# Questioning the importance of being earnest:

# A conversation analysis of the use and function of humour in the serious business of therapy

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**Contents**

**Disclaimer:**

*"Analyzing humor is like dissecting a frog.*
*Few people are interested and the frog dies of it."*

***E.B. White***

quoted in Carr & Greeves (2007)

**Preface**

In one of the key practical guides to Conversation Analysis (CA), ten Have (2007) addresses the issue of presenting CA work. He argues that the nature of CA research does not lend itself to the traditional format, asserting that “there is not one ideal ordered way to use the data or refer to the literature” (ten Have, 2007; p221). In writing this thesis, it has been difficult to impose the traditional format on the research process. Reading ten Have’s (2007) section on publication is reassuring that this is a common experience. The structure conforms where possible, but there are notable deviations in line with CA convention such as an alternative approach to the method section and combining results and discussion. It would be appreciated if the reader would bear these considerations in mind when reading this piece of work.

## Chapter 1: Abstract

This thesis explores the long-standing debate in the field of psychotherapy around the use of humour in psychotherapy and the shift from outcome to process research in psychotherapy research. In line with the social constructionist framework of this study, the researcher's position is outlined. The literature review describes the link between language and the construction of both the therapeutic relationship and humour. The functions of humour in psychotherapy are outlined, and the contribution that Conversation Analysis (CA) can make in this evolution. CA, with its focus on the social action of talk, is employed on three audio-tapes of psychotherapy within this research to identify the resources drawn upon by interactants, and to examine the sequential environments in which humour arises and the responses to humorous utterances.

Linguistic devices used to create humour included hyperbole, irony in conveying contrasting incongruent frames of reference, repetition, empathic self-disclosure, sarcasm, facetiousness, normalising statements, humorous impersonation and anthropomorphic personification. Humour emerged in the sequential environment of repeating and elaborating on diverging viewpoints outside of therapy. Humour in the context of persuasion and resistance functioned to dismantle client resistance and contrast their competing perspectives. Humour made in the context of uncertainty exaggerated pre-existing conversational disruption, allowing a move into repair. Humour was used to contrast new and old ways of viewing situations in the process of therapeutic change. Therapists used humour strategically to move into therapeutic tasks such as formulation, reinterpretation, lexical substitution, invitation to express emotion, praise for following an intervention and empathy.

Results are discussed in relation to humour's potential place in pertinent areas of therapy such as the therapeutic relationship, empathy and emotional connectedness, unconditional positive regard, congruence, resistance, uncertainty and change. Clinical implications are summarised drawing on these concepts. Strengths and limitations of the project are outlined, future research suggested and reflections by the researcher conclude this thesis.

## Chapter 2: Introduction

### Overview

In this section social constructionism will be described as the overall theoretical and paradigmatic framework of this research. Assumptions around language, on which both humour and therapy are dependent, and psychotherapy research will then be addressed. In line with the framework, the researcher's own beliefs and experiences around the subject will be explained in order to maximise transparency of possible influences in the way therapy and humour in therapy may be construed. In the review of the literature which follows the unique aspects of communication in the context of therapy and the therapeutic relationship will be outlined, before providing a brief definition of humour. Having established humour and therapy as constructed in conversation, the specific functions that humour may perform in therapy will be outlined, with a focus on the use of CA in studying therapy and the use of humour. The introduction section will close with a rationale, specific aims and research questions for the study.

### Theoretical and paradigmatic framework

> At heart, the personal exchange defines psychotherapy.
> All else flows from it.
> - Marzillier (2004, p. 394)

Therapy can be viewed as communication or as rhetoric (Strong, Busch & Couture, 2008). In studying communication, it seems necessary to consider existing definitions of the intended unit of analysis, particularly the relationship between language and what it may be considered to represent. At the 28th International Congress of Psychology, Gergen (2000) argued that there were three assumptions in this area that needed to be addressed as psychological science progressed into the new millennium.

According to Gergen (2000), the *realist assumption* embodies those ideas that suggest that there is a discernible 'reality', and that words can, and should, reflect this 'reality'. However, this perspective has been criticised as naïve by some for its simplicity and neglect of the centrality of how language creates and reflects meaning we make of the world (Burr, 2004). The *subjectivist assumption* reflects the widely

held belief that we exist in our own private worlds and that speech is considered to be an outer expression of the inner world. This is an important assumption to acknowledge in relation to therapy, given the perceived significance of the intimacy that is reflected in sharing independent subjectivities. However, Gergen (2000) cautions that one can never truly access another's inner world. Attempts at doing this unavoidably draw on the interpreter's stand-point as a framework for sense making. The *strategic assumption* politicises language as an influential promoter of social action. Thus language becomes reasoned and purposeful, but pessimistically characterises people as manipulative and self-serving.

As questions are raised about the nature of language, the foundations of knowledge are then called into question. Psychotherapists engaging with this debate are becoming increasingly disillusioned with current ideology (Gergen, 2000). Questions are accumulating around proscribed diagnostic approaches to mental health, the rigidity and manualisation of treatment approaches, the questionable 'truth' behind value-laden academic conclusions and how these truths can be inter-connected to create a seemingly 'robust' assembly of 'facts' that form the knowledge base (Gergen, 2000).

Some of the literature reflects this idea, by sampling from a range of sources, from comedians, linguists, sociologists, playwrights, philosophers and psychologists. Humour is such a diverse and interesting field that it invites opinion from a range of perspectives, from which arguments can be made in varying degrees of eloquence and empiricism. From a social constructionist perspective value ascribed to each of these diverse sources remains equal, considering each perspective to contribute something insightful. The origins of these viewpoints will be outlined, in order that the relevance and empirical weight of these eclectic sources be gauged in relation to academia and the discipline in which this research is located: clinical psychology.

It may be useful to consider how humour can be located within the paradigms described above. From a sociological perspective, Davies (1995) claims that humour is resistant to the methodological probing of realism and scientific empirical enquiry. Quantitative researchers have therefore redirected their curiosity (Wiseman, 2008). Davis (1995) claims the explicit logic of science is in combat with the ambiguous logic of humour. Mulkay's (1988) sociological view clarifies this point, suggesting that

scientists pursue a social phenomenon's single correct interpretation whereas humorists demonstrate its multiple interpretations. This point is echoed by the comic musician Victor Borge (1984), who argued there was “more logic in humour than in anything else, because, you see, humour is truth” (p1). However, it seems that his truth and logic differ greatly to empirical logic and realist ‘truth’ to which scientists strive. A drive toward a single focus of attention generates scorn for the multiple interpretations of humor, as the scientific discourse regards the study of humour as ‘undisciplined’, unaware that humour may require a different discipline.

The framework of this research, social constructionism, embraces such multiplicity that is at the heart of both humour and therapy. Burr (2004) describes the principles underpinning this perspective for a clinical psychology audience. First, knowledge should not be taken for granted, but rather critically evaluated acknowledging the influence of inherent assumptions within which ideas are embedded. Second, these assumptions are a product of, and specific to, cultural and historical contexts. Third, these ideas are constructed and maintained in social interchange, in sharing ideas and negotiating versions of events. Fourth, constructions of the world enact some social action, promoting some responses and inhibiting others, further influencing what is permissible and how to interact. Burr (2004) highlights the importance that language plays in constructing the world and draws the focus of interest, or unit of analysis in research, around to the conversation. It is language, she argues, both in its form and its use, that is central to the making, maintenance and contesting of meanings that contribute to how the world is socially constructed (Burr, 2004).

To use social constructionism as a lens through which to focus on humour and therapy seems important. Humour is a feature of everyday conversation and, as discussed later, usually requires joint construction. Similarly, therapy is a collaborative process dependent on the interface between two ways of viewing the world. The multiple interpretative perspectives explored in therapy and the dichotomy of meaning inherent in humour both fit well with the multiplicity of a social constructionist framework in which this research is located. Having considered how the framework fits the subject area of the research, the methodology will now be situated within this framework.

Social constructionism not only takes a critical stance on knowledge, but also on what constitutes evidence and the means by which it can be produced. There has been a growing movement towards questioning psychotherapeutic evidence and research (Marzillier, 2004; Loewenthal, 2006). Strong et al. (2008) combine their clinical, academic and research perspectives in a peer-reviewed article to argue that two major assumptions require a critical stance. One assumption is reflected in the tendency for therapy research to separate the intertwined ideas of conversation (process) from evidence (outcome). The other is the privileged position bestowed to measurable and quantifiable outcomes within the evidence base. Strong et al. (2008) move for a shift from empiricism ("taken-for-granted and near exclusive use of experimental methods and psychometry in evaluating psychotherapy outcomes" p391), where outcome *is* evidence. Instead, they urge researchers to place a higher value on conversation as evidence for evaluating psychotherapy. Originating in Evidence Based Medicine (EBM) and cultivated in a medical paradigm, statistically derived evidence helps to argue questions of probability of effectiveness, but neglects questions such as 'how' or 'why' relevant in this research. Hierarchies of forms of evidence therefore need to be sensitive and specified to the research question being asked (Evans, 2003; Miller & Jones-Harris, 2005). This thesis is more interested to explore how and why questions, and will therefore put less emphasis on traditional hierarchies, which are headed by outcome evidence and randomised control trials (RCTs). Rather, the thesis places value on the process level research.

Perakyla and colleagues (2008) collaborated to publish a selection of studies from this alternate conversation-based perspective in psychotherapeutic research. They critique the EBM paradigm and its assumption that brands of psychotherapy are treated as if the interactions in which therapeutic moves are achieved were uniform, and thus overlooked. This ignores the central tenet of psychotherapy: that each person is an individual (Leudar et al., 2005) and that therapy should reflect this (Stiles, 2008). Perakyla et al. (2008) have claimed that "the assumption about a standardised therapeutic 'input' is therefore unjustified". Conversational evidence, Strong and colleagues (2008) argue, reflects how therapists accomplish therapeutically relevant developments in their talk.

RCTs have long been coroneted as the 'gold standard' in research following the National Service Framework for Mental Health (Department of Health, 1999).

However, more recent political moves by the American Psychological Association (APA, 2006) widened the scope for other methodologies to receive higher positions in the realm of research. Whilst RCTs preside in the political domain, others remain more focused around how "change is the evolution of new meaning through dialogue" (Goolishian & Anderson, 1987, p.48). CA is a methodology that uniquely promises a detailed insight into how this is achieved (Streeck, 2008).

In their book *Psychotherapy Process Research* Rennie & Toukmanian (1992) draw a similar distinction between paradigmatic (outcome) and narrative (process) approaches (Bruner, 1986). The CA methodology utilised in this research is considered by many to fall within the narrative realm (McLeod, 2003), fitting with Riessman's (1993) comments that narrative analysis:

> ...examines the informant's story and analyses how it is put together, the linguistic and cultural resources that it draws upon and how it persuades a listener of authenticity. Analysis in narrative studies opens up the forms of telling about experience, not simply the content to which language refers. We ask, why was the story told *that* way? (p. 2)

One of the principles of conducting research from a social constructionist and 'narratology' perspective is that it is not value-free. In keeping with this principle, it is important to alert the reader to the author's own potential biases as a researcher in approaching this task, in order that the reader can consider why *this* story is being told in *this* way.

**Reflecting on the researcher's position**

From a social constructionist perspective, it is important to make explicit the author's assumptions and experiences around humour and its use in therapy. Humour has always been an important part of my life, and perhaps part of how I construe myself. The first time I thought explicitly about humour was when someone at school surprised me by describing me as funny. For an 'awkward' eight year old girl joining a school two years after most other children had negotiated and established their friendship groups, funny became for me both a social lubricant and a social

commodity. Whilst well received by peers, a frostier reception could be expected by some teachers, who perhaps viewed my use of humour, sometimes rightly, as an expression of defiance. Some of the greatest teachers for me were those who not only enjoyed the humour of the students, but also injected their own brand of humour into otherwise dull subjects.

Since starting the DClinPsy course, I have become increasingly aware of my use of humour. For example, in 'mindfulness' (Teasdale et al., 2004; Fauth et al., 2007) sessions on the course I recognized that my reaction to novel and unusual experiences was an internal comic monologue and stifled laughter. As a Trainee Clinical Psychologist, my experience of academic teaching and clinical practice has raised the use of humour in general, and more specifically in therapy, as salient questions for me. This tendency towards the amusing became more questioned as I detected messages portraying humour as an unhealthy way of distancing oneself from strong emotion.

Core conditions for developing a therapeutic relationship proposed that I remain congruent and therefore faithful to this aspect of personality. However, other messages that I was interpreting from training were that empathy is more formulaic, and that therapy is a serious business. This puzzling internal dilemma was represented by the discrepancy in styles of my first two supervisors: one prioritised establishing a sound therapeutic relationship and the other enthusiastic about technical aspects of therapy. Furthermore, the former fascinated me in his ability to convey therapeutic ideas seamlessly in an informal and often humorous way.

An informal conversation with a group of Clinical Psychologists complicated matters further. Some viewed humour in clients suspiciously or as 'pathological' in people who desperately attempted to amuse their depressed mothers, recycling the stereotype of the sadness behind the smile of the depressed comic[1]. They recounted their challenging experience of working with comedians, which they described as littered with jocular obstacles. From this confusing picture, I struggled to extract a satisfactory conclusion and was passionate about continuing this interesting debate through my thesis. The literature review which follows is an attempt to clarify the different perspectives in this contentious area.

[1] Interested readers in dispelling this urban myth are directed to Carr & Greeves (2007) and Rotton (1992)

## Chapter 3: Literature review

The previous sections on the methodological paradigm, theoretical framework of this research and the position of the researcher will hopefully have oriented the reader to the focus on the process level in the following literature review. First, the therapeutic relationship will be outlined as conversationally achieved in order to locate this important interaction within the chosen theoretical framework. A brief definition of humour will then be offered, which is viewed in a multiplicity of ways. Brief mention will be made of therapeutic approaches that make humour a goal of therapy, before outlining the function of humour in therapy. Following this, the function of laughter will be discussed separately. Finally, the contribution of CA to the use of humour in therapy will conclude the literature review.

### The therapeutic relationship

The therapeutic relationship has been recognised as important in psychotherapy, first intuitively in clinical practice and then more recently quantitatively and academically (Catty, 2006). In the psychotherapy literature, it has been identified as one of the most powerful predictors of therapeutic outcome (Horvath & Symonds, 1991; Wampold et al., 1997; Lambert & Barley, 2001). Bordin (1979), emphasising the commonality across modalities, defines the therapeutic relationship as the client's "positive collaboration with the therapist against the common foe of pain and self-defeating behaviour" (Catty, 2006: p. 221). Conceptualised by some to consist of tasks, bonds and goals (Bordin, 1979; Safran & Muran, 2003), the therapeutic alliance is often discussed as an interpersonal process or a conversational achievement. The concept of the therapeutic relationship remains complex, since a multiplicity of distinctions and similarities can be drawn between the therapeutic relationship, therapeutic alliance, working alliance and transference (Catty, 2006). The discourse in the literature is often around how it is the responsibility of the therapist to establish and maintain a therapeutic alliance, often overlooking the client's contribution (Lambert & Barley, 2001).

Roy-Chowdhury (2006) recently posed the important question of how the therapeutic relationship is talked into being. Using discursive methods to analyze transcripts of family therapy, this systemic family therapist found that "it is necessary for the therapist to be a master conversationalist, capable of interrogating each speech act, by herself and others for the possible meaning concealed within it" (Roy-Chowdhury,

2006, p. 171). The therapeutic relationship as evidenced in his research by engagement was most successful when "there is a demonstrable flexibility of the therapist" (Roy-Chowdhury, 2006; p. 168), or the ability to be able to shift conversational strategy. Roy-Chowdhury (2006) argued that this engagement was necessary before specific therapeutic interventions could be deployed. The absence of such flexibility resulted in resistance. This resistance was conversationally speaking described as the repeated reemergence of unrepaired trouble sources in the conversation, which served to subvert therapeutic aims. This concept of resistance has been further elaborated through the use of CA, revealing a range of conversational strategies. These include the aforementioned reasserting or revising trouble sources, but also non-uptake of aspects of a prior turn, managing and rejecting topic shifts, and the withdrawal of cooperation (Madill, Widdicombe & Barkham, 2001).

The therapeutic relationship, a concept of considerable importance and originating in psychoanalysis, has been paralleled with Rogers' (1951a) humanistic core conditions of therapy (empathy, unconditional positive regard, congruence). Having broadly discussed the therapeutic relationship above, it is important to acknowledge that the core conditions are not mutually exclusive or distinct concepts from the therapeutic relationship but these terms overlap and interlink (Lambert & Barley, 2001; Catty, 2006). No articles were found on how the latter two features of the therapeutic relationship are 'talked into being'. Therefore, literature on empathy will be given particular attention in the section below.

Empathy has been defined as a general psychological concept as "the ability to imagine oneself in another's place and understand the other's feelings, desires and reactions" (Encyclopaedia Britannica, 2009, p.1). Empathy is considered to be both a personality characteristic of the therapist and an important component of therapeutic conversation (Duan & Hill, 1996). Emotional connectedness is considered by many to be a pre-requisite for a successful psychotherapeutic relationship (e.g., Frosh, 1999, Pocock, 1997). Duan & Hill's (1996) article summarizing the research on empathy, highlighted the distinction between cognitive and affective empathy, the former being the intellectual understanding of another's experience and the latter being the partaking in the same emotional state as the other (Bachelor, 1988; Duan & Hill, 1996).

Additional categories of sharing and nurturant empathy are suggested by Bachelor's (1988) content analysis of client perceptions of empathy. The former is the perception of empathic connection as a result of disclosure of relevant personal experiences or opinions, whilst the less empirically supported 'nurturant empathy' is achieved through being perceived as attentive and supportive.

Empathy has been described as an interactional achievement for almost 30 years (Barrett-Lennard, 1981), but it is only recently being demonstrated as such through the use of CA (Wynn & Wynn, 2006). Conversational phases of empathy can be identified as the therapist's 'resonation' with the patient's experience, the therapist's expression of empathy, and the client's reception of it (Barrett-Lennard, 1981; Wynn & Wynn, 2006).

**Defining humour**

Humour theorists Chapman & Foot (1976) clarify humour's multiple meanings as a stimulus, response and disposition. They quote the dictionary as defining humour as referring to that "which causes 'good-tempered laughter' (stimulus); or 'cheerful and good-tempered amusement' (response); or 'the capacity to see the funny side of things' (disposition)" (Chapman & Foot, 1976, p3). When considering humour as stimulus, there are three main theories offered by the field of philosophy to explain humour, summarised in a series of articles by Lippett (1994; 1995a; 1995b): incongruity, superiority and release.

Incongruence between competing ideas gives rise to humour and includes concepts of "the absurd, the unexpected, the inappropriate or out-of-context events" (Foot, 1997, p. 261). Some argue that incongruity alone is sufficient as long as it is perceived in a playful context (Rothbart, 1976), whilst others implicate the role of its sudden perception (Koestler, 1964) or resolution (Suls, 1972). This semantic theory is developed by linguists Raskin & Attardo (1994) into the General Theory of Verbal Humour and highlights the violation of conditions of truthfulness and relevance established in other forms of communication. The superiority theory explained humour as triggered by the observation of others' infirmities and failings, leading to the delight in the downfall of those we dislike or pity. Release theorists' ideas are wrapped up in expenditure and economy, explaining humour through emotional displacement, in that energies are expended on one emotion and the humorous twist can leave them redundant.

Stand-up comic Jimmy Carr, in his quest to understand his trade, concludes in his quasi-academic book that a person's affinity to each particular theory may be more telling about the theorist's outlook on life than about the nature of humour, using amusing examples of 'promiscuous' release theorists and competitive 'superiorists' (Carr & Greeves, 2007). This view links well with social constructionism. With as many explanations of humour as there are humour theorists, each theory of humour is as individual as each person's own sense of humour. An essay by Professor of Speech Communication John Meyer (2000) bolsters Carr's point, highlighting the ease with which each theory of humour can be enlisted to explain a humorous utterance. Meyer (2000) argues the importance of a departure from the mechanics towards understanding it as an active and strategic device employed to achieve certain ends (Dallos & Urry, 1999).

Davies' (1995) sociological approach to the study of humour uses Mulkay's (1988) phenomenological slant of constructionism, symbolic interactionism and post-modernism to describe a novel interpretation of humour. Mulkay (1988), viewing the world as constructed, arbitrary, multiple and tenuous, argues that humour is a *mode of perception* that can comprehend the social world's multiple realities (Davies, 1995). The humorist, in this view, literally sees the world differently from the serious person. Rather than considering humour *as* incongruence, it shifts thinking towards the ability to perceive and hold simultaneously incongruent viewpoints. Seriousness, he argues, represents the search for certainty through a monistic unitary interpretation, viewing incongruence, inconsistency and paradox as problematic. Humour, however, considers them a given (Mulkay, 1988). Humorous discourse, whose language of collaboration accepts diversity, embraces the multiplicity of social realities more comfortably than the serious, in particular the scientific whose language opposes and dominates that to which it is exposed (Mulkay, 1988). In an important distinction from other theories humour, in Mulkay's view, does not merely reflect social difference, but it is pivotal in revealing it (Davies, 1995).

Given that humour can be seen as both a conversational device and interactional achievement serving a social function, interest should focus not on what humour *is,*

but rather on what people *do*. Similarly, the therapeutic relationship was described as a conversational accomplishment. Having established both humour and therapy as interactional accomplishments, the next section will explore the relationship between the use of humour in the context of therapeutic talk.

**Humour in therapy**

The use of humour in therapy has been a topic of great interest in the last 20 years, generating a collection of interesting titles (Buckman, 1994; Franzini, 2001; Fry & Salameh, 1993; Gelkopf & Kreitler, 1996; Haig, 1988; Kuhlman, 1984; Lemma, 1999; Rutherford, 1994; Saper, 1987; Strean, 1994). Martin's (2007) chapter on therapy in his text book *Psychology of Humour* summarises how its therapeutic potential is heralded by a range of diverging therapeutic approaches (Adlerian, behavioural, cognitive, psychoanalytic, rational-emotive and strategic family therapy) to treat a range of psychological problems (depression, stress-related disorders, obsessive compulsive disorder, phobia, personality disorder, schizophrenia and learning disability) using individual, group, family and marital counselling modes of therapy for clients across the life-span.

Before talking about the function of humour in therapy, it may be worth briefly making special mention of when humour is viewed as the goal of therapy. Rational Emotive Therapists (RET) employ humour with people who are perceived to take life too seriously (Ellis, 1977a). A specific goal of RET is the development or re-discovery of a sense of humour and movement away from seriousness (Martin, 2007). Ellis' (1977a) use of humour has been criticised for being aggressive and confrontational, although he assures critics that it is done in an accepting way, promoting a form of self-acceptance of foibles. Provocative Therapy's (Farrelly & Lynch, 1987) use of humour resembles RET in challenging beliefs, feelings and behaviours, and for this semblance shares the same criticisms.

Natural High Therapy (O'Connell, 1987), emerging from the ideas of Jung and Adler, represents a less confrontational therapeutic approach. Resonating with the ideas of Maslow's (1943) humanistic hierarchy of needs, people strive towards self-actualisation, a state of being whereby environmental, physical and basic psychological needs are met. A 'healthy' sense of humour, as a defining

characteristic of self-actualisation, is both the desired destination and the route to its achievement, “the royal road towards self-actualisation” (O’Connell, 1981; p561).

**The function of humour in therapy**

There is a wealth of diverse empirical research around social functions of humour, whilst much of what is written about humour in therapy is largely opinion-based with little investigated empirically (Golan & Jaffe, 2007). As mentioned before, and in line with the theoretical framework, the area of interest now lies in how and why people *do* humour rather than what it *is*. In this section theories around the function of humour in the wider field will be integrated with available academic and clinical opinion in the therapeutic setting in order to review the range of possible functions it could perform in this context. It is acknowledged that it is not clear whether these general humour studies are generalisable to the therapy setting. Given the paucity of empirical research in this field, the more general empirical research may add to an understanding of how humour might function in the therapy room. In the following section studies applying CA to therapy sessions will be presented in more detail to demonstrate empirical findings specific to this context.

Meyer (2000) takes each of the philosophical theories outlined above and considers humour’s possible function in a variety of situations:

> Each theory of humor origin does seem especially fitted to specific situations: relief humor for relaxing tensions during communication in disconcerting situations or relating to a controversial issue, incongruity humor for presenting new perspectives and viewpoints, and superiority humor for criticizing opposition or unifying a group. Their dilemma when explaining rhetorical uses of humor arises when each seeks to explain all instances of humor. (p. 316)

There seems vast potential in therapy for the functions outlined above. Meyer (2000) used these competing theories to devise a continuum of humour’s social functions which spanned identification, clarification, enforcement and differentiation. This organises the function from cohesion to division. Robinson & Smith-Lovin (2001) summarise the social function slightly differently by including meaning making, cohesion building, and tension relief. Whilst the former two can easily be located in Meyer’s (2000) classification, tension-reduction appears to offer something new and will be added as a function separately in summarizing the literature below. Each of these five functions will be described in turn and used to structure the views and

available research around the function in therapy, although these categories may overlap.

Much therapy outcome research attributes success to effective conveyance of empathy, caring and genuineness (Bachelor & Horvath, 1999), mirroring Rogers' (1951b) humanistic ideas. From this perspective the interpersonal relationship between the therapist and client is considered the main vehicle for therapeutic change (Teyber, 1988). Humour could be equally instrumental in conveying or contravening therapeutic conditions. Since there is general agreement on the importance of the quality of a therapeutic relationship, the potential role of humour in the triad of conditions necessary for a secure and trusting alliance will be discussed when relevant.

*Identification*

Humour's contribution to overall therapist effectiveness, independent of orientation, through its unifying function (Meyer, 2000) could be a valuable resource (Martin, 2007). Yalom (1985) discusses the role of humour in group-belonging and acceptance, fostering care and mutual support. Meyer (2000) argues that humor functions to build a supportive relationship by identifying a person with others, creating cohesiveness (Graham, Papa, & Brooks, 1992).

Nelson (2008) in her review article suggests that in the initial stages of therapy, humour could function as affiliative behaviour. As with other social relationships (Kuhlman, 1984), humour represents an important variable to establishing and maintaining a positive therapeutic relationship through building rapport. This has been confirmed both by clients through interview methods (Bedi, et al., 2005), and therapists through survey methods (Franzini, 2000). In the field of communication, Winick (1976) postulates that, in general conversation, feelings that might normally be blocked by the lack of a socially acceptable outlet may be communicated safely through the use of humour. The implications for both the expression of emotion and its facilitation to enhance empathic connection are clear.

