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Laughter as a "serious business": Clients' laughter in prenatal screening for Down's syndrome
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1. Introduction

In this chapter we focus on the use of laughter in interactionally challenging situations, in particular we examine how laughter initiated by one interlocutor is responded to by another participant of an interaction. Scholars interested in humor and other creative or playful uses of language often approach laughter as an interactional phenomenon expressing or accompanying funny, amusing or humorous situations. Research in conversation analysis in the last 40 years, however, has demonstrated that laughter is a complex interactional phenomenon that performs a wide range of functions, from a simple response to humor to doing more "serious business", particularly in contexts that are not immediately thought of as "funny" (Glenn 2003; Holt 2013). Moreover, laughter is used in highly orderly ways, and it may accompany a wide range of social activities. This chapter demonstrates the importance of examining laughter in various social activities so as not to conflate it with and limit to 'having fun' and 'amusement'.

The specific context that we focus on here is prenatal screening (hereafter, PS) for Down's syndrome. Previous research in medical contexts has shown that laughter is often used to "ease" embarrassing, sensitive or painful aspects that are typical of medical encounters, and to create an alignment between participants (e.g. Haakana 1999, 2001, 2002). In our previous work on laughter in PS we have shown that laughter may be employed by nurses to help them achieve the main institutional goal of these interactions, namely facilitating autonomous choice by their clients, i.e. pregnant women, regarding whether they want to take prenatal screening tests or not (Zayts and Schnurr 2011). We have examined two specific contexts in which the nurses' laughter regularly occurs: when the women refuse outright to undergo prenatal screening (which goes against the nurses' beliefs that it is in the women's best interests to take tests and to confirm whether the child they carry has Down's syndrome or not); and when the women address direct questions to the nurses regarding what tests they should take (which interferes with the professional principle of nondirective [or non-intrusive] way of conducting PS consultations). In the first case the nurse's laughter performs the "serious business" of "laughing off" and overcoming the women's resistance to taking the tests; and in the second case it allows the nurses to avoid the precarious situation of having to give advice to the women when institutionally they are not supposed to do so.

In this chapter we focus on the second part of these laughter sequences, namely the women's responses to the nurses' laughter. More specifically, we examine the interactional contexts in which the nurses' laughter is reciprocated by the women and contrast some of those cases with cases where it is not. Our particular focus is on what is interactionally achieved through the reciprocation of nurses' laughter by their clients in these encounters.

2. Laughing together

The phenomenon of speakers "laughing together" has received a lot of attention in the conversation analytical literature. In her early work Jefferson (1979) discusses how laughter that occurs at the end of a speaker's turn, or laughter particles within a speaker's turn, invite laughter by another speaker. The first speaker's laughter thus serves as a "laugh invitation" to the second speaker.

Such a laugh invitation may lead to its acceptance by the second speaker, but this is not always the case (Haakana 2002). A laugh invitation may also be declined, or it may be responded to by silence by the second speaker (in which case the first speaker may extend a laughter sequence) (Jefferson 1979).

To avoid the extension of a laughter sequence, the second speaker may also respond to a laugh invitation with talk (Jefferson 1979). There are certain environments that have been widely cited in the conversation analytical literature where laugh invitations are more likely to be declined. Jefferson (1984), for example, analyzes the cases of trouble-tellings when speakers laugh to show their resistance to the trouble. The acceptance of such laugh invitations by the second speaker may be seen as not taking the trouble seriously. Another context where reciprocation of laughter may be seen as inappropriate is laughter that accompanies a speaker's self-deprecating utterance. Reciprocating laughter in that case may be seen as an agreement with the assessment (Glenn 1991/ 1992).

Some studies have also noted a more nuanced nature of responses to laughter that may include smiling or a smiling voice, and the differences in actions that these other responses perform. For example, smiling may be seen as a "milder" way of expressing speakers' affiliation with the previous utterance when that utterance is constructed as delicate and troublesome (Haakana 1999, 2010; see also Glenn and Holt 2013).

Glenn and Holt (2013) note that the analysis of whether the first laugh constitutes a laugh invitation or not requires a close analysis of the "laughable"[1] (which they define as an action that makes laughter relevant or a turn that is followed by laughter) and the sequential environment of where laughter occurs. Holt (2011: 408 as cited in Glenn and Hall 2013) suggests that "[t]urns characterized by several elements recurrently associated with laughable may be more likely to be seen as inviting laughter". By a similar token, she suggests that a speaker's turns that are concerned with "serious business" and that contain laughter are less likely to be responded to by laughter. Extending this idea to the context of PS consultations, the cases where nurses' laughter is reciprocated by the clients (despite these consultations being concerned with the "serious activities" of managing information- and advice- giving and decision-making about testing) become particularly interesting for close scrutiny.

