Language and Psychoanalysis

Special Issue:
Conversational Analysis in Psychotherapy Process Research

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ISSN 2049-324X

Volume 5, Issue 2, 2016

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Scope

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We welcome a wide range of original contributions that further the understanding of the interaction between Linguistic Analysis and Theory & Psychoanalytic Theories and Techniques. Any relevant manuscripts with an emphasis on language and psychoanalysis will be considered, including papers on methodology, theory, philosophy, child development, psychopathology, psychotherapy, embodied cognition, cognitive science, applied dynamical system theory, consciousness studies, cross-cultural research, and case studies. The journal also publishes short research reports, book reviews, interviews, obituaries, and readers' comments.

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Word limit:
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Content

Conversation Analytic Studies of Psychoanalytic Dialogue: An Introduction to this Special Volume

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Parallel Actions

Two parallel strands developed since the start of the century in psychoanalysis. One was the relational turn initiated by Steven Mitchell (Mitchell, 1988, 1998) and his many inspiring and inspired co-workers (Aron, 2006; Hoffman, 1999, 2006; Knoblauch, 2007), just to mention a few of those authors whose enormous influence in demystifying some psychoanalytic myths held for irrefutable for so many years can be felt from their writings.

Just to mention one point. In *"Influence and Autonomy"* Mitchell (1997) described his study of psychoanalytic therapists' intervention in the process. He provided a detailed description of what went on in the patients' mind (as the analysts thought it were) and what the analysts then said was a summary of the kind "These connections were interpreted to the patient". No clear representation of what the analysts said nor the answer the patients gave to the interpretation. The patient was viewed as deliverer of "material" and the analyst delivered "interpretations". As long as such a model of division of labor seemed to work we had something called "classical psychoanalysis". Doubts increased if what we think we do really is what is done. Meanwhile these doubts are certified:

"We believe that there has not been as much diligence in confronting the reality of our clinical practice, that is, what it really is, and not what we say it is or what we would like it to be" (Canestri, 2011, p. XX).

Parallel voices were heard from one of the most experienced scholars in infant research:

"Although the coconstruction of the intersubjective field is currently of great interest to psychoanalysts, detailed clinical material illustrating the nonverbal and implicit dimensions of this process remains rare" (Beebe, 2012, p. 97).

While many confessed to interpersonalist or intersubjective or relational terminology the empirical study of what was really done in details was still hardly studied by psychoanalysts (be them classical or relational !!) themselves. But by a group of conversation analytic researchers who turned away from studying court interaction or medical discourse in the consulting room of psychotherapists of various schools. The

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study of psychotherapeutic and psychoanalytic discourse was conducted by many researchers with a linguistic or sociological training and interest (see Kächele's concluding remarks), however this was seldom recognized by psychoanalysts. Their publications were published in journals out of reach for many practitioners who practiced eight hours or more per day, although the findings would have interested them. Another obstacle might have been the terminology of linguistic and social scientific jargon, although many clinicians readily joined neuro-psychoanalytic research and learned how to read these publications and study it's terminology.

The Primacy of Interaction

This situation changed when conversation analysis appeared (CA) on the stage. Although blackened as "behavioristic" this turned out as an error. Gail Jefferson who edited the "Lectures on Conversation" of Harvey Sacks (Sacks & Jefferson, 1992, 1995) after Sacks' untimely death in 1975 wrote a lot of papers that took up psychoanalytic topics as e.g., Freudian slips (Jefferson, 1996). What she found was close to the original Freudian approach, however, Freud's observations could be confirmed and extended. One of Sacks' co-authors, Emanuel Schegloff, became one of the most prominent CA-researchers and he wrote a paper "The surfacing of the suppressed" the title of which took up the Freudian "sound". What he discovered was the following: When a slip happened in a conversation and its topic, although relevant for the conversationalists goes unnoticed there is a strong tendency for another slip to happen in the next one or two minutes of the conversation. And he gathered a lot of material where just this happened. Schegloff (2000) published his study in German and two psychoanalysts (Kazanskaya & Kächele, 2000) wrote a comment which substantiated the convergence of CA and the original Freudian position.

In 2008 it was time for a compilation of CA-results in psychotherapy process research (Peräkylä, Antaki, Vehviläinen, & Leudar, 2008). A lot of studies turned to the dimension of therapeutic empathy (Weiste, Peräkylä, & Perakyla, 2014) and it seemed that empathy is a subject that could be studied by CA, although earlier attempts had warned how complex the study of empathy is (Elliott et al., 1982), achieving high agreements among raters cannot be expected.

With such developments CA in psychotherapy loosened a little bit the singular fixation to linguistics only and turned more to the social dimension of human interaction. Linguistics and social science were at the offspring of CA, both were "parents" of CA. A more social orientation originated from the work of Goffman (Goffman, 1981) who invested much energy to embedd interaction and conversation in relevant institutional contexts (Goffman, 1974, 1986). What happened in psychotherapeutic treatment rooms, thus, could be understood as a special type of institutional interaction - dealing with emotions. This was another challenge for CA. But the papers gathered (Peräkylä & Sorjonen, 2012) give a sustained impression of CA-power to deal with emotions as very influential "things" – in interaction, not in indivuals alone. CA kept to the interactive primacy. Interactive – as opposed to an individualistic – primacy could be debated in a clinically important text (Peräkylä, 2015); Goffman's "face-work" and what Freud had termed "narcissism" were brought into a fruitful dialogue.

New Methodological Problems

However, interactive primacy poses a lot of new methodological problems. Schegloff had turned to the macro-micro-problem in early years (Schegloff, 1987) where he refused to explain what happens in conversational interaction by abstract concepts which pre-exist in the interpreter's mind so readily. This was supported by a German social psychologist (Graumann, 1979) who wondered about psychologists' shyness towards interaction. Schegloff showed the relevance of details regularly overlooked when using abstract and prefabricated concepts too fast.

Let me give just one example of the relevance of details. In our CEMPP-project (CEMPP = Conversation Analysis of Empathy in Psychotherapy Process) we compare psychoanalytic, cognitive behavioral and psychodynamic psychotherapy. Of each therapeutic school we have 5 patient-therapist dyads using one session form the start, the middle-phase of therapy and of the terminal phase. Per Dyad are 3 sessions available (beginning, middle, end), per school of therapy we have 15 sessions available.

While transcribing this material we observed that so-called "change-of-state-tokens" (Heritage, 1984) were uttered in some sessions more often than in others. In change-of-state tokens, "hm"s are uttered in a special prosodic fashion: they have two summits and a special shape of intonation. Together with a relatively strong increase of pitch and a slow decrease they have the potential the inform the speaker that the listener's "state" has changed; he understands a story better when e.g., a missing detail is told or when the change of perspective in the narration is understood as an important detail. This is undoubtedly important when you think of a therapeutic intake interview while listening to a patient's narrative, complaints or biography and when you utter such a token the patient experiences a) that you are an active listener and b) that the patient has the influence to change your state-of-mind.

Patients value when they can influence their therapist. It increases their feeling of agency and self-worth. Undoubtedly, this is an important interactional feature. However, we do not know of any study in psychotherapy process research having mentioned this feature before. Narrative Process Coding Systems (Angus et al., 2012; Boritz, Bryntwick, Angus, Greenberg, & Constantino, 2014; Singer & Bonalume, 2010) do not code therapist's utterances while the patients narrative activities, they are oriented to the patient in order to measure improvement(Mendes et al., 2010). However, from a CA-point of view this methodology ignores the therapist's contribution in narrative coconstructing.

Florian Dreyer (this volume) presents an interesting example of how influential the therapist‘s "change-of-state"-tokens are – above all, if they are missed. Adding to his findings we worked on coding all change-of-state-tokens in our transcripts and found the following distribution (see Figure 1):

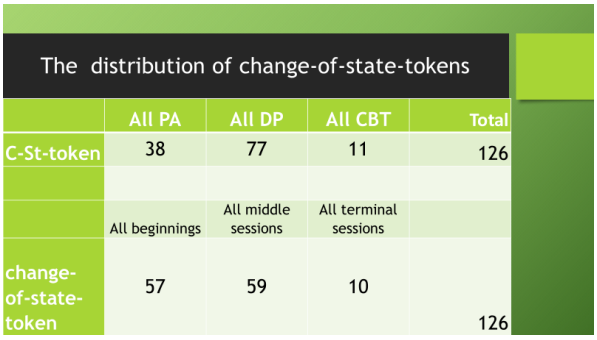

Figure 1

Change-of-state-token distribution

Over all sessions, from beginning to the end, CBT therapist utter a very small number of change-of-state-tokens (CST), less than one per session. The psychodynamic therapists use it most often. Is this a result attributable to therapists' orientation alone? The answer is no, as there is obviously a time factor. If you sum up across all therapies and list according to the state of "relational development" you can find another result: In the beginning CSTs are as often as in the middle; at the end of therapies this sign of acquiring a new understanding in interaction decreases.

This is a very simple result. However, it confronts us with some methodological questions. First, does this difference represent a difference of approach between psychoanalysis, psychodynamic psychotherapy and cognitive-behavioral therapy? Or is it more of the therapist's personality? In what relation stands such a result of micro-analysis to meso- or macro-levels of outcome? How can the relationship of micro-details and macro-outcome be thought? One way is to think of micro-events like the brickstones while building a house. Putting one above the other you can observe how the walls of your house grow.

What about the role of the architect with a plan? All brickstones look like the same. However, there is a difference. Some of them are cornerstones, others not. Removing the cornerstones or those below the others willl produce different results. One important methodological lecture to learn from this way of thinking is that same things are not always the same. This must have consequences for a "coding and counting" – approach (Kondratyuk & Peräkylä, 2011) which treats every element with the same code as if it were the same.

The other way is to think of the micro-macro-relationship in a more systemic fashion including temporality. The effect of omitting a CST in the first meetings might be greater than at the end irrespective of how positive or negative this effect might be. There is something else to be mentioned. If it is right what CA-researchers attribute to CSTs then each CST could be considered according to a part-whole principle. Uttering a CST is, then, not only an element to be counted. For the individual dyad such an element might direct the interactive course slowly in different directions. If a CST is recognized favourably by a patient it might become part of a hopeful investment that the therapist might be a person who is not stubbornly following own rules but is person accessible to

influence by the patient. Thinking that way, a CA procedure could be not simply to count CSTs, but to include the responses of patients to CSTs.

Viewing these two alternatives of the micro-macro-problem both end with an unresolvable clash of the wish to keep to the individualized meanings in the dyad and the wish to understand larger groups of treatment. To find good answers to this, and other types of unresolved methodological problems will be a task for the future. What we have tried here is to present cases of very unusual dream tellings (Marie-Luise Alder), where telling a dream of the last night is used as allusion to the ongoing interaction. Michael Dittmann studies not the final phase of a therapy, but how single sessions are closed with interesting results, e.g. something he calls JETH (Joint evaluation of therapeutic help). More often than not such evaluation is done not by external researchers but by participants themselves. The other attempt here is to compare good and less good solutions for typical problematic situations in therapies which is my contribution. Laura Cariola explores patients' semantic changes in patient person-centred therapy and how it relates to the mind-body paradigm by focusing on body boundaries.

We hope that readers might become interested in this kind of study combining CA and clinical competence in order to better understand what we mean when we speak of the therapeutic process.

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Psychotherapy – Analyzing Conversation of Typical Problematic Situations (TPS)

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Introduction

In relation to the psychotherapeutic process, studies have investigated the influence of personality variables (such as socio-economic background, attachment styles, status differences, race, gender) on the one hand, and training orientations (such as Cognitive Behaviour Therapy, psychodynamic, gestalt, systemic), on the other, but results have been largely inconclusive and ambiguous.

After the National Institute of Mental Health-debate between research-groups of Irene Elkin (Elkin, Falconnier, Martinovich, & Mahoney, 2006) and Bruce Wampold (Kim, Wampold & Bolt, 2006; Wampold & Bolt, 2006) 10 years ago, the relevant question to study patient-therapists matching seemed to be conceptualized as a simple and dichotomous 'method or therapist (personality)' dynamic; however, conversation analysis offers another strategy to conceptualise psychotherapeutic dynamics in terms of 'situationism'.

The methodological rules of situationism can be roughly outlined as:

1. Don't look primarily for diagnostic measures as e.g., social background, attachment style, motivation or type of personality. These abstractions produce *generic* explanations; however, in therapy we look for *how* these variables (and many others) are *individually* realized in interaction.
2. Make talk-in-interaction the center of analysis. Such data are gaze, body movements and talk. Talk includes words, the embodied voice and rhythm used to achieve a definition of the situation.
3. Look for how a common ground (Enfield, 2006; Stalnaker, 2002) is established or not. Common ground outlines the horizon we talk to, it is never a "given" but to be established in situations.
4. Talk-in-interaction has the double potential to repair imbalanced common ground *and* to tear the common ground to pieces.
5. Direct your attention to how common ground activities are managed successfully or not. Without a common ground situationally maintained by interactional and talking activities every special technical procedure in psychotherapy heavily risks to fail.

These guidelines can direct the attention of clinical practitioners and process researchers interested in how such a complex project as 'psychotherapy' is conducted by two people. One could follow Jerome Bruner (1979, preface) who suggested that "interior intellectual work is almost always a continuation of a dialogue." The process of observing of

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conversations is informed by theories that are practiced in situations by focusing on the interactions between two parties (such as practitioners and researchers, or therapists and patients). These observational processes are particularly useful to identify and understand when therapies seem to fail.

Harold Blumer (1969, p. 149) once made a useful distinction by suggesting that "whereas definitive concepts provide prescriptions of what to see, sensitizing concepts merely suggest directions along which to look." Typical Problematic Situations (TPS) is a new sensitizing concept, I do not have a clear cut definition, however a direction where to look. My hope is that one day we might generate a more fully outlined theory of what TPS are and how they can be classified. I use the word "typical" not as a classification marker but as provisional expression of an intuitive sense clinicians have that they have met such a situation often in their professional lifes.

Examples of TPS

Example 1: Caught in a Controlling-Control Frame

In a first interview with his psychoanalytic psychotherapist, a young student presents his compulsive symptom with the following words:

P: yeah so=I behave (.) kind of compulsion to control (--) and when I e.g. go out of the door (.) >then I don't< but when I come in [then I look backwards=
T: [hm: =yap
P: and make sure not to have forgotten anything

He talks calmly and in an expert manner about his 'compulsion to control' his actions: how he makes sure not to have forgotten something when coming home to his girlfriend from university. He speaks with a "scratchy voice." His expectation of help, the reader learns from studying the whole interview, is to control his controlling behavior. This self-description of his symptomatic behavior happens in the first minute of the interview – 45 min later we find the following interaction:

P: it=it's in no re=relation anymore to what I could hold under my surveillance or control? And wished to (.) [how strong this shows up, doesn't it?=
T: [hm;
=hm
(1.2)
T: .hh yea:h? Well, this will keep us busy what you are looking for there (-) what you are seeking (.) seeking
(2.1)
P: seeking (.) yes this is what one could say (1) I think not only contro:l (.) it's seeking =
T: =so it sounds for me (.) It doesn't sound li=like, it's less control it's more seeking, (1) anyhow to look around and seek (1.3)

The patient is alarmed how excessive his controlling behavior is. With a somewhat surprised token, the therapist metaphorically *formulates* (Antaki, 2008) a project for their common work ("this will keep us busy") in the future by replacing "control" by "looking," then "seeking." The patient agreeingly adopts this metaphor *and* directly acknowledges the therapist's formulation. Now the therapist continues the construction of an alternative agenda (Stivers, 2007) by adding a "look around and seek." The therapist talks with 'high energy'. This is a kind of successful 'persuasive communication' addressing the patient as a seeking person.

Example 2: Needing Help and Nobody Can Help

There are other TPS's where therapeutic engagement is urgently demanded. A severely depressed woman in her late twenties begins her 30th therapy session as follows:

P: Ye:s errm again (.) yesterday there was a strong quarrel
(1.5)
T: hm
P: and of course things turn out the same as always (.) and it becomes (2) for me (3) it's really difficult or perhaps **it's existential somehow** (2) it's becoming (2) it becomes more and more important to protect this=this inner core of my self
(3)
T: hm
P: that I am or whatever this is (.) errm which leads to my problem that (2) I do not know what it is and errm (2)
T: hm
P: or who I am (2) in this whole thing (2) errm (2) have no (4) so taken from my inner image I must drive upwards along a wall which somehow protects the small (1) circle somehow (1) so that I can (7) errm (8) yes, well, when she reproaches me or so (2) errm (3) I then have told her (3) now this is for me really so then I must separate inwardly because otherwise nothing would be left of me and
(4)
P: it is as if it would destroy me

This TPS is composed of several interactional details. *First*, the patient's talk is full of self-interruptions. Many sentences are started, but left unfinished. Many new topics without completion. Listeners are set under tension: What might be relevant next? Every topic is relevant, but the fast *series* of relevance systematically downgrades every single topic (Körfer & Köhle, 2007). *Second*, by telling to present things as "always in the same way" (line 4) she utters the expectation that her therapist will be bored while listening to "the same as always." The wave of up- and downgrading relevance has interactive effects: On the one hand, she shows consideration of her therapist's mood which leads her to inhibit full story telling; on the other hand, she increases her demands for help, *third*, by outlining an existential dimension of her threatened core self when (line 9-12) she does "not know" adding "or who I am in this whole thing." *Fourth*, she intensifies her

symptomatic complaints; she suffers from a powerful and paradoxical "inner image" (line 12) to drive along a wall that protects *and* encloses her; someone reproaches her, she has to protect herself against being destroyed (line 18).

… 6 lines omitted…
P: I feel so worn out that I have these thoughts errm (3) when so stressed or I come late to somebody or anything then it comes to my mind (2) so when I am so tired and I drive and want to drive to X-city then I think why doesn't somebody run me over so that it can all end
(2)
T: hhh. Hm
P: what from myself again (1) I do not believe this myself and don't take it seriously (.) it's simply (3) such a thought of desperation °°as I do not (2) know neither backward nor forward°°
T: As you?
P: as I do not know neither backward nor for[ward
T: [ah yes
P: so it isn't that I want to drive against a tree, however I am not sure

She is so worn out that she feels an impulse to bring things to an end ("somebody run me over" and "to drive against a tree"). *Fifth*, while increasing her symptomatic complaints the therapist utters hardly more than go-ahead-tokens. The patient emphasizes her sense of desperation that she knows neither backward nor forward (line 31). As her therapist asks for a repetition of the phrase not-understood the patient loudly repeats and the therapist utters an "information-received token" (line 34). In summary, it is as if the patient would say, "I need your help urgently; however, nobody can help me, not even you!"

It could be a valuable task for CA in cooperation with clinicians to propose what kind of conversational strategy might be helpful in such a TPS. How to overcome false considerateness and blackmail, in order to transform the TPS into a workable position?

Another example of the same kind

Another example from our CEMPP-material has some common features, one of which is the sequentiality of patient's complaints and therapist's "information received tokens." I do not show this but another course of treatment.

This patient, a male professional with family and children, came to therapy after having committed a suicide attempt. He successfully deceived major parts of his family and professional environment about his suicide attempt. He simply lied. However, his state has not improved. He sees no solution and he wishes to withdraw from life completely. He complains about his inability to lead a normal life, he accuses himself to be a burden to his wife, his children and colleagues. Pills a doctor prescribed worsened his situation. In his 17th session after a long series of complaints something different happens:

P: And if I would admit myself to a clinic then I were arrested and then (.) then I could view at my children through err .hh barred curtains and so on the[se things .hh (--)
T: [°°Mhmh;°°
(.)
P: overwhelm me [at the moment
T: [Mhmh, .hh then there these sinister ideas come to your mind (--)
P: Everything [so eh:
T: [Things don't go on (.) it's coming to an end.hh I bring misfortune an' I've brought misfortune and=a very strong wish that .h somebody be there whose hand you may hold tight (.)
P: °right° (.)
T: Like=a child (.) °simply° (---) searching for (.) hold-on (--)
P: °mhmh,°
(11.8)

First, the therapist does not refer to the single content of the many complaints, but understands them as examples for an overall mental state ("these sinister ideas") the patient attempts to convey to the therapist. The therapist exemplifies empathy. Second, the therapist does it by using a theoretically inspired metaphor of childhood experience: searching for a hand to hold on. Thirdly, the therapist minimizes the risk of blaming by a shift of positioning. He uses the pronoun "I" where obviously he paraphrases the patient's accusations to have brought misfortune to many people. Thus, the therapist lets the patient know that he, the therapist, knows such states-of-mind as well. A re-normalizing might be effected. Taken together all these measures seem to calm the patient's state for 11.8 seconds, which is the first pause in the session. It could be considered a reflective pause (Frankel, Levitt, Murray, Greenberg & Angus, 2006).