In the field of communication a sense of humour has been experimentally manipulated and found to be an important factor in developing relationships, particularly in reducing uncertainty (Graham, 1995). It is hypothesised to function as an attempt to release tension and make people feel more comfortable as they are

brought up to a more equal relationship (Meyer, 2000). Given the power imbalance inherent in the therapeutic relationship, humour could operate to mitigate implications of this imbalance. This affiliative function, if taken to more compulsive levels, could form part of the client's clinical picture through placation. Nelson (2008) enlisted attachment theory (Bowlby, 1969) to argue that through humour's identification function, client use of humour may represent a form of compulsive care-giving, perhaps to entertain and lighten the mood of others.

Franzini's (2001) article in the *Journal of General Psychology* constructed a case for the inclusion of humour's role in therapy, in order for greater awareness of its potential uses and risks. He claims that humour, through a process of constructive self-disclosure, allows the therapist to be perceived as human (Franzini, 2001). Gelkopf & Kreitler (1996), in reviewing the potential of humour in cognitive therapy, argued that the use of humour makes a therapist more attractive. These factors may influence and enhance their credibility (Chang & Gruner, 1987; Gruner, 1967, 1985; Malone, 1980), which will impact the likelihood a person will wish to identify with and listen to that person. Conversely, Kubie (1971) explains that as a form of self-disclosure, humour can be considered as a violation of the neutrality of the therapist. However, Jolley (1982) criticizes therapists who do not use humour, suggesting that they might have difficulties with closeness and power. He explained that in using humour, therapists share some of themselves and lose some of the power privileged to the therapist through anonymity and the uni-directional flow of information. Therefore, the choice of whether to use humour may be a reflection of core principles around the nature of therapy and therapist preference. This makes relevant the core condition of congruence between both therapist and therapeutic modality.

*Clarification*

From other perspectives humour is used more as a therapeutic tool or technique, which can rely on humour's function of clarification. In Fry & Salameh's (1987) *Handbook of Humor and Psychotherapy* humour is thought to potentially demonstrate novel positive perspectives, and facilitate a new realisation that previously insoluble problems are solvable (Salameh, 1987). Killinger (1987) (in the same volume) talks about how sensitivity in therapy can be demonstrated by verbal picture-painting, with humour as a useful way to maintain psychic distance whilst shifting clients from a fixed view of themselves or the world. Similarly, in personal construct psychotherapy (PCP) (Kelly, 1991) humour is considered in terms of its

potential to experiment with experience, break free from rigid interpretations and develop more flexible construing, which is argued to engender freedom, choice and empowerment (Viney, 1983). Humour dealing with multiple interpretations and meanings, fits well with PCP's constructivist perspective: it allows a person to move away from naïve realism and offers a change of perspective. It is also thought to provide a common ground for communication or a 'play space' (Gelkopf & Kreitler, 1996) between therapist and client, whilst maintaining and clarifying the complexity of a dilemma (Viney, 1983).

Comic novelist Rosten (1961) described humour as "the affectionate communication of insight" (p15-16). Other writers, reviewing opinion around its therapeutic potential, support this idea and consider humour as a way of acknowledging and accepting another's imperfections (Lemma, 2000). Albert Ellis, founder of RET and proponent of humour in therapy, argued its benefits in an article (1977a) and video (1977b) in which he demonstrated some of his own therapeutic strategies through humour. He showed that humour may help a person to take a more tolerant view of themselves and what they see as their imperfections, but also of the world when it falls short of their expectations or generates feelings of uncertainty. In addition to its role in drawing attention to short-falls, humour could be pivotal as an agent of change. In an article about the contribution of developmental theory to understanding psychotherapeutic change, Stern (1998) talked about moments in therapy where there is an inter-subjective state engendered between therapist and client. This inter-subjective state contained an element of surprise, unpredictability and represented a non-linear jump. This description parallels neatly the qualities used to describe humour, suggesting its potential as powerful therapeutic intervention. Indeed, Buttny's (2001) use of CA on therapy tapes confirms its use in the therapeutic task of 'reframing'.

Further purported benefits that fit with its clarification function include humour's role in making content vivid and memorable (Ellis, 1984). Martin's (1991) description of the social–cognitive construction of therapeutic change emphasizes the importance of memory variables in successful therapy. Retention of new insights in clients' memory of therapy is essential in generating and sustaining client change. Humour's vividness and promotion of greater recall of information, demonstrated in published

studies from a communication perspective (Goldstein, 1976; Gruner, 1967), ensures that as much as possible of what is discussed is remembered beyond the session.

*Enforcement*

Haugeland's (1988) essay interprets philosopher Heidegger's views as categorising people as essentially conformist, compelled to correct those who deviate from their perceived social norms. Wolf's (2002) article from a social behaviour perspective focused on the relationship between humour and normativity. To be rational, he argued, a person must be both obedient and protective of their norms by discouraging deviance and reinforcing adherence. Graham et al. (1992) review the literature around the function of humour. They share Wolf's (2002) view that humour allows a person to construct and enforce norms delicately by softening criticism while maintaining some degree of identification with the recipient. Within therapy, these norms of how people think, behave and feel are frequently addressed and challenged. Humour may offer a gentle or mitigated means by which to encourage a client to both become aware of their own internalised norms, the opportunity to consider others norms and promote change.

However, norms are inevitably influenced by socio-demographic characteristics. Given the social power dimension emerging from humour research, it is important to briefly consider issues of gender, humour and its function of enforcement. Men have long been described in the literature as more likely to engage in conversational humour (Middleton & Moland, 1959), a difference evident from when humour is first developmentally emerging (Castell & Goldstein, 1976). Levine (1976), in analysing stand-up comic scripts, found a big difference in the amount of self-deprecating humour used by comedians (12%) and comediennes (63%). Self-deprecation can be seen in this light as reflecting that a person does not feel above the rules of society, but excessive use can indicate how a person submissively constructs their social status in the world (Foot, 1997). This could be seen as a way in which people self-enforce perceived norms in subtle ways. Within therapy this is an important point to understand client use, as self-deprecating humour could indicate the expression and reinforcement of low self-esteem and self-criticism. This point around assessing receptivity to clinician humour is echoed in Sultanoff's (1994) article in the *Journal of Nursing Jocularity*, a magazine seeking to promote the use of humour in healthcare. Sultanoff (1994) argues that if the client uses humour in a self-deprecating way or

uses excessive sarcasm, it is important to address this directly and ask how the client sees the role of humour in their lives.

This enforcing function is a potentially useful tool for therapists to employ. Questioning and changing a person's perspective can be a threatening experience, potentially leading to defensiveness. In talking about family therapy, Liddle and colleagues (1988) hoped that when people are listening and laughing, they may be promoted to listen with less resistance. Humour is conceptualised by some to permit a person to say things that would be considered unacceptable if stated seriously (Buttny, 2001), as "a way of mentioning the unmentionable" (Clift, 1999; p544). Buttny's (2001) CA research highlights the role of humour in the therapeutic task of reframing and demonstrates the importance of the identification function. His analysis found that humour allowed the therapist to stay aligned with a person whilst discussing alternative perspectives that otherwise might be alienating. There may be some utility in humour to negotiate such potentially difficult conversations. In facilitating these interactions, the core condition of unconditional positive regard may be maintained and conveyed through humour.

In contrast to the point above around humour's role in permitting discussion of taboo subjects, Kubie (1971) shared his opinion that humour may have the opposite effect. He made a case to his psychiatry colleagues that a jocular approach may be interpreted as a way of indicating a subject *is* taboo and off-limits in psychotherapy. In Kuhlman's (1984) book reviewing the short-term and long term impact of humour in therapy, humour was argued to be a way of creating psychological distance between clients and their problems. Depending on therapeutic orientation and method of employment, this could be conceived as a helpful method to facilitate clients to discuss problems whilst diluting a full emotional re-experience, or an unhelpful diversion from processing the issues if a client is struggling emotionally on a particular point. Humour can therefore potentially be invoked to enforce either the therapist's or client's own rules around the degree of emotion talk or emotion tolerance to which they are comfortable (Kuhlman, 1984; Saper, 1987). In terms of a diversionary tactic, some go as far as to say that *any* use of humour by clients is a 'pathological' characteristic, preventing clients from seeing themselves seriously, or an inappropriate defence against emotion that should be eliminated (Marcus, 1990).

*Differentiation*

As a final function, Meyer (2000) argued that humour serves to differentiate. Humour is frequently employed to "contrast themselves with their opponents, their views with an opponent's views, their own social group with others, and so on" (Meyer, 2000, p. 321). This may help clients talk about disagreements in their personal relationships. Those who argue for humour's 'destructive potential' in therapy (Kubie, 1971), focus on this function emerging within the therapeutic relationship. Its potential to threaten the therapeutic relationship has been hypothesised to include thinly masked hostility, diverting or foreclosing 'true' thoughts and feelings (such as anxiety, anger or judgement), hurting or offending the client, intensifying resistance, or confusing the client about the therapist's intent (Kubie, 1971).

An obvious scenario related to differentiation where humour may be inappropriate would be when humour is employed to denigrate, humiliate, deprecate or undermine self-esteem, intelligence or well-being of the client (Pierce, 1994; Saper, 1987). Another concern is that humour may seem flippant and convey that the therapist does not take the client's problems seriously, or that humour may be used 'narcissistically' to show off their own wit (Kubie, 1971; Martin, 2007). Differentiation and fragmentation of the therapeutic relationship may result from the functions of humour to elevate the therapist's position or demote the client's. Due to its duality and ambiguous nature, there is an inherent risk of the humour being misinterpreted by clients (Franzini, 2001). This uncertainty or misunderstanding could divide the dyad, particularly if the client or therapist is prone to orient to messages of rejection.

Similarly, empirical research into group psychotherapy found that over 75% of the humour used by group members was negatively targeted toward people and only 7% was positive (Peterson & Pollio, 1982). When negative humour was directed to a group member, the therapeutic effectiveness of the group was consequently rated as lower and it appeared a means of diverting the conversation. If directed to a person outside of the group, it was rated as more therapeutically effective, appearing as a method of support to promote group well-being. The target and type of humour therefore can influence the cohesion or discord within therapy.

*Tension reduction*

Robinson & Smith-Lovin (2001) argue that the stress-reducing benefits of humour are widely recognized in the literature (e.g., Dienstbier 1995; Lefcourt & Martin 1986;

Martin & Lefcourt 1983; Schacter & Wheeler 1962; White & Winzelberg 1992). Empirical findings suggest there is a complicated, and often controversial, relationship between humor and stress (Kuiper & Martin 1998; White & Winzelberg 1992). However, research shows that people interpret humorous stimuli as more funny and produce more humorous comments when aroused (Bales & Slater, 1955; Cantor, Bryant & Zillman 1974; Prerost & Brewer 1977). Sacks (1974) described these departures from the main focus of conversation as side sequences. Given that therapy can trigger intense emotional arousal in clients, this function of humour has been raised in bolstering arguments for its use in therapy (Golan & Jaffe, 2007).

**The function of not using humour**

The above section described the function of humour in therapy, revealing potential benefits and costs to the therapeutic relationship. Clearly, the use of humour needs to be carefully considered as it has the potential to be interpreted by clients as insensitive, uncaring or excessively self-absorbed (Franzini, 2001). Given these caveats, it is necessary for a therapist to reflect on the intention and impact of the humour they employ (Martin, 2007). It may at this point be useful to consider explicitly the merit in refraining from using humour. The use of humour has been disapproved of in the literature by some because therapy is viewed as not only 'hard work' (Kuhlman, 1984), but a grim and sober affair (Franzini, 2001). Ellis (1977a) offered a counter argument regarding this issue: that therapists view themselves in the same way they view their work, as both important and serious. Whilst his comments are largely facetious, he is making (possibly inadvertently) a valid point regarding congruence.

Offered to guide research in the field, Kuhlman's (1987) model of therapeutic change takes the form of an equation. This model places the choice to engage in humour as the result of client and therapist characteristics and experience, their relationship and environmental or contextual factors. Offering no simple answers, it provides a framework on which to reason through the use of humour. As outlined before, humour may be described as a disposition, as well as stimulus and response. Kuhlman's (1987) model highlights the importance of client and therapist disposition. If a therapist's or client's disposition is not oriented to the use of humour, then, in order for this therapeutic condition to be met, the amount and type of humour used would need to be carefully negotiated between the therapy dyad. A therapist whose outlook does not lend itself to such a way of interacting would be ill-advised to adopt

such an approach in therapy. Likewise, if a client's personal style is not likely to respond well to a humorous approach, the therapy will need to be congruent with this.

The response to humour is as important a consideration as the choice to engage in humour itself. There are times when *not responding* to a client's humour can be detrimental to the therapeutic process, contributing to termination of the therapeutic relationship. For example, Gonick (2004), an American columnist, reported on her struggles with suicidal thoughts and the process of therapy. She described her therapist as attempting to stifle laughter in order to "look properly shrinkish" (Gonick, 2004, p20). The client's goal then appeared to be rousing laughter from the therapist. Whilst sharing humour can be a means of unification, not being able or willing to share such efforts could serve to undermine the relationship.

**The relationship between humour and laughter**

In the previous sections, the various functions that humour may perform in therapy were outlined. It is important to consider separately the subject of laughter. Laughter and humour do not share a perfect linear relationship (Attardo, 2003). There are instances of dead pan or dry humour that, although funny, do not elicit a laugh, and equally, laughter that does not have humorous origins. In this section, this relationship will be further explored.

There are numerous words to describe laughter, from a titter to a roar. Foot (1997) differentiates between the various functions and categories of laughter. Laughter conveys that we find something funny, but also others less related to humour. Laughter expresses friendship, masks misunderstanding, hides feelings, excuses past actions, apologises for future ones, expresses relief, mocks a person or expresses exhilaration or mastery. These functions are important to understand given that Marci et al. (2004) found that laughter occurred every three minutes in their tapes of therapy.

Provine (2000) describes gender differences in laughter where women were found to be almost twice as likely to laugh at a man's joke (71%) than vice versa (39%). Laughter in organisations was found by a study using socio-linguistic methodology to

be an expression of politeness, and a behaviour that communicates and enacts power relationships (Morand, 1996). The role of laughter and smiling in regulation of status in hierarchical relationships has been suggested in other natural observation research (Mehu & Dunbar, 2008). Therefore, issues of status and power influence a person's likelihood to laugh but, in turn, their laughter is influential in shaping their access to power and claim to status. Given the power imbalances in the therapeutic relationship, polite laughter as a response to a therapist comment may be more expected than vice versa. Laughter could also be seen as a means by which clients can reclaim power.

Laughter has also attracted the attention of attachment researchers. Sander & Scheich (2005) discuss laughter as attachment behaviour, with research focusing particularly on bonding parent-child dyads (Bowlby, 1969; Schore, 2003). Laughter between a baby and its primary care-giver ordinarily becomes a coordinated shared experience (Nelson, 2008), correlating with later communication and secure attachment patterns (Beebe, 2003). Other psychoanalytically oriented writers talk about how laughter in therapy influences an attachment relationship between client and therapist (Siebold, 2006), in contrast to the often insecure attachments in other areas of a client's life (Nelson, 2008). Nelson (2008) argues that the emergence of sharing laughter in a therapy session can be viewed as attachment behaviour, powerful in strengthening or weakening the therapeutic relationship, given its impact to engender intimacy (Jefferson, Sacks & Schegloff, 1978) or alienate (Woolf, 2002).

However, after decades of studying laughter both experimentally and naturalistically, Provine (2000) concluded that laughter has little to do with humour. From a behavioural neuroscience perspective, he argued that laughter is an instinctual survival tool of social animals, rather than an intellectual response to wit. "It's not about getting the joke", Tierney (2007, p. 1) wrote when discussing Provine's research in the *New York Times*, "it's about getting along". However, Attardo (2003), in critiquing Provine's (2000) position, reminds readers of the *Journal of Pragmatics* that humour and laughter remain "obviously related" (p. 1288). He also points out discrepancies in Provine's work. Attardo (2003), whose humour theory relies largely on incongruity, draws attention to a "cavalier" (p. 1288) statement by Provine (2003, p. 15) that "our success at incongruity detection is celebrated through laughter". Provine (2000) contradicts himself by stating that ''most laughter is not a response to jokes or other formal attempts at humor'' (p. 42). Attardo (2003) clarifies that

incongruity theories would not tie directly humour and laughter, that laughter is not routinely the response to humour, and that humour is not the only stimulus for laughter. This means that the task of humour identification is a complex one (Attardo, 2003).

Whilst many researchers consider themselves to be exploring humour, it may well be that their focus is largely laughter based. For this reason, the focus needs to be explicitly directed at humour and caution must be exercised for the possibility of being lured down the path of laughter. Attardo (2003) points to pioneering research in diverse fields that have developed more complex means of humour identification, including other contextual and linguistic identifiers (such as Holmes & Marra, 2002). This important issue will be returned to in the methodology section.

**CA's contribution to humour in psychotherapy research**

As mentioned before, therapeutic communication is a particular type of conversation with its own unique patterns of talk and CA is a methodology only recently being applied to this setting. In order to consider CA's findings on the use of humour in psychotherapy, it may first be useful to review briefly some of the work that has emerged generally in the field of psychotherapy. This will provide a foundation on which to locate some of the research around humour in this setting that is of specific interest.

The first study to examine psychotherapy as a particular type of interaction was by Davis (1986), who looked at formulation. Sacks (1992), the founder of this methodology, applied pure CA to psychotherapy, recounting his observations of group therapy in lectures. Bercelli et al. (2008) have identified distribution of turn types and order in therapy, revealing a uniform asymmetric pattern:

1. Therapists can ask questions about clients' personal events at any 'transition relevant place' in the session, and ask many questions.
2. Clients do not usually ask questions except repair-initiation questions.
3. Apart from questions, therapists mainly make statements about client events, grounded in the previous client's talk (formulations or reinterpretations).
4. Clients regularly respond to these statements (in minimal or non-minimal ways).

According to Bercelli et al. (2008), therapeutic talk generally follows two main courses of action: inquiry (series of question/answer sequences to gather information about events), and elaboration (series of reinterpretations and client responses to them, by offering their views and hearing responses to them). Therapists can generate new topics whereas clients generally do not, but rather shift topics gradually through extensions of their responses as far as the therapist allows.

Whilst available research into the area is still quite scarce, CA has offered interesting insights into a range of important areas of interest in therapy, such as cohesion in group psychotherapy (Lepper, 2006), making links in psychoanalytic therapy (Perakyla, 2004), collaboration (Lepper & Mergenthaler, 2007a), cycles of significant interaction (Lepper & Mergenthaler, 2007b), turn-taking (Bercelli et al., 2008) and impasses in systemic therapy (Couture, 2006). Other CA ideas and observations generated about therapy will be discussed as they become relevant through the analysis.

With specific regards to humour, a literature search (see **Appendix 1**) found twelve articles using search terms of "conversation analysis", "humour OR humor" and "therapy". Ten were discarded (see appendix 1 for reasons).

Gale & Newfield (1992) used CA to identify the "paralinguistic features of talk as well as the structural sequencing of the various turn takings in the conversation" (p. 154). They extracted themes of therapist strategies, dynamics and agendas. One of nine therapist strategies identified was the use of humour to switch from a problem-focused to a solution-focused theme. The therapist used exaggeration of a potentially problematic comment by one client and in doing so, they argue, disrupted the conversation, allowing him to shift the focus back to his own agenda (Gale & Newfield, 1992). In the exemplar they use, the therapist is described as having "effectively averted a possible problem and directed the talk towards a more positive conversation" (Gale & Newfield, 1992, p163). This study offers some insight into the function of humour in therapy, but this emerged as part of the wider area of interest around identifying therapist strategies. This therefore does not consider client use of humour or therapist use of humour that would not be considered a therapeutic strategy or related to an agenda.

In directly addressing the topic of humour in therapy, Buttny (2001) argued that coding just therapist utterances is inadequate given that humour is constructed between two people. Buttny (2001) analysed a transcript of therapy with a couple using CA, which he argued allowed him to "get at how humour works in therapy" and "what discursive reality it attempts to construct" (p306). He suggested that humour is valuable in one of therapy's principle activities, re-framing, and owes a proportion of its success to its ability to adopt a playful approach. He argued humour disarms client resistance and creates a space in which to explore contrasting explanations.

Buttny's (2001, 2004) research looked at humorous devices, sequential environments for movement into humour and responses to humour. He found that the vast majority of instances were therapist initiated, and appeared to be designed for various therapeutic moves. Devices included hyperbole, metaphors, hypothetical quotes, repetition, facetiousness, irony, non-lingual vocalisations, and prosodic features. In his analysis, he notes that a humorous approach was adopted: following repeated attempts to explain a therapeutic interpretation; when disagreement arose; in pursuit of a response being withheld; and in being professionally cautious. He examines examples of when humour is intentional and unintentional, but also explores how successful humour was, concluding that it is an "interactional accomplishment" (Buttny, 2001, p312). He discussed a duality behind the humour, in that there is simultaneously light-heartedness but also serious implications, and described how this duality creates a conflict in how to respond depending on whether orienting toward one or other. One of his concluding remarks included how humour "functions as a lubricant to grease the conflicting edges of therapeutic contact" (p. 322), rather than as a break from therapeutic activity.

**Rationale**

Gale & Newfield's (1992) research looked at humour as one of nine strategies used by the therapist to pursue his solution-focused agenda, whereas Buttny's (2001) research focused directly on the use of humour in therapy. His conclusions are based on the unique difficulties of two specific clients in couple therapy in America conducted by one particular therapist at one particular stage of therapy in one particular session using one particular brand of therapy.

The research proposed here examines the content and process of therapy in different contexts, further exploring the use of humour in therapy by both clients and

therapists, and considering its role in the therapeutic process (Viney, 1983). In contrast to previous research, humour will be of interest whether it is attributable to the client or therapist, as learning about therapeutic potential is as important as the way in which clients orient themselves to therapeutic agendas.

**Aims and research questions**

There were a number of aims when first embarking on this research project:

1) The first aim was to weigh up the different perspectives and competing arguments regarding the use of humour available in the literature. This objective was achieved through the literature review above.
2) The main aim of the research was to explore the use of humour employed in therapy. This will be done in a number of ways. The linguistic devices employed in humour attempts will be examined in order to consider the underlying mechanics. The sequential environments in which humour appears and reactions to humour will be analysed to consider the function it may be playing within each context.

Based on these aims, the following research questions have been formulated:

1. What resources do participants draw upon to move from the serious into humour?
2. In what sequential environments does humour occur?
3. What does humour project or make relevant as a response from recipients?

## Chapter 4: Methodology

In the preface it was mentioned that CA research frequently deviates from conventional written structure (ten Have, 2007). Other CA research (e.g., Gale & Newfield, 1992) provides a loose template for a Methodology section. Given that the choice of data analysis determines the mode of data, the rationale for the selection of a research method will first be discussed, before describing the data selected, and then finally narrowing down the scope further by describing the process of selecting excerpts, conducting the analysis, reliability and validity, and ethical considerations.

*Choosing a methodology*

This section will describe the process by which the methodology was selected. Initially, Coding and Content Analysis were considered as potential analytic methods. However, after some consideration, they were deemed to fall short of sufficiently capturing the intricacies of talk-in-interaction (Beach, 1990; Buttny, 2004). Three other methods were subsequently considered: Phenomenology (Sokolowski, 2000), Discourse Analysis (DA) (Gee, 2005) and Grounded Theory (Dey, 1999). However, having considered Starks & Trinidad's (2007) comparison of these three approaches, Phenomenology was ruled out for its focus on the lived experience of participants, and Grounded Theory was disqualified for its focus on social structures and processes. DA, with its interest in the negotiation and construction of knowledge, meaning, identity and social goods was more seriously considered as a potential approach for this study. However, taking note of Wooffitt's (2006) comparison of DA and CA, DA was eventually also ruled out. DA, interested in the relationship between language and the construction of knowledge, seemed a less refined tool for the research task compared to CA's focus on the conversation itself and the social actions that utterances perform (Wooffitt, 2006).

Over the past 20 years, CA is increasingly being applied to organisations to explore how each profession's social goals are being achieved through conversation (Atkinson & Heritage, 1984; Boden & Zimmerman, 1993). This social constructionist approach examines naturalistic accounts, embedded in conversational sequences (Potter & Wetherall, 1999) or talk-in-interaction (Atkinson & Heritage, 1984).

*Data*

Figueroa & Lopez (1991) note a lack of attention to the methodological processes by which data are gathered. Burr (2004) argues that if something insightful is to be said about the way an account was constructed then its context, its history, and intended audience must be explicit.

Two data collection methods were considered: requesting therapists and clients to record their sessions or harvesting existing recordings. The former would involve seeking out therapy dyads and requesting consent prior to new recordings being made, whilst the latter would focus on pre-existing recordings from previous research or clinical reasons. It was thought that in securing consent for such recordings to be made, the data would cease to be naturally occurring, violating one of the conditions for CA research. Awareness of the research interest would likely impact conduct; therefore it was decided to secure pre-existing recordings.

In canvassing a range of sources, a potential pool of data was identified through a research project conducted by the Programme Director at UH comparing Cognitive and Personal Construct Psychotherapy (PCP) (Winter & Watson, 1999). **Ethical approval** was secured (**appendix 2**) through extending the ethical consent for the original study. **Research governance** and **sponsorship** was secured through the University of Hertfordshire (**appendix 3**). The project proposal met **NHS R&D Governance** criteria (**appendix 4**).

The pool of data consisted of 53 audiotapes of the fifth sessions of PCP (24) and Cognitive (29) therapy. Initially two tapes were randomly selected, but having only four examples of the use of humour seemed insufficient. Two more were then selected. Only three were used in the analysis due to concerns over recording quality of one tape (see Table 1 for description).

| Dyad | Religion | Ethnicity | Occupation | Age | Presenting problem |
|---|---|---|---|---|---|
| A | Hindu | Asian | Professional | 40s | Depression |
| B | Jewish | White | Professional | 30s | Depression, relationship problems |
| C | Jewish | White | House wife | 30s | Depression, anxiety |

Table 1: Client characteristics

*Identifying excerpts for analysis*

Both Sacks (1984) and Hutchby & Wooffitt (2008) opt for results being data-driven, and state that analysis should neither be biased by pre-existing ideas nor theoretical assumptions. However, in order to aim the sights of the analysis, the target will need to be readily identified and operationalised. Humour does not lend itself easily to definition (Hatch, 1993), and tends to be readily demonstrated rather than described. This task of defining humour has generally been side-stepped by researchers in the field, who tended to rely on a common-sense or intuitive method in its identification (Emerson, 1969; Vinton, 1989). In previous research, little time was spent on criteria for identifying it, or it was uncritically identified through the presence of laughter (Buttny, 2001; Bonaiuto, Castellana & Pierro, 2003).

