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Client-identified important events in psychotherapy: Interactional structures and practices

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Abstract

This study describes interactional structures and practices in client identified important events in psychotherapy sessions. Twelve of sixteen events from seven client-therapist dyads were found to contain disagreement. A turn-by-turn investigation using conversation analysis displayed three different ways that therapists used to handle disagreement. The first was to orient to the client's disagreement cues by inviting the client to elaborate his/her point and to establish a shared understanding. The second was to orient to the client's disagreement cues but define the therapist's point of view as more relevant to the project at hand. The third was a single case where the therapist did not orient to the client's disagreement cues. The results suggest that disagreement patterns may be an interesting focus for further exploration, and that in future research it might be useful to include for example client selected sequences from other parts of the therapies, or disagreement sequences that are identified on the basis of structural features.

Keywords: *conversation analysis, psychotherapy process, important events, client's perspective, disagreement*

A large body of empirical evidence has repeatedly and convincingly shown that therapists seem well advised to try to establish, monitor, and maintain a strong and positive relationship with their clients early in therapy (e.g. Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Hersoug, Monsen, Havik, & Høglend, 2001; Horvath, & Bedi, 2002; Martin, Garske, & Davis, 2000). Among other things, this requires a good understanding of what clients find important, helpful, or hindering within sessions.

Several lines of research aim to capture clients' perceptions of what happens in therapy sessions. Alliance researchers generally try to capture clients' (and therapists') perspectives of the alliance with one or more of the numerous alliance measures currently in use. As pointed out by several researchers (e.g. Bachelor, 1995; Bedi, 2006; Mohr & Woodhouse, 2001) most of these measures were based mainly on the conceptual and theoretical frameworks of researchers and clinicians. Consequently, clients' perceptions of the therapeutic relationship (which may or may not be different) may be insufficiently covered by these instruments.

One line of research, consisting of a handful of qualitative studies, has attempted to investigate clients' perceptions of the therapeutic relationship without using theory driven alliance measures. Bachelor (1995), Bedi and colleagues (Bedi, Davis, & Arvay, 2005; Bedi, Davis, & Williams, 2005), Fitzpatrick and colleagues (Fitzpatrick, Janzen, Chamodraka, & Park, (2006), and Mohr & Woodhouse (2001) all present findings that point in the same direction: When clients are asked to identify important aspects of the therapeutic relationship they emphasize variables that do not readily fit into the existing alliance theories, and have not received much attention by alliance researchers (like e.g. therapist friendliness, humor, providing positive commentary or compliments etc). They do not emphasize variables that are central to existing alliance theories (like e.g. mutuality and collaboration), and they don't seem to identify their own active involvement as an important aspect of the alliance but focus instead mainly on what the therapist does and says.

A second line of research focuses on capturing and examining clients' perceptions of significant events in the psychotherapy process, arguing that these events most likely contain the effective ingredients of change (e.g. Elliott, 1984). A wide range of important events have been examined across different treatment modalities, including for example helpful and hindering events (Elliott, 1985; Llewelyn, Elliot, Shapiro, Hardy, & Firth-Cozens, 1988; Wilcox-Matthew, Ottens, & Minor, 1997), helping and hindering processes and experiences (e.g. Lietaer, 1992; Paulson, Everall, & Stuart, 2001), important moments (Martin & Stelmaczek, 1988), empowerment events (e.g. Timulak & Elliot, 2003), problematic reaction points (Watson & Rennie, 1994), and narrative processes (Grafanaki & McLeod, 1999). Data collection procedures differ between studies, and while some researchers use qualitative methods of analysis alone others combine qualitative and quantitative methods. Generally, clients' descriptions of significant events within sessions are collected retrospectively and classified into categories of therapeutic impact, sometimes using one of several taxonomies developed for this purpose, and in some studies with the additional examination of the interaction leading to the impact. To summarize the findings, a number of events and factors that clients perceive as significant have been identified. Several studies seem to describe events that are similar in content but use different labels to categorize them. For example Elliott (1985), Martin & Stelmaczek (1992), and Rennie (1992) all identify events involving reflexive self-understanding and becoming aware of experiences or life-situations. In a qualitative meta-analysis of seven studies on significant events Timulak (2007) concludes that the impacts clients identify as being helpful can be described in nine meta-categories: awareness/insight/self-understanding, reassurance/support/safety, exploring feelings/emotional experiencing, feeling understood, empowerment, relief, and client involvement. Timulak notes that events covered by the first two categories were found in all the included studies and that in fact all categories except experiencing, empowerment, and relief were already described in the first study on significant events by Elliott in 1985.

These studies have extended our knowledge about what clients find important in the psychotherapy process in important ways. However, there are also limitations to this approach. First, clients are not necessarily sources of valid information. What clients tell the researcher may be deliberately or unconsciously limited or otherwise distorted depending on a number of circumstances, and there are subtle ways that clients (as well as interviewers and therapists) can influence the course of conversation (e.g. Elliott & James, 1989; Rennie, 1994). Second, the use of methods where participants are asked retrospectively to report and describe important events can be problematic. Even when tape-assisted recall or similar methods are used, there is seldom a complete correspondence between the remembered and the actual event. Third, identifying psychotherapy events that clients find important may help us capture the effective ingredients of change but in order to better understand what goes on in those moments there is also a need for detailed examinations of the micro-processes of interaction within the events.

Studies focusing on these kinds of interactional processes are scarce within the field of qualitative psychotherapy research. The qualitative method conversation analysis (CA) has been used to study the structure and process of interaction between many different types of professionals and clients, where spoken language is the means for the professional practice (Drew & Heritage, 1992). In the past decades, CA has repeatedly attracted interest as a method of particular potential value to psychotherapy process research (see e.g. Gale, 1991; Madill, Widdicombe, & Barkham, 2001; Forrester & Reason, 2006) and there have been a growing number of CA or CA-inspired studies concerning psychotherapy, counselling, and other related areas. Although these studies differ in whether their point of origin is more in language and interaction (as e.g. Buttny, 2001; Antaki, Barnes, & Leudar, 2005), in psychoanalytic theory (as e.g. Peräkylä, 2004; Vehviläinen, 2003), or in psychotherapy process research (as e.g. Lepper & Mergenthaler, 2005, 2007), they have all added to our knowledge about conversational structures and practices in psychotherapy.

