TALKING AND CURE – WHAT'S REALLY GOING ON IN PSYCHOTHERAPY

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TALKING AND CURE – WHAT'S REALLY GOING ON IN PSYCHOTHERAPY

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EDITORIAL
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Editorial: Talking and Cure – What's Really Going On in Psychotherapy

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Editorial on the Research Topic

Talking and Cure – What's Really Going On in Psychotherapy

Nearly 130 years ago Bertha Pappenheim coined the term "talking cure" while she was in hypnotic treatment with Dr. Joseph Breuer in Vienna. Freud adopted this term and it was echoed through a century: "...it all started with the talking cure" (Kächele, 1992, p. 2). Even though talk is so central in psychotherapy, up until now, we know relatively little about the actual structure and properties of it.

Interactional details of psychotherapy have been investigated by anthropologists and linguists since 1960s (e.g., Pittenger et al., 1960; Scheflen, 1973). In the clinical world, the most important pioneers were Horst Kächele and Helmut Thomä, who in 1970s started a large textbank of psychotherapy transcripts that has been used ever since in quantitative and qualitative studies (Mergenthaler and Kächele, 1988) as well as a resource for highly influential textbooks (Thomä and Kächele, 1985/2021, 1994). In quantitative, clinically oriented research, counting of words, topics of talk or length of pauses has revealed patients' style of talk or underlying conflictual social relations (e.g., Luborsky and Crits-Christoph, 1988). Some researchers, however, considered such quantitative approach too simple, insensitive to the details of expression and action which centrally contribute to the therapeutic character of the talk. Gradually, the way for paying more attention to the details of a therapeutic conversation was opened, as the cooperation between psychotherapy researchers and conversation analysts was begun some 20 years ago (see Peräkylä et al., 2008).

This Research Topic presents some of the developments of the conversation analytical (CA) line of research. The 11 papers touch upon four largely overlapping themes.

(1) **Alignment and resistance.** Alignment means participants' collaboration in maintaining actions and activities in therapy, while resistance—in CA terms—means that one participant does not go along in the course of action initiated by the other. Muntigl et al. examined a particular therapeutic technique called chair work: the clients' ways of ways of resisting the therapists' proposals of such work, and the therapists' ways of resolving the client resistance. These ways include proffering of alternatives, as well as accounting for and elaborating on the proposals, and they are intertwined with negotiation of deontic and epistemic relations between the therapist and the client. Scarvaglieri takes up the potential tension between the building of a positive client-therapist relation on one hand, and the therapist's disalingment with the client's communicative activities on the other hand. Examining first encounters in therapy, he shows that such disalingment is necessary for the achievement of the interactive and institutional goals in therapy. Buchholz et al. investigate alignment and resistance during the first 20 min of a therapy session with a 4-year old traumatized child. What they call "doing contrariness" involves the child's practices producing epistemic and affiliative disruptions. The paper also shows the therapists' strategies for preserving or restoring the affiliative dimension of the relationship. Janusz et al. take up couple therapy with clients who are diagnosed with narcissistic personality disorder. They show how the narcissistic clients work to ensure their control of the unfolding

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of the interaction, by not answering the therapist's questions, by blocking the development of the conversational topic, and by conspicuous displays of their interactional independence.

(2) **Organization of affect**. Emotions and affects are at the heart of psychotherapy, and CA offers a way to describe the interactional display, expression and regulation of them in a very close distance. Guxholli et al. investigate the therapists' ways of managing a prolonged disagreement with the patient. They show particular interactive trajectories where the therapist, in the midst of such disagreement, briefly affiliates with the patient by producing a collaborative conversational move, only to return to the disagreement thereafter. The local affiliation is thus in the service of a prolonged disagreement. Muntigl explores talk about the client's upsetting experiences in a single session of client-centered therapy. He shows the therapist's ways of focusing on the client's distress, and the client's ways of opposing this. Through repeated episodes the client's display of distress and the therapist's responses, the participants eventually secure extended emotional work. Avdi and Evans bring together three analytic resources on management of affect. Employing CA, they investigate the client's narration about her anger and guilt and the therapist's responses to it; with psychoanalytic concepts, they explore the possible conflicts and unconscious processes pertaining to these interactions; and by measuring the autonomic nervous system responses, they examine the participants' physiological arousal during the narration and formulations.

(3) **Specific linguistic and non-linguistic resources**. Psychotherapeutic talk—as any spoken interaction—rests upon the participants' command of numerous lexical, grammatical, prosodic and kinetic resources, by means of which they produce and recognize actions that can have therapeutic functions. Etelämäki et al. investigate the therapists' use of two forms of person reference in Finnish language in responses to the clients' complaints. The zero-person (a form that lacks grammatical subject) is used in affiliating responses, whereas the second person (addressing the client directly) is used for reconstructing the client's past history. Knoll et al. examine how silences that occurs after the therapist's continuer receive their meaning in and through the participants' next actions. In most cases, the silence is followed by therapist's turn where they shift the topic, or by the client's turn where they continue on topic. Only in some cases, the therapist, in their next turn, formulates the meaning of silence as a therapeutic event.

(4) **Specific interactional trajectories**. Talk in psychotherapy is distinguishable from talk in many other settings. The distinctness of psychotherapy rests, in part, on the particular, "psychotherapy specific" action sequences. Deppermann et al. show that in psychotherapeutic interaction, the therapists sometimes respond to the clients' narratives, not by taking up the semantic content of the narration, but by topicalizing the "performative self" that the patient enacts through the narration. By doing so, the therapists also focus away from, and even challenge, the identity claims that the content of the narration conveyed. Ekberg investigated sequences where the therapist proposes connections between two experiences that have been discussed separately—for example tying what is currently being talked about, with something that the client told in a prior session. Such connections can contribute to the psychological account of the client's experience.

CA in psychotherapy shows the complexity of the therapeutic task in much more details than could be observed by therapy theories alone (Buchholz and Kächele, 2017). By looking binocularly, clinically and conversationally, onto what is going on in the treatment room, we see the processes of balancing therapeutic alliance and affectivity, alignment and resistance, institutional frames and individualized projects and others. We hope that this Research Topic will show how CA of psychotherapy is of value for linguists, social scientists, psychotherapist and psychotherapy trainers alike.

AUTHOR CONTRIBUTIONS

MBB and AP planned and wrote the article collaboratively.

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ORIGINAL RESEARCH
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Managing Distress Over Time in Psychotherapy: Guiding the Client in and Through Intense Emotional Work

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Clients who seek psychotherapeutic treatment have had personal experiences involving some form of distress. Although research has shown that the client's ability to experience and express painful emotions during therapy can have a therapeutic benefit, it has also been argued that displaying distress may convey a form of helplessness and vulnerability, and thus, clients may be reluctant to cast themselves in this light. Using the methods of conversation analysis, this paper explores how a client's upsetting experience is managed over the course of a single session of client-centered therapy. The main analytic focus will be on (1) the different therapist practices used to orient to the client's distress, (2) the varying forms of client opposition to the therapist's attempts to work with the distress, and (3) the context sensitivity of orienting to distress and how certain practices may be uniquely shaped by what had occurred in prior talk. It was found that, whereas certain types of therapist responses tended to be endorsed by the client, others were forcefully rejected as inappropriate displays of understanding or empathy. By focusing on repeated sequential episodes over time in which a client conveys distress, followed by the therapist's response, this paper sheds light on the interactional trajectory through which a client and therapist are able to resolve impasses to emotional exploration and to successfully secure extended and intense emotional work.

Keywords: affectual stance, affiliation, client-centered therapy, conversation analysis, crying, distress, emotion, empathy

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INTRODUCTION

Psychotherapy offers a setting in which clients are able to report on their personal experiences, some of which involve intense moments of distress. These contexts of self-disclosure are believed to have positive therapeutic benefit. According to Greenberg et al. (1993, p. 271), "some of the most powerful moments in therapy occur when clients allow themselves to experience and express extremely painful self-relevant emotions." Notwithstanding the immense potential value of emotional self-disclosure for facilitating productive therapeutic work, conveying upsetting personal experiences also creates certain interactional challenges. The first relates to the difficulty that therapists may have in responding to the client's past or present feelings in an appropriately congruent manner; that is, therapist responses may not necessarily fit with clients' understandings of their distress, thus infringing on the troubles teller's ownership of personal experience (Sacks, 1995b). Heritage (2011) has termed this challenge a *problem of experience*. Second, clients may not only report on their past distressing experience but may also simultaneously express upset in the present moment (e.g., crying). Thus, in choosing to affiliate with the client's distress, therapists may

not only need to decide which aspect of the distress (i.e., what is reported or expressed) should be oriented to first but may also need to manage distress at both these levels.

These challenges surrounding the client's personal experience of distress are a central concern in psychotherapeutic interactions. If they are dealt with successfully, the therapist and client may strengthen their relationship by creating *communicative attunement* (Elliott et al., 2011) or an *empathic moment* (Heritage, 2011) in which they display shared understanding and mutual affiliation within a sequence of talk. If, however, the management of these concerns is less successful, as when the client rejects the therapist's display of empathy or the therapist does not affiliate in the "appropriate" way with the client's distress, tension and discord may arise in the relationship, and further, the local therapeutic goal of guiding clients through their experiences of grief may be in danger of becoming derailed.

Using the methods of conversation analysis (CA) (Sidnell and Stivers, 2013), this paper examines how a client's upsetting experience is managed over the course of a single session of client-centered therapy. By focusing on repeated sequential episodes over time in which a client conveys distress, followed by the therapist's response, it will be shown (1) how the therapist orients to the client's upset in different ways, (2) how the client opposes the therapist's attempts to work with the distress, and (3) how these disaffiliative sequences provide a novel context in which the therapist can orient in an alternative way to the client's emotional experience. It was found that, whereas certain response types are endorsed by the client, others are forcefully rejected as inappropriate displays of understanding or empathy. It is the latter client responses that draw specific attention to the "problem of experience" and, further, mandate a subsequent reaffiliative move from the therapist. The focus is also placed on how the client and therapist orient to the client's vulnerability in these moments of upset and, further, how the client may use "vulnerability" as a resource to resist further exploration of her feelings in the present moment of therapy. Finally, this single case analysis is illustrative of how, at the end of the episode, the client and therapist are able to resolve impasses to emotional exploration. This case, therefore, maps out the productive—and clinically relevant—trajectory through which a client and therapist are able to successfully secure extended and intense emotional work.

DILEMMAS OF PERSONAL EXPERIENCE

One of the guiding principles behind client-centered therapy is the provision of empathy by privileging and validating the client's ownership of experience (Rogers, 1951). When adopting an empathic stance, Rogers (1957) recommends that therapists also appear *genuine* or *authentic* and show *positive regard* toward the client. Whereas, genuineness means relating to the client's experience in a transparent manner, without putting on a professional attitude or facade that is incongruent to the client's needs (Lietaer, 1993), positive regard refers to "prizing the person" or displaying unconditional acceptance of the client's feelings and experience. Thus, when responding to clients' reports of experience, therapists need to find the right balance between these elements to do productive relationship work. There is certainly a heightened awareness within psychotherapy that offering the appropriate kind of empathy, for example, may pose a significant challenge in certain contexts. As Elliott et al. (2011) have argued, therapists may sometimes need to individualize their response to best suit their client and to know when empathy is called for and when it is not; for example, they have noted that clients who communicate their "inner experiences" more openly may respond favorably to various forms of empathic displays, whereas clients who are "fragile" may instead show an adverse reaction.

By reporting on significant and often distressing episodes of their lives, clients provide therapists with detailed access to their emotions and assessments, or *affectual stance* (Stivers, 2008), pertaining to persons and events. Because reported experiences are infused with affect, they help to build up and create the necessary materials or resources through which therapists may offer affiliation or empathy and, moreover, strengthen the therapist/client relationship. For this paper, empathic responses are viewed as social actions that endorse and display understanding of the teller's felt experience (Heritage, 2011; Kupetz, 2014; Muntigl et al., 2014), in such a way as to ratify the teller's epistemic authority through a range of epistemic markers that index contingency (Hepburn and Potter, 2007).

When persons report to others about their personal experiences, two moral systems become relevant for the interaction (Heritage, 2011). The first is that these disclosures are considered to be "owned" by the experiencer and thus index specific entitlements that are associated with having experienced something first hand (Pomerantz, 1980; Sacks, 1995b): primary rights to know about what happened and to react emotionally or develop an elaborate affectual stance to the event in question. The second is that, in sharing personal experience with others, recipients are mandated to display empathy with the teller's experience. In Heritage's (2011) view, these moral systems may *collide* and cause tension, especially when the empathic response is seen as inappropriate and as infringing on the teller's ownership of experience. Thus, to ensure that an affiliative episode can be achieved, recipients must successfully attend to these relevant interactional issues or dilemmas.

AFFILIATING WITH DISTRESS DISPLAYS

Psychotherapy researchers have noted that distress displays may index client vulnerability in which clients may experience themselves as helpless and lacking control (Greenberg et al., 1993; Greenberg and Paivio, 1997). In these contexts, client-centered therapists face a formidable challenge. On the one hand, therapists are mandated to validate and show understanding of the client's distress. However, on the other hand, clients may resist further topicalization of the distress and further talk that draws even more attention to their vulnerability or helplessness. Expressions of distress may also be seen as opportunities to engage more directly with what is upsetting the

client in the present moment of therapy. Drawing attention to the client's emotional experience in the here and now of therapy is considered to be an effective and beneficial practice in many therapeutic approaches (Rogers, 1959; Perls, 1973; Bugental, 1999; Yalom, 2002; Stern, 2004; Kondratyuk and Perakyla, 2011). Within client-centered therapy, for instance, Rogers (1959, p. 198) argues that client utterances making reference to present moment experience (e.g., "for the first time, right now, I feel that you like me") are referred to as "experiencing a feeling fully, in the immediate present. The individual is then congruent in his experience (of the feeling), his awareness (of it), and his expression (of it)." However, here also, clients may be reluctant to engage more deeply with and express their anguish in the present moment for fear of being too exposed or vulnerable. The difficulty for therapists, therefore, is to offer clients enough security through which they may risk more directly confronting their upsetting experience.

Within CA, there is a growing interest in examining how distress is interactionally dealt with in a variety of institutional contexts, such as caller help lines (Hepburn and Potter, 2007, 2012), medical encounters (Beach and Dixson, 2001), and police interviews (Antaki et al., 2015). One commonly identified response to distress displays that communicates a high degree of empathy is *formulating*. Here, the recipient either provides the gist or summary of preceding talk or draws an implication or upshot of what had been said (Heritage and Watson, 1979; Antaki, 2008)[1]. Other practices, seen in caller help lines and police interviews, have been termed *take-your times* (Hepburn and Potter, 2007) and function to manage emotional disruptions to talk by orienting to the difficulty the distressed speaker has in completing his or her turn.

It is argued that distress may be conveyed in interaction in either of two forms: through a reporting of a past distressful event or via an *in-the-moment* expression of distress (Antaki et al., 2015). In the latter sense, distress is something that emerges in the here and now and is built up through talk and other non-verbal means. Wootton (2012, p. 43) provides a useful working definition when he characterizes *distress* "as roughly denoting those forms of tearfulness which have crying as their most extreme form of expression." In her influential work on crying, Hepburn (2004) has shown that distress may be indexed within expressions or interactional features of varying intensity, such as sniffs, tremulous voice, and sobbing. Other possible distress markers have been noted by Hoey (2014) in reference to sighing. The distinction between reporting a distressing event and expressing distress in the moment may, however, not always be so clear cut in interaction. In psychotherapy, for example, a client's reporting of a distressing experience may be accompanied by in-the-moment distress markers (e.g., sniffs, tremulous voice, etc.). In such contexts, client-centered therapists may need to attend to one or the other forms of distress, for example, by exploring what the past feelings of distress meant (i.e., attending to the report of distress) or by exploring the client's present feelings (i.e., attending to the in-the-moment distress). Alternately, therapists may try to balance these different facets of distress by attending to them sequentially. What will be shown in this paper is how a therapist orients to these different levels of distress and how certain responses end up facilitating or delaying emotional exploration.

[1]Other formulation types have been identified by Weiste and Peräkylä (2013) and are termed *relocating* and *exaggerating*, but these seem to be restricted to psychoanalysis and cognitive psychotherapy.

DATA AND METHODS

The case under examination was taken from the York I Depression Study (Greenberg and Watson, 1998) and forms part of a larger project that examines therapist–client affiliation and disaffiliation (Muntigl et al., 2013; Muntigl and Horvath, 2014b). The client, Eve, is female and was offered 20 sessions of treatment for depression. The therapist is also female, and her mode of practice was client centered (Rogers, 1951). All sessions were video-taped. For this investigation, written informed consent was obtained from the participant for the publication of anonymized data. Persons referred to within therapy, including the client, have been given pseudonyms. From this case, session 15 was selected for transcription and analysis because it represented an extended episode of talk—comprising approximately the first 30 min of the session—in which the therapist made repeated attempts to manage the client's distress. Within this session, Eve topicalizes her upset feelings involving her brother's death that occurred ∼4 years ago. These feelings were triggered by having watched the recording of the previous week's video-taped session (together with a psychologist from the York I study) in which Eve began to discuss this painful incident. A single session, involving topically related episodes of interaction, was chosen to illustrate the important therapeutic practice of distress management (see Schegloff, 1987 for a discussion of this mode of data analysis involving single, extended episodes of interaction). Thus, the aim was to shed important light on how a salient personal experience is dealt with over time and how a therapist and client eventually work through the client's avoidance to perform more intense emotional work.

The methods of CA were used to transcribe and analyze the session. The transcription notation was based on Hepburn and Bolden (2012) and Mondada's (2016) conventions for multimodal transcription (see **Table 1** for the list of transcription notations used). Because client distress and its realization was a major focus in this study, Hepburn's (2004) conventions for transcribing different features of crying were also adopted; for instance, a sniff was transcribed as "°.snih°," and tremulous voice was represented by tildes that enclose a stretch of talk "∼." Sighing was also noted and portrayed as an in-breath ".hh" followed by an out-breath of relatively great intensity "hx" (Hoey, 2014). Because exhalations in sighing are typically high intensity and often were heard to contain a voiceless velar fricative sound, similar to German "ach," Hoey's convention of writing "x" (or "X" for higher intensity) rather than the standard Jefferson (2004) convention of "h" was used—Sighs not containing the voiceless velar fricative sound were transcribed with "h" rather than "x." Furthermore, accompanying visible conduct, such as shoulder and chest heaving were also noted

TABLE 1 | Transcription notation.

Symbol	Meaning	Symbol	Meaning
Transcription notation			
[	Starting point of overlapping talk	↓word	Markedly downward shift in pitch
]	Endpoint of overlapping talk	↑word	Markedly upward shift in pitch
(1.5)	Silence measured in seconds	.hhh	Audible inhalation, # of h's indicate length
(.)	Silence <0.2-s		
.	Falling intonation at end of utterance	Hhh	Audible exhalation, # of h's indicate length
,	continuing intonation at end of utterance	heh/huh/hah/hih	Laugh particles
?	Rising intonation at end of utterance	wo(h)rd	Laugh particle/outbreath inserted within a word
(word)	Transcriber's guess		
( )	Inaudible section	.hh hx	Sigh
wor-	Truncated, cut-off speech	∼word∼	Tremulous/wobbly voice through text
wo:rd	Prolongation of sound	.snih	Sniff
word=word	Latching (no audible break between words)	huhh.hhihHuyuh	Sobbing
<word>	stretch of talk slower, drawn out	>hhuh<	Sobbing—produced at a faster rate
>word<	Stretch of talk rushed, compressed	↑ hhuh<	Sobbing—if sharply inhaled or exhaled
°word°	Stretch of talk spoken quietly	((cough))	Audible non-speech sounds
Word	Emphasis	*(blue)*	Non-verbal behavior (actor indicated by initial)
WORD	Markedly loud		

during sighing where they occurred (Hoey, 2014; Hepburn and Bolden, 2017). Sequence organization was examined with respect to three interconnected sequential slots that typically occur in psychotherapy interaction (Peräkylä, 2019): an initiating action, followed by a responding action and ending with a *third position* action that closes the exchange. In terms of distress display sequences, initiating actions involved a display or report of distress, followed by the therapist's response to the emergence of client distress and, finally, the next position in which the client ratifies or rejects the therapist's action. In the case of rejection, the therapist's subsequent practices to restore affiliation were examined.

THE SESSION TRAJECTORY OF MANAGING CLIENT DISTRESS

From the analysis of how the client, Eve, conveyed distress—by reporting personal upsetting experiences and/or by displaying distress in the moment—and how the client's distress talk was responded to and subsequently negotiated over extended sequences, a certain interactional trajectory involving discreet phases, roughly corresponding to a *beginning*, *middle*, and *end* (Sacks, 1995b; Robinson, 2013), was identified. In more functional terms, these phases may be described as (1) launching a distressing episode of personal experience: orienting to the client's vulnerability; (2) managing continued opposition to emotional exploration; and (3) successful guidance into emotional exploration. The beginning phase consisted of the client's initial reporting of her experience of having watched the prior week's video-recorded session (see Extract 1). While recounting her experience, Eve displayed distress in the present moment, during which the therapist attempted but failed to guide the client into exploring her distress concerning her brother's death more deeply. During this time, the client's vulnerability became repeatedly topicalized and was used as a resource to avoid the therapist's attempts at exploration. Eve's opposition to engage with her present emotions seemed to pave the way for the next, middle phase in which the therapist repeatedly managed the client's opposition to emotional exploration (see Extracts 2, 3). This phase of talk primarily contained a series of formulation sequences in which the therapist would focus instead on the client's reporting of distress, rather than on her here-and-now distress displays. It was found that, although the client tended to affiliate with therapist gist formulations that displayed empathy, subsequent therapist responses that drew more elaborate implications of what the client had said were forcefully resisted and strongly criticized for its inappropriateness. The therapist would work to reaffiliate with the client in two ways: first, by endorsing the client's criticism (Extract 2); then, after being repeatedly reproached, by topicalizing the therapist–client relationship and the anger that the client may have felt from having watched the video (Extract 3). Finally, the third and end phase comprised a resolution in which the client began to work with—rather than resist—therapist actions that targeted emotional expression (see Extracts 4, 5). Here, the therapist alternated between different levels of client distress by responding to the client's reported distress vs. her distress displayed in the moment. By timing her responses in this alternating fashion and by a bodily movement that created a more intimate space between the interlocutors, the therapist was able to secure an empathic moment between herself and the client, which resulted in the client being guided more deeply into immediacy (i.e., how she feels in the here and now) through the production of an elaborate and extended emotional display (Extract 4). Following the client's emotional outburst, the therapist would use directive actions to maintain the client's focus

TABLE 2 | The session trajectory of managing client distress in terms of three discrete phases.

Phase 1 Launching a distressing episode	Phase 2 Managing opposition to exploration	Phase 3 Successful guidance into emotional exploration
• Client's initial distress display • Therapist's response to guide client into immediacy • Client's opposition to exploring her distress • Orientation to client's vulnerability	1. Therapist responses that orient to client's report of distress • Summary formulations • Upshot formulations 2. Client's repeated rejection and criticism of therapist's upshot formulations 3. Therapist response that topicalizes the relationship, addressing client's opposition and anger	1. Therapist responses orienting to client's in-the-moment distress/abandoning rational-focused talk • Immediacy questions • Noticings • Bodily movement to decrease physical space between therapist–client 2. Maintaining focus on client distress • Therapist directive actions

on her distress (Extract 5). These phases are illustrated in **Table 2** and discussed in the remainder of the *Analysis* section.

Phase 1: Launching a Distressing Episode of Personal Experience: Orienting to the Client's Vulnerability

Just prior to Extract 1, the client, Eve, reported on her experience of having looked at the video of the prior session with a psychologist from the York 1 study. The general topic of that session involved her brother's death that occurred ∼4 years ago. The first mention of this incident was not elicited by the therapist but rather was launched by the client ("it's sort of< funny after watching that video last week"). Because Eve's report appears at the very beginning of the session, it speaks to the importance and newsworthiness of the event (Sacks, 1995b). The analysis of this extract will show how the therapist first responds to the client's in-the-moment distress and how Eve, for the most part, avoids or resists the therapist's efforts by repeatedly topicalizing her vulnerability. As a result, the therapist shifts her orientation from exploring Eve's feelings in relation to having watched the video to addressing the client's vulnerability in terms of not being able to engage with her present distress.

In line 06, the client reports being "caught off guard." This implies that something "unexpected," in which she has no control over, had happened. At this time, her talk adopts a tremulous voice quality (see Hepburn, 2004), which signals incipient distress. The therapist then orients to the client's turn by seeking confirmation that her watching the video was responsible for her being caught off guard. After showing strong agreement—first through multiple head nods and then through a series of three consecutive *yeah*s—the client slightly expands on her turn by uttering ">well it< still does." (line 12). The design of and interactional features surrounding this turn merit further discussion. First, the prefacing 2.7-s pause in line 11 may be signaling a hesitation to continue. Second, the "well" is indexing the response's *non-straightforwardness* (Schegloff and Lerner, 2009) and, further, that there may be much more to say. Third, her use of "still" does temporal work by extending her experience of "being caught off guard" to present time and, therefore, further underscores the relevance and impact this experience had and is *still* having on her.

In line 15, the therapist responds by focusing the temporal context of the client's experience more precisely on the present moment: "what's happening inside °right now.°" Questioning formats containing temporal markers, such as "now" or "right now" have been termed *immediacy questions* that guide client experience into the here and now (Kondratyuk and Perakyla, 2011). With this move, the therapist provides the client with an opportunity to elaborate more deeply on her present feelings with respect to the video. But rather than comply with the therapist's request and launch into emotion talk, the client instead utters an account that relates to her lack of ability and energy: "see I- I ↑don't have any good-< uh good resources right now >cause I'm< quite tired." Eve's response is once again produced with a tremulous voice, thus indexing a form of distress. Her up/down dampening motion with her hand (lines 19–20) may also be acting as a "brake" against further attempts at exploring her present feelings. On the one hand, Eve's account reinforces the view that she is vulnerable and helpless; that is, it implies a diminished personal agency in which she may not be able to effectively deal with emotional issues. On the other hand, by adding "right now" to her account, she seems to also be resisting the *membership category* (Sacks, 1995a) of being a *vulnerable person*; that is, the vulnerability is not an enduring trait but is only applicable to her in this specific context.

The therapist then shifts her focus away from Eve's present feelings in relation to the video toward the feelings articulated in Eve's account. She does this by making two attempts at prompting the client to elaborate via a general elicitation in line 21 ("↑uh huh:?") and a more specific elicitation in line 26 ("°what does that mean.°")[2]. The client's repeated conduct of withholding from responding could be conveying opposition to the therapist's actions, but it may also be showing a form of "doing being upset." For example, these client silences, coupled with a sigh in line 28 (".hhh hhh"), seem also to convey a sustained level of distress. This then leads the therapist to produce a candidate answer that topicalizes and simultaneously seeks confirmation of the client's depressed state or helplessness and vulnerability: "you're feeling: [low?] >or you're feeling< vulnerable?" Eve's answer in lines 33 and 34 is produced in a *dispreferred* format (Pomerantz, 1984; Sacks, 1987) that does not grant confirmation of the therapist's candidate choices. First, the turn-initial "well" signals an upcoming non-straightforward answer; second, Eve's response orients to the second option posed in the therapist's question, rather than on her "feeling low," by resisting the term "vulnerable" through her selection of the term "delicate" instead; and third, by stating "feeling more delicate *than normal*,"

[2]See Muntigl and Zabala (2008) for a discussion of general vs. specific elicitation practices in psychotherapy.

Extract 1: 01:12–02:20[3].

```
01      Ther:   how did that- how did that go:,
02              (0.5)
03      Eve:    .hhh [oh]::. ih = [was pre]tty interesting.(.)°was° pretty
04      Ther:        [s-]       [yeah.  ]
05      Eve:    interesting> was actually quite a-< (0.2) ~°°ah°° (0.5)
06              really caught me off gua:rd.~
07              (0.3)
08      Ther:   it caught you=off gua:rd, te- to watch it? to see ↑it.
09              (0.6)
           e    multiple nods
10      Eve:    yea:h. yeh. °yeah.°
11              (2.7)
12      Eve:    >well it< still does.
13              (0.4)
14      Eve:    mm =
15      Ther:   = what's happening inside °right now.°
16              (0.7)
17      Eve:    °uhm.°
18              (1.0)
19      Eve:    ((lip smack)).hhh *~ >see I- I ↑don't have any good-< uh
           e                      *makes up and down dampening motion with
20              good resources right now >cause I'm< quite tired.~*
                left hand palm down----------------------------->*
21      Ther:   ↑uh huh:? =
22      Eve:    = but u::m
23              (0.7)
24      Ther:   >huh what< m.
25              (1.7)
26      Ther:   °what does that mean.°
27              (0.7)
28      Eve:    .hhh hhh.
29              (0.8)
30      Ther:   you're feeling: [low?] >or you're feeling< vulnerable?
31      Eve:                     [.hhh]
32              (1.4)
33      Eve:    ((lip smack)).hhh well jus that <normally I:> (1.1) I'm
34              feeling more delicate than normal.
35              (1.4)
36      Ther:   °mm hm,° >so you're< askin[g me] to go care*fully:[:? or:::.]*
37      Eve:                              [s:o ]               [>.hh.hh< ]
           e                                                *head turn + frown*
38              (1.8)
39      Eve:    ((clicks tongue))  .h[*hh          >HX::.<*]
40      Ther:                       [>are you< apologizing] for feel- uh p-
           e                      *heaving shoulders and chest*
41              f- for (1.3) having tears in your °eyes.° =
42      Eve:    = >.hhh<
           e    smiles
43              (1.5)
           e    nod
44      Eve:    °°hh°° >m.<
           e    smiles
45              (1.5)
           e    shallow multiple nods
46      Ther:   you're apologizing >°for your tears,° <
47              (1.2)
48      Eve:    .hhh HX:::.
           e    *heaving shoulders and chest*
49              (0.7)
50      Eve:    yeah >cause if I< was less tired I'd be
51              more in contro:l. °I guess that's the thing.°
```

[3]"01:12–02:20" refers to "time into the recorded session."

she implies that her delicacy is an exceptional case, thus again resisting the membership category of "delicate/vulnerable person" as an enduring trait.

Dispositional claims, such as "not having good resources," "being tired," "feeling delicate," etc. index the *inference rich* character of "vulnerability" (Sacks, 1995a, p. 40) and, further, open up certain possibilities for responding. In lines 36–41, we see the therapist specifically orienting to these aspects of the client's here-and-now experience by drawing two types of implications. To begin, the therapist formulates the upshot of "feeling vulnerable" in which the therapist is required to proceed gently and cautiously when responding to the client's distress: ">so you're< asking me to go carefully::? or:::." The client, however, seems to reject this option in line 37 by making a negating head turn (on the horizontal axis) while frowning. The therapist then articulates another possible interpretation, which is that the client is apologizing for her display of a negative emotion ("having tears in your °eyes.°") and receives non-verbal confirmation from Eve in lines 43 and 45. Eve also smiles in lines 42 and 44, which may be signaling admission or that she is "pleading guilty" to having displayed her emotions. This latter interpretation seems to bring the focus of talk back toward Eve's initial displays of distress; that is, her tearfulness may be linked to what she had felt when watching the video. Then, in line 46, the therapist redesigns the latter reading of the client's implied action as a formulation ("you're apologizing >°for your tears,° <"), thereby seeking more explicit confirmation from the client. Following a 1.2-s pause and a pronounced sigh that in turn-initial position projects an upcoming dispreferred response (Hoey, 2014), the client once again provides an account. But this time, she lists "having less control" as a reason for not being able to manage or restrain her emotions. Here again, the client depicts herself as not operating at "full capacity," and the inference may be drawn that the client is at risk of being vulnerable (i.e., she may be susceptible to intensely experiencing her distress), somewhat helpless (i.e., she may not be able to control the emotions associated with her distress), and thus not ready to confront her present emotions head on.

Phase II: Managing Continued Opposition to Emotional Exploration

The prior extract has shown that the brother's death is a locus of distress for the client and thus constitutes a relevant theme in therapy. Focusing on the client's distress displayed in the moment by an immediacy question did not, however, result in the further exploration of the client's present emotions concerning the brother. This may be because clients who are experiencing deep distress involving painful past events may be reluctant to express their emotions with more intensity or may not be ready to engage in conversations that explore or interpret their grief. As argued by Greenberg et al. (1993, p. 274), "for most people in therapy there is some sense of vulnerability, embarrassment, or shame in revealing their most personal and vulnerable aspects. There is a sense of risk in sharing experiences that are uncomfortable and private." During this phase of interaction, the therapist would respond to the "content" of the client's distress talk. Thus, by orienting to what the client is saying in her reporting of distress rather than what she is currently feeling, there becomes much less pressure for the client to engage with her emotions in the present. The client, Eve, however, would tend to reject and criticize therapist formulations that worked to explore the content of Eve's reported upset, and this led the therapist to topicalize the therapist–client relationship and Eve's negative emotions directed toward the therapist.

Focusing on the Reported Aspect of Distress: Circumventing the Client's Vulnerability

It was found that when the therapist stayed relatively close to the client's own words, as for example by formulating the gist of client's prior talk, the client would tend to offer agreement and affiliation with the therapist's action. However, when the therapist attempted instead to point out relevant implications of the prior talk, the client would not only voice her disagreement but would also mock or criticize the therapist as having responded in an inappropriate fashion[4]. Consider Extract 2.

In lines 01–05, Eve uses expressions, such as "ho::w, (2.2) deep my feelings we:re" and "ho:w, (0.9) pro ↑ foundly. (2.1) it affected the course of my li:fe." to report on the significance her brother's death had on her. Furthermore, she frames these significant aspects in terms of not having known this beforehand and, thus, as a revelation (i.e., "I: had no idea"). Eve's tremulous voice, interspersed with affect-laden sighs (lines 02 and 10), seems to display severe distress at gaining this newfound knowledge. What begins to emerge here also is Eve's portrayal of herself as vulnerable to unforeseen events happening in her life, events that she does not seem to have any control over. The therapist briefly responds by first offering minimal affiliation with Eve's affectual stance of distress through a head nod in line 06 and then by producing a continuer that prompts more talk from Eve. In lines 08–14, the client elaborates on how her life had been affected: The first expression, "cruising o:n.," implies a carefree and unconstrained attitude; the second, "scra:mbling," is more negative, relating to life being lived in a frantic, confused, and disorganized manner; and the third, "treading wa:ter.," implies a standstill and that there is no progression or development happening for the client.

By way of response, the therapist initially displays empathy with the client's reported distress by formulating the gist of the client's message, in a way that subtly transforms yet stays close to her wording. For example, the client's "I: had no idea" becomes rephrased as "you:: hadn't really fully:> appreciated" and "I >was just< like, (0.3) cruising o:n" as "you were kind of-° (0.4) tryin to carry on blithely." Furthermore, the therapist's metaphorical expression "maybe there's a hole in your ship" (line 22) offers a

[4]This sequential progression of moving from summaries or "reflections" of client's talk to drawing implications or interpretations of this talk may be a general practice that occurs in different therapy approaches, including cognitive-constructivist psychotherapy (Voutilainen et al., 2010). Through this practice, the therapist first secures client endorsement before exploring various implications, consequences, or perspectives (stemming from the client's initial report) that the client had perhaps not considered.

Extract 2: 05:31–07:42.

```
01    Eve:  ~UHm,(2.1) °.snih° (3.3)((lip smack)) .hhh <I: had no
02          idea ho:w,> *.hhh HX::.* (0.4) °hm.° (0.6) ho::w,(2.2)
          e         *heaving shoulders and chest*
03          deep my feelings we:re about that whole thing.(.) an I
04          had no: idea,.hhh ho:w,(0.9) pro ↑ foundly.(2.1) it
05          affected the course of my li:fe.~
06          +(0.3)
          t +slow shallow nod→
07    Ther: mm h:m[::, ]+
          t ---------> +
08    Eve:      ~[an so] I >was just< like,(0.3) cruising o:n.~
09          (1.5)
10    Eve:  *.hhh HX::.*
          e *heaving shoulders and chest*
11          (1.2)
12    Eve:  *e- you know sort of:,(0.4) scra:mbling,*
          e *circles fingers forward-------------->*
13          (3.2)
          e slows down fingers
14          but like treading wa:ter.
15          (1.3)
16    Eve:  °a:n uh,° (0.3) [I just-]
17    Ther:                 [so <yo ]u:: hadn't really fully:>
18          appreciated how much impact his *death °had had on you.°
          t                  shallow nod
          e                                *multiple nods------>
19          (0.3)
          e ---->
20    Ther: °an you were kind of-° * (0.4) tryin to carry on blithely
          e ---------------------->* wipes eye
21          an,(1.9)hadn't stopped to realize
          e      shallow multiple nods
22          maybe there's a hole *in your ship or-*
          e                    *shallow double nod*
23          (7.6)
          e shallow multiple nods
24    Eve:  °.hhh° hx:::.
25          (3.5)
26    Eve:  ((lip smack)) yea:h. =
          e            rubs eyes
27    Ther: = °so his death was very significant for you:.°
28          (1.8)
          e runs hands through hair
29    Eve:  °.snih°
          e clasps hands behind head
30          (1.0)
31    Eve:  hx::.
32          (0.8)
33    Ther: somehow it <s::ounds> perhaps as if,(2.2) you're
34          saying you didn't s:top enough to kinda- (1.5) process
35          it, an (.) integrate *it °an-° (0.4)* change course?
          e                    *drops arms to lap, looks away*
36          (0.3)
```

```
37   Eve:  well. n:- no I never ha:ve.(.)but, =
38   Ther: = mm hm:[:,]
39   Eve:           [I ] mean-
40         (0.4)
41   Ther: °does that° sound important?
         e    looks at T
42         (1.6)
         e looks away
43   Ther: [to do:?]
44   Eve:  [ hx:. ]
45         (2.1)
46   Eve:  ↑gee when you put it like °tha:t.°
         e mocking tone
47         (0.8)
48   Eve:  uhm.
49         (1.1)
50   Ther: >°d'you feel I'm twisting your arm,° <
51         (0.4)
52   Eve:  pardon?
53   Ther: >°d'you feel I'm twisting your arm,° <
54         (0.6)
55   Eve:  hehheh heh.hhh.hhh.hh n(h)o it's just so:
56         O:bvious what you're saying. that of course it's tru:e.
57         .hhh uhm.
58         (0.8)
59   Ther: °°but=chu may not want to. °°
60         (0.7)
61   Ther: °°doesn't°° matter >whether it's< true° °°or not.°°
62         (0.7)
63   Eve:  ((lip smack)) °ooh I don't know.° .hh *.hhh HX:::.*
         e                          *heaving shoulders and chest*
64         (3.5)
65   Eve:  like it- it n- (0.3)*~I mean the thing is is* that,~
         e choked voice             *rubs hand over eyes*
66         (2.4)
67   Eve:  °.snih°
68         (2.9)
69   Eve:  ~(y'know),~
```

relevant extension in meaning to the client's use of "scrambling" and "treading water," for it also implies vulnerability; that is, a hole may cause a ship to sink. It should be noted that the client conveys affiliation along many points of the therapist's turn and afterwards. Eve consistently nods during and immediately subsequent to the formulation and verbalizes agreement in line 26 (see Stivers, 2008; Muntigl et al., 2012).

It is at this point, however, where the conversation proceeds to get off-track. Starting from line 27, the therapist initiates a shift in frame in which she begins to move away from the client's initial revelation and the ways in which her life had been affected into an activity that focuses on the implications of the client's talk ("°so his death was very significant for you:.°"). Furthermore, the client withholds her confirmation from line 28, which may be conveying implicit disaffiliation or even that she is having a hard time grasping the impact that her brother's death had on her life. In line 33 onwards, the therapist continues to draw implications, but prefaces her turn with the epistemic markers "it <s::ounds>," "somehow," and "perhaps." In this context, where the client has not displayed explicit affiliation in her prior turn, the therapist seems to be orienting to this ascription as being something delicate to do. The therapist's formulation explicitly points out the possible consequences of not having "fully appreciated" or "realized" the impact that the brother's death had on her; that is, Eve may have taken more time to reflect on these events ("process it, an (.) integrate it") and to take a more agentive role in her life ("change course"). This more interpretive move by the therapist may be seen by the client as no longer fully endorsing her original stance and that may explain why, in line 37, Eve starts her turn by reluctantly agreeing with the therapist ("well. n:- no I never ha:ve.") and then produces a disagreement token "but." The

therapist then takes another turn (line 41) that explicitly seeks confirmation from the client ("°does that° sound important?"), but rather than offer her endorsement, the client continues to disaffiliate by turning away (line 42) and by producing an exasperated outbreath that overlaps with the therapist's turn continuation ("to do:?").

Explicit disaffiliation occurs in line 46 when the client underscores the "obviousness" of the answer while simultaneously mocking the therapist ("↑gee when you put it like °tha:t.°"). It is here that the client's dilemma in reference to the problem of experience becomes apparent: she is being confronted with an expert's view and (rational) understanding that this perspective on her is correct, which, at the same time, does not orient to her in-the-moment experience of feeling devastated, vulnerable, and exposed. Thus, the "mocking tone" would be indexing the client's reluctance to get in touch with her feelings, but she *is* admitting that the therapist has made a point. Furthermore, Eve's derision is doing additional emotional work; for example, by mocking the therapist, Eve seems to be conveying her annoyance with what the therapist has said and, by implication, that she may be displeased or angry with the therapist[5].

After withholding from taking up a turn at talk and thus allowing the client to continue and account for her disaffiliative response (lines 47–49), the therapist then orients to the interactional trouble by suggesting a possible reason for the client's displeasure (">°d'you feel I'm twisting your arm,° <"); that is, the client may feel that the therapist's interpretation was made too forcefully and is perhaps not in step with the client's own perspective. The therapist's response also orients to who has primary rights to control the direction of the interaction, termed *deontic status* (Stevanovic and Peräkylä, 2014), suggesting that the therapist may have overstepped her bounds. Following a brief *other-initiated repair* sequence in lines 52 and 53 (Schegloff et al., 1977), the client first denies the therapist's reason and then provides an account that criticizes the therapist's prior intervention as being incongruous and inappropriate and challenges its relevance ("it's just so: O:bvious what you're saying. that of course it's tru:e."). There may also be an implication of a breach in the therapist's genuineness or authenticity (Rogers, 1957); that is, in stating the "obvious," the therapist may be running the risk of appearing as lacking an adequate professional commitment and as simply supplying formulaic expressions as a response to the client's troubles. This criticism conveys an affectual stance of continued anger or annoyance at the therapist's response, but what also seems to surface from this is the mismatch between what the client is emotionally experiencing, on the one hand, and the therapist's attempts at describing and exploring her distress, *through words*. This discrepancy will resurface again later and become highly salient in Extract 4.

[5]Reviewer 1 has pointed out that, in emotion-focused therapy terms, the client's anger at the therapist could be construed as "secondary reactive" anger, which may be covering up more basic feelings of psychological pain and/or guilt and may also have been used to "interrupt" the psychological pain.

Subsequently, the therapist does further work to re-establish affiliation, agreement, and a shared perspective on the prior interactional trouble. In line 59, the therapist's utterance ("°°but = chu may not want to.°°") displays her understanding of the client's prior disaffiliative action of line 37; that is, although the client may have realized that she could have more deeply reflected on and dealt with the brother's death, she has no desire to do so. But following "no response" and thus "no confirmation" from the client in line 60, the therapist then provides another opportunity to engage the client by orienting to the implication in the client's prior turn that the therapist's interpretation is not relevant ("°°doesn't°° matter >whether it's< true°°°or not.°°"). However, even this attempt fails to garner an affiliative response. Rather, the client first makes a claim of no knowledge ("°ooh I don't know.°"), which seems to simply dismiss and frustrate the therapist's line of action (Drew, 1992; Hutchby, 2002), then produces a prolonged sigh, and finally proceeds to return to the topic of the brother.

Topicalizing the Relationship: Eve's Anger Toward the Therapist

Within this phase of the therapy, there were repeated sequentially unfolding cycles in which the client reported on and displayed her distress, followed by the therapist's formulation of Eve's experience, ending with Eve criticizing or reprimanding the therapist. Psychotherapy researchers have referred to such episodes as alliance ruptures, especially in relation to strains in the therapist–client relationship, and one of the suggested ways in dealing with these ruptures is to *explore relational themes associated with the rupture* (Safran et al., 2011). For example, clients may feel resentful that the therapist is intruding in the client's personal experiential domain and therapists may thus respond by addressing the client's feelings toward the therapist. Consider Extract 3. Just before this stretch of talk, the client and therapist jointly produced sequences in which the client reported on her distress and on the deep significance of the video: "it's like, (0.9) the la:st 2 weeks have jus- (0.7) not >existed<"; "it's like anything that I was doing in my life is just a shadow."

In lines 01–05, Eve uses vivid descriptors to characterize the issue with her now deceased brother and his wife (i.e., Kevin and Jennifer) as "fresh and ra:w." and conveys distress throughout her turn by repeatedly sighing and adopting a wobbly voice. The therapist, in line 09, produces a gist formulation that captures the metaphorical dimension of Eve's talk ("an open so:re"), which then receives confirmation from the client. Eve continues by stating that this experience prevents her from being rational and disciplined but then ends her turn in line 14 with "I- I >don't °know what I'm saying.° <," while conveying distress by covering her eyes with her fingers, rubbing her eyes, and producing an intense sigh. Here, Eve is expressing her inability to continue, but she is also pointing to the difficulty in articulating her feelings and, by implication, may not find it appropriate for the therapist to continue with talk that is focused on her experience. The therapist, however, responds with a formulation that directly engages with Eve's prior talk. She orients to the intensity of her experience ("so <bi:g"; "kin've = jus seeps into everything") and how this may be making it difficult for her

Extract 3: [10:51–12:20].

```
01    Eve:  and then (0.4) there are this- (.) there's this stuff about
02          ((1.5)) ~K↑e:vin an Kevin and Jennifer an.~ (2.0) (lip smack)
03          *.hhh (0.7) >hx::<* (1.7) man it's just so:, (2.3) ye know.
          e *heaving chest*
04          fresh and ra:w. ~even though it's, (0.6) been a long ti:me~
05          in some ways that,
06          (1.6)
07    Eve:  .hh hx:.
08          (2.0)
09    Ther: >so this is< like an open so:re.
10          (0.6)
11    Eve:  ~yes. like I can't be rational and disciplined about, (1.3)
12          everything else. w- when, (0.5) there's this too.~
13          (0.5)
14    Eve:  I- I >don't °know what I'm saying.° <
          e          covers eyes with fingers
15          (1.7)
          e rubs eyes
16    Ther: [(this is sa-) so <bi:g,>] that (1.1) >that it< (.)
17    Eve:  [ *.hhh          hx:*    ]
          e *heaving chest*
18    Ther: kin've=jus seeps into everything? an it's (2.8) °hard° to be
19          r- (0.3) rational? or.
20          (0.3)
21    Ther: whether you're fee:ling very emotional? and very?
22          (1.4)
23    Eve:  ((lip smack)) >°I dunno.° <
24          (4.6)
          e rubs eyes
25    Eve:  *.hhh hx:.*
          e *heaving chest*
26          (13.5)
          e gazes down, holding fingers at temples
          t gazes at C
27    Ther: ((lip smack)) °are you angry, that (we made you) watch
28          the video.°
29          (1.0)
30    Eve:  .hhh no:.
31    Ther: >°are you angry with<° u:s:.
32    Eve:  no: no no.
33          (1.2)
          t nod
34    Eve:  hx:.hhh
35          (0.7)
36    Eve:  ↑it- >no it was< ih <was: hard> uhm. (1.0)
37    Eve:  no >it ↑ wasn't that it was< hard it was jus.hh wa:y more
38          °intense.°
39    Ther: <mm: [hm ::.:>]
          t shallow nod
```

to be rational. In line 21, the therapist returns to the topic of Eve's "fee:ling very emotional," but then does not complete her utterance. Eve responds with an "°I dunno.°" in line 23, which disaffiliates with, and thereby resists, the therapist's line of exploration (Drew, 1992; Hutchby, 2002), and then makes explicit distress displays by rubbing her eyes, sighing, and holding her fingers at her temples while gazing downwards. By way of response, the therapist now shifts the focus of the conversation

by orienting to what Eve's distress might be conveying at the relationship level; that is, Eve's difficulty in engaging with and endorsing the therapist's responses may have to do with feeling resentment at having to watch the video the previous week and, therefore, being angry toward the therapist and research group (lines 27–31). Eve, however, strongly resists this interpretation and begins to repeat how "hard" and "intense" her experience was.

Phase III: Successful Guidance Into Emotional Exploration

The therapist's attempts at getting the client to focus on her felt emotions in the present moment and at exploring her reports of distressing experience have thus far not received much affiliative uptake by the client. Around 15 min into the session, however, a noticeable shift happens: to begin, the therapist frequently punctuates the interactional sequences with actions that guide the client into the immediacy of her emotional distress. By placing or "timing" her responses in this way, the therapist was able to facilitate a very different trajectory in which the client displayed her distress in repeated sobbing episodes. Furthermore, the problem of experience in terms of the client's difficulty in talking about her distress (because of her vulnerability, feeling devastated, and lacking control) and the therapist's attempts at providing a "rational-empathic" interpretation of Eve's distress becomes resolved. Once Eve's emotions "flood out" or become intensely displayed in the moment, the therapist helps to maintain a high degree of emotional intensity through directive actions.

Overcoming Vulnerability: Guiding Client Into More Intense in-the-moment Emotional Work

The progression in which the client moves toward engaging in more intense emotional work in the present moment is shown in Extract 4. As in previous extracts, the therapist's display of understanding through upshot formulations was consistently rejected by the client.

The very beginning of this exchange, lines 1–19, follows a sequential pattern that bears much similarity to Extract 2. The therapist provides an upshot formulation that seeks confirmation about the centrality of Eve's feelings toward her brother and his wife. Following hesitation, silence, and expressions of uncertainty from Eve (lines 04–07), the therapist produces a question that can be interpreted as targeting the client's *in situ* emotional state ("what's happening") (Kondratyuk and Perakyla, 2011). This leads Eve in lines 12–16 to develop an elaborate emotional stance of anger in which she ridicules the therapist's earlier attempt at getting Eve to focus on "what is central" for her. Here again, as in Extract 2, the client is berating the therapist for having produced talk that is too rational in its focus and that does not match Eve's present experience of the distressing event. The therapist thereafter attempts to reaffiliate with the client by echoing her criticism that the formulation was too rational in scope ("that sounds too rational?") and was incongruous with Eve's feelings ("it doesn't. fit somehow?").

But now, rather than allow Eve to continue with narratives topically related to her brother—as she did in Extract 2—the therapist produces an immediacy question that provides the client with an opportunity to explore what she presently feels ("what is going on.") and, thus, to provide the kind of talk that may "fit" with her experience. What ensues is a sequence comparable to Extract 1: the client initially avoids answering the question through a prefacing 1.2-s pause and an "I >dunno.<," followed by an account that makes an appeal to her momentary vulnerability ("I'm feeling tired? I'm a little delicate"). At this point, Eve also begins to reveal signs of distress, as shown by her tremulous voice and her pronounced turn-final sigh (Hoey, 2014). The therapist then orients to the client's opposition to probe her own present feelings more deeply by offering the client affectual terms that more strongly index "hurt" and "vulnerability" ("you're feeling <bruised>? … fragile?"). But instead of continuing to make her delicacy or vulnerability a topic of the conversation, Eve reframes the impasse to exploring her present experience by recycling the "rationality argument" made previously; that is, in terms of her emotional experience regarding her brother's death, she claims that "∼it's like it's too: emotional ta=even talk about.∼" and, a few lines down, states that words cannot adequately express what she feels. The implications for the ensuing client/therapist interaction are as follows: First, the client's turn tends to discourage further formulations or interpretations of the client's current feelings, and second, she may be signaling a need to explore her feelings at the level of "emotional displays" rather than through talk. Thus, the client's turn may be seen as an invitation to the therapist to help facilitate this line of activity.

What then follows is a carefully orchestrated and negotiated interactional sequence in which the client is able to express her emotions in relation to her past experience of having watched the video. To begin, the therapist leans in toward the client at line 35, creating less physical distance between them. Through this bodily movement, the therapist creates the possibility for more intimacy and a more secure space in which to be delicate or vulnerable. Then, following a long 6.5-s pause, the therapist rephrases the client's prior talk by emphasizing the mismatch between words and feelings *in the present moment* ("doesn't >seem as though< <wo:rds,> (0.4) can express for you. (0.4) what you're feeling °right now,°") and by implying that emotion work can only now be accomplished through *in situ* emotional experiencing. During the latter part of the therapist's turn, the client begins to shake her head in agreement and, in the subsequent silence, brings her hands to her eyes and then begins to weep. The therapist in line 48 continues on with her turn by drawing the client even further into the present moment. She does this by producing a *noticing* (Schegloff, 1988; Muntigl and Horvath, 2014a) that draws attention to her emotional display ("°but you did yourself just° feel it there?"). With this action, it is implied that although words may be an insufficient means to talk about her feelings, that no longer need concern them because she is now able to connect with her feelings without "words." Furthermore, the use of "just" emphasizes the client's here-and-now experiencing, drawing attention to the client's immediate display of emotion. Following this, the client

Extract 4: 13:11–16:08.

```
01    Ther: >so this is< very central. °°somehow:: °° (0.5) your
02          feelings about °°Kevin an Jennifer.°°
03          (0.6)
04    Eve:  °well I° °°I°°
05          (9.8)
06    Eve:  uh yeah.hhh >I don't know.< uhm.
07          (1.1)
08    Ther: what's happening.
09          (0.3)
10    Ther: (why's a-) what's (1.2) yeah: I don=know.
11          (3.1)
12    Eve:  *.hhh HX:::.*
          e *heaving shoulders and chest*
13          (2.0)
14    Eve:  ((lip smack)) well jus being (.) able to
15          say well they(↑ are more) central is like so- more rational
          e nasalized voice quality/mocking
16          than when it's (.) g- (0.5)going u- on. I- I- I don't know.
17          (0.7)
18    Ther: that sounds too rational? it doesn't. fit somehow? =
19    Eve:  = ye- [yeah.  ]
20    Ther:       [what is] going on.
21          (1.2)
22    Eve:  .hh ~I >dunno.< I'm feeling tired? I'm a little delicate,.hhh
23          (1.0)
24    Eve:  a(h)nd~ hx::. hu(hhh)
25          (2.7)
26    Ther: you're feeling <bruised>?
27          (4.9)
28    Eve:  .hhh hh
29          (1.9)
30    Ther: fragile?
31          (3.4)
32    Eve:  ~it's like it's too: emotional ta=even talk about.~
33          (0.6)
34    Eve:  ~that it's- I:(0.4) like you know words an.hhh (0.4)
35          feeling hh just don't fit. hhh so (1.0) uh:(hh)~
          t leans in close to client
36          (6.5)
37    Ther: doesn't >seem as though< <wo:rds,> (0.4) can express for
38          you.(0.4) *what you're feeling °right now,°*
          e          *shakes head ----------------->*
39          (3.1)
          e brings hands to eyes
40    Eve:  *.hhh HX:::.* °.snih°
          e *heaving shoulders and chest*
41          (1.1)
42    Eve:  °°oh(hhh)°°
43          (1.2)
44    Eve:  °°ye.hhh°°
45          (2.0)
46    Eve:  °.snih°
47          (1.4)
```

```
48   Ther: °but you did yourself just° feel it there?
49         *(9.8)
        e *crunches face, covers face with hands-->
50   Eve:  ↑%.hhh hhh >hh hh< (9.6) ↑.hhh >uhu hh hh< (4.9).hhh >uhuh hh
        e ------------------------------------------------------------->
        e %crying----------------------------------------------------->
        t                         leans in further
51         hh< (4.3) ↑.hhh >uhuh hhh hh< (5.1) ↑.hhh >oohuh hh hh hh<
        e ---------------------------------------------------------->
        e ---------------------------------------------------------->
52         (7.0) ↑.hhh >uhu huh< (4.9).hh .hh >uhuh hh hhh hhh< (7.0)
        e ---------------------------------------------------------->
        e ---------------------------------------------------------->
53         ↑.hhh u↑huh ↑huh (2.4) >.hhh< e↑huh ↑hunh*%
        e ---------------------------------------->*
        e ---------------------------------------->%
```

seems to physically shield herself from the therapist by completely covering her hands with her face and then weeps for several minutes, as represented by a long series of in- and out-breaths (Hepburn and Bolden, 2017), before taking up another turn at talk (lines 50–53).

Thus, it would appear that the therapist's placement and timing of her interventions played a crucial role in getting Eve's emotional outburst underway: By offering Eve a secure space to experience intense emotions, by repeatedly drawing the focus of talk on the client's presently felt emotions, and by openly conceding that Eve's distress should be explored by experiencing it in the moment (rather than talking about it "rationally") led to a joint understanding of how emotional exploration could effectively proceed (i.e., an empathic moment) and, thus, to the client's readiness to engage in intense emotional work.

Maintaining the Client's Focus on Her Distress

The next 10 min of interaction primarily involved prolonged episodes of sobbing, and these episodes were interspersed with brief interaction sequences in which the focus of talk was placed on the client's emotional distress, followed by therapist practices that guided the client back into experiencing and displaying her immediate distress. Consider Extract 5.

During Eve's assertion that she just wants to "cry an cry an cry an cry," the therapist offers affiliation through nodding and then by responding in line 06 with acknowledgment ("mm hm:") and a gist formulation that underscores Eve's need to express her sadness in the present moment (i.e., *right now*). The therapist's utterance in line 11, "there'll be time °for <words.>°," implies that the exploration of the client's distress through talk should take a back seat to the importance of having Eve express her emotions. Following a 6.1-s pause, the therapist then directs the client to weep using an imperative (grammatical) format ("(>so you<) let it out."). The imperative design of this directive indexes low contingency (e.g., there is no use of modal expressions, such as *could you* to cater to the client's ability or willingness to perform the action) and the therapist's high entitlement to perform the directive (Curl and Drew, 2008; Antaki and Kent, 2012; Drew and Couper-Kuhlen, 2014). The client's immediate compliance, shown by her engaging in another extended sobbing episode, attests not only to this ratified role relationship but also to the continued secure environment enabling her to weep in the therapist's presence.

DISCUSSION

Research has already demonstrated that, to achieve an elaborate understanding of how therapeutic projects actually unfold over time, it is important to examine longer stretches of interaction, to ascertain whether certain therapeutic interventions are functioning in a more (or less) productive way (e.g., Voutilainen et al., 2011; Muntigl, 2013; Buchholz and Kächele, 2017). This paper has shown that a client's distress may need to be managed over many sequences and that the ways in which distress is dealt with in one interactional phase may occasion different responses from the therapist. But unlike some institutional activities, such as problem presentation and information gathering during primary care visits (Robinson, 2013) or soliciting chair work entry in emotion-focused therapy (Muntigl et al., 2017), which seem to be strongly goal-directed and follow distinct interactional patterns, the direction that the activity of managing distress will take seems to be strongly contingent on the therapist's ability to maneuver around client opposition and deal effectively with the client's intense upset, rather than adhering to goals as such.

There is, however, a model of psychotherapeutic development, originating from the Mount Zion Group in San Francisco (Horowitz et al., 1975; Gazzillo et al., 2019) that bears similarity to the kinds of interdependent, interactional phases being proposed here. Briefly put, these authors state that only after the therapist has successfully passed an interpersonal challenge from the client will clients disclose previously avoided distressing experiences. The claim is that clients will present the therapist with various forms of tests or challenges, such as disagreeing or being angry with the therapist, to gauge the degree of

Extract 5: 20:20–21:24.

```
01    Eve:  hh hh.hhh hh hh.hhh.shih ((swallows)) hhhhunh (0.5)
02          ~but it's=like I don't want to, I jus (.) [feel like I jus]
03    Ther:                                          [mm:         hm,]
04    Eve:  wanna sit down. an I jus wanna lay (0.4) like a ra:g doll,
05          jus cry an +[cry an cry] an cry,~=
06    Ther:             [mm:=hm,   ]
          t            +shallow multiple nods-->
07    Ther: = mm hm:,+ so right now you need to cr↑y:.
          t -------> +
08    Eve:  >.h[h.hh<]
09    Ther:    [you n]eed to weep.
10    Eve:  ah:hh hh
11    Ther: there'll be time °for <words.>°
12          (6.1)
13    Ther: ((lip smack)) (>so you<) let it out.
14    Eve:  >.hhh< uhhuhhuh huhhuh hh hh h
15          (6.5)
          e drops head into hand
          t sits back in chair
16    Eve:  .hhh:: uh hhh hh hh (2.1) °↑hun° (1.9) °>hup<°.HHH uhhh hh heh
17          huh (3.2).hhh >uhhuh hhhh huh< (3.1).hhh wuhuh huh hh
18          (2.7).hhh eheh huh hh (2.8) >↑.hhh<
```

safety on hand (Horowitz et al., 1975). Thus, if therapists are able to "pass the test" by dealing effectively with clients' disagreement or anger, clients will feel secure enough to disclose their distressing experiences. Comparing the above model with this examination of client-centered therapy, the attention was placed on the challenges that the therapist was faced with when responding to client reports or displays of distress. This "problem of experience," as coined by Heritage (2011), was especially salient when the therapist formulated certain implications arising from the client's reported experience. This was taken as inappropriate and was severely criticized, implying that the therapist's understanding of the client's grief was incorrect and unfitting (i.e., too rational). These difficulties in offering "suitable" empathy also seemed to generate implications for what Rogers (1957) had termed being genuine or authentic. By stating the obvious and by providing "rational understandings," it was implied that the therapist cannot fully grasp what is at stake for the client and that the therapist must therefore revert to formulaic expressions. This led to talk in which the therapist topicalized a rupture in the alliance or the growing strains being placed on the therapeutic relationship (Safran et al., 2011).

The overall trajectory of this session of client-centered therapy showed, however, that the therapist and client were eventually able to overcome impasses (in the form of challenges or tests) to exploring the client's present emotions more deeply, and it would seem that affiliation and safety were key factors in enabling this outcome[6]. First, pertaining to social solidarity, the client's eventual engagement with her feelings in the here and now seemed to index an empathic moment, in which shared understanding of how to deal with the distress and mutual affiliation could be realized (Elliott et al., 2011; Heritage, 2011). Finally, weeping has been argued to index intense sorrow and helplessness and suggests that the person has "surrendered" and abandoned all efforts at coping (Frijda, 1986). Eve's extended bout of weeping, therefore, seems to point to the establishment of a secure relationship, partially facilitated through the therapist's bodily action of decreasing the space between her and the client, in which she can *be vulnerable* in the presence of another. It may thus be said that, although there does not seem to be any "hard" interactional evidence that the client was in fact testing the therapist through her repeated opposition or disaffiliation and her displays of annoyance or anger, it does appear, as Horowitz et al. (1975) are suggesting, that establishing client safety is important for moving beyond impasses occurring in therapy.

What this examination has also shown are some of the ways in which a therapist may orient to the client's distress. Drawing from the distinction of Antaki et al. (2015) between *reporting* vs. *in-the-moment distress*, it was shown that the therapist would orient to the former by formulating the client's personal experience. In-the-moment distress, by contrast, was oriented to not only via *immediacy questions* ("what's happening inside °right now.°") and *noticings* ("°but you did yourself just° feel it there?") but also by directive actions that guide clients into the re-entry of a sobbing episode ["(>so you<) let it out."][7]. It may also be said that these response types to distress are not random

[6]Outcome measures have classified this client as recovered from depression at the end of therapy. Although there is no direct evidence that the analyzed trajectory was mainly responsible for this outcome, it is conceivable that the identified shifts in emotion talk played a role in this development.

[7]It should be noted that emotion-focused therapy researchers have identified a list of therapist response types that bear resemblance to the action types of CA (see Elliott et al., 2004). They use speech act labels termed Experiential Response Modes to characterize the different kind of empathic vs. process-oriented actions that therapist responses may be performing. Further research is needed to explore how CA action terms and Experiential Response Modes may complement each other.

choices but are predicated on the immediately prior context or on the kind of interactional work accomplished in a phase of talk, often involving client opposition or the therapist being challenged. Orientation to the client's reporting of the distress, for example, occurred only after the client had resisted exploring her in-the-moment distress[8]. This therapist also first began to manage the client's distress through an immediacy question, thus orienting first to the client's here-and-now distress display and later used a noticing to guide the client into a deeper form of emotional expression. Finally, directive actions were used only when the client had already accomplished prolonged in-the-moment emotional work. Thus, this study sheds light on the context sensitivity of orienting to distress and that certain practices may be uniquely shaped by what had occurred in prior talk.

There are certain limitations to this study. Only one session involving one therapist–client dyad was examined. Future studies, drawing from a larger corpora of distress display sequence trajectories with more clients and therapists of varying therapeutic orientations, will be needed to extend our understanding of the diversity in which episodes of upset may be responded to and managed. What has been shown, however, is that longer-term sequential trajectories may be fruitfully analyzed by focusing on a specific sequence type (i.e., distress display + response) and its reoccurrence over time and that, in doing so, a certain distress management trajectory comes into view—compare similar longitudinal studies that focus on Question/Answer or Conclusion/Response sequences to track resistance over time (Voutilainen et al., 2011; Muntigl, 2013). This study has highlighted the challenges that clients and therapists face when clients are confronted with distressing personal experiences. Horowitz et al. (1975) have claimed that, to move forward, clients need to challenge or test therapists to gain reassurance that it is safe to explore their distress. This paper has illustrated how a secure relationship, one that facilitates therapeutic work, may be accomplished interactionally. Three main points may be mentioned in conclusion. First, productive rupture and repair sequences involving weeping in client-centered psychotherapy may index a change process. Second, using a more content-focused approach (e.g., via formulations) in response to strong client emotional pain or client opposition may be insufficient and can lead to therapeutic impasses or ruptures. Third, a more process-focused approach to emotionally laden client experiences can be more effective and can facilitate extended and productive client emotional expression.

[8]There is another possible reason to explain the therapist's initial use of *empathic-oriented* (e.g., formulations) rather than *process-oriented* (e.g., noticing) responses (Elliott et al., 2004). From research protocol of the York 1 study, which offered either client-centered or emotion-focused therapy to clients, therapists were discouraged from using process-guiding interventions in the client-centered condition. Thus, the therapist here might have initially held off from responding to the client's distress in a more processing guiding, less "rational" manner, thus generating the therapeutic rupture that eventually led the therapist to change tactics and shift to a more flexible way of working with the client. I thank Reviewer 1 for having suggested this.

DATA AVAILABILITY STATEMENT

All datasets generated for this study are included in the article.

ETHICS STATEMENT

The study involving human participants was reviewed and approved by Simon Fraser University Research Ethics [2012s0672]. Written informed consent was obtained from the participant to participate in the York I study and for the publication of anonymized data.

AUTHOR CONTRIBUTIONS

PM performed the analysis of the extracts and wrote the full paper.

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Getting to "Yes": Overcoming Client Reluctance to Engage in Chair Work

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Goals: Securing clients' active and enthusiastic collaboration to participate in activities therapists would like to implement in therapy (e.g., free association, *in vivo* exposure, or the engagement in chair work) is a core mission in therapy. However, from the clients' perspective, these tasks frequently represent novel challenges that can trigger anxiety and reluctance. Thus, a key element in therapy is the negotiation between therapist and client to move beyond such reluctance to potentially effective therapy activities and, at the same time, maintain positive relational affiliation between therapist and client. In this research we examined (1) a collection of therapist proposal/client response sequences that were geared toward recruiting participation in *chair work* and (2) sequences containing hesitation or instances where decisions to engage in chair work were deferred and related relational disaffiliation. Our goal was to identify the conversational resources (both verbal and non-verbal) that worked to reject a proposed activity (or convey impending rejection) and examine the interactional practices directed at resolving client reluctance.

Method: We used the conceptual and methodological resources of Conversation Analysis to examine a corpus of proposal/response sequences that targeted chair work entry in Emotion-focused Therapy.

Results: The resulting data set included some smooth and successful engagements and others more challenging, involving clients delaying or resisting engagement with chair work. Clients were found to defer or refuse engagement through a range of resources such as withholding a response (silence), questioning the authenticity of the task, or directly refusing. We identified specific therapist practices that facilitated engagement in "refusal-implicative" contexts such as proffering "or" alternatives, offering extended rationales for the activity (accounting), and elaborating on the proposals. We observed that the therapists' deontic stance (mitigated and reduced claims to authority) and moderated epistemic positioning (deference to the client's primacy of knowledge and information) played an important role in facilitating engagement.

Conclusion: Our research highlights the kinds of interactional sequences in which clients and therapists are able to achieve alignment in mutually working toward chair work entry. Based on these observations, we offer some practical advice to therapists in formulating proposals to engage clients during in-therapy work.

Keywords: affiliation, chair work, conversation analysis, directives, deontics, emotion-focused therapy, recruitment

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INTRODUCTION

There is an accumulation of evidence that therapists and clients who can agree on the importance of the in-therapy activity proposed by the therapist, and actively collaborate in these tasks, have more successful outcomes than those who struggle to achieve such consensus (Hatcher et al., 1995; Del Re et al., 2012). These findings are consistent with clinical wisdom and are closely mirrored by Bordin's (1975, 1979, 1994) hypothesis that, across different modes of psychotherapy, the alliance in general and the task component of the alliance in particular (i.e., prizing of, and engagement in, the therapist proposed in-therapy tasks) is the core feature of the productive therapy process (Bordin, 1975; Horvath, 2018; Flückiger et al., 2020). However, while the relation between the task component of the alliance and outcome is well documented (Horvath and Bedi, 2002; Flückiger et al., 2018), much less is known about the process of how such consensus is interactively achieved and how clients' reluctance to engage in proposed therapeutic activities is resolved in clinical practice.

Our research program was designed to make inroads toward the better understanding of these processes by closely examining clinical examples of sequences involving specific task negotiations. To explicate these processes, we are utilizing the conceptual and methodological resources of Conversation Analysis (CA) (Heritage, 2004; Peräkylä et al., 2008; Sidnell and Stivers, 2013) that allows us to focus on the communicative sequences that participants use to achieve consensus with respect to therapists' proposals to engage in in-session tasks. In contrast to more traditional lenses used in psychotherapy research that tend to focus on intent and cognition (i.e., the mental process that motivates therapist and client to do or to resist such activity), the CA approach compliments this perspective by prioritizing observable social conduct: How agreement is achieved in conversation; what kinds of interactive resources (verbal, prosodic, and non-verbal) were put in play and in what kinds of sequences? We focus on the interactional ways participants indicate compliance or reticence, communicate lack of affiliation, and so on. We also draw from prior CA research on conversational directives and *deontics* (Couper-Kuhlen, 2014; Stevanovic and Peräkylä, 2014; Stevanovic and Svennevig, 2015), to better understand how increasing degrees of difficulties to task consensus are realized in therapy dialog and how the kinds of sequences that result in more or less successful resolution unfold.

For the current study we chose to examine clinical examples of therapists' and clients' negotiations to engage in a specific therapeutic task: chair work (Greenberg, 1979). Chair work (including both the "empty-chair and the "two-chair" variety) involves the client re-engaging with an unresolved, problem-laden interpersonal situation in a kind of role-play, giving voice, in turn, to different aspects of the unresolved conflict ("split"): The "empty-chair" variant most often involves a relationship with a significant other person, while the two-chair version most often focuses on two (or more) dis-owned aspects within the client, commonly referred to as "splits."[1] In all instances, the goal is to bring the unresolved/split dynamics into the present, here-and-now, of the therapy session, and to help the client move toward resolution or accommodation of the conflictual elements (Greenberg and Higgins, 1980). Because chair work is an expressive, here-and-now enactment that uses imagery and active expression, it is often accompanied by the activation and intensification of painful emotions. For this reason, hesitation, performance anxiety, shame, and/or awkwardness may be associated with this task. As a consequence, some clients may not feel "ready" – or *are reluctant to engage the task* –to participate in what can be an unfamiliar and emotionally intensifying experience.

Chair work is a frequently used and well researched intervention which, at the early stages when the therapist invites the client to engage in it, shares many of the same challenges to gaining task compliance irrespective of the treatment modality or specifics of client issues. Accomplishing "consensus-based" decisions is a common aim in many mental health care contexts (Valkeapää et al., 2020). Achieving task-consensus to do chair work requires that therapists and clients come to parallel orientation to the actual task, and, at the same time, align or realign themselves relationally while confronting this novel task that likely generates a degree of anxiety and tension for the client. This later duality gives us an opportunity to explore the negotiating process from both the instrumental and relational perspectives.

DIRECTIVES IN SOCIAL INTERACTION

Getting others to do things is a pervasive activity in social interaction. These action types, commonly referred to as *directives*, involve some future event or task to be accomplished, orient to speakers' rights and responsibilities, and make relevant some form of acceptance or compliance by the recipient or commitment to carry out the task (Couper-Kuhlen, 2014). Various additional pragmatic dimensions are important to consider when examining directive environments, especially involving imperative formats, such as participant role distributions (participation frameworks), the relation to the ongoing activity and the degree of immediacy or urgency (Sorjonen et al., 2017). Directives may include a variety of action types such as requests, commands, proposals, or suggestions (Couper-Kuhlen, 2014; Landmark et al., 2015; Stevanovic and Svennevig, 2015). The ways in which directives are formulated (e.g., the expressions, words used to design the directive) tend to orient to certain kinds of general principles that involve *entitlement* and *contingency* (Drew and Couper-Kuhlen, 2014). For example, the degree of entitlement to direct another's actions (e.g., assigning homework; giving advice concerning a problem) is often realized in the linguistic design of the directive, such as whether imperative or declarative formats or whether certain modality markers (e.g., will, would, could, should, etc.) are used (Heinemann, 2006; Craven and Potter, 2010). These displayed sensitivities to the speakers' role relationships have also been shown to take account of the participants' agency with regard to who is being mobilized to act, including who will potentially benefit from the future action, if carried out (Clayman and Heritage, 2014; Drew and Couper-Kuhlen, 2014). There may

[1]For a fuller description of techniques involving the chair, see Perls (1973), Greenberg et al. (1993).

also be various reasons for which a recipient may refrain from complying with the directive. Thus, a speaker can orient to these contingencies by making the directive less likely to be refused. For example, prefacing a directive with "I wonder" displays that the recipient may have other (perhaps better) options (Curl and Drew, 2008), and this sensitivity to the other's concerns can make it easier for the recipient to accept the terms of the directive. How speakers design their directives will also be predicated on what Rossi (2012) has termed "low cost" vs. "high cost" actions. Thus, therapists will presumably not need to do much discursive work in getting their clients to take a seat, but for higher cost actions, such as getting clients to engage in chair work, presumably more work will need to be done.

More recently in CA work, this broad spectrum of actions that involves directives (but also *commissives,* such as offers and invitations) has been examined under the general rubric of *deontics*, and more specifically *deontic stance* and *deontic status* (Stevanovic and Peräkylä, 2014). According to Stevanovic and Svennevig (2015:2), "Deontic stance refers to the participants' public ways of displaying how authoritative or powerful they are in certain domains of action relative to their co-participants, and deontic status denotes the relative position of authority and power that a participant is considered to have or not to have, irrespective of what he or she publicly claims." Further, entitlement and contingency hold a central place within this framework for understanding how these kinds of (authoritative) role relationships are negotiated turn by turn.

Directive sequences are commonly found in therapeutic approaches. For example, in chair work, a technique that is regularly used in Emotion-focused and Gestalt therapies, therapists need to recruit clients into this activity, *in situ* (Sutherland et al., 2014; Muntigl et al., 2017). In Cognitive Behavioral Therapy (CBT), therapists often make proposals to clients for homework or future behavioral change (Ekberg and LeCouteur, 2015).

OPPOSING DIRECTIVES

The sequential management of disaffiliation, or of episodes in which disagreement or the withholding of agreement occurs, is a burgeoning topic in CA-focused psychotherapy research. These studies have been examining the sequential environments of questioning and formulating/interpreting (MacMartin, 2008; Vehviläinen, 2008; Voutilainen et al., 2011; Muntigl, 2013; Muntigl et al., 2013; Weiste, 2015). CA research on directive sequences (i.e., invitations, offers, requests and proposals) has been investigating the kinds of interactional features that may be signaling rejection and, moreover, how speakers orient to this form of interactional challenge. For example, it has been shown that silence following an initiating directive action in everyday contexts generally implies potential rejection, and that speakers frequently produce a *subsequent version* of the directive, with the aim of gaining eventual compliance (Davidson, 1984). When rejections are more overtly expressed, it has been found that they are often accompanied by accounts (Heritage, 1984) or even, in the case of invitations, that an account may be offered in place of the rejection (Drew, 1984). There is an extensive literature and history of accounts and accounting practices in CA (see Levinson, 1983; Heritage, 1984; Antaki, 1994). In general, accounts perform some kind of "explanatory" work. However, in CA research, the function associated with the account will always be examined with respect to its place and organization within a sequence (Buttny, 1993; Antaki, 1994). Accounts have been shown to appear in a variety of sequential locations and, most notably, in dispreferred responses in which an explanation is given as to why the "preferred" response (e.g., acceptance) will not be given. Buttny (1993:62) points out that accounting is an interactional achievement and "how they [accounts] are ordered and produced is contingent in part on the recipient". This can be taken to mean that the place in which accounts may appear is shaped by a recipient and may arise where some form of interactional trouble is looming. Accounts have been shown to regularly occur in advice giving sequences in Cognitive Behavioral Therapy. Ekberg and LeCouteur (2015) have found that clients tend to cast their rejections as an inability to comply with the therapist's future proposals. They identified three different types of accounting practices following therapist offers of advice (e.g., how to better manage a daughter's behavior; proposing alternative ways to change own behavior; going for a walk after work, rather than drinking alcohol): appeals to restrictive situational factors (e.g., inability, not having the resources); appeals to a fixed physical state (e.g., being too tired); and assertions of previous effort to do what the therapist was proposing (e.g., the client had already tried it).

Watson and Greenberg (2000: 181) claim that clients in Emotion-focused Therapy are often hesitant to engage in task-related activities such as chair work for a variety of reasons. They may be overly cautious when asked to experience their feelings, they may be scared of losing control, and they may find the proposed task awkward and artificial or not to be relevant. These reasons for the clients' refusals of task-based activities are mainly taken from an "intrapersonal" perspective, what clients feel in certain situations. Our CA approach compliments this perspective by focusing on how opposition (whatever the etiology) is displayed publicly and interactively negotiated. We build on these findings gleaned from the application of CA research on discourses involving directives in general by here focusing particular attention to the relation between the therapist's deontic stance and epistemic positioning and the degree of success or opposition in negotiating chair work.

DATA

The overarching goal in this study is to identify and analyze the interactional resources used in therapy to achieve cooperative engagement with respect to challenging in-therapy tasks. In clinical practice there are a great variety of tasks that therapists may wish to get clients to do, for example: *in vivo* practices, rehearsals of physical behaviors (e.g., relaxing exercises), free association, etc. Each of these tasks has unique features that influence the structure of the interaction. In order to focus on the generic aspects of the process—how these negotiations are realized—we chose to focus on a single specific task and context: negotiating participation in chair work (CW) within

the framework of Emotion-focused/Process Experiential Therapy (Greenberg et al., 1993; Greenberg, 2004). Our data is drawn from the York I Depression Study (Greenberg and Watson, 1998).[2] Eight cases involving video and audio-recordings of clinically depressed clients undergoing emotion-focused treatment (6 females, 2 males) were made available to us. Four of the cases involved recovered clients and 4 were non-recovered. Cases were selected based on the following criteria: completeness of recordings (all sessions taped) and quality of recordings (i.e., best quality visual and audio).[3] The 5 participating therapists (all female) were experienced, trained and supervised in Emotion-focused Therapy/Process-Experiential treatment. For each case, we were supplied with three 1-h long videotaped psychotherapy sessions—from the beginning, middle and late phases of therapy—bringing our total number of sessions in our data to 21. Sessions from each phase were selected according to quality of recording and completeness (both audio and video recordings) rather than session number. Written informed consent was obtained from the participants for the publication of anonymized data. Persons referred to within therapy, including the client, have been given pseudonyms.

METHODS

In this project, we used the methods and conceptual framework of CA (Sidnell and Stivers, 2013), taking into account the standards for qualitative research as outlined in Levitt et al. (2018). Generally, CA aims to identify and describe recurring practices of social interaction (Sidnell, 2013), in which speakers are found to organize their turns at talking and their unfolding sequences of actions such as, for example, answers following questions and compliance following requests (Heritage, 2004). Much analytical energy is often used to illustrate the, sometimes subtle but highly relevant, variations within a practice or sequence, showing how a question or request may be designed in different ways (often having different implications for next response) and how a "recipient" of a first action has different choices of responding (Sidnell, 2013). CA analytic claims are made to abide by standards of *transparency* and *validity* (Peräkylä, 2004), which bear similarity to what has been called *trustworthiness*, a term that is used in other qualitative approaches (Levitt et al., 2018). Transcripts of talk of which analytic claims are based are published alongside the analysis, thus leaving the claims open to inspection and challenge by readers. Validity is gauged with respect to the 'next turn proof procedure', which argues that speakers display their understanding of a prior utterance and that the analyst's interpretation should aim to reflect that understanding (Sacks et al., 1974), and not deviate from it, for example, by offering a more abstract interpretation. Although CA studies often draw from a variety of "cases" (i.e., different sets of participants), the analytic focus is placed primarily on the recurring practice itself, irrespective of who specifically is participating in the social interaction. This is not taken to mean that the participants involved are not important or unique. Rather, the analysis seeks to draw attention to how certain interactional goals are regularly accomplished and the various trajectories used to (or fail to) get there.

Corpus Selection and Transcription

Authors 1 and 3 examined each of the sessions for the occurrence of chair work and found that 18 sessions contained this task-based activity. Although therapists and clients were found to commonly exit and then somewhat later re-enter chair work, we have restricted our focus to first-time entry within a session. These eighteen sessions containing an instance in which the therapist proposed chair work were then selected for further analysis. Each session was transcribed according to conversation analysis (CA) transcription conventions outlined in Jefferson (2004), and further guided by Hepburn and Bolden (2017) and Mondada (2019). Author 3 did all initial transcription work. Author 1 later re-visited all chair work segments and modified the transcripts where appropriate. For space and readability, extracts presented in this paper have been abridged and are slightly simplified versions of the original transcripts. The transcription conventions used in this paper are shown in **Table 1**.

