

Responding to client laughter as therapeutic actions in practice

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Abstract

The widely presumed links between laughter and humour have raised questions about their roles in psychotherapeutic interactions. This study uses conversation analysis to explore client initiated laughter and different kinds of responses to it. By examining sequences leading up to and following client laughter we show two distinctive therapeutic actions that are accomplished. When particular lines of therapeutic questioning are being pursued silence following client laughter functions to prompt further client talk. Client laughter can also occasion rapport building by providing an opportunity for therapists to display they also find something laughable. Both identified actions support important therapeutic work.

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1.0 Introduction

Idioms such as ‘laughter is the best medicine’ and ‘laugh and the world laughs with you’ are commonsense ideas about the psychological benefits of laughing. Interactional research on laughter attests to an element of truth in those sayings. However, it offers a grounded and systematic analysis of the appearance, coordination and actions of laughter in talk. Although not strictly curative, the precise placement of laughter in individual words serves to mark them as a possible source of trouble while at the same time showing resistance to that trouble (Hakaana, 2001; Jefferson, 1984, Potter & Hepburn, 2010). The intimacy and connection joint laughter affords is accomplished by its sequential organization. A first person starts to laughs and soon after others join in. Reciprocating laughter is a way of doing affiliation through showing a shared stance about something as laughable (Holt, 2013, Jefferson, 1979).

While the usefulness of laughter in therapeutic settings has long been recognized, there has also been a concern that it could undermine the serious business of a therapeutic encounter (Saper, 1987). One contribution a conversation analytic approach has made to discussions about the potential benefits and risks of laughter in therapy is to uncouple its widely presumed link with humour. Laughter may have range of interactional roles quite separate from joking or being funny. Potter & Hepburn (2010) go as far as to advocate analytic agnosticism about the function of laughter in talk by proposing it be described in phonetic terms as *interpolated particles of aspiration (IPAs)*. Being undecided about the function of laughter, in the first instance, is consistent with a conversation analytic mentality of grounding interpretations in the observable orientations of what is relevant to the participants (Schegloff, 1997). The present research uses a conversation analytic approach to further advance an understanding of the functions of humour and laughter in psychotherapeutic interactions.

Humour is an important resource in psychotherapy. Therapists regularly use humour - exaggeration, absurdity, wordplay and the like - to invoke a playful frame in response to some kind of interactional difficulty (Buttny, 2001). A playful frame helps to diffuse serious situations. Discussions of delicate matters can be done within a playful frame which is thought to facilitate painful self-disclosure. It can be used to manage non-alignment, for example when responses to therapeutic questions are not forthcoming. Buttny also found humour being used during disagreements such as when clients reject therapeutic versions of their problems.

Research on laughter, as distinct from humour, further develops an understanding of how therapeutic actions are accomplished. In a study of group therapy for addictions, Arminen and Halonen (2007) found that therapists laughed at particular interactional moments to challenge clients. For example, therapists invited group laughter to support their stance that a client's view hindered rather than helped a good therapeutic outcome. The laughter was not being used to invoke a playful frame; rather it was used by the therapist strategically to build allegiances within a group in ways that challenged ideas which were out of line with the therapeutic approach.

The research discussed so far has focused on therapists' use of humour (Buttny, 2001) or their invitations to clients to laugh (Arminen & Halonen, 2007). Buttny suggested that clients rarely initiate humour. On the rare occasions they do, it is to move out of a difficult moment in the therapeutic encounter. In contrast to psychotherapeutic interactions, research on medical encounters has documented patients laugh more often than doctors. In a study of patient laughter in medical consultations Hakaana (2001) found that patient's laughter indexed problematic moments in talk, such as when the patient was presenting an unusual symptom or if the doctor made incorrect assumptions about the patients' health-related behaviours. Haakana also observed that doctor's rarely reciprocated patient laughter.

In this paper we focus on client-initiated laughter in therapeutic encounters. We further

investigate the two different patterns of laughter identified in the literature – reciprocated and non-reciprocated laughter. The analysis seeks to identify and describe the therapeutic actions accomplished in the turns following client laughter. In cases where a particular line of therapeutic questioning is being pursued we show that silence following client laughter functions as a prompt for further client talk. We also show clear cases where clients' laughter provides an occasion for therapists' to build rapport with their clients by accomplishing a joint understanding of a turn as laughable. Our work contributes to interaction research on laughter in psychotherapy by detailing how the functions of laughter are clearly embedded in the structures of turn-taking and sequence.