However, so simply a seriously depressed patient's complaints cannot be cured. The patient comes up with a lot of similar complaints and two minutes later the following sequence is enacted:

P: And then I think to myself (--) for heaven's sake (--) what if your son we:re (--) involved in drugs u[sing drugs and so on and so on.h (1.9)
T: [Mhmh, mhmh,
P: and all these things they are (--) they simply are (--) myriads too much for me=
T: =mh[mh, mhmh,
P: [They are anyhow (2.9) too heavy a burden .h I can (1.8) but for this I am there I am the father I am the one who .hh who should

```
    care and [be in sorrow I cannot
T:                   [Mhmh; mhmh;
P:  simply say .hh (--) I have so many sorrows myself I can't
    (.)
     cannot at the moment think of [this and that
T:
    [Mhmh; mhmh, mhmh;
(2.0)
```

Changing to the topic of caring for his own children the patient seems to indicate why he is unable: because he feels as a child as the therapist uttered a few seconds before. Feeling a child himself his children become an unbearable burden. Accusingly he appeals to himself that he is the father:

```
T: .h but seen from how you simply feel it is
    as if you must (--) get into line (.)
    with the children and can't (.) be a father
    now °could you?° .hh
(2.5)
P: actually yes,=
T:                          =yes=yes,=
P:  =actually (.) [I am a a a
T:                         [yes;
(-)
T: Although you [painfully feel
P:                          [surely
T:  it should not be
       It should be different but .h seen from your
     feelings  (.)  °too  weak  too  small  or  first  too
    helpless;°
   (--)
```

We find the therapist using the metaphor of a child in a way the patient can easily accept (428). This is later dramatically confirmed by the patient telling that he sleeps in his children's room to feel their closeness. The therapist affiliates with the patient's helplessness by doing what he is talking about – taking the "child's" hand. This is more than positioning, it is therapeutic agency (Berán & Unoka, 2015). This segment, finally, results in what Lerner (Lerner, 2013) has called 'other completion'.

```
P: right (-)
T: is there any (-)
P: I'd  [need at the moment
T:         [offering someone protection [and
    security >.h<
P:
    [right
(18.0)
```

Both participants begin to move into a micro-universe of distributed knowledge mutually completing their sentences. This type of collaboratively co-constructed utterances is described by Hutchins and Nomura (2011, p. 29) in the following way:

> In the most frequently studied type of collaboratively constructed utterance, one speaker begins an utterance in a way that projects possible completions. Another speaker then contributes utterance elements that are incorporated into a jointly produced utterance. The acceptance by participants of a collaboratively constructed utterance is strong evidence for the establishment of common ground understanding.

The solution for this TPS establishes a common ground by shifting I-positions with an effect of down-grading the risk of blaming, reformulating some of the patient's utterances and outlining his state-of-mind in a way that confirms that both share distributed knowledge with an effect of renormalising the patient's state-of-mind, which has a soothing effect.

Concluding Remark

After this analysis we can describe further aspects of situationism: Two persons, meeting in mutually unknown biographical and partially shared cultural contexts which they produce and reproduce, and an interaction "face-to-face" (Jaegher, Peräkylä, & Stevanovic, 2016). Both participants bring in their capacities of sense-making and their bodies, above all their voice, which is immediately perceived and mutually reacted to. Skills of social understanding are required while each participant knows that a high degree of unpredictability is co-present with a more or less high level of emotional arousal. These components are brought together in order to achieve some meaningful interaction while working on the common project of "psychotherapy" which is broken down into many smaller part-projects . However, Goffman's formulation at the end of his 1967 "Introduction" to "Interaction Rituals" can serve as an orientation: "a psychology is necessarily involved, but one stripped and cramped to suit the sociological study of conversation, track meets, banquets, jury trials, and street lotering" not, then, men and their moments. Rather, moments and their men" (p. 3). It is these moments, which clinicians know from one patient to the other and from one consulting room to the inhabitants of other consulting rooms. Studied as sequence of situations or moments, it is the foundation of typicality. This and more is a challenge for the future.

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Dream-Telling Differences in Psychotherapy: The Dream as an Allusion

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Introduction

In everyday conversation dream telling occurs seldom: Bergmann (2000) found in his data of many hours of audio recorded family conversations in natural surroundings not a single dream narration. He assumes that psychotherapy should make dream telling more relevant. In our Conversation Analysis of Empathy in Psychotherapy Process Research (CEMPP) project[2] data of 45 audio recorded and transcribed psychotherapy sessions from psychoanalysis, psychodynamic and Cognitive Behavioural Therapy (CBT) we only find four dream mentioning and three dream telling. Surprisingly, none of these occur in psychoanalysis. The function of dream telling in psychoanalysis has been summarized and analysed by Mathys (2011). This paper will focus on one dream-telling sequence from a CBT session. Nevertheless, this sequence is of high relevance for psychoanalysis because it supports the idea that dreams can be understood as an allusion to the therapeutic relationship. In this brief paper I would like to demonstrate how a dream can serve as an allusion to a contaminated talk and a disappointment in the therapist. It might be for the first time that this is shown on the basis of empirical data.

Method

The data analysis is done with conversation analysis (CA) (Sacks & Jefferson, 1995; Sidnell & Stivers, 2013). CA focuses on talk in interaction and any implications done by the researcher must be verified by the subsequent talk. With this method one cannot only analyse a conversation turn-by-turn but also focus on conversational trajectories that shed light on an utterance that can only be understood within that context. The application of CA onto psychotherapeutic conversations has proven to be a tool for fine-grained analysis in order to detect the very subtle notions within a psychotherapeutic process (Buchholz & Reich 2015; Peräkylä et al., 2015; Voutilainen, Peräkylä & Ruusuvuori, 2011).

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[2] Sponsored by Köhler-Stiftung

Results

One Dream from a CBT Session – More than just a Dream?

The dream shown below occurs in a CBT Session. This is the second encounter between a female therapist (T) and female patient (P). The transcripts[3] shown are an English translation of the original German transcript.

Sequence X

451 P: I have temporarily I dreamed that I (1) well either I had burned hands and thus
452 I couldn‘t work at all or I‘ve (--) been somehow (1.1) I don‘t know in the
453 forest I was (.) naked and in need of help
454 [and] then someone passed by looked at me and left again
455 T: [mhmh]
456 P: .h (-) well like (-) one cannot even help me now;

From the first glance this appears like a normal dream report. It fits to Jörg Bergmann's and Anssi Peräkylä's (2014) findings for psychodynamic sessions: The dream-telling starts with no topical connection, no hesitation or justification, the framing of the telling appears to be the teller's dream ("I have … dreamed"), the dream is externalised as an event in the past and the teller is displayed as a reliable and unreliable witness ("I had…" vs. "I don`t know"). However, even though there seems to be nothing extraordinary about that dream something is striking. It is the placing of that dream-telling. Please note that this dream occurs in minute fourteen! In order to understand the function of that dream, we need to rewind the conversation and start the analysis around seven minutes before that dream telling occurs.

Dream-Telling in CBT

After a general review of her situation during the past week the patient starts to tell the therapist that she had a dream last night. This is roughly in minute seven in which the whole dream-telling episode starts. Please read the following sequence:

Sequence A

193 P: .hhh (---) ((coughs)) WELL (-) that was the one thing (1.3) and the other (.)
194 tonight I had a dream

[3] Please note the following rules to read the transcripts: *[Square brackets]* indicate an overlap in speech; the *(pauses)* are captured in round brackets in seconds; a point in a bracket indicates a pause of under 0.25 millisecond; one *hyphen (-)* in brackets indicates a pause of 0.25-0.50 milliseconds; two hyphens indicate a pause of 0.50-0.75 milliseconds and three hyphens indicate a pause from 0.75-0.99 milliseconds; a *.h* means the speaker inhales recognisably; a (h) indicates laughter; superscripted ° indicate low volume; capital letters indicate HIGH volume; inverted >angle brackets< indicate faster speech and the opposite indicates <faster> speech; any semicolon means a fall in intonation and a question mark a raise in intonation; ((double brackets)) contain transcriber's commentaries.

195 T: mhmh
196 (--)
197 P: <ERM> (-) YES and somehow I thought that this dream [series]
198 T: [sorry if I] just
199 [now mh]
200 P: [sorry]
201 (--)
202 P: .HH ((through teeth)) (---) °°fingernail°°
203 (1.9)
204 T: will be (.) will [be?
205 P: [mhm
206 (1.2)
207 T: okay (--) sorry a(h::) [that was
208 P: [yes that was hurting e(h)[e(h)
209 T: [yes now its fine again °mhmh?°

The patient is about to tell her thoughts about a dream series (line 197). The therapist interrupts her due to a hurting fingernail (lines 198-202) and directs her attention away from the patient on to her fingernail. At the end of this sequence she reassures that everything is "fine again" (line 209) and she redirects the attention back to the patient. After this rupture she passes on the turn with an indistinct continuer "mhmh" (Fitzgerald, 2013). This causes a hesitation in the patient's subsequent talk (see sequence B). The indistinct "continuer" forces the patient to reconsider what she was telling and to plan her utterance again.

Sequence B

210 P: <Mh> (.) mhm (-) erm (--) there was a dream series that I had (--) in fact I
211 always had to run away (.) away from something like something threatening
212 me .h (-)
213 T: °mhm°
214 P: and always it was only somehow dark and it was al (-) always supposedly
215 always at night (---) .h and eventually I have
216 [alone]
217 T: [when was that?] when was that dream series?
218 P: well I think it lasted quite long but it happened (-) seldom °well maybe° about
219 (.) I don't know every few months it
220 [mostly like]
221 T: [as a child already?] or now as an adult
222 P: well I can't really say °and° (-) ((coughs)) but I remember I only know (-) that
223 erm two hh (-) don't know erm I estimate maybe around two thousand-
224 three, two thousand-four, two thousand-five
225 T: mhmh

One difference to the findings of Bergmann and Peräkylä is that the therapist does not wait until the patient comes to an end and then asks questions. In this CBT the therapist asks two questions (line 217 & 221) before the patient finishes her dream telling and the questions do not relate to the dream story itself. Speaking with Heritage these are ancillary questions that do not align or affiliate with the first speaker. Nevertheless, by

inquiring about the dream subject the therapist sets the subject itself relevant for the interaction. She up-grades the relevance of the dream subject by questions connected to dreaming. Thus the dream subject becomes something expectable for the psychotherapeutic setting. In the ongoing therapeutic conversation, the patient tells that she could figure out that she was chased by a man. Due to her self-defence training in her real life she managed to beat him down in the dream. Finally, the dream series stopped. Unluckily, it returned last night and this is what she tells the therapist (Sequence C).

Sequence C

248 P: now I cannot remember the face and nothing else but actually (.) erm (--) and
249 somewhere I was to be killed somehow in this [dream]
250 T: [°mh]
251 P: with a scarf (-) .h somehow I was to be suffocated with that=
252 T: =°mhmh°=
253 P: =put around my mouth or around my nose (-) pressed (-) very tight .hh
254 T: °hmhm°
255 P: well this is as much I can remember
256 (---)
257 T: e::r (-) was it already around your mouth?
258 P: yes
259 (.)
260 T: aham

The patient narrates the dream and the therapist receives the telling with interjections (lines 250/252/254). With the ancillary question (line 257) the therapist up-grades the relevance for dream-telling and the dream itself. This leads the patient to present a childhood memory. A memory she has regarding the chasing and the man: She remembers a neighbour sneaking around their garden and her mother screaming nervously "there he is again!". The therapist receives that memory recall with information tokens (interjections). After this association the therapist takes over the turn (Sequence D).

Sequence D

296 T: .H (-) mh h (-) mh (--) do you have any other (.) ideas about those dreams or
297 knowledge (.) so to speak coping (--) how did your family cope with it
298 in the past (--) and=
299 P: =well I never really told this
300 T: hmhm
301 (--)
302 P: I thought (.) my family would say it is something inscrut[able like (.)
303 T: [hmhm
304 P: why it is like that
305 (1)
306 T: hmhm and did you read anything related
307 (1.2)
308 P: HMHM: .h (--) e::r nope (-) I just have
309 (---)
310 T: hh

The therapist starts with delays: inhaling, interjections (line 296). We know from dis-preferred answers that they need some preparation in the hearer's ear (Goodwin & Heritage, 1990). The therapist does not defer to the memory recall but uses this notion to ask for more ideas. By doing so, she slightly downgrades the former recall as 'not sufficient' and has a slight raise in pitch at the word "any other" (in the German transcript the word "noch", line 296), as it is observed in practices of mitigating a message in a more friendly manner. As described for nurses' or doctor's talk with patients we can observe the same style of question here (Depperman & Spranz Fogasy, 2011). The therapist displays herself as agent of the exploration - she asks questions around the subject. These questions explore the dream subject and thereby upgrade dreams as relevant for psychotherapy and for the interaction. At the same time the therapist downgrades the dream telling by sidestepping the dream-content itself. She continues inquiring about dreams and explores the patient's stance towards dreaming. Sequence E is just one example out of seven.

Sequence E

362 T: tzs ((klick of the tongue)) .hh (-) #m# (---) how is it if you listen in your inner
363 self. what does dreaming mean to
364 2.7)
365 P: well it is somehow like (--) this su subconscious [I think after all
366 T: [hmhm
367 (1)
368 P: and everything else one cannot (--) understand [or not
369 T: [hmhm
370 P: grasp as well
371 T: hmhm
372 P: why why for one cannot get access to while (.) living consciously
373 T: yes
374 P: or thinking consciously

The therapist continues asking (lines 362-363) and, therefore, up-grades the subject dream-telling and explores the patient's stance turn by turn. The questions remind on an interrogative style that explore the patient's attitude towards dreams and encourage the patient to take her stance. The patient perceives dreams as something relevant coming from the "subconscious" (line 365) and that dreams reveal things one does not have access to "consciously" (lines 372/374).

An unexpected turn

After exploring the patient's opinion, inquiring about dreams and, therefore, upgrading the relevance of the dream subject, something unexpected happens: the therapist reveals her own opinion about dreams:

Sequence F

399 T: Yes (1.7) ((klick of the tongue)) (-) Dreams
400 (2.1)
401 T: .hh (--) honestly I have to say to you I don't (-) actually I don't know about it
402 P: mhm

403 (---)
404 T: ((klick of the tongue)) .hh (--) erm (1) nevertheless I have an attitude towards it
405 anyway
406 (-)
407 P: mhmh
408 (-)

This is what the behavioural psychologist J. Montangero (2009) writes precisely: "Whenever a patient reports a dream to a CBT therapist, the latter can only politely mention that s/he does not know what to do with it." (p. 240). In the ongoing talk the therapist proceeds to explain her attitude towards dreams. Due to space the sequences will be skipped. What she does is, she builds her arguments along the previous patient's statements. She defines her opinion in contrast to the patient's previous stance. By that she not only down-grades the relevance of dreams but also the patient's stance. She articulates her opinion about the uncertainty and, thus, uselessness of dreams. Obviously, her opinion opposites the patient's stance.

Now again, something unexpected happens. The patient tells another dream. She tells the dream shown at the beginning. Please turn back to the very first sequence X and read it again!

The Dream as an Allusion

Bergmann (2000) wrote that the display of a story is always shaped by its situational circumstances. Researchers on interaction agree that with in an interaction there is more conveyed than just the words we hear. According to the psychoanalytic dream theory a dream can be a reference to the therapeutic relationship. Reading this and taking into account the knowledge from the conversational trajectory this dream is a pictorial display of the current situation. It is an answer to the therapist's sudden down-grading of the dream-telling subject. By the therapist the subject of dream-telling was set to be relevant within the shown Sequences B - F. Due to the sudden and unexpected down-grading the expectations for the further leading conversation should change tremendously. The sudden turn in the conversation can be understood by the phenomenon Freud called "Nachträglichkeit" or "Afterwardsness." This means: Only by the subsequent connection of two or more events under a new sense of recognition, something can appear to be shocking or traumatising. As we have seen the patient shared highly subjective beliefs with the therapist and (i) literally "burned (her) hands" (line 451) at the therapist. In German there is a common saying that somebody burned his fingers after a failed approach to succeed in something. Further, (ii) the patient took the risk to make herself vulnerable – in German we say to get naked when revealing personal issues - while (iii) seeking for help only to find herself in front of a therapist that (iv) looked at her (by exploring questions) and finally (v) dismisses to help her ("one cannot even help me now", line 456). The therapist treats this dream not exactly like an allusion, as Schegloff (1996) suggests it. Nevertheless, she treats the situation as a rupture (Safran, Muran & Shaker 2014) and tries to repair it by telling a "I-am-like-you-experience" in form of a self-disclosure about a dream she had herself. By revealing her own experience, she tries to restore a trustful relationship and tries to repair the disbalance that appeared due to the revealing stories told by the patient.

Conclusion

A general difference between CBT and psychoanalysis is that the latter has a solid dream-theory. CBT lacks such theory, however, there are a small amount of contributions to proposals how to treat dreams in psychotherapy (Beck, 2002; Hill et al., 2003, Montangero, 2009). As Bergmann and Peräkylä (2014, 2016) showed in psychoanalytic encounters the therapist asks about the dream content and, in comparison, in the former analysed CBT session, the therapist uses ancillary questions mainly in order to sidestep the dream-telling. In psychoanalysis post-dream discussion relate the dream to other subjects and, similarities between the dream experience and the everyday experience are pointed out (Bergmann & Peräkylä, 2014). In this CBT example post dream-discussions focused on dreaming in general and the therapist finally down-grades the dream narratives. In psychoanalysis dream narratives are up-graded (Bergmann & Peräkylä, 2016). We could also observe that the CBT therapist acts as agent of the conversation whereas in psychoanalysis the patient takes the initiative of talking. I want to stress the attitude in order to avoid misconception that this example is not chosen due to a bias towards CBT. It is solely chosen due to its unique phenomenon of a dream that can only be understood by taking into account the previous conversation. This example can provide clinicians to pay attention towards differing attitudes between them and their patients. It may be of relevance how therapists react to patient's project formulations, which means to pay attention to their ideas of what might be relevant for the psychotherapeutic process of the "talking cure" (Freud, 1895d). Hopefully, I could show that the clinical practice can benefit from conversation analysis if we use it in order to follow conversational trajectories and trace its effects. I hope to make plausible that a dream narrative can be told as a display of a contaminated talk (Jefferson und Lee, 1981) or a disappointment in the therapist. I would like to encourage the idea to study other dreams on this behalf. Or maybe even other stories told within a psychotherapeutic interaction. Due to the appearance of the dream as a pictorial display of the contaminated talk I would like to propose the assumption that dreams may not only be interpreted but that dream narratives sometimes are the interpretation of a current interactional event itself.

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Acknowledgement

I would like to thank Michael B. Buchholz for all helpful remarks during my research process and encouraging me to publish and discuss it in public. And thanks to Laura Cariola for English corrections.

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Theory at all Points: A Methodological Quest for Psychotherapy Research

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Abstract

There is the common believe that data and theory are two distinct poles on the same scientific continuum. This notion is enriched with ideas from the fields of psychoanalysis, sociology and conversation analysis. The description of conversational reality in accordance with the knowledge of psychotherapeutic theory is exemplified through the analysis of a therapy transcript. A special spotlight is shed on the dyads' use of the recipient signal "mhmh" and its various functions within the talk. Most prominently, the therapist uses this token to reinforce the patient as long as she follows his idea of how she might get better. This small insertion therefore functions as a conversational marker of handling a therapeutic theory. Conversation analysts think of talk as a subject not pre-determined by theoretical believes of the participants. This changes in the analysis of therapeutic talk, which is pre-structured, at least by the professional theories of the therapist. For a proper analysis of the conversation two systems should be taken into account. On the one hand Harvey Sacks' idea of 'Order at all points' and on the other hand the methodological idea of 'Theory at all points'. This combination leads to a description of conversational reality while taking theories into account.

Introduction

There is a reason why most of the performances of the first two symphonies by Johannes Brahms are way shorter than the composer himself intended them to be. In both of them, Brahms included a repetition in the first movement that is often left out in concerts. Why? Because you already heard it. Some listeners think: "Oh, I've heard this before, why do I have to hear it a second time?" Some might even get angry. During my work in the CEMPP-project (**C**onversation Analysis of **Em**pathy in **P**sychotherapy **P**rocess Research) I transcribed three sessions of cognitive behavioural therapy in a fine-grained manner. Little by little I got more and more upset with the transcription. This shouldn't come as a surprise because transcription isn't a researchers' dream but rather fulfilling a duty. But I was more than mildly irritated during my work, which made me wonder: "What is it in this psychotherapy recording I cannot stand?" Some days later, in one of our weekly research group meetings with Marie-Luise Alder, Michael Dittmann and Prof. Michael Buchholz, it struck me. There was a constant repetition of the recipient signal "mhmh" carried out by both patient and therapist. The amount of these repetitions exceeded everything we've heard before. This text deals with the question what the two participants are doing with their "mhmh" and draws conclusions for the analysis of

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http://dx.doi.org/10.7565/landp.v5i2.1559

therapy transcripts. By the way even Brahms stopped the repetitions in his later works. The score of his last symphony doesn't contain one single repeat mark.

