Emotional Experience in

Psychotherapeutic Interacion

Conversation Analytical Study on Cognitive Psychotherapy

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ACADEMIC DISSERTATION

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ORIGINAL ARTICLES

Abstract

The dissertation examines how emotional experiences are oriented to in the details of psychotherapeutic interaction. The data (57 audio recorded sessions) come from one therapist-patient dyad in cognitive psychotherapy. Conversation analysis is used as method. The dissertation consists of 4 original articles and a summary.

The analyses explicate the therapist's practices of responding to the patient's affective expressions. Different types of affiliating responses are identified. It is shown that the affiliating responses are combined with, or build grounds for, more interpretive and challenging actions. The study also includes a case study of a session with strong misalignment between the therapist's and patient's orientations, showing how this misalignment is managed by the therapist. Moreover, through a longitudinal analysis of the transformation of a sequence type, the study suggests that therapeutic change processes can be located to sequential relations of actions.

The practices found in this study are compared to earlier research on everyday talk and on medical encounters. It is suggested that in psychotherapeutic interaction, the generic norms of interaction considering affiliation and epistemic access, are modified for the purposes of therapeutic work. The study also shows that the practices of responding to emotional experience in psychotherapy can deviate from the everyday practices of affiliation.

The results of the study are also discussed in terms of concepts arising from clinical theory. These include empathy, validation of emotion, therapeutic alliance, interpretation, challenging beliefs, and therapeutic change. The therapist's approach described in this study involves practical integration of different clinical theories. In general terms, the study suggests that in the details of interaction, psychotherapy recurrently performs a dual task of empathy and challenging in relation to the patient's ways of describing their experiences.

Methodologically, the study discusses the problem of identifying actions in conversation analysis of psychotherapy and emotional interaction, and the possibility to apply conversation analysis in the study of therapeutic change.

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List of original articles

I Voutilainen, L., Peräkylä, A., & Ruusuvuori, J. (2010) Recognition and Interpretation: Responding to Emotional Experience in Psychotherapy. *Research on Language and Social Interaction, 43*, 85-107.

II Voutilainen, L., Peräkylä, A., & Ruusuvuori, J. (forthcoming). Misalignment as a therapeutic resource. *Qualitative Research in Psychology*.

III Voutilainen, L., Peräkylä, A., & Ruusuvuori, J. (forthcoming). Professional non-neutrality: criticising the third party in psychotherapy. *Sociology of Health & Illness*.

IV Voutilainen, L., Peräkylä, A., & Ruusuvuori, J. (submitted). Therapeutic change in interaction: Conversation analysis of a transforming sequence. Submitted to *Psychotherapy Research* (second, revised version).

Transcription symbols

T:	Speaker identification: therapist (T), patient (P)
[ ]	Brackets: onset and offset of overlapping talk
=	Equals sign: no gap between two utterances
(0.0)	Timed pause: silence measured in seconds and tenths of seconds
(.)	A pause of less than 0.2 second
.	Period: falling or terminal intonation
,	Comma: level intonation
?	Question mark: rising intonation
↑	Rise in pitch
↓	Fall in pitch
-	A dash at the end of a word: an abrupt cutoff
<	The talk immediately following is 'jump started': that is it begins with a rush.
> <	Faster-paced talk than the surrounding talk
< >	Slower-paced talk than the surrounding talk
____	Underlining: some form of stress, audible in pitch or amplitude
:	Colon(s): prolongation of the immediately preceding sound
° °	Degree signs surrounding a passage of talk: talk at a lower volume than the surrounding talk
.hh	A row of hs preceded by a dot: an inbreath
hh	A row of hs without a dot: an outbreath
##	Number signs surrounding a passage of talk: spoken in a 'creaky' voice (vocal fry)
£	Smiley voice
@	Animated voice

1. Introduction

1.1. Object of the study

Psychotherapy is done through talk: talking – more specifically, interaction between the therapist and the patient – is supposed to facilitate a change in the patient. While therapeutic change is understood in different ways in different forms of psychotherapy, it is in probably all of them considered as connected to emotional experiencing: to feeling better, to understanding and appreciating one's emotions, to experiencing emotions as less overwhelming, for example. The means (content and form of talk and ways of interacting) through which therapies aim to these kinds of changes again differ but in many therapies emotional experiences are also a central topic of talk in the actual therapeutic work.

