Laughing with and at Patients: The Roles of Laughter in Confrontations in Addiction Group Therapy

Ilkka Arminen
University of Tampere, Tampere, Finland

Mia Halonen
Research Institute for the Languages of Finland, Helsinki, Finland

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In Minnesota treatment, the therapists aim at breaking clients' denial to encourage them to accept their addiction. However, the confrontation is risky since, instead of making the patient ready for a change, it may strengthen resistance against the diagnosis of addiction and the treatment recommendations. We will explore the role of laughter in confrontational practices. The study is based on conversation analysis of group therapy sessions in an inpatient addiction treatment clinic in Finland (7.5 hours of data altogether). The laughter prevails in three different kinds of practice: laughing off the troubles, strengthening the confrontation by laughing at the patient, and ameliorating the confrontation. Laughter is a flexible device for preventing or resolving the possible risks of confrontation. Key Words: Addiction Treatment, Confrontation, Conversation Analysis, Group Therapy, and Laughter

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Laughter appears in several roles in therapeutic interaction. In our data on addiction therapy, it tends to occur in connection with confrontational practices. In the kind of addiction therapy considered here (the Minnesota treatment, also known as the Hazelden treatment, see Anderson 1981), the therapist is suppose to confront patients. If the therapist chooses to do so strongly and overtly, this may provoke resistance and endanger the whole therapeutic process. On the other hand, if the therapist does not confront patients at all, or if the confrontations are very mild, the therapy may lose its edge and the patient's addictions remain unchallenged, which is as problematic from the point-of-view of addiction therapy. The addiction therapists following the Minnesota treatment paradigm thus face the dilemma of having to confront the patients, which poses a threat to the whole process (Arminen & Leppo, 2001). In this article, we study laughter and invitations to laugh as a strategic solution to this dilemma in addiction therapy. We will also discuss the limits of laughter, and show that some troubles are resistant to being laughed off.

The study has its roots in a large international research project on Alcoholics Anonymous (Mäkelä et al., 1996). Part of the project concerned sharing of experiences in AA (i.e., how mutual help was achieved in interaction at meetings, Arminen, 1998). At time of the project Halonen assisted Arminen by transcribing his data from audiotapes. In addition to transcribing, Halonen also discussed with Arminen different kinds of methodological issues raised by the data. During that time of co-operation, an idea of

another study was born and we established a project to investigate the ways in which the AA set of beliefs was transferred into professional practice, in the Minnesota Model of addiction treatment, which had converted the idea of mutual help through the support of other addicts into a strict program led by the professional therapists and other staff in the clinics. The Minnesota Model is based on the view that patients have to be convinced to see themselves as addicts needing help. Thus, it differs critically from AA in that the treatment is usually not voluntarily attended (e.g., Arminen, 2004; Arminen & Leppo, 2001; Arminen & Perälä, 2002; Halonen, 2002, 2006). The strategies and dynamics of confrontation have been central to our studies, including this study on the role of laughter in confrontations.

In the 1960's, Harvey Sacks (1992a) noted the potential people have to act in covert ways in interaction (i.e., doing actions as if they had not been done). In calls to a suicide helpline, the caller sometimes reported not hearing the answerer's name, thereby avoiding giving a name without refusing to do so. Sacks also pointed out that laughter can act as a ceremonial form for ending the current phase of action, giving it tremendous potential in interaction. Through treating the request for help as a joke, the recipient of the request can respond to the joke instead of the request, and refuse help without overtly doing so. The laughter, as it were, changes the activity structure of interaction so that the request for help is downplayed by laughter and transformed into an invitation to laugh. Laughter can display and soften the delicacies of confrontation in addiction treatment too.

Recent conversation analytical studies have elaborated the role of laughter in interaction, demonstrating that it is more than merely an index of humour or joy. Continuing Sacks' work, Jefferson (e.g., 1980, 1984, 1988) approached laughter related to problems and troubles, drawing attention to the fact that the troubles-teller might laugh while talking about her/his problems, but the troubles-recipient tends to decline to laugh. Through laughter the troubles-teller may display her/his ability to cope with the problem, whereas the recipient's refusal to join the laughter displays sensitivity to the trouble. In contrast, the recipient's laughter might well be heard as insensitive and inappropriate. However, in time outs from the trouble, the recipient might accept the invitation to laugh, and co-construct a time out through shared laughter. Glenn (2003) has further developed Jefferson's ideas of laughing at and laughing with as a relevant distinction for the participants. He understands laughter as an action by which participants can affiliate or disaffiliate with each other. Shared laughter (laughing with) constitutes time out from sorrow, and in joy a celebration. Griffiths (1998) analysed the role of humour and laughter in managing tension in hierarchical, multi-professional teamwork. Humour and laughter allowed "letting off steam," facilitating both a challenge and resistance to the entrenched power structure. Haakana (1999), however, showed that in medical interaction the institutional asymmetries between doctor and patient prevailed in their laughter. Our analysis continues these studies, showing that laughter is a systematic part of delicate confrontational practices in addiction therapy, and that therapeutic interventions in different contexts invite different kinds of laughter.

Background

In recent years, studies on counselling and therapeutic interaction have addressed critical or delicate aspects of the types of interaction. In her study on genetic counselling, Pilnick (2002) identified a number of interactional difficulties, some of which seem to be generic to counselling and therapy interaction. There is always the issue of relevance, since the tasks have to be made relevant for the particular client. Further, the client's perspective always sets the limits to the acceptability of professional practice (Arminen, 2004). If the client suffers from some incompetence, this imposes further requirements for a co-operative and successful therapeutic process (Parry, 2004). These critical aspects of therapeutic interaction are relevant for understanding the kinds of dilemmas that arise out of confrontations in addiction therapy.

The issues concerning relevance of professional activities for the client have been addressed in a number of studies on advice-giving[1] in counselling. The first interactional contingency concerning relevance relates to the question of who initiates the advice-giving (Heritage & Sefi, 1992). If a client overtly requests advice, then a prospective alignment and relevance for advice is given in advance. By contrast, when the counsellor initiates the advice-giving, problems may emerge about whether the client acknowledges a need for advice or its relevance. Previous studies have shown that counsellors have ways to prepare for advice-giving to influence its reception. A counsellor may try either to personalise or depersonalise the advice. It may be tailored to needs by first asking the client's view before the advice is given. The advice can be presented as being co-implicated by the client through this kind of preparatory move, forestalling her/his resistance (Maynard, 1992). Alternatively, intimate, sensitive advice may be given in an impersonal way to avoid embarrassing the client (Peyrot, 1987). For instance, advice in HIV counselling about sexual practice may be presented as directed at everybody rather than singling out a particular client (Silverman, 1997).

Another potential dilemma in therapeutic work arises out of the client's ownership of her/his experience. The therapist has to overcome the potential resistance deriving from the fact that only the client has direct access to her/his emotions, about which it may be difficult to talk. Different types of therapy have characteristic ways of handling the client's ownership of her/his experiences. The family systems therapists use circular questioning in which the family member present is first asked to give her/his view of the client's problem, thereby making relevant the client's response as the owner of the experience, a process which pre-empts the client's potential reluctance and resistance (Peräkylä, 1995). Mutual help fellowships, such as Alcoholics Anonymous and Narcotics Anonymous, use this dynamic indirectly in sharing. AA and NA meetings are based on a series of life-stories in which each member speaks only about her/his own experiences. In sharing, the first story makes it relevant for subsequent speakers to design similar stories. AA and NA meetings are places in which recovering addicts' reciprocal revelations are made relevant (Arminen, 1998).

In addiction studies, the emphasis is put on the treatment outcome measurements or on biogenetic research, though the understanding of the treatment process has been considered relevant for the development of therapeutic practices (Midanik & Room,

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[1] Advice-giving is common activity, although it is not practiced in all kinds of counseling.