Identifying Directive Sequences

Prior research has found that entering chair work in Emotion-focused Therapy (EFT) is regularly accomplished through four distinct interlocking interactional phases: (1) formulating the client's trouble; (2) recruiting participation in chair work; (3) readjusting the participation frame; (4) making contact (Muntigl et al., 2017). This current paper expands upon this earlier analysis by delving deeper into Phase 2 and, more specifically, by focussing on directive sequences in which therapists seek client agreement on subsequent engagement in chair work.[4] We trace how the therapist interactionally manages to engage the client's participation, especially in those contexts in which client agreement to engage in chair work is not immediately forthcoming or even contested. The method of identifying and selecting a corpus of directive sequences is taken from Muntigl et al. (2017). These sequences begin with a therapist's directive action and are completed when client ratification or refusal occurs. Ten sessions from 4 cases of this previous investigation were included in this study and 8 more sessions from 3 additional cases were then added (those containing chair work), applying the same method of identifying chair work phases and directive sequences. Author 1 did the initial sequence analysis and identification of proposal sequences into types. Authors 2 and 3 later re-visited the analysis by checking for appropriateness of sequence-type identification and by inspecting (and elaborating on) the turn-by-turn analysis.

[2]We are grateful to Drs. Greenberg and Watson for generously sharing the anonymized database of the York I study for our investigation.

[3]One case was not transcribed due to time and financial limitations, leaving our total corpus to 7 (3 recovered, 4 unrecovered).

[4]Especially when client agreement was not immediately forthcoming, therapists sometimes produced another (or multiple) proposal(s) to do chair work. Each proposal-response was taken as a separate sequence in this paper and, thus, our number of proposal sequences ended up being larger than the number of sessions analyzed (i.e., 18).

TABLE 1 | Transcription notation.

Symbol	Meaning	Symbol	Meaning
[	Starting point of overlapping talk	↓word	Markedly downward shift in pitch
]	Endpoint of overlapping talk	↑word	Markedly upward shift in pitch
(1.5)	Silence measured in seconds	.hhh	Audible inhalation, # of h's indicate length
(.)	Silence less than 0.2-s		
.	Falling intonation at end of utterance	hhh	Audible exhalation, # of h's indicate length
,	Continuing intonation at end of utterance	heh/huh/hah/hih	Laugh particles
?	Rising intonation at end of utterance	wo(h)rd	Laugh particle/outbreath inserted within a word
(word)	Transcriber's guess		
()	Inaudible section	hx	Sigh
wor-	Truncated, cut-off speech	∼word∼	Tremulous/wobbly voice through text
wo:rd	Prolongation of sound	.snih	Sniff
word = word	Latching (no audible break between words)	huhh.hhihHuyuh	Sobbing
<word>	Stretch of talk slower, drawn out	>hhuh<	Sobbing—if sharply inhaled or exhaled
>word<	Stretch of talk rushed, compressed	((cough))	Audible non-speech sounds
°word°	Stretch of talk spoken quietly	*italics (blue)*	Non-verbal behavior (actor indicated by initial)
word	Emphasis		
WORD	Markedly loud		

PROPOSAL SEQUENCES IN CHAIR WORK

From the directive sequences analyzed, it was found that most initiating directive actions functioned as *proposals*. These are actions that invite the recipient's involvement as opposed to presupposing or demanding it (Stivers and Sidnell, 2016) and position the recipient as both the agent and beneficiary of the action to be carried out (Clayman and Heritage, 2014; Couper-Kuhlen, 2014). With few exceptions, proposals were designed in a highly contingent manner (e.g., involving pre-, in-turn hesitation, heightened/softened pitch, deontic modality of "willingness" or possibility/choice, rising intonation, head tilting), orienting to the client's greater entitlement to decide over the suggested course of action. Turn features commonly referenced the shared nature of the task: "*we* could/should", "*we* can", "can *we*"), and client willingness: "would you be willing", "you need"). Proposals often included a deictic *that*/*this*, indexing a shared understanding of what "work" is being done.

Chair work involves the recall and re-experiencing of, in the present, issues that the client has had difficulties with.[5] As such, by its very nature, it is potentially stress inducing and the client may be reluctant to consent to engage. The degree of ensuing reticence or opposition poses different levels of challenges and requires different interactive resources to resolve or overcome. To explicate the relation between the degrees of client opposition/reluctance and the kinds of conversational resources used by therapists we subdivided the available examples from our database into three broad categories: *Smooth Entry*; *Mediated Entry*; and *Opposition to Entry*. Smooth entry (n = 5) involves sequences in which the therapist's proposal to do chair work around a specific conflict/emotion is followed by the client immediately endorsing the suggested project. Mediated entry (n = 15) is marked by delays in clients providing a response, prompting the therapist to do more interactional work to pursue eventual engagement in chair work. Opposition to entry sequences (n = 6) include client actions that challenge the value or validity of the intervention or that directly refuse participation in the activity. Although more than two-thirds of proposal attempts led to eventual engagement in chair work, in some cases chair work was abandoned following the client's opposition.

[5]Although clients must assume 'roles' in chair work (e.g., 'self' vs. 'significant other'; 'criticized self' vs. 'critic'), it is not a form of role-play (cf. Stokoe, 2014); that is, unlike role-play, which is about simulating 'real life' events, often used as a basis for training, chair work aims at re-creating the catharsis of the person's *real* past or "unfinished business".

Smooth Entry: Proposal Sequences With Affiliative Uptake

In the smooth entry examples, there was only one attempted turn at proposing chair work before the client agreed. Proposals were designed in a highly contingent manner (e.g., involving hesitation, heightened pitch, deontic modality of "willingness", rising intonation, head tilting), orienting to the client's greater entitlement to decide over the suggested course of action.

- **w- wudja** be **willing** to do it**?**
- ↑d'yu **wannu** uhm
- >so is that< something that you**'d like** *to try tuh (.) do:**?**
- ↑**wanna** work with that today**?**
- **.h** >so is that< something that you'd **like to try** tuh (.) do:**?** then is.hh **at least try** to **(0.8)** work toward:

Additionally, in smooth entry, therapist proposal turns commonly feature either a deitic "that" only or "that conflict" as something to work on, displaying that the therapist and client have come to a clear, shared understanding of the in-the-moment conflict. This feature can also frequently be found in

EXTRACT 1 | Owen.

Case 315.9/2C

1	Ther:	so it's.hh a lot of conflict there in terms of.h (0.4)
2		do I want it, am I ready::,
3		(1.8)
4	Ther:	en-th- en we kno:w,(0.4) also from (.) previous times
5		it's a s'rta lo:nging,
6		(0.2)
7	Owen:	+°yeah.°+
	o	+nods---+
8		(0.5)
9	Ther:	*mm hm.
	t	*slow nods-->
10		(3.5)*
	t	slow nods-->*
11	Ther:	**°m?° * ↑wanna work with that today?**
	t	*tilts head, raises eyebrows-->
12		(0.3)
13	Owen:	**+I think so yeah.**
	o	**+nods-->**
14	Ther:	*mm hm.*
	t	*nods--*
15		(0.3) +
	o	nods-->+

turns proceeding agreement, and after previous more extensive turns have been made in scenarios with dissent or rejection.

- so we can work with **that** some more today?
- >so is **that**< something that you'd like *to try tuh (.) do:?
- ↑wanna work with **that** today?
- .hhh is **that conflict** something that (.) we should (.) spend some time on?"

A sequence of smooth entry with the client Owen, who is a student that is also working part-time, is seen in **Extract 1**.

In lines 1–5, the therapist orients to Owen's dilemma by reformulating Owen's description of his desire for and uncertainty about wanting a relationship as a source of conflict and connecting it to previous discussions as "a s'rta lo:nging,". Following this, Owen affiliates with this formulation through verbal acknowledgement and nodding (line 7), leading the therapist to first confirm Owen's acknowledgement and then, in line 11, to produce a proposal: "°m?° ↑wanna work with that today?". By targeting the client's 'willingness' (i.e., wanna), the therapist orients to the client's greater entitlement to decide over the suggested course of action. What is implied through this turn format is that Owen will not only play an agentive role in the impending action, but will also be a beneficiary of the action; that is, what is being suggested will have therapeutic gains for the client. Her granting Owen the prerogative to proceed or not is also designed in a highly contingent manner, involving hesitation, heightened pitch, rising intonation, and head tilting. Owen's verbal response of "I think so yeah.", while nodding (line 13), occurs smoothly and quickly and endorses the therapist's proposal for chair work.

Beginning chair work with a different client, Lisa, is shown in **Extract 2** and illustrates how a therapist adds more specificity to their proposal, indicating right from the start whom the chair work will target and that the activity will be beneficial.

In line 3, the therapist begins to put out her proposal while pointing to the empty chair, which provides some clarity regarding what the therapist will be directing the client to do. Then, in line 5, the therapist continues by mentioning the value (helpful) and the aim (t-to- bring (.) your parents, (0.2) °here.°) of chair work. Contingency is displayed via mitigation (might be) within turn pausing, a proffering gesture with the hand and head tilting. Agreement/compliance occurs in line 8, both vocally and non-vocally. Lisa's response is pro-social, thus affiliative, and endorses or aligns with the activity in progress (leading up to chair work).

Mediated Entry: Therapist Practices for Pursuing Engagement

For most proposal sequences examined, client compliance was not immediate, but deferred. This delay in responding was often signaled by pauses (silence) on the part of the client and by non-vocal actions that could be interpreted as a form of disengagement with the therapist's suggested course of action. In contexts of silence following a proposal, we found that therapists would pursue compliance, not by immediately offering another version of the proposal (cf. Davidson, 1984), but through a variety of interactional practices that highlighted the contingencies associated with making the proposal and the client's upgraded entitlements in deciding the future course of action. In some of the cases, we observed that therapists would put direct pressure on clients to respond (and by implication accept), whereas other practices worked in a more subtle fashion by

EXTRACT 2 | Lisa.

Lisa Case 306cs.11

```
1          (0.5)
2   Ther:  *°somehow it wasn't the right ti-°.hhh
    t      *extends fingers-->
3          ↑d'yu wannu uhm
    t      *splays hands in front, turns head, points to chair out of frame*
4          (    1.8   )*
5          *it might be helpful +tuh- (.) *t-to- bring(.)+    *
    t      *brings hand across-----------*turns to C. palm up C.*
    c                          +gaze forward---------+ gaze to T-->
6          *your *parents, (0.2)°here.°+
    t      *gaze and splayed fingers toward C.-->
    t               *tilts head to C-->
    c      +gaze to T.---------------+
7          (0.4)
8   Lisa:  +mkay              +
    c      +gaze forward, nods+
```

adding more background or relevant circumstantial information to the proposal, making the rationale behind the proposal more transparent. Four practices were identified: (1) Offering an "or" alternative (n = 2); (2) Providing an account (n = 6); (3) Elaborating on the conditions for proposing the activity (n = 4); and (4) Requesting confirmation (n = 3).

"Or" Alternative

When confronted with a delay following a proposal, therapists had the option of appending an *Or*-prefaced alternative to their turn. This practice is seen in **Extract 3**, during which the therapist attempts to engage the client Jennifer in chair work.

Following the therapist's proposal (line 1), there is a significant 1.2 s pause during which Jennifer gives a shallow nod. The therapist then, in line 3, appends an *or* onto her prior turn, which functions in a couple of ways. First, it treats Jennifer's nod as insufficiently displaying acceptance and, second, it gives Jennifer an opportunity to suggest an alternative course of action–thus obviating the need for her to refuse the therapist's proposal if need be–and downgrades the force of the proposal. Further, the extension of the therapist's hands, as an open hand supine (OHS) gesture, toward the client may be seen as an offer (Kendon, 2004) and works to reinforce the downgraded deontic stance set in motion by the stand-alone *or*. Following no response from the client, the therapist continues her turn by supplying an alternative course of action (line 5) and this then immediately receives acceptance by Jennifer of the therapist's original proposal of line 1.

In a study of polar question sequences, Drake (2015) found that turn-final *or* in these sequential environments would index a downgraded epistemic stance or "a lack of commitment to the expressed proposition" (p. 305). This is because this kind of turn format torques preference structure in favor of disconfirmation and opens the floor to possible alternatives. For proposal sequences, however, the orientation is not toward propositions or epistemics, but rather to deontics and the 'orchestration of action' in terms of offers, directives, requests, etc. But otherwise, the function appears to be similar. *Or* in these sequential environments, as shown in **Extract 3**, may be seen to index a downgraded deontic stance in which the client's obligation to comply is mitigated. Space is given to clients to consider alternative responses and, further, an opportunity to refuse (respond with a dispreferred alternative) is created. Additionally, the *Or*-prefaced alternative may ease up the pressure of complying, making it less difficult for clients, such as Jennifer, to deflect the challenging task of chair work.

Accounting

Another therapist practice dealing with delays in responding is *accounting*. These were found to come in two basic formats: Providing an explanation for how the proposal may benefit the client; Providing a justification that highlights the importance of doing chair work. In **Extract 4**, the therapist is attempting to get Sofia to speak with her father and her turn orients to contingency and, following no response, provides an account that explains how engaging in chair work may help her to work through her pain.

The therapist's proposal in lines 5 to 9 is packaged with many features of contingency: a beginning proposal that is self-repaired (line 5), formulating the activity as an *experiment*, modality of ability (*could* express), willingness (would you be willing to) and non-vocal actions (head tilt, extending left hand to side). Following a brief pause in line 10, which signals potential rejection, the therapist continues with an account that indicates the benefits (give you a chance< to work...) and rationale (still seems to be very (.).hh painful, for you) of chair work. There is a significant delay in Sofia's response (line 14) and she also seems to bodily disengage from the therapist by gazing upward and away from the therapist. She then initiates an other-repair, requesting the therapist to clarify the details surrounding her proposal. It would appear that there remains some doubt regarding which painful feelings in relation to her father the therapist is referring to, leading Sofia to this other-repair request in which she seeks confirmation as to whether it was the event pertaining to her father's death. After the repair

EXTRACT 3 | Jennifer.

Jennifer 428 12/2C

```
1   Ther:   *so we can work with that some more today?
       t:   *raises eyebrows-->
2           (+        +  1.2     *)
       j:   +shallow nod+
       t:       raises eyebrows-->*
3   Ther:   or
4           *(2.6)
       t:   *extends hands - open hand supine - to J
5   Ther:   pick up (0.9) anything else? thet
6    Jen:   oh no +this is very interesting+
       j:        +raises eyebrows, looks up/down-->
7           °[I have nothing] come up.°
8   Ther:    [mm * hm *   ]
       t:        *nods*
```

sequence is resolved (not shown in the extract), Sofia does eventually concede to the proposal.

An account that provides a justification for the importance of doing chair work is illustrated in **Extract 5** with the client Jennifer.

During the therapist's proposal in line 7, Jennifer only partially bodily engages with the therapist by looking down and turning her face toward her. After a brief pause, the therapist provides a justification by first mentioning the significance of doing the activity (I think that's important) and then proceeds to indicate why it would be important to do. During this time, the client expresses token affiliation through repeated nods and, toward the end of the account, the therapist draws closer to the client, decreasing the physical space between them. Because proposals for chair work involve a fair degree of emotional commitment and involvement from the client, it may not always be easy for clients to readily comply. Thus, in contexts where clients appear hesitant or reluctant, further explanation and justification may be helpful in reassuring clients of the potential value or benefit of doing this activity.

Elaborating

In the following excerpt we illustrate the practice of elaboration by the therapist. In entering chair work, there are many details to work out. These range from setting up a new spatial arrangement to perform the task to launching a new participation framework in which the actor roles are to be established. Thus, another way to pursue acceptance to the proposal is to elaborate on these conditions by adding more specificity to what is going to happen. This is illustrated in **Extract 6** with the client Ernie.

The therapist is proposing two-chair work in which Ernie begins a dialog by acting out two different sides of himself. There are numerous expressions indexing contingency (can do; you feel would be useful; actually; sort've (0.5) differentiating) and thus an orientation to the client's greater entitlement to ratify the activity. Toward the end of the proposal, lines 5–6, the therapist pauses at points where the client could offer some form of non-vocal token affiliation (by nodding, for example) concerning the two sides that he had just previously described, but does not. Further, although the therapist references these two sides, he does not specify what they are. A silence occurs in line 7 that may imply an impending rejection, but the therapist grabs another turn-taking opportunity in order to elaborate on the two sides. First, the therapist adopts a downgraded deontic stance through evidential markers (that's what I'm hearing) and by checking her understanding (if that fits with what you're experiencing), thus allowing the client to take up upgraded epistemic and deontic rights. Next, the therapist adds more *granularity* to her prior description (Schegloff, 2000) by adding more specificity to what these two positions consist of ('not ready yet' vs. 'just wants it to be dealt with'). The therapist also orients to contingency non-vocally in line 8 by animating her hands in a palm up position, suggesting that what she is proposing is a possibility and that the final decision (deontic authority) will rest with Ernie. The client then voices his confirmation of his inner conflict in line 12.

This practice of elaborating and of making descriptions more granular is, we would argue, being done in the service of securing client affiliation. Just as with Stivers' (2008) observations on story telling, in which tellers make their descriptions more granular to provide recipients with more access to the event in question, thus allowing the recipient an opportunity to affiliate with the telling, so do therapists make their proposals more granular to better specify the conditions surrounding the proposal and help clients to better understand what will be required of them.[6]

Seeking Confirmation

The fourth way of dealing with delays following a proposal was the therapist practice of seeking confirmation after the delay. Confirmation seeking appears in various turn formats such as "that's o↑kay?", "is that alright?", "what you think about that.", "yeah?". Confirmation seeking is shown in **Extracts 7** and **8**.

In **Extract 7**, following a 1 s silence in line 3, the therapist seeks confirmation with turn-final rising intonation "that's o↑kay?", which is followed by a brief pause without any

[6]For practices of making descriptions more granular in psychotherapy/storytelling activities, see Muntigl et al. (2014).

EXTRACT 4 | Sofia.

Sofia 304.07/2C

```
 1   Sofi:   she was'uh (0.2) hospitalized.
     s       nods, gaze to T-->
 2           (0.2)
 3   Ther:   uh huh,
 4           (0.3)
 5   Ther:   t.hh ↑would you be? (0.2) + how wudja feel about=I mean
     s                                 + tilts head-->
 6           it's still? (0.2) you have a lot of feelings, when
     t        motions hands inward
 7           you talk about (0.2) <your father.> .hh en (0.2) would you
 8           be willing to (1.5) actually try an experiment where you
     t                                  extends left hand to side
 9           could express some of these feelings toward him.
10           (0.2)
11   Ther:   .hhh °j'st°=tuh get you:: >give you a chance< to work (.)
12           some of this (0.5) this °stuff° ↑through=because it still
13           seems to be very (.) .hh painful, for you.
14           (3.4)
     s       straightens head, raises eyebrows, gaze upward-->
15   Sofi:   <when my father died?>
     s       scratches leg, lowers chin, directs eyes upward toward T-->
16           (0.3)
17   Ther:   uh huh.
```

client acknowledgement and, in line 6, two more confirmation seeking expressions (`to do that?; yeah?`). Ernie, in line 7, produces overlapping acceptance. In **Extract 8**, a 1.3 s silence follows the proposal. Then, as in **Extract 7**, the therapist seeks confirmation with turn-final rising intonation (`>is that alright?`), which receives immediate confirmation from the client Paula.

According to Stivers and Rossano (2010:27), directive actions such as requests and offers are "high in response relevance", meaning that they strongly mobilize a response from the recipient. Further resources that consist of lexico-grammar, prosody, gaze and epistemic domain (i.e., recipient's degree of/access to knowledge) play a crucial part in strengthening or weakening response relevance. Clients nonetheless sometimes delay their response and one therapist technique for increasing response relevance, as shown in **Extracts 7** and **8**, is to append a confirmation seeking tag after a prolonged silence. This puts further pressure on clients to respond and, as these extracts illustrate, it is met with success.

Opposition: Managing Client Explicit Refusals

A step up from delaying the response to a proposal, and thus expressing impending rejection, is to explicitly *do* a refusal. Two practices of refusing were found in the data: Questioning the authenticity of the activity–refusal by implication–and direct refusals.

Questioning the Authenticity of the Activity

Participating in chair work requires that clients are ready to experience and engage with their emotions in the presence of an imagined other or conflicted self. According to Watson and Greenberg (2000: 181), "they [clients] may find the activities required of certain tasks too artificial and contrived, and feel silly performing them, for example, when asked to talk to an empty chair." **Extract 9** shows a client's difficulty in accepting and going along with the 'imaginative' aspect of chair work.

In this instance of pre-chair work, the therapist is proposing that Ernie express his emotions to his imagined-in-the-moment ex-wife. The therapist's proposal contains a number of turn design features that cast it as unmotivated and conditional on the client's interest: "`throw that out again as a possibility`" (lines 1–2); "`if that would yihknow work at some point`" (line 7). The many pauses, the term "`possibility`", the expression "`where you feel you're at`" and conditional *if* all work together in constructing this proposal as highly contingent on the client's acceptance, but also display a moment-by-moment orientation to his lack of affiliative displays. For instance, Ernie does not only refrain from accepting at numerous places where he could have, but he also delivers muted agreement that is accompanied by non-vocal actions that signal displeasure and disengagement (line 8) and a long whispered in-breath possibly displaying distress (line 10). In response, the therapist immediately follows up with one more attempt in which she orients to Ernie's potential willingness ("`wanna give that a whirl`"). Following no response from Ernie, she then solicits an assessment (and confirmation) from him pertaining to her suggestion to do chair work ("`> I dunno what< you think about that.`") and, later in line 15, provides more granularity (Schegloff, 2000) to deictic *that* by elaborating with "`that ide:ah`".

At this point, Ernie's refusal becomes more overt. He shakes his head in line 15 and then, following a few pauses and

EXTRACT 5 | Jennifer.

Jennifer 428_18/2C

```
 1   Ther:   so how d'yah end up being silenced.
 2           (1.3)
 3   Jen:    hhh
 4           (3.7)
 5   Jen:    fear.
 6           (1.1)
 7   Ther:   *hh can we work with +the chairs a little bit with that?+
     t       *begins to get up, moves out of frame to get chair-->
     j               looks down-->+turns face toward T--------------+
 8           (0.2)
 9   Ther:   +cuz I think that's important.
10           (6.2 +            +)
     j           +shallow nods+
11   Ther:   *there's the part of you (0.5) that (.) has (.)
     t       >>returns to frame, sits in new chair, gaze to C-->
     j       >>arms crossed on stomach, gaze to chair-->
12           *so much more to say + (0.6) then she ever says.
     t       *leans forward-->
     j                     +opens mouth, shallow nods-->
13           (1.2)  +
     j       nods-->+
```

a "tch", he grammatically ties his turn to the therapist's (line 13) by offering a parallel claim of uncertainty about engaging in chair work ("I don't know either"). In line 21, Ernie makes his discomfort explicit by pointing out the artificiality of the proposed task: "it seems a little contrived I-I-I-I °uh w° yihknow,". In lines 22 and 25, the therapist displays affiliation with the client's initial reluctance by a number of acknowledgement tokens (mm hm), nodding, smiling and then by producing a formulation that endorses Ernie's unease concerning the artificial quality of the proposed activity ("so something not quite uh: real about it"). These therapist actions, which work to re-affiliate with the client's opposing viewpoint, engender a movement toward realignment with the activity (see also Muntigl et al., 2012; Muntigl et al., 2013). The realignment is successful, and Ernie voices his willingness to comply (lines 29–30). This extract not only illustrates the level of attention required to track subtle non-vocal indicators (a shift in gaze, pausing), but also how the therapist responds to this by downgrading her epistemic position responsively (what< you think about that.). This shift can work to facilitate the client's explicit expression of his refusal to engage in chair work *in the moment* but, importantly, preserves the alliance (but [I mean I] I'm I'm open to anything) suggesting that the momentum in therapy, which was at risk, is not interrupted.

Direct Refusals

Clients may also directly refuse a therapist's proposal with an unadorned "no", as illustrated in **Extract 10**.

Following the therapist's proposal to do chair work, lines 1–3, a silence ensues, which may be rejection implicative. The therapist smiles in line 4, which may be working to gain an affiliative return smile from the client (Bänninger-Huber, 1992), and then she produces a subsequent version of the proposal (Davidson, 1984), one that, because it more directly seeks confirmation, is more highly response relevant (Stivers and Rossano, 2010). Following a brief pause, Paula refuses ("no:") and then quickly laughs while smiling. The therapist, in line 5, returns Paula's smile, repeats the "no" and then seeks an account from Paula that explains or justifies her refusal. After silences and hesitation, Paula provides an account and the talk turns toward the father and the difficulty that Paula has in facing him in the chair at this moment in time. Unlike some of the other proposals shown previously, this proposal format lacked a clear orientation to contingency and to the client's greater entitlement to give assent, but it also seemed not to display an elaborately articulated description or reformulation of the client's trouble with the father. But by pursuing an account from the client, although the therapist was not able to get Paula to engage in chair work, the conversation was still able to shift toward a clearer focus on the father and some of the emotional difficulties surrounding her relationship with her father.

DISCUSSION

In-therapy tasks form a ubiquitous component in diverse forms of psychological treatments. They may range from free association (Freud, 1940) and chair work (Greenberg, 1979; Hill et al., 2012) to relaxation exercises and desensitization experiences (Russell and Lent, 1982). The rational for each of these tasks and the expected benefit varies, but in each case, the client is invited to engage in an activity that has the potential of inducing anxiety or stress, and therefore opposition. Refusing to engage in a task is doubly problematic for the progress of therapy. Clients may not only miss the opportunity to benefit from the proposed activity, but also refusal or avoidance may induce

EXTRACT 6 | Ernie.

Ernie 422.9/2C

```
1   Ther:   en.h *(0.3)something we can do here, if (.) if this
    t       *looks at, touches nails, gaze away from C-->
2           is something *you feel would be useful.h is*
    t               *looks at C-----------------*
3           *and this would be involving using the chairs
    t       *directs hand, gaze to chair not yet in frame-->
4           *actually is (0.4)   + *is sort've (0.5) differentiating
    t       *gaze down, rubs nose* makes separating motion->
    c                           +gaze toward not present chair-->
5           those two: (.) *sides? of yourself that (0.7)
    t       *gaze to C-->
6           uh::m (0.4) y:ou've described
7           (0.7)
8   Ther:   **°that's° that's what I'm hearing.* >if that fits with
    t       *palms up-------------------------* animated hands-->
9           **what you're experiencing < is there's.h part of you:
10          **that's not ready yet. to deal with it and there's another
11          **part of you that just wants it to be dealt with? and
12  Ern:    +tch that's right.
    e       +turns head, gaze to T-->
```

EXTRACT 7 | Ernie.

Ernie 422.9/2C

```
1   Ther:   right, (.)* and if we (.) * try that here?'en     *
    t           *hands on knees *hands up, forward & back*
2           uh* I'll sit over there. (.)      *
    t         *looks and points to 3rd chair*
3           *like we've done this before? (0.2) + and .h *just (1.0)         *
    t       *looks at C.--------------------------------* extends had to 3rd chair*
    e                                       +tightens lips-->
4           **that's o↑kay?
    t       *looks at C.-->
5             (0.4)+
    e       lips-->+
6           **to [do that?*  yeah? ]
7   Ern:      +[yeah+ (.)+ I think-]+think so=
    e         +nods-+               +gaze forward
    e                     *gets up to bring in second chair-->
8   Ther:   *=ya'think so.  (0.2) okay. (0.2)
    t       *looks back toward C.-->
```

relational stress between the therapist and client, which may further precipitate an "alliance rupture". If clients are opposing engagement with the task proposed by the therapist, they are evidently not in agreement about what is useful/desirable to do in the moment (Safran and Kraus, 2014).

There is an extensive literature examining the *reasons* clients might choose to contest therapists' directives in different contexts (Beutler et al., 2002). We endeavored to compliment this literature by examining the sequential process and the discursive challenges associated with getting a "yes" to proposals of an in-therapy activity. From this perspective, we hoped to take some first steps to discover how certain conversational resources (within a specific sequence type) used by therapists can facilitate client engagement and overcome obstacles of mis-alignment. We began our investigation by first examining extant research on discursive practices on directives in general (e.g., Couper-Kuhlen, 2014; Landmark et al., 2015; Stevanovic and Svennevig, 2015; Kendrick and Drew, 2016). This literature alerted us to the importance of the deontic stance of the person wishing to direct another and the implicit and explicit position of power and authority of the proposer in relation to one who is asked to do something. From our previous work on relational negotiations we also knew that the epistemic claims/position of the prior interaction (getting agreement on the problem that requires task-based work) are likely to play a role in negotiating participation (Muntigl et al., 2017). Thus, it would seem that a lack of intersubjective alignment on the client's emotional troubles – negotiated in phase 1 of chair work entry – might lead to hesitation and rejection,

EXTRACT 8 | Paula.

Paula 312_10/2C

```
1   Ther:   >°cu-°< (0.2) * ↑I wanna try some thing, °if that's okay?°
    t       points finger *nods, raises brow, gets up to get chair-->
    p                                          smiles, uncrosses legs
2           (1.3)
    t       gets & brings in chair, walking backward, back to P-->
    p       legs forward, hands separated on lap
3   Ther:   >is that alright? (cuz I'm gunna=)<
    p       straightens skirt
4   Paula:  =sure.
    p       smiles, tilts head
5           (1.3)
```

EXTRACT 9 | Ernie.

Ernie 422.9/2C

```
 1  Ther:   .hh ^so I've^ *(0.5) throw* that out again as a
    t                     *mimes throw*
 2          possibility and'uh:
 3          (1.3)
 4  Ther:   °uh:m°
 5          (0.4)
 6  Ther:   yihknow, we can see today where (1.3 +)*where you feel you're
    c            +gaze to T-->
    t              *gaze to C-->
 7          at. and if that would (0.8)[yihknow] work at some point,
 8  Ern:                              [°kay°  ]
    e       >>downturned mouth-->   +gaze to hands-->
 9  Ther:   [if yer (0.9) if you (.)] wanna give that a whirl
10  Ern:    [°.hhh°                 ]
11  Ther:   *and see what happens? er
    t       *gaze to chair-->
12          (0.6)
13  Ther:   *> I dunno what < you think about that.
    t       *extends hands out, gaze forward/to E, leans forward-->
14          (0.8)
15  Ther:   +that ide:ah,+
    e       +shakes head-+
16          *(0.6 )*
    t       *smiles*
17  Ern:    tch
18          (0.6)
19  Ern:    I don't know either,=°°I°° °i-it° uh:m
20          (6.2)
21  Ern:    it seems a little contrived I-I-I-[I °uh w°]
22  Ther:                                     [*mhm:.  ]
    t                                          *nods-->
23  Ern:    yihknow,(0.2) uh:m (0.7) hihm (0.2) s:huh
    e       +gaze to T, wide smile-->
24          + [what e(h)l(h)se]* can I sa(h)y[(hh.Hih)]
    e       +extends arms out-*
25  Ther:   [ mm hm:          ]           *[mm hm. *]
    t                          nods-->*smiles*
26  Ther:   [so something not quite]tuh: real about it, er it's
27  Ern:    +[hihuhuh    hh    ]     +
    e       +gaze forward, peaked hands to mouth--> +stops smiing-->
28  Ther:   [sort've] uh
29  Ern:    [yeah]
30  Ern:    [yeah] but [I mean I] I'm I'm open to anything
31  Ther:   [.h    ] [yeah,    ]
```

EXTRACT 10 | Paula. Paula 312_9

```
 1   Ther:   en I was thinking,.h (.) it might be good (0.3) <to go back>
     t                    gaze upward                                gaze to P
 2           to working the way we once did (.)+ a few weeks ago with (.).hh (.)
     p                    + smiles-->
     t                                                    extends hand,smiles
 3           bringing your father into the room,
 4           (0.7)
     t       smiles
 5   Ther:   ju-would that feel comfortable to try that again? I?
 6           (0.4)
 7   Paula:  no:         [hhih heheheheh] [.Hh h     ]
     p       turns head. broadens smile, tilts head, finger to cheek-->
 8   Ther:               [hh::          ] [no, because,]
     t                   raises chin, smiles-->
 9   Paula:  hhhh
     p       smile fades
     t       smile fades
10           (2.8)
11   Paula:  °.h°
12           (4.0)
     t       gaze @ P, fidgeting with hands
     p       gaze @ floor, hand on cheek
13   Paula:  ↑oh because I'm just so:, I'm just- I- I'm so angry
             about all these ↑things because I realized, (1.1)
             that it affects me so much no:w, (0.7) like (2.7) I I really don't kno:w
             like what he:, (2.1) what he ↑wa:nted from me like.h
```

and also requires that the therapist do more accounting and elaborating.

To highlight and focus on the *process* of negotiation in therapy and how therapists deal with opposition or deferral, we chose to restrict our data to one specific task and context: Negotiating chair work in Emotion-focus therapy provided to clients diagnosed with depression. Our hope was that this narrow focus would permit us to more clearly identify the discursive practices that therapists successfully use to resolve incrementally more challenging levels of opposition to a proposed activity. From our corpus of proposal sequences, it was found that in the majority of cases acceptance was not immediate and that clients displayed some form of dissent via delays in responding or by more explicit refusals. Similar to the findings on directives in general (non-institutional) contexts, we found that successful negotiations involved therapists hoping to recruit clients to do chair work taking a flexible and appropriately responsive deontic stance. In smooth entries, the therapists' proposals were developed using tentative, contingent forms such as "like to try", "would you be willing to", "wanna?", "at least try". Therapists also realized a distant non-authoritative position to the topic identified just prior to chair work using deictic forms such as "that" to refer to the topic. This served to downgrade the therapists' epistemic stance and signaled deferment to the client's authority and agency to formulate the content of chair work. Enfield and Sidnell (2017) have argued that the locus of agency is not in the individual, but rather in the social unit. Thus, as the goal of achieving alignment on a task is shared by the therapist/client dyad, the interplay of resources drawn on from both participants work to jointly accomplish future action/behavior. Proposals implicate that the activity to be done is collaborative, needing both participants to control how it will unfold. Contingent formulated proposals further orient to this shared and distributed agency by allocating more responsibility to the client, to confirm what is to happen next.

We provided examples of how silence, delay, or shifting of gaze can indicate opportunities for the therapist to engage with the clients' subtly expressed opposition/reluctance. For example, in **Extracts 7** and **8** the therapist responded to these minimal clues and sought confirmation and, thus, created an opportunity for the clients to either topicalize their concerns or objections or shift their position toward engagement. We noted the use of "or" as a way of offering/prompting the client to formulate or re-define the task. Therapists facing some level of reluctance also engaged in "accounting" or an elaboration and extension of the rationale for engagement in the task without directly re-iterating the request. These observations point to the utility of CA work in showing, for example, how speakers are not only constantly monitoring each other's states of knowledge (or even their willingness to participate in a future activity), but are adjusting their contributions in response to these epistemic (and deontic) shifts (Goodwin, 2018). Importantly, in successful negotiations resulting in eventual engagement, therapists were sensitive to prosodic, non-verbal, as well as verbal indications of opposition or hesitation by the client. Thus, the therapists' actions are not static, but often were modified, sometimes even

mid-turn. What is shown in these exchanges is how therapists responsively shift their deontic positioning during moments in which acceptance is not forthcoming. This kind of moment-to-moment sensitivity closely parallels the positive therapist attribute of "Appropriate Responsiveness" discussed by Stiles and Horvath (2017).

LIMITATIONS

Our sample of proposal/response sequences was relatively limited in size. Although we have been able to identify a variety of ways in which clients (implicitly) contest therapist proposals and therapists manage such reluctance/opposition, there are likely other resources and actions that could be doing this kind of interactional work. We did not attempt to canvass the variety of in-therapy tasks, nor did our data cover diverse treatments or a variety of psychological problems. The goal of this research was to examine practices to overcome/negotiate opposition to a challenging in-therapy task in a somewhat typical context. We anticipate that different tasks in different treatments will have some unique features not evident in our examples. However, the focus of this initial investigation was on aspects of negotiating dissent that we felt are likely shared with a range of challenging in-therapy activities in other contexts.

Working with active and passive reluctance/opposition has an enormous heritage in the literature, both theoretical and empirical. However, relatively little systematic research is available that focuses on how this dynamic is managed successfully as an interactive social achievement. The research we present offers an initial foray in identifying the conversational resources that are sequentially developed, both in clients taking a reluctant position and the ways in which such impasses may be resolved in therapy. A better understanding of how delayed engagement or refusals to perform in-therapy tasks are managed has a potential of making a practical contribution to therapist training and development.

CONCLUSION/RECOMMENDATIONS

Our sample of directives to engage in chair work essentially captured "cooperative" negotiations. Even when engagement in chair work was refused, therapists and clients were able to manage reluctance to engage, repair the drift in task consensus, and maintain a collaborative momentum in therapy. An essential clinical practice in successfully managing reluctance to do chair work seems to be the development of a clear and shared understanding of what the conflict is *before* proposing the directive to engage. Such clarity generates an opportunity to use the deictic "that" as a reference point in the proposal and clarifies the potential benefits of doing chair work, as well as the risks of engagement. Taking a tentative flexible deontic stance creates generous opportunities for the therapist to find a collaborative position wherein clients may assume an agentive role and makes the proposal work for them. Likewise, careful attention and respect to the clients' epistemic authority, supporting their awareness and expertise of their own issues and capacities, creates a context where the therapist can advocate the activity while the client feels supported and entitled to make choices.

Collaborative negotiations are typically responsive and incremental. Therapists approach the proposal to do chair work in an open ended, flexible way by developing an "or" position, seeking ongoing confirmation as the negotiation proceeds and being open to elaborate on and account for the rationale. This flexible/responsive approach is not only more likely to be productive in terms of engagement in the proposed work but will more likely preserve the alliance and therapy momentum if the client refuses to engage in the activity. Our CA study focused on recurring practices that generalized across cases. Future research on this topic using larger data sets (i.e., more sessions) might examine 'typical' practices occurring within a case and compare practices between cases and relate sequences of smooth vs. mediated entry (and opposition) with outcome and alliance measures.

DATA AVAILABILITY STATEMENT

All datasets presented in this study are included in the article/supplementary material.

ETHICS STATEMENT

The study involving human participants was reviewed and approved by the Simon Fraser University Research Ethics Board. Written informed consent was obtained from the participants to participate in the York I study and for the publication of anonymized data.

AUTHOR CONTRIBUTIONS

PM wrote the analysis and produced the final edited manuscript. AH wrote Introduction and Conclusion. LC transcribed the chair work extracts, identified initial set of directive sequences, and provided copy editing. LA supplied the videorecorded sessions and helped to work on the content of the manuscript. All authors contributed to the article and approved the submitted version.

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Positioning Shifts From Told Self to Performative Self in Psychotherapy

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According to Positioning Theory, participants in narrative interaction can position themselves on a representational level concerning the autobiographical, told self, and a performative level concerning the interactive and emotional self of the tellers. The performative self is usually much harder to pin down, because it is a non-propositional, enacted self. In contrast to everyday interaction, psychotherapists regularly topicalize the performative self explicitly. In our paper, we study how therapists respond to clients' narratives by interpretations of the client's conduct, shifting from the autobiographical identity of the told self, which is the focus of the client's story, to the present performative self of the client. Drawing on video recordings from three psychodynamic therapies (*tiefenpsychologisch fundierte Psychotherapie*) with 25 sessions each, we will analyze in detail five extracts of therapists' shifts from the representational to the performative self. We highlight four findings:

- Whereas, clients' narratives often serve to support identity claims in terms of personal psychological and moral characteristics, therapists rather tend to focus on clients' feelings, motives, current behavior, and ways of interacting.
- In response to clients' stories, therapists first show empathy and confirm clients' accounts, before shifting to clients' performative self.
- Therapists ground the shift to clients' performative self by references to clients' observable behavior.
- Therapists do not simply expect affiliation with their views on clients' performative self. Rather, they use such shifts to promote the clients' self-exploration. Yet, if clients resist to explore their selves in more detail, therapists more explicitly ascribe motives and feelings that clients do not seem to be aware of. The shift in positioning levels thus seems to have a preparatory function for engendering therapeutic insights.

Keywords: psychoanalysis, conversation analysis, positioning, interpretation, psychotherapy, social interaction, self

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INTRODUCTION

The self is far from being a unified notion (e.g., Neisser, 1988). This holds also true for different facets of the self, which may be at issue in social interaction. As Bamberg (1997), Lucius-Hoene and Deppermann (2004), Bamberg and Georgakopoulou (2008), and Deppermann (2015) have argued, positioning of selves in narrative interaction can occur on at least two levels: A representational level concerning the autobiographical, told self, and a performative level concerning the interactive and emotional self of the teller. The performative self usually is much harder to pin down, because it is non-propositional and enacted. In everyday interaction, it is unusual to explicitly describe aspects of the partner's performative self. Psychotherapy is different: in their interpretations, therapists regularly topicalize aspects of the performative self explicitly, in particular those that the client does not seem to be aware of, but may offer insights into the client's problems. One environment in therapist's responses shift to the client's present performative self are autobiographical narratives by the client that serve to support a certain identity claim made by the client.

Such shifts are sensitive moments in the therapy. They imply that the therapist claims epistemic authority concerning the client's current feelings, motives, or the interpretation of their behavior. This is in contrast to the usual assumption in Western cultures that the subject has privileged access to the self (Heritage, 2011; Gertler, 2020). Drawing on video recordings from three psychodynamic therapies (*tiefenpsychologisch fundierte Psychotherapie*) with 25 sessions each, in this paper, we analyze five extracts in which the therapist's interpretation shifts to the performative self of the client in response to a client's story. We first introduce Positioning Theory as an approach to conceptualize and study the self in (narrative) interaction on the basis of audio and video recordings (section Positioning in Narrative Interaction). Section Client's Self-Positioning and Therapist's Shifts to the Performative Self lays out the generic sequential structure of episodes in psychotherapy in which therapists shift from clients' autobiographical narratives to their performative self, including the ensuing negotiation of therapists' interpretations by both parties. After a description of data and methods used in this study (section Data and Methods), the main body of the paper is devoted to the in-depth analysis of five extracts in which therapists shift to the client's performative self in their sequential context (section Shifts to the Performative Self in Psychotherapy: Five Exemplary Cases). Section Conclusion summarizes and discusses the findings with respect to their import for psychodynamic therapy.

POSITIONING IN NARRATIVE INTERACTION

Narratives are the primary mode of self-reference in psychodynamic therapy (Boothe, 2004, 2010). Clients tell biographical episodes, recent events, dreams, etc. Yet, already early on, the psychoanalytic talking cure has involved not only recollection but also the focus on the client's repetition of entrenched behavioral patterns in the therapeutic situation (Freud, 1924[1914]). More recent approaches to psychoanalysis highlight this interactive dimension of psychotherapy as being crucial for change (Streeck, 2004). Well-known psychoanalytic phenomena like resistance, transference, and counter-transference operate mainly on the interactional level (Greenson, 1978). Yet, in modern versions of psychoanalysis, this highly asymmetric understanding of the psychotherapeutic relationship, which presupposes a knowing analyst vs. a client who is unaware of their psychodynamic motives, is replaced by a more symmetrical understanding of an intersubjective field to which both client and analyst are equally contributing. Interpretation in the post-bionian model of the analytic field "is no longer considered as the expression of the analyst's knowledge about the client, but as a multidimensional offer of meaning intended to bring new ideas and emotions to life at an intersubjective level" (Civitarese, 2020).

In this paper, we draw on Positioning Theory for the analysis of different facets of the self that are treated as relevant in psychotherapeutic interactions. Bamberg (1997) and Bamberg and Georgakopoulou (2008) distinguish between level-1 positioning, involving the self "as a character in the story" (Bamberg and Georgakopoulou, 2008: 380), and level-2 positioning, the way in which the teller "positions himself (and is positioned) within in the interactive situation" (Bamberg and Georgakopoulou, 2008: 385). Lucius-Hoene and Deppermann (2004) and Deppermann (2015) have elaborated this model, distinguishing representational positioning of the autobiographical, told self, and performative positioning of the emotional and interactive self. Performative positioning is implicit and importantly includes bodily displays. Both modes of positioning are manifested by different discursive practices:

- Representational positioning of the told self includes
  - description of actions, feelings, thoughts, intentions, etc. by narrative clauses;
  - ascriptions to present and past self;
  - enactment by reported dialogue;
  - reported statements by third parties;
  - metanarrative comments on and categorizations from past or present point of view;
- Performative positioning of the emotional and interactive self includes
  - claims to facets of identity by narrative performance and interactional conduct;
  - affective displays by prosody, facial expression, gaze, etc.;
  - positioning vis-à-vis the interlocutor.

Positioning involves not only self-positioning but also other-positioning, i.e., the ascription of facets of identity to the interlocutor (or third parties), which can also be done both by

explicit representations or in a performative mode. Self- and other-positioning can imply each other, as, e.g., when adopting performatively the role of a teacher, the addressee is other-positioned as a student.

Positioning Theory seeks for an analysis of identities as they become referred to and indexed in narrative talk-in-interaction. Conversation Analysis (Schegloff, 2007) equips us with the methodology of sequential analysis, which is needed to show how participants observably orient to situated facets of identity in their interactions and how they understand, treat, and negotiate identity displays. Positioning Theory is compatible with conversation analytic views on the self in interaction (Wilkinson and Kitzinger, 2003). It encompasses membership categorization (Jayyusi, 1984), but it can also address how participants recognizably orient to moral concerns of the self, i.e., the participant's face (Goffman, 1955). Yet, the Positioning approach goes beyond these two approaches by attending to the biographical and to the psychological dimensions of the self as well as they become manifest in interactional episodes (e.g., bodily self-perception, reflexive self-positioning, and ascription of feelings and motives; Deppermann, 2013).

CLIENT'S SELF-POSITIONING AND THERAPIST'S SHIFTS TO THE PERFORMATIVE SELF

Our study deals with narratives in psychotherapy that clients themselves interpret in terms of their personal identity. Thus, we deal with sequences of interaction in which the self is undoubtedly in focus for the participants. In the same way as Vehviläinen (2003) and Voutilainen et al. (2010) have shown, therapists in our data mostly initially respond with empathy or partial agreement with the client's identity claim. However, they never respond with unrestrained agreement or displays of reciprocity, e.g., by a second story about own experiences, as has been shown in other interaction types by Heritage (2011) and Kupetz (2016), but which would violate the neutrality requirement of the psychoanalytic technique. Instead, they provide candidate understandings (Weiste and Peräkylä, 2013), which may even be challenging (Antaki, 2012), and continue their turns by producing interpretations that attribute unconscious motives or unavowed feelings to the client (Greenson, 1978: 37–45; Peräkylä, 2008; Weiste et al., 2015).

The type of sequences we will discuss has the following shape:

- 1A: Story-telling: Client (CL) tells autobiographical story.
  1B: Identity claim: CL interprets story in terms of identity ascription.
- 2A: Display of empathy: Therapist (TH) provides display of empathy and/or partial agreement.
  2B: Interpretation: Therapist shifts focus to the client's present, performative self, pointing out identity aspects that contrast with, undermine, or reframe the client's self-ascription. This shift to the performative level is brought about by focusing on the client's present behavior, their feelings (Peräkylä, 2008; Voutilainen et al., 2010), and/or the (unconscious) motives that make the client tell their story. The focus on the client's performative self can combine with a focus on how the client manages the relationship with the therapist.
- 3: Negotiation of the interpretation: Therapist and client negotiate the meaning or the validity of the therapist's interpretation (Peräkylä, 2005, 2010). This part will minimally consist of the client's response to the therapist's intervention 2B, but may extend to a larger negotiation of interpretations and ascriptions to the client; it can also include argumentative and narrative elaborations.

In this paper, we examine (1) how clients in psychodynamic psychotherapy interpret their own autobiographical narratives in terms of who they are (Bamberg, 2011), (2) how therapists respond to narratives by interpretations shifting to clients' performative self, and (3) how both parties negotiate the meaning and the validity of the therapist's interpretation of the client's self, focusing on whether both parties manage to arrive at a shared understanding of the client's identity, motives, and feelings.

DATA AND METHODS

We draw from two psychodynamic focal therapies with 25 sessions each, video-taped at the Medical Faculty of the University of Freiburg, Center for Psychiatry, Psychosomatic Medicine and Psychotherapy in 2017–2018. Excerpts 1–3 from the first therapy include a male client in his late 60's suffering from depression and a functional pain syndrome subsequent to the death of a family member. The young female therapist was still in her analytic training. Excerpts 4 and 5 are from the second therapy with a young woman in her 20's suffering from psychogenic seizures. The therapist was a psychoanalytically trained senior staff member.

All sessions were exhaustively coded for all occurrences of different types of therapists' responses like understanding checks, repetitions, formulations, and interpretations. Fifty-five instances of therapists' interpretations were transcribed according to GAT2 (Selting et al., 2011, with selected additional multimodal annotations, Mondada, 2018; see **Appendices A, B**) together with their sequential context (with a duration between 1:59 and 7:01 min), i.e., preceding client's narratives and descriptions and following negotiations of the interpretation. All 55 extracts were analyzed by the three authors together using Conversation Analysis with a focus on sequential organization and turn design. Among the 55 extracts, 5 extracts (out of 10) in which the therapist shifts to the performative self of the client have been chosen for this paper.

SHIFTS TO THE PERFORMATIVE SELF IN PSYCHOTHERAPY: FIVE EXEMPLARY CASES

In the following, we analyze in depth five extracts in which therapists respond to clients' autobiographical self-positioning by shifting to performative aspects of client's current self. We have chosen extracts that give evidence of the various dimensions of the performative self that therapists address in their interpretations:

- Unconscious motives that inform client's storytelling (section Redefinition of the Motives for Storytelling: From Identity-Display to Defense Mechanism),
- emotions that are in contrast to client's explicit self-presentation (section Inference From Presuppositions in the Client's Story: From Rational Self-Presentation to Emotional Distress),
- the client's way to conduct the interaction with the therapist (section Interpreting the Client's Way of Designing the Psychotherapeutic Relationship: Claiming an Analogy Between Agentive Self-Relationship and Interpersonal Relationship),
- different objects or causes for the client's emotion (section Observing Non-verbal Conduct: Focusing on an Emotion and Shifting its Object),
- a challenge of the authenticity of the client's representational self-positioning (section Summarizing Impressions From Client's Talk: Challenging the Authenticity of the Performance).

Each section closes with a conclusion concerning the positions that the participants accomplish with respect to the client's self in the extracts: client's representational self-positioning is summarized and related to how the therapist other-positions the patient by shifting to the client's performative self.

Redefinition of the Motives for Storytelling: From Identity Display to Defense Mechanism

Extracts 1–3 are from the first therapy with a young female therapist and an elderly male client. One of the recurrent topics of the sessions are CL's conflicts with authority figures, which had also been discussed before extract 1 starts. The client tells a story about a conflict with a superior at work as evidence for how he acquired psychological strength. The therapists shift to the motives for the client's storytelling[1].

[1]Transcript headers designate the therapy series (I or C), number of session, and beginning and end time of the extract within the session.

Extract 1 | Therapy_I_12_44:10-48:40

001 CL da ischt dann an diesem meine STÄRke entstande;
there then at this my strength developed
002 (0.54)
003 CL an dEm TAG,
on that day
004 TH [HM_hm–]
005 CL (.) wo sie_s jetzt mir dann geSAGT [hat,=]
where she now said it to me then
006 =also DIEter,
well NAME-CL
007 (.) staTIONsleitung,
position of the head nurse
008 (0.69)
009 CL kriegt die Ulli?
will be assigned to NAME-colleague
010 (0.14)
011 TH HM_hm,
012 (0.62)
013 CL und es wär LIEB,
and it would be kind
014 (0.13)
015 CL und k
and
016 (0.18)
017 CL tOll von dir wenn du sie EINarbeiten würdsch,
great if you introduce her to the work
018 (0.29)
019 CL un sie k äh als stEllvertr[etung weiter]hin ARbeiten würdscht.
and will carry on working as vice head
020 TH [HM_hm,]
021 (0.38)
022 CL ((lipsmack)) un ich gesagt liebe SILke,
((lipsmack)) and I said dear name-superior
023 (1.11)
024 CL das WAR_s.
that was it
025 (0.56)
026 TH hm_HM,
027 (0.27)
028 CL SO: (0.34) lass (0.12) ich (.) nIcht (.) mit mir (.) UMgehen.
I won't let me be treated that way
029 (0.64)
030 CL ich hab (0.15) äh drEI viertel jahr die staTION geführt;
I have led the ward for nine months
031 (0.46)
032 CL top.
perfect
033 (0.84)
034 CL ja?
yes

035 (0.12)
036 CL [da gab_s] (.) KEIne beschwerde;
there hasn't been any complaint
037 TH [HM_hm;]
038 (0.23)
(…)
102 CL un NE,=
and no
103 =ich hab noch zu ihr geSAGT;=
I said to her still
104 =äh SILke,=
erm name-superior
105 =ich nehm jetz meinen RESCHTurlaub,
I now take my residual leave
106 (0.52)
107 CL und dann äh äh äh wirscht du mir nicht mehr SEHen.
and then erm you won't see me again
108 (0.1)
109 TH HM_hm;
110 CL ja du KANNscht aber net einfach so:-
well but you cannot simply like this
111 (0.36)
112 CL und da hat aber diese SCHULleitung;
and there this director of the nursing school
113 (0.24)
114 CL der hat mir dann gHOL[fe,]
he helped me then
115 TH [HM]_hm,
116 (0.21)
117 CL und hat mir dann quasi kein KÜNdigungsvertrag;=
and then did not (give) me like a cancelling contract
118 =sondern so_ne (0.31) überBRÜCK[u:ng;]
but kinda bridging
119 TH [HM]_hm;
120 (0.25)
121 CL <<decr> und konnt [ich als sch]ulassistent anfangen >.
and I could start as a school assistant
122 TH [ja:,]
123 (0.7)
124 TH hm*:-
cl *puts hand on his chest–->
125 (1.1)*
Cl –>*
126 CL es [koscht] mich immer noch;=
it still costs me
127 TH [hm;]
128 CL =*aber TRAUT hab ich mich;
but I dared to
cl *smiles slightly———->
129 (0.5)
130 TH <<p> haben sich DURCH*gesetzt;>
(you) prevailed
cl ————————————————————*
131 CL <<p> hab mich DURCHgesetzt>;
(I) prevailed
132 (1.2)
133 TH auf mal so_ner ganz AN:deren ebene;=
just on a very different level
134 =also_s THE:ma,=
so the topic
135 =mit dem wir ja ANgefangen haben die stunde;=
with which y'know we have started this session
136 =war ja (.) eben der neuroLOge?
was y'know PTCL the neurologist
137 ((lipsmack))
138 CL hm_[HM,]
139 TH [äh:]m (.) der die rolle sp
erm who pl- the role
140 (0.13)
141 TH ((creak))
142 (0.16)
143 TH der so: MACHT noch hat so in ihren gedanken,
who still has kinda power like in your thoughts
144 (0.5)
145 TH ah:m; (0.6)
erm
146 TH wo sie sich NICHT durchsetzen konnten.
where you did not prevail
147 TH (.) d[er irgendw]ie:-
who somehow
148 CL [hm_HM.]
149 TH °h (.) un jetz haben sie mir (.) ganz viele geSCHICHten erzählt?=
and now you have told me a whole lot of stories
150 =von denen die [ganze STUNde]über,
of which the whole session long
151 CL [wo des gekLAPpt] hat,
where it worked
152 TH °h (.) geNAU.
exactly
153 (0.24)
154 TH °h°
155 CL ja–
yes
156 TH (.) und
and
157 (1.15)
158 TH ich frag mich ist das so_n mechaNISmus von ihnen;=
I wonder is this kinda mechanism of you
159 =dass sie sich dann dA dran erINnern?

that you remember that then

160 °h ((lipsmack)) u:m (.) sich so !SE:LBST! (.) äh:m (0.21) zu zei:

((lipsmack)) erm in order to erm sho- yourself this way

161 (.) also nochmal AUFzuzeigen:;=

I mean display once again

162 =da gIbt_s auch situationen wo ich das meistern KONnte?

there are also situations in which I (= client) could cope with that

163 (0.53)

164 damit sie sich weniger SCHWACH fühlen?=

so that you feel less weak

165 =in den ANderen situationen;=

in the other situations

166 TH =so was ist (0.64) die ROLle (.) dieser geschichten und dieses

167 (.) dieses erzählens [da(bei),]

so what is the role of these stories and this this telling there

168 CL [das isch_ne] des isch_ne SAche,

this is a this is a thing

169 CL (0.4) da gebe sie mir jetz en SCHLÜSsel?

there you now give me a key

170 (0.44)

171 TH hm_HM,

172 CL (0.2) weil sie des jetz SAge,

because you say this now

173 (0.6)

174 CL des HILFT mir,

this helps me

175 (0.35)

176 CL weil dann werde ich in ZUkunft,=

because then I will in the future

177 =wenn da mal wieder irgendwie was ISCH oder so,

if there is just again something or so

178 CL °h (.) werde ich mich (.) ÖFter mal an diese situationen erINnern.

I will just remember these situ ations more often

179 (0.52)

180 TH °h [°h]

181 CL [wo isch] STARK war;

when I was strong

182 (0.73)

183 TH ich hab das nich ich ich [((knarrt))]

I have that not I ((creak))

184 CL [NE des:]

no this

185 ich glaube ich wollte jetz erstmal nur so (.) in FRAge stellen.=

I guess I wanted now first just only kinda question

186 =was sie damit MACHen;=

what you do with them (= the stories)

187 =ich hab jetzt

I have now

188 °h (.) ich !WEISS! nicht ob es die passende strateGIE [is.]

I don't know if it is the proper strategy

189 CL [hm]_HM–

190 TH °h so_s war einfach nur_ne FRA:ge von dem (.) was hier

pasSIE:RT.=oder?

like it was simply only a question about what is happening here, right?

Client Tells a Story of Prevailing Over an Authority Figure and Interprets it in Terms of Strength (001–131)

The story preface: ("my strength developed on that day," "da ischt an diesem meine STÄRke entstande; an dEm TAG," 001-003) projects an autobiographical key narrative. It is a story about pride and self-assertiveness when facing a threat of devaluation: The client considers himself to be treated as unfair and disrespectful, because he is not appointed as a ward nurse, although he fulfilled this position for 9 months perfectly well and without any complaints (30–36), was praised by the doctors and proved to be a responsible and strict leader of his team (between 38 and 102, not shown). The climax of his story is a reported interaction with his superior, in which he rejects the request to introduce the new ward nurse to her work; instead, he cancels his job on the spot (103–110) and changes to another position that was offered to him in a neighboring nursing school (112–121). The final morale frames it as a story about courage (124–128) in the face of an unjust authority, who does not respect him.

The Therapist's Response: Inquiring Into the Motivation for Telling Stories of Strength

As a first reaction, the therapist shows understanding and empathy by collaboratively formulating the gist of the story as "you prevailed" (130), which is confirmed by the client's repeat (131). The therapist then announces to switch to a "completely different level" (133). She refers back to the stories that the client told over the course of the sessions (135–152) and puts forth the hypothesis that the client tells stories of strength in order to fight feelings of weakness (149–165). In psychoanalytic terms, the client's stories are interpreted as a variety of the defense "mechanism" (158) of reaction formation (Freud, 1937). This can be conceived of as resistance against facing the painful feeling of being left out. The categorization as a "mechanism" (158) of the client implies that there is a motivational process the client is not aware of. The therapist's intervention is clearly not affiliative. It treats the kind of stories the client tells as a behavior in need of psychological analysis. However, the psychoanalytic term "mechanism" may not be transparent to the client, who therefore misses that it hints at questionable motives in need of further exploration (see step 3).

Ensuing Negotiation: Useful Self-Management Strategy vs. Object of Motivational Inquiry

The client does not take the therapist's intervention up as a cue for questioning his hidden motives. Instead, he treats it as a recommendation of a self-management technique to fortify his identity when he feels shaken (168–181). The therapist disclaims that it was her intention to recommend using stories of strength as a self-management technique. By his third-position repair (Schegloff, 1992), she rejects the client's response as resting on a misunderstanding of her interpretation; instead, she insists on questioning the use of this strategy (183–190).

Self- and other-positioning in extract 1

In Extract 1, the client positions his told self mirrored by the perspectives of third parties: He is treated disrespectfully by superior vs. praised by doctors and supported by the head of the nursing school. Third parties serve as warrant of his entitlement to the position he is denied and to his moral rights against his superior, who disrespects him. The client explicitly claims and narratively displays an identity of strength, which he has acquired by a courageous act. The story is a biographical key story, which describes a change in the client's identity by his own agency against all odds and which establishes an important link between the client's former and his present self. The story is presented as a warrant for the factuality of his identity claim: the representational level of the story is treated as primary. The client positions himself by performance as well: His past self is re-enacted with syntonous affect (indignation, anger), and he displays pride by smiling when formulating the morale of the story. Interactively, the client calls for recognition of his courage and his achievement, inviting affiliation with his identity claim, maybe even fishing for the therapist's praise.

The therapist displays empathy with the client and his claimed self of strength. Nevertheless, she shifts the focus and treats the performative level as primary by interpreting the client's story not as a factual story about the becoming of his identity (= representational positioning), but as a performative, strategic self-presentation, whose function is to be questioned, because it serves to avoid facing experiences and feelings of weakness.

The levels of positioning that client and therapist treat as being focal are at clash. While the client focuses on the biographical becoming of his identity, the therapist treats the motivation for claiming this identity as more important. Yet, the client does not understand the therapist's intervention as a cue to explore his motivations in more detail. Instead, he takes it up as a recommendation, which supports the psychological usefulness of his identity claim as a means to enhance his agency and well-being.

Inference From Presuppositions in the Client's Story: From Rational Self-Presentation to Emotional Distress

In extract 2, the therapist's interpretation focuses on an emotion (sadness) that contradicts the client's overt claim (acceptance) but is treated as being presupposed by the client's word choice. Already in the first session, the therapist and the client talk about his loss of bodily strength and endurance because of aging. Comparing himself to others who are worse off, the client stated: "Ich muss zuFRIEde sein." ("I must be satisfied," 05:54). Afterwards, the client told about the need to be cautious because of problems with his prostate gland. After the client concludes his story with an interjection that expresses concern ("HA:I yai yai," 03), the therapist refocuses on the client's prior claim that he has to be satisfied with his health condition, and casts it into doubt (13–15).

Extract 2 | Therapy I_1_09:07-10:46

```
01  CL   aber des_sin Immer noch diese (1.0)
         diese gSCHICHte;
         But these are still always these these stories
02       (0.3)
03  CL   die mir (1.04) dann sage HA:I yai yai,
         which then tell me  ((interjections))
04       (3.7)
05  TH   <<h>HM_hm,>
06       (1.3)
07  TH   sie haben Eben gesagt; (0.2)
         you just said
08  TH   ich !MUSS! (.) zufrieden sein.
         I must be satisfied
10       (1.0)
11  TH   mit dem (0.9) mit ihrer fitness mit SIEBzig.
         with the with your fitness being seventy
12       (1.8)
13  TH   dieses !MUSS! (.) klingt so ein bisschen so*:-
         This must sounds like kinda little bit as if
    cl                                          *smiles–>
14       (1.0)
15  TH   so !GANZ! stehen sie noch nich daH[INter;]
         as if you are not fully behind it
16  CL                                     [nee:,]
            no
17  CL   ((laughs))
18       (2.7)
19  CL   ja ich würd scho
         well I would PRT
20       (0.3)
21  CL   ((clears throat))
22       (1.0)
23  CL   ich freue mich irgendwie jetz auf den FRÜHling,=
         I am looking forward to spring now somehow
24       =und hab halt schon un äh des gFÜHL,=*
         and (I) somehow have erm the feeling
    cl   ————————————————————————————————–*
25       =dass ich äh: auch wenn ich jetz auf_n HIRZberg
         äh äh gehe würd;
         that I erm even if I now would walk up
         the NAME-OF-MOUNTAIN
26       (0.6) ah: (.) oder irgendwo ANdersch,
         erm or somewhere else
27       (0.6) da ein steiler BERG (.) bei uns,
         there a steep mountain in our region
```

28 (0.5) äh da dass ich ((knarrt)) das mit dem:
erm there that I ((creaks)) the thing with the
29 ah: mit der (0.3) i es GE,
erm with the sacroiliac joint
30 (0.3)
31 TH HM_[hm,]
32 CL [sehr wahr]scheinlich (.) ah:: (1.3)
very probably erm
proBLEme kriegen [würde.]
(I) would run into trouble
33 TH [HM_hm,]
34 (0.66)
35 CL des isch_s des geFÜHL isch [da:]
this is it the feeling is there
36 TH [HM_]hm,
37 (1.5)
38 TH genau des_so diese verNÜNftige seite die zu ihnen sagt,
exactly there is this rational side which says to you
39 (2.2)
40 CL [isch s]o_ne ambivaLENZ;
(it) is kind of an ambivalence
41 TH [aber]
but
42 TH geNAU.=
exactly
43 TH =was mich aber interessiert is so eben auch (.) die ANdere;=
but what interests me is just also the other
44 TH =so_n bisschen die emotioNAle,=
kinda little bit the emotional
45 TH =vielleicht auch die TRAUerseite;
perhaps also the sadness-side
46 CL hm_[HM;]
47 TH [di]eses ABschiednehmen;
this saying goodbye
48 (0.8)
49 TH von was was sie ihr ganzes leben (1.5) WICHtig war;=Oder?
to something which your whole life was important, right?
50 CL ((clears throat))(0.4) schon:;
well that's true
51 (1.8)
52 CL weil: es ISCH halt SO,
because it is like this
53 (0.4) zum beispiel mein BRUoder.
for example my brother
54 (0.8) der hat zwar auch im KNIE:,
he has problems with his knee as well
55 (.) un der un der leidet immer;=
and he and he suffers always
56 =weiß der TEUfel was alles;=
the devil knows what else
57 =muss aber keine medikaMENte un nix nehme;
but he does not have to take any drugs or anything
58 (0.6) aber da: (.) der (.) der kann wieder <<knarrig> äh:> TOUrenschie fahren;
but there he he can erm do ski touring again

Client's Story (Before the Extract Until Line 03)

The client talked about health problems, his concerns, the need to be cautious, and his acceptance of his health condition, given that others are worse off.

The Therapist's Response: Therapist Doubts That Client Is Satisfied With His Health Condition (05–15)

The therapist quotes the client's earlier claim that he must be satisfied (07–11) and highlights his use of the modal verb "muss" ("must," 08), which expresses constraint (Zifonun et al., 1997, 1881–1923). She interprets the choice of the verb as making perceivable ("klingt so," "sounds like," 13)[2] that the client is not fully emotionally ready to accept his situation, or, alternatively, not fully convinced that he has to accept it (13–15). This interpretation makes an unavowed emotion explicit (Peräkylä, 2008; Voutilainen et al., 2010) and is clearly designed to achieve intersubjectivity by referring to common ground concerning the client's narrative action in order to persuade him (Weiste et al., 2015). Yet, the therapist thereby changes from the client's explicit self-positioning to an impression she has gained about his present emotional and cognitive stance toward his health condition that the client is taken as not having communicated, but given off (Goffman, 1959) by his linguistic choice.

Ensuing Negotiation: Ambivalence Between Desire and Physical Limitations vs. Focus on Sadness About Loss (16–35)

In overlap with the therapist's interpretation, the client starts to smile, agrees (16), and then laughs slightly (17), which seems to index that he feels being understood. He continues by deploying the imaginary scenario of looking forward to climbing a high mountain (what has been his favorite hobby), stating that he would expect to have problems with his sacroiliac joint (17–35). The therapist confirms and categorizes his account as expressing his rational side (38), thus constraining its validity as expressing only one part of the client's self. The client, in turn, concludes that there is an ambivalence (between his desire to do sports and concerns about limitations of his health condition, 40). By marking a shift in perspective ("the other side," 43), the therapist again changes focus to the client's emotions, now explicitly introducing sadness about having to say farewell to well-beloved habits (43–49). Using the format "what interests me is X" (43), the therapist does not explicitly claim that the client is sad about having to say farewell, nor does she explicitly ask if this is the case. Rather, she establishes this emotional state as a thematic focus (43–49). Using the demonstrative article ("this saying goodbye,"

[2]See Stukenbrock et al. (submitted) for the use of meta-perceptual verbs in therapists' interpretations.

47), she presupposes that it is relevant for and known by the client, urging him to elaborate with a tag (49; König, 2020). The client grants the therapist's intervention by a concessive particle (50); he expands his turn by a story about his brother, who, in contrast to the client, is still able to practice physically demanding sports, although he suffers from various illnesses as well (54 until beyond the extract). This story of social comparison implicitly avows discontent and the feeling of injustice of not being able to perform any more like significant others of about the same age. The client thus partially aligns with the therapist in exploring his emotions concerning physical limitations further, however, without dealing with the emotion of sadness about loss in particular.

Self- and other-positioning in extract 2

The client positions himself as a person who is fond of doing all sorts of physical activities and sports, but who is concerned about his condition because of health problems that have increasingly developed with age. He conceives of himself as being in an ambivalent position, torn between the desire for bodily activities and the acceptance of increasing physical limitations.

While confirming the client's self-positioning and his pragmatic orientations, the therapist focuses on the client being emotionally more affected from the sadness about losses related to aging than he seems to admit. Her first intervention closely builds on the client's prior words and, drawing on a semantic presupposition of his statement, she infers emotional trouble on his part concerning age-related changes in his health condition (07–15). As the client does not take up the issue of exploring the emotions that might cause his "not fully being behind" his acceptance, the therapist explicitly states "sadness about loss" as a topic, an emotion that she at least tentatively attributes to the client.

The explicitation of the inference from the client's linguistic choice is thus a means to cue the client's self-exploration in the direction of the therapist's hypothesis. As the client does not take this direction, in her second intervention, the therapist formulates the inferred emotion explicitly, thus showing more clearly that she ascribes to the client a motive or feeling that he did not address yet.

Interpreting the Client's Way of Designing the Psychotherapeutic Relationship: Claiming an Analogy Between Agentive Self-Relationship and Interpersonal Relationship

In extract 3, the therapist draws an analogy between the topic of the client's story (self-control) and his interactional conduct (his attempt to control the therapeutic relationship).

Throughout the therapy, the client repeatedly reports about measures he takes in order to preserve his health. The therapist comments on one of these stories by ascribing to him that he acts "well-organized, well-reasoned and controlled" (082–084).

Extract 3 | Therapy I_14_32:23-38:25

```
078 TH   =äh äh sie sind ja: sehr bemÜht glaub ich auf
         VIElen Ebenen,=
         erm erm you are y'know very eager on many levels
079      =die: WEGzubauen;=
         to discard
080      =also sie sind ja gehen ja auch aktiv DRAN.=
         I mean y'know you are y'know you actively
081      =<<creaky> ja>,
         yes
082      (0.3) aber auch imme::r se:hr (0.1) organiSIERT;=
         but always very well organized
083      =überLEGT;=
         reasoned
084      =kontrolLIERT auch.
         controlled as well
085      (0.7)
086 CL   aber wisse sie wo des HERkommt;=
         but d'you know where this comes from
087      =weil ich viel im GLETscher gelernt hab.
         because I have learnt much in the glacier
(…)
144      und die (.) die hÖchste äh äh
         konzentrationsübunge (0.3) sind
         beim FELsenklette[rn,]
         and the highest erm erm concentration exercises
         are when climbing rock mountains
145 TH                    [hm]_HM,
146      (1.3)
```

The Client's Story: Autobiographical Self-Positioning as Acting With Care and Concentration

The client seems to receive the therapist's comment about him acting well-organized, reasonable, and controlled (082–084) as praise. He responds by telling a story about how he learned to act with great care and concentration when climbing in the glaciers (086–144). This story expands a series of autobiographical stories in which he portrays himself as exerting agency (080) in a cautious and well-planned manner (082–084).

The Therapist's Response: Shift to the Way in Which the Client Manages the Therapeutic Relationship

The therapist first confirms the client's autobiographical identity claims (147–161), but then shifts to his behavior in the therapy (162–176).

```
Therapy I_14_32:23-38:25 continued

147 TH   ne ich glaub sie haben VIEle sachen in ihrem
         lEben gemacht,=
         well I guess you did many things in your life
148      =wo sie sehr viel kontrOlle: (0.2) und
         konzentration dfür geBRAUCHT haben.
         where you needed very much control
         and concentration
```

149 CL (0.2) ja:,
yes
150 TH (und ja) das hat ihnen sehr sehr viel geNUTZT,=
and yes this has helped you very very much
151 =in vielen situationen in ihrem leben KLAR zu kommen.
to come to terms with many situations in your life
152 CL (0.1) hm;
153 TH sowohl im SPO:RT;=
both in sports
154 =als ouch in ihrer A:Rbeit;=
and in your work as well
155 =wo sie auch va (.) viel [verant]wortung überNOMmen ha:ben;
where you also have assumed much responsibility
156 CL [ja,]
yes
157 CL ja,
yes
158 TH (0.5) und SO,
and so on
159 °h (.) un ich glaube des-
and I guess this
160 (1.8)
161 TH des is ja in ihnen DRIN.
this is inside you y'know
162 (.) ((schmatzt))°h un ich hab mAnchmal das gefühl dass sie das
auch hier bei UNS (0.34) sehr machen.
((lipsmack)) and sometimes I have the feeling that you do this
here with us very much as well
163 (.) also dass sie sehr
kontrolLIE[ren;=
I mean that you control very much
164 =was][sie e]rZÄ:Hle[n;]
what you tell
165 CL [wenn ich][mit ihnen] [S]PRECH;
when I talk with you
166 TH (0.1) ja:,
yes
167 (0.9)
168 TH äh:m; (0.2) un mi:r (1.1) mich auch nur zu_nem gewissen gra::d
(.) ihnen HELfen lassen oder so.=
erm and (that you) let me (1.1) me help you only to certain degree or so as well
169 =also so sehr vorgeben_n THEma?
I mean like you predefine a topic
170 (0.7)
171 TH un mir so_n bIsschen was erLAUben?
and (you) allow me a little bit
172 (1.0)
173 TH a::be::r da ouch_ne kontROLle drin lassen,=
but you still keep some control
174 =wie viel mir pasSIERen darf in der therapie.=
how much may happen to me (=client) in the therapy
175 =und wie viel geSAGT werd[en darf.]
and how much may be told

Re-using her notion of "control" as a leitmotif of her interpretation of the client's self (084, 148, 163, 173), the therapist confirms that the client has come to terms successfully with many situations in his life (148–155) by "very much control and concentration" (148). She concludes that this strategy is deeply rooted in the client's self (159–161). She continues by drawing an analogy between the way in which the client controls himself and his life outside of the therapy with his verbal behavior in the therapy and the way he manages the therapeutic relationship (162–175). She claims that the client controls topics and the ways in which they are talked about (164, 169, 175) in a way that limits the scope of therapeutic help from her (168, 176).

Ensuing Negotiation: Denial of Limited Openness vs. Claim to Resistance Out of Fear

The client insists on the wish that the therapist helps him (177–186) and affirms that he wants to engage fully with the therapist (188–189). Yet, while accepting the authenticity of the client's wish (267–275), the therapist reframes her assumption that the client resists against giving up control (277–289).

Therapy I_14_32:23-38:25 continued

177 CL [ich WÜNsch m]ir
I wish
178 ich WÜNsch mir
I wish
179 (0.6)
180 CL vielleicht sehen sie das SO:,
perhaps you see it this way
181 (0.6)
182 CL wenn sie des so empFINde,=
when you feel it this way
183 CL =Isch es [aber] in mir net SO.
but in me it is not this way
184 TH [hm-]
185 TH (0.1) hm_HM,
186 CL ich WÜNsch mir dass sie mir helfe.
I wish that you help me
187 TH (0.2) hm_HM,
188 CL (0.2) ich würd
I would
189 ich wünsch mir (0.2) dass ich mich richtig schön auf sie EINlasse kann.
I wish that I can really fully engage with you
(…)
267 TH hm des war auch gar nich als VORwurf von mir

[gemeint;=
mmh I didn't mean it as a reproach at all
268 CL [ne NE;]
no no
269 TH =des war einfach] so als_ne beSCHREIbung;
it was simply like as a description
270 TH °h (.) [und sie] haben das jetz so geSA:GT,=
and you now have said it this way
271 CL [ja,]
yes
272 TH =und ich glaube ihnen ihren WUNSCH auch;=
and I believe you that this is your wish
273 =also [((creak))] (0.7) müssen sich keine SORgen machen;=
so (you) don't have to worry
274 CL [hm_HM;]
275 TH =dass ich ihnen (.) das nich ABnehmen würde;
that I don't buy this from you
276 CL °h sie haben des
you have this
277 TH (0.2) da klang wie so_n ABer mit (0.1) in ihrem satz.
it sounded like in your sentence a "but" was included
278 (.) als sie gesagt haben sie WÜNschen sich das?
when you said you wish this
279 (1.1)
280 TH aber es gibt
but there is
281 (.) als gäbe_s Irgendwas was auch daGEgen spricht.
as if there was something which stood against it as well
282 (1.3)
283 CL [hm–]
284 TH gib[t_s da ir]gend_nen WIDerstand;=
is there any resistance
285 =oder_ne AN:gst,=
or a fear
287 =auch davor vielleicht was dann: (0.1) pasSIEren könnte;=
also about what perhaps then could happen
286 =was dann RAUSkommen könnte;
what could come out then
288 (1.5)
289 TH was passiert wenn sie die kontROLle auf (.) geben,
what happens if you give up control
290 (0.6)
291 CL WISse sie;
look
292 (1.6)
293 CL (doch/durch) des dass ich
(but/by) that that I
294 (0.3)
295 CL ((clears throat)) ich kann_s immer (.) nur (.) wiederHOle,
I can always only repeat

In response to the therapist's ascription that the client controls and limits topics (162–176), the client claims his wish to be helped by the therapist and to engage fully with the therapist (177–189). Therapist and client thus express oppositional views on the present, interactive self of the client concerning his aim for interactional control and openness. The client's lengthy account of his wish to open up fully to the therapist, which is continued in the elided part of the excerpt (190–266), is responded to by the therapist by an overt action ascription: she denies that her prior action was to be understood as a "reproach," but recategorizes it as a "description" of the client's way of interacting in the therapy (267–269). She adds that she believes in the seriousness of his wish to be helped by her (272–275). Both concessions are designed to discard the impression that seemed to underlie the client's affirmations, namely, that the therapist attacks the client's moral self in not believing in his authentic and unrestrained engagement in the therapeutic relationship. As before (078–084, 147–161), the therapist takes care to explicitly confirm the client's own positive identity claims (267–273). Yet, these affiliative affirmations are only preliminaries to insisting on her prior ascription that he is afraid of losing control (277–291). She first claims that the client "sounds" (277) as if his talk included an unspoken concessive part, a "but" (277). This time, the therapist not only reiterates the ascription of "control" to the client (289) but also adds more far-reaching motivational ascriptions, asking whether there is "resistance" (284) or "fear" (285) in the client against giving up control. Although the therapist's interpretation is couched in terms of an interrogative, her insistence on the topic and the evidence from the sound of his talk clearly show that she assumes the client to exhibit resistance. Starting in 291 (and continuing beyond the extract), the client reaffirms that he fully engages in the therapy, while conceding that he may not seem to be as "relaxed" as the therapist might want him to be.

Self- and other-positioning in extract 3

The client positions his autobiographical, told self as acting cautiously, planfully, and with a large amount of concentration, i.e., as a person with a high degree of agency. In response to the therapist's challenging ascriptions, he explicitly positions his present, interactive self as engaging fully with the therapy in order to get optimal help.

The therapist fully affiliates with the client's explicit self-positioning, which she explicitly confirms. She uses the psychoanalytic technique of proving the lingering relevance of past experiences for the client's present self by claiming that the client re-enacts biographically entrenched patterns of interaction in the therapy (Levy, 1998). By this, the therapist shifts from the level of the client's autobiographical self-positioning to the client's interactive, present self by way of analogy. The client is other-positioned as acting in a way that is unnoticed by himself and contradicts his explicit claims. The therapist makes a distinction

between believing the client's intentions (not to control and restrict his performance in therapy) and her assumption that the client does not act according to what he claims, thus introducing the distinction between a conscious and an unconscious self of the client as an interactionally relevant reality.

Over the extended negotiation about the relevance of "control" to the client's actions beyond and within therapy, therapist and client do not reach an agreement about how to conceive of the client's interactive self. While both agree on the client's explicit self-ascriptions, the therapist claims that there are additional unconscious motives, which run counter to the intentions of the conscious self. Yet, the therapist unpacks these motivational ascriptions only after the client has not accepted her ascription of a controlling behavior in the therapeutic context and has not engaged in self-exploration concerning the possible motif that the therapist has ascribed to the client.

Observing Non-verbal Conduct: Focusing on an Emotion and Shifting its Object

In extract 4, the therapist focuses on an emotion (sadness) that the client expresses mainly non-verbally and he shifts the object of the emotion to a more self-related concern.

Extracts 4 and 5 come from the second therapy with a senior male therapist and a female client, who suffers from psychogenetic seizures. The client has just told her boyfriend that she breaks up their relation. She talks about her concern that, after they separated, she won't be able to help him anymore.