This study discusses these aspects of psychotherapy – talk, emotional experiences and change – through analyses of audio recordings from cognitive-constructivist psychotherapy. More specifically, the study approaches emotional experiences and therapeutic change *as they appear in therapeutic talk-in-interaction*. The study is sociological in nature and its conceptual basis is in the research tradition of institutional interaction; using the methods of conversation analysis (CA), the study describes how psychotherapy emerges as sequentially organized social action. The data analyses presented in this thesis thus do not draw from the concepts of cognitive-constructivist therapy, nor psychotherapy or psychology in general. As an introduction to the subject, however, I would like to start from the aims of the therapeutic orientation in question.

1.2. Cognitive-constructivist psychotherapy

Cognitive-constructivist therapy is an approach in the field of cognitive therapies. The basic idea of classical cognitive therapy – founded by Aaron T. Beck in 1960's originally for treatment of depression (Beck et al., 1979) – is to examine and change dysfunctional cognitions, and the dysfunctional beliefs (such as *I am responsible for everything* or *Others cannot be trusted*) that the (automatic) cognitions reflect (Karila & Holmberg, 2008). According to Beck (1976), changes in patient's cognitions lead to positive changes in his or her emotional experiencing. As compared to other forms of psychotherapy, cognitive therapy introduces itself as more focused on the present, more time-limited and more oriented towards problem-solving (www.beckinstitute.org). Besides classical Beckian therapy, these ideas are applied also in different kinds of cognitive-behavioural therapies (CBT) (see e.g. www.eabct.com).

Cognitive-constructivist therapy is an offshoot of classical Beckian cognitive therapy. It has been characterized as a post-rationalist cognitive therapy (Guidano, 1991). Compared to Beckian cognitive therapy or CBT, constructivist framework focuses more on subjective experiences and meanings and their historical construction. The 'constructivist' is not taken as social constructivism/ constructionism, but as referring to construction of personal meanings, meaning organisations and the self (Toskala & Hartikainen, 2005; Guidano, 1991). This kind of psychotherapy helps the patient to gain a reflexive (instead of reactive) position towards his or her experiences, in other words, to recognise and regulate his or her internal processes (Toskala & Hartikainen, 2005: 111). A basic idea in therapeutic work is to investigate the patient's internal dialogue between immediate experiences on one hand, and explanations of the experiences on the other (Toskala & Hartikainen, 2005; Guidano, 1991).

In the Finnish context from which the data of this study come, cognitive-constructivist (*kognitiivis-konstruktiivinen*) therapy is mainly practiced under the broad name of cognitive therapy (see Hakanen, 2008). Cognitive therapists apply constructivist conceptions and methods in their work, among other conceptions and methods of cognitive therapies. The therapy orientation thus does not pursue fixed working procedures but rather an integrative and flexible approach (Hakanen, 2008; Toskala & Hartikainen, 2005).

1.3. Empathy in psychotherapy

Management of emotional experiences in interaction is the focal theme of this study. In psychology, this theme is often discussed in terms the concept of empathy. In psychological literature, empathy is understood as an *attitude* on one hand, and as *behavior* on the other. Basically, empathetic attitude involves understanding and appreciating the other's idiosyncratic experience, which can involve actually feeling some of what the other is feeling, or more of a cognitive process of knowing the mind of the other (Bohart & Greenebrg, 1997: 4-5; Rogers, 1959). Empathy as behavior, in the psychotherapeutic context, has been linked especially to empathetic reflections which communicate to the other what the speaker has heard her/him saying and experiencing, while also other kinds of actions, such as displays of attention, interpretations (e.g. Greenberg & Elliot, 1997) or therapist's self-disclosures (Bachelor, 1988) can be heard as communicating empathy (see Bohart & Greenberg, 1997; Kuusinen, 2008; Toskala & Hartikainen, 2005).