The existing research has also shown a close link between laughter and the social context of an interaction. In relation to institutional contexts, laughter appears to depend on participants' institutional roles and responsibilities (e.g. see contributions in Glenn and Holt 2013). Haakana (1999: 132) maintains that "[l]ay persons and professionals use laughter in different ways" that are related to their institutional identities. Glenn (2010: 1487) echoes this idea that "in institutional interactions the distribution and the sequential organization of laughter can reflect and constitute asymmetries of respective roles and tasks". He maintains that these asymmetries are manifest in the distribution of laughter and its responses; and also what activities laughter accompanies. Laughing together can be seen as a strategy of building up rapport and establishing alignment, particularly in those encounters that lead to successful outcomes (see, for example, Adelswärd's [1989] study of Swedish job interviews where more laughter was observed in those interviews that were successful). Laughter can also be a powerful resource of reinforcing the asymmetries of the participants' roles and responsibilities. For example, in the analysis of employment interviews Glenn (2010) shows that the interviewers are typically the ones who initiate laughter, and while it may be reciprocated by the interviewees, the interviewers are the ones who decide whether to extend laughter or to bring the interaction "back to business". Jacknick (2013) in the analysis of ESL classroom interactions shows that laughter may be used as an interactional resource to negotiate participant's epistemic authority. In particular, the author discusses how students employ laughter to question the teacher's answers thus challenging her authority.

Through laughing (or not laughing) together, participants display their understanding of and negotiate their roles and responsibilities in an interaction. And while there are general patterns that can be observed in specific contexts, participants may adapt them to local "contingencies and activities"

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[1] The term "laughable" does not presuppose that the action or the turn that the laughable refers to is funny or amusing.

(Glenn 2010: 1496) of an on-going interaction. In the analysis presented below we examine what roles and responsibilities the participants negotiate and what "contingencies and activities" they orient to when they engage in shared laughter in PS consultations.

3. Data and method

The data for this chapter comes from a large interactional project on prenatal screening for Down's syndrome in Hong Kong that was conducted in 2006–2012. In that project we collaborated with a team of medical professionals from a Prenatal Diagnostics and Counselling Department in one public hospital. We focus here on 34 consultations that we also analyzed in our previous study (Zayts and Schnurr 2011) – albeit with a focus on the nurses' rather than the patients' laughter. These consultations vary in length from 9 to 22 minutes, and the overall recording time is around 7 hours. All consultations were video-recorded and transcribed using transcription conversations traditionally used in conversation analytic research (Jefferson, as published in Atkinson and Heritage 1984; ten Have 2007). The occurrences of laughter were transcribed on a particle-by-particle basis (see Jefferson 1985 for the advantages of this method in analyzing laughter). In the transcripts we also noted the sequential positioning of laughter, laughter initiation and completion points and non-verbal actions of the participants relevant to the analysis of laughter (such as smiles) (Hepburn and Varney 2013).

The participants of these recorded interactions include Hong Kong Chinese nurses (abbreviated as N in the transcripts) and clients: pregnant women (abbreviated as W in the transcripts) who attended the consultation on their own or were accompanied by other family members (typically their husbands). The women in the selected consultations come from the Philippines, so in the consultations English was used as a lingua franca, or common language of the participants. We did not purposefully select the consultations with participants from the Philippines. They comprise the largest group in our corpus because of the socio-demographics of clients in the hospital where the data were collected: the hospital is public and the services are provided at a minimal charge, therefore, the hospital is popular with less affluent groups of the population. The women were 35 years or older and were referred for prenatal screening services due to their advanced maternal age which is associated with higher risks of having a child with Down's syndrome. The screening services in Hong Kong are a routine part of prenatal care and women are offered a choice of: (a) indirect or non-invasive tests (a blood test or a sonographic measurement of a fetus's neck); (b) direct or invasive tests (amniocentesis or CVS); and (c) a no-test option. The first option carries no risk to the mother or the fetus, but offers a lower detection rate and a higher false positive rate than the direct tests that carries a slight risk (1 percent) of miscarriage. As we have discussed in our previous work (e.g. Zayts and Schnurr 2011; Zayts and Pilnick 2014), among the Filipino clients it is not unusual to opt out of testing altogether or to agree to non-invasive and safe testing option due to their Roman Catholic background and the religiously motivated opposition towards termination of pregnancy (which is the only "medical" intervention available to these women if an abnormality is identified).

The widely accepted professional principle among medical professionals involved in the provision of prenatal screening services in Hong Kong and other countries is that the final choice of what testing (if any) to pursue lies with prospective parents. This principle confines the role of medical professionals to providing good quality information about available testing and facilitating clients' decision-making. At the hospital prior to seeing a medical professional (typically a nurse; sometimes a doctor) women watch a video produced by the Hong Kong Department of Health that covers the nature of the syndrome, available tests, and support provided to families with Down's syndrome children. This is followed by a face-to-face consultation. The consultations, although different depending on the family and medical history of clients, typically go through the following stages: (a) consultations opening; (b) history taking; (c) educational stage in which the nurses provide information about Down's syndrome, available testing

options, and their pros and cons; (d) decision-making stage in which clients make a decision what testing option (if any) to pursue; and (e) consultation closing. These stages may be dispersed throughout a consultation (e.g. when participants "revisit" a decision they have made at different stages). In our previous study of nurses' laughter (Zayts and Schnurr 2011) we have observed that most laughter sequences occurred in the education and decision-making stages, and we have attributed this to the fact that this is where most sensitive and potentially face-threatening talk occurs and where the clients' choice regarding testing is negotiated.