Given Provine's (2000) research which associates laughter with a range of precursors, not necessarily humorous, laughter remains an unavoidably unsatisfactory indicator of humour. Whilst briefly acknowledging the possible mismatch between a speaker's intention and a listener's orientation to a comment as humour, Buttny (2004) resigns himself to accept the 'obviousness' of some utterances, using "a commonsense category in which at least one person displays it or orients to it in some way" (p78). Bonaiuto et al. (2003), drawing on both the theoretical base of CA and imposition of practical constraints, relied on laughter as a marker to identify and chart the sequential arrangement of humorous content in conversation. Jefferson (1979; 1985), a significant exponent of CA, claims that laughter is the sign *par excellence* of the humorous character of an utterance. Mulkay (1988) argues that rather than being merely a response to humorous discourse, laughter can provide the social cue that encourages humorous discourse. The laughter invitation made by the humorist is argued to signify the comedic quality of the anticipated comment whilst laughter following a comment is thought to seal "the laughable nature of the utterance" (Glenn, 1989, p. 128).

Hatch (1993) outlines some of the difficulty in using laughter as a criterion to locate humour, including laughter at non-humourous stimuli. Whilst applauded by some for making explicit her critical stance, the result remains the same in her research. Therefore, a more complex means of identification is required to address the issues of sensitivity (not classifying an utterance as humour when it is) and specificity (classifying an utterance as humour when it is not).

In ensuring the criteria for identifying excerpts are sensitive enough to capture all examples of humour in the tapes, criteria will include 'laughter particles' of the speaker of the utterance, even if it is not met with laughter. Holmes & Marra (2002) have been heralded by Attardo (2003) for using more linguistically focused methodology to study humour and have developed more complex criteria to identify humour. Humorous utterances were defined as those which are "identified by the analyst, on the basis of paralinguistic, prosodic, and discoursal clues, as intended by the speaker(s) to be amusing and perceived to be amusing by at least some participants" (Holmes and Marra, 2002, p. 1693). They specify further a wide range of contextual and linguistic clues that may be relevant to the identification of humour, including speaker's tone of voice and the audience's auditory and discoursal responses. Moreover, they include laughter, and, where video recording is available, facial expression, including smiles, which is unfortunately not available in the audio-recordings of this research.

Having spread the net widely to ensure all possible instances are captured, there must be a specification process to sort through the catch in order to discard examples that are not humorous. The Semantic-Script Theory of humour (SSTH: Raskin, 1979; 1985), a popular and well researched theory in the study of humour, may offer further definition that has been adopted by linguistically-oriented research to ensure each candidate is classifiable as humour. Attardo (2003) argued that this theory "established that all humour involves a semantic-pragmatic process (although some humor involves a phonological/morphological/syntactic aspect as well, i.e., verbal humor)" (p. 1287). It is not appropriate to describe this complex theory (see Norrick, 2003; Raskin, 1985) in detail here. However, it is worth highlighting that "the SSTH included a semantic opposition between the scripts… activated by a (fragment of a) text and a violation of the maxims of the principle of cooperation" (Attardo, 2003, p.1287). Grice (1989) explains that the principle of cooperation involves four maxims: quantity (speakers give enough and not too much information), quality (they are genuine and sincere, speaking 'truth' or facts), relation (utterances are relative to the context of the speech) and manner (speakers are direct and straightforward, and try to present meaning clearly and concisely, avoiding ambiguity). For the purpose of analysis, the utterance will be qualified as humour if there is 'a sudden movement between, or unexpected combination of, distinct interpretive frames' (Mulkay, 1988; 26) and if the utterance violates maxims of the principle of cooperation. This is hoped to guide detection specifically toward humour.

*Conducting the analysis*

Original tapes were copied onto CD. Using the criteria outlined above, tapes were listened to and incidents of humour were noted and screened for eligibility to be included. Given the time consuming nature of transcription, ten Have (2007) urges Conversation Analysts to only transcribe episodes that are relevant to the specific research interest. Pomerantz & Fehr (1997) identified ways of initiating and developing the analytic process by grounding each analysis in the identification of a sequence:

> For the start of the sequence, locate the turn in which one of the participants initiated an action and/or topic that was taken up and responded to by co-participants. For the end of the sequence, follow through the interaction until you locate the place in which the participants are no longer responding to the prior action and/or topic.
>
> Pomerantz & Fehr (1997, p.71)

Sequences deemed as sufficient for analysis were identified and dictated both the content to be transcribed and analysed. ten Have (2007) recognises the difficulty posed in identifying a sequence, particularly since new sequences can be triggered by subtle and hinted initiatives rather than marked ones. This is further complicated by the frequency that sequences can 'trail off' rather than reach conclusion (ten Have, 2007). ten Have (2007) argues that these difficulties "should not discourage efforts to try and locate sequences" but mark some "interestingly deviant cases". Therefore, rather than selecting a time period or number of lines prior to the humour, sequences were the unit identified to guide transcription and analysis. For example, if humour emerged in an anecdotal account, the social action that the account played within the prior conversation was traced back to the point that it was initiated; if the humour emerged in a sequence that reflected persuasion then the beginning of the act of persuasion was considered an appropriate place to start. The tapes were listened to and transcripts were read by the supervisor of this research to confirm the sufficiency of the quality and quantity of transcription.

The importance of the transcription process has been stressed (Heritage, 1984; Sacks, Schegloff & Jefferson, 1974). Using the computer program 'Audacity' to assist in accurately measuring silences and pauses, transcription was completed according to the conventions outlined in Hutchby & Wooffitt (2008) (see **appendix 5** for **transcription symbols**). Gale & Newfield (1992) describe the process of CA as

discovery-oriented, and as with their research, no hypotheses were generated in this study prior to analysis.

Two instances where laughter was heard were discarded from the analysis. One example was transcribed (dyad C, line 190, appendix 6) but was not analyzable due to a combination of overlapping talk and recording quality. The other omitted example was not transcribed due to the talk being of insufficient audibility and emerged as the therapist communicated with an unknown interactant who interrupted the session (dyad A). Fourteen instances of laughter in seven segments of transcript were heard sufficiently and included in the analysis (see Table 2).

| Segment | Therapy dyad | Orientation | Therapist | Client | Therapist initiated humour | | Client initiated humour | |
|---|---|---|---|---|---|---|---|---|
| 1 | A | Cognitive | Male | Male | 0 | | 1 | |
| 2 | B | PCP | Male | Female | 0 | 0 | 1 | 6 |
| 3 | | | | | 0 | | 1 | |
| 4 | | | | | 0 | | 4 | |
| 5 | C | Cognitive | Female | Female | 0 | 6 | 1 | 1 |
| 6 | | | | | 1 | | 0 | |
| 7 | | | | | 5 | | 0 | |

Table 2: Description of date and participants

The remaining portion of this section will describe the analytic procedure. The process of analysis began in transcription (see **appendix 6** for **transcripts**). In their chapter on analysis, Hutchby & Wooffitt (2008) talk about the importance of considering both *conversational devices* and *participants' orientations to devices*, or "what interactional business is being mediated or accomplished through the use of a sequential pattern or device" (p98). The analysis will be guided by Buttny's work (2001; 2004), which operationalised and presented CA in this specific area of interest. He first analysed resources used for humour (devices), then sequential environments for movement into humour (the contexts in which humour is used), and finally responses to humour (how participants orient to humour and the impact on the resulting dialogue). See diagram 1.

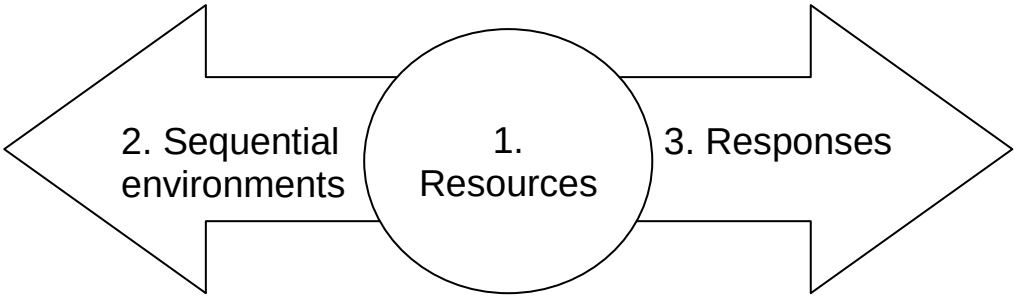


Diagram 1: Analytic procedure

The analysis examined each of these grouped aspects separately for each instance of humour.

This analysis was further guided by the researcher's understanding of CA, which has been influenced predominantly by the work of Drew (2003), Hutchby & Wooffitt (2008), and ten Have (2007). The three central features or analytic concepts that form the foundation of CA (conversational sequencing, turn-taking and conversational repair) and concepts developed specifically in the therapeutic setting heavily influenced the analytic process. These will be described below. For further clarification of the terminology used, a **glossary of terms** is provided in **appendix 7**.

The first central feature of CA is the idea that conversation conforms to types of conversational sequencing. Adjacency pairs refer to a class of utterances that form pairs, for example "How are you?" is the first-pair part to the second-pair part of "Fine, thanks". Whilst the term adjacency implies proximity, other utterances can be inserted (insertion sequence) between them, such as "Why do you ask?" Often second-pair parts have preferred responses. Non-response to a first-pair part is a noticeable violation of conversational rules.

Second, CA is interested in the organisation of turn-taking, and has identified the structural characteristics or 'the speech exchange system' with which people exchange talk, "the system of conventions regulating the exchange of turns and the management of speaker roles among participants" (Hutchby & Wooffitt, 2008, p. 49). Turns were considered by Sacks et al. (1974) as highly organised and consisting of Turn Constructions Units (TCUs), broadly corresponding to categories of sentences, clauses and words. Around these TCUs are Transition Relevance Places (TRP) where a listener can take up their turn to talk. Projection refers to the listener's

attempt to anticipate when the TCU will close and a TRP will fall, ensuring the uninterrupted flow of talk. Interruptions and overlapping talk for CA represent interesting areas where the management of talk requires repair, the third important concept.

Conversational repair includes remedying mismanagement of turn-taking and correction. This latter form of repair, which is the "substantive fault in the content of what was said" (Hutchby & Wooffitt, 2008, p. 57), requires the suspension of on-going turns. Interesting work has been generated around who initiates repair and who completes the repair, creating four different categories of sequences (self/other-initiated self/other-repair) (Hutchby & Wooffitt, 2008).

Within CA of therapy, specialised types and levels of conversational categories have been defined and researched. In the analysis, the surface speech acts will not be distinguished from the therapeutic acts as defined by Labov & Fanshel (1977), whilst the importance of this distinction is recognised. Vehvilainen et al. (2008) distinguish levels of organisation by comparing them to a chess game: a conversational action as moving a piece, local sequence as the move's contribution to the tactic and therapeutic function as the move's contribution to the overall strategy. It is therefore important to acknowledge how an utterance can simultaneously be described as one of many different actions (White, 1979). However, this multiplicity will not preoccupy this research, but rather offer reassurance that actions can be correctly identified in an open-ended plurality of ways (Anscombe, 1959).

Finally, it is also important to clarify and disambiguate some terms, which will be used according to definitions by Bercelli et al. (2008) and Vehvilainen et al. (2008). 'Extension' describes a syntactic continuation of the other's comment, through finishing or continuing the other's turn, often pursuing the therapeutic agenda. 'Formulation' is a re-saying of the perspective expressed by the client, often used to emphasise or extract the psychologically meaningful aspects of the client's turn. 'Reinterpretation' is grounded in what the client has said, but expressed from the therapist's own perspective and its meaning is transformed to something different.

*Validity and reliability*

Validity and reliability as understood in reference to their orientation towards a verifiable truth are thought to be inappropriate for judging the quality of research from a social constructionist framework (Burr, 2004). Although there are no criteria that are

universally accepted (Burr, 2004), the importance of legitimatising analyses is recognised by researchers in this field.

Taylor (2001) suggests a number of ways to enhance coherence and rigour of research. Adopting a quantitative stance, he argues that one can ensure consistency by calculating indices of agreement between raters in coding textual material. Providing in-depth descriptions about steps in analytic procedure can highlight the route with which a researcher has arrived at some of their ideas. Member checking, he adds, allows participants to feed back how well a researcher's explanation fits with their experience. Wood & Kroger (2000) have also suggested criteria for trustworthiness and soundness, and urge researchers to include an audit trail to allow the reader to follow progress from text to interpretation.

The issues of validity and reliability have been considered for this research and an audit trail for independent audit was maintained during the analysis. Reflexivity and member checking is less of a concern for CA than some other forms of qualitative analysis (Burr, 1999). However, Sherrard (1991) criticises researchers for not adopting a reflexive stance and building into research a platform from which participants can comment on their own accounts. Moreover, given the age of the recordings, this useful step was considered to be pragmatically complex and methodologically unnecessary. It is acknowledged that there is a danger in this research of closing the text to alternative readings other than that of the researcher (Parker & Burman, 1993). Therefore, research supervisors were involved in reliability checks. One of the important features of CA is that the data on which the claims are being made is available within the text for readers to verify for themselves. Therefore, the accuracy of claims can be continuously evaluated in reference to the conversational 'proof' presented each time the research is read.

*Ethical considerations*

Ethical approval was obtained for the original research (Winter & Watson, 1999) and extended to cover this research, which was granted by the Barnet, Enfield and Haringey Ethics Committee (see Appendix 2). As the study was exploring process and outcome of a variety of therapeutic approaches, and was still active despite the data collection phase being complete, this research was tacked on to the pre-existing ethical approval. The committee agreed that it would be neither practical nor clinically appropriate to contact the therapy dyads, since they had given their consent for their tapes to be analyzed.

ten Have (2007) outlined the importance of consent to be recorded, to be used for research purposes and for the content of the data to be published. The consent forms used in the original study covered these areas sufficiently to allow this pool of data to be used. ten Have (2007) also outlined the ethical issue around people's common-sense association between "a detailed consideration of people's actions and an unpleasant exposure, or critical assessment, of those actions" (ten Have, 2007, p. 79). One strategy that can be used to minimize this is anonymity. Names and other identifying information have been changed in the transcripts in order to protect participant confidentiality (ten Have, 2007).

## Chapter 5: Results and discussion

### Overview

The analysis will be integrated with the discussion to help the reader make links between the findings and their significance and existing literature. This section will begin by describing the pattern of humour from the tapes and compare this with other findings in the literature. In the main, however, this section will be devoted to identifying the devices or mechanisms that were used to create humour, the sequential environments in which humour was used and the responses to the use of humour. A summary of the main findings relating to the function of humour will be outlined at the beginning of this section.

### Patterns of humour use

The majority of CA research focusing on institutional interaction is most interested in the professional and their actions (Vehvilainen et al., 2008). In contrast, the current research is interested in the construction of talk of *both* participants and found that much of the humour was initiated by clients.

Buttny (2001, 2004) suggested that the majority of humour was initiated by the therapist, stating that this asymmetry may reflect the client's orientation to the therapist as expert by refraining from disrupting the largely serious activity of therapy (Buttny, 1990). Given that most CA research in institutions focuses on the talk and conversational strategy of the professional, the current research offers a useful insight into both professional and client use of humour. Given the differing patterns of humour initiation (see Methodology section), it seems that humour use may be dependent on individual differences, and reflect differences in how each individual of each dyad views each therapeutic encounter.

The stage of therapy may also influence the differences between the findings. Buttny's (2001, 2004) research was an analysis of a one-session consultation, whilst data in this project was from the fifth session of a course of twelve. It could be that in previous sessions each dyad had subtly negotiated the appropriateness and desirability of using humour in therapy, each negotiation emerging with different outcomes. In the process of undertaking this research project, many interesting discussions emerged. One important outcome of these discussions was a point raised around therapist congruence, indicating the influence of individual differences.

Whether humour is used within therapy can therefore be seen as the outcome of a negotiation between those individual differences and how each client's and therapist's view therapy, within the context of each particular therapy event.

Having discussed the frequency and sources of humour use, this section will now analyse each instance of humour and the functions it may be performing within each context.

## Functions of humour use

The analytic procedure focused on identifying the devices or mechanisms that were used to create humour, the sequential environments in which humour was used and the responses to the use of humour. In order to make the analysis of the current project's data more accessible to the reader, these aspects will be integrated by being more grounded in the transcript sequences. The reader is requested to hold the format above (see diagram 1) in mind as the analyses are discussed. The analysis will be integrated into the discussion to further aid the reader to make links between the findings and their significance and the available literature. This section will refer regularly to Meyer's (2000) continuum of humour's four functions outlined in the Introduction.

The analyses of instances of humour will first examine humour's role of differentiation in *unresolved resistance*. Next it will consider how humour can function to unify the therapy dyad in *overcoming resistance* through empathy and reframing. In the section on *conveying disagreement*, humour functions to differentiate a client's viewpoint from that of a third party. The subsequent section will then consider humour's role of enforcement as the dyads grapple with and negotiate the process of *change*. Its function in the context of *uncertainty* will explore its potential for clarification. As these sections unfold, pertinent areas in psychotherapeutic research such as resistance and empathy will be discussed in more detail whilst its relevance to the therapeutic relationship will be an ongoing concern.

### Unresolved resistance

The concept 'therapeutic resistance' has its origins in psychodynamic thinking (Freud, 1904), but is also employed in other modalities (Wachtel, 1982). As mentioned in the Introduction, the therapeutic relationship is facilitated by therapist flexibility, and in the following example of resistance, it seems that the disagreement continues as a result of the rigidity with which the dyad cling to their different

positions. In a discursive analysis of the therapeutic relationship, Roy-Chowdhury (2006) points to un-repaired and unresolved trouble sources emerging again and again in the conversation, which act to subvert therapeutic aims. In another example in this research described in the "Overcoming resistance" section, this rigidity is diffused by employing the flexibility and unifying potential inherent in humour. However, in this following example, both therapist and client become embroiled in a battle of persuasion and resistance, and the client uses humour's differentiation function to encapsulate their diverging viewpoints. As described at the start of this section, the sequential environments, devices and responses to humour will be described separately through reporting and discussing the analysis.

***Sequential environment: resistance***

As the sequence emerges in the following excerpts, the build up of resistance and persuasion before the client resorts to humour will be described. In excerpt 1a, the therapist begins by asking a question (lines 1 and 4), which over the course of the conversation is better understood as a suggestion. However, the client responds with the dispreferred answer, which later can be understood as a decline or rejection of the therapist's suggestion.

*Excerpt 1a*

1. Th: Would it be any different to you if you
2. (1.2)
3. Cl: Spoke into [a ()
4. Th: [SPOke these things into [↑a: (.) tape recorder=
5. Cl: [and listen
6. Th: =Yeh
7. (.6)
8. Cl: .hh I doubt it very much ↑because (2.1) strong feeling (1.7)
9. wid erm (2.8) it's the interaction with the other person which is
10. err=
11. Th: =°right°=
12. Cl: =↑very (1.0) ↓calming
13. (1.1)
14. Cl: .hh I've never tried actually t::o speak °int[o a tape recorder°
15. Th: [°right°

The client anticipates what the therapist is about to ask and demonstrates to the therapist that he understands through conversational projection by taking up potential turn taking opportunities (line 3). The therapist indicates that he has not completed his turn and intends to complete it, demonstrated through the deliberate and strong counter-interruption (line 4) where he reclaims his turn. The client initially responds to it simply as a question or inquiry, giving the dispreferred response, evident in the dispreference markers (Pomerantz, 1984). These include a pause before he responds and constructing his response so that the disagreement is as weak as possible, diluting a firm unambiguous decline to a strong doubt. The rise in tone of "because" (line 8) immediately indicates he will present an account or justification for why he might disagree. Having shown his intention, he then takes time before carefully constructing and selecting how he will present his reasoning. However, the noticeable absence of the therapist taking up the next turn (line 13) results in the client's next turn being oriented towards repair. He re-constructs his second-pair part in a way that suggests a re-interpretation of the therapist's first-pair part more as advice or suggestion of intervention, by indicating he had not tried it in the past.

The therapist goes on to build his argument supporting his suggestion and encouraging the preferred response. He does this by presenting two alternative strategies and dismissing them (lines 16 to 33). He leaves enough potential turn taking transition relevant places (Hutchby & Wooffitt, 2008) through pauses and voiced pauses ("erm") to successfully invite the client to co-construct these dismissals.

*Excerpt 1b*

16. Th: I'm just bearing in mind what you said about your wife (0.6)
17. Th: and daugh[ter ] that you .hh that there's (0.6)
18. Cl: [yes]
19. Th: >an obstacle there< to you [hh ] freely
20. Cl: [yes]
21. (0.8)
22. Th: er:::m=
23. Cl: =talking to [them
24. Th: [talking to <u>them</u>
25. Cl: Yes there is an obstacle [( )
26. Th: [and there's ALSO there seems to be
27. an obstacle (0.2) in your mind to talking to your<u>self</u> that it's the

28. first [sign of- you were going to say
29. Cl: [yes
30. Th: madness
31. Cl: Ye:::s
32. Th: presumably
33. Cl: Yes

Having dismissed the plausibility of the two alternatives, the therapist then heightens the persuasion for his intervention (lines 35-40). In lines 42-43, he then uses the dismissals of one option to increase the desirability of his original suggestion. He ends his turn with a question designed to persuade by dismissing one option *and* supporting the adoption of his suggestion that is designed to elicit an affirmative response, given their previous conversation.

*Excerpt 1c*

34. (1.3)
35. Th: m-maybe having a- (.) tape recorder that
36. ↑you (0.2) talk int::o (0.9) and record the thoughts >doesn't
37. matter whether you play them back or not< but maybe the th-
38. slightly <differe:nt> (0.8) >interpreta↓tion< (0.3) that you
39. place on that (0.3) that you:::'re (0.4) >recording your thoughts<
40. >that you're (.) expressing them and recording them .hhh
41. Cl: ((cough))
42. Th: and that you're- you know (0.8) is that more socially
43. acceptable (1.2) 'n talking to oneself um from what you've said
44. Cl: ↓Hmm
45. Th: that maybe that's tru:e

This encourages the client to respond affirmatively to the question in the last section of the therapist's turn, which also included persuasion for the suggestion the client had previously declined. The client's response at this stage is to respond firmly and affirmatively (preferred response to question; line 46) and he reluctantly (given the pauses, voiced pauses and quietness of his response in lines 47-51) begins to accept the other clause in the therapist's prior turn.

*Excerpt 1d*

46. Cl: ye:s I think you're ↑ri:ght it would be more socially ↓acceptable

47. (0.5)
48. but e::rm
49. (0.9)
50. *°I don't know whether I can- (um I will try it)°*
51. (1.1)
52. IT SEEMS you know that the:::re must
53. be e:::::::rr an element of sympathy from the person themselves
54. (0.9) er:::::::r I err for example >wouldn't speak to anybody who
55. was unsympathetic to my troubles<
56. Th: Rig::ht

This acceptance appears unconvincing and more like submission, given the quietness and croakiness of his agreement (line 50), barely audible on the recording. However, this agreement emerges as a pseudo-agreement as the client returns to bolstering his counter-argument or resistance, which is only superficially responded to or acknowledged in the therapist's subsequent turn (line 56). In response to this absence, the client continues the task of building and strengthening his counter-argument and also his resistance, through humour (line 57-58) below:

*Excerpt 1e*

57. Cl: Aa:::ghh whether a tape recorder can (0.6) re(hh)act in this way
58. I don't know actually wheth[er ah erm ()

The client is then disagreeing with or explicitly resisting the therapist in a mitigating way by inserting laughter tokens and using sarcasm (Bercelliet al., 2008; MacMartin, 2008). However, CA would view resistance in therapy as pathologising clients (Hoyt, 2002) and produced by both participants. Everything happening in treatment is viewed as an interactive event, commonly created by both client and therapist (Streeck, 2008). In this example, it is evident that resistance results from both the client resisting the therapist's advice, and the therapist resisting the client's declination.

***Mechanism: anthropomorphic personification***

In this example the client uses humour to summarise the dissonance between the therapist's suggestion and his concerns around its utility. After a pause, he selects a particular verb incongruent for use with an inanimate object, and emphasises this incongruence through humour shown by inserting the 'laughter particles' into this

verb “react” (line 57). Laughter, however subtle, in this research was found to be a useful conversational tool for the client to demonstrate humorously the incongruence between the perspectives of therapist and himself. The humour emerges as the client imbues an inanimate object with animate properties, which has in this research been termed ‘anthropomorphic personification’. This improbable description captures the incompatibility of these competing arguments, and serves to differentiate their positions (Meyer, 2000). In humour that is thought to serve the function of differentiation, the derision is focused at the violation or unusualness of the opponent’s viewpoint (Meyer, 2000). In this case, the sarcasm around the sympathetic response of the tape recorder points to the violation of logic of the therapist.

Presenting first the humorous premise of a sympathetic tape recorder reaction allows the client to delay presenting his own views on this or dismissing them. However, rather than rejecting this idea, he instead uses an epistemic marker saying “I don’t know actually” (line 58). His amusement at the clause before this perhaps negates his need to clarify his viewpoint, and instead softens his overall dismissal by not stating it. This approach invites the therapist to join with him through laughter in shared amusement at such a premise, softening his rejection of the idea with humour.

***Response: change of persuasive strategy***

The therapist does not audibly respond to the humour and turns down the client’s invitation to laugh. Rather, the client, who appears to intend to continue his turn, is interrupted by the therapist’s firm and pressing intention to speak using a loud in-breath and speaking loudly (lines 59-60) to regain the floor.

*Excerpt 1f*

| | | |
|---|---|---|
| 57. | Cl: | Aa:::ghh whether a tape recorder can (0.6) re(hh)act in this way |
| 58. | | I don’t know actually wheth[er ah erm () |
| 59. | Th: | [.HHHH |
| 60. | Th: | >WHAT OTHER<? (0.9) outlets are there for yo:u (0.9) °to:::::o° |
| 61. | | er- explore to talk to someb[ody when you- >when you< feel= |
| 62. | Cl: | [.hhhh |
| 63. | Th: | =par(.)ticularly ↓restless |
| 64. | Cl: | .tch .hhhhhhh When I’m re:stle:ss I ↑think e:rr I try |
| 65. | | >very hard to DO something< (0.5) |

66. th[at I don't mind ↓doing at least you know like=
67. Th: [°yes°
68. Cl: =tidying up some paperwork o::r (1.1) °er:::::r° washing up or err
69. or ea::ting something I ↑often eat something as to ()
70. Th: Right
71. (2.7)
72. Th: Ok[a::::::::::::::::y.]
73. Cl: [But err ] °I'll try with the tape recorder°
74. (6.2)
75. I don't think (0.8) ne:::::rr (0.8)
76. >°don't think it would work because-er°< (1.1) I ↑think w:::
77. I'm asking for sympathy or understanding when I'm (0.8)
78. [when >I want to< ta:lk]
79. Th: [°okay° ]
80. (1.7)
81. Th: Fine
82. (1.2)

The therapist's question, designed to elicit further alternatives, narrows the preferable responses to those related to talking, shown by his emphasis on the word "talk" (line 61). The client's response highlights alternatives that do not involve talking, and he acknowledges his deviation from the therapist's invited responses with an emphasis on the word "DO" (line 65). The therapist's minimal ambiguous responses (line 70 & 72) are discourse markers that indicate boundaries in topics of conversation. This once more prompts the client to repair the conversational disruption by ending his turn, and by unenthusiastically and reluctantly submitting to his demand (line 73). However, the long silence of over 6 seconds in line 74 indicates perhaps the tension and difficulty in the conversation that the disagreement has generated. However, despite his submission, he continues to softly repeat his counter-argument (lines 75-78), continuing the pattern of resistance and persuasion (in subsequent talk not reproduced here).