2.0 Method

The data for this study were sourced from <http://ctiv.alexanderstreet.com>, an online collection of more than 2019 hours of counseling and therapy videos available for study. Four complete therapy sessions were initially selected as data. The criteria for selection were: they were recordings of an actual therapy session (as opposed to role plays or interviews about therapy), each example was a different kind of analytic technique and each contained 5 or more instances of laughter. Those four sessions were fully transcribed using standard conversation analytic conventions (Jefferson, 2004). Excerpts containing laughter from a further 10 sessions, again selected on the basis they were from actual therapy sessions, were transcribed to expand the number of cases. The resultant collection included 144 cases of laughter.

For this study instances were considered if they were hearable as laughter. In line with conversation analytic work, the selection of cases was not dependent on whether they were related to humour or joke telling. Instead a more technical understanding of laughter was used - breathiness either outside or within words - what Potter and Hepburn (2010) have called interpolated particles of aspiration. Following Jefferson (1985), each case of laughter

was carefully transcribed paying close attention to the number of particles of laughter, where the laughter began or ended, and some of its prosodic features such as loudness.

Each case in the collection was listened to multiple times. Notes were made about its position in talk (i.e. within words or outside them, at the beginning, in the middle or at the end of a turn of talk), whether it was responsive or not, and if the laughter was from one person or was shared. The actions the laughter seemed to be accomplishing were also considered. Following a conversation analytic mentality, interpretations of actions were validated by the parties in the interactions – what participants were observably displaying as a relevant action to them. Each case was also evaluated with respect to the literature on laughter in interaction and on structural aspects of therapeutic talk. Did it illustrate or illuminate laughter or other phenomena already described? Additionally, the type of therapy done was considered for how it might usefully inform the analysis of the relationship between an instance of laughter and what it was accomplishing in the talk.

An outcome of the methodological process followed was a focus on cases where clients laughed first. Those cases revealed two different interactional trajectories. Silence following clients' laughter was followed by more talk by the client or the therapist laughed in response. The analysis identified the different actions those trajectories were associated with and the sequential organization of turns scaffolding those actions. In this paper we present 9 cases to support our findings. The examples were selected for their clarity and conciseness.

The video associated with each excerpt can be found by going to the website <http://ctiv.alexanderstreet.com> and following the link 'counseling session' on the left-hand side of the page. Click on the heading 'video type' and it will take you to an alphabetical list of videos of psychotherapeutic sessions. The title of each excerpt below gives the name of the video as it appears of this alphabetic list and the time of the excerpt within the video.

3.0 Analysis

The analysis is structured around two different kinds of response to client laughter that we observed. One kind of response to client laughter is silence. Four cases are shown where the therapist is clearly following a particular therapeutic line of inquiry and the client uses laughter to display a stance towards their response as problematic, namely it does not progress the sequence, thus is nonaligning. The silence following that laughter functions to confirm the client's response is inadequate and to the relevance of more client talk. We then show four cases where client laughter occasions an opportunity for stance alignment or affiliation with a turn as laughable, which is realized with reciprocal laughter. This part of the analysis highlights how therapists' responsive laughter builds rapport between the parties by accomplishing a joint understanding about a turn as laughable. Overall, the analysis shows occasions of client laughter are an important resource for accomplishing two quite different kinds of therapeutic practice – prompting client talk and rapport building.

3.1 Client laughter followed by silence to prompt further client talk

We begin by presenting an excerpt that occurs immediately prior to our first case of silence following client laughter. This excerpt is shown because it clearly establishes that a particular therapeutic line of questioning is in progress. It also illustrates other sorts of practices, aside from silence after laughter that therapists use to prompt expansion of their clients talk.

The excerpt is taken from a solution focused therapy session in which the client has the goal of losing weight and maintaining the weight loss. The therapist is using a particular analytic technique dubbed 'the miracle question', which involves asking the client to imagine their problem has miraculously resolved itself (Berg & DeJong, 2008). In the extract below the therapeutic question is launched at line 01 - "how could you tell in the morning" with subsequent versions of it observable at lines 05 and 07. The therapist receipts the client's tentative answer that she might remember it in a dream is receipted with "okay" at lines 10

and 12 after which the client provides another answer to the question.