In our analysis we employ conversation analysis to illustrate the patterns in which nurses' laughter is responded to by their clients. Conversation analysis is concerned with the "interactional accomplishment of particular social activities" (Drew and Heritage 1992: 17). These activities are comprised of sequentially organized social actions, which are described in relation to their context, social organization and any alternative means by which these actions (and activities) can be realized. We have applied conversation analysis to analyzing PS encounters in our previous work (e.g. Zayts and Schnurr 2011; Zayts and Pilnick 2014; Pilnick and Zayts 2014) and have noted that the advantage of this methodology is on the close attention to the *processes* involved in PS, for example, examining not only whether autonomous choice by the clients has been achieved but also *how* it has been achieved. Our analysis of the interactional data is also ethnographically informed. In particular, in our analysis we selectively draw on the information about participants' backgrounds that was obtained in the interviews with the participants prior to and after the consultations. Such an approach of combining the analysis of interactional data with ethnographic observations yields additional insights into the analyzed interactions (for the advantages of this method see Maynard 2003; Silverman 1999; Pomerantz 2005; Waring 2012). The approach also proves particularly useful in analyzing such complex phenomenon as laughter in all its instantiations so as to shed light on its various conversational functions, including both 'playful' and 'serious' ones.

In our previous work on nurse's laughter (Zayts and Schnurr 2011) we followed Haakana (2002) in identifying laughter sequences for analysis. In particular, we examined every occurrence of nurses' laughter in the data that was *not* preceded by laughter in the previous turn regardless of the position of laughter within the turn (i.e. regardless of whether it occurred in the turn-final position, within the turn, or as a responsive laugh). In examining the patterns of the reciprocation of nurses' laughter by their clients in this paper, we revisit these data, albeit with a focus on the response that the nurses' laughter receives. As responses we consider laughter as well as smiling/ smiling voice as the phenomena closely linked to laughter (which can be considered as "milder" response to laughter). Table 1 below represents the distribution of laughter and its responses in our data corpus.

Table 1. Distribution of laughter and its responses in PS encounters
(Zayts and Schnurr 2011)

	Occurrences of Laughter and its responses			
	Women		Nurses	
Laughter in initiated turns	54	61%	72	64%
Smiling/smiling voice in reciprocated turns	19	21%	13	12%
No reciprocation (i.e. no laughter/smiling)	16	18%	27	24%
Responses	N=89	100%	N=112	100%

As Table 1 demonstrates there are more cases of nurses' (volunteered) laughter (72 cases) in the data corpus than women's laughter (54 cases). These numbers point to an interesting trend in the analyzed data where the nurses volunteer laughter more often than the women. There are, however, fewer occurrences of the reciprocation of laughter by the nurses (13 cases) than by the women (19 cases); and the total number of the occurrences of the laughter is higher in the case of the women (82% as compared to 76% for the nurses). Previous studies of laughter in medical contexts (e.g. Haakana 2001) have shown that typically it is patients who laugh more and in most cases their laughter is not reciprocated by doctors. As Haakana notes (2001: 196), particularly when dealing with delicate issues, "by not laughing the doctors seem to be doing the right thing". In the PS context, the higher occurrence of the laughter initiated by nurses in comparison to the clients'-initiated laughter may be explained by the very different nature of these encounters in comparison to other medical contexts. As the main goal of these PS consultations is to provide information to clients about available testing and facilitating clients' decision-making, naturally the nurses get to do more talking in these consultations than the clients, and they also initiate laughter more frequently. In contrast, in primary care contexts where other studies of laughter were conducted (e.g. West 1984; Haakana 2002) patients present their acute medical problems to doctors and therefore talk and laugh more. In terms of the total number of the occurrences of laughter, our study supports the idea that in general clients laugh more than the medical providers. In what follows we will discuss what functions these instances of reciprocated laughter may perform.

The analysis presented in the next sections is structured along three main functions of reciprocated laughter in the analyzed corpus: managing risk talk (4.1) and negotiating participants' epistemic (4.2) and deontic (4.3) status and stance. Except for Example 1 that comes from the history-taking stage, all other examples come from the educational and the decision-making stages where, as we have previously observed (Zayts and Schnurr 2011), most of these laughter sequences occur.

4.   Analysis
4.1. Shared laughter as a means of managing risk talk

In PS consultations most talk relates to various risks. For example, in the history-taking stage participants discuss a woman's advanced maternal age and the associated higher risks of Down's syndrome, as well family history and lifestyle practices that may potentially increase a woman's risk of having a child with abnormalities. The educational stage, on the other hand, involves the explanation of several types of risks: the "risk of occurrence" (the probability of abnormalities happening in a fetus; and the risks associated with testing [e.g. miscarriage]), the "risk of knowing" (psychosocial and interpersonal implications that finding out about abnormalities via testing may have on a client and the family) (Sarangi et al. 2003), and the "risk of not knowing" (psychosocial implications of not pursuing any testing [e.g. increased anxiety]) (see also Pilnick and Zayts 2014; Yau and Zayts 2014). Naturally, this relatively high amount of risk talk may easily lead to a heightened anxiety among the clients that may be both explicitly lexicalized by them (e.g. clients admitting that they are *worried*) and conveyed through various non-verbal means (e.g. crying).

To address their clients' anxiety the nurses routinely employ laughter along with other verbal and non-verbal strategies to reassure their clients and to put them at ease. In Example 1 the woman's anxiety is related to taking a drug in the first trimester of her pregnancy to induce menstruation. As it turns out, the drug may lead to abnormalities of the heart and the limbs in a fetus. Together with other complicating factors in the woman's family and personal health history, this puts her at a higher risk of having a child with abnormalities. In our analysis below we look at what is achieved in the interaction through the nurse's laughter and particularly its reciprocation by the woman.