2005). The studies on treatment interaction may be relevant by, for instance, showing how interactional practices contribute to the treatment outcome (Stivers, 2005). The studies on addiction therapy have shown that conversational organization is a constraint on the therapy process as well as a major resource. The social norms embedded in the patterns of everyday interaction set the limits for the suitability of therapeutic intervention (Peyrot, 1987, 1995; Weinberg, 2000). Group therapy practices employ general socio-psychological processes such as sharing, in which patients reflect on their own experiences with the help of the experiences of others (Steffen, 1994). Finally, treatment ideologies both guide and constrain the therapeutic practice. Therapeutic ideals and ideologies are translated into patterns of interaction in the therapeutic practice so that, for instance, confrontation becomes a definitive part of the Minnesota treatment model (Arminen & Perälä, 2002; Halonen, 2006; Yalisove, 1998).

Confrontation is an interactional practice that is characteristic of addiction therapies in general, and of 12-step therapies in particular. In confrontations, the professional aims at breaking the client's denial in order to encourage them to accept her/his addiction (Anderson, 1981; Yalisove, 1998). Therapists understand confrontation as a one-directional process in which the therapist imposes a change in the client's views. However, scrutiny of confrontations shows that it is a double-edged sword in that the outcome of confrontation is not a public display of a distinct change in the client's identity, but an acknowledgement of the existence of more than one view regarding the issue confronted. For clients, confrontations may make a goal of resistance available, and may also induce teaming against the therapist. For these reasons, confrontations may also lead to counterproductive outcomes and reinforce rebellion against the official goals of the treatment (Arminen & Leppo, 2001; Halonen, 2006).

In this article, we employ conversation analytical methods to unravel the role of laughter in confrontations. We will point out three distinct, but interrelated, practices involving laughter in interaction. First, we will show that confrontations may be constructed in a way that enables the confronted person to see the trouble in a new and comical light. This can be called "laughing off troubles" (c.f. Sacks, 1992a). In the instances considered, the therapist uses extended, strategic question-answer pairs; hence, we have called these sequences "Socratic". Moreover, we show that some problems may resist the therapist's efforts to make them the subject of laughter. Second, therapists can also invite other patients to realize a problem that the person confronted has not or will not recognize. The therapist may invite these other patients to indicate their realization with laughter. On these occasions, the therapist invites other patients to laugh at the confronted patient. As cruel as this practice may sound, it exists in the treatment literature, referred to as "mirroring" (Steffen, 1994). Third, the therapist may use laughter to ameliorate a confrontation that has encountered passive resistance. If the confronted patient has not aligned with the confrontation, the therapist may need to reopen the interaction so as not to block the whole therapy process. The therapist may try to reframe the interaction as non-serious through laughter. In all, we discuss the multiple roles of laughter in therapeutic interaction and show that laughter may play different roles in various interactional contexts.

Data and Methods

The group therapy data of the study comes from a Finnish inpatient clinic for addicts. The clinic uses the so-called Minnesota Model, based on the ideology and the program of Alcoholics Anonymous, in their treatment. The cornerstones of this ideology are: (a) addiction is a disease and (b) addiction cannot be cured, but one can stay sober and recover by regularly attending AA-meetings. The treatment lasts for four weeks, during which time every patient has to attend at least eight AA-meetings. The therapy group meets five times a week for an hour and a half with the therapist and five times without the therapist as a peer group. The therapist and six to ten patients constitute the group. The therapists are (former) addicts.

As mentioned, our interest in this therapy arose from a study on Alcoholics Anonymous. Working in the setting of a clinic and getting the sessions videotaped was different from the AA study. To gain access to the clinic, we had to convince both the director and some individual therapists of the usefulness of our investigation. We had to take part in both strategic and tactical language games to assure them that our work would help the clinic in its competition over treatment markets and benefit therapists in their clinical work.

Concerning ethics, we were asked to give a comprehensive description of the data collecting process and the ways in which the confidentiality of the participants would be secured. These were evaluated by the prospective funding agency of our study. We used conversation analysis (CA), the principles of which will be discussed in the next section, to explore examples of talk at work in addiction treatment. To explicate context-bound meanings, CA research demands access to actual interactional events that will be audio or video recorded. The use of recordings makes particular ethical questions salient. All our data collection is based on the written permission of the all participants, whose identifying details have been changed in the transcripts to secure confidentiality. Participation in the study was voluntary. This is particularly important in the use of intimate materials like therapy data. Further, CA research is neutral towards the participants; the analysis focuses on the organization of interaction and talk at work, not on the personalities involved. The IRB approval was not an issue; it is needed only in medical research projects in Finland.

We started the process by negotiating with the staff in the clinic after which Halonen, Arminen, and Anna Leppo, our research assistant, each separately spent two days in the clinic as a participant observer. This was a routine procedure in the clinic. All the prospective employees of the clinic, and other contact people, went through this procedure. The next step was to negotiate with the patients in the clinic. From everyone joining the study we obtained written permission to videotape and analyze the interaction. The ones who did not want to join were placed in another group; it was emphasised that joining the study was completely voluntary. About one of ten patients and two of four therapists refused to take part in the study.

After obtaining permission from all the participants, the field work started. It included both interviews and field observations, which were done when we spent a couple of days in the clinic joining all the same activities the patients did (at the request of the clinic personnel). Field notes were done also when videotaping various therapeutic practices (group therapy, peer group sessions, individual counselling). The tapes form our

main data. It was done by video camera without the researchers being at the group session. Our analysis focuses on the tapes (i.e., activities made available for the analysis in the tapes). The field notes have, however, provided us important background understanding, without which we could not have competently addressed issues we came to understand being relevant for the whole therapy process. There is a hermeneutic circle between field notes and video taped instances of activities. The field notes directed us to pay attention to certain activity types and, vice versa, the videotaped situations offered us keys to understanding the field notes.

In this article we focus on an activity called the "morning circle" or "feeling circle" in which every morning all the patients took extended, pre-allocated turns of talking about how they felt that morning and how they felt between the group meetings, (for example, in the AA meeting last evening). The "feeling circle" is the environment for patients to bring up every kind of trouble, and they are, if not advised, at least encouraged to do so. The problems they bring up can be described as something in between troubles talk and complaining. They are related as personal harms (e.g., turns are primarily first-person narratives about their own feelings, and only secondarily complaints about misconduct by somebody else, see Jefferson, 1980, 1988). In their institutional context, they can also be heard and responded to as complaints because the personnel including the group therapist may be held responsible for their well-being in the clinic[2]. Thus, the "feeling circle" is an activity in which the therapists can monitor whether the patients accept or resist the treatment. One important thing they pay attention to is patients' honesty and openness, that is, how much they offer information about last evening's AA meetings or talk about their feelings, especially negative ones. It is of course impossible to get into the patients' minds, but experienced therapists can usually separate openness "done" in order to please the therapist and openness motivated by hope for a change. A different and a very crucial issue, which we do not have space to handle here, is that the motivation or the reason for the openness might be totally irrelevant from the point of view of the result of the treatment. The patients are not expected to glorify the circumstances, but to analyse them and themselves: The therapists can also handle praises as problematic, as a symptom of not realising or accepting all the aspects of the treatment and, more importantly, the addiction.