From Musical to Scientific ideas

In the year 1982 the famous sociologist Jeffrey Alexander wrote the widely cited quote, that "science can be viewed as an intellectual process that occurs within the context of two distinctive environments, the empirical observational world and the non-empirical metaphysical one" (p. 2). With this sentence, Alexander elegantly avoids the notion of a contradiction between the empirical and the metaphysical point of view. He subsumes both under the idea of an "epistemological continuum" with said points of view as polarities. He arranges it in a one-dimensional figure (see Figure 1) of a line on which, in his words, "one can […] arrange all the different components of scientific thought in terms of such degrees of generality and specificity."

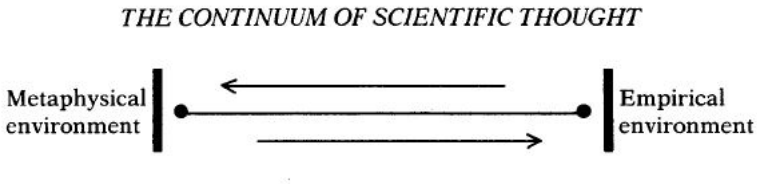

Figure 1

The continuum of scientific thought

Scientists are therefore moving leftwards and rightwards and claim to have a position on this continuum while doing research. This idea of different positions on the continuum is elaborated by Alexander, after he introduces this first model.

Data and Theory

While explicating the idea of the continuum, he introduces the concepts of *data* and *theory*. He does this through the division of the continuum in smaller parts. The dividing points are labelled as in Figure 2.

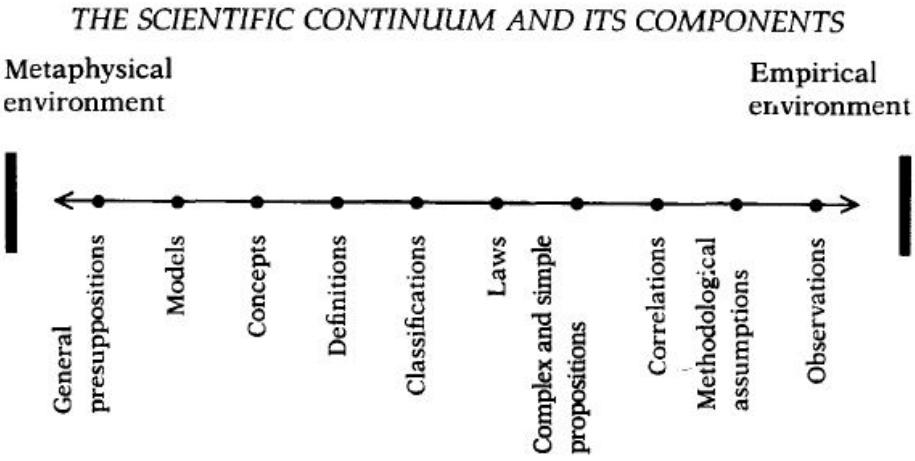

Figure 2

The scientific continuum and its components

With these dividing points, every scientific thought can be placed alongside this measurement, enabling an adaptable point of view, concerning the question of what is *data* and what is *theory*. For Alexander, everything to the left of a given point of view is called *theory*, while everything to the right would be *data*. For example, a psychiatrist using a chapter of an internationally distributed classification system as the *International Statistical Classification of Diseases and Related Health Problems* – ICD (Dilling, Mombour, & Schmidt, 2008), may see correlations between different mental illnesses as data, while using a model of psychopathology as a theory, in which he or she integrates the classification system. *Data* and *theory* are therefore constantly intermingled.

From Freud to Blumer

An aspect that should be brought into consideration is Freud's idea of a linking between healing and research. For him, there is no gaining of insight without a curative effect on the patient, neither is there a cure that doesn't contain fruitful findings which may be implemented in theories (Freud, 1926e). With this idea, Freud manages to interweave *data* and *theory*. They are no longer separated in "what theory says" and "what therapy says", but rather placed on a continuum as Alexander proposed it.

Whether one would share Freud's following thoughts or not, that psychoanalysis is the only method using this concept, one idea rises from this starting point. An idea, co-produced by the patient and the therapist in order to explore and/or cure the problems displayed in the session, also acts as starting point for the building of personal theories of both therapist and patient. This notion resembles a concept brought into being by Herbert Blumer. Blumer (1954, p. 7) proposes to look at theories as "sensitizing concepts." He explains: "[…] it [the sensitizing concept] gives the user a general sense of reference and guidance in approaching empirical instances. Whereas definitive concepts provide prescriptions of what to see, sensitizing concepts merely suggest directions along which to look."

This mechanism also works the other way round. Personal or explanatory theories, brought into the session by either therapist or patient, on which they both agree, may enhance the curative power of the shared talk. A shared theory results in an increase of the common ground of the speakers, in a "general sense of reference and guidance".

Harvey Sacks – Order at all Points

To put this idea in a more abstract form, there is a constant exchange between the immediate talk of patient and therapist and the various personal, explanatory, ordinary and professional theories running through their minds. One could say, that theoretical ideas and the empirically observable talk of the participants take place at the same time. Although those theories are not directly observable and the idea is not to ascribe an intentional, theory-based usage of utterances to the participants of the talk, a negation of the presence of theory in the talk would bereave the analysis of therapeutic conversation of one of the core therapeutic elements. From this consideration arises a serious problem: When theory plays a major role in therapeutic talk, how can we know which one is currently in the minds of therapist and maybe patient. The short answer is: We can't. For the long answer, a sidestep is needed to Sacks' (1995) *Lectures on Conversation*. Sacks starts with an observation:

> Now, for whatever reasons there were, the social sciences tended to grow such that the important theories tended to have a view that if you look at a society as a piece of machinery, then what you want to consider is the following: There are relatively few orderly products of it. There is, then, a big concern for finding 'good problems;' that is, to find that data which is generated which is orderly, and then attempt to construct the machinery necessary to give you those results (p. 483)

For Sacks there was a main concern in social sciences research. Professionals reverse the standard way of research. Starting from the 'chaotic' society there is a need for an orderly question from which an equally ordered research design may evolve. Said question is determined by various kinds of interests. For example the theoretical beliefs of the researcher, interest in publishing texts fitting into the focus of research journals or the need to satisfy the financier of the whole study. Such a pre-structured design leads to the acquisition of pre-structured data, which is later used to confirm the formerly established theory.

Behind such a way of thinking is the assumption that the "thing" a theory should describe, exists. In view of the fact that a theory should prove stable over time, the "thing" itself has to show this stability too.

Sacks proposes a methodological idea on how to take said pre-structured designs into account. He postulates that the idea of replicable, constant research findings is a misconception based on the fact that 'order' is imposed by the researcher himself. If one

wants to find order, one will find order. He explicates this by depicting how statistical procedures come along with vast amounts of constraints and an in-built uncertainty, but nevertheless succeed in ordering the (psychological) world. Here the question becomes obvious, whether the statistical procedure produces, discovers or imposes order.

There is no way around the creation of a specific order in research which, by itself, is no problem at all. It becomes difficult in the moment the researcher stops taking into account that this order is, at least partly, imposed by himself. Sacks' idea of order at all points tackles this difficulty on a more basic level. For him there is "Order at all points" (p. 484) which means that, in social sciences, one has no need to build research designs, or as he put it: large machineries, enabling a researcher to observe a recurring, stable and reproducible pattern. Rather one may observe and describe carefully what is going on around oneself.

The Methodological Proximity of Conversation Analysis and Psychoanalysis

When researching psychotherapy there are also conversational actions at work, which order the therapeutic talk. In most psychodynamic approaches, the therapy is carried out and perceived as a "talking cure". This term was coined by Berta Pappenheim, a patient of Josef Breuer. Freud (1910a) describes her case as follows:

> The improvement in her condition, which would last for several hours, would be succeeded next day by a further attack of 'absence' and this in turn would be removed in the same way by getting her to put into words her freshly constructed phantasies. […] The patient herself, who, strange to say, could at this time only speak and understand English, christened this novel kind of treatment the 'talking cure (p. 11)

Although the metaphor of 'putting something into words' may be criticised in terms of conveying a hidden meaning behind the words, which is done brilliantly by Leudar and Costall (2009b) referring to Reddy (1979), this shall not be the point of interest. Freud himself transforms the notion 'put into words' to 'speak and understand' and manages to bring in the communicative partner. The 'talking cure' itself is being grounded in the conversation of Pappenheim and Breuer or, more general, in the communication of the two participants. This idea remained over the last century. Irrespective of the therapeutic school, communication is seen as an interaction between the therapist and the patient (for psychodynamic therapy (PT) see Streeck (2006) and for cognitive behavioural therapy (CBT) see Hoyer, Jacobi, and Leibing (2006)). Following from this, therapy may be described and observed through the methodological glasses of conversational order at all points. CBT as well as PT use communication as a means to place methods in the therapy. 'Interventions' come with the same regulations, as the therapist is placing an utterance to stop the patient from continuing a behaviour, topic, etc.. The term derives from the Latin word 'intervenio', which literally translates to 'coming in between'. But in between what? As the talk of the patient is interrupted, the therapist places his or her

utterance between what has been said previously and what is anticipated by the therapist to be the continuation of the prior talk. An assumption of what will be said is deemed to be trustworthy enough to change the trajectory of the talk. Arriving at this point, a knowledge gap opens up: How does the therapist know what the patient is going to say? The methodological problem of this question is dealt with in Leudar and Costall (2009a); here we can state that the term of 'intervention' always involves some sort of intentionality, a theorizing about the other.

Ascription of Intentionality versus Description of Conversational Reality

This assumption of an intentionality resembles the previously mentioned idea of Sacks. 'Interventionists' apply a 'machinery of methods' which produces, discovers or imposes order in the thoughts and feelings of the patient. An utterance of the patient leads to an intervention of the therapist with which he or she tries to adjust the assumed pathological continuation of the other. In CBT this adjustment is achieved mostly through learning procedures. PT on the other hand uses the information perceived in the talk alongside the feelings and ideas of the therapist. Both therapies transcend the pure observation and description of what is seen in the session so as to discover order. An order seemingly necessary to help the patient. Remembering the idea of Sacks one may ask the question, whether said order is truly discovered, (co-)produced by the two participants or even imposed by the therapist. Following Leudar and Costall the difficulty of ascribing intentionality and therefore theorizing about the other may be avoided by extended observation and description of the conversational reality. Rather than 'Why is X doing Y?' one may ask 'How is X doing Y?' Applying this methodological idea of Conversation Analysis to psychotherapy, as well as psychotherapy research, the same shift occurs. Instead of 'Why does X behave in a way Y?' or 'Why does X feel Y?' both participants would observe and describe 'How is X expressing his/her behaviour/feeling Y?' There are loads of fruitful findings once one applies this structure of questioning the material.

Interplay of (Psychotherapeutic) Theory and Conversation Analysis

Taking a closer look at the program of the ICCAP 2016 (International Conference on Conversation Analysis and Psychotherapy) it becomes clear, that concepts like "collaboration", "empathy", "resistance" and "interpretation" have found their way into the analysis of conversation. This observation itself is not problematic. It becomes difficult with the idea that constructs, with a history, deeply embedded in a theoretical frame, may be explored and even explained solely through an atheoretical method. The usage of the terms themselves comes with the imposition of a range of theoretical thoughts. If these are left aside in the analysis, the concept itself is weakened to a point where it is nothing more than a pseudo-defining shell conveying an unclear subset of features.

This leads me to the idea of "Theory at all points" (TaaP). The combination of "at all points" is taken from the previously mentioned *Lectures on conversation*. It emphasizes the uncertainty whether a researcher is discovering or imposing a theory in the data. As

well as order, theory itself is not only not problematic but a "sensitizing concept" along which to look. Stretching the idea by Sacks even further, if one engages in the search for an indication of a specific theory of one of the participants, one will find it. It's not a new finding that there is a confirmation bias in science. Therefore my proposition is to take into account that the apparently discovered indications for theories (of the participants) may as well be produced or imposed by the researcher. The same holds true for clinicians talking to their patients. To order their own perceptions of what is going on in the therapeutic talk, therapists build up their own local sensitizing concepts, their own theories. At this point it should be noted, that the term 'theory' itself stems from the ancient Greek word "theōria" which literally translates to "looking at" or "gazing at". Perception is therefore an in-built feature of theory. To put it in therapeutic terms: The perception of what a patient is saying comes along with the building of a local, ad-hoc-theory of the therapist. Those ad-hoc-theories are, to a large extent, influenced by the meta-theoretical schools of thought the therapist commits himself to.

To take into account that psychotherapy sessions are a form of communication that is asymmetric insofar that the therapist has a theoretical, as well as a practical training functioning as a supplementary tool in the talk, possible concepts of a meta-theoretical school of thought should also have their places in the analysis of the talk. Those concepts have to be describable within the transcript to meet the idea of "How is X doing Y". Through this, there once again occurs a shift from the question "Why does therapist X react in a way Y to patient Z?" to the question "How does therapist X react to patient Z?" The way the therapist is reacting is no longer only seen as an outcome of an application of a meta-theoretical frame of mind to another person's mind but rather as a communicative event co-constructed by two persons.

Analysis of a Transcribed Psychotherapeutic Session

This idea will be explained with the help of a transcribed psychotherapy session. This session is part of our CEMPP-project (**C**onversation Analysis of **Em**pathy in **P**sychotherapy **P**rocess Research) located at the International Psychoanalytic University (IPU) in Berlin. Under the guidance of Prof. Michael Buchholz and Prof. Horst Kächele, a group of students transcribed 45 therapy sessions on GAT-level (Selting et al., 2009). The sessions were taken from the corpora of the "Münchner Psychotherapiestudie" (MPS) (Huber, Klug & von Rad, 1997). All of the transcribed patients were diagnosed with depression. The patient conveys to the therapist that she will be busy with her final exams for the next months and therefore may not be able to focus on one of the main therapeutic goals, "getting in touch" with herself. She tells the therapist that those final exams act as obstacles, blocking her way to the establishment of a self-contact. In this surrounding, the following scene occurs.

The Transcript

1 T: dass Sie da: .hh (---) äh:: kein Kopf dafür haben, werden, für Privates, (1,5)
2 *that you there (---) won't have a head for, for private stuff (1,5)*

3 °also;°
4 *well*

5 (2,7)

6 P: also ich denk halt bis der zwei(h)te Ma(h)i vorbei ist;
7 *Well I think until the 2nd of May has passed*

8 T: bis der zweite Mai vorbei ist; <und dann> denken Sie <sieht's
9 *Until the 2nd of may has passed and then you think it'll look*

10 wieder n bisschen anders [aus;]
11 *a little bit different again*

12 P: [°ja] (.) denk ich schon°
13 *Yes I do think so*

14 T: mh[mh::,]
15 P: [°und da°] is nur noch eine Sache auf die ich mich dann zu
16 *And there is only one thing on which I have to*

17 konzentrieren hab [und]
18 *concentrate and*

19 T: [m::;] mhmh:,
20 (1,0)
21 P: also abgesehen jetzt von der Stellensuche a:ber;
22 *well despite the search for a job but*

23 T: m::;=
24 P: =°des° (2,0) °denk ich wird auch noch,°

25 *this (2,0) i think will work out too*
26 T: hm:: mhmh:, (1,5) .hhh na ja. (-) ähm: (1,3) also Sie kommen ja

27 *hm mhmh (1,5) well (-) ähm (1,3) so you do get*
28 zurecht [jedenfalls]

29 *along anyway*
30 P: [mhmh,]

In the following description of the transcript, I will use the numerations of the lines in the German original. The corresponding English translation is located right under the German version.

Description of the Conversation

The therapist starts in line 1 by emphazising that the reason why the patient is momentarily not able to get into contact with herself is because she "won't have a head for, for private stuff". This is followed by a pause of 1.5 seconds and the subsequent "well", which are used for passing the conversational floor. It takes another 2.7 seconds until the patient responds to this ascription with a temporal restriction of what was formerly said. The particle "halt" (line 6) weakens the previous account, in this example the description of her own thoughts. This weakening is restricted to a period of time until the 2nd of May. The therapist rephrases the last part of what the patient has said and completes the assumed rest of her sentence. With the alleged finish of her sentence the therapist emphasizes the meaning of an end of this temporal restriction. "<und dann> denken Sie <sieht's wieder n bisschen anders aus;" (lines 8 and 10). This completion by the therapist implicates that it had already looked a little bit different before. Therefore he speaks about returning into a previous state, a state that the patient has left only temporally. This utterance can be linked to his first sentence. The patient can start once again to have a head for private stuff. The return into this previous state is facilitated through the notion "n bisschen". Said notion takes away the immediacy and weight inherent in such a return. Through this small addition, returning can be seen as a gradual process.

The patient answers, in a quiet voice, that she believes in a return on the 2nd of May but the word *denken* (to think) allows for the possibility that she might not have a head even after the negotiated date. She does not know whether something will change then, she only thinks it.

The therapist answers to this partial agreement with the short interjection "mhmh::,". He signalizes through the usage of this small particle that he received the agreement of the patient. Subsequently, she herself does not wait until the therapist finishes his interjection but starts to add further information to what she previously said ("ja denk ich schon" line 12). She starts with "und da" (line 15), depicting that everything following from this point is also attributed to the time after the 2nd of May. From this day on, she would only have one more thing to concentrate on (lines 15 and 17). What this "one more thing" might be is not directly clarified. Right before this depicted scene, the two are talking about whether the patient wants to get more into contact with herself. That's why it is likely that the one more thing to concentrate on is she herself, respectively her private life. With this thought the task to get into contact with oneself would turn into a challenge for her abillity to concentrate.

This extension of the patient is answered by the therapist with a recipient signal (line 19). Following Ehlich (1979) I subsume all possible combinations of [m], [n] and [ə] (which additionally can be linked by a [h]) under the term *recipient signal*. This time, the therapist uses a two-part signal, in which the second part is mentioned at exactly the same moment the patient places her "und" (line 17). This "und" shows that she hasn't finished her sentence yet. At least a subclause would have been added here. The first part of the two-part interjection coincides with this signal of an extension of her sentence. She stops said extension and the therapist commences with the second part of his interjection, the "mhmh:,". Afterwards another pause is formed, this time with the length of 1.0 seconds (line 20) after which the patient restricts the previously said once again.

To her opinion she has to deal not only with getting into contact with herself, but also with the search for a workplace (line 21). Once again she will not be able to fully concentrate on her quest for getting into contact. To put it in a different phrasing: From May on, there will only be one thing I'm gonna focus on, except the other thing that is important then. This new limitation implemented by the patient is answered by the therapist with a recipient signal once again. While the first two interjections (lines 14 and 19) expressed an agreement (this is achieved through the fact that these interjections have a two-syllable structure with a rising intonation contour in the end) towards what has been said by the patient, the recipient signal in line 23 only has one syllable. Here (line 23) the therapist doesn't show agreement anymore but rather reacts with an *information receipt token* (O'Keefe & Adolphs, 2008). The patient, as a reaction to that, restricts her own previously made limitation after a pause of 2.0 seconds (line 24).

She again uses the impression "denk ich" (I think, line 24) and describes that the second thing, the search for a job, will work out too. At this point she does not speak about her own contribution to this "working out". She expects it to settle by itself. Afterwards, the therapist continues with a combination of two recipient signals, first a one-syllable-token which is prolongued and second a two-syllable-token. Initially he again starts with an *information receipt token* which is subsequently accompanied by the two-syllable-token "mhmh:," showing agreement with what the patient has said. Following a pause of 1.5 seconds, the therapist starts with a "Na ja" (well) (line 26). The various perspectives on this small particle were described by Harden (1989). He divides the particles on the basis of their phonological form. The way the "Na ja" is pronounced in this sequence, the point in the end is an indicator for a falling intonation in the end of the "ja" is pictured as followed (p. 143):

> The *na ja* of this type can be constantly interpreted as a deliberative utterance concerning a previous utterance, which shall neither be totally confirmed nor totally denied. In other words, the speaker signalizes that the previous utterance is only to some extent suitable to the complexity of the topic. (Author's own translation from Germany to English)

If one follows the perspective of the author on the particle, there are two possible versions how the shown example of "Na ja" can be understood.

a) The therapist ponders over the patient's last utterance. He neither confirms, nor denies her last sentence in line 24. (°des° (2,0) °denk ich wird auch noch,°)
b) The therapist ponders over his own previous utterance. The Confirmation ("mhmh:," in line 26) of what the patient has said becomes the object of a subsequent confirmation or denial. The importance of the "mhmh:," is reduced.