***Summary***

In this research, humour emerges in the sequential environment of persuasion and resistance. This research shows the role of humour in resistance to be about capturing neatly the counter-argument by humorously framing the opposing

viewpoints in a way that emphasizes their incompatibility. This was achieved in a mitigating way by inserting laughter tokens and using sarcasm (Bercelli et al., 2008; MacMartin, 2008). This research echoes Buttny's (2001, 2004) finding of humour's role in disarming resistance, albeit not overly successful in this instance, and demonstrates that clients also use humour to capture the incompatibility of perspectives.

However, this sequence indicates that resistance emerges as an *interactional phenomenon* where the client's resistance of the therapist's intervention is met with the therapist's resistance of his reasoning and decline. It is this unresolved and un-repaired trouble source that is repeatedly played out in their talk and threatening the therapeutic relationship. CA would consider resistance as produced by both participants. Everything happening in the therapy room, including the therapeutic relationship, is viewed as an event interactively and commonly created by client and therapist (Streeck, 2008). Roy-Chowdhury (2006) points out that persuasive strategies vary between disciplines, and that "for the psychotherapist, the persuasion must make sense within the therapee's life world" (p. 169), rather than rely on category entitlements such as in medical consultations (Hak & Boer, 1995). Clearly in this example, the persuasion did not make sense.

Meyer's (2000) continuum would see this instance of humour as a means of differentiating viewpoints. Boland & Hoffman (1983) consider humour as allowing communicators a way of:

> ...transcending recurring arguments or patterns because messages with humour can get people to laugh at contradictions as a way of accepting their existence… instead of frantically, futilely or tragically seeking to correct or eliminate them. (Meyer, 2000, p. 329)

In the above example, it seems that the therapist's reluctance to join the client in the humorous former position left him in the latter. With these points in mind, there seems to be a clear role for humour from both the client and the therapist in dealing with disruption that could be described as resistance in the therapy conversation. In using humour to try to accept their differences, both parties can protect the therapeutic relationship when it may be at its most delicate.

**Disarming resistance with empathy and reframing**

In the previous segment of therapy talk, resistance emerged as a sequential environment in which humour emerged. Resistance sets the scene once more as the problematic and challenging conversational landscape, littered with humorous comments. In the sequence below, humour is used repeatedly by the therapist to overcome resistance. Contrary to the rigidity of the previous example, this resistance was dealt with more flexibly by the therapist by using empathic and re-interpretative comments that relied on humour as a vehicle for its delivery. This section will draw heavily on but not repeat the section related to empathy in the Therapeutic Relationship part of the introduction in analysing the conversational sequence itself. In this section, the sequential environment of resistance is disarmed by the humorous device of expressing empathy through its ability to unite the dyad, in order to challenge the client whilst preserving the therapeutic relationship.

***Sequential environment: resistance***

In the following sequence, the client is resisting the therapist's attempt to move the client from problem saturated talk to considering solutions, particularly in returning to a previously suggested intervention. This agenda is met with considerable resistance from the client and humour is used frequently by the therapist in this sequence. Given the frequency of humorous utterances in a short space of time, the sequential environment, mechanisms and responses around these five instances of humour will be discussed as the sequence unfolds.

Consistent with Gale & Newfield's (1992) finding, the sequence features repeated use of humour set in the sequential environment of client resistance to move from problem-saturated talk and to use a previously suggested solution. The therapist asks a question (lines 1-2) to help the client think about alternative ways of tackling her problems in an attempt to elicit the answer from the client (lines 1-2). Line 3's in-breath indicates the client's intention to respond. However, after a pause, the client responds with "I DUNNO" (line 5), a response well known as an indicator of unwillingness or inability to answer a question, and functioning to close down unwanted lines of questioning (Hutchby, 2002; MacMartin, 2008).

*Excerpt 2a: Dyad C*

1. Th: IS THERE ANY
2. OTHER way you? you could go about <u>that</u>?
3. Cl: .hhh

4. (6.0)
5. Cl: I DUNNO I just said to him look you can see he
6. doesn't want it or-err you know say to Stephen do you wan' 'im
7. (to) get off yo::u and he'll go yeah. ( )
8. (2.1)
9. Cl: But it takes a long time to get them apar:::t.
10. Th: Hmm
11. Cl: And then (.) I get (.) kicked for it (.) °I get [(.) told] off for?°=
12. Th: [so it? I mean]
13. Th: I mean I I ( minefield )
14. sort of? huh .hhhh huh [.hhhhhh
15. Cl: [yeah
16. Th: you know
17. Cl: YEAH he was like that as a BABY
18. Th: WRESTLES you [(to the ground etcetera it's all a bit
19. Cl: ( ) [NUR::::sery!
20. Cl: That's right!
21. Th: All a- All a bit too much. No. I? I'm? I wonder first of all whether
22. erm (0.3) you as a general ru::le (0.5) err even its quite?- err
23. especially if its for quite short periods
24. <WHERE YOU SEE THEM> um you sa::y
25. that they're at it non-stop and I KNOW what you mean!
26. $↓Because >I get a bit of that as< we:ll!$ HAH HAH!

The therapist tries to elicit the favoured response from the client, but the client resists this by returning to describing her current tactic. The therapist explains the intervention, and her re-interpretation is shown through expressing tentatively her idea of praising good behaviour. There are a range of markers indicative of a re-interpretation, such an epistemic marker ("I wonder" line 21), figures of speech ("as a general rule") and voiced pauses (err, erm, um). She starts to introduce the idea of praising the positive, but interrupts herself in order to challenge the idea that their challenging behaviour is "non-stop". In an attempt to reduce the likelihood of her disagreeing to any part of her turn, she moves into an empathic self-disclosure and normalising statement (Leudar, Antaki & Barnes, 2006) in lines 25-26. The humour forms part of her conversational strategy to prevent any further avoidable misalignment.

***Mechanism: Empathic self-disclosure***

The mechanism behind the humour here lies in the sudden unexpected alignment of viewpoints and shared experience. This is conversationally achieved through a formulation statement featuring elements of self-disclosure and normalization, taking the client's experience from problematic to more universal. This linguistic platform of self-disclosure and normalization launches both humour and the therapeutic act of 'sharing empathy' (Batchelor, 1988). In twice using the first person reference (lines 25-26), she is constructing experiences as shared (Halonen, 2008). This statement appears to change the therapist's position or identity from expert to parent.

Incongruity theory suggests that people laugh at what surprises them, is unexpected, or is odd in a nonthreatening way (Berger, 1976; Deckers & Divine, 1981; McGhee, 1979). Here, an accepted pattern of therapist anonymity is violated. In the sudden alignment of their situations, this non-threatening but slightly unconventional parallel brings with it the ingredients required to create humour.

***Response: Re-interpretation***

The use of humorous empathy appears to allow the therapist to strategically move into a challenge or re-interpretation. In this case after using it to normalise the experience of frustration at her children's behaviour, the therapist moves in to challenging the notion that the behaviour is "non-stop", mentioned prior to the use of humour. By creating the experience as shared, she aligns with the client and builds credibility for her intervention through experience.

*Excerpt 2b: Dyad C*

| | | |
|---|---|---|
| 1. | Th: | $↓Because >I get a bit of that as< we:ll!$ HAH HAH! |
| 2. | Cl: | Yeah. |
| 3. | Th: | .HH um? But it ISN'T non-stop. There must be occa::sions |
| 4. | | >even relatively short ones< where they are NOT at it (0.4) |
| 5. | | <And I think you should tr:::y and hone in on tho:::se>. |
| 6. | | And actually HEAVily reinforce occasions where they are |
| 7. | | co-operating |
| 8. | | (0.7) |
| 9. | Cl: | Hmmmm |
| 10. | Th: | Okay even if its good for- and in fact you shouldn't wait. |
| 11. | | Because if you wait that extra fi::ve minutes |

12. >for that five minutes all hell would have broken loose
13. and you would have lost< $the opportu::nity$

This expression of shared experience then allows the therapist to continue the persuasion for her intervention of praising good behaviour, which has previously been dismissed or resisted by the client.

Following the excerpt outlined above, the subsequent talk features the client continuing to resist the therapist's idea of positive reinforcement ("IT JUST MEANS you can't turn your back!"; section not reproduced here). The therapist continues to promote her idea and uses humour as she moves on, by minimising the opportunities for the client to interrupt, to talking about dealing with unwanted behaviour (excerpt 2c-ii, line 5-6). This represents a return to the problem and to the example the client discussed earlier (excerpt 2c-i). It is at this point that she moves into humour by formulating the opposing features of Andrew's behaviour (excerpt 2c-ii, line 7-8) which seems to function as a way of showing that she has been listening and understanding her difficulties (excerpt 2c-i from previous talk).

*Excerpt 2c-i: Dyad C*

1. Cl: SO if he's lying on top of Ste::::phen- he thinks he's being nice-
2. he's KISSing him and he's holding him so- and Stephen's
3. screa::::ming >in pain most of the time<
4. .hh ↑I said Andrew? HE DOESN'T WANT IT!
5. >You know< <he's cry::ing> (0.9) He doesn't SEE that.
6. <He just sees what he::e wants to do to him.>
7. (1.9)
8. And it err it always ends up in a fight!

*Excerpt 2c-ii: Dyad C*

1. Th: =and again >as I said< err constantly reinforcing? >Times
2. when they are doing what they should do appropriately.<
3. >in some way and constantly um having to remind yourself
4. they've been quite good< I must go in and sa:::y something
5. >°And then you've actually got to find a way of dealing with
6. (something in) the situation°-< well FOR EXAMPLE if you find
7. him you know <umm err> sort of err kind of kissing and

8. tortu(hh)ri(hh)ng Ste(hh)phen at the same ti::me=
9. Cl: =Yeah=
10. Th: =and when you say? I'm suspecting he knows what he's
11. doing when he's doing that. °I suspect he does know what he's
12. doing° .hh
13. Cl: Yea:::h!

***Mechanism: empathic metaphor***

The therapist uses the information that the client offered earlier (excerpt 2c-i) and formulates it back, extending it slightly by hinting towards a re-interpretation. The metaphor "tortu(hh)ri(hh)ng" forms one part that indicates a re-interpretation regarding awareness of harm caused in contrast to line 5 (excerpt 2c-i) where the client assumes Andrew's ignorance. The insertion of laughter particles in the metaphorical term indicate the exaggerated hyperbolic use of the term, not meant to be taken literally. The mechanism that transforms this comment (lines 7-8) into humour is around the dichotomy in selection of verbs encapsulated in the child "kissing and torturing" his brother simultaneously. This is partly achieved through the use of metaphorical exaggeration, taking his behaviour to the extreme to emphasise the dichotomy.

Ferrara (1994), in her analysis of therapeutic talk, identified the construction of metaphors as one of a number of discourse strategies in psychotherapy. Bercelli et al. (2008) argue that metaphor and hyperbole are features in psychotherapist re-interpretation that can be skilfully used in therapeutic ways. This mechanism of hyperbole or metaphorical exaggeration has been found in previous research to be a source of humour in therapy and a means of re-framing (Buttny, 2004). Humour shares many similarities with metaphor, such as their duality and the bringing together of two concepts (for a more complex discussion of this relationship, see Kyratzis, 2003).

***Response: Re-interpretation***

Humour represents a tool the therapist uses to move into re-interpretation. In the above excerpt, the formulation of the client's prior talk and subtle move into re-interpretation using humour allows her to disarm the client's defences (Liddle et al., 1988). She then moves into subsequent therapeutic action (Antaki, Barnes & Leudar,

2008) by presenting more plainly her re-interpretation of events (lines 10-12). This statement seems key to moving into therapeutic action (Antaki et al. 2008).

This humorous re-interpretation elicits a minimal agreement from the client (line 9). Similar to the findings of Bercelli et al. (2008), the minimal agreement in response to the re-interpretation is pursued further to ensure the genuineness and extent of agreement. This is pursued by disambiguating from metaphor and repeating the re-interpretation (lines 10-12) until the agreement is repeated and more emphatic (line 13). Other features that indicate the metaphor's role as hinting toward a reinterpretation include the speculative markers in line 6 ("FOR EXAMPLE"), and epistemic markers in line 10 ("I'm suspecting"), repeated in line 11 ("I suspect").

This metaphorical exaggeration is crucial in the creation of humour. The formulating features of the statement are crucial to demonstrating empathy through summarising concisely the psychologically significant parts of what the client has said. The therapist here is formulating back information that the client disclosed earlier in the session (excerpt 2c-i) to show that she is listening and has understood. This statement helps to validate the client's experience which repeatedly has been impeding the therapist's attempts to promote her intervention. By attempting to persuade the client to reward the children when they are 'being good', it appears to prompt the client to reaffirm the 'badness' of their behaviour. As mentioned above, empathy is conversationally achieved. In order for a statement to be considered as empathic, the accuracy of this statement must be confirmed by the client. In this example, the accuracy of formulation is indicated through the client's minimal confirmation (line 9).

Having used humour to validate the client's experience through conveying empathy and securing confirmation it was received as such, the therapist then moves back into promoting the original intervention. The client's resistance to answering this question causes the therapist to persist in her comments (line 19). In the continuing conversationally problematic environment of resistance, she then extends the play-frame further by using humour twice more (line 18 and 25) in relatively rapid succession.

*Excerpt 2d: Dyad*

14. Th: Um BUT YOU KNOW. Is there <u>any</u> other way
15. that you could approach that from the way you do:::o

16. which is to to to get in the aggravation like you do do::o
17. you get kicked and and and an an sort of
18. <*ge::t off your brother!*> all that kind of stuff
19. ↑Is there <u>any</u> other way you can deal with it?
20. In a more positive manner.
21. (2.5)

The client's resistance was addressed by the therapist using humour in the form of impersonation (line 18) and re-interpretation (line 25).

***Mechanism: Impersonation***

Impersonation in the data demonstrates again how humour can be used to convey empathy. By re-enacting a scene from the way that the client currently approached her children's behavioural difficulties and the reaction she gets, this impersonation reflects an attempt to formulate what the client has been saying.

This formulation and expression of empathy serves to further validate the client's experience and helps the therapist to return to promoting the client to think about other possibilities and encourage her to re-interpret the situation herself. In line 19, the therapist asks this as a closed question, encouraging her to respond affirmatively. However, in lines 22-23, the client's resistance to generating alternatives is shown once more through a pause, dispreference markers and hedges (words and phrases which soften or weaken the force of a statement), indicative of a dispreferred answer. She then misaligns with the question by responding with "because", which typically answers a "why" question, for example "why do you respond the way you do?" In doing so the client justifies and defends her own behaviour.

*Excerpt 2e:*

22. Cl: Well I mean it's just? Because Ste::phen's got
23. such a <u>pier</u>cing scream. It's like you just wan' it to stop!
24. Ev- >you know< <u>ev</u>ery time something's happening
25. Th: Its ve(hh)ry <u>use</u>ful <<u>that scream</u>> i(hh)sn't i(hh)t!
26. [HAH HAH.
27. Cl: [Ewweurgh! He'd scream all the time!

***Mechanism: Re-interpretation***

It is at this point that the therapist moves in with humour again, using her response to re-interpret the scream (line 25). The humour appears to lie in the contrasting adjectives used to describe the scream. The client's turn (line 23) emphasises the quality of the scream ("piercing") and mentions the impact that it has on her ("It's like you just wan' it to stop!"). The therapist then offers a re-interpretation (Bercelli et al., 2008) of what the client has said, extending it by conveying the functionality of the scream. This seems to be achieved by emphasising the first syllable in "useful" (line 25), which challenges the client to think about how her response to its volume and tone may benefit the child. Inserting laughter particles into her tag question ("i(hh)sn't i(hh)t!"), the therapist solicits an agreement (Bercelli et al., 2008).

***Response: (Eventual) alignment***

The therapist's humorous re-interpretative statement and the client's response seem to indicate some misalignment, in that the client responds to the frustrating nature of the scream (line 27 "Ewweurgh! He'd scream all the time!").

*Excerpt 2f: Dyad C*

| | | |
|---|---|---|
| 25. | Th: | Its ve(hh)ry useful <that scream> i(hh)sn't i(hh)t! |
| 26. | | [HAH HAH. ] |
| 27. | Cl: | [Ewweurgh!] He'd scream all the time! And the thing is you don't |
| 28. | | even have to be in the same roo:::m and you automatically shout |
| 29. | | <Andrew! Get off!> because it (0.9) its like you can see what's |
| 30. | | happening throu- through a brick wall! |
| 31. | Th: | Hmmm |
| 32. | Cl: | Some times admittedly i- its not Andrew and |
| 33. | | he says ooh I didn't do anything |

However, her comments starting in line 27 ("And the thing is…") seem to begin to re-align with the therapist's reinterpretation of the function of the scream and the impact it has on her behaviour, in that it has become so automatic and routine that she has made a mistake in allocating blame. In this example, whilst initially misaligning to the serious function of the humorous comment, the client re-aligns to its serious function.

***Summary***

In this research, resistance has emerged as a sequential environment for the emergence of humour once more. In this example, the therapist uses humour to

express empathy. This is achieved by formulating back aspects of the client's talk, and using self-disclosure, metaphorical exaggeration and impersonation. In expressing empathy through humour during a sequence of resistance, the therapist is unifying herself with the client when there is a clear conversational divide. In formulating back client talk, the use of metaphor can capture and exaggerate inconsistencies and hint towards a re-interpretation. Humour has also been observed to help deliver re-interpretative utterances. The use of humour can give rise to empathy, which can then help the therapist to move into re-interpretation. Alternatively, the humour can represent the vehicle of re-interpretation itself.

Some of the humour examples fit well with the cognitive category of empathy (Bachelor, 1988; Duan & Hill, 1996) described above, such as the impersonation, which demonstrates that humour can be a useful tool to convey empathy conversationally. One example of humour contains some self-disclosing 'sharing empathy' (Batchelor, 1988), revealing the therapist's position as a mother and her children as sometimes disruptive in order to convey her understanding and an empathic connection.

Meyer's (2000) classification of humour's functionality would place the empathic features of the therapist's use of humour firmly within the identification category. The utterances that contain aspects of re-interpretation would fit well with the clarification function. He argues that

> ...through the identification and clarification functions, or the relaxing elements of humor, parties can lower defences and be more open to seeing the new perspectives required to appreciate humor. Viewing new perspectives and laughing together at them can enhance communicators' identification with each other and move communication to a "comic frame" away from a rigid "tragic frame".
>
> *(Meyer, 2000, p.329)*

These two functions of humour render it a useful tool to dismantle resistance within the session, and the flexibility inherent in humour creates different opportunities within this therapy talk compared to the rigidity of the previous one.

**Elaboration on a disagreement with another**

As described in the 'Unresolved Resistance' section, the nature of two opposing viewpoints in a disagreement in therapy lends itself well to the duality on which much

humour is reliant. In the first example, humour neatly framed the incompatibility of the therapist's and client's viewpoints. In the following section, the analysis will focus on how clients use humour in a similar way to describe disagreements outside of the therapy room.

***Sequential environment: Autobiographical account***

In the following two sequences, humour emerges as the clients elaborate on disagreements with other people. Given their many similarities, these segments will be described in parallel. In the first example, elaboration is offered at the request of the therapist, when he questions a particular term the client uses (line 3-5). Being requested to elaborate on the term, she moves into an extended autobiographical sequence (line 6) that acts as an illustration. As this account progresses, the point that she wants to repeat and elaborate on is regarding the unfriendliness of her mother.

*Excerpt 3a: Dyad B*

| | | |
|---|---|---|
| 1. | Cl: | (1.2) ↑>but it still?< hh-.hh it HU:::RTS me::e (1.0) a little |
| 2. | | to have to do this to my ↑pa::rents because I am clo:se to them |
| 3. | Th: | (1.9) Hmmm (3.0) When you sa:y DOI- (0.7) how could you DO |
| 4. | | this to your parents- when you say DO this to them wha-wha- |
| 5. | | what do you actually mea::n? |
| 6. | Cl: | Break away from them (0.7) ↑Actually (how) I upset my |
| 7. | | mo:ther yesterda::y it was (1.7) she said to me my MY little |
| 8. | | brothers girlfriend met my parents for the first time and she |
| 9. | | wasn't at all what we expected (0.9) a::nd |
| 10. | | >so I said to my mother< well <what do you think of |
| 11. | | he::r (0.7) he::::r-e:::::::r> and 'e said well? she was a bit |
| 12. | | disappoi::nted >AND then she said to me< that DEBOrah |
| 13. | | had actually said to my brother Pe::te (0.6) tha:::t (0.3) ↑she |
| 14. | | thought my mother hadn't be::en (.) very friendl::::y (0.7) |
| 15. | | >my mo'her said she didn't know wha' she was talking |
| 16. | | about< I said well it ↑has be:en said befo:re that you |
| 17. | | haven't be:::en friendly (0.4) and she rea:::lly took offence! |
| 18. | | (0.6) >she said< she got off the ↓phone- >she said< Philli::::p |
| 19. | | °to my father° plea:::::::se tell Raffiella: (1.2) tha(gh)t (0.7) |
| 20. | | its not ↓tru:::::::::e (0.5) and she r- she wouldn't ↑talk to me::e! |
| 21. | | (1.2) and I said t- I said to my father put my- >put ↓mummy |

22. back on the< phone.- so she came back on the phone. °she s-°
23. ↑and I said to her I CAN'T >BELIEVE< you took it so
24. PERsonally you made a comment to me::e (0.3)
25. I came back with? (0.6) Yes. (.) you know its been said befo:re
26. sometimes that ↓you haven't been ve'y friendl:y
27. an' you taken it PERsonally she said wull (0.2) you give me
28. a list of pe:ople YOU ↓think (0.8) tha(gh)t (0.3) YOU tell me
29. exac- you?- >she said< you give me a list of people .h who
30. yo:u think I haven't been very friendly with. (.) AND I DI::D!!! (0.5)
31. AN' SH(hh)E DIDN'T LI::KE IT!!

To build the argument that her mother is unfriendly, she: recounts a recent situation illustrating another person's agreement (lines 12-14); offers a zero-person agreement statement with neutral perspective markers ("it ↑has be:en said befo:re that you haven't be:::en friendly"; Halonen, 2008); confronts her mother with her conduct during the telephone call itself (lines 17-24); repeats the zero-person statement (lines 25-26); and following her mother's pressure to shift from zero-person to specific people, describes offering a list of people in agreement. Building her case through the evidence can be compared to purposefully building tension in anticipation of a punch-line in a joke for the express purpose of releasing tension by relieving the incongruity (Maase, Fink & Kaplowitz, 1984). The client's hesitation and re-phrasing of how she would like to present the part just prior to this punch-line (lines 27-30) shows the importance attached to delivery, or perhaps is evidence of her own excitement at recounting how she had 'won' the argument.

This sequential environment of elaborating on a disagreement with a third party is the same context for the emergence of humour in the next example. Following a question from the therapist inviting the client to elaborate on the therapist's abstraction, the client offers an autobiographical example to illustrate her complaint and the disagreement with her mother.

*Excerpt 4a: Dyad C*

1. Th: In this kind of situation ↑where (0.3) ↓where you were *very ill*
2. and go off to your mother- is that something that you don't think
3. they're resentful about or understand that <(that's really what
4. you want to do)? °Or do you () get yourself ()°?=

5. Cl: =↑WELL (1.0) I mean I get these ↓sinus infections
6. so many times and I'm usually ok.
7. ↑But I've never had this high temperature (0.6)
8. AND QUITE FRANKLY I thought I was- (0.3)
9. >IN AND OUT OF<? conscious- that I was very?
10. I felt very very stra::nge (0.4)
11. so I just ra[ng and said-
12. Th: [well you would do with a? Its not like you're a child
13. with a high temperature although ( ) very ea:::sy.
14. Cl: Yea:::::h. And I've ↑NEVER ↓I never have temperatures
15. It was just under one hundred and fou::r. (0.7) so I-
16. >I sorta rang my mum when I got in and said I didn't feel well
17. so my ↑dad ↓said take your temperature and ring me BACK<
18. (0.3) so when I went to ring 'im back
19. (then I was HUN::::G up) for an HOU::::R
20. >and I was getting °worse and worse eventually I got in and I
21. said what it was°< ↑THING IS WITH MY MUM:M (1.7)
22. $↑VERY STRAN:::GE$ she'd say to um take your temperature
23. >and I'll tell 'er what it< i::s and she says >↓Don't be so stupid.<
24. (0.7) ↑she ↑NEVER BE↓LIE::::VES ME. (1.0)
25. She's always got this thing abou::t saying ↓>don't be so stupid<
26. and you have to like? explain:::n yourself for her (0.8)
27. °very strang[e° sh-] she's always=
28. Th: [°that must be very annoying°]
29. Cl: =like that with m::e!. (1.1) If they- if if she thinks I'm not
30. t-s-saying something that's ri::ght O::R?
31. if they think they're ri::ght
32. they always say >don't be so stupid<
33. and I'll say >alright then?< (0.4) an' you know
34. I s::s- $I s(hh)aid to her$ I've got this really high temperature
35. she goes ↓>don't be so stupid<
36. and I said alright then I haven't
37. YOU KNOW! s- They never BELIEVE ME!

Similar to the previous example, the client builds evidence in her account, this time by elaborating on the context, severity and atypical nature of her illness. There are

many repetitions of the various components ("don't be so stupid" lines 23, 25, 32; "they never believe me" line 24; "alright then" line 33) that form the humorous segment itself (line 34-37), almost as if building the account in order to distil an eloquent humorous delivery. It is interesting how the subject of the suggestion to measure her temperature changes. Originally indicated as her father (line 17), to hypothetically her mother ("she'd say to um take your temperature" line 22), the client's account constructs her as doing what she is told and then being disbelieved. Finally, this piece of information is omitted as the introduction of humour utilises only the components in the account necessary to frame the ludicrous nature of the situation as perceived by the client.