Example 1

The woman will be 42 years old at her expected time of delivery. She has a history of terminating a pregnancy in the past and a family history of mental retardation.

```
1   N:          How many tablets did you take?
2   W:          (°         °) I think it's four ((looks worried))
3   N:          Four tablets. (1.9) ((writing)) >All together,< (.) at one time, or:=
4   W:          =No.
5               (1.5)
6   N:          °Three weeks. Fourteen weeks.° ((writing)) (2.0) Ok. Nah, um, (2.1), according to the
7               literature review, that, (.) because we come across this drug (.) quite often, ok? Um, we
8               know that this drug may- sometimes, may cause um, abnormality with the heart, (.) and
9               the limbs, alright? So, we can have ultrasound to look for any- any abnormality with the
10              heart and the limbs.
11  W:          On the baby?
12  N:          Yes. ((nods))
13              (4.2)
14  N: →        Seems that you are very worried? ((N smiles and pats W on the arm)) hh huh [huh huh ]
15  W: →        [Hh hmm] Y(h)es:: ((smiles))
16  N:          Uh, (1.5) we have to check ultrasound first. ((N pats W on the shoulder and keeps her
17              hand there)) Alright? [And then-]
18  W:          [Now?]
19  N:          Ehm, maybe next week. Now we have the blood test.
20  W:          Mm hmm.
21  N:          Uh ((N removes her hand)) it's quite common. °Ok?° It's, we come often- we often come
22       →      across this drug. °Ok?° You don't- you don't have to be too worried. [We w(h)ill
23       →      ch(hh)eck ultra(h)sound first]
24  W: →        [((smiles)) ]. Ok.
```
((N makes arrangements for the ultrasound examination))

This extract starts with the nurse clarifying how many pills the woman has taken and informing her about the serious side effects of the drug as reported in the specialist literature. This is followed by a statement that the hospital can perform an ultrasound to check for abnormalities. The mother's non-verbal behavior (a worried look) and a very quiet (inaudible to the researchers) response to the nurse convey her anxiety. From line 14 onwards the nurse begins to actively reassure the mother by employing a number of verbal and non-verbal strategies. She acknowledges the mother's state (*seems that you are very worried*, line 14) and explicitly reassures her (*you don't- you don't have to be too worried*, line 22). She even pats the mother on the arm and the shoulder (and keeps her hand on the shoulder while she talks). While touching may largely be considered inappropriate outside the examination stages of medical encounters, we have observed in our data that the nurses often pat and touch the clients in an attempt to reassure them. There are a number of studies that have indicated that it is typically easier for the nursing staff to establish rapport and a more trusting relationship with their clients (e.g. Horrocks, Anderson, and Salisbury 2002). More close contact with the clients than expected may also be explained by the less asymmetrical relationship between the nurses and the women in the analyzed consultations.

The nurse also talks about the drug as being quite common and something that the medical professionals often come across (in an attempt to reassure the mother that she knows what she talks about and how to deal with it). Of particular interest to us are two occurrences of laughter and their

reciprocation. The first occurrence of the nurse's laughter follows her statement that the mother seems to be worried. It is an extended laughter (that starts with audible aspiration and extends to three full beats of laughter). The second instance of the nurse's laughter occurs immediately after her explicit reassurance that the mother does not need to worry (lines 22–23). This sequential location of the nurse's laughter signals that laughter is indeed used to mitigate the risk talk and to reassure the woman. In both cases the woman's responses are more "reserved". In the first instance, the woman produces an audible aspiration followed by a confirmation of the nurse's observation that she is worried which incorporates a laughter particle. The woman also smiles (line 15). In the second instance the woman just smiles (line 24). Previous studies have shown that more "reserved" responses to laughter, such as smiling, may be due to a delicate nature of talk (Jefferson 1985; Haakana 2010), as is indeed the case in this example. This "reserved" response may also signal the mother's orientation to the institutional asymmetry between the nurse's and her own role. The mother's response, nevertheless, signals her affiliation with the nurse. The laughter and its reciprocation thus serve to mitigate the risk talk in this exchange and establish alignment between the participants with regards to what can be done about managing the woman's risks.

Since ensuring the client has enough information to make an informed choice is the main agenda of PS consultations, in addition to managing the risk talk and reassuring the women, another important aspect that the nurses' job involves is ensuring that the women fully understand the information about Down's syndrome and available testing options. As the nurses are dealing with a very diverse client population in terms of their birth history (first-time and experienced mothers), sociocultural backgrounds (speakers with higher or lower language proficiency; native and non-native speakers of English and Chinese) and socioeconomic statuses (high income, college educated and above, and low income, low education level), the information delivery inevitably involves negotiation of the participants' existing and new knowledge. It also involves the negotiation of what knowledge participants *need to have* in order to make an informed decision. Information delivery thus becomes a *jointly accomplished activity* where the nurses, on the one hand, "tailor" the information to each individual woman depending on her previous knowledge (Zayts and Kang 2010) and the women, on the other hand, co-construct with the nurses what they know (and need to know) in order to make an informed decision. Since 'not knowing' (or "non-understanding") statuses may be potentially face-threatening, participants routinely employ laughter as a strategy of negotiating their knowledge.

