclaim. Sweeney also released a CD recording of the show, along with a theatrically-released film version in 1998 through Miramax. The film was directed by Sweeney and produced by her friend Quentin Tarantino, who also plays the part of himself.
Like the narratives crafted by Birbiglia and Pryor, Sweeney successfully utilizes humor to display just what happened when cancer affected two adults in the same family...at the same time...under the same roof.

**Plot**

Sweeney dedicates the book “To Mike,” and includes the poem *Parting* by Emily Dickinson:

> My life closed twice before its close;  
> It yet remains to see  
> If Immortality unveil  
> A third event to me,

So huge, so hopeless to conceive,  
As these that twice befell.  
Parting is all we know of heaven,  
And all we need of hell.

**Abstract**

The prologue and first few chapters of *God Said, “Ha!”* consist of mini-stories utilized to establish Sweeney and her relationships with the major figures in her life, and provide a mechanism for the development of the plot. During the summer of 1994, as a promotion for the release of her soon-to-be-major-flop of a film *It’s Pat*, Sweeney was asked to co-host MTV’s Summer Vacation Countdown from Hawaii with supermodel Daisy Fuentes – whom Sweeney describes as a “statuesque goddess” (p. xvi). Not only did Sweeney hate the notion of Hawaiian sun exposure – she claims that her skin “seems to have been made for a rainy forest in Ireland” (p. xii) – but they were both required to wear bathing suits. The comparatively insecure and pasty Sweeney groans, until she remembers something once said by Francois Gilot, the artist and former lover of Pablo Picasso, when she was asked why she thought Picasso was attracted to her: “Vell, he vas attracted too me becuz I was very very butte-e-fowl und very, very intel-ee-gente”
Sweeney had previously adopted Gilot’s matter-of-fact attitude whenever she needed a boost in her self-confidence – like the time she somehow attracted an actor she thought was handsome while she was dressed in her amorphous Pat costume.

Sweeney boarded the plane for Hawaii, armed with Gilot’s “I am beautiful and intelligent” frame of mind, and had a blast, claiming “Life just isn’t too bad if you can pull off a little attitude adjustment” (p. xvii).

Orientation

Sweeney’s first chapter tells of her relaxing vacation to England and Ireland with filmmaker friend Quentin (Tarantino, who directed Pulp Fiction) after she left Saturday Night Live. One day, they visited a small island off the coast of Ireland called Inish Turk. On the shoreline, both Sweeney and Quentin pocketed “lucky” rocks to keep and remind them of their trip. When they returned to the boat, a friend said, “You know the curse, don’t you? They say that for anyone who takes a rock off an island off the coast of Ireland, misfortune lies ahead” (p. 6). They ignored her and kept the rocks.

Sweeney then shares a story from her childhood to introduce the significance of her relationship with her brother Mike. When Sweeney was six she decided to steal $1.50 from her mother’s open purse. Racked by guilt and desperate to ditch her loot, Sweeney walked to the neighborhood market and bought a gallon of orange sherbet. She snuck back to her garage and ate as much as she could, but there was still plenty left and it was melting rapidly. Sweeney needed to find someone to get rid of the evidence, and fast. Luckily, a three-year-old Mike was playing in the sandbox out back, and proceeded to eat the remaining two-thirds of the gallon. Sweeney hid the carton behind some tools at the back of the garage, and they walked back to the house for dinner. Their mother was
incredibly suspicious of their recent escapades (“Now are you sure you don’t want to tell me something?” p. 11), but Sweeney lied through her teeth. That is, until Mike began to spew orange sherbet all over the floor (“It was like a fountain!” p. 12).

And Mike looked up at me with these big eyes like, “I can’t believe I blew it.” It was such a poignant look and I’ll never forget that look (p. 12).

She notes the irony in Mike starting his own ice cream truck business when he was eighteen, and discusses his propensity for becoming engaged in turf wars with a pre-existing ice cream-selling cartel already in the area.

Once Sweeney became an adult living in New York City and Los Angeles, she would usually see her parents for about two or three weeks a year. She describes one particular visit from her rather provincial, small-town mom and dad in which they dragged her to an obnoxious off-Broadway show called *Nunsense*. This, and several other factors, resulted in a rather aggravating evening. Sweeney uses this funny story to characterize the somewhat strained relationship between her and her parents.

After the third of her four years at *Saturday Night Live*, Sweeney and her husband went through an amicable breakup. Sweeney was incredibly excited to live on her own again, and purchased a little bungalow back in Hollywood – which she dubbed “my Shangri-La,” a symbol of her independence. She developed an elaborate fantasy for her new home involving sophisticated gourmet dinner parties and petite soirees marked by witty conversation and general leisure. She would spend long afternoons listening to music and writing all the screenplays she ever wanted to write.

And that’s when God just said… “Ha!” (p. 27).
Complicating Action

Two of Sweeney’s brothers, Mike and Jim, also lived in Los Angeles. Sweeney notes that before she moved away to New York, she shared an apartment building with Mike. They would co-host parties together, including one huge, ten-hour-long Thanksgiving dinner. Sweeney said when she bought her house, it was sad not to live right next door to Mike anymore.

Mike hadn’t been feeling well for awhile and, being a 30-year-old single guy without insurance, was constantly tested for HIV at the free clinic. The tests always came back negative and, “They didn’t keep searching for anything else” (p. 31). Mike was experiencing all kinds of weird symptoms – numbness in his left leg and chin, aching teeth and stomach, and tiredness. Sweeney said that because he figured it would go away, and because he knew that she would make a big deal about it, Mike did not tell her a thing about his symptoms.

While Mike was visiting a friend in Rochester, he passed out, was rushed to the hospital, and was diagnosed with an ulcer. He told Sweeney over the phone that was relieved to have found a reason for his horrible stomachache, and complained that the hospital nurses were surly. The doctors in Rochester had decided to do more tests, and eventually found that Mike had stage four lymphoma. “And there are only four stages,” Sweeney said (p. 33). Mike was in the hospital for six weeks. Sweeney set her family up with a hotel suite – “sort of a hotel apartment” (p. 33) – and Mike began to receive treatment.

They had given him an enormous dose of chemotherapy. It seemed to be unraveling the tumors but with lymphoma it’s tricky – lymph systems interact, if you will, and the devilish cancer could be anywhere, everywhere. Based on Mike’s age and condition, he had a forty percent chance of recovery. We
thought these odds were beatable. I looked at it like a class that you had to get into the top forty percent of in order to graduate. Easy.

But chemo kills cells, not just cancer cells. The bet with chemo is that the cancer cells won’t grow back and the healthy ones will replace themselves. This is a layperson’s description of chemo, but we did basically come to understand that the whole point of it was to make you sicker and then make you better. It’s kind of like dropping a neutron bomb into your body and then hoping that you have a kick-ass, internal Red Cross crew ready to pick up the pieces. Mike and I referred to the chemo as Drano.

Mike wasn’t doing well. One of his doctors there told Mike he was the sickest patient in the cancer ward. Another said, “Are you religious?” When Mike looked up at him, surprised, the doctor said, “If I were you, I would start praying.”

I guess that’s a prescription, in a way (pp. 33-34).

Sweeney notes that the previous weekend, her movie It’s Pat received terrible reviews and was closed after a week. But suddenly her career seemed such a puny concern. Sweeney offered her apartment to Mike “just temporarily – and until he could get back on his feet and feel well enough to be alone in his apartment again” (p. 35). Jim would come over constantly. After a few weeks, Sweeney’s distraught parents drove down from Spokane, Washington and moved in to Sweeney’s house too.

The catastrophic nature of the situation was slowly sinking in. People were bringing multiple suitcases.

And, for the next nine months, there we all were in my perfect little house made for one (p. 35).

Sweeney devotes the next five chapters solely to her suddenly altered life, and finally allows herself the opportunity to vent about the increasingly infuriating idiosyncrasies of her parents – people she had spent half of her life living away from. “And they’re there because of an awful crisis. You find that you can never really lose your temper because of the enormity of the whole situation” (p. 36). Appropriately, Sweeney titles Chapters 7 and 8 “Mom Rant” and “Dad Rant” respectively.
For example, this is how my mother would answer the phone: “Hello, this is Jeri Sweeney answering the telephone to take down a message for her daughter, Julia Sweeney.”

I had to take her aside and say, “You know, hello. That would be fine” (p. 37).

Sweeney also complains about her mother’s propensity for stringing together disconnecting ideas and trying to present them as one thought, her invasive laundry drying procedures, her wonderment at the miraculous technology of elevators, and her habit of constantly interrupting Sweeney when she was attempting to work in her office.

Another time she came back and she said, “Julie. I’m sorry to bother you, but the light has gone out in the bathroom and I found another bulb, but I didn’t know if you wanted it screwed in in some special way” (pp. 38-39).

Sweeney notes her mother’s attitude toward medical professionals as being authoritative experts in all health matters.

My mother is from that generation where they believe that doctors know everything about everything.

We’d be in a hallway in the hospital, and we’d be coming out of the office of the lymph cancer specialist. And he would have just given us a lot of information that is really somewhat confusing, but mostly scary, and on top of that, very very technical. And we’d see a group of doctors. (We’d know because they were all men and they kind of looked like stockbrokers, except they were wearing white instead of blue pinstripes.)

At that moment my mother would say, “There are some doctors. Maybe you should go ask THEM about lymph cancer.” And I would look at her like she’d just arrived from Mars. But she’d go on: “I just tracked down the number of Dr. Moore, you know, my old OB-GYN? And I was thinking that maybe you should call him and ask him what HE knows about lymph cancer” (pp. 40-41).

Sweeney’s dad spends all of his free time listening to National Public Radio on his walkman – even staying up for a special Canadian broadcast that starts at 3:00 a.m. He apparently has a thing for Cokie Roberts, and constantly provides his family with news updates. Sweeney’s dad is also a voracious reader, and is prone to spouting off arbitrary bits of information, which she says was oddly comforting given the circumstances. When Sweeney was growing up, her dad worked as an Assistant U.S.
Attorney specializing in Indian Land Law, which sounds good on the surface – until you find out he actually strove to remove Native Americans from their reservations when the government wanted their land. This led to many ethical arguments between Sweeney and her dad. Sweeney discusses her father’s “case that got away” involving a Native American family known as the “So-Happys.”

And sometimes still, many years later, you can find him in the kitchen late at night, with a drink in one hand and the other hand on the counter, looking at the floor, and muttering, “Those damn So-Happys” (p. 46).

Sweeney notes that things in her Shangri-La slowly began to change.

Where I once had Samuel Adams bottled beer in the refrigerator, that would be drunk and replaced with canned Pabst Blue Ribbon beer.

Or, if I had fresh chunky salsa from Trader Joe’s in the refrigerator, that would be eaten and replaced with a can of Del Monte tomato paste that my mother was sure could double as salsa (p. 49).

Even if I used words like “pasta,” it was as if I were throwing my big-city ways right into their faces. They’d say, “You mean, noodles?” And if I used a phrase like marinara sauce, it would really blow their minds. So after a few months I was reduced to saying things like, “Hey, how about we have noodles with the red topping for dinner?”

Now, you have to bear in mind that I had spent years in therapy talking about my family and my parents and learning how to do things like, oh…set boundaries. But, now here I suddenly was, in this huge situation, with Mike sick and my parents there, and the medical bills mounting. And there was nothing I could do but accept the surreal nightmare that life had become (p. 50).

With Mike sick, the family had an inordinate number of errands to run: Going to the Social Security office to try to put Mike on Medi-Cal, acquiring a Disabled Parking Pass, and getting one of Mike’s numerous prescriptions filled. Someone also had to escort Mike to the UCLA Cancer Center for treatment almost every day.

Mike got radiation five days a week and he got two different kinds of chemo. One chemo he got every three weeks, we called that the Big Chemo. That went into his veins and required him to sit for about four hours with an IV. The other one we called the spinal tap chemo, and that went directly into his spinal column, and that he got every other day (p. 51).
Sweeney describes Mike as a master boundary-setter and the most private member of her family up until his diagnosis. If someone wanted to get close to Mike, it had to be on his terms. When Mike was a teenager, he even had a doorbell installed outside his bedroom door.

So, for someone like Mike – to be so sick, and in my home, with our parents there – it was a particularly huge invasion of his privacy. So, we all just pretended that my parents were there on this extended visit.

Mike had this habit of asking each doctor or nurse, the first time he encountered them, for their “card” so he could verify their credentials. Then he would quiz them on their educational backgrounds.

I’m not exactly sure why Mike did this, but I think it was just one of the ways he could hold on to a bit of control (p. 52).

The doctors prescribed Marinol – basically marijuana in pill form – for Mike’s pain and diminished appetite. However, marijuana in leaf form tends to work better.

Fortunately our brother Bill, who lives in Spokane with his wife and kids, was able to get his hands on some real primo stuff.

Bill’s always had this talent.

In high school, he’d occasionally sell pot out of the family basement without our parents’ knowledge. And my mother was always saying things like, “Oh, that Bill is so popular! But why do his friends only stay for five minutes?” (p. 53).

With friends and family in and out of the house to visit and lend a hand – and everyone needing a place to sleep – things became incredibly frenetic in Sweeney’s life.