Extract 4 | Therapy C_20_20:34-22:50

01 CL also ich BRAUCH das nich dass ich irgendwem (0.2) so HELfe;=s
I mean I don't need it that I help anybody
02 (0.6)
03 CL eher darum dass (0.6) äh:m (2.3) °h mein HERZ dabei (0.7) extrems wEh tut;
rather it's about that erm my heart is aching extremely
04 TH hm_HM;
05 CL bei dem gedAnken dass ich ihm dann
thinking that then I him
06 (0.6)
07 CL ähm:
erm
08 (0.4)
09 CL ja,=nicht mehr n:: ja;=
well no more/ well
10 =ihn nicht AUF:fangen kann,
not being able to catch him
11 TH hm_[HM,]
12 CL [nicht HELfen] kann,=einfach
not being able to help simply
13 (0.4)
14 CL dess: (0.1) er dass ihm halt nicht GUT geht.
that he that he just is not well
15 TH (0.1) hm_HM,
16 (0.8)
17 CL dass dass er
that that he
18 (1.2)
19 CL ich könnte locker drauf verZICHten,
I could easily do without
20 CL ((aborted laughter)) <<laughingly> ihm zu HELfen >;=aber
((laughs)) helping him but
21 (0.8)
22 CL [äh:m:]
erm
23 TH [HM_hm,]
24 (1.6)
25 CL nur wenn_s ihm dann GUT geht.
only if he is well then
26 (0.5)
27 TH HM_hm;
28 * (3.0) *(3.5)* (3.7) * (2.7) *(1.5)* (6.5) *
Cl *nods 3x* *nods 2x*crisps lips* *crisps/bites lips*
29 * (5.7) *
Cl *eyes fill with tears*
30 TH ((lipsmack)) (.) so_n bisschen traurig macht sie das SCHON dieser gedanke.=ne?
it makes you kinda little bit sad though this thought
31 (0.5)
32 CL ((lipsmack)) <<f> ja:;>=
yes
33 =*auf jeden FALL,>
definitely
cl *smiles——->
34 CL [jaha;]*
yes
cl ——->*
35 TH ja [da]ss ihre wege jetzt auseinANder gehen,=
well that you will be going separate ways now
36 =dass sie (0.76) ihm danach nich (0.46) nich mehr
that you him afterwards no no more
37 (0.3)
38 TH ((lipsmack)) <<creaky> ja >.
yes
39 TH ((lipsmack)) HELfen können.
will be able to help
40 CL (0.2) ja.
yes
41 (6.5)
42 CL °h da muss ich halt wIrklich auf mich AUFpassen,
I really just have to take care of myself
43 (0.3)
44 CL wenn ich dann zu HAUse bin,
when I will be at home then

45 (0.3)
46 CL °hhh dass ähm: (1.8) ja,=ich dann nich so (2.9) in diesen
(0.8) in diese TRAUer;=
that erm well I then don't drown so much in this in this sadness
47 =schmErz oder so was da (0.5) hiNEINverfalle (.)
pain or kinda something of that kind
[sozu]sagen;=also °h
so to say I mean
48 TH [hm;]
49 (1.9)
50 CL dass mich das nicht zu:: (0.3) se:hr EINnimmt;
that it doesn't absorb me too much
51 (0.8)
52 TH hm_hm;
53 (0.8)
54 CL sondern dass ich halt auf MICH (.) natürlich gUcke;
but of course that I just look after myself
55 CL (.) auf mich AUFpasse,
take care of myself
56 TH hm_HM;
57 (5.3)
58 CL mhja:hh,
myes
59 (1.4)
60 TH °h des is ja sicher WICHtig;
this is certainly important
61 (0.5)
62 TH andererseits ein bisschen (0.75) auch die traurigkeit spÜren
°h hilft vielleicht (.) dann auch (.) sich innerlich (1.3)
dann auch noch mehr (0.3) zu verABschieden.
on the other hand a little bit also to feel the sadness perhaps
then also helps to say fare well still more mentally
63 (0.8)
64 CL ja,=auf jeden FALL;
yes definitely
65 (0.8)
66 TH <<p> gehört halt daZU,>
y'know it's part of it
67 (0.3)
68 CL <<creaky, p> ja>;
yes

The Client's Story: Concern About Her Boyfriend (01–25)

The client had told about her boyfriend's eating disorders and his problems to come to terms with his life. She tells that she feels bad when thinking that she won't be able to help him anymore in the future after they split. In the lengthy pause that emerges after her account (28–29), the client nods several times and looks away from the therapist; she crisps and bites her lips; her eyes begin to fill with tears.

The Therapist's Response: Focus on the Client's Emotion (30–39)

The therapist provides an interpretation that assigns an explicit emotional interpretation to the client's non-verbal conduct (cf. Muntigl and Horvath, 2014): "it makes you kinda little bit sad though this thought" (30). The modal particle "schon" indexes a concession that the therapist expects the client to make, thus showing that he conceives his interpretation to be at least partially different from her explicit self-presentation (30). The client confirms without reserve, slightly smiling (32–34). However, the therapist continues his turn by explicitly adding a formulation of the object of her sadness, namely, the separation from the boyfriend (35), which is different from what the client had talked about before, i.e., the inability to support her boyfriend anymore (see 09–12). Still, the therapist then realigns with the client's prior focus of not being able to help anymore (36–39).

Ensuing Negotiation: Joint Shift to Client's Self-Related Emotions and Need for Coping

Taking up the therapist's ascription of sadness ("traurig," 31 → "traUer," 46), the client elaborates on it by claiming that she will have to take care of herself by not letting herself drown in this emotion (42–55). The therapist explicitly agrees (60), but then claims that the client will need to face the sadness about the end of the relationship in order to be able to say farewell and psychologically cope with it more comprehensively (62). Both agree (64–68).

Self- and other-positioning in extract 4

The client first explicitly positions herself as being distressed by not being able to comply with the exigencies of her moral ideal self concerning the support she should provide her boyfriend.

The therapist does not question the explicit self-positioning of the client. Rather, he gradually shifts the focus away from the boyfriend and the client's moral self to her own emotions (Peräkylä, 2008; Voutilainen et al., 2010) caused by the experience of the split-up and the need to cope with them properly. This change is managed by attending to the client's performative, non-verbal displays and by topicalizing their emotional content.

The therapist's shift from the client's explicit self-positioning as being concerned about the loss of her ability to help her boyfriend to the emotion of sadness implies a shift in focus from the other-related concern about the boyfriend to the client's emotional self. This combines with a shift of the object of the emotion, namely, from the loss of the ability to help to the loss of the relationship itself. This shift paves the way for the therapist's permission to allow for her sadness sufficiently in order to be able to cope with the separation from the boyfriend. The therapist's shift to the client's performative self is thus used as a cue to enhanced emotional self-exploration by the client, on which the therapist builds his recommendation.

The client aligns with the therapist's shift to her performative emotional self and affiliates with his statements. The shift in focus establishes the common ground between therapist

and client about the client's emotional state that is needed as a basis for the intelligibility and acceptability of the therapist's recommendation.

Summarizing Impressions From Client's Talk: Challenging the Authenticity of the Performance

In extract 5 from an earlier session, the therapist seemingly gives just a summary of the client's prior talk, which, however, can be heard as challenge building on the impression that the client interactional performance conveys. The client had talked for the first 11 min about her current life situation (preparing university exams, leisure-time activities, boyfriend, and plans to move to another town). She stated that she did not suffer from seizures recently, but reported eating problems, which, however, she claimed to be under control of "her head" (01–06).

Extract 5 | C_2: 11:10-12.40

01	CL	ja.=aber darauf (0.31) schaltet sich mein kOpf meistens dann ganz gut EIN.
		but then mostly my head intervenes properly
02	TH	HM[hm,]
03	CL	[und der sa]gt (.) hier (.) trotzdem,
		and it says nevertheless
04	TH	(0.36) HM_hm,
05	CL	<<p> iss> trotzdem [(so)]
		eat nevertheless so
06	TH	[sodass das gewicht] jetzt nicht zu stark
		nach UNten gegangen [ist] bis jetzt.
		so that your weight hasn't decreased too much until now
07	CL	[nein.]
		no
08	TH	oder nicht GEhen (wird).
		or (will) not decrease
09	TH	°h
10		(1.39)
11	TH	((lipsmack)) ja,
		yes
12	TH	(0.61) °h also eigentlich wenn man ihnen so ZUhört,=
		so actually if one listens to you
13		=muss man SAgen,
		one must say
14	TH	°h klingt es so dass sie jetzt im AUgenblick mit a (0.2)
		it sounds as if now at the moment with
15		mit AUSnahme eigentlich dieser (0.44) °hhh körperlichen beschwerden,
		with the exception of your bodily problems
16		(.) ihr leben eigentlich so ganz gut im GRIFF haben.=Oder?
		you can cope with your life quite well, right?
17		(0.25)
18	TH	hm (.) klingt SO.=Oder?
		sounds like that right?
19	TH	würden sie,
		would you
20		wie sehen SIE das;
		how do you see it?
21	CL	°hhh
22	TH	äh:m:
23		(1.41)
24	CL	jein,
		yes-no
25	CL	((laughs))
26	TH	hm_HM?
27		(0.37)
28	CL	äh:m: (.) bei mir ist es SO dass ich das ähm: (1.71)
		erm with me it is this way that I am able erm
29		gut nach AUßen;
		well to the outside
30		((laughs)) so:;
		like
31	TH	hmHM?
32	CL	(0.4) ähm DARstellen kann [glaub ich auch.]
		erm to present I guess
33	TH	[hm_HM,]
34	TH	°h ah JA.
		oh I see
35	CL	also ich (0.25) erTAPpe mich auch;
		so I catch myself as well
36	CL	(.) !SEIT! diesem klinikaufenthalt hab ich das geMERKT,
		since this stay at the hospital I have realized
37	CL	°hh äh:m: weil mir des auch da ein therapeut geSAGT hat,
		erm because there a therapist also told me
38		(0.43)
39	CL	dass (.) ich ä:hm auf VIEles immer schön gleich wegLÄCHel?
		that I erm in response to many things I always just smile them away
40	TH	hm_HM,
41	CL	(0.28) ah:m: und (0.98) wenn ich so EINS zwei mal über dinge
		geSPROchen hab;
		erm and when I like once or twice talked about things
42		(0.3)
43	CL	dass ich dann auch relativ neutRAL.
		that I reported relatively neutral then as well
44		(1.04)
45	TH	hm_[HM,]
46	CL	[DAR]stell:e;

The Client's Story: Presentation of a Rational and Trouble-Free Self (Until 05)

The client tells about various domains of her life, mostly smilingly. She does not mention major problems and presents

herself as a well-organized and goal-oriented person by her account. Her health problems are only addressed in response to an inquiry by the therapist; yet, they are portrayed by the client as being under her control.

The Therapist's Response: Challenging the Impression the Client Gives by Mirroring (06–20)

The therapist completes and thereby confirms the client's story, stating that she manages to control her weight appropriately (06–08). He summarizes the impression created by the client's account with "you can cope with your life quite well" (16). This summary is framed by verbs of perception (12, 14, 18) as how the client "sounds" when "listening" to her. In particular, the concluding repeat "klingt SO. = Oder?," "sounds like that, right?" (18) can be heard as a challenge, because again the perceptual impression that the client's story conveys, but not its truth, is highlighted. The tags *oder?* ("right," 16, 18; see König, 2020) and the following questions (19–20) explicitly ask the client to take a stance on this impression, thus implicitly calling, or at least allowing, for the client's self-repair.

Ensuing Negotiation: Client Admits Insincerity

With the ambiguous response token "jein" (a blend of *yes* and *no*), the client indexes that no straightforward answer is possible and projects a complex elaboration (Bücker, 2013). The client avows that she is able to give a favorable, unproblematic impression "to the outside" (28–32), thus letting infer that this does not correspond to how she actually feels. When saying that she "catches herself" (35) when "smiling away many things" (39), she adumbrates that this is a habitual way of presenting herself that she herself often is not aware of, but was only averted to by a former therapist (37).

Self- and other-positioning in extract 5

The client initially positions herself as a rational, goal-oriented person, who can cope with the (minor) troubles she faces. The therapist confirms this positioning, yet by stressing its perceptual nature and explicitly asking for the client's take on this impression, he implicitly leaves room for doubt and indexes the need for deeper elaboration concerning the validity of the client's self-positioning. The therapist does not explicitly other-position the client. In response, the client avows a lack of sincerity in her self-presentation, distinguishing a habitual facade of unproblematicity for others from the real self[3], which, however, she does not elaborate on in the context of the extract.

CONCLUSION

In Western culture, there is a deep-rooted assumption that subjects have privileged access to their own self (Heritage, 2011; Gertler, 2020). This assumption is embodied in most interaction types in the preference not to question subjective experience and self-related statements, but instead to affiliate with them and show empathy. Yet, the rationale of almost every psychotherapy includes to cause psychological change by altering clients' self-perceptions, self-ascriptions, and understandings of motives and goals by the therapist's interventions. This includes questioning the client's epistemic authority on their own self, which is a sensitive move that has to be carefully considered each time anew.

One way to question the client's authority concerning their self is to shift from the client's focus on their autobiographical, told self of which they are conscious to their performative self, which they enact in the interaction with the therapist. This latter self usually is rather, in terms of Goffman (1959), "given off" than part of what the client intentionally conveys about their self. In psychoanalytic terms, addressing the performative self thus often means to address unconscious and sometimes conflictual aspects of the client's personality, feelings, and motives. Prior research on interpretations has shown that they regularly include ascribing emotions to the client that they have not explicitly addressed or even seemed to hide (e.g., Vehviläinen, 2003; Peräkylä, 2008; Voutilainen et al., 2010; Muntigl and Horvath, 2014). Our analyses show that shifts to the performative level of client's conduct therapists' interpretations can still address other facets of the client's self. In particular, they can concern motives for their interactional conduct that the client did not address in their talk, claims about how the client designs the current interaction with the therapist, a shift in causes or objects that are seen as causes for the client's emotions, and challenges of the authenticity of the client's self-positioning, again pointing to unavowed motives and emotions of the client. The shift to topicalizing such performative aspects of the client's conduct amounts to a severe face threat in at least two ways: epistemically, the client is treated as not being (fully) authoritative on their own self; morally, the adequacy of the client's behavior, their goals, and motives are put into question. Thus, psychotherapists are faced with the dilemma to get clients to conceive of their selves in new and often oppositive ways, but yet to respect the clients' face.

In the data, we could see that therapists deal with this dilemma by a particular design of the interpretations that address the performative self of the client as the therapist perceives it *in situ*. Therapists produce lengthy multi-unit turns that start with a display of understanding and empathy with the client that explicitly ratify the client's perspective. Only after this do they turn to a competing perspective that the client does not seem to be aware of, but that is treated as equally or even more important, ascribing behaviors, motives, and feelings that are different from the ones the client has addressed (extracts 2–5) or that serve as a motivational explanation (extract 1). This competing perspective is not just posited, but argumentatively backed with reference to the client's own prior talk (Weiste et al., 2015), to a common ground that has been built earlier in the psychotherapy, general world knowledge, and the therapist's own imaginations concerning the told episodes. Thus, the interpretation is not just delivered as a unilateral observation from a more authoritative, expert position, but therapists try to ground it intersubjectively in joint observation of the client's talk and behavior and their shared interactional history. Furthermore, the therapist's interpretation is introduced in a more or less

[3]The client's distinction between a publicly displayed and a real self is reminiscent of Reich's psychoanalytic account of the "facade" (Reich, 1933) and Goffman's socio-psychological account of self-presentation (Goffman, 1959).

tentative, hypothetical way (see Stukenbrock et al. submitted), which invites the client to self-explore further in the direction of the self-aspects that the interpretation points at. This observation corresponds to current conceptualizations of psychoanalytic interpretation (Heimann, 2016; Civitarese, 2020) that stress its intersubjective and relational aspects.

Yet, this complex and careful design of the therapist's shift to the client's performative self does not always cause clients to align with it, agree with the therapist's interpretation, and indulge in enhanced self-exploration (as in extracts 1, 4, and 5). They may resist (extract 3) or confirm only partially or in passing without entering into a more detailed exploration of the interpretive perspective that the therapist offers (extract 2). In addition, as extract 1 has shown, there may even be a deep misunderstanding between client and therapist in the sense that the client overtly agrees with the therapist, while misconstruing the therapist's action and assessment.

We found that the therapists' shift to the performative self involves focusing on the client's feelings and motives, but less on categorical psychological or moral identity claims (e.g., strength, rationality, honesty), which are focal in clients' stories. Thus, different facets of the self matter to different participants. While prior research on psychotherapy has shown that therapists' interpretations attend in particular to emotions that the client did not address, the positioning perspective adopted in this paper enlarges the picture of how therapists attend to latent psychological aspects. Psychodynamic therapists are more generally sensitive to the here-and-now performance of the client, which importantly includes their ways to conduct the interaction with the therapist, their bodily displays and motives that their discursive actions make available for the therapist. In this way, therapists attend to a larger notion of the client's self that transcends autobiographically based narrative representations in favor of the vision of a performative self that reveals itself in the ways it acts *in situ*.

Sequential analysis of the negotiations between client and therapist following the therapist's shift to the performative self show that such shifts promote the therapeutical agenda by inviting the client's self-exploration (cf. Peräkylä, 2010). Therapists do not necessarily expect clients to confirm straight away the interpretations that they tentatively offer about the client's self. Rather, they use them to elicit and deepen the client's self-exploration, which does not always have to follow closely along the lines of what the interpretation has suggested. Rather, the interpretation can be treated by both parties as a starting point for exploring a better understanding of the client that is to be worked out collaboratively. However, if the client resists to this elicitation, therapists insist on their interpretation, often couching it in more definite and more saturated terms (Will, 2016), making it less tentative (as in extract 3). The shift in positioning levels thus seems to have a preparatory function for promoting the therapeutic agenda and for engendering therapeutic insights, which build immediately on what is intersubjectively observable in the client's multimodal conduct.

DATA AVAILABILITY STATEMENT

All datasets presented in this study are included in the article.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Ethik-Kommission der Albert-Ludwigs-Universität Freiburg. The patients/participants provided their written informed consent to participate in this study. Written informed consent was obtained from the individual(s) for the publication of any potentially identifiable images or data included in this article.

AUTHOR CONTRIBUTIONS

All authors have conducted the analyses presented. AD has written the paper. CS was responsible for data collection. All authors contributed to the article and approved the submitted version.

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APPENDIX

Appendix A | Transcription Conventions GAT 2 (Selting et al., 2011).

[ ]	overlap and simultaneous talk
=	immediate continuation with a new turn or segment, latching
°h/h°	in-/outbreaths of ~0.2–0.5 s duration
°hh/hh°	in-/outbreaths of ~0.5–0.8 s duration
(.)	micro pause, estimated, up to 0.2 s duration
(0.5)	measured pause
and_uh	cliticizations of units
uh, uhm, etc.	hesitation markers, so-called "filled pauses"
:	lengthening, by about 0.2–0.5 s
::	lengthening, by about 0.5–0.8 s
((laughs))	description of laughter and crying
<<laughing>>	comment on speech delivery with indication of scope
SYLlable	focal accent
sYllable	secondary accent
!SYL!lable	extra strong accent
?	rising to high
,	rising to mid
–	level intonation
;	falling to mid
.	falling to low
<<p>>	piano, soft
<<f>>	forte, loud
<<decr>	decrescendo, becoming softer
(may i)	assumed wording

Appendix B | Multimodal Transcription Conventions (Mondada, 2018).

**	Gestures and descriptions of embodied actions are delimited between two identical symbols (one symbol per participant) and synchronized with correspondent stretches of talk.
* – –– >	The action described continues across subsequent lines.
– – –– > *	until the same symbol is reached.
—-	Action-apex is reached and maintained.

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ORIGINAL RESEARCH
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Exploring Conversational and Physiological Aspects of Psychotherapy Talk

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This study is part of a larger exploration of 'talk and cure' that combines the examination of talk-in-interaction with nonverbal displays and measurements of the client's and therapist's autonomic arousal during therapy sessions. A key assumption of the study is that psychotherapy entails processes of intersubjective meaning-making that occur across different modalities and take place in both verbal/explicit and nonverbal/implicit domains. A single session of a psychodynamic psychotherapy is analyzed with a focus on the expression and management of affect, with an aim to describe key interactive events that promote change in both semantic and procedural domains. The clinical dialog is analyzed discursively, with a focus on the conversational processes through which new meanings are jointly constructed and affective states shared; detailed attention is paid to nonverbal displays of affiliation and affect. Furthermore, we explore whether the interactional patterns implicated in joint meaning-making, as revealed by analyzing the therapeutic conversation, have correlates in the autonomic arousal of the two protagonists, as reflected in their heart rates. Conversation analysis has still untapped potential to illuminate interactional patterns that underlie the practice of psychotherapy. In this exploratory study we suggest that discursive analyses of talk-in-interaction can be enriched through detailed focus on nonverbal displays as well as measures of physiological arousal. Drawing upon the analysis, we suggest that bringing the methodological strengths of language-based analysis into fertile dialog with embodied quantitative data can help our explorations of what's really going on in psychotherapy.

Keywords: conversation analysis, psychotherapy process, autonomic arousal, nonverbal interaction, implicit domain, psychoanalytic psychotherapy

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INTRODUCTION

Although there is a proliferation of theories of psychotherapy, there is relatively little in-session research that explores in detail the processes through which change takes place as a session unfolds. In this exploratory single-case study, we examine in detail, and from different perspectives, one session of psychoanalytic face-to-face psychotherapy with an aim to describe therapeutic interaction on both explicit/conscious/verbal and implicit procedural levels (Stern et al., 1998). Our aim is to explore ways to expand our understanding of the interactional processes underpinning

psychotherapy by studying the therapeutic conversation in conjunction with nonverbal displays (primarily of affiliation and disaffiliation) and psychophysiological measures of participants' autonomic arousal during the session. Our methodological approach can be described as a 'layered analysis' (Avdi et al., 2020), as we examine the same interactional events on different levels and using different methods, and combine findings in an attempt to generate a multi-layered, clinically-informed description of therapy process. In line with the focus of this special issue, our broader aim is to better describe 'what takes place' in psychotherapy.

In this study, we approach psychotherapy as a relational process of intersubjective meaning-making; that is, a process through which client(s) and therapist jointly construct meaning, through multiple modalities of communication. Psychotherapy in this sense relies on a particular kind of conversation in a relational context that fosters the reconstruction of meaning and the reformulation of the client's subjectivity (e.g., Avdi and Georgaca, 2018). Since its inception as the 'talking cure', language and meaning have been considered fundamental aspects of psychotherapy, and several discursive and conversation analytic (CA) studies have described different elements of the processes implicated in meaning construction in therapy (for reviews see Avdi and Georgaca, 2007; Peräkylä et al., 2008; Smoliak and Strong, 2018).

In recent years, however, there has been a growing recognition that psychological and social phenomena cannot be viewed in isolation from bodily processes, and researchers increasingly include affect and nonverbal, embodied aspects of communication in studies of human interaction (Cromby, 2012; Wetherell, 2015). The inclusion of affect and embodiment is arguably particularly pertinent in the study of psychotherapy, which entails affectively laden conversations about one's self, life and relationships. Affect is intimately linked with meaning construction in psychotherapy and is an integral part of the work of therapy. Psychotherapy as an institutional practice promotes explicit discussion of the client's affective experience and also examines the manifestation of affect in the session. In most psychotherapy schools, affective experience and expression are considered clinically relevant tasks that play an essential role in constructing new meanings and promoting therapeutic change. Furthermore, the experience, expression and processing (or working through) of affect -particularly negative affect- are considered key mechanisms of therapeutic action (e.g., Greenberg and Safran, 1989). Several important processes of therapy center on affective experience, such as the explicit naming of affect, mirroring and reflecting back the client's affect, and the regulation of affect through the therapist's 'holding' or containing presence (Slochower, 1991; Fonagy and Target, 1996).

Contemporary discursive theories assume that affect 'permeates all utterances across all contexts' (Besnier, 1990, p. 433). In this framework, embodied and affective processes are conceptualized as distinct, dynamic processes that are inscribed in discourse and therefore inseparable from it (Wetherell, 2015). In addition to explicitly referring to one's emotions, affect is mostly conveyed implicitly through various discursive, linguistic, and communicative devices – such as prosody (pitch, tempo, volume of speech and pauses), intonation, lexical choice, syntax – many of which are context and culture dependent (Besnier, 1990). Generally, such work argues that the speaker's affective state is usually alluded to through nonverbal means, rather than explicitly articulated.

Psychoanalytic theory has long recognized the centrality of embodied, affective experience for psychological functioning, our internal world, and our interactions with others. In psychoanalytic theory of change (e.g., Gabbard and Westen, 2003), a key mutative factor is 'insight': that is a process, comprising of cognitive and affective components, whereby unconscious motivation, wish, affect and other psychic elements become conscious. Insight operates within the declarative or conscious verbal domain and concerns knowledge that is explicit, readily brought into conscious awareness, and symbolically represented; in therapy it is promoted primarily through the therapist's interpretations.

In addition to the role of insight, in psychoanalytic theory change is also mediated through the therapeutic relationship and analytic setting (Slochower, 1991). This process of change occurs on an implicit procedural or relational domain; it is non-conscious and represented non-symbolically in the form of *implicit relational knowledge*, i.e., knowledge about ways of 'being with' the other (Stern et al., 1998; Lyons-Ruth, 1999). Change of this sort is seen to rely on implicit, non-conscious relational exchanges between therapist and client, as they co-create a way of being with each other that produces qualitative shifts in procedural 'knowing about relationships' (e.g., Beebe and Lachmann, 2002, 2014; BCPSG, 2002, 2010, 2012). In contemporary psychoanalytic conceptualizations, shifts in implicit relational knowledge often take place following 'moments of meeting', that is moments of authentic person-to-person connection that are usually associated with heightened affect (Stern et al., 1998, p. 904). Stern et al. (1998) describe such moments as affectively 'hot,' unique moments of opportunity that, if seized, can bring about change. They represent moments where 'the habitual framework -the known, familiar, intersubjective environment of thee therapist-patient relationship– has all of a sudden altered or risks alteration' (1998, p. 911), often occurring when the therapeutic frame is challenged or broken. On a subjective level, they can be experienced as unfamiliar, unsettling or weird yet full of potential. Importantly for our purposes, such changes on an implicit level are closely associated with affect; these mutative exchanges implicate several affective processes, such as the mutual recognition and regulation of affective states, moments of affective understanding, and moments where this understanding is lost and then re-established in a process of self- and co-regulation of affect between interacting partners (Beebe and Lachmann, 2002; BCPSG, 2008). So, change in the implicit level takes place in an intersubjective context that is created through affective communication and mediated nonverbally; it includes several nonverbal behaviors such as vocal rhythms, gaze, orientation, intonations, posture, facial expression etc. (Stern et al., 1998).

These mechanisms of change, i.e., insight and shifts in implicit relational knowledge, are complementary, potentially mutually reinforcing, and often intertwined; however, they are distinct as

they operate in different domains and through different change mechanisms (BCPSG, 2008). Drawing upon the above, in this study, we attend to nonverbal behaviors and autonomic arousal in addition to language, in an attempt to take into account both the explicit and implicit domains of psychotherapy process.

The therapeutic task, in line with these ideas, involves two key therapist activities: interpretations and 'holding' or containment (Slochower, 1991). Interpretations are a defining feature of psychoanalytic technique whose function is to make an unconscious phenomenon conscious (Gabbard and Westen, 2003). Interpretations invite further elaboration, reflection or emotional expression and aim to promote insight. In an interpretation the therapist introduces some additional meaning in what the client says, usually by providing links between different domains of experience, traditionally linking defense and anxiety in the context of past experience, current life and relationships, and the therapeutic relationship or transference (Malan, 1995). These meanings are thought to be unconscious, and possibly defended against, but evidenced within the client's associations, transferential actions and affects. Interpretations often focus on the unconscious mechanisms employed in the service or resistance, i.e., defense mechanisms. The terms, 'resistance' and 'defense' have become utterly fixed in psychoanalytic theory but can be problematic as their use outside psychoanalytic theory can be quite pejorative. In psychoanalytic theory, resistance is a defense against insight, the active, unconscious opposition against recognizing aspects of one's experience (a feeling, experience, memory, phantasy), when this knowledge is somehow unacceptable (Rangell, 1983). Psychoanalytic interpretations often focus on manifestations of resistance and explore the underlying affect/wish/idea/experience that is being defended against. Another type of interpretative activity involves transference interpretations that concern resistance in the context of the therapeutic relationship (Gabbard and Westen, 2003).

A metaphor commonly used to describe the non-interpretative aspect of psychoanalytic work is 'holding,' originally developed by Winnicott (1963), who drew parallels between psychotherapy and the parent-infant relationship. This term in the context of psychotherapy refers to the affective 'holding' provided by the psychoanalytic setting and attitude in the context of the therapeutic interaction. It is both a necessary backdrop to interpretative work and a curative factor in and of itself and is associated with the therapist's reliably available and responsive presence (Slochower, 1991), which provides a regulatory function to clients' affective arousal. Over the last decade there has been a shift from framing this as work done by the therapist to recognizing the bi-directional nature of interaction and to highlight the mutual co-regulation of affect in psychotherapy (e.g., Beebe and Lachmann, 2002; BCPSG, 2010, 2012). Interpretation and holding are not always easy to disentangle and are often mutually reinforcing.

Several studies using Conversation Analysis (CA) have examined the design, organization, trajectory, and function of interpretations in the context of psychoanalytic psychotherapy as well as clients' responses to them (e.g., Vehviläinen, 2003; Peräkylä, 2004, 2008, 2010). These studies suggest that the preferred response to an interpretation is 'an extended agreement' (Bercelli et al., 2008), whereby the client provides further, usually autobiographical, material or elaborates, rather than simply confirming the idea or agreeing. A common way in which therapists encourage such elaboration, when it is not forthcoming, is by adding increments to the interpretation (e.g., Peräkylä, 2010).

Although the psychoanalytic concept of holding has not been studied explicitly by CA, several studies have examined the affective dimension of the clinical interaction, in line with the recognition of the importance of studying affect when examining social interaction (e.g., Voutilainen et al., 2010; Weiste and Peräkylä, 2014). In these studies, the expression and management of affect has been studied in relation to lexical and syntactic choices, pauses, as well as nonverbal displays such as prosody, gesture, and facial expression. For example, there is evidence that prosody plays an important role in creating meaning and regulating affect independently from the content of talk (e.g., Tomicic et al., 2014; Weiste and Peräkylä, 2014). Vocal characteristics such lower volume, slower rhythm, and softer intonation, as compared to surrounding speech, have been described as 'soft prosody,' and have been shown to be an important conversational resource in psychotherapy that can function to elicit emotional expression and to facilitate the emergence of new meanings (e.g., Weiste and Peräkylä, 2014; Kykyri et al., 2017). Other aspects of affiliative and empathic response include verbal continuers (e.g., 'uh huh,' 'yeah') and nods (Stivers, 2008; Voutilainen et al., 2019), affiliative (compassionate, caring) facial expression (Chovil, 1991; Peräkylä and Ruusuvuori, 2012), pauses (Levitt, 2001), and smiling.

Although psychoanalytic holding has not been studied using CA, the overlapping idea of the therapeutic alliance has, particularly through focus on the concepts of alignment and affiliation. Stivers (2008) suggested a distinction between alignment and affiliation, two separate functions of the listener's response in the context of storytelling. Alignment concerns the activity of storytelling itself, and refers to cooperative actions that facilitate the conversational sequence. Affiliation refers to verbal and nonverbal actions that display acceptance and agreement with the teller's affective stance, and as such is associated with empathy, rapport, reciprocity, engagement and interpersonal sensitivity (Lindström and Sorjonen, 2013). A few recent CA studies have used these concepts to examine the establishment, maintenance and repair of the therapeutic alliance in psychotherapy (e.g., Sutherland and Strong, 2011; Muntigl et al., 2013; Muntigl and Horvath, 2016).

Given that discursive research on the affective and nonverbal processes implicated in therapy is rather limited, and in order to contextualisz our study, in the next section we present literature from two related areas of research: nonverbal interaction in psychotherapy and interpersonal physiology in social interaction.

Nonverbal Interaction in Psychotherapy

Human interaction is inherently multimodal, in the sense that it relies upon the intertwined cooperation of multiple channels of communication; these include the vocal/aural modality, i.e., speech and prosody, and the visuospatial modality, i.e.,

facial expression, body movement, gaze, gesture etc. (Stivers and Sidnell, 2005). These different modalities work together to construct meaning, through more or less coherent courses of action, and as such meaning is co-constituted across verbal and nonverbal modalities rather than merely constructed through talk (Cromby, 2012). Importantly for the context of psychotherapy, nonverbal aspects of communication and the manifestation of affect in talk are conveyed and processed primarily non-consciously, through an embodied form of knowledge (Besnier, 1990).

Given the multimodal nature of face-to-face dialog, the different modalities can work together, i.e., the same message being conveyed across verbal and nonverbal domains (for example tone of voice, facial expression and verbal content). However, these different modalities may at other times convey different messages. Such intermodal discrepancies can be either a communicative resource, as is the case in humor or sarcasm (e.g., Besnier, 1990), or potentially problematic for communication, especially if this incongruence goes unmarked. This has been described as creating a 'double bind' for the listener; in the infant development literature such intermodal discrepancies -e.g., simultaneous positive facial affect but negative vocal affect- have been described as affective communication errors, and are considered a risk factor for the development of disorganized attachment (e.g., Lyons-Ruth, 1999; Beebe et al., 2012). Importantly, there is some evidence that when such discrepancies occur between modalities it is generally the non-referential, i.e., nonverbal, signs tend to override other signs (Besnier, 1990).

Although limited, research on nonverbal processes (such as body orientation, postural sharing, smiling, nodding, and prosody) in psychotherapy suggests that nonverbal behavior is crucial for the therapeutic alliance and for the creation and communication of empathy (Hall et al., 1995; Knoblauch, 2000; Philippot et al., 2003). Much of research on nonverbal interaction has used the concept of *interpersonal coordination*, a term that refers to the degree to which the behaviors in an interaction are non-random, patterned or synchronized in both timing and form (Bernieri and Rosenthal, 1991). Two well-studied phenomena associated with interpersonal coordination are behavioral matching or mimicry (doing what the other is doing) and interactional synchrony (the intersubjective covariation of behavior or internal states in interacting partners, see e.g., Feldman, 2007). There is ample evidence that in social interactions we tend to match our behavior with that of our interaction partner on both verbal (e.g., tone, word choice, laughter, speech accent, syntax, and intonation) and nonverbal levels (posture, gesture, facial expression etc.). This occurs from very early in life and is considered an automatic, non-conscious process that is, however, regulated by top-down processes. Interpersonal coordination is associated with liking, affiliation, rapport, cooperation, self-other merging, perspective-taking, empathy, smoothness of interaction, and prosocial behaviors (Lakin and Chartrand, 2003; Chartrand and van Baaren, 2009). It is considered fundamental for the formation of social bonds, and it is assumed that it has evolved in order to communicate shared understanding and a sense of togetherness, and to help establish shared affectivity and empathy.

In the literature on psychotherapy 'being in sync' is thought to constitute a key component of rapport (Lakin and Chartrand, 2003) and has been associated with therapist responsiveness and the therapeutic alliance (Koole and Tschacher, 2016). In research on psychotherapy, for example, postural congruence and physical mirroring between client and therapist during sessions has been found to correlate with perceived empathy (Davids and Hadiks, 1994) and rapport (Raingruber, 2001), and movement synchrony has been shown to be positively associated with the therapeutic alliance, session quality and therapy outcome (Tickle-Degnen and Rosenthal, 1990; Ramseyer and Tschacher, 2006, 2011, 2014).

In a related line of inquiry, Bänninger-Huber and Widmer (1999) studied therapist's nonverbal responses to client's smiles in psychodynamic therapy and suggest that such nonverbal responses play an important role in regulating negative affect and constitute an important implicit component of the therapeutic alliance. Their findings suggest that an optimal degree of conflictive tension (associated with the therapist not responding to the client's affiliative invitations), while maintaining relationship security is associated with therapy outcome (e.g., Bänninger-Huber and Widmer, 1999; Benecke et al., 2005). Similarly, research on ruptures and repairs of the therapeutic alliance (e.g., Safran and Muran, 2006) suggest that therapeutic interaction consists of periods of responsiveness interspersed with periods of mismatch and non-complementarity. In fact, there is evidence that psychological resilience, attachment security and therapeutic change are promoted through processes of rupture and repair in attunement and through mutual regulation, rather than simply by being in sync (e.g., Safran and Muran, 2006).

Interpersonal Physiology and Psychotherapy Process

The autonomic nervous system (ANS) activation is closely associated with affective and cognitive processes, as well as other physical processes such as movement. For this reason, measures of ANS activation, such as electrodermal activity and heart rate, are considered correlates of affect and more specifically of the arousal component of affect. Affect is generally conceptualized in terms of two independent dimensions: valence (refers to its hedonic tone, positive/negative) and arousal (refers to the associated degree of bodily activation) (Posner et al., 2005). Autonomic activation is associated with the arousal component of affect, although the valence of affective experiences cannot be deduced from such measures. Indeed, it seems that different emotions such as anger, fear, happiness, and joy are all associated with increased physiological arousal, whereas sadness -and in particular sadness that is not accompanied by crying or anxiety- is associated with decreased arousal (Kreibig, 2010). Research on the physiology of social interaction generally and psychotherapy more specifically has a long history but is limited and rather fragmented (for recent reviews see Palumbo et al., 2016; Kleinbub, 2017). A review of this literature is beyond the scope of this paper, but findings from research on autonomic arousal in psychotherapy and other contexts that may be relevant to psychotherapy are briefly presented below.

There is some evidence that processes of self-construction, identity negotiation and positioning in social interaction are associated with increases in autonomic arousal, particularly in situations of threat to identity or blaming (Lyons and Cromby, 2010; Päivinen et al., 2016). In relation to the context of storytelling, Voutilainen et al. (2014) found that, when listening to stories characterized by ambivalence (i.e., where the storyteller had both a negative and positive stance toward the event narrated), the recipient showed increased autonomic arousal as compared to listening to 'purely' happy or sad stories. In a related study (Peräkylä et al., 2015), displays of affiliation by the recipient were associated with increased autonomic arousal in the recipient and decreased arousal for the teller. This finding was interpreted as reflecting a sharing of the 'emotional load' between interacting partners, whereby the listeners' engagement regulated the teller's physiological arousal (Peräkylä et al., 2015). This hypothesis was also explored in the context of psychoanalytic therapy with similar results: the therapists' empathic displays were associated with increased arousal in the therapist and decreased arousal in the client; challenging, on the other hand, was associated with increases in the therapists' arousal whilst challenging, and the clients' arousal in the session as a whole (Voutilainen et al., 2018). On the other hand, in the context of couple therapy, clients' autonomic arousal was found to increase when their words were mirrored by another speaker or when they were the topic of discussion, as well as sometimes during silent moments (Seikkula et al., 2015).

Findings from studies examining autonomic arousal in romantic couples suggest that lack of congruence between one's feelings and behaviors as well as lack of emotional expressiveness are associated with increased arousal (Perrone et al., 2014). Similarly, actively suppressing emotional expression has been found to be associated with increased physiological arousal in both interacting partners (Butler et al., 2003). A similar argument was made by Marci and Riess (2005) in a single case study of psychodynamic therapy, where the client's elevated autonomic arousal, in combination with her well-controlled demeanor, was interpreted as reflecting unexpressed affect. It seems that the suppression of affect may also be associated with increased autonomic arousal and in psychoanalytic terms this could be conceptualized as relating to intrapsychic conflict.

Another group of recent studies examining autonomic arousal in psychotherapy focus on physiological concordance or linkage, 'the social coupling of two (or more) individuals in the here-and-now of a communication context that emerges alongside, and in addition to, their verbal exchanges' (Tschacher and Meier, 2020, p. 558). Some early studies showed evidence for autonomic concordance between clients and therapists (e.g., DiMascio et al., 1957), a finding that has been explored further more recently (e.g., Marci et al., 2007; Villmann et al., 2008; Karvonen et al., 2015; Seikkula et al., 2015, 2018; Kodama et al., 2018; Tschacher and Meier, 2020). Findings from these studies are mixed; however, one finding that has been shown across several studies on psychotherapy sessions (as well as in studies of simulated sessions, e.g., Marci and Orr, 2006; Messina et al., 2013; Palmieri et al., 2018) is a correlation between ratings of empathy and the degree of physiological linkage between therapist and client. Despite some such relatively consistent findings, research on interpersonal physiology in psychotherapy is still in its infancy and is characterized by methodological and conceptual diversity which makes it difficult draw any definite overarching conclusions, other than that there is evidence of autonomic linkage between therapist and client during sessions (Kleinbub, 2017). Initial findings suggest that physiological linkage in interacting partners -both in the context of psychotherapy and other contexts- may be implicated in several different relational processes that are fundamental to the process of therapy, such as empathy and rapport, affect contagion and nonverbal, implicit communication of affect, the therapeutic alliance, and mutual affect regulation. These observations highlight the complexity of the therapeutic encounter and support the view that it is important to take into account nonverbal (and arguably non-conscious) aspects of the interaction when studying psychotherapy process.

This Study

In this paper we adopt a case study approach and examine a single session of face-to-face psychoanalytic psychotherapy using conversation analysis, with an aim to track the process of therapy through one session. Although case studies are limited in their generalizability, they can illustrate important clinical concepts and techniques, help formulate hypotheses about clinical process, and can contribute to theory building. In this case study, we use a 'layered' analysis, in the sense that we examine the session on three different levels: conversation, nonverbal displays and autonomic arousal, and then combine these observations to produce a multi-layered description of the process of therapy.

METHOD

Materials and Methods

The material in this case study is drawn from a larger research project, conducted at the Aristotle University of Thessaloniki, Greece as part of broader study that aims to study the process of psychotherapy on multiple levels (Seikkula et al., 2015). It involves video-recording of sessions of face-to-face psychoanalytic psychotherapy conducted in a public, community mental health center that provides weekly psychoanalytic therapy. Ethics approval has been granted by the Center's scientific council. To date, seven therapies, conducted by two experienced, female psychoanalytic therapists have been recorded, with a total of 137 sessions.

Clients are informed about the study at the intake interview and, if interested, are fully informed about the study by a graduate researcher. There are no specific inclusion criteria, as the study aims to explore routine clinical practice in naturalistic settings. All sessions are video-recorded and in specific sessions (at the start of therapy and then approximately every 6 months) both therapist and client wear heart-rate monitors to record their autonomic arousal during the session. Within 24 hours of these 'measurement sessions,' the researcher conducts Stimulated Recall interviews (Kagan et al., 1963) with the client and therapist separately. At the start of therapy and

at the measurement sessions clients complete the CORE-OM (Evans et al., 2000) and the Working Alliance Inventory (Horvath and Greenberg, 1989). In this study, we do not refer to findings from the interviews.

The research material used in this case study consists of the video and detailed transcript of the session, including key nonverbal displays, and the autonomic arousal of each participant the duration of the session. With regards to autonomic arousal, both participants wore a small portable sensor (Firstbeat Bodyguard) that recorded their heart rate (HR) during the session. The sensors were synchronized using a Network Time Protocol (NTP) server to a resolution of 1 s and, at the start of each measurement session, the computer used to record the session was also synchronized with the same NTP server. Based on these measurements the Absolute Stress Vector (ASV), a second-by-second index that reflects sympathetic nervous system arousal, is calculated. The ASV is derived from the heart rate (HR), high frequency power, low frequency power and respiratory variables derived from heart rate variability (HRV): 'ASV is high when heart rate is elevated, HRV is reduced, and respiration rate is low relative to HR and HRV' (Kinnunen et al., 2006, p. 2). The ASV has been described as a new HRV-derived variable, which arguably shows resilience to heart rate artifacts and reflects sympathetic arousal more accurately than simple HR; it has been found to correlate with self-reports of stress (Myllymäki, 2006) and has recently been used in studies examining physiological arousal in psychotherapy[1] (e.g., Seikkula et al., 2015; Kykyri et al., 2017).

Methods of Analysis

The process of analysis was multi-layered and iterative. The session was transcribed verbatim and then key nonverbal displays were added to the transcript. Due to the nature of the analysis, which necessitates longer stretches of talk, the extracts are segmented into speakers' turns, rather than lines as is more common in CA. In addition to transcribing verbal interaction, nonverbal aspects of the interaction were marked in the transcript, following the respective turn. These included displays of affiliation (facial expression, gaze, prosody, and smiling) and markers of tension and regulation of negative affect (adaptors). The transcription notation is shown in **Table 1**.

For the analysis of talk, the session was initially segmented into topical episodes (TEs), i.e., periods of time during which a specific topic was discussed. Coding of the TEs was carried out independently by two researchers and any discrepancies were resolved through discussion. This initial thematic coding provides a broad-brush description of the main topics discussed in the session. Next, talk in each topical episode was examined through conversation analysis (CA) with a focus on talk about affect.

Conversation analytic is an approach to studying social interaction that draws upon ethnomethodology, a sociological approach developed in the 1970s that 'seeks to explicate processes of inference upon which the everyday social order is based' (Peräkylä et al., 2008, p. 12). CA examines the organization of interaction with a focus on the sequence of utterances, and over the last 15 years has been increasingly recognized as a powerful tool for psychotherapy research that can help study how affectively laden meanings can are transformed in and through the therapeutic interaction (for an introduction to CA in psychotherapy see Peräkylä et al., 2008). In this study, we draw upon and adapt the methods of CA to study one session of psychoanalytic psychotherapy with a focus on talk about affect as well as on the manifestation and management of affect in the session. More specifically, we initially examined talk-in-interaction on a macro-level, i.e., following the transformation of the meanings surrounding affect through the session, and subsequently focused on the 'local level,' by studying in detail specific interactional events of therapeutic work around the client's affect, with a focus on the therapist's verbal and nonverbal responses to the client's expression of affect. We suggest that expanding the focus of analysis to longer stretches of talk than is common in CA allows us to trace the gradual transformation of meaning through the session, and to map the client's changing responses to the therapist's interventions across the full time-scale of the session. Finally, the contours of physiological arousal, as reflected in the ASV of participants, were examined in relation to the topics discussed and the interactional work carried out. ASV data were read from commercial software export noted above into R (version 4.0.2, R Core Team, 2020). The quantitative data analytic strategy was purely descriptive following the CA, reporting means and standard deviations for both protagonists across the whole session and within the TEs and using plots of the ASV to allow the reader to align the detailed analyses of the

TABLE 1 | Transcription notation.

Symbol	Meaning
(2)	Silence in seconds
(.)	Silence <0.2 s
.	Falling intonation at end of utterance
,	Continuing intonation at end of utterance
?	Rising intonation at end of utterance
(. . .)	Lines of extract omitted
°word°	Utterance spoken quietly
WORD	Utterance markedly loud
Word	Emphasis
.hhh	Audible inhalation
Hhh	Audible exhalation
	Stretch of talk slower
>word<	Stretch of talk rushed
heh	Laugh particles
wo:rd	Prolongation of sound
wor-	Truncated, cut-off speech
((cough)) ((sigh))	Audible non-speech sounds
[word]	Transcriber's note
[	Starting point of overlapping talk
]	Endpoint of overlapping talk
((looks away))	Nonverbal behavior

[1]For a list of publications using Firstbeat measurement devices see: https://www.firstbeat.com/en/science-and-physiology/white-papers-and-publications/.

discourse both within the sequence of ASV changes across the full session, and, in "zoomed in" plots by extract.

Case Description

The specific therapy was selected for further analysis in collaboration with the therapist. The therapy consisted of 30 sessions of face-to-face psychoanalytic therapy lasting 15 months, and the session discussed in this paper is session 19, which was the second measurement session. The therapist described the therapy as 'stuck' and said she struggled to make sense of the specific session.

The client, 'Kate,' is a white, heterosexual married woman in her late thirties, who came to therapy experiencing anxiety and depression, which she attributes to difficulties in her relationship with her father. Her father has serious health problems and Kate has been looking after him over the past few years, as his health gradually deteriorated. He is described as demanding, uncooperative, irritable, and at times verbally aggressive. This leads to many fights, and Kate feels intense guilt about her angry outbursts. She has two older brothers, who live away and are not involved in their father's care. Her mother died several years earlier. During the course of therapy, Kate became pregnant and terminated therapy shortly before giving birth, despite the therapist's encouragement for her to continue. The therapist is a senior female psychiatrist and psychoanalyst, in her mid-fifties, with over 25 years clinical experience.

FINDINGS

The session split into eight TEs, as shown in **Table 2**.

We initially present a simple description of the trajectory of autonomic arousal through the session for both participants, followed by analysis of the session in terms of conversation and nonverbal interaction.

Quantitative ASV Data

There are 2,863 s (47′16″) in the session but 57 ASV values were missing for the therapist from 09:36:37 (2,041 s into the session) to 09:37:33 (2,097 s). These data -two sequences of numbers, one per person per second – are very simple beside the enormous complexity and elaboration of verbal and nonverbal communication data: the data from each person are purely one dimensional, there is no turn-taking, no overlaps, more accurately, every second is an overlap of two values. However, there are many ways to analyze such data and conventions about how best to simplify and highlight aspects of the data. Here, we have used plots against time and a violin plot to show distributions.

Figure 1 plots all the ASV against time across the whole session so as to map the data to the CA below.

This shows the marked changes in ASV over time for both participants; the client's mean ASV (194.3) is higher than the therapist's (109.7), so too for the variance (2,086 vs. 480.2). The client's ASV declines across the session unlike that of the therapist. This is shown by the regression lines showing some fit to a simple linear relationship of ASV with time for the client.

Figure 2 is a violin plot organized by the TEs. This removes the sequence of the ASV changes within each TE so, instead of the jagged ups and downs, the distribution of values within the TE can be more readily observed. It can be seen that the means and variances vary quite markedly between TEs, markedly more so for the client than for the therapist. It can also be seen that, as well as the differences in means, ranges and variances, there are clear differences in the distributions of values between TEs: some are bimodal, i.e., with two distinct most frequent values, e.g., client TE 7, though most are unimodal; some show strong "skew" with a long thin distribution of high ASV above the median, very different from the short wide distribution below the mean, e.g., Therapist TE 3.

Analysis of Conversation and Nonverbal Interaction in the Session

In terms of content, the key theme of this session, which is a central issue throughout the therapy, concerns Kate's difficult feelings toward her father; she becomes angry with him easily and behaves abruptly toward him, and is then riddled with guilt.

TABLE 2 | Topical Episodes with time, duration, and autonomic arousal values for client and therapist.

TE	Theme	Start	End	Duration (sec.)	Client ASV		Therapist ASV	
					Mean	*SD*	Mean	*SD*
1	Initial problem construction: Kate's guilt, sense of inner badness and fear about father's death	9:02:41	9:07:40	299	219	45.3	100	13.1
2	Account of recent incident of father's rejection	9:07:41	9:13:18	337	219	63.2	119	24.6
3	3 stories about difficult relationship with Father and his rejection	9:13:19	9:24:59	700	202	42.3	110	20.5
4	Father's will and sense of injustice regarding her brothers	9:25:00	9:32:01	421	198	40.2	100	16.1
5	Frustration and anger with brothers	9:32:02	9:35:51	229	188	28.4	108	24.3
6	Interpretative work regarding anger, guilt and self-blame	9:35:52	9:40:56	304	166	38.4	121	16.3
7	Account of difficult relationship with father and sense that he doesn't care	9:40:57	9:46:29	332	173	25.5	101	15.3
8	Interpretative work regarding anger, guilt and self-blame	9:46:30	9:49:52	202	164	24.1	130	28.3

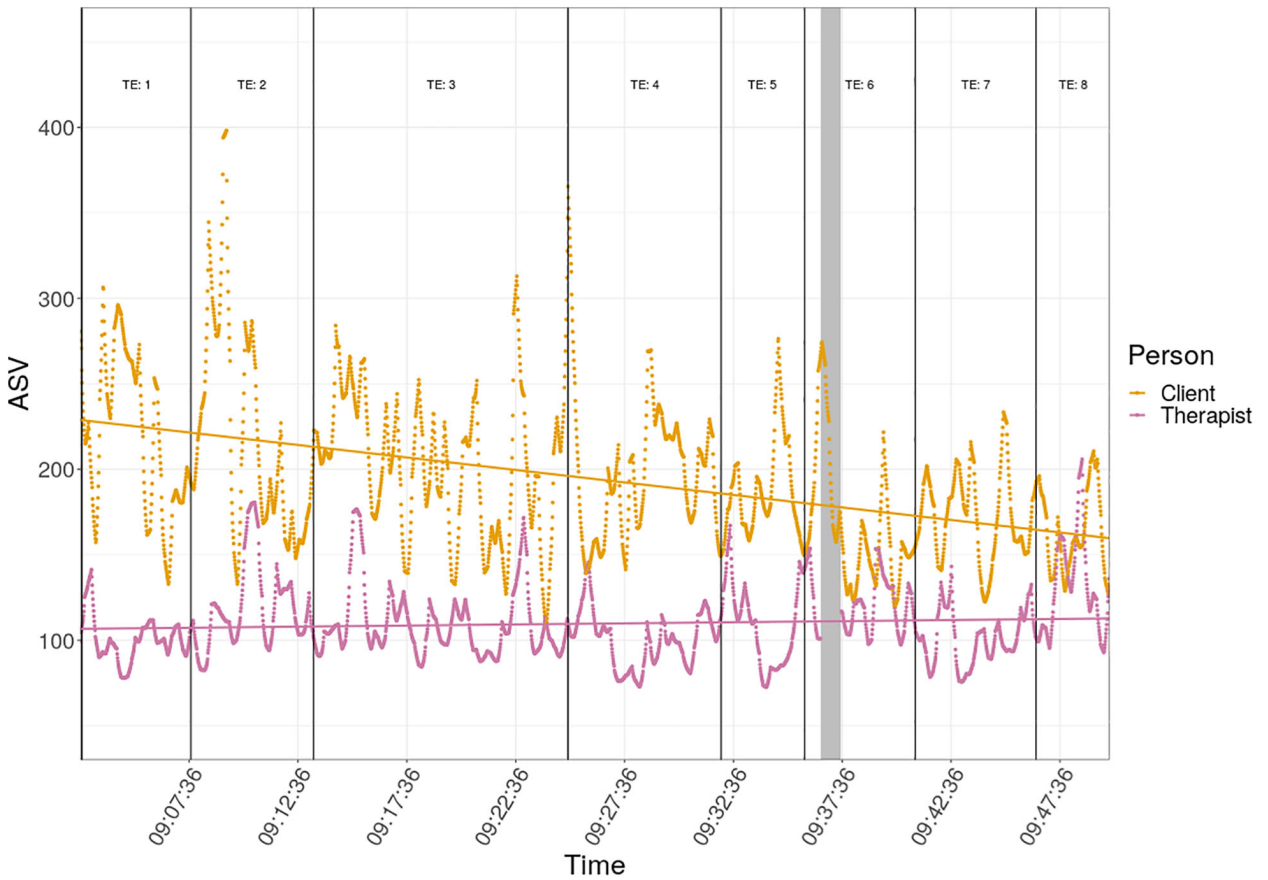

FIGURE 1 | Absolute stress vector (ASV) and ASV linear trend against time for client and therapist. Vertical lines mark the boundaries between the numbered Topical Episodes (TEs). The gray vertical rectangle marks the missing therapist ASV values.

Much of the discussion through the session is oriented toward resolving the affectively charged 'puzzle' that Kate introduces in the first topical episode: her recurring, persistent, crippling guilt, and sense of internal badness. In the analysis that follows we examine interactional work around affect with a focus on the therapist's verbal and nonverbal responses to Kate's affective expression and the ensuing, gradual shifts in affective experience and meaning construction.

Initial Phase: Shifting Affect From Anger to Longing

In the initial phase of the session, which includes TEs 1–3 and lasts approximately half of the session time, Kate introduces the problem and then narrates several incidents concerning her relationship with her father that illustrate his 'difficult character' and his rejecting behavior toward her. The conversation during this phase is asymmetrical, in the sense that Kate speaks in long stretches of talk, in an animated tone, and expresses her frustration with her father both verbally and nonverbally. The therapist, speaks very little in this initial phase; in the first 25 min of the session, she only utters seven turns, out of which six are brief formulations that focus on Kate's affect and one is a question inviting reflection, in response to Kate's initial turn. This is characteristic of psychoanalytic practice in which space is given for the clients' free association to develop in order for the unconscious associations to gradually manifest. Below, we present two extracts from this initial part of the session to illustrate the interactional processes implicated in managing affect.

This session takes place after a one-week break and starts with Kate providing an account of a difficult time she had during the intervening fortnight. She reports how one day she started to cry and was unable to stop, repeating the phrase 'I am a bad person,' filled with guilt about having shouted at her father during one of their arguments. She completes this initial problem description in a reflective manner, wondering what has changed: she used to feel justified in her anger toward her father, but this has recently changed. Following Kate's opening turn, the therapist joins in her account and invites exploration of the factors that may lie behind her increased guilt. Kate tentatively suggests that perhaps her guilt is associated with underlying fear and sadness about the prospect of her father's death. In this initial construction, the problem is defined as relating to Kate's strong negative feelings, which are represented as outside her control and understanding; as such the agenda for the session is set to help solve the 'puzzle' of Kate's intense guilt and anger.

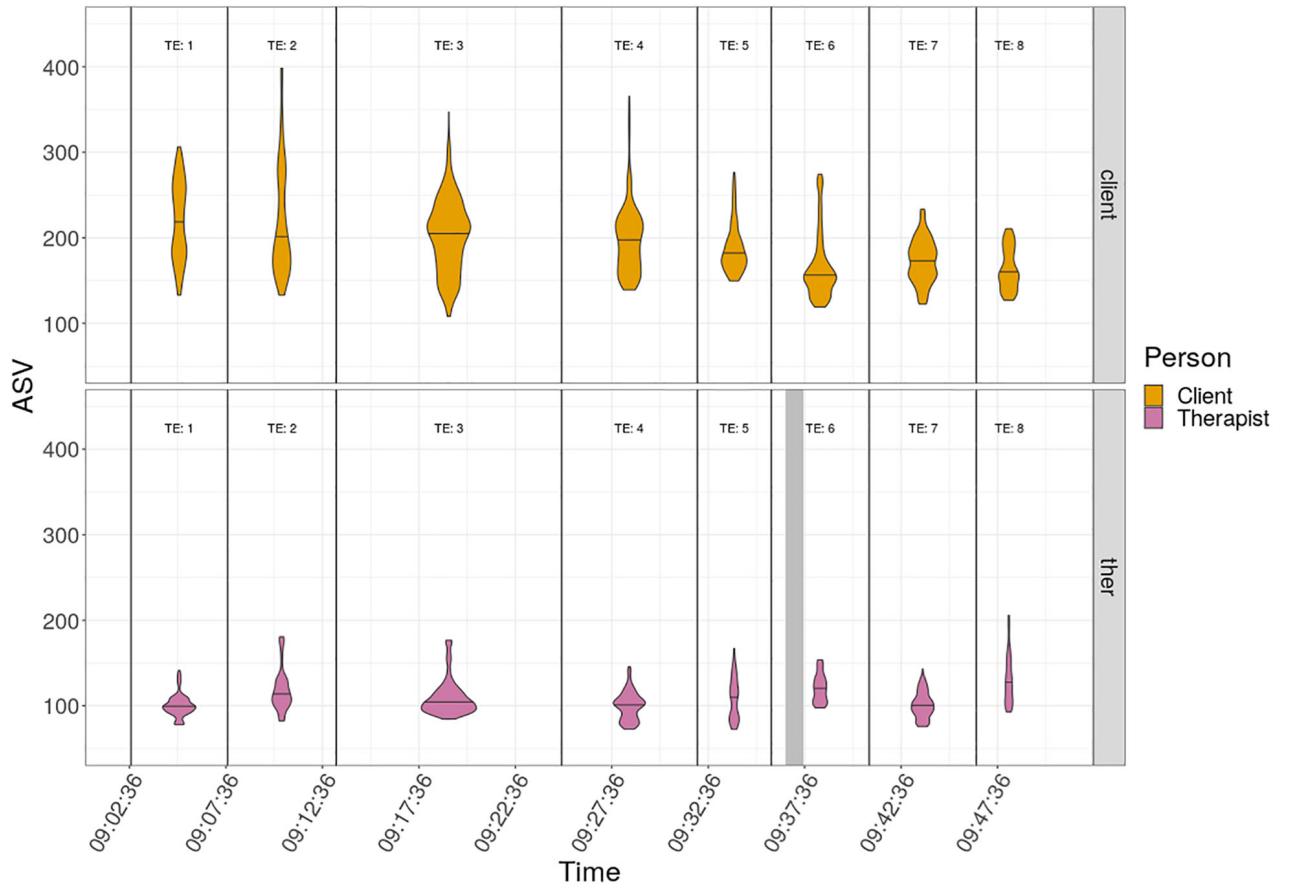

FIGURE 2 | Violin plot of ASV of client and therapist by Topical Episodes. Separate violin plots of ASV are positioned on the midpoints of the TEs for the client and therapist. A violin plot gives a picture of the distribution of values. The areas of the "violins" are proportionate to the number of values hence the larger violins for the longer TEs and the larger violin for the client than the therapist for TE 6, which has the missing therapist ASV values. The violins stretch from the minimum to the maximum ASV value per person per TE and the horizontal waist lines on the violins mark the median scores for the person and TE. The widths of the violins show the actual distribution of values (which are marked on the *y*-axis).

Following the opening interaction described above, Kate narrates a recent incident with her father and she concludes with the evaluation that it upset her: she was driving her father to a regular hospital appointment and had arranged to stop briefly and meet a friend on the way there. This friend complimented her on her creativity, praising something she had recently made; her father did not acknowledge the compliment but rather complained about the delay in getting to the hospital (the whole narrative with its introduction and evaluation lasts from 9:07:40 to 9:10:51). **Extract 1** below follows the narration of this incident and the ASV of the protagonists through the extract is shown in **Figure 3**.

At the start of turn 1, in completing her storytelling Kate evaluates it as part of a pattern ('it happened before') and as affectively relevant (it 'upset me'). She then (1b) begins to 'replay' the dialog with her father, addressing him as if he were present. Enacting part of a dialog is a powerful way to convey affect in conversation and possibly induce it in the listener (Besnier, 1990). In discursive research, vivid descriptions are considered a rhetorical strategy of factualization, that is as a way of rendering an account plausible as accurately depicting facts. In this way, the possibility of one's account being assessed as biased by the listener is minimized (Edwards and Potter, 1992). Similar 'enactments' are a common feature in Kate's talk in this session. From a psychoanalytic perspective, this turn design could be seen as a (non-conscious) way of managing guilt: Kate talks as if she *expects* the therapist to doubt her version of events or assume that she is somehow at fault, and so her account is structured in such a way as to convince that it is a true and accurate record of what actually happened. During this narration, Kate's talk becomes louder and more animated; the therapist, however, displays few signs of engagement and alignment with Kate's story: she has a neutral facial expression, looks away from Kate much of the time, and does not provide any verbal continuers.

In terms of autonomic arousal, as can be seen in **Figure 3**, Kate's arousal reaches its highest value in the session as she narrates the incident with her father described above (9:08:22 – 9:10:51), and her ASV remains elevated throughout the interaction presented in **Extract 1**. The therapist's arousal also rises significantly during Kate's storytelling, and peaks about

EXTRACT 1 | From 9:09:36 to 9:13:15.

1a	K	(3) .hhhh and this upset me, once more, [although it is] something that I know, it has happened before in be:tter and worse ways (.)
		((K gestures and then touches her face))
1b		And then I said to him, dad, I say, what do you want me to do? To die completely? 100 percent? like (.) > not spend any time on my own things? on the things that I have to do? all the time<, most of my time I do things for you
		(. . .)
1c		and I told him (2) if it was anyone else, I say, > and somebody said something like that, like, they would smile, they would smile from ear to ear, if somebody said something good about their child, and you, like, the only thing you care about is that we won't get there [to the hospital] at quarter to as you wanted?< and even then (1) .hhh ((sighs)) he didn't say anything
1d		and then (.) I was thinking about (3) my mother *((K bites lips))* how she was the exact opposite of that, like, m:y mum (.) like, I would make >a small ball out of plasticine< and she would act as if, like, I: had received a pri:ze in nuclear physics (1) oh, look at what my child made (.) and it could be nothing, for her (.) in her eyes it was the: greatest thing in the world
		((T neutral facial expression))
2	Th	((coughs)) °You miss that a lot°
		((T empathic facial expression))
3	K	I do miss it, on the other hand I was thinking that that >perhaps my mother EXAGGERATED because she saw that nothing like this was coming from my father< *((gestures))* (. . .) perhaps she exaggerated because (.) my father showed (.) no positive response to anything like that
4	Th	So, he disappointed you (0.5) °in the past too° <°°your father, [not just now°°>
		((T empathic facial expression))
5	K	[((sighs)) *((K bites her lips))* (2) I don't have a very clear memory but (.) I don't remembe:r my father saying well done for anything (.) of course he was away a lot (.) I don't know if I don't remember it because I have repressed it (.) >I don't know if I don't remember it because this over-< because my mothe:r's exaggerated joy was enough for me (.) I don't know

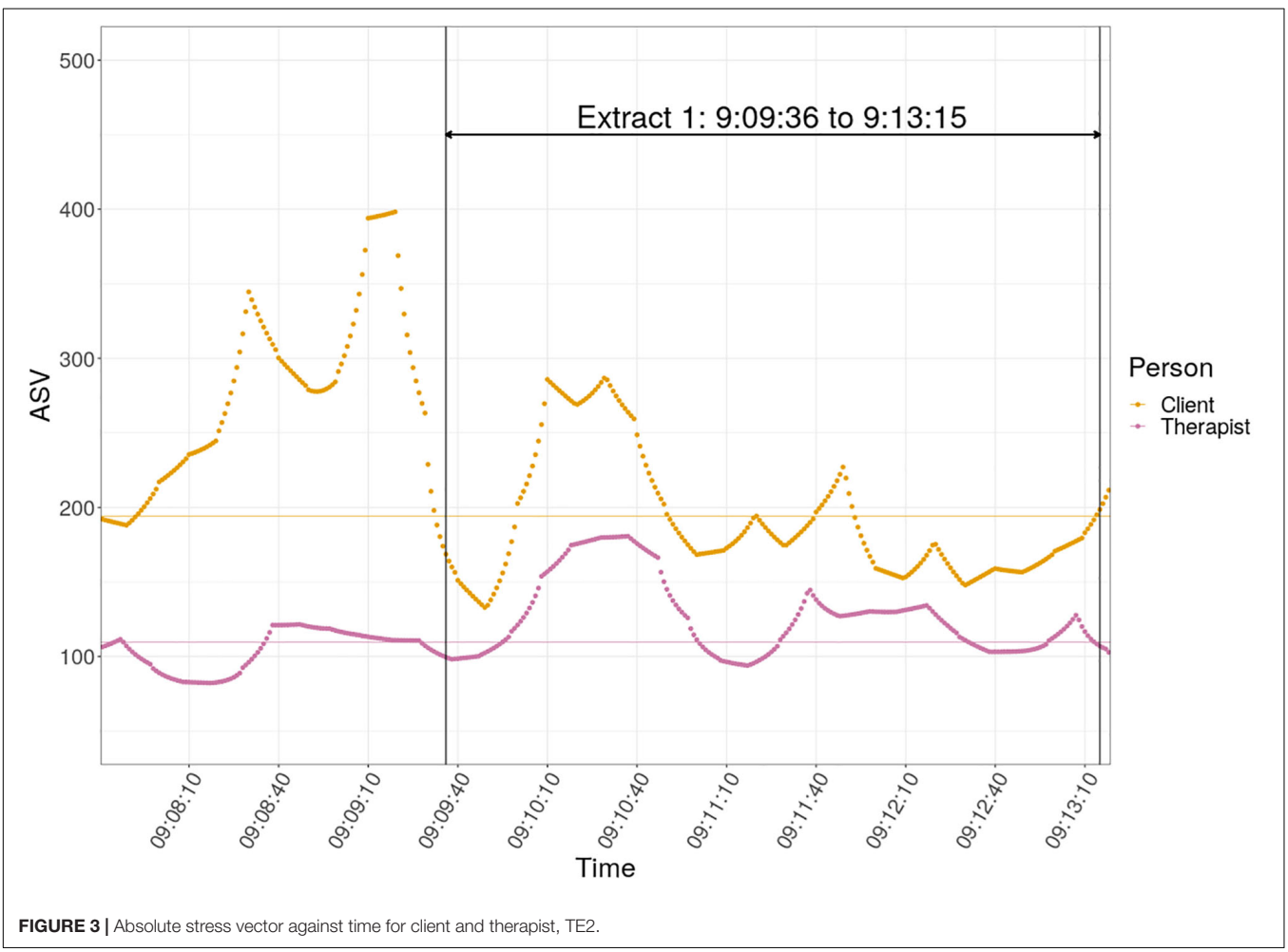

FIGURE 3 | Absolute stress vector against time for client and therapist, TE2.

40 s after Kate's highest peak, during the evaluation presented in turn 1. Furthermore, as can be seen in **Figure 3**, for a period of about 50 s during this interaction (9:10:09 – 9:11:00) both participants' ASV is elevated. It is interesting to note that, although the therapist displays few nonverbal signs of 'being with' Kate during this narration, her autonomic arousal peaks soon after Kate's highest arousal point, in what could be considered an indication of physiological linkage or, in clinical terms, embodied responsiveness. Following this, and for the remainder of **Extract 1**, described below, both participants' ASV is not particularly elevated.

In response to Kate's turn, the therapist makes a brief formulation (turn 2) that selectively focuses on Kate's affect, thus shifting focus from the description of events to affective experience. Formulations are utterances that show understanding of the previous speaker's turn by proposing a version of it; at the same time, they often subtly change what has been said through selection, deletion and transformation (Antaki et al., 2005). Formulations are used extensively in psychotherapy and serve several different functions that promote the work of therapy, such as displaying understanding, transforming clients' complaints into psychological difficulties that can be addressed through therapy, managing the progress of interaction etc. (Antaki, 2008). Weiste and Peräkylä (2013) suggested that three types of formulation tend to be used in psychodynamic therapy. *Highlighting formulations* show understanding of the client's turn, and selectively highlight its clinically relevant aspects, which often relate to affect. In *rephrasing formulations,* that usually concern the client's subjective experience, the therapist proposes his or her version of the client's subjective experience by renaming it, and in this way invites self-reflection and further emotional expression. *Relocating formulations* propose links between the experiences described in the client's turn and experiences that took place at other times (usually childhood) or in other (relational) contexts.

Through this brief formulation (turn 2), the therapist sidesteps reference to the father's behavior or to Kate's own anger and focuses instead on Kate's subjective experience of lack ('you miss that'). This is designed as an extension of Kate's talk, in the sense that it is spoken from within Kate's perspective, but does not focus on affects that are expressed (i.e., frustration and anger) but rather on lack and longing: Kate has not mentioned these affects but the therapist deduces them from Kate's associations. In this way, the therapist names Kate's not-yet expressed feelings of missing parental approval. This shift from facts to feelings and from anger to longing is also facilitated nonverbally; as she speaks, the therapist uses a very low volume voice, which is intimate and soothing, looks at Kate with a concerned facial expression, and smiles slightly.

In response (turn 3), Kate provides a minimal confirmation followed by a disjunction ('on the other hand') and shifts focus again on her mother, wondering whether her mother was overly encouraging so as to counteract her father's lack of approval. From a psychoanalytic perspective this shift would be considered an example of resistance; Kate momentarily gets in touch with her feelings of missing parental approval but very quickly moves away from them, as, presumably, they are too painful. In her next turn (turn 4), the therapist does not respond to Kate's reference to her mother but steers the conversation back to the clinically relevant issue of Kate's disappointment in her relationship with her father. Furthermore, she adds another increment in the formulation, suggesting that disappointment is a long-standing issue in Kate's relationship with her father. In this way, the therapist invites Kate to talk about the past; this is another important aspect of psychoanalytic technique, where current difficulties are explored in relation to past experiences. In addition, the therapist replaces the rather vague construction 'you miss that' (turn 2) to 'he disappointed you,' thus naming Kate's feelings more specifically and placing them in a relational context. In terms of meaning construction, the therapist introduces the idea that Kate feels disappointed in her relationship with her father and has felt so since childhood, although Kate has not made any such reference. Again, the therapist delivers this formulation in very low volume voice, with a soothing and affiliative tone, and displays a compassionate facial expression.

In response to this repeated invitation to talk about her disappointment, Kate hesitates and then disconfirms the therapist's suggestion (turn 5): she cannot remember her father disappointing her and provides several explanations for this. This opposition to experiencing disappointment would be considered another manifestation of resistance from a psychoanalytic perspective. This time, the therapist remains silent and Kate recounts three further incidents from her recent past, over an 8-min stretch of uninterrupted talk. It is interesting to note that, although Kate opposed the suggestion that her father disappoints her, the stories she spontaneously narrates are examples of her father's lack of recognition and approval; as such they can be considered elaborations in response to the therapist's invitation to talk about her disappointment. The first story concerns an incident that occurred several years earlier. At that time, her father still lived on his own and Kate used to visit him regularly. On one such visit, she expressed her wish to rest but her father wanted her to cook something for him; he became very angry when she delayed preparing his meal and screamed at her to leave his house. She left the house, drove to the cemetery, and sat by her mother's grave, crying for several hours. In terms of affect, there is a mismatch between the sad content of the story and the angry affective tone of the storytelling; in psychoanalytic terms, this mismatch could be conceptualized as an indication of internal conflict and defense (anger as defense against sadness). In terms of autonomic arousal, as can be seen in **Figure 4**, both participants' ASV is elevated during the narration of this story (from 9:14:53 to 9:15:40).

The next extract starts with the therapist's response to Kate's storytelling described above.

Extract 2 illustrates Kate's gradual acknowledgment of her sadness and longing for her father's recognition and approval. In response to Kate's storytelling, the therapist repeats, in a soothing and affiliative tone, her suggestion that she is disappointed (turn 6), thus inviting and validating Kate's hidden feeling both verbally and nonverbally (Voutilainen et al., 2014). Kate confirms this minimally (turn 7), but then blames herself for feeling this way; again this would be considered a sign of resistance, as it shifts focus away from the painful feeling to frustration and

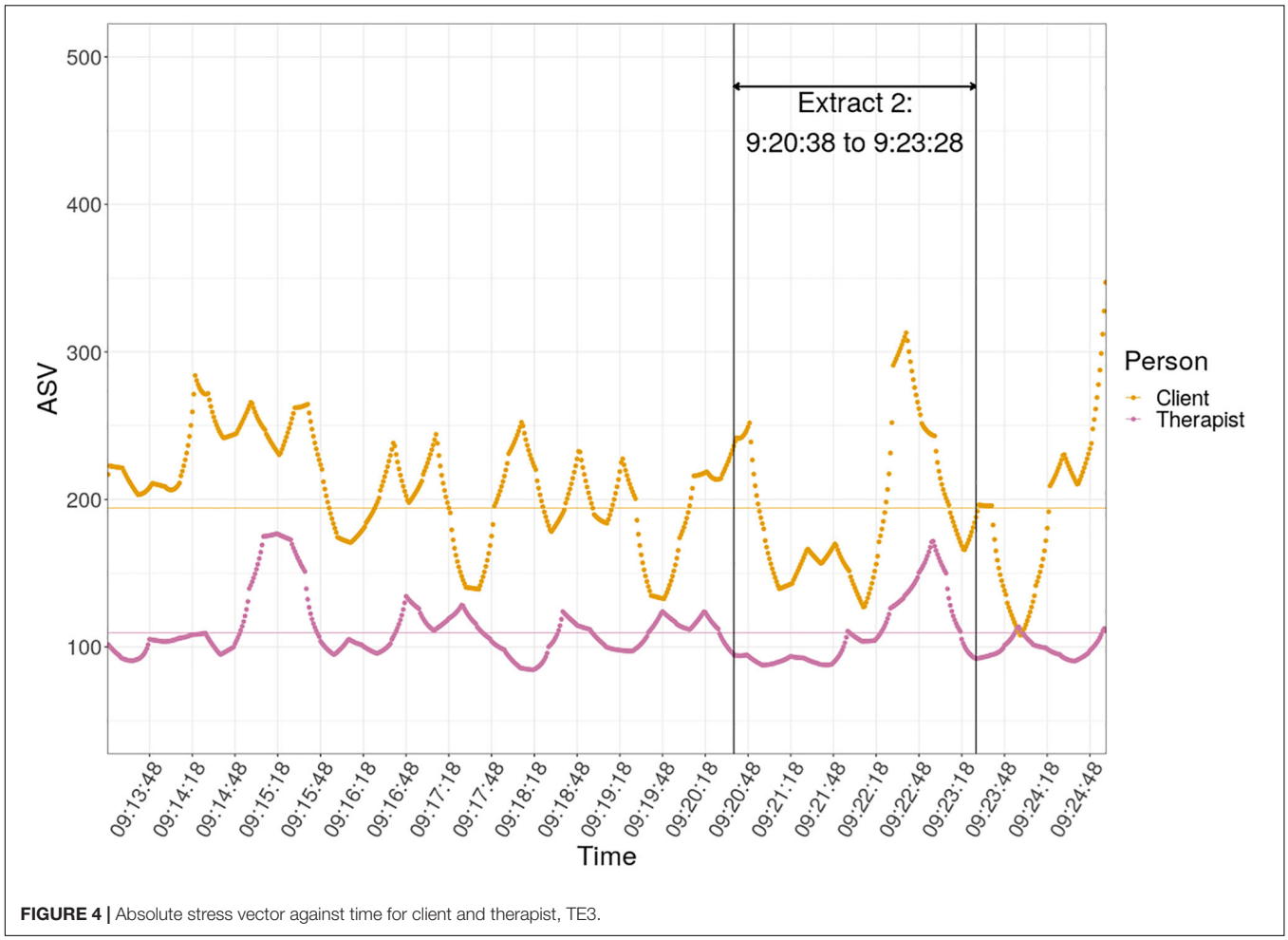

FIGURE 4 | Absolute stress vector against time for client and therapist, TE3.

EXTRACT 2 | From 9:20:38 to 9:23:28.

6	T:	you feel very disappointed *((gentle tone of voice and empathic facial expression))*
7	K:	I am disappointed, on the other hand I think (.) that it's my fault because >he has said it once, twice, five times, ten times, a hundred<, eh ENOUGH, I should not keep asking for this *((shrugs))* approval *((T empathic facial expression))*
8	T:	*((shrugs))* ye:s, but (.)°this is not how things are inside you° *((K wrings her hands and shifts in her seat))*
9	K:	(2) ((sighs)) *((wrings hands))*
10	T:	inside you, this is something that you need, °and you feel disappointed°
11	K:	(6.5) ((sighs)) (.) that is the truth Hhh *((C wrings her hands))* (. . .) it's NOT THAT I have, like (0.5) that I want my father >telling me every day< well done my child, thank you (. . .) I don't expect that *((K touches her face)),* just a little (1.5) some recognition for wha:t (1) for what I do, on a personal level *((purses lips))* (. . .) but why is it so difficult for him? (1) to show me, to show me in some way that yes ((tch)) I recognize tha:t (.) I see that you are trying, that's all
12	T:	°°that is what you'd want °° *((empathic facial expression))*

self-blame. This time, however, the therapist persists (turns 8 and 10) and challenges, albeit in an affiliative manner, Kate's reporting of her own experience. This leads to an extensive agreement by Kate (turn 11), as she talks about her longing for her father's recognition and expresses her sadness that this is not forthcoming; the therapist validates these feelings with a brief formulation that highlights her wish (turn 12).

In terms of autonomic arousal, as can be seen in **Figure 4**, both participants show elevated ASV during the affectively charged interaction presented in **Extract 2**. Kate's ASV peaks when she expresses her wish for her father' recognition and approval (turn 11) and remains elevated until the end of the extract (9:22:33 – 9:23:38). The therapist's arousal peaks about 20 s after Kate's highest ASV. As such, it seems that as Kate gets in

touch with her longing for her father's approval, the therapist's autonomic arousal also rises, in what could be considered an indication of physiological linkage between participants and affective responsiveness.

In sum, the extracts described above entail interactional patterns that are quite typical in this session: Kate narrates several incidents that focus on her father's rejecting behavior that angers her. She recounts these incidents in vivid detail but makes only vague reference to her subjective experience. The therapist responds with brief formulations that focus on feelings that lie 'behind' her anger; in psychoanalytic terms these feelings would be considered defended against, i.e., unconscious. Kate opposes these formulations and the therapist remains silent allowing Kate's associations to emerge. The stories that Kate narrates are arguably elaborations in response to the therapist's formulation, although they are not marked as such. In psychoanalytic terms, this delayed elaboration could be considered an example of free association, where the client on the one hand resists, whilst on another level responds to the therapist's intervention.

In terms of the characteristics of the conversation, in the initial phase of the session, talk is distributed asymmetrically between participants; Kate has quantitative and semantic dominance, in the sense that she talks most, often in long stretches of talk, and introduces the topics of discussion in each episode. The therapist is silent much of the time and her talk is in the form of brief formulations that refer to Kate's hidden affect, as described above. With regards to nonverbal aspects of the interaction, there is a marked difference in the prosodic features of the participants' talk throughout this initial phase. The client speaks in fast tempo, in a loud, modulated and fairly high-pitched voice; these prosodic characteristics are often associated with physiological and emotional arousal (Soma et al., 2020). The therapist, on the other hand, speaks very quietly, in a low volume, slow rhythm, and low pitch voice. This marked lack of prosodic matching can be seen as a nonverbal, implicit process of self- and mutual affect regulation on the therapist's part, which functions both to soothe and to invite the expression of painful feelings. In addition, the therapist alternates between misalignment and affiliation toward the client's narrative, both of which arguably promote the work of therapy. When she speaks, the therapist displays many nonverbal signs of affiliation and empathy, thus fostering a sense of safety and inviting deepened affective experience. On the other hand, she shows few signs of engagement and affiliation when listening to Kate's storytelling. Although non-affiliative responses to the client's narration are considered non-preferred (Stivers, 2008) and arguably impact negatively the therapeutic alliance (Safran and Muran, 2006), from a psychoanalytic perspective they can be seen to promote the work of therapy by maintaining (unconscious) conflict, which eventually leads to emotional expression and self-reflection.

Latter Part of the Session: Working With Resistance and Managing Self-Blame

In the latter part of the session (TEs 6–8), the therapist shifts to more active interpretative work in the face of continuing resistance on Kate's part. This part differs markedly from the initial half in terms of conversational characteristics. The therapist talks significantly more; her utterances are longer, and the majority of her turns are designed as rephrasing formulations. In addition, the therapist responds more promptly to Kate's disagreements and actively interprets her resistance. In this part of the session Kate assumes too much agency for the difficulties in her relationship with her father and oscillates between anger and self-blame. This is interpreted by the therapist as a manifestation of resistance: Kate gets angry and blames herself in order to avoid experiencing disappointment. A fairly long extract from this part of the session is presented below, with an aim to illustrate this aspect of psychoanalytic work and explore its affective and embodied dimensions.

The interaction described takes place at the start of TE 6. **Extract 3** is presented in three consecutive segments and is used to illustrate how the therapist gradually builds a psychoanalytic interpretation that links various aspects of Kate's talk and provides an explanation for Kate's intense guilt.