***Mechanism: Incongruence between viewpoints***

Eliciting a client's autobiographical account or narrative (Perakyla et al., 2008) is a common activity in therapy. In recounting disagreement and disbelief through extended sequences such as storytelling, humour in this research emerges in the incongruence and contrast between the client's own view against another's. This can be through the client recounting her own response of unexpected (on the other's part) disagreement or misalignment:

*Excerpt 3b: Dyad B*

29. Cl: exac- you?- >she said< you give me a list of people .h who
30. yo:u think I haven't been very friendly with. (.) AND I DI::D!!! (0.5)
31. AN' SH(hh)E DIDN'T LI::KE IT!!

or of incongruous (on the client's part) agreement or alignment:

*Excerpt 4b: Dyad C*

34. Cl: $I s(hh)aid to her$ I've got this really high temperature
35. she goes ↓>don't be so stupid<
36. and I said alright then I haven't
37. YOU KNOW! s- They never BELIEVE ME!

In excerpt 4b, this pseudo-agreement (line 36) represents apparent agreement but, given the previous content of the client's talk, the sarcastic nature of her response can be assumed. From the current analysis, humour is used in recounting misalignments outside of therapy, emerging through capturing the opposing

viewpoints. Through the differentiation function, both are constructing their talk to emphasise the violation or unusualness of the opponent's viewpoint (Meyer, 2000).

***Mechanism: Repetition***

These misalignments outside therapy provide fruitful grounds on which to cultivate further crops of humorous comments. The central features of what was constructed as humorous remain the same but are extended in different ways. Excerpt 3b above reveals a misalignment between the client and her mother and this theme is repeated, extended and elaborated through embedded repetition in excerpt 3c (lines 53 and 57-58):

*Excerpt 3c: Dyad B – several lines of prior talk omitted*

50. Cl: those people that (0.8) ermm she::e has
51. fallen out with. I know (1.0) and when I'm with them >I'm
52. very conscious of the fact that< (0.4) they don't (0.3) like my
53. mother (.) f[or some r(hhhhh)eason=
54. Th: [hmm
55. Th =hmmm
56. Cl: or::::r I was (offending) them °so I have to tread ve'y gently °
57. And it makes me want to be even more friendly
58. with $these people$. .hhh (1.2)

The client elaborates on this disagreement by firstly using sarcasm in repeating her opinion on how other's view her mother negatively, showing the humorous intent of her comment by inserting laughter particles in "f[or some r(hhhhh)eason". She continues this elaboration by secondly widening this gulf of disagreement between her mother and herself by aligning herself with people who share her viewpoint, and the facetiousness of this statement is shown in her 'smile voice'.

***Responses: Eliciting emotion***

Following from excerpt 3b above, the client continues to emphatically elaborate on the evidence in support of her mother's unfriendliness.

*Excerpt 3d: Dyad B*

31. Cl: AN' SH(hh)E DIDN'T LI::KE IT!!
32. Th: hmm[m
33. Cl: [I gave her FIVE or six-na::::mes of pe:::ople (1.0)

34. Th: hm[m
35. Cl: [And she couldn't accept it!- I said well ma::ybe it something
36. that yo::::u do which isn't ve'y friendly which offends pe:ople.
37. (0.5) .hh I said look at this i- .hhh I said ↑LOOK!! (.)
38. You've NOW taken offence. at what I've said to ↓yo:::u.
39. Look how ↑PERsonally you've ↑TAken it! (0.2)
40. >YOU won't even ta::lk to me! You can't even talk to
41. me ↑sensibly no::w. (0.7) She really took offe::nce!=
42. Th: =hmmm (2.0) hmm (0.6) and does she do that quite a bi:::t?
43. Cl: (0.8) She obviously does. (1.2) [she takes things very=
44. Th: Hmm[m
45. Cl: =personally. (1.4)
46. Th: And how?- what affect >do you think< that has on ↓yo:::::::u.-
47. How does that make you fee::l? when she does that.
48. Cl: (11.1) >Well I-< (0.9) °ugh° (3.0) <I don't (0.1) ever> se:::e
49. her doing it. Bu::t its uncomfortable for me::e. (1.8) to
50. have to:::::o (1.8) those people that (0.8) ermm she::e has

The therapist moves in with a formulating question (line 42). This allows him to show he has understood and to close that pattern of talk (Heritage & Watson, 1979; Antaki, 2008), and draw out the relevant parts to move into therapeutic action (Antaki, Barnes & Leudar, 2005). He moves to encourage her to explicitly express the emotions underneath (line 46-47) (Rae, 2008).

In the other sequence, the client uses humour (lines 34-36), to which the therapist does not respond audibly. The client emphatically repeats her point in generalised terms ("They never BELIEVE ME!" line 37; "they never sort of believe you first time" line 41). The therapist appears to offer her acknowledge tokens (line 44) to show she is listening and interested and declines at this point to direct the conversation. This may be due to picking up the discrepancy between the specific nature of the client's account and the generalised statements used, hinting that the story itself may be one example or representative of a wider issue. The use of silence here represents a useful action (or inaction) to invite the client to elaborate.

*Excerpt 4c: Dyad C*

34. Cl: $I s(hh)aid to her$ I've got this really high temperature
35. she goes ↓>don't be so stupid<

36. and I said alright then I haven't
37. YOU KNOW! s- They never BELIEVE ME!
38. And you have to sort of say well I ha::::ve
39. And >d'you want to come and look at it<
40. before they say oh? ↓alright then.
41. (1.3)
42. I don't know what it is they never sort of believe you first time
43. ( )
44. Th: Yeah.
45. (1.5)
46. Cl: Yeah. I remember years ago that (comes a time)
47. we've always lived in town houses
48. (1.8)
49. and they've always always made me wear slippers.
50. And I've always said if I wear slippers I'll fall down the stairs.
51. And I used to fall down the stairs all the time.
52. Couple of times I'd really hurt myself.
53. And they had these really (0.8) ornate banisters up ( )
54. And if you got your arm stuck >in it or something< and you fa::ll
55. and you're like hanging.
56. (0.9)
57. ↑Loa:::::ds of times I'd be left there and like about half an hou:r
58. saying- I thought I'd broken my leg a couple of times
59. and they ↑NEVER COME TO ↓never came to me you know
60. (1.4)
61. °really weird°
62. (1.2)
63. Th: (°dussat make you angry°)
64. (3.0)
65. Cl: ↑Ye:::ah
66. (1.1)
67. ↓°I suppose so°
68. Th: Hmmmm.

From elaborating extensively with the use of humour one example to illustrate her point, the client then moves into another autobiographical account (line 46 onwards).

This shows similar themes of feeling that her point of view was overlooked (line 13-14), that serious harm could come to her (lines 51-52; 58) and that her needs and harm were disregarded (lines 57 and 59). In line 59 whilst describing a story in the past, the client shifts from past tense to present tense ("they ↑NEVER COME TO ↓never came to me you know"), and corrects herself back into past tense, to fit with her autobiographical account from her past. There are interesting changes in prosodic features; that which is spoken in present tense is louder and higher in pitch, before she reduces her pitch and volume as she returns to speaking of the past. Interestingly the client uses the term "really weird" (line 61) previously in her account to express her disbelief at her parents' actions. This somewhat vague and emotion-neutral comment spoken quietly is picked up by the therapist. The therapist directs the client to make explicit the evident emotion in her account, by asking a direct question ("(°dussat make you angry°)"), in the same volume as the client ends her account with in line 61.

***Summary***

Within this section the use of humour has been described in the context of elaborating on disagreements with another. The sequential environment of elaboration on a disagreement has been created through autobiographical accounts where the evidence to support their viewpoint had been presented. Within these accounts, there was noticeable repetition of their point and the constituent parts of the humorous utterance before humour itself was employed. The mechanisms within this context relied on sarcasm and the succinct presentation of the incongruity of viewpoints. It was compiled from repeated previous parts of non-humorous speech related to the incongruity and support for their viewpoint, and extended through repetition of humour in the client's subsequent speech. Responses to the use of humour in this context followed similar directions in that the humour itself was not responded to by the therapist, and this non-response invited the client to continue to offer further elaboration. This elaboration was either closed down by a formulating question from the therapist, or concluded without intervention from the therapist. Interestingly, in both examples the therapists invited the clients to express the emotion that underlay their accounts.

Linking back to the last section and its focus on empathy, it seems that humour can function to describe implicitly emotional material. In both of these examples, the therapist moves in with questioning to invite the client to explicitly describe their emotions. This questioning to uncover evident, but disguised affect seems to be an

important stage of the process of establishing empathy with the client (Barrett-Lennard, 1981; Wynn & Wynn, 2006). Their questions function to name client feelings explicitly to ensure accurate resonation. Questions which suggest probable emotional states within them communicate an empathic connection, having deciphered the emotion heavily hinted at but obscured through the use of humour.

**Change**

The previous examples of humour relied on the contrast of opinion between two different people: client and therapist, or third party. This section will look at the role of humour in simultaneously holding two competing perspectives achieved through therapeutic change.

Much therapeutic success is reliant on clients being guided to achieving new perspectives or insights into their personal lives. Through the process of change, a person can find themselves in a complex position of holding simultaneously the familiar, but unhelpful previous perspective and the novel, but slightly foreign new insight. The following two examples explore the use of humour in this difficult transition. In the first example the client uses humour to impose and enforce her new perspective onto her old patterns of behaviour. The client's use of humour hints at, but disguises, the emotional impact of these patterns. In the second example the client is beginning to change her behaviour, but emotionally struggles with this change. The therapist uses humour to reframe to diffuse the emotion in order to further enforce her new approach.

***Sequential environment: Incongruence between previous and current perspective***

Therapists regularly present clients with new perspectives when considering their problems. Clients have a range of responses open to them, from rejection to various levels of acceptance. One active form of acceptance is extended agreement, which can be conveyed though the use of autobiographical material as evidence to support the therapist's reinterpretation. In the following excerpt, the client talks about a PCP (Kelley, 1991) concept, discussed presumably in a prior session. She provides autobiographical information that fits with the re-interpretative framework that the therapist was offering.

*Excerpt 5a: Dyad B*

1. Cl: And I've actually <d'you know> I've actually done this (0.6)
2. as an experiment

3. Th: You did look at the matrix did you?
4. Cl: E:::rr (1.4) No I've acted out the matrix dependency matrix.
5. ↑I:::'ve (1.3) seen what happens when you pursu:e
6. ↑or (0.4) when you start to respond but Alberto >has ↑now<
7. (0.3) withdra::wn and is now has now ↑basic(h)ally
8. ↑(h)esca(h)ped in my opinion
9. Th: Mmm
10. Cl: whereas with somebody I've met recently (0.6)
11. <I'm not giving ↓everything>
12. Th: Ri:[ght?
13. Cl: [I'm holding ba:ck and he is pursuing
14. Th: Ah ri::ght

The therapist's question regarding whether she had looked at "the dependency matrix" appears to be a mild misalignment. From this point, it becomes evident that the term "dependency matrix" takes on two meanings, as an object and a concept. In the former, the therapist asks if the client had looked at the object (line 3), to which the client responds with a dispreferred second-part pair (line 4), with dispreference markers (Pomerantz, 1984) of hedges and pauses. She then repairs the misunderstanding and clarifies how the dependency matrix had influenced her. She achieves this by manipulating the verb that was used. The therapist's "look at" object (line 3) becomes the client's "acted out" concept (line 4), in that, she explains, she used the ideas to understand her relationships with others. Having dealt with the direct question, she then addresses the dependency matrix as a re-interpretation, using an extended agreement connecting the concept with her experience (line 4-8).

***Mechanism: Metaphor***

As mentioned before, metaphors can be used to conjure up images within their descriptions. The use of metaphorical language seems to be used by the client to re-interpret relationships following the introduction of "the dependency matrix". In the current research, the client illustrates this with the use of humorous metaphor, in her choice or selection of the particular term "escape" (lines 8 and 18). Mulkay (1988) described laughter as being both a response to humorous discourse, but also providing the social cue that announces and encourages it. The intention to use humour seems to be announced in line 7 by the client as she inserts laughter particles into the preceding word "↑basic(h)ally".

The client starts this segment by selecting her role as pursuing (line 5) initially, whereby she is the subject of an active verb associated with chasing. This is closely followed by an alternative passive description of her responding (line 6), dependent on the activity of the other. She first replies to the latter descriptive account by describing Alberto's withdrawal in relation to her responding to his interest, and then moves on to the former by describing Alberto's escape in relation to her pursuit. With the word choices she has made, she is conjuring up similar but conflicting scenarios. In one she uses language that conveys a more neutral sequence of approach-avoidance. In the other her language is more emotive, reflective of a chase, and indicative of the influence of her own role. The humour lies in her re-categorising his "escape" in terms congruent with returning to the original description of the pursuit. This description creates a more dramatic, desperate, emotive picture.

Furthermore, the connotations of him having escaped indicate he has been lost completely, rather than stepped back possibly to return. But the choice of words, the use of humour and the insertion of laughter disguise the emotional impact of this perceived outcome.

***Response: Lexical substitution***

Formulation is another response to client humour. The client continues to elaborate on how the re-interpretation had shaped her understanding of events. The therapist then targets the emotive terms she uses to describe the pacing of relationships that formed the basis for the humour, and offers a lexical substitution (line 20; Rae, 2008). Substituting words is a tool used to reveal explicitly the emotion underneath (Schegloff, Jefferson & Sacks, 1977). The therapist takes a neutral term "pacing" (line 20) to replace her array of terms. Lexical substitution functions to accomplish three things: to demonstrate that the therapist is monitoring talk very closely, that he is making sense of the client's talk, and to propose that the client should express feelings in a more explicit unvarnished way (Rae, 2008; Vehvilainen et al., 2008).

*Excerpt 5b: Dyad B*

15. Cl: A::::nd (2.0) >I know it (sounds as though James) will have< to:::
16. (0.6) respo:nd (0.8) but I don't want to respond t' him in
17. such a way ↑that (0.9) he feels that there is dependency
18. and that he's going to >a:lso: feel the need to esca:pe<
19. ↑or (0.4) disengage
20. Th: So your pacing's (a bit do you find when you meet a new

21. person)
22. Cl: I am (pacing)
23. (1.4)
24. Th: How does that fee::el
25. Cl: O::h ↑I'm not (.) ↑I don't (1.4) ↑I enjoy it some↓times and
26. other times I wish I didn't have to >do it<.
27. because it- it's a form of a ga:::me.

In this instance, by using a neutral term (line 20) and seeking agreement (line 22), the therapist then moves into drawing out a response that explicitly conveys the emotional impact (line 24).

The role of humour in eliciting explicit emotion talk has been indicated in the previous section, as humorous utterances of the client can be laced with implicit but disguised feeling through selection of descriptive and metaphoric words. Lexical substitution is a strategy to isolate events from emotion, in order to explicitly and specifically address underlying emotion. This use of humour represents a useful time when therapists can invite the client to make explicit their underlying hinted affective state, in order to promote an emotional connection with the client.

***Sequential environment: Incongruence between action and emotional reaction***

In the second example the situation in which humour emerges involves a client's description of behavioural change at the therapist's suggestion, which incurs strong emotions that threaten to disrupt the conversation.

In the following excerpt, the therapist is offering a re-interpretation and suggests an intervention, encouraging the client to be more flexible in her own rules (lines 1-8). Before her turn is finished the client offers agreement tokens, then repeated agreement (line 9, 11, 13, 15). The therapist then requests a more extended agreement (line 16) to which the client offers an autobiographical account:

*Excerpt 6a: Dyad C*

1. Th: I'm saying to you? (th)at you've got to be mo::re flexible
2. (.) in? (.) some? (.) >of your own rules if you like<
3. how 'bout- how you (.) go abou::t it. (.) >for example<
4. .hh umm although its desirable to d- to do all sorts of things
5. without having .hh umm (0.1) Ste::phen .hh around (.)

6. it might be better for you to be doing wo::rk
7. >related things in the morning<
8. and [just kinda get on::n with it?
9. Cl: [Mmmm yea:::h I HA::ve bee::n
10. Th: in the afternoon:::n=
11. Cl: =yeah
12. Th: You've been doing tha::t in fact
13. Cl: Yea::h
14. Th: ↑Go:::::::d.
15. Cl: Yeah
16. Th: °>how's 'at been.<°
17. Cl: EVEN HOU::SEHOL' THINGS that I used to Da:sh around
18. and try 'n do i(t) all while 'e wasn't there (2.2)
19. °un then::n not have time to do anythin(g) else°
20. so I::: lea:::ve it °I tend to leave it now°
21. COZ I was a:::ngry coz >I spent all day yesterday
22. coz I hadn't been in the house [I was cleanin the house=
23. Th: [yes
24. Cl: =[I did their room
25. Th: [yes:::s
26. (2.2)
27. Cl: >Took them< upstairs to get undressed and
28. >by the time I come up< they'd sorta made their whole bedroom
29. into a pi:::rate ship you know out of e::verything °and anything°
30. n' it really BUGS me (1.8) an' u:::::::sually I would 'av
31. (0.5) ss- (0.6) gone ma:::d an' done it all
32. before they got into bed
33. >coz I can't bear a< thing ou::::t [you know when its bed time
34. Th: [°ri::::ght°
35. Cl: =everything has to be [.hhhh in place
36. Th: [↑uuuuh! why can' they s- ↑why can't=
37. they sleep in a pirate ship!=

The client's account is an extended agreement to the intervention. However, her response emphasises the emotional consequences she has encountered in changing her behaviour ("COZ I was a:::ngry" line 21; "n' it really BUGS me" line 30; "I can't

bear a< thing ou::::t" line 33). Interestingly she uses language in a subtle way to differentiate between feeling angry and acting angry ("an' u:::::::sually I would 'av (0.5) ss- (0.6) gone ma:::d an' done it all). Having emphasised her anger at the untidiness, a disagreement in viewpoint between the therapist and client emerges in terms of the importance of her own rules of tidiness. The therapist responds to this anger, and perhaps her urge to tidy up, with humour to offer a mitigated challenge (line 36-37). The client's assertion that she leaves tidying now (line 20) seems overlooked by the therapist at this point in this conversation through the emphasis the client places on her annoyance at their mess. There is a simultaneous cohesion as the client adheres to the behavioural aspect of the intervention whilst disagreement in the cognitive and emotional dimensions of clear rule violation and emotional consequence.

***Mechanism: Metaphor***

This instance is another example of humour created through metaphorical language as the therapist reinterprets the situation by seeing the situation from the children's viewpoint, employing a metaphor to shape her question (lines 36-37). MacMartin (2008) points out the pre-suppositional quality of questions, such as leading questions used by barristers. The therapist's question of "↑why can't they sleep in a pirate ship!" brings with it the presupposition that it is not mess but re-categorizes it as a pirate ship. This statement also indicates her position that she cannot think of a reason against it. This side steps the issue of the mess which appears to be the cause of the client's irritation. In presenting the situation from a child-like perspective, the client is able to see the humorous side of the events (use of 'smile voice' line 44).

The therapist here (line 36-37) uses a challenge to convey a misalignment, but the use of humour, whilst conveying the previous turns as unexpected or misplaced (Vehvilainen, 2008), ensures a less confrontational and more playful challenge. This fits with Buttny's (2002; 2004) conclusion that humour allows people to stay aligned whilst discussing diverging viewpoints. This divergence seems a useful context in which therapeutic work can occur, but the use of humour allows the therapeutic relationship to remain unscathed. This humour could be viewed as Meyer's (2000) differentiation function. But there seems to be an element of enforcing the behaviourally adopted intervention, bolstering its acceptance through cognitive challenging to impact her evident emotional response.

***Response: Empathy and praise***

As the talk continues, the client initially resumes what she was saying before the therapist interrupted with humour ("=SO I'VE left it"), and then immediately responds to the serious side with a direct and emphatic disagreement ("NO:::::::O."), congruent with the emotions she had expressed suggesting her negative viewpoint on the situation.

*Excerpt 6b*

| | | |
|---|---|---|
| 36. | Th: | [↑uuuuh! why can' they s- ↑why can't= |
| 37. | | they sleep in a pirate ship!= |
| 38. | Cl: | =SO I'VE left it. NO:::::::O. I've just- °you know- they put like a-° |
| 39. | | put a- they got a hoo:::ver with a- |
| 40. | | with a blanket tied on it for a ma::::st un- |
| 41. | Th: | HU::::::H ↑HU:::::H ↓HU:::::H HU:::::H. |
| 42. | | (0.5) |
| 43. | Cl: | >everything-< I know!= |
| 44. | | =$But it annoys me when you've spent all da:::::::y doing it$= |
| 45. | Th: | UH Huh! |
| 46. | | (2.3) |
| 47. | Cl: | Its different if they'd done it all day |
| 48. | | and then you clear it up and go to bed |
| 49. | | but its because I'd cleared up all day |
| 50. | | and then they made a mess °when they come in° (0.8) |
| 51. | | Its always the wrong way rou::::::nd. |
| 52. | | [I'VE just le::::ft it ] they've shut the door |
| 53. | Th: | [I suppose ] |
| 54. | Th: | Ok well I think tha::t's ↑pretty goo::::d! um tha::t >you know< |
| 55. | | I can tell you're annoyed [and I] think that's understandable |
| 56. | Cl: | [yeah] |
| 57. | Th: | but to actually lea:::ve it and |
| 58. | | let them get on with it for the moment= |

As the client intends to continue with this approach ("I've just-") she interrupts herself to respond to the humour itself as she begins to recount and elaborate on the humorous scene. Her softened, quieter tone indicates a shift in itself ("°you know- they put like a-°") and the content that follows indicates her willingness to share this

humorous viewpoint (line 38-40, 43). Such an elaboration and agreement with this perspective ("I know!") could be indicative of her changing viewpoint. In elaborating the scene, the client is extending the play-frame and showing she is able to see the funny side. Here, the therapist is able to separate their views in a way that fosters the protection of the therapeutic relationship and enforces the intervention.

The client returns to the cause of her irritation whilst moving out of humour by using a "smile voice" (line 44), and backs this up by justifying her feelings (lines 47-51). The therapist begins to address this issue at the moment there is overlapping talk (lines 52 & 53). The client clarifies the point that whilst she was frustrated, she followed the intervention regardless, taking further steps to repair the conversation. The therapist then responds with a mixture of praise (line 54) and empathy by acknowledging and validating her frustration ("I can tell you're annoyed [and I] think that's understandable").

***Summary***

In both these examples humour emerged as clients find themselves in the transition between old and new perspectives. In negotiating these changes, there were mild misalignments in both examples where the dyads were orienting to the new territory in slightly different ways to the therapist. Humour emerges as a way for the client to find a language to encapsulate the incongruency between these divergent perspectives. It also represents a gentle way for the therapist to enforce further change, adjusting cognitions and emotions to complement behaviour. Progressing through such change can evoke strong emotions. These emotions can be hinted at but disguised by the client's use of humour. Humour can be utilised by therapists to challenge underlying cognitions that drive their emotional response in a mitigated way that protects the therapeutic relationship, allowing the client to join the therapist through laughter.

Some argue that at the heart of the experience of therapy lies paradox (Gibney, 1996). It is within the unsolvable riddle of paradox that Jungians (von Franz, 1970) amongst others (Gibney, 1996) locate the origins of psychological and spiritual growth. Humour is a means by which clients may be able to reflect their experience of such growth. It would be important for therapists to be vigilant for such expressions of change, in order to capitalise on them.

**Misalignment and uncertainty**

The previous examples of humour emerged in the context of two opposing perspectives: disagreement in sessions (resistance) or disagreement recounted in sessions (conveying disagreement) or simultaneously holding two internally held perspectives through the process of therapeutic change. Through the analysis of data, a couple of instances of humour emerged from a break in the flow of conversation, in that turn-taking patterns had broken down, not through opposing perspectives but due to confusion and ambiguity about perspectives.

In the sequential environment of uncertainty, the following two examples will look at the context of misalignment first through not eliciting an expected empathic response and second through confusion around the direction in therapy. Both humorous utterances encapsulated an element of unexpectedness.

***Sequential environment: Misalignment through not eliciting empathy***

In excerpt 7a, the client is describing her worries that her loneliness will continue long into the future. Here, it seems that the client, who perhaps is not feeling fully attended to, may be expecting some kind of response. In the absence of such a response, she may be attempting to elicit an affirmation and validating response from the therapist.

*Excerpt 7a: Dyad B*

| | | |
|---|---|---|
| 1. | Cl: | I don't know- I'm very worried about it (.) I'm going ↑grey |
| 2. | | (0.8) |
| 3. | | >I suddenly keep on noticing grey< hai::rs |
| 4. | | (0.3) |
| 5. | | John |
| 6. | | (1.7) |
| 7. | | and it bo:thers me |
| 8. | Th: | Does it?= |
| 9. | Cl: | =as if I'm getting o::ld very old |
| 10. | | (0.9) |
| 11. | | and I'm going to- because ↑I |
| 12. | | (0.6) |
| 13. | | I meet so many people and can't make up my mi:nd |
| 14. | | (0.5) |
| 15. | | I'm worried °that I'll always be on my o:wn° |
| 16. | | (1.1) |

17. °it will be° (0.9) will be ↑TERRible to st-
18. to do what I'm doing exactly what I'm doing for another
19. (0.6)
20. °thirty years°
21. (1.5)
22. or maybe I'll di:e I don't know=
23. Th: =Do you think [that's where we (.)
24. Cl: [hh hh-hh .hhhh
25. Th: come back to ↑the [(.) sorta-
26. Cl: [hh hh hh hh hh .hh

By mentioning the therapist's name in line 5, followed by a long pause, the client appears to attempt to repair the conversational disruption by inviting him to respond. However, his response in line 8 to her concerns invites her to continue elaborating. Whilst her following comments are littered with pauses, none are long enough (1.0 seconds; Jefferson, 1988) to suggest a further invitation to the therapist, until the moment before her humorous comment where a gap of 1.5 seconds is left unfilled.

***Mechanism: Exaggeration***

The time in which she is left 'hanging' ironically leads her to morbid 'gallows humour' (Freud, 1905). And similar to Freud's ideas (1905), this dark form of humour may well afford her a coping mechanism to protect her from the painful emotions that she is implying. The client uses hyperbole to catastrophize further the bleakness she perceives in her future. The quiet voice, pauses and repetition in the client's speech indicate an emotive tone, and having made some pretty negative predictions, she exaggerates the negativity to such an extent that she finds the humour in it. This links well with the tension-reduction function proposed in Robinson & Smith-Lovin (2001). The literature on humour indicates the emotional displacement function of humour, which would fit with this example, whereby a build up of uncomfortable emotion may be displaced through laughter (Lippett, 1995b; Provine, 2000).

***Response: Re-interpretation***

The therapist's response to this client's use of humour was not to attend to the humour itself but to head straight back into the therapeutic work.

