BREAKING THE RULES OF COMMUNICATION:
Verbal and nonverbal impoliteness in the American hospital drama *House M.D.*

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Tiivistelmä – Abstract

Tämän tutkimuksen tarkoituksena oli tutkia epäkohteliaisuutta amerikkalaisessa sairaaladraamassa *House M.D.*, jota on esitetty Yhdysvalloissa vuodesta 2004 lähtien, ja Suomessa vuodesta 2006 lähtien. Sarjan päähenkilönä nähdään äärimmäisen epäkohtelias ja tyly lääkäri Gregory House, joka ei säästele sanojaan niin kollegoidensa kuin potilaidensakaan kanssa. Hän rikkoo jatkuvasti sekä potilas – lääkäri –suhteen välisiä viestintänormeja, että muitakin kohteliaisuussääntöjä, joita voidaan kahden ennestään tuntemattoman viestijän välillä olettaa olevan.

Ensimmäinen tutkimuskysymys koski sitä, millaisia epäkohteliaisuusstrategioita päähenkilö sarjassa käyttää. Tämän tutkimuskysymyksen perustana käytin Jonathan Culpeperin luomaa viittä epäkohteliaisuusstrategiaa, jotka puolestaan perustuvat Brownin ja Levinsonin viiteen kohteliaisuusstrategiaan. Toinen tutkimuskysymys puolestaan keskittyi Housen potilaiden reaktioihin; siihen ymmärsivätkö he epäkohteliaisuutta, ja jos ymmärsivät, miten he siihen vastasivat.

Analyysiä varten etsin ja litteroin kaikki Housen ja klinikkapotilaiden väliset keskustelut toiselta tuotantokaudelta. Keskusteluja oli yhteensä kymmenen kappaletta. Valitsin nämä keskustelut siksi, että House on erityisen epäkohtelias klinikkapotilaitansa kohtaan. Litteroinnin jälkeen analysoin jokaisen epäkohteliaisuustapauksen sekä potilaan reaktion ja lajittelin ne eri kategorioihin.

Epäkohteliaisuustapauksia löytyi lähes 100. House oli epäkohtelias jokaiselle potilaalle ja käytti kaikkia Culpeperin strategioita, mutta erityisesti niitä, jotka kohdistuivat potilaiden positiivisiin ja negatiivisiin kasvoihin. Noin viidesosa potilaista ei kuitenkaan ymmärtänyt epäkohteliaisuutta. Lähes kolmasosa ymmärsi, mutta pysyi hiljaa. Toinen kolmasosa ymmärsi epäkohteliaisuuden, ja myös vastasi siihen jollain tavalla. Loput eivät saaneet tilaisuutta vastata, tai heidän reaktiotaan ei näytetty lainkaan.

Asiasanat – Keywords politeness, impoliteness, impoliteness strategies, House

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1. Introduction

Politeness is a part of our everyday lives although we may not always notice its presence. Each time when we find ourselves in a social situation with another person we have to consider the rules of communicational behaviour. Sometimes these rules are automatic but sometimes we have to pay careful attention to them. This is notable especially when we meet new people and most of all when these people come from a different culture with the kinds of communicational norms that we ourselves are not used to.

We may often notice impolite behaviour more easily than polite behaviour. It could even be claimed that impoliteness has become relatively common today. If we, for instance, consider the way in which the Finnish youngsters used to address their teachers compared to how they address them now, there is a significant change in the degree of politeness used. However, these changes have been gradually approved by the society, and this is why it is acceptable to address one's teacher by using only their first name in today's Finland.

This thesis examines the phenomenon of impoliteness by investigating a famous American hospital series *House M.D.*, which has been aired in the United States since 2004, and in Finland since 2006. The show is known especially for its main character breaking the norms of communication, not just in a regular social interaction but in doctor – patient interaction, too. Thus the main focus of the thesis is on the impoliteness strategies that the main character of the series, Dr. Gregory House, uses. The basis of the analysis is on Jonathan Culpeper's impoliteness strategies (1996) but also Peter A. Andersen's categories of nonverbal communication (1999) are used when the issue of nonverbal impoliteness is considered. The secondary focus is on the reactions of Dr. House's patients after he has been impolite towards them. For this I used Derek Bousfield's (2007) theory on the anatomy of impoliteness, and more particularly his chart of how impoliteness can be responded to. This question is analysed by examining both verbal and nonverbal communication as well.

The reason for choosing this topic was that although impoliteness has gained a great deal of attention in the recent years it is still not studied as much as its opposite phenomenon, politeness. Furthermore, impoliteness has rarely been viewed by

investigating a certain TV-series. One such study, however, is a pro gradu thesis by Tuire Oittinen (2010). In the thesis, Oittinen studies the construction of face-threatening acts in the American television series *Gilmore Girls*. Nevertheless, Oittinen's focus is on Brown and Levinson's politeness theory, whereas in the present study the focus is on Culpeper's impoliteness theory, which was developed by using Brown and Levinson's politeness model. Thirdly, to my knowledge, impoliteness and nonverbal communication in particular have not been studied in the same context to a great extent. Finally, since 2004 *House M.D.* has been one of the most viewed TV shows worldwide and thus worth examining.

The data consisted of ten conversations between Dr. House and his clinic patients who represented both sexes and various ages and racial groups. These conversations were chosen because Dr. House is incredibly rude and inconsiderate towards his clinic patients. This is due to the fact that he does not want to work clinic hours but would rather focus on his "main cases": the patients who have serious, mysterious illnesses. Furthermore, it was more interesting to study impoliteness between total strangers than between relatively familiar people because it has been claimed that people are more impolite towards the people they know than towards strangers.

After finding all the clinic patient conversations in the second season of the series, all of them were carefully transcribed looking at, not just the verbal, but also the relevant nonverbal aspects of the conversations, such as facial expressions. After this, all the instances of impoliteness were analysed according to Culpeper's list of impoliteness strategies as well as Andersen's list of nonverbal communication types (Culpeper, 1996 and Andersen, 1999). However, Andersen's list was merely used as a further categorisation for nonverbal instances, not as a primary tool.

The data revealed nearly a hundred instances of impoliteness, depending on the way of counting. This means that because some of the instances were interrupted by another speaker's turn, for instance, they could therefore be counted as either one or two instances. Over a half of the impoliteness instances were either positive or negative impoliteness, that is impoliteness that is targeted towards the hearer's positive or negative face wants. However, each of the strategies listed by Culpeper was used at least seven times. Most of the impoliteness involved also nonverbal elements, such as different facial expressions and tones of voices. Some instances of impoliteness were

created through nonverbal communication only.

The patients responded to impoliteness in various ways. Some patients remained silent after the face attack, some accepted it, and some countered it with either defensively or offensively. However, approximately one fifth did not even understand the face attack, and similarly one fifth did not have a chance to respond at all, or their reaction was not showed to the viewer.

I will start by introducing some of the key theories in the fields of verbal and nonverbal communication, as well as in the branches of politeness and its opposite phenomenon, impoliteness studies. In addition, I will define what a good doctor is, or is expected to be in today's Western society, and also briefly examine the communication in health-care settings. I did not differentiate between doctors in Finnish and American societies because the norms seem to be relatively similar in both cultures. After this, I will go into details of this study by presenting the data itself, as well as the methods of both data collection and data analysis. In the sixth chapter I will present the results of the analysis with a number of relevant examples from the data, and then finally discuss and conclude the findings.

2. Verbal and nonverbal communication

Communication is an ongoing process. It has no beginning or an end, and it perpetually changes. Human communication in particular is highly unique compared to the one of animals, although there have been numerous attempts to teach human communication to certain primates. Unlike animals, humans use language in a natural, spontaneous and creative way. Communication is a very collective activity as well; human society could not exist without human communication, and the other way around. (Trenholm & Jensen, 2008: 5-6). Communication can be divided into two main categories, verbal and nonverbal communication, both of which I will introduce in the following chapters.

2.1. Verbal communication

Verbal communication is a vast field of research, which is studied not merely in linguistics but in other fields of research as well, such as psychology and anthropology.

There are several ways to study communication in linguistics, too, such as from the viewpoint of conversation analysis (CA), or pragmatics. For this study I have chosen to examine verbal communication from the pragmatic point of view because pragmatics as an area of linguistics includes the main focus of interest of this paper – impoliteness. In the following chapters about verbal communication I will present some of the basic concepts of verbal communication as well as pragmatics. I will conclude this chapter by examining the relationship between verbal communication and impoliteness.

2.1.1. Verbal communication from the pragmatic point of view

The modern pragmatics has its origin in the philosophy of language. Its roots are in the 1930s but especially during the past twenty years the interest in pragmatics has grown immensely. As verbal communication in general, also pragmatics is a target of interest of linguists, as well as psychologists and anthropologists, for instance. Whereas syntax studies the language from a formal point of view, and semantics studies the relationship between words and their meaning, pragmatics examines language from a viewpoint of language users; how something is interpreted in a certain context. (Huang, 2007: 1-2). Huang defines pragmatics in the following way:

> "Pragmatics is the systematic study of meaning by virtue of, or dependent on, the use of language. The central topics of inquiry of pragmatics include implicature, presupposition, speech acts, and deixis." (Huang, 2007: 2).

The definitions of pragmatics by other researchers are fairly similar to Huang's definition. For instance, both Mey (2001) and Verschueren (2009: 3) refer to Charles Morris's (1938:6 as quoted by Mey 2001:4) famous definition of pragmatics being "the study of the relation of signs to interpreters". Mey (2001: 5-6) expands this by clarifying that pragmatics is not merely interested in the end-product (language) but its producers (language-users). Moreover, he brings up the importance of the social context. Humans always use language in a certain society in a certain period of time and this affects the language use. Mey finally summarises pragmatics as the study of "the use of language in human communication as determined by the conditions of society" (Mey, 2001: 6).

One of the central concepts in pragmatics is **utterance-meaning**, or **speaker-meaning**. Whereas **sentence-meaning** refers merely to the abstract meaning of a sentence regardless of the context, utterance-meaning refers to what a speaker intends or wants to

communicate. For instance, if someone says *it's really cold in here* in a room with a window open, they do not only make a statement about the room temperature but perhaps make a hidden request for someone to close the window. (Huang, 2007: 11). Another important pragmatic concept is a **speech act**, which is very closely connected to utterance-meaning. Speech acts are verbal actions with which we perform different actions, such as promising, demanding, or requesting. They can also be described as "the basic or minimal units of linguistic communication" (Searle 1969: 16 as quoted by Mey 2001: 93.) The number of speech acts in a language, depending on the definition, has been estimated to be something between several hundreds to several thousands. (Mey, 2001: 93-105).

There are various ways of categorising speech acts. One of the most common and used distinction is the one of **direct** and **indirect speech acts**. Whereas a direct speech act refers to the match between the sentence type and the intention of the act, an indirect speech act does not (Huang, 2007: 110.) For instance, if we return to the example of an utterance-meaning, there is a range of ways of requesting someone to close the window. If we say *can you close the window, please?,* it is a question by which we request someone to close the window. Therefore it is a direct speech act. However, if we say *it's really cold in here*, it is a statement by which we do not only want to state something about the low room temperature but make someone close the window. Therefore it is an indirect speech act.

This is not the only way of categorising speech acts, however. One of the most prominent categorisation is the one by Austin (1962 as quoted by Huang, 2007: 102-103) who divides speech acts into **locutionary, illocutionary,** and **perlocutionary acts.** A locutionary act is the basic act of speaking, or in other words, the production of a meaningful linguistic expression. It refers to the physical aspect of producing a certain utterance, for instance the choice of language, deixis or grammar. An illocutionary act, in turn, refers to the function; what the speaker intends to communicate. Here, the social conventions have an extremely important role. Examples of illocutionary acts are apologising, joking, and thanking. The third speech act type, a perlocutionary act, refers to the effect that an utterance has on the addressee. Each utterance always has either an intentional or unintentional consequence on the addressee. Examples of perlocutionary acts are inspiring or persuading; they both have a certain effect on the addressee's feelings. This effect is also called a perlocutionary effect.

Searle (1977 as quoted by Mey 2001: 119) was not happy with Austin's taxonomy because of its inconsistency and incompleteness, and therefore suggested a more profound categorisation for speech acts by using different criteria. The five categories that he ended up with were **representatives, directives, commissives, expressives** and **declarations.** Representatives are assertions about a certain state of affairs, and can therefore be also called assertives. They can either carry a true or false value. *It will be a stormy day today* would therefore be a representative. Directives are orders or requests whose intention is to direct the addressee towards a certain goal, for instance *could you stop smoking?* The force of directives might differ from wishes to harsh orders. Commissives are promises that are created by the speaker, and which create some kind of an obligation to him or her, for example *I will bring the book to you by Monday.* Expressives literally express the inner and subjective state of the speaker, for example *I regret that I could not be there.* Finally, declarations are statements that change the state of affairs somehow. For instance, if a priest declares a couple to be husband and wife, they will be married from that moment onwards. (Mey, 2001: 120-122).

Mey (2001: 124-126) agrees with Searle about his criticism towards Austin's classification. Nevertheless, he notes that Searle's classification, in fact, resembles the one by Austin but he also gives credit for Searle's classification for being more oriented towards the real world. Moreover, Mey emphasises that it is crucially important to pay attention to contextual conditions when one describes speech acts and the use of language in general. I agree with Mey about Austin's and Searle's classifications for being too theoretical. Language and conversation never consist of merely single sentences, and even if they did, the context must always be taken into account, as Mey points out. Nevertheless, the distinction between direct and indirect speech acts is relatively clear, and therefore I will use it while discussing verbal communication and impoliteness in the next chapter.

2.1.2. Verbal communication and impoliteness

Perhaps the most important pragmatic concept regarding the present study on impoliteness is the indirect speech act because it is usually associated with the concept of politeness. Generally, the more indirect the speech act is, the more polite it is. For example, if we want someone to be quiet, we can use the direct version *shut up!* or the

indirect version *could you remain silent for a moment, please?* The indirect version is a very polite way of asking for silence, whereas the direct version would be considered rather impolite by most people. However, the degree of politeness is tied with factors such as the power relations, cultural conventions, and the degree of closeness of the participants, and this is why we might sometimes use the less polite version. For instance, some parents might tell their kids to *shut up,* but they would not probably say it to their co-workers. (Huang, 2007: 115-117). This issue is discussed more closely in Chapter 3.

It should be noted, however, that although indirect speech acts are commonly associated with politeness, there are instances when indirectness can, in fact, be quite rude as well. This might be the case if two people are close friends with each other and they know that the other person will not be offended very easily. For instance, if two friends meet in a cafeteria and the other one has recently bought new trousers, the other friend might comment on them by saying *well those kinds of baggy trousers are now fashionable I heard,* which clearly means that the trousers do not look good at all. This kind of a remark can only be made if the addressee is in really good terms with you, if even then. These kinds of formally polite and yet impolite utterances are very common in Dr. House's speech as well, which will be later discussed in the analysis.

I have now introduced the concepts of verbal communication that are relevant considering the present study. Nonetheless, verbal communication is only one part of our communication and therefore we have to examine another essential part of the human communication next.

2.2. Nonverbal communication

Although spoken language is a significant part of our everyday communication, most researchers in the field agree that nonverbal communication is at least equally important as verbal communication, and some even argue that it is more important. This is based on the estimates that only about one third of human interaction is, in fact, verbal. Here it must be kept in mind that nonverbal communication is not language although its functions might be similar. Nonverbal communication exists beside language, and nonverbal and verbal communication are usually present at the same time. (Andersen, 1999: 1-2). In this chapter I will introduce the main differences between nonverbal and

verbal communication and present the categories into which nonverbal communication can be divided. I will also provide examples of the importance of nonverbal communication in the doctor – patient interaction and briefly discuss the relationship between nonverbal communication and impoliteness.