In psychotherapeutic literature the function of empathy is understood basically in two ways: as a background variable that is used to establish a relationship in which therapeutic treatment can take place (e.g. Beck, 1976), or as a central variable of therapeutic change in its own right (e.g. Rogers, 1957; Warner, 1997). In the latter kind of understanding, a basic idea is that experiences of the therapist's empathy help the patients to relate more

'empathetically' to their own experiences, and so recognize and accept experiences that they have previously held as shameful or unacceptable. This idea is maintained also in cognitive-constructivist therapy. (Bohart & Greenberg, 1997; Kuusinen, 2008; Toskala & Hartikainen, 2005.)

The patients' perceptions of the therapist's empathy have been shown to be linked with positive outcome of the therapy (see Orlinsky & al, 1994). Empirical studies on the actual composition of empathy in therapeutic sessions have focused on the content of the empathetic responses, e.g. whether the therapist refers to cognitions or emotions (Tausch, 1988; Brodley & Brody, 1990; see Bohart & Greenberg, 1997: 20-21). In this study, the focus is on how the therapist's responses relate to the patient's previous turns at talk (and their implications to further talk), and so on sequential and interactional features of what might be heard as empathy (cf. Ruusuvuori, 2005; Pudlinski, 2005; Ehrling, 2006; Hepburn & Potter, 2007).

Above I have introduced the topic of this study in clinical and psychological terms. As psychotherapy and emotion are usually considered as 'psychological' phenomena, it was necessary to put the phenomena of this study on the psychological and clinical map. However, I will next turn to literature that comes closer to the conceptual basis of this study, as it approaches psychotherapy from the perspective of language use and social action.

1.4. Psychotherapy as social action

The conceptual basis of most of the research on psychotherapy is on clinical theories or more general psychological or medical theories of mental health (see e.g. Lambert & Ogles, 2004; Rennie & Toukmanian, 1992; Pachankis & Goldfried, 2007). In some studies, however, psychotherapy is understood primarily as a *social institution*. Such studies often involve a critical perspective towards psychotherapeutic or psychiatric discourses. In sociology, psychotherapy has been viewed, rather than as a treatment to pre-given disorders, as a part of a process that actually produces what is taken as psychopathology (Scheff, 1966; Morrall, 2008; cf. Parsons, 1951). Some recent studies also explore the ways in which psychotherapeutic discourses have been spread into public life and popular culture, promoting such conceptions as the fragility of the self and need for confession of private hurt (Furedi, 2004 on *therapy culture*, cf. Kivivuori, 1992). Sociology of psychotherapy involves also analyses on power relations and subjectivity in therapies (e.g. Rose, 1996; Hook, 2003, 2001) and on history of psychiatric treatment (e.g. Helén, 2007; Helén & Ojakangas, 1994) drawing from Foucault's (e.g. 1967) thinking.

Besides sociology, also clinical research has sometimes approached psychotherapy as a social institution. Besides showing how therapies for example maintain traditional gender and family relations, critical clinical studies have sought to reformulate existing psychotherapeutic theories and practices, or to create new (e.g. feminist and postmodern) therapies (see Hare-Mustin, 1983; McNamee & Gergen, 1992; Avdi & Georgaca, 2007).

This study takes a different position in relation to psychotherapeutic theories and practices than the studies referred to above. Clinical considerations are not the point of departure for the study, but they are either not taken under investigation or evaluation as such. Rather, the study aims to explicate the relation between the psychotherapeutic theories and the actual events of social interaction in the therapeutic sessions (Peräkylä & Vehiläinen, 2003; Peräkylä, Ruusuvuori & Vehviläinen, 2005). In more general terms, this study follows a tradition that aims to describe psychotherapy as *language use and social action*, as it emerges in the actual sessions between patients and therapists.