Some of these studies investigate central aspects of the therapeutic relationship but CA as a method has not been used to specifically investigate important events in therapy.

This study takes as its starting point the need to understand more about what goes on in moments in therapy that clients find important. Unlike much previous research, the focus is not on capturing or categorizing clients' perceptions of the therapeutic relationship or of significant events. Neither is it on linking specific events or process conditions to outcome. Instead, the aim is to describe interactional structures and practices in client identified important events. The rationale for this is the assumption that meaning is constantly created, maintained, and reshaped in ongoing conversational interaction. In other words, the participants' subjective understanding of what goes on is manifested in what they say and how they say it. A turn-by-turn study of the therapeutic interaction in events that clients find important will offer an opportunity to explore what takes place between client and therapist and how they make sense of it while it is happening.

Method

Participants

The data were collected as part of a larger research project focusing on how therapists and clients identify, experience and handle important events in the therapeutic relationship.¹ Eight therapist-client dyads participated. The therapists (two men and six women) were all in an advanced three year training program to become chartered psychotherapists, licensed to practice by the Swedish National Board of Health and Welfare. Their ages ranged from 37 to 57. All therapists had several years work experience in various health care professions (e.g. psychologist, social worker), and a minimum of two years' experience doing psychotherapy under supervision. The clients were all self-referred, and presented with a variety of symptoms and problems comparable

to what is typically seen in psychiatric polyclinics, for instance anxiety, depression, and various interpersonal problems. There were one man and seven women with ages ranging from 20 to 57. Clients' mean GAF-score at the beginning of therapy was 58, ranging from 53 to 72, which indicates mild to moderate symptoms. Informed consent was obtained from all participants before the onset of data collection. In the data extracts discussed in this paper, names, sex and other identifying contextual information have been omitted or altered to ensure the anonymity of all concerned. The therapies were short-term psychodynamic therapies, consisting of approximately 15-20 one-hour weekly sessions. All therapists received individual supervision once a week throughout the therapies by trained and experienced supervisors.

Procedure

The eight participating therapist-client dyads were asked to videotape three sessions; one in the beginning, one in the middle and one towards the end of the therapy. The video recordings from the beginning of therapy were all taped at the third session; the recordings from the middle were taped around the tenth session, and the recordings from the end around the fifteenth session.

As soon as possible after each videotaped session, semi-structured interviews were conducted with clients and therapists separately. During the interviews the videotape was used as an aid to recall the session. The client was always interviewed first in each therapist-client dyad. After a brief introduction the client was asked to *"tell [me] about an occasion in this session when something happened in the contact between you and your therapist that you found important"*. The client was asked to locate each such occasion on the videotape and to indicate where it started and ended. The selected episodes were then timed and given verbal cues to enable later identification.

Data

This article deals with the episodes selected by the clients from the sessions videotaped at the beginning of therapy. All eight therapist-client dyads recorded their third session. One of the recordings failed due to technical problems. In the remaining seven recordings the clients identified all in all sixteen episodes as examples of when something important happened in the contact between them and the therapist. Five clients identified two episodes each, and two clients identified three episodes each. All the selected episodes contained conversational turns involving both client and therapist. The average length of the episodes was 2 minutes and 50 seconds, ranging from 1 minute and 10 seconds to 6 minutes and 50 seconds.

The sixteen episodes selected by the clients were transcribed according to a simplified version of Jefferson's system for conversation analysis (Jefferson, 1985; Drew & Heritage, 1992). Transcripts and tapes were used simultaneously in the analytic procedure. The analysis was conducted using the Swedish original, and the final versions of the transcripts were translated into English by the first author. ²

Analytic procedure

Conversation analysis. In this study conversation analysis (CA) was used as a tool in the analysis of the data. It is a qualitative method with its roots in ethnomethodology, and was developed to study the structure and process of naturally occurring talk in interaction (cf. Heritage, 1984; Hutchby & Wooffitt, 1998; Peräkylä, 2003). Methodologically, CA belongs in the interactional tradition of social science research. Empirically it rests on the assumption that meaning is produced in the structures and practices of manifest social interactions. Its main analytic aim is to offer detailed descriptions of the process by which meaning emerges in turn by turn interaction between active subjects.

CA makes some important theoretical assumptions about talk and interaction (Peräkylä, 2003). The first is that *talk is action*. CA argues that all actions, whether everyday actions like greeting a friend, or institutional actions like making a diagnosis, are accomplished through conversational interaction. The second is that all *talk is structurally organized and based on orderly procedures*. These structures can be observed and systematically analyzed through the study of turn-by-turn interactions in naturally occurring talk. The third is that *interaction is context shaped and context-renewing*. Each turn in a conversation is shaped by how the current speaker hears and understands what the prior speaker has said. By producing a relevant next turn, the participants demonstrate their understanding of the previous turn and set a context that will shape the next speaker's talk. Hence, meaning and intersubjective understanding is created and maintained through this ongoing process of displaying understanding and having it openly or tacitly confirmed, repaired or modified by the next participant at any next turn in the conversation.

The CA research process begins with recording and transcribing in detail naturally occurring talk. The data set is then carefully explored in order to identify characteristic recurring interactional structures and practices and a relevant focus for further analysis is selected. All examples of the phenomenon to be studied are collected and a detailed case-by-case, turn-by-turn analysis is then performed with the aim of demonstrating the different paths the interaction can take and how the phenomenon is produced by the participants' actions. All analytic claims must be grounded in the observable data and the results are compared and contrasted to the knowledge base about conversational structures and practices that previous CA research has accumulated over time.