4.2. Shared laughter as a means of negotiating participants' epistemic statuses and stances

In the analysis that follows we draw on some recent conversation analytical work on epistemics that discusses how participants negotiate knowledge in an interaction (Heritage 2012). This work makes a distinction between *epistemic status* (one's knowledgeability about a certain domain of knowledge) and *epistemic stance* (speakers' position towards each other's epistemic statuses in an interaction), and *epistemic authority* (whether participants have [primary] rights to certain knowledge). Heritage (2012: 1) observes that "epistemic statuses of the speaker and hearer are a fundamental and unavoidable element in the construction of social action". In relation to the information delivery, the epistemic statuses of the speaker and hearer are crucial as they determine what information is delivered to a client and in what ways this is done.

Example 2
At the time of delivery the woman will be 40 years old. She has previous experience of prenatal screening as she had 4 pregnancies and delivered 2 children in the past.

1. N: →   First of all, do you still remember what is Down's syndrome? ((smiles))

7

2. W: → Hehe.
3. N: Because you were seen here two years ago?
4. W: Ye::s. We just watched the video.
5. N: → Yeah heh
6. W: → Hehe[he]
7. N: [No]w. This is a condition which is related to the chromosomal abnormality, ok? The kids
8. having Down's syndrome have mental retardation. Mm. We know that there is no
9. relationship with family history. Even if there is no family history of Down's syndrome,
10. as your age is a little bit high, then your risk of having a Down's syndrome baby is higher
11. as well, OK? Like you, at delivery you will be forty years, and the risk, you know? [You
12. know what the risk is?]
13. W: [One in four- (.) eight hundred]. One in eight hundred.
14. N: One in one hundred.
((N continues with the information delivery)).

In our corpus to tap into their clients' knowledge or to establish their epistemic statuses, the nurses often employ "initial inquiries" (Zayts and Kang 2010), a type of question-response sequence that precedes the information delivery (e.g. *Do you know/ remember…?*). In Example 2 the woman is an experienced mother who has undergone prenatal screening in her previous pregnancies, so a certain level of knowledge about Down's syndrome can be safely presumed. The nurse, however, in line with her institutionally assigned role as information provider, needs to deliver that information to the mother. While in the interactions with less experienced women (first-time mothers) there is a divide between the epistemic statuses of the speaker (the nurse, a knowledgeable medical professional) and the hearer (a woman; non-knowledgeable lay person) that warrants information delivery, with more experienced women the speakers and hearers' epistemic statuses converge to an extent, and the delivery of information that is already known becomes a repetitive and somewhat redundant activity. When the nurses still carry on with the information-giving, they typically mitigate this activity. In this example this mitigation is done non-verbally through smiling (line 1) as well as verbally through the account that the nurse gives for her action (*because you were seen here two years ago* [therefore, you could have forgotten this information, line 3). The nurse's smile is reciprocated by the woman with two full beats of laughter (line 2). In line 4 the woman confirms that she remembers what Down's syndrome is and notes that she also has just watched the video (together with other women seen in the hospital for prenatal screening). This latter acknowledgement makes the nurse's information delivery even less relevant. It, therefore, leads to another short instance of laughter from the nurse (one laughter beat, line 5) that is again reciprocated by the woman (an extended laughter sequence comprising of three laughter beats, line 6). By reciprocating the nurse's laughter, the woman, on the one hand, signals her understanding of the peculiar situation that the nurse finds herself in: questioning the woman's memory and still having to provide the information that the woman appears to remember well. On the other hand, the reciprocation of laughter does something else: it terminates the topic of "inquiring about the woman's epistemic status" and allows the participants to move on to the next topic (Holt 2010). Interesting about this example is that the woman's laughter on both occasions is more "pronounced" than the nurse's laughter (the nurse's smile is responded with two full beats of laughter [lines 1–2]; and one beat of laughter is responded to with three full beats of laughter [lines 5–6]). As we can see in this interaction, lay participants may also take on a knowledgeable epistemic stance, thus questioning the epistemic authority of professionals. In this example, while the topic is terminated by the woman through laughter, the nurse is the one who terminates the woman's laughter and initiates a new topic (that is marked by the discourse marker *now*, line 7) thereby regaining her institutional (and interactional) authority. This is

typical of our data corpus: while both nurses and women engage in laughter, it is usually the nurses who bring laughter to an end and resume the "business at hand".

Heritage (2012) observes that participants' epistemic statuses are not static: they may change as an interaction progresses. In our corpus, laughter is also employed by the participants during the actual information delivery to adapt to their changing epistemic statuses from 'not knowing' to 'knowing' after they receive the information about PS from the nurses. Example 3 comes from the end of the information delivery stage. The nurse has just explained in detail all testing options to the woman. At this point in the interaction it may be assumed that the woman understands what her choices are and is able to make a decision.

Extract 3
The woman in this consultation is 42 years old. This is her first pregnancy. Prior to this extract, the nurse has explained the woman's increased risk of having a child with Down's syndrome due to her age. The nurse has also introduced CVS and amniocentesis as possible testing options.

1	N:	So, so far are these choices clear? ((smiles)) ((points to the information sheet in front of
2		her))
3	W:	Yes. ((smiles))
4	N:	So (.) uh (.) it's up to you hh whether you- which test you want
5		(2.0)
6	N:	.h or do you need to discuss with your husband?