The "feeling circle" is organised so that every patient talks one at a time; it is forbidden to interrupt or otherwise interfere with the turns for the other patients. The therapists may, however, intervene the turn when they judge that necessary. The time of turn is not restricted, but the therapist will take care that everyone has time to talk. After the circle, turns are no more pre-allocated and "ordinary conversation" is allowed. This paper concentrates only on the "feeling circle," that is, to the environment where the troubles are first introduced. This data is altogether 7.5 hours and consists of 73 pre-allocated, extended "feeling turns" of patients. In approximately 40% of these turns the patients bring up some trouble. The therapists do not deal with all the problems the patients describe; only about a third of them are topicalised by the therapists. While

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[2] The categorization of patients' "activities" and "speech acts" are a critical part of the "work" achieved in the clinic. Thus, as much as we aim at analyzing the "work" of the clinic, we should avoid definite a priori categorizations, which does not mean that a researcher could analyze objects without any pre-understanding (for theoretical discussion of the etic/emic distinction and the role of researchers' knowledge, see Arminen, 2005).

problems are usually treated seriously and handled in an empathetic or supportive way, therapists sometimes confront and challenge patients.

The research interest of Arminen and Halonen has been primarily academic. The researchers are not alcoholics, addicts, or therapists working in the area. The research project, though, was developed in collaboration with therapists so that they could reflect their working practices with the help of our analysis of the international processes. Subsequently, the findings of the study have been discussed numerous times with the therapists. For Halonen, the project was her doctoral research (Halonen 2002). For Arminen, who was leading the research project, the project was a post-doc study.

Conversation Analysis

CA originated in the work of Harvey Sacks and his colleagues in the 1960s as a means of analyzing the social organization of everyday conduct (Sacks, 1992a, 1992b; Silverman, 1998). Recently, CA has broadened into a program for the study of any type of social interaction, also covering various goal-oriented institutional settings. In all, CA is concerned with how things are talked into being, and how talk is at work in institutions. CA considers talk as a primordial medium for the orchestration of activities across different settings. Through talk, people create and sustain an understanding of what is going on and what they are doing. Since talk amounts to action as actors make sense of the ongoing event and negotiate their roles, CA is a program of reverse engineering[3] that unravels the basic building blocks of social interaction. The aim is to reveal the architecture of intersubjectivity (i.e., people's methods of communicating and showing their understandings of each other's talk, identity, and actions).

The basic working principle of CA research is so simple that it is difficult to grasp; it studies what an utterance does in relation to the preceding utterance(s) and what implications it has for the next one(s). In technical terms, this is called "sequential analysis" (Heritage, 1984; Pomerantz & Fehr, 1997). CA focuses on utterances, actions, and even absences of action as objects that gain their meaning in relation to ongoing talk. CA challenges the idea that a word, utterance, or any item has a permanent meaning. For instance, a silence may or may not have a meaning. A recipient's silence after an assessment can be a way to disagree (Pomerantz, 1984), but in other contexts a silence may have entirely other meanings (such as a way to display a mutual understanding of the terminal stage of interaction). To sum up, CA considers sequences of interaction rather than individual sentences, scrutinizing the context-sensitive interpretative work of participants and the situated meanings of utterances.

Ultimately, CA may reveal hidden rationalities and tacit meanings in communication. If B, while calling A, says, "your line has been busy," B may seem to provide just a factual description of a failed attempt to communicate. However, we may ask what B suggests to A through this statement. Note that this is an empirical question; you can test what you will accomplish by using the phrase. It seems that this statement works as a fishing device (Pomerantz, 1980), an indirect request for more information that invites the other party to indicate with whom she or he has been speaking. In this

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[3] The term "reverse engineering" came to our knowledge through Daniel Dennett (1991). Originally, the term comes from a special field of engineering that deciphers how complex structures, such as pyramids or gothic churches were built in the first place.

way, CA may address the implications of talk. CA may also investigate tacit meanings. For instance, a practice called self-repair, in which a speaker produces a correction to what s/he has just said, opens for examination the inferential work through which the speaker has displayed her understanding that something she just said has been troublesome and hence repairable. This again allows both participants and an overhearing analyst[4] to draw inferences about the speaker's understanding of her identity and role in the situation (Arminen, 1996).

A specific branch of CA (studies of institutional interaction) focuses on questions of what talk does in goal-oriented settings (i.e., in institutional environments, Arminen, 2005). The analytical goal is to specify how the parties' orientations to a context become consequential for their conduct (Schegloff, 1991). In other words, CA does not presuppose that a context such as a medical, therapeutic, or legal institution is simply an external constraint that forces the participants behind their backs. For instance, a doctor, a therapist, or attorney may have institutional power, but it must be exercised and made consequential through interaction with clients (see Gale, 2000; O'Halloran, 2003). The studies on institutional interaction may discern how institutional realities are talked into being and institutional power exercised. Verbal interaction may be highly consequential for the parties concerned; for example, in courtrooms, where competing strategic verbal performances are used to credit and discredit a case (Drew, 1992); calls for emergency services may routinely initiate a service delivery process, but they may also fail with fateful consequences (Whalen, Zimmerman, & Whalen, 1988). Talk in institutional settings is not an innocuous side-issue, but a vehicle of action and power. In contrast to some shortsighted views, CA does not deny the existence of power, but deliberates on its exercise (Hutchby, 1996). This may also open up opportunities to reflect upon power relationships and even contest them.

As a whole, the studies on institutional interaction explore the ways in which talk is specialized, simplified, reduced, or otherwise adapted for institutional goals (Drew & Heritage, 1992). The distinct patterns of interaction in institutional settings are not merely a fingerprint through which the type of interaction can be recognized, but, primarily, the participants' ways of organizing and arranging the accomplishment of institutional tasks. The analyst's ultimate aim is to demonstrate the working of interactional patterns to explicate how institutional activities are carried out.

On Trustworthiness of Analysis of Videotaped Interactions

CA starts with actual instances of action and their recording, not from averages, ideal types, or generalizations. In our case, this means that our work is based on the actual patterns of therapy as documented in the video recording. Consequently, the validity of CA work can be demonstrated in terms of individual exhibits of interaction (for the transcription conventions, see Appendix A). The instances we analyze exhibit the patterns of therapy we discuss. This makes possible the ostensive demonstration of claims; what Peräkylä (1997) has called the transparency of analytic claims. A researcher should be able to pin down the analysis to a demonstrable detail of talk and action. The reader of this text should be able to detect the therapy patterns discussed in the data

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[4] The analyst here, and subsequently, means the person committed to explicating social action, in this context, the conversation analyst.

extracts, if we have been successful in making our analysis clear enough. As mentioned, validation by the next turn is the fundamental technique. In our data, the next turn (and sometimes the lack of it) is the resource upon which the analysis is based on. For instance, a successful confrontation is codified in the next position by a collaborative laughter (extract 1, to be discussed).

However, CA researchers should not be satisfied with simply stating how an individual instance of a phenomenon works (although they have sometimes been criticized for only describing individual pieces of data). Rather, the analysis of instances of data should amount to generalizable invariances[5] (for a detailed discussion on analytic procedures in CA, see Arminen, 2005). Our analysis applies both to the four instances discussed and eight other instances not presented due to space restrictions. That is, we have checked that all the other instances we have do not contradict claims we present here. Initially, we were thrilled to notice that laughter seemed to follow confrontations made by the therapist, and we came to think, partially following an earlier analysis by Sacks (1992a, 1992b), laughter could be a way to "laugh the problems away." Our subsequent analysis, however, forced us to rethink our original "hypothesis." Laughter did not seem to have only one role, but we were able to note three distinct, but interrelated patterns of laughter in confrontational sequences in addiction group therapy. In this way, we found out that laughter may relax the problem, display sensitivity to the delicacy of the situation, or actually confront the patient (by making him or her the topic). We can assume that these patterns have regularity. Although all instances of interaction are absolutely unique, the patterns of interaction make social actions possible. Without patterns, if interaction were just random flow of events, there could be no organized society. The regularities of interaction follow the sequential nature of interaction (i.e., each moment of interaction both makes relevant and narrows down the number of possible activities by making some inappropriate). Laughter as any other item in interaction is regulated. You can try this out; try laughter in the middle of a funeral, after a key point made by the lecturer, or at the breakfast table after any commonplace remark. There are not an unlimited amount of lawful places for laughter.