After a short pause of around 0.3 seconds, the therapist delays the ongoing talk even further. He achieves this through an "ähm" (line 26) right before the next pause of 1.3 seconds. After this assembly of hesitation markers he begins a new sentence in which he

starts a summary of what has been previously said. This is made clear through the use of the particle "also" (so) and the adverb "jedenfalls" (anyway). Both words are linked to a prior communicative element. Throughout the whole sequence there are differently articulated interjections of the therapist. The importance of those small bits of speech shall therefore be further examined.

An Interjection about Interjections

The term "interjections" describes a collecting basin for completely diverse words and utterances. In earlier works on this topic there often occurs the question of why such ubiquitous particles of speech have been researched so poorly. Schachter and Shopen (1985) describe this fact under the circumstance that each and every language owns its own subset of interjections. Possibly one might get to an answer through the reception of Schegloff (1982). He delineates that the widely used division into "real talk" and seemingly conversationally irrelevant "detritus" (p. 74) has a meaning. Schegloff impeaches the characterisation of relevant and irrelevant talk and therefore tries to widen the focus of attention towards those apparently irrelevant features of conversation. This "detritus" enables the participants of a talk to see their shared communication as a product of two different minds. The ongoing small signals coming from a listener help the speaker to see him- or herself inter-acting with somebody else. The partitioning of speech into "relevant" and "irrelevant" would be a necessary presupposition for the detection of locally distributed roles in the talk, namely speaker and listener. Moving a step further: By starting to treat the "detritus" as conversationally relevant as well, consequently following Schegloff, the (necessary) illusion of separated roles in talking and therefore the illusion of separated speakers would collapse. Communication would emerge as a model where the participants share a medium through which understanding is achieved. This idea leads in the same directions as for example the "dyadic state of consciousness" (Tronick, 2005) or the "bidirectional interactive field" (Aragno, 2008).

Categorization of Interjections

Probably the widest known categorization is the division into primary and secondary interjections. While secondary interjections are either parts of words or a combination of such parts imbued with definite meaning, primary interjections are "phonologically and morphologically anomalous" (Ameka, 1992a, p. 105). Primary interjections are built out of sequences of sounds that may not be found in other parts of the language. Norrick (2009) is working with the pragmatic (in the linguistic meaning) effects of primary and secondary interjections on the turn-taking structure of talk. Norrick underlines the special importance of the intonation contour when observing interjections. This seems logical concerning the unclear semantic structure of most of the interjections.

Rodero (2011, p. 25) adds the following: "…it is understood that the emotional load conveyed by intonation is sustained by movements in the intonation curve and by pitch levels".

Primary and secondary interjections share the feature that they appear separated from other utterances in a way Bakhtin (2010) describes it. He postulated that there has to be a short pause of speech between two utterances, to detect that they are not connected to one

another. Therefore they can't be directly connected to other utterances as a pre- or suffix to them. Neither can they be woven into an utterance without distinct pauses indicating the limits of the interjections. A good overview can be found in a text by Ameka (1992a). He starts with the features of interjections that were brought together by the ancient Romans. Interjections include "non-words" (p. 102) what might be a hint for the non-lexical origin of some interjections. They derived from nature sounds rather than being developed out of a language. Furthermore, the interjection is neither affected by the surrounding syntactic form nor has it a grammatical function. Ameka concludes that interjections develop as a "reaction to a linguistic or extra-linguistic context, and can only be interpreted relative to the context in which they are produced" (p. 108).

Ameka also emphasizes that even in the ancient world interjections were seen as means to convey a feeling or emotional state. This still holds true in the modern days. An example for this property can be seen in Goffman's (1978) "response cries". Ameka implements a division into expressive, conative and phatic interjections. As an example, the expressive ones show how the speaker feels in the present moment. Examples for this type are "Ouch" or "Yuck". The conative and phatic interjections are dealt with in another work by Ameka (1992b). To sum it up: Conative Interjections focus on the gaining of attention while phatic ones are partly responsible for structuring and maintaining the talk itself. They are auxiliary particles which do not have to have lexical meaning themselves but are nevertheless highly important for the continuation and the order of the talk. The group of the recipient signals are phatic interjections as well.

Recipient Signals in the Text

The first appearance of such a *recipient signal* in the shown transcript is in line 14. In advance the patient describes the date up to which she won't "have a head" for her "private stuff". The problem with this is that "private stuff" is highly relevant for the therapy. The therapist takes her statement into account and rephrases it. He also adds a new perspective to the talk; namely a possible change of pace after the 2nd of May. Although the therapist did not raise his voice in the end of line 10, it is clear that he is asking her a question. This becomes evident when the patient answers him in line 12. This answer also ratifies the perspective the therapist opened up before. His idea of a possible change from the 2nd of May is agreed upon by the patient. As a reaction to this agreement the therapist offers a two-syllable-token "mhmh::," in line 14 with an rising intonation in the end. This phonological form is attributed to agreement by Ehlich (1979). The agreement is even strengthened through a prolongation of the second syllable. This syllable is around 0.5 seconds longer than expected.

Directly afterwards the patient continues to think about the perspective brought into being by the therapist (line 15). She even underlines that, after the 2nd of May, she has the potential to concentrate on only one thing, getting in contact with herself. The therapist starts, as the patient is still speaking, with the continuation of giving *recipient signals*. He accompanies her at first with a prolonged "m::;" with falling intonation towards the end. According to O'Keefe and Adolphs (2008, p. 88) this particle shall be understood as *information receipt token*. This group of particles are "strongly associated with asymmetrical interaction where one of the participants is a power role holder". After this token, he goes on with another prolonged two-syllable-token, depicting confirmation. The

two tokens in line 14 and 19 are nearly similar concerning their prosodic features. But not only the way they sound resemble one another, also is their conversational surrounding quite alike. Both times it functions as a confirmation of what the patient has said. And both times the patient previously did follow the perspective brought in the talk by the therapist in lines 8 and 10. He confirms that she is still "on track".

The next instance of a *recipient signal* occurs in line 23. After a pause of 1.0 seconds, the patient restricts her own, previously made utterance. She opens up to the therapist that, next to her "private stuff", she also will have to deal with her search for a job (line 21) and is rewarded with another *information receipt token*, prolonged as well and also with falling intonation. But this time there is no second, confirming, two-syllable-token. Therefore the *information receipt token*, which is associated with an hierarchical asymmetry in the talk is standing all by itself. The therapist does not give any sign of confirmation to the patient. She continues without a pause in line 24 but does not end her sentence immediately. It takes another pause of 2.0 seconds until the patient is ready to say that the search for a job will work out too. In line 21 she displays her second thoughts about the possibility of a change from the 2nd of May on. Those doubts are dispelled by herself directly after the *information receipt token* by the therapist that is not accompanied by a two-syllable-confirmation ("mhmh,"). After she stepped back from her further concerns the therapist reacts again with two recipient signals, this time to her notion of stepping back. The first on, in line 26, cannot be interpreted clearly due to the unchanging intonation. The second one is, once again, a two-syllable confirmation. The therapist brings this signal of confirmation in exactly the moment where the patient starts or restarts to approximate his perspective. He always confirms when the patient moves towards his own points of view and shows an *information receipt token* the only time she dares to disagree with his thoughts on how she should get in contact with herself. This Go or No-Go idea gives the observer a feeling of looking at a mechanised communication. Only when the patient does the appropriate thing, namely developing the idea of the therapist, a reward by the therapist can be achieved.

Widening the Scope of Analysis

So far for the description of this short episode of a therapy session. This first part of the analysis was strictly focusing on the structure of the talk. A fine-grained report of what is happening in the interaction of the two participants comes close to the original concept of "theōria". As mentioned before it literally translates to "looking at" or "gazing at". Over the last pages we took a look at the communication with a far higher resolution than everyday-talk is allowing it. This close look enables possible readers to follow the author's thoughts as well as enabling the reader to profoundly disagree. In the case of an improper interpretation by the author, the reader has the possibility to discriminate whether the problem is in the description of the transcript itself or occurs later in the more theoretically founded parts of the analysis.

As researchers we are dealing with parts of therapies, probably years after they were recorded. This brings us into the privileged position of having as much time as we want. In contrast to the clinicians, we don't have to react immediately to an utterance another person made. Analysing a conserved communicative event places the researcher in a reconstructing position. The reconstruction itself is fed by the observation of a past event.

In addition to mere observation however, there is further information concerning the context of the talk. The context in which the talk took place plays a major role in the subsequent analysis. For the example worked on, it is known that the therapist underwent training in cognitive behavioural therapy. The sequence stems from a recording of a 16th session of the therapy making it one of the middle sessions. Furthermore we know that the patient is diagnosed with depression. There is no further information concerning the severity of the illness and eventual comorbidities.

Cognitive Behavioural Theories about Depression

Cognitive Behavioural Therapy (CBT) has the idea that associations between dysfunctional cognitive schemes and negative mood are building up in episodes of depression (Risch, Stangier, Heidenreich, & Hautzinger, 2012). Those associations are easier to reactivate once they have been established. The more they are reactivated, the easier a patient falls into the depressive mood. After a while the negative mood solely can lead to the occurrence of said dysfunctional cognitive schemes. In addition to that there is evidence for CBT that a lack of positive reinforcement leads is a main factor in depression (Hautzinger, 2008). The "Stiftung Deutsche Depressionshilfe" (German foundation for help for depression) (2016) describes on its homepage a five-level approach of CBT which primarily focusses on changing the negative patterns of thought. The first level is about defining the key elements of the patient's problem. What brings him or her into the therapy? The authors act on the assumption that it is in this first step where a working alliance between therapist and patient is built. The usage of the psychoanalytical term "Arbeitsbündnis" (Greenson, 1966) (working alliance) in the cognitive behavioural frame of mind points towards a general acceptance and acknowledgment of the "common factors" (Grencavage & Norcross, 1990).

The second level targeted in CBT for depressed patients aims at the balance of the patient's activity. Over the time, a shift should be achieved towards less emotional wearing activities. The therapist helps the patient to discriminate different activities concerning the amount of distress they cause. The patient should increase the amount of relaxing activities or occupations linked to joy and well-being. The therapy works as a tool to help the patient with the evaluation of those activities. Through this, the patient develops a better feeling for how to improve his or her inner balance. The next step is to engage, with the backup of the therapist, in social interaction. Said engagement is rehearsed in a joint role play, where the therapist takes the place of possible others in difficult social situations. This is rather a re-engaging in the social structures the patient has been in before. A goal on this level is for the patient to distinguish deadlocked patterns of thought that slipped in over the episodes of depression. CBT aims to show their patients that those patterns of thought are a personal problem and cannot simply be attributed to a hostile society.

Second to last, the forth level again aims at some level of balancing. This time it's all about a balance between pleasant and unpleasant activities in the patient's daily life. In a way this acts as an implementation of the second level. While the second level focussed on the cognitive schemes responsible for the imbalance, on the fourth level the imbalance itself, in the patient's life is tackled. In the end this approach has a fifth step with the focus of retaining and stabilising the achieved results.

This method has its grounding in the theory that the patient is stuck in a so called "depressiven Spirale" (Berking & Rief, 2012, S.43) (depression habit spiral) in which the negative mood of the patient and the lack of positive reinforcement from the outside world contribute to a vortex, sucking the patient in. The longer he stays in this condition, the deeper he gets and the more difficult it gets to escape it. The Behavioural therapist tries to interfere with this spiral in an attempt to decelerate or stop the force of the spiral. Hautzinger (2009, online-article) describes this as followed: "Goal and task of Cognitive Behavioural Therapy is to stop and reverse the depression habit spiral and to initiate a constructive, resolving development, respectively to gain control" (Author's own free translation from German to English).

In addition to the depression habit spiral there is also the factor of *learned helplessness* which has to be taken into account by the therapist. This central mechanism in the cognitive behavioural paradigm is defined by Craighead and Nemeroff (2004, p. 94): "In the field of clinical psychology, it has been suggested that ascribing negative events to something about the self that also is not subject to personal control produces a state of 'learned helplessness', which promotes and/or accompanies depression". The amount of perceived control over negative events contributes to the perception of those events. A person that experiences a lack of agency regarding the question "How do events in my life turn out?" learn that they can't help themselves in the face of a probably unpleasant situation. The models of treatment and description of depressive mechanisms presented so far are by no means to be seen as an exhaustive list for the way CBT deals with depression. They should rather act as *sensitizing concepts* along which we can enhance our interpretation of the analysed sequence.

Bringing it all together

In a first step we described in a fine-grained manner what kind of communicative manoeuvres the therapist and patient of this cognitive behavioural session engage in. This conversation analytic approach proves suitable for a very accurate look on the transcript. Subsequently we focused on the *recipient signals* of the therapist. At which points of the talk does he use one of those tokens? After what kind of utterances by the patient follow which kinds of *recipient signals*? To which reactions does the use of such a *recipient signal* lead? This step was done, influenced by conversation analytic, psychoanalytic and linguistic theories. Afterwards there was a short introduction to the disorder-specific theories and methods of Cognitive Behavioural Therapy regarding depression. This step can give answers to questions like: Which theoretical pre-conceptions help Cognitive Behavioural therapists when getting into contact with their patients? How do therapists perceive depression? Which ways of healing are prevalent in the school-specific canon? The synthesis of what was outlined in these different steps lies in the combination of the "data" (following Alexander (1982) and the "theōria" in the literal translation with what we know nowadays as *theory of treatment*.

The second level of the previously mentioned CBT-approach aims at the creation of a new balance between positive and negative activities in the patient's life. In advance to the analysed part of the therapy session the patient told that she does not have a head for private stuff at the moment. A therapist following the CBT-approach depicted by the "Stiftung Deutsche Depressionshilfe" (2016) would be expected to bring up a contrasting

point of view. A point of view that helps the patient to shift in the direction of a more balanced situation where she might also have a head for her private stuff. The repetition of the date, first mentioned by the patient, and the subsequent proposal of a different perspective, from this date on, can be seen as an attempt to enter into negotiations with her on how she will try to balance her life in the future. But this doesn't happen. Instead of comparing notes with one another on how this date can be met or how other balancing forces can step into the life of the patient, an asymmetric communication is developing. The patient mainly follows the therapist in his perspective and is always answered with a confirming *recipient signal* (lines 14, 19 and 26) as long as she follows his proposed perception on how things change from the 2nd of May on. If we take the depression habit spiral into account the quote by Hautzinger (2009) slightly changes: "Goal and task of [a Cognitive Behavioural therapist] is to stop and reverse the depression habit spiral and to initiate a constructive, resolving development, respectively to gain control" (Author's own free translation). The disclosure of new perspectives can have exactly this effect, but only if the patient can accept the proposal of the therapist as an option for herself. If this acceptance seizes to exist, the repetition of the therapists proposal remains a mere mimicking of what has been said by the person to help her.

In this transcript the therapist works also with two other techniques: Positive reinforcement and extinction of behaviour. Whenever the patient follows the perspective of the therapist, namely the change of pace after the 2nd of May, she gets a similar reaction, a two-syllable-token "mhmh", picturing confirmation and agreement to her utterance. In the frame of classical conditioning this would increase the probability of the occurrence of a similar behaviour. Through this the therapist gets the patient to positively connote and further pursue his own perspective. If the patient restricts the fit of the therapists perspective or challenges the feasibility of the proposed idea another mechanism jumps in. The confirming two-syllable-token fails to appear, the patient does not get any further reinforcement in the moment of doubt. The paradigm of conditioning names this feature *extinction* The probability of occurrence is lowered when the desired reaction fails to appear. As an example line 21: All of a sudden, after she didn't get any reinforcing confirmation the patient shifts the direction of her thought.

The ways in which the knowledge of theoretical pre-conceptions change our point of view regarding our data resembles the idea of "Order at all points" proposed by Sacks. Each analysis of data comes with the question whether the examination produces, discovers or imposes theory. Surely, if one starts the search for one specific theory or even a set of theories in their transcripts or audio recordings, they will find it. By going back to the labelling of Psychotherapy as a form of communicative exchange, as a "talking cure" we find the necessary help to simplify this problem. A theoretical belief shows itself through the medium of talking. Therefore, by describing the communication of the participants first, we get a reliable basis for the further application of (meta-) theoretical concepts. Even though this first description seems to be rather atheoretical it is far from that. Linguistic as well as conversation analytic theories present themselves as toned glasses through which we look onto the data. There are always *sensitizing concepts* guiding our perception. As a result the continuum of scientific thought proposed by Alexander is rather a conceptual idea than applied in the (social) sciences. The two poles of the continuum cannot be reached due to the simple fact that *theory* and *data* are constantly interwoven. This poses no problem for science at all, as long as this

interconnection is spelled out. To accept this interconnectivity means that one has to act under the presupposition of *Theory at all points.*

Author's Biography

The author is currently in the graduate program of the International Psychoanalytic University in Berlin and working in the CEMPP-Project (Conversation Analysis of Empathy in Psychotherapy Process Research) under the scientific lead of Prof. Michael Buchholz. Earlier publications dealt for example with Formulations in Psychotherapy. Together with the other contributors of this issue there have been two publications on 'Freudian Slips as a chance for Empathy' and on 'Architectures of Empathy'.

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Moving closer. A Conversation Analytic Perspective on how a Psychotherapeutic Dyad Works on Closing their Encounters

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Abstract

This pilot study analyzes a blank space of research: How is the actual therapeutic session closed and how do single closings contribute to the over-all process of therapy? Data corpus is a completely transcribed single short-term psychodynamic psychotherapy. All 28 closing sequences were fully analyzed with Conversation Analysis. The over-all structure of therapy is unfolded in closings in three ways: i) as a joint activity with 'audible' steps, describable as *scheme of closing*, ii) as alignment organization that reveals three *closing types*: compact, stretched and commented closings. (These types can be seen as manifest realizations of an implicit communicative problem, the *coda dilemma*: How to close a session with open topics?) And iii) thirdly, therapist and patient typically display their interactional affiliation towards the therapeutic process with *joint evaluation of therapeutic help* (JETH). Clinical relevant learnings of this study are: i) closing section is to be unilaterally initiated by the therapist while the patient actively suppresses open topics, ii) therapist has deontic authority only and his action is subject to approval, iii) psychotherapeutic dyad establishes a social relationship by projecting closing and iv) therapy is co-actively and locally produced when expansions after closings are taken as a comment on the therapeutic situation.

"Ending is ever present, long before the final separation, casting its shadow on therapy from the start and, when it comes, is a culmination of all the countless little endings that have prefigured it. In Rilkes words, 'So we live, forever taking leave'" (Holmes, 1997, p. 170).

Introduction

The fringes of therapy have been an important field of psychoanalytic research: How to start the first therapeutic session(s), as well as initiating the termination of therapy. But there is a blank space of research on *closing the actual therapeutic encounter*. The present study analyzes how a psychotherapeutic dyad manages to open up, conduct and terminate the closing section of a therapeutic encounter. Conversation Analysis is applied to 28[4] GAT transcriptions of a single short-term psychodynamic psychotherapy from the

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[4] Because session 23 was cancelled, numerical there are 29 sessions, but indeed just 28 conducted treatments.

1980s with an obsessive-compulsive patient. The focus of the study is on the *actual closing section* of each therapeutic encounter, and a single-case over-all process of closing therapeutic sessions. The short-term therapy is divided into three thirds (see Figure 1) i) the beginning sessions (1-9), ii) the mid sessions (10-18), iii) the end sessions (19-28) and the last session (29).