In the first part of this interaction (**Extract 3A**), the therapist introduces a topic shift. Kate has been talking about her frustration with her brothers over the previous two TEs (4 and 5) and the therapist shifts focus abruptly on Kate's feelings of anger and guilt in relation to her father. Although this sudden shift is misaligned with Kate's previous turn, it is designed as if it were a continuation of her talk and is spoken in a gentle and low volume voice, accompanied by a concerned facial expression. Kate does not respond verbally but sighs (turn 2). In the next part of the formulation (turn 3) the therapist refers for the first time in the session to apparent facts ('there are many things . . . life behind') rather than Kate's subjective experience. This externalizing shift from feelings to facts functions to validate Kate's description of events as accurate, and by implication her reactions as justified. In this construction Kate is represented as having no choice but to do all the things she does for her father, which result in her leaving 'her own life behind' (a phrase used by Kate earlier in the session). In this way, her anger is an understandable and justified response to the situation she finds herself in. Throughout the therapist's turns, Kate does not respond verbally but displays markers of negative affect. Kate completes the therapist's turn (turn 4), thus jointly constructing an account that explains her guilt as resulting from her justifiable anger. The therapist, on the other hand, suggests a more experience-near description (turn 5) ('you feel you are doing something bad'), using the words Kate introduced in the very beginning of the session ('I am a bad person'). Using the client's words from different parts of the session is one way in which therapists weave disparate experiences and affects into a coherent story, thus creating links between meanings that remained disjointed in the client's talk.

Following this joint construction, however, there is evidence of misalignment; **Extract 3B** Kate refers to her guilt and her wish to rid herself of this feeling (turns 6 and 8), whereas the therapist persists in maintaining that Kate's anger is understandable (turns 7 and 9). This misalignment serves the therapist's interactional project as she sidesteps the issue of guilt and self-blame and underscores the idea that Kate's anger is the 'natural' response to her father's behavior. This is met with further resistance, however, as Kate next represents her own inability to accept her father's behavior as the problem, as shown in **Extract 3C**.

EXTRACT 3A | From 9:35:52 to 9:36:54.

1	T:	Err yes, but ((clears throat)) (2) °you get very angry with your father° ((coughs)) and the angrier you get (2) °°the more guilty you feel°°
		((T empathic facial expression))
2	K:	(2) Hhhhh
3	T:	So, while, it angers you that he does not recognize the things you do, in many different ways, the fact that, you, <there are many things that you cannot not do and so you leave your own life behind (.) eh, all this> ((coughs)) I am sorry (.) all this though (.) is something (.) that makes you °very angry° (.) and then, the angrier it makes you
		((K looks away, wring her hands, sad facial expression))
4	K:	I feel guilt
5	T:	the more you feel that you are doing something bad
		((K wrings her hands, looks down, sad facial expression, bites her lips))

EXTRACT 3B | From 9:36:55 to 9:37:45.

6	K	(4) *((K bites lips))* and this, with the guilt
7	Th	Although, yes, of course (.) [you get angry]
		((T shrugs))
8	K	Hhh (4) and this, about this guilt, I also try to understand it because it is (.) I don't want to feel that (.) [no one wants to feel that
9	Th	[you feel guilty] every time you get angry with him *((K touches her hair, looks down, clears her throat, bites her lips))* (1) bu:t (2) how could you not be? (3) *((K bites her lips))* you describe a father who.hhh ((coughs)) disappoints you (.) I won't say all the time, but disappoints you often
10	K	(6) Hhhhh
11	Th	In smaller and in more serious ways
		((T empathic facial expression))

EXTRACT 3C | From 9:37:46 to 9:40:56.

12	K:	((sighs)) (8) I don't know (7) Hhhhh I think I need to find a way to (.) accept it (1.5) things will not change (.) >my father will not wake up one morning and start sayi:ng well done<, for bigger or smaller things, or <in his own way> show it ((clears throat))
		((T looks away))
13	T:	It looks like, though, that right now.hh you cannot accept.hh how much this angers you (.) how much it disappoints you (4) *((K is about to speak, T speaks before her))* so, you say, I MUST ACCEPT IT (.) ok, it may be °that you must accept it° but<right now> this is not °what you feel°
		((K purses her mouth))
14	K:	(2) I say that I must accept it because it is something that will not change
15	T:	Yes, but right now (.) you (.) need (.) his recognition for what you are, for all the things that you do for him, and when you don't get it (.) it costs you a lot and you get angry with him (.)
		((K wrings her hands, nods, looks down))
16	K	(1.5) And with myself *((T looks away, shifts leg position))* I get angry with myself too, as well as getting angry with him
17	T	Yes, and then you feel guilty because you (.) the next day you tell him again ((tsch)) trying to give him an opportunity to repair, HOPING that this time (.) he will say something better, he doesn't do that your father
18	K	*((K smiles slightly, looks down, plays with her hands, mouths 'no'))*
19	T	and the disappointment grows (.) you feel like an idiot like you said (3) and of course, you become less tolerant emotionally (.) it is already massive, the tolerance you show °in this situation° and then
20	K	((Sighs))
21	T	when you get angry, you suffer (.)°you feel° (.) °°that you have done something bad°°
		((K purses her lips, nods slightly, looks down))
22	K:	(5) *((K forced smile, like a grimace))* I'm either angry hehehe or guilty ((forced smiles))
23	T:	(1.5) .hh (.) I think the guilt is there because you °get angry°
24	K:	Yes, that's why I said it >as soon as the anger passes the guilt starts<
25	T:	It is as if you believe, like ((T shrugs)) that you shouldn't get angry
26	K:	(2.5) Yes, >I shouldn't pay him any attention<
27	T:	Or that it would be possible for someone not to get angry *((K bites her lips))* (7) Yes (.) you could pay him no attention if ((coughs)) if you didn't do a thousand things for him
28	K:	(4) ((sighs))

In response to the therapist's rephrasing formulation, Kate is silent and then shifts the focus back on herself and the need for her to accept how things are (turn 12). In terms of clinical process, it seems that Kate's resistance intensifies here: instead of recognizing her father's failings and the feelings these engender in her, she blames herself for the way she feels. The therapist responds with another rephrasing formulation that concerns the here-and-now of the session (turns 13 and 15). In psychoanalytic

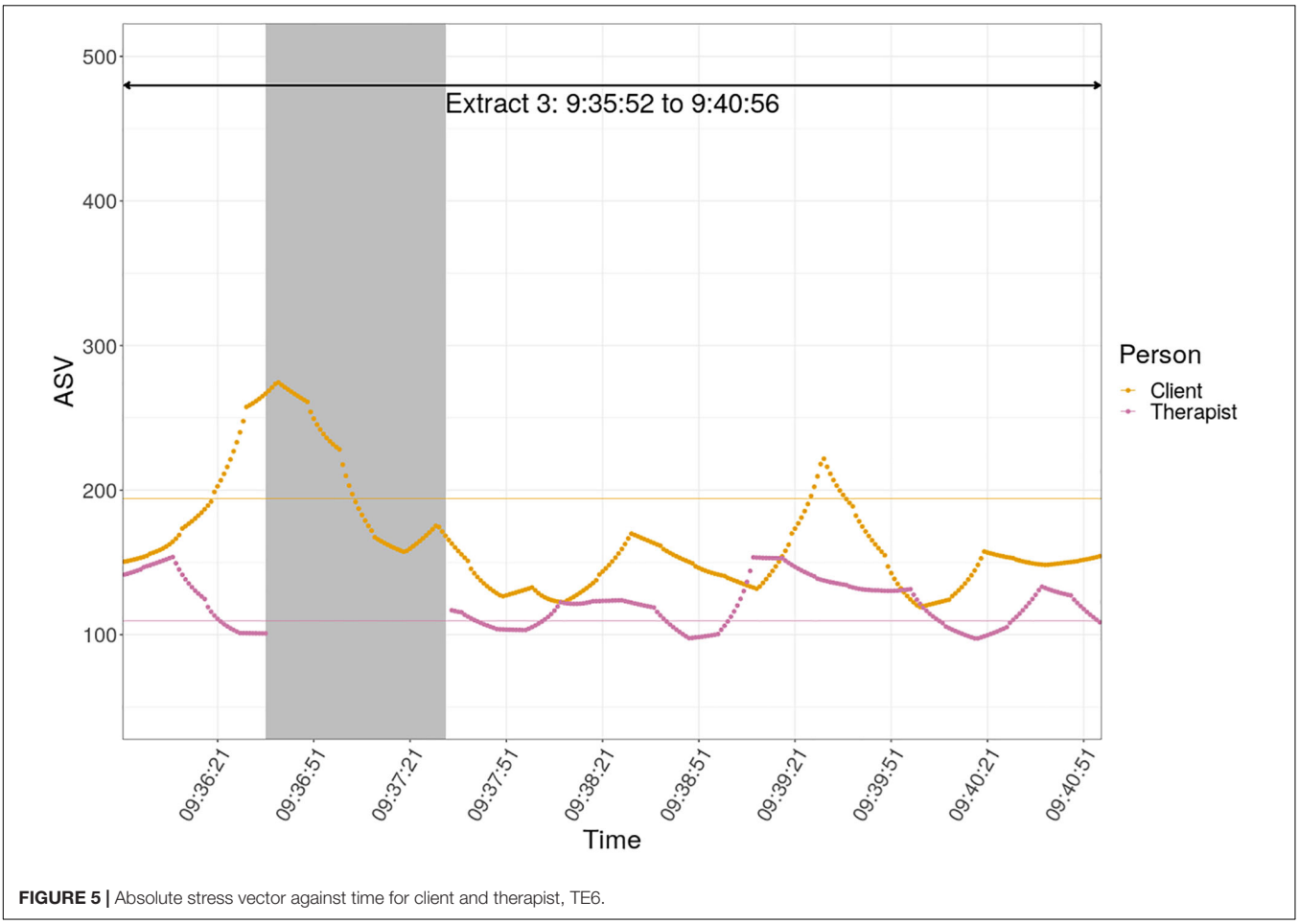

FIGURE 5 | Absolute stress vector against time for client and therapist, TE6.

terms, this is a defense interpretation: Kate's wish to accept things results from her difficulty in accepting her disappointment in her father and is, therefore, a defense. In response, Kate's self-blame becomes even more explicit (turn 16) but the therapist ignores this (turns 17, 19, and 21) and restates her formulation. In the final part of this sequence, the therapist introduces another layer in her formulation (turns 25 and 27): the problem lies in Kate's expectation that she should not get angry and her self-criticism and this leads to Kate eventually get in touch with the sadness (turn 28).

In terms of autonomic arousal (**Figure 5**), Kate's arousal gradually decreases as the interaction unfolds; indeed, Kate's mean ASV is at its lowest in this part of the session. This is interesting, given that the interaction in this topical episode is intense in terms of clinical work. The therapist's ASV on the other hand rises when Kate starts to talk about getting angry with herself and during the delivery of her interpretation (turns 16 to 25, from 9:39:09 to 9:40:30).

The interaction described above is quite typical of the therapeutic work in the latter part of the session. Most of the therapist's turns take the form of rephrasing formulations that concern aspects of Kate's affective experience, namely her hurt and disappointment, that the therapist considers to lie 'behind' her current difficulties, namely her anger, guilt and self-blame. The therapist persistently brings these unacknowledged feelings to the fore, represents them as linked with her more conscious feelings, and highlights her resistance to acknowledging these feelings in the here-and-now of the session through self-blame. The therapist can be seen to gradually build a psychoanalytic interpretation that introduces a different perspective regarding her guilt, thus challenging and expanding Kate's understanding of her own experience; these challenges are accompanied by displays of affiliation. In this process, the therapist assumes semantic and interactional dominance; she introduces topics and new words in the conversation, and -in some instances- does not offer the floor or her turn overlaps with Kate's.

DISCUSSION

This study aimed to combine a detailed description of one session of psychodynamic therapy through the analytic tools provided by conversation analysis, whilst paying close attention to nonverbal interaction, with insights gained from examining the trajectory of autonomic arousal of participants through the session. The starting point for this exploration is a recognition that the process of therapy takes place on both explicit/verbal and implicit/nonverbal/procedural levels (BCPSG, 2008, 2010)

and, therefore, that affective nonverbal displays by therapist and client are fundamental to the co-creation of meaning and therapeutic change. Conversation analysis provides many tools for examining talk-in-interaction in psychotherapy, and several interesting insights have been generated through discursive research on psychotherapy (e.g., Peräkylä et al., 2008; Smoliak and Strong, 2018). The implicit or procedural level of interaction, however, although recognized as fundamental to the process of therapy, is harder to grasp with discursive methods. Our interest in noting nonverbal displays when analyzing conversation and, importantly, in including measures of autonomic arousal in our study are in the spirit of exploring ways to include the implicit realm when studying psychotherapy process.

There is an extensive research literature on infant-parent interaction using multimodal microanalysis to examine live embodied interaction (Beebe, 2014, 2017), and it has recently been suggested that this could be extended to the study of implicit processes in psychotherapy (Beebe, 2017). Indeed, some recent studies have applied microanalysis to psychotherapy with interesting results (e.g., Harrison and Beebe, 2018; Avdi and Seikkula, 2019; Avdi et al., 2020; Graver, 2020). Drawing upon the literature on infant-parent interaction may provide conversation analysts with both concepts and analytic tools that can help include the implicit domain when studying the process of therapy.

In this case study, although the analysis was data-driven to a large extent, the interactional processes that were observed were conceptualized through the lens of psychoanalytic theory. Conversation analysis provides psychotherapy researchers with powerful tools to examine in detail the minutiae of therapeutic interaction. We suggest that theorizing such descriptions through specific clinical theories can help bridge the gap between psychotherapy research and clinical practice, and provide clinically relevant descriptions of therapy process, contribute to the development of clinical theory, and promote therapist reflexivity.

In this study we expanded the focus of analysis from brief interactional sequences to longer stretches of talk spanning the whole session in an attempt to track the development of meanings over time (Buchholz and Kächele, 2017). This 'zooming out' allowed us to observe what, from a psychoanalytic perspective, would be considered the process of free association. The client in this session, especially in the initial part, often accepted the therapist's formulations minimally and at times disconfirmed them; the therapist remained silent in response and the client next narrated stories that were thematically relevant to the therapist's invitation and arguably constitute delayed 'extensive agreements' (Bercelli et al., 2008). The therapist's formulations were thus resisted initially but responded to with a time delay, and presumably non-consciously.

Focusing on longer stretches of talk also allowed us to observe the structure of the session as a whole. As the session progressed, the therapist became markedly more active in interpreting Kate's resistance and this more challenging work came only after a long period during which the therapist primarily listened and reflected Kate's underlying feelings. As described in the analysis of the conversation, the therapist shifted from allowing Kate's associations to emerge with minimal interventions on her part, to more actively countering Kate's resistance as it emerged in the session. However, the more challenging interpretative work was always accompanied by an affiliative and empathic stance on the part of the therapist. In this sense, the 'holding' and the insight-oriented aspects of psychoanalytic work can be seen to be used in conjunction with each other and to reinforce each other (Gabbard and Westen, 2003). Moreover, examining the conversation through the session illustrated repeated cycles between resistance and transient affective insight, which is not uncommon in clinical practice. Analyzing the whole session, rather than focusing on specific moments of change, illuminated the slow and painstaking therapeutic work undertaken in helping clients overcome their defenses against painful affect. This is in line with the psychoanalytic perspective, whereby resistance is not considered a failure in interaction but an opportunity to explore unconscious conflict (Greenson, 1967).

In terms of therapist technique, it was interesting to note that in this session, there were no instances of 'pure' extensions, i.e., therapist responses that merely reflect the client's preceding turn. Even in the briefest of her formulations, the therapist introduced a slight shift, as she tended to orient to unexpressed, i.e., unconscious, affects. This may be specific to psychoanalytic therapy, which attends to potential hidden meaning in the client's utterances and actions (Greenson, 1967). Another key aspect of this therapist's technique was the use of nonverbal behavior as an interactional resource. As discussed in the analysis, she tended not to display affiliation toward Kate's storytelling, particularly in the earlier phases of the session; this could be seen as a way of maintaining affective tension, which would then lead to affective expression and self-reflection (Benecke et al., 2005). Later in the session she delivered her interpretative statements which were far more challenging than her interventions early in the session, at the same time she increased her nonverbal affiliative displays and manner. We believe this maintained the alliance and promoted a sense of safety around the interpretative challenges.

ASV Data

With respect to autonomic arousal, the observation that the therapist's arousal is markedly lower than the client's, and with lower variance over time, points to the differing roles of the two participants and the different intensity with which they engage in the affective work of the session. There is some evidence that therapists' affect regulation capacities are well-developed through their training and clinical experience (Messina et al., 2013; Soma et al., 2020). As can be seen in **Figures 1**, **2**, as the session progresses, the therapist's physiological arousal is stable in both intensity and variance. In contrast, there are marked differences in the client's level of arousal in different topical episodes, with the initial part of the session showing both higher arousal and high variance in ASV, which could be seen to reflect shifts in affective state. It seems that for the client, the initial part of the session, during which she narrates several 'problem' stories and the therapist gently reflects the underlying sadness and disappointment, is associated with more autonomic arousal and more intense affective shifts, in comparison to the latter part of the session. This is interesting, given that as the session

progressed, and in particular TEs 6 and 8, entail more intense interpretative work and arguably more challenge. One hypothesis could be that, following the expression of anger and frustration in the first part of the session, Kate later begins to experience feelings of sadness, associated with lower autonomic arousal (Kreibig, 2010). Another hypothesis could be that the reduced arousal in the latter part of the session is not about the specific affect but may follow reduction in Kate's internal conflict. This is in line with observations that suppressing emotional expression may be associated with increased arousal (Perrone et al., 2014). In addition, it was interesting to observe that in the early phases of the session there are several points at which the therapist's ASV became elevated in response to Kate's storytelling, although there were no visible markers of this arousal.

Overview

Although only a single session of a single case, we believe that the findings support somewhat extending and expanding the foci of conversation analytic research on psychotherapy. One aspects of the extension in this study was temporal: moving from the traditional CA focus on specific speech turns to the entire time span of the session. This was not a single shift but a process of repeated zooming out and back in. Expanding the focus was threefold. The first expansion, to focus not just on talk is of course not new in CA, but we believe the detailed attention to the prosody and nonverbal information from the session video helped develop earlier analyses that were primarily based on the session transcript. The second expansion has been to draw explicitly on psychoanalytic and infant development theories in contrast with CA's more traditional quasi-atheoretical approach to analysis. The final expansion has been to draw on the ASV data, through simple, largely visual, inspection of the ASV against the analysis of conversation. This, we believe, showed interesting patterns, including the therapist's short periods of increased ASV early in the session not associated with any visible markers of arousal, the trend of decreasing physiological arousal over the session for the client, and associations of ASV with talk at the extract level. We encourage others to explore the possible gains from including nonverbal displays and adding physiological information to detailed analysis of talk, in the attempt to learn more about what actually happens in the therapeutic consulting room.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Scientific Board, Hellenic Centre of Mental Health and Research. The patients/participants provided their written informed consent to participate in this study. Written informed consent was obtained from the individual(s) for the publication of any potentially identifiable images or data included in this article.

AUTHOR CONTRIBUTIONS

EA and CE contributed to the conception and design of the study. EA contributed to acquisition of data, analysis of conversation, and reviewing literature. CE contributed with discussion of the CA through its development. CE contributed to quantitative analyses and plots. EA drafted the manuscript. EA and CE revised the manuscript. Both authors contributed to the article and approved the submitted version.

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How Speakers Orient to the Notable Absence of Talk: A Conversation Analytic Perspective on Silence in Psychodynamic Therapy

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Silence has gained a prominent role in the field of psychotherapy because of its potential to facilitate a plethora of therapeutically beneficial processes within patients' inner dynamics. This study examined the phenomenon from a conversation analytical perspective in order to investigate how silence emerges as an interactional accomplishment and how it attains interactional meaning by the speakers' adjacent turns. We restricted our attention to one particular sequential context in which a patient's turn comes to a point of possible completion and receives a continuer by the therapist upon which a substantial silence follows. The data collection consisted of 74 instances of such post-continuer silences. The analysis revealed that silence (1) can retroactively become part of a topic closure sequence, (2) can become shaped as an intra-topic silence, and (3) can be explicitly characterized as an activity in itself that is relevant for the therapy in process. Only in this last case, the absence of talk is actually treated as disruptive to the ongoing talk. Although silence is often seen as a therapeutic instrument that can be implemented intentionally and purposefully, our analysis demonstrated how it is *co-constructed* by speakers and indexically obtains meaning by adjacent turns of talk. In the ensuing turns, silence indeed shows to facilitate access to the patient's subjective experience at unconscious levels.

Keywords: silence, conversation analysis, psychotherapy process research, psychodynamic therapy, single case study

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INTRODUCTION

Psychotherapy is the incremental pursuit of exploring the patient's past and its impact on the present. Session by session, the therapist and patient extend and build on matters discussed previously and in like manner, each therapy session is organized by sequences that produce topic development. Instead of an uninterrupted and ongoing exchange of turns of talk, however, therapy interaction also allows for extended moments of silence. If implemented skillfully, silences can encourage clients to reflect, to connect with their feelings and to continue with their line of thought (Hill et al., 2003). In concert, such silent moments give therapists room for observation of their clients and time to decide on how to respond and continue with the session, but also to refocus after

distraction (Ladany et al., 2004). Followingly, silence is not (always) a sign of disengagement but, on the contrary, a multifunctional intervention type that possesses a communicative value albeit nonverbally (Lane et al., 2002; Ladany et al., 2004). The aim of the present paper is to examine how, from a conversation-analytic perspective, speakers in psychodynamic therapy[1] orient to silences that occur in their interaction.

The approach of researching silence varies across disciplines. Psychotherapy process research (PPR) takes a more interpretive stance as it typically assesses phenomena such as silences by *post hoc* analysis and categorizes them according to the effect that speakers perceive and describe in retrospect (cf., e.g., Levitt, 2001; Hill et al., 2003). As such, PPR addresses the therapeutic benefits attributed to the use of silence and the various functions associated with it. Conversation analysis (CA), on the other hand, is concerned with the way speakers reach a point in talk where silence is a possibility and how they subsequently give meaning to this discontinuity in the following turns of talk (cf. Hoey, 2020). CA thereby provides a formal description of the sequential circumstances that result in the absence of talk and allows for detailed analysis of turns of talk that are adjacent to silences. In short, PPR assigns meaning to silence in retrospect based on individual interpretation, whereas CA describes how speakers collaboratively establish and continuously negotiate its meaning in the here and now.

Research into the perception and interpretation of silent moments in psychotherapy has shown that silence has the potential to facilitate a plethora of processes within each speaker's inner dynamics. Such processes are described in the Pausing Inventory Categorization System ('PICS,' Levitt, 1998), which was assembled based on a grounded theory analysis of interpersonal process recall interviews. An interviewer replayed segments of the client's last therapy session in which pauses of at least 3 s occurred. Clients were then asked to describe their experiences of these moments. This qualitative approach aimed at the exploration of clients' experiences of pausing in psychotherapy in order to establish a manual that could be applied to therapy transcripts, also allowing for the examination of different types of pausing and their relationship with process measures (Levitt, 1998). Based on her grounded theory analysis, Levitt (1998) proposed a typology of silences that differentiates between disengaged, feeling, reflexive, expressive, associational and mnemonic pauses.

In a subsequent publication, Levitt (2001) divided these clusters into three highest order categories: productive or facilitative types of pausing, obstructions and neutral types of pausing. Congruent with what Ladany et al. (2004) would state in their later publication, Levitt (2001) stressed the heterogeneous character of the phenomenon due to the discrete categories she had identified. These authors thus ascribe the occurrence of silence to varied processes, while underlining that therapeutic silences are to be seen "as active moments instead of viewing them simply as moments in which discourse is absent" (Levitt, 2001, p. 306). Frankel et al. (2006) applied the PICS manual to data from client-centered psychotherapy sessions in order to assess good-outcome and poor-outcome therapies for the occurrence of productive, obstructive and neutral silences. Silences were selected according to the 3-s minimum criterion, then coded and their frequency compared to clients' outcome scores. Their analysis suggests that therapists should stimulate silences if they appear to be emotional, reflective and expressive as these types of productive silences can be associated with good-outcome therapies (Frankel et al., 2006).

In the abovementioned studies, participants reflected on how they experience silences during therapy interaction through recall procedures and, as such, attributed meaning and function in retrospect. These qualitative reports provide valuable insight into the perception of silent moments during therapy sessions, into internal processes associated with them and how these relate to therapy outcome. The processes that underlie and result in silence were identified not because they were observable, but because participants were asked afterwards about their interpretation of these silences. At the opposite side of the spectrum, CA investigates what speakers actually do display when their talk is temporarily discontinued and as such takes a very different approach to the analysis of silence.

Conversation analysis is concerned with the dynamics of turns at talk between speakers, how they are locally managed and altogether sequentially construct interaction. The turn-taking model (see Sacks et al., 1974) provides a formal description of the sequential circumstances that are followed by an absence of talk. Turns of talk are allocated by a current to a specific next speaker, other speakers self-select or the current one continues talking. If these options are temporarily suspended by conversational partners, silence arises within a turn or in between turns. Apart from minor pauses or conversational gaps, CA treats silence as an interruption to the ongoing stream of talk or, in other words, as intervening "in the progressive realization of some interactional unit" (Hoey, 2020, p. 20). The positioning of silence thereby accounts for different types of silences. An absence of talk can occur as intra-turn pause or as inter-turn gap or as silence after a sequence-final turn (Sacks et al., 1974; Hoey, 2020). The latter type of silence is termed "lapse" and the focused-on silence in the current study. Lapses are defined as moments in talk at which all participants refrain from self-selection (Hoey, 2018).

Lapses can occur when speakers are engaged in ongoing alternative activities that require their focus and attention, which makes talk optional and silence allowable (Hoey, 2015). In the context of the present study, talk *is* the ongoing activity that both therapist and patient are engaged in. Hence, the occurring silences are not accounted for by other ongoing activities or alternative engagement. Hoey (2015) refers to such "silences where talk should be" (p. 442) as the conspicuous absence of talk and points out that a relatively static positioning of the participants' bodies normally demonstrates that all parties are still committed to carry on with the conversational activity (based on data that was assembled in settings where participants were engaged in ongoing activities while talking). This is of course

[1]The single case investigated in this study was selected from the psychodynamic treatment condition of the Ghent Psychotherapy Study (GPS). The therapist followed psychodynamic treatment protocols for the purpose of the GPS but had been trained in psychoanalytic therapy. In this paper, the term psychodynamic therapy is therefore used synonymously to the term psychoanalytic therapy.

inevitably the case in therapy interaction, where therapist and patient remain in seated position, facing each other, until the end of session, and until then remain committed due to the formal contract of the session that both parties agreed upon.

From a conversation-analytic perspective, at least within Hoey's research, silence thus accounts for a lack of progressivity in talk. As discussed in the above sections, psychotherapy process research takes a different stance and distinguishes between different types of silences when evaluating their impact on the interaction and, consequently, on the progressivity of the treatment itself. In the psychoanalytic approach to therapy, the phenomenon has gained an even more prominent role within the patient's healing process. The observable level of talk, on which the phenomenon manifests, thereby gets surpassed and intrapsychic conflicts that let silence occur are taken into consideration as well. Psychoanalytic practice aims at elevating unconscious and repressed materials into conscious levels. The classical psychoanalytic view on silence was initially rather limited in that it interpreted silence as a form of resistance that undermines the analysand's free association and thus production of signifiers (Gale and Sanchez, 2005). The analysand's ego is thereby hold responsible for repressing the verbalization of unacceptable thoughts or feelings (Zeligs, 1961). According to Arlow (1961), prolonged silence therefore "demonstrates how unconscious resistance may be transformed into conscious reluctance to talk, and may be used very effectively to demonstrate to the patient the reality of a conflict which heretofore had been quite unconscious" (p. 50).

More recently, however, the Lacanian approach to talking therapy acknowledges the effect silence has on the chain of signifiers produced by the speakers as a form of punctuation (Pluth and Zeiher, 2019). Instead of a "lack of anything to talk about next" (Hoey, 2017, p. 129), Pluth and Zeiher (2019) characterize silence as a *rest* in the movement of language, which deliberately or undeliberately adds meaning to what has already been said. Therefore, silence is complementary to the signifiers produced by the speakers and not simply an absence of words (Sabbadini, 1991). Apart from its contribution to the meaning of words, it is also considered instrumental in developing the analysand's ability to reflect, to internalize interpretations and in developing the capacity to be alone, which altogether "promote[s] the acquisition of insight" (p. 217, Gale and Sanchez, 2005). As such, silence is not conceptualized as an absence of therapeutic talk, but an inherent and meaningful part of therapeutic interaction. Silence can be used to facilitate, initiate or constitute specific therapeutic goals and is perceived as an integral part of the therapeutic toolkit.

In contrast, the current study examines therapeutic silence from a conversation analytical perspective (rather than as a therapeutic tool) and studies how silence emerges as an interactional accomplishment of the interactants within therapeutic discourse and how these silences attain their *interactional meaning* in and through the subsequent talk by participants. We will restrict our attention to one particular sequential context in which a turn by the patient comes to a point of possible completion (cf. Selting, 2000), followed by (or produced in overlap with) a continuer by the therapist upon which a silence of at least 3 s follows. In these cases the ensuing silence is an interactional accomplishment of both interactants as "non-talk (. . .) emerges when all participants demonstrably forgo the opportunity to speak at a TRP[2], and persists until the production of some utterance that ends the silence" (Hoey, 2020, p. 30). The goal of this study is (1) to analyze these post-continuer silences with respect to their positioning within the larger episode of talk (where and when do they occur?), and (2) to examine how these silences indexically obtain interactional meaning by the adjacent utterances of the interactants. In our conclusion and discussion we will compare our analyses of the collaborative accomplishment of silence as an interactional practice to the manualized recommendations on silence as a therapeutic tool. We chose to conduct a single case study as we wanted to gain a complete and comprehensive view of the occurrence of silent moments within the larger course of the conversation at hand and in regard to the patient's overall treatment trajectory.

MATERIALS AND METHODS

Data

For this study, a single case was selected from the database of the Ghent Psychotherapy Study (GPS; Meganck et al., 2017), a randomized controlled trial on the treatment of major depression. With this single case design we investigate an individual patient's treatment process ($N = 1$), i.e., intrasubject research (Hilliard, 1993). The use of the term "single case" is therefore distinct to the CA-coined idea of a single case in the form of an isolated manifestation of a particular phenomenon (cf. Sidnell, 2013). The case selection was conducted in the context of an overarching research project on the interactional practices of psychotherapy. We selected a case from the psychodynamic treatment condition of which recordings of all 20 sessions were available. We selected three sessions (1, 12 and 18) that were fairly evenly distributed across the treatment and therefore gave us a relatively complete overview of all stages of the therapy. These had been transcribed using the Jeffersonian notation (see Hepburn and Bolden, 2017). The data assembled within the GPS consisted of audio recordings, which limited our analysis to verbal communication. Therefore, visual aspects that come into play during silent moments, i.e., embodied behavior of the speakers, could not be included in the analysis.

Participant Characteristics

The patient was a woman in her late fifties from Flanders, Belgium. As all patients in the GPS, she met DSM-V criteria of major depressive disorder. The patient further reported mild alcohol abuse that had been present for several months at the time of her intake. At the time of the treatment, she was single, divorced and in employment. In the years before, she had already sought counseling. The patient gave specific informed consent to let the audiotapes of the sessions

[2]Transition Relevance Place (TRP) refers to points of possible completion "which make turn transition relevant but not necessary" (Selting, 2000, p. 478).

being used for research purposes. The therapist was a 34-year-old male with 11 years of clinical experience. He had a postgraduate clinical training in psychoanalytic therapy. In order to conduct specific psychodynamic treatments for the purpose of the GPS, he had received additional training based on the Unified Psychodynamic Protocol for depression (UPP-depression; Leichsenring and Schauenburg, 2014). This protocol integrates empirically supported psychodynamic interventions for depression. In addition, the psychodynamic therapists that participated in the GPS were guided by Luborsky's (1984) manual for psychoanalytically oriented therapy.

Conversation Analysis

Eminently suited to study interactional phenomena, such as silences, is conversation analysis (CA), the methodological approach we chose to apply in this study. This inductive qualitative method aims at identifying the structure of language use – more specifically the practices of speaking and actions in talk that constitute that structure – based on the assumption that the speakers' exchange and management of turns of talk persistently and unavoidably follows an orderliness or at least an orientation toward that orderliness (Maynard, 2013). With its sociological roots and close relation to ethnomethodology, CA research facilitates an unmotivated and mainly descriptive inquiry into the observable attributions and displays within participants' conduct (Maynard, 2013). As such, it lends itself to be applied to all research contexts in which social interaction is at the center of interest. CA thereby follows robust research principles in that it uses meticulous transcriptions as research instrument (in addition to the original audio-recordings) and treats the conversational methods that speakers themselves display as evidence for its claims. In short, only what the participants make observable to each other is observable to the researcher and *only that* is thus reportable as evidence.

Procedure

CA takes a relatively neutral approach in that it pursues an objective and unmotivated stance and focuses on local and situated procedures and achievements in talk while aiming at examining their generalizability across contexts (Svennevig and Skovholt, 2005). Its methodological procedure follows a systematic course of action: The data analysis starts with the examination of a single manifestation of a particular phenomenon (cf. Sidnell, 2013). After that, the researcher returns to the database in order to identify other excerpts in which the selected phenomenon occurs. The observations made during the initial qualitative analysis of the first case are then compared to and analyzed in light of the additional excerpts. At this point, the conversation analyst has assembled a collection of the researchable phenomenon and is as such working quantitatively in order to examine reoccurring conversational patterns or features of the phenomenon (cf. Maynard, 2013; Sidnell, 2013). The analysis of all excerpts still remains a qualitative inquiry – facilitated by complex transcription and the input the researcher receives from fellow conversation analysts during data sessions.

This study presents several excerpts that we find exemplary for the observations made during the data analysis. The advantage of transcription is that it preserves the spoken word, which would otherwise be as ephemeral to its investigator as it is for its speaker and receiver. Preservation makes it retrievable, examinable and representational of the actual event (Lapadat and Lindsay, 1999). A pause of x seconds as shown in the excerpts is thus merely a representation of the silence that actually occurred and only an observable fact because of the transcription. As such we, paradoxically, use transcription to capture a phenomenon that does not consist of a verbal event and is only represented by its measurement in duration.

Our initial criteria for the selection of excerpts concerned the sequential environment and the minimum duration of the silences. The initial analysis of excerpts in which extended moments of silence occurred, led to the identification of a particular sequential construction that we subsequently applied as selection criterion for assembling our collection. We selected excerpts in which a particular type of sequence construction manifested, consisting of a turn that receives a continuer and/or acknowledgment token prior to the silence. A total of 74 silences that manifested in this particular type of sequential environment were identified. Restricting our data collection to instances of post-continuer silence, provides control of the sequential environment (cf. Hoey, 2020). We applied the same 3-s minimum criterion as was applied in Levitt's research (1998, 2001) and also in the studies that used the PICS manual for their data analysis (Frankel et al., 2006; Stringer et al., 2010; Daniel et al., 2018). The rationale behind the minimum duration of 3 s is that these silences are considered meaningful and not just accidental disfluencies (Stringer et al., 2010). This minimum pause duration thus appears as an accepted standard for research on silence. The sequences were constructed as follows:

- The patient's turn (extended episode of talk or answer to one of the therapist's questions)
- The therapist's display of listenership (continuer)
- [Optional: The patient's confirmation (acknowledgment token)]
- Silence of min. 3 s
- The therapist's or patient's next turn.

We chose to select excerpts in which the "mh mh" sound, a classic continuer, is produced prior to the silence (either adjacent to or in overlap with the turn by the patient). Hereby speakers explicitly forgo the opportunity to become the next speaker and demonstrate that their conversational partner is allowed to continue talking (cf. Gardner, 1998). Therefore the projected next action is the continuation of talk by the former speaker, i.e., the patient. The therapist thus abstains from claiming the next turn of talk and gives the patient the opportunity to further extend on the matter at hand. However, if both speakers forgo the opportunity to extend the current or to start a new turn, silence arises although the continuation of talk was projected by the use of the continuer. We therefore examined moments in the

interaction where a notable absence of talk presents in order to analyze how speakers orient towards these silences.

RESULTS

In our data, 74 instances were identified in which silence manifested in post-continuer position. We found 17 instances of post-continuer silence in session 1, 34 in session 12 and 23 in session 18. In session 12 the patient presented with the highest degree of emotional distress. Therefore, the higher frequency in silences may have been due to the emotional processing during this session. **Excerpt 1** gives an example of the particular sequential environment that, in this study, was used to identify post-continuer silences. The excerpt is taken from a larger episode of talk during which the patient reflects on the memories she has of her parents. Her relationship with her parents is a reoccurring topic in her treatment sessions and often elicits strong emotions. Our data revealed that the speakers often tended to accomplish silence during such emotional episodes of talk.

The excerpt is a prototypical example of the sequential context we investigated in this study. The patient's line of talk reaches a point of possible completion as she states that she can see traits of her mother and father in herself (lines 587 and 588) and that she has now gained the ability to recognize these (line 591). At the first TRP, her turn receives a continuer from the therapist (line 589) and then again (line 592) after her turn-extension. A substantial silence of 13 s follows (line 593) during which both speakers forgo the opportunity to talk. The interactional meaning of such a silence is, however, indexically established by adjacent utterances and as such negotiated by the participants in the subsequent turns at talk.

In this study, we investigated the uptake after post-continuer silence, which led us to distinguish three distinct interactional environments based on the first turns subsequent to the silence, which speaker produces these and how they are constituted in relation to the ongoing discourse:

(I) After the silence the therapist produces a new turn in which he moves away from the subtopic discussed prior to the silence and returns to an overarching topic and/or agenda. In these instances the silence – *retroactively* – becomes part of a topic closure sequence. Silence thus marks the closing off of a "sequential environment where topic does not flow out of a prior topic" (Button and Casey, 1985, p. 4). With the following turn, a new (sub)topic gets nominated. This seems to be the prerogative of the therapist, as, in our corpus, we did not find examples of the patient redirecting the course of talk back to a former topic. When silence marks topical closure, there is no interactional orientation to the therapeutic function and/or meaning of the silence. We identified 27 of such instances in our data.

(II) After the silence the patient produces a new turn in which she elaborates on the topic discussed prior to the silence. This was the case in the majority of instances, namely in 45 out of the 74 excerpts. These elaborations are explicitly linked to the talk prior to the silence (using anaphora or other linking devices) and are often shaped as self-characterizations or as descriptions of emotional states. As such, the patient categorizes and/or summarizes the talk prior to the silence. In these instances the silence is interactionally – and again retroactively – shaped as an intra-topic silence. Although there is no explicit characterization of the silence as part of the therapeutic talk *per se*, the silence indexically is attributed interactional meaning by the adjacent utterances as part of a specific therapeutic activity (discussing/exploring topic X).

(III) After the silence the therapist's next turn explicitly characterizes the silence as an activity and/or event. The turn contains a *formulation* (in the classical sense, cf. Garfinkel and Sacks, 1970) of the silence as a therapeutic event. This is quite rare as we only found two examples in our data, but it does show an explicit membership orientation to silence not as the absence of talk but as the presence of other therapeutically relevant events.

Excerpt 1: Excerpt 1.

587	P:	kheb ook een stukje van haar meegekregen net als een stukje
		some things I inherited from her just like I inherited some
588		van mijn vader,
		things from my father
589	T:	mh ↑mh
590		(2.9)
591	P:	en k herken het ook (.) makkelijker bij mij zelf nu.
		and it is easier now for me to recognize these by myself
592	T:	=<mh ↑mh>
593	→	(13.3)

Silence as Topical Closure

The first context we discuss where silence plays a role is in the negotiation of topic closure. With the initiation of the session, it is generally the patient who introduces a topic in response to an invitation by the therapist to tell about his or her current state of being. In the successive accomplishments of conversational projects, the speakers sometimes depart from the main topic in order to discuss, for example, additional background information or to reflect on emotions that were experienced at a particular point in time. Such conversational projects are the result of (sub)questions asked by the therapist that establish (sub)topics (van Kuppevelt, 1995). This sometimes leads to extended narrative episodes of the patient during which the therapist mostly demonstrates listenership, e.g., through the use of continuers, and is only sporadically claiming a turn. When the respective subtopic does not seem to elicit more material from the patient, the therapist formulates new interventions, such as requests for elaboration, or the subtopic gets closed off and the speakers move on to the next. This is similar to the structural organization found in cognitive and relational-systemic therapy sessions (cf. Bercelli et al., 2008). Also in psychodynamic therapy speakers alternate between inquiry and elaboration sequences. Silence, however, seems to play a role in the "closing off" of such conversational projects as can be seen in **Excerpt 2**.

Excerpt 2: Excerpt 2 (session 1).

328 T: zij je zelf ook sportief?
are you a sportive person
329 (0.5)
330 P: geweest.
used to be
331 (0.9)
332 P: ben ↑vroeger zeer sportief geweest. ja
I used to be very sportive yes
[lines 333–336 omitted]
337 P: en nu de laatste tijd ↑niets meer.
and now as of late nothing anymore
338 (0.6)
339 T: en [( )
and
340 P: [↑hooguit een beetje gaan wandelen.
going for a walk at the most
341 (0.8)
342 T: mhm en de laatste tijd dat is,
mhm and as of late is that
343 P: ja.
yes
344 T: sinds 2012? of ervoor nog?
since 2012 or even before that
345 (2.5)
346 P: eigenlijk al < °sinds ↓ja sinds 2012 is da nie echt ja.° >
actually already since yes since 2012 it is not really yes
347 (1.2)
P: was er zo af en ↑toe nog ne keer ↑iets van sport.
there has been a bit of sport occasionally
348 ne keer gaan fietsen: keer gaan wandelen: keer gaan zwemmen:
cycling or going for a walk or going for a swim
349 .hh ma ↑eigenlijk het laatste jaar is da (0.7) en da k
but in the last year that is actually (0.7) and that I
350 vroeger ↑mij altijd voornam op het werk ook.
in the past planned on taking the stairs at work
351 ge ↑neemt de trap na de tweede verdieping. (0.8)
you will take the stairs to the second floor (0.8)
352 de laatste maanden. neem ik weer de lift.
in the last couple of months I take the elevator again
353 T: uh ↑huh uh huh
354 is ↑da voor u een signaal,
is that a sign to you
355 P: voor mij is dat een signaal.
for me that is a sign
356 T: om te ↑herkennen van ja nee t ga [nie,
that lets you recognize like yeah no it's not going
357 P: [nee t ga t ga ↑weer
no it's not going
358 nie goe [met mij.
well with me again
359 T: [mh ↑mh
360 → (9.6)
361 T: en de ↑eerste keer was da na uw, scheiding?
and the first time was that after your divorce
362 (1.8)
363 T: of daarvoor [al,
or even before that
364 P: [eerst (.) nee.
at first (.) no
365 was ja. na mijn scheiding nee was ↑eigenlijk ↑eerst de
was yes only after my divorce no actually the divorce was first
366 scheiding. k heb dan een hartprobleem gehad ook. [dan
I also had some heart problems back then

In this first session of the patient's treatment, the speakers are establishing a timeline of the patient's unstable wellbeing, discussing the first occurrence of depressive symptoms and how these were related to certain life events. **Excerpt 2** shows an initiation of a subtopic by the therapist as he asks about the amount of exercise that the patient is doing and how this has evolved over the past years. This conversational project is situated along the sidelines of the session's overarching topic, i.e., the review of the patient's history of depression. After the patient's extended telling ends and before moving on to the next inquiry sequence, both speakers remain silent for almost 10 s. The therapist's next intervention then redirects the course of talk back to the overarching topic.

The therapist's request for information in line 328 initiates a subtopic about the patient's sporting activities. After summing up various types of sports that she did in the past (lines omitted), the patient concludes the list by mentioning that she is not participating in any type of sport lately (line 337) except for going for a walk occasionally (line 340). In response to the therapist asking for clarification on the point in time when she stopped doing sports (lines 342 and 344), the patient explains that the frequency of it has decreased since 2012 (lines 346–349). Since a couple of months she has even stopped taking the stairs at work and takes the elevator instead (lines 349–352). The therapist poses the question whether this is to be seen a sign (line 354), which receives confirmation in line 355. The therapist then extends the patient's prior turn by adding "that it is not going well" (line 356), which gets in turn extended by the patient in lines 357 and 358 "no, it's not going well with me again." This turn receives a continuer by the therapist, which is, however, produced in overlap. After the silence of 9.6 s during which the patient's turn does not get extended, the therapist initiates another inquiry sequence by asking whether she first experienced depressive symptoms before or after her divorce (lines 361 and 363), thereby redirecting the conversation back to the establishment of a chronological timeline. Through the use of the discourse marker "and" at the beginning of the turn, his request for information explicitly links back to the talk prior to the silence.

The intervention and response sequence prior to the silence is produced in the format of a collaborative turn-sequence (see Lerner, 2004) and connects the subtopic to the overarching topic by characterizing the amount of physical activity as an indicator of the patient's state of mental wellbeing. In line 358 the sequence is potentially complete. The therapist's use of the "mh mh"-sound in line 359 marks the receipt of the patient's prior turn (Gardner, 1998). The continuer further demonstrates "the understanding that extended talk by another is going on by declining to produce a fuller turn in that position" (Schegloff, 1981, p. 81). During the silence in line 360, the patient is therefore given the opportunity to extend her turn and to further elaborate on the "signaling function" that taking the stairs has. As both speakers forgo the opportunity to talk and subsequently return to a prior topic, the silence here is constitutive of sequence as well as topical closure.

Silence thus appears to contribute toward the structural organization of talk as it retrospectively marks the closure of the sequence. With inquiry sequences therapists prepare the ground for elaboration and that elaboration is either accomplished by a series of therapist statements "grounded in previous clients'

talk" (Bercelli et al., 2008, p. 44) or, as we found in our data, by narrative episodes during which patients themselves further extend and elaborate on previous turns (as will be demonstrated in the analysis of **Excerpts 3** and **4**). The use of continuers in response to a patient's turn demonstrates that the therapist treats this talk as potentially extendable (see Schegloff, 1981; Gardner, 1998) and leaves it up to the patient to make use of the opportunity for extension. In **Excerpt 2**, this opportunity remains unexploited. This results in an absence of talk after which the therapist initiates the continuation of the preceding topic. The speakers do not communicate about whatever caused or happened during the silence and as such, the discontinuity of the interaction is not treated as disruptive. Silence thus appears as an unproblematic and untopicalized occurrence that facilitates the transition to an alternative (sub)topic.

Intra-topic Silence

Silence does not necessarily have to mark the closing off of previous sequences or subtopics. In other cases, speakers produce an extension of prior turns after extended moments of silence and as such, show an ongoing orientation toward the relevance of the topic at hand. However, these seconds during which both speakers remain silent are not treated as problematic or as a disturbance to the progressivity of the conversation. Instead, silence even seems facilitative of the patient's insight as can be seen in **Excerpts 3** and **4**. In these excerpts, the patient continues talking after the silence by further elaborating on the respective topic. Although these "empty" seconds do not consist of talk, they accomplish the continuation of a line of thought that often results in more emotional statements by the patient.

In **Excerpt 3** the patient is telling the therapist about her feelings of pity toward her mother and herself. At the beginning of the session she reported that she had cried that day because of the memories of her mother. In this succeeding episode of talk, she continuously extends her turns with short pauses in between while the therapist demonstrates listenership through the use of continuers and repetitions. The excerpt shows three post-continuer silences with a maximum of almost 26 s in line 62. Although the audio does not allow us to observe whether the patient is actually crying throughout this episode of talk, she notably gets emotional as is inferable from the production features: The turn in line 49 is produced with lowered voice volume, in line 54 she seems to be sniffing her nose, in line 63 the patient's voice is wobbly and the turn is produced with aspiration at the beginning and a sigh at the end. These features display the patient's distress and may indicate that there is crying (for a detailed analysis of different elements of crying see Hepburn, 2004).

The first post-continuer silence (line 48) occurs after the patient reports the huge feelings of pity that she experiences for her mother but also for herself as she has not received all the maternal attention that she needed (lines 24–41). The therapist then mirrors part of the patient's prior turn (line 43) and uses the same personal pronoun as referent, thereby putting himself into the position of the patient. This form of repetition serves as an indirect request for elaboration (cf. Knol et al., 2020). Instead of further elaboration on the feelings of pity toward her mother, the patient treats the therapist's other-repeat as a repair initiation and responds by repeating herself ("but also for myself, yes," line 45). The therapist's continuer in line 47 indicates that the patient is given the opportunity to further extend her turn. The ensuing post-continuer silence lasts for almost 12 s (line 48) until the patient states that she is feeling sad because of this (line 49). Another continuer is followed up with a single word-repetition by the therapist ("om," a Dutch conjunction that can be glossed as "because of that," line 53). The particle projects a subordinate clause to be completed by the patient and is thus functioning as an invitation to elaborate. It is produced with a slightly rising intonation contour, indicating stronger invitation for turn-extension than the preceding continuers. Instead of extending her telling, a silence of 22 s occurs (line 54). In line 57, the therapist again mirrors part of the patient's preceding utterance, which invites continuation. The patient adds that she has missed her mother in the past and nowadays still continues missing her (line 59). This response once again receives again a continuer by the therapist after which both speakers remain silent for almost 26 s (line 62). In line 63, the patient states, with a slightly shivering voice and outbreath at the end of turn, that "this is painful." The demonstrative links back to the utterances that precede the silence although it remains ambiguous where "this" refers to exactly (the memories of and feelings towards her mother or talking about them in the here and now).

Contrary to **Excerpt 2** in which the silence is in retrospect indexical of topical closure, the silences in **Excerpt 3** are implicitly treated as meaningful within the patient's assimilation of emotions. This is established by the patient's provision of an emotional interpretation, which is presented as a consequence of the thoughts and experiences that she reported prior to the silence. **Excerpt 3** also shows that prolonged silences do not only occur as a single manifestation at a specific point in the interaction but that episodes of talk can contain multiple silences. The cumulative occurrence of these silences is not only a product of the patient's slow pace in the production of turns but is also constructed by the therapist as he actively refrains from talking (except for selective repetition and the use of continuers). That he does not intervene but allows for these extended moments of silence to arise, demonstrates the consistent orientation toward encouraging the patient to independently continue elaborating. Here, silence leads to an extension of the (implicit) emotional content of the topic talk, which is enhanced by the therapist's interventions. Silence thus seems to facilitate deeper insight into the patient's emotions and inner conflicts, which the following excerpt is another example of.

Excerpt 4 is taken from session 18, which is relatively close towards the end of the patient's treatment pathway. She reflects on her experiences with and related emotions for her ex-husband. At this point in treatment, the patient has already improved her ability to independently elaborate on the sources of her emotional distress and to come up with problem-solving lines of thought. In this episode of talk, she is contemplating whether to meet with her ex-husband and whether it is safe for her

Excerpt 3: Excerpt 3 (session 12).

24	P:		en kvoel eigenlijk (1.1) ee- een enorm ja een medelijden met haar,
			and actually I feel (1.1) *a- enormous well pity for her*
25			(1.1)
26	T:		mh ↑mh
27			(2.0)
28	P:		en ook medeleven medelijden met mezelf,
			and also sympathy pity for myself
29			(3.8)
30	T:		mh ↑mh
31			(1.6)
32	T:		[( )
33	P:		[en euh in gedachten was ik ook met haar aant babbelen,
			and uhm in my thoughts I was also talking to her
34			(0.8)
35	T:		mh ↑mh
36			(1.9)
37	P:		en heb k haar vertelt van dak zoveel (0.3) gemist heb van haar.
			and I told her that I have missed so much from her
38			(1.1)
39	T:		mh ↑mh
40			(0.6)
41	P:		en nekeer ne knuffel,
			the occasional hug
42			(11.9)
43	T:		(van ik had ook) v::f:: medeleden met haar;
			(and I also felt) pity for her
44			(2.1)
45	P:		maar ook met mezelf ja,
			but also for myself yes
46			(0.2)
47	T:		mh ↑mh
48		→	(11.9)
49	P:		°daar voel k mij dan verdrietig om. °
			I then feel sad because of that
50			(0.8)
51	T:		mh ↑mh
52			(1.5)
53	T:		om,
			because of that
54			(21.8) ((patiënt lijkt zakdoek te nemen))
			((patient seems to be taking a handkerchief))
55			((patiënte snuit))
			((patient sniffs her nose))
56			(7.0)
57	T:		k voel mij dan verdrietig;
			I then feel sad
58			(3.8)
59	P:		k heb haar zo gemist, k mis haar nu nog,
			I missed her so much I still miss her now
60			(0.5)
61	T:		mh ↑mh
62		→	(25.9)
63	P:		hh das pijnlijk (.) hhuh
			this is painful
64			(0.3)
65	T:		mh ↑mh
66		→	(14.4)
67	P:		kherinner mij dak als kind (0.6) ((snuift)) (1.4) dikwijls bij haar bed kroop,
			I remember that as a child (0.6)*((sniffs))* (1.4) *I used to crawl*
68			in bed kroop,
			into her bed

Excerpt 4: Excerpt 4 (session 18).

111	P:		(kheb ooit) wel fijne momenten gehad ma s:oms heeft hij mij
			I have had lovely moments but sometimes he still uh
112			toch euh
113	T:		=mh ↑mh
114	P:		ja vernederd sommige momenten (.) straal genegeerd,
			well humiliated me (.) *completely ignored me*
115			.hh en da was euh vrij pijnlijk voor mij,
			and that was painful for me
116	T:		mh ↑mh mh[↑mh
117	P:		[en als k DAARAAn denk dan kan k et (.) ja.
			and when I think about that then the (.) *yes*
118			(2.2)
119	T:		mh ↑mh
120			(2.4)
121	P:		het negatieve de negatieve (.) gevoelens kunnen de positieve
			the negative those negative (.) *emotions can overrule*
122			(.) wegdrukken.
			the positive ones
123			(0.8)
124	P:		van denkt daar alsteblieft nog ne keer aan eh voor je u weer laat
			so please think about that uhm before you let yourself get
125			(.) gebruiken, (.) h[ehh
			(.) *used again* (.) *hehh*
126	T:		[mh ↑mh
127		→	(3.7)
128	P:		kweet nie of hij daar op (.) op (.) aanstuurt of dat hij da
			I do not know whether he is aiming at (.) *at* (.)*that again or*
129			wil proberen kweet het nie.
			whether he wants to try that again
130			(0.3) ((snuift)) (0.6)
			(0.3) *((sniffs))* (0.6)
131			ma dan is mijn vraag hoe k- hoe ga k in mijn kracht
			but then my question is how c- how can I stand in my
132			staan om te kunnen nee zeggen.
			own power to be able to say no
133			(1.3)
134	T:		mh ↑mh
135		→	(8.7)
136	P:		of ga k trouwens ook mijn kracht vinden om.hh om (0.9) te vertellen
			or besides that will I also find the strength to (0.9) tell him
137			over mijn gevoelens, (1.1) zowel de positieve als de negatieve.
			about my feelings (1.1) *the positive as well as the negative ones*

to talk about the negative feelings that past experiences with him have evoked. She is afraid that he may start emotionally abusing her again if she would give him the chance to. Similar to **Excerpt 3**, the duration of the between-speaker silences increases throughout this episode of talk with a maximum of almost 9 s in line 135.

The patient reports that she has had lovely moments together with her ex-husband (line 111) but immediately adds that at certain moments he had been ignoring her (lines 111–114), which caused a lot of pain (line 115). Whenever she is now thinking back, the negative emotions overrule the positive ones (lines 117–122). In lines 124 and 125, she formulates an imperative turn construction as if she is reminding herself of these negative memories in order to prevent getting abused. The therapist produces continuers throughout the patient's telling (lines 113, 116, 119, and 126). After a lapse of almost 4 s, the patient shares her doubts about her ex-husband's intentions (lines 128 and 129). In lines 131 and 132, however, she redirects the focus of her talk back toward herself by declaring that she is looking for a way to say no. This turn again receives a continuer by the therapist after which both speakers remain silent for 8.7 s (line 135). In her succeeding turn, the patient remains reflective about her own ability, asking herself whether she will find the strength to tell her ex-husband about her feelings (lines 136–137).

Excerpts 3 and **4** show that silence is facilitative of reflection. The therapist does not close off the sequence after the occurrence of silence but encourages elaboration by producing turns that mirror the patient's preceding utterances or through the use of continuers. As such, he seems to remain in the backseat of the conversation, providing support and encouragement for the patient's independent elaboration on the respective topic without being too directive in his interventions. In **Excerpt 3**, this results in an evolution of the patient's talk from a descriptive stance toward an emotionally reflective one. **Excerpt 4** shows a similar evolution in that the patient's talk moves from the description of negative and painful memories toward a more proactive stance that is reflective of her own competencies in dealing with the (emotions for her) ex-husband.

Silence as a Therapeutic Event

In our data, the participants rarely reflected on the silence itself. Whenever this was the case, silences were notably longer in duration. The following excerpt presents a moment in the therapy session during which a remarkably long silence occurs that seems facilitative of the patient's exploration of feelings that she is experiencing (line 769). In contrast to the two preceding examples, however, this does not manifest implicitly in the patient's succeeding talk but is explicitly pointed out by the therapist. In the intervention that succeeds the silence, the therapist topicalizes this disruption to the ongoing talk (line 770). In her response in line 772, the patient reports on the cause of this disruption as having a peaceful feeling.

Excerpt 5 shows two episodes of talk. In lines 648–672 the participants arrive at a turning point within the session as the patient discovers that her parents' attributes and behaviors not necessarily have to be transferred onto the next, i.e., her own, generation. She states that this revelation gives her the feeling of "letting go" (line 662). The therapist adds that she is now finally able to break free (line 664), however, "not in a rush" (line 668) but, as the patient extends his turn, by "gently letting go" (line 672). After this collaborative turn-construction (see Lerner, 2004), the participants elaborate on the peaceful feeling and the support she experiences from the people surrounding her (lines omitted). The patient points out the she has come to the revelation because of the inner conversation she had with herself, which was possible because she had the day off. She elaborates on her work schedule, after which the therapist brings in a positive assessment about the type of work that the patient is doing (lines 757 and 759). After stating that she still finds it joyful to continue working at a restaurant, the conversation arrives at a notably extended silence of almost 72 s (line 769). The therapist then topicalizes the silence in line 770 by guessing that she was lost in thought during the silence. The patient responds that she experiences a peaceful feeling (line 772). After another but shorter silence of 8.5 s (line 775), the therapist asks whether she is feeling sleepy (lines 776 and 780) to which the patient responds that she is actually feeling energetic (lines 782 and 783).

In this excerpt, the silence is treated differently to the silences in **Excerpts 2–4** as it becomes topicalized in the form of a meta-communicative description and as such brought to the surface of the conversation. More specifically, it is not the silence itself that is topicalized but the activity that took place during the silence (being lost in thought). In the other examples, moments of silence are not treated as disruptive but simply become integrated into the course of talk. These silences were, however, notably shorter as they only reached a maximum duration of 26 s. In **Excerpt 5**, the disruption is made explicit because of the therapist's guess on what caused the silence. The question remains whether this may also be related to its duration. Both speakers remain silent for more than a minute, which indicates a more substantial discontinuity in the discourse than in the other instances. Although the progressivity of talk is temporarily put on hold, the speakers do not treat this in a negative sense. The patient assigns a positive feeling as the cause (the peaceful feeling) while the therapist seems to be keen on assigning a more psychophysiological cause (feeling sleepy). Whenever such underlying processes become the topic of the conversation, as in **Excerpt 5**, participants show an orientation toward assigning a function to the silence. Such instances can be analyzed by means of CA but also allow for an interpretive analysis as it is common in PPR.

This analysis demonstrated that after inquiry sequences, further elaboration by the patient as projected by the therapist's use of continuers, is not always produced, which results in the occurrence of silence between the speakers. After that, either the therapist launches an elaboration sequence through the use of mirroring and/or follow-up questions or the patient continues talking and if so, these utterances are produced with a more emotional stance. Silences appear cumulatively and not as single manifestations, and throughout such episodes of talk the between-speaker silences tend to increase in duration. Occasionally, prolonged silences become topicalized and only in these cases, the potential disruption of talk is actually treated as disruptive.

DISCUSSION

Irrespective of the type of interaction, sequence endings "systematically provide for the occurrence of silence" (Hoey, 2020, p. 11). In the context of psychotherapy, the therapist can opt to intervene whenever patients fall silent in order to maintain the progressivity of talk. Especially in the psychoanalytic tradition, however, silence has been recognized as a meaningful contributor to the therapeutic relationship and valuable in assisting the patient to connect with his or her subjective experience at unconscious levels (Warin, 2007). According to Sabbadini (1991), silence can "transform unconscious anxiety, concerning some as yet unknown and unworked-through inner conflict, into more manageable, though often more painful, conscious anxiety" (p. 409). **Excerpt 3** showed an example in which the patient, after an extended period of silence, reported on painful emotions evoked by the memories of her mother. The silence here thus seemed to have facilitated access to deeper layers of the patient's repressed memories. These findings are thus consistent with the

Excerpt 5: Excerpt 5 (session 12).

648	T:	( ) hetgeen [wa da ze gedaan heeft	
		that what she has done	
649	P:	[wij zeggen soms allemaal allez ja ik betrap	
		sometimes we all say - well yeah I catch	
650		mij daar ook op van da wij nie de dingen echt ((snuift))	
		myself doing that, too - that we do not always do that sort of	
651		(1.0) nie altijd bewust doen.	
		things ((sniffs)) (1.0) *really consciously.*	
652		(3.4)	
653	P:	dat onze manier van reageren (.) ergens euh (.) ja ((snuift)) (1.1.)	
		that our way of reacting (.) somehow uhm (.) yes ((sniffs)) (1.1)	
654		ge duikt terug in ervaringen en in in dingen die je meegemaakt hebt	
		you dive back into experiences and the things you have been going	
655		en dan ga je (0.3) [((snuift)) op zo n manier reageren maar	
		through and then you (0.3) *((sniffs)) react to that in such a way*	
656	T:	[mh ↑mh mh ↑mh	
657		(1.6)	
658	P:	geschiedenissen hoeven zich nie te herhalen eh, ((snuift))	
		but history does not have to repeat itself ((sniffs))	
659		(2.1)	
660	T:	mh ↑mh	
661	→	(11.6)	
662	P:	kvoel t nu inderdaad als een (.) loslaten.	
		It now feels to me as a (.) *letting go*	
663		(2.6)	
664	T:	ge zij precies ook klaar om (0.8) finaal uit te breken.	
		you are exactly ready to (0.8) *finally break free*	
665		(0.4)	
666	P:	ja	
		yes	
667		(1.1)	
668	T:	nie in een vlucht,	
		not in a rush	
669		(0.3)	
670	P:	nee nee nee [( )	
		no no no	
671	T:	[maar meer in een	
		but more in a	
672	P:	zachtjes loslaten	
		gently letting go	
673	T:	uhu uhu	
		(lines 674–756 omitted)	
757	T:	ist- tis iets da je nog altijd doet.	
		is it- it is what you are still doing	
758		(1.0)	
759	T:	helpen in den horeca.	
		helping out in the restaurant	
760	P:	ja	
		yes	
761		(0.4)	
762	T:	das wel gebleven.	
		that has remained	
763	P:	ja ( ) ja	
		yes ( ) *yes*	
764		(3.9)	

(Continued)

Excerpt 5: Continued

765	P:		da doe k nog altijd graag, (1.6) nu doe k het graag, (.)
			I still enjoy doing that (1.6) *now I do enjoy it* (.)
766			nu ist uit vrije wil,
			now it is voluntarily
767	T:		mh ↑mh
768	P:		((lacht))
			((laughs))
769		→	(71.6)
770	T:		(zo even) weg in gedachten;
			lost in thought for a moment
771			(1.3)
772	P:		zo n vredig gevoel nu.
			such a peaceful feeling now
773	T:		mh ↑mh
774	P:		pff (1.1) ja,
			pff (1.1) *yes*
775		→	(8.5)
776	T:		slaperig?
			sleepy
777			(0.6)
778	P:		hm;
779			(0.4)
780	T:		slaperig,
			sleepy
781			(1.2)
782	P:		< j:a > (3.3) ja e- e- nee eigenlijk, tgeeft mij tgeeft mij
			yes (3.3) *yes a-a- no actually it also gives me it gives me*
783			energie ook, tgeeft mij
			energy, too it gives me
784	T:		mh ↑mh

aforementioned functions attributed to silence and its value for the therapeutic process (cf., e.g., Gale and Sanchez, 2005).

One aspect that contrasts the psychoanalytic discourse to regular social interaction is that the analyst allows the analysand to speak at great length, only interrupting him or her if that is absolutely necessary for the analyst's understanding, thereby approaching the analysand from his or her own frame of reference as much as possible (Fink, 2007). When silence occurs in the analysand's discourse, it provides "a gateway that leads from the conscious to the unconscious and can be used to enhance and enable self-exploration" (Warin, 2007, p. 48f.). Still, in **Excerpts 2** and **5**, the therapist himself eventually chose to intervene by producing a next turn of talk. The research method that was used in the current study enabled us to investigate *how* the therapist constructed his subsequent turns. CA, however, does not provide the instruments to identify what determined the therapist's decision to break these silences. In **Excerpt 2**, the therapist redirected the talk back to the overarching topic without addressing the silence or its underlying processes. Maybe he had the impression that the silence would not elicit more fruitful material or maybe he felt as if the patient was struggling too much with inner conflicts. Another possible explanation may concern the phase of treatment as this example was selected from the first session and the therapist may have prioritized the review of the patient's history over possible introspection at that point. Interestingly, in our data, it was always the therapist who initiated topical closure after silence (by initiating new or returning to prior topics). Hence, regarding topic management, this asymmetry points toward a division of roles, with the therapist being the one who is more inclined to guard the topical structure of the interaction.

The duration of the silence in the last example in our analysis (**Excerpt 5**), was remarkably long in comparison to the other silences that were presented. Another striking aspect of that episode of talk was that after the revelation and the patient's description of her feelings as "breaking free," the speakers had already moved on to a more neutral topic when the silence occurred. The effect of the positive emotions she described was possibly delayed as she fell silent during the more general elaboration on her employment in the restaurant. Holding a silence for a long time thereby allows for visualizations to become brighter and emotions clearer (cf. Warin, 2007), which would be a possible explanation for her response to the therapist's question that broke the silence. According to Sabbadini (1991), prolonged duration of a silence also makes it increasingly harder to break it. This may account for the topicalization of the silence as it possibly was "the elephant in the room" and probably safer to address than to formulate an intervention that aims at continuing with what came prior to the silence.

The four examples further illustrated that although it is primarily after a patient's turn that the speakers fall silent, it is also

the therapist who temporarily forgoes the opportunity to talk. Until one of the speakers self-selects and continues speaking, the silence thus exists as an interactional product of both speakers' verbal disengagement. This also supports the assumption that "therapists are more active participants of a communicative 'system' than traditional psychoanalytic theory would assume" (Buchholz, 2019, p. 814). Hence, as Sabbadini (1991) states, silence is an interpersonal phenomenon that "can take place only within a relationship" (p. 410). What remains unaddressed in the psychoanalytic literature on silence, however, is how it relates to therapists' use of continuers, such as the "hmm"-sound. This form of recipient talk is most frequently used in psychoanalytic practice, as this technique expresses attentiveness and encourages the analysand to continue talking while the meaning of this sound remains difficult for the analysand to uncover (Fink, 2007). Delaying a response in such a way helps patients "to develop their troubles stance in more detail" (Muntigl et al., 2014, p. 33). Our analysis supports this finding since, in the case of intra-topic silence, the use of continuers and the ensuing silences seemed to elicit further emotive elaboration by the patient. The absence of talk provided for a moment to evaluate what had been said and to then slightly move away from it in order to articulate a somewhat greater understanding or result that the prior talk has built up toward.

Previous research on the meaning and function of silence in the context of psychotherapy attributes a significant value to its use (cf., e.g., Gale and Sanchez, 2005; Frankel et al., 2006). On the one hand, it can be implemented intentionally as a therapeutic instrument, serving various beneficial purposes within the therapeutic process if sensitively employed by the therapist (Lane et al., 2002; Ladany et al., 2004). On the other hand, the ability to remain silent in the presence of someone else is also understood as "an achievement on the part of the patient" (Winnicott, 1958, p. 29). And even from a conversation analytical perspective, "the developing of an ability in a relationship to be silent" is acknowledged as a crucial aspect of interpersonal interaction (Sacks, 1995, p. 50). Our study is complementary to these findings. We demonstrated that silence is constituted as an interactional achievement by both speakers and that its meaning (on an interactional level) is indexically established in the speakers' adjacent turns of talk. Our analysis showed that if silence becomes part of a topic closure sequence, speakers do not show an interactional orientation to the therapeutic function or meaning of the silence. If silence is co-constructed by the speakers in the form of an intra-topic silence, speakers implicitly attribute interactional meaning to it within the subsequent utterances. These silences are constituted in the ongoing discourse as moments that allow continuing with the current course of action in order to reach a therapeutically relevant point. As such, silence becomes part of the therapeutic activity at hand. Lastly, if silence between the speakers explicitly gets topicalized and therefore oriented to as an event in itself, it is not referred to as an absence of talk but as the presence of other therapeutically relevant processes and is treated as a resource for building a next action.

The current study was limited to the occurrence of silence in a specific sequential environment, namely a sequence construction in which the therapist's use of continuers prior to the silence projected the continuation of the patient's current stretch of talk. This continuation was either accomplished after a moment of silence or the patient did not extend her turn at all. Our analysis, however, showed that, in most cases, speakers in psychodynamic therapy do not treat the discontinuity of talk as disruptive. The therapist switched topics or formulated interventions that elicited further elaboration. He did so without using hesitation markers or other markers of reluctance that would display an awareness of the unaccomplished projection of the use of continuers. When the patient extended her turn after the silence, she provided material that demonstrated a more emotional stance as if the absence of talk had facilitated access to deeper levels of her unconsciousness. Whenever the silence was actually treated as a discontinuity of talk, speakers made this explicit by referring to the underlying processes that manifested during the silence. Followingly, the meaning that an absence of talk receives within the respective episode of talk, depends on its relation with the adjacent turns (cf. Hoey, 2015, 2020).

Our findings suggest that silence bears a potential to become interactionally – and therefore also therapeutically – meaningful, but that it is up to the speakers to make use of this potential. Using conversation analysis, we provided a detailed picture of the speakers' practices of speaking leading up to silence and how they can make the occurrence of silence therapeutically relevant in their subsequent turns of talk. Although the phenomenon had already received a fair amount of attention in psychotherapy process research and in psychoanalytic theory, this study shows how CA research can contribute to the practitioner's knowledge base, such as treatment manuals and therapy training. Investigating psychotherapy through the lens of CA provides extensive and microdetailed descriptions of actual interactions and thereby opens new dimensions to the existing understanding of therapy as a practice (for an extensive report on the contribution of CA findings to the stocks of interactional knowledge, see Peräkylä and Vehviläinen, 2003). Empirical research into social interaction thereby shows how professional knowledge, i.e., theoretical concepts and ideas, become translated by participants into situated conversational behavior. Silence in psychotherapy seems to be the golden ticket that gives access to insight and emotional awareness on the part of the patient. CA research, such as the current one, informs practitioners in more concrete terms about the sequential environments in which silence occurs, about the observable features of these environments and, consequently, how participants deal with silence as an interactional resource.

AUTHOR'S NOTE

The data for this research was collected as part of the Ghent Psychotherapy Study (Meganck et al., 2017), a randomized controlled trial on the treatment of major depression (registered on the Open Science Framework; ISRCTN 17130982). Our sample consisted of a small subsample of audio-recordings and was selected without consideration of outcome measures.

DATA AVAILABILITY STATEMENT

The data collection generated for this study consists of anonymised transcript excerpts and is available on request to the corresponding author. Requests to access these datasets should be directed to a.s.l.knol@rug.nl.

ETHICS STATEMENT

The Ghent Psychotherapy Study was approved by the Ethical Committee of the University Hospital of Ghent University. All participants provided their written consent to participate in this study.

AUTHOR CONTRIBUTIONS

AK: main author of the manuscript, main investigator responsible for data-analysis and interpretation. TK: reviewer of the manuscript, contributed to the study design and to the data-analysis and interpretation. MD: reviewer of manuscript, contributed to the to the study design and to the data-analysis and interpretation. SV: reviewer of the manuscript. MH: main reviewer of the manuscript, contributed to the study design, performed the data-analysis, and contributed to the interpretation of the results. All authors contributed to the article and approved the submitted version.

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Conflict of Interest: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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First Encounters in Psychotherapy: Relationship-Building and the Pursuit of Institutional Goals

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This article examines how therapists and patients start building and managing relationships and pursue institutional goals at the same time. Based on a corpus of 6 audio-recorded therapies (client-centered therapy and psychodynamic therapy), I investigate first encounters between therapists and patients as the starting points of any therapeutical process and the place where a relationship between the interactants is established for the first time. Following a microlinguistic qualitative approach and applying methods from conversation analysis and discourse analysis, I show how therapists, on the one hand, try to align with patients to build a positive working alliance and, on the other hand, work to fulfill specific interactive tasks of therapeutic discourse which demand disaligning with the patients' communicative activity and their interactive expectations. Specific interactive "jobs" that need to be fulfilled in psychotherapy are identified, namely the performance of institutional roles by the interactants, the establishment of an interaction structure and the pursuit of helpful change in the patient. I show at which places in the interaction therapists (dis-)align with the patients' projected communicative activity and how aligning and disaligning are related to the interactive process and the establishment and performance of these interactive jobs. The analysis shows that, at the beginning of therapy, alignment and disalignment are both important processes for the following reasons: Aligning with the patient contributes to a positive relationship, which has been shown to be vital for successful psychotherapy, while disaligning introduces the patient to the specific discursive mechanisms that characterize therapeutic discourse and constitute the basis for its effectiveness. Overall, the paper argues that reducing therapy to a dichotomy between relationship and "technique" seems overly simplistic, as both aspects need to be handled and managed at the same time.

Keywords: therapeutic relationship, process research, discourse analysis, client-centered therapy, psychodynamic therapy, alignment, conversation analysis, change research

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INTRODUCTION

The therapeutic relationship between client and therapist is generally considered among the most important factors for successful psychotherapy and "the best and most reliable predictor of outcomes" (Ribeiro et al., 2013, 295). The importance of the therapeutic relationship is not restricted to any specific approach, and it has been shown to be "a reliable predictor of positive clinical outcome[s] independent of the variety of psychotherapy approaches and outcome measures" (Ardito and Rabellino, 2011, 1). The therapeutic relationship constitutes "the healing alliance between the client and the clinician" (Norcross and Lambert, 2018b, 303). In this paper, I investigate how the relationship between therapist and client can be operationalized and understood from an interactionist perspective, i.e., a perspective that is based on the documentation and analysis of the interaction between therapists and clients. I ask which aspects of the many interactional processes within therapy can be identified that considerably contribute to establishing and managing the therapeutic relationship and how therapists and clients affect and change their relationship at different points in the interactive process. I thus strive for both an interactionist understanding of the therapeutic relationship and an identification of vital interactional processes that impact the relationship, both negatively (threatening or weakening relationship and alliance) and positively (strengthening them).

In the following, I first describe the qualitative linguistic approach I follow in this paper. I then detail the linguistic methodology that I rely on as well as the data that form the basis of my analysis (section "Methodology and Data"). Based on a discussion of established approaches to the therapeutic relationship and interactionist-linguistic research on relationships in general, I suggest factors that allow us to identify crucial points in the establishment and management of the therapeutic relationship (section "Analytic Procedure"). In the section "Results," transcripts from therapy sessions (psychodynamic therapy and client-centered therapy) are analyzed that show how therapists and clients establish and manage relationships. A number of practices are identified that are used – mainly by therapists – to uphold a positive therapeutic relationship while at the same time pursuing processes related to the institutional purpose of therapy. After discussing these findings and the theoretical and clinical implications in section "Discussion: Relationship Management and the Pursuit of Institutional Goals in Therapy," I point out the limitations of this study and future directions (section "Limitations and Future Directions").

THE THERAPEUTIC RELATIONSHIP FROM AN INTERACTIONIST PERSPECTIVE

A widely accepted definition of the therapeutic relationship is "the feelings and attitudes that the therapist and the client have toward one another, and the manner in which these are expressed" (Gelso and Carter, 1985, 159). Focusing on communicative (inter)action in this article, I add that the relationship is not only about "expressing" feelings and attitudes – as "expressing" suggests an explicit verbalization – but also about acting on them in some way, including non-verbally, for example with a head nod (Muntigl et al., 2013). A working therapeutic relationship in this sense does not necessarily include that therapist and patient like each other or feel sympathy for each other, but that they can work together in a therapeutically productive way.

Traditionally, the therapeutic relationship has been studied in great detail via questionnaires and checklists that are suitable to quantitative statistical analyses. While this methodology offers many advantages, including reproducibility, comparability and the attribution of exact impact scores to specific parts of the therapeutic process (Norcross and Lambert, 2018a), it has been pointed out (e.g., Muntigl and Horvath, 2014; Norcross and Lambert, 2018b; Muntigl, 2020; Storck et al., 2020) that it is difficult to address a number of relevant questions in this manner. First, questionnaires or checklists do not document the therapeutic relationship itself, but only what the participants are willing and able to (consciously) disclose about the interactive processes between them. Qualitative approaches, in contrast, document and investigate the process itself, which means that the "relationship in action" (Muntigl and Horvath, 2014, 327) becomes the object of analysis, including the contribution of the *patient* to the relationship. Whereas traditional measures are set up to treat therapy and the therapeutic relationship simply as the outcome of the therapist's behavior and thus "neglect, relatively speaking, the productive contribution of the client to the therapy relationship" (Norcross and Lambert, 2018b, 307), an interactionist approach by design treats any interactive process, including establishing and upholding a relationship, as produced by all involved parties (Garfinkel, 1967; Sidnell and Stivers, 2013). Such an approach therefore allows us to study not only the patient's impact on the therapeutic relationship, but also the techniques and methods deployed by the *therapist* to *manage* the patient's contributions. Studying the therapeutic process as it unfolds also promises to further our understanding of *causal* connections within the therapeutic process. Whereas quantitative measures can reveal important *correlations* between different parts of therapy – like the therapist's degree of empathy and its correlation with the success rate of therapy (Elliott et al., 2018) – detailed investigations of interaction in therapy have the potential to demonstrate how and why such factors contribute to helpful therapy. As a result, qualitative approaches allow for insights into how different aspects of the therapeutic relationship combine and work together – parts [like alliance vs. collaboration and self-disclosure vs. emotional expression (Norcross and Lambert, 2018a)] that quantitative research approaches often treat as separate, stand-alone practices (Norcross and Lambert, 2018b, 311), although in interactive reality neither therapist nor patient experiences or produces them separately. An interactionist approach therefore renders a picture of the therapeutic relationship that corresponds much more closely to the experience of the participants, while at the same

allowing insights into the interactive processes that go beyond what participants themselves are able to consciously perceive while communicating.

METHODOLOGY AND DATA

Methods

In this paper, such insights into the details of the interactive process are sought based on established methods of linguistic conversation analysis (Sidnell and Stivers, 2013) and discourse analysis (Redder, 2008; Tannen et al., 2015). These approaches investigate communication as a joint process by all involved interactants who together produce certain activities (like telling a story or rendering an interpretation) or whole conversations and institutional processes (like an individual psychotherapy). As interaction is sequentially organized – i.e., in most cases a question will be followed by an answer, an invitation by an acceptance – specific patterns of interaction can be reconstructed through close interaction analysis (Redder, 2008). These approaches thus also make it possible to offer a detailed account of the "competences that ordinary members use and rely on in participating in intelligible, socially organized interaction" (Heritage and Atkinson, 1984, 1). Works within both approaches (see e.g., Ehlich, 1986; Heritage, 1998; Mondada, 2007; Redder, 2008; Stivers, 2008) have also shown that any or all features of an utterance or a turn may play a role in the doing of the action or constituting the activity. Therefore, interaction is documented and investigated in as much detail as possible, which includes documenting pauses, false starts, interjections (um, uh huh) and preface starters (well, okay). Another important characteristic is that these approaches base their analytic claims on what is publically available for viewing and hearing; that is, the original data on which the analysis is based are represented, which allows others to judge the validity of the analytic claims made. The methods applied here thus make it possible to offer a detailed description of the processes through which participants constitute and manage their relationships, and to reconstruct their activities and the institutional or individual goals they pursue through communication.

Data

These methods are applied to a corpus of 6 audio-recorded short-term therapies (psychodynamic therapy and client-centered therapy) that were conducted in Germany. The patients were offered psychological treatment of up to 12 sessions after they had physically recovered from suicide attempts.

The corpus consists of six successfully completed therapies, three of which were carried out by a therapist trained in psychodynamic therapy (Delgado et al., 2015) and three by a therapist who uses the client-centered therapy approach (Rogers et al., 2013).

The conversations were transcribed following conversation analysis conventions (Jefferson, 2004), except that the lines are numbered like a musical score that depicts all participating "voices" (speakers) at a particular moment in the same line (cf. Rehbein et al., 2004). The horizontal position of the words thus indicates the order in which they were uttered. The transcription follows a medium level of abstraction and does not include all prosodic information, as the analysis focusses mainly on the verbal content of the exchanges.

Ethics

The data presented here was collected by Norbert Dittmar. The study received ethics approval from FU Berlin and written informed consent was obtained from the participants for the publication of anonymized data. During and after data collection, clients had the right to cancel participation and opt out of the study. The recorded data were then deleted. Persons referred to in the transcripts, including clients and their family members, have been given pseudonyms.

ANALYTIC PROCEDURE

As interactionist research on relationships shows (Goffman, 1959, 1966; Volosinov, 1930/1973; Locher and Watts, 2008; Linke and Schröter, 2017), any relationship is constantly monitored and managed by the participants. In principle, therefore, every communicative act has the potential to considerably modify or change a relationship. In a qualitative investigation of relationships, this might be taken to imply that everything that goes on between the participants has to be documented and analyzed in microlinguistic detail. As such an approach is not feasible in the context of this investigation, I instead suggest parts of the interactive process between therapist and patient that strongly contribute to the establishment and management of the therapeutic relationship. I thus identify ways to operationalize the therapeutic relationship within an interactionist research approach (cf. Muntigl and Horvath, 2014).

As any interpersonal relationship is initially established when people meet each other for the first time, I focus on *first encounters* in psychotherapy. This makes it possible to show how therapist and patient begin creating a relationship and how these crucial initial moments impact the interactive process between them.[1] It also allows us to follow the development of their relationship and understand the interactive dynamics that underlie the changes and modifications it goes through.