As for the relationship between confrontations and laughter, we observed that laughter may be part of the confrontation itself, or may follow it and ameliorate it. In the first category, the therapist must invite the patients to laugh at their problems in artful ways, such as through the use of "Socratic" questions. In these cases, the answer to the therapist's question relaxes the trouble, minimises it, and offers a remedy for the possible complaint. These sequences are closed by the patients laughing together. An exception would be if the patient who is confronted does not laugh and others also remain quiet. This was the first regularity we observed. The second regularity takes place, when the

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[5] As the editors of TQR pointed out, the issue of generalizability in qualitative research is usually discussed more in terms of transferability. The idea of discovering something that is universal or invariant is not usually something qualitative research desires or achieves. In this respect, CA differs from some other types of qualitative research. Many of the interactional patterns CA discusses have strong generality (i.e., they exist in a distinct, recognizable form throughout a given culture, and some cases even cross cultures, see Schegloff, 1987 on systematic similarities between repair practices cross cultures). Many interactional patterns of telephone communication have a very strong regularity within cultures. Schegloff (1968) pointed out that all but one of the telephone openings followed a certain pattern, subsequently following the principles of analytic induction, he modified his account to make that one deviant case to fit into his analysis (see also Arminen & Leinonen, 2006).

therapist points out some problem the patient has not recognized by teasing him or her. In these cases the therapist invites other patients to laugh at the confronted patient who does not laugh. The teasing and the consequent laughter build up the inter-subjective strength of the confrontation. The third regularity follows the cases in which the therapist uses laughter to soften a confrontation, when there has been no response from the confronted patient. In these sequences, laughter contributes to reframe the confrontation that has been met with resistance.

Analysis

The Therapist Provokes Laughter: The Socratic Method of Laughing Off the Problem

We will first analyse the therapist's use of the "Socratic" question-answer sequence technique to resolve a complaint or a problem introduced by the patient. The therapist poses strategically designed questions to achieve question-answer pairs that eventually lead to the solution to the trouble that is seen in a humorous or non-serious light. The answer may also function as a remedy for the complaint, but not automatically. In our first case the question-answer sequence completely relaxes the trouble and offers a remedy to the complaint.

Before the first extract of the therapy interaction, Matti (a male first name) has said that he had a negative feeling about the AA meeting last night, but he does not elaborate on this feeling in any way. The therapist (MT) topicalises Matti's problem (lines 1-4) at the end of the circle. The way he addresses Matti as *mister* (line 1) hints at a strategic manoeuvre of getting ironic. The atmosphere in the group is informal and everybody, including the therapist, is on first-name terms. It is also ironic to combine the first name and the formal title, since titles are rarely used in Finnish and are always combined with the surname. By using too formal an address term, the therapist can picture Matti as vain or somebody who presents himself as a "very important person." This address already hints that perhaps the therapist does not see Matti's trouble that serious and somewhat exaggerated. This question is the first one that opens the issue, and it is subsequently followed by a series of questions leading to the relaxation of the trouble. Matti responds to the question with laughter at the very first word of his answer (line 5 *I d(h)on't;* in Finnish the negation starts the turn *e(h)em mää*). It is impossible to say whether the laughter is responsive to the ironical address or if it relates to the telling of the trouble itself (cf. Glenn, 2003; Haakana, 1999). Once he has explained what exactly his problem was, the therapist starts (line 18) to unravel the situation described. The transcription can be followed a little like a dialogue in a novel. The main difference is that in the transcription, simultaneous talk is marked exactly in the place where it started in actual speech (see, e.g., lines 4 and 5). More detailed explanations of the marks used can be found in Appendix A in the end of this paper. The speakers are referred to by names and the therapists by MT (male therapist) and FT (female therapist). Plain F or M refers to female or male participant, which we could not have identified by voice or with help of the picture. "Sign?" after the name means that we strongly believe that the speaker is the named one, but we are not absolutely sure.

(1) Staring [PR 11]

| 1 | MT: | mitäs:? #öö# mitäs sitte Matti herral oli niin, (0.8) |
| | | *wha:t? #uh# what did'y mister Matti have so, (0.8)* |

| 2 | | <u>ne</u>gatiivista sitte. |
| | | *negative then.* |

| 3 | | *(0.8)* |

| 4 | MT: | <u>su</u> <u>r</u>yhmäkokemukses[sa. |
| | | *in your group experie[nce.* |

| 5 | Matti: | [e(h)em mää tiä mää jotenki |
| | | *[I d(h)on't know I somehow* |

| 6 | | kuvitteli että (siel), |
| | | *imagined that (there),* |

| 7 | | *(0.5)* |

| 8 | Matti: | yks tyyppi katso? tai <u>kyl</u>lä se <u>kat</u>teli mua koko ajan kun |
| | | *one bloke looked at? or surely he was lookin at me all the time when* |

| 9 | | se p<u>uh</u>u niitä juttujaan, |
| | | *he told his stories,* |

| 10 | | *(0.8)* |

| 11 | MT: | joo?, |
| | | *yeah?,* |

| 12 | | *(0.5)* |

| 13 | Matti: | se jotenki niinku <u>o</u>su niin se? (0.3) jotenki niinku <u>a</u>rvosteli |
| | | *it somehow like hit me erm he? (0.3) somehow like criticised* |

| 14 | | (siinä) <u>mun</u> puhetta s-, |
| | | *(there) what I said s-,* |

| 15 | | *(1.8)* |

| 16 | MT: | °ah<u>aa</u>° |
| | | *° I see.°* |

17   *(0.8)*

18   MT: oliks siel pa<u>lj</u>o v<u>ä</u>kee.
             were there <u>plenty</u> of people.

19   *(0.5)*

20   Matti: oli siel semmonen k<u>o</u>lmisen∘kymmentä∘.
             there were about ∘thi<u>r</u>ty∘.

21   *(0.3)*

22   MT: .tjoohh
             .yeahh

23   *(0.8)*

24   MT: mite-s   ne m<u>uu</u>t, (0.5) kakskyt↑<u>y</u>heksän tyyppii mite-s ne oli,=
             how-PRT   how-PRT
             how about those <u>others</u>, (0.5) twenty↑nine blokes how were they,=

25   Matti: =e:ihän ne   k<u>a</u>ttonu k(h)u s(h)itä <u>y</u>htä.=
             =y'know they jus(h)t l<u>oo</u>ked at th(h)e one.=

26   All: *=[he [he heh heh heh*

27   MP: *[hah [hah hah hah*

28   FP: *[hah hah [hah*

29   FP: [se katto sua   ja sä (--) (sitä),
             [he looked at you and you (-) (at him),

30   *(0.5)*

31   MP: [n<u>i</u>i n<u>i</u>i.
             [yeah yeah.

32   MP: *[(---)=*

33   FP: *=he he .hh=*

34   MP: *=heh heh heh heh*

MT moves to another patient's problems.