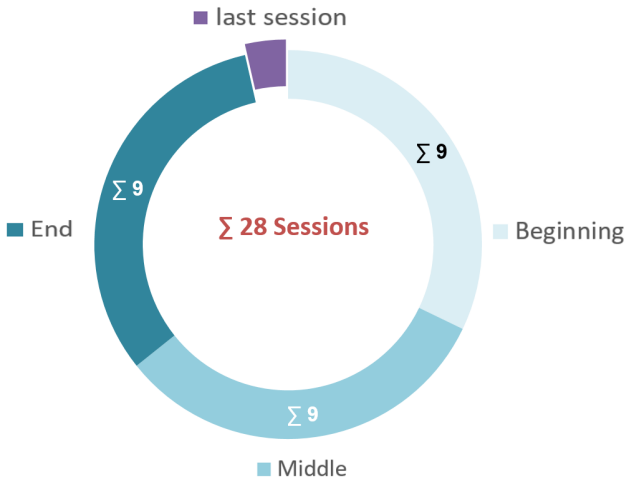

Figure 1

Segments of short-term therapy

Mundane Closing

Before we turn to closing in an institutional therapeutic setting, there are some essentials on closing that are *prefigurative* to institutional closing. In their classical contribution to closing mechanisms in conversations, (Schegloff & Sacks, 1973) paid attention to closing sections in everyday talk and identified a problem in closing: When does 'not talking' close down a conversation and is, therefore, no Transition Relevant Place (TRP)? They detected that participants do not just stop talking but co-produce the suspension of TRP with exclusive markers such as adjacency pairs. In their "minimal scheme" (Raitaniemi, 2014, p. 73) the exchange of these adjacency pairs like "bye" at the end of conversations is called terminal component (see lines 3 and 4 in Figure 2). But these exclusive markers cannot be placed in every moment, that is why participants i) increase the relevance of closing and ii) try to verify if the co-participant wants to continue talking. This negotiation procedure is called *pre-closing component* (see lines 1 and 2 in Figure 2), because topic talk can be re-opened or closed. Contrasting with mundane closing, how do therapist and patient open up the closing process of therapeutic encounters?

```
1  Speaker A: okay
2  Speaker B: okay
3  Speaker A: bye bye
4  Speaker B: bye
```

Figure 2

Minimal scheme

Therapeutic Closing

The structure of mundane closing can be seen as *primordial scene* (Schegloff, 1996) for therapeutic closings, and coincidentally a therapy is distinct from everyday talk. To analyze therapeutic interaction, there are some constraints to be considered, for example that both participants need to have pragmatic knowledge (Peräkylä & Vehviläinen, 2003) about the specific institutional genre - that is different for therapist and patient. The resulting communicative asymmetry implicates a dilemma. A closing element opens up and conducts the end of a movement in a musical performance, just as the therapeutic dyad has to 'strike the right chord' in closing, that is why, I will refer to this problem as the *coda dilemma*: How can the encounter with open topics be closed down in a therapeutic helpful way? The therapist has to ensure the rules of therapeutic interaction. So the therapist has to unilaterally open up the closing sequence, though the patient might have open topics or "unmentioned mentionables" (Schegloff & Sacks, 1973, p. 303) and because "professionals lack the epistemic authority" (Stommel & te Molder, 2015, p. 284) to ensure that the actual encounter can though be closed down, both, therapist and patient, need to negotiate the process of closing as an "interactional achievement" (Schegloff & Sacks, 1973, p. 290). On the one hand, topicalization of unmentioned mentionables in the process of closing therapeutic encounters is dispreferred and on the other hand the therapist needs the patient to actively co-work on the conduct of closing. How do interlocutors conduct the closing procedure and which communicative techniques do they apply to solve the coda dilemma?

Types of Therapeutic Closing

The over-all structure of therapy reveals some answers to the question of communicative techniques analyzable on a micro-level: I found three different closing types with different frequencies (see Figure 3)[5]. All in all there are 13 compact (2-4-7)[6], 9 stretched (3-4-2) and 6 commented (4-1-0; 1) closings. First the *compact* style is characterized by

[5] On the x-axis there is visualized time and on the y-axis there is the frequency. There are three columns, for the first, the second and the last third of the therapy. Each column consists of 9 closing sessions, whereby green stands for compact, red for stretched and orange for commented closing types.

[6] This format displays the frequency in the segments of this therapeutic over-all process: (1st third-2nd third-3rd third). The last session is separatedly attached by a semicolon.

its compact way of dealing with insertions, like arrangements, linking to next session, complaint remedies or re-open topic talk (see Example 1). By contrast, stretched closings deal with insertions in an extensive way (see Example 2). *Commented* closings extend the actual encounter after the terminal exchange (see Example 3). Comparing all of the 28 sessions, one result is that the appearance of the different closing types is related to the process of therapy: While the commented type decreases from beginning to end, the compact type increases.

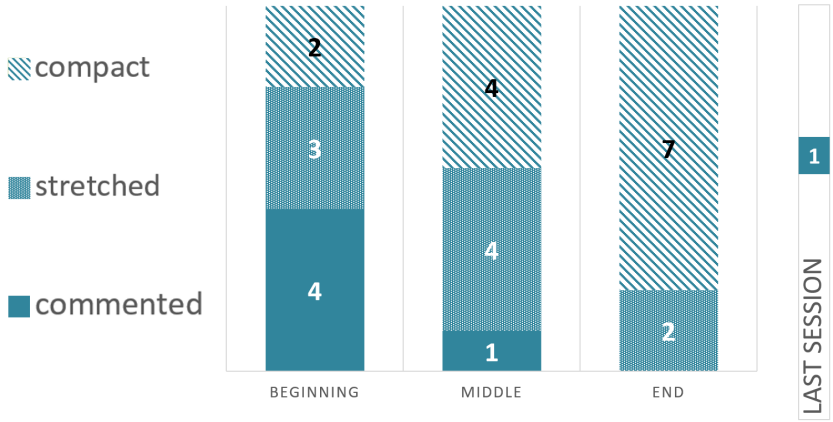

Figure 3

Types of closing (frequency)

The three types of closings can be seen as manifest realizations of an implicit communicative problem, the coda dilemma. To ensure that the actual encounter can be closed down, though there are unmentioned mentionables, both, therapist and patient, co-construct the closing sequence typically by *evaluating* the therapeutic process so far, what I call *Joint Evaluation of Therapeutic Help* (JETH). This evaluative solution corresponds with the function of mundane preclosings and is understood as in-session qualification done by the participants themselves in their orderly interaction (Schegloff & Sacks, 1973, p. 290)[7]. In the material these small evaluative elements locally handle the coda dilemma in an affiliative way either as JETH type 1) unilaterally offered or 2) interactively performed.

Transcriptions of closing sequences are analyzed in three procedural categories: i) mutually calibrated steps of closing, following the minimal scheme proposed by Schegloff and Sacks (1973), as a process of Joint Activity (f.e. see Clark, 2006), ii) expressing an "informational imperative" (Enfield, 2006, p. 399) or (Un-)Common Ground as a certain closing type (compact, stretched or commented) and iii) affording a particular degree of an "affiliative imperative" (ibid.) or Joint Commitment as JETH type

[7] The authors describe that orderly interactions "were produced so as to allow the display by the coparticipants to each other of their analysis, appreciation, and use of that orderliness" (ibid.).

(1: unilateral offer or 2: interactional performance). Like reading a clavier excerpt there must be known some transcript notes:

underlined stands for emphasis

„.h“ (with a dot) indicates in- and just „h“ exhalation

! means loud and

° silent speech

[simultaneous

[speech is characterized by open parentheses

pro:::longation is marked by „:“

Figure 4

Transcript Notes

Example 1: Compact Style

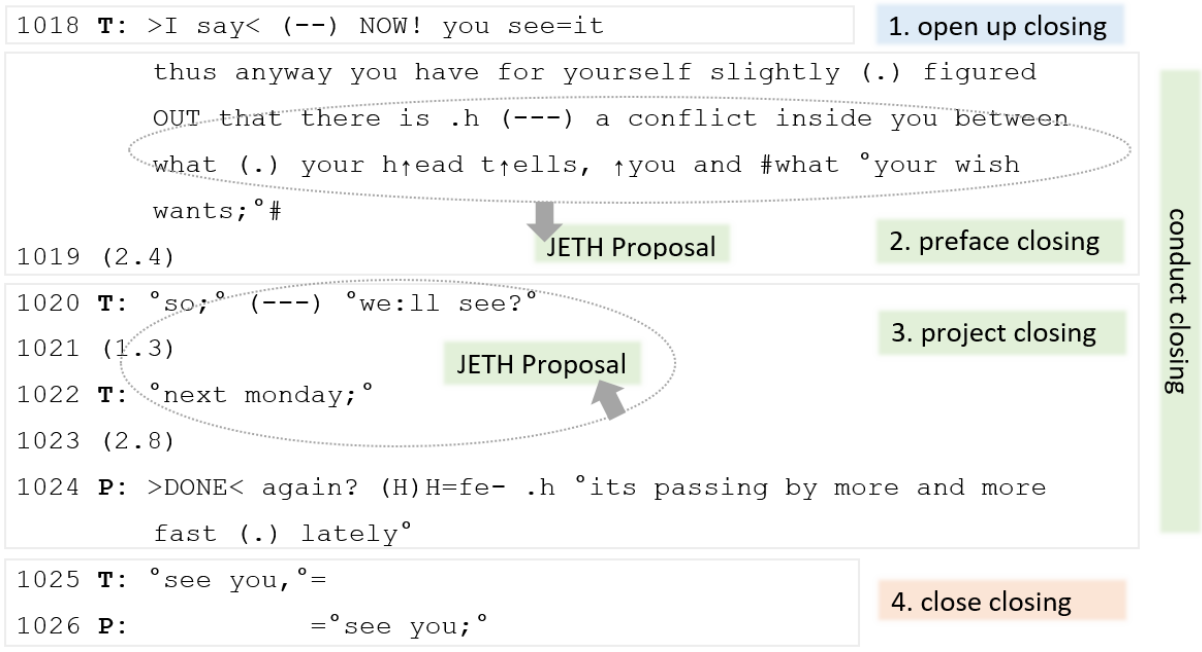

Figure 5

Transcript of closing sequence of session 10

This first example is a compact closing with two JETH as unilateral offers. An intermission of two weeks, when the therapist has been in another country, preceded this tenth session. Just before this sequence the interlocutors deal with the ‘display of interest’ by asking questions or staying silent.

The therapist unilaterally opens up the closing sequence with a prosodic boundary marker ("NOW!") that differentiates the prior talk from what follows. As gatekeeper" (Erickson & Shultz, 1982) of therapeutic rules he continues to preface closing (see end of line 1018) with an "upshot" (Button, 1987). Generally spoken, an upshot's function is understandable as expression of "deontic authority" (Searle, 1995), that is to inter-actionally co-produce authority that is dependent on confirmation of the other (Stevanovic & Peräkylä, 2012). With these deontic means the therapist makes relevant the patient's reaction. The upshot's second, specific functional aspect is a possible pre-closing, that what is said until now, can be confirmed in the upshot's sequential position to close the prior topic or to take the upshot's insight as a proposal for elaboration. This concluding remark can be heard as a proposal for the other to co-evaluate the session, represented by the upshot, and therefore an upshot in the end of the encounter is a JETH proposal, and the following pause a Turn Relevant Place (TRP). It is remarkable, that the patient (in line 1019) does not react and does not say whether he has something to say or not. The sequential order of talk makes visible how 'doing communicative resistance' is done. This is a Typical Problematic Situation (Buchholz, 2016), because it was found that pauses up to approximately three seconds (Frankel, Levitt, Murray, Greenberg, & Angus, 2006) indicate a pause for reflection while longer pauses mark a communicative rupture (Safran & Muran, 2000) in the "interaction engine" (Levinson, 2006). A challenge for the interactants is to paradoxically repair the interaction engine to set the stage for closing down the mutual orientation towards interaction.

The therapist places again a boundary marker ("°so;°") what conversationally functions as "discourse marker" (Helmer, 2011, p. 50)[8] what can be analyzed as empathetic towards the recipient, because it i) reverts to common ground and ii) connects the prior turn (not the previous topic) with the actual one and thereby routes the other's expectations that a topic shift might follow. Closing is projected by the therapist who connects the actual with the following encounter ("°we:ll see?°" "°next monday;°") by proposing JETH through an "arrangement" (Button, 1987, p. 104). This creates a "closing-relevant" (Schegloff & Sacks, 1973, p. 306) or "strongly closing implicative" (West, 2006, p. 386) environment: on the one hand arrangements open up a potentially new topic, and on the other hand the communication of a next encounter stresses that there is nothing more to say, because the interlocutors do not add new aspects to prior talk and therefore co-orientate towards taking leave. The first time in this sequence the patient actively participates (1024), but not does not confirm the second JETH as a future activity proposal. By loudly breathing out and placing a glottal stop ("(H)H=fe-") the patient sites a "misplacement marker"[9] (Schegloff & Sacks, 1973, p. 320).

Thereby the patient communicates the therapist how to interpret his utterance: as not being sequentially connected to the prior closing sequence or what the therapist just said

[8] Helmer 2011 analyzes german 'also' as a discourse marker that produces cohesion between one and another turn and thereby is a reference for "intersubjectivity" (ibid., p. 51).

[9] Misplacement marker can be understood as "an orientation by their user to the proper sequential-organizational character of a particular place in a conversation, and a recognition that an utterance that is thereby prefaced may not fit, and that the recipient should not attempt to use this placement in understanding their occurrence" (ibid.).

before. The patient's expression of 'misplaced surprise' connects to what was described afore as 'doing communicative resistance' (1019), because he explicates that he likes to extend topic talk and does not want to move towards closing. Coincidental opposing projects (Alder, Brakemeier, Dittmann, Dreyer, & Buchholz, 2016) in the conduct of closing are i) what can be interpreted as the patient's 'active-passive mode' or hands-off approach of cooperation (see actively saying nothing, though it would be expectable in 1019; actively saying something, though it is not expectable: misplaced surprise in 1024) and ii) the therapist's consequent work on closing with deontic means, so to speak as a 'demonstration of coherence' (see boundary markers in 1018 and 1020; JETH proposals in 1018 and 1020-1022). The locally produced solution of the coda dilemma in this session is, that the patient cooperates in an active-passive mode while the therapist demonstrates coherence - leading to non-marked dispreference of topicalization of unmentioned mentionables: The prior turn of the patient is treated as non-relevant to the process of closing so that the therapist initiates the terminal exchange what is accepted by the patient who thereby closes down the encounter (1025-1026).

The tenth session i) consists of four distinct steps of closing (open up, preface, project and close closing section), ii) with a high "economy of expression" (Enfield, 2006, p. 399) or common-ground activities by cooperating in a compact way[10], iii) that is not yet highly affiliated interactionally, using two unilateral offers (JETH type 1) without explicit confirmation (neither: explicit disagreement) towards the proposals, marking a rather low level of Joint Commitment.

[10] This minimal reactiveness on the coincidental opposing projects of the interlocutors can be analyzed as acting on a Common Ground of closing, insofar as both interlocutors deal minimally with the therapist's project of closing down, and with the patient's project of prolonging closing. The insertion of the patient (l. 1024) for example is *not* treated as an "action formulation" (Thompson, Fox, & Couper-Kuhlen, 2015, p. 4), but as common knowledge as an "action in its own right" (Schegloff & Sacks, 1973, p. 290). That is why the function of the patient's utterance is not a contentual expression of not knowing about closing, but a formal display of lacking interactional affiliation (having unmentioned mentionables or another communicative project than the therapist).

Example 2: Stretched Type

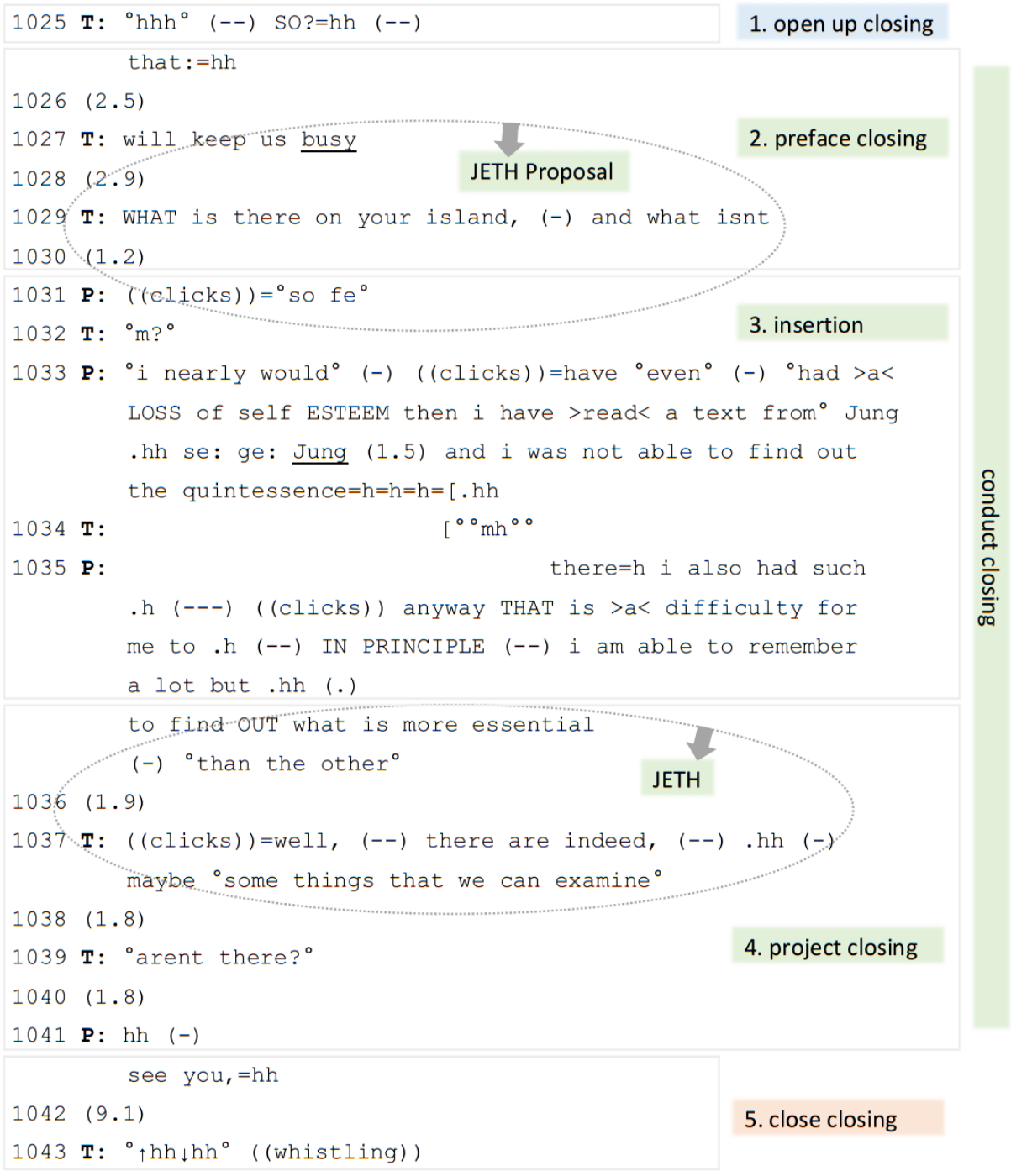

Figure 6

Transcript of closing sequence of session 12

The second example is a stretched closing with two JETH, first as an unilateral offer and second as an interactional performance. This session shows how the two participants deal

with unmentioned mentionables inserted in the conduct of closing. The last topic is about the fantasy of being on an island. The therapist opens up closing by placing a prosodic boundary marker ("SO?") and conducts closing with a covert announcement ("will keep us busy" "WHAT is there on your island, (-) and what isn't") that is encased by three pauses (1026; 1028 and 1030). These pauses structure the conduct of closing as a process that needs to be differentiated from prior topic talk, because the expectancy of pauses as Transition Relevant Places (TRP) has to be transformed into conversational *non-expectancy* of further talk. The preface of closing is not clearly understood as conversational non-expectancy by the patient's following unintelligible utterance (1031). This ambiguous turn initiates an insertion of patient-sided topic talk about dealing with "LOSS of self ESTEEM" that is minimally supported by the therapist ("°°mh°°"). This insertion stretches the conduct of closing, but it does not suspend the process as a whole. The communication of unmentioned mentionables is possible, but dispreferred in closing sequences, as can be seen in the next turn of the therapist who i) projects closing empathetically with "well" as a "face-threat mitigator" (Jucker, 1993) and ii) does not deepen further contents. The projection of closing is strengthened, because the therapist coherently links "°some things that we can examine°" to what the patient said immediately before ("find OUT what is more essential (-) °than the other°"). This turn connection subsequently co-produces a project formulation, and therefore a JETH, created by sequential[11] and contentual[12] coherence. The therapist increases the relevance of suspension of TRP by asking a question directly (1039), that is again encased by two pauses (1038; 1040). This time it is understood as projection of closing and suspension of TRP, as we can see in the next turn of the patient who does not (actively) confirm that interactionally co-produced JETH, but (indirectly) accepts it by initiating the close of closing (1041).[13]

The twelfth session i) consists of five steps towards closing (open up, preface closing, insertion, project and close closing section), ii) expressing a medially economical information and expectation management or common-ground activities by cooperating in a stretched way[14], iii) that is affiliated interactionally, using a co-produced project formulation as a Joint Commitment.

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[11] Sequential coherence is created by mitigating a potential face-threat after patient's topic talk and before therapist's non-topic talk.

[12] Contentual coherence is created by linking to patient's last said words.

[13] In relation to the missing second pair part (therapist's answer goodbye greetings), this closing sequence seems to be rather odd. But we have to recognize, that there is not assuredly no second pair part, because we do not see the therapist nodding, skaing hands, waving or performing a non-linguistic movement. Whatever we think that this ‚index change' means, we have to stick methodologically to what we know from the interactant's reaction, and because this reaction is absent, it is this absent turn valuing the first one as none to react to.