At the beginning of this extract the nurse inquires whether the choices that she has presented are clear to the woman (line 1). Since admitting to non-understanding of something that has just been explained is potentially a face-threatening issue, the nurse mitigates her question with a smile. The woman confirms that the choices are clear to her, thereby also establishing and confirming her epistemic status of someone who knows (line 3). The confirmation is accompanied by the reciprocation of the nurse's smile (line 3) that brings this exchange to an end, and the nurse moves on to the next topic of making a choice. The new topic is marked by the discourse marker *so* (line 4). Thus in this example, similarly to Example 2, the shared smiling among the participants displays their orientation towards bringing one topic to an end due to the now 'knowing status' of the woman and shifting to another topic.

Recurrently, we see a different pattern of laughter in our data when there is a clear "epistemic imbalance" between the participants as Example 4 demonstrates:

Example 4
The woman in this interaction is 38 years old. This is her second pregnancy but she has no previous experience of Down's syndrome screening (her first child was born in the Philippines). This example comes after the nurse has taken the woman's medical and family history.

1	N:		Ehm: have you watched video (.) today?
2	W:		Mm hmm.
3	N:		Ah:: (1.5) ((takes notes)) Do you have any idea of Down Syndrome?
4			(1.3)
5	W:		Mm: °no.°
6	N:	→	N(hh)o:. Have you seen children like this before?
7	P:		Mm hmm.

In Example 4 the nurse confirms with the woman that she has watched the video on Down's syndrome (line 1) and employs an initial inquiry (*Do you have any idea of Down Syndrome?*, line 3) to tap into how much the woman understands about Down's syndrome. While the woman did watch the video, she acknowledges, after a pause and a slight hesitation that she does not know about Down's syndrome. This leads to the nurse's reserved laughter: she reiterates the woman's response that incorporates a laughter particle (line 6). The nurse's laughter here signals the dispreferred nature of the woman's response. In other words, there is an expectation that after watching the video, women have some idea about Down's syndrome that will facilitate the subsequent information delivery. The nurse then attempts another initial inquiry (*Have you seen children like this before?*, line 6) to elicit whether the woman indeed has no previous knowledge or experience of seeing children with Down's syndrome. What is interesting about this example is that the nurse's laughter is *not* reciprocated by the woman. This signals that the woman does not treat the nurse's laughter as an invitation to laugh. The lack of the reciprocation of laughter suggests that the participants are orienting to two different issues in this interaction. While the nurse's laughter is oriented towards the fact that the woman who has just watched a video about Down's syndrome says that she does not know what it is, the woman's laughter signals her orientation to the topic of Down's syndrome as a serious matter. Sequentially, the absence of the reciprocation means that the topic of "how much the woman knows about Down's syndrome" is not terminated at that point and the nurse continues to inquire about the woman's state of knowledge.

Examples 2 to 4 demonstrate how through laughter and its reciprocation (or non-reciprocation) the participants negotiate their epistemic statuses and stances prior to and during the information delivery to facilitate this process.

Alongside epistemic dimension of communication participants also negotiate their *deontic authority* that relates to the "right to determine others' future actions" (Stevanovic and Peräkylä 2012: 297). As Stevanovich and Peräkylä (2012: 298) note, epistemic and deontic authority are interrelated concepts: "epistemic authority is about *knowing* how the world 'is'; deontic authority is about *determining* how the world 'ought to be'". In our previous work (Pilnick and Zayts fc) we have discussed that in PS consultations negotiation of deontic authority relates to who gets to make a decision about what tests (if any) a pregnant woman should take. We have shown that on some occasions medical professionals exercise their deontic authority overtly and tell the women what test they should take. More typically though, decisions about testing involve a careful negotiation of the participants' deontic rights. Even when the professionals choose to direct their clients in the decision-making towards the options that they (the professionals) favor, this is done in more covert ways by, for example, giving recommendations, listing out (preferred) testing options, or foregrounding specific psychosocial concerns (e.g. these women's worries) as the basis for the decision to undertake a specific test (see also Pilnick and Zayts 2014). In our last two examples we examine how participants employ laughter as another "covert" strategy of negotiating their deontic authority.

4.3. Clients' laughter as a means of negotiating deontic authority

Decision-making in PS consultations involves decisions about what information a woman needs to know before making an informed decision about testing, and the actual decision-making about testing. In Zayts and Schnurr (2011) we have observed that nurses routinely employ laughter in responding to the women's dispreferred activities as a means of resisting those activities. As Glenn (2003: 141) notes, "structurally resistance means acting to discontinue the activity proposed or in progress". In Example 5 the nurse laughs in response to the woman's refusal to receive more information about one of the tests, amniocentesis, as she has decided not to pursue invasive testing. The nurse, however, is required to give full information about all available tests as part of her job (and as a necessary step in helping the woman

make an informed decision). We focus on what is achieved through the reciprocation of the nurse's laughter by the woman.