(1) Positive *Solution focused therapy, part 1, in brief therapy for addictions* 8 44.48-45.22

01 → TH: how could you ↑tell:: ↓tomorrow morning
02 (1.2)
03 CL: .HHH (3.0) Um: (0.4) (I dunno)
04 (1.2)
05 TH: [>what would let you<]
06 CL: [.hh may]be
07 TH: [<what would make] you think that,
08 CL: [maybe](0.8) ↑ER ↓maybe i could
09 remember something that i dreamed about
10 TH: okay
11 CL: poss:ibly
12 TH: okay
13 (.)
14 CL: um:: (1.2 .hh or (0.2) um:: (0.4) maybe I would (.) be (0.2)
15 <I'll be thinking so posit:ive when I wake up that
16 heh <I wont want to eat as ↓much as I .hh Hi (0.2)
17 normally have or

The beginning of the extract shows the client having trouble answering the therapist's question. Following the question is a long delay (line 02) and then the client responds by signaling her readiness to take the conversational floor with a long and loud in-breath. The client also shows she is searching for an answer with a visible display of cognition "Um". The therapist produces subsequent versions of the question at lines 05 and 07, which was identified by Muntigl and Hadic Zabala (2008) as a therapist's practice for prompting a client to expand on their response.

The first subsequent version of the question was premature from the client's point of view because it was launched in overlap with her beginning to talk more. That unfinished reformulation was on its way to "what would let you (think that)", which is different from a second successful subsequent version, "what would make you think that". Modifying the question reformulation by replacing "let" with "make" intensifies the question and underscores it as a therapeutically relevant line of inquiry.

The client answers the reformulated question in two ways - the first answer is that she could remember something that she dreamed about and the second is she would be feeling

more positive. Both answers are prefaced with “maybe” which construes them as offers. The maybe-prefaced answers are important because they are evidence the client is orienting to the therapist’s authority to evaluate their adequacy. A therapeutically adequate response will fulfill the client’s turn-taking obligation and place the responsibility back on the therapist to progress the interaction. The client’s first response proffer – remembering a dream – is receipted by the therapist with “okay”, which is another kind of response that prompts expansion to a therapeutic line of questioning (Muntigl & Hadic Zabala, 2008). In this case the client also displays her uncertainty about the adequacy of her response when she adds the further hedge to it “possibly” at line 11. The therapist’s second “okay” and the silence shows the therapist is leaving the conversational floor open to the client to continue talking.

Extract 2 begins with the second answer to the question posed at the beginning of extract 1. That answer provides the therapist with a hook that further progresses the therapeutic project launched in extract 1 by making it more specific, namely from “how could you tell in the morning” (extract 1, line 01) to “how could you tell you that you’re feeling more positive” (extract 2 lines 24-25). The target phenomenon - client laughter occurs in response to that that question (line 29).

(2) *Positive Solution focused therapy, part 1, in brief therapy for addictions 8 45.07-45.47*

14 CL: um:: (1.2) .hh or (0.2) um:: (0.4) maybe I would (.) be (0.2)
 15 <I’ll be thinking so posit:ive when I wake up that
 16 heh <I wont want to eat as much as I .hh Hi (0.2)
 17 normally have or
 18 TH: .hh okay ↑we’ll go back a >little bit ()<
 19 CL: [okay]
 20 TH: [when you] feel: (.) more posit:ive
 21 (0.4)
 22 CL: mhm
 23 (1.6)
 24 → TH: How:: (.) >could you< tell: (.) that you’re feeling
 25 → more pos:itive
 26 (1.0)
 27 → CL: I don’t know
 28 (.)
 29 → CL: eh ↑hi hi
 30 (0.8)
 31 → CL: .hhh maybe I hav:e a better (.) att:itude:
 32 TH: okay

At the beginning of extract 2 the client is searching (“um::”) for an alternative (“or”) answer. She treats this response, like the previous one, as tentative by prefacing it with “maybe”. The response is completed with “or”, which projects there are other possible answers and the one that has been given is not certain. The therapist now treats the client’s response as sufficient to progress the therapy because she topicalizes an aspect of it “we’ll go back a bit” (line 18). The therapist targets the theme of positivity. She reformulates the client’s “I’ll be thinking so positive” (line 15) to “when you feel more positive” (line 20) and uses that reformulation to launch a revised question (lines 24-25). The reformulation makes the content more definite. It changes the tense from the future to the present and makes it more psychologically concrete – from thinking to feeling. Reformulating and recycling elements of a client’s turn in relevant ways is a standard therapeutic practice (Antaki, 2008).