To identify central relationship-building moments in these first encounters, I rely on a conceptual distinction first suggested by Hausendorf and Quasthoff (2005). They explain that, when communicating, participants perform specific interactive jobs, thereby creating a certain discourse type. For example, within

[1]Even the first session of psychotherapy, though, does not start with a blank slate, as patients and therapists hold expectations that can affect interaction and relationships. In the cases discussed here, this becomes visible when patients bring along photos or letters to show to the therapist (**Figure 1**) or when they utter their expectations about the objectives of the therapy early in the first session (**Figure 3**). While these instances show that patients think about therapy before the first session and prepare for it, the relational expectations that they can be expected to bring along as well are more difficult to investigate based on conversational data. I therefore refrain from discussing these in detail in this paper.

the discourse type of storytelling, the interactants cooperatively pursue jobs such as demanding and giving attention to a longer turn by one of the participants, rendering a narrative turn and reacting during and after that turn (Sacks, 1995; Schiffrin, 2006; Norrick, 2010). If they consistently fail to complete these jobs – for example, if the aspiring storyteller is unable to get the attention of the recipients for a longer narrative turn – they will be unable to perform the overarching discourse type (in this case storytelling). Within institutionalized discourse types, we find that establishing and performing institutional roles (i.e., client vs. agent), establishing a certain institutional interaction structure (for therapy see e.g., Turner, 1972; Lakoff, 1982; Scarvaglieri, 2017; Peräkylä, 2019) and pursuing specific institutional goals constitute jobs that regularly need to be performed by the participants. In this paper, I specifically focus on *institutional roles* and the interactive processes in which they are established and subsequently performed, because these processes can have a specifically strong effect on the relationship between the interactants (Koerfer et al., 2018). Furthermore, they also affect other important parts of therapy, like the establishment of an interaction structure (i.e., performing certain roles also means establishing a certain interactional structure) and the pursuit of institutional goals (see below, sections "Results" and "Discussion: Relationship Management and the Pursuit of Institutional Goals in Therapy").

While the concept of interactional roles is concerned with what could be called the meso-level of interaction – since the focus is mostly on *what* is done cooperatively, less on *how* this is done – the concept of *alignment* (Stivers, 2008; Lee and Tanaka, 2016) allows us to focus on the microlinguistic level of interaction. Alignment refers to the activity in progress and can be used to investigate whether the participants are taking part in the same kind of activity. Aligning responses join in the activity projected by an interactant and thus make cooperation possible "by facilitating the proposed activity or sequence, accepting the presuppositions and terms of the proposed action or activity, and matching the formal design preference of the turn" (Stivers et al., 2011, 21). While an aligning response thus takes part in the same activity, disalignment consists of no reaction at all or a reaction that pursues another activity. In ordinary conversation, this might be, for example, talking about the weather or the latest sports news instead of answering a question. Interactional alignment does not imply agreement: "... one can disagree but still cooperate with the general aims of the interaction" (Muntigl and Horvath, 2014, 329). For example, a negative response to a suggestion about a joint activity would constitute an act of disagreeing while aligning, whereas beginning to tell a story that is not related to the suggestion would be a form of disalignment, even if not explicitly disagreeing.

Concerning relationship, we may expect that participating in the same activity contributes to a stronger relationship, and that consistent interactional alignment by therapist and patient can thus serve as an indicator of a working relationship (Muntigl and Horvath, 2014). We may also expect that constant or repetitive disalignments in an interactional dyad will put a strain on the relationship. While these expectations serve as a starting ground, my analysis of specific instances of interaction in therapy demonstrates that disalignments are an important and essential part of the therapeutic process. The data show that an important aspect of relationship management by the therapist is dealing with what could be deemed "necessary" disalignments and being able to uphold a working therapeutic relationship with the patient.

In the following, I investigate extracts from first encounters in therapy (macro-perspective), as that is where every relationship is initially formed and because early relationship formation has been shown to be particularly important for successful therapy (Horvath and Bedi, 2002, 55). Within these encounters, I specifically focus on the establishment of different institutional roles by the participants (meso-perspective) and ask whether participants align interactively and cooperate in the same activity or disalign at certain places in the interaction (micro-perspective).

RESULTS

Patients as Experts

In verbally oriented therapies – such as client-centered therapy, psychodynamic therapy and psychoanalysis – patients and therapists perform different roles (Scarvaglieri, 2017). An important aspect of these roles concerns epistemic authority – that is, the idea that interactants have different types of knowledge about different domains of reality as well as different degrees of certainty about these knowledge domains, and that they will index domains about which they have specific knowledge in conversation (Labov and Fanshel, 1977; Heritage and Raymond, 2005; Heritage, 2013). In most cases, for instance, interactants will claim epistemic authority on their own mental processes, thereby marking "territories of self" (Heritage, 2013, 382). Failing to constantly maintain "such territories is to risk deracination and, at the limit, even depersonalization" (ibid.). In verbally oriented psychotherapy, the client needs to claim epistemic priority about their specific biographical experience, and thus to perform the role of expert in regard to their own emotions, perceptions and specific events they were part of. In general, therefore, the client's role conforms to conventional principles of epistemic authority, as participants are generally expected to know best about their own experience. The therapist, in contrast, will often take on the role of someone who is able to contextualize the patient's experiences and offer explanations for or a different understanding of them (cf. Muntigl et al., 2013; Weiste et al., 2016; Scarvaglieri, 2019a). Performing this role can thus present a challenge to established principles of epistemic authority, according to which the patient, as the person who had these experiences, is best suited to understanding and explaining them. These roles thus present challenges for both participants and can potentially strain their relationship. Nevertheless, the following extracts show that these roles are established and performed immediately at the beginning of a therapy.

The first extract (**Figure 1**) is taken from the first session of one of the client-centered therapies. The patient is a middle-aged

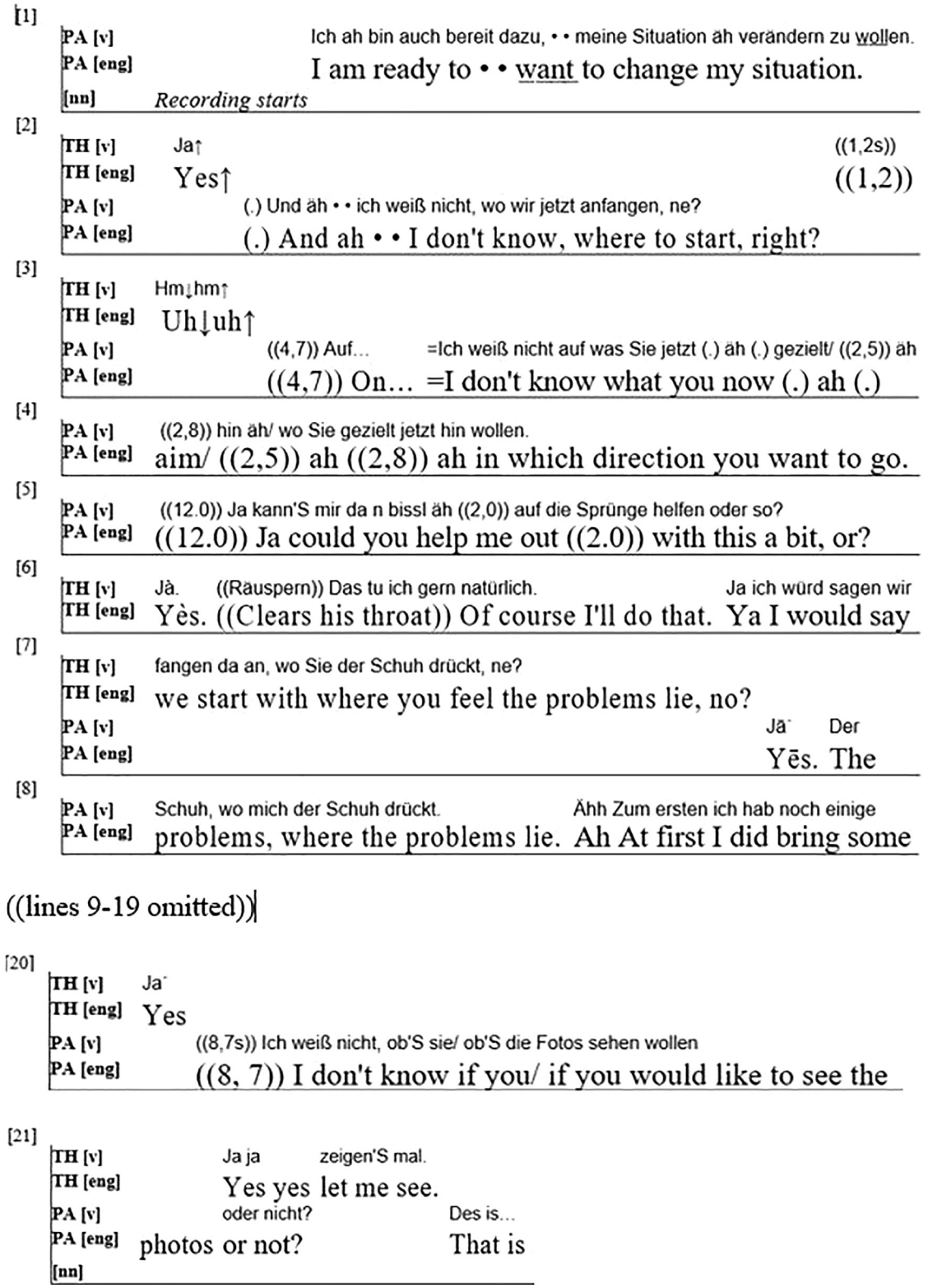

FIGURE 1 | (PA = Patient; TH = Therapist).

man who shows symptoms of alcohol use disorder during the therapy.[2] I present the very first utterances that were recorded of this therapy (greetings or welcomings were not recorded).

The patient first states his willingness to change. He then makes three attempts to get the therapist to start off the conversation by choosing the topic they should talk about. At first he mentions that he himself does not know what to talk about or "where to start" and adds the question tag "right" (German "ne") to draw a response from the therapist (line 2). The therapist reacts after a brief pause with an acknowledgement token ("Uh uh" (line3)) but does not accept the turn. After another pause, the patient again mentions a lack of knowledge, this time about "the direction" the therapist might "want to go" (line 4). The therapist again does not react verbally, which leads to a long pause and the patient now explicitly asking whether the therapist could "help me out ((2.0)) with this a bit" (line 5). The therapist reacts to this question by asking the patient to "start with where you feel the problems lie"[3] (line 6–7). Thus, the therapist again refuses to choose a topic, instead giving this task back to the patient. The patient demonstrates difficulty with this reaction as he repeats the therapist's utterance, still searching for a suitable starting point.

We thus see that, from the start of the first session, the therapist treats the patient as the expert on his own experience and perception and as the only person able to choose the relevant topics in the session. He does this implicitly, by not reacting to the patient's invitations to choose a topic, and explicitly by asking the patient to choose a topic himself and, a bit later in this session, explaining to him his version of Freud's "fundamental rule" (Freud, 1900/1913). In this short sequence alone, the therapist thus uses multiple interactional devices – non-reaction, evasive responses and explicit explanations – to establish the patient's role as the expert on his own life experience.

On the micro-level of linguistic investigation, we find that disaligning with the patient's projected activity plays a big part in this initiation to a new discourse structure and the institutional distribution of roles. The patient repeatedly tries to project a common activity in which the therapist tells the patient "where to start" and "in which direction to go,"[4] but the therapist twice reacts only minimally through acknowledgement tokens or not at all, he does not cooperate in the activity. This changes only when the patient poses an explicit question asking for "help." Now the therapist answers and thus formally aligns with him, although in his response he suggests pursuing another activity than the one proposed by the patient (the patient choosing the topic instead of the therapist suggesting one). We thus find that the therapist first disaligns, and that when he re-aligns (cf. Muntigl and Horvath, 2014, 340–41) formally – by responding to the patient's questions – in his answer he shows that he still disagrees with the patient's suggestion about their joint activity.

The patient at first seems to be irritated by this behavior, which is indicated by the long pauses he makes within and between utterances (lines 3, 4, 5) and by false starts (line 3) and self-repairs (lines 3, 8). A bit later though, the patient starts adjusting to the new role, by asking the therapist whether he wants to see the photos the patient brought to the session (lines 20–21). In everyday interaction with friends or colleagues, mentioning that one brought photos along would commonly lead to the other side suggesting to share them and discuss them together. After mentioning the photos, the patient here does not wait for such a reaction by the therapist. Instead, he asks himself whether the therapist wants to see them: "I don't know if you/if you would like to see the photos or not?" (lines 20–21). Although he again uses a "I don't know" construction (cf. line 3, 4), this time it is rendered as a "yes/no" question that is supplemented by a question tag ("or not"), which makes it clear that a response is expected. This time, the therapist reacts quickly and agrees to look at the pictures ("Yes yes. Let me see." (line 21)), even before the patient finishes his turn. The patient thus appears to have made a first step in adjusting to his new role and in understanding that the therapist will not always follow established patterns of everyday interaction. Therefore, by explicitly asking for it, the patient himself ensures that things are discussed that are important to him.

Overall, in these few utterances from the beginning of the therapy we see a therapist immediately establishing institutionally differentiated roles and using a number of interactional and linguistic devices to do so, including disaligning, re-aligning and disagreeing. While it is difficult to discuss the intentions of the therapist or the reasons for his behavior based on conversational data, the effects of his behavior consist in introducing a specific conversational structure and the different roles of therapist and client. The patient's reactions suggest that he is slowly adapting to these changes.

The second extract (**Figure 2**) shows similar behavior, and it also demonstrates the difficulties patients have in adjusting to their role. The extract stems from the first session of a psychodynamic therapy with a female patient in her twenties. I again present the very first utterances of the therapy.

After a short, unintelligible sequence, the patient asks what the therapist wants to talk about.[5] As in the first example, the therapist, after pausing briefly, does not react by suggesting a topic. He disaligns with the patient and instead gives the question back to the patient and asks her what she "would (prefer) at the moment" (line 1–2). In another striking parallel to the first extract, the patient then repeats the therapist's question, thereby giving herself time to think. She then states that she cannot decide, and that "somehow (everything) is weighing on me at the moment" (lines 3–4). This example thus again shows a therapist disaligning with the patient and refusing to choose a topic, instead insisting that the patient choose for herself. In

[2]The alcohol problems become manifest as the therapy continues. In the session documented here, the patient was not drunk or noticeably under the influence of alcohol.

[3]In German, this is formulated as a phrase that literally means "where the shoe squeezes you."

[4]From the perspective of metaphor analysis (Buchholz, 1998; Buchholz et al., 2008; Tay, 2013) it is noticeable that the patient here repeatedly frames therapy as process of joint movement that has a starting point and a direction.

[5]Parentheses indicate that the transcriber was not fully sure about the content of the utterance.

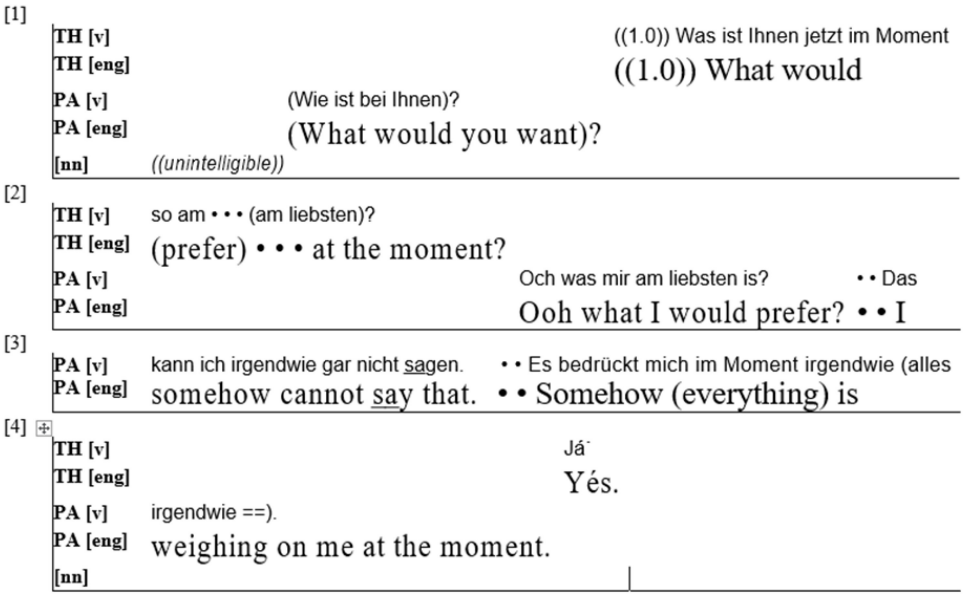

FIGURE 2 | (PA = Patient; TH = Therapist).

both examples, the therapists immediately work to establish a certain role distribution. Patients are made to choose a topic, demonstrating to them that they are the experts on their own experience and best able to decide what is important in therapy. To establish this role, therapists disalign with the patient and thus accept a potential strain on the relationship.

Therapists as Experts

While therapists work on making patients talk about their own experiences, they sometimes present suggestions about the context of the patient's experience or possible explanations for it (Peräkylä, 2004, 2005, 2019). Therapists thus work to establish themselves in a role where they serve as experts in understanding the events and experiences that the patient has just described.

The third extract (**Figure 3**) stems from the same session of the same (psychodynamic) therapy as the second. The patient had mentioned that, after physically recovering from her suicide attempt and being released from the hospital, she began to feel much worse than during her recovery in the hospital and again experienced suicidal thoughts. The therapist then offers an explanation for why these thoughts might have reoccurred.

The patient finishes her turn by stating that she wants to get off of her medication ("I do not want that" (line 19) refers to the medication). As she does not take the turn after a pause of 2.5 seconds, the therapist assumes the right to talk and offers a possible explanation for her negative feelings after returning home from the hospital. He "imagine[s]" that at home "things reoccur that were there before" (lines 20–21) – that is, that the patient is again in the pathogenic biographical situation in which her problems appeared in the first place. He also suggests that the hospital had certain advantages, like "relief," "distance" and "a certain pressure" (lines 23–24), that were lost after the patient left the hospital.

With this, the first explanatory turn of the therapy, the therapist starts to establish himself as someone who is willing to contextualize the patient's experience and offer potential explanations. He does this even though the patient is projecting another activity: she had mentioned her negative feelings and then moved on, focusing instead on her goals and expectations for the therapy. By changing the activity and the topic of conversation, the therapist here disaligns with the patient. He talks about the reasons for her emotions instead of her goals in therapy. We then see that the patient accepts this change and aligns with the new activity. She thus accepts the role the therapist takes on. She offers a number of agreement tokens ["Yes" (line 22) "True," "Yes that's right" (both line 24)], but later denies that she felt pressure while in the hospital, instead stating that she felt safe and relaxed there. She thus aligns with the new activity but disagrees with the therapist's assumption about her feelings. She thereby claims epistemic authority (Heritage, 2013) for her own experiences and feelings. The therapist, by rendering a suggestion about the roots of her feelings and her experience in the hospital, had turned the patient's epistemics into a domain over which he also claimed authority, but the patient, by rejecting parts of the therapist's claim, restores a hierarchy according to which she preserves epistemic priority. After such a (partial) rejection of an explanatory utterance (Peräkylä, 2004), the therapist has various options, including elaborating on his explanation (Peräkylä, 2005), insisting or retreating (Muntigl et al., 2013). In this case, the therapist retreats [he accepts her rejection (lines 26, 29)], thus demonstrating to the patient that he accepts her epistemic authority about the content of her feelings. Nevertheless, the therapist presented himself here as someone who is able to offer explanations for the patient's inner processes. The patient accepted and aligned with this activity,

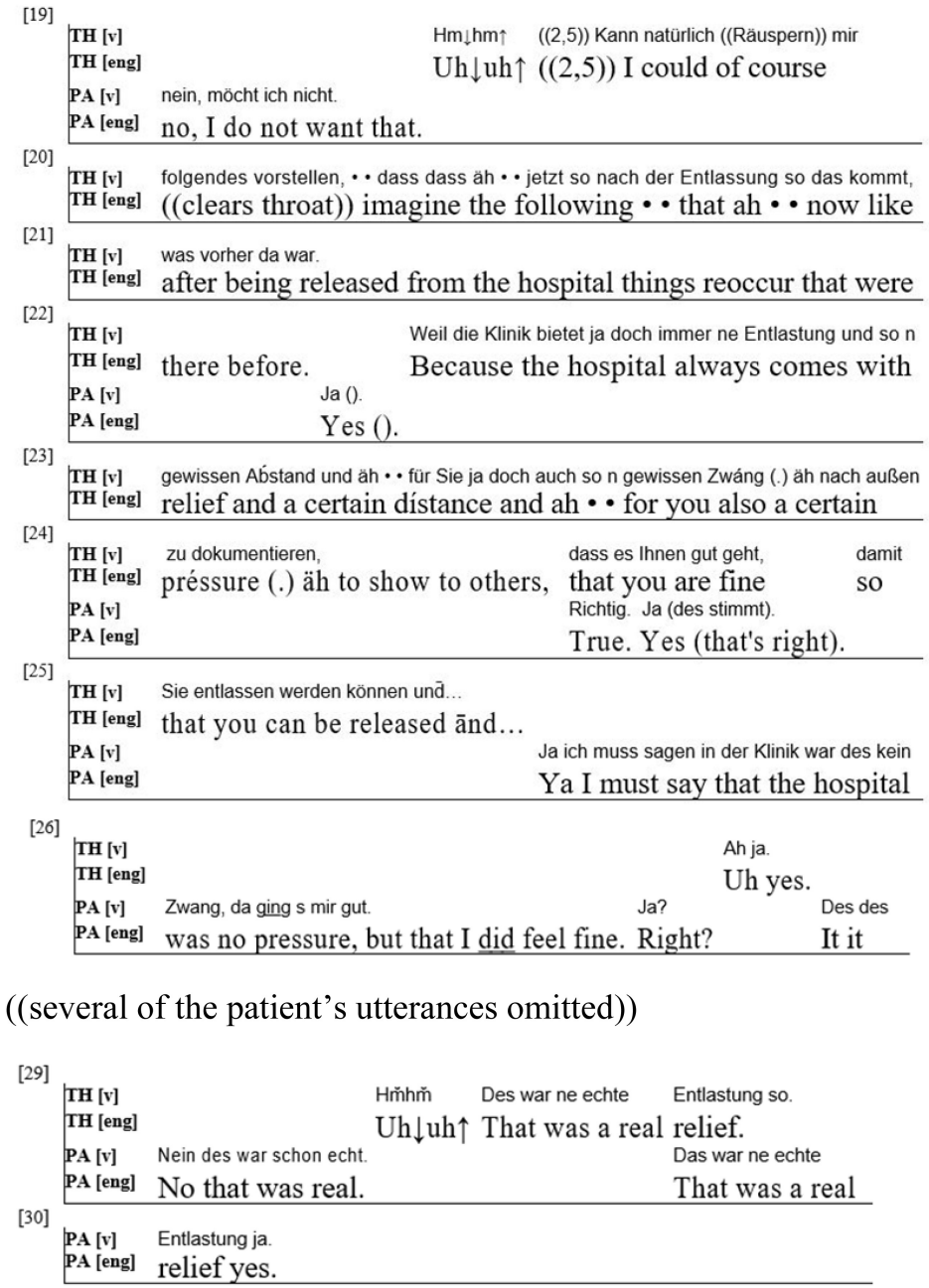

FIGURE 3 | (PA = Patient; TH = Therapist).

and she also accepted the therapist's proposed explanation, but rejected the part where he tries to describe – not explain or contextualize – her feelings while being in the hospital. We thus find that both interactants here cooperatively establish themselves and each other as experts for different parts of the patient's experience: the patient as the expert regarding the experience itself (the "what" of her feelings), the therapist as the expert regarding contextualizing and understanding this experience (the "why" of the feelings). This example thus shows how both participants work to establish separate domains of authority concerning the patient's epistemics. We also notice that this establishing of roles includes processes of disalignment and realignment with the patient's activity by the therapist.

To illustrate these processes further, I point to an example from a third therapy, the first session of another client-centered therapy (**Figure 4**). Before the extract presented here, the therapist and the patient had examined the patients emotions at home vs. during her stay in the hospital (this extract does thus not start at the beginning of the session). The patient is a woman in

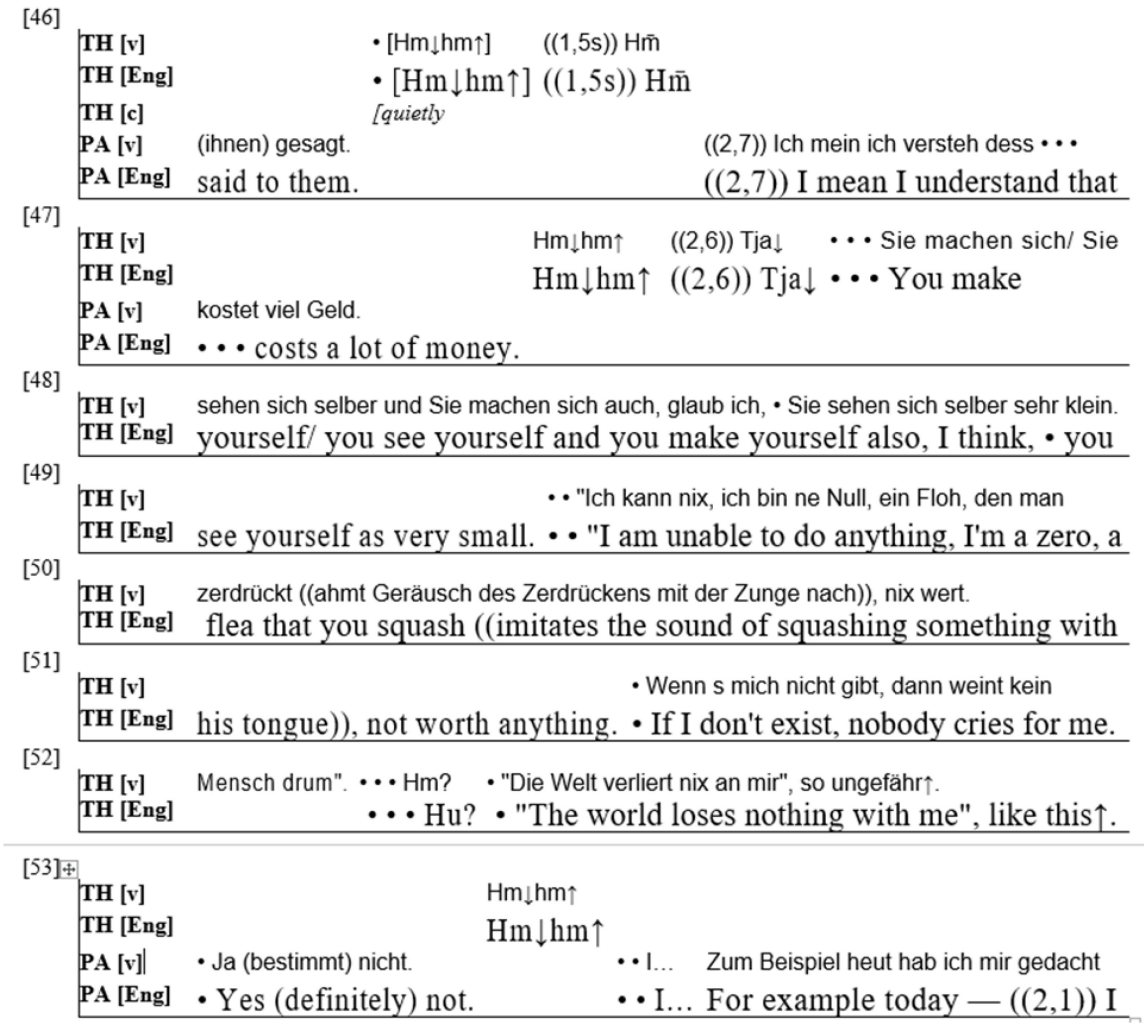

FIGURE 4 | (PA = Patient; TH = Therapist).

her fifties who has a very difficult relationship with her husband and shows signs of a depressive disorder.

The session had started with the patient expressing how well she had felt while in the hospital, which, as in the third example, contrasts strongly with her feelings after returning home. Together, the therapist and the patient then examine the reasons for the positive emotions in the hospital, with the therapist repeatedly asking the patient to search for explanations and also offering potential reasons himself. Then the patient describes that she left the hospital against her will. She says she had mentioned that she had wanted to stay longer (line 45, not represented), but had to leave anyhow. In lines 46 and 47, she expresses understanding for this, as a hospital stay "costs a lot of money." Then the therapist comes in and changes the activity that the two interactants are pursuing. Whereas before the patient was mainly describing her feelings as well as specific events (like talking to the doctors, leaving the hospital), the topic shifts to a general description of the patient's character traits. The therapist sketches a picture of the patient's view of herself ("you see yourself," line 48) and of her behavior toward herself ("you make yourself," ibid). After this general characterization, according to which the patient sees herself as and makes herself "very small" (line 49), the therapist uses auditory depictions (Scarvaglieri, 2013b; Clark, 2016) and thinks aloud from the patient's perspective (Yamaguchi, 2005; Tay, 2013, 112) to sketch the picture of a person who has very little self-regard. He closes by stating from the patient's perspective that the world would lose nothing if she ceased to exist, to which the patient agrees empathically.

We thus find the therapist changing the activity that the interactants had pursued together for a while. His disalignment here allows him to present a characterization of the patient and "reflect" to her, in a detailed and quite compact manner, his impressions of her. This activity is part of the client-centered technique and aims to make patients aware of parts of their self that they are as of yet unaware of. It is supposed to contribute to an image that patients have of themselves that more

closely resembles the actual structures of their self. According to the underlying therapy theory (Eckert et al., 2006; Rogers et al., 2013), a more "realistic" view of the self will significantly contribute to processes of healing. The therapist's disaligning here is thus related to what, in traditional terms, could be called "technique" – it allows the therapist to present his impression of the patient. In doing so, the therapist accepts the risk this might pose to the therapeutic relationship with the patient, and he introduces himself as someone who is able to describe the patient in significant detail and in quite unambiguous terms. The example thus shows that therapists manage relationships and "technique" – presenting different and new knowledge to the patient and establishing themselves as experts in explaining and understanding the patient's experience – at the same time, in the same utterances, and that both aspects are relevant to understand the therapeutic process.

Managing Resistance

In the following, I present an example in which the patient shows himself unable (or unwilling) to perform the role of the expert on his biographical experience. This example (**Figure 5**) stems from the same therapy (first session) as example 1 (middle aged male patient, alcohol abuse).

The excerpt starts with the therapist pointing out the relevance of events that the patient had just talked about (the suicide of his sister, the divorce from his wife). He mentions that the patient seems unable to "get over" these experiences (line 48) and asks him to elaborate on them. The patient replies that he does not know "how to talk" about this and that these "situations" "just weigh" on him (lines 51–52). He leaves a very long break between his utterances and does not expand on them. The therapist initially reacts with supportive continuers and by leaving the floor to the patient – overall, almost 40 seconds pass in which nothing happens besides the patient expressing an inability to talk. By refusing to accept the turn, the therapist thus insists on the therapist/client role distribution. As the silence stretches, however, the therapist does assume the turn. After initially refusing to align with the patient's projected activity (the therapist helping the patient to talk about his experience), he formally re-aligns with the patient, simply by accepting the right to speak. However, he does not offer any suggestions about how the patient might feel regarding the life experiences that had been mentioned, he thus does not do "the patient's job." Instead, he talks about what the patient might want or expect from the therapist in the current situation ("I do have the feeling that you're expecting a guideline about what you can say to me and what not" (55–57)). The therapist thus meets the patient halfway – he formally re-aligns by taking the turn and temporarily freeing the patient of the pressure to speak, but he does not offer suggestions about the patient's feelings regarding the experiences in question.

This example shows a therapist reacting to a patient who does not perform his role. After at first disaligning with the patient's projected activity, he later re-aligns formally by accepting the turn, but changes the topic of the conversation. The therapist thus on the one side alleviates the pressure on the patient to speak about something he clearly has problems addressing, and on the other side keeps the focus on the patient's inner experience. We see how the therapist here tries to find a middle ground between making the patient speak about himself and establishing institutional roles and structure, and the need to uphold a working relationship, which includes adapting to the patient's needs and (in)abilities in the therapeutic situation.

Overall, this example adds to our finding that therapists pursue aspects of relationship and technique at the same time and that they adapt their behavior according to the patient's actions, while still striving to achieve institutional und interactional goals.

DISCUSSION: RELATIONSHIP MANAGEMENT AND THE PURSUIT OF INSTITUTIONAL GOALS IN THERAPY

In the five extracts just examined, we have found that therapists frequently disalign with the patient's projected activity, and that they also perform actions that could be seen as infringing on the patient's epistemic authority. Both of those practices – repeatedly disaligning and contesting epistemic authority – can be problematic for a functioning therapeutic relationship (Muntigl et al., 2013; Muntigl and Horvath, 2014; Weiste et al., 2016). This seems even more relevant at the beginning of a therapeutic process, as there is no interactional history between the two participants, no shared common ground to rely on. What is more, the therapists here are dealing with persons who are recovering from suicide attempts and have a special need for a strong and reliable relationship with a caregiver. The therapist's behavior may thus seem counterproductive. This impression changes, however, when we focus on the accompanying actions that therapists perform in these situations, and when we try to understand which objectives the therapists are pursuing when they disalign and challenge epistemic authority.

First, we see that the therapists modify and adapt their disaligning and challenging utterances, in the third example by framing them not as fixed knowledge about reality, but as possible imaginations ("I could imagine that"; cf. Muntigl and Horvath, 2014, 331), and by downgrading the propositional content ("a certain distance," "a certain pressure"; concerning the framing of potentially controversial content cf. Vehviläinen, 2003, 578). Other means that have a similar effect are expansions that widen the topic of the talk and thus make it easier for the patient to identify elements with which they can agree (Peräkylä, 2005, 173–74), the explicit presentation of new knowledge as suggestions, proposals or in the form of a question (Vehviläinen, 2003, 597; Muntigl et al., 2012, 126; Scarvaglieri, 2013a, 159–62), various forms of hedges (such as "epistemic downgraders" (Muntigl and Horvath, 2014, 332; see also Ehlich, 1990; Weingarten, 1990; Weiste et al., 2016) and try-markers (Sacks and Schegloff, 1979, 18).

These linguistic devices either "weaken the illocutionary force" (Ehlich, 1990, 219; my translation) of an utterance, for example by turning an assertion into a question or a statement into an assumption, or reduce the scope of the propositional content of these disaligning and potentially

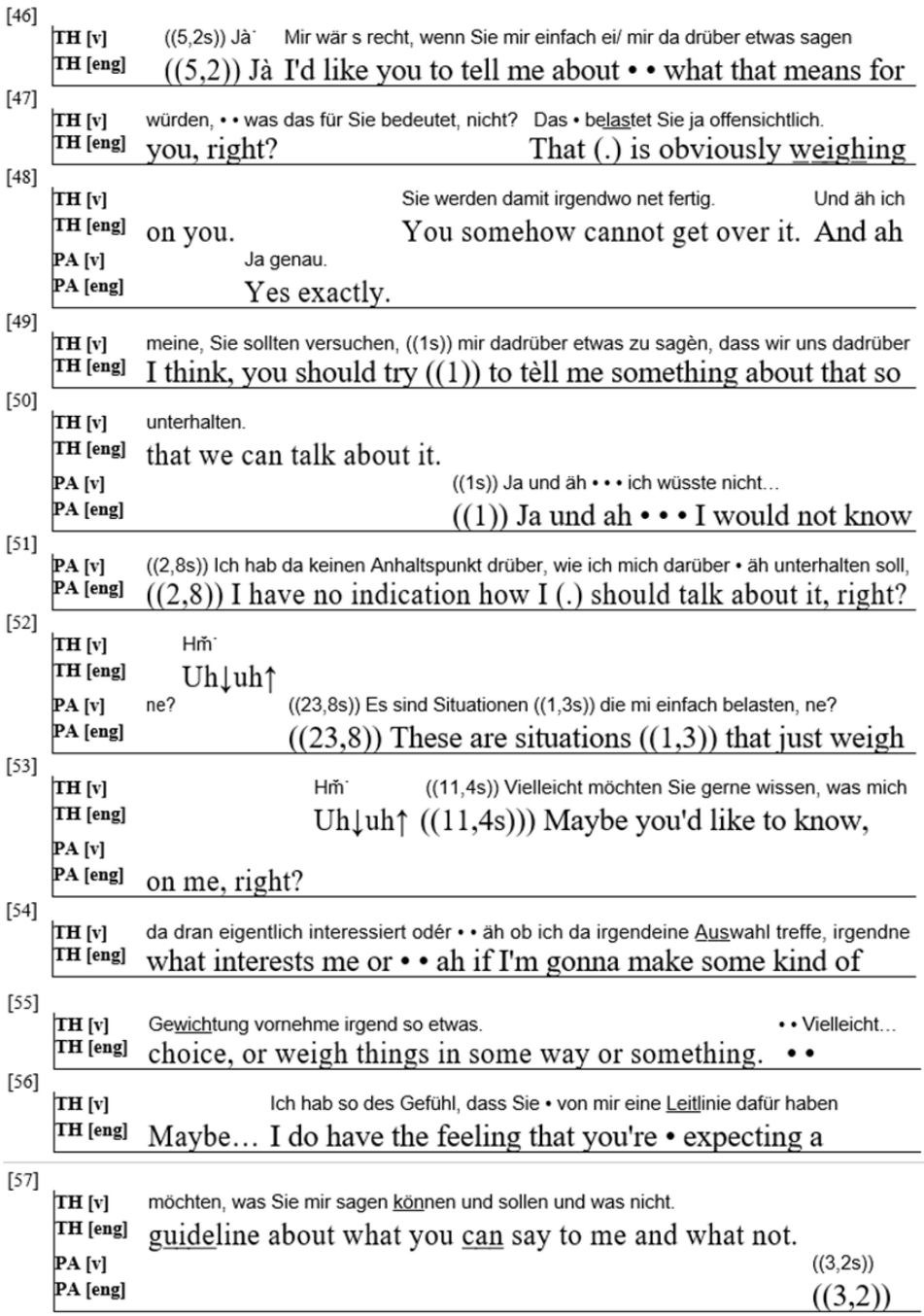

FIGURE 5 | (PA = Patient; TH = Therapist).

controversial statements, which leads to less far-reaching statements that in principle should be easier for the patient to accept (Scarvaglieri, 2013a). Both of these techniques – weakening the illocutionary force and lowering the propositional weight of an utterance – can potentially further a critical examination of the utterance's content by the patient and communicate to the patient that they decide whether to accept it or not. With these techniques, therapists strive to mitigate the potentially problematic relational consequences of disaligning utterances or utterances that infringe on epistemic authority (cf. Weiste et al., 2016).

In addition to modifying disaligning and challenging utterances, therapists also use interactional means – i.e., specific actions – to mitigate the relational effects of any problematic turn. They attempt to realign with patients at a later point in the interaction (extract 3), explicitly

retreat from statements that challenge epistemic authority (extract 3) (Muntigl et al., 2013) and explain disalignments (extract 1) to mitigate their effects on the therapeutic relationship. There are thus linguistic and interactional devices that make it possible for therapists to verbalize new and different knowledge and for patients to discover new insights, and to at the same time uphold a working relationship with the patients.

Second, in the examples above, disaligning actions by the therapists are related to the introduction of specific roles and an institutional structure of interaction. In the most basic terms, therapy consists of two processes (Scarvaglieri, 2017): the patient verbalizes their biographical knowledge, and then therapist and patient discuss and thereby change or adapt this knowledge. We have seen that the therapists' disaligning actions serve to introduce and support this structure and the respective roles of patient and therapist. The therapists did not respond to patients' questions about where to start the therapy in a conventional manner – i.e., by suggesting a topic – and instead gave the question back to the patient, kept silent or explained in detail that such questions would in principle not be answered. Disalignments are thus related to establishing the client as the expert regarding their personal experience who knows best what is important to them and what thus needs to be discussed in therapy. Other examples of disalignment observed above include therapists commenting on the experience just described by the patients, thereby establishing themselves as persons able to contextualize the patient's experience and introducing the "second" part of therapy, the discussion of the patient's experience. These disalignments are thus also related to establishing the characteristic discursive structure of therapy and its specific distribution of roles (therapists as experts in contextualizing and understanding experience, patients as experts in choosing from their biographical experience). Disalignments thus help create the specific interactive character of therapy.

Third, by disaligning with the patient's projected activity, therapists are able to introduce new knowledge and a diverging perspective on the patient's experience. This can be seen as an essential element of verbally oriented psychotherapy (Vehviläinen, 2003; Peräkylä, 2004; Weiste et al., 2016) that allows patients to change their perspective of self and others (Scarvaglieri, 2019b) and to understand their biographical situation differently and in terms that support a productive handling of their situation (Scarvaglieri, 2019a). In this regard, disalignments are thus related to the institutional purpose of therapy, i.e., to promote positive mental and behavioral change in the patient (Graf et al., 2019; Pawelczyk, 2019).

The data not only showed that therapists use several means to reduce the effect of disalignments on the therapeutic relationship, but also that patients are able to adapt to these changes, as early as in the first session. As patients adjust and become used to their role and the specific conversational structure, they will expect disalignments by the therapists and thus will not perceive them as particularly problematic. The potentially negative impact of any disalignment on the relationship between therapist and client therefore decreases as the therapy proceeds and patients get used to its interactional structure. The disalignments early in the therapy, as discussed here, thus establish a basis for therapeutic work in the later sessions.

Overall, I have found that alignments and disalignments by therapists are related to not only relationship management, but also the characteristic structure of therapeutic discourse (roles, interactional structure) and its purpose (achieving mental and behavioral change through communication). The data show that therapists focus not only on establishing a working therapeutic relationship with patients – not even in the initial moments of the first session, not even with psychologically unstable patients – but also, and equally, on pursuing institutional goals and establishing interactive roles and a specific structure of interaction. These objectives demand interactive disalignments between therapist and patient that have the potential to harm their relationship. Therapists pursue them nevertheless, which demonstrates the value they place on them. To mitigate the effects of disalignments and reconcile the pursuit of institutional goals with relationship management, therapists use specific interactional and linguistic devices that are designed to activate patients and show them that they can accept or reject such utterances. Therapy thus shows itself as a complex balancing act in which processes of relationship management, institutional goals and institutional structure need to be pursued at the same time. Each action, whether it is part of a therapeutic "technique" or not, affects and regulates the therapeutic relationship, and the therapists' actions take this into account. The data thus show that therapy as both a clinical process and an object of scientific study cannot be reduced to a dichotomy between relationship and technique, and that both aspects have to be considered at the same time, as they both constitute the basis of any therapy and are regularly pursued and managed at the same time.

LIMITATIONS AND FUTURE DIRECTIONS

While the present study has shown how therapists and clients co-manage the relationship and at the same time pursue institutional goals, it has illustrated its findings through a limited number of examples. Although these examples are backed by analyses of a broader corpus that consists of six different therapies, the research presented here has to be understood as exploratory in nature. Taking data from other backgrounds (including other types of therapy) into account might well lead to observations of further and different ways of introducing and managing the therapeutical relationship.

When operationalizing the therapeutic relationship, decisions were made to focus on specific aspects. While these decisions are firmly grounded in interactionist relationship research, we can expect to find further important practices of relationship management when focusing on different aspects. Along the lines of the above argument about the convergence of "technique" and relationship (from a theoretical and empirical

perspective), it would seem promising to focus, for example, on interpretations and similar therapeutic interventions and the relational challenges these activities present and how these challenges are dealt with.

A further limitation concerns the fact that, due to the limited scope of this study, it was not possible to examine how different relationship-management techniques change through the course of a therapy or how the initial establishing of the relationship influences its development over time. Such a longitudinal, supra-session (cf. Bercelli et al., 2013; Voutilainen et al., 2018) investigation of relationship management would constitute another fruitful avenue in the study of the therapeutic relationship.

Finally, to overcome the general limitations of any qualitative study while simultaneously preserving its ability to make the relationship itself visible, it would seem promising to combine qualitative research with quantitative measures. It would for example seem worthwhile to code different types of disalignments by the therapist (e.g., whether they concern the patient's role or the therapist's role, whether they occur after a pause in the conversation or during or immediately after the patient's turn) and the types of reactions these provoke (e.g., acceptance, resistance, silence) to further understand the distribution of disalignments and their effects on interaction (cf. Ribeiro et al., 2013). This would allow us to study the interactional impact of the discussed measures on a broader scale and lend further evidence to the emerging picture of therapy as a complex combination of individuals and institution, processes and outcome, and relationships and technique.

DATA AVAILABILITY STATEMENT

All datasets generated for this study are included in the article.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by the ethics committee of FU Berlin. The participants provided their written informed consent to participate in the study. Furthermore, persons referred to in the transcripts, including clients and their family members, have been given pseudonyms.

AUTHOR CONTRIBUTIONS

CS performed the analysis of the data and wrote the whole article.

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Proffering Connections: Psychologising Experience in Psychotherapy and Everyday Life

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Conversation analytic research has advanced understanding of the psychotherapeutic process by understanding how psychotherapy is organised over time in and through interaction between clients and therapists. This study progresses knowledge in this area by examining how psychological accounts of experience are progressively developed across a range of helping relationships. Data include: (1) approximately 30 h of psychotherapy sessions involving trainee therapists; (2) approximately 15 h of psychotherapy demonstration sessions involving expert therapists; and (3) approximately 30 h of everyday conversations involving close friends or family members. This article reports an analysis of techniques that are used to bring together two experiences that were discussed separately, to proffer a candidate connection between them. This proffering of candidate connections was recurrently used in psychotherapy. If confirmed by a client, a proffered connection could be used to develop a psychological account of a client's experiences, which could then warrant some psychological intervention. In contrast, the proffering of connections was observed in only one of the everyday conversations included in the current study, where it was used to develop psychological accounts of experience. This shows that although proffering candidate connections is an everyday interactional practice, it appears to be used with greater frequency in psychotherapy, to advance its specific institutional aims.

Keywords: conversation analysis, everyday conversation, psychotherapy, non-specific benefit, reference, connections

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INTRODUCTION

> ". . .it might be conceivably argued that psychoanalysis. . .succeeds, when it does. . .because the analyst, in the practice of his method, quite unwittingly allows the patient to recondition certain inadequate social patterns in terms of the present situation" (Rosenzweig, 1936: 412)

Psychotherapy, at least in its traditional, mainstream, and predominant senses, is a fundamentally interpersonal and interactive endeavour. In contrast to biomedical treatments, such as pharmacology, psychotherapeutic interventions typically involve social encounters where individuals or groups experience sustained reflective engagement about their mental disorders, problems, or complaints. The ultimate goal of psychotherapy is to transform, in some way, an individual's or group's experience to help alleviate a disorder, problem, or complaint (Wampold and Imel, 2015). Even when psychotherapeutic interventions are not interpersonal, such in bibliotherapy and computerised treatments (Marrs, 1995; Grist and Cavanagh, 2013; Eells et al., 2015), there are nonetheless interactive encounters between a person and a therapeutic medium that are intended to sustain reflective engagement.

Interaction thus appears to be a central part – or even *the* central part – of psychotherapy. Nevertheless, crucial aspects of interaction have been overlooked in attempts to understand the psychotherapeutic process. This study aims to further understanding of psychotherapy through fine-grained analysis of its moment-by-moment production in and through social interaction.

Although some definitions of psychotherapy acknowledge that interaction between a therapist and client provides a medium for therapy (e.g., Jørgensen, 2019: 26), psychotherapy research does not typically emphasise comprehensive exploration of how therapy is produced in and through these social encounters. For example, recent reviews conducted by the American Psychological Association's Task Force on Evidence-based Relationships and Responsiveness (Norcross and Lambert, 2019) highlight a range of relational practices that are accomplished in and through social interaction. Nevertheless, these reviews do not specifically acknowledge social interaction as a bedrock of psychotherapy. Social interaction provides the infrastructure necessary for the accomplishment of social institutions such as psychotherapy, as well as constituting the primordial site of human sociality more generally (see Schegloff, 2006). It is therefore necessary to understand the details of social interaction to understand the psychotherapeutic process.

One field of research specialising in the study of social interaction, conversation analysis, has been increasingly applied to the study of psychotherapy (Madill et al., 2001; Peräkylä et al., 2008; Buchholz and Kächele, 2013; Peräkylä, 2013, 2019; Madill, 2015; Buchholz, 2017). Focusing, in detail, on the moment-by-moment progress of social interaction, conversation analysis provides means for understanding how "...psychotherapeutic processes are embedded in the concrete details of social interaction" (Peräkylä, 2019: 278). The current study contributes to this analytic enterprise, focusing on ways clients and therapists progressively establish psychological accounts of experience that align with the goals of psychotherapy.

To date, most conversation analytic research investigating psychotherapeutic encounters has focused on ways participants organise these encounters into sequences of action (Peräkylä, 2019). Both in psychotherapy and social interaction more generally, organising actions into sequences enables participants to understand a current action in relation to the actions that precede it, as well as in relation to what a current action may make relevant as potential next actions (Schegloff, 2007). For instance, the following fragment from a psychotherapy session is organised into two sequences.

In this fragment, both sequences are initiated by the therapist, and each is designed differently to implement particular actions. The therapist's first turn (lines 1–2) is designed as a question about the client's experience of 'visions', namely whether they occur less frequently when he is with his parents. The client confirms this by explaining why he does not experience as many visions in this context (lines 4–5). In contrast to this first sequence, which is initiated by the therapist's question, the second sequence (lines 6–7) is initiated by an 'upshot formulation' (Antaki et al., 2005). This formulation exposes something implied, although not stated, in the client's prior turn. This enables the therapist to highlight an aspect of the client's problem: namely, that he is more likely to experience visions when alone and inactive. Through two short sequences – a question-response sequence followed by a formulation-confirmation sequence – the therapist and client progress toward a particularised and psychological account of the client's experience. Instances like this demonstrate how, at a fundamental level, understanding the organisation of social interaction is essential for understanding the psychotherapeutic process, which "takes place *through these sequences*" (Peräkylä, 2019: 265, emphasis added).

Beyond revealing the fundamental importance of sequence organisation for understanding how psychotherapy progresses, recent conversation analytic research has incorporated a broader perspective. One avenue of inquiry involves extending analysis beyond relatively short sequences of action, such as in Fragment 1, to focusing on the organisation of psychotherapy over longer periods of time (Voutilainen et al., 2011, 2018; Bercelli et al., 2013; Buchholz and Kächele, 2017). This level of organisation appears to involve alternating periods of enquiry (Bercelli et al., 2008, 2013), where therapists and clients work to recognise relevant aspects of the client's circumstances (Voutilainen et al., 2010b), and elaboration (Bercelli et al., 2008, 2013), where the parties are predominantly focused on interpreting those circumstances (Voutilainen et al., 2010b). Through this process, the understanding of some matter that is a focus within therapy, such as feelings of blame (Voutilainen et al., 2011), can be progressively understood and transformed over time. This research shows how, over time, participants collaboratively produce particular versions of a client's experience (Peräkylä, 2019).

A second way in which conversation analytic research has understood the organisation of psychotherapy over time is through an examination of the use of referential practices (Clark and Rendle-Short, 2016; Buchholz and Kächele, 2017;

Fragment 1: Antaki et al. (2005: 632)

01	THE	.h are things ↑better at your mum and °dad's:° (.)
02		in terms of your j- d↑y not get as many of th' ↑visio:ns.
03		(1.2)
04	CLI	>w'll I don't get as many ↓visions cos there's< ↑more
05		people to ↑tal:k to, more things to ↑do
06	THE	so ↑that happens most when yer: (.) on your ↓own, an' y'
07		got nothing to do.
08		(1.2)
09	CLI	ye:h.

Voutilainen et al., 2018; Peräkylä, 2019). Through reference to a variety of entities from diverse 'ontological domains' (Enfield, 2013) – such as people, places, objects, time, and conduct – participants can focus on particular referents for particular purposes. For example, Voutilainen et al. (2018) show how repeated used of the reference 'dominant' connects one discussion about a client's sister-in-law to a current discussion about the client herself. Foundational interactional processes, such as reference, can thus become incorporated into accomplishing the business of psychotherapy.

By considering the organisation of psychotherapy over time, conversation analytic research is progressively understanding how the psychotherapeutic process helps clients overcome the difficulties that brough them to therapy (Peräkylä, 2019). Sustained research is needed in this area to continue specifying the precise ways diverse psychotherapeutic approaches share a capacity to alleviate clients' difficulties (Rosenzweig, 1936; Rosenthal and Frank, 1956; Stiles et al., 1986; Wampold and Imel, 2015). Sustained research will also inform understanding how psychotherapy differs – if it differs at all – from other types of 'helping relationships' (Rogers, 1958), such as those that one might have with a close friend or family member (Siegfried, 1995; Kozart, 1996; Mondada, 1998; Pain, 2009; Pawelczyk, 2011; Jørgensen, 2019). The current study is designed to address these matters by exploring how psychological accounts of experience are progressively developed in conversations that occur across different types of helping relationships.

DATA AND METHODS

This comparative conversation analytic study (Drew and Heritage, 1992; Sidnell, 2009) involved video recording both psychotherapeutic and everyday – or mundane – interactions that occurred in Australia. Ethical clearance was provided by the Queensland University of Technology (QUT) Human Research Ethics Committee for both the psychotherapeutic (Approval reference: 1600001155) and mundane data (Approval reference: 1600001058). Each party to a recorded interaction was independently informed about the study and asked whether they were willing to consent to participate. Data were only collected if each party freely and independently consented to participate.

Mundane data were collected in a variety of settings, including private homes and public spaces (e.g., parks). Each interaction involved a small group of friends or family members. Approximately 30 h of interaction were video recorded across 20 dyads and 2 triads. Psychotherapeutic interactions were video recorded within a single clinic that is predominantly staffed by trainee psychotherapists. This clinic specialised in a range of different psychotherapeutic approaches. **Table 1** reports the therapeutic approach that therapists explained to clients as the predominant approach they were adopting. Nevertheless, correspondence between the researcher and trainee therapists indicated that many moved beyond a single psychotherapeutic perspective to adopt an 'integrative approach' (Norcross and Goldfried, 2019). Approximately 30 h of recorded psychotherapeutic interaction was examined across four therapist-client dyads.

TABLE 1 | Participant details for psychotherapy data.

Dyad	Predominant Approach
Male client, female therapist	Interpersonal Therapy
Female client, female therapist	Psychodynamic Psychotherapy
Male client, female therapist	Cognitive Behavioural Therapy
Female client, female therapist	Schema Therapy

Psychotherapeutic data were collected during the first year of clinical practice for trainee psychotherapists, when they were still learning fundamental aspects of different therapeutic approaches. Focusing on trainees rather than more experienced therapists foregrounds the therapeutic context rather than the skill of individual therapists. By comparing therapeutic interactions involving trainee therapists with mundane interactions involving friends or family members, the study aims to examine how interactional practices are designed, either in similar or different ways, to suit the institutional contexts of psychotherapy and the everyday contexts of mundane interaction.

Although the focus of the current study relates to the therapeutic context rather than the skill of individual therapists, a secondary aim of the study was to examine whether the interactional practices that comprise the focus of the study are restricted to trainee therapists or might also comprise the practice of more experienced therapists. To fulfil this aim, additional data were obtained from demonstration sessions of therapy conducted by expert psychotherapists. Most of the database is comprised of recordings made in the United States of America. Approximately 15 h of these demonstration sessions were sourced from the Counseling and Therapy in Video database published by Alexander Street Press, a source of data previously used for conversation analytic research (e.g., Kondratyuk and Peräkylä, 2011; Muntigl and Horvath, 2014).

The study used typical methods for conversation analytic research (Sidnell, 2013). Analysis commenced with a phase of 'unmotivated examination' of the psychotherapy data. Using this unmotivated approach, rather than guiding analysis by psychotherapeutic theory, provided opportunities to notice phenomena that might not be foreground or otherwise anticipated by such theories (Sacks, 1984; Peräkylä and Vehviläinen, 2003; Madill, 2015; Voutilainen and Peräkylä, 2016). Specialised transcription conventions for spoken (Hepburn and Bolden, 2013) and embodied conduct (Mondada, 2018) were employed to facilitate detailed analysis (please refer to the **Appendix** for a transcription key). The names of all participants, and any third parties mentioned in the data, were replaced with pseudonyms.

In the present study, the unmotivated examination phase of analysis resulted in identification of a recurrent practice where one party cited some prior conduct. These citations could relate to the conduct of another (e.g., "You said. . ."), oneself (e.g., "I mentioned. . ."), some group (e.g., "We discussed. . ."), or objects such as documents (e.g., "It says. . ."). These instances were gathered into a collection (Sidnell, 2013), which was progressively expanded through analysis of the mundane data in addition to the psychotherapeutic data. A separate report describes the generic properties of citing sources (Ekberg, Unpublished; see also Goffman, 1974, 1979; Pomerantz, 1984). The study reported

here focuses specifically on the similarities and differences between the use of this practice across psychotherapeutic and mundane interactions.

ANALYSIS

Proffering Connections in Psychotherapy Sessions

In their attempts to progressively understand mental disorders, problems, or complaints, psychotherapists and clients dedicate considerable time, over many psychotherapy sessions, discussing the client's circumstances. Over time, an increasingly shared understanding of these circumstances enables either of these parties – although usually the therapist – to proffer candidate connections between experiences that have been discussed at different times within a session, or even across different sessions. The following analysis will consider the use of 'locational tying techniques' that are used to invoke some past utterance as relevant for a present discussion (Sacks, 1995). These techniques facilitate bringing together two or more things that have been previously discussed, but not in relation to one another. Once these matters are co-located, a current speaker – usually the therapist – can pursue a course of action that involves a connection between these matters. This connection is typically a candidate one, and so the recipient – usually the client – may confirm or reject it. If confirmed, these connections can facilitate the progressive establishment of psychological accounts of clients and their circumstances.

The following fragment is an instance where a locational tying technique is used to proffer a candidate connection between two matters that have not been discussed in relation to one another. It comes from a fourth session of psychotherapy involving a male client and female therapist (Dyad 1 in **Table 1**). It begins with the client making a claim about his tendency to exhibit emotional detachment. During this discussion, the therapist proffers a connection between what the client is currently discussing and something he mentioned two sessions previously. This previous mentioning is introduced through use of a locational tying technique.

Fragment 2: D1/S4/07:46–08:59

```
01     CLI     It's also: useful (.) being able to slightly detach from it I
02             guess:,
03             (0.3)
04     CLI     >Like [I know it's < ] the:re > but I don't-< (0.2) I don't fully
05     THE           [(°Mm.°)        ]
06     CLI     let it affect me I guess,
07     THE     ΔUh huh,
               Δnodding-->
08             (0.4)Δ(0.2)
       the       -->Δ
09     CLI     #I dunno,# it's: (0.3) >#kind of a defen(ce) mechanism I
10             guess#< and pa:rt of Δprobably how I: ⌂sta:rted (0.2) expressing
       the                           Δgaze at notes-->
       the                                        ⌂...-->
11             emotions:. ⌂Originally.
       the             -->⌂writing-->
12              (1.2)
13     THE     MM::.
14             (1.6)
15     THE     S:o::: when you're sayin' a detachment is ⌂#that- that-# the
                                                    -->⌂, , ,-->
16             thin⌂:g: (.) that Δwe talked #about# (.) where you .hhh you
                -->⌂          -->Δgaze at client
17             feel a bit worried because you #feel like you::# (0.2)
18             Δ°ou-°
               Δlowering and raising hands-->
19     CLI     (>#Bottled) [up.< Ye:ah:.#]
20     THE                 [  Bottle it  ] upΔ an' you: intel[lectu'li]se
21     CLI                                                   [#Yeah.# ]
       the                                      -->Δ
22     THE     a#bout it but# you're n:ot actually .hhh connected °#with the#
23             emotion.
24     CLI     Mm:Y::EA:H.=[But ] a bit more intentional probably¿
25     THE                [(T-)]
```

(Continued)

Fragment 2: Continued

```
26              Δ(0.6)
        the     Δnodding-->
27      THE     Y:ep.
28              (0.6)⌂(0.4)
        the          ⌂gaze at notes-->
29      THE     #Y:e:p.#Δ
                     -->Δ
30              (1.0)
31      THE     °°Mm:.°°
32              (1.8)
33      THE     °Mkay,° an' u::m:, (1.8) th:at's s:omething that's come up a
34              °f-°cou⌂ple a times as #like ah:: (0.2) something that's a
                   -->⌂gaze at client-->>
35              <worry># for you: that you're gonna, .hhh u::hm::, (0.6) sort of:
36              (0.3) crAsh: do:wn at one point becaus:e (0.4)
37      CLI     #Mm[:#]
38      THE        [You]'ll 'ave sto:red it up an':: (0.2) yeah. Yep.
39              (0.5)
40      CLI     >#Becoming less of a< worry with ti:me I'd say now. But# yeah.
41              (0.6)
42      CLI     #I guess it's the concern that I always try and# keep in mi:nd,
```

In this fragment, the therapist seeks to clarify the meaning of the client's term 'detach' (line 1), which she attributes to something the client has recently said: "when *you're saying* a detachment" (line 15, emphasis added). To make this clarification, she refers to something about which the client is 'worried' (line 17). The design of the therapist's term includes citing the source of this claim (Ekberg, Unpublished; Goffman, 1974, 1979; Pomerantz, 1984). She does this by prefacing her reference to 'worry' with an description of it as "the thing that we talked about" (lines 15–16). This citing of a source functions as a locational tying technique, invoking something that occurred elsewhere as relevant for the present (Sacks, 1995). The technique indicates that what is being discussed now – detachment – is going to be connected to something this dyad have discussed before.

Before the therapist specifies the connection that she is making between the present and a past discussion (lines 15–18), the client completes the therapist's turn to specify "the thing that we talked about" (line 16) as "bottled up" (line 19). The client's expression may be a vocalisation of the therapist's hand gesture (lines 18–20), as "bottled up" has not actually been used in previous sessions. The client did, however, mention in his second session of therapy that he intellectualises his emotions, and the therapist refers to this in her response (lines 20–23). By this point in their conversation, the therapist has used a locational tying technique to bring together two matters that were raised separately. In doing so, she is able to ask a question about a candidate connection between them: "So when you're saying a detachment is that the thing that we talked about where you feel a bit worried because you feel like you. . .bottle it up and you intellectualise about it but you're not actually connected with the emotion" (lines 15–23). The therapist orients to the client's epistemic primacy in this matter (Heritage, 2012), making this connection within a question that seeks the client's confirmation or rejection as a relevant next action. What has been proffered here therefore remains a candidate connection until it is confirmed by the client.

Following the client's qualified endorsement of this connection (line 24), the therapist then claims that the client's tendency to detach or intellectualise has come up before in therapy, and is connected to the client's concerns about this contributing to periodic emotional breakdowns (lines 33–38). In contrast to the first connection, which was proffered to the client through a question, this second connection is instead asserted by the therapist. The client nonetheless treats this as a matter over which he has epistemic primacy, providing a qualified endorsement of the connection the therapist has made (line 40). It is in this sense that these candidate connections can be understood as proffered. They are presented by one party to another, for the recipient to ultimately confirm or reject.

In this fragment, the therapist proffers a candidate connection between one matter – the client's detachment – and another matter discussed earlier in therapy – the client's intellectualising. The therapist then goes on to proffer a broader candidate connection between these experiences and the client's risk of emotional breakdown. This proffering of connections appears to be a common undertaking in therapy, occurring in many therapy sessions. If this candidate connection comes to be accepted by the client, this may then inform the dyad's psychological account of the client and their circumstances. The next fragment illustrates this process.

The following fragment is another instance where a candidate connection is proffered across matters that have been discussed within therapy. It comes from a tenth session of psychotherapy involving a female client and female therapist (Dyad 4 in **Table 1**). The fragment comes midway through discussion of the origin of the client's belief that her relationships will eventually fail, because people will abandon her once they come to know her personality and health challenges (the latter is referred to in the fragment as 'fibro', for fibromyalgia). The therapist is sitting next to the part of a whiteboard that she has written on. Her writing documents key points about a

discussion that has continued up until the beginning of this fragment. This part of the whiteboard is approximately forty-five degrees counter clockwise from the therapist's overwhelming physical orientation towards the client. Due to her physical position, the therapist rotates her head to shift her gaze between the client and the whiteboard throughout the fragment. She also refers, on multiple occasions, to two beliefs that the client holds, which are written next to one another on the whiteboard: (1) "If people know me they will leave"; (2) "If I am myself they will leave." Through both her verbal and physical conduct, the therapist proffers a candidate connection in which these beliefs underpins the client's behaviour with different types of people. The fragment begins following the therapist's question about whether the client's experiences of abandonment go beyond recent experiences to include her time at school.

Fragment 3: D4/S10/49:12-51:00

```
01   CLI   W:e::ll l:ike (0.6) (°khh°) (0.3) r:e:ally the o:nly:: (1.7)
02         n:o:::. >I was gonna-< re:ally the o:nly thing that >I could
03         think of was my< e::x boyfriends.=but I (had a few) (0.2)
04   THE   Mmm,=
05   CLI   =f:riendships:: (1.0) de°teriorate.°
06   THE   Mmm,
07         (0.6)
08   CLI   (°back there as) well.°
       ((16 s omitted; client explains relationships))
17   THE   Whe:re you've sort of expo:sed yours:elf and the:n: (0.4) been
18         let do:wn by that pe:rson?
19         (.)
20   CLI   #Ye☖ap.#
     the      ☖...-->
21         (.)
22   THE   Mmm.
23         ☖(3.0)Δ(1.2)
     the  -->☖writing-->
                Δgaze to whiteboard-->
24   THE   Δ>And I'm< a:lso wondering >a couple of< weeks ago ☖you said☖
          -->Δgaze: notepad -->                          -->☖,,,,,,,,☖
25         Δ(0.4)Δ(0.2) ho:w >if you've< appli:ed Δfor a job sΔomewhere and
          -->Δ.....Δgaze: board----------------------Δ...........Δgaze: cli-->
26         you've ha:nded in your résumé and then: (0.2) o:r you get an
27         interview an- >an' (then) you< +ca:n'Δt go ba:cΔ:k,+
     cli                                  +nodding-------------+
     the                                       Δ.........Δgaze: board-->
28   CLI   Yeap.
29         (.)
30   THE   I:'m wondering if that-  (.) we talked a bit aboutΔlike (.) i:f:
                                                        -->Δ...-->
31         they <kn:↑o:Δ:w↑ +me:,> (.)+ they won't want +me.
                 -->Δgaze: client-->
     cli                 +nodding--+              +nodding-->
      ((16 s omitted; discussion about beliefs written on whiteboard))
43   THE   And I'm w:ondering if that's why it's so ha:rd to go into
44         Δ☖those Δsh:ops because it ☖a:ctivates these +fee:lings,
           Δ.......Δgaze: board-->
            ☖.........................☖hand on board-->
     cli                                          +nodding-->
45         (.)+
     cli   -->+
46   THE   That are p:ro☖:baΔbly r:ealΔly s:tro:ng☖ly l:inked to s:omething
                  -->☖,,,,,,,,,,,,,,,,,,,,,,,,,,,,☖
                     -->Δ.........Δgaze: client-->
47         e:ls:e. [ L i k e ] a f:riendsh:ip +o:r (0.2)+ .hh a pa:rtne:r¿
48   CLI           [(°Yeah.°)]
                                      +nodding--+
49         (0.2)
50   THE   Δ☖>BuΔt ☖it's the<  Δs:Δa:me fee:l+ing, ☖in [a  dif]f'rent
```

(Continued)

Fragment 3: Continued

```
51    CLI                                                [(Mmhm)]
      the    Δ....Δgaze:  board--Δ..Δgaze: client-->
              ⌂......⌂hand toward board--------------⌂hand in air-->
      cli                                    +nodding-->
52    THE    <conte⌂xt.>
               -->⌂,,,-->
53            (0.2)⌂ + (0.4)
      the       -->⌂
      cli         -->+
54    CLI    ~Yeap.~
55    THE    ΔDo you Δthink thΔatΔ (.) applies for tho:s:e (0.2)
          -->Δ.......Δ----┬---Δ..Δgaze: client-->
                          └>gaze: board
56    CLI    ~Ye:ah~ and i:t a:lΔsoΔ kind of +goes baΔckΔ to like
                                          +...-->
      the                      -->Δ..Δgaze: board------Δ..Δgaze: client-->
57           +Δ~th+e people just t+olerating or ΔpretendingΔ to °like me:.°~
             +--┬-+,,,,,,,,,,,,,,,+
                └>points at board
      The   -->Δgaze: board----------------------Δ.........Δgaze: client-->>
```

The fragment begins with discussion about the history of the client being abandoned by others, which has focused on close friendships and romantic relationships. Then, at line 24, the therapist specifies the source of her upcoming claim ("a couple of weeks ago you said"). Using this locational tying technique invokes something discussed in a previous therapy session, about how the client cannot return to shops where she has unsuccessfully applied for work. Following this, the therapist uses another locational tying technique to return to aspects of their more recent discussion in this session: "we talked a bit about like if they know me, they won't want me" (lines 30–31). By bringing together things that were previously mentioned separately, the therapist can ask a question about whether there is a connection between them. This is subsequently expanded further by the therapist, who asks a question that connects the client's beliefs about shops with relatively intimate types of interpersonal relationships such as with "a friendship or partner" (lines 43–47). A connection is thus proffered where beliefs about abandonment, which have been developed in the context of close interpersonal relationships, are used to explain why the client is not able to return to shops where she has unsuccessfully applied for work. In contrast to Fragment 2, which contained more qualified confirmation, the candidate connection proffered in this fragment receives much stronger confirmation from the client (e.g., lines 56–57). This confirmation facilitates psychological activities that are pursued subsequently.

Through proffering a candidate connection based on beliefs about abandonment, the therapist proposes a psychological account of the client's experience. This is accepted by the client, who subsequently expands this connection to include other matters the dyad have discussed (lines 56–57). In the following session (data not shown), the therapist resumes this discussion, referring to it as a discussion of an 'abandonment schema.' She uses this to initiate informing the client about schema therapy, the predominant approach used in her sessions with the client (see **Table 1**). The therapist continues to explain how she hopes to use this to change how the client relates to schemata such as the abandonment schema. The proffering of a connection thus provides a basis for advancing a psychological account of the client's challenges, and then a potential psychological solution.

The instances considered to this point relate to adverse experiences. The focal practice can also be used to highlight a client's strengths. The next fragment is one such instance. It comes from an eighth session of therapy involving a female client and female therapist (Dyad 2 in **Table 1**). The client is attending therapy due to depression and anxiety. The fragment begins partway through a discussion about a period of intense anxiety the client experienced as a child. Across this fragment, the therapist proffers a connection between what the client reports happening during her childhood and what she is now experiencing as an adult.

Fragment 4: D2/S8/48:33–50:29

```
01    CLI    I think I ha:ndled it (.) quite well Δcons(h)idering how young
      the                                    Δnodding-->
02           I: wa:s an:'=
03    THE     = °↑Mm:.°
04           (0.3)
05    CLI    hoΔ::w (.) kn:owing how h- horrible it #f:elt.#
      the   -->Δ
06           (.)
07    CLI    ΔLike I'm: pri:tty impΔressed with myS(H)E(H)ELF that I:  .hh (.)
      the    Δnodding-------------Δ
```

(Continued)

Fragment 4: Continued

```
08            >you know< got #through i:t# witho[ut    any     ma:]jor (.)
09     THE                                      [°° > Mm↑hm↑<hm.°°]
10     CLI     i:nterr: uption:s Δo:r,
       the                      Δnodding-->
11     THE     °Yea[h:.°]
12     CLI         [tch+]=u::hm, (.) a:nything like tha:t.
       the          -->+
          ((54 s omitted; discussion of parents, school, duration of
            distress, and progressive signs of abatement))
51     THE     °So there's° th:ree: to +f:o:ur years of:: (.) +f:eeling
       cli                            +shallow nodding-------+deep nodding-->
52             m:isera[ble in scho]o:l:,=
53     CLI             [M m : : :, ]
54     CLI     =Y:eap.
55             (0.3)
56     THE     °Ohka:y.°
57             (.)+
       cli     -->+
58     THE     >And I'm jus'< thinking, >you know< you s:aid that (0.4) >you
59             man+aged to get< through #a:ll of tha:t,# (0.2)+(0.2) a::nd
       cli        +nodding-------------------------------------+
60             >without any< +major dis:ruption+s an' it was s:o:: ha+:rd >and
       cli                   +nodding----------+                    +nodding-->
61             it was< s:o: difficul[t.]
62     CLI                           [ M]m:.
63             (.)+
       cli     -->+
64     THE     Yeah.=>And I'm jus' thinking about (i')< n:o+:w:, what's
       cli                                              +nodding-->
65             happening with yo:u, (0.2) where you feel like you <can't cope>
66             with whatever you have, (0.3)+ >so it< s:eems a:lmos:t that it's
       cli                             -->+
67             +pretty different_
       cli     +nodding-->
68             (.)
69     THE     >You know< whe::re (0.3) you actually got through such a
70             difficult perio[d.=S:o what] makes: (0.3)+ so whAt's causing you
71     CLI                    [Mm::  h:m. ]
                                                    -->+
72     THE     >to think< that you ca:n't (0.3) cope >with the< difficult
73             emotions.=> 'Cause you< have done i[t bef:o:re,]
74     CLI                                        [   Mm:y:ea:]:h.   I £guess£ I
75             neve[r £thought of] it like that.£
76     THE         [(°°Mmhm°°)    ]
77             (.)
78     CLI     (>Like<) I've neve:r[: ]
79     THE                         [°O]kay,°
80             (0.4)
81     CLI     I've n:ever cons:idered that to be the s:ame th:ing but I guess
82             it I:s. ((continues))
```

Toward the beginning of this fragment, the client mentions her resilience during a period in her childhood when she experienced intense anxiety: "I think I handled it quite well" (line 1). In the moments that follow (data not shown), the discussion moves away from this specific focus on the client's ability to manage her anxiety. The therapist, however, subsequently brings the discussion back to this matter. She does this by producing an upshot formulation that focuses on the duration of the client's period of anxiety (lines 51–52). Following the client's confirmation of this (lines 53–54), the therapist then cites something the client mentioned even earlier: "you said that you managed to get through all of that, and without any major disruptions" (lines 58–60). This locational tying technique makes relevant the client's resilience during a period of her childhood when she experienced intense anxiety, so it can be considered in relation to the current discussion of the client's contemporary challenges.

Having returned the focus of discussion to the client's resilience during a period of past anxiety, the therapist connects

this with a matter that has been a focus of both this and prior therapy sessions: "And I'm just thinking about it now, with what's happening with you, where you feel like you can't cope with whatever you have" (lines 64–66). This makes a connection between two periods in the client's life during when she has been confronted with intense anxiety. This connection enables the therapist to highlight a difference in the client's understandings of those periods. As with the second connection in Fragment 2 (lines 33–40), this connection is asserted by the therapist ("what's causing you to think that you can't cope with the difficult emotions because you have done it before", lines 70–73). As was also the case in Fragment 2, the client nonetheless treats this assertion as something to be confirmed. It is in this sense that the connection can be understood as a candidate one, and moreover one that has been proffered for confirmation or rejection.

By proffering a candidate connection between the client's childhood and her present, both periods during which she has reported experiencing extreme mental distress, the therapist warrants asking the client why she was able to cope in the past but does not appear to be able to do so in the present (lines 70–73). Developing an understanding of this has the potential to enable the client and therapist to conceptualise both the challenges that confront the client, as well as the resilience that she might employ to address these challenges. This exploration is accomplished by connecting different experiences the client has reported at particular points of the therapeutic process. This proffers a connection that may come to comprise a psychological account of the client, her experiences, and her capacity for resilience.

The above fragments highlight ways trainee psychotherapists proffer connections between experiences that the therapist and client have discussed at particular points of the therapeutic process. This enables therapists to bring together experiences that were not previously connected to consider, with the client, whether there is indeed some connection between those experiences. This practice does not appear to be restricted to trainee psychotherapists. As the following fragment demonstrates, highly experienced therapists also employ this practice to proffer candidate connections between clients' experiences. This fragment starts approximately seven minutes into a therapy session involving a male client and male therapist. Before coming to therapy, the therapist asked the client to complete a 15-page multimodal life history inventory (Lazarus and Lazarus, 1991). The therapist has read the client's completed inventory prior to the beginning of this session and refers to this during a focal moment in the fragment that follows.

Fragment 5: Lazarus (1997)

01	THE	...I want to <z:oo:m in> to s:omething like <what i:s:> an issue
02		.hhh that you and I m:i:ght: (.) try and tackle.
03	CLI	.snnn=.hhhuh O:::h:: I:: don't (0.2) th:ink: ↑>I don't< know if
04		I'm getting more satisfied with things↑.=U:hm (0.2) ↑my ca:r↑
05		f:inally blew up, (.) so I went out I bought a (.) bought a new
06		pick up.
07		(.)
08	CLI	My f:i:rst- (.) real m:ajor purchase right,=.mphh (.) >so as I
09		was just beginning to get outa< debt, paying off my undergraduate
10		>graduate< l:o:ans:,.hhh a:h this and that=>blah, blah, blah,<
11		BLA:::h a:h >things are going< well with my m:o:ther and he:r
12		.hhh a::h (0.5) the H:A:Teful situation with her previous
13		employment.=.hhh u::h (.) .h=A:NYWAY so then you're moving
14		a:lo:ng (if-) I've- (.) graduated with my masters finally it was
15		a big sticking point at that- >at- at-< that time an' > an' it <
16		l:ooks pro:mising,=<I r:eally th:ink I:'m gonna f:ind a ba:ck
17		door into a program by next f:all, (.).hhhh s:o:. (0.2) a::h=
18	THE	=A p:rogram meaning a pee >haych [+dee< program?]=Uh huh.+
19	CLI	[( )]
		+nodding----------+
20	CLI	Y[eah.]=>And you<kno:w uhm: (0.5) .snif >and I said it<
21	THE	[Okay.]
22	CLI	befo:re, an' >an' I< I don't when it's supposed to:: (.) f:ee:l
23		(0.2) fee:l a:h >and may<be that's why I feel more cavalier, .hh
24		I: don't know when the heck that supposed to get more u:hm (0.6)
25		tch a:h:: (1.4) more s(h)atisfy:ing:.=I don't think it's a- I
26		don't think it- ↓you know:,↓ (0.2) >I THInk< m:oney's
27		impo:rtant.=>°ah-°=you know I-< I:'m: (0.4) I th:ink money's
28		impo:rtant.=I think it-=and I think it's impo:rtant to (tell
29		someone aga-) y- >if it's like an< a:ppendage. Being an
30		appendage. .hhh U:hm, (0.2) bo::y >you know< that's: (.) °m-°
31		(1.6) it's i:dyllic to really think people give a da:mn. You

(Continued)

Fragment 5: Continued

32		know, they really do:n't. And u:hm, (0.2) m:ostly.
33		(.)
34	CLI	.hhh A:h, (.) you're an a:ppendage, you're- you're- you:'re
35		#a:h# a l:ine in a b:udget, you::'re (.) °mp° (.) a (.) f:a:c:e
36		(.) a:h f:loating above a d:esk the:re. Answering pho:nes. .hhh
37		(.) S:o::
38	THE	Δ.hh Interesting.=>'Coz what you're< s:aying n:o:w ti:es in:to:
		Δ...-->
39		.hh Δm:a:ny th:e:mes:, that: .h we:re reiterated in he:re. .hhh
		-->Δpicks up life history inventory-->>
40		A:nd th:at i:s a kind of an i:dealism on the o:ne ha:nd that's:
41		s:ma:shed by the ha:rsh rea:lity that you've expe:rienced. .hhh
42		A GREat a:nger, disillu:s:ionment at th:at at ti:mes:, .hh BA:ck
43		to w:ell it ca:n't be all that ba:d, back to well it's w:o:rse
44		than tha:t, I [mean t]hat- that's s:ort of circula:rity [you see.]
	((22 s omitted; therapist proposes a way to address this circumstance))	
55	THE	ho:w do you f:eel about that little speech I've just made?=
56	CLI	=.snff (0.2) hmmm, (.) I: gue- >I didn't-< (.) >can't believe I
57		put it in there,< but (.) apparently I did.° e-° u:hm, (.) I:
58		th:ink that's tru:e.>I- I< feel a lot- .hhh >yeah I feel a lot
59		of< a:nger. ((continues))

In this fragment, the client moves from describing circumstances that provide a potential for satisfaction (lines 3–17) to circumstances that are depicted as intractable obstacles to satisfaction (lines 20–37). From line 38 the therapist connects what the client has just been verbally describing and what the client had written in his life history inventory. He does so by picking up the inventory and citing it as the source of his claim ("themes that were reiterated in here", line 39). By using this technique, the therapist brings together two things that the client has expressed separately: in his current discussion with the therapist and when completing the life history inventory. Having brought these two matters together, the therapist produces an explanation that proffers a connection between them: "a kind of an idealism on the one hand that's smashed by the harsh reality that you've experienced" (lines 40–41).

The therapist culminates his extended turn by underscoring its candidate status, asking the client about the appropriateness of the explanation he has proffered (line 55). The client's response confirms that the therapist's explanation connects these matters (lines 57–59). Thus, very early in this dyad's relationship, a connection between two matters that were raised separately come to be proffered by the therapist and accepted by the client. Here in Fragment 5, a psychotherapy session involving an expert psychotherapist, and above, in fragments from sessions involving trainee psychotherapists, such proffering of candidate connections facilitates the progressive establishment of psychological accounts of clients and their circumstances. This type of activity is thought to be a fundamental aspect of psychotherapy (Jørgensen, 2019). As the next section shows, however, psychotherapy is not the only context where this occurs.

Proffering Connections in Mundane Interaction

In contrast to psychotherapeutic interactions, the use of locational tying techniques to proffer candidate connections between experiences was much less common in the mundane interactions that were recorded for the current study. The following fragment, however, comes from one conversation that is an exception. Throughout this conversation there are numerous attempts by Peter to proffer candidate connections in relation to Dean's interpersonal experiences. Each of these instances relates to a focus these two men have on discussing trauma that Dean has apparently experienced at some point in his past. The fragment begins with Peter summarising a section of a book that he has previously shown to Dean when they were travelling together on a bus. Apparently they were not able to discuss this section of the book openly in a public place, so Peter seeks to resume their discussion of it now.