In this study all transcriptions were made by the first author. In accordance with CA research tradition the data exploration was done between the authors as well as in a larger team involving experienced CA-researchers.³ When a relevant focus of analysis had been collaboratively established, the first author performed the preliminary case-by-case, turn-by-turn analyses of the

conversations. The analyses were then discussed with the other authors and successively refined and organised into descriptions of the three different interactional trajectories described below.

Selection of extracts. In the first step of the analysis, the recordings and transcripts of the 16 selected episodes were carefully examined for recurring interactional structures and practices. A recurrent theme that was identified was sequences in which client and therapist disagree. The disagreements spanned over a wide range of topics; from how to formulate or prioritize the tasks and goals of the therapy to how to describe or understand finely nuanced experiences outside the therapy or in the therapeutic relationship. There were also variations in the level of disagreement ranging from minor differences in understanding or experience to more obvious disagreements and impasses.

In the second step of the analytic procedure, all sequences containing clients' expressions of disagreement were collected from the transcripts to allow a detailed micro-analysis. Six of the seven therapist-client pairs had at least one sequence containing client disagreement. Across the data corpus 12 such instances were found.

Results and Discussion

When the 12 sequences containing clients' expressions of disagreement were analysed, three different ways that therapists use to handle disagreement could be discerned:

- I. The first and most common way is when the therapist orients to the client's disagreement cues by inviting the client to elaborate his/her point of view and to establish a shared understanding acceptable to both participants.
- II. The second way is when the therapist orients to the client's disagreement cues but defines his/her own point of view as more relevant than the client's.
- III. The third way is when the therapist does not orient to the client's disagreement cues.

In the following sections each way of handling disagreement will be analysed in more detail.

I. Establishing a shared understanding

The most common way to handle disagreement that was found in the sequences selected by the clients was when the therapist oriented to the client's disagreement cues by inviting the client to elaborate his/her point of view and to establish a shared understanding that was acceptable to both participants. This interactional pattern was present in half of the episodes.

In the following I will examine two sequences where a shared understanding is established in two slightly different ways; in the first extract by co-creating one version that is acceptable for both client and therapist and in the second extract by allowing the co-existence of two different but equally valid versions. The analysis will focus on how reformulations of previous accounts and assessments of previous events are packaged, on how disagreement is expressed and oriented to, and on the role of lexical choice in accomplishing a shared understanding.

Ia) Establishing a shared understanding by co-creation. The first extract shows therapist and client talking about how the client typically reacts in conflicts with his wife. The therapist refers to a previous session and summarizes his version of what was said at that time.

Extract 1

CT6-1 (3) -1 (2)

01 T mm because I'm thinking about it from what
02 you told me a::m: once before that if I
03 understood you right it was if you've had a
04 conflict
05 C mm

06 T and you think you've been trying to take some
07 initiative to aah talk (.2)[about]=

08 C [mm]

09 T = the incident you get some small:: reaction
10 that she's answering you surly as you see it
11 and then you withdraw

12 C mm

13 T And then she takes the initiative (.2)
14 to a talk (.2) maybe a couple of days later

15 C ye::h or it's a:ah [it can it can]=

16 T [did I understand you
17 right]

18 C = it can be that that I (.) try to s
19 or say like often it's kind of when you've
20 lain down (.2) in bed for to sleep

21 T mm

22 C because it's like it's easier when the lights
23 are out sort of [I] don't know

24 T [mm]

25 C then I can say like what's up sort of (.2)
26 and then it comes well you never bring anything
27 up (2.0) and that's:: (.4) so that's e:h

28 T mm but then you think you've tried

29 C ye::h it happens sometimes you know it's not
30 always like that /continues talking/

A speaker's attempt to summarize what has previously been said in a conversation, either by proposing a formulation of the main points of it or by trying to formulate its relevant implications or consequences, is a basic conversational feature known in CA as a *formulation*. In the above extract, the therapist's formulation of what was said in a previous session begins in line 2 and

continues to line 14, intercepted by minimal confirming responses (acknowledgement tokens) from the client in lines 5, 8 and 12. To note here is how the therapist packages the formulation. By starting with "if I understood you right" (lines 2-3), the therapist presents the formulation as his subjective and tentative summary, thereby opening up a possibility that he might have understood something (or everything) wrong and giving the client an opening to present a different version or comment on any perceived misunderstandings.

In CA terms a formulation is constructed as a conversational adjacency pair with a preference for agreement (Heritage & Watson, 1979), meaning that if one speaker formulates something, the other speaker is expected to acknowledge and confirm that formulation. It is important to note that in CA the terms *preferred* and *dispreferred* have nothing to do with the psychological motives of the speaker, but simply refer to how adjacency pair sequences are normatively organized. Whereas preferred actions are generally delivered in a fairly straightforward manner, dispreferred actions are most often marked by features that make them structurally different from preferred actions. Typical markers of disagreement are for instance long pauses, pre-sequences of weak agreement followed by disagreement, hesitation sounds, and restarts (Heritage, 1984). When, in line 15, the client responds to the therapist's formulation that it is usually the client's wife who "takes the initiative to talk" [about conflicts], his utterance contains several of these disagreement markers. He starts with a prolonged "ye:h" that prosodically sounds more like a no. This weak and reluctant initial agreement is then followed by the word "or" that signals the start of an alternative account, a hesitation sound ("a:ah"), and a restart ("it can it can").

In lines 16-17 the therapist picks up the disagreement cues and orients to the client's utterance as a disagreement by asking for clarification ("did I understand you right"). In lines 18-27 the client then tells his version by describing a typical situation in which he thinks he has tried to initiate talking about a conflict. To note here is how the client packages his account more as a slight adjustment of or a complement to the therapist's version than as a correction of something

that has been completely misunderstood. By stressing the word “can” in line 18, saying that “it can be that I try”, the client acknowledges the therapist’s version as being at least partly right before proceeding with his alternative account. The therapist responds with minor acknowledgement tokens in lines 21 and 24, and then makes an attempt at formulating the implication of this new account by saying “but then you think you have tried” in line 28. The client confirms this with a prolonged, affirmative “ye::h” in line 29 but then adds that “it happens sometimes, I mean it’s not always like that” (line 29-30). By stressing that his own account is true sometimes, but not always, the client is acknowledging that there may be other valid accounts, implying that the therapist’s version might in fact also be valid sometimes, if not always. A shared version that is acceptable to both parties has then been established and this being accomplished the client goes on to talk about another topic.