Example 5
The woman is 38 years old and this is her first pregnancy. Prior to the interaction included in the extract the nurse explained to the woman what Down's syndrome is, what the woman's risk is of bearing a child with the condition, and the pros and cons of different testing options. Following the information delivery, the woman has made the decision not to pursue any testing and to continue the pregnancy.

```
1   N:          Would you like to have more information on amniocentesis?
2   W:          ((shakes her head throughout the utterance))
3               No (it's not-it's not ne[cessary)]
4   N: →        [You d(h)on't] wa(h)nt [hah >hah hah hah< hah]
5   W: →                                [heh heh huh huh huh]
6       →        I'm s(h)o(h)-
7   N: →        Yo(h)u don't w(h)ant.
8   W: →        I don't wa(h)nt t(h)o.
9   N:          Ok, now. Uh, in fact, this screening test can- uh
10              estimate your risk again. If it is high:, then, we will
11              advise you to go for amniocentesis.
12  W:          Mm hmm.
13  N:          If the risk is low? Then we will not arrange further
14              testing. Detection rate is eighty-six percent. So you
15              would prefer not to know of any amniocentesis=
16  W:          =No.
```

By announcing her decision to the nurse (not included in the extract) the woman has established her deontic authority. The nurse then inquires whether the woman would still like to receive information about amniocentesis (that she has not yet delivered) (line 1). On the surface, the nurse's question does not appear to threaten the woman's deontic authority (that is, the right to make a decision about the continuation of pregnancy), the implication of the nurse's question, however, goes beyond a simple inquiry about providing more information. As Stevanovicj and Peräkylä (2012: 309) note, providing more information may be used as an indirect strategy "to resist the unfavorable deontic implications of the first speaker's utterance".

A woman's overt refusal to receive the information (that is strengthened by shaking her head as she speaks) (lines 2–3) is interrupted by the nurse's confirmation of the decision that contains laughter particles (*You d(h)on't wa(h)nt*) and five full beats of laughter (line 4). The nurse's laughter signals her disaffiliation with the woman's action of refusing information. In our previous work we discussed that in such cases the nurses use laughter to "laugh off" their clients' refusals (Zayts and Schnurr 2011). On the one hand, the nurse's laughter signals her resistance; on the other hand, it also mitigates this process of negotiating participants' deontic rights, making it less confrontational.

The woman reciprocates the nurse's laughter (five beats of laughter, line 5) and then attempts to provide what looks like an account for her decision (*I'm s(h)o(h)-*, line 6). As Lyman and Scott observed (1967: 46), speakers typically use accounts to justify or excuse their "untoward" actions and to "bridge the gap between actions and expectations" (Lyman and Scott 1968: 46). The reciprocation of laughter and the presence of the incomplete account in the woman's response signal the woman's awareness of the dispreferred nature of her refusal and serve to mitigate it. This is followed by another repetition of the woman's decision not to receive the information about amniocentesis by the nurse

(line 7) who inserts laughter particles into her speech. The nurse's laughter is again reciprocated by the woman who confirms her decision (line 8).

This example thus presents an extended laughter sequence in which the nurse's laughter is repeatedly reciprocated by the woman. The nurse's extension of laughter can be seen as a continued attempt to express her resistance towards the woman's decision and perhaps an invitation to reconsider it. The reciprocation of the nurse's laughter by the woman, on the one hand, mitigates the dispreferred action of refusing the information. On the other hand, it may also be seen as an attempt to bring this topic to an end, thereby signaling that this is her final decision.

While it is the woman who terminates the laughter sequence, it is the nurse who brings the consultation "back to business": she resumes the talk about different tests, bringing up amniocentesis yet one more time as the procedure that the woman will be advised to consider if her screening test results are positive (i.e. the woman's risk of having a baby with Down's syndrome is identified as high). The nurse's last attempt to explain the procedure (lines 14–15) is again refused by the woman (line 16).

In Stevanovicj and Peräkylä's (2012) terms, it can be described as an example of "deontic incongruence" where the nurse's and the woman's agendas are misaligned and each other's actions are treated as dispreferred. Through laughter and its reciprocation the participants engage in a complex process of negotiating their deontic rights. The laughter in this example allows both participants to make claims to their deontic rights, and to minimize the effect of their dispreferred actions.

In the last example we examine how the participants employ laughter to negotiate their deontic authority in the actual decision-making process.

Example 6
(This example is also analyzed in Zayts and Schnurr 2011: 12)
The woman in this encounter is 38 years old and this is her fourth pregnancy. Prior to this extract, the woman has expressed her firm decision not to undergo any testing due to religious reasons. Nonetheless, she has accepted the nurse's invitation to provide information on available tests. The extract comes at the end of the information delivery when the woman announces her final decision.

1. N: → <u>Or</u>:, you can adopt the third choice, that is no test ((smiles through the utterance)).
2. W: Yes.
3. N: → Yes. That's what you want? ((smiles))
4.   (0.6)
5. W: <u>That's </u>what we want.
6. N: → O(h)k heh heh

((14 lines are omitted in which the nurse makes arrangements with the woman to have an ultrasound at eighteen weeks of gestation))

21. N: So you will not change your mind? Ah huh huh [huh huh]
22. W: [°N(h)o:°]
23. N: Anyway, you will continue with the pregnancy?
24. W: Yes.
25. N: Yeah, °I see.° So, you will not em:: ultrasound only.
26. W: Ultrasound please.