After Matti's description of his experience, the therapist acknowledges his problem (line 16) and starts to deal with the problem using questions (from line 18 on). The therapist's first question, however, may seem irrelevant in handling the patient's problem in that the number of people attending the meeting does not seem to be essential to the patient's feeling of discomfort. In fact, the topicalization of an ancillary aspect of the difficulty may be the first step away from it (see Jefferson, 1984). Further, the design of the yes/no question involves a candidate answer (that there had been a lot of attendants in the meeting) shows that the therapist is already guiding the patient toward the satisfactory response at that point (Halonen, 2006; Lloyd, 1992; Pomerantz, 1988). After successfully establishing that there had been plenty of people there, about thirty, the therapist formulates a new question (line 24), the design of which is again critical. First, the clitic particle -s is connected to the question word *how* (in Finnish *mite*), marking the questioner claim as possessing knowledge about the answer (Halonen, 2002). The question design, further, includes an unnecessary amount of detail (i.e., the exact number of participants). This extra information directs the recipient to "add" something to the interpretation of the question (cf. Grice, 1975). For the patient the question seems humorous. The laughter tokens appear in the middle of Matti's answer (line 25) and the other patients join the laughter after him. Moreover, the content of the answer also shows that Matti recognized the therapist's point, and the trouble seems to have vanished. The subsequent collaborative laughing sanctions the fact that the patient in target has grasped the trouble in a new light. The participants laugh the trouble off together. After the sequence, the therapist moves on to another patient's problem and they never come back to this one; the difficulty has been resolved[6].

In the next extract, the therapist applies the same strategy, but the sequence develops differently. Like in the case above, we can first note that the patient seems to get the humorous point the therapist has brought up with his questions (lines 15-19). However, here the patient does not treat it as a solution to the problem, nor does the therapist; the trouble is handled further after the laughter sequence (from lines 31-34 on). Initially, Marja had related that she sleeps badly or hardly at all at the clinic. She had wondered whether she should go to talk to the clinic's nurse, Maila. In line 1, she completes the complaint by expressing a wish concerning the future (see Jefferson, 1988). Here the therapist acknowledges the problem (line 3), and from there on he starts to pose questions that again concern an ancillary aspect of the sleeping problem, the patient's smoking (line 5). The conclusive question then comes at line 15. Just as in the previous extract, it is marked by the particle -*s*, indicating that the therapist claims to know the answer.

(2) Sleeping [PR 11]

1   Marja: saes ees <u>yhen</u> yön nukuttua <u>i</u>llasta <u>aa</u>muu.
                        I'd like just <u>one</u> night's sleep from <u>e</u>vening until <u>mo</u>rning.

---

[6] A joint laughter that was initiated by the target confrontation shows a strong emotional attunement-there and at the point the problem had got a solution. Of course, it is very difficult (practically impossible) to tell to what degree the solution lasts. It is possible that the problem comes back. It would be fascinating to combine detailed analysis of action and then have follow up studies. Generally, resources do not allow that.

2   *(1.5)*

3   MT: ∘.hjoo∘
             ∘.yeah∘

4   *(2.0)*

5   MT: joo .=.hh me-<   #mm# poltak sä tupakkaa=
             yeah.=.hh mm-< #mm# do you smoke cigarettes=

6   Marja: =.thh ja paljon.
             =.thh and a lot.

7   TM: ja yöllä.
             and at night.

8   *(0.5)*

9   Marja: [no<
             [well

10   MT: [ooksä tuolla tupakkahuonees paljo yön aikaa.
             [are you there in the smoking room a lot during the night.

11   Marja: no#:#< viime< (.) puoli viiren aikaa mä oo viimeks istunu
             we#:#ll< last< (.) it was half past four last time I was there

12   ∘tupakall[a∘.
             ∘smok[ing∘.

13   MT: [just joo.
             [yeah right.

14   *(.)*

15   MT: .hh mite-s   siellä uni tulee.
             how-PRT
             .hh and how do you get sleep in there.

16   *(0.8)*

17   FP: *m(h)m*

18   FP: *£.hh£*

19   Marja: £ei£ s(h)itä s(h)iellä t(h)ule £.hh .hhh mut sit ku   menee£

o(h)e doesn't g(h)et sl(h)eep £there£ .hh .hhh *but then when one*

20   sänkyyn niin,
            goes£ to bed then,

21   *(.)*

22   MT?:   (sit) (--).
            (then) (-).

23   Marja: taas nukah-<(.)ta hetke aikaa ja: (.) (käännän kyl- aamul
            again one falls (.) asleep for a minute and(.)(I turn arou- to wake

24   herätä) (--) mä ole kaua jo valavonu.
            up in the morning) (-) I have already been awake for a long time.

25   *(.)*

26   MT: .thh no viimeaikaiset tutkimukset osottanut et paremmi nukkuu
            .thh well the recent studies have shown that one sleeps better

27   tota niinku, (.) tsängyssä kun, (.) tupakkahuonees esimerkiks.
            like erm, (.) in bed than, (.) for example in a smoking room.

28   *(2.0)*

29   Marja: kyl sinne tupakkahuoneesee(nki nukkua).
            surely one can also sleep there in the smoking room.

30   *(0.8)*

31   MT: mut se:< >se se<   jos yöllä kävelee ja muuta
            but the:< >that that< if one walks around at night and so on

32   ni se on semmonen et se: tota: on vähän< (.) ei paljon edesauta sitä.
            so it is like a that it is a little bit<   (.) it won't much help it.

33   *(.)*

34   MT: mut meeppä juttelee vaa Mailan kanssa
            but do go to have a chat with Maila.

The therapist starts to handle the sleeping problem seriously as something that can be solved with the clinic's nurse.

Here as in (1), the therapist confronts an aspect of the patient's trouble by pointing something humorous in it. The "Socratic" confrontation includes recognizable features such as the topicalization of an ancillary aspect of the problem via candidate answer questions (lines 5, 7, 10). The conclusive question (line 15) is met with laughter (lines 17-19). Two other patients allow soft, restrained laughter tokens first, before the confronted patient produces her answer including laughter tokens within her turn (line 19). Though the patient laughs in the anticipated slot, she does not agree with the therapist, but she quickly returns to the trouble, resisting his solution. She seems to appreciate the humorous outcome of the question-answer sequence, but still shows that in her mind her problem is not resolved. Further, at the middle of line 19, after her minimal one-sentence answer, Marja breathes in heavily, indicating her attempt to keep her turn of talk at the possible turn transition where the others could have taken it (i.e., could have started to laugh together, cf. extract 1, lines 25-26). Here the confronted patient's continuation of her turn forestalls the possible recognition point where shared laughter might have started. Also Marja's initial answer at line 19 was resistant to being laughed off. Subsequently, her continuation grows more and more serious, the laughter tokens disappear from her voice, and the time for laughter is over.

The therapist for his part continues to treat Marja's sleeplessness as laughable through his flippant comment about recent studies (lines 26-27). A silence of two seconds follows the therapist's second invitation to laugh, after which Marja replies in serious opposition (line 29). All the levity has vanished at this point. The therapist then also adopts the serious tack (lines 31-32). Finally, the therapist agrees with Marja's initial suggestion of talking about her sleeplessness to the nurse at the clinic. The therapist gives up his intervention and agrees with the client to guarantee a working consensus for the continuation of the therapy process.

The patient's laughter in this extract shows that patients can appreciate the strategy of nullifying the trouble even when not completely agreeing with it. Nevertheless, after the patient's resistant turns, the therapist has to acknowledge that the problem cannot be laughed off. The therapist can use an extended series of strategic questions to provoke the patients' laughter and solve their problems by nullifying their troubles and complaints. As we saw in extract 1, this can genuinely solve the problem, and in extract 2 we saw that even though the comic intention of the questioning can be appreciated by the patient with laughter, this strategy does not always resolve the problem or defuse the complaint. This technique might also be used simply to put the complaint in the right perspective; perhaps the situation is not as bad as the patient thinks.

Seeing a situation in a new light and laughing at it may be cathartic. In cathartic laughter, the patients laugh together both at and with the patient (see Glenn, 2003). We can see that when the trouble is nullified, all the patients laugh together. When the trouble turns out to be resistant, laughter is dissipated and fades away when the patient who is confronted starts to argue with the therapist.