And after a few months, the lines started to blur and it became difficult to identify whose house this really was. I think this happened partially because, well, I have a lot of furniture in my house that I inherited from my parents when they moved from the big house to the condo: my coffee table and my end tables and my lamps are all things that I grew up around. With my parents suddenly living with me, and my brother there pretty much all of the time (and my other brothers around all the time), it felt like I was living at home again.

I found myself walking around thinking things like, *When I go to college, I’m gonna get my own dorm room and I’m gonna do whatever I want!* Then I’d remember, *Oh my God, I already went to college* (p. 54).
Sweeney also notes that each of her three cats responded to the chaos in completely different ways. Gus and Frank chose, essentially, to bail, while the fat and lazy Rita assumed the role of caregiver the best way she knew how.

Rita became Nurse Rita, because she was constantly with Mike, and he loved it. Since Mike was sleeping in my room most of the time, that meant he was sleeping with Rita, too. When Mike would get home from chemo and need to lie down he would immediately say, “Where’s Nurse Rita?” And Rita would run and jump on the bed. (Rita has to get a real real long run going before she can throw her weight up that many feet to the bed, so what would be a small, regular leap for an ordinary-sized cat is a really big deal – a grand gesture – for Rita) (p. 62).

On Halloween, Sweeney was roped into playing Pat for what she swore was the very last time. It turned out that everyone – the general public and Sweeney herself – was sick of Pat, and her performance was appropriately halfhearted. Sweeney then shares a long anecdote about her time working as an accountant before she became an actress and comedian, and the two exceptionally strange co-workers who provided inspiration for her characterization of Pat.

Mike had “a date with his radiation therapist” (p. 75) every Monday through Friday morning (“It’s like taking antibiotics or something – you can’t miss a day,” p. 76). Sweeney, who tried to accompany him to every appointment, says that they both found the procedure to be “very interesting and very high tech” (p. 76).

The very first day takes several hours because they have to figure out exactly where the radiation beams should be sent. Then they usually tattoo that area, so they don’t miss when it comes time to zero in with the shot of radiation. These tattoos are nothing elaborate, just a little blue dot on just that spot. Then, after that first visit on day one, the next days are, relatively speaking, easy. You show up, and after waiting anywhere from fifteen minutes to an hour, you’re popped into the treatment room and get zapped. That’s it. You’re free to leave.

The X-ray room is full of equipment and you feel like you’re somewhere on the Starship Enterprise. When it’s the moment of truth, laser beams light up in various colors and zoom in on the exact spot. For Mike, the point of impact happened to be on his head (pp. 76-77).
The skin on Mike’s head became burnt, dry, and scaly, so his family constantly applied creams and lotions to the area. Because radiation patients typically keep the same appointment time each day, Sweeney and her brother got the chance to get to know many of their fellow sufferers. “Being in the same boat with the same people proved comforting” (p. 77). It is also quite clear that the relationship between Mike and the author began to deepen. They would try to guess their fellow patients’ cancer type based on how they were wearing the hospital blue-paper cover-up garments upon emerging from the changing room. All Mike had to do was take off his hat.

Mike, being the Sweeney kid most concerned about appearance, was naturally distraught when after the first chemo, he lost all of his hair. But he was eventually able to develop this look for himself. He took to wearing black jeans and a black T-shirt and a black baseball cap.

I gave him this Reservoir Dogs T-shirt that he started wearing constantly. And as Mike would come out of the radiation room, he always had this oddly amused expression on his face. And our eyes would meet and then we’d laugh this little laugh like, “How weird is this?”

Mike said that what I was going to get out of his illness was a fabulous doctor husband. And we were always scouting the hallways for the cutest doctors. If a doctor treated Mike and he wasn’t handsome enough or single, we’d always ask for a second opinion (pp. 78-79).

Sweeney describes the dualistic desires she felt while serving as a caregiver to a close family member.

When you’re around someone who’s as sick as Mike was, you have a couple of urges. One is to be really healthy. I mean, you want to get up and take your vitamins, and exercise, and eat your green leafy vegetables and meditate.

But, on the other hand, you have this equally strong urge to be really unhealthy. You want to eat fried foods and drive in fast cars and take up dangerous sports and stuff like that.

One day, I was feeling really stressed out and really down and I became possessed by the latter urge. I really needed a release of some sort, so I decided to do something a little unhealthy and dangerous, and for me that meant to smoke myself a cigarette and buy the new book by the Pope (pp. 80-81).
Sweeney says she does not “really smoke – only very, very occasionally – and only when I’m really, really stressed out” (p. 81). She was also not a huge fan of Pope John Paul II, but enjoyed disagreeing with him so consistently. Sweeney notes that on that particular day, she felt and looked awful, but headed to the bookstore anyway.

And I just found myself staring up at all the books, when one in particular caught my eye. It was entitled The Atheist’s Guide to Getting Through the Day: There IS a Tomorrow. Wow, I thought, that’s interesting that someone would take the time to write that book. Then I thought, Where the hell’s the book called WHAT HAPPENS WHEN YOUR BROTHER HAS CANCER AND YOUR FAMILY MOVES IN WITH YOU?

And I started feeling worse and worse, and at just this moment – and I hesitate to report this to you because, well, it’s embarrassing and also I’m really not into scatological humor in any way, but, at just this moment – I suddenly let out the loudest fart. It was like a foghorn went off in Book Soup. And everyone kind of looked up. I didn’t know what I should do. I didn’t know whether I should flee the scene or look around like it wasn’t me.

Of course, I just stood there frozen, like a deer caught in the headlights. With the Pope’s book. God, was I humiliated.

And before I could collect myself, this head came around the bookcase and this guy said, “Julia?...Julia Sweeney?” I wanted to say, “You recognized my call?” but instead I looked up sort of terrified and said, “Yes?”

And he said, “Remember me? It’s Marshall from The Groundlings Theater?” I didn’t remember Marshall, but I did what I always do in that situation, which is to overcompensate. So I said, “Marshall! Marshall! Marshall! Wow, it’s just so great to see ya, Marshall.” And he said, “So, hey, are you still on Saturday Night Live?” And I said, “No, no. I’m really just…not on that show anymore.” And he said, “Oh, so, what are you doing now?” And I said, “Oh, just, you know, nothing.”

And then he said, “Oh, hey, how is that Steve? You know, you two are the cutest couple.” And I said, “Oh, Steve’s doing well. But, you know, we got divorced.” And then I tried to make my escape, and Marshall came up behind me and he said, “Oh, hey, how’s Mike? Is he still handling the box office at the theater? You know, that Mike Sweeney is so funny.” And I said, “Oh, you know, Mike’s taking some time off from work right now because…he has cancer. Well, nice seeing ya, Marshall.”

And I took my book and I ran up to the register and I paid for it, and you can imagine at this point how much I really, really wanted a cigarette (pp. 82-84).

Sweeney’s parents are “militant nonsmokers” (p. 81), so she had to be extremely careful to keep the car from smelling like smoke on her drive back home. After flicking
her cigarette out the window on Sunset Boulevard, she realized that it had somehow flown back into her car, landed on the backseat, and ignited a small fire. She pulled into the driveway, put out the fire, and flicked the cigarette into the grass. The morning after telling her parents an elaborate lie about a horrible old man in a pickup truck flicking a cigarette onto her backseat, they loaded into the car to take Mike to chemo.

And as we were, my dad leaned down to the grass and then stood up and said, “Look. It’s a cigarette.”

And I said, “That’s it! That’s the cigarette the horrible man was smoking!”

And my dad responded “Wow. Because this cigarette has lipstick on it.”


Tensions among the family began to rise. Sweeney’s mother pulled the author aside one day and said that due to her husband’s drinking, constant listening to NPR, and other factors, she was going to break up with him. Sweeney told her mother no, not yet, because there was nowhere else for her to sleep. Sure enough, for the next few nights, Sweeney’s mom slept on the pull-out sofa in the living room. Late one night, Sweeney left her bedroom for a glass of water and found her mother watching a movie – *In a Lonely Place* with Humphrey Bogart – alone at three in the morning. Sweeney joined her, and eventually, so did her father.

Then Mike came out of his bedroom, and he joined us on the sofa. And at one point, my mom reached over and took Mike’s hand and held it. I saw this from the corner of my eye, and I expected Mike to politely let her hold it for a minute, then pull his hand away, because this is something he never would have let her do. But I was surprised that for a long long time, Mike just let her (pp. 90-91).

Before “the calamity hit my life and home” (p. 92), Sweeney had immediately hit it off with her friend David’s brother, Carl, an avid bow hunter who lived in Idaho. They began holding long distance telephone calls, and Sweeney soon realized that Carl was the first man she was really attracted to since her divorce two years before.
Carl and I would talk on the phone and we would get into these big ethical arguments about animal rights. And then I would hang up and go to sleep and dream that he was running after me through the forest – naked, with nothing but a bow and arrow (p. 93).

Eventually, Carl decided to visit Sweeney.

I kept thinking, Oh, this is great, I’ll have all these candles lit in the living room and I’ll have finger food on the coffee table. Carl and I will be snuggled up on the sofa and my mom will walk in, clapping her hands together, and say, “Hey! What’s on TV tonight?”

I mean, how was I going to get my father to clear his 5000-piece puzzle of a map of Sarajevo that he got for his fifty-dollar contribution to NPR off the dining-room table so I could pour some wine and look into Carl’s eyes, deeper and deeper than ever before?

Well…

What I didn’t anticipate was how my parents’ presence provided this hotbed of titillation the likes of which I had never experienced before.

You see, my parents, well, they know I’m not a virgin. I mean, I was married for five years. But, by the same token, they’re not really going to condone me starting up a sexual relationship with someone right under their noses. On the other hand, I am an adult and this is my house, so it was kind of a tricky situation.

It meant that Carl and I had to sneak around.

And I haven’t had to sneak around with a guy for about sixteen years and, you now, I forgot. I forgot how exciting that is.

Carl slept on the pull-out sofa in the office out back and I slept out on the sofa in the living room and we would spend time with the family and then at night I would go out and say “good night” to Carl, for, you know, about an hour.

We found ourselves playing footsie underneath the dining-room table, and my mother was suddenly making all these traditional meals and saying things like, “You two be sure to be home at six, I’m making meat loaf!”

I felt like a Catholic schoolgirl again and I was saying things like, “Oh, my parents are so weird. Let’s go make out in the garage” (pp. 94-95).

Sweeney also discusses the humorous circumstances surrounding the confirmation of her suspicions that her parents had “heard them” one afternoon when she and Carl thought they finally had the house to themselves. She notes that Mike was still
doing well with his treatments, but he had received so many spinal taps that scar tissue had built up along his spinal column and the technicians could no longer access it.

One day, we were at the medical center, and Mike was in the examination room, up on the table. My brother Jim was there, and my mom, and my dad, who was reading a 30,000-word article in *The New Yorker* all about the plague in India, you know, as a diversion. The doctor came in and he said, “Mike, this is what I suggest. I think that we should put a shunt – which is a plastic opening – into your forehead so that we can put the chemo directly into your cranial fluid.”

Mike said, “Listen, Doc, if you think you’re gonna put a faucet into my forehead, you may as well give me a lobotomy at the same time.”

Then there was this awkward pause and my mother chimed in and said, “Oh, Mike. I don’t think it’s like a faucet. I think it’s more like a…a spigot.”

I think even the doctor was embarrassed. He said, “Well, Mike, let me tell you something. My patients who have the shunts, well, they, they LOVE them.” And Mike said, “They do, do they? Then by all means give me a shunt.”

So Mike got a shunt. And after that his refrain became, “I love my shunt!” Every time the doctor came into the examination room, he’d say, “Hi, Mike. How’re you doing?” And Mike would say, “I’m not doing too well, Doc, but I’ll tell you one thing. I love my shunt!”

And to just show you how surreal things were getting, at night, the whole family would watch shows like *ER* and *Chicago Hope* and whenever anyone would come into the emergency room Mike would yell out, “Give ‘em a shunt! They need something to love!”

Sweeney comes to the realization that her mother began watching the Bogart movie in the middle of the night because her TV turned on each time the VCR was scheduled to record something. This process occurred every weekday night, and the technologically-regressive Sweeney did not know how to turn it off. Somehow, Sweeney uses this event to powerfully characterize their collective experience – especially her mother’s.

But then she actually got involved in the show, and I really love her for that quality – her ability to just give herself up to something, even if it is three o’clock in the morning.

That’s what life was like then, all accommodation and no solving. Because there wasn’t a solution to the big things, and it made us not even try to solve the littler things (p. 102).
The family began watching and identifying with an old English film Sweeney acquired from a friend – *I Know Where I'm Going*. The theme song became stuck in their heads, so they began to sing and hum it constantly.

And sometimes we’d find ourselves humming it at the hospital, and eventually we started to use it as a homing device to find each other. You’d be walking by the gift shop and you would hear this familiar tune, and you would look in and there’d be one of us Sweeneys, buying some Life Savers. For the first time, I felt like we were a tribe. And one with our own not-completely-logical theme song (p. 103).

Sweeney then decided to visit the gynecologist for her annual appointment a few months early.

And I went in. And I was examined. And about a week later I was in my office and I got a call from my doctor and he said, “Julia, we got the test results back. And I’m sorry, but it appears that you have cancer.” And I said, “What!” And he said, “Yes. You have cervical cancer and it’s spread to your uterus and your fallopian tubes and I recommend that you get a hysterectomy right away.” And I said, “But this is impossible! You know, my brother has cancer.” And he said, “Oh, really. What kind?” And I said, “Lymphoma.” And he said, “Oh, that’s completely unrelated. And I said, “Well, I know it’s unrelated. I’m just saying this is just horrible timing. I mean, couldn’t this wait?” Obviously it couldn’t (p. 105).