[14] Re-open topic talk is dispreferred in the conduct of closing, and can be seen as an *uncommon*-ground activity, because the interlocutors structurally do not know about the other's open topics. Conversational consequence is that the patient has to learn about *topicalization* (in terms of dealing with asymmetric talk implications of having to know about which topics can be placed or re-opened at a certain time).

Example 3: Commented Type

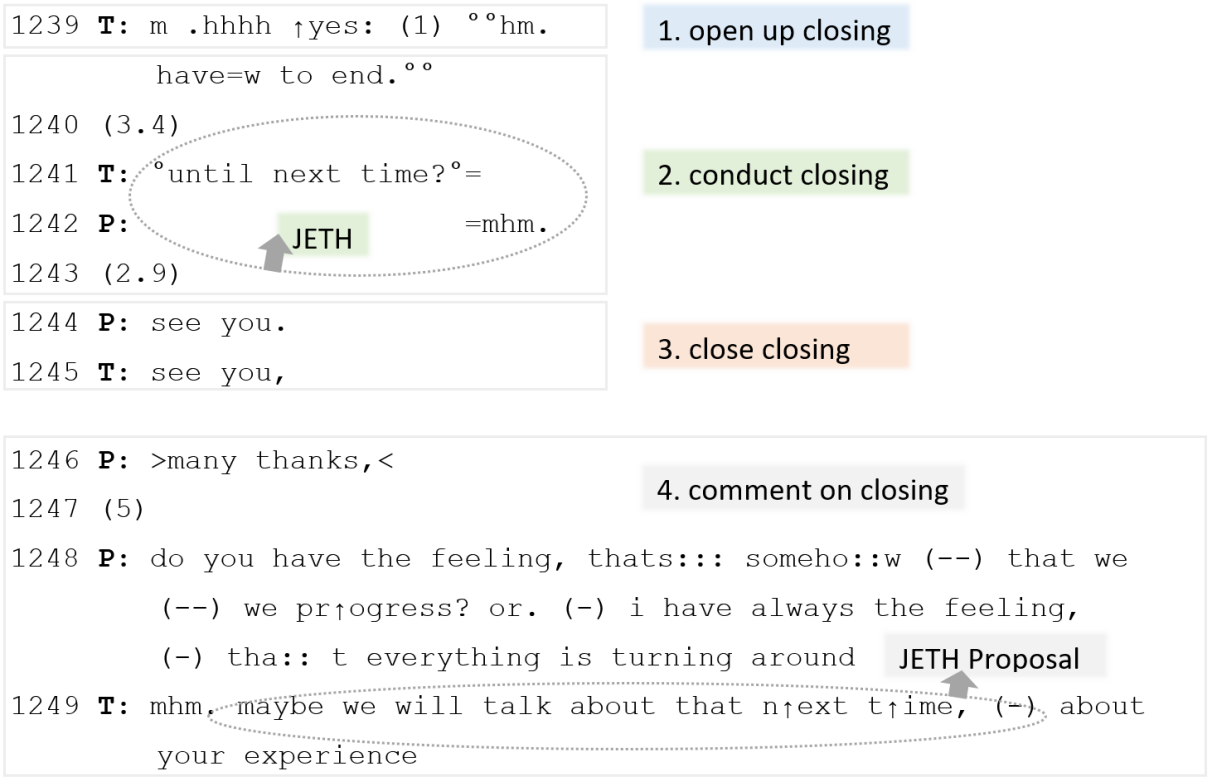

Figure 7

Transcript of closing sequence of session 03

The third session is a commented closing with two JETH first as an interactional performance and second as an unilateral offer. The last topic of this session is about tensions the therapist stresses when the patient talks about feelings while eating. The patient describes anger and contrasts possible expectations of being hindered by this anger in other situations as well, by saying that in total he was fine. Closing is opened up by the therapist who initiates the sequence with a coherent boundary marker ("↑yes:") and unilaterally verifies that there is nothing left to say ("hm."). This process of initiation and unilateral verification is accompanied by long inhaling (."hhhh") and declaration (pause of 1 sec.), that marks the following utterance as prolonged or misplaced (see Example 1) in terms of its sequential position, but coherent in terms of closing as an unit in its own right. Closing is conducted by the therapist who places an "overt announcement" (Button, 1987) and thereby directively works on projecting closing ("have=w to end."). The directive closing attempt of the therapist is a TPS that is a delicate communicative act: After a second rather long pause (see lines 1239 and 1240) the therapist projects closing by 'softening' the directive attempt[15] with an "initiation

[15] The therapist repairs his previous directive attempt and this 'softening' can be analyzed as empathetically modulation of the other's expectations and thereby affords „the patient's recognition of his own mind in the therapist's mind" (Fonagy & Allison, 2015, p. 2).

action" (Thompson, Fox, & Couper-Kuhlen, 2015, p. 4) that links to the next session ("°until next time?°").

This initiation action is the first part of JETH that i) asks for verification (assumingly that no unmentioned mentionables will be risen), ii) increases the relevance of active cooperation, who is encouraged to answer the interrogative pre-turn of the therapist[16] and iii) connects the actual with the upcoming encounter. The second part of the JETH is the verification by the patient ("mhm."). After a third rather long pause (2.9) the interactants exchange goodbye greetings (1244-1245). Techniqually seen, the patient's next turn re-opens a new (topic) talk, that is why we can understand this postsession time as comment on the previous talk. To open up closing in a directive way needs to be expressly consented to. A seemingly harmless question ("do you have the feeling, thats::: someho::w (--) that we (--) we pr↑ogress?") is placed by the patient, what is called "by-the-way syndrome" (West, 2006, p. 380): the placement of important concerns in the postsession time *en passant*. Interestingly, the speaker addresses the hearer's feelings, what can be analyzed as a connection to the last topic (of anger as a by-the-way feeling). This connection re-opens a topic, but "why that now" (Schegloff & Sacks, 1973, p. 299)?

The communicative functions of the patient's comment on the previous closing process is to mention unmentioned concerns connected to the last topic, that he himself can not solve, what is conversationally indicated by tying back the topic on himself ("i have always the feeling, (-) tha::t everything is turning around"). Through this "complaint remedy" (Davidson, 1978), formulated as metaphorical dizziness that could be treated, the patient positions himself as needy and the therapist as help giving. That is what was called "reverse projects" (Alder et al., 2016): The patient's trial to establish these communicative roles can be seen as contrary towards the therapist's project of closing down the session, because to elaborate on the complaint remedy means to continue the therapeutic interaction. The therapist reacts conversationally clever while stressing i) the "standing relationship" (Button, 1991, p. 251) ("n↑ext t↑ime,"), ii) the patient as communicative competent agent of talk ("your experience"), iii) closing again as an unit ist own right, while not deepening the re-opened topic and iv) therefore solving the coda dilemma locally by placing a JETH proposal ("maybe we will talk about that n↑ext t↑ime,").

The third session i) consists of four steps towards closing (open up, project, close and comment the closing section), ii) expressing a high economical information and expectation management or common-ground activity by cooperating in a stretched way, iii) that is affiliated interactionally, using a co-produced project formulation, marking a Joint Commitment.

[16] Interestingly, the therapist does not ask a question like "do we see us next time?," but places a risingly intonated formulation, that implies that both participants know about the upcoming meeting; we can assume they both know the date, the time and the place. With that said, epistemic knowledge is clear: it is not about negotiation of a possibly not happening next encounter, and the therapist's utterance is not understandable as 'real' appointment, but as a functional linking of the actual with the following session.

Conclusion

There are two structural different consequences that can be subtracted out of this study of closings, that are 1) methodological and 2) practical – leading to "situationism" (Buchholz, 2016). There is a methodological consequence, to analyze the material as if we look through a prism that refracts the light threefold, describing practices of i) Joint Activity consisting of distinct steps of closing (see Figure 8 - Scheme of Closing), ii) with different degrees of economy of expression (see Figure 3 - Types of Closing: high/compact, medially/stretched or low/commented) and iii) with unilateral or Joint Commitments as a display of interactional affiliation (see JETH as joint project formulation).

This differentiation allows us to understand the three closing sequences as reciprocal actions established by Common-Ground Activities and Joint Commitments: the first example consists of four steps performed in a compact way, expressing high Common Ground-Activities, that are interactionally disaffiliated, the second example realizes in five steps a stretched closing style with a medially economical information and expectation management, that is interactional affiliated and the third example again accomplishes closing in four steps in a commented manner with Uncommon-Ground Activities, that are interactional affiliated. The participants deal with differences in their common knowledge about i) when to place an utterance ("Kairos" Erickson & Shultz, 1982, p. 72), ii) how long a session is ("Chronos," ibid.) and iii) what topics are allowed in a closing sequence.

The three closing types reflect that information management: the compact style is a very economical expression of information management, the stretched style has common and uncommon shares or parts and the commented style expresses resistance against the communicative process of closing and therefore is an Uncommon-Ground activity. On the other hand, the interaction needs commitments towards a Joint Action, what manifests itself in affiliative evaluations that can be co-productions or unilateral proposals. Insofar the distinction between Common-Ground Activities and Joint Commitments can be fruitful for clinicians to understand closing of therapeutic encounters as a situation with 'audible' steps, indicating a process in closing and therapy *en bloc* instead of a stable construct.

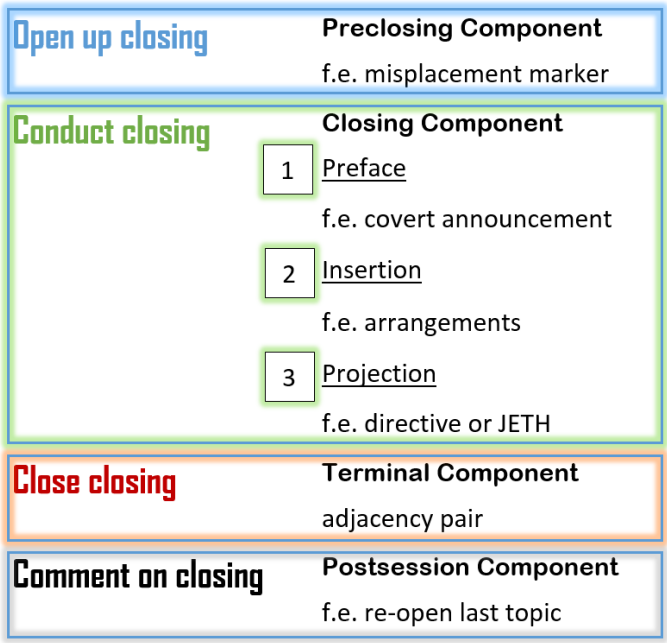

Figure 8

Scheme of closing

The Scheme of Closing is induced from 28 closing sequences and expresses an over-all structure of commitments towards the therapeutic closing process. There are up to six sequences that are co-constructed consecutively. Like two people assemblying a table through cooperation (Clark, 2006, p. 127 ff.), the participants commit towards closing as a Joint Action, that needs to be accomplished stepwise. Following practices are taken from the Scheme of Closing as clinical relevant learnings:

1. While there is a mutual verification of unmentioned mentionables in mundane conversations (Schegloff & Sacks, 1973), one finding of this study is, that the therapist as the "gatekeeper" (Erickson & Shultz, 1982) in most of the time initiates closing section unilaterally. By unilaterally open up closing, the speaker "reduces" expectancies from mundane preclosing procedure, whether something is left to say. This reduction practice is described by Clayman (1989, p. 685) as "sequential deletion of practice at junctures where, in ordinary conversation, they would be relevant and expectable". Preclosings as 'hinges' between topic talk and closing component do not allow reinvocations of new topics (Hartford & Bardovi-Harlig, 1992, p. 97; "preclosing questions fail as a closing device" at Stommel & te Molder, 2015) what is different to Schegloff and Sacks show it for everyday talk. This process supports the insight, that therapists should "help patients raise new problems early" (White, Rosson, Christensen, Hart, & Levinson, 1997, p. 165).
2. This communicative strategy expresses that the function of preclosings, to evaluate the readiness for closing, in therapeutic talk is not done through answering preclosing questions, but through unilaterally open up and preface

closing therapist-sided. That is one reason why therapeutic interaction is to be called communicative asymmetric. But as Lakoff (1980, p. 11) puts it, "the one who appears to hold the power does not hold it": the therapist has deontic authority only and his action is subject to approval. With that said, i) it was found to be helpful for prefacing closing to give a summary or upshot of the session as an "orientation statement" (White et al., 1997, p. 165) and ii) the conduct of closing is due to two important consequences: to hold ready a slot, first, to re-open topic talk (*insertion*), for example by asking "anything else?" (ibid.) or to place a typical last topic like an arrangement and, second, to co-evaluate the session so far (*to project closing*). While the preface increases the relevance for closing, the projection constricts possible expectations of re-open topic talk. Repeated JETH proposals (see Example 1) seem to be helpful to work towards closing.

3. The projection can connect to future encounters understandable as "continuity of care" (West, 2006, p. 415) and creating a "standing relationship" whereby the participants "elaborate upon it and constitute it as relevant for their talk and conduct, *in* their talk and conduct" (Button, 1991, p. 272). Therapeutic techniques to project closing are Joint Evaluations of Therapeutic Help (JETH) or active linking to next session.
4. To deal with expansion after closing not only as patient-sided maladaptive action, but as a comment on the situation, that, if taken into conversational account, affords the opportunity to work on the *communicative* resistance with communicative means - accessible for both participants.

Besides contentual deliberations 'why' the patient acts in a certain way, Conversation Analysis stresses reflections on formal and functional aspects, the 'how' of conduct of interactions This how is described by JETH that functions as i) postprocessing of the collaboration of the actual session and ii) preparation of possible following encounters. These characteristics open a chance for the therapeutic dyad 'moving closer' by ritually working on the social relationship. But it is a skilful act to close the actual encounter as expression of collaboration of two communicative competent interlocutors and at the same time giving a push to the necessarity of further treatment. To dare to walk this tightrope can succeed by drawing on interactive resources, instead of highlighting individual indigence. This *inter*action requires courage, because, in dyads, both interlocutors commit towards an active contribution, that can be claimed and evaluated mutually.

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Exploring the Language of Body Boundaries in Person-Centred Psychotherapy[1]

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Abstract

This study is based on the assumption that verbal expression of the body boundary personality is a dynamic personality state depending on immediate social demands rather than a stable personality trait. By drawing Fisher and Cleveland (1958), the exposure and internalisation of social values, and behavioural expectations represent the most important influence in the formation of body boundary finiteness, and also the development of psychological disturbances (Rogers, 1951, 1961). Given this relationship between body boundary formation and Roger's influence on the development of body psychotherapy, this correlational study explored the use of words and changes in body boundary finiteness of twelve patients attending person-centred psychotherapy. Changes of personality expressions were assessed by measuring the strengths of associations between barrier imagery, as measured using the Body Type Dictionary (BTD) (Wilson, 2006), and the general semantic content, as measured using the Linguistic Inquiry Word Count text analysis program (LIWC) (Pennebaker, Booth, & Francis, 2007).

Introduction

This article aims to explore whether the clarification of internalised familial and social values would stimulate changes in patients' body boundary finiteness. Such changes in the expression of one's body boundary awareness would indicate the presence of a dynamic and temporal personality state rather than a stable personality trait.

Fisher and Cleveland (1958), the exposure and internalisation of familial, stable and secure values and behavioural expectations are assumed to represent the most important influence in the formation of bodily boundaries (Fisher & Cleveland, 1958). Although exposure to a stable and secure family environment is typically perceived to be a fortunate occurrence, Rogerian person-centred theory (1951, 1961) states that the internalisation of values that are incongruent with the true self contribute to the development of psychological disturbances. Given the theoretical relationship between body boundary formation and Rogerian person-centred theory, patients should experience changes in their body boundary finiteness within an empathic psychotherapeutic process. Such changes in body boundary finiteness would represent some empirical support

[1] This article has been published in a similar format as Cariola, L. A. (2015). Semantic expression of the body boundary personality in person-centred psychotherapy. *International Body Psychotherapy Journal, 14,* 48-64.

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related to the effectiveness of psychotherapy to bring about changes in the body boundary awareness as well as indicating how body boundary awareness is embodied in the language patients' use within the psychotherapeutic context. Out of this context, this study might helpful to practitioners of body psychotherapy to further their understanding of the intra- and inter-psychotic functions associated to the of the body boundary personality.

Fisher and Cleveland's Body Boundary Concept

Fisher and Cleveland (1956, 1958) observed that individuals vary in the appraisal of their body boundaries to the extent that "there is considerable variation in the firmness or definiteness persons ascribe to their body boundaries. At one extreme is the individual who views his body as clearly and sharply bounded, with a high degree of differentiation from non-self objects and the opposite pole is the person who regards his body as lacking demarcation or differentiation" (Fisher, 1970, p. 155). Fisher and Cleveland reasoned that individuals would project their phenomenological experience of their own body boundaries onto their environment. Therefore, individuals with more definite body boundaries would show a greater tendency to direct their visual attention to the protective and enclosing features in their environment, as opposed to individuals with less definite body boundaries.

In a series of empirical studies using projective tests, including the Rorschach inkblot test (Rorschach, 1921), Fisher and Cleveland developed a manual scoring system that measured the frequency of words that related to the definiteness and permeability of an individual's body boundaries. Barrier imagery emphasised the protective and enclosing features of the boundaries of a definite structure and surface, whereas penetration imagery related to the fragility and permeability of definite boundaries. Based on this scoring system, a high frequency of barrier imagery corresponded to a High Barrier personality, whereas a low frequency of barrier imagery indicated a Low Barrier personality. Examples of Barrier responses were *"a striped zebra", "a woman wearing a high-necked dress", "a tower with stone walls", "a man smoking a pipe",* and *"a pregnant woman",* and examples of Penetration responses included *"a man climbing though a window", "an amputated arm", "an open mouth"* and *"a bleeding leg"*.

Most importantly, Fisher and Cleveland (1958) suggested that an individual's degree of body boundary finiteness is correlated to the social values and behavioural expectations learned from the interactions in family environments. For example, mothers of High Barrier personalities scored lower on maladjustment and rigidity scales than mothers of Low Barrier personalities. Based on this result, Fisher and Cleveland (1958, pp. 259-260) interpreted that individuals with definite body boundaries would have mothers that provided a secure model and strong values as well as the ability to maintain stable and intimate relationships, whereas individuals with less definite body boundaries would grow up in family atmospheres characterised by instability, insecurity and tension. Although High Barrier personalities might be construed as a favourable personality trait compared to the Low Barrier personality, it has to be noted that Fisher and Cleveland's observation of High Barrier patients with rheumatoid arthritis showed reservations in expressing negative emotions, such as anger and frustrations. The focus on enclosing peripheries and the rigid appearance of bodily stiffness might, on a psychosomatic level,

reflect a defensive function by containing and controlling these negative emotions that are perceived as unacceptable, overwhelming or threatening. The body functions, then, as an enclosing container "whose walls would prevent the outbreak of these impulses" (p. 55). If also not explicitly stated by Fisher and Cleveland (1958), the extreme development of high and low body boundaries might be perceived to result in defensive forms of affect regulation, whereas body boundaries in the middle range on the High-Low Barrier personality continuum might represent more functional forms of regulating emotions.

These findings are also consistent with psychodynamic theories that perceive early socialization experiences to represent one of the strongest influences on the formation of a coherent self and bodily schema (Ogden, 1989; Bick, 1968, Winnicott, 1971). Thus, individuals with coherent self and bodily schemas are assumed to communicate their internal mood states to their social environment, whereas the inhibition to express one's internal experiences is assumed to indicate dissociation from one's emotions and thoughts (Bollas, 1987). Based on the Freudian theory (1923) that perceives a relationship between the body and the unconscious, Cariola (2015) identified that autobiographical memories of High Barrier personalities used more words associated to primordial mental activity, such as group references, somatosensory processes, and spatial references. In contrast, Low Barrier personalities showed increased use of semantic content related to conceptual thought, such as self-reference, as well as affective and cognitive processes. Primordial mental activity and conceptual thought represent similar concepts to the Freudian (1900) modes of cognitive functioning that differentiates between the primary and secondary processes. The primary process is concrete, irrational, unrelated to spatio-temporal constraints, and free from social and moral conventions. It is also the principal awareness of young children, and it has also been associated with the cognitive functioning of ASC, including dream, meditative, mystical and drug-induced hallucinatory states. In contrast, the secondary process is abstract, related to the principles of grammar and logic, time and space, social and moral conventions, and it is the cognitive functioning of older children and adults.