To sum up, in this extract the therapist offers a subjective and tentative formulation of something the client has said in a previous session. The therapist’s choice of words opens up a possibility for the client to comment on any misunderstandings. When the client expresses disagreement, the therapist picks up on the cues and asks for clarification. The client then makes a slight adjustment to the therapist’s version, and the therapist offers a new formulation which this time is acknowledged by the client and thus acceptable to both participants.

Ib) Establishing a shared understanding by allowing two co-existing versions. As will be shown in the second extract, establishing a shared understanding can also be accomplished by allowing the therapist’s and the client’s versions to exist simultaneously as two different but equally valid ways of understanding. The extract starts with the therapist giving her version of what happened between her and the client during the last session.

Extract 2:

CT4-1 (3) -1 (3)

01 T and in one way I can think that what
02 happened between us last time
03 C mhm
04 T was a lot about boundaries a:nd
05 (.3) [sorting up] a:nd ehh
06 C [yeah yeah maybe] but on the other hand
07 I shouldn't have to have any boundaries when
08 I'm here so that's sort of
09 (2.0)
10 C should I?
11 T mm [how do you think]if you're thinking you:=
12 C [because]
13 T =shouldn't have to have any boundaries
14 C well it's b it's not what I'm here for
15 to mark things but it'shehe tohehe sorthoho
16 hohoof hehehe [hehe]
17 T [hehe]
18 C hemhm so it's: [it's] a bit double=
19 T [mhm]
20 C =maybehehehe (.3)
21 T mhm
22 C on my part
23 T mm=
24 C =and that's sort of not what I meant
25 T but it can be both (.2) I'm thinking
26 that if if this is what is important
27 to you (1.0) to (.6) sort of try
28 a::nd [e:hzz]
29 C [mm]
30 T I mean you should get to try me out as well

In the above extract, therapist and client are talking about what went on between them in the last session. The therapist says that what happened last time “was a lot about boundaries and sorting up” (lines 4-5). Making assessments of social activities that the speakers have participated in is a common feature of everyday conversation. Pomeranz (1984) has demonstrated how such assessments are produced as products of participation. With the *assessment* the speaker claims knowledge of that which is being assessed. Pomerantz (1984) describes assessments as *turn constructional units* (TCU:s) which contain a referent and an overt assessment turn. When a recipient of a prior assessment makes an assessment referring to the same referents as in the prior, this is called a *second assessment*. Assessments may be less common in institutional conversations than in everyday social interactions, but at least in psychodynamic psychotherapy (as is the case here) it is probably not uncommon that client and therapist talk about and assess various aspects of the therapeutic interaction. As with formulations, the preferred response to an assessment is generally agreement. Disagreements on the other hand are generally dispreferred and produced with various disagreement markers.

In lines 1-5 the therapist makes an assessment of the therapeutic interaction in the previous session by saying that “in one way I can think that what happened between us last time was a lot about boundaries and sorting up”. To note here is how the therapist, just like the therapist in extract 1, packages the assessment as subjective and tentative. The phrase “in one way I can think” (line 1) opens up both a possibility that others might make different but valid assessments of the same situation, and that the therapist might be able to think about what happened in more than one way. In lines 6-8, the client interrupts the therapist’s assessment. The initial rather weak agreement (“yeah yeah maybe”) is a disagreement marker that is followed by the client’s disagreeing second assessment; “but on the other hand I shouldn’t have to have any boundaries when I’m here”. The client’s use of the phrase “on the other hand” (line 6) links her utterance to the therapist’s initial

expression “in one way” (line 1) and demonstrates that the client is orienting to the ongoing conversation as a discussion where different ways of understanding a shared experience are being put forward.

The client’s assessment that she “shouldn’t have to have any boundaries” is followed by a 2 second pause in line 9, leaving room for the next turn agreement or disagreement that is usually expected to follow an assessment. When no response is immediately forthcoming, the client makes an issue out of the absence by asking “or” in line 10, thereby clarifying that an answer is expected. The therapist responds with a noncommittal “mm” (line 11), which is neither agreement nor disagreement. The therapist is then orienting to the disagreement cues by inviting the client to elaborate on the thought that she “shouldn’t have to have any boundaries” (lines 11 and 13) in therapy.

In lines 14-24 the client starts explaining why she “shouldn’t have to have any boundaries”. Although nothing particularly laughable is going on, the client’s speech is intercepted by laughter and in line 17 the therapist briefly joins in. CA work on medical interactions (Haakana, 2001) and multiparty assessment talk at Swedish youth detention homes (Osvaldsson, 2004) has demonstrated that laughter can be used to establish the participants’ orientation to the situation or activity as delicate or tense, the laughter simultaneously demonstrating their awareness of the problem, and serving as a potential remedy. The client’s laughter in lines 14-20, and the client’s and therapist’s mutual laughter in lines 16-17 suggest that both participants are orienting to the situation as somewhat uncomfortable, trying to handle the tension by laughing.

In the following, therapist and client jointly set about re-establishing a shared understanding. In line 18, the client says that what she was doing last session might unintentionally have been “a bit double” on her part, which shows that the client may now be seeing the therapist’s assessment of last session as at least partly valid. To this the therapist responds that “it can be both” (line 25), acknowledging that there may be more than one valid way to understand what happened. Client

and therapist thereby find a way to include both participants' experiences as simultaneously valid, allowing for a shared understanding of the situation.

To summarize, in this extract the therapist offers a subjective and tentative assessment of what happened during the previous session. As in the previous extract, the therapist's choice of words opens up a possibility for the client to comment on it. The therapist orients to the client's disagreement cues by asking her to elaborate her point of view. Mutual laughter displays that both participants are aware of and trying to handle the potentially tense situation. Therapist and client then establish a shared understanding by including each participant's version as valid.