She seriously considered keeping the news from her family; they had enough on their plates already. But Sweeney knew she could not successfully hide a hysterectomy for long.

So. I went into the house and I told everybody and of course, you know, they were devastated, and Mike immediately said, “Oh, you just couldn’t stand it, could you? I bet it was hard for you, being an actress, with me in the cancer spotlight all the time!” And then later he said, “Jules, you just got a little sympathy cancer.”

Between Mike and me that was really no joke. We really felt like I did have sympathy cancer.

Well there I was having to lose my reproductive organs. And, you know, I always figured I’d have a child someday, but I had never chose to up until this time and now it looked like that was going to be impossible. I guess I always thought of my reproductive organs like this great shiny bike that I had in the garage that I was totally going to ride someday. But I never had taken the opportunity to ride it yet, and now someone was trying to steal my bike.
On the other hand, if you have to get cancer you actually have an advantage in having cancer of a reproductive organ. Because you can simply take it out. I mean, it’s not like having cancer of the liver or the lungs, where you need that organ to continue daily existence. With a reproductive organ, you simply remove it.

So this led me to thinking, what if you got cancer of the fat? Then you’d have to have this emergency liposuction. And my doctor told me that some people actually do get cancer of the fat (p. 106).

When Sweeney called the Cedars Sinai Comprehensive Center to schedule her hysterectomy, the receptionist was less than cooperative.

She said, “Oh, yes. I have your name here. Miss Weenie.” I said, “No, that’s Sweeney.” And she said, “Yes, Miss Weenie.” And I said, “No, that’s Sweeney.” And she said, “That’s a weird name. Weenie.” And I said, “No, it’s not! ‘Cause it’s Sweeney!” And she said, “Oh, well. I can’t make an appointment for you right now because it turns out that your cancer is a very rare type of cervical cancer and they’ve sent all of your slides to the UCLA Pathology Department where they are studying that type of cancer there.”

And I said, “Oh. Wow. Well, is there some way we could get these slides back, so I could make an appointment so I could, you know, try to get rid of this cancer?” And she said, “Well, the courier service is taking a really long time.” And she really didn’t know when they could get the slides back. So then I said, “Well certainly there’s something we could do to help expedite this process.” And then she said, “Well, I suppose if you’d like to pick them up?” And I was thinking, I bet she’s never asked anyone to pick up their own slides ever. But I said, “Well, coincidentally, I will be at the UCLA Cancer Center tomorrow and I suppose I could just hop over to Pathology and pick up my slides.” And without seeming to blink an eye or note the irony in that statement, she agreed (p. 108).

Sweeney headed over to the pathology department while Mike received chemo, and found the building to be huge, and not set up to have any regular person stroll into it.

Eventually she tracked someone down.

And I said, “Yes. My name is Julia Sweeney and I’m looking for my slides.” And she said, “Oh. What research project are you working on?” And I said, “Oh, no research project. They’re slides of me. They’re my slides.” And she said, “Oh. Nobody picks up their own slides.” I said, “Yeah, that’s what I thought” (p. 109).

She was told to visit Dr. Yao Fu on the eighth floor.

Well, I went up to the eighth floor and I found Dr. Fu’s office door and I opened it. And it was like something out of a movie set. There were books piled high to the ceiling and there was a Xerox machine next to a filing cabinet next to a microscope and peering over his microscope was Dr. Fu.
And I said, “Hello, Dr. Fu? My name is Julia Sweeney and I’m looking for my slides.” And he said, “Oh. What research project are you working on?” I said, “No research project. They’re slides of me.” And he said, “Oh. Nobody picks up their own slides.” And I said, “I know.” And he said, “Wait a minute, you mean to tell me that you have this cancer?” And I said, “Yes.” And he said, “Oh my goodness. This is incredible, you know, I have been studying this very rare kind of cervical cancer here at UCLA for the last twenty years, and I’ve never actually met someone who had the cancer.”

And I said, “Oh, Dr. Fu, here I am” (p. 110).

Dr. Fu told Sweeney that she had an incredibly rare type of cervical cancer. Only fifty cases had been diagnosed up to that point, and none resulted in death.

And so we went and got coffee and he told me all about his research and theories and I told him all about me. And at one point he took this torn AT&T envelope out of his back pocket and he put it on the table and he drew my reproductive organs and he kind of explained to me what they were going to do and then he said, “Are you sad about losing your fertility?” Only he said, “Fertility.” And I said, “Yes. I am sad about it. But, you know, I’d rather live.” And he said, “Yes. Living is better.”

And so we walked back to his office and on the way he even squeezed my arm and said what a wonderful day this was. And it was true, it did turn out to be the most delightful afternoon.

So I don’t know… I figure, if I have to be the kind of girl that they ask to pick up her own slides, when they would never ask anyone else to pick up their own slides, and if I happen to be the kind of girl who they always forget at Starbucks, then at least I’m the kind of girl who gets to meet people like Dr. Fu (p. 110-111).

Sweeney’s parents eventually decide to visit their friends in Florida, leaving the two ornery cancer sufferers home by themselves.

Well, we immediately started answering the phone, “House of cancer!” And we seriously considered putting a sign out front that said INTERNATIONAL HOUSE OF CANCER.

If anything wasn’t working, or a houseplant was a little droopy, or even if a tree out front was a little sad-looking, we’d say, “Maybe the tree has cancer.”

And my black cat, Rita, she started to lose the hair on her back and on her sides. And we started thinking, Oh no! Now Rita has cancer! But we took Rita to the vet and the vet assured us that Rita did not have cancer, although he couldn’t explain why she was losing her hair (p. 118).

Mike was having a hard time digesting food, so a few weeks before he had a port installed into his abdomen so that his caregivers could pump nourishment directly into his
stomach. It was working pretty well, but when Mike was alone with Sweeney he suddenly started to have a reaction to it.

One night he started throwing up and throwing up and it didn’t seem like there was any end in sight. And Mike was really reluctant to go to the hospital. For him it just meant losing control, so he would always wait until the very last moment before he would go (p. 118-119).

There had been no let up in Mike’s vomiting, so at three in the morning they both agreed to go to the emergency room. Sweeney describes this as “The Long, Long Drive” (p. 120).

Mike was in the passenger seat and he was leaning up against the car door trying not to throw up in the car. And he was wearing his Reservoir Dogs T-shirt, which was by then worn thin and stained.

I was driving the car thinking, Now I have cancer too. At one point Michael said, “What did I do to deserve this?” That was so unusual, I mean, Mike never asked why. I said, “Mike, no one would deserve this. No one.” And Mike said, “Yeah, even Christ only suffered for a day.”

We got to the emergency room and they could see that Mike was really dehydrated. They wanted to get a saline solution into him right away, but the veins in his arms were all exhausted and so they were trying to get a needle in up over his ear. And he was continuing to throw up and I was standing in the doorway looking in on this. And, to just show you what a wonderfully dark sense of humor Mike had, in even the most horrific of circumstances, he turned to me and said, “I guess it’s not so funny now that you have cancer too, huh?” And I said, “Yeah, Mike. ‘Cause normally I’d be laughing my ass off” (p. 120-121).

Sweeney describes the surrealism of an emergency room in the middle of the night, and her and Mike’s now-weary and jaded reaction to it all.

A hospital provides nonstop entertainment. There are the brave people, the tragic people, the crazy people.

As the saline solution dripped into Mike’s arm, we just sat and stared at the wall we shared with the crazy man we couldn’t see. It was like watching a television show with a screen the size of the whole wall, but with the picture off. A few months before, Mike and I would have been suppressing our laughter. But by now, we just looked at each other, smiled weakly, and shook our heads occasionally. These bizarre scenes had now become our norm. Everything seemed so incredibly regular (p. 122).

It seemed ghostly, standing in the emergency room-hallway, waiting for Mike to get discharged, on the pay phone with another hospital that would soon be mine (p. 122-123).
After Mike was discharged and his parents back on the scene, he began getting worse and worse. One night, Mike just insisted that he stay at his own apartment.

He was tired of staying with me and I could see why. His apartment reminded him of himself. And he was starting to forget himself and he needed the reminding (p. 123).

Sweeney stayed with Mike one night, and slept in his waterbed.

We kept the door between the bedroom and living room open so we could talk. Mike and I talked almost all night long through the open door. We remembered Gillian’s Island episodes we loved. We sang the song. Mike was coughing a lot and he was starting to have a hard time talking. I believed that the slur in his speech was from the painkillers, and I’d often argue with him that I thought he was taking too many. But my “know-it-all” attitude was wrong. Something more sinister was going on for Mike – something much more terrible than taking too many drugs. The cancer was still growing. Despite the chemo, the radiation, despite everything (p. 124).

Sweeney notes that this apartment used to belong to her and her ex-husband. Mike moved in after they switched to a larger unit in the same building.

And so I was lying there, looking at the ceiling, seeing the paint that was still there after nine years, when I had first moved in and had painted the bedroom a very girlish pink. Mike had painted white over the top of it, but parts of the old paint still peeked through at the corners near the window.

This room was so familiar and so foreign, it sent shivers down my spine. But the water bed lulled me into a dreamy state, morphing the past and present (p. 125).

Sweeney began to break down emotionally as Mike continued to decline.

I guess it’s human nature to want to find even the smallest reason for the person to be responsible for their own misfortune, but in the end, sometimes really shitty things happen to innocent people, and there’s not a damn thing that can be done about it.

The new discoveries of Mike’s elusive cancer opened a flood of sadness for me. I couldn’t sleep anymore. I would close my eyes and only see Mike’s now-small frame in the hospital bed. He seemed like a wounded bird lying there, his big eyes just looking up at you. And his smile was so big because his face had become so small. It was hard to believe that this was the same brother that used to put me into a headlock on the front lawn and hold me down until I cried uncle.

I couldn’t cry deeply enough. Hard enough. Memories of our life together were constantly hemorrhaging into my head. I know that’s a strong image, but that’s what they felt like, a hemorrhage. Besides our familial relationship with all the
usual memories, he had been the center of my life since August in a very big way. I was completely unprepared emotionally for him to die (p. 127).

The hospital instructed the Sweeneys to have Mike sign Power of Attorney forms, make a will, and get his banking taken care of while he still could.

Then Mike signed his bank account over to me and my mother cried. When it was all over, we just sat there, like, okay, now what? Is this when he dies?

We were all just silent. What do you say in a situation like that? And then Mike sat up in bed with what seemed like renewed vigor. He smiled and suggested we all watch the O.J. Simpson trial. He said he was looking forward to the next witness, who was a bartender at the restaurant where Nicole ate the night of her death. (Apparently, according to Mike, Nicole had eaten fusilli with marinara sauce on the night of her murder). So, we all pulled up chairs and watched the O.J. trial for the rest of the afternoon.

Then Mike started feeling a whole LOT better. He challenged me and Dad to a game of Scrabble. Mike won easily with a triple word bonus on the word “exit” (p. 127-128).

But Sweeney says that it became a triumph if Mike was able to eat a small breakfast.

It was around this time that the family made this nonverbal shift in our hopes. And we stopped praying for Mike to get better and started to pray for an end to his suffering.

Then Mom started talking about Mike going to heaven (p. 129).

Sweeney was reminded of her high school religion class taught by a Jesuit priest.

One day in our religion class, he said, “Perhaps heaven is an instant. If there’s no time after death, perhaps heaven is just that light at the end of the tunnel, that great moment of awareness, and it happens like that.” And he snapped his fingers. “Heaven is an instant” (p. 130).

Sweeney could not wait to share this notion with someone. She told her mother the second she got home from school.

And then my mother, with the Comet in one hand, took the other and slapped me across the cheek. And I could never understand why she would have that reaction. But, maybe you don’t walking into the bathroom of a Catholic mother of five who’s Cometing out the tub and tell her that heaven is an instant (p. 131).

Against Sweeney’s wishes – she was afraid to send Mike a signal that his family did not think he was going to survive – Mike’s parents arranged for him to receive last
rights. Sweeney was playing Scrabble with Mike alone when Father Sullivan entered the room.

And Mike, being Mike, immediately asked him for his card and started quizzing him about his credentials.

Father Sullivan said, “Mike, you’re just gonna have to take it on faith this time.” And so there, over the Scrabble board, Mike received the last rights.

After Father Sullivan left, Mike turned to me and said, “Mom and dad sent him.” And I said, “Oh, I know. I’m sorry.” And Mike said, “No, actually, that was pretty cool.”

Mike continued to decline and pretty soon his organs started to go one by one. But he just kept on ticking and the doctor said that he would. He said he had the heart and lungs of a thirty-one-year-old and he was just going to keep on ticking for awhile. But soon even the doctors couldn’t explain why Mike was alive and eventually one doctor suggested that maybe it was just psychological at this point. Maybe Mike just wasn’t emotionally ready to go.

So, they sent this therapist in to talk to Mike. And she sat down next to his hospital bed and said, “Mike, I want you to visualize that you’re on a trampoline right now. Imagine yourself going up and down and up and down and really feel yourself going up and down. And now I want you to imagine just jumping off to the side a little bit.”