The example starts with the nurse telling the woman about one possible choice – not pursuing any testing (line 1). The nurse smiles as she talks about this option. As we have already noted, in the interviews the nurses commented on their strong preference of testing to no testing; therefore in this

example, smiling can be considered a "milder version" of expressing that this is the nurse's dispreferred option. The nurse also smiles when she confirms the woman's brief response of not wanting to pursue testing (line 3); and produces an extended laughter (line 6) to the woman's stronger assertion about her decision (line 6). Example 6 is thus another example of "deontic incongruence" where the nurse resists the woman's deontic right to make the decision of not pursuing any testing. The absence of the reciprocation of laughter by the woman in the first part of this exchange signals that the woman treats this exchange as "non-laughable" or serious.

The nurse's question in line 21 (*So you will not change your mind?*) is in a declarative form which is typically used to confirm a response (in this case, the woman's decision) rather than to question it. Nevertheless, the very fact that the question is being asked, raises the issue of the woman's deontic right. The nurse's extended laughter (5 full beats) that follows the question mitigates the face-threatening nature of her action. The woman's brief (and quiet) response that confirms her decision incorporates a laughter particle (°N(h)o:°, line 22). The low volume and the laughter mitigate the refusal. Laughter in the woman's response also serves as an attempt to terminate the nurse's repeated actions of questioning her right to make the decision, and the discourse marker "*anyway*" in the nurse's next turn signals the end of this topic and the move to the next one (Lenk 1998).

5. Discussion and conclusion

In this chapter we have examined the second pair part of the laughter sequences negotiated by nurses in PS consultations. Building on existing research of shared laughter, particularly in institutional contexts, we have shown that there are certain regularities in how the pregnant women in our data reciprocate (or do not reciprocate) the nurses' laughter. These regularities appear to be closely related to the specific activities of the PS consultations that the participants engage in, such as communicating risk information and making a decision about potentially pursuing testing for Down's syndrome.

We have shown that shared laughter may be *affiliative* and serve to establish rapport between the participants. This happens in those cases when the nurses employ laughter to mitigate the risk talk that is prevalent in the analyzed interactions, and to reassure the women. In such cases, the women laugh *with* the nurses (Glenn 2003) to express their affiliation with the nurses' actions. However, as we have shown, shared laughter may also express participants' *disaffiliation*. In the analyzed interactions, these are those cases where participants engage in negotiating their epistemic and deontic statuses. As Jacknick in her analysis of ESL classroom interactions notes:

> Despite expectations based on institutional role, epistemic authority is not owned by one party or another; rather, it is claimed by participants with different roles [...] in different ways, and laughter is instrumental in displaying (dis)alignment with claims (2013: 199).

Applying this idea to the context of PS, there are certain roles that are institutionally assigned to the participants, such as information- provider and information- recipient (for a detailed discussed see Zayts and Schnurr 2014). Based on those roles, one can expect a certain "epistemic divide" between the nurses and the women. However, as we have shown in our analysis, in consultations with more "experienced" expectant mothers (for example, those who know about Down's syndrome and screening and testing options from their experience in previous pregnancies), participants' epistemic statuses may converge to an extent. In these cases, the activity of information delivery that the nurses are institutionally required to perform then becomes somewhat redundant. In such cases, shared laughter is used by the participants strategically to negotiate their epistemic statuses. The nurses laugh to mitigate the potential face-threat of the inquiries about the women's epistemic status; whereas the

women laugh to terminate the topic of "inquiring about their knowledge" and to establish their epistemic authority. Examples like these reflect the complexity of the process of negotiation of participants' epistemic statuses in institutional interactions: while professionals have an *a priori* "privileged" epistemic status due to their professional knowledge and expertise, one cannot automatically assume that there is necessarily an "epistemic imbalance" (Heritage 2012: 32) between professional and lay participants. As a contrast, we have shown that when there is an epistemic imbalance between the participants, the women do not reciprocate the nurse's laughter, and therefore, the activity of inquiring about their epistemic status may be continued by the nurses.

Finally, shared laughter may also be employed by the participants to negotiate their deontic authority. The issue of deontic authority is particularly sensitive in the context of PS consultations where clients (women and their partners or significant others) are expected to make an autonomous informed choice of what testing (if any) to pursue. As we have shown elsewhere (e.g. Pilnick and Zayts fc), autonomous informed choice is difficult to attain interactionally: even when the medical professionals are not advising their clients directly what to do, they could still express their preferences in more indirect ways. In Example 6, for instance, the nurses' resistance to the woman's decision not to pursue any testing is expressed through repeated questioning of the woman's choice, as well as non-verbal resources such as smiling and laughter. As we have shown in our analysis of Example 5, the negotiation of deontic authority may involve negotiating the actual right to make the decision (Example 6), as well as the epistemic grounds (i.e. the knowledge) that would be sufficient to make an informed decision (Example 5).

By focusing on the client's responses to the nurses' laughter this chapter has shed further light onto the interactional complexities of laughter in the medical context where, as we have shown, laughter performs a range of important functions which assist interlocutors in negotiating and ultimately achieving their interactional goals. In these contexts, laughter is not only used to mitigate and facilitate risk talk, as might have been expected, but, perhaps more interestingly, it is also frequently employed as a means to negotiate interlocutors' epistemic statuses and stances, as well as their deontic authority. And we believe that it is in particular these latter functions relating to epistemic and deontic stances that provide promising avenues for future research in the endeavor to better understand the interactional complexities of laughter, and thereby contributing more broadly to our understanding of 'language play'.

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