Rogerian Person-Centred Psychotherapy

The Rogerian approach to therapy generally refers to the theories and clinical practice of Carl Rogers (1902-1987), the founder of the person-centred psychotherapy. According to the person-centred approach, a supportive and loving family environment in which children experience their parents' unconditional positive regard represents the basis of the development of a positive congruent self and self-worth. Yet, to obtain his/her basic needs to obtain parental approval, the child also "internalizes" his/her parents' conditional values of what constitutes acceptable and love-worthy behaviour, no matter how bizarre and irrational. These internalised parental values may fail to reflect the person's authentic emotional experiences, action tendencies and values, and eventually, the child will start to distort and deny any experiences of the true self that are perceived as incongruent would fail to win parental approval. Consequently, the discrepancies between the conditional parental values and the individual's experiences result in a split between the experiencing phenomenological self and the true self. A person who is preoccupied in fulfilling a great variety of internalised values that are incongruent with the true self tends to engage in rigid attitudes and maintain behaviours and values that

further reinforce a negative self-concept to the extent that such a person might even become completely cut off from their own inner resources and their own values and are governed by a secondary and treacherous valuing process which is based on the internalisation of other people's judgments and evaluations" (Thorne, 2003, p. 138). The person-centred theory states that the discrepancy between the phenomenological self and true self represents the basis for the development of psychopathological disorders.

Rogers' Core Conditions

Person-centred psychotherapy employs a non-directive approach emphasising the therapists' use of reflection as a means to summarise what the clients expressed about their feelings and thoughts so that patients' phenomenological experiences are fully acknowledged by the therapist. Most importantly, Rogers (1961) stressed the notion of the psychotherapeutic climate as a pre-requisite for a deep understanding by the therapists of their clients and for the desired psychotherapeutic changes to occur. Through the psychotherapeutic processes that depend substantially on three core conditions — 1) the therapist's congruence or genuineness, 2) unconditional positive regard, 3) empathic understanding — patients will be supported to gradually assume more courage to trust their intuitions, values, needs and desires. This growth enables patients to find their phenomenological self and develop a stable and healthy self-concept, in addition to recognising their personal worth that is independent of external approval.

Allport's Transient States

Allport (1961; Allport & Odbert, 1936) suggests that some units of personality (e.g., states and activities) are temporary and related to external events. He further stated that the expression of personality traits is dynamic and largely influenced by the motive to regulate tensions related to basic biological necessities, (e.g., hunger, sleep and feelings of security). As adults, these basic needs become more complex and abstract, but the need to reduce tensions remains activated; for example in social relationships, when individuals will engage in behaviour to gain approval from their social environment in order to maintain a positive self-image. Such a relationship between social approval and personality development, as proposed by Allport (1961), also represents a central rationale in Fisher and Cleveland's (1958) theory of the body boundary formation. For example, a series of empirical studies have shown that individuals with more finite body boundaries will also have more defined concepts of parental figures and will "have parents who stood for certain definite values and ways of doing things" (p. 249). Parents will not only be representative of definite values, but, more importantly, their social interactions will inevitably influence their children's internalisation of these social values and the development of associated socialisation processes. These internalisations are perceived to represent the primary foundation of the development of an individual's body boundary structure and self-concept.

Hypotheses

Given that previous research demonstrated that High Barrier personalities use semantic content associated with primordial mental activity in the written narration of everyday and dream memories (Cariola, 2015b), the first hypothesis (H1) predicted that barrier

imagery would correlate positively with semantic content associated with primordial thought, such as group references (i.e., first-person plural pronouns and inclusion words), perceptual process (i.e., seeing, hearing and feeling), and spatial references (i.e., relativity, space and motion), bodily processes (i.e., body, health, sexual and ingestion) and references related to personal concerns (i.e., work, achievement, leisure, home, money, religion and death). Barrier imagery would be negatively correlated with semantic content related to conceptual thought, such as self-reference (i.e., first-person singular pronouns), verb forms (i.e., common verbs, auxiliary verbs, present tense, past tense and future tense), affective processes (i.e., positive emotions and negative emotions) and cognitive mechanisms (i.e., insight, causation, discrepancy, tentativeness, certainty, inhibition and exclusion words) in the combined spoken psychotherapy transcripts. Correlations of semantic content consistent with the research hypotheses would then demonstrate external validity in which an association between barrier imagery and primordial mental activity can be generalised to naturally occurring language behaviour and to experimentally derived autobiographical memories.

Additionally, psychological theory proposes early socialisation experiences and internalisation of social and behavioural values, or the lack thereof, influence the development of the body boundary formation (Fisher & Cleveland, 1958; Rogers, 1961). Considering that person-centred therapy aims to support patients to trust and become consciously aware of their organismic experiences and values, the second hypothesis (H2) predicted that progressive psychotherapy sessions would be correlated positively with barrier imagery in Low Barrier patients but correlate negatively with barrier imagery in High Barrier patients. In this sense, this study it based on the assumption that the expression of the true self as well as the formation of the body boundary lies in the middle range rather than the extreme ends on the True-False Self and High-Low Barrier personality continuums.

Method

Data

Patients' verbal behaviour in psychotherapy transcripts were sourced from the online 'Counselling and Psychotherapy Transcripts' database (2012) provided the data for this study. According to the accompanying 'Counselling and Psychotherapy Transcripts' handbook (2012), the psychotherapy transcripts were provided by practicing therapists who adhered to the American Psychological Association's Ethics Guidelines, and were selected by an editorial board of distinguished practitioners and academics. The transcript database of the Rogerian person-centred approach to psychotherapy, however, is the most comprehensive because it offers a range of transcripts of individual therapies based on twenty consecutive sessions, with the twentieth session representing the final session. In contrast, the transcripts of the other psychotherapeutic modalities were often provided with only a few consecutive sessions. Out of this context, the transcripts selected for the purpose of this study were based on patients that attended twenty psychotherapeutic sessions.

The psychotherapy transcripts used in this study were based on 12 patients (7 men and 5 women) who attended 20 consecutive once-weekly Rogerian person-centred

psychotherapy sessions. The demographic information of the patients, including age range, sexual orientation and marital status, can be seen in Table 1.

Table 1

Demographics of patients' age range, sexual orientation and marital status

	Age Range			Sexual Orientation		Status		
Gender	**11-20**	**21-30**	**31-40**	**Heterosexual**	**Bi-sexual**	**Single**	**Engaged**	**Married**
Male (N = 7)	1	5	1	6	1	6	-	1
Female (N = 5)		4	1	5	-	3	1	1

The 12 person-centred psychotherapy transcripts had a total text length of 1,699,534 words with a mean of 3,836.42 words per psychotherapy transcript (SD = 3,057.79). The therapists' verbal behaviour had a total text length of 358,137 words, with a mean of 1,577.70 words per psychotherapy session transcript (SD = 678.36). The patients' verbal behaviour had a total text length of 1,341,397 words with a mean of 6,210.17 words per psychotherapy session transcript (SD = 2,773.22).

Measures and Analysis

The Body Type Dictionary (BTD) (Wilson, 2006) is computer-assisted dictionary that calculates the frequency of semantic items categorised as barrier imagery and penetration imagery, based on Fisher and Cleveland's (1956, 1958) scoring system of body boundary awareness (Cariola, 2014a, b). In total, the BTD contains 551 words for barrier imagery, 231 words for penetration imagery, and 70 exception words that prevent the erroneous matching of ambiguous word stems that are assigned to 12 semantic categories (Wilson, 2008).

The Linguistic Word Count Inquiry text analysis program (LIWC) (Pennebaker, Booth, & Francis, 2007) calculates the frequencies of predefined types of semantic content. The LIWC is based on approximately 4,500 words and word stems that are assigned to 80 semantic categories. The LIWC dictionary is hierarchically organised so that one word can be ascribed to different main categories and sub-categories. The semantic categories are based on the following categories: 'Function Words, 'Psychological Processes'' and 'Personal Concerns'. Each of these categories has sub-categories. For example, as noted by Tausczik and Pennebaker (2010, pp. 27-28), the 'function words' category includes to the 'articles' sub-category, which is made up of three words (i.e., a, an, the). Grammatically based categories are based on the classification of semantic items that relate to objective grammatical conventions; however, the semantic content of other categories, such as 'emotions', is made of semantic items that rely on the researchers' subjective judgment.

For the computerised content analysis, the BTD and LIWC were applied to the texts using the PROTAN content analysis software program, which measures occurrences of category-based lexical content in texts (Hogenraad et al., 2003). The PROTAN computes the frequency rate, which indicates how many total lexical items match the dictionary

categories (Wilson, 2008). The frequency rate used in this study for both linguistic and grammatical variables was based on the following formula:

$$Frequency\ rate = \sqrt{\frac{frequency\ count}{no.\ of\ tokens\ in\ segment}} x1000$$

To obtain a better understanding of the quantitative derived results, samples of patient's verbal behaviour were selected to demonstrate the use of semantic content within the psychotherapeutic settings and to how the semantic content aligned to existing psychotherapeutic theories and constructs.

Statistical Analysis

Initial descriptive statistics regarding the frequencies of barrier imagery revealed that the psychotherapy transcripts had a mean 1.72 of and a median of 1.69 (SD = .66). By drawing on the methodology applied by Fisher and Cleveland (1958), the median value of 1.69 for the barrier imagery frequency of the first psychotherapy session was used to divide the psychotherapy transcripts into two patient groups that used high and low frequencies of barrier imagery at the beginning of their therapy. Therefore, psychotherapy beginnings with barrier scores less than the median value (< 1.69) were categorised as 'Low Barrier patients', whereas Barrier scores greater than the median value (> 1.69) were categorised as 'High Barrier patients'.

After the psychotherapy transcripts were divided into two equal parts, the descriptive statistics showed that the Low Barrier patients (N = 6) had a mean of 1.54 (SD = .49) and that the High Barrier patients (N = 6) had a mean of 1.84 (SD = .57) for the barrier frequencies in the psychotherapy transcripts. As a result of this median division, 6 of the 12 patients were classified as High barrier patients and 6 were classified as Low Barrier patients. The High Barrier patients were 3 men aged 11 to 30 years and 3 women aged 21 to 40 years. The Low Barrier patients were 4 men aged 21 to 30 years and 2 women aged 21 to 40 years.

A Spearman rank correlation coefficient (Spearman, 1904) was used to explore the strengths of association between barrier imagery and the semantic content of the LIWC in the patients' overall verbal behaviour. The test was also used to explore the strengths of associations between the progression of sessions and barrier imagery in the psychotherapy transcripts of Low and High Barrier patients.

Results

Consistent with the first hypothesis (H1), the results demonstrated that barrier imagery correlated positively with semantic content associated with primordial mental activity (Tables 2 and 3).

Table 2

Positive Spearman rank correlation coefficients of positive correlations between barrier imagery and semantic content of the patients' verbal behaviour in the combined psychotherapy transcripts

Linguistic variable	Barrier imagery
1st plural pronouns	.275**
3rd singular pronouns	.194**
Articles	.396**
Prepositions	.235**
Family	.251**
Anger	.221**
Inhibition	.138*
Inclusion	.191**
Swear words	.182**
Biological processes	.324**
Body	.348**
Health	.202**
Ingestion	.337**
Work	.270**
Leisure	.383**
Home	.519**
Money	.444**
Death	.224**
Relativity	.446**
Motion	.367**
Space	.395**
Time	.223**

Notes: * $p < .05$ level, ** $p < .01$ level

Table 3

Negative Spearman rank correlation coefficients between barrier imagery and semantic content of the patients' verbal behaviour in the combined psychotherapy transcripts

Linguistic variable	Barrier imagery
Pronouns	-.278**
1st singular pronouns	-.226**
Impersonal pronouns	-.356**
Verbs	-.326**
Auxiliary verbs	-.328**
Present tense	-.180**
Negations	-.353**
Affective processes	-.363**
Positive emotions	-.376**
Anxiety	-.179**
Cognitive processes	-.422**
Insight	-.408**
Causation	-.160*
Discrepancy	-.158*
Tentativeness	-.257**
Exclusion	-.241**
Perceptual processes	-.268**
Feeling	-.316**

Notes: * $p < .05$ level, ** $p < .01$ level

Group references, such as first-person plural pronouns (e.g., we, us, and our), and inclusion words (e.g., and, with, and include) showed a weak positive association with barrier imagery. The use of collective group references resonates with a lack of self-other differentiation and over-inclusive thinking. In this sense, self-expectations and internal experiences are over-generalised in relation to others, such as the patients' therapist and partners, which can be observed in the following phrases: [Patient 3]*"Are we supposed to sit here and just tell anything that comes to my mind?"* or *"Well we were both more or less elated because we both want to get this problem resolved, so we are quite hopeful."*

Particularly, the weak negative correlation between barrier imagery and first-person singular pronouns (e.g., I, me, and mine) implies a reduced self-focus. By drawing on person-centred psychotherapy (Rogers, 1961), a reduced self-focus would be indicative of a blocked interpersonal communication, or so-called defence mechanism of denial, in which patients are unaware of their feelings. In this sense, conversations maintain a superficial tone, referred to as phatic conversations (Malinowski, 1972), and contain a restricted level of self-disclosure by focusing on objects and, in relation to the psychotherapeutic context, problems that are non-immediate and external to the self (Rogers, 1961). In contrast, an increased self-focus emphasises internal mental processes that relate to affective and cognitive states and changes, whereas an increase usage of group-references and non-immediate others associated with barrier imagery relate to

interpersonal material processes (Halliday, 1985). Consistent with this view, there was a weak positive association between barrier imagery and third-person singular pronouns (e.g., she, her, and him), indicating an increased non-immediate, or extended, other-focus related to the patients' exploration of their personal relationships. A high prevalence of third-person singular pronouns might also represent a staging strategy to regulate their discomfort of being the focus in the conversational situation (McCarthy, 1991) as well as to justify their feelings and concerns. This strategy indicates reduced personal responsibility and dissociation from statement ownership (Hancock et al., 2008) within the psychotherapeutic context, which can be observed in the following example: [Patient 6]

> COUNSELOR: *"And that leads you to be very - well you said skeptical - I guess also leery about what's going to happen here."*
>
> PATIENT: *"Well yeah well part of my bad experience. Well part of my experiences comes with working as a counselor with myself. Which I am doing now. And I am working in state and in hospitals and so forth. And realizing that these guys that I am working with are you know my superiors. Do not know me. Or know every little. And like just the resident physiatrist I went to last year I knew damn well I knew more about physiology or just about people than he did. He did not - he would give me back the next week what I had tried to tell him the week before completely reversed. Completely ignoring what I had meant. And just I guess being basically insensitive. Which just makes me feel like I am not getting ahead of things just unwinding. Not exactly or continuing my therapy."*

Person-centred psychotherapy assumes that psychological disturbances are acquired through the process of familial and social introjects that are incongruent with the values and experiences of the phenomenological self. This process precedes the embodiment of these values within the body boundary (Fisher & Cleveland, 1958). Therefore, a weak positive association between barrier imagery and family-related references (e.g., daughter, husband, and aunt) highlights the inflated focus on family related themes, as demonstrated in the following patient's statement: [Patient 11] *"Because I was already invited by Jodie's mother over to dinner. See, it was almost like - and I sat down and thought about, tried to think about that, too. And, I was thinking...because I felt this before, that my mother might have rejected me, like my mother did not really care. You know I think I told you that last week."*

Barrier imagery correlated moderately positively with home references (e.g., apartment, kitchen, and house), which mirrors a focus on the immediate and intimate social environment and indicates an emphasis of container-schematic precepts — e.g., [Patient 110] *"And, I guess what happened was, some kids had rung this old lady's doorbell, so she had come up from the basement to answer the door, and her husband had seen the kids running away from the door, and so he knew who they were and so he told her, and she came over and told my neighbour. And, the neighbour got all mad, and she was sitting there yelling at two of her own kids and one of the people across the street's kids, and she screamed at him about, oh, maybe she sent him home."*

A weak to moderate positive correlation between barrier imagery and references to personal concerns, including work (e.g., job, majors, and Xerox) and money (e.g., audit,

cash, and owe) relates to a materialistic and achievement orientated focus, e.g., [Patient 124] *"I - although I enjoy sort of basking in the accomplishments - well, based on when I go back home. Like, I have spoken quite a few times to my - well, the old high school keeps inviting me back. I was the first graduate in class,"* and in relation to monetary references, *"So, I remember I went out and I bought her something from K.M. Hightower's...like I spent like a whole part-time pay check, which is like 15 bucks. It's, well...but I mean it was still a substantial amount for just like a small housewarming gift for somebody who is not even a relative or really that close."* This materialistic and goal-orientated focus could possibly relate to being socially positively evaluated by others based on superficial values rather than on personal inter-personal qualities. Conversely, a weak positive correlation between barrier imagery and leisure words (e.g., cook, chat, and movie) is consistent with the creative expression and unstructured behaviour associated with primordial mental activity — e.g., [Patient 2] *"So, I read his psychology book. However, he does not because I do not do it that much. I am not interested in that much, you know. I like to read, but I like to read novels historical novels, and he does not."*

As expected, barrier imagery was weakly to moderately negatively associated with affective processes (e.g., happy, cried, and abandon), including positive emotion (e.g., love, nice, and sweet) and anxiety words (e.g., worried, fearful, and nervous) that are related to the reduced conscious awareness of both positive and anxiety-related emotional experiences and the communication to the therapist. Although a heightened primordial mental activity typically relates to reduced affective processes, barrier imagery showed a significant weak positive correlation with anger words (e.g., hate, kill, and annoyed) and swear words (e.g., damn, piss, and fuck), which indicate an emphasis of anger-related experiences associated with a body boundary finiteness within the psychotherapeutic context. These anger emotions can be directed towards the self in the form of references related to self-harming, e.g., [Patient 6] *"And, you know, it was like really stupid, but it was like about the third night within the last week that I woke up and wanted to cut myself, which is just really. Like I before that had gone through a fantastically long time,"* or the feeling of anger in relation to others, e.g., [Patient 27] *"Well, I think to be worried about that is, it makes sense to me because I just I feel like if you are angry and you are angry while somebody is saying something to you, you ought to be able to tell them you are angry or express it or say something or do something."*

According to Rayner (1995, pp. 101-102), aggression involves the actual or simulated activation of muscular movements associated with primordial mental activity to bring about a negation and separation as well as a reaction of perceived threats and a self-preservation function. Considering that high barrier individuals introjected their parental social and behavioural values, such as the socially unacceptable expression of rage and anger (Fisher & Cleveland, 1958), the expression of anger within the therapeutic context would facilitate an essential cathexis to explore interpersonally distressing experiences that result in a gradual resistance to maladaptive parental and social introjects (Freud, 1905; Fenichel, 1945). A resistance may be then perceived as an adaptive manifestation of the patient embodying an agent of change (Coghlan, 1993; Nevis, 1987) in which the patient would resist the learned masochistic submission to parental demands as a means to avoid interpersonal rejection, as well as the harsh criticism of the internalised sadistic parental super-ego (Freud, 1923).

Given that the inhibited expression of anger-related emotions has been associated with the stiffening of the body musculature in High Barrier personalities (Fisher & Cleveland, 1958), the positive correlation between barrier imagery and aggression words might represent a psychotherapeutic feature of the previously repressed anger and the loosening of the conditioned punishment-reward behaviour to avoid socially rejecting and disapproving social judgment (Pennebaker, 1989; Pennebaker & Beall, 1986; Traue & Pennebaker, 1993). Accordingly, there was also a significant positive correlation between barrier imagery and inhibition words (e.g., block, constrain, and stop), which might be related to the inhibited expression of High Barrier patients' thoughts and feelings. In contrast, the weak correlations between barrier imagery and verbs (e.g., walk, went, and see), including auxiliary verbs (e.g., am, will, and have) and present tense verbs (e.g., is, does, and hear) indicates a reduced reality-based behaviour and now-and-here concern associated with primordial mental activity (Robbins, 2011).

Barrier imagery also showed a weak positive association with death-related references (e.g., bury, coffin, and kill), such as self-directed aggressive behaviour in the form of suicidal ideation, e.g., [Patient 6] *"Well, when I tried to kill myself about two years ago or whenever it happened, and I saw a psychiatrist where I was when I got out of the hospital."* Given the relationship between destruction and anger, as noted in the psychoanalytic literature (see Hurvich, 2003), the use of anger words and destructive death-related references might also be indicative of the presence of annihilation anxieties, such as through the use of death-thematic fantasies, e.g., [Patient 32] *"I cannot conceive of it, and yet, personally — if everyone I knew now died, I think my life would be completely different because I would not have any expectations to live up to their expectations."* Particularly, and consistent with Fisher and Cleveland's (1958) observation, Bowlby (1980) conceptualised death-related fantasies to represent patients' unconscious revenge and desire to hurt their parents due to the parental rejection of the patient's feelings and inner self that created feelings of loneliness and the parental demands that require compliance in which the patient would feel responsible for their parent's sense of well-being to be deemed lovable and worthy.