Jim was with Mike when he died a few hours later. He, and some of Mike’s closest friends, had put buckets of water at the sides of the bed and they put his hands in it and they said to him, “Mike, you’re in a boat. We’re ferrying you.” And they even picked up the mattress by the edges and swayed it gently back and forth. It was like a water-bed ferry boat, and Mike loved water and boats. He loved the ocean, and he loved traveling to places like Hawaii. And then he drew his final breath.

So that’s how Mike died. Being ferried across by his friends (p. 131-133).

Sweeney and her parents were at home when Mike passed. She says it is funny how that works – after going through the entire experience with Mike, they missed his death. Yet, a woman who only knew him casually entered the room right as it happened.

I’m so glad Mike had such a beautiful death. When you think of all the horrible deaths there are, that most people have had, Mike’s seemed to be one of the most pleasant at the very end. And since death is a birth too, I hope he felt his delivery was untraumatic and somehow rejuvenating, even if the long journey leading up to it was hellish.

And I hope that for Mike, finally giving up all control meant that he ultimately gained some (p. 134).
Sweeney was scheduled to undergo her hysterectomy three days after Mike passed away. Although she really wanted her parents to go back home, they stayed in town.

I have to say, I was so whacked out from Mike dying that I barely thought about my own impending surgery. In a way, it was a blessing. I am sure I would have been very insecure and psychologically overwrought if I were just dealing with my own cancer, out of the shadow of Mike’s. But somehow, my cancer seemed like an afterthought, an embarrassment really. And everyone was so exhausted and unraveled from Mike that I felt like someone complaining about their cough at a funeral.

I just wanted to get it over with.

I had two strong feelings about the procedure I was about to undergo. I’ll admit, the first was cosmetic. Every time I got out of the shower, I would look at my stomach and I would try to memorize the image. My pre-hysterectomied scarless abdomen. I would just stand there as the steam moved around the bathroom, and the mirror slowly came to reflect my hazy form. Then I would wipe a part of the mirror with my hand, the part that revealed my tummy, and just stare at its smoothness.

I mean, don’t get me wrong – my stomach has never been my strong point and it’s no tragedy to have a scar there. In fact, I subscribe to the belief that scars are badges of honor. No, for me, the stomach-staring phase I went through was more about the permanent change of it. I remembered when my mother told me I was going to grow pubic hair, and I was so shocked and bewildered that I would stare at my nether region in the mirror and imagine how it would be. Not wanting it, NOT wanting it. Just thinking, *Wow...That’s gonna be weird.*

And that’s sort of what this was like.

The second feeling I had was stronger and darker and creepier.

It was this sadness that enveloped me. And it wasn’t about not being able to have kids. I saved all that hysteria for later.

Somehow, in the few short weeks since I’d know of its existence, I had become attached to my cancer. It simply didn’t seem like a foreign entity trying to destroy me. It seemed more like a part of me that had gotten, well, a little out of control. A part of me that was also a part of Mike.

I know, weird things go through your mind when you go through something like this.

I had only one night of major panic, and, in retrospect, it wasn’t so bad. (I had been kind of wondering when the alarm button would hit.) I was so abnormally nonhysterical about the whole thing, it almost seemed suspicious.

But then it happened. The shoe filled with dread finally dropped.
The night before the surgery, as I started to drift off to sleep in the darkness, the image of a scalpel cutting me open, and all my insides being revealed, came to me and just scared the bejeezus out of me. My heart started racing, and my face heated up, and beads of sweat formed on my brow.

I suddenly felt like such a, a…body. This sensitive machine that oozed and breathed and that blood ran through, that digested and defecated and saw things and heard things and slept and woke up. All of the reality of this just came bounding down on me like it was a train, chug-a-chug-a-chug-a-chuga-a-ing into my forehead. And my aliveness became so real to me. I could hear myself breathe. I could feel my blood racing through my heart. And my heart was beating so fast, and I could feel every beat. And my body felt like a single unit, like every part had a vital role to play. And a part was going to be taken from me and it felt as though every other part of me would feel that difference, that absence of something. And then my heart began racing so fast I thought it was going to burst. My breathing was erratic, and sweat was pouring down my face. I was having a good old classic panic attack (p. 135-138).

Sweeney says thoughts of three things enabled her to finally fall asleep that night: war movies, Mary Tyler Moore, and the warm feeling associated with the morphine she would receive the next day washing over her.

I’ve never been in a war, but I’ve seen plenty of war movies, and come on, what about all those wounded people? Did they sit around sobbing because they’d lost their uterus? Okay, I know that doesn’t make sense, but you see where I’m going, right? (p. 138-139).

Then I thought of a quote by Mary Tyler Moore. She once said, “You can’t be brave if only wonderful things happen to you” (p. 139).

When Sweeney woke up from her procedure the next day, her doctor told her the surgery was a huge success. They were able to remove the entire tumor and save her ovaries. Obviously, keeping these organs is important because, as Sweeney points out, they emit important hormones (like estrogen). The doctor recommended that Sweeney receive nine weeks of radiation just to be safe. And, to keep her ovaries away from the deadly rays, Sweeney’s doctors simply moved them up about a foot-and-a-half from their original position.

I took a moment to imagine my ovaries swimming around my armpits.

I said, “Oh…Okay.”
The doctor must have seen the look of confusion in my groggy eyes and said, “Don’t worry, they work from wherever they are.”

“Oh. Great” (p. 142).

The doctor also said another benefit of keeping her ovaries is that she could have eggs extracted, mixed with sperm, and implanted in a surrogate mother if she had any desire to raise a biological child.

*Oh, great, now I have to meet a guy and a girl!*

Then he said, “Now, if you really are interested in having a biological child, I must tell you that the radiation can actually damage your ovaries even in their new position. So I would recommend that we go in now. We can harvest about twelve eggs.

And I was thinking, *Why twelve? Because…they’re eggs?* (pp. 142-143).

The doctor also said that they do not have the medical technology to freeze the eggs by themselves. They have to be fertilized first and then they could be held up to five years. Sweeney was told she needed to know who her sperm donor was going to be…right then.

So I said, “Well, okay. I have been seeing someone for a couple of months and I don’t know if now is the exact moment to broach this…” I could just imagine myself saying to Carl the next time he’s in town, “Hey, before the movies on Friday night, why not fertilize all my eggs? ’Cause, you know, things might really work out between us.” And then I would give him the thumbs-up. And then I’d smile like a maniac (p. 143).

And so I got out my address book, and I thought, *What are the criteria? The criteria are: Someone I know, whose number I have, who I think I could possibly fall in love with one day, and not only fall in love, but we’d want to spend many, many years together. And we’d want to raise a child together and not only raise a child together, but it would have to be our biological child and then we would have to hire a woman to have the child for us.*

*So who fits that description?* (p. 143-144).

**Evaluation**

Despite describing her incredibly in-depth, specific, and obsessive childhood fantasy of someday having seven children –without ever envisioning a husband (“He had
no occupation. No personality. And he never got anything for Christmas,” p. 149) – Sweeney decided not to extract any eggs. She notes that as she got older, the idea of being “happily childless” (p. 152) seemed increasingly appealing. But then two things happened that changed everything: When she married her ex-husband, she wanted to have everything with him – including children. Then she got cancer and had her uterus removed. She finally had to come to terms with the fact that she was never going to be pregnant. (For an analysis of Sweeney’s decision-making process, see below). When Sweeney came home from the hospital, her parents were there, ready and willing to help in any way.

I was in a tremendous amount of pain, but I tried not to take the painkillers that my physicians had prescribed for me. I just figured, if I could endure the pain on my own, or if I could do that thing where you visualize the pain and then encompass it, and then transcend it, I would really enjoy those Percodan a lot more later with a margarita.

Now, after you have a hysterectomy or any abdominal surgery, the name of the game is to keep fluid running through you. You have to drink a lot of liquid and you have to go to the bathroom and keep a chart and, well, it’s just pretty awful.

And one day I was in the bathroom and my mother was on the other side of the closed door and she yelled in, “Julie, did you go yet?” And I said, “Uh, yeah…” And she said, “Good girl!” And as I was sitting there on the toilet, I thought, You know, I think this is my lowest moment (p. 156).

Sweeney finally felt well enough to send her parents on their way. Her friend David would move down from Aspen to see her through radiation.

And so my parents packed up all their bags and then loaded up the car. And you know, my parents have always been either a source of comedy or a reason to be in therapy for me.

I’d always thought of them as being really provincial and kind of wacky and I always jumped on the dysfunctional family bandwagon. But it wasn’t until that year when the shit really hit the fan that I saw how really functional they ultimately are.

And when I think of the hundreds of images that I now have in my head, of my father filling out Social Security forms late into the night or my mother whipping up Jell-O for Mike in the kitchen or each of them taking one of Mike’s arms when he was too weak to walk to the car by himself, I think how horrible it
must have been to have brought a child into this world only to have to help him out again…

As the car drove away I realized that my feelings for them had deepened so much (p. 156-157).

Sweeney experienced a sense of déjà-vu when she began her radiation treatment.

David moved into the now-vacant guest room for the big radiation extravaganza. Every morning at 8:45 we went to Cedars Sinai so I could get my radiation and David would wait for me in the waiting room just like I had for Mike. And when I would come out, I’m sure I had an oddly amused expression on my face and our eyes would meet and we’d laugh that little laugh like “How weird is this?”

It was so strange to suddenly be on the other side of this experience; it almost felt like Mike and I and David were square-dancing (p. 158).

Sweeney was able to bond with her radiation therapist because they had, coincidentally, gone to the same high school. They often talked at length about the stern English teacher Sister Antonella. One day Sweeney’s radiation doctor told her that they “lost” one of her ovaries. Sweeney thought he meant that it had been destroyed by the radiation.

And my doctor said, “No, no, no, I don’t mean that one of your ovaries has died. I mean, we’ve lost one of your ovaries. We’ve been looking at these X rays…” And then he turned toward this big X ray of my midsection that was hanging on the lighted wall behind him. He continued while he brushed his hands all over my innards, “You can see this one,” and then he pointed to a little round glob about the size of a dime that seemed lodged next to my stomach. And then he said, “But the other one’s gone off somewhere.” And then he threw his hands up in the air, like he was Columbo.

I said, “Oh, wow.” And I sat down, suddenly feeling guilty that I had such a rebellious ovary. Then he tried to comfort me and said, “You know, I’ve seen this before, and it’s not unusual for an ovary, once cut off from its responsibilities, to travel.”

Now, I suppose I understand that. If I were an ovary and I suddenly didn’t have to deal with that fallopian tube anymore, I’d probably want to go around and see some stuff.

I said, “I guess what we are looking for here is the anatomical equivalent to Florida.”

The doctor said, “Don’t worry, it’s going to turn up eventually.” And I said, “Now, I’m not going to, like, cough it up, am I?”

He said, “No, that’s pretty much impossible” (p. 164).
Sweeney mentions that she now speaks to her parents much more frequently than before “this whole ordeal” (p. 165). And despite losing her brother, her uterus, and any chance at having biological children, Sweeney’s life seemed to even out a bit.

As you can imagine, things have slowed down considerably back at my house. After I finished my radiation treatment, my black cat, Rita, miraculously grew back all of her fur.

I still get a lot of mail for Mike. Mike subscribed to a lot of different periodicals, some of which are starting to lapse. And one of them is to Buzz magazine. In the last several months I’ve gotten two of those computer-generated notices for Mike, one that said, “Hey, Mike! Where’d ya go?” And the next one said, “Mike Sweeney, where’ve you been?”

And I finally, finally have my house all to myself. And you know what? I really, really love it. But sometimes, when I sit there, I wonder, Why does it feel so empty? (p. 167).

Quentin and Sweeney got on the phone and compared their years. They were quite different, to say the least.

You see, before my year from hell, Quentin and I would routinely talk about our hopes and dreams. Then, as the year progressed, I watched Quentin realize all of his. And, in total honesty, it was a joy to see someone so deserving get so much. And, of course, I have to admit that I loved the dark hellish comedy of the whole thing. “Hi! Congrats on the Academy Awards! That’s quite an achievement!” “Thanks. But how’s your cancer?” “Oh, worse, I’m bleeding from the radiation, but enough about that, how’s your girlfriend?” And then I would have to fall into spasms of laughter. Finally, Quentin said, “We’re taking that damn rock back” (pp. 168-169).

They traveled back to Ireland and partied hard for a week. Then, in a large group, Sweeney and the rock set sail for Inish Turk.

And once there, after much champagne and salmon and soda bread, we rose and carried the rock on a blanket with dried flowers, herbs, and Quentin’s cigar, like it was the King of Siam. We marched across to the other side of the island and I flung the rock back over the cliff, back down among its kind.

I didn’t want to make such a big deal of it, or to give in to the truth of the curse, but I have to admit, as I saw that white rock sail through the sky, so individual against the green and blue backdrop of water and land, and then fall onto the shoreline, where I was unable to distinguish it in the white sea of a million broken stones, something in me felt released (p. 171).
Coda

Sweeney concludes with a post script saying that she is still together with Carl.

“So far, so good. Okay. Extremely good” (p. 172).