Sociolinguistic studies of psychotherapies started in the time when recording techniques become commonly available (cf. lectures by Sacks in 1960's in Sacks, 1992, vol 1: 3-20, 268-280; see Peräkylä & al. 2008). Pittenger et al (1961) described in detail an audio recording of the first five minutes of an initial psychiatric interview, paying particular attention to the implicit meanings conveyed by the lexical and prosodic choices of the participants. Scheflen (1973) presented a microanalysis of a segment of family therapy, focussing especially on the coordination of language, posture and gesture of the participants. Labov and Fanshel (1977) analysed a segment of psychotherapy interaction using speech act theory, and the line of their work was more recently continued by Ferrara (1994), who examined various discourse strategies (such as repetition of the other's talk, construction of metaphors, and joint production of utterances) in a large corpus of tape recorded data (see also Ferrara, 2002 on resistance). (Peräkylä & al., 2008: 7-10.)

Speech act perspective has been applied also by Stiles (1992) who classified utterances in psychotherapy on the basis of how the speaker relates to his or her interlocutor in three dimensions (*source of experience, frame of reference* and *presumption*). This taxonomy was developed using psychotherapeutic data but it was later used to study particulars of communication (e.g. role dimensions) in other contexts as well (see Stiles, 1992; cf. Bales, 1999). Linguistic perspectives, drawing e.g. from Bakhtin, have been applied also in more clinically-oriented psychotherapy research (e.g. Leiman, 2004; Seikkula, 1993; Angus & McLeod, 2004).

In 1990s, and especially after the turn of the Century, research on psychotherapy and counselling has rapidly increased within conversation analysis (that is the approach taken in this study) and discursive psychology (see Edwards, 1997; Jokinen & Suoninen, 2000). A central research theme has been how therapists reformulate the client's talk for purposes of therapeutic work. Studies have explicated the ways in such reformulations serve, for example the joint definition of a problem (Davis, 1986; Buttny 2004), elicitation of client's talk (Hutchby, 2005), diagnosis and history-taking (Antaki & al., 2005) or preparing for interpretation (Vehviläinen, 2003; Peräkylä, 2004a). CA studies have also examined the client's actions after the therapist's interventions, explicating ways in which clients convey resistance or alignment with the therapist's actions (Hutchby, 2002; MacMartin, 2008; Peräkylä, 2005; Bercelli & al., 2008; Falk, in preparation). Besides individual therapies, also couple-, family- and group therapies and counselling have been widely studied from the perspectives of interactional and discursive practices (Gale, 1991; Jones & Beach, 1995; Edwards, 1995; Peräkylä, 1995; Arminen, 1998; Halonen, 2008; Wahlstöm & Kurri, 2005; Partanen, 2008).

Furthermore, studies on interactional / discoursive practices of therapies have discussed such issues as epistemic rights (Peräkylä & Silverman, 1991; Vehviläinen, 2003; Rae 2008), intersubjectivity (Arminen, 1998; Vehviläinen, 2003; Peräkylä, 2008), morality (Kurri & Wahlström, 2001; see also Bergmann, 1992) and agency (Kurri and Wahlström, 2007; Halonen 2008; Partanen & al., 2006). Orientation to emotion, which is a focal theme in this study, has been described in terms of therapists' intensification or regulation of clients' descriptions (Peräkylä, 2008; forthcoming; Rae, 2008; see also Ehrling, 2006 on research interviews of psychotherapy patients) and use of emotion descriptions by clients (Edwards, 1995) and therapists (Vehviläinen, 2008). One of the tasks of this study is to extend the repertoire of CA research on psychotherapy further towards emotional communication.