*Excerpt 7b: Dyad B*

22. Cl: or maybe I'll di:e I don't know=
23. Th: =Do you think [that's where we (.)
24. Cl: [hh hh-hh .hhhh
25. Th: come back to ↑the [(.) sorta-
26. Cl: [hh hh hh hh hh .hh
27. (1.6)
28. Th: ↓>do you think that comes back to the
29. sort of pattern you talk about<
30. do you remember the term slot rattling
31. Cl: Ye:ah
32. Th: .HHH that=
33. Cl: =that's throwing yourself into ↑other options ↓isn't it
34. Th: Well, i- i- i- its on the one ha::nd (0.5) is the >sort of<
35. the e- the parental expectations and (0.7) the
36. >sort of< confo::rming a::nd (0.4) and then there's
37. th- the part of yo::u that wants to:: >that gets to a point<
38. where you feel claustrophobic and wants to (0.5) reb-
39. rebe- and get ou:t of tha::t
40. Cl: ↑>I don't know how to do it< ↓tho:ugh!=

The client's humour is overlooked, partly because the therapist had already used the client's previous comments to move into a re-interpretation (lines 23, 25, 28). It seems that he was taking up his turn just as the humour was being delivered (line 23). He is likely to have been waiting to take up his turn and intended to offer his re-interpretation before the comment was made. As he moves into the re-interpretation her laughter interrupts him, and at the end of line 23 he makes a little room for it, continuing his turn in line 25. He makes excess space for her to continue to respond with laughter to the humour (line 25-6) with a safety pause (line 27) before starting once more.

Having discussed humour's role in empathy and emotion expression, humour also seems to be able to play a role as a response to the *absence* of resonation or withholding of empathy expression. The client seems to move into humour in the absence of any affirmation or validation from the therapist, almost as a method of eliciting empathy.

***Sequential environment: Misalignment between problem-talk and change***

Following the discussion about the client's mother's unfriendliness (transcript continues from where this ended thus *3e*), another misalignment occurs. Following the therapist's request to elaborate on her phrase "do it to them", a lengthy autobiographical account emerges to elaborate (see "Elaboration on disagreement with another" section). Following this lengthy elaboration, the therapist then uses a question to shape the client's next turn to move her out of general complaint regarding her mother towards change. He seems to be reorienting her to a more therapeutic focus in order to promote therapeutic change (lines 70-72).

*Excerpt 3e: Dyad B*

| | | |
|---|---|---|
| 59. | | And it makes me want to be even more friendly |
| 60. | | with $these people$. .hhh |
| 61. | | (1.2) |
| 62. | Th: | °mm-b[u-° |
| 63. | Cl: | [BUT THEN!!! >I mean< did she::e? The way she got on |
| 64. | | the phone. She put my father on the phone to talk to me:::e. |
| 65. | | (1.4) It was again::n like she wasn't treating me:e like |
| 66. | | an equa:l adult.[ Sh]e was reprimanding me. |
| 67. | Th: | [Hmmm right ] |
| 68. | Th: | ye:s. |
| 69. | | (0.7) |
| 70. | | .hhhhhhhhh (0.5) And is that a situation:::::n (0.8) |
| 71. | | >just to reitera:te< that mm- is that a situation you want to |
| 72. | | mo:ve beyo::nd?= |
| 73. | Cl: | =↑MMM. |
| 74. | Th: | Ri::ght. |
| 75. | Cl: | ↑°yeah!° I don't know what to do. |
| 76. | Th: | °hmm° |
| 77. | | (5.9) |
| 78. | Cl: | Sure this tape is working? .hhhhh |
| 79. | Th: | Its going round I think= |
| 80. | Cl: | =°>yes it is working<° |
| 81. | | (0.4) |
| 82. | | HI SU::E!!! |
| 83. | | (0.5) |

84. Th: [so (it) is
85. Cl: [ .hh HH-hh-hh! .hh hu::h ↑.hhhh .hhhh .hhhh hhhhh. (1.0)
86. tsch-yes °I er- so John I er- I I just don't know why we are eve:n°
87. what direction we're going in?

Again the shift from problem-focused to solution-focused talk emerges as a context for humour (Gale & Newfield, 1992). Responding to this conversational shift, the client tells the therapist that she doesn't know what to do (line 75). The lengthy pause of 5.9 seconds indicates that again the conversation seems to be disrupted. In this excerpt it is not the shift in problem to solution focus, but the resulting break down in turn taking or conversational misalignment that appears to be the context. Given the surrounding talk, this misalignment may be related to the client's statement in line 75, which may have represented not a statement but a request for advice from the therapist. Whilst she appears to have a well-rehearsed way of talking about the problem, as the conversation shifts to change or solutions, her loquaciousness turns to reticence as her fluency dries up. The conversational silence of 5.9 seconds is an extensive time in the domain of talk. Perhaps it was her discomfort with this silence that led her to fill it with a sudden topic shift.

The client changes the subject dramatically and directs her attention to the tape recorder. She addresses her attention to Sue, the person who has requested the session be taped. Evidence to support her uncertainty and confusion is shown in her response following the disruption (lines 85-87). This fits with ten Have's (2007) observation of the common experience of heightened unease or anxiety through being recorded.

***Mechanism: Directing conversation to absent parties***

The misalignment with the therapist and the disruption to the conversation may have prompted the client to search for another focus for her attention, and notices the tape recorder. She uses this as an opportunity to change the topic of the conversation and the humour emerges from her orienting to, and addressing the non-present researcher who requested that the session be recorded. In doing so, the incongruence of addressing an absent person creates humour which aligns her to this absent third person at a time when the therapeutic dyad is in misalignment. Her humour appears to align her with the researcher, indicating Meyer's (2000) identification function. In doing so, she further differentiates herself from the therapist beyond the division creating from the disruptions to the flow of conversation.

***Response: Repair***

The distractive use of humour to move away from the conversational disruption further disrupts the dialogue. However, the subtle misalignment prior to the humorous topic shift was made more explicit by such a dramatic break in the conversation. This then allowed the client to explicitly request the therapist to perform some kind of conversational repair in order to align them both once more.

The client follows her humorous comment with laughter and uses the disruption to the conversation to repair both the humorous aside and the ambiguity and misalignment prior to the humour. In excerpt 3f, the same re-interpretation is offered as was offered in 7b above considerably earlier.

*Excerpt 3f: Dyad B*

80. Cl: =°>yes it is working<° (0.4) HI SU::E!!! (0.5)
81. Th: [so (it) is
82. Cl: [ .hh HH-hh-hh! .hh hu::h ↑.hhhh .hhhh .hhhh hhhhh. (1.0)
83. tsch-yes °I er- so John I er- I I just don't know why we are eve:n°
84. what direction we're going in?
85. Th: °*Hm°
86. (0.7)
87. Cl: ↑°I don't know°
88. (1.2)
89. Th: I MEAN it ju- it just seems from my poin:t of vie::::w
90. in the sense of? °s't of°(.) just from °m-m° the perspective that
91. I'm looking at. (0.9) that? (0.6) in terms of? (.) looking at a
92. la::::rger perspective. (0.4) .hhhh (0.5) that (0.4)
93. >I mean< if you ima::gine (0.4) a situation that (0.8) on the one
94. hand you've got the >parental expectations< wi- the various
95. pressures °which. (0.7) which w- we've ta:lked abou:t
96. and keep manifestin::g°. .hhhh On the other han::d (0.4) there's
97. the there's the >potential< (0.4) if you li::ke? (0.8) errrm
98. SLOT-rattling rebellion against tha::t…

This comment on process instigated by the client prompts the therapist to respond with his original re-interpretation once more (lines 89-98). It seems the disruption in

the conversation and rapid invitation to repair from the client has moved him into re-interpretation abruptly. This suddenness impacts the structure of his response by it featuring a large number of pauses, use of epistemic markers to the therapist's perspective ("I MEAN", "from my point of view", "from the perspective I'm looking at"), neutral perspective markers ("in terms of", "in the sense of", "looking at the larger perspective"), evidential or speculative markers ("it just seems"), figures of speech ("on the one hand") before getting to his re-interpretation (line 94).

***Summary***

Through analysis of the data humour emerged from a client's indication of therapist misalignment and her uncertainty of the moment-to-moment direction in therapy. Humour may well serve as an early indicator of feelings of ambiguity and uncertainty in clients in the same way that research has identified humour as an indicator of ambiguity and paradox in organisations (Hatch, 1993). The use of humour could alert the therapist to this kind of misalignment. A therapist may then locate the source of the misalignment in order to preserve the therapeutic relationship which may be threatened by excess uncertainty. The existence of competing contradictions within therapy provides circumstances ripe for experiencing uncertainty. Humour with its double meanings and duality represents a perfect vehicle for displaying and capturing such contradictions (Meyer, 2000). Furthermore, it can be used to differentiate further from the therapist when they are experiencing the relationship as beginning to rupture.

The experience of therapy at times generates feelings of uncertainty for the therapist. Downing (2000) argues that "a collaborative therapist must demonstrate enormous flexibility, tolerance of uncertainty and humility" (p. 222). This "demands an emotional maturity of a practitioner who is capable of sitting with uncertainty, resisting the premature solution and helping the family to bear the tensions involved" (p.105). Meyer (2000) argues that the four functions of humour represent illuminating methods for communicators to deal with contradictions rather than feeling oppressed or trapped by them. Humour may help both therapists and clients to stay with the uncertainty rather than prematurely resolve it.

**Overall Summary of Results and Discussion**

In this research, humour is used by both client and therapist in the sequential environment of persuasion and resistance. In the section on Unresolved Resistance, the role of humour in resistance lay in harnessing its differentiation function by capturing the counter-argument. This was achieved by humorously framing the opposing viewpoints in a way that emphasizes the incompatibility. This research echoes Buttny's (2001, 2004) finding of humour's role in disarming resistance, and demonstrates that this humorous strategy is also employed by clients to capture the incompatibility of perspectives. This analysis supported the idea that resistance may be best conceptualised as an *interactional phenomenon* where the client's resistance of the therapist's intervention was met with the therapist's resistance of his reasoning and decline.

In the section on Overcoming Resistance, the therapist used humour to express empathy by formulating back aspects of the client's talk. This was achieved through self-disclosure, metaphorical exaggeration and impersonation. In expressing empathy through humour during a sequence of resistance, the therapist was unifying herself with the client when there was a clear conversational divide. In formulating back client talk, the use of metaphor captured and exaggerated inconsistencies and hinted towards a re-interpretation. Humour was also observed to help deliver re-interpretative utterances. The use of humour can give rise to expression of empathy which can then help the therapist to move into re-interpretation or the re-interpretation can be the vehicle of re-interpretation itself.

The use of humour also emerged in the sequential environment of Elaboration on a disagreement, which was created through autobiographical accounts. The mechanisms within this context relied on sarcasm and the succinct presentation of the incongruity of viewpoints. Humorous utterances were compiled from repeated previous parts of non-humorous speech related to the incongruity, supporting their viewpoint. Humour was extended through repetition by the client in the subsequent speech. Responses to the use of humour in this context followed similar directions in that the humour itself was not responded to by the therapist. This non-response invited the client to continue to offer further elaboration. This elaboration was either closed down by a formulating question from the therapist, or concluded without intervention from the therapist. In both examples the therapists invited the clients to explicitly express the emotion that underlay their accounts.

In the section on Uncertainty, humour emerged as clients found themselves in the transition between old and new perspectives. In negotiating these changes, there were mild misalignments in both examples where the dyads were orienting to the new territory in slightly different ways to the therapist. Humour emerged as a way for the client to find a language to encapsulate the incongruity between these divergent perspectives, and a gentle way for the therapist to enforce further change, adjusting cognitions and emotions to fit with new behaviour. As clients progress through such change, strong emotions can be evoked. These emotions can be hinted at but disguised by the client's use of humour. Humour was utilised by therapists to challenge underlying cognitions that drive their emotional response in a mitigated way that protects the therapeutic relationship, allowing the client to join the therapist through laughter.

In the section of Uncertainty and Misalignment, humour emerged from a client's indication of therapist misalignment and her uncertainty of the moment-to-moment direction in therapy. Humour may well serve as an early indicator of feelings of ambiguity and uncertainty in clients in the same way that research has identified humour as an indicator of ambiguity and paradox in organisations (Hatch, 1993). The use of humour served to de-rail the already disrupted conversation to a greater degree, in order for either the therapist to repair the disruption, or the client to invite the therapist to repair the original disruption. It seems humour may have disrupted the conversation, but in a way that exaggerated the pre-existing misalignment enough to allow repair to be initiated.

## Chapter 6: Clinical Implications

### General

This research indicates the usefulness for therapists to attend to the conversational interaction played out within the dyad. CA is a method that highlights the intricacies of talk and the social action that may be performed. Focus on content alone may result in valuable information being missed. It is probable that many clinicians have an awareness of this level of talk, and for many this awareness may be implicit. Increased consideration of the process features of therapy during training may be useful to help clinicians develop an explicit understanding of this level of communication and what the client may be telling them indirectly.

### Unresolved resistance

This research indicates that humour may offer clinicians and clients alike the opportunity to laugh at contradictions as a way of accepting their existence in order to overcome the interactional pattern of resistance. When the pattern of resistance predominates and grinds the therapy session to a metaphoric halt, humour may be a means by which to capture the disagreement, in order to 'agree to disagree'. In using humour to try to accept their differences, both parties can protect the therapeutic relationship when it may be at its most delicate.

### Overcoming resistance

In this study humour emerged as a way of lowering defences to facilitate clients to see new perspectives, reducing rigidity to foster a more flexible way of construing the world. Therapists may consider using humour to implement new ideas or interventions and to break down client reluctance to adopt them. It may also be adopted as a means of delivering empathy, for example through impersonation, metaphor and self-disclosure. This method of demonstrating empathy would then provide a useful step into re-interpretation. The two functions of identification and clarification of humour render it a useful tool to create flexibility to dismantle resistance within the session.

### Differentiating viewpoints from third party

Linking with the last section and its focus on empathy, the findings indicate that therapists may wish to consider some instances of client humour for its potential to indicate emotional material. The use of humour may prompt them to consider inviting the client to make this emotional experience explicit. This questioning to uncover

evident, but disguised affect seems to be an important stage of the process of establishing empathy with the client (Barrett-Lennard, 1981; Wynn & Wynn, 2006). Questioning the humorously presented account could function to name client feelings explicitly to ensure accurate resonation. Questions which suggest probable emotional states within them communicate an empathic connection, having deciphered the emotion heavily hinted at but obscured through the use of humour.

**Change**

Some locate change and spiritual growth within the unsolvable riddle of paradox (Gibney, 1996). In this research, humour is a means by which clients may be able to reflect their experience of such growth. It would be important for therapists to be vigilant for such expressions of change, in order to capitalise on them. Equally important would be for therapists to consider the use of humour to help guide the client in the direction of therapeutic change.

**Uncertainty**

Having identified in this research the emergence of humour in response to uncertainty, therapists may wish to be vigilant to the emergence of humour as a possible indicator of misalignment or uncertainty in the client. In being aware of such misalignment, the therapist may then locate the source in order to preserve the therapeutic relationship which may be threatened by excessive uncertainty. The existence of competing contradictions within therapy provides circumstances ripe for experiencing uncertainty. Humour with its double meanings and duality represents a perfect vehicle for displaying and capturing such contradictions (Meyer, 2000). Furthermore it can be used to differentiate further from the therapist when they are experiencing the relationship as beginning to rupture.

The experience of therapy at times generates feelings of uncertainty for the therapist. Downing (2000) argues that “a collaborative therapist must demonstrate enormous flexibility, tolerance of uncertainty and humility” (p. 222). This “demands an emotional maturity of a practitioner who is capable of sitting with uncertainty, resisting the premature solution and helping the family to bear the tensions involved” (p.105). Since Meyer (2000) argues that the four functions of humour represent illuminating methods for communicators to deal with contradictions rather than feeling oppressed or trapped by them, humour may help both therapists and clients to stay with the uncertainty rather than prematurely resolve it.

## Chapter 7: Methodological strengths and limitations of the study

There are strengths to using CA as a methodology, most of which have been described in the Introduction and Method section in relation to shifting paradigms of research and evidence. It may be unnecessary to repeat them here but might be more important to reflect on why they should be presented so early. The points made in these sections were linked to what could be conceptualised as a revolution in psychotherapeutic research of which CA could play a significant part. CA being currently such a minority and specialist methodological movement may have prompted pre-emptive justification. My experience of how proponents talk of CA suggests the significance that is placed on it, but also the sense that it is overlooked, misunderstood or dismissed by other perspectives. However, given that humour and therapy are both conversationally achieved, and humour is a complex linguistic device, CA represents the most appropriate method for its study.

There are a number of limitations as a result of the choice of methodology. The research is not able to link the objective observations of how humour is used to outcomes or experience of interaction, such as ratings of therapeutic success or satisfaction. Furthermore, this research does not provide a generalisable or comprehensive account of how humour is used in therapy, but rather a comprehensive account of the humour used according to our criteria for humour detection in the three tapes that were analysed. Another limitation of CA is that it can only make comments on the intention of the interactants based on their talk, without triangulating methodologies to gain an insight into each individual's intention.

Segerdahl (1998) has raised a number of criticisms about CA, likening its approach to "over-hearing strangers on a train" (p. 287) to reflect the multiple possibilities that could be hypothesised in the absence of familiarity with contextual information. He goes on to say that using CA on a transcript tells us no more about a conversation than the pixels of a photograph may tell us of the scene it portrays, dismissing this level of analysis as irrelevant. He criticises the method as speculation after intense scrutiny. He points out the neglect of both the trivial (inconsequential) and complex (contextual and socio-cultural) aspects of talk, considering the findings to be a product of the research tool and method used. He adds that the method claims to yield findings that are read from the data, but he considers the method to be inherently interpretative. He argues that these interpretations are then the unit of analysis rather than the conversation itself from which the interpretation originated.

Another concern lies around how CA reflects a process by which social norms are overemphasised and discussed as fundamental. It is hard to not be convinced by his argument around the reifying iterative circularity inherent in CA illustrated through his comment that "the notion of displaying what is going on presupposes that something is *in fact* going on" (Segerdahl, 1998, p. 311).

He makes a good case and having completed this piece of work, some of the concerns that he raised are understandable. However, the questions this research was attempting to answer were CA ones specifically linked to the use of humour. In doing so, the research is drawn to a relevant focus through this application, rather than inferring patterns regarding what Segerdahl (1998) may consider the irrelevancies of random talk. Many of these philosophical points are no longer important if the purpose of the analysis is to focus on situations that people find troublesome (Segerdahl, 1999). Using the tools of CA, ideas around the construction of humour and speculations around some of the functions that it may have played within these moments of therapy have been generated. In having such a specific way of applying the skills and techniques meaningfully to this focus, it is reassuring that the serious pitfalls outlined above are less of a contentious issue. The research has been unavoidably interpretative but with a social constructionist perspective, any potential sources of bias have been made as explicit as possible. Transcripts have been included in the appendix for the reader to scrutinise themselves, and they are invited to draw their own interpretations.

The credibility of this CA analysis may be vouched for partly through the experience gained through attending a CA workshop/conference, discussions with CA experts and extensive reading of examples of CA research and guides. Furthermore, the conclusions that have been made have been discussed and agreed with two supervisors and are consistent with available research in relevant fields of research. Being familiar with both CA as a research method and practice issues within psychotherapy, the researcher's experience matches appropriately the demands of conducting this type of research. Being mindful of the different types and levels of conversational categories (Labov & Fanshel, 1977; Vehvilainen et al., 2008) discussed in the Method section, this research, being constructed by a Trainee Clinical Psychologist rather than a Professor of Communication and Rhetorical Studies has gravitated towards the therapeutic acts level of abstraction. This reflects a source of bias and paradigmatic inclination that could be seen as slanted,

prejudiced and blinkered, or conversely informative, revealing and advantageous, or simultaneously both.

There are limitations linked to the choice of data. The age of the data made it difficult and inappropriate to contact dyads, as their memory of the session would likely be compromised over time. The rationale for making the recordings may have had an impact on the way in which the dyad interacted and so recordings made as part of routine clinical practice may yield different results. Whilst choice of audio rather than videotapes was due to practicalities such as availability, one limitation of this work would be that it prevented access to visual cues such as gaze direction (Goodwin, 1981) or hand gesture (Schegloff, 1984). However, methodologically, CA's explicit focus on the organization of *talk*-in-interaction means that such cues are not studied as they would in interactional kinesthetics (Kendon, 1990). Audio does not capture everything that occurred in an interaction (Hutchby & Wooffit, 2008) but rather is thought of as a "good enough record of what happened" (Sacks, 1984, p. 26).

One other factor that ought to be taken into account is gender difference in joining laughter (Jefferson, 2004). Although there is much debate around the potential for stereotyping, Jefferson (2004) described how a woman is more likely to join in with a man's laughter than vice versa. Given that the therapist was male in two out of three dyads, this tendency may be a product of the gender mix of the sample. That the most laughter emerged from the all female dyad may be relevant here.

## Chapter 8: Suggestions for further research

It would have been useful to have analysed more therapy sessions, as the observations are based on only three sessions. Further research could use a larger number of tapes. This would enable the generation of larger collections from which to identify repeated patterns and uncover more ways in which humour can be used within therapy. It was difficult in this research to make sense of the talk without observation of eye contact, gesture and facial expression, particularly smiling. Analysing video-tapes with interactional kinesthetics (Kendon, 1990) could help to understand more fully the conversational exchange (including non-verbal cues) in which humour is created.

One interesting observation through comparing this research with Buttny's (2004) was the differences found in the use and initiation of humour in therapy. Potential reasons for this have been hypothesized in the Patterns for Humour Use section. Further research would be useful to clarify how humour is negotiated over time and by gender, through subtle conversational encouragement and discouragement. Conversation analyses of the use of humour through a course of therapy would help to clarify one problem, whilst changing assumptions around the use of humour over a course of therapy could be usefully assessed using self-report methods alongside an analysis of the talk itself. More quantitative methods may uncover gender differences in humour initiation and laughter response. Member checking would illuminate the intention of each individual and would be a useful adjunct to future research. However, this would represent triangulation as it would fall outside of the remit of CA itself, since the talk is the evidence.

## Chapter 9: Final self-reflections

Reflections have been shared as they arose as this research was written. Rather than repeat them here, more personal reflections on the impact that undertaking this research has had will be explored here. Embarking on this project has been a tremendous challenge. Intellectually, being immersed in an unfamiliar methodology has been an interesting process of discovery that has been generally self-directed and solitary, but simultaneously has led to networking with some of the most prominent names in the field. This has been both daunting and exciting. Clinically, the process of learning more about CA has helped my clinical work through becoming more thoughtful about the social action that client talk and my own might serve. Shifting my attention from content of talk to incorporate process has helped my practice as a Clinical Psychologist by helping me to identify the unspoken aspects within therapy, often hinted at through subtleties of talk illuminated by the CA approach. I have learnt a tremendous amount through this research about the gulf between theory and practice in therapy, and CA literature has helped to fill in the gap and link the two. It has also been invaluable in addressing the dilemma between the reputation of therapy as a serious business and the pressure towards congruence and remaining faithful to my own personal style, espoused by Rogers (1961a). I feel reassured that using humour is acceptable within therapy but furthermore, understanding the complexities, I can be more reflective and selective in its use in the future.

Personally, I have observed and reflected on the role that humour plays in my life through the functionality that this form of delivery can offer within conversation, particularly the role it plays in my close relationships. I have discovered just how important it is both in terms of interpersonal interaction but also as part of how I perceive myself and construe my identity, regarding the importance I place on humour rather than how funny I see myself. In undertaking this research, it has been interesting and in some cases pivotal to find out whether others share this view of me.

This research feels very personal to me, both in terms of the subject area and also how attached I feel to the process and the product itself. This is likely to have had an effect on the way the thesis was written and my experience of the process of its completion.

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# Appendices

**Appendix 1:** Literature search

**Appendix 2:** Ethical approval email

**Appendix 3:** University research governance information

**Appendix 4:** Research & Development approval

**Appendix 5:** Transcription symbols

**Appendix 6:** Transcripts

**Appendix 7:** Glossary of CA and other relevant terms

## Appendix 1: Literature search

Reasons for discarding articles from the literature search: an article reviewing qualitative methodologies (Leech & Onwuegbuzie, 2008), no or minimal passing reference to humour (Kurri & Wahlstrom, 2005; Kozart, 2002; McCabe, Leudar & Antaki, 2004), not analyses of therapy: focus groups (Gough, 2004) or interviews (Holloway & Jefferson, 2005), interactions involved brain-damaged and communicatively-impaired clients and were not analyses of psychotherapy (Speech & Language Therapy (Simmons-Mackie & Damico, 2009; Walsh & Leahy, 2009) and Nursing (Gordon, Ellis-Hill & Ashburn, 2009)). One of the remaining three (Friedlander, Wildman, Heatherington, & Skowron, 1994) was reporting the findings of one of the final two (Gale & Newfield, 1992).