Framework and Structure

When analyzed broadly, *God Said, “Ha”* utilizes a chronological plot structure framed by Sweeney’s visit and return to Ireland: Sweeney takes a rock from Inish Turk, Mike gets sick, her parents move in, Mike’s condition worsens, Sweeney is diagnosed with cervical cancer, Mike passes away, Sweeney has a hysterectomy and decides not to extract eggs, Sweeney returns the rock to Inish Turk. The curse attached with taking the rock from the island provides Sweeney an (admittedly silly) reason for her “year of hell,” allows her to establish a beginning and ending to the story, and demonstrates the author’s propensity for making sense of a traumatic experience through narrative. Sweeney says that a part of her felt released the second she let go of the rock. In retrospect, this event becomes significant because it marks the conclusion of Sweeney’s brush with cancer, providing her with a sense of finality and closure, and allowing her to begin to move on from this long string of traumatic events.

To humanize her characters and provide greater context for readers, Sweeney also places a photograph at the start of every chapter: Headshots of her parents; action shots of her cats; even the diagram of her uterus, fallopian tubes, and ovaries drawn by Dr. Fu. Some of these photos are humorous: The chapter “A Dozen Eggs,” referring to the number of ovum that could have potentially been extracted from Sweeney, features a grocery store shelf with cartons of chicken eggs. Most importantly, the audience is able to view photos of Mike’s physical transformation from cancer-free to chemo patient – even
a shot of Mike receiving radiation – as if it were a photo album or scrapbook of his cancer experience. Offering a multi-sensory text may provide readers with an easier route to understand, identify with, feel emotion for, and gain knowledge from Sweeney’s struggles. Interestingly, Sharf and colleagues (in press) have begun to analyze scrapbooks as a form of illness narrative.

Within this main framework, however, Sweeney’s plot structure tends to unfold randomly with numerous subplots and episodes disrupting the narrative’s chronological continuity throughout its 34 chapters. Each chapter is separated episodically or thematically with a handful of related episodes. For instance, Sweeney uses Chapter 2 to tell a story from her childhood, Chapter 3 to describe her parents’ visit to New York City a few months before Mike became ill, and Chapters 8 and 9 to summarize the idiosyncrasies of her parents, particularly during their time at her Shangri-La. These temporal diversions feed into the main plot, deepening, developing, and providing context for its primary themes. This narrative also employs a considerable amount of ruminative, static segments to demonstrate Sweeney’s attempts to justify decisions, make sense of her situation, reclaim lost identities, and reassert control.

**Themes**

First, Sweeney’s use of figurative language and humor allows those with or without personal cancer experiences to understand and identify with the toll that the illness and its treatment procedures can take on actual individuals. Sweeney utilizes many textual cues for interpretation, often to designate emphasis, interior monologue, sarcasm, and/or comedic timing. These tools include: CAPS, ellipses (...), *italics*, exclamation points (!!!), and in one instance, **bold type**. Perhaps because *God Said, “Ha!”* originated
as a spoken monologue, the author employs an extremely conversational writing style, which helps to increase reader intimacy, emphasis, and engagement. Sweeney frequently writes in short, choppy phrases and sentence fragments, and often begins paragraphs and individual sentences with conjunctions (“And,” “Well,” “Like,” “You know,” “So,” “All right,” “Oh”) to emulate a spoken interaction.

Being a naturally humorous individual, a successful comedian, and a talented writer, Sweeney’s narrative is funny first because she chose to find the absurd side frequently inherent in such chaotic and hellish situations. As Sweeney mentions optimistically in the prologue, “Life just isn’t too bad if you can pull off a little attitude adjustment” (p. xvii), maybe this was simply her way in which to cope with trauma.

Sweeney’s narrative emphasizes three main themes: Sweeney’s perception of Mike’s cancer experience, Sweeney’s suddenly diverted life, and Sweeney’s perception of her own cancer experience.

“International House of Cancer”: The Construction of Mike’s Illness and Its Impact on Sweeney

Sometimes really shitty things happen to innocent people, and there’s not a damn thing that can be done about it (p. 127).

Sweeney rationalizes Mike’s losing battle with lymphoma in rather fatalistic terms, pitting a blameless victim against an unstoppable villain, an evil invader robbing Mike of his previous identity. Cancer is blamed for the physical and emotional distance Mike experienced from his moral self. Sweeney is again able to demonstrate her apt sensemaking ability through the use of relatable and comprehensible metaphors, comparisons, and imagery. These also allow her textual descriptions of the illness experience to take on a transformational effect for audiences – portraying a form of chaos
and treatment one might not have previously been able to grasp by connecting it with universal concepts and items.

The narrator describes Mike’s physical suffering essentially as *going through hell* and *wasting away*. Sweeney denotes Mike’s cancer cells as “devilish” (p. 33) and the trip to the hospital as “The Long, Long Drive” (p. 120). Chemotherapy is compared to “Drano” (p. 34) – which, as the detective film spoof *The Naked Gun* (1988) appropriately points out in typical deadpan fashion, “(Will) clean you out, but it’ll leave you hollow inside.” Sweeney also says that the body must possess a “kickass, internal Red Cross crew ready to pick up the pieces” after receiving chemo treatment. The target for radiation waves is described as a “tattoo” (p. 76), receiving radiation as “getting zapped” (p. 76-77), and the complicated-looking equipment in the radiation room as similar to that of the “Starship Enterprise” (p. 77) from *Star Trek*. Sweeney also optimistically rationalizes Mike’s odds of survival as attempting to finish in the top fortieth-percentile of a college class. Like many of us when it comes to our age – 45-years-old as being only halfway through our life, for example – Sweeney is playing the numbers game to attempt to cope with something she simply cannot.

Mike is also characterized as an extremely independent individual who is used to being in control of his own life. Obviously, cancer robbed him of that. Mike went from not needing anything to suddenly needing everything over the span of a few days. Sweeney describes a suffering Mike as no longer looking or feeling like himself. Mike seeks agency, comfort, and an attempt to reclaim a sense of his former self by returning to his own apartment, asking his doctors for their “cards” and educational backgrounds on which to quiz them later (described as absurd, compulsive, and humorous by Sweeney.
because it is such an odd behavior that happens to typify Mike so appropriately), and waiting until the last possible moment to go to the hospital. Sweeney also notes that the image-conscious Mike was able to designate his own new look – black jeans, black shirt, and a baseball hat – as a measure of control and a statement regarding his new identity. Mike’s worn-down and stained *Reservoir Dogs* t-shirt, a gift from Sweeney at the start of his treatment, becomes a metaphor for both the passage of time and the concordant degradation of his body. He also looks forward to being cared for by “Nurse Rita” the cat, from whom Sweeney is able to gain comedic mileage by crafting the image of her bulbous mass attempting to jump onto Mike’s bed.

*Why Is This Theme Funny and Compelling?*

By analyzing Sweeney’s delineation of Mike’s lymphoma experience and eventual death, it is not difficult to immediately draw comparisons to the results of Keely and Kellas’s (2005) study of final conversation narratives. Like that study, Sweeney’s tale of Mike’s losing battle with cancer enabled her to gain insight into their relationship, negotiate her own identity by recalling her conversations with Mike, and make sense of her loss and death in general. This relationship is also impacted by Sweeney’s changing identity – from older sister, to caretaker, to caretaker and fellow sufferer.

Sweeney immediately signifies to the audience the importance and distinctiveness of her relationship with Mike by casting them as “partners in crime” from an early age. The orange sherbet story (with its surprising deviation of “spilling the beans” through projectile vomit) is sweet, funny, engaging, personable, and provides the audience with good reasons to buy into the narrative fidelity of Sweeney’s story. Readers understand that Mike and Sweeney demonstrate – or, at least, once demonstrated – the irreplaceable
bond inherent among close sibling duos. Contrasting the image of a youthful Mike placing Sweeney in a headlock on their front lawn – as images begin “hemorrhaging” (p. 172) into Sweeney’s head – with the shriveled skeleton he later becomes makes Mike’s illness and death all the sadder. He was once a cute little kid like everyone else, and anyone who has ever lost a close sibling to a long illness can certainly relate. Thus, the reader feels deeply for Mike, and, by extension, for Sweeney.

But Sweeney argues that the dying process actually strengthened the dynamic of that traditional familial relationship. After Sweeney moved from Hollywood to New York, she and Mike were not nearly as close as they were when they shared an apartment building. However, when Sweeney assumed the role of Mike’s older sister/caregiver, Mike provided a larger presence in her life than perhaps he ever had. Sweeney demonstrates their propensity to bond in the radiation treatment waiting room by attempting to guess other patients’ cancer types, shooting each other what Sweeney describes as slight “how weird is this?” (p. 79) looks after Mike walked back into the lounge following treatment, and joking that they might as well find Sweeney a cute, single, and fabulous doctor husband while they were there. Sweeney also demonstrates their sense of closeness as they wearily acknowledged the bizarre humor of the crazy man in the emergency room after Mike suffered a severe vomiting spell overnight.

Once Sweeney’s identity changed to older sister/caregiver/fellow cancer sufferer, this bond became even stronger, and initially took on the absurdist, darkly humorous undertones that assist in making this theme compelling. Mike was previously the sole member of the extremely exclusive, not-so-swank club “Sweeney Kids with Cancer.” When Mike received word that his older sister had been forced to join his little group, he
responded hilariously, “Oh, you just couldn’t stand it, could you? I bet it was hard for you, being an actress, with me in the cancer spotlight all the time!” (p. 106), and stated that she “just got a little sympathy cancer.” This, obviously, represents a huge deviation from the reaction the audience would expect under such horrendous circumstances – although cervical cancer is not typically as dire as stage four lymphoma. The reader gets the sense that Mike utilized humor certainly to help his sister feel better by downplaying its severity, but also in an extremely loving way, to welcome her to his private club, and perhaps to express a sense of relief that he was no longer sailing on the cancer boat alone, so to speak. For the relatively private Mike, experiencing relief from being the sole focus of everyone’s attention may have been a welcome respite.

Sweeney and Mike flaunted their collective identity when their doting parents visited friends in Florida by dubbing Sweeney’s bungalow the “International House of Cancer” (p. 118) and blaming everything that went awry – like their wilting plants – on cancer. The siblings could have sat alone in their house feeling sorry for themselves, but they decided to make a mockery of their condition instead by co-constructing such an absurd topic of humor. Sweeney’s decision to include these details adds to the narrative’s fidelity. Their utilization of humor over self-pity allows such dire topics to become more easily-digestible, and audiences tend to reward this notion with empathy and attention. We also see instances of the siblings’ relational identity by Mike’s “I guess it’s not so funny now that you have cancer too” (p. 121) crack between vomiting spells (and Sweeney’s wearily humorous, saddened response).

Sweeney was also able to negotiate her own identity by recollecting her interactions with Mike. Perhaps Mike’s erudite sense of dark humor helped Sweeney to
not take her own cancer diagnosis as seriously. Not only did Sweeney watch Mike mock his doctor by sarcastically stating “I love my shunt!” and ask Father Sullivan for his card when he arrived to deliver last rights, she was also a co-interactant in Mike’s humorous comments which downplayed her condition in relation to his own. Witnessing Mike’s reactions to his lymphoma may have enabled and encouraged Sweeney to approach and recall her own cancer experience with humor – like making jokes about coughing up her lost ovary, or having to meet a guy and a girl in order to make a baby – after Mike was no longer with her. Certainly, Sweeney’s natural inclination to be humorous helped her in this situation, but perhaps developing a closer relationship with her brother throughout his illness experience was freeing. Mike’s ability to find the absurd in his situation – and his positive reactions when Sweeney did the same – gave Sweeney permission to utilize humor during and after her individual plight. Mike’s tendency to rib Sweeney for having cancer also signaled to Sweeney that she really was a huge part of her brother’s life. People do not generally joke about such serious matters unless they are close, and Mike knew that Sweeney would appreciate the attempts. The reader gets the sense that Mike would not have rather shared the unifying bond of having cancer with anyone else.

Finally, the recounting of Mike’s lymphoma experience enabled Sweeney to make sense of her loss and death in general. This can be seen in Sweeney’s selection of the Dickinson poem Parting to accompany her dedication of the book to Mike: “Parting is all we know of heaven/And all we need of hell.” Sweeney chooses to acknowledge the irony of Mike winning Scrabble on the word “exit,” states her beliefs that death is actually a birth, uses Mike’s passing – being ferried across by his closest friends – as a description for what she believes constitutes a beautiful death, and hopes that the
stubborn Mike finally allowing himself to give up all control meant that he ultimately gained some. The “heaven is an instant” tale from Sweeney’s childhood simultaneously sheds light on her Catholic schooling and upbringing and advances an interesting theory about the afterlife just as Mike is about to pass away. It is also interesting to note the extent to which Sweeney discusses her views of religion and an all-powerful being in God Said, “Ha!” In 2006, Sweeney began performing her third monologue Letting Go of God which describes the inner search that ultimately led to her public proclamation that she is an atheist.

Sweeney’s narrative about Mike’s lymphoma experience provides an interesting contrast to that of her own in terms of her moralization of cancer. It also sheds light on Sweeney’s relationship with her brother, and what Mike’s illness and death ultimately taught her about herself.