The client also has trouble answering the revised and more specific therapeutic question as evidenced by the gap of silence at line 26. Her response claims insufficient knowledge, a kind of account regularly deployed for not answering a question in therapeutic contexts (Hutchby, 2002; Muntigl & Choi, 2010) and in mundane interactions (Beach & Metzger, 1992; Weatherall, 2011). After a short silence the client produces three laughter particles (line 29). Post-positioned laughter particles regularly occur in dispreferred responses such as not providing answers to information questions. Laughter in dispreferred responses regularly function to modulate its nonalignment with the launched action (Shaw, Hepburn & Potter, 2013). In this case the client is displaying a stance towards her response as insufficient for progressing the therapeutic course of action. The therapist smiles in overlap with the last two particles of client laughter showing some affiliation with the client’s stance but remains silent (line 30). That silence functions as a prompt to further client talk, evidenced by the client next answer proffer “maybe I have a better attitude”.

Extract 3 is later in the same therapeutic encounter as extracts 1 and 2 and notably

shares similar features. At the beginning of extract 3 the therapist asks what it would take for the client to change her behavior. The therapist uses the client's response "motivation" to formulate a revised version of the question, which uses the client's answer to further progress shows a therapeutic inquiry. The client's response to "how are you gonna get this motivation", which does not answer the question and is delayed, claims insufficient knowledge to answer and is interspersed with laughter particles. The silence following that laughter is oriented to by the client as prompt for further talk.

(3) Prayer *Solution focused therapy, part 1, in brief therapy for addictions* 8 51.00-51.23

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01 TH: °>what would it take for you to do that<°=
02 CL: =motivation
03     (0.4)
04 TH: okay
05     (0.8)
06 → TH: alright=<so how you gonna get this motivation
07 → CL: mtch.hh £I don't kno(h)(h)w£ [↑hi hi] (.) ↓hi hi hi
08 → TH: [ (eheh) ]
09 →     (1.6)
10 → CL: <maybe if I said a pray:er before I ° go to bed°
11 TH: ↑oh:::
12 CL: that might help .hh I I I I I strongly believe:
13     (.) that prayer works

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At line 7 the client responds to the therapist's follow-up question, after a delay (lip-smacking and an in-breath), with a claim of insufficient knowledge to answer "I don't know". Laughter particles are inserted into the last word of that claim and develop into five laughter particles at the end of the turn. The delay and the account for not answering the question are regular features of dispreferred responses (Schegloff, 2007). In this case the response does not provide an answer to the question. The post-positioned laughter particles function here in the same way as they did in extract 2, to display a stance towards the response as problematic and to modulate its nonalignment as an insufficient answer.

The client's laughter in and after her account for not answering, shows her own stance towards the response, namely that is problematic. Further evidence of the insufficiency of her response is the silence following it, where the therapist could, but doesn't take a turn of

talk. That silence prompts the client to provide another response, where the tentative answer is that she will find the motivation through prayer. Silence places pressure on clients to produce answers which can be used to progress a therapeutic project (Muntigl & Hadic Zabala, 2008). That pressure is perhaps even more effective in cases where clients are already orienting to that nonalignment because they are displaying an understanding of their own answer as insufficient. The client in the above extracts is aligning with the overall therapeutic project by producing possible answers that might progress the therapy. In the extract above, that progression is accomplished when the therapist evaluates of the client's response about prayer as news "oh".

The next extract is taken from a therapeutic session with a couple. The husband (HB) is complaining about his wife (WF) not prioritizing her relationship with him. The therapist asks for a specific example of the type of thing that he is complaining about. Identifying particular patterns of behaviours that can be changed is an important aspect of behavioral therapy which is the style being practiced in this interaction (Deffenbacher 2008). The husband does not answer the question and his responding turn includes laughter.

(4) *Sick Behavioural couples therapy, in couples therapy with the experts* 12 49.16-49.52

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01  HB:  >y'know< I- I'm sure it wasn't in:ntentional °but°
02      (0.6) .hh hh <theres some things that happened that
03      really jus': (0.2) made me cr:awl back inside of
04      myself and say ↓er:: (yeaha)
05 → TH:  <FOR example
06      (0.8)
07 → HB:  mtch (.) .hhhhHHHH HHHHH hi hi .hh °mtch°
08 →      (0.4)
09 → WF:  <(how bout when) you were sick
10  HB:  >that was one of them<

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At line 7 the husband's turn includes two beats of laughter and has other characteristics typical of dispreference including that it is delayed. While he is breathing out (at line 7) the husband turns his gaze towards his wife, and upon the conclusion of his second, and final, laughter particle shifts his gaze back towards the therapist. The changes in the

husband's gaze suggest he is ready to handover speakership rights – an interpretation that is supported by the silence at line 8. The wife takes the conversational floor offering a candidate answer to the therapist question “how about when you were sick”. The husband accepts his wife's candidate answer and goes onto provide further detail (not shown in the above extract) of his ambulance visit to hospital and how his wife waited till she finished work to visit him.