II. Verbalizing different opinions

The second way to handle disagreement that was found in the sequences selected by the clients was when the therapist oriented to the client's disagreement cues but defined his or her own point of view as more relevant than the client's.

In the following I will examine two sequences where this is done in two different ways. The theme in the two extracts is similar; client and therapist disagree on what they need to do in order for the therapy to be effective. In the first extract the disagreement is verbalized and the participants' differing opinions are compared and talked about. In the second extract the disagreement is also verbalized but the client's point of view is not validated or compared to the therapist's. The analysis will focus on how disagreement is expressed and oriented to, and on the role of lexical choice in verbalizing differing opinions.

IIa) Verbalizing different opinions by inviting the client's version. In the following extract client and therapist are talking about how to proceed. Previous activities in the session have stirred up strong feelings in the client, who is visibly emotionally affected. The therapist tries to explore these feelings by asking about them but the client says that he wants to talk about something else.

Therapist and client discuss whether the client should try to stay in touch with the feelings he's experiencing and talk about them, or if he should "put the lid on" and avoid them.

Extract 3

CT2-1(3)-2(3)

01 T you said you said like this I'm trying to
02 think about something else
03 (4.0)
04 C ye:ah like I (2.0) have to talk about
05 something elsehh (.5) instead of this
06 T because?
07 C A:ah (5.0) to leave this becaus::e
08 (4.5) well to get away from it or to put
09 the lid on or yeah
10 T yes (.3) so here we are sort of in [ahh]=
11 C [hhhh]
12 T =[evenhh though you're laughhinghh ehehe hehe
13 hehehe what were you thinking]
14 C [hhhhhhhh] a new clash [hehe]
15 T [hehe] yeah or a choic:e
16 I think a choice that that that that now you're
17 standing >it's like standing at a crossroads
18 like this< because you are saying that here I'd
19 like to talk about something else and put the
20 lid onhh aha [a new]=
21 C [ye:ah]
22 T = clash you say or choosing to stay and feel
23 whatever it is that you're feeling right
24 now

25 C it feels like a waste of ti time just to
26 to
27 T to feel?
28 C yeah
29 T okay [hehehhh]
30 C [hhhhhhh]
31 T yes
32 C like it's like it's not so important like you
33 have to: keep on talking
34 T °okay°
35 (3.0)
36 T °then I think we have slightly (2.0) different
37 pictures of maybe what (.2) could be important°
38 (4.5)
39 T because in me when it happens when you're moved it [it]=
40 C [mm]
41 T feels really important (2.0) /continues talking/

The above extract starts with the client saying tentatively and with long pauses that it is as if he has to “talk about something else instead of this” (lines 4-5), to “get away from it or to put the lid on” (lines 8-9). The therapist, in line 10, starts to summarize the situation by saying “so here we are standing before...”, but before the therapist has verbalized her idea of what is going on the client interrupts her, starting to laugh. The therapist joins in the laughter, leaving her sentence unfinished. As in extract 2 there is nothing particularly laughable going on. Their differing opinions have not yet been put into words but the mutual laughter indicates that both participants are orienting to the situation as tense and as a potential disagreement.

In line 13, the therapist asks the client what he was thinking. The client completes the therapist's previously unfinished sentence by answering “a new clash” (line 14), and then they both

laugh again. The therapist acknowledges the client's assessment of the situation with a "yeah" in line 15, but then immediately adds the second assessment "or a choice I think" (lines 15-16). To note here is how the therapist, just like the therapists in the previous extracts, packages her assessment as subjective. Adding "I think" to her assessment in line 16 lexically matches it to the question "what were you thinking", in line 13, which leads up to the client's assessment. This both underscores the subjective qualities of their respective experiences and verbally links the two differing points of view.

Unlike in extracts 1 and 2 though, there is no attempt at establishing a shared understanding here. Instead, the therapist points out their differing accounts by putting the client's formulation next to her own: "A new clash you say or choosing to stay and feel whatever it is that you're feeling right now" (lines 22-23). The client resists the invitation to talk about her feelings and instead disagrees, saying that "it feels like a waste of ti time just to to [feel]" (lines 25-26). Apart from the content we can see that the sentence is also structurally marked as a disagreement by the two restarts (ti time, to to) and the hesitation that leaves the sentence unfinished. The therapist then finishes the sentence for the client in line 27 ("to feel?"), the client confirms that the therapist got it right in line 28 ("yeah"), and in line 29 the therapist acknowledges that she has heard what the client has said ("okay"). Client and therapist then start laughing together (lines 29-30) which suggests that they are still orienting to the situation as tense.

In lines 32-33, the client continues to elaborate his disagreement, saying "like it's like it's not so important [to feel]", and that instead he has to "keep on talking". Just like in lines 25-26, the verbal content and the restart (like it's like it's") marks it as a disagreement. The therapist responds with a noncommittal "okay", in line 34, said in a low, soft voice, followed by a 3 second pause leaving room for the client to continue arguing his case in the next turn, which he doesn't. The therapist then goes on to verbalize the disagreement by formulating her understanding of their differing points of view in lines 36-37: "then I think we have slightly different pictures of maybe

what could be important”. Again it is interesting to note how the formulation is packaged. By saying “I think”, the therapist presents the formulation as her subjective summary. At the same time the choice of verb implies a less than 100% certainty of being right. The low, soft tone of voice and the choice of words further tone down the disagreement and add a tentative quality to the formulation: They have “*slightly* different pictures” (not *completely* different), of “*maybe* what *could* be important” (not what is *definitely* important). Describing the disagreement as “having slightly different pictures” also acknowledges the possibility of their differing subjective experiences being equally valid, since two pictures representing the same reality may be quite different without one being more true or right than the other.