**The Dystopian Shangri-La: Sweeney’s Alteration of Life Plans**

“Shangri-La” is a fictional utopia, a permanently happy land isolated from the outside world as described in the 1933 novel Lost Horizon by British author James Hilton. Following her divorce and departure from a chaotic and strenuous job at Saturday Night Live, Sweeney developed an elaborate fantasy of her Hollywood bungalow, a place of sophistication, leisure, feminine ambiance, and privacy. She was able to enjoy it for a month. As Mike and her parents are invited into Sweeney’s paradise – the “perfect little house made for one” (p. 35) – her utopian sense of independence ultimately turns into dystopian dysfunction. Sweeney again copes with her suddenly altered lifestyle through the use of humor, and ultimately learns to bond with and cherish her parents in a way she had not in quite some time. Sweeney states that she always believed her family to be
dysfunctional and her relationship with her parents to be rather strained. But when the chips were down, Sweeney learned just how functional they all could be.

*Why Is This Theme Funny and Compelling?*

Sweeney draws a good deal of comedy from the proceedings by juxtaposing her fabricated ideal of the Shangri-La with the real life chaos she actually experienced. The author welcomes her audience to laugh at the surrealism of her suddenly sad and disheveled life first by characterizing the notion of once again bunking with her parents as reverting back to her teenage Catholic schoolgirl days. As an independent and professionally successful adult living in large metropolises for half her life, Sweeney had clearly grown out of her adolescence in Spokane. Yet, it seemed that all of the progress she had made through independence and maturation had suddenly been dashed once her parents began to get comfortable in her home. Everything that made Sweeney independent, cultural, and tranquil was seemingly shifted and sullied by her past. It is a nightmare most individuals in the audience can understand – taking the less fun aspects of adolescence (rules, lack of privacy, and independence) and swapping them with the best perks of self-sufficient adulthood. This situation is funny because Sweeney is being forced to deal with situations most readily experienced by teenagers, not grown women.

For instance, Sweeney no longer possessed complete control over the food situation in her own home: Goodbye, delicious Samuel Adams bottles and fresh Trader Joe’s salsa. Hello, PBR cans and Del Monte tomato paste! Sweeney’s parents frequently barged into her “room” (actually her office, where she attempted to get work done) with banal questions and stray observations, clearly violating any sense of privacy or boundaries she might have previously possessed. Once her parents begin fighting,
Sweeney is thrown into the middle of the situation to referee. Sweeney must also hide the fact that she smoked and was sexually active, even saying that Carl’s visit caused her mother to begin making traditional meals like meatloaf, and resulted in Sweeney playing footsie under her own dining-room table. Sweeney says that having to sneak around brought unexpected titillation, although she felt as though she was essentially telling Carl, “Oh, my parents are so weird. Let’s go make out in the garage” (p. 95). Sweeney also jokes about how she could not wait to get out of her house and go to college, before remembering that she was actually in her 30s.

Sweeney utilizes a description of the paint on Mike’s bedroom ceiling as a metaphor for the sudden merging of her hopeful past with the dreary present. When Sweeney lived in her old apartment before passing it on to Mike, she had painted the bedroom a very girlish pink. Mike painted white over top of it, but parts of the old paint still peeked through at the corners. The pink paint, a symbol of her past filled with a strong, independent, and feminine identity and a vibrant sense of promise for the future had literally been white-washed. Though patches of pink were still visible, Sweeney is acknowledging that her present identity has been separated from much of what once made her her. This seems somewhat ironic, considering Mike sought out his apartment to reclaim a sense of his former self.

The arrival of Sweeney’s parents brings about a clash of two different ideologies and eras. Immediately the reader is treated to epic bouts of conservatism vs. liberalism, naivety vs. cynicism, provincialism vs. sophistication and worldliness. The reader experiences the atypical complications associated with taking one’s small-town parents to a Broadway play. Sweeney fights with her father about Native American rights and the
demeaning portrayal of Catholic nuns. Elevators become cutting-edge technological wonders. Finger foods and candles intended for Carl’s presence are replaced with a 5,000-piece puzzle of a map of Sarajevo and Sweeney’s mother asking, “Hey! What’s on TV tonight?” (p. 94). Even the seemingly ubiquitous terminology of “pasta with marinara sauce” becomes too uppity for Sweeney’s parents before it is reverted to “noodles with red topping” (p. 50).

For anyone used to seeing their parents for three weeks of the year, spending almost every minute with them for nine months straight would certainly be a jarring twist. Unsurprisingly Sweeney allows herself the opportunity to vent about her parents’ escapades by using humor in order to cope. The reader – especially the independent adult – is able to place oneself in Sweeney’s shoes – and perhaps see a little of their own parents in Sweeney’s mom and dad – through the inclusion of idiosyncratic character traits. For instance, Sweeney characterizes her mother’s perception of doctors as all-knowing entities whose infinite understanding of all health matters dwarfs any consideration she might have possessed on the matter. This reflects her sense of traditional powerlessness as a passive participant in medical encounters. The author also gives the audience a taste of her mother’s rambling speech patterns:

“Oh! How was House Guest? I love that Sinbad, I see him on TV and your TV isn’t working because the cable is out of sync with the channels on the TV and I don’t know how to fix it and I want to because I have a video I want to watch but I can’t because I’m making soup in the kitchen but the soup is boiling over and your father could finish it, but he can’t because he’s been drinking” (p. 113).

Sweeney also describes her general sense of physical and mental dishevelment in a slowly-unraveling life. In this case, she utilizes sarcasm:

So I went to my nearby grocery store, Pavillions. And they were having this big sale on Friskies, like three for eighty-nine cents. So I decided to get a bunch. And...You know, when you’re in the grocery store at midnight, on a Friday night,
buying fifteen dollars’ worth of cat food, and you’re a single woman in her mid-thirties…well, that’s a special feeling…(p. 114).

Sweeney’s trip to the bookstore – in which she was forced to share a string of personal shortcomings to a person she could not even remember – also demonstrates her conceptualization of approaching a feeling of “rock bottom.” The fact that she included the details of her loud public fart, and easily-identifiable deer-in-a-headlight response, characterizes the state of Sweeney’s from-bad-to-worse day and displays a sense of vulnerability. Sharing such personal and embarrassing information could allow the narrator to become more “real” to the audience and a worthy recipient of one’s empathy. It is also quite humorous to consider Sweeney’s belief that cigarettes and the Pope’s new book were sources of equivalent toxicity.

It could easily be argued that the most compelling moments in God Said, “Ha!” do not include Sweeney’s utilization of humor. The same is especially true of this theme. Sweeney initially paints her parents in broad strokes as wacky characterizations that serve the purpose of filling her life with humorously-grating strife. But after all the bitching Sweeney does about her mother, the second she holds Mike’s hand and he does not let go, or gives herself up to a movie in the middle of the night because she can no longer find a solution to the littlest problems …she becomes a real person. Drama is the truly transcendent aspect of Sweeney’s narrative because it demonstrates a real humanizing effect to Sweeney’s initial character sketches (in the case of her parents) – but it would not demonstrate the same power without the use of humor. Unlike Birbiglia and Pryor’s narratives, Sweeney’s story does not seem to build to a hilarious/frightening/surreal climax the equivalent of jumping through a window or lighting oneself on fire. But then again, these stories did not result in a loss of anything as large as one’s brother or uterus.
In Sweeney’s narrative, humor does not serve as the story’s centerpiece. Instead, comedy is sprinkled throughout the proceedings, making the story more digestible and allowing the audience to appreciate its moments of undeniable sweetness all the more. Mike’s death, Sweeney’s panic attack, Sweeney sleeping in her old bedroom in Mike’s apartment, and the late night film session would not possess the same emotional wallop and compelling sense of engagement if the audience had not been “softened up” first by Sweeney’s sense of humor.

Just as the audience begins to view Sweeney’s parents as real people and not simply as wacky caricatures, Sweeney starts to see the functionality displayed by her formerly dysfunctional family. She thinks about her mom whipping up Jell-o, her dad filling out social security forms in the middle of the night, and both of them carrying Mike to the car when he was too weak to get there himself. The family even adopts their own unifying theme song. Sweeney mentions that she speaks to her parents much more now than before the year of chaos.

This narrative is also compelling because of the inherent uncertainty attached to its outcome. More specifically, the odds seem to be against this family in terms of emerging from this tumultuous time in one piece, let alone closer than they once were. There are multiple factors at play: Sweeney describes her tenuous relationship with her parents, their threats of divorce, her not being as close to Mike as she once was, *It’s Pat* resulting in a huge box-office flop, the fact that she had just gotten over a divorce. It all intrigues the reader. Because one is not entirely sure how the proceedings will all pan out, the story becomes compelling. The audience asks themselves what they would have done if they were in Sweeney’s situation, how they would have handled it. It seems that
Sweeney had no idea how she did it either – but one does not often think they can undertake certain things until one is forced to go through it.

“Sympathy Cancer”: Sweeney’s Perception of Her Own Illness

Because no one had yet written the self-help book “WHAT HAPPENS WHEN YOUR BROTHER HAS CANCER AND YOUR FAMILY MOVES IN WITH YOU?” (p. 82), Sweeney was forced to wade through her chaotic situation without any outside authoritative guidance. But whatever stress Sweeney felt in relation to her family’s initial trauma was certainly exacerbated by her own cancer diagnosis and impending hysterectomy. As a single, thirty-something female with no children, Sweeney was forced to come to grips with an illness that would have a major impact on her future. Yet, the author immediately contrasts the severity and meaning of her condition with that of her brother’s. Where Mike’s lymphoma is moralized as a relinquishment of the moral self due to an evil and mercilessly invasive foreign manifestation of destruction, Sweeney characterizes her cervical cancer as an organic part of her body that had simply grown mildly out of control.

Sweeney expressed gratitude at the “advantage” of being able to remove one’s reproductive organs to rid the body of cancer and still maintain the capacity to carry on throughout one’s daily existence. This led her to humorously point out the “convenience” of developing cancer of the fat. The author’s ability to downplay her own cancer experience in relation to her brother’s allowed her illness to become somewhat of an afterthought (“an embarrassment really,” p. 136). Her brother was dying or immediately deceased. She did not have cancer of the lungs, liver, or brain. To Sweeney, there seemed to be more pressing matters at hand than her cervical cancer. She felt like “someone
complaining about their cough at a funeral” (p. 136). Though she experienced flickers of worry, dread, shock, inconvenience, and irony – “Now I have cancer too” (p. 121) – Sweeney’s impending hysterectomy was placed on the backburner while Mike was still alive or unburied. The procedure was just some distant event she wanted to get over with. “In a way, (the timing) was a blessing. I am sure I would have been very insecure and psychologically overwrought if I were just dealing with my own cancer, out of the shadow of Mike’s” (p. 136). Instead, Sweeney was “abnormally nonhysterical about the whole thing” (p.137).

Perhaps most interestingly, Sweeney says she experienced a “dark and creepy” (p. 137) feeling of sadness at the prospect of having to relinquish the cancer from her body. The illness and its inherent experience was also a part of the recently-deceased Mike, and the relationship he had with Sweeney during his final months was characterized by their shared identity as siblings with cancer. She felt as though parting with her cancer would be like turning her back on a unique bond that only the two of them shared – her official resignation as the sole remaining member of the “Sweeney Kids with Cancer” club.

**Why Is This Theme Funny and Compelling?**

Sweeney uses figurative language to describe the physical ramifications of her procedure, simultaneously increasing audience engagement and providing a transformative sense of understanding for the reader by painting a vivid picture. Sweeney characterizes her attempts to conceptualize the cosmetic deviation brought about by her surgical scar not as a sense of shame at its permanence, but as being similar to her attempts to envision puberty before she had begun to experience any changes. When Sweeney’s mother told her that she would grow pubic hair, she stared at her groin in the
mirror – much like she did with her stomach before her hysterectomy – and imagined how it would look with hair. “Not wanting it, NOT wanting it. Just thinking, Wow...that’s gonna be weird.” (p. 137).

Sweeney also characterizes her re-positioned and wayward ovaries as “swimming around her armpits,” (p. 142), “suddenly rebellious” (p. 164), as free entities who would of course want to travel the world and see some stuff after no longer having to deal with “that fallopian tube anymore” (p. 164), “the anatomical equivalent to Florida,” (p. 164), and as an organ that had a plausible chance of being coughed up by Sweeney. She also notes the irony in the doctor’s statement that he could harvest a dozen ova – “Why twelve? Because...they’re eggs?” (p. 143).

The emotional implications of Sweeney’s illness experience are designated through the metaphor of her unused reproductive organs as “this great shiny bike that (she) had in the garage that (she) was totally going to ride someday” (p. 106). Sweeney had not taken the opportunity to ride her bike, and now someone was attempting to steal it. Suddenly, she must come to terms with her inability to birth children.

I never imagined that, someday, I would identify with the barren women of the Old Testament...And I have to admit that I find it a little appealing that those Old Testament guys kept falling for gals who had a difficult time conceiving (p. 145).

The author humorously points out the inconvenience of having to meet a quality guy and a girl to create a baby through surrogacy, and depicts the absurdity of approaching Carl about fathering her children as taking their rather casual relationship to a completely maniacal stratosphere of severity far too quickly (“‘Hey, before the movies on Friday night, why not fertilize all my eggs. ‘Cause, you know, things might really work out between us,'” p. 143). She also copes with the embarrassment of having to tell
her mother when she went to the bathroom post-surgery by joking that it was quite possibly her lowest moment. After all, her mother excitedly exclaimed “Good girl!” (p. 156) after a successful trip, as if Sweeney had just learned to use the big girl’s potty.

Sweeney notes her own propensity for using “dark hellish comedy” (p. 168) to cope with her string of bad luck by comparing her year from hell with Quentin’s twelve months of lifelong dream fulfillment.