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1 conversation analysis.mp. [mp=ti, ab, tx, ct, hw, tc, id, ot, bt] (1074)
2 (humor or humour).mp. [mp=ti, ab, tx, ct, hw, tc, id, ot, bt] (21108)
3 therapy.mp. [mp=ti, ab, tx, ct, hw, tc, id, ot, bt] (1153500)
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Institution
(1)Department of Clinical Speech & Language Studies, 184 Pearse Street, Trinity College, Dublin, Ireland
Title: "Cajoling" as a Means of Engagement in the Dysphagia Clinic.[Article]
Source: Seminars in Speech & Language. Engagement in Clinical Practice. 30(1):37-47, February 2009.
ISSN: 0734-0478
Link to the Ovid Full Text or citation
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Author: Simmons-Mackie, Nina Ph.D., BC-NCD 1; Damico, Jack S. Ph.D. 2
Institution
(1)Department of Communication Sciences & Disorders, Southeastern Louisiana University, Hammond, Louisiana; (2)Department of Communication Disorders, University of Louisiana at Lafayette, Lafayette, Louisiana
Title: Engagement in Group Therapy for Aphasia.[Article]
Source: Seminars in Speech & Language. Engagement in Clinical Practice. 30(1):18-26, February 2009.
ISSN: 0734-0478
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Institution:
(1)Clare Gordon BSc MSc RN Nurse Consultant Stroke Care, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, Christchurch Hospital, UK
(2)Caroline Ellis-Hill MSc PhD DipCOT Senior Lecturer School of Health Sciences, University of Southampton, UK
(3)Ann Ashburn MPhil PhD FCSP Professor of Rehabilitation University Rehabilitation Research Unit, School of Health Sciences, Southampton General Hospital, UK
Title: The use of conversational analysis: nurse-patient interaction in communication disability after stroke.[Article]
Source: Journal of Advanced Nursing. 65(3):544-553, March 2009.
ISSN: 0309-2402
DOI Number: 10.1111/j.1365-2648.2008.04917.x
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Author: Leech, Nancy L. 1; Onwuegbuzie, Anthony J. 2
Institution
(1)School of Education, University of Colorado Denver
(2)Department of Educational Leadership and Counseling, Sam Houston State University
Title: Qualitative Data Analysis: A Compendium of Techniques and a Framework for Selection for School Psychology Research and Beyond.[Article]
Source: School Psychology Quarterly. 23(4):587-604, December 2008.
ISSN: 1045-3830
DOI Number: 10.1037/1045-3830.23.4.587
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Author: Kurri, Katja a; Wahlstrom, Jarl b
Institution
(a)Clinical Psychologist, Department of Psychology, University of Jyvaskyla, Tapiolantie33 as 1, 00610 Helsinki, Finland.
(b)Professor of Psychology, Department of Psychology, University of Jyvaskyla, Finland
Title: Placement of responsibility and moral reasoning in couple therapy.[Article]
Source: Journal of Family Therapy. 27(4):352-369, November 2005.
ISSN: 0163-4445
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Author: Hollway, Wendy 1; Jefferson, Tony 2
Institution
(1)The Open University, Milton Keynes, UK
(2)Keele University, UK
Title: Panic and perjury: A psychosocial exploration of agency.[Article]
Source: British Journal of Social Psychology. 44(2):147-163, June 2005.
ISSN: 0144-6665
Link to the Ovid Full Text or citation
http://ovidsp.ovid.com/ovidweb.cgi?T=JS&NEWS=N&PAGE=fulltext&AN=00002408-200506000-00001&D=ovfth

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Author: Gough, Brendan *
Institution: School of Psychology, University of Leeds, UK
Title: Psychoanalysis as a resource for understanding emotional ruptures in the text: The case of defensive masculinities.[Article]
Source: British Journal of Social Psychology. 43(2):245-267, June 2004.
ISSN: 0144-6665
Link to the Ovid Full Text or citation
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Accession Number: 00006826-200404000-00004.
Author: McCABE, R.; LEUDAR, I. 1; ANTAKI, C.
Institution: Unit for Social and Community Psychiatry, Department of Psychiatry, Bart's and the London School of Medicine, Newham Centre for Mental Health, London; Psychology Department, University of Manchester; and Discourse and Rhetoric Group, Department of Social Sciences, Loughborough University
Title: Do people with schizophrenia display theory of mind deficits in clinical interactions?.[Article]
Source: Psychological Medicine. 34(3):401-412, April 2004.
ISSN: 0033-2917
Link to the Ovid Full Text or citation
http://ovidsp.ovid.com/ovidweb.cgi?T=JS&NEWS=N&PAGE=fulltext&AN=00006826-200404000-00004&D=ovftg

<9>
Database: PsycINFO
Accession Number: Book: 2004-12485-000.
Title: Talking problems: Studies of discursive construction. [References].
Book Series Title: SUNY series in communication studies.
Year of Publication: 2004
Author: Buttny, Richard.
Institution: Buttny, Richard: Syracuse University, Syracuse, NY, US
Source: (2004). Talking problems: Studies of discursive construction. ix, 214 pp. Albany, NY, US: State University of New York Press.
ISBN: 0-7914-5895-4 (hardcover)
Publisher Information: State University of New York Press
Publication Type: Book; Authored Book
Update Code: 20051212
Link to the Ovid Full Text or citation

http://ovidsp.ovid.com/ovidweb.cgi?T=JS&NEWS=N&PAGE=fulltext&AN=2004-12485-000&D=psyc4

<10>
Database: PsycINFO
Accession Number: Peer Reviewed Journal: 1992-32238-001.
Title: A conversation analysis of a solution-focused marital therapy session.
Year of Publication: 1992
Author: Gale, Jerry; Newfield, Neal.
Institution: Gale, Jerry: U Georgia, Athens, US
Source: Journal of Marital & Family Therapy. Vol 18(2) Apr 1992, 153-165.
ISSN Print: 0194-472X
Publisher Information: American Assn for Marriage & Family Therapy
Other Publishers: Blackwell Publishing; United Kingdom; Wiley-Blackwell Publishing Ltd.; United Kingdom
Publication Type: Journal; Peer Reviewed Journal
Update Code: 19920901
Link to the Ovid Full Text or citation
http://ovidsp.ovid.com/ovidweb.cgi?T=JS&NEWS=N&PAGE=fulltext&AN=1992-32238-001&D=psyc3

<11>
Database: Your Journals@Ovid
Accession Number: 00000454-200204000-00005.
Author: Kozart, Michael Frederick MD, PhD 1,2
Institution
(1)Department of Psychiatry, University of California, Los Angeles
Title: Understanding Efficacy in Psychotherapy: An Ethnomethodological Perspective on the Therapeutic Alliance.[Article]
Source: American Journal of Orthopsychiatry. 72(2):217-231, April 2002.
ISSN: 0002-9432
DOI Number: 10.1037/0002-9432.72.2.217
Link to the Ovid Full Text or citation
http://ovidsp.ovid.com/ovidweb.cgi?T=JS&NEWS=N&PAGE=fulltext&AN=00000454-200204000-00005&D=yrovfte

<12>
Database: Your Journals@Ovid
Accession Number: 00012003-199412000-00005.
Author: Friedlander, Myrna L. 1,3; Wildman, Julie 1; Heatherington, Laurie 2; Skowron, Elizabeth A. 1
Institution
(1)Department of Counseling Psychology, University at Albany, State University of New York
(2)Department of Psychology, Williams College.
Title: What We Do and Don't Know About the Process of Family Therapy.[Article]
Source: Journal of Family Psychology. 8(4):390-416, December 1994.
ISSN: 0893-3200
Link to the Ovid Full Text or citation
http://ovidsp.ovid.com/ovidweb.cgi?T=JS&NEWS=N&PAGE=fulltext&AN=00012003-199412000-00005&D=yrovftb

## **Appendix 2:** Ethical approval email

-----Original Message-----
From: Winter David
Sent: 17 July 2008 10:52
To: 's.k.jeffrey@herts.ac.uk'
Subject: FW: ethics query

As promised.

David

-----Original Message-----
From: OKane, Alison [mailto:Alison.OKane@rnoh.nhs.uk]
Sent: 16 June 2008 14:38
To: Yuksel Bulend (RVL) Barnet & Chase Farm Hospitals NHS Trust; Winter David
Subject: FW: ethics query

Dear Bulend/David

A quick reply (below)  (No action required)

Alison O'Kane
Administrator,
Barnet Enfield & Haringey REC
R&D Office
RNOH NHS Trust
Brockley Hill,
Stanmore
HA7 4LP
Tel: 020 8909 5318
Fax: 020 8385 7151

_____

From: Tanja Wigley [mailto:tanja.wigley@nres.npsa.nhs.uk]
Sent: 16 June 2008 14:37
To: OKane, Alison
Subject: RE: ethics query

Dear Alison

I agree, this can go through as a minor amendment - change/addition to the research team.

Best wishes,

Tanja

Tanja Wigley
Senior Research Ethics Service Manager for North Central London
Tel: 07766 602 971

From: OKane, Alison [mailto:Alison.OKane@rnoh.nhs.uk]
Sent: 16 June 2008 14:22
To: Tanja Wigley
Subject: FW: ethics query

Dear Tanja

Would you be kind enough to look at the exchange of messages below and give me your thoughts? My feeling is that it is a minor amendment (a change/addition to the research team)? For your information, Professor David Winter is a Clinical Psychologist and member of our committee.

I look forward to hearing from you

Thanks

Alison

Alison O'Kane
Administrator,
Barnet Enfield & Haringey REC
R&D Office
RNOH NHS Trust
Brockley Hill,
Stanmore
HA7 4LP
Tel: 020 8909 5318
Fax: 020 8385 7151

_____

From: Winter David [mailto:David.Winter@beh-mht.nhs.uk]
Sent: 16 June 2008 13:56
To: Yuksel Bulend (RVL) Barnet & Chase Farm Hospitals NHS Trust
Cc: OKane, Alison
Subject: RE: ethics query

Thank you for such a prompt response, Bulend. Of course I am happy for Alison to ask the NRES coordinator.

Regards,

David

-----Original Message-----
From: Yuksel, Bulend [mailto:Bulend.Yuksel@bcf.nhs.uk]
Sent: 16 June 2008 13:26
To: Winter David
Cc: Okane Alison
Subject: RE: ethics query

Dear David

In my view I do not see any problem with the new member of the research team - under your supervision - listening or analysing the existing tapes. Similar studies, definitely in my research areas, has been done and published in the past. However, the goal posts are constantly moving in "Ethics" world. Would you mind if Alison asks the NRES coordinator their opinion as well. Then we will be more clear.

Dear Alison

Would it be possible to ask the NRES coordinator - the newly appointed lady, whether we can go ahead with David's study without delay?

Thanks

Bulend

_____

From: Winter David [mailto:David.Winter@beh-mht.nhs.uk]
Sent: 16 June 2008 13:11
To: Yuksel, Bulend
Subject: ethics query

Dear Bulend,

Approximately 15 years ago, I commenced a comparative process and outcome study of personal construct, cognitive, and psychodynamic therapy together with a PhD student, Sue Watson. This study, which was approved by the former Barnet LREC, generated a considerable amount of data, as is generally the case in research on psychological therapies, and resulted in various publications. As new methods of analysis are being developed for some of the measures collected, these are being applied to the data by my colleagues and myself, and so the study is still active although data collection ceased several years ago. Amongst the data collected were audiotapes of some of the therapy sessions, which have been transcribed and which we intended to wipe when the analyses were completed. This has not yet been done as some of the methods of analysis that were being developed require the researcher to listen to the tapes rather than read the transcripts. I now have a student who wishes to apply one of these methods of analysis to the tapes for her DClinPsy thesis, and who would therefore join the research team for the study if this were possible. However, I would appreciate your opinion on whether this can be covered by the original ethical approval for the study as it would probably neither be possible nor clinically appropriate to contact the research participants (who had originally consented for the tapes to be listened to by members of the study team) to ask for their consent to a new member of the team listening to the tapes.

I am afraid that I cannot give you the reference number for the study at present as I have just moved office and all of my files are packed in boxes. However, should you need it, I will let you have this as soon as possible.

Regards,

David

## Appendix 3: University research governance information

University of Hertfordshire

John M Senior
BSc MSc DSc PGCE CEng FIET FRSA FHEA
Professor of Communication Networks
Pro Vice-Chancellor (Research)
and Dean of Faculty

c.c. Liz Nolan, Research Office

University of Hertfordshire
Hatfield, Hertfordshire
AL10 9AB
UK

Switchboard 01707 284000
Fax 01707 284115
www.herts.ac.uk

Gerard Leavey
Research & Development
St Ann's Hospital
St Ann's Road
London
N15 3TH

26 June 2008

Dear Gerard Leavey

**RE: PROJECT TITLE: CAN LAUGHTER BE THE BEST MEDICINE? A CONVERSATION ANALYSIS OF THE USE AND FUNCTION OF HUMOUR IN THE SERIOUS BUSINESS OF THERAPY**

**PROJECT NO. (R1): 08/H0723/49**

**CHIEF INVESTIGATOR: SARAH JEFFREY**

**INVESTIGATOR (IF DIFFERENT FROM ABOVE):**

**SUPERVISOR/S: PIETER W NEL, PROFESSOR RICHARD WISEMAN**

This letter is to confirm that the above project complies with the University of Hertfordshire's research governance criteria. On this basis the University is willing to act as sponsor

The project is not a clinical trial according to the criteria laid out by UM Association Ltd insurers and therefore indemnity can be given. A copy of the letter of indemnity is attached.

Any changes to the duration of the project, investigators, or deviations from the protocol may negate this cover and sponsorship arrangements. Should such a change be made then the Chief Investigator should be advised that the UH Research Office and the awarding ethics committee will need to be notified and advice sought about whether the sponsorship agreement still stands.

Yours sincerely,

Prof John Senior
Pro-Vice Chancellor (Research)

University of Hertfordshire,
College Lane,
Hatfield
Herts
AL10 9AB

Tel: 01707 284301
Fax: 01707 284782

INVESTOR IN PEOPLE

POSITIVE ABOUT DISABLED PEOPLE

## Appendix 4: Research & Development approval

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust


Ms Sarah Jeffrey
38 Roff Avenue
Bedford
Beds
MK41 7TE

R & D Department
Barnet, Enfield and Haringey Mental Health Trust
Admin Block
St. Ann's Hospital
St. Ann's Road
London N15 3TH

Tel: 020 8442 6503
Fax: 020 442 6503
Email: Research.Department@beh-mht.nhs.uk


28 October 2008

***ref-*** *EJS/cb*

Dear Ms Jeffrey,

Title of Study: **Can laughter be the best medicine? A conversation analysis of the use and function of humour in the serious business of therapy**
REC reference number: **08/H0723/49**

I am pleased to note that you have received the favourable opinion of the Research Ethics Committee for your study.

All projects must be registered with the Research Department if they use patients, staff, records, facilities or other resources of the Barnet, Enfield and Haringey NHS Mental Health Trust.

The R&D Department on behalf of Barnet, Enfield and Haringey NHS Mental Health Trust is therefore able to grant approval for your research to begin, based on your research application and proposal reviewed by the ethics committee. Please note this is subject to any conditions set out in their letter dated *05 August 2008*. Should you fail to adhere to these conditions or deviate from the protocol reviewed by the ethics committee, then this approval would become void. The approval is also subject to your consent for information to be extracted from your project registration form for inclusion in NHS project registration/management databases and, where appropriate, the National Research Register.

Permission to conduct research is also conditional on the research being conducted in accordance with the Department of Health Research Governance Framework for Health and Social Care*:

- Appendix A to this letter outlines responsibilities of principal investigators

- Appendix B details the research governance responsibilities for other researchers. It also outlines the duties of all researchers under the Health and Safety at Work Act 1974. Principal investigators should disseminate the contents of Appendix B to all those in their research teams.

It is required that all researchers submit a copy of their report on completion and details on the progress of the study will be required periodically for longer projects. Copies of all publications emanating from the study should also be submitted to the R&D Department.

Furthermore, all publications must contain the following acknowledgement.

*"This work was undertaken with the support of Barnet, Enfield and Haringey NHS Mental Health Trust, who received "funding" from the NHS Executive; the views expressed in this publication are those of the authors and not necessarily those of the NHS Executive".*

*"a proportion of funding" where the research is also supported by an external funding body; "funding" where no external funding has been obtained.*

Best wishes and every success with the study.

Yours sincerely,

Dr Eric Johnson-Sabine
Director of R & D

*Further information on research governance can be obtained on the DH web pages at http://www.doh.gov.uk

**Appendix 5: Transcription symbols**

The transcription glossary is based on the system developed by Gail Jefferson (1984, 2005) which is used in the majority of conversation analytic publications and described in more detail in Hutchby & Woofitt (2008) and ten Have (2008). Below the transcription conventions and symbols are described in detail:

In the left margin are the line numbers, the speaker and other information for reference in the rest of the text:

| | | |
|---|---|---|
| *Excerpt x* | | all excerpts are identified by number for reference in the rest of the text |
| 28.<br>29. | | lines are numbered so that they easily can be referred to in the rest of the text |
| 30.<br>31.<br>32. | Cl:<br>Th:<br>Cl?: | The identity of the speaker is shown next to the line number<br>It is anonymised and abbreviated and paired with a colon<br>If the identity is unclear it is shown with a question mark |
| 33.<br>34. | Cl: → | The use of a sideways arrow in the margin points to specific parts of an extract discussed in the text. |
| (1.5) | | The number in brackets indicates a time gap in tenths of a second. |
| (.) | | A dot enclosed in a bracket indicates a pause of less that 0.2s or a “micropause” |
| = | | Equal signs indicates latching, in that talk is latched onto prior talk without any audible gap or lapses in between. For example: |
| 1.<br>2. | Su:<br>Tr: | So you think getting smarties might help=<br>=yeah, it would make all the difference |

It is also used to indicate the continuation of a turn in talk across intervening lines of transcript, for example

3. Su: But I don't think you [understand the principle] behind=
4. Tr: [but I worked really hard ]
5. Su: =the smarties concept

[ ] Square brackets between adjacent lines of concurrent speech indicate the onset and end of a period of overlapping talk

.hh A dot before an h indicates speaker in-breath. The more h's the longer the in-breath

hh An h indicates an out-breath. The more h's the longer the out-breath. Used to transcribe laughter.

sma(h)rties The insertion of an h or in-breath within a word indicates the presence of laughter "particles" or laughter "bubbling" within it

((eats smarties)) Description enclosed in double brackets indicates a non-verbal activity that is difficult to write phonetically. May enclose transcriber's comments on contextual or other factors.

smar- A dash indicates the sharp cut-off of the prior word or sound

sma:::rties Colons indicate that the speaker has stretched the preceding sound or letter. The more colons the more elongated the syllable.

smarties! The exclamation mark is used to indicate an emphatic or animated tone

( ) Empty parentheses indicate the presence of an unclear fragment on the tape

| | |
|---|---|
| (smarties) | The words within a single bracket indicate the transcribers best guess at an unclear utterance |
| smarties. | A full stop indicates a stopping fall in tone. It does not necessarily indicate the grammatical end of a sentence. |
| smarties, | A comma indicates a continuing intonation. |
| smarties? | A question mark indicates a rising inflection. It does not necessarily indicate a question. |
| *smarties* | An asterisk indicates a croaky pronunciation |
| ↑smarties<br>↓smarties | Pointed arrows indicate a marked rising or falling intonational shift. They are placed immediately before the onset of a shift |
| <u>smar</u>ties | Underline fragments indicate speaker emphasis. |
| SMARTIES | Words in capitals mark a section of speech noticeably louder than that surrounding it |
| °smarties° | Degree signs are used to indicate that the talk they encompass is noticeably quieter than the surrounding talk. |
| smar(t)ies | A (t) in brackets indicates a guttural pronunciation. |
| >smarties< | Inward chevrons indicate that the talk delivered at fast pace. |
| <smarties> | Outward chevrons indicate that the encompassed talk was produced noticeably slower than the surrounding talk. |
| $smarties$ | Pound signs mark words that are pronounced in ‘smile voice’. |

## Appendix 6: Transcript

### Transcript

Side ways arrow symbol (→) will be used to indicate where the researcher has detected the use of humour.

**Dyad A:**

**Time: 41.56**

Th: Would it be any different to you if you
(1.2)
Cl: Spoke into [a ()
Th: [SPOke these things into [↑a: (.) tape recorder=
Cl: [and listen
Th: =Yeh
(0.6)
Cl: .hh I doubt it very much ↑because (2.1) strong feeling (1.7)
wid erm (2.8) it's the interaction with the other person which is
err=
Th: =°right°=
Cl: =↑very (1.0) ↓calming (1.1)
Cl: .hh I've never tried actually t::o speak °int[o a tape recorder°
Th: [°right°
Th: I'm just bearing in mind what you said about your wife (0.6)
Th: and daugh[ter ] that you .hh that there's (0.6)
Cl: [yes]
Th: >an obstacle there< to you [hh ] freely
Cl: [yes]
(0.8)
Th: er:::m=
Cl: =talking to [them
Th: [talking to them
Cl: Yes there is an obstacle [( )
Th: [and there's ALSO there seems to be
an obstacle (0.2) in your mind to talking to yourself that it's the
first [sign of- you were going to say
Cl: [yes
Th: madness
Cl: Ye:::s
Th: presumably
Cl: Yes
(1.3)
Th: m-maybe having a- (.) tape recorder that
↑you (0.2) talk int::o (0.9) and record the thoughts >doesn't
matter whether you play them back or not< but maybe the th-
slightly <differe:nt> (0.8) >interpreta↓tion< (0.3) that you
place on that (0.3) that you:::'re (0.4) >recording your thoughts<
>that you're (.) expressing them and recording them .hhh
Cl: ((cough))

41. Th: and that you're- you know (0.8) is that more socially
42. acceptable (1.2) 'n talking to oneself um from what you've said
43. Cl: ↓Hmm
44. Th: that maybe that's tru:e
45. Cl: ye:s I think you're ↑ri:ght it would be more socially ↓acceptable
46. (0.5) but e::rm (0.9) *°I don't know whether I can-
47. (um I will try it)°* (1.1) IT SEEMS you know that the:::re must
48. be e:::::::rr an element of sympathy from the person themselves
49. (0.9) er::::::r I err for example >wouldn't speak to anybody who
50. was unsympathetic to my troubles<
51. Th: Rig::ht
52. Cl: →Aa:::ghh whether a tape recorder can (0.6) re(hh)act in this way
53. I don't know actually wheth[er ah erm ()
54. Th: [.HHHH
55. Th: >WHAT OTHER<? (0.9) outlets are there for yo:u (0.9) °to:::::o°
56. er- explore to talk to someb[ody when you- >when you< feel=
57. Cl: [.hhhh
58. Th: =par(.)ticularly ↓restless
59. Cl: .tch .hhhhhhh When I'm re:stle:ss I ↑think e:rr I try
60. >very hard to DO something< (0.5)
61. th[at I don't mind ↓doing at least you know like=
62. Th: [°yes°
63. Cl: =tidying up some paperwork o::r (1.1) °er:::::r° washing up or err
64. or ea::ting something I ↑often eat something as to ()
65. Th: Right
66. (2.7)
67. Th: Ok[a:::::::::::::::y.]
68. Cl: [But err ] °I'll try with the tape recorder°
69. (6.2)
70. I don't think (0.8) ne:::::rr (0.8)
71. >°don't think it would work because-er°< (1.1) I ↑think w:::
72. I'm asking for sympathy or understanding when I'm (0.8)
73. [when >I want to< ta:lk]
74. Th: [°okay° ]
75. (1.7)
76. Th: Fine
77. (1.2)
78. Th: I::f (.) >that's not available< (0.8) if you feel unable to:::
79. >talk to your wife<
80. Cl: °hmm[m°
81. Th: [and certainly you don't feel able to talk to your daughter
82. from what you've said
83. Cl: ↓No::::o
84. Th: Would it be better to::: (1.0) talk to a tape recorder (0.2) talk to
85. yourself or do nothi:ng
86. (6.1)
87. Cl: I never tried a tape recorder but I could ↓try
88. Th: Right ok.
89. Cl: But talkin[g to myself I ] have ↓trie:::d

90. Th: [.HHH ((coughs))]
91. (1.4)
92. Cl: And I::: I don't like doing it because it is e::rr (.)
93. really I have to be very very upset about something
94. °to talk to myself°[ (]) °*but I do actually sometimes*°
95. Th: [Ri::ght]
96. (6.0)
97. Th: Well yo:::u >you seem to be saying that< yo:::u'll >give it a go<
98. (0.8)
99. Cl: Tape recorde::r. Yes. Yes. I tink I could give it a [go
100. Th: [It's an
101. experiment that's:: wor::th trying out
102. (1.6)
103. Cl: ↑°Ye::s it is worth trying I spo::se°.
104. (13.9)
105. Th: Is there anything else that you can think of…

**Dyad B:**

**Time: 00.37**

1. Th: That's interesting what you said about the [(speech)
2. Cl: [↑So::::o
3. Cl: exactly what is mentioned here (0.8) about the
4. dependency matrix (1.8) >is that rarely do two partners match
5. themselves so well that each supplies all the wants of the
6. other.< What's mo:re >°(is what often happens is) the reciprocal
7. dependency break down leaving one person clinging and
8. wistful where the other is restless and (impatient)°<
9. And I've actually <d'you know> I've actually done this (0.6)
10. as an experiment
11. Th: You did look at the matrix did you?
12. Cl: E:::rr (1.4) No I've acted out the matrix dependency matrix.
13. ↑I:::'ve (1.3) seen what happens when you pursu:e
14. ↑or (0.4) when you start to respond but Alberto >has ↑now<
15. (0.3) withdra::wn and is now has now ↑basic(h)ally
16. →↑(h)esca(h)ped in my opinion
17. Th: Mmm
18. Cl: whereas with somebody I've met recently (0.6)
19. <I'm not giving ↓everything>
20. Th: Ri:[ght?
21. Cl: [I'm holding ba:ck and he is pursuing
22. Th: Ah ri::ght
23. Cl: A::::nd (2.0) >I know it (sounds as though James) will have< to:::
24. (0.6) respo:nd (0.8) but I don't want to respond t' him in
25. such a way ↑that (0.9) he feels that there is dependency
26. and that he's going to >a:lso: feel the need to esca:pe<
27. ↑or (0.4) disengage
28. Th: So your pacing's (a bit do you find when you meet a new
29. person)
30. Cl: I am (pacing)
31. (1.4)
32. Th: How does that fee::el
33. Cl: O::h ↑I'm not (.) ↑I don't (1.4) ↑I enjoy it some↓times and
34. other times I wish I didn't have to >do it<.
35. because it- it's a form of a ga:::me.