2.2.1. Differentiating verbal and nonverbal communication

As with most concepts, there is not a single, clear definition for nonverbal communication. However, Andersen (1999) defines nonverbal communication as *analogic, nonlinguistic* and *governed by the right brain hemisphere*. It should be clarified that by *analogic* he refers to the messages that have a "direct, nonarbitrary, intrinsic relationship to the thing they represent" (Andersen, 1999: 3), which means that messages look or sound exactly like what they represent. For example, a hug instantly conveys a meaning, depending on the context. For example, if two friends meet, a hug has a function of a greeting. If, however, a friend is sad, a hug has a comforting function. Verbal communication, in turn, is digital communication. It communicates via arbitrariness: one cannot guess from the word *tree* what it refers to. Exception to this rule are the onomatopoeic words. They might, for instance, represent some kind of a sound (*bark, knock-knock, boom*) and are therefore slightly less arbitrary. (Andersen, 1999: 3-4).

In addition to the afore-mentioned, there are other major differences as well. For example, verbal communication is single-channelled and relatively manipulated, whereas nonverbal communication is multi-channelled and relatively honest. This is based on the fact that nonverbal communication is usually much more spontaneous and therefore it is more difficult to lie. We often think about what we say, but not how we move our head or our gaze. Another difference according to Andersen is that verbal communication is a culturally based system, whereas most of nonverbal communication is a biologically based system. As a case in point, facial expressions tend to communicate same things in most cultures. However, Andersen notes that some nonverbal communication, such as certain gestures and the role of touching are not the same in every culture. These differences might sometimes cause misunderstandings if one is not familiar with a certain culture and its norms of communication. (Andersen, 1999:16).

Knapp et al. (2002:5) have noted a few problems considering the definition of nonverbal communication as being "communication effected by means other than words". Firstly, it is the hand movements that are used in sign languages and yet they are considered linguistic. Therefore "verbal" and "linguistic" cannot be synonyms. In addition, some spoken words such as *buzz* or *murmur,* which are onomatopoeic, are not clearly verbal. Knapp et al. (2002:7) point out as well that although certain information is being processed in one hemisphere, most likely the other hemisphere is not entirely inactive. Moreover, some nonverbal behaviour is connected to verbal behaviour more than others. An example of this are **emblems,** which have a direct verbal translation. The OK-sign made with the thumb and the index finger is an emblem, for instance.

In order to use nonverbal elements of communication in everyday social interaction one must be able to identify nonverbal expressions precisely, as well as to respond to them right. In this sense nonverbal communication resembles verbal communication. These two processes of interpreting and responding are called **encoding** and **decoding**. For instance, decoding of facial expressions begins already as an infant, and develops as we grow older. As for encoding, infants as young as two months of age are already able to express several different facial expressions. There have not been many studies about the changes in facial expressions that are related to age. However, there is some evidence that people's expressiveness tends to decline as they grow older. This is related to biological changes such as wrinkling and weakening muscles. (Feldman & Tyler, 2006: 181-195).

In addition to age, gender and culture affect nonverbal communication as well. Stereotypically, men are considered to be louder, smile and gaze less, and to express their emotions seldom, for instance, whereas women are thought to be more sensitive. Nevertheless, these are not merely stereotypes. Studies show that women do smile more than men, their faces are more expressive, and that they gaze more often, whereas men are louder and use less conversational responses, such as *uh-uh*. (Hall, 2006: 202-207). Whereas Andersen (1999) argues that nonverbal communication is mostly biologically based, there are many cultural differences to be found considering nonverbal communication. For instance, the American OK-sign has a negative meaning in some other cultures. It has also been found out that Arabs gaze longer and more directly, and sit closer to each other than the Americans. (Matsumoto, 2006: 220-221). Therefore nonverbal communication may partly be biologically based but culture clearly has a

great effect on it.

Because nonverbal communication is such a vast area, there are various kinds of categories into which it can be sorted. In the following subchapter I will introduce one of these categorisations created by Andersen (1999), which I will later use in the analysis, too.

2.2.2. Categorising nonverbal communication

There are various ways to categorise nonverbal communication and here I have chosen Andersen's (1999) classification because it is a very broad and detailed one. Firstly, he divides nonverbal communication into two parts: the body codes and the contextual codes. The first group refers to the body as a medium of communication, which can be either conscious or unconscious, and either intentional or unintentional. This group has five different main categories: (Andersen, 1999: 30-73).

1. Physical appearance: sex, clothing style, race, age, ethnicity, stature, body type, mood
2. Kinesics: body movements, divided into
     a) facial expressions,
     b) gestures and
     c) interactional synchrony (how two individuals move together as they communicate)
3. Oculesics: face and eyes, divided into
     a) eye contact (when both look into each other's eyes)
     b) pupil dilation and
     c) eye movement
4. Proxemics: interpersonal space and distance, divided into
     a) territoriality
     b) crowding and density (how many people in a certain space)
     c) personal space
5. Haptics: touching, divided into
     a) types of touch (professional, social, friendly, loving etc.)
     b) touch avoidance
     c) touch and relationships
     d) touch taboos (what kind of touch to avoid)

The second group consists of the contextual codes of nonverbal communication. They are not directly connected to a certain person but to the environment. The group is divided in the following way:

1. Macroenvironments: the actual location (Finland, Jyväskylä, Spain, Barcelona etc.)
2. Microenvironments: smaller than macroenvironments (buildings, rooms, parks etc.)
     a) sociopetal/sociofugal environments
     b) seating arrangements
     c) temperature
     d) colour

        e) lighting
        f) sound
        g) environmental efficacy
3. Chronemics: the way we structure time and the meanings we attach to time
        a) waiting time
        b) spending time
        c) talk time
        d) body speed
        e) other types of time (biological, personal, physical etc.)
4. Olfactics: the study of nonverbal communication through scent and smell
5. Vocalics: pitch, rhythm, tempo, resonance, control, accent

As can be noticed, nonverbal communication includes several factors connected both to the speaker and the addressee, as well as the physical environment. I feel that Andersen's classification is quite exhaustive. However, I would place the last subgroup of the contextual codes (vocalics) into the first group since it is tied more to the speaker than the environment. I have also taken this into account in the analysis.

If we examine the communication between a doctor and a patient, many of these factors classified by Andersen have a great effect on the communicative situation. Looking at the first group, the body codes, the physical appearance of a doctor is the first thing that a patient sees when he or she walks into an examination room, and therefore it ought to be pleasant. Moreover, some patients might carry differing attitudes towards doctors that represent a race that they themselves do not. Facial expressions have a great importance on the communicative situation as well. A doctor who smiles a little every now and then is likely easier to talk to than a doctor who constantly has a sour face. In close connection to this is the direct eye contact between a doctor and a patient. If a doctor does not look the patient in the eyes, the patient may feel that the doctor is disinterested in him or her. Finally, touching can sometimes be a part of the doctor – patient interaction. The touch between a doctor and a patient ought to be as functional – professional as possible. (Andersen: 1999: 46.)

If we consider the second group, the contextual codes, there are some points that should be noted in doctor – patient interaction as well. For instance, the hospital environment might be scary to some people because hospitals are usually related to unhappy issues, such as illness and death, and thus they may cause nervousness in people. That is why a paediatrician's room often has nice pictures or toys to catch children's eyes and to make them feel more comfortable during the examination. Moreover, the way a doctor speaks might have a great effect on the examination. A very quick tempo of speaking, or a

peculiar accent might cause varying reactions in patients, such as confusion or even irritation.

Andersen's definition of nonverbal communication is very reasonable. However, his claim about nonverbal communication being mostly biologically based is rather blunt. As Matsumoto's (2006) research shows, there are plenty of nonverbal factors that differ from each other in separate cultures. However, Andersen's categorisation of nonverbal communication is taking a range of factors into account and therefore I am using it in the analysis.

2.2.3. On facial expressions

Before taking a look at the relationship between nonverbal communication and impoliteness there has to be a few words said about facial expressions because they play an important role in the analysis. Face itself has a number of functions in interpersonal communication. It mirrors our attitudes, gives nonverbal feedback to the ones we listen to, and most importantly tells others how we feel (Knapp et al., 2002: 305.)

Facial expressions can either be spontaneous or intended and they usually have an impact on others (Knapp et al., 2002: 335.) Emotions can sometimes be quite difficult to interpret but there are six basic emotions are relatively easy to recognise: happiness, anger, disgust, sadness, surprise and fear. They are not widely recognised only in the United States but also globally. (Knapp et al., 2002: 326). Some general features of these six basic emotions are listed below. The list is slightly shortened from the one of Knapp et al's. (2002: 326-331).

> 1. Surprise: The brows are raised (...). The skin below the brow is stretched. Horizontal wrinkles go across the forehead. The eyelids are opened (...), the white of the eye (...) shows above the iris and often below as well. The jaw drops open so the lips and teeth are parted, but there is no tension or stretching of the mouth.
> 2. Fear: The brows are raised and drawn together. The wrinkles in the forehead are in the center (...). The upper eyelid is raised (...) and the lower eyelid is tensed and drawn up. The mouth is open and the lips are either tensed slightly and drawn back or stretched and drawn back.
> 3. Disgust: The upper lip is raised. The lower lip is also raised and pushed up to the upper lip or is lowered and slightly protruding. The nose is wrinkled. The cheeks are raised. (...) The brow is lowered, lowering the upper lid.
> 4. Anger: The brows are lowered and drawn together. Vertical lines appear between the brows. The lower lid is tensed and may or may not be raised. The upper lid is tensed and may or may not be lowered (...). The eyes have a

hard stare (...). The lips are in either (...) pressed firmly together, with the corners straight or down; or open, tensed in a squarish shape as if shouting. The nostrils may be dilated, but this is not essential to the anger facial expression (...).
5. Happiness: Corners of the lips are drawn back and up. The mouth may or may not be parted, with teeth exposed or not. A wrinkle (...) runs down from the nose to the outer edge beyond the lip corners. The cheeks are raised. The lower eyelid shows wrinkles below it and may be raised but not tense. Crow's feet wrinkles go outward from the outer corners of the eyes (...).
6. Sadness: The inner corners of the eyebrows are drawn up. The skin below the eyebrows is triangulated, with the inner corner up. The upper eyelid inner corner is raised. The corners of the lips are down or the lip is trembling.

In sum, the positions of the eyebrows, eyelids and lips have the greatest effect on facial expressions. However, it must be kept in mind that the range of human facial expressions is innumerable and not all of them are as easy to decode as these six basic expressions. Moreover, different people might have different kinds of interpretations on the same expression. Therefore one also has to use the context to interpret facial expressions, as can be later seen in the analysis.

2.2.4. Nonverbal communication and impoliteness

Whereas different kinds of speech acts can be used in order to express politeness or impoliteness, nonverbal communication can function similarly. The relationship between nonverbal communication and impoliteness has barely been studied. Nevertheless, some ideas on the topic have been introduced in some researchers' work. For instance, Culpeper (1996: 357-358), whose theory of impoliteness will be discussed in more detail later, has brought up certain nonverbal strategies that are clearly impolite. These strategies include coming physically too close to a stranger, or ignoring the other person in a conversation, for instance by not listening what they are saying. In another work of his, Culpeper (2011a: 136) lists nonverbal behaviours in British culture that are impolite. Among these behaviours are for instance spitting, rolling one's eyes and turning one's back at someone.

Culpeper (2011b: 57-60) has touched the area of prosody as well. Sometimes it is not *what* is said that is impolite but *how* it is said. This means that prosody has its own effect on utterances. Prosody is defined as being variation in loudness, pitch, intonation, and speaking tempo, for instance. In Andersen's (1999) categorisation prosody belongs to the group of vocalics. An utterance that would otherwise be formally polite can be made impolite by changing the tone of voice. This can be seen later in the examples of

the data where the main character of the series, Dr. House, uses varying tone of voice in his impolite remarks towards his patients. By changing one's tone of voice from sarcastic and ridiculing to a positive and delighted one the effect of an utterance would change completely.

Kendon (2004), in turn, has studied the anatomy of gesture. Although he has not studied the relationship of gestures and politeness or impoliteness as such, there are some gestures that can be considered impolite in several contexts. For example, there are a number of ways to point something or someone with one's finger or fingers (see e.g. Kendon, 2004: 206.) If someone threats another person, they might use their index finger in order to strengthen the effect of the threat. Furthermore, mothers might tell their children that it is impolite to point someone on the street. However, pointing is not necessarily always an impolite gesture.

Another gesture that Kendon (2004: 250) has analysed is the open hand. Again, open hand is not an impolite gesture in itself but when it is used in a certain way it can be considered as such. For example, if someone puts his palm towards someone and turns his face slightly away, it might mean that they are done with listening, or that they want to reject something. A similar effect can be created if one keeps his palms towards the ground and waves his hands across the air horizontally. Nevertheless, this gesture needs a facial expression indicating a negative feeling as well.

After considering both verbal and nonverbal communication as well as their relationship with impoliteness, it is time to go deeper into this pragmatic phenomenon. Next I will present some of the most important theories in the field of politeness and then move on to impoliteness theories.

3. Politeness and impoliteness

Politeness has been the target of interest in social studies of language, linguistic pragmatics, sociolinguistics and social theory in Western Europe and northern America for decades now. Furthermore, the phenomenon has been a part of studies in Japan and China for millennia. (Watts, 2003: 9-10, 53). Politeness is also more widely studied than impoliteness although the latter has gained a great deal of attention during the past

couple of decades as well. The following politeness theories include the ones which are most relevant considering the present study, as well as criticism against them.

3.1. Politeness theories

Although the present study is about impoliteness, before defining this specific concept we have to start by defining its opposite phenomenon, politeness. No one is born with knowledge of polite behaviour. Instead, it is something we have to learn, i.e. to acquire as we grow up. (Watts, 2003: 9) The most noted names in the field of politeness studies include Penelope Brown, Stephen C. Levinson, Robin T. Lakoff, and Geoffrey Leech. Many of them base on their research on Grice's co-operative principle and maxims of politeness, which were the starting points of politeness research. By co-operative principle Grice meant that people co-operate when they converse with each other. In relation to this there are four maxims, also referred to as "Gricean maxims": the maxims of quantity, quality, relation and manner. They support the idea that one should for instance be as relevant, clear, orderly and truthful in a conversation as possible. (Yule, 2010: 147). The co-operative principle was favoured especially by Brown and Levinson whose model of politeness is introduced next.

3.1.1. Brown and Levinson's model

Brown and Levinson (1987: 1,57) argue that politeness is a medium with which potentially aggressive parties are able to communicate with each other. Furthermore, they state that language usage is, after all, what social relationships consist of and therefore verbal exchanges as well as the politeness included in them are worth examining. Requests, for instance, are extremely common in every culture, and there is always a certain degree of politeness in them. This is why Brown and Levinson want to study the abstract principles behind cross-cultural polite language usage.

3.1.1.1. The concept of face

The central concept of Brown and Levinson's (1987) research is the notion of **face** whose definition they base on Goffman's earlier definition (Goffman, 1967 as quoted by Brown and Levinson, 1987:61). Face refers to the public self-image that every person wants to claim for themselves. It consists of two specific desires, or **face-wants**: the

negative and positive face. The first refers to the desire of a person to be unimpeded in one's actions, and the latter refers to the desire to be approved of. For example, if someone suggests they should *do this together,* they are showing interest towards another person's positive face. By contrast, if someone says that they will *leave you alone so that you can concentrate,* they are showing interest towards another person's negative face.

Brown and Levinson argue that the notion of face is, in fact, universal, which means that all model persons - or **MP**s, as they call a wilful and fluent speaker of a natural language - have a both negative and positive face. In addition, all MPs are rational agents who "choose means that will satisfy their ends" (Brown and Levinson, 1987: 59.) However, Brown and Levinson do admit that face is subject to many kinds of cultural specifications. Furthermore, they claim that it is every MP's mutual interest to maintain each other's face. According to them, people constantly co-operate in order to maintain face in interaction, which is based on the mutual vulnerability of face. In other words, since people do not want to lose their own face, they do everything to save the other's face. At this point it should be noted that this claim as well as the claim of universality has received a great deal of criticism which will be discussed later. (Brown and Levinson, 1987: 13, 58-62).

3.1.1.2. On FTAs and different strategies of politeness

Another important concept in Brown and Levinson's work is an **FTA**, a face-threatening act, which is heavily connected to the concept of face. By an act they refer to any kind of verbal or non-verbal communication. Therefore an FTA is a kind of act that intrinsically threatens the other person's face, either the negative or the positive one. Acts that threaten a hearer's negative face are for instance orders, advice, warnings, offers, and expressions of strong (negative) emotions. All these are offensive towards the hearer's freedom of action somehow. Examples of acts that threaten a hearer's positive face are criticism, insults, mentioning of taboo topics, boasting and so forth. All these indicate that the speaker does not care about the hearer's feelings. (Brown and Levinson, 1987: 65-67).