The therapist’s formulation of the disagreement in terms of “having slightly different pictures” is followed by another long pause (line 38) where the client withholds his response. When the client does not take his turn to agree or disagree, the therapist goes on to elaborate her point of view, saying that “In me when it happens when you are moved it it feels really important” (line 39-41). To note here is how, despite the equalizing and subjective wording and the toning down of the disagreement, both participants are orienting to their institutional roles as client and therapist. When the therapist refers to what he is feeling as really important”, he is not simply being subjective, but is also orienting to his role as an expert with a trained therapist’s knowledge of what is important to do in order to accomplish therapeutic progress. Previous CA studies have demonstrated how clients talking to officials who mobilize an expert role in the conversation can comply with this by withholding a response or withdrawing cooperation (cf. Heritage & Sefi, 1992; Madill et al., 2001). Here the client is withholding responses, creating long pauses both in lines 38 and 45.

To sum up, in this extract the therapist picks up on the client’s disagreement cues in the forms of laughter, restarts, and hesitations and verbalizes the disagreement in words that underline the subjective quality of their respective viewpoints, validates the client’s point of view (at least

partly), and tones down the disagreement. But instead of negotiating a compromise that is acceptable to both participants, as in extract 1 and 2, the therapist stresses his own point of view as important, thereby mobilizing an expert identity within the context of subjectivity. The client, on the other hand complies with this role by withholding responses.

Iib) Verbalizing different opinions by promoting the therapist's version. As will be shown in the next example different opinions can also be verbalized and the therapist can mobilize an expert identity without validating the client's point of view. The theme is very similar to that in extract 3 above. Therapist and client are talking about last session, in which the client became sad and cried. They have different opinions on whether crying in session is helpful or not.

Extract 4

CT3-1 (3) -1 (3)

- 01 T mm you get stressed because time is running
02 C yes and because I can't talk when I get
03 stressed and so then (2.2)e:ehh. yeah well
04 it's like time is running and I'm just:
05 sitting here crying and then I'd rather try
06 to say things I mean tell things
07 T yes
08 C A:ahh and I can't if I'm sad because it
09 mm (.2) we:ll (.2) it gets difficult to talk
10 (2.0)
11 T well here I have to say that here I don't
12 agree with you because I believe part of part
13 of what is healing I believe is to experience
14 a feeling together
15 C mm

16 T and find out what it's like (.2) to just
17 experience the feeling together with me
18 C mm
19 T what's it like being in this (.4) whatever it
20 it is sadness
21 C mm
22 T what's it like showing it what's it like her
23 seeing eeh and so on (1.0) eeh as I see it
24 I think it's well used time
25 C mhm mm okay
26 (6.0)
27 T do you agree or you don't quite agree do
28 you
29 C A:ah (2.0) i::t's kind of new to mehh
30 buthh [I've] been so focused on=
31 T [Mm]
32 C =telling all the details so I'll
33 T mm
34 C be able to tell as much as possible bu:t
35 I mean of course ye:ah it seems kind of
36 smart
37 T [Yes]
38 C [If that's] what you're supposed to learn
39 that you're to: you're to handle your feelings
40 it seems smart to practice doing that [hehh]
41 T [.hhh]
42 yeah but do we agree on what we should do
43 because I was thinking that that this
44 that this is: I was thinking we talked a bit
45 about that last time
46 C mm hhh.

47 T this about (.2) what shall we say what what
48 should be the focus (.5) e:h and I'm
49 thinking that it's important that we're that
50 we're sort of agree about the focus
51 C mm I don't know I don't feel that I have
52 an opinion (.5) you're trained in this I'm
53 sure whatever you think will be fine
54 T ↑ye:ah
55 C that's (.2) more or less how I feel
56 (1.5)
57 T mm::
58 (2.5)
59 C I just want to feel better
60 T mm
61 (1.2)
62 C and then exactly how I learn or how I start
63 feeling better it doesn't really matter
64 to me (.2) but maybe you think that matters

The above extract starts with the client saying that “I can’t talk when I get stressed” (lines 2-3) and “it’s like time is running and I’m just sitting here crying and then I’d rather try to say things, I mean tell things” (lines 4-6) and “I can’t if I’m sad because it gets difficult to talk” (lines 8-9). The therapist, in line 11-12, answers that she doesn’t agree with the client “because I believe part of what is healing /.../ is to experience a feeling together” (line 12-14). She goes on to elaborate that this also includes to “find out what it’s like to experience the feeling together with me” (lines 16-17), to find out “what it’s like being in this whatever it is sadness” (lines 19-20), and “what’s it like showing it, what’s it like her seeing it” (lines 22-23). This is intercepted by minimal responses from the client in lines 15, 18, and 21. To note here is how the therapist packages her assessment. The disagreement is clearly and straightforwardly verbalized, there is nothing tentative about it,

there is no attempt to tone down the disagreement, and there is no attempt to validate the client's point of view or to allow their differing assessments of the situation to coexist. Instead the therapist clearly states that as she sees it experiencing a feeling together is an important task in therapy. She also states that this includes finding out what it is like for the client to experience the feelings together with the therapist, to show her feelings to the therapist and have her see them. Here the therapist is both orienting to the activity at hand as psychotherapy, and making visible their different roles as therapist and client. When she ends her turn in lines 23-24 by saying that "as I see it I think it's well used time", she is not only restating their disagreement but also mobilizing and expert identity as the one who knows what needs to be done in order to achieve therapeutic progress.