The silence after the husband's laughter functions as a prompt for further talk. In this case the wife takes the floor and produces a possible answer to the therapist's question. As one member of the couple she has some entitlement to knowing about occasions that upset her husband. However, he has primary rights to know about what upsets him about her. The relative rights to knowledge to answer the question are displayed by the wife by offering a candidate answer, which is accepted by the husband. The matter of speakership rights to answer questions aside, the above except is another example of where silence after client laughter functions as a prompt for further talk. In this case, as in the previous two cases the laughter occurs in a responsive turn, so all parties – therapist and client – are orienting to the inadequacy of the response for progressing the particular line of therapeutic inquiry.

Excerpt 5 is the final example of silence after client laughter as a prompt to further talk. The type of psychotherapy is adolescent family therapy. A mother and daughter are present in the interaction, although it is only the daughter (DA) who speaks in the extract below. The therapist is asking about whether homework causes fighting in the family. A follow-up question at line 14 shows a particular line of inquiry is being followed. The client laughter occurs in line 19.

(5) Homework *Adolescent family therapy, in child therapy with the experts 4* 39.08-39.53

08 TH: <what about homework.
09 (0.6)
10 DA: he says ^that he- he knows I could do a lot better,
11 but (0.2) he knows i'll probably improve in (0.4)
12 future, and he kind of (.) for a while he (was
13 [go-]

14 TH: [what makes] him think it will improve in the
 15 future.
 16 (0.6)
 17 DA: denial.
 18 (0.4)
 19 DA: .hhh hhh .hhh
 20 (0.2)
 21 DA: mtch <I don't know
 22 (0.6)
 23 TH: .hh <so what how do you do you go ho:me (0.2)
 24 <to his house> when you have school work,

The follow-up question in line 14 topicalizes an aspect of the daughter's answer to her first question. The therapist asks why the daughter thinks her father holds a view that her school performance will improve (lines 14 and 15). After a delay, the daughter gives a single word answer "denial" at line 17. The therapist remains silent, which can function to prompt further response. At line 19 the daughter laughs, shown in the transcript as an in breath followed by a beat of laughter and then another in breath. Post-completion laughter displays a stance on the turn just completed – in this case that the answer is in some way problematic.

The therapist maintains her silence in response to the daughter's laughter, which prompts a claim of insufficient knowledge to answer. In contrast to extracts 2 and 3 where the claim to insufficient knowledge was a first response to a question, here it is a second response after an answer has already been given. In this subsequent position it seems the daughter is closing down that line of questioning, which is another function of *I don't know* in response turns in therapeutic interactions (Hutchby, 2002). The therapist orients to that closing by asking a question that is formulated as an upshot "so what do you do when you go home".

The daughter's laughter after her "denial" answer displays a stance towards it as problematic in some way, but in this case it is unclear as to what that trouble is. The answer was delayed, which is regularly a feature of dispreferred responses but its form is short and simple, which is typical of a *preferred* response (Schegloff 2007). Some turns are designed to be equivocal as to whether they are serious or not (Holt 2013), which appears to be the

case here. A possibly non-serious answer can be received seriously or with laughter (Holt 2013). The silence after the daughter's laughter in this case is a serious response that upholds the therapeutic integrity of the sequence.

The analysis so far has demonstrated silence following client laughter functioning as a prompt to further talk. In all four cases, a clear therapeutic line of inquiry has been in progress. In excerpts 2, 3 and 5 the particular therapeutic project was observable because revised versions of questions were being asked. In excerpt 4 the therapist was asking for a particular example of a behavior. In all cases the responses had features typical of dispreference. Laughter particles before, in or after a response are a further feature indicating dispreference. Shaw, Hepburn & Potter (2013) suggests that laughter functions to modulate the nonalignment. In this context silence functions as a prompt for further talk because the burden of responsibility to further the therapeutic project remains with client who has yet to produce an answer that will be treated by the therapist as closing the sequence or grounds for expanding it.