Resistant problems also touch upon the cornerstone of the Minnesota treatment. Following the ideas of the recovery program of Alcoholics Anonymous, the Minnesota treatment sees the addiction to alcohol and drugs as the primary condition, of which the other troubles are corollaries. The patients in treatment do not always see things as the

Minnesota treatment suggests. Marja, who claims to suffer from insomnia, seems to conceive it as a genuine problem that cannot be laughed off. Laughing off seems to be appropriate for difficulties that are not fundamental. The views of both therapist and patient differ at times, which is one of the contingencies that affect the therapy process and the outcome of therapeutic intervention. The therapy process is also intended to build a unified perspective on the problems. In fact, this is the primary aim of the confrontations. One type of resistant problem that is handled through confrontation is a problem the patient has not recognized.

Mirroring: Pointing Out a Problem the Patient has Not Recognized by Laughing at It

In the previous section we examined cases in which the patients told about some trouble or complained about something in their turns, and the therapist tried to show that there was really no trouble or anything to complain about. In this section we will analyse the reverse case, in which the patient praises the treatment, but the therapist reminds her/him about possible problems.

Here the laughter has a different role than in the previous cases. The social distribution of laughter (i.e., who laughs at what at which point) is also crucially different. In the previous cases, the therapist provoked the patient to laugh in order to invite others to join in laughing together, but in this sequence the therapist begins laughing, and invites other patients to join in laughing at the patient, who is confronted by that. In terms of group dynamic, the real target of this action is not the person in question, but the rest of the group, who are induced to reflect upon their experiences and progress with the help of the patient in question.

In extract 3, Lauri, the patient who will be confronted, is in his first day at the clinic and in the group. He is the last patient in the circle. He is relating how good it is to be in the clinic, although he himself also shows that he is aware of the possibility of problems (see the *yet* in line 1). He is about to complete his turn (line 3), but he starts to elaborate his descriptions again (lines 7-18) after the therapist has focussed on his ability to enjoy the good feeling (line 5). The therapist's turn seems to anticipate the forthcoming confrontation because it topicalises the good feeling in a special way. She refers to the feeling by the modifying pronoun *that* (in Finnish *siit*), by which she focuses on the patient's description of his good feeling, not feeling good in general. The content of this "siit" [that] remains unspecified, and it invites further elaboration to be continued exactly as the patient does at lines 7-18 (for prospective indexicals, see Goodwin, 1996). The therapist confrontation proper starts at line 20.

(3) A positive attitude [PR 9: 44]

```
1    Lauri:    ei oo mitää [negatiivist, (0.8) viel ollu mitää]ettäh,
               there's nothing negative, (0.8) nothing yet so h,
               [((FT nods))              ]

2              (3.0)
```

3   Lauri: ei mul m<u>uu</u>ta oo.
               there's nothin more.

4   *(.)*

5   FT: ◦>.tjoo<,◦ sä osaat n<u>au</u>ttii siit hyväst olost.
               ◦>.yeah<,◦ you know how to enjoy that good feeling.

6   *(0.3)*

7   Lauri: j<u>oo</u> ja sit totah, mhh (1.0) ja:, >just tota:<, (0.3) tää
               y<u>ea</u>h and then well, mhh (1.0) and:, >really like:< (0.3) the

8   il[mapiiri on tääl <u>tosi</u>] hyvä ja[h,
               a[tmosphere here is really] good and h,

9   FT: [((nods))   ]   [◦/mm◦

10   *(.)*

11   Lauri: .mt (.) mul kolahti heti ku mä t<u>u</u>lin tänne ku meni
               .tch (.) it struck me at once when I c<u>a</u>me here when you went

12   r<u>öö</u>kihuoneesee ni   kaik[ki nous ja kätteli   ja esitteli
               to the sm<u>o</u>king room then [all got up and shook hands and introduced
               [((TF nods))

13   esitteli ja,   (0.5) se jo kolahti h<u>e</u>ti <u>e</u>kana,
               themselves and, (0.5) that struck me r<u>i</u>ght first

14   *(2.5)*

15   Lauri: et, (0.3) toi hyvä <u>i</u>lmapiiri tekee <u>tosi</u> p<u>a</u>ljon.
               like, (0.3) the good <u>a</u>tmosphere re<u>all</u>y does a l<u>o</u>t.

16   *(3.5)*

17   Lauri: tääl o <u>tosi</u> mukava olla et [kaikki o hyvii
               it's really <u>nice</u> to be here like all are good
               [((TF is nodding))

18   tyyppei et mä en oo?, (0.5) keneltkää (älynny) mitää vikaah.
               people like I haven't?, (0.5) figured anything wrong with anyone h.

19   *(1.5)*

| 20 | FT: | ∘katotaan:?, (0.5) minkälainen∘ sä oot sitte ku, krhym tulee |
| | | *∘let's see:?, (0.5) what∘ are you like when, krhm ((coughs))* |

| 21 | | tulee jotai vast(h)oink [(h)äy[mi(-) |
| | | *there are some s(h)etb[(h)a[cks* |

| 22 | FP: | *[he [h heh heh* |

| 23 | MP: | *[HH   [hheh* |

| 24 | MP: | *[Krhym krhy[m ((coughs))* |

| 25 | FT: | [£miten sä otat |
| | | *[£how will you face* |

| 26 | | se vasta[an£ (0.8) odotan mielenkiinnolla. |
| | | *that£ (0.8) I'm looking forward to that.* |

| 27 | FP&FP: | *[((whispering something))* |

| 28 | | *(1.5) ((FT nods; whispering continues))* |

| 29 | FT: | että niitäki voi [tulla. |
| | | *they can co[me too.* |

| 30 | Lauri: | *[.tch* |

| 31 | | *(0.5)* |

| 32 | Lauri: | voi mu[t mä oon kyl aina ottanu tosi |
| | | *yes bu[t I have always taken everything really* |

| 33 | FT: | *[(---),* |

| 34 | Lauri: | positiivisesti kaikki et kyl mä [(suunnillee) |
| | | *positively so that sure I   [(about)* |

| 35 | FT: | [£AIjaa£ |
| | | *[£OH really.£* |

| 36 | | *((FT nods vigorously once))* |

| 37 | | *(.)* |

| 38 | | *((Other patients except Lauri laugh))* |

39   *(0.5)*

40   FT: £n:o:£ (0.8) katot(h)aa, haha .hhh
                 £we:ll£ (0.8) let's s(h)ee, haha .hhh

41   *(0.5)*

42   Lauri: j[oo
                 y[eah.

43   FT: [hyvä.
                 [*good.*

44   *(0.5)*

The therapist moves on to another topic.

The therapist confronts the patient's description by raising the forthcoming setbacks (line 20). These are presented as presumed by using the conjunctive *when* (in Finnish *ku*), which makes it clear that there will be some, in contrast to conjunctive *if.* The therapist laughs through the word *setbacks* (in Finnish *vastoinkäymisii*), the main point of the turn. Other patients join in the laughter (lines 22-23), and the therapist also smiles in her later turn where she reformulates her point (lines 25-26). Lauri, the patient concerned, does not laugh at any point in the confrontation sequence.

This is an example of teasing, which the therapist uses as a form of social control, intervening in the patient's fulsome praise to remind those present of the other aspects of the treatment. It is also teasing in the sense that all laugh at the recipient in the sequence (see lines 22, 23 and 38), who himself does not laugh, trying to circumvent and counteract the teasing (Drew, 1987; Glenn, 2003). The therapist and the patient do not align themselves. The patient sticks to his view of his positive attitude even after the reminder of the forthcoming setbacks and the therapist persists in doubting the patient's claims of enduring positiveness (see lines 35, 36 and 40). After the first expression of doubt (line 35), the patient falls silent and only once later acknowledges the confrontation (what?) with the particle *joo* (line 42, paraphrased in English as yeah), which is a mildly compliant response that indicates some degree of resistance (Sorjonen, 2001).