Fragment 6: MESI008/09:29–10:38

01	PET:	It said s:omething abou:t (1.6) (°ah- > it°) was< S:AYIng that-
02		>you know< (0.2) these pe:ople who've been (0.2) <damaged> by
03		tra:uma, (0.2) think that they're ba::d pe:ople.
04		(1.1)
05	PET:	>And that they< don't dese:rve to have a good li:f:e,

(Continued)

Fragment 6: Continued

06		(0.4)
07	PET:	And the- (.) the s:ooner, (0.6) everybody aro:und them kno:ws
08		tha:t, (.) >and gets< rid of them an:' (.) kicks them <o:ut>
09		an' (0.2) m:o:ves on: °the-° (.) the better off: they- they'll
10		be.
11		(.)
12	DEA:	°Mm.°
13		(0.4)
14	PET:	So: (0.4) an' I remember you s:aying to ME (0.6) that- (0.4)
15		you've never s:ta:yed (0.4) had good friends for too lo:ng.
16		(0.2)
17	DEA:	Mm.=
18	PET:	=Or- or- (.) or been <close> to people for too lo:ng because
19		you always push them away.
20		(0.3)
21	DEA:	Yeah. Unconsciously.
22		(0.3)
23	PET:	Yeah.
24	DEA:	(°Yeah.°)
25		(.)
26	PET:	And I remember you saying the same thing to me: >you know,<
27		I'll get sick of you too.
28		(.)
29	DEA:	(°Mm. Hm:.°)
30		(0.3)
31	PET:	Δ(#Of-#)Δ (.) meaning- (.) I- I: Δwill get Δs:ick of you.Δ
		Δ.....Δtouches chest----------Δpoints---Δ,,,,,,,,,,,,,Δ
32	DEA:	°Mm hm.°
33	PET:	Um >I remember you< s:aying that to me.
34		(.)
35	DEA:	°Yep.°=
36	PET:	=>And I< think ↓o:h.↓ (0.2) °that's:° (.) that's the (sup of)
37		that.=So >that's what that< <paragraph> was about that I was
38		re:ading you. #well# (.) (more >highlighting< the book that) (.)
39		it s:truck me (.) it i:nstantly went to me: and s- °s:aid° well
40		that's what- (.) thats's the way De:an was speaking.
41		(0.3)
42	DEA:	Mm:.

In this fragment, Peter and Dean are discussing a psychological topic: trauma. Peter refers to claims about trauma that are made in a book he has been reading (see, for example, line 1). He then connects this with things that he claims Dean has said in the past about his interpersonal experiences (e.g., lines 14–15). Consistent with previous observations in psychotherapy (Bercelli et al., 2013; Weiste and Peräkylä, 2013), citing something said in the past can be a locational tying technique to place prior conduct in a new context where it can take on a different meaning. Here, by citing Dean's prior conduct, Peter can proffer a candidate connection between that conduct and what the book claims about people who have experienced trauma.

Citing Dean's prior conduct provides means for Peter to proffer a connection between Dean's interpersonal experiences, and thereby facilitate a psychological account of those experiences: namely, that Dean behaves in a similar way to the manner in which this book claims people with trauma tend to behave. A similar observation has been by Arminen (1998) in a different therapeutic context, Alcoholics Anonymous, where connections are made between a member's experience and an experience described on a television program. Across that context and the context of the current study, this practice is used in a comparable way: to proffer a candidate connection between two or more experiences. This proffering of candidate connections was recurrently observed in therapy, but was far less common in the mundane interactions that were recorded for the current study.

DISCUSSION

Existing attempts to explain how psychotherapy works tend to focus exclusively on therapeutic interaction, rather than

comparing these encounters with other types of social interaction. This may be one reason for the longstanding difficulty in determining how diverse approaches to therapy share a common capacity to alleviate mental distress (Rosenzweig, 1936; Rosenthal and Frank, 1956; Stiles et al., 1986; Wampold and Imel, 2015). Although some psychotherapy researchers consider psychotherapy as a social or cultural practice (e.g., Wampold and Imel, 2015; Jørgensen, 2019), ongoing research is needed to understand what distinguishes therapy from social or cultural practices that occur in other contexts (Siegfried, 1995; Kozart, 1996; Mondada, 1998; Pawelczyk, 2011; Jørgensen, 2019). Comparative conversation analytic research affords opportunities to explore this matter (Drew and Heritage, 1992).

It is possible that the bulk of therapeutic encounters are comprised of mundane interactional practices (Mondada, 1998), which are used in ways that suit the particular roles and activities that comprise this institutional activity (Lakoff, 1982; Drew and Heritage, 1992; Pain, 2009; Pawelczyk, 2011). In recognition of this possibility, the current study involved directly comparing psychotherapeutic and mundane interaction. The current study identifies a practice that is relatively pervasive in psychotherapy but appears to be much less common in mundane interaction. This practice involves use of locational tying techniques to bring together two or more experiences that were independently discussed, enabling a candidate connection to be proffered between them. In instances where a candidate connection is confirmed, this can facilitate the production of a psychological account of such experiences. In psychotherapy, as observed above in the analysis of Fragment 3, the production of a psychological account of a client's difficulties can then facilitate the pursuit of a psychological solution.

The findings of the current study are congruent with similar conversation analytic studies of psychotherapy (Wowk, 1989; Parker, 2003; Vehviläinen, 2003; Peräkylä, 2004). Although the foci of these studies are somewhat different to the present study, each considers ways therapists connect different experiences reported by clients, often across multiple therapy sessions. The current study supports and extends this analysis. In particular, by comparing ways candidate connections are proffered across psychotherapeutic and mundane interaction, the current study highlights how this practice can be used to psychologise experience. This is consistent with findings by Arminen (1998), who considers how connections are made between the experiences of different people participating in Alcoholics Anonymous (see also Halonen, 2008). Taken together, the findings of these previous studies and the current study suggest that proferring connections can be used to psychologise people individually or collectively. Moreover, this practice can occur across a range of 'helping relationships' (Rogers, 1958), although it seems to be used more frequently in therapeutic settings, where this practice contributes to core activities for psychotherapy.

More generally, the results of the current study are consistent with the perspective that parties to psychotherapeutic encounters are recurrently engaged in activities that share a generic focus on systematically identifying possibly relevant aspects of experience (Bercelli et al., 2013). Along with similar studies (Arminen, 1998; Parker, 2003; Vehviläinen, 2003; Peräkylä, 2004; Halonen, 2008; Pain, 2009), the current study finds that exploration of possibly relevant aspects of experience routinely involves attempts to connect experiences. If such connections can be made, these can form the basis of a psychological account of experience, which can then underpin subsequent therapeutic work.

Identifying candidate connections is theorised to be a central activity for psychotherapy (Tomm et al., 2014; Jørgensen, 2019). The current study provides evidence of this, and highlights how this can distinguish therapy from other types of social encounters. This finding is congruent with transtheoretical views of psychotherapy, such as understanding a "…patient's reports as meaningful stories to be interpreted and modified in collaboration with the therapist" (Frank and Frank, 1991: 73). As reflected in the quote at the beginning of the article, this finding is also consistent with longstanding recognition that a core part of psychotherapy is the identification and reconditioning of 'patterns' (Rosenzweig, 1936). In the ongoing effort to understand such common factors that seem to underpin the success of a diverse range of therapeutic processes (Rosenzweig, 1936; Rosenthal and Frank, 1956; Stiles et al., 1986; Wampold and Imel, 2015), the type of comparative work undertaken in the current study is important to identify social practices that help answer this enduring question.

According to prior conversation analytic research (Voutilainen et al., 2010b; Bercelli et al., 2013), psychotherapeutic encounters appear to be organised according to general types of interactional projects (Schegloff, 2007). This level of organisation appears to involve alternating periods of enquiry (Bercelli et al., 2008, 2013), where therapists and clients work to recognise relevant aspects of the client's circumstances (Voutilainen et al., 2010b), and elaboration (Bercelli et al., 2008, 2013), where the parties are predominantly focused on interpreting those circumstances (Voutilainen et al., 2010b). The current study has focused on a practice that provides means to integrate enquiry and elaboration. Doing so has highlighted the potentially protracted nature of this process, which routinely involves proffering candidate connections between experiences that were separately mentioned across several therapy sessions. This is consistent with the observation by Bercelli et al. (2013) that psychotherapy is characterised by alternation between different interactional projects. The current study identifies one practice through which this alternation is accomplished.

The alternation between different interactional projects in psychotherapy distinguishes this type of interaction from other types of institutional interaction. For example, primary care consultations for acute medical conditions are characterised by a typically liner progression through a series of interactional projects, or 'phases' (Robinson, 2003). In contrast, psychotherapy appears to be characterised by more non-linear progression, such as by returning to past matters that may be relevant to a current activity.

At a more general level, alternation between different interactional projects also distinguishes psychotherapeutic from mundane interaction. In mundane settings, talk about troubles tends to be oriented to by participants as an episodic activity, and one which is routinely closed so the parties can return to 'business as usual' in which troubles are not the focus of their interaction

(Jefferson, 1984, 1988; Holt, 1993; Maynard, 1997, 2003). In contrast, talking about troubles *is* the usual business of therapy (Davis, 1986; Ferrara, 1994; Ruusuvuori and Voutilainen, 2016; Jørgensen, 2019), even though troubles may not be discussed in the same way in psychotherapy as it is in mundane interaction (see Voutilainen et al., 2010a). With the exception of mundane interactions such as the one considered above, a crucial difference between mundane and psychotherapeutic interactions is that the latter involves sustained focus on troubles over a multitude of encounters (Ferrara, 1994; Voutilainen et al., 2018). This sustained focus on an individual and their experiences is a key point of difference between the diverse activities that are likely in mundane social interactions. This may account, at least in part, for the recurrent use of the focal practice in psychotherapy in contrast to its relatively more scare use in mundane interaction. The current study shows how proffering candidate connections is one way therapists and clients can sustain focus on the client's troubles across the psychotherapeutic process.

There are several limitations to the current study that should be considered when interpreting findings and planning future research. First, the study used data collected from a small number of therapists working from a range of psychotherapeutic approaches. Although this allowed identification of an interactional practice that occurs across this diversity, there was no scope to examine different therapists who claimed to use the same therapeutic approach. Second, the current study was limited in focus to dyadic psychotherapy involving individual clients and therapists. Further research will be necessary to determine whether these findings are transferrable to other types of therapeutic encounters, such as with groups of people or conducted via alternative media, such as computerised treatments. Third, it is possible the practice of proffering candidate connections was originally developed for psychotherapy and subsequently appropriated in everyday contexts for purposes such as psychologising. That is, rather than being a mundane interactional practice that is used to accomplish the business of psychotherapy, it is possible that this practice originally developed in psychotherapy and has been subsequently adopted for use in mundane settings (see Pawelczyk, 2011). Notwithstanding these limitations, the current study illustrates the promise that comparative research holds for understanding what unites diverse approaches to psychotherapy and how this might be distinct from other types of supportive encounters.

If psychotherapy is indeed "an unusual social relationship" (Wampold and Imel, 2015: 56), the current study, along with existing conversation analytic research, helps to understand the precise ways therapy differs from what typically occurs in other types of social encounters. The findings of this study highlight ways that everyday interactional practices appear to be adapted to suit the local context of psychotherapeutic encounters. In psychotherapy, the repeated use of practices, such as using locational tying techniques to proffer candidate connections between experiences, provides means for therapists and clients to progressively develop a psychological understanding of the client and their circumstances. This understanding may ultimately contribute to meeting the needs that motivate clients to participate in therapy.

DATA AVAILABILITY STATEMENT

The datasets presented in this article are not readily available because data sharing is not permitted under the ethical clearances for this study. Requests to access the datasets should be directed to SE (stuart.ekberg@qut.edu.au).

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Queensland University of Technology (QUT) Human Research Ethics Committee. The patients/participants provided their written informed consent to participate in this study. Written informed consent was obtained from the individual(s) for the publication of any potentially identifiable images or data included in this article.

AUTHOR CONTRIBUTIONS

The author confirms being the sole contributor of this work and has approved it for publication.

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Conflict of Interest: The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

APPENDIX

Transcription Conventions

Speaker labels	
CLI	Labels in upper case indicate lines that transcribe verbal conduct.
cli	Labels in lower case indicate lines that transcribe embodied conduct. Where there is no lower case label, this indicates the conduct is attributable to the speaker on the immediately above line in the transcript.
Temporal dimensions	
Wo[rd] [Wo]rd	Square brackets mark speaker overlap, with left square brackets indicating overlap onset and right square brackets indicating overlap offset.
Word = word	An equals sign indicates absence of discernible silence between two utterances or actions, which can occur within a single person's turn or between the turns of two people.
Word (0.4) word	A number within parentheses refers to silence, which is measured to the nearest tenth of a second and can occur either as a pause within a current speaker's turn or a gap between two speaker's turns.
Word (.) word	A period within parentheses indicates a micropause of less than two-tenths of a second.
Vocal conduct	
Word.	A full stop indicates falling intonation at the end of a unit of talk.
Word,	A comma indicates slightly rising intonation.
Word¿	An inverted question mark indicates moderately rising intonation.
Word?	A question mark indicates rising intonation.
Word_	An underscore following a word indicates level intonation.
Word	Underlining indicates emphasis being placed on the underlined sounds.
Wo:::rd	Colons indicates the stretching of the immediately preceding sound, with multiple colons representing prolonged stretching.
Wo::rd	Underlining followed by one or more colons indicates a shift in pitch during the pronunciation of a sound, with rising pitch on the underlined component followed by falling pitched on the colon component that is not underlined.
Wo::rd	An underlined colon indicates the converse of the above, with rising pitch on the underlined colon component.
↑Word↑	Upward arrows mark a sharp increased pitch shift, which begins in the syllable following the arrow. An utterance encased with upward arrows indicates that the talk is produced at a higher pitch than surrounding talk.
↓Word↓	Downward arrows mark a sharp decreased pitch shift, which begins in the syllable following the arrow. An utterance encased with downward arrows indicates that the talk is produced at a lower pitch than surrounding talk.
WORD	Upper case indicates talk produced at a louder volume than surrounding utterances by the same speaker.
°Word°	Words encased in degree signs indicate utterances produced at a lower volume than surrounding talk. Double degree signs indicate utterances produced at an even lower volume than surrounding talk.
<Word	Words preface with a less-than symbol indicates that this utterance is 'jump-started', sounding as though it begins earlier than it might otherwise had.
>Word<	Words encased with greater-than followed by less-than symbols indicate talk produced at a faster pace than surrounding talk.
<Word>	Words encased with less-than followed by greater-than symbols indicate talk produced at a slower pace than surrounding talk.
Wor-	A hyphen indicates an abrupt termination in the pronunciation of the preceding sound.
#Word#	Hash signs encase utterances produced with creaky voice.
~Word~	Tilde signs encase utterances produced with tremulous voice.
£Word£	Pound signs encase utterances produced with smile voice.
W(h)ord	When interpolated within a word, the letter 'h' encased in parentheses indicates plosive laughter.
Whord	When interpolated within a word, the letter 'h' indicates breathy laughter.
W(f)ord	When interpolated within a word, the letter 'f' encased in parentheses indicates nasal laughter.
hhh	The letter 'h' can indicate audible oral exhalation, with more letters indicating longer exhalation.
.hhh	A full stop followed by the letter 'h' indicates audible oral inhalation.
.snn	A full stop followed by the letters 's' and 'n' indicate audible nasal inhalation.
tch	This convention is used to transcribe a dental click.
(Word)	Words encased within single parentheses indicate an utterance that was unclear to the transcriptionist.
((Description))	Words encased in double parentheses indicate aspects of conduct for which there is no established transcription convention.
Embodied conduct	
ΔconductΔ	Triangles indicate the beginning and end of embodied conduct of a particular participant.

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⌂conduct⌂	House symbols are used as an alternative to triangles, to distinguish some embodied conduct that co-occurs with some other conduct.
+conduct+	Plus signs indicate the beginning and end of embodied conduct of a another participant.
Δconduct-->	An arrow indicates an action continues across subsequent lines,
--> Δ	until a corresponding arrow is reached.
Δconduct--> >	A double-headed arrow indicates an action continues beyond the end of the fragment.
. . . .	Full stops indicate the preparation of an action.
- - - -	Dashes indicate the maintenance of an action.
, , , ,	Commas indicate the retraction of an action.

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ORIGINAL RESEARCH
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Practices of Claiming Control and Independence in Couple Therapy With Narcissism

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Four couple therapy first consultations involving clients with diagnosed narcissistic problems were examined. A sociologically enriched and broadened concept of narcissistic disorder was worked out based on Goffman's micro-sociology of the self. Conversation analytic methods were used to study in detail episodes in which clients resist to answer a therapist's question, block or dominate the development of the conversation's topic, or conspicuously display their interactional independence. These activities are interpreted as a pattern of controlling practices that were prompted by threats that the first couple therapy consultation imposes upon the clients' self-image. The results were discussed in the light of contemporary psychiatric discussions of narcissism; the authors suggest that beyond its conceptualization as a personality disorder, narcissism should be understood as a pattern of interactional practices.

Keywords: couple therapy, conversation analysis, narcissism, independence, vulnerability, sequence, topic, identity

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"Das erste steht uns frei, beim zweiten sind wir Knechte"
"The first is free to us, in the second we are servants"
Goethe

INTRODUCTION

Couple Therapy With Clients Who Have Narcissistic Problems

In this paper we investigate a set of interactional practices occurring in the context of initial couple therapy consultations with partners who have narcissistic problems. Because these patients have difficulties displaying weakness or need for help, they often deny the necessity of individual therapy and are more motivated to come to couple therapy due to the risk of losing their partner (Links and Stockwell, 2002). Furthermore, couple therapy with patients showing narcissistic conduct is of particular interest because long term relationships are regarded to have a stabilizing if not healing effect (Ronningstam et al., 1995; Lewis, 1998, 2000).

During couple consultations couples with narcissistic spouses often report basic communication problems and, accordingly, a significant level of stress. This is in line with the results of experimental studies that indicate that narcissistic spouses are highly problematic to their partners. They are

described as showing hostility—e.g., criticism, insults—while discussing conflicts (Peterson and DeHart, 2014; Lamkin et al., 2017), as exhibiting aggressive behavior during competitive tasks (Keller et al., 2014), and as acting in an exploitative manner (Konrath et al., 2014).

Along this line, studies show that treatment of narcissistic personality disorder poses a huge challenge for couple therapy as well as for individual therapy. Yakeley (2018) reports rejection of diagnosis, feelings of unfair treatment or premature termination of therapy as serious difficulties impeding psychotherapy. A similar picture is drawn by Tanzilli et al. (2017) who identify the problem of establishing a good enough therapist-patient relationship as a main obstacle for individual therapy.

Couple therapy with a narcissistic spouse provides a specific naturalistic setting for a couple's interpersonal spectacle (MacFarlane, 2004), which the therapist can witness as (implicit) addressee or overhearing listener (cf. Goffman, 1979). Lachkar (2004) highlights the circular, destructive patterns of communication in borderline-narcissistic couples that are enacted during couple therapy sessions. Links and Stockwell (2002) identify as a particular challenge the heightened defensiveness in individuals with narcissistic problems when a partner is witnessing an interpretation, or responding with disdain and anger for the therapist's comments.

In diagnostic manuals, narcissism is conceptualized as personality disorder that characteristically includes impairments of self-functioning and predominant self direction, manifests in *"a pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy"* (APA, 2013). In clinical theories, grandiosity is understood as defense against an internal state of vulnerability (Kohut, 1971; Levy et al., 2007, 2011; Ronningstam, 2012). In contrast to this intrapersonal view, recent approaches conceptualize personality disorder as part of a dynamic system of interactions (Livesley, 2018) including interpersonal or situational factors. These factors can amplify individual personality predispositions, with the result that, for example, the presentation of a patient's grandiosity may vary or oscillate during a therapeutic session depending on how secure the patient feels in the relationship with the therapist (e.g., Hopwood, 2018). Assuming the manifestation of narcissistic disorder, conceptualized as impairment in self-functioning, depends on certain social conditions, further research at the intersection between the internal world and the self in the social world is needed. To understand this, we need concepts that come from the sociology of the self.

Self in Social Interaction

In our view, the clinical depiction of vulnerability in narcissistic personality, and the work of Goffman on the generic vulnerability of self in social interaction, ideally complement each other. As Peräkylä (2015) argued there is a yet unrecognized theoretical connection between Goffman's theory of face and the psychiatric understanding of disturbances of self in personality disorders. This link between Goffman's depiction of the self and contemporary clinical theories regarding narcissism implies that it is the experience of "face" that has been impaired in personality disorders, especially in pathological narcissism.

Throughout his writings, Goffman pointed out that whenever individuals engage in interaction, they necessarily display what they claim to be. In his early work (Goffman, 1955), he discussed this in terms of "face." Face arises from the positive social attributes that a person, through her line of action in interaction, claims to herself, and that she expects others to ratify. In other words, Goffman contends, by anything we do in interaction, we claim a particular image of self either by saying or doing.

Goffman thus points out that the self is thoroughly social. For a person to be in good face, they need recognition from their interaction participants. Furthermore, the sociality of the self involves that we are not only sensitive to our own face and self, but also to the face of the other. The Goffmanian actor feels embarrassed also when it is the interaction participant who loses their face (Goffman, 1955).

In his 1955 essay and elsewhere, Goffman is very sensitive to the emotional meaning of the self thus claimed. Borrowing psychoanalytic terminology, he points out that we *cathect* our selves: we attach positive emotion to our self-image. But on the other hand, we are also inherently anxious about our self. The others may not ratify the self that we claim to be. This means that our face and our self-image is perpetually vulnerable (Goffman, 1983).

For Goffman, vulnerability of the self is an inherent by-product of social interaction: engaging in the interaction means accepting the risk of not being attended to, of not being ratified and responded to as what we claim to be (Goffman, 1955, 1971). The clinical theories of narcissism specify vulnerability of the self by pointing out that there are individuals who are, as it were, hyper-vulnerable. Since Freud's essay "On narcissism" (Freud, 1957, orig. 1914) these individuals are called "narcissistic" insofar as they are utterly dependent on approval and attention by others (Kohut, 1971, p. 17) and in great need to be loved and admired (Kernberg, 1975, p. 227).

By investigating the interactions of narcissistic persons, we can see a "highlighted" version of the vulnerability that is there, in more implicit forms, in all social interactions. On the other hand, the Goffmanian way of understanding the omnipresence of self and its vulnerability in social interaction can help us to see more clearly self-related risks in our clinical materials.

Analyzing the Self in Social Interaction: Conversation Analysis

In his publications, Goffman never dealt with psychotherapy, let alone psychotherapeutic interaction. Although his work on the intricacies of self-presentation in social interaction was enormously influential, he never based his studies on recordings of actual social episodes but relied mainly on ethnographic observations and occasionally on newspaper clippings or quotes from novels. This is where conversation analysis comes in.

Conversation analysis was developed as the microanalysis of the practices through which social order is generated by the interactants in the minutia of the unfolding social interaction in

ordinary everyday life.[1] In its early years, conversation analysis was focused on the identification and description of basic, if not universal mechanisms and devices of the organization of social interaction. It is a basic premise of conversation analysis that the various parts, which make up the interactional machinery, have the twin features of being context-free and context-sensitive (Sacks et al., 1974, p. 699). The principles of this interactional machinery regulate, e.g., the alternation of speakers, conversational repair, topic development, or reference to persons. They apply across different social contexts, but at the same time they provide opportunities for the participants to display their understanding of and orientation to the particular contextual conditions of the interaction.

The potential of conversation analysis for the study of interactants' practices to particularize a social encounter prompted researchers to extend the area of study beyond informal everyday interaction and to include institutional talk, e.g., courtroom proceedings or emergency calls (Drew and Heritage, 1992), psychotherapy (Peräkylä, 2019), psychiatry (Bergmann, 1992, 2017), and of talk involving atypically developed participants, e.g., individuals with aphasia (Goodwin, 1995, Goodwin(ed.), 2003) or autism (Maynard, 2005). More recently, conversation analysis has been used as a method in studies on family and couple therapy, embracing interactional patterns in the establishment (Sutherland and Strong, 2011) and ruptures and repairs (Muntigl and Horvath, 2016) of the therapeutic alliance, in circular questions (Diorinou and Tseliou, 2014), and in interactional asymmetries (Janusz et al., 2021).

Conversation analytical research has also picked up Goffman's idea of self in social interaction. Although his concept of self does not directly translate into detailed conversation analytical observations, conversation analysts have started to investigate specific contexts of action and sequential environments in which the situated identities of participants become relevant or participants orient themselves to face problems (see Maynard and Zimmerman, 1984; Lerner, 1996). Studies thus far have demonstrated that participants' orientation to issues of face concerns only specific moments of interaction. In their analysis of agreements on assessment sequences, Heritage and Raymond (2005) suggested that claims and sometimes disputes regarding knowledgeability involve not only epistemic issues such as social expectations, rights, and obligations to know but also issues of face. However, Goffman's radical claim regarding the *omni relevance* of face has not been met with empirical evidence from CA studies, which focus on clearly definable conversational objects.

According to its epistemological stance, conversation analysis abstains from judgments about the facticity of impairments of self-functioning, of narcissistic personality disorder, or other clinical conditions; it cannot contribute directly to our understanding of personality disorder. It can, however, analyze when and how a participant's behavior becomes "noticeable" for the co-participants—and for the researcher—as unexpected, inappropriate, improper, and, thus, as possibly non-normal. Based on this procedural conception we do not ask "what is and who has a narcissistic personality disorder," but instead we ask "when" is a narcissistic personality disorder.[2] Thus, our main focus is on when, where, and how an activity occurs in a couple therapy session that clinicians will identify as features of narcissism.

The focus of our paper is on the question how clients who have narcissistic problems act in the interactional context of couple therapy. Particularly we seek to analyze in detail the activities of these clients in situations in which they are expected to answer personal questions. And we closely look at how they respond when their personality or behavior is commented upon by the other spouse or the therapist.

THE METHOD

Participants

The data set, with which our study started, comprises the initial therapy sessions of seven couples who all reported problems in their marital relationship.[3] For each of these couples at least one spouse was diagnosed as showing features of personality disorders. In four of these couples, one spouse respectively (three men, one woman) was diagnosed with narcissistic features. These four couples together were taken as database for this paper.

All the therapists had systemic training in communication, structural systemic theory, and the Milan approaches, which was their primary therapeutic approach. Yet they also had additional training in psychoanalytic or psychodynamic therapy.

Research Setting

The decision to include only first consultations in the dataset is based on the fact that, within the systemic framework, first sessions are usually more structured than the following therapeutic sessions, which facilitates the comparisons between cases. In systemic couple therapy first consultations, therapists encourage the spouses to define their therapy goals and desired changes, actively investigating how the complaints may be influenced by the couple's interaction. In the Milan approach the circular questions are used while gathering the information about the relational patterns in the family; the therapist's aim is to observe what may prompt change in the interactions (Selvini et al., 1980). In structural approaches the therapist is expected to observe the family transactions, particularly those related to the

[1]Many of the first generation conversation analysts (Sacks, Schegloff, Sudnow, Turner) originally were students of Goffman, but in their groundbreaking work they were strongly influenced by Garfinkel's (1967) program of ethnomethodology.

[2]This ethnomethodological shift in asking is inspired by Moerman, who has done field research with the Lue tribe in Thailand and who showed that the question "who are the Lue?" needs to be reformulated and substituted by the question "When are the Lue?" (Moerman, 1974, p. 66).

[3]Originally the data set also included two crisis couples. In the course of analysis these two couples were excluded and only used as a heuristic medium for comparison.

presented problem, as well as organizing the interview in such a way that the therapist's leadership is the source of safety and confidence for the couple (Weber et al., 1985; Nichols and Tafuri, 2013).

The issue of safety is particularly important during the first sessions. The spouses are faced with the difficulty that they have to talk to a stranger—the therapist—about their most private marital affairs, their disappointments with each other, their common history of conflicts, their mutual injuries and transgressions, their most intimate wishes, hopes, and experiences. Usually both spouses are aware—or at least sense—that each of them has a share in the turmoil and jeopardy of their marriage. And even though the therapist's role is to reformulate the "blaming utterances" in terms of problematic relational patterns, interactional studies show that this kind of circular perspective may contribute further to developing blaming conversational sequences (Patrika and Tseliou, 2016).

Taken together, the constellation of a couple therapy implies for both clients that they have to cede control of the image they want to preserve. And this situation is considered as particularly threatening for clients who already have difficulties in receiving and maintaining recognition of their ideal self image (Links and Stockwell, 2002; MacFarlane, 2004).

Method of Analysis

In analyzing early exchanges between therapist and clients, we were guided by the methodological principles of conversation analysis, i.e., at the first stage of analysis, the data were studied in an "unmotivated way" (Sacks, 1992, p. 175). The fact that the examined conversations took place during a psychotherapeutic session played initially no role in the analysis of the data, and the clients' utterances were not scanned for clinical symptoms. The researchers made any effort to avoid speculating about the clients' intentions or goals, instead they committed themselves to stick to the maxim of observability. The validity of a description had to be attained by referring to an observable detail in the ongoing interaction. In this, the researchers followed the ethnomethodological "study policy", to treat everyday activities as members' methods for making those same activities reflexively "accountable," i.e., observable and describable (Garfinkel, 1967).

Based on video recordings of the psychotherapeutic sessions, major parts of the core data set, and additional consultations, were transcribed according to the established transcription system in conversation analysis, originally developed by Jefferson (1984). The analysis started by "making an observation". What struck the researchers' attention were moments in which the interaction ran off in an unexpected way: Something unusual happened, a manifest interactional "hitch" occurred, an interruption of the flow of interaction, a client's noticeable intervention, or some other infraction of a conversational rule. Particular attention was given to the ways in which the participants created these conspicuous moments or contributed and responded to them, and projected—as explicit statements or questions, as presuppositions, or by implication through their actions—positive or negative attributions regarding the self of themselves and each other.

A collection of these noticeable events and their interactional management was made, still without any clinical interpretation but with an eye to the question, how these events are related to the interactional positioning and self images of the participants. Various episodes were analyzed turn by turn with regard to their interactional unfolding and with the aim of identifying and disentangling various meaning layers of an utterance in a given sequential environment. Eventually, "interactional control" was identified as the common thread, running through the collected episodes. The concept of interactional control pertains to activities of clients with which they resist interactional dependence on others (therapist or spouse) or stipulate the conversation's further course. The analysis showed that controlling activities are prompted by threats to the clients' interactional self-images, and serve as means to manage such threats and to maintain the purported self.

Procedure

The data of our study was gathered from couple therapy first consultations that were conducted in the Family Therapy and Psychosomatics Department, Medical College, Jagiellonian University Krakow.[4] In the department, therapy sessions are regularly video recorded for the purpose of training and supervision. The cases that make up our database were selected by the therapists who identified couples that were particularly difficult to talk to. As a result, in the course of the therapy the therapist came to the conclusion that a personality pathology might be lingering in the background. Couples who were identified by the therapists as meeting the criteria were informed about the research project and were asked about their willingness to participate in it. Those who agreed to participate finally signed the statement of agreement. The narcissistic symptomatology was on the level of Personality Disorder. The initial diagnosis of Personality Disorder was later on confirmed by formal testing with the Shedler–Westen Assessment Procedure SWAP (Shedler and Westen, 2007).

In the next step the transcribed video recordings of four first therapeutic consultations were analyzed. As a result of the data analysis the phenomenon of interactional control in NPD couples emerged as the main object of our study. In order to find out whether these phenomena occurred more than just once, we went again through the recordings of the four sessions that were the data of this study. For comparison, we also dealt with in an unsystematic manner other recorded sessions with spouses that were not diagnosed with narcissistic personality disorder, but since this was done in an explorative mode it was not included in this paper. The distinct controlling practices in narcissistic spouses were not identified in spouses indicating other than narcissistic personality problems, and in spouses without PD related problems. However, a systematic comparison needs to be done in future studies.

[4]The project got agreement of the Bioethical Committee, Medical College, Jagiellonian University nr 1072.6120.76.2020.

RESULTS

The controlling practices employed by the spouses with narcissistic problems pertain to the sequential position in interaction, to the management of the topical flow of the conversation, and to the display and enactment of identity. In the following, these three areas of practices will be dealt with one by one, although actually they overlap and are intertwined, which is why the same examples are sometimes used for different analytic purposes.

Controlling the Sequential Position

In our data, the clients repeatedly make moves whereby they interactionally sidestep from being in the responsive position. Generally in social interaction, every sequence-initiating utterance stipulates the type and range of subsequent activities. By asking a question, a speaker generates an expectation for the recipient to answer and restricts the terms of his/her response. Thus, a recipient is strongly constrained by the question and its formulation, its mode and its presuppositions; the recipient's turn is "sequentially dependent upon the previous one" (Schegloff, 1968, p. 1076).

In psychotherapy, the question–answer–regimen is loosened; questions are not formulated as pressing requests for information but as invitations to cooperate by volunteering an answer. Indeed, in the following segment, (The meaning of the transcription symbols in the **Appendix**)

#1 Know something more about you

```
01 T:  aha coś jesz↑cze bym mogła o panu wiedzieć
       Oh, I'd like to know something more about you(H)
02     (2.0)
03     tak na dzień dobry co .hh co by £było£ ważne
       like for the beginning that .hh that would be important
```

-the psychotherapist does not even formulate a question but states her wish to know more about her recipient, the husband. And since the husband remains silent for 2 s, she continues by telling him why his participation is important.

The psychotherapist's unobtrusive move to coax husband to talk about himself is only partly successful. Client does respond, but he does not answer the therapist's question.

#1 ctd.

```
04 H:  nie nie wiem nie wiem [co jest dla pani ważne
       no I don't know- I don't know what is important for you
05 T:                       [mmhm
         n/t  ---------------------------
06     w tym momencie (.) trudno mi powiedzieć
       at this moment (.) it's hard for me to say
                    ((H sneers)) -----------------
                   n/t    ----------------------
07     proszę jakieś py↑tanie to odpowiem pani na pytanie
       please give me a question then I will answer the question
08 T:  ∘dobra∘
       ∘right
```

In his rejection ["No"] the client takes issue with two features of the therapist's initiative move. He refuses the opportunity to decide by himself what is important for him and what he would like to talk about. And although the client, by formulating a counter request, does respond to the therapist's question, he does not answer it. He resists the conditions that are set and controlled by the therapist's question, and formulates for his part the conditions under which he would be willing to answer. Thus, his sidestepping response and counter request can be seen as a move to control the terms of his participation.

It is not unusual in everyday interaction that recipients, instead of answering a question and thereby implicitly accepting its legitimacy, try to resist the constraints of the question-answer format and alter the course of interaction (Stivers and Hayashi, 2010; Heritage and Raymond, 2012). In many people-processing organizations, interaction consists of a series of question–answer-sequences (Drew and Heritage, 1992), and although clients are expected to stick to the conditions of the question, they often sidestep or resist questions as has been shown for police interrogations (Jol and Stommel, 2016), news interviews (Clayman, 2016), counselings (Muntigl, 2013), psychotherapy (Yao and Ma, 2017), and other institutional contexts (Chevalier and Moore, 2015).

However, H's reluctance in extract #1 to submit to the sequential ties of a previous question is not a singular, but a recurring event that can be observed as a habitual pattern in many other instances in this therapeutic session, as in the following segment:

#2 Is this necessary / 18.15

```
01 T:  czy oprócz komunikacji pan by coś jeszcze do↑dał:
       would you add something more apart from communication
02     (1.5)
03 H:  m::::::        ↓nie potrzebne to ↑jest
       m::::::        ↓no is this necessary
       g/h (W)  --------(T)
04     czy uważa pani że to jest potrzeb↑ne
       do you(T) think that it's necessary
05 T:  znaczy co [czy jest potrzebne
       what do you(H) mean [that is necessary
06 H:            [w tym momen↑cie żebym coś
                 [at this moment for me to
07     doda↑wał do ↑tego
       add something to ↑it
                    ((H turns his head aside and sneers))
08     (1.0)
```

About 15 min into the first session with a couple at the age of about 40 years, the therapist invites the clients to tell more about their reasons to come to therapy. After the wife has provided some information about herself and her view of the couple's problems, the therapist turns to the husband and asks for his supplementary statement. Instead of answering by giving the information asked for, the husband responds with a counter question requesting to know whether this is necessary. Research has shown that there is a dispreference for patient-initiated questions in physician-patient encounters and that questions that are nevertheless asked by patients are modified in order to indicate their dispreferred status (Frankel, 1990). In segment #2 the client's counter question is not marked as a dispreferred activity. With his inquiry about the necessity of the therapist's question, he not only challenges the therapist's professional authority but steps out of the interactional space in which his action is controlled by the therapist's preceding question. By asking a question

himself, he occupies a sequential first position, thus making an answer by the therapist "conditionally relevant" (Schegloff, 1968, p. 1084) and exerting for his part control of the therapist's subsequent action.

In one of his early lectures (1964) Sacks remarked that "the attempt to move into the position of 'questioner' seems to be quite a thing that persons try to do. (...) As long as one is in the position of doing the questions, then in part they have control of the conversation" (1992, p. 54). And with regard to adult–child interaction Mishler (1975, p. 99) has observed that "when adults initiate a conversation with a question, they retain control over its course by successive questioning, (...) when children ask an adult a question, the adult regains control by responding with a question." It seems obvious that the question–answer-sequence has an inbuilt logic of control. Questions not only stipulate that a response is due but also determine what kind of answer is expected.[5] As we have shown, it is a characteristic of narcissistic clients that they "break out" after a personal question by side stepping responses or counter questions. With their maneuvers of resistance they mark the psychotherapist's preceding question as an infringement of their autonomy, and, at the same time, conspicuously re-claim their independence.

Controlling the Topic

In our data, clients control and restrain the topical flow of the therapeutic conversation. Below, we will show practices whereby this is accomplished.

Participants in a verbal interaction always talk "about something," and what they talk about constitutes the "topic" of the conversation. In general, topic is characterized by two complementary components that together form a contradictory unit (Bergmann, 1990). On the one hand there is a constraint that ensures that there is a topical flow at all. This constraint of progressivity imposes on every speaker the obligation to contribute something new to the ongoing verbal exchange. On the other hand the obligation to introduce new items is counterbalanced by the constraint not to chuck in just any new matter but to stay on topic and to show consideration for the maintenance of the conversation's actual topic. Topic development usually is the outcome of the co-interactants' cooperation, but a participant may use stricter "topic control to avoid the gainsaying of troublesome evaluations" (McKinlay and McVittie, 2006). The more detailed organization of topic is dependent on the type and institutional purpose of the encounter.

In couple therapy sessions, one way for the clients to contain and dominate the conversation's topic is by persevering and insisting on one's own point of view, an example of which can be found in the following segment.

#3 Totally different

01	T:	>no to zawsze jest to problem tej drugiej osoby< a **nie** .hh
		>it's always other person's problem< and .hh
02	W:	Indeed=
		Indeed=
03	T:	= nie wspólny i::
		= and not joint one and::
04		i myślę że (.) taką perspektywę przywrócenia (.)
		and I think that (.) restoring the perspective of (.)
05		tego: wspól:nego zajmowania się .hh problemami
		this: ta:king care together of .hh problems
06		I to by było ↓coś=
		And it would be ↓something=
07	H:	**=[mhm----------]**
08	W:	=[To nie jest kwestia] przywrócenia (.)
		=[It's not the case to] restore (.)
09		to jest [kwestia żeby] zbu↓dować
		it's [the case to] build it.
10	T:	[(wybudowania)]
		[(building up)
11	W:	>Bo nie da się przywrócić coś=
		>You can't restore something=
12	T:	=**mhm**=
13	W:	=czego nigdy nie ↓było< .hh
		=that has never↓existed< .hh
14		Tak naprawdę:: y:: (3) to (.) nas (.)
		In fact:: y:: (3) there's (.) more (.)
15		wię-cej >dzieli niż łączy<=
		that >separates us than connects<=
16	T:	=Aha=
17	W:	=>Taka jest prawda<
		=>That's the truth<
18		.hh Zupełnie inne podejś↑cie zupełnie inna psychi↑ka
		.hh Totally different attitude, totally different psyche
19		zupełnie inny poziom y:: odczuwa↑nia zupełnie inne
		totally different level of experiencing, totally different
20		pogla↑dy
		views
21	T:	=Dobrze=
		=Good=
22	W:	=na wszyst↓ko
		=for everyth↓ing
23	W:	I to jest dla mnie [proble]matyczne
		And that's for me [proble]matic
24	T:	**[Okay]**

Through a repair practice that comes close to "lexical substitution" (Rae, 2008) the wife rejects what the therapist's said about of restoring the common ground of the couple's life *(l.8 "It's not the case to restore")*, and introduces an alternative version of the marital state of affairs (*l.9 "it's the case to build it")*. In her subsequent utterances (l.11, 13, 14–15) she emphasizes and explains her view before entering into a monolog with a list of differences between her and her husband. This list is instructive in two ways. On the one hand the list is built as a series of extreme case formulations ("totally . . .") that are used "in anticipation of non-sympathetic hearings" (Pomerantz, 1986, p. 227), to underline the rightness of a case and to forestall possible refutations. On the other hand W's list is remarkable insofar as it is constructed out of four items (l.18–29) and as such it deviates from the "three-partedness" that Jefferson (1990, p. 89f.) has shown to be "a basic structural principle" of lists. With the twofold overdoing of her case, W. clearly marks that for her this issue is non-negotiable and not worth talking about any longer; for her the topic is closed.

[5] An even stronger characterization of questions as a tool of power can be found in Canetti's (1982) "Crowd and Power": *"All questioning is a forcible intrusion. When used as an instrument of power it is like a knife cutting into the flesh of the victim"* (p. 284).

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The following two extracts show yet another type of topic control. In these instances, topic control occurs after a problematic issue was brought up and described by the spouse. At the beginning of Extract 4 (l.1–3) the wife describes the husband's state of mind which she views as problematic.

#4 Emotions not feelings 21.13

01 W: Problem też jest taki że:: .hh jak się- (.)
Problem is also that:: .hh in what way (.)

02 jak się W:iktor dystansu↑je:
in what way Ja:kub is distanc↑ing himself

03 No to też jakby y::albo nie ma kontaktu
Well it also as if u:h or he had any connection

04 >ze swoimi< emocja↑mi=
with his emotions

05 T: **=Mhm=**

06 W: =y::
=u:h

07 (3.0)

08 W: albo <nie wiem co się z nimi dzieje>=
or <I don't know what is happening with them>=

Although his wife is talking about him, the husband does not take the opportunity to respond but remains silent (see pause of 3 s in line 07). Only when his wife points out her inability to understand her spouse's mental and emotional life *("I don't know what is happening with them")*, he offers a comment:

#4 ctd.

or <I don't know what is happening with them>=

09 H: =Robię co mogę żeby nie mieć ↑nie=
=I do my best in order not to have ↑yeah=
g/h (T)----------
((smirking))

10 W: =No właśnie=
=well exactly=

11 T: **=Mhm=**

12 H: =mm-hm (0.6) mm-hm (2.0) (∘no [tak∘)
=mm-hm (0.6) mm-hm (2.0) (°well [yes°)
[H tilts head]

13 T: [pan takie
[you(m) have

14 swoje zadanie żeby .h nie mieć kontaktu ze
such a task as .h not to have any connection

15 swoimi uczu↑ciami
with your fee↑lings

With his statement *"I do my best in order not to have them"* the husband transforms that which his wife has just described as a problem into his achievement. But with his smirking face he frames his utterance as a funny remark, and he even looks at the therapist, thereby apparently monitoring her response and possible appreciation. In case of success, a funny remark generates joint laughter, which in turn regularly leads to a termination of the topic at hand.[6] However, in the extract above, instead of laughter, his wife reacts with a comment that displays "knowing" (l.10: *"well exactly"*), and the therapist, in her response, treats his utterance as a serious statement, ignoring its ironic sub-meaning. In the end, his joke did not terminate the subject. The misalignment between the therapist and the husband's actions continues over the next turns:

[6]On jokes and funny remarks as "exit devices" in interaction, see Haugh and Musgrave (2018).

displays "knowing" (l.10: *"well exactly"*), and the therapist, in her response, treats his utterance as a serious statement, ignoring its ironic sub-meaning. In the end, his joke did not terminate the subject. The misalignment between the therapist and the husband's actions continues over the next turns:

#4 ctd.

13 T: [pan takie
[you(m) have

14 swoje zadanie żeby .h nie mieć kontaktu ze
such a task as .h not to have any connection

15 swoimi uczu↑ciami
with your fee↑lings

16 H: .hh mm hhh nie nie wiem czy uczuciami
.hh mm hhh no I don't know whether it is about

17 (1.0)

18 emocjami nie uczuciami=
feelings rather emotions not feelings=

19 T: **=Mhm**

The husband starts answering hesitantly (l.16), he expresses doubt as to the appropriateness of the therapist's wording and, after a pause of 1 s., continues by correcting the therapist's choice of words (feeling vs. emotion). While the semantic significance of the repair remains unclear, it is interactionally consequential in two ways: it induces an interruption of the topical flow (Egbert, 1997), thus releasing the husband from having to respond to the issue brought up by his wife (connection with his emotions). And by rejecting her vocabulary the husband furthermore calls into doubt the therapist's professional competence and displays unwillingness to enter into a therapist-patient relationship with her.

An even more powerful and bold practice to take control of the conversation's topic can be found in the following extracts. Above, we examined these extracts regarding the control of sequence; yet the same examples also involve control of topic. Despite the fact that it is the therapist's task to lead the conversation and guide the couple through this first session, we observed in our data several instances in which the patient acts in such a way to decide the subject of the talk and how it should be approached. In the following example, the therapist's request for basic personal data from the husband leads to a silence of 2 s.

#1 (cited above/reduced)

01 T: **Oh, I'd like to know something more about you(H)**
02 **(2.0)**
03 T: **like for the beginning that .hh that would be important**

The silence is terminated by the therapist who continues by expanding her question and by underlining the importance of the husband's participation. In his subsequent response, the husband refuses to give an answer by pointing to his lack of knowledge regarding the therapist's expectation (1.04). Directly after that, the husband instead asks for a clear cut question from the therapist in order to deliver the requested information (l.07):

#1 ctd.

04 H: **no I don't know- I don't know what is important for you**
05 T: **[mmhm**
n/t ----------
06 **at this moment (.) it's hard for me to say**
((H sneers)) ----------
n/t ----------
07 **please give me a question then I will answer the question**
08 T: **∘right**

Whereas (02) showcases the husband's resistance to enter into topical talk according to the therapist's stipulation, the following extract (01) captures an episode in which the same patient blocks the therapist's initiating move by redirecting the topical focus away from him to the therapist.

#2 (cited above/reduced)

T: **would you add something more apart from communication**
(1.5)
H: **m:::::: no is this necessary**
g/h (W) --------(T)
04 H: **do you(T) think that it's necessary**

```
      n/t ----------------------
07    please give me a question then I will answer the question
08 T: ◦right
```

Whereas extract (02) shows the husband's resistance to enter into topical talk according to the therapist's stipulation, the following extract (01) captures an episode in which the same patient blocks the therapist's initiating move by redirecting the topical focus away from him to the therapist.

```
#2     (cited above/reduced)

01 T:  would you add something more apart from communication
02     (1.5)
03 H:  m:::::: no is this necessary
       g/h (W)  --------(T)
04 H:  do you(T) think that it's necessary
06     at this moment for me to
07     add something to ↑it
                  [H turns his head aside and sneers]
```

After a pause of 1.5 seconds and a hesitation marker (*m::::::*) the husband first rejects the therapist's question and continues to sidestep an answer with a counter question inquiring after the topic's necessity. Instead of talking about his perspectives and problems, he initiates a move to transform the conversation into a meta-discussion about the necessity of the therapist's question—contesting, thus, her professional authority.

To summarize: How and in which direction the topic of a conversation develops in the flow of talk is in many ways unpredictable for the co-interactants. In the situation of a couple therapy clients may find themselves in awkward situations because the subjects that were brought up jeopardize their ideal self and invoke their vulnerability. As we have shown, clients apply various methods to gain control of the conversational topic, with the effect of diverting or forestalling talk about issues that could threaten their face. They can insist on a subject by extended and monologic utterances, or they can block the further development of the topic by eliciting laughter with a funny remark or a joke. The most blatant mode of steering the conversation away from a threatening topic is to engage the therapist in meta-talk by casting doubt on the therapist's entitlement to know and to ask questions about personal issues.

Controlling the Displays of Identity

According to Sacks et al. (1974), a key aspect of the turn taking machinery of conversation is that it can accommodate "interaction between parties with any potential identities" (p. 700). Social identities of participants of conversation are brought into being through their ways of operating the turn-taking system. Sacks et al. (1974, p. 718) highlight the local transformations of such identities: the machinery of conversation "is compatible with multiplicities of, and changes in, the social identities of some 'same' participants." In what follows, we will examine such multiplicities of clients' identities in couple therapy.

A distinction is often made between two facets of self and identity. One facet has to do with what is explicitly said or believed about a person, and the other facet has to do with what a person experiences or conveys about themself through their actions—without necessarily putting into words these things (see Goffman, 1955; Neisser, 1988; Leary and Tangney, 2012). Bamberg (2007); Deppermann (2015), and Deppermann et al. (2020) broadly distinguish between "told self" and "performed self"—a distinction that we find particularly useful in the study of couple therapy and that we will adopt in the following. "Told self" involves the verbalized attributions that the spouses make about themselves and each other; "performed self" involves what they convey about themselves through their actions.[7]

In first sessions of couple therapy—like those that we use as data—issues of identity are particularly pertinent. The therapist's primary task is to learn to know the couple: who the spouses are and what is their problem. For the therapist, the told self—what the spouses tell about themselves—is important, but at least equally important is the performed self, i.e., what the spouses convey about "who they are" through their actions.

We will now go through our extracts once more, re-elucidating them from the point of view of identity construction. Let us consider once again Extract 2 shown above. The therapist requested the husband to tell her more about himself, and the husband declined to answer:

```
#1     (cited above/reduced)

04 H:  no I don't know- I don't know what is important for you
05 T:                        [mmhm
06     at this moment (.) it's hard for me to say
07     please give me a question then I will answer the question
```

The husband does in effect refuse to tell about himself: thereby he withholds any further specification of his told self. In terms of the performed self, however, the husband is much more active. Refusing to answer the question is a powerful move in performative self-presentation: the husband displays that he is not someone that is controlled by the therapist.; he highlights his independence from the therapist. In this context it also can mean that he is not one who would be seeking help. Thereby he claims and demonstrates strong independence.

Extract 2, also shown above, involves identity construction that is very similar to that in Extract 1. Again, the husband declines to disclose more about his problems or the problems of the couple as he sees them, and thereby, he withholds further specification of his told self.

```
#2     (cited above/reduced)

01 T:  would you add something more apart from communication
02     (1.5)
03 H:  m:::::: no is this necessary
04     do you(f) think that it's necessary
05 T:  what do you(m) mean [that is necessary
06 H:                      [at this moment for me to
07     add something to ↑it
```

In terms of performed self, his counter question (lines 3-4) shows, like in Extract 2, that he (i) not controlled by the therapist. The specific context where the husband now claims independence is of importance: in line 01, the therapist is eliciting description of the couple's problems, as seen by the husband. By the very act of declining to answer, the husband conveys something about his relation to problems: as he has neither the need nor the will to specify problems, he also shows that he has not burning problems, at least such that could be dealt with here, in couple therapy.

In the cases shown above, the most intensive identity construction seems to take place in the performative rather than declarative field. Consider now extract 5 shown below, where the issues of told self are central. In the closer look, however, performative aspects of identity are equally important also here. Shortly before the exchange that is shown in Extract 4, the

[7]The distinction between "told" and "performed" self is linked to a question about the place of "content" or talk in CA. Although CA follows Wittgenstein's dictum that "the meaning of a word is its use in language" (Wittgenstein, 2002 [1953], p. 18), it also pursues the question, how a content is formulated, e.g., in the use of "membership categories" or in practices of "formulating" such as "formulating place" (Schegloff, 1972) or "formulating planes" (Goodwin and Goodwin, 1996).

In the cases shown above, the most intensive identity construction seems to take place in the performative rather than declarative field. Consider now extract 5 shown below, where the issues of told self are central. In the closer look, however, performative aspects of identity are equally important also here. Shortly before the exchange that is shown in Extract 4, the wife has complained about the husband's habit of smoking marijuana (data not shown). In Extract 5, the husband challenges this.

#5 My way of functioning

01 H: To nie jest taki problem że ja jaram zio↓ło
it is not a problem that i smoke we↓ed

02 to jest taki[problem że ona (.) ma (.) jakiś (.)
it is a [problem that she (.) has (.) some (.)
[husband indicating wife with his hand]

03 problem> w przetwarza[niu tej informa↓cji<
problem> in process[ing this informa↓tion<
[----------x *husband shakes his head in negation*

04 prawdopodobnie >[przez to że na początku< jak była
probably >[because at the beginning< when she
[---------- *[husband moves his hands aside and*

05 w tej ciąży
was in this pregnancy
---------- *alternately rhythmically lowering and raising them.*

06 właśnie y: zapadłem przez miesiąc y: w: w pro-(blem) w
just u: I fell for month u: in: in pro-(blem)
---------- *At the end he hits his knees three times with his*

07 nałóg
in addiction
----------x *hands]*

08 nie wiem >chyba tak to trzeba nazwać< .hh
I don't know >maybe this is how it should be named< .hh

09 (3.0)

10 T: trudno mi to roz[strzygnąć=
It's difficult for me to ju[dge=

The husband engages in a complex description of the couple's problem, whereby he also conveys a self-description. First, in line 01, he rejects the wife's problem attribution (data not shown), and then in lines 2–3 claims that the problem is in fact in the wife's inability to understand the smoking. While the wife's prior complaint ascribed an identity of "problem source" to the husband, he now makes a counter-ascription, claiming that the wife is the problem source. The husband continues his account by admitting that he has had an addiction. The admission is couched by minimizing devices, such as temporal reference (for a month) and relativizing the categorization "addiction" (*maybe this is how it should be named*). On the level of the told self, the husband thus builds an image of himself of a non-problematic marijuana user, mistreated and misunderstood by his wife—thus, as a victim rather than the evil-doer.

A few seconds later, the husband again makes moves that entail an identity of a victim. In response to what the therapist said at the end of the previous extract (line 4) about the difficulty for him to judge (whether husband's marihuana use was an addiction), both spouses assert that they don't expect the therapist to judge (data not shown). This prompts the therapist to ask what they think the therapy is about (line 16 below). The wife's answer is that they would learn to communicate (lines 16–17).

#5 ctd.

16 T: a o co
What about then

17 W: Y:: Chyba bardziej o to żeby jakoś nauczyć się komuniko↓wać
U: I guess more about that learn somehow to communi↓cate

18 (1.0) tak (.) tak [mi się wy↓daje
(1.0) this (.) this is [what I ↓think
[---------- spouses mutually gaze at each other

19 T: **[mmhm]**

20 H: zresztą [podejrzewam] że ty się [zgodzisz] też z tym co ja
anyway [I suspect] that you [agree] also with what I'm
->---x ->---x *[husband looks at wife]*

21 mówię że nie rozumiesz mojego sposobu fun[kcjonowania]
saying that you don't understand my way of fun[ctioning]
[wife nodded once] ->---x

22 to >może być tak że<=
and it >may be so that

23 W: =y:=

24 H: =że problem=
=that the problem=

25 W: =tak=
=yes=

26 H: =nie tkwi do końca we mnie tylko w tobie=
=is not after all in me but in you =
->----------->-

27 W: =y:=

28 H: =jest taka [op↑cja]
=is there an [opt↑ion] like that
->---x *[husband smiles while looking at wife]*

29 W: no y: nie do końca się zgadzam ale >rzeczywiście jest tak<
Well u: I don't agree entirely but >actually it is like that<

30 że (1.0) y mamy troszeczkę z mężem jak się okazało: y: inny
that (1.0) u we have slightly different >point of view on the

31 punkt >widzenia na świat< Y m: ja jestem osobą raczej religijną
world< with my husband u m: I'm a rather religious person

Rather than taking stance to W's suggestion, or in some other way dealing with the therapist's question, H returns to his earlier arguments, pointing out that W does not understand him (line 20) and that the problem is in W rather than in H (22–23, 25). Again, he assumes the identity of a victim.

As the told self that the husband claimed as being someone who was misunderstood by his spouse, not the source of the problems, but rather a victim of his wife's behavior, the performative identity looks rather different. The husband is engaged in a self-defense that he delivers in an agitated way, speaking quickly, in high pitch, and gesticulating brisky while he talks. He delivers his utterances in a self-initiatory way, and not as answers or other responses to the therapist's initiations. This sequential and topical control is most clearly to be seen in the latter part of extract 4, where the husband fails to respond to the therapist's question (l. 16) and W's answer to it (l. 17–18). Rather, he pursues his own self-initiatory agenda. And even more: he designs his (re-)definition of the couple's problem in lines 19–20, 22–23, 25 as a claim for the wife to agree with, thereby departing from the normative turn-taking system of couple therapy (where the therapist is the one who asks questions). By this self-initiatory action where he takes the first position in the sequential organization, the husband displays an identity. In

spite of the declarative claim of being a victim, his performance constitutes him as an independent actor.

Let us consider now another example where the told self is only the surface of the interaction, and yet identity work is equally done in terms of the performed self. We will return to extract 3 discussed above. At the beginning of the extract, the therapist is describing a "typical" way of experiencing problems in couples—seeing the problem in the other spouse—and then depicting the apparently better alternative in the "perspective of restoring" (l. 04–05) and joint care of the problems (line 05).

```
#3      (cited above/reduced)
01 T:   >it's always other person's problem .hh
02 W:   Indeed=
03 T:   =and not joint one and::
04      and I think that (.) restoring the perspective of (.)
05      this: ta:king care together of .hh problems
06      And it would be ↓something=
07 H:   =[mhm----------]
08 W:   =[It's not the case to] restore (.)
09      it's    [the case to] build it.
10 T:           [(building up)
11 W:   >You can't restore something=
12 T:   =mhm=
13 W:   =that has never ↓existed< .hh
```

While the husband in line 07 seems to at least minimally agree with the therapist's formulation of the alternative perspective, the wife in lines 08–09, 11, and 12 refutes it. The refutation has first a kind of positive edge in it, as she in line 09 talks about building up (something new) as an alternative to "restoring." However, as she continues her utterance (lines 11 and 12), she shifts the referential focus, and emphasises the negative, that there is nothing to restore. Thereby, she starts to build a told self for herself and the husband as an inherently unhappy couple. This building of the negative identity is intensified as the wife continues her talk:

```
#3      ctd.
14      In fact:: u:h (3.0) there's (.) more (.)
15      that   >separates us than connects<=
16 T:   =Aha=
17 W:   =>That's the truth<
18      .hh Totally different attitude  totally different psyche
19      totally different level of y:: experien↑cing totally different
20      view↑s=
21 T:   =Good=
22 W:   =for everyth↓ing
23 W:   And that's  for  me  [proble]matic
24 T:                        [Okay]
```

As we have shown above, with a list of descriptions employing extreme case formulations the wife in lines 14–24 depicts the couple as a lost case. Now if we turn to the performed self, a rather different picture emerges. As it was argued in the prior section, W takes in extract 5 the control of topic and control of sequence to herself. By changing the topical perspective (from expectation of restoration to lamentation of failure) and by moving from a responsive position prepared for her by the therapist, to the first position through her emotionally loaded self-disclosure, she displays interactional independence from the therapist. This independence is colored with what might be termed "passionate honesty," as the openly negative attributions for the couple shows.

In the beginning of this section, we made a distinction between told and performed self. The cases examined in this section showed that the *told* selfs claimed by the participants were rather variable: In extracts #1 and #2, the patient avoided identity avowal; in extract #5, the patient presented himself as a victim and located the problem in the spouse; whereas in extract #4, the patient actively assumed problems as part of the couple identity. While the picture of the told selfs was thus variable, the examination of performative selfs showed a more unified picture. In all cases shown above, the patients' performative selfs foregrounded their independence of the interaction at hand, and hence, of their interaction participants.

We suggest that this performative claim to independence is as important, if not more important, than the variable declarative claims, in the clients' identity work and self presentation in the first consultations. Furthermore, we suggest that the claim to interactional independence is strongly context dependent. Couple therapy consultation as a social situation involves a possibility of dependence: the couple is there to seek help. The local sequential contexts that we examined above involved more specific possibilities for dependence, especially when the spouse attributes problems to the client. Therefore, we suggest that the claims to independence are prompted by *risks of dependence,* emerging in the couple therapy interaction.

DISCUSSION

In this paper, we have described, using CA, three facets of interaction—sequence, topic, and identity construction—where narcissistic clients in our sample can be seen to exert interactional control. We observed,

(1) that in situations in which clients find themselves obliged to answer a personal question, they often resist and, by stepping out of the dependent sequential position, take control of the interaction engine;
(2) that in situations in which the consultation is about to turn up unfavorable and threatening subjects, clients often make steps to control and stipulate the direction of the therapeutic talk; and
(3) that in situations in which clients face the danger that their self-images may become precarious and form cracks, they take measures to maintain in their expressions and actions a presentation of themselves that foregrounds their independence.

The clients' controlling practices pose different challenges and difficulties for the couple therapists. There seem to be two key areas of the therapeutic work that these difficulties pertain to: the ability of disclosing weaknesses and personal problems and related to it establishing the therapeutic relationship.

The Problem of Establishing the Therapeutic Relationship

Bordin's classical concept of therapeutic alliance (Bordin, 1994) involves engagement in collaborative, aim oriented work, as well as developing reciprocal, interactive relationships. We suggest that the clients' display of independence can involve a major challenge for the development of the "micro-level" therapeutic collaboration.

One aspect of Brodin's theory concerns the working alliance. It means that building up an alliance is an active, sometimes

implicit process of negotiation that starts from the very beginning of treatment and is renegotiated in the course of the subsequent therapeutic sessions (Bordin, 1994; Hatcher and Barends, 2006). The practices of clients with narcissistic problems by which they deny interactional dependence and control the course of the encounter may block this "implicit process of negotiation." These practices very often induce—in the therapist as well as in the spouse—silence, hesitation markers, verbal disfluency, and other displays of momentary confusion, that can indicate micro-level difficulties with building up the "reciprocal, interactive collaboration" between all participants of couple therapy talk.

The other aspect of alliance, according to Bordin's theory, pertains to the affective bond. The clients' controlling practices may also be seen as blocking the evolvement of the affective bond between them and the therapist that is constituted by mutual dependence, and that contribute to the collaborative work. Through their controlling practices, the clients mark their own independence and authority, but at the same time they implicitly display their disregard for the therapist's face by correcting his/her vocabulary or by undermining his/her agenda.

Focusing on the development of the therapeutic alliance at the initial stages of treatment, Ronningstam (2012) suggests that narcissistic patients are prone to provoke and control the therapist, while Dimaggio et al. (2006) depict their tendency to power struggle. Our observations are in line with this, but our study furthermore shows that the very interactional organization of the first counseling session with its overall question–answer structure arrests the clients within a frame of (sequential) dependence that may add to their resistance and obstruction of the development of the alliance.

The Problem of Addressing and Disclosing Weakness

Resistance to disclosure of one's personal affairs tends to happen early in psychotherapy, mostly already during the first couple consultations. In disclosing the couple's problems, the spouses often locate the problem in the other spouse. They also take defensive positions while being described by their partner as the source of marital problems. Our study has shown that clients with narcissistic problems seem to use more specific strategies to thwart the disclosure of their personal problems. In our view, these practices can be traced back to the client's anticipation that uncontrolled topic talk, with its soft and inconspicuous transition from one subject to the next, may disclose weaknesses or flaws and is therefore perceived by clients as "risky."[8]

Clinical literature suggests that narcissistic individuals are particularly sensitive to threats to self-esteem (Freud, 1957). Higher rate of psychotherapy dropout among narcissistic patients has been understood as reflecting efforts to manage self-esteem (Ellison et al., 2013). It is in line with classical observations of Abraham (1927, orig. 1919) who described the tendency of narcissistic patients to actively disrupt interventions that threaten their grandiose self-image.

The risks that a client may anticipate concern his/her self image and can arise from three intertwined contingencies. To begin with, the therapist, based on his/her institutional authority, is entitled to define the conditions of talking and to ask personal questions—an asymmetry that clients with narcissistic problems can perceive as a threat of their independence. Second, the spouse can be an additional source of threat for the client's face as he/she is witnessing how he/she talks about their marital situation; he/she is also a witness of the therapist's comments and may furthermore build a temporary coalition with the therapist (Janusz et al., 2021). Third, as we have shown, a client may perceive the unrestrained topical flow of the therapeutic talk as threatening since it could lead to statements or stories revealing about his/her problems or weaknesses.

The co-occurrence of the risks to self and the controlling activities in our data may be interpreted in light of the classical clinical debate regarding vulnerability and grandiosity in narcissism. Grandiosity manifests itself in therapeutic sessions seldomly as "grand grandiosity," i.e., as boasting and bragging, but more often as display of momentary superiority and interactional dominance. Exercising control is one of the forms in which "small grandiosity" may appear; the one who is in control can bask in his/her supposed admirability. Kohut (1971); Kernberg (1975), and Levy et al. (2007, 2011) suggested that in narcissistic patients, the grandiose mental states oscillate or even co-occur with vulnerable mental states. On the basis of empirical studies, other authors (Cain et al., 2008; Pincus and Lukowitzsky, 2010) have pointed out that there are particular social contexts that intensify the duality between grandiosity and vulnerability, resulting in self-esteem dysregulation. First session in couple therapy might be one such context.

The dialectics of risks to the self and controlling activities are not something that we would expect to find only in the environment of couple therapy and with narcissistic persons. Goffman (1955) suggested that all interactions bring about risks to the participants' selves, and that such risks are normally responded to through corrective work—face work—to restore the threatened selves. Couple therapy with narcissistic patients can be taken, therefore, as a "prism" that makes particularly salient and noticeable dynamics of self in social interaction, that are there in all social encounters.

Limitations of the Study and Suggestions for Future Research

It can be argued that couple therapy first consultations are awkward if not threatening to all patients, not only narcissistic ones. Clinical experience suggests that the first consultation is particularly menacing for narcissistic patients. Yet, further systematic studies comparing narcissistic and non-narcissistic patients are necessary. An additional study would be most interesting in which first and later consultations are compared with regard to the question whether clients with narcissistic

[8] We want to stress that our notion of "anticipation" is not cognitivistic, but refers to the interactants' expectations and perceptions of the future which is one of the "contexts" to which they are oriented in their actions; see the early paper of Drew (1995) on "anticipatory interactional planning" or Streeck and Jordan (2009) on the "forward-looking nature of embodied communication."

problems continue with their controlling practices or learn to let go and loosen their defensive habit.

A further line of research that we were unable to pursue arises directly from the constellation of couple therapy. Though we identified the controlling practices of narcissistic clients as interactional maneuvers, we did not take the triadic structure of the couple therapy interaction systematically into account. In most cases, our focus was on the interaction between the therapist and one spouse, rather than on the triad. But the simultaneous presence of therapist and intimate partner in which always one of them is the addressee whereas the other is the passive listener, is certainly relevant with regard to the practices of presenting, and sustaining to display, a coherent ideal self image. Research on the ways in which controlling practices affect triadic therapy constellations and are affected by it would be a necessary and most intriguing complement of our study.

A critical issue lingering through our entire text pertains to the question how statements about the interactional realm (controlling behaviors, interactional risks) can be linked to statements about the internal realm (personality related dispositions, perceptions of the risks for the self, narcissism). This is a big and not least philosophical issue and can, of course, not be tackled in a single—and moreover empirical—study. In our study we have proceeded under the assumption, which is a principal methodological presupposition in CA, that no one can look behind the forehead of another person and therefore the other's mind is for no one directly accessible.[9] On the other hand, in the everyday world we are able to "see" the intentions of others, to "read" their minds, since we have no other choice than to equip their behavior with meaning[10]. In that sense, the mind of others is "transparent" for us (Coulter, 1977). Ethnomethodological and conversation analytic studies deal with "cognitive" issues such as expectations, memory, or perception, but these issues are always and only dealt with as observable activities. Along this line we approached "narcissism" as an object that is accomplished and realized in and through interaction. This in accordance with more recent psychological theories (Hopwood, 2018; Livesley, 2018) in which it is argued that personality disorders cannot be conceptualized as an intrapersonal feature only, but must also be seen as a phenomenon in the interpersonal context. Yet, we also acknowledge that mind, as a subjective experience that emerges in interactional contexts, is real and relevant for the understanding of personality disorders. Based on our co-constructive view on personality disorders, two questions arise that might be topics for future studies.

The diagnosis of "narcissism" (or any other personality disorder) is the final outcome of a series of tests, interviews, and other assessment procedures through which professionals are able to identify and "read" observable interactional events as "signs" or "evidence" of an unobservable intrapersonal condition, i.e., as a symptom of a hidden pathological disposition (Bergmann, 2017). On the other hand, laypersons observe each other in all interactions, also making some kind of colloquial personality assessment. Little is known about the question how the mode of professional diagnosing and the mode of lay assessing are related to each other. A study is needed in which the divergent logics of psychological assessment in lay and professional contexts are laid out and reconstructed.

A second, parallel study would be necessary in order to shed light on the respective epistemic status of the peculiarity/impairment that occasioned the demand for psychotherapeutic help. Usually, the professional program of testing and probing leads to a diagnostic category in which the contributions of the test procedures and of the social interaction with the test personnel has vanished. The problem is objectified and ascribed to an internal malfunctioning, with the result that the client now appears as the sole responsible carrier of an illness. A challenge—for clinicians and researchers alike—is to understand "personality disorder" as not a fixed internal trait, but as patterns of contextual interaction triggered by specifiable interactional conditions.

Implications for Practice

The couple therapy meetings with patients who have narcissistic problems pose specific challenges for the therapist. Addressing the client's personal affairs, problems, and vulnerability may be perceived as threatening and may lead directly to resistance and to obstructive, non-cooperative responses. But addressing the client's practices of interactional control and marking of independence may trigger balking and competitive reactions. A lesson that can be taken from our study is that in our view it is advisable for therapists, working with a client who shows narcissistic problems, to organize the first couple therapy session in an unobtrusive mode and to exercise their institutional authority in a weakened manner for the moment being. This "open" interactional strategy may, of course, also be perceived as threatening (as we have shown in section "Controlling the Sequential Position"), but it increases the chances that the client by him-/herself will find ways of cautious participation that can in the further process develop into more unrestricted and non-controlling co-operation.

Another challenge in couple therapy with clients having narcissistic problems lies in therapists experiencing confusion, having the feeling that it is difficult to work with these clients. The therapists may not be able to pinpoint the practices generating this impression. The results of our study should enable therapists to disentangle their intuitive understanding, i.e., to discern and identify in the course of interaction itself, the activities and phenomena that cause their uneasiness. Knowledge about the

[9] A famous statement of Garfinkel (1963, p. 190), that became a cornerstone of ethnomethodology's self-conception, is: "There is no reason to look under the skull since nothing of interest is to be found there but brains."

[10] With regard to the strangeness of others, Husserl (1960, p. 114) spoke of the "verifiable accessibility of what is not originally accessible." Recent heated debates about "epistemics" between ethnomethodologists and conversation analysts show that there is much room for divergent understandings of such a perspective; see the discussions in the journal "Discourse Studies" 2013 and 2016.

controlling practices of clients with narcissistic problems will help therapists to work with their own internal and interactional responses. Thereby, they may become able to better regulate their own input to the problematic interactions.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Bioethics Committee of Collegium Medicum at Jagiellonian University. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

All authors listed have made a substantial, direct and intellectual contribution to the work, and approved it for publication.

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APPENDIX

TABLE TA1 | Transcription symbols.

Symbol	Meaning
T/W/H:	Speaker identification: therapist (T), wife (W), husband (H)
you[f] or [m]	Second person singular pronoun f-feminine or m-masculine
[ ]	Overlapping talk. overlapping non-verbal activities
(.)	A pause of less than 0.2 s
(0.0)	Pause: silence measured in seconds and tenths of a second
( )	Authors' comments
-> —x	The beginning and the end of the non-verbal activity
(( ))	Non-verbal activities
°word°	Talk lower volume than the surrounding talk
WORD	Talk louder volume than the surrounding talk
.hh	An in breath
hh	An out breath
£word£	Spoken in a smiley voice
@word@	Spoken in an animated voice
#word#	Spoken in a creaky voice
wo(h)rd	Laugh particle inserted within a word
w_o_rd	Accented sound
wo-	Abrupt cut-off of preceding sound
wo:rd	Lengthening of a sound
>word<	Talk faster than the surrounding talk
↑↓	Rise or fall in pitch
nod/A	Person marked as A is nodding
g/A (B)	Person marked as A is gazing at person marked as B

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Safeguarding the Therapeutic Alliance: Managing Disaffiliation in the Course of Work With Psychotherapeutic Projects

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Therapeutic alliance is a central concept in psychotherapeutic work. The relationship between the therapist and the patient plays an important role in the therapeutic process and outcome. In this article, we investigate how therapists work with disaffiliation resulting from enduring disagreement while maintaining an orientation to the psychotherapeutic project at hand. Data come from a total of 18 sessions of two dyads undergoing psychoanalytic psychotherapy and is analyzed with conversation analysis. We found that collaborative moves deployed amidst enduring disagreement can assist the therapist in furthering the disagreement as part of the ongoing psychotherapeutic project. Relying on their collaborative format, therapists utilize collaborative moves to temporarily mend the disaffiliation without necessarily changing their position and re-affiliating with the patient. We show how the relation between the therapist and the patient gets transformed in the moment-by-moment work accomplished in the psychotherapeutic talk.

Keywords: therapeutic alliance, disaffiliation, disagreement, psychotherapeutic project, collaborative move

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INTRODUCTION

In conversation analytic studies, the term affiliation is used to describe actions with which a recipient displays that s/he supports the affective stance of the speaker (Lindström and Sorjonen, 2013) or, as Jefferson (2002) put it, that s/he is on the same side with the speaker. An affiliative action is exemplified in the following spate of talk, where recipient (J) affiliates with speaker (M) by strongly agreeing with the latter's assessment.

(0) American English conversation (Pomerantz, 1984: 66, In Lindström and Sorjonen, 2013: 354).

```
01  M  You must admit it was fun the night we we[nt down
02  J ->                                          [It was great fun...
```

Because of their supportive nature, affiliative actions have a pro-social character (Stivers et al., 2011) and foster social solidarity (Lindström and Sorjonen, 2013).

In a well-known study on storytelling, Stivers (2008: 37) showed how recipients affiliate with the storyteller through responses that support and endorse the teller's stance, where stance means "the teller's affective treatment of the events s/he is describing." In a similar vein, Heritage (2011) investigated recipients' responses to their co-participant's telling of a personal experience and showed how emotional first-hand experiences invite others to produce an evaluation by affirming its meaning and nature, thus affiliating with the teller's stance toward the experience. The affiliative strength of the response, he argued, is determined by the capacity of the response type to convey that the recipient is tuning in to the experience and one way to do it is by actively participating in its articulation. These findings shed light on how being "with" someone requires not only sharing the same epistemic stance on their personal experiences but also endorsing the displayed affect and emotion (Peräkylä and Sorjonen, 2012; Ruusuvuori, 2013).

In their review on affiliation in conversation, Lindström and Sorjonen (2013) argued that context can play a crucial role in shaping and constraining affiliative displays, distinguishing between ordinary and institutional encounters where affiliation can have diverse relevancies. For example, Ruusuvuori (2005) investigated trouble-telling sequences in healthcare consultations and found a very different pattern compared to ordinary conversation. In her study, the majority of professionals displayed no affiliation to troubles-telling patients and, when they did, they prioritized the patient by focusing on his/her experience, without disclosing their own.

In psychotherapy, affiliation has been investigated as a responsive action by the therapist endorsing the preferences realized in the client's prior utterance (Muntigl et al., 2013). Focusing on relational stresses in Emotion-focused Therapy (Greenberg et al., 1993; Greenberg, 2002), Muntigl and Horvath (2014) found that in order to re-affiliate, the therapist retreats from his/her position and joins with the client's position brought up in his/her disaffiliative response. Re-affiliation, they observed, can be achieved both verbally (by utilization of discursive markers of agreement or formulations) and non-verbally (nodding). Prosody is another important means to achieve affiliation. In a study on the prosodic aspects of therapists' empathic communication, Weiste and Peräkylä (2014) showed how therapists' formulations of clients' descriptions of emotions can lead up to two different trajectories of interaction: one validating the client's emotional description and the other evaluating and challenging it. The difference, they found, lies in the prosodic features of the formulation, with the validating trajectory characterized by prosodic continuity whereas the challenging trajectory characterized by prosodic disjuncture.

Antaki (2008: 27) defined formulations as the most (ostensibly) cooperative practice used by therapists to "display their grasp of, and present an alternative to, the client's accounts of their experiences." Visualizing the therapist's practices in a descending gradient from more combative to more cooperative moves (**Figure 1**), he placed formulations at the *more cooperative* end of the slope, where *cooperative* refers to practices that are designed in such a way that shows that the therapist is cooperatively following the line of the client's account (Ibid., 30). Other cooperative/collaborative[1] practices investigated in conversation analytic studies include extensions and collaborative completions. Similar to formulations, extensions are a powerful means to display intersubjectivity (Vehviläinen, 2003). Therapists can use extensions as a way to show to the patient that they hear and understand what s/he is saying (Sacks, 1992: 58). In conversation analytic studies of mundane interaction, collaborative completions are a third practice where speakers construct the turn collaboratively, with the subsequent speaker pre-emptying completion of the previous speaker's turn constructional unit (Sacks et al., 1974). Other less affiliative actions are interpretations, corrections and challenges (Antaki, 2008).

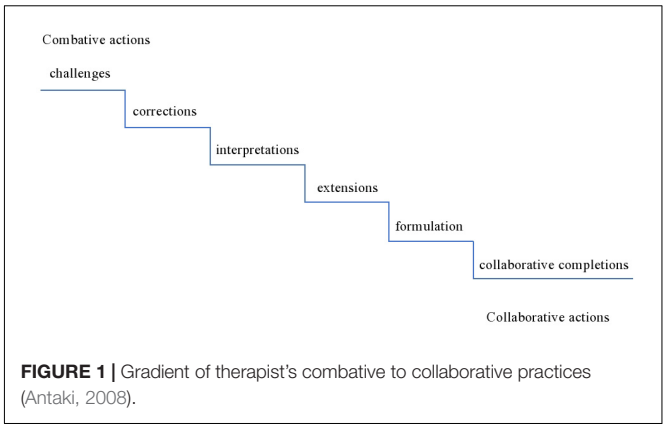

FIGURE 1 | Gradient of therapist's combative to collaborative practices (Antaki, 2008).

Therapists use both supporting and challenging actions to assist the patient in moving forward from the current capacity to accommodate innovative moments or new experiences to a potential greater capacity (Ribeiro et al., 2013). While supporting actions confirm and validate the client's experience, challenging actions move beyond client's maladaptive self-narratives. In their work, therapists make moment-by-moment decisions on how to guide the clients to perceive alternative perspectives (Greenberg and Safran, 1987; Lomas, 1987; Ribeiro et al., 2013). This moment-by-moment work transpires in therapeutic projects, defined as "interactional projects[2] with accompanying therapeutic aims" (Peräkylä, 2019: 273).

For the successful implementation of a therapeutic project, it is important that the patient goes along the therapist's suggested interactional direction (Schegloff, 2007). Patients can put the therapeutic alliance at risk in a number of ways. For example, they can misalign with the therapist's interactional project by steering the interaction in diverging directions (Voutilainen et al., 2010) or disaffiliate with the therapist by not endorsing his/her understanding of the client's situation (Muntigl and Horvath, 2014; Muntigl, 2020). Likewise, therapists

[1]In conversation analytic literature, the terms *cooperative* and *collaborative* are used interchangeably. To avoid confusion, from here on in the text we will use the term *collaborative*.

[2]Schegloff (2007: 244) defined interactional project as "a course of conduct being developed over a span of time (not necessarily in consecutive sequences) to which co-participants may become sensitive, which may begin to inform their inspection of any next sequence start to see whether or how it relates to the suspected project, theme, stance, etc."

might also undermine the therapeutic alliance and disaffiliate with the client by not responding empathically to the client's prior talk (Muntigl and Horvath, 2014) or by challenging her/him with strong oppositional statements displaying unsupportive disagreement. Weiste (2015) defined the latter as therapists maintaining their divergent perspectives, disregarding the clients' claim as unrealistic and claiming privileged access to the clients' domain of knowledge. In response to unsupportive disagreement, clients react with irritation and anger. Such ruptures put the accomplishment of the therapeutic project at risk by straining the therapeutic relation.

Ruptures can however be worked through in a number of ways. One way for therapists to mend a rupture is by displaying supportive disagreement. Weiste (2015) showed how, in psychoanalysis and cognitive psychotherapies, therapist's supportive disagreement implies work at finding congruence with the client's perspective, validating the client's emotional experience, and respecting his/her epistemic primacy. Such supportive disagreement, in turn, prompts clients to confirm and elaborate their experience. In a similar context of disagreement, Muntigl et al. (2013) found that in Emotion-focused therapy, talk is organized in such a way that therapists maintain affiliation by neutralizing potential conflict and preserve client's epistemic primacy or experience by privileging their viewpoint. As these findings show, the relevancies and displays of affiliation vary not only among the different contexts in which the interaction occurs, but also within various approaches to one type of institutional context, being psychotherapy.

While it is widely accepted that the role of the therapeutic bond is central to the psychotherapeutic process and positive outcomes (Horvath and Bedi, 2002; Orlinski et al., 2003), how this bond is formed and maintained at the interactional level remains understudied (Lepper and Mergenthaler, 2007). In psychoanalysis, Loewald (1960: 16) proposed that it is the significant interactions between patient and analyst which ultimately lead to structural changes in the patient's personality. The aim of this study is to enhance our understanding of how participants orient to the therapeutic relation during the moment by moment unfolding of the therapeutic work. To this end, we focus on one particular psychotherapeutic approach, being psychoanalytic psychotherapy, and investigate how therapists work with disaffiliation resulting from enduring disagreement. The focus of our work is twofold: (a) to describe how therapists deploy collaborative moves amidst enduring disagreement as part of their work with the therapeutic relation; and (b) to show how these collaborative moves while aiming to soothe disaffiliation, are not necessarily affiliative in nature and do not indicate re-affiliation on behalf of the therapist. In this way, we show how therapists seek to maintain the therapeutic alliance at a safe place by not necessarily being always on the same side with the patient.

DATA AND METHOD

Data come from a total of 18 sessions of two dyads undergoing psychoanalytic psychotherapy. The first dyad (10 sessions) is at the end of their second year of the psychoanalytic process. The therapist is a woman in her early forties and the patient a man in his late twenties. The second dyad (8 sessions) is at the very beginning of the psychoanalytic process. The therapist is a woman in her late twenties and the patient is a woman in her mid-thirties. Each session lasts 50 min, amounting to a total of 15 hours of interaction. We video recorded the sessions during 2016-2017 and obtained informed consent from both therapists and patients. No statement of the ethics of the research design was requested from the University of Helsinki Ethical Review Board in the Humanities and Social and Behavioral Sciences as the study does not meet the requirements specified by the Finnish National Board on Research Integrity on ethics approval. All names and other identification potential details in the data extracts are altered.