3.2 Responsive Laughter to build rapport

The final excerpt in the previous section showed client producing an answer that was designed to be non-serious or at least equivocal in its seriousness. The silence following that answer treated it as serious, which is one possible response to a laughable (Holt 2013). Another possible response is laughter. In this section we show therapist laughter in response to client laughter accomplishes rapport because it accomplishes a mutual understanding of a turn as laughable. In the first two cases it is what the therapist says that becomes jointly understood as laughable whereas in the final two cases it is something the client says.

The first excerpt in this section is taken from a solution focused therapy session. The client is describing how she gave up smoking. We join the interaction as she is explaining how a workplace policy limiting smoking to outside impacted on her smoking – in summer it

was okay but in winter it was too cold. The client laughs as line 5 and the therapist joins her in laughter in line 6.

(6) Easiest Thing *Solution focused therapy, part 1, in brief therapy for addictions* 8 36.06-36.15

01 CL: <it was okay in the sum:mer but in the win:ter it
02 was just (0.4) you know [.hh an-]
03 TH: [good thing you li]ved in
04 mid:west
05 → CL: yea(h)h hi hi [hi hi]
06 → TH: [hi hi] hi hi
07 CL: right
08 TH: ↑ri:::ght

In lines 01-02 of the above extract the client is describing the weather conditions that she had to experience to smoke. Her turn of talk is not complete at line 02 because she is having trouble formulating what is like in winter. Silences and perturbations in a turn of talk can provide entry points for a next speaker to provide possible completions of the turn (Lerner 1996). Completion of a turn of talk by a next speaker is regularly a collaborative action because it displays an understanding of what was going to be said (Lerner 2004). In line 03, the therapist does not provide a grammatically fitted completion of the client's turn but offers a general positive assessment of the location. For the client the harsh winters of the Midwest of the United States of America were a "good thing" because they motivated the client to give up smoking.

The collaborative completion of a turn is effectively an offer to be accepted or rejected (Lerner, 1996, 2004). In line 05 the client accepts how the therapist has completed her turn with "yeah", which has a laughter particle inserted into it. The laughter develops into four clear beats of laughter and in the latter two the therapist laughs with the client and continues laughing for a further two beats after the client stops. The client is treating the therapist's completion of her turn as a laughable and by joining with that laughter the therapist builds the joint understanding of it as laughable.

The pattern in the above extract is consistent with patterns of laughter found in joking

sequences – the participant that launches a joke may not laugh first but only after another participant is audibly laughing (Glenn, 2003). However, joking is an activity that is poorly fitted to therapeutic interaction. Instead seriousness and non-seriousness is an accomplishment that is jointly negotiated over sequences of turns (Holt, 2013). In the above extract, and the one below, the client’s display of a therapist’s turn as laughable provides a possible occasion for non-seriousness. By building up a joint understanding of a therapist’s turn as laughable the important business of rapport building is accomplished.

Extract 7 is from a behavioural couple’s therapy session where the rather delicate matter of physical intimacy between the clients is being discussed. The therapist has just finished a personal anecdote that when he vacuums, his wife interprets it as a signal that he wants to have sex with her that evening. The extract begins as the therapist asks the husband of the couple (HB) about possible things his wife might do to help strengthen desire for her. Perturbations regularly precede delicate matters in talk and the idiomatic metaphor “in the mood” for wanting sex further indicates it as a sensitive topic (Lerner, 2013).

(7) Vacuuming *Behavioural couples therapy, in couples therapy with the experts* 12 59.00-59.24

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01  TH:      .hhh eRm:: (0.8) mtch eR:: <what are some
02           things that i:ris could do °that would° put
03           you in the mood
04           (0.4)
05  HB:      .hh hhh hh
06  TH:      <that don't involve vacuuming?
07 → HB:      HeH Ha ha [ha ha .hh ]
08 → TH:      [eheh hi   ]
09  WF:      eHH
10           (0.6)
11  HB:      °.hh mtch° <I dunno I jus- I Have to have
12           the feeling that (0.4) she r- (1.2) I have to-
13           (1.4) HH I Have to >get over the idea that im
14           going to get hurt again<

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The silence following the therapist’s question followed by the big in-breath adumbrates a dispreferred response. In the face of a dispreferred response the speaker who has launched

the question can move to change it, for example by making it more closed or changing its presupposition. The function of revising the question is to change the way it is formulated with a view to an aligning response (Schegloff, 2007). After the delay, the therapist changes his question by adding an increment to it – a unit of talk that is grammatically fitted to a turn that has already been brought to possible completion (Walker, 2004). The extension of the question to refer to vacuuming recycles something of the previously told anecdote with a twist because vacuuming would likely be housework that the wife did anyway.