The client's response to this is a rather noncommittal "mhm mm okay" (line 25), followed by a withheld response, resulting in a long pause (line 26). In lines 27-28, the therapist picks up these disagreement cues and orients to them as a disagreement by first asking and then stating: "Do you agree or you don't quite agree, do you". In the following lines, the client responds by saying that "it's kind of new to me" (line 29), but "if that's what you're supposed to learn, that you're to you're to handle your feelings it seems smart to practice doing that" (lines 38-40). To note here is that with regard to verbal content, the client's response may seem like an agreement but it contains several disagreement markers. The client starts with a hesitation (A:ah) and a pause in line 29, there are two more hesitations in line 34 (bu:t) and line 35 (ye:ah), and there is a restart in line 39 (you're to you're to). Once again, the therapist picks up the disagreement cues and asks: "but do we agree on what we should do?" (line 42). She refers to them talking "a bit about this last time" (line 44-45) and then states that it's important that they "agree about the focus" (line 50), thereby again evoking her role as the expert, who knows what is important to do. The client responds by withholding cooperation and by openly referring to the therapist's role as expert, saying that "I don't know if I have an opinion" (lines 51-52), and "you're trained in this, I'm sure whatever you

think will be fine” (lines 52-53). The therapist gives minimal responses to this in lines 54, 57, and 60 and when she doesn’t take her turn to respond to the client’s assessment, the client continues to elaborate her point. The extract ends with the client orienting to the therapist’s status as expert by challenging her, saying that “exactly how I learn or how I start feeling better it doesn’t really matter to me, but maybe you think that matters” (lines 63-64).

To sum up, in this extract the therapist verbalizes the disagreement straightforwardly. There is no attempt at validating the client’s point of view, but instead the therapist mobilizes an expert identity by orienting to the activity at hand as psychotherapy, by drawing attention to their respective roles as therapist and client, and by stating what tasks she considers important in order to achieve therapeutic progress. As in the previous extract, the client is complying with the therapist’s expert identity by withholding responses and withdrawing cooperation, but here the client also openly challenges the therapist’s position as the expert who is “trained in this” and knows what matters.

III. Not orienting to the client’s disagreement cues

A third way of handling disagreement was found in one single case where the therapist did not in any way orient to the client’s disagreement cues.

In extract 5 therapist and client are talking about the client’s ex boyfriend, with whom she has had a problematic relationship.

Extract 5

CT7-1 (3) -1 (2)

01 C I think I’ve taken the first step now
02 T mm
03 (1.4)
04 C sort of realized

05 T mm

06 C that it's not working [*hrm*]((clears throat))

07 T [hm]

08 C and even if I can think that it's cowardly

09 to kind of withdraw like that I've gotten

10 an unlisted phone number (2.0) so he can't

11 call me now

12 T I think that's wise

13 C ye:ah

14 T °that's what I think°

15 C you do

16 T ye:ah

17 C [it was an i it was an i] it was impulse thing

18 T [I mean it's not]

19 T hh. yeah

20 C when I found out he was seeing someone else

21 T hh. yeah yeah I think that's wise

22 C hh. Yeah it was it was then I felt really

23 attacked

24 T hh.yeah

25 C in some way I had to defend myself

26 T .hhyeah

27 (2.5)

28 T yeah I think that's really wise I mean i i

29 it's just like you're saying Tina you you don't

30 know how to move on but you at the same time

31 you have started to [move on kinda]

32 C [yeah yeah]

The above extract starts with the client making an assessment of her actions. She says that she has “taken the first step now” (line 1) towards breaking away from her ex boyfriend. Even though she “can think that it’s cowardly to kind of withdraw like that” (lines 8-9) she has arranged for an unlisted phone number so that he can no longer call her. The therapist responds to the client’s account with minimal acknowledgement tokens in lines 2, 5, and 7, and then delivers a second assessment of the clients actions by saying that “I think that’s wise” (line 12). We thus have the client’s assessment that getting an unlisted phone number was “cowardly”, and the therapist’s assessment that it was “wise”.

In institutional conversations between professionals and clients, the professional is normally the expert who is expected to know more than the client about the problem and how to handle it. In previous CA research on conversations between British doctors and primary care patients Heath (1992) showed that when doctors deliver diagnoses or assessments, most patients respond only minimally or remain silent. One of few occasions when patients gave extended responses was when the doctor’s point of view differed from the patient’s expectations. This is very different from everyday non-institutional conversations in which participants frequently react to the information they are receiving, for example by actively assessing or evaluating it, or by marking it out as important or interesting. Heath (1992) showed that open disagreement with the doctor seldom occurred. Instead patients tried to encourage the doctor to reconsider the assessment through indirect and cautious utterances like for example descriptions of the subjective side of the illness. In two studies of conversations between Finish primary care doctors and patients Peräkylä (1998, 2002) has extended this line of research and demonstrated how doctors and patients interact to maintain a balance between authority and accountability in the delivery of diagnoses and assessments, and how patients’ extended responses to the doctors’ statements are examples of how the patient’s agency counterbalances the doctor’s authority as an expert.

In the sequence at hand, the client acknowledges the therapist's assessment that "it was wise" [to get an unlisted phone number] with a neutral *ye:ah* (line 13), but the utterance is prolonged and is phonetically perceived as slightly hesitant, thus indicating a possible disagreement. In line 14, the therapist restates that "that's what I think". The *sotto voce* repetition of her assessment may be an attempt to close the sequence or a sign of the therapist picking up on the client's disagreement. It is noticeable though that there is no verbalization of the disagreement, no invitation to the client to elaborate her point of view, and no attempt at mobilizing an expert identity by connecting the assessment to the therapeutic project.

In the following turns we can see how the client is actively creating opportunities for the therapist to reconsider her assessment. In line 15, the client checks to see if the therapist is really going to stand by her opinion by asking "you do", which the therapist confirms with a "yeah" in line 16. This is followed by turns where the client adds the information that getting an unlisted number was "an impulse thing" (line 17) "when I found out he was seeing someone else" (line 20). She further adds that "I felt really attacked" (lines 22-23) and "I had to defend myself" (line 25). To note here is the restarts in line 17 ("it was an i it was an i it was impulse thing"), marking the client's utterance as a possible disagreement. We can also note that the therapist does not topicalize or otherwise pick up the client's added information or the disagreement cues. Instead the therapist responds with neutral acknowledgement tokens and repetitions of her original assessment in lines 19 ("hh. yeah"), 21 (hh. yeah yeah I think that's wise"), 24 ("hh. yeah") and 26 (".hh yeah"). The acknowledgement in line 26 is followed by a pause. When the client doesn't take her turn to add more information, the therapist again states her original assessment, this time upgrading it a bit, saying "that's really wise".