It is worth mentioning here that in Albania, it is common practice that, in psychoanalysis, the patient sits (instead of lying down) in a 45-degree angle with the therapist. Another difference with the traditional psychoanalytic practice regards the frequency of the meetings, with the first dyad meeting every other week, whereas the second every week. To distinguish between conventional psychoanalysis and its adjusted format, we refer to the practice in our data as *psychoanalytic psychotherapy*.

Data was analyzed with conversation analysis (CA). As a first step in the analytic procedure, the recordings were listened to a number of times. We first collected all the instances in which the therapist deploys a collaborative move – a total of 117 (56 from the first dyad and 61 from the second one). We identified *collaborative moves* based on Antaki's (2008) gradient of therapist's more combative to more collaborative practices, with the more collaborative including practices used to display that the therapist is collaboratively following the line of the patient's account. These practices included:

(1) *Collaborative completions* (16) defined as the pre-emptive completion of one speaker's turn constructional unit by a subsequent speaker (Sacks et al., 1974); they can be produced as an affiliating utterance, built as a continuation of the turn-in-progress and as a completion of that turn (Lerner, 1991).
(2) *Formulations* (11) defined by Heritage and Watson (1979, 1980) as actions that propose a version of events following the previous speaker's own account but introduce a transformation.
(3) *Extensions* (5) referring to a speaker extending the previous speaker's turn as a way to promote a further account of what the patient is saying (Vehviläinen, 2003).

As the therapist's actions are more combative or more collaborative in their format and not necessarily in their local force (Antaki, 2008: 27), next we focused on the interactional environment in which these moves are deployed. In a second revision, we regrouped the therapist's collaborative moves based on the type of environment in which they were deployed, focusing mainly on the ones deployed amidst environments of disagreement – a total of 32 (22 from the first dyad and 10 from the second one). We considered disagreement to be a significant environment for the

therapeutic relation as it fosters disaffiliation and can impede the implementation of the therapist's interactional project at hand.

Next, we demarcated the stretch of talk within which the collaborative move occurs, starting from the moment when the disagreement between the therapist and the patient first emerges, following its escalation until the deployment of the collaborative move by the therapist, up to the therapist's restating her position on the issue at stake. These stretches of talk were then transcribed using CA transcription conventions (Jefferson, 2004). Our analysis focused on the sequential function that collaborative moves play in managing disaffiliation.

THERAPIST'S UTILIZATION OF COLLABORATIVE MOVES

We found that one way for therapists to foster the ongoing affiliation with the patient is to make use of a collaborative move. On the other hand, when deployed amidst disagreement, a collaborative move can be used to soothe the disaffiliation. In this section we show four instances where therapists deploy a collaborative move to either foster the ongoing affiliation or soothe the disaffiliation resulting from enduring disagreement.

Collaborative Move Deployed Amidst Affiliation

One type of environment in which the therapist deploys a collaborative move is when she and the patient are affiliated, meaning they share the same affective stance with regards to what they have been talking about so far. Such a move can foster the ongoing affiliation which in turn, with the therapeutic relation being at a safe place, allows the therapist to advance the interactional project. The following talk is an example of one such use of a collaborative move (indicated in all extracts with an arrow). It is extracted from a mid-session section of dyad I. The patient is talking about his recent plans to start a new music band. Toward the end of a story telling sequence on his previous bands, the patient mentions the name of his second band, "blind spot." Extract I shows what happens next.

Extract I. SIV "tërheqës" [18:13 - 18:58]

```
01 T si e ka pas titullin grupi? blind? s[po::t?]
     what was the band's name? blind? s[po::t?]
02 P                                    [blind] spot. [po.]
                                        [blind] spot. [yes.]
03 T                                                  [mhm.]
04 (1.0)
05 P ((gëlltitet)) #ky:# i dyti që
     ((swallows)) #thi:s# second one that
06 T po,
     yes,
07 P që kam pasur (>°domethën°<) i pari e ka pasur analgesics
     that I've had (>°I mean°<) the first was called analgesics
08   me këta që (0.4) e nisëm nga zero °që°
     with these that (0.4) we started from zero °that°
09 T mhm, analgesics.
     mhm, analgesics.
10 P po.
     yes.
11 (0.5)
12 T £okej,£
     £okay,£
13 P kshu. [emrin e::]
     so. [the name of::]
14 T       [kush i vinte] emr(he)at=.hh=hehehe
           [who picked] the na(he)mes=.hh=hehehe
15 P emrat nga këngë janë m(he)arrë dome[thënë faktikisht po,]
     the names they a(he)re from songs I me[an actually but,]
16 T                                    [A:: janë nga këngë.] okej.
                                        [Aha:: they are from songs.] okay.
17 P ë::,
     u::hm,
```

(Continued)

Extract I. Continued

```
18 (2.5)
19 P  ësht- (.) domethënë analgesics është marrë nga një këngë e Kora Lou,
      it's- (.) I mean analgesics is from a song by Kora Lou,
20    (0.5) blind spot është marrë nga një këngë e Noah domethënë [janë marrë] kshu thjesh::
      (0.5) blind spot is from a song by Noah I mean [they are] from like just::
21 T                                                              [°ëhë°]
                                                                  [°ehe°]
22 P  (0.4) >°ku di unë,°<
      (0.4) >°I don't know,°<
23 (1.0)
24 T  °ëhë°=
      °ehe°=
25 P  =ë:: (0.6) thjesht duke u përpjek me i gjet një emër domethënë
                 just    -ing try       to find   a   name meaning
      =u::hm (0.6) just trying to find a name I mean
26    që   të ishte njëçik   kshu
      that to be    a little like
      that was a little like
27 (1.2)
28 → T  [tërheqës.]
         attractive
        [attractive.]
29 P    [edhe::] (0.5) #e# tërheqës   domethënë [është] ajo  ideja që
         and           -  attractive  meaning    is     that idea  that
        [a::nd] (0.5) #yeah# attractive I mean [the] idea is that
30 T                                           [°mh,°]
31 (3.5)
32 P  °po:,°
      °bu:t,°
33 (2.5)
34 T  nëse do- (.) krijoni një grup tjetër si do ia vije emrin?
      if you will- (.) create another band how would you call it?
```

In the beginning of the extract, the therapist topicalizes the band name, expanding the sequence by means of a repair initiation (line 1). The patient accepts the shift in focus of talk and grants the information requested (line 2) but soon after goes back to the story of his first band "with these that we started from zero" (lines 7-8), orienting to his previous elaboration as in need of an uptake by the therapist. The latter, however, pursues her interactional project, being exploration of the new topic (band names) by first recycling the name of the band (line 9), followed by another inquiry into the authors of the names (line 14). The therapist's talk is produced in smiley voice, culminating in laughter, conveying a sympathetic stance toward the band names. In response, the patient aligns by granting the information required (lines 15, 19-20) and also affiliates with the therapist by partaking in the amusement through shared smiles and laughter (lines 12, 14, and 15).

In line 21, by means of a continuer (Schegloff, 1982) produced immediately following a transition relevant place (Schegloff, 2007), the therapist invites the patient to continue talking. The patient, however, displays difficulties in completing his turn (notice the extended sound in "just:" at the end of line 20; the short 0.4 s pause and the filler "I don't know" produced in increased speed and low volume in line 22; the gap in line 23; all these accompanied by a hand gesture indicating word searching). In response, the therapist produces another continuer (line 24), this time orienting to the patient's turn as incomplete by declining a relevant uptake following the gap in line 23. The patient picks up his account by recycling the last word "just" in the beginning of the turn, making a second attempt at completing it (lines 25-26: *= u:hm (0.6) just trying to find a name I mean that was a little like*). Similar difficulties are displayed here as well, when in the beginning of the turn he produces a prolonged filler "u:hm," followed by a 0.6 s long pause; another filler "I mean" at the end of the utterance; and a 1.2 s long gap (line 27). Also, a similar hand gesture indicating word searching accompanies the difficulties in producing the talk.

In response to the patient's displayed difficulties, the therapist "helps out" the patient by completing his turn (line 28: *[attractive.]*). She provides a candidate word which the patient displays difficulties in producing. While the patient orients to his previous turn as complete (see how line 29 starts with "and": *[a:nd] (0.5) #yeah# attractive I mean [the] idea*

is that), the therapist, on the other hand, orients to it as incomplete. By means of a "helpful utterance completion" (Ferrara, 1994) she supplies a candidate word which qualifies the band names and completes the patient's turn. The patient confirms by producing first a minimal agreement token "yeah," next a repetition of the word "attractive" (line 29). In addition to offering lexical help, the therapist explicates content at risk of being left unsaid by the patient (Koivisto and Voutilainen, 2016). This content is of relevance to her interactional project of exploring the band names, which she has explicitly pursued thus far in the talk and will continue to do so (line 34). Lastly, the content at stake matches with her previously displayed sympathetic stance toward the names of the bands, now explicitly referring to them as "attractive."

Collaborative Move Deployed Amidst Disaffiliation

Advancing an interactional project might not always be an easy task for the therapist. Disaffiliation resulting from enduring disagreement is one type of environment in which the therapist and the patient share different affective stances with regards to a topic of talk. As the following analysis of extracts II and III will reveal, deployment of a collaborative move amidst such an environment aims at soothing the disaffiliation which in turn, with the therapeutic relation being temporarily restored, allows the therapist to advance the interactional project at hand.

Collaborative Move Deployed Amidst Covert Disagreement

The following extract is from the same dyad (I). The therapist and the patient are talking about the patient's need for therapy. In the beginning of the session, the patient tells at length about his recent engagements with a series of new activities, depicting himself as open minded, willing to take up new challenges, open to new experiences, in short, a person of many talents. In response, the therapist questions his need for therapy. The patient does not answer the question, in its place attributing the recent positive changes in his behavior to therapy. The talk in extract II (a) below shows what happens next, when the therapist pursues her interactional project, inviting the patient once more to elaborate on his need for therapy. Here we see how, despite the patient's alignment with the therapist's project, the therapeutic relation is nevertheless put at risk as an ostensibly long-standing disagreement resurfaces, conducing to disaffiliation. In what follows, we first show how the disagreement transpires (extract II a), next how the therapist attempts at soothing the disaffiliation by deploying a collaborative move (extract II b).

Extract II (a). SV "është koha jote" [17:00 - 17:50]

```
01 T .hh po përsa [i përket] nevojës për terapi [që ka qenë] gjithmonë pyetja ime
     .hh what about the need for therapy [which has] always been my question
02 P              [°m°]                          [°mhm°]
03 T [£e] e herëpashershme£
     [£from] time to time£
04 P [po  po] e  di
     [yes yes] I know
05   (3.3)
06 T ↑si  e  shikon tani.
     ↑how do you see it now.
07   (0.5)
08 T në kt- në ktë moment=
     in thi- in this moment=
09 P =°mhm°
10   (2.4)
11 P n:uk është e nevojshme e nevojshme në kuptimin (.) ku di unë=
     it:'s not necessary necessary in the sense (.) I don't know=
12 T =mhm=
13 P =të pasurit ndonjë nevojë imediate ose ndonjë gjë
     =having any immediate need or anything
14   (0.8)
15 T imediate nuk ka qenë as në fillim
     it was not immediate in the beginning neither
16 P jo as ↑në fillim mund të ketë qenë pak më kshu domethënë po::
     no neither ↑in the beginning it might have been more like I mean bu::t
17   (2.0)
18 P m:: imediate mund në kuptimin që okej (0.5) #e# atëherë e ndiej që kam pasur
     erm:: immediate might in the sense that okay (0.5) #urm# at the time I feel that I
```

(Continued)

Extract II (a). Continued

19 nevojë domethënë [po që]
needed it I mean [but]
20 T **[mhm,]**
21 (0.6)
22 P tani e kam kshu ((luan me duart)) °ku di un°
now it's like ((plays with his hands)) °I don't know°
23 (3.3)
24 P s'është se kam nevojë më tepër më pëlqe:n,
it's not that I need it it's more like I li:ke it,
25 (0.5)
26 T **[mhm]**
27 P [do thoja] sesa (0.5) nevojë domethënë që ku di unë
[I would say] more than (0.5) a need I mean that I don't know

The talk above reveals that the patient's need for therapy is a recurrent topic among this dyad: the therapist accounts for her turn as having "always been [her] question" (line 1), and the patient in line 2 first acknowledges it (Goodwin, 1980; Jefferson, 1983), then explicitly confirms it (line 4). Moreover, this topic seems to be an issue of long-standing dispute as the therapist and the patient orient to each other's stances as conveying opposite viewpoints. In the beginning of the extract, the therapist questions the patient's need for therapy and invites him to elaborate on the topic (lines 1, 2, 6, and 8) [this is the therapist's second attempt, the first one - not shown here - occurring right before the above stretch of talk]. The patient indicates that he understands the question (see the acknowledgment tokens in lines 2 and 4, and also the confirmation in line 4) yet delays the response for quite some time (see the gaps in lines 5, 7, and 10). The dispreferred response (Schegloff, 2007) is then designed in such a way that by mitigating his need for therapy ("not necessary;" "not immediate"), the patient avoids both claiming that he needs therapy which would be in open disagreement with the therapist but also that he doesn't need it which would be incongruent with his own stance (lines 11 and 13).

Despite the patient's interactional work to avoid overt disagreement, the therapist does not endorse his stance. What is more, she openly confronts him by rejecting his claim as incorrect (line 15). The patient responds immediately with a *pro forma* answer which soon transforms into a mitigated response (lines 16, 18-19), displaying a clear orientation toward avoidance of overt disagreement. In response to the therapist's continuous lack of endorsement of the patient's stance (see the gap in line 23), the latter proceeds with a new claim, being that it is not out of need but rather "it's more like [he] likes it" (line 24) that he comes to therapy, conveying thus lack of willingness to bring the therapeutic process to an end, a natural implication of admitting that he has no need for therapy.

In the next approximately 1.5 min, the patient accounts for what he finds beneficial and enjoyable in therapy, concluding that although it is not necessary, he would nevertheless like to continue with it [data not shown here]. This final remark produced right before extract II (b) reveals that the disagreement concerns the broader implication of the need for therapy, being the patient's continuation of therapy, which he seems to be in favor of. While the patient indicates that he has not changed his stance, there is no indication of the therapist having changed hers either, the disagreement remaining thus pending in the air as they enter the ensuing talk. The therapist's collaborative move under scrutiny here transpires amidst such moment of enduring disaffiliation. Its local function, as the analysis will reveal, is to soothe the disaffiliation so that the therapist can proceed with the interactional project at hand.

Extract II (b). SV "është koha jote" [19:32 - 20:40]

01 T mcht .hh #ë::#
mcht .hh #u::hm#
02 (2.5)
03 T <plotëson një lloj kënaqësie?> do të thuash në qoftë se nuk është
<it fulfils some sort of pleasure?> you mean if it's not
04 një nevojë po mbase jep një lloj kënaqësie?
a need but perhaps gives some sort of pleasure?
05 P Po, (.) po. jep një lloj kënaqësie °dome[thënë°]=[ësh:]
Yes, (.) yes. it gives some sort of pleasure °I me[an°]=it's:
06 T [mhm,]
07 (0.4)

(Continued)

Extract II (b). Continued

```
08 T çfar? është ajo që të jep kënaqësi në qoftë se
     what? is it that gives you pleasure if
09   mundemi që t- (0.4) [të shkojmë] pak më:: (0.6) .hh (0.6)
     we can (0.4) [go] a little mo::re (0.6) .hh (0.6)
10 P                     [mhm,]
11 T m::: më:: më në [detaj]ose më në:: #m:::# në të kuptuarit
     m:: mo::re more in [detail] or more i::n #m:::# in understanding
12 P                     [mhm,]
13 T e  kësaj. gjëje
     of this. thing
14 (1.0)
15 P e para ësh ajo që   domethënë ësh (0.6) [ora ime=]
     first  is  it  that meaning   is         hour my
     first of all it's I mean it's (0.6) [my hour=]
16 → T                                       [=është] koha jo[te.]
                                               is     time your
                                             [=it's] your ti[me.]
17 P                                                    [po.] ësht (0.4)
                                                         yes  is
                                                        [yes.] it's (0.4)
18 T mh[m,]
19 P   [një] kshu,
        a    such
       [a] like,
20 (1.5)
21 P m:: nuk e di:: është ajo ideja domethënë që ph:: si të thush (0.5)
     uhm:: I don't kno::w the idea is that I mean ph:: how do I put it (0.5)
22   edhe kjo pjesa që ëm (0.5) edhe (.) të njohurit e vetes nuk është
     also this part that uhm (0.5) also (.) knowing one's self it has
23   se ka ndonjëherë fund domethënë [edhe,]
     no ending I mean [and,]
24 T                                [mhm,]
25 (2.0)
26 P qoftë edhe me   raste kur ku di unë mund (.) mund të më duket
     also when I don't know I might (.) it might seem
27   edhe:: (1.7) ë:: stanjante domethënë shum,
     even (1.7) u::hm stagnant I mean very,
28 (1.0)
29 T mhm,
30 P pa ndonjë ecuri të madhe prap- (.) domethënë kur reflektoj,
     no significant progress yet- (.) I mean when I reflect
31   e shoh që okej diçka e mësova sidoqë të ishte puna domethënë
     I see that okay I learned something no matter what I mean
32   nuk [ësht se ka] qën (1.2) ë:: një orë e pavlefshme ose
     it's [not that it] was (1.2) u::hm a worthless hour or
33 T     [mhm,]
34 P ku di un domethënë edhe kjo më ka bërë që ku di unë ta shoh si
     I don't know I mean and this has made me I don't know to see it as
35   (1.2) ë: shum:: orë shpërblyse domethënë [ktë,] (0.6) m.
     (1.2) u::hm a very rewarding hour I mean [this,] (0.6) m.
36 T                                          [mhm,]
```

In the beginning of the extract (lines 3-4), the therapist expands the prior sequence [not shown here] by opening up an other-initiated repair sequence addressing trouble with understanding the patient's response (Schegloff, 2007). By topicalizing "pleasure," she accepts the patient's shift in focus of talk from the need for therapy to him liking and enjoying it. Such a move is already a first step toward collaboration; the therapist displays an orientation toward accepting the patient's

reason to continue with therapy and alters her interactional project accordingly. She leaves the exploration of the patient's need for therapy behind and moves on to invite exploration of therapy as a pleasure fulfilling experience. This attempt is nevertheless not very successful as instead of aligning with the therapist's altered project, the patient orients to it as somewhat problematic.

The patient first confirms straightaway by producing the affirming particle "yes" twice, followed by a repetition of the last part of the therapist's previous turn "gives some sort of pleasure" (line 5). His immediate confirmation however seems to orient more toward the collaborative nature of the therapist's move than the assertion itself. In his response, the patient treats this assertion as problematic in some way. Incompatible with the immediate and rather strong confirmation, the patient displays thinking, treating the therapist's assertion as news hence not what he meant (he gazes away from the therapist while prolonging the vowels of the verb *is* here translated as "it's:"). Moreover, by delaying the elaboration made relevant in the therapist's post-expansion, the patient orients to it as a dispreferred. As Schegloff (2007) argues, a preferred response would have been a sequence-closure relevant in which the therapist endorses the patient's stance in regard to his need for therapy, therefore reaffiliating with him.

In pursuit of her interactional project, the therapist makes a second attempt at getting the patient to expand his answer, this time using a wh-question (lines 8-13: *what? is it that gives you pleasure if we can (0.4) [go] a little mo::re (0.6).hh (0.6) m:: mo::re more in [detail] or more i::n #m:::# in understanding of this. thing*), working as a specific expansion elicitor (Muntigl and Zabala, 2008). In response, the patient produces a first part of his answer though not without difficulties (*first of all it's I mean it's (0.6) [my hour =]*). Prior to responding, there is a 1-s-long gap (line 14), whereas while responding, the patient gazes away from the therapist (line 15, up to producing the words "my hour"); he pauses for 0.6 s before the production of the first list item while making back and forth short head movements indicating searching; he accompanies the word search by making round circles with his hands, as an illustration of the mental process he is going through. The therapist acknowledges the success of this second move by responding collaboratively *([= it's] your ti[me.*).

In line 16, where the target action of our analysis is deployed, the therapist utilizes a highlighting formulation (Weiste and Peräkylä, 2013), showing that she is collaboratively following the line of the patient's account. Remember that the therapist and the patient are disaffiliated when entering the talk. By means of this collaborative move, the therapist works to soothe the disaffiliation in two ways. Firstly, by latching the formulation onto the patient's prior turn, the therapist produces it very similarly to a helpful utterance completion (Ferrara, 1994), supplying the vocabulary item the patient displays difficulties in finding. In this way, she not only acknowledges the difficulties but also accepts the answer (notice how the turn is prosodically produced with a closing intonation). Secondly, by formulating "it's my hour" (line 15) as "it's your time" (line 16), the therapist displays understanding of the patient's answer and, at the same time, receipt of it. While producing the turn, she gazes away from the patient, toward her left-hand side, and accompanies the gaze with a wide hand gesture. Both gestures indicate a cognitive process in progress, most probably including recalling as the patient has already mentioned the word "hour" in his previous talk taking place right before extract II (b) [data not shown here] saying that what he likes about therapy, among other things, is that it is his hour. In this way, she shows that she has been attentive to his talk and remembers what he has said.

The patient rushes to confirm (line 17: *[yes.] it's (0.4)*) yet, instead of item listing initiated prior in the talk (line 15), he proceeds with a transformative answer (Stivers and Hayashi, 2010), retrospectively transforming the focus of the question's agenda from the pleasure he derives from therapy to going back to talking about its benefits (lines 21-35). While the therapist attempts at repairing disaffiliation through stretching out a hand at collaboration for the ensuing talk, the patient treats the disaffiliation as in need of resolution rather than merely soothing, pursuing the therapist's endorsement of his stance. Misaligning with the therapist's interactional project, he bypasses the topic of therapy as a pleasure fulfilling experience and goes back to accounting for how he benefits from therapy, hence his need for it (lines 21-35). In what follows, the focus remains on the patient's needs that are fulfilled in therapy, as described by the patient. The therapist aligns with the patient's diverging interactional project and does not go back to questioning neither his need for therapy nor the pleasure it fulfils. In this way, she contains further escalation of disagreement by leaving the differences in their positions behind, extending her collaboration to include the patient's control over the ensuing talk.

Collaborative Move Deployed Amidst Overt Disagreement

Sometimes, the disagreement between the therapist and the patient is more overt, including a persistent pursuit of the interactional project by the therapist. The talk in overt disagreement is more explicit and both patient and therapist openly affirm their different positions on the matter. In the following stretch of talk a collaborative move is deployed amidst one such environment. It is extracted from the very beginning of a session from the second dyad. The session starts with the patient asking the therapist how she has been doing, adding that while the focus is always on her, human kindness necessitates reciprocation. The therapist first finds it difficult to answer, next produces a short response, and soon after diverts the focus of talk on the patient, stating that this is the time and place to talk about her. The patient agrees and following a gap of 4 s, the talk ensues as shown below.

Extract III. OIV "filtruar" & "se sa" [00:35 – 02:30]

01 P për çfarë do flasim sot hehe[he]
what shall we talk about today hehe[he]
02 T [hehe] .hh nganjëherë mendohet që kur- (0.6) ë::
[hehe] .hh sometimes it is believed that when- (0.6) e::rm
03 pacientët ë- [vijnë] me këtë fjalinë mendohet që:: është më tepër si
patients erm- [come] with this sentence it is believed tha::t it's more like
04 P **[°mhm.°]**
05 T një mekanizëm mbrojtës (0.2).hh ë? ata kanë aq shumë gjëra
a defense mechanism (0.2).hh no? they have so many things
06 për të fol[ur sa]që::
to ta[lk about tha]::t
07 P [po.] duhet t'i:: (.) filtrojnë.=
[yes.] they have to:: (.) filter them.=
08 T **=mhm,=**
09 P =domethënë si t'i filtrojnë. .hh është si të je- të kesh një:: bidon të madh me
=I mean filter them how. .hh it's like be- having a:: big can of
10 ujë dhe:: ta hedhësh në një shishe pak më të vogël dhe duhet të vesh hinkën,
water a:nd pouring it in a slightly smaller bottle and you must put the funnel,
11 T **mhm,**
12 P mcht për të:::: për të mos u derdhur nëpër >shishen e vogël,<=
mcht so tha::::t so that it doesn't spill through >the small bottle,<=
13 T =°mhm,° mcht .hh ë- mendon që kjo:: (0.2) bëhet e mundur nëpërmjet (.) ë- (.)
=°mhm,° mcht .hh erm- do you think that thi::s (0.2) is made possible through (.) erm- (.)
14 të ↑folurit pra [asociimit të] lirë ë?
well ↑talking [free associ]ation no?
15 P [mcht po.]
[mcht yes.]
16 T °nëse ne flasim flasim flasim ne ndoshta në .hh (0.6) nuk e di ne folëm pak
°if we talk and talk and talk we might at .hh (0.6) I don't know we talked a bit
17 për atë teknikën e:: asociimit të lirë pra të flasësh çfarëdolloj gjëje
about that free association technique meaning talking about anything
18 që të vjen [në mend]
that comes to your [mind]
19 P [po.]
[**yes.**]
20 (1.0)
21 T [mcht .hh] pasi mendohet që (.) kur (.) pacienti
[mcht .hh] as it is believed that (.) when (.) the patient
22 P **[.hh]**
23 T flet (.) >çfarëdolloj gjëje që i vjen ndërmend,< .hh (.) ne marrim disa
talks (.) >about anything that comes to his mind,< .hh (.) we pick up several
24 s- aspekte të: të fjalimit (0.8) ë? dhe ja- janë pikërisht ato të cilat po
s- aspects o::f of the speech (0.8) no? and they'- they're exactly those which if
25 t'i përpunosh, (.) arrijnë të bëjnë atë: (1.0)
you process, (.) they mount to tha:t (1.0)
26 P po. [.hh]
yes [.hh]
27 T [lën]gun, o
[li]quid, o
28 P ë:: vetëm se ti m- mendoj që mund të shërbesh [si hinkë] ë:: për të::
- only that you t- think that can to serve as funnel - for to
e::rm it's just that you I- I think that you can serve [as a funnel] e::rm to::
29 T **[=mhm,=]**

(Continued)

Extract III. Continued

30 P [(((gëlltitet))] mcht për të udhëhequr një lloj:: ë:: linje në mënyrë që (.)
swallows for to lead a sort - line in way that
[((swallows))] mcht to lead some sort:: of e::rm a line so that (.)
31 → T [filtruar.]
filter
[filter.]
32 P siç thashë të mos të derdhet jashtë sepse unë (.) bidonin e kam të madh,
as said to not to spill out because I can it have big
as I said it doesn't spill out because (.) my can is big,
33 .hh e:[dh]
an(d)
.hh a:[n(d)]
34 T [prapë i kthehemi pjesës së kontrollit ë?]
again it return part of control -
[**again we return to the issue of control no?**]
35 P eh [hehehe]
-
well [hehehe]
36 T [duhet ta dimë] se çfarë hedhim në:: ëm:: në gotë.
must to+it know that what throw in - in glass
[we must know] what we pour i::n erm:: in the glass.
37 P jo se çfarë hedhim por ë:: të shk[ojë aty] ku::
no that what throw but - to go there where
not what we pour but e:rm that it go[es] whe::re
38 → T [se sa.]
that how+much
[how much.]
39 P duhet. të shkojë saktë.
should to go correctly
it should go. the right way.
40 T **mhm,**
41 P mos ë- ë- domethënë:: mos të shkojë dëm sepse ëm ti je
not - - meaning not to go waste because - you are
so that it doesn't erm- erm- I mean:: it doesn't go to waste because erm you are
42 shishja e vogël, unë jam (.) bidoni i madh. [në këtë] rast.
bottle small I am can big in this case
the small bottle, I am (.) the big can. [in this] case.
43 T **[°mhm,°]**
44 T **°mhm,°**
45 P ë:: në rast tjetër nuk e d(he)i s(he)e(he) do të ishe ndoshta ti
e::rm in another case I don't kn(he)ow ca(he)u(he)se perhaps you would be
46 bidon shumë i madh po në këtë rast
a very big can but in this case
47 (2.8)
48 P mcht ë- përderisa unë kam për të folur atëhere do [zbrazem] unë.
mcht erm- as I have to talk then I will [pour out.]
49 T [°po°]
[°yes°]
50 (3.5)
51 P nuk më vjen në mendje asnjë gjë [tani]
nothing comes to my mind right [now]
52 T **[°mhm,°]**
53 P **hehehe**

In the beginning of the extract, the patient asks for help from the therapist to pick a topic of talk (line 1). The therapist interprets the patient's request as a defense mechanism (lines 2-3 and 5-6) implying that she has a lot to say but can't due to psychological barriers. By declining to help, the therapist is not only engendering a dispreferred action (Schegloff, 2007), she is also disagreeing with the patient's implied claim that she doesn't know what to talk about. To appease the combative potency of the interpretation, the therapist (a) mitigates the temporal validity of her interpretation (see the use of "sometimes" in the beginning of the turn, line 2); and (b) attributes the interpretation to external referents: *the therapists* (notice how the turn is formatted in passive voice: "it is believed that," line 3) and *the patients* (as opposed to this one therapist interpreting this one patient's behavior).

The patient interrupts and following a *pro forma* response (see the agreement token "yes" in line 7 in response to the therapist's use of the question tag "no," which can also be translated as "isn't it" in English, in line 5) proceeds to complete the therapist's turn. Claiming her right to know about patients' experiences by merit of being a patient herself (Pomerantz, 1980), she starts talking about what patients need, "filtering" in this case (line 7). Despite seemingly in agreement with the therapist, the patient disagrees by attributing her difficulties in picking a topic not to her internal psychological barriers but rather to the lack of a funnel that will help her in filtering her talk (lines 7, 8-9, and 11).

In her response in line 13 onward, the therapist invites the patient to freely associate when talking in therapy by elaborating on how free association is conducted and what its therapeutic aim is. Here again the patient responds *pro forma*, seemingly in agreement with the therapist (lines 15, 19, 26) to only go back to the funnel metaphor, this time explicitly asking the therapist to "serve as a funnel" (lines 28-30: *e:rm it's just that you I- I think that you can serve [as a funnel] e:rm to: [((swallows))] mcht to lead some sort: of e:rm a line so that (.)*). It is in this moment of their talk, amidst enduring disagreement, that the therapist produces two collaborative moves, orienting to the disaffiliation as in need of soothing. In the first move (line 31: *[filter.]*), the therapist recycles the patient's word "filter" (first mentioned in line 7). Overlapping with the patient's swallowing, the therapist hurries up to give her the word she thinks the patient is looking for (see how she uses a filler "e:rm" and prolongs both the filler and "to:" in line 28). By recycling the patient's own word, the therapist shows that she has not only heard but also understood what the patient previously said. As the patient declines to elaborate, an action made relevant by the therapist's invitation to freely associate when talking in therapy, this first collaborative move treats the ongoing disaffiliation as in need of soothing.

The patient however declines the therapist's "help" and sequentially deletes the collaborative completion of her turn (line 30: *[((swallows))] mcht to lead some sort: of e:rm a line so that (.)*). In accounting for why she needs the therapist to serve as a funnel, the patient is not only declining the latter's invitation to associate freely but also restating her different position on the matter. In response, the therapist makes another interpretation, this time attributing the patient's position to her controlling tendencies (lines 34 and 36: *[again we return to the issue of control no?] [we must know] what we pour i:n erm: in the glass.*). The patient corrects her interpretation (line 37: *not what we pour but e:rm that it go[es] whe:re*) to which the therapist responds with a second collaborative move (line 38: *[how much.]*), a collaborative completion (Lerner, 1991) of the patient's turn following word searching (notice the use of filler "e:rm" in line 37). In what follows, the patient continues to account for her position, while the therapist makes no further attempts at pursuing her interactional project in which the patient would associate freely. The therapist does not go back to the issue under dispute, thus neither reaffirming her position nor confronting the patient's.

Similar to what happens in extract II, the therapist's collaborative moves do not imply re-affiliation with the patient. She and the patient remain disaffiliated throughout the talk, and the collaborative moves deployed here demonstrate the therapist's orientation toward soothing the disaffiliation. The difference, however, lies in the fact that here the therapist pursues her interactional project more persistently by proceeding from implicit to more explicit talk, openly affirming her position on the matter. Her collaborative moves orient to the disaffiliation as in need of soothing yet reaffiliation is not achieved as neither she nor the patient endorses the other's position.

Collaborative Move Deployed to Further the Disagreement

So far, we have shown how therapists make use of a collaborative move as a means to either foster the ongoing affiliation or soothe the disaffiliation, in both cases maintaining an orientation toward furthering the interactional project at hand. The analysis of its local function reveals that when deployed amidst disaffiliation resulting from enduring disagreement, the collaborative move does not necessarily indicate that the therapist is re-affiliating with the patient. In extracts II and III, we saw how, soon after the collaborative move, the therapist goes back to her disagreeing stance. Hence the practice of "helping out" the patient is a demonstration that the therapist has been with him/her all along paying attention to what s/he has been saying and thus understanding his/her talk rather than an endorsement of his/her opposing stance. In two instances in our collection, this is even more so the case as the therapist does both actions within the same turn: (1) attempts at collaboratively completing the patient's turn while at the same time (2) goes back to her stance. Here we show one of these instances. As the stretch of talk leading to this move is fairly long, we first show how the move is designed and its sequential position (Extract IV (a)). Next, we show the longer version of the stretch of talk where the move is deployed, which allows us to analyze its local function, being the therapist's orientation toward advancing her interactional project (Extract IV (b)).

Design and Sequential Position of the Collaborative Move

The talk here is extracted from a mid-session section from the first dyad. The therapist and the patient are talking about the patient's recent dreams.

Extract IV (a). SVII "e orës" [17:37 - 18:48]

```
275 T >çfar? të      duket abstrakte<
       what to+you seems abstract
      >what? is it you find abstract<
276 (0.7)
277 P nuk e  di (.) domethënë këto  idetë që   më    vijnë>°domethënë°shumë kshu ku    di   un<
      not it know   meaning   these ideas that to+me come  meaning   very  such where know I
      I don't know (.) I mean these ideas that come to my mind >°I mean° they're very like I don't
278   një largim  nga  diçka::, (1.2) nga  pjesa (0.8) [rixhide,] matematikore, ose
      a   parting from something     from part         rigid     mathematical  or
      know< a departure from something, (1.2) from the (0.8) rigid part, mathematical, or
279 T                                                   [mhm,]
280 P e- (1.0) kornizuar ose nuk e  di    po [që   prapë më    duket]
      of       framed    or  not it know  but that again to+me seems
      of- (1.0) framed or I don't know but [yet it seems]
281 → T                                     [e  orës,] (1.0) e  mbajtjes në kontroll]
                                             of clock        of keeping  in  control
                                            [of the clock,] (1.0) of keeping the session
282   [të seancës] qoftë dhe duke:: .hh nd- ndjekur   orën  në kuptimin që   dhe- (0.2)
       of session  even  and -ing       ch-  check on  clock in meaning  that and
      [under control] even by .hh ch- checking the clock in the sense that also- (0.2)
283 P [°mhm,°]
284 T duke e  ndje- ndjekur gjithmonë [kur  është.] fundi.
      -ing it fo-   follow  always     when is      end
      by always che- checking [when it's] the end.
285 P                                [°mhm,°]
```

In the beginning of the extract, the therapist takes issue with the patient's rejection of her previous interpretation as "too abstract" [data not shown here], openly confronting him (line 275). In response, the patient initiates another attempt at elaborating on the therapist's interpretation (lines 277-280) to only abandon it halfway, going back to rejecting it (line 280). It is right before the projected upcoming of the rejection that the therapist comes in with the move under scrutiny here.

The therapist's turn in lines 281-282 and 284 is designed as collaborative completion of the patient's previous turn. The therapist hooks her turn into the patient's previous one: she recycles the preposition "e" at turn initial position and produces the rest of the turn as a grammatical continuation of the patient's. This proposition may be used as an adjective initial particle (the patient ends up using it as such, the adjective being "e kornizuar" in Albanian, translated in English as "framed") but also as an initial particle indicative of the genitive case (the therapist makes such use of it, the genitive case of the word "orë" ("clock" in English) being "e orës" (of the clock)). In Albanian language, the noun comes before the adjective, thus the therapist turn becomes: "... a departure from something, from the (part) rigid, mathematical, or of the clock, of keeping the session under control ..."

As the patient's turn is produced with notable difficulties, the therapist attempts at soothing the ongoing disaffiliation by helping out the patient and giving him the word he seems to be searching for. Nevertheless, as the subsequent analysis will reveal, what is structurally constructed as a collaborative move – an extended hand at a moment of need – turns out to be a reaffirmation of the therapist's previous disagreeing position. In the next section, we show how the disagreement emerges and escalates.

Local Function of the Collaborative Move

In this session, the therapist and the patient talk about the patient's two recent dreams. During the first 8 min, the patient describes his dreams; for the rest of the session, the therapist and the patient engage in interpreting the dreams together. A close look at the interpretation sequences in this session reveals a recurring pattern of more or less the following organization: (a) first either the therapist or the patient topicalizes an element from the dreams; next the therapist invites the patient to elaborate on its meaning using the free associations technique; the patient either does not elaborate, engaging instead in dream telling, or initiates elaboration but does not establish connections, meaning or explanations, either case giving way to misalignment; (b) in her next move, the therapist suggests an interpretation with which the patient openly disagrees or agrees minimally, either way not elaborating on it as made relevant by the therapist's action initiation, resulting in disaffiliation.

A similar pattern can be observed in the extract below where the therapist and the patient are talking about a fourth element from the dream, "the academic writing guy." In the dream, the patient's academic writing lecturer appears as his therapist and continuously interrupts him. His statistics lecturer also appears at

some point in the dream, asking him to go and see his therapist, inferring the academic writing lecturer. The therapist invites the patient to freely associate on who the "academic writing guy" might resemble to. Again, the patient fails to elaborate and, as the therapist pursues an answer, the patient finally claims to not have one, saying that he can't find any resemblance to "some concrete person." A long silence of 5 s ensues before the talk proceeds as shown in extract IV (b) below.

In the beginning of the extract, the therapist suggests that one possible interpretation might be that the academic writing guy resembles the patient himself (line 256). As in the previous extract, the interpretation is mitigated (the interrogative format frames the turn as hypothetical; uncertainty markers are incorporated in the talk, i.e., the epistemic modal auxiliary "can" and the 0.2 s pause; the turn is uttered in a soft tone of voice), orienting to the epistemic asymmetry with regards to

Extract IV (b). SVII "e orës" [25:09 - 26:45]

256 T [mendon? dhe që mund të jesh] (0.2) °deri diku një pjesë e vetes tënde aty?°
[do you think? that you might be] (0.2) °to a certain degree a part of yourself there?°
257 P [>nuk e di< nuk e di:,]
[>I don't know< I don't kno:w,]
258 (1.8)
259 P °pjesa e:: (1.2) pjesa rixhide ndoshta ose [pjesa°]
°the part o::f (1.2) the rigid part perhaps or [the part°]
260 T [<MHM,>]
261 (3.6)
262 T <°pjesa e statistik[ave°,>]
<°the part of statist[ics°,>]
263 P [°mhm,°]
264 (3.0)
265 P <°tashi° nga ana kërkimore> po(h) dh(h)e domethënë
<°well° on the research aspect> ye(h)s a(h)nd I mean
266 [në kuptimin] (1.8) nejse unë jam:: k- shumë kokëfortë domethënë e
[in the sense] (1.8) anyway I am:: s- very stubborn I mean and
267 T **Mhm,**
268 (2.5)
269 P për shumë gjëra po ph:: °ku di unë,°
about many things but ph:: °I don't know,°
270 (3.5)
271 P ose ndoshta një lloj (1.0) °m-° (0.3) largimi? ndaj kësaj po ph:: >ku di unë<
or perhaps some kind of (1.0) °uhm-° (0.3) departure? from this but ph:: >I don't know<
272 (0.2) [prapë] më duket shumë abstrakte nuk më::
(0.2) [still] it seems too abstract it doesn't::
273 T [°mhm,°]
274 (1.2)]
275 T >çfar? të duket abstrakte<
>what? is it you find abstract<
276 (0.7)
277 P nuk e di (.) domethënë këto idetë që më vijnë> °domethënë °shumë kshu ku di un<
not it know meaning these ideas that to+me come meaning very such where know I
I don't know (.) I mean these ideas that come to my mind >°I mean° they're very like I don't
278 një largim nga dika::, (1.2) nga pjesa (0.8) [rixhide,] matematikore, ose
a parting from something from part rigid mathematical or
know< a departure from something, (1.2) from the (0.8) rigid [part,] mathematical, or
279 T [mhm,]
280 P e- (1.0) kornizuar ose nuk e di po[që prapë më duket]
of framed or not it know but that again to+me seems
of- (1.0) framed or I don't know but [yet it seems]
281 → T [e orës,] (1.0) e mbajtjes në kontroll
of clock of keeping in control
[of the clock[3],] (1.0) of keeping the session

[3] *The word "orë" in the Albanian language means both "watch" and "clock." In extract 4 (a), the patient lost his wristwatch whereas in here, the therapist is referring to the wall clock in the therapy room.*

(Continued)

Extract IV (b). Continued

```
282    [të seancës] qoftë dhe duke:: .hh nd- ndjekur    orën në kuptimin që   dhe- (0.2)
        of session  even  and -ing       ch-  check on  clock in meaning that and
       [under control] even by:: .hh ch- checking the clock in the sense that also- (0.2)
283 P  [°mhm,°]
284 T  duke e  ndje- ndjekur gjithmonë [kur  është.] fundi.
       -ing it fo-   follow  always      when is      end
       by always che- checking [when it's] the end.
285 P                                  [°mhm,°]
286 (4.5)
287 T  sensi i (.) ose shqetësimi yt    i- (.) i herëpashershëm i  kohës
       sense of    or  concer     your  of-    occasional       of time
       the sense of (.) or your concern of- (.) occasional concern of time
288    °që    duhet të ndoshta::° .hh° ë°? nuk ndjen që   duhet humbur koha=
        that ought to perhaps        -   not feel  that ought loose  time
       °that ought to perhaps° .hh °right°? you don't feel that time should get lost=
289 P  =mhm,=
290 T  =edhe këtu
        and  here
        here as well
291 (1.2)
292 T  dhe nëse nuk flet (0.5) është një humbje kohe
       and if   not talk       is    a   loss   time
       and if you don't talk (0.5) it's a loss of time
293 (0.5)
294 P  °mhm,°
295 (9.4)
296 T  çfar?  n- ndjesish ose ndjenjash pate n:: në mëngjes kur
       what? s- sensations or feelings did you have in:: in the morning when
297    u zgjove apo dhe n- (0.2) në orën katër
       you woke up or even at- (0.2) at four o'clock
```

access to the patient's inner experience (Weiste et al., 2016). The patient agrees partially and hesitantly, naming parts of himself that might resemble to what the notions of "academic writing" and "statistics" represent: rigidness (line 259) and stubbornness (line 266). In this moment in the talk, the therapist and the patient are both affiliated and aligned, as they share the same stance (the therapist produces several agreement tokens in lines 260, 263, 267, and 273, accompanied by nodding throughout the lines 260-262) and the patient is engaged in the same interactional project with the therapist, beginning to elaborate on the therapist's suggested meaning within the same real-world referential frame.

Their affiliation is, however, short-lived. The patient does not succeed in establishing a meaningful link between the element in the dream and his real-life world personality trait, "rigidness." He ends up rejecting the therapist's interpretation as "too abstract," one which "doesn't . . ." (line 272) possibly *convince* or *make sense* to him. The therapist questions the acceptability of the patient's answer (line 275: > *what? is it you find abstract* <) as she responds with an understanding check that functions as a repair initiation (Schegloff et al., 1977) pursuing expansion (Muntigl and Zabala, 2008). Similar to findings from other CA studies of psychotherapy when patients do not respond to therapist's action in a manner that is relevant to the interactional goals (Muntigl and Zabala, 2008; Koivisto and Voutilainen, 2016), the therapist orients to the patient's response as resisting her interpretation without elaborating on his grounds for not endorsing it and, what is more, declining to produce an alternative interpretation. The therapist's confrontational turn is produced with irritation (the talk is speeded up, her problem with understanding is not accounted for, and her gaze is stern), and so is the patient's (he looks away from the therapist, shrugs his shoulders in a quick and tense gesture, and frowns).

The patient starts to expand his answer by unpacking "these [abstract] ideas that come to [his] mind" (line 277). In an attempt at elaborating on the meaning of the dream, he produces a three-part list (Jefferson, 1990) of candidate descriptors of his personality traits which he might be departing from (lines 278, 280: *a departure from something, (1.2) from the (0.8) rigid [part,] mathematical, or of- (1.0) framed or I don't know but [yet it seems]*). The first item, "rigid," is recycled from his own previous talk (line 259); the second one, "mathematical," bears similarity to the therapist's "the statistics' part" (line 262); a third new item, "framed" (line 280), is added before he ends the listing only to go back to his previous position as projected by the use of the contrastive "but," possibly heading toward *abstract*. Overall, the patient's turn is produced with hesitation: it is embedded with uncertainty markers (notice the recurrent use of the knowledge disclaimer "I don't know," the filler "I mean," and the self-repair initiations) as well as visible difficulties in

producing the words (vowels are prolonged at the end of a TCU and the in-turn silences are also long). The entire turn is accompanied by hand gestures indicating word searching, shrugging and gazing away from the therapist, all pointing to the patient being engaged with necessary cognitive work to produce the answer.

It is in this moment of the talk when the therapist's interactional project is critically stalled that she comes back to their previous disagreement with a seemingly collaborative move, to only reassert her stance with regards to the patient's "sense of control" as a plausible interpretation of him having lost the watch in the dream (data not shown here). In line 281, the therapist intervenes right before the patient reiterates his disagreement, interrupting him as soon as he utters the contrastive "but." Though produced not immediately after the patient's word searching (see the long pause of 1 s in line 280, accompanied by hand gesture indicating searching), the therapist's turn is designed as to collaboratively complete the patient's previous turn (lines 281-282, 284: [*of the clock*[3]] *(1.0) of keeping the session [under control] even by.hh ch-checking the clock in the sense that also- (0.2) by always che-checking [when it's] the end.*). Similar to what happens in extracts II and III when the patient's turn is produced with notable difficulties, here as well the therapist seems to attempt at soothing the disaffiliation by giving him the word he is searching for. Nevertheless, what is structurally constructed as a collaborative move turns out to be a return to her disagreeing position.

By seemingly adding to his list of candidate descriptors of his personality traits, what the therapist actually does is bring forth evidence of how his "sense of control" is exhibited in the therapy. The evidence has a three-fold function: (a) the therapist comes back to her previous stance, affirming once more that there is a meaningful connection between the watch and the time, and losing the watch might mean that the patient let go of his controlling tendency (of the time in this case); (b) she strengthens her interpretation by offering evidential grounds for it: "keeping the session under control even by checking the clock . . . by always checking when it's the end" (lines 281-282; 284), and "you don't feel that time should get lost here as well" (lines 288, 290); and (3) accounts for the unacceptability of the patient's previous answer (the understanding check in line 275) by explicating "the abstract" relation between a personality trait (rigid, mathematical, framed) and how it is demonstrated in therapy (what the patient actually does as a result of possessing the trait), a relation the patient did not elaborate upon.

The therapist grounds her position on the therapeutic setting, a physical reality to which both have access to and where the patient's overt behavior is exhibited. In further escalating the disagreement, the therapist maintains an orientation toward the interactional project of dream interpretation. The patient however withdraws from engaging in further talk and the therapist accepts his disengagement by moving on to a new topic (lines 296-297). They agree to leave their opposing views behind and move on to another interactional project. In this way, further escalation of disagreement is contained, allowing for the therapeutic work to resume.

DISCUSSION

This study sheds light on how the psychotherapeutic process takes place through sequentially organized patterns of talk. We have focused on one particular realm of experience-under-transformation in psychotherapy, the *relation* between therapist and patient (Peräkylä, 2019). This study revealed one way in which therapists in psychoanalytic psychotherapy attempt at mending relational ruptures while maintaining an orientation to the therapeutic work. We showed how locally collaborative actions can assist therapists in pursuing the disagreement as part of the ongoing psychotherapeutic project, while momentarily mending the arising disaffiliation with the patient. Relying on the sequential properties of collaborative moves, therapists can show their patients that they have been carefully listening to them and understand their perspective. However, these helpful behaviors do not necessarily imply re-affiliation with the patient. What they do is earn the therapist the right to hold on to her/his position and even come back to it if the issue at stake is of therapeutic relevance. By clearing out the way of potential mishearing and/or misunderstanding of the patient's view, the therapist legitimizes her/his right to sustain the disagreement while, at the same time, acknowledges the necessity and importance of remedying the relational rupture. In this way, the therapist maintains simultaneous orientation toward the therapeutic work and the relation with the patient, constantly balancing between therapeutic projects and relational dynamics.

These findings correspond with Sacks' argument that, in conversation, attempts at "coming to an understanding" is one way to deal with disagreement (1973). Schegloff (lecture XV) quotes Sacks having said that 'conflict does not arise because people do not understand each other. It's that the first way, the first line of defense for dealing with conflict is to turn it into a problem of understanding or even hearing.' While in our study the therapist displays understanding as a means to hold on to her/his position, in other studies we see a similar orientation toward making sure a shared understanding has occurred before disagreeing with the patient. For example, Koivisto and Voutilainen (2016) showed how one practice that therapists use to not endorse the client's answer is to deploy a disaffiliative candidate understanding (Antaki, 2012). Where acknowledgment or validation is made relevant, therapists initiate repair as a way to legitimately pass the opportunity to affiliate with the client without openly challenging the later.

However, coming to a shared understanding is not always possible. As extracts in this and other studies disclose (see for example Voutilainen et al., 2018) often times in psychotherapeutic talk the therapist and patient do not sort out the disagreement by coming to an agreement but rather by accepting that they have diverging viewpoints and moving on to a new therapeutic project. Such orientation to disagreement suggests that, when the balance between the therapeutic work and the therapeutic relation is at risk, therapists tend to privilege the later. This inclination toward safeguarding the relation resonates with findings from studies of human interaction which

reveal an overall tendency toward solidarity and cooperation (e.g., Clayman, 2002; Tomasello, 2008). In a study of laughter in complaint sequences, Holt (2012) found that recipients of complaints use laughter to display a somewhat disaffiliative stance with the teller and misalign with the activity by contributing to topic termination while subtly maintaining social concordance.

Just as disagreement and conflict might put the solidarity at risk, mere displays of being "with" the patient can withhold the therapeutic work. Although a general level of affiliation needs to be maintained throughout the therapeutic work in order to secure the patient's commitment to therapy, it is important for the patient to learn to move safely and freely between moments of affiliation and disaffiliation rather than being persistently stuck in one or the other position (Peräkylä, 2019: 273). This study explicated how "momentary transformation of relation" (Peräkylä, 2019: 271) as one realm of experience targeted in psychotherapy takes place amidst such moments and how therapeutic aims intertwine with interactional projects in the moment-by-moment work accomplished in the psychotherapeutic talk. While the present study investigated one particular practice (collaborative move) deployed amidst one specific type of interactional environment (disagreement), much remains to be investigated regarding various degrees of collaboration displayed by each such move or other types of environments that put the therapeutic relation at risk. Likewise, unearthing other practices that therapists deploy to address ruptures in therapeutic alliance can further inform our understanding of how patients' transformation of experience takes place in psychotherapy.

DATA AVAILABILITY STATEMENT

All datasets presented in this study are included in the article.

ETHICS STATEMENT

Ethical review and approval was not required for the study on human participants in accordance with the local legislation and institutional requirements. All participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

AG collected, transcribed, and translated the data, and wrote the article. All authors contributed in data analysis.

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Conflict of Interest: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

APPENDIX A. CA TRANSCRIPTION CONVENTIONS

D:	Speaker identification: for example Doctor (Dr), Patient (P), Mother (M)
[ ]	Brackets: Onset and offset of overlapping talk
=	Equal sign: No gap between two utterances
(0.0)	Timed pause: Silence measured in seconds and tenths of seconds
(.)	A pause of less than 0.2 seconds
.	Period: falling or terminal intonation
,	Comma: level intonation
?	Question mark: rising intonation
↑	Rise in pitch
↓	Fall in pitch
-	A dash at the end of a word: an abrupt cutoff
<	Immediately following talk is 'jump started', starts with a rush
> <	Faster-paced talk than the surrounding talk
< >	Slower-paced talk than the surrounding talk
____	Underlining: some form of stress, audible in pitch or amplitude
HI	Capital letters: talk that is louder than the surrounding talk
:	Colon(s): Prolongation of the immediately preceding sound
° °	Asterisks surrounding a passage of talk: talk with lower volume than the surrounding talk
.hh	A row of 'h's prefixed by a dot: an inbreath
hh	A row of 'h's without a dot: an outbreath
#	Number signs surrounding a passage of talk: spoken in a 'creaky' voice (vocal fry)
£	Smiley voice
@	Animated voice

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Distributing Agency and Experience in Therapeutic Interaction: Person References in Therapists' Responses to Complaints

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The primary means for psychotherapy interaction is language. Since talk-in-interaction is accomplished and rendered interpretable by the systematic use of linguistic resources, this study focuses on one of the central issues in psychotherapy, namely agency, and the ways in which linguistic resources, person references in particular, are used for constructing different types of agency in psychotherapy interaction. The study investigates therapists' responses to turns where the client complains about a third party. It focuses on the way therapists' responses distribute experience and agency between the therapist and the client by comparing responses formulated with the zero-person (a formulation that lacks a grammatical subject, that is, a reference to the agent) to responses formulated with a second person singular pronoun that refers to the client. The study thus approaches agency as situated, dynamic and interactional: an agent is a social unit whose elements (flexibility and accountability) are distributed in the therapist-client interaction. The data consist of 70 audio-recorded sessions of cognitive psychotherapy and psychoanalysis, and the method of analysis is conversation analysis and interactional linguistics. The main findings are that therapists use the zero-person for two types of responses: affiliating and empathetic responses that distribute the emotional experience between the client and the therapist, and responses that invite clients to interpret their own experiences, thereby distributing control and responsibility to the clients. In contrast, the second person references are used for re-constructing the client's past history. The conclusion is that therapists use the zero-person for both immediate emotional work and interpretative co-work on the client's experiences. The study suggests that therapists' use of the zero-person does not necessarily attribute "weak agency" to the client but instead might strengthen the clients' agency in the sense of control and responsibility in the long term.

Keywords: agency, person reference, conversation analysis, interactional linguistics, psychotherapy interaction, Finnish

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INTRODUCTION

One of the prime reasons clients request psychotherapy is their experience of a loss of agency in life (Wahlström, 2006). Clients may feel that their ability to attribute thoughts, feelings and actions to themselves, to control their own actions, and to influence their own choices is severely restricted (e.g., Avdi, 2005). The various psychotherapeutic traditions use different methods for seeking to help clients develop their diminished agency. For instance, in humanistic therapies, introspective reflections in a supportive environment are thought to empower clients to become more self-determining, while, in behavioral therapies, gaining new skills is seen as a means of increasing clients' agency by providing more options for acting (Williams and Levitt, 2007). By contrast, in therapies that draw on social constructivism, agency is understood to be negotiated and constructed in clinical interaction (Avdi, 2005). Therapist responsiveness is understood to facilitate the joint construction of new interpretations of previous experiences as well as new meanings attached to previously used words. This is thought to increase clients' ability to adopt a reflective position toward their experiences and that in way diminish non-agentic positioning (Avdi et al., 2015).This framework thus emphasizes the role of linguistic practices in the process of displaying and diminishing clients' non-agentic positioning of themselves (e.g., Avdi, 2005; Toivonen, 2019).

According to previous research, one linguistic practice for non-agentic positioning is the use of "agentless" talk, i.e., the "avoidance" of personal reference forms (Kurri and Wahlström, 2007). When clients use obscure personal forms, therapists often use specific person references (Kurri and Wahlström, 2007), in particular the second person singular pronoun, to invite them to move from a non-agentive to a more agentive and responsible position. Nonetheless, it is not only clients who use impersonal forms when referring to themselves; occasionally, therapists also use impersonal forms when referring to clients. Kurri and Wahlström (2007) studied one therapist's use of agentless formulations and found that the therapist treated the client's agentless formulations as a delicate matter and used agentless formulations as a step-by-step strategy when working toward agentic reformulations. They suggested that the therapist's use of agentless formulations is a strategy for saving the client's face (Kurri and Wahlström, 2007).

In our study, we explore therapists' use of impersonal forms, in particular the zero-person construction, when referring to clients. We compare them to turns in which therapists refer to the client with a second person singular pronoun. In our analyses, we draw on interactional linguistic studies on the use and meaning of Finnish personal forms in everyday informal interaction (Laitinen, 2006; Visapää, 2008) and interactional and anthropological studies on agency (Enfield and Kockelman, 2017). The aim is to gain understanding of the ways in which these two different personal forms (the zero-person and second person singular) are used in psychotherapy interaction, given that personal forms allow for the distribution of agency in various ways (see e.g., Couper-Kuhlen and Etelämäki, 2015).

Recent studies of language and social interaction suggest that agency is dynamic and social and show that agency can be distributed in different ways in interaction (see e.g., Enfield, 2013; Enfield and Kockelman, 2017). According to these studies, agency is rarely the possession of single individuals; rather, over a course of action, agency can be distributed in such a way that the individuals involved play more or less complementary roles in performing the action. Moreover, multiple individuals can be joined in a single unit of motivation and accountability. Agency in interaction is, thus, understood as "a fission-fusion affair involving constant navigation of separateness and boundedness, affiliation and disaffiliation, an endless tacking back and forth between inhabiting different social units, with always-relevant consequences for our social relationships, both fleeting and enduring" (Enfield, 2013, XVI). In this study, we adopt this view of agency. Thus, we understand agency in two different ways. First, we understand agency as flexible, social and distributed (Enfield, 2017): an agent is a social unit whose elements (flexibility and accountability) are dynamically distributed in real-time interaction between the therapist and the client. Second, agency can refer to clients' ability to take initiative and responsibility for their actions in everyday life, which is a more traditional view of agency in psychotherapy. In this study, we focus on the dynamic distribution of agency between the therapist and the client in the therapy session, and extend the idea of distributed agency to emotion and experience. We analyze how the client's earlier emotions and experiences are constructed in the psychotherapy interaction either as shared or non-shared by the client and the therapist, that is, either as epistemically accessible to both of the participants or not. We analyze the dynamic construction of agency and experience through the use of personal forms in Finnish psychotherapy interaction. We use this linguistic phenomenon as a concrete and observable example of negotiating and constructing agency *in situ*. By focusing on the therapist's responsive turns, we discuss the ways in which such turns both share and support the client's agency. In what follows, we begin by shortly introducing the Finnish zero-person construction and the previous research on the topic in the context of psychotherapy and everyday interaction. This will form the basis for our analysis, presented in the section Results.

ZERO-PERSON IN PREVIOUS RESEARCH

Due to their different grammatical structures, in particular person systems, different languages possess different affordances for distributing agency and experience in interaction. In the following, we first provide a brief overview of the Finnish person system with a focus on the impersonal forms, in particular on the form called "zero-person." We then give a brief review of the ways the zero person has been described in previous research on psychotherapy. Lastly, we demonstrate how the zero-person is used for distributing agency and experience in everyday informal Finnish interaction because this will provide the basis for our analysis of the use of the zero-person in psychotherapy interaction.

As in many other languages spoken in Europe, Finnish features personal pronouns for expressing the first, second and third person in both the singular (SG) and plural (PL):

minä ("I"), *sinä* ("you.SG"), *hän* ("she/he"), *me* ("we"), *te* ("you.PL"), *he* ("they.PL"). Finnish is, however, distinct in that in addition to the first, second and third person singular and plural form, it features a personal passive and a zero-person. In Finnish, the personal passive form always implies a human agent. For example, the passive clause *poikaa lyötiin kivellä* ("the boy was hit by a stone") implies that the boy was struck by a stone thrown by a human agent or agents. In addition to the personal passive, however, Finnish possesses a zero-person construction (marked as Ø in the translation lines of the transcripts). The zero-person construction has no overt subject, and the predicate verb appears in the third person singular form:

(a) kattelee vanhuksia
Ø look-3SG elderly.people-PL-PAR
Ø (one)[1] looks at elderly people

(b) kirjattuna pitää pis[tää joo.
registered-ESS Ø must.3SG put-INF PRT
as registered Ø (one) must put it yes.

The difference between the Finnish personal passive and the zero-person is that whereas the passive refers to a collective agent, the zero-person refers to an individual but unspecified agent (Laitinen, 2006). Depending on the context, the zero-person can refer to either one of the speech act participants (first, second, or third person), in other words, it can be interpreted as "anyone," "I," or "you."

In earlier research on Finnish, the zero-person was first analyzed as a "missing person." Its use was claimed to be a negative politeness strategy to avoid explicit personal reference. Based on conversational data, newer research has, however, criticized this view and suggested that in affective contexts, the zero-person offers an indexical site to be identified with, "an empty place of the common experience, constructed for anyone to enter" that invites the recipient to view or experience the world from that place (Laitinen, 2006, 218; see also Laitinen, 1995). Moreover, in the context of directives, it has been suggested that it is employed as an offer to distribute agency between the participants more evenly than in requests with explicit personal forms (Couper-Kuhlen and Etelämäki, 2015). Research on Finnish psychotherapy interaction has largely adopted the former view.

Prior research on psychotherapy has suggested that the grammar of verbs plays a key role in mediating linguistic constructions of personal agency (Todd 214). It has been argued that clients who feel they are in an object position with respect to the difficulties they are facing use stative verbs (such as *have* a problem, *is* depressed) to display their problems (Todd, 2014). Previous research on Finnish psychotherapy has suggested that the agent of a particular action is typically left unspecified by using, for instance, zero-person verb forms (Kurri and Wahlström, 2007; see also Toivonen, 2019). According to these studies, clients use the zero-person form in at least two types of interactional contexts. First, clients employ it to diminish their personal responsibility (Kurri and Wahlström, 2007). By using the zero-person, clients can present themselves as victims, as people who lack control over the actions they are describing. The zero-person form is also typically used when clients describe themselves as objects or stooges of someone else's actions (Toivonen et al., 2019). In this case, the other actor can be anything that is referred to as initiating the action or creating the client's circumstances, such as a diagnosis, divorce or childhood events (Toivonen et al., 2019).

These types of expressions are noted to provide clients with a strategy to save face as a moral person when describing, for instance, their alcohol use, drunk driving or other presumably morally questionable behavior (Kurri and Wahlström, 2007; Halonen, 2008). Prior research has shown how therapists point out, challenge and reformulate such expressions (e.g., Kurri and Wahlström, 2007; Partanen et al., 2010), as it is their therapeutic task to place the client in an agentic position in his or her life (Kurri and Wahlström, 2007). Second, the zero-person form enables clients to discuss their own experiences in a way that constructs the experiences as commonly sharable (Halonen, 2008). By leaving the reference open, clients can invite others to identify with their description. Therapists, in turn, have been found to use the zero-person construction to show that the client's description is typical or general, for instance, for all addicts in group counseling (Halonen, 2008). The zero-person can also function as a face-saving strategy by not defining whose experience is in question: it enables discussion on difficult issues without pointing a finger at the client (Kurri and Wahlström, 2007; Halonen, 2008).

As mentioned at the beginning of this section, interactional linguistic research on the Finnish zero-person has largely rejected the view that the zero-person is used as a face-saving or negative politeness strategy because these theories are not directly compatible with an interactional view on language and interaction (see also Schegloff, 1988). Instead, it has suggested that zero person forms are typically found in two types of contexts: in affective accounts, and directives. In affective accounts, it invites the recipient to share the experience and the stance with the teller (e.g., Laitinen, 1995, 2006; Visapää, 2008) as in Example (1):

Example (1): Grieving brother

```
01 Mari: ja sekin on aika .hhh ikävää tuala että
         and it is also quite .hhh unpleasant there that

02          lohduttaa   tommosta     .hhh surevaa
         Ø comfort-3SG that-kind-of .hhh grieving.person
         Ø (one) comforts a grieving person .hhh like that

03       ja  sit  kattelee tommosia     vanhuksia             että
         and then look-3SG that-kind-of elderly.people-PL-PAR PRT
         and then looks at elderly people like that so

04       (.) kauheen tällästä mullekin    .h[hh]
         (.) for me too awfully like this .hhh

05 Anne:                                    [nii-i.]
                                             yes.
```

In affective contexts, it is thus suggested that the zero-person form is used for inviting the recipient to share an emotional stance toward the experience (Laitinen, 2006; Visapää, 2008). In other words, it can be used for distributing the experience.

[1]In order to make the translation more accessible to non-Finnish readers, we use the English "one" in parentheses in the translation line. Note, however, that that the Finnish person system is different from the English one, and that the zero-person form does not function similarly to "one" in English.

In the context of directives, on the other hand, the zero can be used for negotiating the agency of the future action with respect to responsibility and accountability for the action. It offers to distribute agency more evenly between the participants than the 1st and 2nd person forms (Couper-Kuhlen and Etelämäki, 2015; see also Rossi and Zinken, 2016 on similar phenomena in Italian and Polish). This is exemplified in the following Example (2). The example comes from a telephone call where the reason for the call is that Satu (who lives in Northern Finland) has forgotten her wallet in Vesa's (who lives in Southern Finland) car during Vesa's visit to Northern Finland. Satu now calls Vesa in order to ask him to send her the wallet by mail as a registered letter.

Example (2): Satu's wallet (Couper-Kuhlen and Etelämäki 2015: 20-22)

```
01 Satu: sitä mä tässä ajattelin et että (.)
         what I was thinking was if (.)

02       kyllähän sitä kai     uskaltaa
         PRT-CLI  PRT  maybe Ø venture(-COND).3SG
         Ø (one) could venture perhaps

03       niinku lähettää kirjattuna kirjeenä.
         send it as a registered letter.

04 Vesa: kirjattuna       pitää    pis[tää joo.
         registered-ESS Ø must.3SG put-INF PRT
         as registered Ø (one) must send it yes.

05 Satu:                            [joo.
                                    yes.
```

Satu's request (lines 1–3) is formulated as a declarative statement including a modal verb *uskaltaa* ("venture") with a zero-person construction. Correspondingly, Vesa's response is formulated as a declarative statement that includes the modal verb *pitää* ("must") with a zero-person construction. The modal verb *pitää* ("must") in Vesa's turn expresses stronger necessity that the one in Satu's turn, and by that means Vesa displays independence in evaluating how the wallet will be best sent. Although it is clear that Vesa will perform the future action, both participants thus participate in deciding upon that action. In turns involving directions that are formulated with a zero-person construction, the zero-person occurs typically together with modal verbs that express the necessity/desirability of the proposed action (e.g., "can," "need," "must"). These turns are, moreover, declaratively formulated; i.e., they are formulated as statements that invite the recipient first to evaluate the rationale behind the action as well as the manner of the performance of that action. By offering the recipient of a directive a place to co-evaluate the necessity/desirability and manner of performance of an action, the combination of the zero-person and a modal verb distributes agency—accountability and responsibility over the action—between the participants more symmetrically than first or second person forms.

In the following, we explore psychotherapists' use of person reference forms. More specifically, we investigate how the use of the zero-person and second person singular pronoun distributes the client's experience and agency in the therapist's talk and how the choice of personal form corresponds to the action that the turn is accomplishing.

DATA AND METHODS

The data consist of 70 audio-recordings of actual psychotherapy encounters in Finland, collected in 1999–2009 in two different private sector clinics. The data come from four different dyads: two therapists with four different clients. One therapist is an experienced psychoanalyst, representing an object-relations-oriented psychoanalytic school. The other therapist is an experienced cognitive therapist, representing a cognitive-constructivist strand of cognitive therapy. The lengths of the encounters vary from 45 to 60 min and comprise ∼30 h of interaction from both therapy approaches. The data are transcribed according to the transcription conventions developed by Jefferson (2004). Both clients in cognitive therapy were women in their twenties suffering from depression. One suffered also from panic attacks, while the other had been diagnosed with a personality disorder. In psychoanalysis, one of the clients was a man in his forties suffering from depression and work-related burn-out. The other client was a woman in her sixties experiencing a difficult situation in her life (her husband was terminally ill). In cognitive therapy, regular planned meetings were held approximately once a week. In psychoanalysis, the frequency of the sessions was approximately three times a week.

Informed consent was obtained from all the participants for the publication of any potentially identifiable images or data included in this article. The therapists informed the clients of the research, both verbally and in writing. They were also given the possibility to withdraw their consent at any point of the data collection. The researchers were not present in any of the therapy encounters. The anonymity of the therapists and clients has been carefully ensured: all names and other details which might enable identification of the participants have been altered in the text and data excerpts.

The data were analyzed by means of conversation analysis and interactional linguistics. Conversation analysis is a systematic method for studying human social interaction. According to conversation analysis, social actions are accomplished through adjacent utterances (Schegloff, 2007; Stivers and Sidnell, 2012; Clift, 2016). This means that a prior utterance constrains the following turn, which shows what social action the prior utterance was understood to be; for instance, questions elicit answers, formulations elicit confirmation or rejection, and the sharing of an emotional experience elicits affiliation. Interactional linguistics is the conversation analytically informed study of linguistic structure and meaning, the starting point of which lies in understanding language as a thoroughly interactional phenomenon (Couper-Kuhlen and Selting, 2018).

The centrality of sequences of adjacent actions and linguistic structures has some important implications for conversation analytic studies of psychotherapeutic interaction. Thus, phenomena that are specifically relevant for psychotherapy, such as the therapist-client relationship and the expression of emotions in interaction, are examined in the context of sequences of actions, for example clients' descriptions of their experience and therapists' formulation of that experience (Peräkylä et al., 2008; Peräkylä, 2012). Conversation analysis and interactional linguistics assume that interpersonal relations, emotions and the like exist in and through sequences of actions.

Consequently, the aim of conversation analytic studies in psychotherapy is to describe not only these actions but also the way psychotherapeutic processes occur through sequences of such actions (Peräkylä, 2019). In this study, we focus on one aspect of that therapeutic process, the distribution of the client's experience and agency and describe how it is accomplished through the therapist's choice of the personal form. Rather than analyzing this linguistic form (person reference) as such, we use the results of previous interactional linguistic studies to analyze how agency is distributed in psychotherapy interaction.

Our analysis began by first collecting every sequence of actions in which the client complained about a third party, for instance, their mother or spouse. We decided to restrict our analysis in this context because previous studies have shown that complaining about a third party is a problematic activity in everyday interactions (see Heinemann and Traverso, 2009), and both the zero-person form and the second person form were found to be used in this context (see Voutilainen et al., 2010a). In these complaints, clients present themselves as having been inappropriately treated by the third party in question and describe the negative experiences they have encountered with that person (Voutilainen et al., 2010a). From 60 h of interaction, 74 such third-party complaints were identified. Next, we analyzed the therapists' responses to the clients' third-party complaints and investigated the ways in which these responses addressed the clients' accounts. At this point, we paid specific attention to the person reference forms that the therapists used in their responses. On the therapists' responses to the 74 third-party complaints in our data, 51 were formulated with a zero-person, and 23 with a second person singular pronoun. The cases were divided into three categories based on the immediate sequential context and the personal reference form (zero-person or second person singular) used in the therapist's turn. These categories were (1) a zero-person form when displaying empathy (32 cases), (2) a zero-person form when inviting an interpretation (19 cases), and (3) the second person form in the context of tracing the problematic elements of the client's life history (23 cases). In the Results section below, we present these categories through four data examples.

RESULTS

In the therapists' responses, we found that the zero-person form occurred in two contexts: in displays of empathy toward the client's emotions and in interpretations of the client's experiences and circumstances. In turn, the second-person singular pronoun was used when the therapist was re-constructing the client's history. In the following, we first discuss the use of the zero-person and then compare these uses to cases where the therapist uses the second person singular pronoun.

Empathetic Use of the Zero-Person: Treating the Experience as Actual Here and Now

We found that the zero-person form treats the client's experience as actual and epistemically available in the here-and-now of the therapeutic situation or in the client's current life more generally. As has been demonstrated in everyday talk (Laitinen, 1995, 2006), the use of the zero-person presents an experience as shareable and thus epistemically available to the recipient. In therapeutic interaction, the therapist can project a sense of speaking "from within" the experience when using the zero-person (Vehviläinen, 2003; Voutilainen et al., 2010b; Weiste et al., 2016). In other words, the zero-person is used for displaying empathy: for displaying recognition and understanding of the client's emotional experience as expressed by the client.

Extract (3) below is drawn from a cognitive psychotherapy session. It represents an example of the use of the zero-person in a turn functioning as an empathetic response. The client discusses her persistent fear of being physically assaulted when out in the city (lines 5–11). This fear is particularly intense during the night, even when the client is with her boyfriend, Ville (lines 16–20, 23). The client's talk is hesitant and perturbed: it includes several pauses, and self-initiated same-turn repairs of different types (see Schegloff, 2011).

Example (3): Feeling unsafe with Ville too

```
01 T:   mut jos sää kuljet yksin vaik
        mut if you go alone for example

02      Pietarsaaressa(0.6) ää niin sua pelottaa
        in Pietarsaari (0.6) then you are afraid

03      jos sä kuljet Villen kans niin ei niinkö.
        if you go with Ville then (you are) not (afraid) is that so.

04      (0.6)

05 C:   .hfff niihän kyl mua välillä en mää mm
        .hfff yeah well I am sometimes I don't mm

06       y-ähhhhhh (0.8) no (0.8)
         ermhhhhhh (0.8) well (0.8)

07       ei:: no päivisin (.) päivisin jos
         no:: well during the daytime (.) during the daytime if

08       kulkee jonku muun kanssa niin on semmonen et (.)
         Ø (one) goes with someone else so Ø (it) is such that (.)

09       ne ajatukset kiinnit- ei ne ei ne niinku
         the thoughts faste- they don't they don't like

10       sit ei ahdista (.) eikä niinku tunnu siltä et
         then Ø (one) doesn't feel anxious (.) and like Ø (one) doesn't feel
like

11       kaikki kattoo tai ei .hhh [ei oo]
         everyone is watching or isn't .hhh isn't

12 T:                              [mmm  ]

13 C:   semmonen (.) on jotenki sitte niinku ajatuksetki siin
        like (.) is somehow then like the thoughts too

14      ihan muualla sitte      ku     on kaveri siinä vieressä ja
        are somewhere else then when Ø (one) has a friend there beside and

15      .hhhh  (0.3)  ei keskity siihen ahistukseen ja
        .hhhh (0.3) Ø (one) doesn't focus on the feeling of the anxiety and

16      mut et yöllä nii en mä välttämättä (0.8)
        but during the night so I don´t necessarily (0.8)

17      Villenkään kanssa (0.3)
        with Ville either (0.3)

18      oo semmonen    turvaton olo     kyllä
        be the-kind-of unsafe   feeling PRT
        have that kind of unsafe feeling indeed

19     (0.3) emmä jotenki usko että
       (0.3) I don´t somehow believe that

20      se niinku pystyis puolustamaan mua
        he could like defend me

21     (0.9)

22 T:   °mm-m°.
```

```
23 C:   mmm (0.4) keltään että,
        mmm (0.4) against anyone so

24 T:=> et Villenkin  kanssa  on     turvaton  m[m.
        PRT Ville-CLI with  Ø be-3SG unsafe PRT
        so with Ville too Ø (one) feels unsafe mm.

25 C:                                          [n-nii.
                                                y-yeah.
26      (1.9)

27 C:   KRÖHM et  joskus      miettii   just et
              PRT sometimes Ø think-3SG PRT PRT
        KRÖHM that sometimes Ø (one) thinks exactly that

28      pitää      et  mä  haluisin  hommata jonkun (0.6) semmosen laillisen
        Ø must-3SG PRT 1SG want-COND get     some (0.6)  the-kind-of legal
        Ø (one) must that I would like to get some of those (0.6) legal

29      itsepuolustusvälineen
        self-defense tools((continues))
```

In her account in lines 5–24, the client uses the zero-person form (lines 7–8, 10, 13–15) to display her experience as shareable (Laitinen, 1995, 2006). In line 24, the therapist takes the turn and produces a formulation that highlights the key descriptive element of the client's account (from lines 16–20, 23) (Weiste and Peräkylä, 2013): the client is afraid, even when accompanied by her boyfriend. The therapist's turn begins with the particle *et* ("that"), which marks it as a paraphrase of the client's previous turn. The emotion (feeling unsafe, literally translated "is unsafe") is picked up from the client's previous turn. Like the client in her account (lines 7–8, 10, 13–15), the therapist uses the zero-person form of the verb in the formulation ("Ø is"). It is noteworthy that whereas in lines 16–18 the client begins to formulate the utterance as a negative statement but self-interrupts and reformulates it as a positive one, the therapist's formulation is constructed as a positive statement. Moreover, whereas at the end of her account (lines 16–17) the client uses the first-person form *emmä välttämättä Villenkää kanssa* ("I don't necessarily [feel safe] with Ville either"), the therapist uses the zero-person in her formulation. The therapist's formulation with the zero-form does not, thus, merely echo the agency and experience in the client's account. Instead, the therapist reformulates the client's account based on the self-repair in the client's utterance, and the zero-person offers the client a place as an experiencer of this re-formulated account (see Laitinen, 2006).

On completion of her formulation (line 24), the therapist produces the particle *mm* which conveys acknowledgment and confirmation, and by producing it at this point, the therapist positions herself as the recipient of her own formulation. Thus, she orients to her formulation as if it were the client's words that she receives. By using the zero-person form, the therapist can be heard to speak "from within" the client's experience (Vehviläinen, 2003, Voutilainen et al., 2010b, Weiste et al., 2016), thereby distributing the agency of the experiencing subject between the therapist and the client. The use of the zero person creates a place for an experience that is shared, not through lived life but through empathetic imagination. The therapist therefore treats the experience as available and understandable as such, and, in that way, she avoids implying that the client needs to provide a further account of the experience. The client confirms the therapist's formulation (*nii,* "yeah," line 25), and nevertheless elaborates on the feeling (lines 27–29) by using the zero-person herself, thus continuing to treat the experience as mutually shared.

In this example, both the client and the therapist use the zero-person to co-describe the client's experience, which has been made mutually available during the therapy session. The therapist's use of the zero-person displays empathetic stance to the client's account (see also Voutilainen et al., 2010b, Weiste et al., 2016). By treating the client's experience as epistemically available, the therapist makes shared experience possible. In other words, through empathetically formulating the client's words, the therapist, as it were, participates in the client's experience.

Interpretive Use of the Zero-Person: Analytical Distancing From the Experience

Another context where therapists use the zero-person is when interpreting the client's experience. Example (4) shows a case in point from a psychoanalytical therapy session. Prior to the example, the client has been discussing the time in her childhood when she lived with her mother. She describes herself as an obedient girl who always attempted to comply with her mother's wishes. Moreover, she constantly felt that she was "necessary, yet not very important" to her mother. Prior to the extract, the client has hesitantly suggested that her mother was quite unreliable for a child, and the therapist has pointed out that it is difficult for the client to say anything bad about her mother. At the beginning of the extract (lines 1–15, 18–20), the client elaborates further on her experience of her mother's unreliability.

Example (4): Ingenious means for mother

```
01 C:   mhhh ja ja ehkä myöskin ihan vaan se että
        mhhh and and maybe also just the thing that

02      kun .mhhh  jos lähetään siitä ajatuksesta
        when .mhh if we start with the idea

03      äitini oli ee- ikään kuin epäluotettava
        my mother was kind of like unreliable

04      minulleki .mhhhh vaikka va- vastentahtosesti
        for me too       although I am re- reluctantly

05      sanon sen (.) ilmasen sen näin mut et (1.0)
        saying it (.) expressing it like this but that (1.0)

06      et et minä tunsin et minulla oli niin (0.5)
        that that I felt that I had so (0.5)

07      paljon vastuuta (0.4) et minun täytyy vaan (0.3)
        much responsibility (0.4) that I have to just (0.3)

08      yrittää ja tehdä ja (0.5) mennä ja tulla ja
        try and do and (0.5) go and come and

09      .hhhh (.) että (0.7) et niinku (.)
        .hhhh (.) that (0.7) that like (.)

10      et se liikkuu aika (0.4)
        that it moves quite (0.4)

11      et minun harteilla oli niin kummallisen
        that I had such a peculiarly heavy burden

12      suuri taakka ku minä ymmärsin et
        on my shoulders when I understood that

13      et äiti voi koska vaan unohtaa avaimet ja
        that mother could any time forget her keys and

14      hukata rahansa ja siis
        and lose her money and I mean

15      ihan tämmöstä epäluotettavuutta.
        this sort of unreliability.

16      (1.0)

17 T:   nii,
        yes,
```

```
18 C:    että mm (0.5) et kun äiti oli noin unohtavainen
         that mm (0.5) because my mom was so forgetful

19       ja äiti ei (1.5) minun täyty muistaa
         and mother didn't (1.5) I had to remember

20       ja havaita ja huomata ja,
         and notice and realise and,

21       (3.5)

22 C:    näin.
         like that.

23 T: => et sillon   sen    vois         kääntää myöskin  toisin päin
         PRT then  Ø it-GEN can-COND.3SG turn    also-CLI other way around
         that then Ø (one) could turn (it) the other way around

24    => ja  ajatella että sehän  on     äidiltä
         and think    that it-CLI be-3SG mother-ELA
         and think that it is indeed a ingenuous means for mother

25    => nerokas   tapa  sitoa sinut.
         ingenuous means tie   2SG-ACC to bind you.
         to bind you

26       (2.5)

27 T:    kun sinun piti olla aina aina huolestunut hänestä.
         because you always always had to be worried about her.

28       (0.5)

29 C:    niin   voishan          sen    nii[nkin
         PRT  Ø can-COND.3SG-CLI it-GEN PRT-CLI
         yes Ø (one) could also think of it

30 T:                                    [ja sillon  ei ollu aikaa
                                          PRT then  Ø NEG be time-PAR
                                          and then Ø (one) had no time

31       ajatella itseäsi eikä (0.5) eikä omaa elämää.
         to think about yourself nor (0.5) nor Ø (one's) own life.

32       (2.0)

33 C:    nii et eihän hän sanonu että et
         yes so that she didn't say that

34       @voi voi kun minä olen niin huonomuistinen@
         @oh I'm so forgetful@

35       että (0.5) että ett (0.4)
         so (0.5) so that (0.4)

36       @pane sinä nyt Mirja mielees@ tai jotain sellasta
         @you keep that in mind now Mirja@ or something like that

37       (.) sitä hän ei sanonu.
         (.) this she didn't say.
```

In her account, the client uses the first-person form when describing her experience (lines 5–7, 11, 19). Unlike the previous extract where the client used the zero-person form, here the client does not invite an empathetic recognition of her experience as strongly; rather, by reflecting on her childhood experience, she offers a place for an interpretation by the therapist. In his response (lines 23–25, 27), the therapist offers an interpretation of the client's experience that differs in content and perspective from that offered by the client herself. The therapist's turn begins with the particle *et* ("that") (line 23), which marks that the turn is based on the contents of the client's previous turn. This is followed by a zero person construction with a modal verb *vois kääntää… ja ajatella* ("Ø [one] could turn… and think") (lines 23–24). Thus, the design of the turn does not specify whether the person who could turn the thought around is the therapist or the client. The zero-person offers the client a slot where she can examine her thoughts from the therapist's perspective. In other words, while the therapist is the one who delivers the interpretation, through the zero-person he offers the place of the analyzer/examiner of the past situation to the client and so distributes the agency in interpreting the experience between himself and the client.