The husband laughs whole heartedly in response to the therapist's addition to the question, which displays an understanding of it as laughable. The therapist joins the husband's laughter after 3 beats, which is consistent with the three-part turn structure identified by Glenn (2003) for a joke. The wife also briefly laughs, albeit after the other two have finished, which shows her appreciation of the therapists turn as a laughable. After some further delay the husband offers a hedged response to the question which doesn't actually answer it, instead describing something that he thinks he needs to do to rekindle desire for his wife.

In both the previous extracts the therapist has laughed in response to a client's laughter. By laughing together the therapist shows rapport with clients by building intersubjective understanding of a turn as laughable. In extract 7 the therapist occasioned the possibility of the rapport building at the exact moment when a delicate question had been asked and a breakdown of alignment was possibly imminent. However, it is not always something that the therapist says that is possibly laughable. In the following two extracts where the client laughs first it and the therapist laughs responsively, it is a joint understanding of something the client says as laughable that is displayed.

Extract 8 is from a solution focused therapy session. The therapist is summarising information about the client's life that she has just heard. At line 09 the therapist

compliments the client by expressing surprise at all the things that the client accomplishes in her life.

(8) Kids *Solution focused therapy, part 1, in brief therapy for addictions* 8 24.19-24.45

01 TH: so:: going to school (.) and raising two children
02 CL: yes:
03 (0.6)
04 CL: and working part time
05 TH: <working part [time] on top of all this
06 CL: [mhm]
07 CL: yes
08 (.)
09 TH: wow:: I don't know how you do it
10 → CL: .hh um (1.0) °I don't° ei(h)ther
11 → TH: hi hi ha ha .hh
12 CL: its er (0.4) <sometimes its kinda diffi[cult er-]
13 TH: [°im sure]
14 it is°
15 CL: um (0.6) I seem to manage (0.4) °(er)°

Compliments are a difficult action to respond to in interaction (Pomerantz, 1978). A compliment involves a speaker attributing a praiseworthy attribute or achievement to a recipient. However, conflicting principles exist to guide responses to compliments. On the one hand it is preferable to avoid self-praise; on the other it is best to avoid disagreement. Pomerantz (1978) documented various ways the conflicting principles are handled by recipients of compliments – by downgrading the evaluation (e.g., “I’m not that busy”) or by assigning the reason to an external cause (e.g., “the children help a lot”). In extract 8 the client shows a third type of possible response –agreeing with the compliment but downgrading that agreement by treating it as non-serious - note the laughter particle inserted in “either”.

In response to the client’s laughter, which treats her agreement to the compliment as non-serious, the therapist laughs. Affiliating with the client’s stance towards her turn as non-serious is a way building rapport – where joint understanding and mutual stance is accomplished. In the above extract that moment occasions the client to self-disclose that she finds her life quite difficult at times. Buttny (2001) suggested that an important function of

humour in therapy was to invoke a more playful frame for airing serious issues. The above extract is an example of how a serious matter can emerge from a sequence of non-serious turns.

The final extract in this section is another case where the client laughs first and the therapist laughs responsively. Like the previous extract, the following one is where a joint understanding is built of something the client says is non-serious. We join the interaction as the therapist is suggesting that the husband initiates physical intimacy such as hand holding, even if he does not actually feel intimate. The therapeutic idea behind this advice has its roots in behaviourism – where the observable action is given primacy rather than thoughts and feelings.

(9) Money Back Guarantee *Behavioural couples therapy, in couples therapy with the experts*

12 1.02.17-1.02.37

01 TH: >I can also< guarantee you that its not
02 gonna happen (0.2) unless you a:ct as if you've
03 got it
04 (2.8)
05 HB: hhhh written guarantee
06 (0.2)
07 TH: yup
08 WF: t[hh]
09 HB: [.hhh] the [money back]
10 → WF: [hi hi] .HHH [hi hi hi]
11 → HB: [hi hi hi]
12 TH: I'll take care of the [(kidneys) [you know]
13 → HB: [hi [ha]
14 → WF: [hi] hi
15 [ha ha]
16 → TH: [hi hi] ha
17 (0.2)
18 WF: HI [.HHH hi]
19 TH: [<Are you willing] to do it
20 (2.2)

The therapist underscores his advice by offering a guarantee as to its effectiveness.