In short, throughout this whole extract the therapist doesn't orient to the client's disagreement cues in any way, either by verbalizing the disagreement, inviting the client to elaborate her point, or by linking her assessment to the therapeutic project and her status as expert. The client, on the

other hand, is actively counterbalancing the therapist's expert authority by providing new information that might make the therapist change her mind.

Conclusions

This study focused on sequences from the third session in psychotherapies in which clients had identified that something important happened in the therapeutic relationship. It was found that several of these sequences contained disagreement between client and therapist. A detailed turn-by-turn analysis in line with CA-method displayed three different ways that therapists used to handle disagreements. The first way was when the therapist oriented to the client's disagreement cues by inviting the client to elaborate his/her point of view and tried to establish a shared understanding acceptable to both participants. The second way was when the therapist oriented to the client's disagreement cues but defined his/her own point of view as more relevant than the client's by mobilizing an identity as expert that both participants oriented to. The third way was a single case where the therapist did not in any way orient to the client's disagreement cues.

A detailed analysis of the interaction in these sequences yielded descriptions of how clients and therapists interact to display and handle disagreement in the therapy situation. The analysis showed that clients' disagreements were not mainly displayed in direct verbal content. Instead disagreements were displayed through structurally specific and clearly distinguishable features such as pauses, delayed responses or failures to take an assigned turn in the conversation, hesitations, restarts, an initial weak agreement followed by disagreement, or cautious attempts at adding information that might change the therapist's point of view. It was demonstrated how laughter, both unilateral and mutual, was sometimes used as a way of marking participants' awareness of a tense or awkward situation, for instance in the build-up of a potential disagreement, and as a way of handling the tension. It was also discussed how therapists' orientation or non-orientation to clients' disagreement cues, and therapists' lexical choice and way of packaging their

utterances contributed to achieving a sense of shared understanding and toning down differing points of view or to accentuating disagreement.

A central feature of the present study is its starting point in sequences that clients have identified as important. In CA research, the data set is normally searched until every example of the phenomenon to be studied is found, including deviant cases. As discussed by for example Lepper & Mergenthaler (2007) this points to one of the main problems when CA is applied to psychotherapy process research. Since CA has nothing to say about clinical relevance and a CA analysis is far too detailed to be used on the entire set of data, the major challenge lies in finding reliable criteria that will help identify clinically relevant sequences for analysis. The client driven data selection used in this study may have increased the risk of missing deviant cases or additional interactional patterns that may be present in other parts of the data. Still, it is well in line with prior research on significant events and on the therapeutic relationship showing that clients' perceptions of the therapy process are valuable indicators of outcome, which increases the chance that the material selected for analysis in this study is indeed clinically relevant. The results of the analysis suggests that disagreement patterns may be an interesting focus for further exploration, and that it might be useful to extend the analysis, including for example client selected sequences from other parts of the therapies, or disagreement sequences in the data that are identified on the basis of structural features.

A main result of this study was that a majority of the sequences in which clients identified that something important happened in the therapeutic relationship contained disagreement between client and therapist. This is quite different from what has been described in research investigating clients' perceptions of important events within therapy or clients' perceptions of the therapeutic relationship, which have mainly emphasized positive therapist behaviours like friendliness, and providing support or affirmation. It is important to recognize though, that the focus of the present study is different from these studies. Just because an interaction is *structurally organized* as a

disagreement it is not necessarily *experienced* as such. The main focus of a CA study is always on the structure and process of interaction. Whether the participating clients experienced these interactions as disagreements, whether it was the disagreements that made the clients find these sequences important, and whether the clients found these sequences important in a positive or a negative way was outside the scope of this study but raise important questions for further research.

Based on the reflections above, a natural next step in this project would be to look at how the clients describe their experiences in each of the selected sequences to see if specific interactional patterns in expressing and handling disagreement are associated with specific types of events, or with positive or negative experiences of the therapeutic relationship. A second path for further research would be to investigate whether specific interactional patterns are associated with good or bad outcome, and a third path would be to use existing alliance measurements to identify instances of high and low quality alliance, using the CA method to see if disagreement is a central feature of the interactional micro processes at such instances, and if specific ways of handling disagreement are associated with alliance quality and/or therapy outcome.

This study is too small for any generalizations to be made outside the data set, and there are (most likely) other ways that therapists use to handle disagreement in therapy interactions than the three presented here, so what is there really to learn from these results? CA is a slow and labour intensive method, but one of its strengths lies in the patient accumulation of knowledge over time by constantly comparing and contrasting new findings and adding it to the existing base of CA knowledge on different kinds of interactions. Hopefully this study can be a first step towards describing conversational features that may help sensitize therapists to the kind of interactions that clients find important, to the strategies clients may use to display disagreement or discomfort in the therapeutic interaction, and to the strategies therapists use to successfully handle these situations.

Notes

1. Data from other parts of the project will be reported in forthcoming articles.
2. The original transcripts in Swedish are available from the first author on request.
3. The authors wish to thank all members of the Discourse Group and the SIS-group at the Department of Child Studies, Linköping University for valuable comments and help during the various stages of data analysis.

Appendix 1: Transcription symbols*

Symbol	Meaning
C	The client (speaker designation)
T	The therapist (speaker designation)
[Starting point of overlapping talk
]	Endpoint of overlapping talk
(2.4)	Silence measured in seconds
(.)	Silence lasting less than 0.2 seconds
word	Emphasis
wo:rd	Prolongation of sound
wo(h)rd	Laugh particle inserted within a word
hehe/ haha/ hhh etc.	Laughter
.hhh	Inhalation
hhh.	Exhalation
?	Raising intonation at the end of an utterance
°	Enclose talk that is noticeably more quiet
><	Enclose talk that is noticeably speeded up
((word))	Transcriber's comments

* Simplified from Jefferson (1985) and Drew & Heritage (1992).

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