The interpretation changes the perspective and suggests that the motivation for the client's childhood behavior came from the client's mother instead of the client. The client initiates a partial confirmation with a concessive phrase, *niin voishan sen niinkin* ("yes Ø [one] could also think it so"), also using the zero form (line 29), and so takes the interpretive position offered by the therapist. The therapist intervenes in this (line 30) with a turn that is marked as a continuation of his previous turn by the particle *ja* ("and"). This turn presents the client with the consequences of her mother's behavior: it offers the experience ["no time to think about (one's)self nor to live Ø (one's) own life"] to the client to identify with. The client then produces an apparent confirmation (line 33). It begins with an agreeing particle, *nii* ("yes"), followed by an *et* ("so that") initiating elaborating talk where the focus is on her mother. Nonetheless, the content of the talk is in slight contradiction to the therapist's suggestion in lines 23–25. However, the client maintains a reflective position on her experience and so aligns with the therapist's interpretative project that he suggested through the zero-person form.

The two examples above illustrated the two contexts in which the therapists in our data use the zero-person in their responses to the client's third-party complaints. In the empathetic response, the zero-person treated the client's experience as recognizable to the therapist. In the interpretative response, the therapist presented his own interpretation of the client's experience, and, by using the zero-form, invited the client to share the interpretative position. In contrast to these two uses of the zero-form, we will next discuss cases where the therapist refers to the client with the second person form.

Creating Asymmetric Agency: Second Person Reference

Whereas, the zero-person in therapists' formulations invites patients to deal with their experience, either emotionally or by taking an analytic stance toward it, we found that second person references are used for re-constructing the client's past history. We argue that in these cases, the use of the second person singular pronoun treats the client's experience (in relation to third parties) as not shared by the client and the therapist, thus displaying asymmetric epistemic access to the experience (cf. the zero-form). Instead of providing an empathetic response to or an interpretation of the client's previous account, turns that include a second person singular pronoun make relevant a further explication of the experience.

Example (5) provides a case in point. The example is from cognitive therapy, where the client has discussed a recent meeting with her father (referred to as *Matti*) in which her father had described her mother's behavior as outrageous when she had been a child. At the beginning of the extract, the client moves to discuss the conflict of loyalty she feels between her divorced parents.

Example (5):

```
1 C:    ja tota hhh mth tommosia se puhu äää
        and erm hhh mth he spoke those kind of things erm

2       .hhh ja hhh [musta se on hirveen vaikee tilanne ku mulla
        .hhh and hh  for me it is an awfully difficult situation

3 T:               [(  )

4 C:   on kuitenki (1.5) kuitenki siis sillai (.)
       as I have nevertheless (1.5) nevertheless in a way (.)

5      Matista se kuva että et se on lähteny se on jättäny meijät
       the picture of Matti that he went away he left us and

6      ja et mä oon katkera tavallaan siitä siis sillä lailla
       I am bitter in a way about that in such a way

7      et mä oon saanu sen (.)äidin .hhh      [katkeran asenteen
       that I have received (.) mother's .hhh a bitter attitude

8 T:                                          [mm.

9 C:    siihen?
        towards him?

10 C:  et .hh ja::    [mut et,
       that .hh a::nd but then,

11 T: =>              [mut toisaalt          sä  tunnistat     myös
                       PRT on-the-other-hand 2SG recognise-2SG also
                       but on the other hand you recognize also

12    => ton äidin mistä se Matti puhuu .hh  tempperamenttisen ja
         that mother that Matti speaks about .hh a temperamental and

13    => pelottavan äidin.
         frightening mother.

14 C:   Joo-o kyllä mut et ei se nykyään enää niin
        Yeah yes but that nowadays she no longer has

15      raivokohtauksia siis semmossia että .hhh kylhän se on (.)
        fits of rage I mean like that that .hhh she has(.)

16      aina ollu semmonen äkkipikanen tai tempperamenttinen
        always been like short-tempered or temperamental

17      semmonen,
        like that,
```

In her account, the client uses the first-person form "I" (lines 2, 4, 6–7). As the client does not use the zero-person form, she does not invite as strong an empathetic recognition of her experience as in Example 3. Instead, by reflecting on her childhood experience, the client offers a place for an interpretation by the therapist. The therapist responds to the client's account by highlighting the other side of her conflict of loyalty, that is, her mother and her unpredictable behavior (lines 11–13). The turn begins with a contrastive conjunction *mut* ("but") followed by the adverb *toisaalta* ("on the other hand"), followed by a declaratively formulated B-event statement that concerns the client's perception *sä tunnistat myös* ("you also recognize"). B-event statements, namely declaratively formulated utterances that fall into the recipient's knowledge domain, function as polar questions by making a confirmation or disconfirmation the relevant next turn (Labov and Fanshel, 1977). The beginning of the therapist's turn ("but on the other hand") maintains the relevance of the client's experience—as recounted by the client—but the rest of the turn suggests that there is another side to the client's story. The therapist's assertion is thus empathetic toward the client's description, but it also confronts the client's talk by bringing in elements that have not been mentioned explicitly, namely, the client's negative attitude toward her mother. By formulating her turn as a B-event statement with a second person singular pronoun, referring directly to the client as "you," the therapist indicates more of an epistemic asymmetry between the participants than in the previous examples, where the zero-person form suggested a shared affective or interpretative stance. Furthermore, compared to the zero-person form, which implies shared agency, the use of "you" also evokes "I," and thus two separate agents in the on-going situation.

In comparison to the uses of the zero-person in the context of empathy, here the client's experience is construed as belonging to the client's domain of knowledge, as something that the therapist can infer but to which she lacks equal epistemic access. This invites the client to relate herself to the therapist's suggestions and consider the ways in which she can, or cannot, agree with them. The client's response (line 14) begins with a conjunction chain *joo kyllä mut* ("yeah yes but"), whose basic function is to claim that the other speaker has incorrect or insufficient knowledge (Niemi, 2014). In this way, the client also implies epistemic asymmetry between the participants. This is followed by talk that returns to the present: the client's mother no longer suffers from outbursts of rage. The client uses the characterization "temperamental" (already used by the therapist in line 12), which is quite different from, and in a way more complimentary than, the characterization "getting sudden and frightening fits of rage."

In sum, unlike the empathetic responses with the zero-person, here the experience in question (a negative stance toward the client's mother) is not displayed as being equally accessible to the participants; rather, the therapist seeks to help the client identify all the aspects of the past experience that need to be dealt with in the therapy session. As we claimed in the analysis of the previous extracts, shared agency and shared epistemic stance are bounded in the use of the zero-person form. For shared agency, the participants require shared knowledge. When using the second person form, the therapist implies that there is insufficient shared knowledge for shared agency to be attributed when describing the experience.

The next extract (6) further elaborates on the therapist's use of second person references. It comes from the same therapy session as Example (4) and it is a direct continuation of it.

Example (6): Challenging the Client

```
39 T: => vaan sinun   piti         keksiä se.
         PRT  2SG-GEN must.PST.3SG figure it
         instead you had to figure it out.

40       (0.6)

41 T: => todeta et niin on.
         to discover that so it is.

42 C:    niin mä sanosin että se oli enemmän niinkun
         yeah I'd say that it was more like

43       lähtösin minusta itsestäni.
         originating from myself.

44       (0.4)

45 T:    entäpä jos se oli äidistä.
         what if it was from mother.

46       (1.4)

47 C:    ö:: (.) niin nii mut nii.
         erm (.)yes yes but yeah.

48       (3.3)

49 T:    mut et siinähän (0.2) ikään kuin
         but that there (0.2) like

50   =>  syytät    siitä  itseäsi      että
         blame-2SG it-ELA yourself-2SG PRT
         you blame yourself that

51   =>  se oli        sinun  (0.5)  virheesi    että
         it be.PST.3SG 2SG-GEN       mistake-2SG PRT
         it was your (0.5) mistake that

52   =>  olit   niin huolehtiva (1.0)
         be-2SG so   caring
         you were so caring (1.0)

53       entäpä jos äiti tahallaan (.)
         what if mother on purpose (.)

54       sanotaan nyt tahallaan lainausmerkeissä
         let's say on purpose in quotation marks

55       (0.4) aiheutti sen.
         (0.4) caused it.

56       (4.0)

57 C:    niin no siis tiedostamatta eiks pitäis sanoa.
         yeah well unconsciously shouldn't one say.

58       (0.7)

59 C:    e[ihän se ollu
         it wasn't

60 T:     [mutta kuitenkin tahallaan.
           but anyway on purpose.
```

In response to the client's elaboration after the interpretation in Example (4), the therapist sums up the meaning of the client's mother not telling the client that she should take care of things: the client had to figure it out for herself (line 39). The turn begins with the conjunctive adverb *vaan* ("instead"), which makes the turn a direct syntactic continuation of the client's previous turn. Consequently, the turn aligns grammatically with the client's previous turn, but it shifts the focus from the mother to the client. Moreover, the turn includes the modal verb *piti* ("had to"), expressing necessity. The modal verb construes the past situation as a burden to the client and already implies that this necessity perhaps came from the client's mother (which the therapist in his later turn in line 45 explicitly suggests). Again, through the second person reference, an asymmetry between "you" and "I" is established; the therapist (first in lines 49–55 and then in line 60) infers aspects of the clients past experience that have not been made available in the previous talk but have to be traced. Here, the therapist does not invite the client to co-interpret the experience but instead suggests, and later in line 60 insists on, an interpretation, regardless of the client's resistance (first in lines 42–43 and later in lines 57–59).

The client's response begins with the particle *nii no* ("yeah well"), which implies disagreement. It is followed by talk that transforms the therapist's suggestion that the client's mother "on purpose," (*tahallaan*, line 54) caused the client's over-developed sense of responsibility into a view that is more favorable toward the client's mother: she did it "unconsciously" (*tiedostamatta*). As we can see from the continuation (lines 59, 60), this is followed by a sequence where the client and the therapist disagree on the real state of affairs in the past. Unlike the extracts where the therapist used the zero-person form, the therapist does not suggest that the client's experience is available in the here-and-now of the therapeutic interaction; rather, there is a gap between the therapist's and the client's knowledge. However, in her response in line 57, the client uses the zero-person form and so suggests a more shared agency and a more symmetric epistemic relationship between the participants when interpreting the experience in psychotherapeutic terms.

To sum up, the second person reference was used in situations where the client's experience and emotion were not dealt with as mutually accessible and shared but as an experience that must be traced from the client's life history. The therapists' turn with the second person reference re-constructed the client's life history from the therapist's perspective, offering a version that differed from the client's account for the client to evaluate. By doing this, they challenged the client's previous understanding. The asymmetry that the person reference builds between "you" and "I" (in contrast to a shared understanding of emotion or interpretive agency in the uses of the zero-person) can be seen to reflect this epistemic difference and distance from the experience.

Summary of the Results

In the four examples above (3–6), we discussed the use of personal forms in three types of therapist responses: a zero-person form displaying empathy, a zero-person form inviting interpretation, and a second person form in the context of tracing the problematic elements of the client's life history. We proposed that these forms perform distinct functions in therapeutic interaction. The use of the zero-person in general creates symmetry between the participants. When used in the context of empathy, it displays access to and understanding of the experience described by the client. Thus, it creates a symmetric relationship toward the emotive experience and functions as an

empathetic response. Moreover, it invites the client to retake the "position of the zero"—the experiencing subject—and to notice and live through the emotive experience together with the therapist. When used in the context of interpretation, in turn, the zero person invites the client to adopt the position of an observing subject together with the therapist. In this use, it aims to create distance between the experienced emotion and the client and invites the client to take an interpretive perspective on the experience together with the therapist. The use of the second person form "you" always invokes the speaking "I" (Benveniste, 1966 [1956]) and thus foregrounds the separateness of the knowledge and agency of the participants. In our cases, the therapist uses the second person form in turns where s/he names an emotion or experience that has been implied but not previously named in the client's talk. The use of this form thus explains the client's experiences from the therapist's perspective and aims to identify the experience to be dealt with in therapy.

DISCUSSION

As Enfield (2013) observes, social agency is a dynamic, interactional phenomenon. Our analysis demonstrates that this perspective is also applicable to and informative for the study of psychotherapeutic process. The strength of the conversation analytic and interactional linguistic approaches adopted in this research lies in their efforts to study agency as a two-way relationship distributed over the course of actions performed by the therapist and client during therapeutic sessions. Thus, the analysis centers neither solely on the inner processes occurring within the client nor on the interventions performed by the therapist. Instead, the focus of analysis is the joint negotiation of agency and the consequent transformation of the description of the client's experience (see also Peräkylä, 2019).

Our analysis indicates that, when several options exist for person reference in a language, psychotherapists' choice of a particular alternative gains its specific meaning in its interactional context. In the case of third person complaints, the use of the zero-person form, which has previously been described as a "vague" person reference (Kurri and Wahlström, 2007), did not merely imply weak agency for the client (or the therapist); rather, it indexed the sharedness of the experience and agency in the contexts of empathy and interpretation. In comparison to the zero-person form, the choice of the second person singular pronoun placed the client more clearly 'on stage' as the target of the talk. This separateness, too, performs therapeutic functions. In the context of responses to third party complaints, the separateness of the agents (therapist and client) served to trace or identify the experience to be dealt with, in order to make the experience mutually available here and now. By contrast, in the situations where the therapist used the zero-person form, the person reference did not objectify the client as an agent under someone else's surveillance; instead, it implied the boundedness of the agents. In other words, the experience was not scrutinized from outside but within the slot opened up by the zero-person.

Our study also indicates that in Finnish psychotherapy sessions, the use of the zero-person distributes accountability and responsibility for the emotive experience between the therapist and the client. In that way, it invites the client to relate with the emotive experience in the here-and-now of the therapy session. Moreover, the use of the zero-person in interpretative actions to distribute accountability and responsibility for an action invites the client to construct an interpretative position toward the past experience in question. This, in turn, may help clients first to re-interpret the distribution of agency (accountability and responsibility) of their experiences and to adopt an interpretative perspective in the future: to analyze the distribution of accountability and responsibility in their lives and adopt an agentive position with respect to their decisions.

Our study specifies earlier research on agentless talk (Kurri and Wahlström, 2007). In contrast to that research, our study demonstrated that "vague" person references by therapists in the context of empathy and interpretation do not simply attempt to save the client's face; rather, they distribute agency between the client and the therapist. By using a zero-person form in these contexts, the therapists offered their clients a position to identify with, a position of empathetic understanding and interpretation of their experience (e.g., Eagle and Wolitzky, 1997; Greenberg and Elliott, 1997).

Our data comes from Finnish psychotherapy interactions which does not mean that the distribution of agency would be a uniquely Finnish phenomenon (see, e.g., Enfield and Kockelman, 2017, Rossi and Zinken, 2016). This raises interesting questions on how the distribution of agency is accomplished in other languages since person systems in languages organize person in different ways (Siewierska, 2004, Malchukov and Siewierska, 2011). The study of distribution of agency in therapeutic interaction opens thus an avenue to comparative studies on how cultural and language differences manifest in psychotherapeutic work.

In this study, the focus of analysis was the detailed ways in which personal forms are used in real time therapeutic interaction and therapists' use of these linguistic means for subtly distributing agency between themselves and the client. In this respect, we found no differences between the two therapeutic approaches (cognitive therapy and psychoanalysis). It should be born in mind, however, that our dataset contained just one therapist from each approach, and thus the question of differences between therapeutic approaches in the distribution of agency remains for further research.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

Ethical review and approval was not required for the study on human participants in accordance with the local legislation and institutional requirements. The

patients/participants provided their written informed consent to participate in this study. Written informed consent was obtained from the individuals for the publication of any potentially identifiable images or data included in this article.

AUTHOR CONTRIBUTIONS

ME, LV, and EW: conception and design of the study, acquisition, analysis, interpretation of data, and drafting and revising the manuscript. All authors contributed to the article and approved the submitted version.

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GLOSSARY

2	Second person
3	Third person
Ø	Zero person
ACC	Accusative case
CLI	Clitic
COND	Conditional
GEN	Genitive case
ELA	Elative case
ESS	Essive case
INF	Infinitive
NEG	Negation
PAR	Partitive case
PL	Plural
PRT	Particle
PST	Past
SG	Singular

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Doing Contrariness: Therapeutic Talk-In-Interaction in a Single Therapy Session With a Traumatized Child

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Conversation analysis (CA) of children-adult—interaction in various contexts has become an established field of research. However, *child therapy* has received limited attention in CA. In child therapy, the general psychotherapeutic practice of achieving empathy faces particular challenges. In relation to this, our contribution sets out three issues for investigation and analysis: the first one is that practices of achieving empathy must be preceded by efforts aiming to establish which kind of individualized conversation works with this child (Midgley, 2006). Psychotherapy process researchers in adult therapy (Stiles et al., 2015) have found that therapists "invent" a new therapy for each patient (Norcross and Wampold, 2018). The second issue is that it can be difficult for adults to understand the ways in which children express their conflicts and issues. In particular, play activities in therapy, e.g., with dolls, can open up additional scenarios of interaction. The play scenario can be used to disclose unformulated problems masked in everyday and family interactions. The third issue is how to respect the child's higher degree of vulnerability, compared with adult patients. How is it communicated and dealt with in therapy? We present an interaction analysis of a single case study of the first 20 min of a child therapy session with an adopted girl aged 4 years brought to treatment because of "unexplainable rage." The session was videotaped; parents granted permission. We analyze this session using an applied version of CA. In our analysis, we describe "doing contrariness," as a conversational practice producing epistemic and affiliative disruptions, while "avoiding doing contrariness" and "remedying contrariness" are strategies for preserving or restoring the affiliative dimension of a relationship (in child therapy). We show how these practices operate in various modes and how they are used by both parties in our case study to variously aid and impedethe achievement of empathy and understanding.

Keywords: trauma, children in treatment, doing contrariness, psychotherapy, adoptive children, conversation analysis

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INTRODUCTION: DOING CONTRARINESS

Interaction involving children has been extensively studied in conversation analysis (CA) (Goodwin, 2006; Kidwell, 2013). CA has studied treatments of children with language disorders like stuttering (Leahy, 2004; Leahy and Walsh, 2010) and children with autism spectrum disorder in an educational environment (Korkiakangas et al., 2012) and in parental care (Ramey and Rae, 2015). Others have studied interaction with children with Asperger's syndrome (Rendle-Short, 2017), the role of fatherhood in family therapy (Suoninen and Wahlström, 2010), or of morality in helping institutions (Bergmann, 1990).

CA studies of the entire process of child *therapy* have been conducted (Gardner and Forrester, 2010; Lester and O'Reilly, 2015; Stafford and Karim, 2015; Rendle-Short, 2017) to study the influences of parental behavior, of institutional contexts like schools or psychiatric wards. Studies contrasting CA perspectives on interaction with theory-of-mind approaches have documented the influential contribution of the helping personnel like psychiatrists or teachers or even parents, in producing a child's symptoms (McCabe et al., 2004; Stivers et al., 2017).

Hutchby (2007) studied the work of counselors with children of 6 years (or older) whose parents were divorcing. The counselors' participation has the aim of helping these children to better cope with their parents' divorce. Counselors bring to the consultation the success of therapeutic vision, in seeking to bring into play counseling relevant topics and interpretations, but achieving their aim depends "in part on children's recognition of, and willingness to go along with, that aim" (p. 131). Hutchby documents that handbooks for counselors do not sufficiently inform on how to achieve that aim because they ignore the conversational details. He makes a strong argument for studying the "true richness of the interactional resources brought into play by both counselors and children" (p. 134). This "true richness" he calls *bricolage,* a kind of do-it-yourself for the counselor. S/he has to invent therapy based on skillfully taking the child's individuality into account. However, the aim—to help with coping with the parent's divorce—is predefined by the institution. The counselor's skills aim at winning the child's participation, but he crucially notes that children often resist; this is most impressively shown *via* the case of a boy of 6 years responding to the counselor's questions with "I don't know" more than 60 times in a single session. Hutchby's analysis shows how "don't know" is not merely an assertion about insufficient access to or lack of information. The response is identified as part of a "game" played with or against the counselor, or even as a strategy (p. 117). Hutchby here uses the term "resistance" as equal to "unwillingness" (p. 121); in medical sociology, the term "non-compliance" is used to describe when patients do not follow their doctor's instructions.

Hutchby's findings on child *counseling* can be fruitfully compared with the situation of child *therapy*. The child counseling described by Hutchby has a predefined target: learning difficulties, parental divorce, bullying at school, etc. It is also time limited (5–10 sessions) and mostly offered in an institutional context. The kind of child therapy we describe here often lasts many more sessions and frequently takes place in private practice. It also often has no institutionally predefined target. Instead, as in our case study, it is frequently the parents who seek to predefine the aim of therapy, and therapists may fear that the child will be taken out if the therapy does not conform to these aims. Young children do not openly articulate self-defined aims for therapy in many cases. Therapists try to find out about their aims by observing how the child comments on being brought to therapy. Therapists try to "read" these comments, observe the child's play for references to an unformulated grievance, unrecognized pain or conflict, or use other observables to decide on how to *individually* perform therapy with a child. If things go well, it can happen that the child likes coming to therapy and that this can lead to her/him setting her/himself up in a somewhat opposing position to that of the parents. This can manifest in practices of what we call "doing contrariness" (DC). We will discuss instances of DC as they appear in the analysis and only give a short characterization here. It is a conversational practice involving a one-sided use of power by one of the participants which thwarts another person's plans or expectations. The use of power consists in creating a distinction, and assuming the authority of valuing one side of it as positive, the other as negative. Its operational mode is often as a disruption, violating expectations. Because of its disruptiveness, it can have considerable effects on participants. Both the conversational disruption that it consists and the unbalanced distribution of strongly positive and negative emotional values that it affects can threaten their affiliative network. We also observe practices responding to or preemptively seeking to avoid contrariness, aimed at restoring conversation and affiliation or at keeping them intact. These repair activities (in a broad sense) we call "remedying contrariness" (RDC) and "avoiding contrariness" (ADC), respectively.

MATERIALS AND METHODS

We provide an interactional analysis of a therapy session with a young child. Ina (pseudonym) is a 4-year-old girl. After giving birth to her, her mother left her in the care of a hospital. Ina was placed with a foster care family for half a year and then was adopted. She is brought to treatment because of frequent outbreaks of rage against other children and her adoptive parents. The clinical hypotheses for her are that she has a deep desire for her mother's love and in the same moment a strong hatred toward her for having left her alone. This is a strong emotional burden and a cognitive conundrum she cannot solve. A further clinical hypothesis is: parents in adoptive families often wish to be accepted as "genuine parents," addressed as "mom" and "dad." After some time, adoptive children often realize what a powerful position in family life they can achieve by *not* fulfilling their parent's wishes (Feder, 1974; Nickman, 1985; Haimes, 1987)—a generalized example of "doing contrariness." Ina's situation, as a child having suffered from traumatic losses in early years requires a different therapeutic approach than the one documented in Hutchby (2007). The session has been recorded on video and audio. The parents have given their permission to use the material for publications.

Our Study Aims at Answering the Following Guiding Questions

How are the conventions of conversation adapted to the purpose of therapeutic talk between therapist and child? Do they use playing scenarios to negotiate and solve conflicts arising from the traumatic history of the child, and if so, how? How is their conversation affected by whether they have aligning and non-aligning interactional goals? We focus on one interactional practice (doing contrariness) and strategies to address it (remedying/avoiding doing contrariness) which we identify in various multimodal guises and show which role they play in answering these questions as well as for the therapeutic process of treating a child with traumatic experiences. We hope to contribute to a better understanding of therapeutic interactions, which has potential benefits also for therapy: applied analyses such as the one we are presenting can have a kind of supervisory function for therapeutic talk and for institutional conditions (Karim, 2015). CA research has also contributed to a better understanding of the details of children's talk about traumatic experience (Bateman et al., 2015).

Although we are oriented toward CA in our analytical approach, we also make use of the toolbox of broader linguistic analysis as well as insights from psychotherapeutic research and clinical experience.

There are two main issues that are particularly important for our analysis of the interactional processes in child therapy and of how they influence therapy outcome, in our view. They concern the length of conversational stretches that are usually considered in analysis and the question of how to deal with less conventionalized language (here, of and toward young children).

Regarding the first issue, in CA, analyses are often conducted on sequences of only a few turns in length; this has produced the very influential concept of the adjacency pair (Schegloff and Sacks, 1973). Certain adjacency pairs in specialized contexts have not only produced highly conventionalized linguistic forms, such as greeting-greetings, but also various kinds of offers, requests, invitations, and their respective responses. There is a preference bias for the production of positive responses over negative ones, and in perception, negative responses are also dispreferred in that they cause a higher cognitive load (Bögels et al., 2015; Kendrick and Torreira, 2015), leading to conventionalization also in the type of response, not only its form. Sometimes, analytical attention in CA can seem to focus on short sequences and strict sequentiality. However, this is not so on principle: Sidnell (2013) discusses several types of evidence in CA that are not restricted in this way, and Schegloff (2007) substantially extends the notion of adjacency pair beyond immediate sequentiality *via* expansion. Recent pragmatic models also show the relevance of meaning dependencies across longer stretches of discourse in everyday conversation (Farkas and Bruce, 2010; Ginzburg, 2012; Roberts, 2012; Goodwin, 2015). Together, these approaches allow to take effects into consideration that arise from the interaction of the content and illocutionary force of the current turn with (the retrospective interpretation on behalf of the participants of) conversational acts having taken place many more turns before. This is particularly important for understanding conversation in a psychotherapeutic setting, where long-distance effects and their negotiation between therapist and patient are part and parcel of the interaction (Buchholz and Kächele, 2017). One of the aims of CA has been to contribute to an understanding of how meaning is "achieved" in interaction (Garfinkel, 1967; Heritage, 1984). The understanding of meaning underlying this idea is that it

> …lies not with the speaker nor the addressee nor the utterance alone as many philosophical arguments have considered, but rather with the interactional past, current, and projected next moment. The meaning of an entire utterance is a complex, not well-understood, algorithm of these emergent, non-linear, sense-making interactions (Schegloff et al., 1996, p. 40).

Since we here are also interested in this interactional aspect of meaning as something that arises out of the pragmatic negotiation between therapist and patient, we also adopt a methodological stance that considers more than the immediate context of a turn in order to make this meaning visible. Focusing on a single session and proceeding chronologically over a relatively long part of it (roughly 20 min), our analysis shows how certain topics occurring at the beginning resurface at a later stage and are then negotiated again in the light of the progressing discourse. Themes from the previous day's session are also continued.

The second issue concerns unconventional language. In close adherence to ethnomethodology (Garfinkel, 1967), the action a turn performs can be interpreted in CA partially *via* the immediately ensuing response of the interlocutor, relatively independent of the formal linguistic content of the turn. That does not mean that the formal content is of no interest to CA analyses. As an example, if an interlocutor begins a conversation by saying, "I hate having to see your face again every morning," and this is met by a response along the lines of "Yeah, good to see you too, Bob," then by the principles of CA, the facts that these are the initial turns of a conversation and that the first turn is treated by the interlocutors as if it were a greeting, will make sure that such a sequence is correctly analyzed as a greeting-greeting pair, even though the first turn is a highly unconventional member of such a pair. Here, we are also interested in this unconventionality, and what effects it might have. While such an exchange might actually conform to the specialized greeting conventions established between a specific pair of coworkers, treating it as just any greeting-greeting would miss crucial aspects of the social actions performed by it, especially if it occurred in a therapeutic context. Heritage (2011a) has pointed out the risks of concentrating on conventional language in the context of medical interactions[1]. This is at least as appropriate in the case of psychotherapy. Although psychotherapeutic theory has developed just as much specialized jargon as any profession, in the conversation between patient and therapist, there is no predefined set of conventionalized terms one has to learn in order to participate successfully. Pawelczyk (2011) talks of "personalized meanings." For each

[1]"…interactional practices developed for ordinary conversational contexts can have dysfunctional consequences when they are unreflectingly implemented within the medical visit" (Heritage, 2011a, p. 339).

therapy, patient and therapist invent and locally conventionalize a set of terms and routines together. For the successful analysis of psychotherapeutic interaction, it is necessary to allow for the treatment of (in a global sense) unconventional linguistic and interactional behavior, including not only neologisms, creative imagery, and metaphors but also the omission or delay of expected responses and other forms of non-cooperative communication, as meaningful in its unconventionality. All of these forms of communicative behavior are means to expressing thought processes, intentions, and emotions which the interlocutors are not used to putting into words and for whose expression perhaps no conventionalized means exist, and which the goal of the therapy it is to negotiate and resolve in the personal interaction between therapist and patient. In child therapy, these challenges and difficulties are exacerbated many times. An individualized way of interaction has to be established between the interlocutors, only by means of which conversational meaning can be created. In the conversation we analyze, therapist and patient often ostensibly talk about some object in their surroundings, while at the same time they negotiate a personal issue of the patient in a therapeutically relevant way. In order to show that this is the case, we make use not only of CA methods but also of a broader range of pragmatic analysis as well as insights from clinical experience. However, our analysis is empirically anchored to the observables of the interaction. Psychotherapy talk-in-interaction is accessible to empirical methods beyond introspection.

We provide an interaction analysis of segments from the transcript of the first 20 min of a video-taped child therapy single session conducted in the private practice of the third author[2]. We present English translations of the German GAT-2 transcripts (Selting et al., 2011) including descriptions of the bodily behavior of both participants, additionally illustrated by pictures. The entire interaction was divided into segments that constitute therapeutically relevant episodes. We proceed chronologically through the segments, however omitting some of them for reasons of space. Those that are included were selected for showing how some therapeutically relevant development is related to instances of doing or resolving contrariness. For speech acoustic analyses of the same session, see Dreyer (2018). Other analyses with the same material (a qualitative multimethod project) have been published (Brandstetter, 2018; Dreyer, 2018; Hamburger and Bleimling, 2018; Heller, 2018) as part of a collaborative effort from our Berlin-based research network to throw a light on the complexity and variety of information contained in such material by illuminating it from the angles of various disciplines and approaches.

THE BEGINNING OF THE THERAPEUTIC SESSION

In the first segment, directly from the beginning of the session, we witness how Ina uses conversational non-participation to do contrariness, with the effect of excluding her adopted father from the conversation. The session starts when Ina, just brought in by her adoptive father, puts her head around the door frame to look into the play therapy room:

Segment 1—Introducing T, Therapist; F, Father, and Ina

```
1   T:    <<ff> 'HALlo.>
2         (1.2)
3   T:    <<f>Ina;>
4         (1.3)
5   T:    Come on in- ((Ina hides behind
          her adoptive father who first
          enters the anteroom of the
          therapy playroom))
6         (12.1)
7   F:    (??I have here??)
8   T:    oKAY;
9         (1.1)
10  T:    and NOW?°
11        (2.3)
12  F:    yes:;
13  T:    <<t> BYE papa
14  F:    BYE,
15        (1.4)
16  F:    °by:::e°
17        (1.1)
18  F:    <<p> °by:::e° <
19        (1.0)
20  F:    <<p> See you SOON.<
21        (2.9)
22  Ina:  °oh=h° °°how good°°
23        (7.5)
```

The therapist offers several greetings to Ina (1–5), who does not respond with a greeting of her own. This constitutes an act of refusing to submit to what Goffman termed "mutual monitoring":

> "Persons must sense that they are close enough to be perceived in whatever they are doing, including their experiencing of others, and close enough to be perceived in this sensing of being perceived." (Goffman, 1963, p. 17)

That is just what the therapist attempts to initiate with Ina, after she has been brought in by her adoptive father. People take note of each other in greeting and give a conventionalized signal that they acknowledge the interaction as such. In adult life, greeting response is considered conditionally relevant (Sacks and Schegloff, 1979). A refused greeting can be experienced as a violation of expectations by the greeter and this can potentially be exploited by the non-greeter. A non-greeter does more than just refuse greeting: s/he denies "mutual monitoring" by purposefully violating expectations. Such an omission has been termed a "noticeable absence" by Sacks and Jefferson (1992/1995). Omitting the greeting can here also be considered an instance of "doing contrariness."

[2]Readers who wish to study the German transcripts should contact the first author.

Silently Ina takes off her coat (during a long pause, line 6). The therapist initiates the expectable process of saying good-bye to the father as a next step by articulating an expectation: "and NOW?" (line 10). After a pause the father responds with a second position utterance, his slightly extended "Yes" (12). This sequence seems to have no content. However, the situational context indicates that it is time to say good-bye to the father, so that Ina's session can begin. Both adults seem to expect Ina to initiate or at least to contribute to this procedure, none of which she does. Her continued conversational inactivity has strong effects on the "participation framework" (Goodwin, 2018) of the two adults: the therapist now assumes Ina's role and starts the farewell sequence (line 13), indicated by adding "papa" after her "BYE." The therapist seems to "jump in" (Corrin, 2010): she must have deemed a contribution by Ina to be so necessary that not only did she take it upon herself to provide it, but she also performed it as if she were Ina herself. Ina's "doing contrariness" by non-participation in the practice of saying goodbye amounts to refusing to acknowledge the father's presence at all.

The father tries four times, with pauses in between, to get Ina to say goodbye (14–20)—but no response from Ina can be elicited although he uses a variety of prosodic contours and lexical expressions to say goodbye. His expectation to be responded to is not fulfilled, and yet he simply tries again and again, instead of explicitly addressing Ina's failure to conform to interactional expectations—we could call this "doing vulnerability," as counterpart to Ina's "doing contrariness." Both adults interpret Ina's "doing contrariness" as repairable *via* a silent but powerful communicative agreement to further *ignore* Ina's behavior. The therapist attempts to mitigate the affiliative damage caused by Ina's behavior by acting as a version of Ina that does comply with the adults' expectation. Their agreement is sealed by the father accepting to be vicariously addressed as "Papa" by the therapist—a rather unusual communication among adults. Father and therapist seem to agree to treat the therapists' response in Ina's stead as if it were sufficient "absence of evidence of misunderstanding" (Albert and Ruiter, 2018, p. 281) to be able to treat the entire episode as constituting successful communication.

A new participation framework between Ina and the therapist is eventually established by Ina's first remark, "how good," after the father leaves. That she speaks for the first time only once he leaves, and gives a positive evaluation directly upon his departure indicates that her "doing contrariness" was directed against the father. She is willing to participate but only once he is gone.

We have seen in this first segment how "doing contrariness" (DC) is characterized by behavior that violates conversational expectations and uses this violation to affect the affiliation and emotional ties between participants. Fundamentally, DC makes a contrastive distinction, valuing one side as positive, the other as negative. In this first segment, it is the adoptive father as participant in the interaction who is valued negatively by Ina's refusal to participate until he is gone. Both the act(s) by which DC can be performed and its effects are highly contingent upon the existing affiliative network between the participants and the roles they take on in the conversation: if it had been the therapist who had performed a silent non-participation, this would certainly not have affected the father in the same way. Attempts at repairing DC (which we call "remedying contrariness") must be equally sensitive to the participants' network. The therapist's "jumping in" for Ina, and the father's going along with it, can be seen in this light. This is an action which only repairs the conversational dimension of the disruption Ina has produced in the sense that it at least allows the conversation to proceed in the direction projected by the father and the therapist. The therapist-as-Ina and the father use this role performance to eventually move on beyond Ina's non-participation, but by allowing his multiple attempts at saying goodbye to remain unreciprocated, the father shows that the affiliative damage is left unrepaired. However, under the circumstances, it might have been the least damaging course of action overall. Directly addressing Ina's non-participation and asking her to "correct" it would probably have caused further affiliative damage. Executing a correction implies that the preceding move is faulty or problematic in some aspect, and thus that the sequence is marked/unexpected from the perspective of a smooth discourse progression (Ginzburg et al., 2014; Łupkowski and Ginzburg, 2016). Between adult speakers, and executed without face-saving actions, a correction would additionally violate conventional social expectations and thus threaten the affiliation between participants. It would be a claim to authority by the correcting speaker and reduce the other speaker's agency. It would thus also be what we call doing contrariness. The therapist (or the father) could have presented Ina's non-participation as such a disruption by attempting to "correct" it with a direct request toward her to participate. This might have "repaired" the conversation by forcing her to contribute, but given Ina's demonstrated contrariness, it would have likely been taken as a rebuke and, instead of repairing the affiliational disruption with Ina, would have instead exacerbated it. Foregoing the opportunity to assert their own deontic authority and power and to incurring some face loss themselves, the therapist and her father spare Ina the face-impairing and emotionally hurtful act of correction. ADC can therefore be distinguished from other repairs by targeting not only the communicative disruption but also the social-affiliative disruption caused by DC; it cannot be performed *via* an act of DC itself. The type of creative solution the therapist and father use to try to avoid the incurrence of further affiliation cost is often what is needed in psychotherapy in various modes and situations, and one of the reasons it can be so difficult.

"Doing repair," especially self-repair, can help to maintain or improve social relationships (Schegloff, 1992). After one party has violated the other's expectation, repair acknowledges a failure in performing a relevant contribution and accepts the obligation to an undisturbed common sociality. The crucial aspect here consists of acknowledging the other's expectations. In Schegloff's words:

> "This is the sense in which these repair positions provide a defense of intersubjectivity. They are the last structurally provided positions because after these positions there is no systematic provision for catching divergent understandings." (Schegloff, 1992, p. 1325)

Young children in medical consultations have often been observed to not respond to greetings (Cahill, 2010). In our case, several attempts at repair do not succeed and leave the affiliation partly damaged. Our analysis of this DC *performed through silence* shows that the new framework between therapist and Ina has a "history" burdened with this failed repair.

In the following segment, we will further explore the crucial dependence of DC on the role that a participant takes on in a conversation, in that we will see it creating a negative evaluation of part of one's self.

THE CREATION OF A COMMON (PLAY) WORLD

Segment 2—Starting Therapeutic Conversation

```
24 T:   O:H, what's that jumper you
        have?
25      (2.5)
26 Ina: a baby dress
27 T:   yeah:,
28      (--)
29 Ina: a BIG one;
30 T:   °ya° (.) HOW big;
31 Ina: a >very <<p> very° < very bIg°°
32 T:   erm (.) HOW big (--) <<h> SO
        O:O:?
33      (2.5)
34 Ina: ?hm=?hm ((shakes head))
35 T:   >uh uh<?
36 Ina: !SO! <<p> big->
37 T:   ((laughing)) ?SO:: (---)
38      (1.1)
39 Ina: ((xxx xxx)
40 T:   and you fit i:n? ((Ina dashes
        into the treatment room and
        throws herself onto the beanbag
        with a rotation of her body))
41 Ina: yea:h
42      (2.5)
```

The therapist's question (24), prefaced with a playful interjection of surprise and amazement, is accompanied by a deictic gesture; *via* her gaze, she points at Ina's jumper. Slightly disparagingly, Ina calls it a baby dress (German "Babykleid") (26). This is contrasted by her subsequent assertion of the "bigness" of the jumper (29).

The therapist initiates the next sequence of questions, "how big?" (30 f.). She suggests a size *via* gesture (32) and Ina rejects the suggestion *via* a shaking of her head and a negative interjection (34). The following rhythmical copy of that interjection by the therapist uttered with question intonation (35) resonates at the affiliative level, while also conveying amazement and surprise. The epistemic question of how big the sweater is, repeated in abbreviated form, is replied to by Ina's embodied demonstration (36), responded to by the therapist's surprised response (37) again with a gestural demonstration of size. After a pause (38), suggesting the topic has closed, the therapist takes the topic up again: "And you fit in?" (40), explicitly establishing the link between the jumper's size and Ina's. Ina's strong embodied response (40) demonstrates her body control and strength, signaling that she is already big. Only then follows her spoken confirmation (41). Ina clearly shows a very different attitude to the attribute of "bigness" than to that of baby-like qualities from the beginning of the segment.

Moving to a more therapeutic aspect of the analysis, Ina's disparaging voice when talking about the "baby dress" indicates a distance to the "baby-self" in favor of a more grown-up "child-self," which is as "big" as the jumper. Talking about the size of the jumper implicitly has a bearing on Ina's status as either baby or older child. The jumper is used for a comparative contrast between two available selves, a "big" one and a baby one.

Ina clearly positions herself as being "big," and expresses a negative evaluation toward being "a baby." There are observable indications (disparaging prosody when discussing the "baby dress," augmentative repetition and emphatic prosody when discussing the "bigness," the explicit link made by the therapist between the sweater and Ina, agreed to by her) that the conversation is not only about the sweater, but also between two versions of Ina in play here. Ina distances herself from a version of herself that is "small." While children occasionally express wishes to be more grown up, in this specific case, we take this to be a clinically relevant observation, namely as an indication of a strong negative affect toward her own (past) self, probably related to her traumatic adoption experience. In this section, DC is mostly visible in the negative attitude Ina expresses toward her "baby-self." The contrariness that is being done, the hostile attitude Ina expresses toward herself and the repair efforts undertaken against it is best analyzed from a perspective which understands that Ina can act as either of these roles, the "baby-self" and a "child-self," that are in conflict with each other. We argue that this is an example for how therapeutic observations can work together with CA in an understanding of what happens in therapeutic conversation. An analysis of therapeutic conversation must be able to capture such aspects in order to establish a connection between interactional observation and clinical interpretation and outcome. We suggest that there exists a need in the analysis of child therapeutic conversation both for special attention to unconventional means of creating pragmatic meaning (talking about the sweater as a stand-in for talking about Ina) *and* for observing long-distance relationships within the discourse progression.

BUILDING THE GAME—A BABY IS MADE

Conversational events and actions diverging from expectations have high *epistemic* ("novelty") value because they have the potential to increase knowledge by adding unexpected (i.e., new) information. However, they bear the risk of causing affiliative disruptions, especially when concerning issues that the participants are emotionally invested in. For therapeutic

practice, this means a delicate balancing task: therapists aim at exploring expectation discrepancies not as disappointments (= violating their own *affiliative* expectations in order to achieve a high epistemic value) but instead work to combine their high informativity with an effort at restoring the affiliative dimension at the same time. We have seen an attempt at such an other-oriented affiliative repair already when the therapist stood in for Ina saying goodbye to her father. In the following segment, we will see how such an repair attempt can also be self-oriented to prevent a previous action from becoming a disruption and damaging affiliation, literally seeking to *avoid* doing contrariness. Such a task includes transforming the therapist's own *affiliative* disappointments (and other affects) into something that is *epistemically* relevant. We will see how such an attempt can fail.

Segment 3—The Table Scenario Is Prepared

```
43       ((T walks to the table))
44  Ina: we'll do it again with play
         dough ((jumps up from the
         beanbag and runs to the table))
45       =like we did (last time)
46  T:   = ya:? You want to play with
         dough again?
47       (1.6)
48  Ina: and you must (--) ((Ina sits
         down and pushes chair noisily
         toward the table))
49       (1.9)
50  Ina: ((reaches for the can with the
         play dough, shakes it, takes the
         next can, shakes it))
         >where is< (.) still (---)
         ((puts can loudly on table))
51       (1.6)
52  Ina: baby in it;
53       (6.3) ((takes the third can,
         shakes it. Ina puts the other
         can noisily on the table, pushes
         the chair back noisily, bends
         down after the lid has fallen
         off while T sits down))
54  T:   you know what, Ina? (-) ((T &
         Ina looking at each other))
55       the BABY; (-)
56       you mean the play dough baby I
         made (--)
57       YESterday; (.) right?
58       (1.7) ((Ina nods in agreement))
59  T:   I have taken it to safety (---)
         ((opens can))
60       so that nothing ha↑ppens to it.
61       (1.1) ((T puts the lid on the
         table))
62  T:   LOOK, ((puts empty can noisily
         on the table))
63       (1.0)
64  T:   there it=is
65       (2.6)
66  T:   <<p> You see? ((T. shows the
         play dough baby in her hand, Ina
         suddenly stretches her arm
         forward with open hand))
67       (1.2)
```

Both move to play at the table. Ina indicates continuation of a play project from the past session (43). The therapist reformulates Ina's project (45), yet in a slightly different way. Ina declares that she wants to do "it" again with play dough (German "wir machen *das* wieder mit Knete"), but the therapist asks for confirmation about playing with the dough. It seems that for Ina, playdough is not the actual object of play, but a tool for another play activity. Her non-response to the therapist's clarification question is again a "noticeable absence," indicating a contrast between the two projects, or perhaps an objection to the therapist's question.

Ina tries to assign play roles (48), but her deontic authority is limited; now, it is the therapist who does not respond. Another obstacle materializes: Ina cannot find the playing equipment where she expected it to be (49–52). Noisily, she searches for the play dough baby, without success.

The therapist, after silently observing Ina's activities, starts an account (53), prefaced by "you know what, Ina?," responded to by an intense exchange of gazes. Then follows another preface after a self-repair—the turn construction is interrupted (54) by a reference to what Ina did (55) and a confirmation that the therapist understood what Ina was looking for, with a projected ending with a tag (56), to which Ina agrees by nodding. However, she crosses her arms, a gesture expressing a mood between expectation and defiance. By using several prefacing moves, the therapist attempts to *avoid* doing DC herself, because she probably suspects that her intention to inform Ina that the baby is "taken to safety" (58) is likely to become troublesome, since Ina is already signaling some discontent.

However, she cannot fully avoid DC here. By opening the can, presenting the playdough baby with "there it is" (63) and "you see" (65), the contrariness is exacerbated: Ina is informed that she was searching in vain while the therapist knew where the baby is, that the therapist did not cooperate in her project. The affiliation framework is at risk, Ina's disappointment might transform into defiance. The therapist attempts to restore a "common ground" by presenting the play dough baby, efforts designed at balancing their epistemic positions by sharing knowledge with her that had been privileged before.

The therapist clearly indicates that she appreciates the complexity of this interaction. She cannot entirely avoid doing contrariness directed at Ina, in the sense of taking an opposing position, because her actions of hiding the figure and only disclosing its location at her own discretion reveal that while Ina might make claims to authority, it is the therapist whose deontic (protecting the doll) and epistemic (determining and knowing

its location) authority is actually superior. She tries to mitigate the force of this contrariness *via* special conversational means, by formulating cautiously, using tags like "right?," and by integrating Ina's perspective with phrases like "you mean…," "look" and "see." In this, she treats Ina as if Ina's and her own claims to authority (epistemic and deontic) were actually balanced, i.e., she affords Ina some authority as if she were an equal, e.g., another adult (Hagemann, 2009; Jefferson, 2012). Her hedges all gently ask for Ina's agreement to the goal that the baby figure should be protected, that in fact the therapist's project, while seemingly contrasted with Ina's, actually aligns with her interests too. In this way, she attempts to convey the epistemic content (the act of revealing the figure's location and her motives for hiding it) without incurring affiliative costs, and to point out ways of conversational negotiation that do not have to involve all the negative effects of "doing contrariness." Ina makes no indication of giving this agreement.

We suggest that the therapist's effort at *not* doing contrariness has parallels in other aspects of human interaction. Hutchby describes how the child in his case uses "I don't know" sometimes as a game or a strategy. He adds:

> "However, at certain points in the child's talk we find evidence that, for him, answering with 'Don't know' is itself a way of producing serious talk. In other words, the child occasionally uses 'Don't know' in such a way as to display that he is not playing a game." (Hutchby, 2007, p. 115)

"Not doing something" has been earlier observed (Bateson, 1981) in how dogs distinguish between "playing attack" and seriously biting. Dogs (and certainly humans) can perform actions to demonstrate that they are *not* doing a different action that might also have been executed in the same context. By this process of implicature (Grice, 1989; Levinson, 2000), the *contrast* itself between one action performed to another *not* performed can be used as a resource to continue conversation, and to keep it e.g., on the side of playfulness (in the case of the dogs). In this segment, we have seen how the therapist used hedges and integrating formulations instead of doing contrariness, i.e., as actions that are performed partly because relevant alternative actions would have involved doing contrariness (with all of its disruptive effects). This was done in order to not violate the affiliative dimension of her relationship to Ina (or repair such a violation). We call this "*avoiding* doing contrariness" (ADC). Our inspiration for that comes from a remark by Tarplee (1996), observing how mothers of 2-year-old children teach them the pronunciation of difficult words, after the child has made an initial mispronunciation:

> "The way they come off is not as corrections, but as re-elicitations. By *avoiding* doing contrastivity, and by being delayed, they appear to 'try again' - to give the child an opportunity to have another go - without explicitly indicating that the child's first attempt was problematic. In this way, they seem to manage the work of repair in a particularly subtle fashion." (Tarplee, 1996, p. 426) (italics in the original).

Tarplee notes that "contrastivity" is *avoided* by the teaching adult *via* delaying an utterance which corrects the child's failed attempt. Repeating the word without delay would signal the child's attempt as having been "problematic," in the manner of an other-oriented repair; but by delaying the repairing utterance, it becomes ambiguous between a response and a renewed initiating move, a prompt for the child to have another go. The too obvious contrast between the child's and the adult's pronunciation is made less prominent. *Avoiding* some of its impact has implications for the epistemic and deontic hierarchies between the speakers. Tarplee is mainly interested in the prosody of correction and in showing that already children of that age are capable of recognizing it; her "contrastivity" is quite closely related to the general notion of "contrast" between alternatives (here, the differing pronunciations) in linguistic pragmatics. We take her observations only as a point of departure and would like to concentrate on another aspect here: spacing the utterances apart in time and thus avoiding the contrastivity means the mother is effectively treating the child like she would an adult, hedging a correcting move in order to not infringe upon the other's epistemic or deontic authority. Producing the correction in direct temporal succession to the child's attempt would be to exploit the actually existing difference in deontic and epistemic authority between adult and child, but not doing that protects the child's vulnerability by affording her/him the authority s/he cannot claim for her/himself. The adult treats the child as if correcting her without hedging could be taken as "doing *contrariness*": if the same interaction took place between adult equals it would likely be contrariness, because the unhedged correction could be taken as an unwarranted claim to authority and negatively affect their affiliation. Avoiding this action has the potential of raising the child's status above that which she is conventionally entitled to and thus strengthening her affiliation with her. We observed something similar in this segment: the therapist attempted to downplay the imbalance between her own epistemic and deontic authority and that of Ina, trying to avoid appearing to impose her authority. Therapeutically speaking, repairing instances of doing contrariness is highly important: unresolved episodes of it could turn into a lasting strain on the patient-therapist bond, constituting a rupture in the therapeutic alliance (Safran et al., 2011). In contrast to the instance of RDC seen in the first segment, which was a kind of other-oriented repair aimed at restoring affiliation, in this case, ADC is performed almost simultaneously to the action that is potentially doing contrariness, and it is self-directed.

SUMMARY OF INTERVENING SEGMENTS

We leave out the next four segments (4–7) of the transcript (89 lines in the unabridged transcript[3]), but give a short summary, so that readers may still follow the development of the session. The therapist still attempts to negotiate a mitigating solution for the conflict that has just occurred, asking whether Ina wants to form her own play dough baby and offering to make one for her. Ina refuses and mostly responds bodily, kneading her fingers and reaching forwards as if to grasp the play dough figure. The disaffiliated context *seems* not fully repaired. Gradually,

[3]The line and segment numbering is left as it is in the German original transcript, to facilitate comparison. If you are interested in the original transcript, please contact the first author.

Ina's family history is integrated into the play scenario on the table in a form of reenactment. Within this family-reenactment, Ina pursues projects different from those of the therapist. The therapist's project is aimed at protecting the baby; however, Ina's project's aims have not yet fully materialized. The two of them make reference to an unconventional narrative they had developed the previous day, namely that the baby figure had chosen its parents. Ina and the therapist then give names to the figures they are forming: a family with mother, father and grandmother. A "thief" is also discussed, a figure that played a role in the previous day's session and will again do so in the following segments. Ina then asks for the therapist's help to form a new baby figure. They discuss which color the figure should have. After a short misunderstanding, Ina chooses blue. Despite indications that they are still pursuing diverging projects, in agreeing to form the baby together they share an empathic moment in "odd communion" with each other (Garfinkel, 1952, p. 114; Heritage, 2011b, p. 183), but their conflict is still unresolved.

Segment 8—A Robber on the Stage

In the following segment, Ina and the therapist introduce a new character into the play activity. Within the play, this character is doing contrariness, which Ina and the therapist use as a stand-in to negotiate their actual conflict outside of the play.

159 Ina: I'll go ahead and make the head;
160 T: good ((closes the can, looks at Ina)
161 (10)
162 Ina: ((reaches over the table to the dolls, takes small blanket in her hand)) and this=is the blanket;=
163 ((takes the red wooden baby in her hand) =and this is yet another BAby;
164 T: mh=ya; (.) that's a red baby,hm,
165 (14.3)
166 Ina: ((puts red baby in front of her on a playdough box, rolls playdough ball in her hand)) the head's finished;
167 (2.0)
168 Ina: ↑↑AH! -
169 T: h(h)m(h)m[(h)m
170 Ina: [the head must not roll; ((rolls the dough ball between her hands))
171 it CAN't roll yet; (--)
172 (3.6)
173 T: Head on HEAD
174 (1.9)
175 Ina: ?hm?,hm:; [Roll-]
176 T: [and now] the TUMMY?
177 (2.3)
178 T: a TUMMY <<dim> still for the bAby?
179 <<p> hm hm?>
180 (3.9)
181 Ina: °mh,=hm,° ((assenting; with her hands she continues to work the playdough using all her body's strength))
182 (3.5)
183 Ina: and I am the rOBBer;
184 (1.0)
185 T: <<p><<dim> YOU: are the rObber
186 (2.2) ((Ina nods, continues working on dough))
187 T: the Ina-rObber, ((Ina nods)
188 (4.5)
189 Ina: And a cake
190 (2.7) ((Ina opens drawer under the table))
191 Ina: <<p><<all> YOU must that;>> (---)
192 ((mutual gazes))
193 T: Ina, (.) the (.) tummy, (.) ((Ina pauses in her movement))
194 T: it could also, ((mutual gazes))
195 look at this baby (.) there it's ALSO round; (.) right?, (--)
196 it could also become a blue round °tummy°
197 Ina: ((takes a roll of playdough out of the drawer and rolls it out vigorously))

The therapist follows Ina in her project of forming another playdough baby. Ina comments on what she's doing with phrases like "this is…" (the blanket, still another baby, etc.). The therapist (164) seems to disagree when Ina produces another baby. Her utterance is prefaced with an extended "mh=ya: (.)," perhaps indicating the type of open class other-repair initiation that Corrin (2010) links to teaching situations between mother and child. The content of the therapist's statement that the baby is red borders on being superfluous (it is evident to all participants that it is red). The intention seems to lie in the implicature that it is *not blue*, and therefore going against what had earlier been agreed upon. She seems to perform this contrast-by-implicature *instead* of a more overt move pointing out the transgression against agreement, an instance of avoiding doing contrariness. Ina continues with verbal pointing: "the head's finished" (166). Throughout, the two share longer pauses while silently working, both are intensely engaged with building the stage and forming the baby. Ina's slightly alarmed warning that the baby's "head must not roll" is accompanied by the therapist's humming (169), which is apparently intended to calm Ina, who follows it up with "it can't roll" (171). Ina's gesture (right hand above her own head) is commented on by the therapist (173).

The therapist's proposal to form a tummy for the baby (176–181) is repeated and, after pauses, agreed to. After working silently for a while, Ina comes up with a surprising new play role for herself (183). A "thief" (german *Dieb*) had been mentioned by the therapist before (95). Now, a somewhat stronger term is used: a robber (german *Räuber*). This new character on the stage can be ascribed several meanings.

A first one is that Ina's taking up the role of the robber is a form of doing contrariness against the therapist. This view is supported by the subsequent interaction: the therapist uses a contrastive accent on the pronoun in her response, "You: are the robber" (185), evoking a comparison with other identities of the robber that she perhaps would have thought more plausible. The move is thus unexpected and gives Ina an initiative; it also affects their affiliative relationship because Ina's choice to take on the role of the robber, who is antagonistic toward the other figures, also sets the two players up as antagonists. Ina here exploits the porous boundary between her "actual" and her play role. Ina is outside of the play, the robber inside, but the two are the same person. The situation is reminiscent of topological objects such as a Klein bottle that have no clearly defined inside or outside[4]. Once again, as in the first and second segments, DC is practiced with an aspect of roleplay. The therapist adds a second meaning after a pause with a remark: "The Ina-robber" (187). Ina nods her agreement. In German, "der Inaräuber" is ambiguous between one who has stolen Ina and a robber named Ina. The therapist offers this new meaning which integrates active and passive aspects of this new character. The robber is the antagonist of the baby (we will see this unfold in the following sequences), but the therapist, instead of highlighting this contrast, makes an effort at *avoiding* "doing contrariness" by integrating the two contrasting accounts. She creates a "*conceptual* framework" (Goodwin, 2018) which keeps both the robbing subject-agent and the passively robbed child active.

From a clinical perspective, a third layer of meaning could be offered *via* biographical interpretation here: Ina sees herself as "robbed" from her biological parents by her adoptive parents. The robber is an "identification with the aggressor"; which is why Ina came into treatment. In this line of reasoning, Ina's fast transformation is a kind of re-telling of her biographical story, using the treatment for just the purpose of leaving the straightjacket of her history (Gallagher, 2015).

Segment 9—A Scary Thief Appears

In the following segment contrariness escalates into violence. The therapist does not commit to a role either within *or* outside the play. The conflict is resolved by achieving mutual agreement to separate play roles from real roles.

198 Ina: ((Ina rolls the playdough, puts it into the box for a short time, fixes T. with a look from below with lowered head)) <<gruff and deep voice><<ff><<cresc>give your BA!BY to me. >>>
199 (4.0)
200 T: ((moves mother- and father-figure rhythmically toward Ina)) the bAby has, (--) chosen us.
201 we are to be the (.)
202 we are the parents now °of the baby°
203 (1.3)
204 T: <<h> Y↑A::, (-) that's ri↑ght.->
205 we will not hand it over.
206 (1.0)
207 Ina: let (.) me caress (--) that: ((Ina rigorously rolls the dough roller back and forth))
208 T: NO,
209 (3.3)
210 T: you::.h (.) <sound <<acc> a little bit dan↑gerous.>
211 Ina: <<h> *LET me CARess it;*>=
212 T: ! ↑↑HOO:::
213 °h (.) Y↑ou sound !ve:ry! dangerous;
214 Ina: #*Y↓A::*# ((loud deep voice)
215 (1.2)
216 T: .HHEH (--)
217 *TOTALly dangerous* ((raspy voice)
218 (1.9)
219 T: ↑↑!HOO::::::!
220 (1.2)
221 very very very dangerous
222 Ina: ((Ina slaps T's hand with the rolling pin))
223 T: HEY!, (.) STOPP (-)
224 (1.3)
225 STOPP
226 (1.3)
227 <<p> (--) hitting hurts.->
228 (1.8)
229 Ina: mother only (---)
230 T: mh=hm, right,
231 on the hand it hurts
232 (1.4)
233 T: the mother is a doll=
234 =<<p> that doesn't hurt that much.>
235 (5.5)
236 Ina: I need her still.
237 (2.2)
238 T: CHILD (---)

[4]Conversation analysts have observed such topological, Moebius-like, confusion in analyzing talk-in-interaction: see, e.g., Garfinkel and Rawls (2016, p. 145); Jefferson et al. (2015, p. 143).

239 (1.0)
240 little (-) Baby (---)
241 little baby
242 (2.9)
243 Ina: <<yelling> GIVE THE BABY TO ME.>
244 (2.1)
245 T: ↑↑boo-hoo ^!Hoo:::!, (-)
246 aren't you DANgerous
247 (3.1)
248 Ina: <<f> what's that smell here:;->
249 (1.5)
250 T: the baby (--)
251 <<p> it smells like BAby here>
252 (4.6)
253 Ina: <<gruff and deep voice> <<f>> *#H↓OH↓O:,#*
254 T: ↑↑ hOOU: ↑hOO::
255 (1.5)
256 T: ↑↑ <<f> °h hOO:::,>
257 (1.2)
258 ↑hO::.!
259 ↑↑hOO::.!
260 Ina: <<ff><hissing> drop it:::>>
261 (1.8)
262 T: <<stuttering> a a a are you A= ((moves the dolls forward))
263 <<dim> are are are (.) you <<p> a <<pp> a->
264 (1.5)
265 T: SCARy↑thief? (---)
266 Ina: <<yelling> !yA=HA=HA=HA:::;!> ((both hands clapping))
267 T: ((weezing)) OH::;
268 (--)

Ina turns into a robber with a loud and gruff voice; the therapist takes on the role of the adoptive parents who defend their custody of the baby (198–205). "Normal" family circumstances do not hold: the baby is said to have "chosen" the parents here (200). A strong antagonism between the two play roles is built up, initiated by Ina's adoption of the robber as play role, and furthered by the therapist's choice: since it was the adoptive parents who actually chose Ina, the therapist takes on a risky role—in Ina's eyes the therapist-as-adoptive-parent robbed the baby from her biological mother. Ina's antagonistic stance as the robber, adopted when she took on that role in an act of doing contrariness, is met in kind by the therapist. In the logic of the play world, the baby figure on the stage is actually situated between two robbers: a contrastive framework emerges with Ina on the one hand projecting to rob *and* to caress the baby; on the therapist's side the project is to protect *and* to adopt the baby, which is viewed by Ina as both "robbing" and "being robbed."

To Ina's repeated and intensifying demands that she hand over the baby, the therapist-as-parent responds at first with a refusal and then by saying that Ina sounds dangerous, with each increase in vocal intensity of the demand mirrored by an increase in the dangerousness asserted by the therapist's responses (207–221). The conflict escalates when Ina hits the therapist's hand with the rolling pin, which she responds to by exclaiming "stop," followed by a justification: "hitting hurts" (222f.). "Doing contrariness" has escalated into a small event of violence. The invisible border between the play world and the "real" world is torn apart for a moment. It is possible that Ina's hitting was performed also as an in-game action (this is implied by her justification, see below), but the therapist's reaction, the hand having been hit being that of both her in-play character and herself, is not.

As is so often the case, this escalation into violence is the culmination of a series of failed attempts at communicating. In the preceding turns, reiterations of Ina's demands followed by the therapist's commenting on how dangerous Ina sounds, make for somewhat anomalous adjacency pairs: normally, a provocation-response sequence of turns deals with a single issue, the issue is then either resolved or participants agree that they cannot agree (Farkas and Bruce, 2010). In either case, conversation moves on. This is clearly not the case here: conversation has come to a standstill; instead of progressing, the issue is reiterated with increasing intensity by both participants until it turns into an outburst of violence, a clear case of communication failure. We think that one reason for this failure might lie in how the therapist chooses to respond to Ina's demands: commenting on her dangerousness is not the response of a parent who is threatened by a robber, but that of an adult not fully entering into the play world of a child. By not committing fully to either role, the therapist robs Ina of a possibility to develop her play's progression: the therapist's responses, because they are given from an outside role, cannot be adequately reacted to from within the realm of Ina's play. As a child, Ina probably is still lacking the competence to switch between roles as effortlessly as the therapist. Thus, her only available response to the (from her perspective) illicit contributions of the therapist is to reiterate her own contributions, and to intensify them. The culmination into violence is here also preceded by both of them doing contrariness unchecked, with no attempt at repair being made.

The border between the worlds of play and reality is restored when Ina states that her hitting is aimed at the play mother, "mother only" (229), and the therapist accepts this, both agreeing that the mother doll might be hit but not the real hand of the therapist. This is a cooperatively executed repair, initiated by the therapist's exclamation to stop, but the solution for how it can be mended is first proposed by Ina and then accepted and implemented by both after the rules have been made explicit by the therapist. Previous attempts at resolving contrariness were failures perhaps also because they were unilateral. The two of them keep their antagonism to the world of the play (differentiating more properly between the two worlds) and thus do not allow it to affect the affiliation between the actual players.

We would like to argue that this complex act of conflict resolution is very similar to a repair: there is a deviant move, Ina's hitting, which causes the therapist to bring the previous course of interaction to a standstill, other-initiating the repair-like process

(223–225). She then points out what was objectionable about Ina's move ("hitting hurts," 227), targeting it as something to be remedied, a reparandum. Ina responds with a turn that is like a reformulation and a self-repair ("mother only," 229) in the sense that it accepts the objection and clarifies that the object of her troublesome move was the mother figure, not the therapist. The therapist seems to accept this ("right," 230) as an agreement that hitting should be restricted to the play figures (231–234), and conversation is then allowed to continue. The trouble-source here is a transgression against social norms, but dealing with such can be treated as an instance of repair (Albert and Ruiter, 2018). Ina initiates conversation again after a pause (236): "I need her still." It is clear that by "her," Ina refers to the "mother" figure which they had just agreed could be hit instead of the therapist (233). This is ambiguous between Ina saying that she still needs the mother figure for playing later, or that she is in need of a real mother. After another pause, the therapist responds with a mother's calls for her child (238–242), suggesting that she adopts the latter interpretation. However, Ina responds by yelling loudly and demanding to be given the baby as the robber (243): they are back in the play world. After this suspension of antagonism between their actual world roles, they take their doing contrariness up again, now perhaps limited to their play roles.

For the sake of brevity, we leave out some aspects of what happens next, but note that after the therapist plays a fearful mother (imitating a scared stutter), she finds a new name for Ina's play role: "a scary thief" (265), which Ina enthusiastically confirms.

CA studies of adult therapy draw attention to therapeutic (re-)formulations. A consistent result is that therapists use reformulations in order to turn a patient's attention to special moments of expression (Antaki, 2008) or to help a patient find the right word for an experience (Rae, 2008). This is what the therapist tries to do here, by commenting on and increasing the "dangerous" aspect of Ina's utterances. The therapist's action is best described by what (Deppermann, 2011) calls a "nationalization;" although her attempts seem to fail initially leading to the violent outburst (210–225), once she calls Ina's play role a "scary thief," Ina can agree. Finding an (unconventional)[5] term that matches an unclear idea, nailing down something foggily imagined, or defining a role with a name seems to be a helpful strategy in adult (Knol et al., 2020) and child therapy. It collects a multitude of individual experiences into a coherent category. As in Deppermann's examples, a pause (264) precedes the notionalization, possibly indicating a cognitive process of word finding in the therapist's mind. The notionalization is delivered here by imitating the low pitch of Ina's voice and is thus introduced "in-play" instead of as an outside labeling, an effort aimed again at *avoiding* contrariness in this essential therapeutic act. The notionalization encapsulates in a single word how Ina feels scared and how she—in her role as robber—scares others.

[5]In German, it is "Gruseldieb," a compound coined *ad hoc*.

Segment 10—A Baby Thrown in the Compost

Ina achieves a moment of reconciliation with her devalued baby-self.

```
269 Ina: ((claps both hands 4x on the
         lumps of play dough)) and the
         [baby has to cry
270 T:   [BAby?
271      the-.h (--) SCAry thief
272      (1.4)
273      <<p> would like to like you; >
274      wu=err:: ((simulates a crying
         baby, 0.8))
275      <<p> it's crying now? > (---)
276      ((loud Baby-cry imitation, 1.4
         sec))
277      <<h>So?>
278      (1.1)
279      ((utters a Baby cry, 1.4 sec))
         (-) ((Baby cry, 1.3 sec))
280      (1.5)
281 Ina: <<f> [H↓O=H↓ ==H↓O::! ((raspy
         voice)>
282 T:   ((wheezes)) (---)
283      you? (.) YOU::,
284 Ina: ((laughs hoarsely, 1.3 sec))
285      (1.3)
286 T:   <<p> <<t> wha:t(.) is it you
         want with the baby after all.>>
287      (1.0)
288 Ina: >i:n the TRASH <<dim> throw it
         in the compost.>
289      (2.2)
290 T:   <<len> we don't want (.) to
         give our baby in the trash;>=
291      =in the compost.
292      (4)
293 T:   then, (1.3) > it's no longer
         with us you know;<
294      (2.5)
295 T:   and, (.) our b↑aby has already
         been <somewhere;> else anyway
296      (3.2)
297 T:   it has chosen Us as parents
298      and nOw we do not want to give
         it away
299      (2.9)
300 Ina: <<baby talk> hallo::;>
301 T:   <<h> HALLO:;>
302      <<h> you are a baby TOO?>
303      (4.2)
304 Ina: <<imitating baby talk> hehe<
         yAH->
305 T:   <<h> yA [OH::]
306 Ina: [<<Baby talk> HA->]
```

307 T: you want to come into my arms, huh?
308 Ina: <<baby talk> yA>
309 T: ya.
310 (1.6)

The conversation is accompanied by strong performance sounds. The scary thief is presented very powerfully, expressing dominance rhythmically, bodily, and vocally. The therapist's question about what the scary thief "wants with the baby after all" (286) is answered in a surprising fashion: it is to be thrown on the compost.

Therapeutically, this is a crucial and emotionally touching scene. We have seen how the thief/robber and the baby took sharply antagonistic roles and how difficult it was for Ina to find an exit from a biographical dilemma—does she want to be the baby or to have it? Did she choose her parents or was she chosen? A radical solution to the increasing contrariness and antagonisms is to get rid of the baby as if it were trash. The therapist works against this solution. Her play-parent voice says she does not want to give the baby away (290 f.). However, after some reasoning by the therapist, a new interaction starts unexpectedly (300): Ina uses a baby-like voice to utter a greeting, and the therapist responds by regreeting and asking if Ina is now "also a baby." The question whether the voice, which had been the scary thief a moment ago, is "also a baby" is answered twice: first, as a direct answer to the question, "hehe yeah" (304) after a pause. Then a second time, when the therapist invites her to be picked up, and she agrees (307–308). As the scary thief, Ina despised the baby role, but she accepts it for herself now. In a sense, she repairs the affiliation to her own baby-self which she had opposed before by acting against it as the robber (and already in a milder form in segment 2). This only lasts for a moment, however.

Segment 11—A Baby Found on Grandma's Arm

The moment of reconciliation passes again. However, both find a way to provide Ina with solace after her traumatic biographical experience is reunderstood. A baby given away by her mother can still find affection from her grandmother or from her therapist. An "odd communion" is created.

311 Ina: <<baby talk> dead (-) I'm being made[6].>
312 (1.7)
313 T: you will be made ↑↑ dead? (-)
314 Ina: <<baby talk> YAH,>
315 T: <<h> can you come back to life, then?
316 Ina: <<baby talk> nope>
317 T: OH:::.
318 Ina: I will be thrown in the compost °today° (---)
319 T: <<p> hm(.) REALLY?>
320 Ina: [<<baby talk> YaHa>,]
321 T: [<<h> you (.) you wanted to come into my arms, didn't you? (--)
322 Ina: <<baby talk> No->
323 (1.6)
324 T: [(xxx xxx)]
325 Ina: [You stup]id; (-) shithead;
326 (1.7)
327 T: <<all> <<h> I am a stupid=err (.) stupid WHAT?>>
328 Ina: <<f> SHIThead
329 T: <<p> hm-> ah=HA? (-)
330 so SO! (--)
331 and you are a baby on the compost? (-)
332 Ina: <<baby talk> >YES<
333 (xxx) on the compost;
334 T: hm:; (-)
335 A:nd can one visit you on the compost=
336 =and find you?
337 Ina: <<baby talk)>Nope>
338 (1.0)
339 <<baby talk> da:rr da:rr:: (.) A::RM>
340 T: <<h> O::h what a SWEEt baby> you are (-)
341 <<h> you want [onto:]
342 Ina: [<<baby talk> GRAND::MA>]
343 (1.3)
344 T: <<hh> ↑grandma's arms you want to come to?>
345 Ina: <<baby talk> ye:::ah;

Ina develops a full phantasmatic narrative: the baby will be "made dead" (311) and is thrown on the compost "today" (318). The therapist responds with utterances of incredulous amazement. Ina finds a way out of her life narrative: the adoptive parents have robbed the baby away from the natural parents in Ina's view. A fight unfolds in the play. The therapist, on the side of her adoptive parents in Ina's view, is insulted as a "stupid shithead" (325, 328). "Doing contrariness" is increased up to this verbal violence. The baby is to be thrown on the compost. However, the therapist now replies to the insult mildly with acknowledgment tokens ["mh ah=HA" and "soso!," (329)], instead of opposing this solution. By the therapist accepting Ina's assertion of being on the compost (331) in a calm voice, she trades her claim for epistemic and deontic authority about the state of affairs for a renewal of their affiliation (characteristics of ADC), so that they both meet at the same emotional height at the same place. Ina now responds calmly to the therapist's confirmation question that she is a baby on the compost, namely with a clearly pronounced

[6]In German children's speech, *tot machen*, lit. "to make dead" is a frequent substitute for *töten* "kill." We are preserving this distinction here in the translation although we're aware that it's not a regular expression in English.

"YES" repeating "on the compost" (333). This is the place where she situates her baby-self. Because the two have accepted this set of affairs for the time being and are no longer in conflict about it, an "odd communion" in Garfinkel's terms has been set up there, a common order of a "strange community" that can be lived by those involved—on a compost heap or in treatment rooms.

> "Under such circumstances, the practical achievement of an empathic moment concerns, to adapt Garfinkel's (1952, p. 114) marvelous phrasing, how persons 'isolated, yet simultaneously in an odd communion, go about the business of constructing an order together." (Heritage, 2011b, p. 183)

From clinical experience (Vischer and Vischer, 1987), it is known that to be in the arms of adoptive parents would be perceived as something like a betrayal of the biological mother. Grandmothers are often more easily accepted by adoptive children. A similar dynamic seems to be in place here as well: by calling for a grandmother in babytalk (342), Ina initiates a role change by the therapist. This solution is a repair to the previously failed attempts (at 307 and again at 321) at providing Ina with the solace of an embrace despite the contrariness in the roles they were playing; the therapist picks this up (344) and *via* the role-change they can restore their emotional affiliation and comfort Ina. The conflict is not resolved but suspended and delegated to other roles for the time being. Once again, a role change is cooperatively constructed as part of a complex repair allowing for an affiliative restoration.

DISCUSSION AND CONCLUSION

Securing emotional affiliation is considered to be one of the main tasks in psychotherapeutic treatment, with adults and more so with children. "Empathy" is a concept in psychotherapy process research (Elliott et al., 2018) that has been often studied but not yet fully understood (Weiste and Peräkylä, 2014; Buchholz et al., 2017). CA has identified "challenge" as the counterpart to empathy (Voutilainen et al., 2018). Empathy and challenge are concepts informing conversational practices used by therapists in order to achieve change. Clinicians (Giora, 1989) know that children sometimes are a challenge for adults, and we have learned that adult patients sometimes display high levels of empathy for their therapists (Dekeyser et al., 2009; Buchholz and Kächele, 2015, 2017; Buchholz et al., 2015). We focused on the complex practice we call "doing contrariness," and two ways to deal with it, the pre-emptive strategy "avoiding contrariness," and "remedying contrariness," a kind of repair. In our analysis of this session, we used them as concepts that could describe conversational practices used by both participants.

In our analysis, "Doing contrariness" was observed in different modes: *via silence* (refusing goodbye as "noticeable absence" which provoked repair activities); as an *embodied* practice (prosodically, using voice and other parts of the body); and as a practice of conflicting conversational *projects*. These modes have one feature in common: violation of (communicative and social) expectations, at the cost of risking affiliation and/or epistemic agreement. Which mode will be used depends on situated opportunities. We have seen it here often sequentially practiced after a delay and responded to with a pause, which aligns with previous findings about the correlation of delay in responses and their unexpectedness (Bögels et al., 2015; Kendrick and Torreira, 2015). Both might indicate a cognitive calculation of risks related to violating expectations and of how to respond. In the beginning, we broadly characterized "doing contrariness." We observe two recurrent elements: (a) communicative behavior (including the omission of actions) that goes against the conventional expectations for the interaction situation and its participants (dictated in part by the maxims of cooperative communication (Grice, 1989) and in part by sociocultural norms); (b) the relation between interlocutor affiliation and claim to authority, which often turns out to be an exchange equation. This relation is affected by this communicative behavior. We have seen that it can differentially target affiliations projected by several roles an interlocutor might assume, i.e., it is highly sensitive to the social and interactional positioning of interlocutors. Its disruptive effect on affiliation is such that it can actively change participative frameworks by excluding some members and that it can contribute to an escalation into violence. Some aspects of "doing contrariness" can be probably described formally in terms of "strategic conversation" (Asher and Lascarides, 2013), others *via* the more socioculturally oriented concept of "impoliteness" (Culpeper, 1996, 2011; Bousfield, 2010).

We suggest in addition that it would be extremely useful for the interactional analysis not only of psychotherapy to develop general criteria for when turn sequences can be considered anomalous or deviant and to study how this relates to non-progression of communication or even violent outbursts.

We have also seen that aspects of how to deal with "doing contrariness" can be considered part of a larger typology of practices including repairs, especially if a definition of repair is employed that also allows it to target transgressions against social conventions (Albert and Ruiter, 2018). "Doing contrariness" often constitutes a claim to authority insofar as a participant uses it to diverge from a cooperatively followed conversational path and instead obliges their interlocutors to adapt to a unilaterally executed move (e.g., Ina's silence, her hitting). This normally effects a disaffiliation between interlocutors unless their power imbalance is such that such unilateral moves are allowed for one of the participants. On the other hand, "avoiding" contrariness can meaning to forgo an authoritative claim (e.g., a correction) that could be made for the sake of maintaining or strengthening affiliation, as seen in segment 3. In our analysis, we have observed several instances of attempts at "avoiding" and "remedying" it, both successful and unsuccessful. "Avoiding" it means a pre-emptive self-initiated attempt at reducing the negative effects of a DC-move on both the conversation and the affiliation, or to perform a different move instead of DC. "Remedying" DC is a kind of complex repair. Notably, the most successful attempts at remedying contrariness we observed consisted of collaborative efforts, in which both participants had to signal their agreement to accept a proposed solution as a repair. We suggest that such a solution involves an additional step in learning and distinguishing: in a further unexpected move, participants conducted a shift from affiliation to epistemics or between roles they assumed and thus opened a new way for re-establishing communication. RDC can be related to the

taxonomy of repairs developed by Albert and Ruiter (2018). They describe the category of "other-initiated other repair" (OIOR), where a reparandum in the speaker's talk is both identified and repaired by the interlocutor, and state that this is far rarer and more difficult compared with self-repair. As they (p. 296–298) point out, forms of OIOR are frequently accompanied by acts professing hesitation or reluctance, and in everyday interaction found more regularly directed against children than against adults. Self-repair as a conversational practice is a skill children gradually learn in the course of development (Forrester, 2008). In our case study, we have seen RDC as other-oriented (segments 1 and 8) as well as self-oriented ADC (segment 3), and we have distinguished a third kind, that of cooperatively executed repair (segments 8 and 11). Probably because dealing with contrariness targets affiliative relationships more than conversational fluency, this last type seems to be the most successful because it necessarily involves willing cooperation between participants.

Doing and resolving contrariness affects the collaborative effort at discourse progression which requires "that the separate perceptual frameworks of each participant must be integrated into a common task" (Goodwin, 2018, p. 295), here that of doing child psychotherapy. We think that the concepts of doing/resolving contrariness can also be related to the concept of (the repair of) therapeutic alliance ruptures (Safran et al., 2011). While DC/ADC describe events at the very local scale of conversation, such events have the potential to lead to a perceived rupture in the alliance between therapist and patient, a "tension or breakdown in [their] collaborative relationship" (Safran et al., 2011, p. 80), at the scale of their (current) overall relation. The concept of the alliance and suggestions for how to repair its ruptures are based on adult therapy, where the therapeutic task is much more transparently discussable than in child therapy. For future research, it would be worthwhile to investigate under what circumstances DC/RDC/ADC events can lead to or prevent such ruptures, both in adult and in child therapy.

As a last discussion point, there is also another concept that is something of a counterpart to "doing contrariness." It is "doing vulnerability":

> "If both interaction and individual are autonomous systems, then they are in continual tension with each other in each ongoing interaction. These tensions get manifested in what might be called vulnerability. What is interesting about the confluence of enaction and interactional sociology that we propose in this paper, is that both the individual and the interaction can be conceptualized as vulnerable. Vulnerability hangs together closely with autonomy. It is at the interplay between individual and interactional autonomy and vulnerabilities that the co-creation of significance and significant action happens ...." (Jaegher et al., 2016, p. 6)

Applying CA and other methods of interactional analysis to psychotherapeutic processes requires considering how to approach vulnerability as the center of meaning making. It is undeniable that Ina showed her vulnerability as the downside of "doing contrariness," and that both the therapist and her father (in segment 1) make efforts at protecting it. Her vulnerability has a history in very early life, and it produced effects that rendered her nearly incapable of accepting a kind of support and help which her young mind understood as betrayal. The practice of child therapy should not be analyzed without a profound understanding of such traumatic experiences and of psychological development. We have tried to integrate some insights from these domains. To fully integrate trauma and vulnerability into CA, studies of psychotherapy will be a task for the future.

GERMAN TRANSCRIPTS

If readers are interested in the original German transcripts—please turn to the first author.

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DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author/s.

ETHICS STATEMENT

Written informed consent was obtained from the individual(s), and minor(s)' legal guardian/next of kin, for the publication of any potentially identifiable images or data included in this article.

AUTHOR CONTRIBUTIONS

BW conducted the therapeutic session providing the primary data for the study. MB conceived of the general idea of the study. MB, TB, and BW contributed to the analysis. MB wrote the first draft and TB revised draft of the paper together with MB.

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