Similar to affective processes, cognitive processes (e.g., cause, know, and ought), including insight words (e.g., think, know, and consider), causation words (e.g., because, effect, and hence), discrepancy words (e.g., should, would, and could), tentativeness words (e.g., maybe, perhaps, and guess) and exclusion words (e.g., but, without, and exclude), and negations (e.g., no, not, and never) were weakly to moderately negatively correlated with barrier imagery. Specifically, the reduced use of insight words, tentativeness and causation words indicate a lower presence of self-reflection and the sense-making processes of the content that is being explored within the therapeutic context. Similarly, low frequencies of discrepancy words and exclusion words indicate a reduced presence of complex cognitive processes to produce accurate accounts of experiences and insights. To some extent, the reduced usage of semantic content that is classified to measure cognitive processes may indicate a lowered neurotic defence mechanism of intellectualisation in which patients would avoid unconscious conflicts through the process of reasoning and logic (Freud, 1936).

Furthermore, barrier imagery was weakly to moderately positively correlated with biological processes (e.g., eat, blood, and pain), including references related to the body (e.g., cheek, hands, and spit), health (e.g., clinic, flu, and pill) and ingestion (e.g., dish,

eat, and pizza), e.g., [Patient 3] *"She would be sleeping (Body) and wake (Body) up the next morning, I am dead tired (Health) because I laid there and worried all night about something I really did not need to be worried about. I used to chew (Ingestion) my fingernails (Body) clear back to the quick …."* The moderate to strong positive correlations with relativity (e.g., area, bend, and exit), including references related to motion (e.g., arrive, car, and go), space (e.g., down, in, and thin) and time (e.g., end, until, and season), as well as prepositions (e.g., to, with, and above), further reflect the psychosomatic characteristic and somatosensory impressions associated with primordial functioning (Robbins, 2011) — e.g., [Patient 124] *"How will I interact now (Time)? Why should I have done that? Why should not I have just come (Motion) in (Space) here and be honest? I hope I am being honest. However, just the thought that...."* Barrier imagery was also moderately positively associated with articles (e.g., a, an, and the), which correspond to the tendency of objectification, which reflects the concreteness in primordial mental activity (Bucci, 1997; Mergenthaler & Bucci, 1993; Loewald, 1978) and a heightened focus on surface-defining objects — e.g., [Patient 11] *"Not that I care about the fellow. It is just the point of the thing."*

Conversely, barrier imagery was weakly negatively correlated with perceptual processes (e.g., observing, heard, and feeling), including feeling words (e.g., feels and touch), indicating a reduced receptivity to environmental sensory stimuli and lowered sensitivity of the external skin body boundary in spoken therapeutic discourses compared to written autobiographical memories (Cariola, 2015b). This low activation of perceptual processes typically relates to conceptual thought (Robbins, 2011). Based on cognitive psychology, a deflation of sensory processes has also been identified as a marker of memory inaccuracies (e.g., Johnson et al., 1980; Hernandez-Fernaud & Alonso-Quecuty, 1997; Schooler, et al., 1986). Within the therapeutic context, a reduction of perceptual processes might relate to discursive themes that are based on patients' fuzzy memory representations of their inter- and intra-psychic experiences that form part of their personal truths (Brainerd & Kingma, 1984; Reyna & Brainerd, 1998; Spence, 1982). A reduction of perceptual process is also consistent with the Rogerian (1961, p. 110) assumption that individuals would defensively exclude insights that are inconsistent with their internalised value systems. Lower frequencies of perceptual process in heightened barrier awareness would then indicate patients' dysfunctional ability to acknowledge their internal and external reality, as well as their lowered ability to understand their own or others' implicit or explicit mental states. This decreased ability indicates a limited capacity to engage in self-reflective and mentalisation processes (Fonagy & Target, 1996).

Strengths of Association between Barrier Imagery and Psychotherapy Sessions

A Spearman rank correlation coefficient showed that in High Barrier patients, progressive sessions were weakly negatively correlated with barrier imagery, $r = -.216$, $p < .05$, but progressive sessions were not significantly correlated with barrier imagery in Low Barrier patients, $p > .05$. Therefore, the second hypothesis (H2) was only partly confirmed.

The reduction of barrier imagery in High Barrier patients suggests that a supportive therapeutic environment that enables patients with previously heightened body boundary

finiteness to clarify their parental and social introjects that were incongruent with the phenomenological self. The empathic and non-judgmental therapist allows patients to explore and reflect on their emotions and thoughts, including frustrations and traumatic experiences. This factor results in the lowering of the encapsulating body boundary. Particularly, the absence of punishing interpersonal judgment would result in the reduction of muscular sensitivity associated with a socially conditioned punishment-reward response (Fisher & Cleveland, 1958).

Given that body boundaries develop as a response to the internalisation of social values that are to some extent inconsistent with the patients' phenomenological self (Fisher & Cleveland, 1958), the nurturing and empathic environment of the person-centred therapeutic environment would encourage functional forms of self- and other-relating, as well as facilitating the patient to formulate values and behavioural responses that are congruent with the needs of their phenomenological self. A reduced body boundary embodies a functional self-other differentiation that might enable patients to acknowledge their feelings and rely on their own judgments and values, in addition to a greater capacity to trust others and to engage with their experiences. This functional body boundary would further allow patients to fulfil the potentials of their ideal self.

Discussion and Conclusion

The results of this study were partly consistent with some of the research hypotheses. Consistent with the first hypothesis (H1), barrier imagery positively correlated consistently with semantic content associated with primordial mental activity, such as group-references, biological processes, relativity and personal concerns, whereas barrier imagery correlated negatively with semantic content associated with primordial thought, such as self-references, verbs, and cognitive and affective processes.

Because the correlations of barrier imagery in relation to the patients' verbal behaviour within the psychotherapeutic context were consistent with the semantic tendency of the written narratives of everyday memories (Cariola, 2015), to the extent that that it can be generalised to both experimentally derived autobiographical memories and naturally occurring psychotherapy-based language behaviour (Elmes, Kantowitz & Roediger, 1991; Rosenthal & Rosnow, 1984). Conversely, barrier imagery correlated positively with anger words, which are typically associated with conceptual thought. Such an inflation of anger words in relation to body boundaries provide some confirmation of the patients' frustrations regarding internalised parental values that constitute a thickening of the body boundary. The person-centred therapeutic approach would then represent a process in which these parental and social internalisations and their inconsistency with the patients' phenomenological self would form part of the patients' conscious awareness.

The results also demonstrated that barrier imagery was reduced in High Barrier patients and that barrier imagery did not increase in Low Barrier patients (H2). This change in barrier imagery suggests that the empathic and unconditional acceptance of the therapeutic relationship in person-centred interventions enable patients to explore their emotions and insights in addition to ridding themselves of inauthentic values that are not

congruent with the phenomenological self or their personality predispositions. This psychotherapeutic process resulted in changes of body boundary finiteness.
There was also a reduction in barrier imagery in High Barrier patients throughout the therapeutic process, but barrier imagery did not increase in Low Barrier patients (H5). Such a change of barrier imagery might confirm that the empathic and unconditional acceptance of the therapeutic relationship in person-centred interventions enables patients to explore their emotions and insights while ridding themselves of inauthentic values that are not congruent with the phenomenological self or their personality predispositions, thus resulting in the changes of body boundary finiteness. High Barrier patients also showed a reduction of self-references, anxiety words and death-related semantic content (H7). Such a reduced self-focus and lower use of negative affective themes would further indicate the effectiveness of the therapeutic process in alleviating patients' psychological suffering, such as their experiences and emotions associated with hopelessness, rejection and disappear. Negative emotion words, however, were not reduced in High or Low Barrier patients when comparing the first and final psychotherapeutic sessions (H4).

The results did not produce compelling evidence that would suggest a change of semantic content associated with primordial mental activity in Low and High Barrier patients (H3 and H6). High Barrier patients, however, showed a reduction in discrepancy and insight words at the final psychotherapy session. A reduction in discrepancy words indicates the lowering of absolute claims, the so-called 'shoulds', 'oughts' and 'musts' (Ellis, 1994; Horney, 1945) that represent the internalised social values that hinder patients' ability to respond more spontaneously and openly to their environment and to be more tolerant towards the self and others (Higgins et al., 1986; Ogilvie, 1987; Tajfel, 1959; Tajfel & Wilkes, 1963). An increase in insight words also reflects heightened levels of self-reflection and understanding of one's own psychological processes, such as needs, emotions and behavioural tendencies. A comparison between the first and final psychotherapeutic sessions of Low Barrier patients shows a reduction in achievement and work related references, which indicates a reduced focus on labour and success. Conversely, an increase in references related to money is congruent with the concrete and materialistic focus of High Barrier personalities. An increase in motion processes is also typically associated with the primordial mental activity. The reduction of human references, however, indicates a lower focus on social relationships, which would be associated with a Low Barrier personality. Low Barrier patients' increased used of hearing words from the first to final therapeutic session, however, might indicate an increased sense of openness to experience (Hirsch & Peterson, 2009).

The semantic changes might also suggest that Body Boundary personality represents a personality state rather than a stable personality trait, as put forward by Fisher and Cleveland, 1958). In this sense, the Body Boundary personality might be a temporary personality state that is influenced by situational and external events. As pointed out by Allport (1961, Allport & Obert, 1936), the expression of personality states are largely motivated and regulated in relation to the satisfaction of basic biological necessities (e.g., hunger, food, sleep, feelings of love and anxiety). In particular the High Barrier personality typically tends to adapt to behavioural expectations and social values to gain approval from their social environment (e.g., parents and friends) in order to maintain a positive self-image and get their basic biological needs met (Fisher & Cleveland, 1958). The semantic changes exhibited by the High Barrier personality indicate an adaptation to

the expectations that typify the therapeutic context, such as a reduction of anxiety, rather than representing a genuine personality change.

In summary, the results provided some confirmation of the research premise that person-centred psychotherapy would clarify patients' social value systems and behavioural expectations that are embodied in the increased body boundary finiteness. Out of this context, the results of this study indicated that individuals with high body boundaries tend to differ in their semantic expression from patients with lower body boundaries. In this sense, the use of linguistic features may enable therapists to differentiate between patients with high and low body boundaries, and changes in linguistic features may indicate defensive mechanisms that are associated with the hard body shell being dissolved through the psychotherapeutic process.

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Some Afterthoughts – or Looking Back

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The relationship of "psychoanalysis and language" was in the center of many theoretical and clinical discussions ever since Freud (1916/17) had declared:

> Nothing takes place in a psycho-analytic treatment but an interchange of words between the patient and the analyst. The patient talks, tells of his past experiences and presents impressions, complains, confesses his wishes and his emotional impulses. The doctor listens, tries to direct the patient's processes of thought, exhorts, forces his attention in certain directions, gives him explanations and observes the reaction of understanding or rejection which he in this way provokes in him (p. 17)

In contrast to the clear recognition of psychoanalysis as discursive activity - as Lacan (1953) espoused it succinctly - for quite a time the main stream activity on the relation of psychoanalysis and language was focused on Freud's theory of symbols. Language and the development of the ego was a favourite topic in the New York study group on linguistics (Edelheit, 1968). As Freud had developed his own rather idiosyncratic way of understanding symbols, some conceptual work with the different usage of the term symbol had to be done. Victor Rosen in his paper on *"Sign Phenomena and their relationship to unconscious meaning"* (1969) demonstrates that the work of the psychoanalyst can be conceptualized as a process of differentiating conventional symbols from sign phenomena. Understanding meaning by common sense has to be completed by understanding the additional unconscious meaning any concrete piece of verbal material may carry. The technical rule for the analyst of evenly hovering attention is directed to just this process. Listening to his patient's associations the analyst receives the conventional meaning of what he listens to. Suspending his reaction to this level of meaning he then tries to understand potential meanings beyond the everyday meaning. By interpreting the analyst usually uses a perspective that is not immediate in his patient's view.

However, Forrester (1980) expressed, in his introduction of his book *"Language and Origin of Psychoanalysis"*, astonishment that there were only a few treatises on psychoanalysis, which dealt directly with the role of language in the course of treatment

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http://dx.doi.org/10.7565/landp.v5i2.1562

(p. X). Detailed studies concerning "spoken language in the psychoanalytical dialogue" were just beginning to blossom in the eighties of the last century (Kächele, 1983).

Praising the Freudian dictum many a times psychoanalysts - often unintentionally - have been followers of the philosopher Austin (1962), who in his theory of speech acts, proceeds from the observation that things get done with words. In the patterns of verbal action, there are specific paths of action available for interventions to alter social and psychic reality. In psychoanalysis, writes Shapiro (1999), "the prolonged interaction between patient and analyst provides numerous opportunities for redundant expression of what is considered a common small set of ideas in varying vehicles and at various times, designed to get something done or to re-create an old pattern" (p. 111). However, speech, if it is to become effective as a means of action, is dependent on the existence of interpersonal obligations that can be formulated as rules of discourse. These rules of discourse depend partly on the social context of a verbal action (those in a court of law differ from those in a conversation between two friends), and conversely, a given social situation is partly determined by the particular rules of discourse. Expanding this observation psychoanalytically, one can say that the implicit and explicit rules of discourse help to determine not only the manifest social situation, but also the latent reference field, that is transference and countertransference.

If the discourse has been disturbed by misunderstandings or breaches off the rules, metacommunication about the preceding discourse must be possible which is capable of removing the disturbance. For example, one of the participants can insist on adherence to the rule (e.g., "I meant that as a question, but you haven't given me an answer!"). In such metacommunication, the previously implicit rules which have been broken can be made explicit, and sometimes the occasion can be used to define them anew, in which case the social content and, we can add, the field of transference and countertransference can also change.

The compulsion arises from the fact that analyst and patient have entered into a dialogue and are therefore subject to rules of discourse, on which they must be in at least partial (tacit) agreement if they want to be in any position to conduct the dialogue in a meaningful way. It is in the nature of a question that the person asking it wants an answer and views every reaction as such. The patient who is not yet familiar with the analytic situation will expect the conversation with the analyst to follow the rules of everyday communication.

The exchange process between the patient's productions, loosely called "free associations", and the analyst's interventions, loosely called "interpretations", most fittingly may be classified as a special sort of dialogue. The analyst's interventions encompass the whole range of activities to provide a setting and an atmosphere that allows the patient to enter the specific kind of analytic dialogue:

> If any kind of meaningful dialogue is to take place, each partner must be prepared (and must assume that the other is prepared) to recognize the rules of discourse valid for the given social situation and must strive to formulate his contributions accordingly (Thomä & Kächele, 1994b, p. 248)

The special rules of the analytic discourse thus must be well understood by the analysand lest he or she waste the time not getting what he or she wants. Therefore she or he has to understand that the general principle of cooperation is supplemented by a specific additional type of meta-communication on part of the analyst. As we have already pointed out the analyst's interventions have to add a surplus meaning beyond understanding the discourse on the plain everyday level.

How does one add a surplus meaning? Telling a joke is a good case for working with a surplus meaning not manifest in the surface material. Jokes have a special linguistic structure and most often work with a combination of unexpected material elements and special tactic of presentation. Reporting clinical examples from the literature Spence et al. (1994) suggest that the analyst is always scanning the analytic surface in the context of the two-person space, consciously or preconsciously, weighing each utterance against the shifting field of connotations provided by (a) the course of the analysis; (b) his or her own set of associations; and (c) the history of the analysand's productions (p. 45). An experimental way to detect the generation of such ad-on meanings was Meyer's (1988) effort via post-session free associative self-reports to find out "what makes the psychoanalyst tick".

For such questions, which are basic for the psychoanalytic enterprise the development of conversational and discourse analytical methods was crucial moving the pragmatic use of language as speech on empirical grounds. When Sacks et al. (1974) proposed a "simplest systematics for the organization of turn-taking behavior in conversation" it was obvious that such tools would be of high relevance to psychotherapy as an exquisite dialogic enterprise. Although Mahony (1977) gave psychoanalytic treatment a place in the history of discourse, Labov and Fanshel (1977) probably were the first to apply such concepts to empirical investigation of psychotherapy sessions. In Germany the linguist Klann (1977) connected "psychoanalysis and the study of language" no longer focusing on the traditional discussion on symbols but focusing on the pragmatic use of language as therapeutic tool exemplified by role of affective processes in the structure of dialogue (Klann, 1979).

In this arena many things that take place in the relationship between patient and analyst at the unconscious level of feelings and affects cannot be completely referred to by name, distinguished, and consolidated in experiencing (see Bucci, 1995). Intentions that are prelinguistic and that consciousness cannot recognize can only be imprecisely verbalized. Thus in fact much more happens between the patient and analyst than just an exchange of words. Freud's "nothing else" must be understood as a challenge for the patient to reveal

his thoughts and feelings as thoroughly as possible. The analyst is called upon to intervene in the dialogue by making interpretations using mainly linguistic means.
Of course, it makes a big difference if the analyst conducts a dialogue, which always refers to a two-sided relationship, or if he makes interpretations that expose the latent meanings in a patient's quasi-monological free associations. Although it has become customary to emphasize the difference between the therapeutic interview and everyday conversation (Leavy, 1980), we feel compelled to warn against an overly naive differentiation since everyday dialogues often are:

> characterized by only apparent understanding, by only apparent cooperation, by apparent symmetry in the dialogue and in the strategies pursued in the conversation, and that in reality intersubjectivity often remains an assertion that does not necessarily lead to significant changes, to dramatic conflicts, or to a consciousness of a "pseudo-understanding"…In everyday dialogues something is acted out and silently negotiated that in therapeutic dialogues is verbalized in a systematic manner (Klann, 1979, p. 128)

Flader and Wodak-Leodolter (1979) collected these first German studies on processes of therapeutic communication. Some years later these researchers discovered the rich material available at the Ulm Textbank (Flader et al. 1982). This was probably not surprising because the availability of original transcripts for linguists was at the time very limited. Amongst others, the opening phase of Amalia X's treatment, that phase of familiarizing the patient into the analytical dialog and the transition from day to day discourse into the analytical discourse, was examined (Koerfer and Neumann 1982): Towards the end of the second (recorded) session Amalia X complains about the unusual dialogic situation in the following way: 'alas, I find this is quite a different kind of talk as I am used to it'.

This kind of difficulty has been described by Lakoff (1981) succinctly: "The therapeutic situation itself comprises a context, distinct from the context of 'ordinary conversation', and that distinction occasions ambiguity and attendant confusion" (p. 7). In fact we are dealing with a learning situation comparable to learning a foreign language though less demanding:

> If in fact psychotherapeutic discourse were radically different in structure from ordinary conversation, we should expect something quite different: a long period of training for the patient, in which frequent gross errors were made through sheer

> ignorance of the communicative system, in which he had time after time to be carefully coached and corrected (Lakoff, 1981, p. 8)

This perspective supports our maxim of the treatment technique: as much day-to-day dialogue as necessary to correspond to the safety needs of the patient, to allow this learning process and as much analytical dialogue as possible to further the exploration of unconscious meanings in intra and interpersonal dimensions (Thomä & Kächele, 1994b, p. 251 ff).

In the following years, the "linguistic turn", the inclusion of pragma-linguistic tools into the study of the psychoanalytical discourse, gained considerable momentum (Russell 1989, 1993). For example, Harvey Sacks (1992) described "conversational analysis" (CA) that put "coherence" in the center, which also plays a central role in attachment research. Lepper and Mergenthaler (2005) could show in a group therapy setting and in a psychodynamic short therapy (Lepper & Mergenthaler 2007) that the "topic coherence" stands in a close connection with clinically important moments, insights and changes.

Systematic investigations on the special conversational nature of the psychoanalytic technique have become more diversified. The linguist Streeck (1989) illustrates how powerful conversational technique were even in identifying prognostic factors for shared focus formulation in short term therapy related to positive outcome where psychometric instruments failed. The role of metaphor in therapeutic dialogues has developed into a field of its own (Spence, 1987; Buchholz, 2007; Casonato and Kächele, 2007). Intersubjective conceived treatment research enlarges the empirical frame by including dimensions of conversational practice, narrative representation and use of metaphor. Is it too far reached to connect the development of the relational perspective in psychoanalysis with the rise of narrative treatment research focusing on what happens between patient and analyst in great details as Buchholz (2006, p. 307) does?

The mechanism of psychoanalytic interpretation had been the object of an early discourse-analytic case study by Flader and Grodzicki (1982) recently followed by a larger sample studied by Peräkylä (2004). The issue whether discourse in psychoanalysis proper is different from discourse in psychotherapy might be no longer in the center of interest. The more empirical material is studied the less these differences show up. Patients and their analysts display a range of conversational strategies in the diverse therapeutic situations as Streeck (2004) has illustrated.

The contributions of the Berlin study group on conversational analysis have shouldered the unfinished task to detailing what goes on in psychotherapeutic sessions on a level that will certainly enrich our understanding.

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