As was previously mentioned, all MPs are rational agents and this is why they want to avoid hurting the other person's face. Therefore they naturally want to avoid doing the

FTAs as well, or at least minimise the possible threat (Brown and Levinson, 1987: 68). Brown and Levinson have listed five super-strategies concerning doing the FTAs and these strategies are introduced in the following figure:

```
                                              1. without redressive action

                              on record                        2. positive politeness

        do the FTA
                                         with redressive action
                              4. off record
                                                               3. negative politeness

        5. don't do the FTA
```
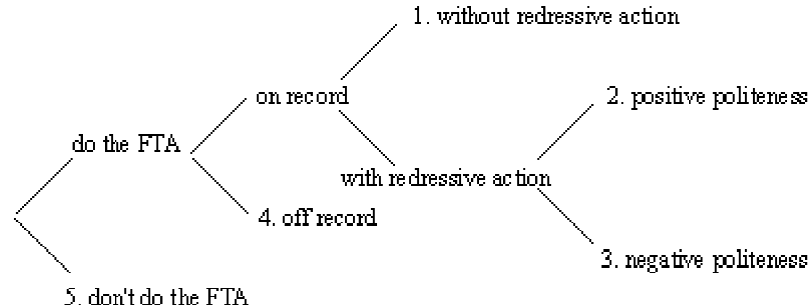
Figure 1: Politeness strategies (Brown and Levinson, 1987: 69)

Firstly, the speaker can either choose to do the FTA (1.-4.), or completely withdraw from doing it (5.). The speaker should choose the latter option if the risk to hurt the hearer's face is particularly great. An example of this strategy cannot thus be provided because it specifically involves something that is eventually not said. If the risk is not immense and the speaker chooses to do the FTA, he or she must choose whether to perform it **on record** (1.-3.) or **off record** (4.). Off record means that the speaker's intentions are more or less ambiguous, and that they have not committed to a certain intent. For example, if a speaker states that he or she does not have any money, it does not necessarily mean that he or she wants to borrow money. Therefore the responsibility is also transferred to the hearer. The off record strategies that Brown and Levinson provide are for instance *give hints*, *use tautologies, use metaphors,* and *be ambiguous.* (Brown and Levinson, 1987: 68-70, 211-225).

If the threat to hurt the hearer's face is slightly smaller than with the fourth strategy, the speaker can choose to go on record. On record means that the speaker makes his or her intentions clear to the other participant. For example, if a speaker *promises* to do something, there is only one intention. On record strategies are divided into two parts: the speaker can either do the FTA with or without a redressive action. If there is still a minor risk to hurt the hearer's face, the speaker should choose to do it with the redressive action. There are two kinds of redressive actions: **positive politeness** is oriented towards the hearer's positive face (2.), whereas **negative politeness** is oriented

towards the hearer's negative face (3.). Brown and Levinson provide a number of both strategies. Strategies of positive politeness include *exaggerate interest with the hearer, avoid disagreement, joke, offer,* and *promise*, and negative politeness strategies include *give deference, apologise,* and *be pessimistic*. (Brown and Levinson, 1987: 68-70, 106-187).

Finally, if the risk to hurt the hearer's face is very small, the speaker can choose the first strategy, which is doing the intended act baldly, without any redress. If, for instance, the addressee is a very close member of a family, the risk is rather small and the redressive action is not needed. Brown and Levinson do not provide a similar exhaustive list on how to be polite bald on record but they include imperatives such as *help!, hear me out..., excuse me, bring me wine* and *you may go.* (Brown and Levinson, 1987: 68-70, 96-98).

Brown and Levinson argue that each rational agent tends to evaluate the risk for the possible threat similarly, which means that everyone always chooses the same strategy under the same situation. The reason for this is that the advantages of each strategy are the same. As a case in point, if the speaker chooses to go on record, he or she can gain praise for being honest and not misunderstood. If the speaker goes off record he might get credit for tactfulness. Moreover, if he chooses positive politeness the speaker can minimise the face-threatening aspects of an act by convincing that he likes the addressee. Again, if he chooses negative politeness, he can sustain social distance. Finally, the advantage of not doing the FTA at all is that the speaker avoids offending the addressee entirely. Here, of course, the disadvantage is that the speaker cannot communicate the message he wants to. (Brown and Levinson, 1987: 71-72).

3.1.1.3. Criticism on Brown and Levinson's theory

Brown and Levinson's work on politeness has gained an extensive amount of criticism. One of the most eager critics is Richard J. Watts. He calls Brown and Levinson's model a production model because it is an attempt to create a theory of how people produce linguistic politeness. Firstly, he criticises the point where the phenomenon of politeness is reduced to rational means-goals behaviour. Secondly, he points out that the role of the addressee is almost entirely left out. For example, there is no mention of the ways in which the addressee might react to the speaker's politeness strategy. Thirdly, he notes

that a major problem in Brown and Levinson's model is the rational choice that the speaker has to make in order to choose the right strategy. Does the speaker has to go through the whole process before he or she can make the correct choice? Moreover, Brown and Levinson do not provide the possibility for the speaker to choose more than one strategy. (Watts, 2003: 85-88).

Watts, however, is not alone with his criticism. As Limberg (2009: 1377) argues, Brown and Levinson (1987) have treated impoliteness as a pragmatic failure. He, as many other researchers, has adopted a view according to which impoliteness may well be systematic, functional, and sometimes intentional. This is evident in discourses such as courtroom hearings (Culpeper, 1996). Nevertheless, Limberg does give credit to their work as being somewhat groundbreaking in the field of politeness studies.

Fraser (2005) has found a number of challenges in Brown and Levinson's (1987) model, too. He states, for example, that bald on record strategy cannot be a politeness strategy since it does not involve any politeness. He continues by arguing that Brown and Levinson fail to explain what the status of politeness is within linguistic pragmatics and that they do not separate politeness from deference as other researchers do. These two, after all, are not synonymous. One might, for instance, say *sir, would you mind shutting up?* and therefore use deference but still not be polite in one sentence. Finally, he questions the claim for universality. For example, the Japanese concept of face is quite different from the Western one (Matsumoto, 1988 as quoted by Fraser, 2005: 74.) Fraser argues that cross-cultural politeness research should be cast aside entirely. He states that the existing model of Brown and Levinson has to be worked on to a great extent if it is not totally rejected. (Fraser, 2005: 66-80).

I feel that Brown and Levinson's theory treats language and communication from an extremely theoretical and simplistic viewpoint although they did study the language use in a community. I also think that every language user would not always choose the same face-saving strategy because some people are more polite than others, and some people want to express directly how they feel instead of hiding their true feelings. However, the reason why I have focused on Brown and Levinson to a great extent is because so far they are the only ones who have attempted to create exhaustive and systematic strategies of politeness. Furthermore, their strategies have served as a starting point for Culpeper's (1996) theory, which is used in the present study.

3.1.2. Other insights on the notion of politeness

In addition to his criticism of Brown and Levinson, Watts has tried to define the concept of politeness as well. He admits that the task is not easy and he starts his definition by first considering the term **polite behaviour.** According to Watts, polite or politic behaviour consists of "mutually shared forms of consideration for others" (2003:30) in a given culture. This means that the social norms and conventions affect the use of politeness depending on the culture. He argues that politic behaviour, or socially appropriate behaviour, must be assessed with the following factors: the type of social activity, the speech events occurring in that activity, the common cultural expectations shared by the participants, and the social distance of the participants. He continues with a claim that there are two kinds of possible behaviours; the one that leads to communicative breakdowns, and the other that makes other people like one's opinion. The first type Watts considers non-politic, and the second politic behaviour. (Watts, 2005: 51).

Watts also points out that there is, in fact, a great deal of disagreement among people when they are asked what polite behaviour is. These definitions might consider the use of language, certain considerate acts, or the quality of a person's nature. Sometimes polite behaviour is even connected with negative qualities such as insincerity. There is the same problem with characterising *polite language*. For some, it might mean polite utterances such as *thank you* or *sir,* and some might describe it as sounding hypocritical or distant. However, these different interpretations are "folk interpretations" of politeness, which Watts calls **first-order politeness,** or **politeness$_1$.** (Watts, 2003: 1-2, 4).

Watts (2003: 9-10) then argues that the interest and theorisation of politeness should, in fact, concern the discursive struggle over politeness$_1$. This means the ways in which lay members evaluate polite behaviour instead of the ways in which social scientists do. He refers to "politeness as a concept in a sociolinguistic theory" as **second-order politeness**, or **politeness$_2$**. Here it should be noted that politeness$_1$ and politeness$_2$ as terms were originally introduced by Eelen (2001, as quoted by Watts 2003: 4). Politeness$_2$ differs considerably from our everyday understanding of politeness: it focuses on polite language in the study of verbal interaction, and is a technical term. However, he also questions if politeness$_2$ can even be theorised.

Also Mills has suggested an alternative model for analysing politeness. She finds Brown and Levinson's (1987) model rather restricted and agrees with Watts (2003) that politeness is a much more complex phenomenon than what Brown and Levinson have argued. Mills herself proposes a model that takes into account the relationship between an individual and the norms that this particular individual considers to exist in the surrounding society. (Mills, 2003: 57, 62-63).

For instance, Mills (2003: 65) points out that there is great variability among the speakers in the society and this has to be taken into account when considering the theory of politeness. She has interviewed white, middle-class women who feel that politeness is "their job" in group conversations, and she observed this to be true as well. Thus, the expectations considering politeness are different depending on the person. This is closely connected to the concept of appropriateness, which refers to the way in which individuals assess their utterances compared to the existing group norms (Mills, 2003: 70). Mills (2003: 73) concludes that politeness is thus "a question of judgement of utterances in relation to a hypothesised appropriateness".

Watts (2003, 2005) and Mills (2003) both discuss issues that Brown and Levinson did not consider in their work. In my opinion, however, Watts's does not provide anything concrete as Brown and Levinson (1987) do although his ideas on theorising politeness are well justified. Mills, by contrast, states quite clearly that the theory of politeness should take individuals into account and also provides reasons and examples for her statement. However, Mills's (2003) emphasis has mostly been on the study of politeness from the viewpoint of gender whereas Brown and Levinson or Watts have not had a specific target in their research. Watts (2003), too, has done a great amount of research on politeness$_1$ and politeness$_2$ but for the purposes of this study it is not relevant to examine their theories more in depth. Instead, I will continue with impoliteness.

3.2. Impoliteness theories

After considering some of the key theories of politeness I will now move on to the theories of impoliteness. Impoliteness is not as widely studied as politeness but there are some fields of discourse in which it has been the target of research, such as political discourse, military discourse, courtroom discourse, police discourse, as well as TV

shows and CMC (computer-mediated communication) (Limberg, 2009:1377.) However, the TV show in question was a reality quiz show *the Weakest Link*, not a written drama series.

Next I will introduce impoliteness from Jonathan Culpeper's viewpoint because he has studied the phenomenon extensively and his theory has not been challenged by other researchers so far. I also base an extensive part of my analysis on his theory of impoliteness strategies. Additionally, I will discuss Bousfield's (2007, 2008) theory of impoliteness as well as his theory of responding to impoliteness since the other research question of the present study is examining responses to impolite expressions.

3.2.1. Culpeper's theory

Impoliteness has several synonyms in the English language and somehow they all refer to the evaluation of negative behaviour (Culpeper, 2010: 3233). Culpeper (1996, 2010, 2011a, 2011b) has studied the phenomenon of impoliteness extensively, and his definition of impoliteness is the following:

> "Impoliteness is a negative attitude towards specific behaviours occurring in specific contexts. It is sustained by expectations, desires and/or beliefs about social organisation, including, in particular, how one person's or group's identities are mediated by others in interaction. Situated behaviours are viewed negatively when they conflict with how one expects them to be, how one wants them to be and/or how one thinks they ought to be. Such behaviours always have or are presumed to have emotional consequences for at least one participant, that is, they cause or are presumed to cause offence. Various factors can exacerbate how offensive an impolite behaviour is taken to be, including for example whether one understands a behaviour to be strongly intentional or not." (Culpeper, 2010: 3233)

Thus in short, impoliteness is behaviour that is meant to cause offense. It is also very context governed, which means that a certain kind of behaviour might not be always impolite. Impoliteness also involves some kind of a conflict between the participants.

Culpeper (1996) makes a distinction between inherent impoliteness and mock impoliteness and reminds us of Leech's (1983 as quoted by Culpeper, 1996: 350) definition of absolute and relative impoliteness. Absolute politeness means acts that are independent of the context whereas relative impoliteness is context governed. This means that some acts are inherently polite and some inherently impolite. In cases of inherent impoliteness the target is usually performing some anti-social activity, such as

picking one's nose. By pointing out someone performing such action it is impossible to save the other person's face. (Culpeper, 1996: 350-351).

Mock impoliteness, or banter, is surface impoliteness. Its intention is not to cause offense but rather to show solidarity and social intimacy. We can, for instance, call our friends silly or stupid in certain situations and still not truly mean it. Leech (1983 as quoted by Culpeper 1996: 352) has created an actual banter principle:

> "In order to show solidarity with h, say something which is (i) obviously untrue and (ii) obviously impolite to h [and this will give rise to to an interpretation such that] "what s says is impolite to h and is clearly untrue. Therefore what s says is really means is polite to h and true."

This principle is based on the assumption that the closer the person we interact with, the less polite we have to be. There has been evidence that extremely close relationships have extreme impoliteness in them. (Culpeper, 1996: 352). However, in the present study this does not seem to be the case since Dr. House is extremely rude to his patients even though he does not know them at all.

According to Culpeper, impoliteness has several different functions. The first type of impoliteness, affective impoliteness, stems from emotions such as anger and aggression. Its function is to target one's own frustration at someone else, to blame others. Coercive impoliteness is related to power. The producer of this type of impoliteness and the target might, for instance, have a clash of interest and the producer wants to show his power over the other. Entertaining impoliteness, in turn, has an entertaining function, as the name suggests. The target of this type of impoliteness may or may not be aware that people are joking at his expense. The final type, institutional impoliteness reminds slightly coercive impoliteness. However, it appears on an institutional level where the society allows someone to be impolite, such as in courtrooms and armies. This type of impoliteness is not challenged. By contrast, it is accepted. (Culpeper, 2011a: 221-245).

Culpeper also wants to prove that conflictive communication is not marginal to human behaviour at all, as Leech (1983: 105 as quoted by Culpeper, 1996: 350) has claimed. First he tries to clarify the circumstances when people are impolite. In order to do that, he goes back to Brown and Levinson's theory (1987) about presence of politeness, which claims that it is normal for people to co-operate to maintain each other's faces.

This is based on the mutual vulnerability of the face: it is in everyone's mutual interest to maintain each other's face because they do not want their own face to be threatened either (Brown and Levinson, 1987: 61). However, Culpeper points out that there are situations where this vulnerability is, in fact, not mutual, which causes the motivation not to threaten face disappear. For example, there might be a conflict of interest between the participants: another participant might benefit from the fact that the other participant loses their nerves. Situations like these occur in court rooms and army training camps, for instance. Additionally, if another participant is more powerful than the other, they do not have to be mutually polite to each other. This applies to the present study because the participants are a doctor and a patient, and doctors are usually considered as more powerful because they have the knowledge and skills to cure their patients. (Culpeper, 1996: 354).

In his recent work on impoliteness Culpeper (2011a) has created a list of impoliteness formulae that apply to the English language. He completed his work with the help of the Oxford English Corpus (OEC). The list includes the following (examples are in brackets):

1. Insults (*you dirty little bastard)*
2. Pointed criticisms/complaints (*that was absolutely horrible)*
3. Unpalatable questions and/or presuppositions (*why can't you do anything right?)*
4. Condescensions (*that is very immature)*
5. Message enforcers (*do you understand?)*
6. Dismissals (*go away)*
7. Silencers (*shut the fuck up)*
8. Threats (*you'd better be there or else...)* and
9. Negative expressives (*damn you)*

Culpeper points out though that the list is not exhaustive and that some points are more context-governed than others. Moreover, the list includes only verbal formulae. (Culpeper, 2011a: 134-136).