1.5. Social management of emotions

Sociological theories offer perplexingly many different ways to understand the place and significance of emotion in social life. Sociological theories emphasise differently cultural (Durkheim, 1980 [1912]; Goffman, 1959; Hochschild, 1979), psychological (Scheff, 2003), biological (Turner, 2000) and macrostructural (Kemper, 1990) facets of emotions (Turner & Stets, 2005). While the theoretical and methodological approach taken in this study, conversation analysis, does not involve a theory of the 'source' of emotions (for example in terms of social constructionism or biology), the CA perspective comes closest to the cultural, discursive and 'dramaturgical' approaches in sociology. In general terms, these sociological approaches seek to explicate how culture provides *scripts* for expression and management of emotion (Turner & Stets, 2005: 26-28). They suggest that acting according to the cultural scripts serves for social systems and integration, but the scripts can also be used for individual (strategic) purposes (Durkheim, 1980 [1912]; Goffman, 1959; Hochschild, 1979; Clark 1990; see Turner & Stets, 2005: 26-28; cf. also Edwards, 1999; Gergen, 1999; Collins, 2004).

This study shares this script-perspective as it examines the ways in which emotion is presented in the manifest interaction (thus focusing on *displays* on emotional experiences, not on psycho-physiological experiences); the ways in which management of emotion is socially organized; and the ways in which the management of emotion is linked to strategic and institutional purposes (here in terms of therapeutic tasks). However, instead of studying how the participants of interaction *as individual actors* follow or make use of 'feeling rules' (Hochshild, 1979) or 'emotion discourse' (Edwards, 1999), the aim of this study is to look at how the participants treat the emotion as relevant in their *collaborative action*. In other words, the analytical focus is not so much on cultural codes or individual purposes than on emergent social action and achievement of shared understanding.

Emotion is an emergent theme in CA (Peräkylä, 2004b). Studies that focus on management of emotional displays in interaction include e.g. Hepburn (2004) on crying in helpline calls (see also Hepburn & Potter, 2007); Jefferson (1984a), Haakana (1999), Vöge (2010) and Potter & Hepburn (forthcoming) on laughter in different settings; Heath

(1988) and Sandlund (2004: 160-226) on embarrassment in medical consultations and academic seminars respectively; Heath (1989) on expression of pain in medical consultations; and Whalen and Zimmerman (1998) on 'hysteric' displays of anxiety in emergency calls. (For a brief overview, see Peräkylä, 2004b: 9-10.)

Different 'modalities' of expression have been shown to serve as vehicles of emotional communication. Thus, orientation to emotion or affect (I use the two terms interchangeably) has been located in facial expressions (Peräkylä & Ruusuvuori, 2006), prosody (Selting, 1994; Couper-Kuhlen, 2009; Local & Walker, 2008) and lexical and syntactic choices (Sorjonen, 2001; Hakulinen & al., 2004; Haakana & Sorjonen, forthcoming). For example, the use of extreme-case formulations (e.g. *never*, *always*, *all the time*) appears to be a common means to mark an utterance as affective (Pomeranz, 1986; Edwards, 2000). In general terms, different linguistic strategies of displaying stance (taking a position towards something, displaying attitude) can be associated with affect and emotion (e.g. Du Bois, 2007; Haddington, 2006; Kärkkäinen, 2006; Keisanen, 2007; Goodwin, 2007).

In this study, the focus is not on particular emotional displays (such as laughter or facial expressions) but on broader actions through which the participants express their understanding on the emotional experiences under discussion. In this sense, this study has much in common with earlier research on troubles telling (Jefferson, 1980, 1988; Jefferson & Lee, 1992; Ruusuvuori 2005, 2007) and complaining (Drew, 1998a; Günthner, 1997; Drew & Walker, 2009; Ruusuvuori & Lindfors, 2009). Furthermore, earlier research has shown that also such actions as assessments (Goodwin & Goodwin, 2000), accounting (Buttny, 1993: Ch. 6), delivery and reception of news (Maynard, 1997, 2003; Freese and Maynard, 1998) and requesting (Wootton, 1997: Ch. 4) can be heard as conveying emotion. (See Peräkylä, 2004b: 10; Peräkylä & Sorjonen, forthcoming.)