Now we can ask what the therapeutic goal of the teasing is, if any. Through her "let's see" (line 23) at the beginning of her confrontational turn, the therapist indicates that she has some knowledge of what will happen to Lauri suggesting that he will face some setbacks. The therapist displays an understanding that recovery from addiction is not all roses, but means hard work and possible setbacks. Further, the plural form of the verb *see* (*let's see* line 20, in Finnish *katotaa*) makes the future of Lauri's actions common to the whole group, not the therapist alone. She finishes her turn by making the critical point (the setbacks) with some laughter tokens. In this fashion, the therapist occasions an opportunity for a joint action for those patients who have recognized what she is talking about (Jefferson, 1974; Lerner, 1993). In other words, the therapist suggests that something is going to happen to Lauri, and her laughter points out how the recipients can show their shared understanding with her. Some patients join in her laughter,

displaying their shared understanding. The therapist has invited a selective response to her confrontation via a reference to asymmetrical states of knowledge of the recipients (Goodwin, 1987). The therapist has invited laughter from those patients who already know that recovery is not as rosy as Lauri seemed to suggest.

In terms of addiction therapy, the therapist seems to have induced a mirroring process (Steffen, 1994), a pivotal aspect of group dynamics in addiction therapy in which patients reflect on their own experiences with the help of the experiences of others. Here the therapist induces teaming with "older" patients who can see Lauri a reflection of themselves at the beginning of the treatment. This type of confrontation is a pedagogic device through which the therapist builds a normative framework for the desired progress in the therapy so that the patients can evaluate their own progress. For the older patients, this teaming is meant to strengthen the group spirit. As for the newcomer, it is a confrontational practice meant to break his denial. The overly positive attitude can be understood as part of his false consciousness.

The problem of patients not recognizing their problems is a genuine one. The mirroring and invitations to laughter via teasing are a possible way to "awaken" the patient. However, this kind of confrontation can be experienced as hostile and humiliating. A too severe confrontation may induce the patient to quit the treatment. Indeed, not all patients finish their treatment. On the other hand, confrontations may also be a part of the beginning of recovery process, in which the person adopts the identity of a recovering addict. In purely numerical terms, the treatment outcomes of the Minnesota model have been the same or slightly better than other types of addiction therapies (Keso, 1988; McMahon, 1998). As a whole, the Minnesota treatment and its ethics have remained controversial, and such confrontations have also been criticised (Arminen & Perälä, 2002; Yalisove, 1998).

The Minnesota therapists themselves are concerned to do the best for their patients. Our data shows that they actively orient to their patients' well-being and avoid overly hostile confrontations. The first two examples showed that the therapist may use humour to impose new perspectives on their clients' conditions. These are delicate ways of working with patients. The therapists are, or at least try to be, as sensitive as possible. It may also be claimed that in the third case the therapist's laughter not only strengthens the confrontation, as an invitation to the others to join in laughing at one patient, but also marks orientation to the delicacy of the confrontation and thus ameliorates it; the confrontation without laughter might be even harsher.

Therapists try systematically to take their patients' feelings and ownership of their experiences into account. This also becomes apparent in the cases when the therapists fail to be sensitive in their confrontations, cases in which laughter has another new role. The laughter may also work as a way out of failed confrontation.

Softening the Confrontation Afterwards: Responsive Laughter

In all the previous examples the therapists invited some or all of the patients to laugh, either preceding the confrontation or as part of the confrontation. There are also cases in which laughter is responsive to the actions done. Laughter may be invoked to soften confrontations that have been resisted. In these cases, the therapist also displays sensitivity to patients who seem to resist the proposed course of action.

In our fourth and final extract, the therapist uses laughter to soften a confrontation after passive resistance by a patient. Sari had been telling about a dream that she was back in school, where she could not decide which subject to take in an exam. She interprets her dream as standing for her ambivalence and struggle with AA. She cannot decide whether to start attending AA or not. After Sari's lengthy turn (not shown here), the therapist acknowledges the end of the patient's turn (*mm*, line 1) and starts to deal with the dream and its analysis. The therapist's response is confrontational in that he demands decisions from her (lines 3-4). After a weak delayed response (line 6), the therapist chooses counterfactuals as his strategy. He suggests that perhaps the cure for not wanting to join AA would be to order her to drink and forbid her joining, the patient could then resist the therapist by staying sober and attending AA. These counterfactuals might be considered funny, but nobody laughs. Sari, the patient in focus, remains silent and frozen, her only reactions being a couple of coughs (lines 17 and 25). Nor do any of the other patients laugh. We will now focus on how the therapist responds to this deadlock. And what we find again is laughter.

(4) The dream [PR 11: 13]

1	MT:	*mm↑m.*

2   *(2.0)*

3	MT:	*.thh no n*y*t kun sä oot* ai*kuinen .mhhh nii nythän sun pitää*
		.thh well now when you are an adult .mhhh so now you *have to*

4		i*tte* p*äättää eiks nii.*
		m*ake up your mind don't you.*

5   *(0.3)*

6	Sari:	*mm:=*

7	MT:	*=eiks ois h*y*vä. (.) onks se et m*ää *määrään sut ryyppäämää takasi.*
		=wouldn't it be good. (.) is it like that I'll order you back to drinking.

8   *(5.0)*

9	MT:	*ja sit* kiel*län sult menemästä ∘AA:ha∘.*
		*and then I'll forb*i*d you to go ∘to AA∘.*

10   *(0.5)*

11	MT:	*∘.joo:∘.*
		∘.yeah:∘

12   *(5.0)*

13   FP: *KRHym ((coughs))*

14   *(0.8)*

15   MT: ∘s(h)ä nyt sitte(h)∘ .hhh
                          ∘y(h)ou now th(h)en∘ .hhh

16   *(0.8)*

17   Sari: *∘kryhym∘ ((coughs))*

18   *(0.5)*

19   FP: *.nff ((sniffs))*

20   *(1.0)*

21   MT: teetki, (.) nyt <u>toi</u>sinpäin   sillon sää
                          you do, (.) now the <u>oth</u>er way round then you

22   teit opettaj(h)an m(h)ieliks (jos)?,
                          pl(h)eased the t(h)eacher (if)?,

22   *(0.8)*

23   ?:   *.nff ((sniffs))*

24   *(0.8)*

25   Sari: *krhym ((coughs))*

26   *(1.3)*

27   MP: nii kuinkas siinä <u>kä</u>vi sitte.
                          so how did it <u>go</u> then.

Other patients engage in figuring out how Sari's examination went in reality while Sari concentrates on the meaning of the dream.

     Overall, Sari receives the therapist's confrontation with a very limited degree of response. Only in line 6 does she produce a minimal acknowledgement, *mm.*, accompanied by a nod after the therapist initiates his confrontation. Subsequently, the patient refrains from producing any verbal responses and her posture remains frozen (see lines 7-26). She sits still and remains passive, a form of passive reception of counselling talk, which has been called passive resistance in the literature (Heritage & Sefi, 1992; Silverman, 1997). We may also consider the patient's declining to display an

acknowledgement as an indicator of trouble and a lack of alignment between the parties. Sari has only acknowledged the preliminary component of the therapist's confrontation *now then you're an adult... you've got to make up your mind...* (3-4). The therapist's confrontation, the ironic advice to *go back drinking* (7) is met with silence (10), and the therapist's next suggestion *do not go to AA* (9) does not invoke any immediate response (10-12).