It should also be noted that this is not Culpeper's first attempt to categorise impoliteness. In his earlier work, Culpeper criticised that none of the earlier studies about impoliteness had comprehensively focused on impoliteness and its theory and therefore he wanted to create a framework that is otherwise similar, but opposite to Brown and Levinson's politeness theory, which was discussed previously in Chapter 3.1.1.2. Whereas Brown and Levinson created strategies that are meant to save the other

person's face, Culpeper created strategies that are meant to attack the other person's face. (Culpeper, 1996: 356).

The list of Culpeper's impoliteness strategies is the opposite of Brown and Levinson's list. They both consist of five different super-strategies which are listed below. First there are Brown and Levinson's original politeness super-strategies, then Culpeper's reversed version.

1) *Bald-on-record strategies*: the FTA is performed 'in the most direct, clear, unambiguous and concise way possible' (Brown and Levinson 1987:69).
2) *Positive politeness* – the use of strategies designed to redress the addressee's positive face wants.
3) *Negative politeness* – the use of strategies designed to redress the addressee's negative face wants.
4) *Off-record* – the FTA is performed in such a way that "there is more than one unambiguously attributable intention so that the actor cannot be held to have committed himself to one particular intent" (Brown and Levinson: 1987:69). In other words, perform the FTA by means of an implicature (Grice, 1975)
5) *Withhold the FTA*.

(Culpeper 1996:356.)

(1) Bald on record impoliteness - the FTA is performed in a direct, clear, unambiguous and concise way in circumstances where face is not irrelevant or minimised.
(2) *Positive impoliteness* - the use of strategies designed to damage the addressee's positive face wants. Examples:
    - Ignore, snub the other
    - Exclude the other from an activity
    - Disassociate from the other
    - Be disinterested, unconcerned, unsympathetic
    - Use inappropriate identity markers
    - Use obscure or secretive language
    - Seek disagreement
    - Make the other feel uncomfortable
    - Use taboo words
    - Call the other names
(3) *Negative impoliteness* - the use of strategies designed to damage the addressee's negative face wants. Examples:
    - Frighten
    - Condescend, scorn or ridicule.
    - Invade the other's space
    - Explicitly associate the other with a negative aspect
    - Put the other's indebtedness on record
(4) *Sarcasm or mock politeness* - the FTA is performed with the use of politeness strategies that are obviously insincere, and thus remain surface realisations.
(5) *Withhold politeness* - the absence of politeness work where it would be expected.

(Culpeper 1996:356.)

The five different politeness strategies are connected to the degree of the possible face

threat. According to Brown and Levinson (1987), one has to estimate the degree of the face threat that is involved in the planned act. One has to consider the social distance of the participant, for example. The less powerful or distant he or she is the less politeness is needed. Therefore Brown and Levinson's first strategy is the one where least politeness is needed. Correspondingly, Culpeper's first impoliteness strategy is the clearest and boldest, and the same principle applies to his strategies; the more distant the addressee is the more face-damaging the act is.

As can be noticed, the strategies are otherwise similar but opposite except for the fourth strategy, sarcasm or mock politeness. Its counterpart in Brown and Levinson's (1987) version is off-record politeness. Culpeper justifies the difference by explaining that as off-record politeness can be very ambiguous, and so is sarcasm. The addressee has to do some additional work in order to understand it. (Culpeper, 1996: 356). Moreover, Brown and Levinson's strategies have not taken nonverbal communication much into account, whereas Culpeper has done so in his list of sub-strategies (Culpeper, 1996: 358).

3.2.2. Bousfield's discursive approach

Culpeper's framework of impoliteness has not received much challenging views so far. This is most likely because very few researchers have studied the phenomenon in depth. Nevertheless, Bousfield (2008) notes that Culpeper's theory has not been tested empirically and since it is parallel but opposite to Brown and Levinson's model it is vulnerable to same kind of criticism as the original one. For example, Bousfield criticises the open-endedness of Culpeper's (1996) list of impoliteness strategies. Thus Bousfield himself intends to build a model that is based on empirical evidence and that concerns in-context discourse, his emphasis being on the interactive spoken discourse. Eventually, he wants to show how impoliteness can be countered, controlled and managed. (Bousfield, 2008: 3-5, 91).

3.2.2.1. The beginnings, middles and ends of impolite utterances

Bousfield's approach on investigating impoliteness is a rather discursive one. He emphasises the importance of co-text, which means everything that has been said before the present moment and what is likely to be said next, and notes that language shapes

the situation and the situation shapes the language (Bousfield, 2008: 170.) Bousfield understands impoliteness as being communication that is intentionally both gratuitous and conflictive. Face-threatening acts are delivered either unmitigated in contexts where mitigation is needed or with deliberate aggression. Bousfield also notes that impoliteness is successful only if the speaker's intention is understood by the hearer. (Bousfield, 2008: 72). This issue will be discussed more thoroughly in the following subchapter.

According to Bousfield, impolite utterances have three different stages. The first one is preparing for impoliteness, or **pre-impoliteness***,* which can function as a similar kind of pragmatic pre-sequence as a pre-invitation (*what are you doing on Monday?,* for example). For instance, in a situation where a father is angry at his son for having been caught smoking, he might say *ok boy you listen to me now, you listen to me carefully.* It is clear that an utterance such as this does not follow polite patting on the head but rather scolding or even rage. However, pre-impoliteness does not have to be a single sentence but can extend to a longer sequence of utterances. (Bousfield, 2008: 147, 150).

Bousfield divides impolite utterance middles into simple and complex impoliteness. A simple utterance realisation is what he argues Culpeper (1996) as well as Brown and Levinson (1987) having used in their models. This means that an utterance is taken out from its context and analysed as such. Complex impoliteness, by contrast, involves repeated utterance realisations. In order to create impoliteness, one may use a certain feature repeatedly. The feature can, for instance, be a word, a phrase or a grammatical structure. For instance, the father who has caught his son smoking may repeat himself by saying *Is this how I raised you? No, it's definitely not how I raised you. Is this how your mother raised you? No, it's not. So this how you thank us, then?* However, the repetition does not have to occur within the same turn but can extent to several turns. (Bousfield, 2008: 154-155).

Bousfield finally touches the issue of impolite utterance ends. Here, he mentions the type of forcing feedback. Returning to the example of a father and a smoker son, in the end of conversation the father might say *so I really hope I will never see you smoking again, do you understand me?* Here, the father does not just make a threat of some degree but intensifies it by asking if the son has understood what he is saying. (Bousfield, 2008: 166).

3.2.2.2. Responding to impoliteness

In this study the main focus is undeniably on the producer of impoliteness. However, responding to impoliteness is an essential part of the particular communicative situation where impoliteness occurs. Once we have now examined impoliteness from the speaker's point of view we may turn to the one of the hearer's. As mentioned earlier, Bousfield (2008) argues that impoliteness has to be understood by the addressee so that it can be considered successful impoliteness. He lists four different cases of impolite exchanges:

> 1. If the speaker intends to hurt the hearer's face and the hearer understands it, impoliteness is successful.
> 2. If the speaker intends to damage the hearer's face but hearer fails to understand it, impoliteness attempt is failed.
> 3. If the speaker does not intend to hurt the hearer's face but the hearer still finds his or her face threatened, then face-damage is accidental. The reason for this can be the hearer's hypersensitivity, for instance.
> 4. If the speaker does not intend to hurt the hearer's face and the hearer understands unintentionality, impoliteness is incidental. The reason for this may be cultural misunderstanding, for instance.   (Bousfield, 2008: 72-73)

The two first cases involve intended impoliteness whereas two latter cases involve unintended impoliteness. However, in all of the cases the hearer somehow perceives that his or her face has been attacked. This is an important notion because in this study the impoliteness is not always understood by the clinic patient but only by the viewer of the series.

Bousfield (2007: 2195) states that any response to an offending situation can cause frustration or anger and therefore lead to a new impolite utterance. Thus it depends on both of the speaker and the addressee whether an impolite situation turns into an actual fight. The following table summarises the stages after an offending situation has been triggered by an impolite act.

Counter

Offensive

Defensive

Respond

Accept

Offending Situation
'Triggering Event'
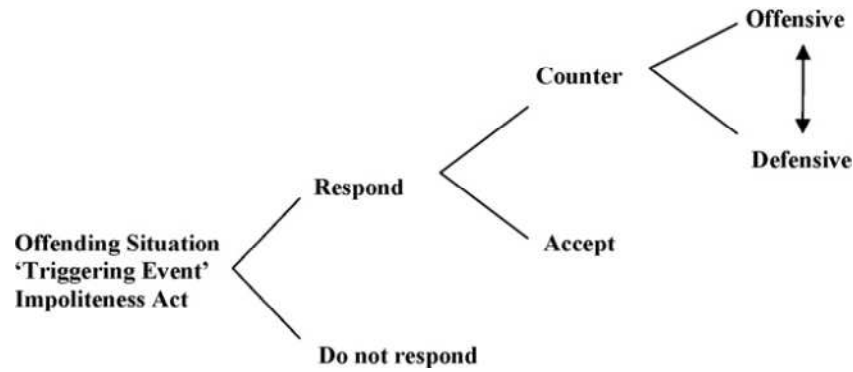Impoliteness Act

Do not respond

Figure 2: Stages of impolite utterance responses (Culpeper et al. 2003: 1563 as adapted by Bousfield, 2007: 2195)

The recipient can either choose to respond or not to respond to the impolite act. In fact, staying silent and accepting the face attack might sometimes be the most successful strategy. Bousfield notes though that remaining silent might mean that the hearer did not hear what the speaker said or did not understand the content of the FTA. Furthermore, it can indicate that the hearer has been caught by surprise and does not come up with anything to reply. (Bousfield, 2008: 188.)

If the addressee chooses to respond to an impolite act, they can either **accept** the face attack, or they can try to **counter** it. An example of accepting a face attack is apologising, or another kind of agreement. Sub-strategies for countering a face attack are **offensive** and **defensive** ones. An offensive strategy means that one attacks a face attack with another face attack. For instance, if the speaker yells at the hearer, the hearer might reply by yelling back. A defensive strategy, by contrast, means that one defends their own face. Examples of a defensive strategy are to dismiss the attack by making a joke or to give an explanation if possible. (Bousfield, 2007: 2198-2201).

Vuchinich (1990 as quoted by Bousfield 2007: 2202-2212) identifies five ways of terminating a conflict: (1) Submission To Opponent, (2) Dominant Third Party Intervention, (3) Compromise, (4) Stand-Off, and (5) Withdrawal. The first one means accepting the opponent's position, or in other words, giving in. The second one, a dominant third party intervention, means that a third person interferes in the conflict and finishes it. The third person may, for instance, be more powerful than the participants. Furthermore, the intervention may sometimes fail. Compromising means negotiation between the opponents about the two opposing positions. In the fourth strategy, stand-off, neither of the opponents agrees to submit or compromise, and the topic changes.

Similar to this strategy is the fifth strategy, where both the opponents leave the conflictive situation, often physically.

In my opinion Bousfield's (2008) criticism on Culpeper's (1996) model is only partly justified. Firstly, Culpeper himself notes that the list of positive and negative impoliteness sub-strategies is not exhaustive. Additionally, there are fewer examples of negative impoliteness strategies than the positive ones. How can one know what kind of further strategies could be placed into these two categories, and can an exhaustive list even be made? Secondly, Culpeper argues that the first strategy, bald-on-record impoliteness is somehow "ruder" than the second and third strategy. Is then none of the sub-strategies of positive and negative impoliteness extremely rude as well, for example *call the other names* or *ridicule*? In his study related to these strategies Culpeper does not provide consistent examples of each strategy, which is why they are left slightly vague.

However, Bousfield's (2008) criticism on Culpeper's methods of testing his impoliteness strategies is not justified. Like Bousfield, also Culpeper uses a real life discourse in his analysis. In fact, both of their examples are taken from an army discourse. Therefore Culpeper's examples are not any less simple or out of context than Bousfield's. Moreover, there is a problem in Bousfield's own categorisation of responding to impoliteness. Not responding to a face attack and accepting a face attack are very similar to each other. In a way, staying silent might also mean that the hearer has accepted the face attack although he would not express it verbally with an apology, for example. However, I have tried to distinguish these two in the analysis.

Bousfield's (2008) view and starting point for analysing impoliteness might differ from the one of Culpeper's (1996) but it is not anyhow better. This is why I will use both of these strategies in my analysis: Culpeper's strategies when analysing the impolite utterances and Bousfield's response categories when analysing the patients' reactions to face attacks.

3.2.4. Other notions on impoliteness

Considering the present study, Culpeper's (1996, 2011a) and Bousfield's (2007, 2008) theories are undeniably the most relevant. However, considering the topic of rule

breaking, there are a few other insights that are worth taking a look at as well. The first one is Kienpointner's (2008) theory on impoliteness and emotional arguments and the second is Lakoff's (2005) ideas about the society's changing views on politeness and impoliteness.

Kienpointner's starting point in investigating politeness is slightly different than Culpeper's or Bousfield's. Namely, he explores the relationship between impoliteness and emotional arguments. First Kienpointner defines impoliteness/rudeness as "prototypically non-cooperative or competitive communicative behaviour" (Kienpointner, 2008: 245), which for instance destabilises personal relationships, makes it difficult to achieve mutual goals, and creates a hostile emotional atmosphere. In turn, he defines emotions as psychophysical processes experienced as strong feelings. Kienpointner emphasises that emotional relationship of the participants substantially affects the communicative situation. He refers to Brown and Levinson's (1987) politeness theory which examines the role of power, rank, and the social distance of the participants, and connects these three to emotions such as fear, awe, and respect, whereas minimal social distance is connected to love, sympathy, anger and hate. (Kienpointner, 2008: 245-247). Especially the first case applies to this study where Dr. House and his patients are socially distant. In general, patients usually respect their doctors and might also be awed by their skills and actions.

Kienpointner criticises the view according to which emotions have usually been treated as fallacies and non-cooperative. Instead he points out that there are emotions that have rational aspects in certain contexts. He distinguishes *personal attacks (ad hominem)* and *appeals to the emotions of the masses (argumentum ad populum)* as being the two subtypes of emotional arguments and these two subtypes having their own subtypes. Personal attack subtypes involve impoliteness and they include:

> "1. direct personal attacks questioning the physical and mental abilities of the attacked person, often combined with insults and swearwords ("abusive *ad hominem*");
> 2. accusations of being inherently and permanently biased ("poisoning the well");
> 3. reproaches concerning the membership within a social group, which, according to the speaker, has negative properties ("guilt by association")."
>
> (Kienpointner 2008: 248)

Subtypes of appeals to the emotions of the masses that are relevant for impoliteness include:

> 1. the "rhetoric-of-belonging" (speaker appeals to the desire of the audience to belong to a certain group.)
> 2. If the relevant group is the majority, to which all "normal" persons "naturally" want to belong, this subtype is a "common-folks" *ad populum* argument.
> 3. The "mob-appeal" *ad populum* argument is the "rhetoric-of-belonging" subtype combined with the appeal to popular sentiments like sympathy, hate and anger, and the "common-folks" subtype.
>
> (Kienpointner 2008: 248)

Kienpointner (2008) reminds, however, that there is no necessary link between emotional arguments and impoliteness since for instance appeals to pity or sympathy are rather linked with politeness instead of impoliteness. (Kienpointner 2008: 247-248).

Robin T. Lakoff has conducted extensive research on the field of politeness and impoliteness studies as well. She raises a question regarding whether politeness is more salient in some cultures than others. She mentions England and Japan as examples as having constant debate over issues of politeness. Furthermore, she asks what happens when politeness systems face a shift of some kind. She does not directly address the latter question but instead focuses on the first one. The Americans, for instance, seem to become very upset about sexual coarseness in public contexts. However, people now permit the use of wider range of terms than in the fifties, for instance. The same thing applies to the violence in the media. Other phenomena that Lakoff mentions are flaming - hostile interaction on the Internet forums, for example - and the loss of polite conventions. According to her, immediacy, distance and anonymity encourage people to violate the norms of politeness. (Lakoff, 2005: 24-32).