Again linking her experience with that of Mike’s, Sweeney describes her rather poignant feelings of being engaged in a square dance with Mike and David as she takes her brother’s place as the guest of honor at “the big radiation extravaganza” (p. 158). She also says she was sure she had an oddly amused expression on her face as she left treatment, her eyes meeting David’s before they laughed “that little laugh like ‘How weird is this?’” (p. 158).

Sweeney characterizes her panic attack the night before undergoing surgery as being set-off by the image of a scalpel cutting her open, and all of her insides spilling out. She uses the image of a train “chug-a-chug-a-chug-a-chuga-a-ing” (p. 138) into her brain, bringing along with it the reality of the situation. She says that she suddenly felt like such a “body” (p. 138), an organic, interdependent unit that functions like a complex machine rather than an existential being with a soul; an instrument whose organs work like the intricate pieces of a clock – with the removal of the smallest gear irrevocably impacting the whole of the system – rather than a unique individual who lives and experiences a different worldview than others. It is interesting to watch Sweeney’s perception of her very existence revert from a feeling of interpretation to the mechanistic view of biomedicine. The reader is drawn in by Sweeney’s remarkable and compelling use of
imagery to describe her feeling of the physical fragility inherent in the human experience and her sense of sudden vulnerability.

Sweeney also uses narrative to justify her decision to not extract and fertilize her eggs (leaving behind any hope of raising biological children) by tracing the evolution of her thoughts on the prospects of motherhood. She discusses her rabid and extremely detailed childhood desire to birth seven children – all at once, “like a litter” (p. 147). Sweeney had names picked out for each imaginary child, and knew their food preferences, future occupations, and what they would receive for Christmas each year.

Then I began to design a house for us to live in. It would have three stories, with a kitchen like this, a TV room like that, and a library, a Ping-Pong room, and an art room and a sewing room. And a Lego room. Oh. And a music room. And a get-away-from-all-the-people room, which would be wallpapered with happy-face stickers (as a ten-year-old in 1970, I couldn’t imagine a more soothing and meditative environment) (p. 147).

Sweeney notes that she abandoned this fantasy when she began noticing boys at age thirteen or fourteen, and actually became devastated by the notion that one of her imaginary children was preparing for his junior year abroad in Europe when she herself had never been. After Sweeney finished college, she felt it was inevitable that she would eventually have children – but only after she lived a little first so her kids could benefit from a mother who was worldly-wise and mature. But she began to realize that the more she worked and visited Europe, the less she wanted to give that freedom and those opportunities up.

It began to dawn on me that all of the terrific life experiences I was having weren’t simply to deposit in a savings account I could bequeath to my children – all of this wonderful living was for me (p. 150).

She began flirting with the idea of living “happily childless” (p. 151). Sweeney drew inspiration from Catholic nuns, as well as two of her aunts and many friends.
without children who loved kids, but never felt as though they had missed out on something essential to her happiness. She also noted that she could moan about the population problem without feeling any guilt, and could conjure up dire images of the future of civilization, without being fearful for her offspring. Part of Sweeney’s decision-making process involved turning commonly-accepted stereotypes on their heads:

I guess I had been socialized to think that anyone without children had to be depressed about it, or was plagued, or terribly unlucky or something. And the very idea of choosing not to have children, well, that had an air of immorality about it.

And I grew up thinking that people who didn’t have children were the type who would go out and carouse in bars all night, dancing on the table tops, tossing money in the air while they threw their heads back in raucous laughter. But as I got older, I began to realize that those people were the type of people who did have children.

The other myth that started exploding in my head was the idea that people who chose not to have children didn’t like them, like the witch in “Hansel and Gretel” or W.C. Fields (p. 151).

Sweeney said that when she got married, she wanted to have children once again. But then she got cancer and had her uterus removed. “Both of these developments threw a serious wrench into my mix” (p. 153). Sweeney rationalizes her sacrifice by putting its importance to her life into perspective, and, once again, flaunting the benefit of her cancer experience. Sweeney considers herself lucky to have gone through such a medical struggle, one which forced her to find answers to some profound questions about herself. She provides readers in similar predicaments with a step-by-step manuscript of her decision-making process, in the hopes of assisting them in coming to their own conclusions.

I finally had to accept the fact that I was never going to be pregnant: I will never get to have my spouse put his hand on my swollen belly, great with child. I will never have someone rush ahead of me and grab my shopping bags because “I shouldn’t be carrying anything heavy and I should get off my feet.” I will never eat for two. And I know I’ll miss the experience of actually giving birth, which
is something that I’ve always looked forward to, despite the pain, just for the sheer miracle of it.

But if that’s my heaviest cross to bear, it seems like such a light one.

Don’t get me wrong, I spent plenty of moments in anguish coming to terms with my reality, but sometimes it’s in your limitations that you find your greatest strengths.

I began to realize that I have no overwhelming emotional need to have my specific genetic code continue after me. Not that I’m ashamed of it or anything, but I don’t feel like my DNA has something going for it over anyone else’s. And, at the risk of sounding like an ad for an adoption agency, there really are just too many children out there who need parents, and I believe that adoption can bring a child and a parent together in a way that is seriously spiritual and totally valuable. And that’s cool.

So, I figure I’m in a good space. I can still raise a child, although I can’t bear one, and in a corny way, I’m glad that my own medical struggle has forced me to answer some deeper questions that I might have otherwise just skimmed over or avoided completely.

And that makes this cross of mine feel like a feather (p. 153-154).

Finally, Sweeney’s narrative of her illness experience provides readers with a blueprint that outlines her beliefs on how the world should operate. Mostly, this pertains to Sweeney’s view of the shortcomings of the medical professionals with whom her family was forced to work. Much more than Birbiglia or Pryor, Sweeney offers a critique of the power hierarchy, shortsightedness, and lack of congeniality often inherent in medicine. Sweeney notes her ease in identifying groups of doctors, because they were always men who looked vaguely like stockbrokers (“except they were wearing white instead of blue pinstripes,” p. 41). This comment emphasizes Sweeney’s perception of hospital doctors as professional, well-polished, starchy, unapproachable men who stand on imaginary pedestals and possess a lack of commonality with patients.

Sweeney mentions that the providers working at Mike’s free clinic never tested him for anything other than HIV. They simply repeated the same tests numerous times. Diagnosing Mike’s lymphoma earlier could have potentially saved his life, but the
possibility of Mike having cancer – or anything other than HIV – was never once considered. Mike also mentioned the “surliness” (p. 32) of the nurses in Rochester. Sweeney often characterizes her and Mike’s doctors as being unaware, or less than appreciative, of her family’s intentional or unintentional elicitation of humor. When Mike and his mother mistakenly envisioned his shunt as a “faucet” and a “spigot” (p. 99), their doctor responded with awkwardness and embarrassment rather than acknowledging the humor in the ridiculousness of their preconceived notions. In response to Sweeney’s blatantly absurd worry about coughing up an ovary, her doctor says straight-faced, “No, that’s pretty much impossible” (p. 164) without an ounce of irony or recognition of the statement’s peculiarity. Sweeney views these doctors as impersonal, bland, and possessing a misplaced a sense of humor.

Sweeney also notes the lack of accommodation and compassion she experienced during her telephone call with the receptionist at the Cedars Sinai Comprehensive Cancer Center. Not only did the receptionist butcher Sweeney’s name numerous times (“Miss Weenie,” p. 107), she also asked Sweeney to pick up her own slides, and failed to acknowledge the irony in the fact that she had already planned to go to the UCLA Cancer Center that day to take Mike to chemo for treatment of his own cancer. Sweeney draws humor from the proceedings through the repetition of the statement, “Oh. Nobody picks up their own slides,” (pp. 109, 110) to exemplify the irrational lack of protocol and courtesy exhibited by the receptionist.

By mocking a traditional power structure – not even allowing Dr. Fu’s status and graciousness to stop her from cracking on his Asian-accented pronunciation of “fertirity” – Sweeney is able to reduce the authoritative legitimacy of health professionals as know-
it-all, endlessly professional entities that dominate the field of medicine. Instead, they often take on the absentminded and fumbling characteristics popularly portrayed by TV detective Columbo, particularly as Sweeney’s doctor expresses his confusion over the photo of her missing ovary by throwing his hands up in the air.

However, Sweeney acknowledges great satisfaction at her meeting with Dr. Fu. Her description of his earnestness and value placed on absorbing the individual experience of a cervical cancer sufferer – having been relegated to analyzing case studies and microscope slides for twenty years – demonstrates the capacity of some doctors to emphasize the humanity of their patients. Sweeney’s description of Dr. Fu’s office as being “like something out of a movie set” (p. 110) allows the reader to generate a clear image of its layout and items. Sweeney also demonstrates her ability to bond with her radiation technician because they attended the same high school. The author essentially says that there are helpful and “delightful” (p. 111) medical providers out there, but patients may have to stroll through a bunch of crap before meeting one.

**Subtextual Issues**

The moral of Sweeney’s narrative journey demonstrates the importance of coming to terms with the alteration of life plans. She characterizes the entirety of Mike’s experience, and her own before the hysterectomy, as being regressive and chaotic. Ultimately, though, Sweeney expresses the reestablishment of a sense of normalcy and reclaims a feeling of health restored – well, as much as one can after losing one’s brother, uterus, and the capacity for having children – by chucking her rock back onto the Inish Turk shoreline. Thus, a small – but incredibly significant – portion of Sweeney’s narrative exemplifies a progressive restitution form. Because Sweeney demonstrates an
ability to meet suffering head on, accepting her own illness and seeking to use it to engage in a deeper level of decision-making, her story also emulates a quest narrative. Sweeney describes herself as becoming a stronger person through dealing with troubles and adversity.

*Biomedical vs. Interpretive Perspectives*

Sweeney provides a good deal of clinical medical information in addition to a personal interpretation of the phenomena. This can be seen in her propensity for quoting her doctors when they discuss the implications of her hysterectomy (biomedical), as well as her inclusion of a lay description of chemotherapy as she understood it, based on a social or personal perspective.

*Engagement vs. Fatalism*

By simply reading the book’s title – *God Said, “Ha!”* – one can determine that Sweeney takes a rather fatalistic view in describing her and Mike’s experience of illness. Getting cancer seemed to be a matter of fate (‘Sometimes really shitty things happen to innocent people, and there’s not a damn thing that can be done about it,” p. 127). The success attached with its treatment is also out of one’s hands. The radiation and chemotherapy could either take – and the tumor could shrink or disappear – or, in Mike’s case, adhering to the treatment regimen could simply be delaying the inevitable. However, Sweeney emphasizes Mike’s psychological control which allowed him to pass away when he was ready. Sweeney also demonstrates engagement through her decision to salvage the ability to create biological children, and, perhaps most importantly, through her aptitude in attitude adjustment.
CHAPTER VI
Discussion

This research attempted to analyze the employment of productive humor throughout the process of illness trauma narrative construction, and determine what the humorous aspects of the narrative product express to receivers about the illness experience. Through narrative and phenomenological analysis of funny stories about traumatic experiences by writer-comedians Mike Birbiglia, Richard Pryor, and Julia Sweeney, this thesis determined that the use of humor appeared to function effectively in assisting in the creation of a compelling narrative and drawing attention to unique health issues.

Birbiglia discusses the implications of coming to terms with a rare and publically unfamiliar sleepwalking disorder, RBD, by characterizing his experience as initially liberating, and eventually as dangerous – losing all control over his inhibitions. He also discusses his transcendence of denial and the consequences of leading a life suddenly altered by illness.

By cheating death, Pryor was able to describe a particularly extreme outcome of severe drug addiction. He portrays his relentless dependence on freebase cocaine through themes of desperation and helplessness, and leading to an inevitable brush with death. Pryor also discusses the physical and emotional agony of recovery from the nearly fatal third-degree burns he suffered as a result of an “accidental” self-immolation.
Through the employment of humor and pathos, Sweeney recapitulates the distinctive experience of suffering from cervical cancer while living with her parents and as her brother, Mike, succumbs to lymphoma. She characterizes Mike’s cancer as a devastatingly invasive predator, and describes how their relationship was strengthened by her assumption of caretaker and co-sufferer roles. Sweeney also discusses the alteration of her peaceful, sophisticated, and independent life plans, and utilizes her own cancer experience as a critique against health care providers and as rationalization for her decision not to bear biological children.

All three stories fulfill the requirements of narrative as prescribed by Lablov (1972), but differ somewhat in plotline form and structure. While Birbiglia, Pryor, and Sweeney adhere their main framework along the temporal chronology of abstract, orientation, complicating action, evaluation, result, and coda (with Pryor utilizing a bit more spontaneity and continuity gapping), Sweeney’s use of anecdotal asides and stable ruminations that do not directly advance the main narrative laterally (focusing instead on proving character and contextual depth) allows her story to unfold somewhat arbitrarily rather than engaging in a persistently forward-moving momentum.