CA studies thus have started to provide cumulating knowledge on the ways in which emotions are expressed and regulated in immediate social interaction. In terms of sociology of emotions, they can be seen to offer empirical descriptions of micro-processes that for example Goffman (1959), Scheff (1990) and recently Collins (2004) have viewed as constitutive for society, as well as for individual experiences.

This study seeks to make a further contribution to this line of conversation analytical research. Psychotherapy offers a particularly interesting setting for the study of interactional management emotion since working with patients' emotional experiences – through talk – is one of its basic tasks (see Edwards, 1995; Peräkylä, 2008; Rae, 2008; Vehviläinen, 2008; Ehrling, 2006).

1.6. Change in interaction

Therapeutic change is a major theme in clinical research on psychotherapy. Clinically oriented psychotherapy research can be divided into two main directions: outcome research and process research. Outcome research seeks to compare different therapeutic approaches in terms of the measurable change they produce in patients (see e.g. Knekt & al., 2008) while process research aims at describing the actual events of therapy process

that amount to change (see e.g. Laitila & al., 2005; Stiles et al., 1990). Process researchers have investigated interaction between the therapist and the patient for example by trying to identify interactional events that are significant in the change process (e.g. Elliot, 1989) and by analysing dialogical aspects (e.g. positions that the speaker takes in relation to other) of speech (Leiman, 1997; Seikkula, 1993). Furthermore, Leiman and Stiles (2001) have integrated Vygotsky's (1978) concept of zones of proximal development to studies of change processes, arguing that phases of the clients' change can be located first to collaborative action with the therapist, before they are shown in the clients' own actions (cf. Stiles & al., 1990).

Leiman and Stiles' idea on zones of proximal development connects easily with CA of psychotherapy, which in general terms, according to Peräkylä & al. (2008), investigates the ways in which the expressed understandings concerning the patient's experience get transformed in and through adjacent turns at talk. CA studies of psychotherapy (as well as of other interactional settings) thus far, however, have mainly concentrated on recurrent, 'static', practices – for example on the ways in which therapists' formulations edit the clients' talk. These studies have explicated local transformations of understandings on micro level (see Peräkylä & al, 2008; Antaki, 2008). This study introduces a new dimension of CA study of the transformation of understandings concerning the patient's experience, as relations between adjacent utterances will be described also from a longitudinal perspective, with the aim of pinning down a more robust therapeutic change across a series of sessions.

Recently, Lepper & Mergenthaler (2005, 2007 and 2008) have suggested that conversation analysis could contribute to the study of therapeutic change. They combined CA with another methodology, namely therapeutic cycles model (Mergenthaler, 1996) to study clinically significant interactions. The significant events (periods of heightened therapist-client engagement) were identified using the cycles model and then analyzed by means of conversation analysis. Lepper & Mergenthaler suggest that through comparison, this approach can be used for studying the relation between therapeutic work and outcome. CA was used also by Leudar & al. (2008) who studied therapeutic processes within a session in group therapy for children.

In this study, CA is used to study a therapeutic process. A process of change over time in a particular recurrent sequence (i.e., pair of utterances) is explicated. This kind of longitudinal approach to adjacent utterances has been recently taken in studies of teaching and learning (cf. also Heritage & Lindström, 1998; Wootton, 1997). Studies have described changes over time in interaction in for example second language learning (Young & Miller, 2004; Mondada & Pekarek Doehler, 2004), classroom interaction between children (Melander & Sahlström, 2009), physiotherapy (Martin, 2004) and speech therapy (Sellman, 2008). On the basis of empirical analyses, these studies suggest that learning processes amount to changes in the ways in which learners interact with others (i.e. to changing participation, Lave & Wenger, 1991; see Vehviläinen, 2009: 186-187). In this study this idea is applied to study of therapeutic change (cf. Leiman & Stiles, 2001; Peräkylä & al., 2008).