Lakoff argues that impoliteness is gradually increasing in the American society particularly. This is worth considering since the present study examines the use of impoliteness in an American TV series. Lakoff (2005) lists some of the changes that she thinks will lead to loss of *civility*, a term which Lakoff uses side by side with politeness. Firstly, the diversity in America increases. Those who formerly defined the rules of politeness are not the only ones governing the public discourse. New styles have emerged. Secondly, there is a new channel of communication: the Internet. Especially older generations might be afraid of it since it has introduced a new arena for language

use that does not follow traditional conventions. Thirdly, media competes for ratings and audience. Lakoff argues that in order to gain attention one has to behave worse. This can be seen for instance in the popularity rise of the reality television. Fourthly and finally, there is an increase in what Lakoff calls camaraderie politeness. This means that in today's America, people are willing to tell anyone almost anything. If one was not, he would be considered to have a lack of trust on others. The camaraderie politeness thus reduces the use of the negative politeness which has traditionally been used with socially distant people. (Lakoff, 2005: 36-38).

Lakoff's (2005) ideas are highly relevant considering the present study. The changing rules of politeness and impoliteness have brought up TV series such as *House M.D.* where breaking the norms is the main focus. Doctor House's impoliteness is undeniably one of the crucial factors which have made the series so popular. It is not likely at all that a similar series would have been successful in the 60s or 70s. People accept rule breaking today and it has been turned into humour of some degree, although not everyone necessarily enjoys it.

4. Defining a good doctor and communicating in health care settings

In the previous chapters I have discussed both verbal and nonverbal communication in addition to the politeness and impoliteness phenomena. Because the present study is about doctor - patient interaction, a few words deserve to be said about the definition of a good doctor and the expected kind of communication in health care settings, such as in hospitals. In this section I have not distinguished the Finnish and the American health care systems but instead discuss the Western system in general.

Health and illness are very emotional topics. In the area of medicine, verbal communication might often be quite complex because of the difficult medical terminology. Thus the role of nonverbal communication is highly significant. Furthermore, it is crucial for a doctor to get all the needed information about a patient in order to make the right diagnosis and decisions about the possible treatment. Misunderstandings are therefore more serious than in some other fields of work life. In addition, people might feel that the doctor – patient interaction is somehow intimidating because it is about a very personal matter: one's own health. (Martin & Friedman, 2005: 3).

Doctor – patient encounters are imbalanced in the way that one participant usually has more power and knowledge than the other. Participants' communicative styles are very different as well. However, they do have a mutual goal – curing the patient. This is why especially the doctor has to be very careful in analysing the nonverbal cues that might provide information that verbal communication does not. Moreover, the behaviour of the doctor has a great effect on the patient. If a doctor is seemingly nervous about test results, it might increase the patient's anxiety. (Martin & Friedman, 2005; 5-6).

The Finnish Medical Association has defined the qualities that a good doctor has and, in my opinion, they can be generalised to apply to doctors in all cultures. At first it must be pointed out that there are always two levels in the doctor - patient interaction: intellectual and humanistic. The intellectual level refers to an analytical approach, expertise and the attention to details, whereas the humanistic level refers to the ways in which the doctor tries to understand the patient's inner world and their suffering. Therefore a doctor should be both an intellectual expert and a close, understanding person. (Lääkärin Etiikka: 2005, 15).

The most important part of the patient care is the actual interaction between a doctor and a patient and the relationship between them. Considering this, already at the beginning of the meeting it is important to greet appropriately: to shake hands and to look the patient in the eyes. The patient has to trust the doctor. It is not recommended for a doctor to emphasise their own personality very strongly, for example by wearing unordinary clothes. Laughter and humour might turn out to be good tools during the interaction but the doctor has to be careful not to hurt the patient's feelings. Additionally, the doctor must let the patient tell their story without interruptions and outer disturbance must be avoided. (Lääkärin Etiikka: 2005, 41).

In addition to these nonverbal aspects of a doctor – patient encounter, there are certain factors that are considered to be a part of a normal visit to a doctor's appointment. Firstly, the doctor ought to introduce themselves properly. Secondly, they should clarify briefly what the appointment is about and how much it takes time. Thirdly, the opening question should be made by the doctor. For instance *"so please, tell me how you've been feeling?"* is such a question. Fourthly, the doctor should encourage the patient and respond to their stories every once in a while with short replies but also give time for the

patient to reply. Fifthly, they should make sure if they have understood the patient and ask further details if needed. Sixthly, they should keep the patient aware of the procedures that are taking place next and make sure that the patient has understood everything. Finally, they should close the examination decently, for example by summarising what is the present situation and together with the patient agree what will happen in the future. (Nowak, 2011: 437-438).

Considering all these factors, *House M.D.* and its main character House (as he is referred to in the show) are the most suitable targets of this research because House breaks many of the previous rules and expectations mentioned. Moreover, this study focuses on both verbal and nonverbal impoliteness, both of which House uses. The research questions of this thesis are:

1. What kind of impoliteness strategies does House use in the series?
        - How is impoliteness created verbally?
        - How is impoliteness created nonverbally?
2. How do the patients respond to House's impoliteness?

Further reasons for choosing this particular series, as well as the methods of data gathering and analysis are presented in the following chapter.

5. The present study

5.1. About *House M.D.*

House M.D. is an American drama series. The events take place in Princeton Plainsboro teaching hospital where Doctor Gregory House, together with his team, cures patients with mysterious illnesses. House, as he is referred to in the series, is extremely cynical towards people and life in general. He does not treat his patients with respect or dignity, nor does he trust anyone. All he cares about is to find out what is wrong with his patients and to cure them, to solve a puzzle. In the process, he does not care whether his actions are morally acceptable or not and this is why he often finds himself in trouble with both his team and his boss.

The first episode of *House M.D.* was aired in 2004 and the eighth season is now being

aired in the United States. In Finland, the fifth season started in February 2011. The series is distributed to over 60 countries and was recently named as the most popular current television program. *House M.D.* has won five Emmy Awards and two Golden Globe awards. It is produced by Heel and Toe Films, Shore Z Productions and Bad Hat Harry Productions in association with Universal Media Studios. During its eight seasons it has had several different executive producers, for example the lead actor Hugh Laurie himself. (*House M.D.* official website, 2011).

5.2. Choosing and collecting the data

For this study I decided to choose *House M.D.* for a number of reasons. Firstly, it is a very well-known TV series all over the world and it has become extremely popular during its eight seasons. Secondly, *House M.D.* is a new kind of a hospital drama. The main character does not represent the ideal doctor, the one who is always polite and thoughtful towards his patients, and admired by his colleagues. By contrast, House is incredibly rude and ignorant and often interested in his patients only because they have a mysterious disease. Thirdly, the well written dialogue of the series provides an excellent opportunity for a pragmatic research in the field of impoliteness studies.

There were numerous possibilities which to analyse for the purposes of this study. For instance, House interacts completely differently with his co-workers than with his boss Lisa Cuddy, or his ex-girlfriend Stacy Warner, who works at the same hospital in the second season. House also has a different attitude towards his main case patients than his clinic patients. This is because the clinic patients usually have very minor illnesses such as cold or a headache, and House is not interested in treating such illnesses. Therefore he is often extremely rude to these patients and wants to get rid of them as quickly as possible. Moreover, he knows that he will never meet them again and thus he can be rude. This is the reason why I chose to analyse the conversations between House and the clinic patients.

Because there are not as many clinic patients in the newer seasons of House than in the earlier ones, I decided to choose the second season for the analysis. In addition, I have analysed some of the episodes of the first season already in my bachelor's thesis (Laitinen, 2010). One by one I watched each of the twenty-four episodes of Season 2 and I found ten different clinic cases of varying length. The patients represented

different kinds of age and racial groups, and both sexes. After finding all the clinic patient cases of Season 2, I transcribed each of the conversations between House and the patients. In this, I used some of the English subtitles of House that could be found in www.subscene.com, a website that provides subtitles for movies and TV series.

5.3. Methods of analysis

5.3.1. Analysing House's impoliteness strategies

After transcribing all the conversations between House and his patients I went through each extract in order to find all the cases of impoliteness, both verbal and nonverbal ones. I excluded the sections where House is talking to his ex-wife Stacy in the middle of the examinations because my intention was to study merely the doctor – patient interaction. However, I did take those parts into account from the patient's point of view.

After finding all the cases of impoliteness I used two ways of categorising the instances of impoliteness. I categorised each case of verbal and nonverbal impoliteness according to Culpeper's (1996) list of impoliteness super-strategies and sub-strategies. Here is a thorough list of Culpeper's strategies:

> (1) Bald on record impoliteness
> (2) Positive impoliteness
>   *- Ignore, snub the other*
>   *- Exclude the other from an activity*
>   *- Disassociate from the other*
>   *- Be disinterested, unconcerned, unsympathetic*
>   *- Use inappropriate identity markers*
>   *- Use obscure or secretive language*
>   *- Seek disagreement*
>   *- Make the other feel uncomfortable*
>   *- Use taboo words*
>   *- Call the other names*
> (3) Negative impoliteness
>   *- Frighten*
>   *- Condescend, scorn or ridicule.*
>   *- Invade the other's space*
>   *- Explicitly associate the other with a negative aspect*
>   *- Put the other's indebtedness on record*
> (4) Sarcasm or mock politeness
> (5) Withhold politeness
>   (Culpeper: 1996, 356-358)

Very soon it became apparent that some of the instances of impoliteness could fall into more than one category. Nevertheless, I only placed each instance into one category, the

one that it belonged most clearly to.

Although Culpeper's (1996) strategies are the basis of my analysis, I also used Andersen's categorisation of nonverbal communication as an additional tool. This is due to the fact that most of Culpeper's strategies concern verbal impoliteness. However, I left out most of the Andersen's (1999) second group, the contextual codes, since they focus on the environment, and therefore are not relevant considering the present study. Therefore the chosen categories were:

1. Physical appearance: sex, clothing style, race, age, ethnicity, stature, body type, mood
2. Kinesics: body movements, divided into
      a) facial expressions,
      b) gestures and
      c) interactional synchrony (how two individuals move together as they communicate)
3. Oculesics: face and eyes, divided into
      a) eye contact (when both look into each other's eyes)
      b) pupil dilation and
      c) eye movement
4. Proxemics: interpersonal space and distance, divided into
      a) territoriality
      b) crowding and density (how many people in a certain space)
      c) personal space
5. Haptics: touching, divided into
      a) types of touch (professional, social, friendly, loving etc.)
      b) touch avoidance
      c) touch and relationships
      d) touch taboos (what kind of touch to avoid)
6. Vocalics: pitch, rhythm, tempo, resonance, control, accent

Categories from 1-5 are categorised as body codes by Andersen but as I argued earlier, I think that vocalics should be placed into this group as well. They are relevant to the present study and thus included.

5.3.2. Analysing the patients' responses to impoliteness

For the second research question I marked all the patients' responses and reactions to House's impoliteness. Responses to Culpeper's fifth strategy, withholding politeness, were not always possible to analyse because already analysing the original strategy itself is about assuming what could or should be there. Therefore there were fewer responses (or lack of responses) than instances of impoliteness. I divided the responses into four categories:

1) The patient did not understand House's face attack

2) The patient understood House's face attack but remained silent

3) The patient understood House's face attack and responded (either verbally or nonverbally)

4) The patient did not get a chance to respond because either House continued talking or the patient's reaction was not shown at all.

I used Bousfield's (2008) chart of responding to impoliteness (below) as the basis of the analysis.

Offending Situation/Triggering Event/Impoliteness act (Bousfield 2007):

      1. Do not respond
    2. Respond
        2a. Accept
        2b. Counter
            -> Offensive
            -> Defensive

However, Bousfield's chart only includes categories 2) and 3), the instances when face attacks are understood. Despite of this, I included categories 1) and 4) in the analysis as well because not responding to impoliteness is as relevant as responding to it.

6. Results: Impoliteness and responding to it on *House M.D.*

Having now introduced the methods of both data collection and analysis I will move on presenting the results of the analysis. I will start this chapter by providing examples from each of Culpeper's impoliteness strategies after which I will move on to report the findings of how House's patients responded to his impoliteness. All the instances of impoliteness that are relevant in the examples are underlined. In the latter part of the analysis the responses are underlined as well. It should also be noted that impoliteness that does not represent the strategy in question is not marked in any way. Nonverbal parts of the pieces of conversations are marked in square brackets and a loud or emphasised tone of voice is marked in bold font.

6.1. The impoliteness strategies used by House

In all of the extracts there were a number of impoliteness instances to be found and the total approximate of impolite instances was nearly 100. Each of Culpeper's strategies was present in the data but some strategies were clearly more frequent than others. Some strategies were used surprisingly little. In this section I will provide examples of each of Culpeper's impoliteness strategies, starting from bald on record impoliteness, and finishing with withholding politeness.

6.1.1. Bald on record impoliteness

Bald on record impoliteness is the most obvious and most straightforward impoliteness there is. According to Culpeper (1996), this kind of impoliteness is especially common among people who have a close relationship. However, in all of the following examples House examines patients whom he has never met before, which makes the effect of bald on record impoliteness even stronger. Slightly less than one fifth of the impoliteness instances were bald on record impoliteness.

In the first example an older man has come to the clinic for the second time. He is suffering from stomach pains. He wants House to write him a new prescription because the previous doctor has prescribed him a medicine that is designed especially for black people.

> Example 1: Season 2, episode 3
>
> House: Snap, crackle, pop. Got some Rice Krispies in there?
> Patient: That bad, huh?
> House: You were here yesterday. <u>I see from the chart that Dr. Foreman prescribed **medicine**, not a miracle. Gotta give this stuff more than a day.</u>

The patient thinks that Dr. Foreman was racist by prescribing him a drug that helps black people in particular. When House realises that his colleague has treated the patient only yesterday, House tells the patient quite rudely that the medicine does not work in one day. The fact that the patient is over 60 years old does not prevent House from being rude to him. The effect of impoliteness is enhanced by House's emphasised tone of voice when uttering the word *medicine*. Moreover, first he is looking at the medical charts but then he raises his head up while saying it.

If we consider Andersen's categorisation of nonverbal impoliteness, here impoliteness is partly created with the help of three different categories. House's slightly aggressive and annoyed mood represents the first group, physical appearance. His head movement and facial expression belong to the group of kinesics. Third factor, the tone of voice, represents the group of vocalics.

The second example is from a conversation between House and a middle aged woman who is suffering from a headache.

Example 2: Season 2, episode 4

House: Oh. Poor cat. You're allergic. We can control it with
antihistamine, one pill a day.
Patient: Pills?
House: You don't like to swallow. Not surprised. Forget the
pills. I'll give you a nasal spray.
Patient: Steroids? [House makes an annoyed facial expression]
Is there something else you can give me?
House: Well, if you lived by the river, I've got a bag.

House discovers quickly that the patient is allergic to cats. First he suggests antihistamines for a cure, an idea which the woman does not seem to like at all. House then proposes the use of nasal spray, which the woman refuses as well. House is starting to become irritated and his facial expression shows (Picture 1) that he is clearly annoyed with the patient. Although irritation is not included in the list of six basic facial expressions (Knapp et al., 2002), the raising of the eyebrows, wide opened eyes and tight lips suggest a negative emotion which can be interpreted as annoyance due to the context. Thus, in this case the impoliteness is not verbal, only nonverbal. It is created through a facial expression, which belongs to the group of kinesics.

Picture 1: Irritated face (Season 2, episode 4)

When the patient asks for the third kind of medication, House replies that if she lived by a river, he'd recommend a bag, which suggests that the woman should drown the cat in the river. Although the impoliteness here is slightly implicit, it can still be considered bald on record impoliteness since the real meaning is easy to detect.

The third example of bald on record impoliteness is from an examination of a young female patient. When House enters the room he greets the patient before looking at her. When he raises his face up he notices that the woman is already on the examination table without trousers and makes quite a surprised facial expression (Picture 2).

Example 3: Season 2, episode 9

House: Good afternoon. I'm Dr. House. I'm going to be looking at your... [sees that the woman is on the examination table without trousers, makes a negatively surprised facial expression] Perfect [smiles reluctantly]. Excuse me. [uses the phone] I need Dr. Foreman in the exam room 1 for a consult. So, when did this start?