These “wounded storytellers” (Frank, 1995) each utilize regressive, progressive, chaos, and restitution elements – with Sweeney also emulating a quest form – within their moral/core narratives and provide a varying mixture of biomedical/categorical and interpretive/spectral views of illness. Birbiglia seems to express the greatest feelings of engagement over his power to determine the course of his illness experience, while Pryor and Sweeney most notably delineate a sense of fatalism.
The authors’ ability to describe their experiences through deft characterization and visually-engaging figurative language aids in the argument that the use of humor calls attention to their distinctive health issues. Birbiglia and Pryor, for example, uniquely personify their disorder as divergent aspects of their persona that quickly grow out of control. “Sleeping Mike” and “The Pipe” initially provide the authors with a sense of friendship, compassion, and/or liberation from social decorum. But when Birbiglia transforms into “The Hulk” and Pryor is almost killed by the growing vitriol of his increasingly-attached pipe, the authors characterize their former “friends” as manipulative beings who have sought to claim the authors’ pre-existing moral selves all along. Birbiglia and Pryor also utilize these alternate personas (Mudbone included) to separate themselves from the vulnerability of their “naked I” (duPre, 1998, p. 161).

Sweeney’s characterizations of herself and Mike, meanwhile, demonstrate their ability to co-construct a hilarious, wildly original reaction to their shared identity of cancer. Notions like “hogging the cancer spotlight” and living in “The International House of Cancer” demonstrate their ability to cope by humorously belittling that which scares them the most. The idiosyncrasies of Sweeney’s doting parents also enable the most emotionally-taxing elements of her story to become more easily digestible for the reader.

Birbiglia, Pryor, and Sweeney each utilize irony, metaphor, hyperbole, understatement, and sarcasm to effectively draw humor from their experience. Because they shared their stories verbally, Birbiglia and Pryor were afforded the opportunity to utilize gestures (like Birbiglia’s karate pose charade session), exaggerated facial expressions (slightly raised eyebrows), idiosyncratic word choice (“burnt up”), and paralanguage (impersonations, mocking tones) as humor cues for interpretation. Sweeney
uses textual humor cues such as CAPS, ellipses (...), *italics*, and exclamation points (!!!). These authors' unique uses of characterization and figurative language as cues for humorous interpretation allow them to place their fingerprints all over their own experiences, making their stories their own and nobody else’s. As discussed below, these tools also provide the audience with a sense of engagement and approachability to threatening subject matter.

In keeping with Sharf and Vanderford (2003), Birbiglia, Pryor, and Sweeney also utilize humorous narratives to make sense of their illness (Sweeney frames the main events of her story with her trips to Ireland to pick up and dispose of the “lucky” rock), reclaim a lost sense of control (Birbiglia is able to trap the Hulk each night by taking strong medication and strapping himself down in a sleeping bag with mittens over his hands, and actually succeeds in making this a socially acceptable and possibly enigmatic behavior), demonstrate a change in identity (Pryor classifies himself and others receiving treatment in the burn ward as “[a] motherfuckin’ burnt up”), justify or critique their decisions (Birbiglia and Pryor mock themselves for allowing a sense of denial to keep them from receiving treatment – “Maybe I should see a doctor. Maybe I’ll eat dinner” – while Sweeney backs her decision to not extract and fertilize her eggs), and proclaiming a sense of community (Birbiglia’s “Sleep While Standing” tour encouraged audience members to record their own sleepwalking stories in a booth at each venue. Birbiglia’s publicity tour also allowed him to discuss the ramifications of RBD on widely-disseminated radio and television programs like ABC’s “The View.”)

For the most part, these authors generate humor by violating their audiences’ expectations regarding some aspect of their illness trauma experience, and providing a
pleasurable sense of liberation from the release of one’s previously inflexible preconceived notions. For instance, Birbiglia undercuts the beliefs of most audience members that someone suffering a near-death experience would likely be too rattled to instigate humor attempts immediately following the incident. Yet, after the ER doctor told Birbiglia that he should be dead, Birbiglia “zings him,” saying, “No, you should!” Sweeney’s portrayal of Mike’s blatantly sarcastic exclamation “I love my shunt!” reflects a deviation from the traditional notion of a passive patient respecting a doctor’s authority. The audience experiences liberation by witnessing the ridicule of a professional and influential figure of power who, in this case, deserves the comeuppance.

In each of these cases, humor functions to emphasize and increase mutual understanding of the illness experience between sufferers and non-sufferers. The use of figurative language, such as metaphor, functions in providing the audience with a sense of imagery. An author’s ability to characterize elements of his or her unique experience by comparing them to universally-recognized feelings, actions, and items enables individuals who could only fathom what it would be like to have, say, HIV, gain a new comprehension of the illness experience. Sweeney demonstrates this concept by saying that Mike’s radiation equipment looked like it belonged on the Starship Enterprise from “Star Trek.” Birbiglia juxtaposes his diminutive stature with that of “The Hulk” to describe his propensity for jumping through windows when he relinquishes control over his body. Pryor even nonverbally acts out how difficult it was for him to set his pipe down and walk away from it when he reached the peak of his addiction.

Humor may also promote transcendence – or, as Sharf and colleagues (in press) call it, an “aligning moment” (p. 22) – when disseminating the illness experience through
narrative by allowing the audience into the author’s life and promoting identification with what the author was forced to endure. The development of imagery aids in developing the plausibility and rationality of one’s story, and the use of humor has been shown to increase an individual’s likeability (Wanzer et al, 1996). Effective humor provides the author with a socially-acceptable method of dealing with embarrassment, sharing complaints, and admitting feelings of inadequacy, facilitating the dissemination of even the most sensitive information related to his or her experience. Thus, audience members are likely to develop a sense of empathy for authors as they openly and honestly discuss their vulnerability through humor. If the author tells an effective story, they will encourage their audience to ask themselves the question, “What would I do in this situation?”

A large aspect of this notion involves the ability of humor to reduce the threat of menacing concepts and the negative feelings one experiences while thinking about them. One of the best ways to exert one’s control and power over threatening concepts is to lampoon them. For instance, one could reduce Osama bin Laden or Kim Jong-il to wearing women’s lingerie to achieve a similar effect. The same thing goes with a family’s battle with devastating cancer, or an individual’s severe drug abuse, chronic sleepwalking, or death. The authors of these humorous narratives are essentially telling their audience, “Hey, it’s okay to laugh at this scary stuff. Look at me. It happened to me and I’m still laughing. If I can laugh, so can you.” Pryor’s humorous and self-deprecating consideration of the implications of his drug use even allowed his audience to feel comfortable enough about the topic to make fun of him right in front of his face.
It would not be much of a stretch to consider the fact that most people would rather laugh at/with something than experience real, personal fear or sadness (unlike the kind felt while watching a scary or tear-jerking movie). Part of the experience of listening to an individual talk about a traumatic event involves the sharing of these threatening emotions. Sometimes this expectancy turns individuals off from wanting to receive that message – “I’m just not in the mood to be depressed or scared by cancer tonight. If I wanted to hurt, I’d walk around the intensive care unit of the hospital.” Thus, the message does not hit them quite as squarely in the gut.

Humor, however, serves to sort of mask these threatening feelings, enticing the listener to let their barriers down so that he or she can be more willing to pay attention to the speaker’s experience. Although the presence of fear and sadness is sometimes still sensed by the reader of a humorous narrative, this experience of discomfort is softened by the positive feelings associated with laughter – a function utilized to belittle threatening subject matter and often to signal that an individual has come to terms with a traumatic experience (with the exception of the instances described in Bethea et al., 2000, in which a number of participants who used humor to discuss difficult information were simultaneously sending metacommunicative signals that expressed distress and a need of assistance).

The audience, having gained empathy for and identification with the speaker, expresses pleasure in the liberation of witnessing an individual effectively embrace the lighter side of trauma. Thus, the listener is essentially being shown – right there before his or her eyes – how to cope with the threatening subject matter. Because the speaker also appears to have come to terms with the experience, the audience is more readily able
to laugh. The audience knows that the author will understand that they are laughing *with* and not laughing *at* him or her.

As expected, the most compelling moments of Birbiglia and Pryor’s narratives utilize situational humor. Birbiglia’s climax involves his jumping through a window, and Pryor’s his self-immolation. There is not a great deal of direct pathos included in the proceedings – with, to a slight degree, the exception of Birbiglia’s discussion of how a comedian’s inherent sense of denial almost killed him, and Pryor’s acknowledgment that the medical professionals in the burn ward were wonderful.

Sweeney, however, suffered a deeper and more permanent sense of loss than either of the previous authors. Thus, she utilizes humor and pathos together more readily in an interdependent fashion. Humor seems to soften the audience up to her narrative, bracing them for the tougher parts. Instances of pathos – like Mike and his mother holding hands – humanize Sweeney’s initial character sketches and allow the listener to begin developing feelings of identification. Sometimes, humor and pathos are delivered simultaneously – such as when one considers the story of Sweeney, her brother, and the orange sherbet in retrospect, and when Sweeney says, “Yeah, Mike. ‘Cause normally I’d be laughing my ass off.” The use of pathos also allows further instances of humor to become funnier because they are more personal.

This analysis has attempted to identify the forms and functions of humor in illness trauma narratives as numerous and multifaceted, and its presence may be effective in humanizing and calling attention certain health issues. Humor may also assist in allowing the dissemination of traumatic or embarrassing information to become more palatable for audiences, and less face-threatening for storytellers.
Limitations and Suggestions for Future Research

In order to gain a more precise, categorical view of the content and forms disseminated through humorous illness trauma narratives, future research should attempt to implement content analytic forms of investigation. According to Kline (2003), content analytic methods tend to systematically classify the surface content of texts in mutually exclusive groups as factual information that can be subject to statistical analysis, without attempting to explain any qualitative meanings of the text (like this author’s attempts to clarify various interpretations). A content analytic approach may allow this research to advance thematic categories that might be considered to be more generalizable and could be replicable for future research. For example, this thesis had no scientific means of measuring the case study authors’ actual coping effectiveness while crafting and sharing humorous stories about their traumatic experiences. Each of the respondents is also a comedian; thus, their occupational success depends on making others laugh. Not only might the audience have been expecting (or primed) to laugh at the proceedings (because they were receiving the product of inherently funny people), the authors could have simply crafted their humorous tales of trauma without the intent to cope, but simply to develop material and acclaim. While this may be an exceedingly cynical view, the truth of the matter is that this thesis could only employ MetaHIT (Bethea et al., 2000) to gain a general sense of the authors’ ability to come to terms with their experience through its dissemination.

This thesis analyzed the product of high humor oriented writers and comedians because, theoretically, these individuals should provide the most effective models of humorous illness trauma narratives for the general public to replicate. All three case
studies received critical and popular acclaim, and stood up to the elements of this analysis as examples of highly-proficient, highly-compelling, and highly-humorous stories about the traumas associated with severe medical issues. Future research should analyze the health narratives of members of the general public to gain a different, perhaps more organic, perspective.

It is the hope of this author that his bloated thesis may provide a sense of consideration among health communication researchers of the heuristic value attached to the study of the private and public value of humorous illness trauma narratives in coping with and understanding the personal experience inherent in disturbing medical issues. This thesis attempted to provide three model examples of humorous illness trauma narratives, and develop a rationale for the value of pursuing the private and public functions of humorous health narratives. Future research could place more of an emphasis on funny stories about chronic disorders, such as comedian Josh Blue’s accounts of living with cerebral palsy. Different forms of storytelling could also be analyzed, such as humorous graphic novels – particularly Harvey Pekar and Joyce Brabener’s *Our Cancer Year*.

As Sharf and colleagues (in press) believe, the conclusions drawn from such future research should be disseminated through “translational” means, working toward broader personal, organizational, and societal changes by providing theoretical and complex information that is accessible to practitioners and the general public. Humorous health narratives can provide medical practitioners, governmental bodies, and the general public with entertaining and approachable delineations of their individual worldview, but only if the information presented to them regarding the topic is equally as engaging.
Empirical research should be conducted to test the causal relationships associated with the personal benefits of writing a humorous narrative advanced in the feedback loop/framework included in Appendix A. Through a review of the associated literature, the author of this thesis could hypothesize that one’s ability to laugh at a traumatic experience – acquired through the passage of time, or the review of one’s initial narratives previously crafted about the topic – can increase one’s sense of cognitive distance from the event even further (duPre, 1998). This sense of cognitive distance can increase one’s perspective of the event, which allows for the effective crafting of a humorous narrative (Sharf, 2005). One’s ability to share funny stories related to a disturbing experience can increase his or her receipt of social support (Pennebaker, 2000; Sharf & Vanderford, 2003), which serves to increase the amount one laughs about the topic (duPre, 1998).

To keep this feedback loop from becoming deviation amplifying in nature, the propensity for humor narration to simplify one’s cognitive recollection of the event is also considered (Pennebaker, 2000). The increasing one-dimensionality of an event causes the cognitive energy one expels on its rumination to decrease (Pennebaker, 2000). This enables an individual to forget or move on from the experience, thereby reducing the need to write humor narratives about the same experience (Crow & Pennebaker, 1997). Although these relationships have been demonstrated as significant on an individual basis, researchers may want to test the collective impact they could potentially have on one another.
Conclusion

This thesis has attempted to demonstrate that public storytelling and memoirs – if crafted and shared effectively – may elicit beneficial private/intrapersonal and public/interpersonal functions, and might be utilized as effective media for the formulation and dissemination of humorous health narratives. Through the study of three illness trauma narratives that utilize humor, this thesis has analyzed the forms in which productive humor was employed throughout the process of narrative construction, and the information the humorous aspects of the narrative product expressed to audiences about the illness experience. More specifically, this thesis has attempted to demonstrate that the integration of humor with health narratives may effectively call attention to health issues such as RBD, severe drug addiction, and cancer.
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