Time 11.02

1. Cl: I ↑ca:n't! I really can't see it happening. I can't see myself being
2. married with a family
3. Th: Can you say a little more about whe: [()
4. Cl: [Why?
5. Th: Hmmm
6. Cl: (1.8) Becau::se I've been (.) offered that (1.5) in a recen- in the
7. la:st couple of years (0.8) and I've rejected it because its ↑too
8. (0.9) bo:ring its too unspontaneous too (0.9) to::o- or perhaps

its- it was >because it was the wrong person<
If ALBERTo would have wanted tha:t (0.6) I don't know how I
would have erm °how I would have reacted°
Th: Hmm
Cl: (1.88) I don't know- I'm very worried about it (.) I'm going ↑grey
(0.8) >I suddenly keep on noticing grey< hai::rs (0.3) John
(1.7) and it bo:thers me
Th: Does it?=
Cl: =as if I'm getting o::ld very old (0.9) and I'm going to-
because ↑I (0.6) I meet so many people and can't
make up my mi:nd (0.5) I'm worried °that I'll always be on my
o:wn° (1.1) °it will be° (0.9) will be ↑TERRible to st-
to do what I'm doing exactly what I'm doing for another
→ (0.6) °thirty years° (1.5) or maybe I'll di:e I don't know=
Th: =Do you think [that's where we (.)
Cl: [hh hh-hh .hhhh
Th: come back to ↑the [(.) sorta-
Cl: [hh hh hh hh hh .hh
Th: (1.6) ↓>do you think that comes back to the
sort of pattern you talk about<
do you remember the term slot rattling
Cl: Ye:ah
Th: .HHH that=
Cl: =that's throwing yourself into ↑other options ↓isn't it
Th: Well, i- i- i- its on the one ha::nd (0.5) is the >sort of<
the e- the parental expectations and (0.7) the
>sort of< confo::rming a::nd (0.4) and then there's
th- the part of yo::u that wants to:: >that gets to a point<
where you feel claustrophobic and wants to (0.5) reb-
rebe- and get ou:t of tha::t
Cl: ↑>I don't know how to do it< ↓tho:ugh!=
Th: =°Ri::ght°. (0.9) But then- Do you remember the analogy
to do ↑with (1.0) the say th- the religious community
in the last century ↑where (0.5) the younger people were
rebelling (0.8) by just doing the opposite of what their
the elders wanted and that was in a sense ↑a (0.8)
a slot rattle on the same dimension whereas
maybe part of what we've been talking about
is trying to find some way forward for you
that's isn- (0.3) isn't just a simply a reaction against
but more finding out (0.7) erm wha- what you want
Cl: (2.5) °I don't know really° (3.0) °I don't ↓know°

Time 28.13

Cl: ↑I felt really good [about that and I thought
Th: [.hhhh
well if I could do that ↓mo::re=
Th: =ye::::es

5. Cl: in re- a- app[l::y that (0.4) to my parents=
6. [(( slap ))]
7. =>LOOK!< ↑NOW (0.3) I'M NOT ↓GOING TO D:O THIS
8. BECAUSE °such an' such an' such° and its nothing personal
9. but I've decided I'm not going to do it .hh ↓because of this
10. reason °or because I'm more independent now° (0.6)
11. ↑If I can (1.5) If I can start to do::o that with everybody
12. Th: yes
13. Cl: >then< I can begin to say no::[o nn feel good about it
14. Th: [yeah-hmmm
15. Th: Ri:::::ight (0.7) [tap] (0.4) ri::ight and think that's an (.)
16. an important point .hhhh <AND THAT MAY> BE ER (0.7)
17. that that >what you did last night< may have be::en >a brick<
18. like a bri:ck might'nt it in a buildi:ng
19. Cl: (1.1) O:::::::::h it wer- i-
20. Saturday night ye[s ] (0.6) yes [°yes° ]
21. Th: [yeah] [That's right]
22. Cl: (0.7) YES (0.3) °that's right°
23. Th: (partly) significant
24. Cl: (1.2) ↑>but it still?< hh-.hh it HU:::RTS me::e (1.0) a little
25. to have to do this to my ↑pa::rents because I am clo:se to them
26. Th: (1.9) Hmmm (3.0) When you sa:y DOI- (0.7) how could you DO
27. this to your parents- when you say DO this to them wha-wha-
28. what do you actually mea::n?
29. Cl: Break away from them (0.7) ↑Actually (how) I upset my
30. mo:ther yesterda::y it was (1.7) she said to me my MY little
31. brothers girlfriend met my parents for the first time and she
32. wasn't at all what we expected (0.9) a::nd
33. >so I said to my mother< well <what do you think of
34. he::r (0.7) he::::r-e:::::::r> and 'e said well? she was a bit
35. disappoi::nted >AND then she said to me< that DEBOrah
36. had actually said to my brother Pe::te (0.6) tha:::t (0.3) ↑she
37. thought my mother hadn't be::en (.) very friendl::::y (0.7)
38. >my mo'her said she didn't know wha' she was talking
39. about< I said well it ↑has be:en said befo:re that you
40. haven't be:::en friendly (0.4) and she rea:::lly took offence!
41. (0.6) >she said< she got off the ↓phone- >she said< Philli::::p
42. °to my father° plea:::::::se tell Raffiella: (1.2) tha(gh)t (0.7)
43. its not ↓tru:::::::::e (0.5) and she r- she wouldn't ↑talk to me::e!
44. (1.2) and I said t- I said to my father put my- >put ↓mummy
45. back on the< phone.- so she came back on the phone. °she s-°
46. ↑and I said to her I CAN'T >BELIEVE< you took it so
47. PERsonally you made a comment to me::e (0.3)
48. I came back with? (0.6) Yes. (.) you know its been said befo:re
49. sometimes that ↓you haven't been ve'y friendl:y
50. an' you taken it PERsonally she said wull (0.2) you give me
51. a list of pe:ople YOU ↓think (0.8) tha(gh)t (0.3) YOU tell me
52. exac- you?- >she said< you give me a list of people .h who
53. yo:u think I haven't been very friendly with. (.) AND I DI::D!!! (0.5)
54. → AN' SH(hh)E DIDN'T LI::KE IT!!

55. Th: hmm[m
56. Cl: [I gave her FIVE or six-na::::mes of pe:::ople (1.0)
57. Th: hm[m
58. Cl: [And she couldn't accept it!- I said well ma::ybe it something
59. that yo::::u do which isn't ve'y friendly which offends pe:ople.
60. (0.5) .hh I said look at this i- .hhh I said ↑LOOK!! (.)
61. You've NOW taken offence. at what I've said to ↓yo:::u.
62. Look how ↑PERsonally you've ↑TAken it! (0.2)
63. >YOU won't even ta::lk to me! You can't even talk to
64. me ↑sensibly no::w. (0.7) She really took offe::nce!=
65. Th: =hmmm (2.0) hmm (0.6) and does she do that quite a bi:::t?
66. Cl: (0.8) She obviously does. (1.2) [she takes things very=
67. Th: Hmm[m
68. Cl: =personally. (1.4)
69. Th: And how?- what affect >do you think< that has on ↓yo:::::::u.-
70. How does that make you fee::l? when she does that.
71. Cl: (11.1) >Well I-< (0.9) °ugh° (3.0) <I don't (0.1) ever> se:::e
72. her doing it. Bu::t its uncomfortable for me::e. (1.8) to
73. have to:::::o (1.8) those people that (0.8) ermm she::e has
74. fallen out with. I know (1.0) and when I'm with them >I'm
75. very conscious of the fact that< (0.4) they don't (0.3) like my
76. → mother (.) f[or some r(hhhhh)eason=
77. Th: [hmm
78. Th =hmmm
79. Cl: or::::r I was (offending) them °so I have to tread ve'y gently °
80. And it makes me want to be even more friendly
81. → with $these people$. .hhh
82. (1.2)
83. Th: °mm-b[u-°
84. Cl: [BUT THEN!!! >I mean< did she::e? The way she got on
85. the phone. She put my father on the phone to talk to me:::e.
86. (1.4) It was again::n like she wasn't treating me:e like
87. an equa:l adult.[ Sh]e was reprimanding me.
88. Th: [Hmmm right ]
89. Th: ye:s.
90. (0.7)
91. .hhhhhhhhh (0.5) And is that a situation:::::n (0.8)
92. >just to reitera:te< that mm- is that a situation you want to
93. mo:ve beyo::nd?=
94. Cl: =↑MMM.
95. Th: Ri::ght.
96. Cl: ↑°yeah!° I don't know what to do.
97. Th: °hmm°
98. (5.9)
99. Cl: Sure this tape is working? .hhhhh
100. Th: Its going round I think=
101. Cl: → =°>yes it is working<°
102. (0.4)
103. HI SU::E!!!
104. (0.5)

105. Th: [so (it) is
106. Cl: [ .hh HH-hh-hh! .hh hu::h ↑.hhhh .hhhh .hhhh hhhhh. (1.0)
107. tsch-yes °I er- so John I er- I I just don't know why we are eve:n°
108. what direction we're going in?
109. Th: °*Hm° (0.7)
110. Cl: ↑°I don't know° (1.2)
111. Th: I MEAN it ju- it just seems from my poin:t of vie::::w
112. in the sense of? °s't of°(.) just from °m-m° the perspective that
113. I'm looking at. (0.9) that? (0.6) in terms of? (.) looking at a
114. la::::rger perspective. (0.4) .hhhh (0.5) that (0.4)
115. >I mean< if you ima::gine (0.4) a situation that (0.8) on the one
116. hand you've got the >parental expectations< wi- the various
117. pressures °which. (0.7) which w- we've ta:lked abou:t
118. and keep manifestin::g°. .hhhh On the other han::d (0.4) there's
119. the there's the >potential< (0.4) if you li::ke? (0.8) errrm
120. SLOT-rattling rebellion against tha::t…

**Dyad C:**

**Time: 6.30**

Th: In this kind of situation ↑where (0.3) ↓where you were *very ill*
and go off to your mother- is that something that you don't think
they're resentful about or understand that <(that's really what
you want to do)? °Or do you () get yourself ()°?=
Cl: =↑WELL (1.0) I mean I get these ↓sinus infections
so many times and I'm usually ok.
↑But I've never had this high temperature (0.6)
AND QUITE FRANKLY I thought I was- (0.3)
>IN AND OUT OF<? conscious- that I was very?
I felt very very stra::nge (0.4)
so I just ra[ng and said-
Th: [well you would do with a? Its not like you're a child
with a high temperature although ( ) very ea:::sy.
Cl: Yea:::::h. And I've ↑NEVER ↓I never have temperatures
It was just under one hundred and fou::r. (0.7) so I-
>I sorta rang my mum when I got in and said I didn't feel well
so my ↑dad ↓said take your temperature and ring me BACK<
(0.3) so when I went to ring 'im back
(then I was HUN::::G up) for an HOU::::R
>and I was getting °worse and worse eventually I got in and I
said what it was°< ↑THING IS WITH MY MUM:M (1.7)
$↑VERY STRAN:::GE$ she'd say to um take your temperature
>and I'll tell 'er what it< i::s and she says >↓Don't be so stupid.<
(0.7) ↑she ↑NEVER BE↓LIE::::VES ME. (1.0)
She's always got this thing abou::t saying ↓>don't be so stupid<
and you have to like? explain:::n yourself for her (0.8)
°very strang[e° sh-] she's always=
Th: [°that must be very annoying°]
Cl: =like that with m::e!. (1.1) If they- if if she thinks I'm not
t-s-saying something that's ri::ght O::R?
if they think they're ri::ght
they always say >don't be so stupid<
and I'll say >alright then?< (0.4) an' you know I s::s-
$I s(hh)aid to her$ I've got this really high temperature
she goes ↓>don't be so stupid<
→ and I said alright then I haven't
YOU KNOW! s- They never BELIEVE ME!
And you have to sort of say well I ha::::ve
And >d'you want to come and look at it<
before they say oh? ↓alright then. (1.3)
I don't know what it is they never sort of believe you first time
( )
Th: Yeah. (1.5)
Cl: Yeah. I remember years ago that (comes a time)
we've always lived in town houses (1.8)
and they've always always made me wear slippers.

55. And I've always said if I wear slippers I'll fall down the stairs.
56. And I used to fall down the stairs all the time.
57. Couple of times I'd really hurt myself.
58. And they had these really (0.8) ornate banisters up ( )
59. And if you got your arm stuck >in it or something< and you fa::ll
60. and you're like hanging. (0.9).
61. ↑Loa:::::ds of times I'd be left there and like about half an hou:r
62. saying- I thought I'd broken my leg a couple of times
63. and they ↑NEVER COME TO ↓never came to me you know
64. (1.4) °really weird° (1.2)
65. Th: (°dussat make you angry°) (3.0)
66. Cl: ↑Ye:::ah (1.1) ↓°I suppose so°
67. Th: Hmmmm.
68. Cl: I don't know what made me thou- think of it.
69. Its just it always used to happen you know
70. it used to take quite a whi::::le for them to? (1.9)
71. realise that there was something that actually ( )
72. Th: I suppose er? going going back to the part of the problem (0.6)
73. with being alone >with a couple of kids to look after<
74. ↑this is that there is no one there to support you is there.

Time: 13.59

75. Th: ↑Yes and I don't mean rules as in written ru:les-
76. but you know they become rules
77. <It's the way things A:RE>
78. >and they're quite rigid and they don't change
79. and they're not flexible< (0.6)
80. (Eman) I'm saying to you? (th)at you've got to be mo::re flexible
81. (.) in? (.) some? (.) >of your own rules if you like<
82. how 'bout- how you (.) go abou::t it. (.) >for example<
83. .hh umm although its desirable to d- to do all sorts of things
84. without having .hh umm (0.1) Ste:::phen .hh around (.)
85. it might be better for you to be doing wo::rk
86. >related things in the morning<
87. and [just kinda get on::n with it?
88. Cl: [Mmmm yea:::h I HA::ve bee::n
89. Th: in the afternoon:::n=
90. Cl: =yeah
91. Th: You've been doing tha::t in fact
92. Cl: Yea::h
93. Th: ↑Go:::::::d.
94. Cl: Yeah
95. Th: °>how's 'at been.<°
96. Cl: EVEN HOU::SEHOL' THINGS that I used to Da:sh around
97. and try 'n do i(t) all while 'e wasn't there (2.2)
98. °un then::n not have time to so anythin(g) else°
99. so I::: lea:::ve it °I tend to leave it now°
100. COZ I was a:::ngry coz >I spent all day yesterday
101. coz I hadn't been in the house [I was cleanin the house=

102. Th: [yes
103. Cl: =[I did their room
104. Th: [yes:::s
105. (2.2)
106. Cl: >Took them< upstairs to get undressed and
107. >by the time I come up< they'd sorta made their whole bedroom
108. into a pi:::rate ship you know out of e::verything °and anything°
109. n' it really BUGS me (1.8) an' u:::::::sually I would 'av
110. (0.5) ss- (0.6) gone ma:::d an' done it all
111. before they got into bed
112. >coz I can't bear a< thing ou::::t [you know when its bed time
113. Th: [°ri::::ght°
114. Cl: =everything has to be [.hhhh in place
115. Th: [↑uuuuh! why can' they s- ↑why can't=
116. → they sleep in a pirate ship!=
117. Cl: =SO I'VE left it. NO:::::::O. I've just- °you know- they put like a-°
118. put a- they got a hoo:::ver with a-
119. with a blanket tied on it for a ma::::st un-
120. Th: HU::::::H ↑HU:::::H ↓HU:::::H HU:::::H.
121. (0.5)
122. Cl: >everything-< I know!=
123. =$But it annoys me when you've spent all da:::::::y doing it$=
124. Th: UH Huh!
125. (2.3)
126. Cl: Its different if they'd done it all day
127. and then you clear it up and go to bed
128. but its because I'd cleared up all day
129. and then they made a mess °when they come in° (0.8)
130. Its always the wrong way rou::::::nd.
131. [I'VE just le::::ft it ] they've shut the door
132. Th: [I suppose ]
133. Th: Ok well I think tha::t's ↑pretty goo::::d! um tha::t >you know<
134. I can tell you're annoyed [and I] think that's understandable
135. Cl: [yeah]
136. Th: but to actually lea:::ve it and
137. let them get on with it for the moment=
138. Cl: .HH HHHHH! HHHHHHH! (cough)
139. Th: (some one of already today ( ) another lot)
140. (0.4) I think its very good indee:::::d!

Time: 35.12

141. Th: When you tend to say anything
142. (2.5)
143. Cl: E:::::RM
144. Th: what would you respond to (.) if they're? fighting or they're?-
145. you know if it gets to a period of time
146. for an amount of time when they're [doing whatever ( )
147. Cl: [ WELL I MEAN

148. Cl: SOMETIMES even when he doesn't think he's hurting Andrew
149. I mean? Even if he's ly:::ing on top of him and cuddling him
150. and kissing him really hard which he used to do
151. when he was a BAby >to some< (0.9)
152. some children at nur:::sery
153. and an' knock them fly::ing >you know?<=
154. Th: =Mm=
155. Cl: =he's just very heavy ha:::nded
156. Th: Hmm.
157. Cl: SO if he's lying on top of Ste::::phen- he thinks he's being nice-
158. he's KISSing him and he's holding him so- and Andrew's
159. screa::::ming >in pain most of the time<
160. .hh ↑I said Andrew? HE DOESN'T WANT IT!
161. >You know< <he's cry::ing> (0.9) He doesn't SEE that.
162. <He just sees what he::e wants to do to him.>
163. (1.9)
164. And it err it always ends up in a fight!
165. Th: Hmm!
166. Cl: And me HAVING TO TAKE Stephen away!
167. AND I have to take him to another room
168. >°and then Andrew gets angry°< of course
169. and kicks me in the back >or something [you know<
170. Th: [IS THERE ANY
171. OTHER way you? you could go about that?
172. Cl: .hhh
173. (6.0)
174. Cl: I DUNNO I just said to him look you can see he
175. doesn't want it or-err you know say to Stephen do you wan' 'im
176. (to) get off yo::u and he'll go yeah. ( )
177. (2.1)
178. Cl: But it takes a long time to get them apar:::t.
179. Th: Hmm
180. Cl: And then (.) I get (.) kicked for it (.) °I get [(.) told] off for?°=
181. Th: [so it?I mean]
182. Th: I mean I I ( minefield )
183. sort of? huh .hhhh huh [.hhhhhh
184. Cl: [yeah
185. Th: you know
186. Cl: YEAH he was like that as a BABY
187. Th: WRESTLES you [(to the ground etcetera it's all a bit
188. Cl: ( ) [NUR::::sery!
189. Cl: That's right!
190. Th: All a- All a bit too much. No. I? I'm? I wonder first of all whether
191. erm (0.3) you as a general ru::le (0.5) err even its quite?- err
192. especially if its for quite short periods
193. <WHERE YOU SEE THEM> um you sa::y
194. that they're at it non-stop and I KNOW what you mean!
195. → $↓Because >I get a bit of that as< we:ll!$ HAH HAH!
196. Cl: Yeah.
197. Th: .HH um? But it ISN'T non-stop. There must be occa::sions

198. >even relatively short ones< where they are NOT at it (0.4)
199. <And I think you should tr:::y and hone in on tho:::se>.
200. And actually HEAVily reinforce occasions where they are
201. co-operating
202. (0.7)
203. Cl: Hmmmm
204. Th: Okay even if its good for- and in fact you shouldn't wait.
205. Because if you wait that extra fi::ve minutes
206. >for that five minutes all hell would have broken loose
207. and you would have lost< $the opportu::nity$
208. so in fact if you if you >you know< if you sort of
209. you are awa:::::re that they're doing whatever and they're
210. co co-operating reasonably ni:::cely not perfectly necessarily
211. but you know for them reasonably ni:::cely for fi::ve minutes
212. Perhaps you should go i::n and? sa::y something li:::ke
213. you know °its very nice that you're playing nicely together°
214. OR whatever [( )
215. Cl: [YEAH I've tried it although I remember you telling
216. me that once before and I have tried it
217. Th: Whenever. And I would do it OFTEN.
218. Cl: Yeah
219. Th: You can't over- do it coz then I think you should do it OFTEN.
220. Whenever. And as I said if you leave it too long
221. then then it could degenerate to som::e poi::nt
222. so I think[ that is generally something you should=
223. Cl: [°hmm°
224. Th: =be really vigilant about at the moment >so that I I think<
225. it is it is? such a drag when they are um? non-co-operative.
226. And you're [telling them
227. Cl: [IT JUST MEANS you can't turn your back!
228. Th: Oh I know! Its its [really quite (scary)
229. Cl: [Even if you say oh you're really good.
230. I mean you've only got to turn your back and it starts.
231. Th: I know its really wea:::ring. >But? But?< (0.3)
232. The::e >sort of< individual thi::::ngs um (0.2) we sai:::d
233. °( ) each by himself° and Andrew is obviously
234. much better (.) <by himself> s[o now maybe=
235. Cl: [yes
236. Th: =it's a good opportunity having kinda got that bit settled a bi::::t
237. erm i- er th- the separateness sorted now you need to ACTually
238. be trying to to[ alter the the togetherness=
239. Cl: [°hmmm°
240. Th: → =or the $non-togetherness$ a bit [mo:::re Oka:::y?=
241. Cl: [°Yeah°
242. Th: =and again >as I said< err constantly reinforcing? >TImes
243. when they are doing what they should do appropriately.<
244. >in some way and constantly um having to remind yourself
245. they've been quite good< I must go in and sa:::y something
246. >°And then you've actually got to find a way of dealing with
247. (something in) the situation°-< well FOR EXAMPLE if you find

him you know <umm err> sort of err kind of kissing and
→ tortu(hh)ri(hh)ng Ste(hh)phen at the same ti::me=
Cl: =Yeah=
Th: =and when you say? I'm suspecting he knows what he's
doing when he's doing that. °I suspect he does know what he's
doing° .hh
Cl: Yea:::h!
Th: Um BUT YOU KNOW. Is there any other way
that you could approach that from the way you do:::o
which is to to to get in the aggravation like you do do::o
you get kicked and and and an an sort of
→ <*ge::t off your brother!*> all that kind of stuff
↑Is there any other way you can deal with it?
In a more positive manner.
(2.5)
Cl: Well I mean it's just? Because Ste::phen's got
such a piercing scream. It's like you just wan' it to stop!
Ev- >you know< every time something's happening
Th: → Its ve(hh)ry useful <that scream> i(hh)sn't i(hh)t!
[HAH HAH.
Cl: [Ewweurgh! He'd scream all the time! And the thing is you don't
even have to be in the same roo:::m and you automatically shout
<Andrew! Get off!> because it (0.9) its like you can see what's
happening throu- through a brick wall!
Th: Hmmm
Cl: Some times admittedly i- its not Andrew and
he says ooh I didn't do anything

## Appendix 7: Glossary of terms

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|---|---|
| Acknowledgement tokens | Utterances used to indicate listening or understanding of the speaker |
| Adjacency pair | These are commonly occurring pairs of utterances such as question-answer, introduction-greeting |
| Analytic concepts | The central features of CA include: turn-taking, management of overlapping talk, the organisation of repair and the organisation of turn construction design. |
| Continuer | Utterances made by the listener to signify agreement with content or to encourage the speaker to continue |
| Discourse markers | These are words such as 'well' and 'right' which are usually used to mark boundaries in conversation between one topic and the next. They can also sign post relationships between utterances |
| Correction | A specific form of repair of the substantive fault in the content of what was said |
| Embedded repetition | The inclusion of some part of prior talk to show connection and continuity |
| Epistemic markers | Phrases which refer to knowledge or belief e.g. "I think…" |
| Evidential speculative markers | Phrases that indicate uncertainty e.g. "it seems that", "maybe", or "perhaps" |
| Exemplar | An example of a conversational phenomenon to demonstrate analytical claims |
| Extended sequences | Long segments of monologue, e.g. stories |
| Extended agreement | Agreement to a speaker that involves an affirmative response and corroborative statements indicating agreement such as autobiographical material |
| Extension | A syntactic continuation of the others comment, through finishing the other's turn or continuing it, often in pursuit of the therapeutic agenda |
| Filler | Fillers are utterances that do not usually carry conventional meaning. They are inserted in spoken discourse to allow time to think, to create a pause and so on. |

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| Figure of speech | An expression that uses language in a nonliteral way, such as a metaphor or synecdoche, or in a structured or unusual way, such as anaphora or chiasmus, or that employs sounds, such as alliteration or assonance, to achieve a rhetorical effect. |
| First pair part | See adjacency pair |
| Formulation | The re-saying of the perspective expressed by the client which is often used to emphasise or extract the psychologically meaningful aspects |
| Hedges | Hedges are words and phrases which soften or weaken the force with which something is said e.g. ‘kind of’, sort of’, ‘by any chance’, ‘admittedly’. |
| Hyperbole | Obvious and intentional exaggeration. An extravagant statement or figure of speech not intended to be taken literally |
| Idiolect | Also known as a ‘personal dialect’, this term refers to the language particular to an individual. |
| Insertion sequence | A sequence of utterances separating an adjacency pair. |
| Interruption | A specific type of overlap, identifiable through the interrupted speakers response indicating the violation of turn-taking rules. |
| Intonation | The rise and fall in pitch that occurs in speaking |
| Introduction Markers | Utterances to set the tone for subject changes, used prior to a shift in topic e.g. “OK”, “So” |
| Irony | The use of words to convey a meaning that is the opposite of its literal meaning. A technique of indicating an intention or attitude opposite to that which is actually or ostensibly stated |
| Latching | The seamless continuation of speech between speakers, denoted by a = sign in transcription between speakers or lines. Also used in the case of interruption |
| Misalignment | Misalignment is shown in the discrepancy of understanding in the talk between two or more people e.g. misunderstandings, mishearings, disagreement etc. |
| Minimal response | A brief utterance suggestive of understanding or but not necessarily agreement e.g. yes, hmm |

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| Membership categories | An aspect of conversational description. Culturally available resources which allow us to describe identify or make reference to other people, or to ourselves e.g. girl, trainee, snowboarder, sister. These are non-neutral inference-rich descriptions. |
| Metaphor | A symbolic use of language. Can refer to a figure of speech as a term or phrase that suggests a non-literal resemblance |
| Neutral perspective markers | A neutral perspective refers to the shift away from having an identifiable perspective subject of I, you, he/she etc. Rather than saying “I kicked the cat”, a neutral perspective would phrase it “The cat was kicked”. Neutral perspective markers are phrases in conversation that mark this shift of perspective e.g. “from this point of view” or “in a sense”. |
| Overlapping talk | When two or more speaker talk simultaneously. Mostly occurs at transition relevance places |
| Preference | An inferential aspect of an adjacency pair sequence, where certain features of the first pair part indicate the preferred response in the second pair part. A preferred response is usually immediate. A dispreferred response usually features dispreference markers, including delay, qualification, explanation, pauses, hedges, etc. |
| Projection | Projection refers to the listener’s attempt to anticipate when the TCU will close and a transition relevance place will fall, ensuring the uninterrupted flow of talk. |
| Prosodic features | The features of the voice such as speed, volume, intonation and stress |
| Pseudo-agreement | Used to save face, the pseudo-agreement occurs when one speaker appears at first to agree with another, but in the continuing utterance the speaker expresses a viewpoint that differs from the initial agreement |
| Re-interpretation | A statement that is grounded in what the client has said, but is caught and expressed from the therapist’s own perspective and its meaning is transformed to something different from the client’s. Usually associated with epistemic markers, neutral perspective markers, evidential speculative markers, an evaluative component, figures of speech, metaphors and psychological professional terms. |

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| Repair | Includes the remedying of turn-taking mismanagement and correction, which refers more to a substantive fault in the content of what was said through mishearing, misunderstanding, choice of words etc. |
| Speech acts | A speech act refers to what is done when something is said, such as warning, threatening, promising. It can be direct and explicit, congruently mapped onto what was said, or it can be indirect, such as having an implied meaning. |
| Speech exchange system | Structural characteristics governing the exchange of talk. The system of conventions regulating the exchange of turns and the management of speaker roles among participants e.g. different systems for lectures, conversation etc. |
| Second pair part | See adjacency pair |
| Tag questions | Tags are strings of words which are normally added to a declarative statement. Their inclusion turns the statement into a question e.g. "…isn't it?" |
| Turn Construction Unit | These are the way that speech are organised, which broadly correspond to linguistic categories of sentences, clauses and words. |
| Transition Relevance Place | Transition Relevance Places are the places in speech where a speaker may be indicating their turn construction unit will be ending and a listener can take up their turn to talk. |
| Utterance | Any use of words or sounds, the basic unit of research in CA |
| Vague language | Vague language such as "or something", "or whatever", occurs deliberately in spoken language to soften the impact made by the speaker |
| Vocal sounds | Sounds made in conversation non-recognisable as words |
| Voiced pauses | Noises made by the speaker to give the speaker time to pause, whilst indicating a desire to hold the speaking turn e.g. "err", "umm" |