Picture 2: Surprised facial expression (Season 2, episode 9)

House's expression is not merely surprised but also slightly disgusted. Surprise is communicated through raised eyebrows (Knapp et al., 2002). Although disgust is listed as one of the six basic expressions, the exact details of House's face cannot be seen from such a small capture. However, one can infer from the context that he is disgusted as well. It is not an appropriate reaction for a doctor considering that the examination is completely normal for their profession. House does try to correct his impolite reaction, though, by saying *perfect* and forcing a smile on his face. Again, impoliteness is created

only nonverbally, and more precisely through kinesics, as in Example 2.

In the next piece of conversation House has discovered that his patient has a sexually transmitted disease. The patient seems to be very upset by House's discovery and swears that there must be a mistake.

Example 4: Season 2, episode 15

Patient: But there must be some mistake.
House: You got any kids?
Patient: Yeah.
House: Any of them take guitar lessons?
Patient: No.
House: Tennis, art, acting?
Patient: My daughter does karate. Why?
House Give this to her sensei. Oh, wait. Does your wife play tennis?
Patient: No.
House: That's what I figured. It never hurts to make sure. For Miyagi.

House believes that the patient is innocent and begins to question him about his children. His aim is to find out whether the children have any hobbies that involve a male teacher. It turns out that the patient's daughter does karate after which House asks the patient to give a similar prescription to the karate teacher. Although he does not directly claim that the patient's wife is having an extramarital affair with the karate teacher, it is expressed clearly enough in order to be bald on record impoliteness.

The fifth and final example of bald on record impoliteness is from the second conversation between House, his Chinese patient and the patient's teenage daughter who is translating the conversation between her mother and House. They have seen House earlier when he prescribed the patient decongestants and the daughter birth control pills without her mother knowing about it. Now they have returned to the clinic because the mother is still ill. It turns out that the daughter has mixed up the drugs.
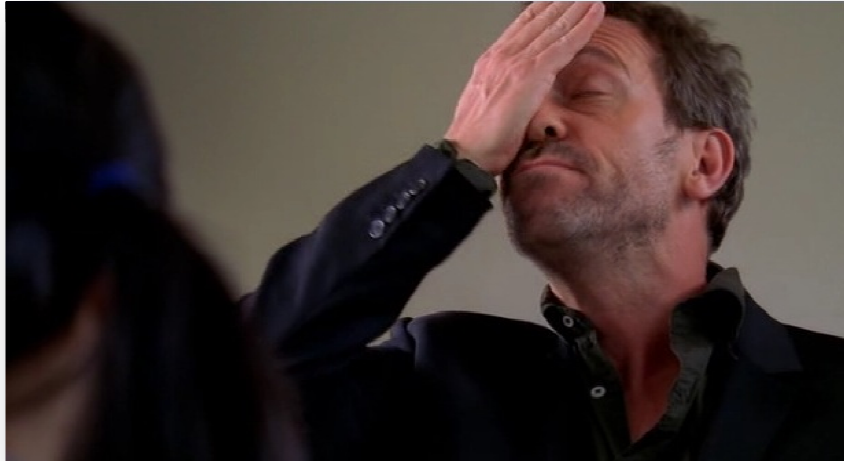
Example 5: Season 2, episode 18

House: How could you get them mixed up? [yelling] They come in a little wheel, they don't look anything like decongestants.
Girl: Oh, god! The cashier put them both in the same bag. I thought I gave her the right ones.
House: [touches his head in a non-believing way]

Picture 3: House slapping his forehead (Season 2, episode 18)

Once House realises the daughter's mistake he yells at her that how she could mix up something like decongestants and birth control pills. After the girl explains what must have happened House slaps his head in order to signal that he thinks the daughter is really stupid (Picture 3). Therefore the nonverbal impoliteness is again created through kinesics. Nevertheless it is not created just through a facial expression but also through a hand movement. In addition, vocalics are used through a louder tone of voice. In general, doctors are not expected or supposed to show their feelings very grandly and least of all show that they find their patients or their family members stupid.

6.1.2. Positive impoliteness

Positive impoliteness refers to the strategies that are designed to damage the addressee's positive face wants. As was discussed earlier, a positive face want means a person's will or need to be a part of a certain action, or to be approved of. Culpeper (1996) has listed a number of sub-strategies for positive impoliteness, and a great deal of these was found in the data. In fact, positive impoliteness was the second most used strategy: slightly less than one third of the impoliteness instances were positive impoliteness.

The first example of positive impoliteness is from the same extract as Example 1 where the patient is not pleased with the previous doctor prescribing him medicine that is designed especially for black people.

Example 6: Season 2, episode 3

Patient: Look, my heart's red, your heart's red. And it don't
make no sense to give us different drugs.
House: You know, I have found a difference. Admittedly a
limited sample. But based on my experience over the last 90
seconds, all black people are morons. Sorry. African Americans.

House does not appreciate that the patient questions his colleague's judgement, especially if it has been studied that certain drugs have a better effect on African Americans than others. This is why he ends up calling black people morons, which is one of the sub-strategies of positive impoliteness; *call the other names.* Moreover, here House particularly means that this patient is a moron because he says that he bases his argument on his experience over the last 90 seconds. Although a doctor would have disagreement with their patient, they should never call them names but instead they should try to compromise.

In the next example House does not use verbal but nonverbal impoliteness by ignoring the patient during an examination. House has started asking the patient questions about his condition, when suddenly his ex-girlfriend Stacy, who is currently working in the hospital, rushes in.

Example 7: Season 2, episode 6

House: Symptoms meaning... diarrhea. A lot of diarrhea.
Patient: Ten or twelve times a day. It's really embarrassing. I'm a
flight attendant and...
Stacy: [enters room looking angry, slaps House in the arm.]
House: On the upside, my hiccups are gone.
Stacy: You went to his group.
(Arguing continues....)
House: Listen, I can get my rocks off any time I want. What I
don't seem to be able to do is my job without you hanging over
my shoulder.
Stacy: [leaves the room, and returns after House has asked the
patient a couple of more questions]
Stacy: I'm trying to protect you. Cuddy and I may be the only
people stopping you from jumping off a cliff...
House: You're pissy.
(Arguing continues...)
House: And none of this has anything to do with me?
Stacy: No, nothing. Except that you can't or won't just let it go.
Let it go.
Stacy: [leaves]
House: [to patient] You're being poisoned.

In this extract it is, in fact, Stacy who is acting impolitely first. However, instead of telling her to leave the examination room, House immediately starts arguing with her, completely ignoring the patient. This does not happen only once but twice because Stacy returns after she has left once. Only when Stacy has finished and left the room for the second time, House tells the patient what is wrong with him. The sub-strategy in question is thus *ignore the other.* It is not suitable for a doctor to have a conversation involving one's private life while examining a patient.

There were other instances of ignoring the other as well. In Example 8 a mother has arrived to the clinic with her son whose stomach is completely red.

Example 8: Season 2, episode 23

Mother: They don't itch. Not raised. He's had his MMR. [House does not say anything, only walks to the sink] No one's sick at school. His father took him camping.
Patient: We caught two spiders.
Mother: You didn't tell me about the spiders.
House: Did you get a new couch?
Mother: Do you think there might be some sort of toxin?
House: [does not listen to the mother's question] What color is it?
Patient: Red.

When the mother starts explaining her son's condition, House does not say anything. Instead, he walks away to the sink. The mother continues by telling about a camping trip that her son had with his father. House ignores the story entirely and asks if the family has a new couch. The mother then becomes worried about toxins and asks about them, which House, again, completely ignores. He inquires about the colour of the couch and does not even let the mother finish her question before he takes his turn. Whereas Example 7 was nonverbal ignoring, this example is both nonverbal and verbal ignoring.

Another sub-strategy named by Culpeper (1996) is to *use taboo words*, which includes swearing and using abusive or some sort of profane language. In Example 9 House tells his patient that he has a sexually transmitted disease. The patient seems to be quite upset about this so House decides to tell him that he is not the only one who comes to the clinic because of similar conditions.

Example 9: Season 2, episode 15

Patient: It's my prostate, isn't it?
House: Nope. Not your prostate. Herpes.
Patient: Herpes?
House: Herpes. Your turn. If it makes you feel any better, half
the patients who come into this place have some sort of <u>crotch
rot.</u>

When trying to make the patient feel better House uses a rather colloquial term *crotch rot*, which is not expected from a doctor at all. Doctors are expected to use professional and decent language especially when they are describing something that their patients are suffering from. Therefore this is an instance of using taboo words.

In the tenth example an Asian mother has come to the clinic with her daughter, who is in her early teens. The mother does not speak English at all, thus the daughter translates. She suspects that the mother probably has PMS. House disagrees.

Example 10: Season 2, episode 18

House: Judging by the redness around your mom's nostrils, and
the tissue she's got conveniently stashed inside her wrist band,
<u>I'd say her problem is more likely a URI than a PMS.</u>
Girl: URI?
House: Upper respiratory infection. A cold.
Girl: I don't think so.
House: <u>I also think she's got a problem with SAC.</u>
Girl: SAC?

House figures out quite quickly that the daughter wants him to prescribe birth control pills for her mother's PMS but that it is the daughter who needs them herself. Instead of saying that the mother has a cold, he first uses an abbreviation URI, which stands for upper respiratory infection, a medical term for a cold. After this House explains what the abbreviation stands for, and only after that he clarifies that it means a cold. Once he has started using abbreviations, he continues with another abbreviation, SAC, and again the daughter is very confused and has to ask what it stands for. This sub-strategy is *use obscure language*.

Another sub-strategy of positive impoliteness that House used was *being disinterested.* This example is from the same extract as Example 2, where House tells the middle aged female patient that she is allergic to cats.

Example 11: Season 2, episode 4

Patient: The top of my head's killing me.
House: Hmmm [disinterested facial expression]. We spent a
week doing 'top of head' in anatomy. [looking very bored and
disinterested] I know just where it is.
Patient: Ow! That is not the top of my head!

When the patient explains what is wrong with her, House merely sits on his chair and looks at the woman. However, he does not look the patient in the eyes. His facial expression is extremely bored (Picture 4). This can be interpreted due to features such as wrinkled forehead, downward turned eyes, and also from his first reply, which is a mere "hmm". After that he uses sarcasm, which will be discussed later.

Picture 4: Disinterested House (Season 2, episode 4)

If we consider Andersen's (1999) categorisation of nonverbal communication, here impoliteness is created through categories 1, 2, and 3. House's mood (physical appearance) is bored rather than enthusiastic and interested. His facial expression (kinesics) conveys the same thing. Finally, House's eye contact (oculesics) with the patient is non-existent when he listens to her at first. A good doctor ought to listen to their patient and at least seem interested even if he really is not.

The fifth sub-strategy used by House was *seek disagreement.* The patient of Example 9 has brought his wife to the hospital in order to clarify things between him and his wife. Earlier House discovered that the husband has a sexually transmitted disease. House has decided to play a game of finding out which one of the married couple has had an extramarital affair. He has invented a lie according to which one could get herpes from a

toilet seat. The wife does not believe it, which proves that the husband is the one who is guilty.

> Example 12: Season 2, episode 15
>
> Wife: What?
> House: <u>He could believe that you can get herpes from a toilet seat, or he could be cheating on you and just be happy to have an out.</u>
> Patient: The toilet seat makes sense, doesn't it?
> House: <u>Sure, but she'd only refused to believe such a well presented lie if she were innocent. And since you both can't be innocent... "You rutty jackass".</u>
> Wife: Oh, you... [takes the wedding ring off her finger and hurries out of the room]
> Patient: Thanks a lot.

In a normal doctor - patient situation a doctor is finished with his work when he discovers the illness and prescribes medicine for it. It is not a doctor's job to decide on their patients' behalf whether their marriage will continue or not. House could have easily told that there is no way to find out which of them had the disease first, and that they have to solve the issue together.

6.1.3. Negative impoliteness

Whereas positive impoliteness attacks the addressee's positive face, negative impoliteness attacks the addressee's negative face, that is, an addressee's will or need to be unimpeded, not distracted by others, and free from all kinds of imposition (Brown and Levinson, 1987). Culpeper (1996) has listed sub-strategies for this super-strategy as well, and a few of these could be found in the data. However, sub-strategies such as *explicitly associate the other with a negative aspect* and *put the other's indebtedness on record* were not found at all. Despite of this, negative impoliteness along with the strategy of positive impoliteness formed over a half of the impoliteness strategies found in the data; slightly over one third of all the instances were negative impoliteness which makes it the most common strategy.

The first example of negative impoliteness involves a patient who has come to the clinic because of coughing. It turns out that he has no health insurance.

Example 13: Season 2, episode 8

Patient: [coughs] Two months like this.
House: Let me guess, no insurance. Just heard about the free clinic. <u>It's a good move. You don't want to skimp on the essentials like wristwatches, MP3 players.</u>

This sub-strategy would be *ridiculing*. In the United States, health insurance is extremely important because the health care is funded with the help of private health insurances provided by independent insurance companies. If one does not have an insurance, hospitals are not obligated to treat him except in case of emergency. Once House draws a conclusion that the patient does not have the insurance, he starts mocking him by suggesting that he finds a wristwatch and an MP3-player more important than his health and that is why he visits a free clinic although he has been coughing terribly for two months. Even if this was true, doctors do not decide if their patients are acting right if they do not have a health insurance and use the services of a free clinic.

This was not the only instance of ridiculing a patient. In the following example a mother has come to the clinic with her young daughter and suspects that she has epilepsy.

Example 14: Season 2, episode 21

House: She responsive?
Mother: No, no, it's like she's in a zone. And her abdominal muscles become dystonic.
House: <u>Big word. Someone's been on the interweb.</u>
Mother: I looked up a few articles on epilepsy. You know, there's actually some really great youth soccer leagues that would cater specifically to her special needs, and... I think it might explain why she's been having a hard time in preschool.
House: Let's confirm your diagnosis before you have her held back.

While describing her daughter's problem, the mother uses medical terminology, such as *dystonic*, and House starts ridiculing her for finding these medical expressions in the "interweb". Nowadays it seems that people try to diagnose themselves with the help of the Internet instead of seeing a trained doctor first. This is something House clearly disapproves and thus makes a remark about the mother's language use.

The third example of ridiculing involves a patient who has come to the clinic to ask for a medicine that is normally used for preventing pregnancies. What is peculiar about the case is that the patient is male. He is hiding the reason behind his true intentions why he

needs the medicine and thus makes up a lie.

Example 15: Season 2, episode 14

Patient: I love cows.
House: [stares for a moment, then takes pills out of his pocket] Any particular...variety? Guernseys? Holsteins? [takes a few pills]
Patient: Which are the black and white ones?
House: God.
Patient: I pass a farm on my way to school. And they're so beautiful. They're so majestic. I dream about them. Leather shoes, hamburgers. How can anybody do that to a cow?
House: Make love, not belts. It's beautiful.
Patient: I haven't actually…
House: Well, relax. Something we doctors deal with all the time. I'm gonna write you the name of a drug. You don't need a prescription. And it looks just like depo-provera.
Patient: But does it do the same thing?
House: Oh, God, no. That stuff has all sorts of nasty side effects. It's real medicine. No, this is all you need. Your frat buddies will be completely fooled. Tell them how appalled the doctor was. Lots of laughs.

Although House later discovers that the patient is lying about the cows, he believes the patient's story at first because he tells it in such a convincing way. House begins his ridiculing by asking what kind of variety of cows the patient likes most. Later in the conversation he modifies the old anti-war slogan "make love, not war" into "make love, not belts". Then he agrees to write the patient the name of a drug. Here, it is clear to the audience that House is only ridiculing the patient because of his cheerful tone of voice and a casual attitude. Finally, he ends the meeting by using a colloquial expression used by young people; "lots of laughs" and smiles at the patient, which he never does sincerely.

House does not ridicule only young men or mothers but children too. Example 16 is from the same extract as Examples 5 and 10. This Example is from the beginning of the conversation where a Chinese mother has come to the clinic with her translating daughter.