I have now briefly introduced the object of this study, and fields of research to which this study aims to make a contribution. In the following sections I will discuss in more detail the theoretical and methodological basis of the study.

2. Method

2.1. Study of institutional interaction

The study of institutional interaction is a research tradition that draws from conversation analytical, and originally ethnomethodological (Garfinkel, 1967), notions on constitution of social realities in interaction. Studies of institutional interaction seek to unravel the ways in which professional institutions (in, for example, education, healthcare, or legal system) are reproduced in interaction between professionals or professionals and clients. A key idea is the dual conception of context: social action is both context-shaped (i.e. participants orient to the context in their action) and context-renewing (the context is built in and through action) (Heritage, 1984).

Research on institutional interaction seeks to show how participants through their interactional practices *invoke and orient to* specific institutional norms, tasks and identities (Drew and Heritage 1992; cf. Parsons, 1951). Through conversation analytical methods, the studies examine how the practices of everyday conversation are modified for institutional purposes. The presence of the institution can be located for example in lexical choice, turn design, turn-taking organisation or in asymmetry between participants in terms of epistemic positions or control over the course of interaction (Drew & Heritage, 1992). Besides comparison with everyday conversation, also comparison between institutions reveals features of interaction that are typical to the institution in question (Drew, 1998b; Peräkylä, Ruusuvuori & Vehviläinen, 2005).

Institutional interactions typically involve specialised professional knowledge and specific professional goals. The study of institutional interaction takes up these in two ways. First, the researcher has to have enough knowledge on the institution and professions in question to be able to recognize institutionally relevant actions and sense-making practices of the participants (Arminen, 2005). This kind of ethnographic knowledge becomes particularly important in cases where all the participants of the interaction are professionals who share the professional knowledge, for example in the case of interaction between pilots (see Auvinen, 2009).

Another way in which the study of institutional interaction relates to professional conceptions considers the relation between professional theories or ideologies and the actual practices of professional interaction (Peräkylä & Vehviläinen, 2003; Peräkylä, Ruusuvuori & Vehviläinen, 2005). Conversation analyses of the institutional encounters can specify, correct or add new dimensions to professional theories, particularly to those that consider the interaction between professionals and clients (Peräkylä & Vehiläinen, 2003 on *professional stocks of interactional knowledge*; Peräkylä, 1995). This kind of dialogue can help the professionals to reflect their everyday work. For example, conversation analytical studies have discussed the relation between actual practices and the principles of patient participation and shared decision making in heath care

consultations (e.g. Stivers, 2007; Collins & al, 2007; Lindfors, 2005; Ijäs-Kallio & al., forthcoming). Respectively, one aim of this study is a dialogue with theories of cognitive therapy, as well as with more general theories of psychotherapy, considering for example the role of empathy in psychotherapy.

This kind of engagement with clinical theories in not without risks. A critic might say that this study takes the foundations of the professional discourses for granted and focuses too much on practical concerns of the professionals (see Georgaca & Avdi, 2009). For example, the therapist's persuasive actions could be discussed both in terms of treatment and in terms of power; and this study concentrates on the former (cf. Hook, 2003). In methodological terms, however, research on institutional interaction - including this particular study - does not take the professional ideas for granted but, more accurately, begins with ethomethodological 'bracketing' of them (Peräkylä, Ruusuvuori & Vehviläinen, 2005; Avdi & Georgaca, forthcoming; Heritage, 1984; Schütz, 2007 [1932]). In other words, the study of institutional interaction aims at describing the inner ('commonsense') logics of institutions as they are actualized in the participants' intersubjective action. Then, besides to practical concerns, these descriptions could be linked also to (more critical) considerations on social relations (Peräkylä 2004b; McIlvenny, 2002; Arminen, 2005: 81-82).