Offering such marked advice makes a response relevant with acceptance being the preferred response (Heritage & Sefi, 1992). The relevance of a response to advice is evidenced in the above case where, in its absence, the therapist pursues one “are you willing to do it” (line 19).

The husband responds to the advice by seeking confirmation of the strength of the guarantee by asking if the advice comes with a written guarantee. He then reformulates the guarantee as one that gives you money back. The wife has started laughing after the therapist confirmed the guarantee would be a written one, which turns into more sustained laughter at lines 10, with the husband laughing with her for three beats confirming his turns as non-serious. The therapist further develops the non-serious tone by suggesting the money they get back will be put to good use. The husband laughs for two beats and the wife laughs with him and then the therapist laughs with the wife. The therapist builds rapport by further developing the non-serious theme the husband initiated and by laughing with the clients.

4.0 Discussion

A goal of this paper was to further explicate how laughter functions in psychotherapeutic interactions. By examining what preceded client initiated laughter and what followed it, we have highlighted the importance of investigating laughter and its actions over sequences of turns of talk. Our findings add complexity to what has previously been glossed as therapists' use of humour or the function of laughter to index troubles in talk. They also complement a growing body of conversation analytic literature that documents how psychotherapy is actually done in practice (Antaki, 2008).

We have identified one sequential context where clients initiate laughter. Namely when a particular line of therapeutic inquiry is being pursued and the client produces a non-aligning response such as *I don't know*. Laughter particles after disaffiliative actions work to modulate the non-alignment (Shaw, Hepburn & Potter, 2013). Thus clients display their understanding that they are stalling rather than progressing the therapeutic project. Laughter is a feature like no-fault accounts and palliatives that work to redress the alignment that is threatened by dispreferred responses (Schegloff 2007).

Silence typically followed client-initiated laughter in dispreferred responses to therapeutic lines of inquiry in our data. By remaining silent, the therapist provided an additional turn-taking opportunity for clients to provide a therapeutically adequate response. Essentially, the silence functioned to prompt further client talk replicating a finding in similar sequences that don't involve laughter (Muntigl & Hadic Zabala, 2008). It seems likely that silence after client initiated laughter puts even more pressure on the client to produce further talk by leaving it up to the client to further progress the therapeutic action that has been launched. In our collection of cases the silence was successful in prompting more client talk. Further cases are needed to establish what happens in the absence of further client talk and also to discover what if any circumstances leads to therapists reciprocal laughter following a dispreferred response to a question they have launched.

A second sequential context where clients initiate laughter is to show their stance towards a previous turn as not serious. In that environment, after just a few beats of client laughter the therapists also laughed so the parties were laughing together. The joint laughter accomplished a shared stance towards a turn of talk thereby establishing rapport between the parties. Although the client initiated the laughter in all our cases, the turn that was cast as laughable could be produced by either party.

The turn taking structure that we found accomplished joint laughter has parallels with turn taking sequences that scaffold jokes in everyday interaction (Glenn, 2003). However, in the present context the joint laughter was embedded in larger courses of action involving therapeutic work. As such they are better described occasioning a moment of non-seriousness. Far from undermining the therapeutic project they supported it by building rapport.

In the case of couple therapy, rapport building is quite complex because it involves more than just two parties. In the examples we presented joint stance was built in a stepwise fashion that differently involved the parties. In one case the husband initiated the laughter

that was reciprocated by the therapist and then the wife – the laughable was produced by the therapist. In the other, the wife laughed first at a laughable produced by the husband, followed by the husband laughing and then the therapist. It seems possible that gender or institutional roles may shape the ways rapport is built. Teasing those out in cases of couple therapy may offer some insights into the ways relationship dynamics play out in therapeutic encounters.

Laughter and humour are both separate and related phenomena in therapeutic encounters. Clients can laugh where a particular line of therapeutic questioning is being pursued to index their response as stalling, rather than progressing, that interactional project. Silence following client laughter in that sequential environment functions as a prompt for further client talk. Client laughter can also display a stance towards a previous turn of talk as laughable. Such moments provide an opportunity for therapists to build rapport by showing they share that stance by laughing with the client. The distinctive therapeutic actions accomplished in the turns following client laughter highlights a close attention to sequence is key to understanding what is accomplished in interaction.

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