Example 16: Season 2, episode 18

Girl: She has menstrual problems. They're really bad. The pain keeps her in bed all day. Plus, she's super depressed.
House: She said **super** depressed?
Girl: She heard that birth control pills can make her feel better.
House: She wants birth control pills for her PMS? [doubting facial expression]
Girl: I guess.

The girl explains her mother's condition. She adds that the mother is *super depressed*, which makes House asking if that was what her old mother really said. House emphasises the word *super*. Then the daughter claims that her mother wants birth control pills and House realises that the daughter is lying and wants the pills for herself. House repeats what the daughter has just said with a doubting facial expression (Picture 5) in order to clarify what the problem is and to show how stupid it actually sounds. Therefore kinesics and vocalics are additions to verbal impoliteness in this example.

Picture 5: Doubting House (Season 2, episode 18)

Although most of the negative impoliteness sub-strategies involved ridiculing the patient somehow, there was another sub-strategy to be found as well. The following example is from the same extract as Example 13, where a man named Chuck has come to the clinic without a health insurance.

Example 17: Season 2, episode 8

House: Uhh.. Chuck. I'm going to break from the parable of the wicked doctor and tell a little story about a patient. Let's call him... Buck, who has low O2 stats and crackling lung sounds.
Patient: Like I have?
House: Buck has idiopathic pulmonary fibrosis. His lung tissue's turning to rock. There's no known cause, no treatment. He is slowly suffocating.
Patient: You're talking about me?
House: Lung transplant's about a half a million dollars, but this poor sucker's got no insurance. If he tried to sign up now, he'd be excluded, pre-existing condition. But let me confirm with my lawyer. She confirms. If only Buck hadn't been diagnosed with fibrosis before he got insurance. So... back to the exam.

House has already found out that the patient has a cold. However, since he has no health insurance, House wants to teach him a lesson by telling him, in a form of a story, that he has a lung disease which will eventually kill him. After House has finished his story, the patient leaves the room in shock and therefore the sub-strategy is *frighten* (Culpeper, 1996). Firstly, a doctor should never lie to a patient to prove a point. Secondly, even if the diagnosis was correct, a doctor should not tell a patient that his lung tissue "is turning to rock" or that he is "slowly suffocating".

6.1.4. Sarcasm and mock politeness

In these two strategies politeness is performed with clearly insincere intentions, which then makes the performed utterances impolite. As for instance irony, also sarcasm is heavily related to the context. Mock politeness, in turn, is surface politeness, which can be interpreted in an impolite way because of certain contextual clues. There were surprisingly few examples of these two strategies in the data; less than one tenth, which makes this strategy the least used one.

In the first example of sarcasm a middle aged female patient has come to the clinic because her head hurts.

> Example 18: Season 2, episode 4
>
> Patient: The top of my head's killing me.
> House: Hmmm. We spent a week doing 'top of head' in
> anatomy. I know just where it is. [touches the woman's face
> with two fingers]
> Patient: Ow! That is not the top of my head!

In this example, House looks very disinterested towards the patient at first, and when the woman explains that the top of her head is aching, House replies it being exactly what they studied on their anatomy classes in the medical school. Since we know that medical schools do not teach something that is "top of head", this is a clear instance of sarcasm. Doctors should understand that patients might use terms that are not straight from a medical study book instead of mocking them sarcastically.

The second example of sarcasm involves the same conversation:

Example 19: Season 2, episode 4

House: Your sinuses are clogged. Judging by the scratches on
your hands, I'm guessing a new cat.
Patient: It was my mother's. She's dead.
House: You keep a dead cat?
Patient: No. My mother's dead.
House: Oh. Poor cat. You're allergic. We can control it with
antihistamine, one pill a day.

House guesses that the patient has recently taken a cat. She explains that it was her mother's and that the mother is now dead. At first House does not realise that it is the mother who is dead, not the cat. Once she corrects him, House pretends he is feeling sorry for the cat. This is clearly insincere because the viewer knows that House is not interested in cats' feelings, and that people do not generally feel sorry for animals whose owners die, but rather the other way around. Therefore this is an instance of sarcasm. No one, let alone a doctor, should be sarcastic when someone has recently told that they have lost a family member.

Mock politeness was slightly more common than sarcasm. Example 20 is from the same conversation as Example 1. The patient does not want to take a drug that is designed especially for black people and demands that House prescribes him another medicine.

Example 20: Season 2, episode 3

Patient: Look, my heart's red, your heart's red. And it don't
make no sense to give us different drugs.
House: You know, I have found a difference. Admittedly a
limited sample. But based on my experience over the last 90
seconds, all black people are morons. Sorry. African
Americans.

In Example 1 it was noted that House uses bald on record impoliteness when he calls all black people morons. This is not where the impoliteness stops, however. After he has insulted the patient, he quickly corrects himself by saying *Sorry. African Americans*, which is the politically correct version. However, this correction is clearly insincere because House has just insulted the patient, which indicates that he clearly does not care about the patient's feelings and would not have to correct himself anyway. Moreover, House's facial expression enhances the insincere effect. If the correction was sincere, House would not have an angry facial expression with eyebrows drawn together and a hard stare in his eyes (Knapp et al., 2002). If House had not insulted the patient in the first place he would not need to use mock politeness either.

Picture 6: Insincere face (Season 2, episode 3)
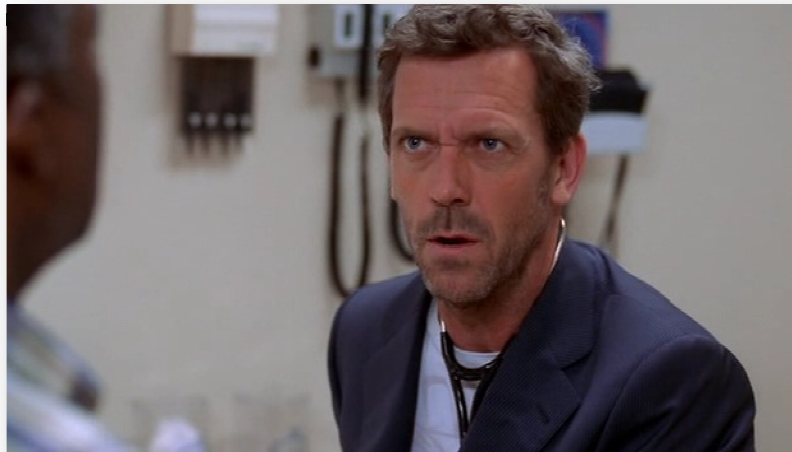
The next example of mock politeness is from a conversation between House, Dr. Cuddy, who is House's boss, House's patient and the patient's wife. House has examined the patient earlier, and after that they have agreed on meeting again. House arrives late in the meeting.

> Example 21: Season 2, episode 15
>
> Cuddy: Mr. and Mrs. Lambert's appointment was over an hour ago.
> House: <u>Sorry. I was sick.</u> And my team needed an emergency consult. Your wife has herpes.
> Wife: What? That's impossible. I don't have any...

In this episode, as in other episodes as well, House has a main case that is very challenging because of an unknown medical condition. Main cases take most of House's time and energy, and he is not very enthusiastic dealing with the clinic patients. This is why he arrives late and claims having been sick, also using the word *sorry*. This is clearly not true since House provides another, true, reason as well: an emergency consult with his team. Additionally, he does not look like he has been sick. Therefore this is an instance of mock politeness and targeted to all the people present in the room.

The next example is from the same conversation. During the conversation it turns out that the patient has been having an extramarital affair, and House is the one who manages to reveal it.

Example 22: Season 2, episode 15

House: Sure, but she'd only refused to believe such a well
presented lie if she were innocent. And since you both can't be
innocent... "You rutty jackass".
Wife: Oh, you... [takes the wedding ring off her finger and
hurries out of the room]
Patient: Thanks a lot [annoyed].
House: My pleasure [with a smirk on his face].
Patient: Honey. Wait! Please.

After the patient's wife realises that her husband has been having an affair, she hurries out of the room taking her wedding ring off. The patient runs after her and thanks House sarcastically. House replies it being his pleasure with a smirk on his face (Picture 7). This is generally a polite utterance, but in this context it is mock politeness because House is not sorry for revealing the patient's secret.

Picture 7: Smirk (Season 2, episode 15)

6.1.5. Withholding politeness

The final strategy, withholding politeness, means politeness that is expected in a certain situation but is left out for some reason. In the data there were a number of instances where House either ignored general interactional manners or the ones belonging to a doctor in particular. A little over one tenth of the instances involved withholding politeness.

For example, in some of House's clinic examinations that are shown from the beginning House enters into the examination room without greeting the patient or introducing himself:

Example 23: Season 2, episode 18

House: [enters the room, does not greet]
Patient: [speaking Mandarin]
Girl: She's been taking the decongestants, but she' not getting
better. She also says... [talks at the same time as the mother]
House: What?!

A lack of greeting is impolite not only in doctor – patient discourse but also in any kind of face-to-face conversation when one meets a new person. In doctor – patient interaction it is usually the doctor who is expected and supposed to make the initiation for greeting and a possible hand-shake. This does not happen in the example and therefore the patient starts to explain her symptoms in Mandarin straight away.

House was impolite in the ends of examinations, too:

Example 24: Season 2, episode 15

House Give this to her sensei. Oh, wait. Does your wife play
tennis?
Patient: No.
House: That's what I figured. It never hurts to make sure. For
Miyagi. [collects his things and leaves without saying goodbye]

In a normal doctor – patient encounter it is usually the patient who leaves the room first, and the doctor says at least goodbye. Here neither of these happens, which gives the patient the impression that the doctor was in a hurry and that the patient was only disturbing him.

Withholding impoliteness can also be seen as an absence of certain polite utterances expected from a doctor. For example, doctors tend to tell patients what they are going to do next in order not to cause discomfort:

Example 25: Season 2, episode 4

House: Hmmm. We spent a week doing 'top of head' in
anatomy. I know just where it is. [touches the woman's face
with two fingers without warning her]
Patient: Ow! That is not the top of my head!

In this example, House does not warn the patient that he is now going to examine her head, or that it might hurt. Instead, he merely touches the patient's face (Picture 8), which then hurts her. In a normal interaction the touching might be considered impolite as well but doctors are supposed to touch their patients and warn about it (Nowak,

2011.) Therefore the fact that it hurts is not what is impolite but the lack of warning.

Picture 8: House touches patient's face (Season 2, episode 4)

The next example particularly is against what the doctors are taught. It is from the same conversation as Example 13. A young man has come to the clinic and it has turned out that he has no health insurance. After a certain series of events, House begins to tell the patient, Chuck, what is wrong with him, addressing him as "Buck".

Example 26: Season 2, episode 8

House: Buck has idiopathic pulmonary fibrosis. His lung tissue's turning to rock. There's no known cause, no treatment. He is slowly suffocating.
Patient: You're talking about me?
House: Lung transplant's about a half a million dollars, but this poor sucker's got no insurance. If he tried to sign up now, he'd be excluded, pre-existing condition. But let me confirm with my lawyer. [looks at Stacy who just stares] She confirms. If only Buck hadn't been diagnosed with fibrosis before he got insurance. So... back to the exam. [withholds politeness by just letting the patient leave although he just heard he is dying]
Patient: [leaves the room in shock]

Here, House tells the patient that he will die by telling a story about a Buck. After he has finished his story about the dying Buck, he does not say anything but lets the patient leave the room in shock. Later it is revealed to the viewers that Chuck only had flu and that House wanted to teach him a lesson about health insurances but this does not erase the fact that he told someone that he is dying in a form of a story and then let the patient leave.

In sum, all of the five strategies listed by Culpeper (1996) were used. However, positive and negative impoliteness strategies were clearly the most common strategies, together comprising approximately two thirds of all the instances. The other three strategies, bald on record impoliteness, withholding politeness and sarcasm/mock politeness created only one third of the instances in total, the latter being the least used strategy.

6.3. The patients' responses

Next I will present examples of how House's versatile face attacks are reacted to, or if they are reacted to at all. In the examples, both the preceding impoliteness and the response to it (or the lack of it) have been underlined.

6.3.1. The instances where the patients do not understand the face attack

The instances where House's face attacks were not understood was sometimes very difficult to separate from the next category, the instances where the face attack is understood but not responded to. This is because both categories mean that the patient remains silent. However, based on the hints on the patients' faces and in their behaviour one could count that approximately one fifth of House's face attacks were not understood by the patients at all.

For example, the woman who has come to the clinic because her sinuses are clogged looks very puzzled throughout the conversation. In the end of their conversation House attacks her face three times.

> Example 27: Season 2, episode 4
>
> House: You're allergic. We can control it with antihistamine,
> one pill a day.
> Patient: Pills?
> House: You don't like to swallow. Not surprised. [the patient
> just stares at House] Forget the pills. I'll give you a nasal spray.
> Patient: Steroids? [House makes an annoyed facial expression]
> Is there something else you can give me?
> House: Well, if you lived by the river, I've got a bag. [the
> patient stares at House looking puzzled]

First House attacks the patient's face by saying that he is not surprised about the patient's unwillingness to swallow. Then he makes an extremely annoyed facial expression when the woman refuses a nasal spray as well. Finally House suggests he

should give her a bag if she happens to live by a river. Each time the patient's face is shown, it shows no signs of irritation or understanding the face attack. Instead, the patient's face looks puzzled and confused (Picture 9).

Picture 9: Puzzled and confused patient (Season 2, episode 4)

In another example House is ridiculing the patient who has lied about cows.

Example 28: Season 2, episode 14

House: Make love, not belts. It's beautiful.
Patient: I haven't actually…
House: Well, relax. Something we doctors deal with all the time. I'm gonna write you the name of a drug. You don't need a prescription. And it looks just like Depo-Provera.
Patient: But does it do the same thing?

The patient wants to get the drug and thus he does not notice that House is ridiculing him. He is sure that House has believed his lie and is going to write him a name of a drug, similar to Depo-Provera. This is revealed when he asks House if it does the same thing.

If we consider the common factors of the patients who did not understand House's face attacks at some point of the examination, they were all usually depicted rather stupid or naïve. The middle aged woman with the cat, for instance, refuses two different kinds of medicine that would help her. The young man who wants Depo-Provera claims that he loves cows instead of telling the truth. Therefore it is logical that these patients do not always understand impoliteness, such as ridiculing or sarcasm.

6.3.2. The instances where the patients understand the face attack but do not respond

Not responding to impoliteness means staying silent after one's face has been attacked. There might be several reasons for this, such as simply accepting the face attack or not knowing how to respond to it. Although sometimes House's patients miss the impoliteness completely there were a number of instances when the patients' facial expressions show that they have caught the impoliteness at least on some level. Despite of that they decide not to respond to it. Slightly less than one third of the responses belonged to this category.

In Example 29 House has implied that the patient's wife is having an affair with their daughter's karate teacher.

> Example 29: Season 2, episode 15
>
> Patient: My daughter does karate. Why?
> House Give this to her sensei. Oh, wait. Does your wife play
> tennis?
> Patient: No.
> House: That's what I figured. It never hurts to make sure. For
> Miyagi.
> Patient: [stares at the prescription and House]

Although House's accusation is extremely personal and hurtful, the patient chooses not to say anything. Instead, he stares at the prescription and House and his facial expression shows some kind of irritation (Picture 10). In a larger close up one can see that the patient has wrinkles in his forehead and that the corners of his lips are turned downwards, which are signs of negative emotions rather than positive ones (Knapp et al. 2002). Moreover, the contextual clues reveal the irritation as well. However, it is most likely targeted at the situation rather than House himself.

Picture 10: Irritated patient (Season 2, episode 15)

In Example 30 House calls his patient a moron. The patient is already irritated by the fact that he has been prescribed medicine that is designed for black people in particular. However, he does not respond to House's insult and merely stares at him with a serious facial expression (Picture 11). The patient has wrinkles in his forehead and the corners of his mouth and eyes are turned slightly downwards which also tell that the patient is not pleased with House. House then continues his turn by apologising his politically incorrect expression – black people – and changing it to *African Americans.*

Example 30: Season 2, episode 3

Patient: Look, my heart's red, your heart's red. And it don't make no sense to give us different drugs.
House: You know, I have found a difference. Admittedly a limited sample. But based on my experience over the last 90 seconds, all black people are morons. [the patient stares at House with a serious look on his face] Sorry. African Americans.