In a group situation, passive resistance opens a specific interactional challenge: If a silence emerges, to whom does the turn then belong? Here the therapist himself orients to the interactional problem, and after his second suggestion does not receive a response immediately, he says *yes* [joo] with a heavy inbreath (11). This kind of "joo" is normally used to register the recipient's response (Sorjonen, 2001); here it simply registers the lack of uptake. Again this "joo" would allow a speaker transition, but neither the patient nor the other patients come in (12-14). In this context, when a patient is confronted and subsequently declines verbal interaction, and the other patients refrain from taking any active stand in the conflict, the turn is returned to the therapist. Further, as both this patient and the other patients have avoided acknowledging the therapist's proposal, the therapist is forced to work his way out of an interactional dead-end. At this point, some laughter emerges in the therapist's voice at line 15 as he says something softly. The utterance itself is barely audible, but it seems that he is starting to modify his confrontation; *If you now then*. The soft voice with laughter tokens gives the impression of a weaker and more negotiable position, implying that he is considering modifying his stance. However, the patients still refrain from taking a turn (16-20), after which the therapist produces his future-oriented proposal *do it the other way round, don't please the teacher* with some laughter in his voice. Again some delay emerges before Sari comes in with a constrained laughter token (25). Through her joining in the laughter, although only after some delay (22-24) and in a constrained form, the patient has finally produced some minimal acknowledgement and the interactional cul-de-sac has been bypassed. In this instance, the therapist used laughter to make his confrontation softer, but only after the patients forced him to do so. The therapist has thus to orient to the patients' passive resistance, and to the possibility of patients forming a team that re-aligns the power relationships in group therapy (cf. Kangasharju, 1996).

Laughter and Confrontations

In addiction therapy, laughter can be used as a strategic resource to handle delicate activities such as confrontations. The therapist's ways of provoking laughter are therapeutic tools that enable confrontations, laughter providing a device for maintaining the conversational interaction under circumstances as face-threatening as a confrontation. By occasioning laughter, the therapist can soften a confrontation so that the confronted patient is offered a chance to frame the ongoing action as less serious than it might be (in extracts 1 & 2). Further, laughing together provides a co-operative way for the parties to close the ongoing episode in overt alignment. Laughing is one of the few things in conversational interactions that the parties can do simultaneously together (Sacks, 1992b). All participants can laugh together just as in (1). Doing it together strengthens their togetherness and mutual solidarity, which may enhance the therapeutic process.

On the other hand, laughter is also a social object that can be used for inducing coalitions between parties. In (3), the therapist confronted a new patient with laughter in her voice. This confrontation facilitated mirroring, which some older patients became actively involved in. This may have been a successful part of the therapy process in that patients were encouraged to reflect on their progress. However, this confrontation did not induce the new patient to become actively involved in the therapy. This indicates that therapists should be sensitive in their assessment of how strong confrontation each individual patient is psychologically able to cope with. Too strong a confrontation may contribute towards denial and overt resistance that may endanger the completion of the whole therapy process. Irrespective of the outcome here, we can start to see the interactional delicacies in the therapy process.

Further, in (4) the therapist countered the patients' passive resistance with his laughter to build an exit from the unengaged confrontation. The therapist's invitation to laugh, however, was not reciprocated strongly by the patients. Extract 4 provides a case in which the collaborative nature of the therapy is very much in danger and where the therapist's confrontation is about to turn on itself. Here, the therapist's success was only partial and limited. Nevertheless, here laughter was also a powerful device that at least opened the way out of the interactional dead end.

To sum up, our analysis has shown us that addiction therapy is a sensitive process in which the therapist is not the only active party. This analysis has also had some practical relevance as it demonstrates that the patients' passive resistance can influence the power balance in therapy. Through this we can see the main dilemma of addiction therapy; the therapists have to navigate their way between Scylla and Charybdis. The therapist's explicit confrontations may provoke resistance and risk losing the patient. On the other hand, if the therapist refrains from confrontational practices, the patients' addictions remain unchallenged and the therapy may become inefficient. The analysis of the therapy process may contribute towards unraveling and elaborating the third way of creating confrontations that are sensitive enough not to threaten the patients.

Our study has also revealed some limitations of this approach. Although we have a considerable amount of data, it does not amount to a quantitative analysis. Since the group therapeutic processes are so complex that there is an infinite number of complicating factors that almost any social situation or process is unique, we cannot provide any quantified account of these phenomena. On the other hand, this complexity makes a sensitive qualitative approach seem suitable for heuristic understanding of the therapeutic practices. The heightened understanding can at its best allow new insights into therapeutic processes to develop.

Conclusion

To sum up, laughter is a crucial part of therapeutic processes and critical for managing confrontations in group therapy. The nature/function of laughter is not unified, but differs depending on the context and type of therapeutic intervention. Laughter can be the goal of intervention. The therapist may want to get the patient's problems laughed off. Laughter may also have a group dynamic role in inducing teaming among patients as part of the confrontation. Finally, laughter can also be responsive in that the therapist may respond with laughter to a failed confrontation and use it a as way out of an impasse.

All of these usages have one thing in common. The laughter marks and reflects the sensitivity and delicacy of confrontational practices. Laughter is often associated with completing problematic actions such as troubles-telling. In group therapy, the talk tends to be mostly somehow problem related. Perhaps it is not so surprising that most sessions tend to end with laughter, which is also one of the few things participants can do together at the same time and has an immense group dynamic power. In all, laughter displays participants' understanding of the affective nature of their action. Laughter is a great deal more than a mere index of amusement.

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Appendix A

Transcription symbols

.	falling intonation
,	level intonation
?	rising intonation
?,	slightly rising intonation
/yes	rise in pitch
\yes	fall in pitch
(.)	a micropause less than two tenths of a second
(0.5)	pause timed in tenth of seconds
[	overlapping talk starts
]	overlapping talk ends
=	latching; no silence between turns or utterances
.hhh	inbreath
hhh	outbreath
.yes	word pronounced breathing in
.mt	smacking sound
yes	quiet voice
YES	louder voice/shouting
#yes#	creaky voice
yes	stress on a word or a syllable
@yes@	animated talk
y(h)es	pronounced with laughter
£yes£	pronounced with smile
>yes<	faster pace
<yes>	slower pace
yes:	lengthening of the sound
(yes)	item in doubt
(−)	indecipherable talk

((yes)) transcriber's comments
?:   speaker unknown

Author Note

Ilkka Arminen is a Professor, Department of Sociology and Social Psychology, University of Tampere, Finland. He is one of the co-authors of *Alcoholics Anonymous as a Mutual-Help Movement - A Study in Eight Societies* (1996) and the author of *Therapeutic Interaction - A Study of Mutual Help in the Meetings of Alcoholics Anonymous* (1998), and *Institutional Interaction- Studies of Talk at Work* (2005). He has also published articles in a number of edited collections and journals, including *Acta Sociologica, Discourse & Society, Discourse Studies, Journal of Pragmatics, Mobile Communication Research Annual, Personal and Ubiquitous Computing, Philosophy of the Social Sciences, Research on Language and Social Interaction, Text, and The Sociological Quarterly.* Ilkka Arminen, Department of Sociology and Social Psychology, 33014 University of Tampere, Finland; Email: ilkka.arminen@uta.fi

Mia Halonen earned a PhD in Finnish linguistics from the University of Helsinki, and is working as a post-doc researcher at the Research Institute for the Languages of Finland, Helsinki. Her area of specialization is linguistic construction of interactional practices, which she has studied both in conversations among friends and in institutional interactions, especially in group therapy interactions. She is especially interested in the expression of epistemic stance in interaction, and she has studied e.g. utterance particles, negation and responding to compliments in Finnish. She has published on these issues both in English and in Finnish. She is currently investigating the acquisition of Finnish as a second language by second generation immigrant school children. Mia Halonen, Research Institute for the Languages of Finland, Sörnäisten rantatie 25, FIN-00500 Helsinki, Finland; Email: mia.halonen@kotus.fi

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