Picture 11: Serious face (Season 2, episode 3)

Example 31 involves a situation when House is examining a young male patient when suddenly House's ex-girlfriend Stacy rushes into the room.

Example 31: Season 2, episode 6

House: Symptoms meaning... diarrhea. A lot of diarrhea.
Patient: Ten or twelve times a day. It's really embarrassing. I'm a flight attendant and...
Stacy: [enters room looking angry, slaps House on the arm]
Patient: [looks puzzled at Stacy]
House: On the upside, my hiccups are gone.
Stacy: You went to his group.
Patient: [opens his mouth, looks puzzled at House]
(....)
House: Listen, I can get my rocks off any time I want. What I don't seem to be able to do is my job without you hanging over my shoulder.
Stacy: [leaves the room]

At first the patient looks very surprised and even opens his mouth a bit (Picture 12) but yet remains silent. A reason for him staying silent might be that he finds the surprising situation interesting rather than insulting.

Picture 12: Mouth open (Season 2, episode 6)

The next example of not responding to House's impoliteness is taken from the extract where House has earlier discovered that his patient has a sexually transmitted disease. The patient and his wife have arranged a new meeting with House and his boss, Dr. Cuddy.

Example 32: Season 2, episode 15

Cuddy: Mr. and Mrs. Lambert's appointment was over an hour
ago.
House: Sorry. I was sick. And my team needed an emergency
consult. [the patient and Cuddy look annoyed] Your wife has
herpes.
Wife: What? That's impossible. I don't have any...

House arrives late to the meeting and claims that he was sick. Cuddy and the patient look annoyed but do not reply. The viewer knows that Cuddy is used to House's impolite behaviour and therefore she knows when he is lying. She also knows that it is useless to accuse House of being late or lying about it because she has very little power over him, although she is his boss.

The final example of not responding to impoliteness involves withholding politeness in a situation where House has indirectly told his patient that the patient is dying of pulmonary fibrosis.

Example 33: Season 2, episode 8

House: Lung transplant's about a half a million dollars, but this
poor sucker's got no insurance. If he tried to sign up now, he'd
be excluded, pre-existing condition. But let me confirm with my
lawyer. [looks at Stacy who just stares] She confirms. If only
Buck hadn't been diagnosed with fibrosis before he got
insurance. So... back to the exam. [withholds politeness by just
letting the patient leave although he just heard he is dying]
Patient: [leaves the room in shock]

Even though House seems to have a very careless attitude towards his patient, the patient does not stay demanding further explanations or help for his situation. Instead, he leaves the room quietly in shock.

To sum up, the instances where the patients understand the face attack but do not respond are rather different from each other. At times the patients do not bother to answer but rather let House finish his speaking turn (Examples 30 and 32) whereas at times the lack of response suits the scene better than responding (Example 29 and 33). After all, the clinic patients do not play an important role in the series like House does.

6.3.3. The instances where the patients understand the face attack and respond

As explained earlier in Chapter 3.2.2.2., Bousfield (2008) divides responding to impoliteness into two: accepting and countering the face attack. Accepting includes apologising, for instance. Countering the face attack is divided further into offensive and defensive strategies. An offensive strategy includes responding with a new face attack, whereas defensive strategy includes joking or explaining, for example. A little over one third of House's face attacks were responded to in some way. Most of the patients countered his face attack but there were also a few instances where the patient accepted the face attack. The three first examples of responding to a face attack represent the more common choice, countering. Furthermore, they are defensive ones and involve explaining.

In Example 35, House accuses the patient for returning back to the clinic too early because the medicine does not work in one day. The patient then counters the face attack by explaining annoyed that he did not even take the medicine yet.

> Example 34: Season 2, episode 3
>
> House: Snap, crackle, pop. Got some Rice Krispies in there?
> Patient: That bad, huh?
> House: You were here yesterday. I see from the chart that Dr. Foreman prescribed **medicine**, not a miracle. Gotta give this stuff more than a day.
> Patient: I didn't fill that Oreo's prescription [annoyed tone of voice]

Another instance of defensive explaining was found in the following conversation:

> Example 35: Season 2, episode 18
>
> House: How could you get them mixed up? [yelling] They come in a little wheel, they don't look anything like decongestants.
> Girl: Oh, god! The cashier put them both in the same bag. I thought I gave her the right ones.
> House: [touches his head in a non-believing way]

When House realises that the daughter has mixed up her and her mother's medicine he yells at the girl how it is possible. The daughter then counters the face attack by explaining that the cashier put the both drugs in the same bag.

Whereas the previous examples were verbal countering, the third example of defensive explaining is, by contrast, nonverbal.

Example 36: Season 2, episode 14

House: Absolutely nothing. Your blood work is perfect. You've got lots of vitamins, minerals, all kinds of proteins. Including a little something I like to call bovine serum albumin, which you get from eating the animals mentioned. Or cow. You don't really worship cows. So I have to wonder, what could be more humiliating than someone calling your girlfriend a cow and not being metaphorical?
Patient: [Shows a picture of a beautiful woman.]
House: Nice.

Earlier in the conversation the patient has claimed that he needs a certain medicine because he loves cows. House later finds out that it is a lie and inquires the patient about the true reason. After a while, the patient counters House's ridiculing nonverbally by showing him a picture of a beautiful woman, the patient's step mother, who is the real reason behind the patient's visit on the clinic.

The two following examples show the use of offensive strategies.

Example 37: Season 2, episode 3

Patient: Look, my heart's red, your heart's red. And it don't make no sense to give us different drugs.
House: You know, I have found a difference. Admittedly a limited sample. But based on my experience over the last 90 seconds, all black people are morons. Sorry. African Americans.
Patient: I'll see another doctor.

In Example 34 the patient counters the face attack offensively by saying that he wants to see another doctor. House has called him a moron because he has refused to take a drug that is designed for black people and therefore finds it a racist drug. House mockingly corrects his insult by changing the term *black people* into *African Americans* but at this point the patient is already too irritated to continue the conversation with House.

The other example of countering a face attack offensively is from a conversation where a middle aged female patient has come to the clinic because of a headache. House does not warn that he is about to touch the patient's cheeks.

Example 38: Season 2, episode 4

House: Hmmm. We spent a week doing 'top of head' in anatomy. I know just where it is. [touches the woman's face with two fingers]
Patient: Ow! That is not the top of my head!

The lack of House's warning makes the patient yell that it is not the top of her head, which is an accusation towards House and his behaviour. As was discussed earlier in the analysis, the doctors ought to tell their patients what they are about to do next in order not to cause unnecessary surprises.

Accepting a face attack was slightly more difficult to detect because remaining silent, a strategy that Bousfield (2007) differs from accepting, is very similar to it. However, some responses to House's face attacks can be considered accepting:

Example 39: Season 2

House: Did you get a new couch?
Mother: Do you think there might be some sort of toxin?
House: [does not listen to the mother's question] What color is it?
Mother: Red.
House: Is that where you watch your cartoons after you take your bath?
Patient: Mmh
House: Fall asleep sometimes?
Patient: Yes.
(…)
House: I'll write you a prescription for one of these. Just wet and apply.
Mother: [smiles acceptingly]

In this example, a mother has brought his son to the clinic because the son's stomach has turned red. House asks the mother if the family has recently bought a new couch. The mother begins to worry and asks if there might be some sort of toxin involved. However, House does not listen to the mother and interrupts her question by asking what colour the couch is. The mother accepts the interruption by answering House's question immediately. After a couple of more questions House takes a towel and tells the mother to "wet and apply". The mother does not respond verbally but her smile reveals that she has understood the comical situation and consequently accepts the face attack, House's ridiculing.

When the patients counter the face attack defensively, they partly admit that the face attack is deserved or justified (Examples 34, 35, 36) because they want to provide an

explanation for their actions. In that sense a defensive strategy resembles accepting the face attack (Example 39). By contrast, offensive countering means that House has gone too far (Examples 37, 38) and the patients want to show their discontent.

6.3.4. The instances where the patients do not have a chance to respond to the face attack

About one fifth of the instances where House attacked his patient's face did not either show the patient's reaction at all, or then House continued talking and therefore did not give his patient a chance to respond to his face attack. The following three examples are such instances:

> Example 40: Season 2, episode 3,
>
> House: On the theory that you didn't trust him because he's **black**. Well, I'm going to prescribe the same medicine and see if you fill it this time.
> Patient: I'm not buying into no racist drug, okay?
> House: [snorts] It's racist because it helps black people more than white people?
>
> Example 41: Season 2, episode 4 and
>
> House: Hmmm. We spent a week doing 'top of head' in anatomy. I know just where it is. [touches the woman's face with two fingers]
> Patient: Ow! That is not the top of my head!
> House: Nah. Close enough for clinic. Your sinuses are clogged.
>
> Example 42: Season 2, episode 8
>
> Patient: You're talking about me?
> House: Lung transplant's about a half a million dollars, but this poor sucker's got no insurance. If he tried to sign up now, he'd be excluded, pre-existing condition. But let me confirm with my lawyer. [looks at Stacy who just stares] She confirms. If only Buck hadn't been diagnosed with fibrosis before he got insurance. So, back to the exam.

In Example 40 House snorts in a ridiculing way after his patient says that he does not want to use a racist drug. After the snort he keeps talking and thus does not give his patient a chance to react. In Example 42 he says that cheeks are close enough to the top of the head for clinic examination and then continues by telling that the patient's sinuses are clogged. In the final example there is impoliteness inside impoliteness. House calls the patient poor sucker, although he does it indirectly inside a story. Again, the patient is not given an opportunity to respond.

To conclude, all different kinds of responses listed by Bousfield (2007) were found in the data. A little less than one third of the face attacks were understood but not responded to, and a little over one third of them were understood and also responded to. Here, however, accepting the face attack was quite rare: most of House's face attacks that were responded to were countered either defensively or offensively. Moreover, one fifth of his face attacks were not understood at all, and respectively one fifth was not showed to the viewer or given a chance to be responded to at all.

7. Discussion and conclusion

The analysis of the data gave a varying range of results. In this chapter I will summarise and conclude the findings and discuss them from different viewpoints. Considering the first research question about which impoliteness strategies House uses in the series, it was found out that all the impoliteness strategies listed by Culpeper (1996) were used. However, all of Andersen's categories of nonverbal communication were not present: two of them, proxemics and haptics (Andersen, 1999), were not involved in any of House's face attacks.

Bald on record impoliteness varied from the extremely explicit ways of insulting into slightly more implicit ways of offending someone. Both verbal and nonverbal communication were used. Nonverbal ways of offending were mostly conveyed through facial expressions but also tone of voice and mood. In part of the face attacks nonverbal communication enhanced the effect of the verbal face attack, whereas in part nonverbal elements formed the face attack alone.

What was notable about the first strategy was that although Culpeper (1996) claims that bald on record impoliteness is common particularly in extremely close relationships, in the data the distant relationship did not prevent House from using this strategy. Reasons for someone using this strategy with relatively unknown people might be that they do not care about other people's opinion in general or that they are highly annoyed and decide to go bald on record because they know that they will never meet that person again. After all, it is in most people's interests to stay in good terms with the ones they are regularly in contact with. Furthermore, it is one of the features of the series that House is impolite and rude towards people, no matter if they are his patients or

colleagues.

Positive and negative impoliteness were the most used strategies. The reason for the high frequency of these strategies could be the fact that positive and negative impoliteness were the only two strategies with a long list of sub-strategies. In point of fact, the problem with Culpeper's (1996) strategies was that bald on record impoliteness often overlapped with positive and negative impoliteness strategies. For instance, a certain instance of impoliteness could be found on Culpeper's list of positive or negative impoliteness sub-strategies, and still be extremely rude and therefore also bald on record impoliteness. Nevertheless, not every instance of bald on record impoliteness represented some of the positive and negative impoliteness sub-strategies, and not every instance of positive or negative impoliteness was necessarily bald on record impoliteness.

Nonverbal communication played an important role in creating impoliteness in positive and negative impoliteness strategies as well. Again, it either created the impoliteness alone or strengthened the effect of verbal impoliteness. The tone of voice and facial expressions were the most common ways of doing this, but the use of oculesics was present as well; House avoided a direct eye contact with his patients.

The fourth strategy, sarcasm /mock impoliteness, was rather infrequent. This was somewhat surprising in a sense that House as a television character is considered to be quite sarcastic in general. In some cases of sarcasm/mock politeness one needed pre-information about House in order to understand the impoliteness, whereas in some cases one could understand the impoliteness because of a general knowledge. Moreover, this was the only strategy which always involved verbal impoliteness, nonverbal elements being there only as strengthening factors. One might argue that this is due to the fact that sarcasm and mock politeness are always primarily verbal phenomena but certain gestures can be sarcastic and mockingly impolite in a certain context as well, for example a thumbs-up in a desperate situation without a solution.

The final strategy, withholding impoliteness, was the most complicated strategy to analyse since it involved detecting something that is not there. In addition, it is a matter of an opinion to a great extent. Some instances of withholding impoliteness involved the absence of manners that are expected from anyone in a normal interaction (greeting,

saying goodbye), whereas other instances involved utterances that are expected from a doctor in an examination, for example telling the patient about the following procedures.

The other research question examined the reactions and responses of the patients. The analysis revealed that many of the patients did not understand House's face attack. Although conversations are written beforehand instead of being spontaneous there may be a few reasons why the patients are made to react as they do. For example, the patients with most absurd problems and peculiar behaviour are made to look stupid. Thus it is logical that they do not understand House's face attacks. In addition, sarcasm and mock politeness are heavily related to context. Often one has to know the person well in order to understand that he is being sarcastic, mocking you, or that he is joking. Furthermore, patients do not normally expect a doctor to behave impolitely and therefore miss the impoliteness completely.

One of the questions that must be raised here concerns the definition of impoliteness. Bousfield (2008), among others, has stated that impoliteness is successful only if the hearer understands it. Based on this one might argue that House is not impolite as long as the patients do not understand his face attacks. In a normal isolated speaker – hearer situation it would undeniably be so. However, conversations between House and his clinic patients involve a third party; the viewer. They understand House's impoliteness although the patients would always not. This is why House is considered such an impolite doctor.

Those patients who understood House's face attacks either remained silent or countered the face attack. Accepting a face attack was rather rare. Moreover, I think that remaining silent is also a form of accepting a face attack, and thus it was rather difficult to separate these two. A countering strategy that the most patients used was mainly defensive instead of an offensive one. For instance, the patients explained their actions after they had been ridiculed or mocked by House.

The fourth type of responding was not being able to do so because House did not give a chance for it, or the response was not shown to a viewer. I combined these two because they are related to the factors of production such as the manuscript and shooting, and thus not relevant considering the second research question.

One of the difficulties in analysing the data was the fact that impoliteness is a very subjective phenomenon. Some people might be offended much more easily by a certain utterance than others. The effect that an impolite utterance has is *a feeling* and it is sometimes rather hard to evaluate whether an utterance hurts someone's feelings or not. Therefore it is highly possible that another researcher would analyse the same data completely differently. However, that is one of the features of qualitative research.

Based on the analysis, a question which arises is what the functions of impoliteness in the series are. Culpeper (2011a) has listed different functions of impoliteness, and one of them is entertainment. This applies to the series: one of clearest functions of impoliteness is, indeed, humour, although in the series it is not targeted at other people present in the situation but at the viewers instead. The degree of the humour is rather dark but it seems to appeal to a large number of viewers today. It has been clear with a number of other TV series as well, such as *Monty Python, the Black Adder, the Simpsons, Six Feet Under,* and *Weeds*. Another function could be to highlight and criticise diverse issues such as diagnosing oneself with the help of the Internet, or refusing a drug that helps only a particular racial group. However, these are merely assumptions and studying the functions would be a good idea for further studies.

Another issue where additional study is undeniably needed is the relationship between impoliteness and nonverbal communication because it has been studied very little. Although I focused on nonverbal aspects in this study, one could expand the research to more spontaneous discourses such as TV interviews or talk shows. One might argue as well that the lack of spontaneity is a weakness of this study; that a written dialogue is less important to study than a real life conversation. In my opinion, however, it is equally important because written drama is made to represent real life situations and themes. Its analysis can provide valuable information on human behaviour and make us understand how communication works as much as a spontaneous dialogue.

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