Having said all this, it should be acknowledged that the articles of this study refer to clinical concepts perhaps more, and in a less 'agnostic' manner, than conversation analysis of psychotherapy usually has done (cf. e.g. Antaki, 2008; Rae, 2008). It is pointed out in the articles that they in many ways describe the same phenomena to which psychotherapeutic concepts refer. These concepts involve *empathy*, *validation of emotion*, *therapeutic alliance*, *interpretation*, *challenging beliefs*, and *therapeutic change*. During the initial stages of the data analysis, some of these concepts served as heuristic tools that led me to recognize institutionally relevant practices (see Arminen, 2005). It should be emphasized, however, that the results of the data analysis do not rest upon psychotherapeutic or clinical concepts. Any reader who is familiar with conversation analysis should be able to understand and evaluate the data analyses and the results of this study, also without reference to these clinical concepts.

2.2. Conversation analysis

In investigating institutional interaction, this study uses the methods of conversation analysis. In CA, the interest is in the means through which participants intersubjectively create and interpret the social scene which they are in. The meaning of the participants' actions is understood in relation to their sequential context. In this sense, CA continues the tradition of Garfinkel's (1967) ethnomethology. (Heritage, 1984; Silverman, 1998). Conversation analysis was founded by Harvey Sacks (a student of Goffman and co-worker of Garfinkel) and his colleagues in University of California in 1960's (see Sacks, 1992; Sacks, Schegloff & Jeffersson, 1974). Sacks's key idea was to use recordings of naturally occurring conversations to study the *organisation of social action*, in its own right (cf.

Goffman, 1983) and in a data driven way (instead of drawing from pre-given theoretical idealizations) (Silverman, 1998; Schegloff, 1992).

The first conversation analysts confirmed that talk-in-interaction is finely organized (see Lerner, 2004). Studies explicated the systematics of such generic practices of conversation as turn taking (Sacks, Schegloff & Jefferson, 1974; Jefferson, 1984b), repair (Schegloff, Jefferson & Sacks, 1977) and openings (Schegloff, 1979) and closings (Schegloff & Sacks, 1973). Seminal research yielded also notions of *adjacency pair* (Sacks, 1992; Schegloff, 2007) and *preference* (Sacks, 1992; Pomeranz, 1984). It was shown that conversation is basically organized as pairs of turns (actions), of which the first pair part (e.g. a question or an assessment) creates a particular relevance to a certain action in the second pair part (an answer or a second assessment, respectively). Further, actions that agree with or accept what was suggested in the first turn are preferred, over the actions that disagree or decline (so, for example, agreement with the first assessment is preferred over disagreement). This preference is maintained in conversation through marking disagreement or rejection as problematic, for example by delaying response. (Sacks, 1992, Vol 2: Winter 1970, lecture 4, Spring 1972, lecture 1; Pomeranz, 1984; Schegloff, 2007.)

During the first decades in the history of CA, research focused mainly on informal, everyday conversations. The study of institutional interaction within CA (in the sense described above) started from the study by Atkinson & Drew (1979), which compared everyday conversation and talk in court. (Heritage, 2004; Arminen, 2005.)

While conversation analysis has its roots in sociology, it has been widely applied and developed also in linguistics and other disciplines. In general, CA research examines the sequential organisation of interaction, the actions participants accomplish in their turns at talk, and the design of the turns. Besides talk, analysis takes into account nonverbal aspects of expression such as pauses, laughter and prosody. When using video recorded data, CA studies also increasingly attend to visual aspects of interaction. Turns at talk are analysed as actions and in relation to their *sequential context* in the conversation: how a turn is an interpretation of the previous turn and which implications it gives to the next turn, and how it becomes meaningful also in relation with the larger phases of conversation. (Heritage, 1984, Ch. 8; Heritage & Atkinson, 1984.)

In CA, data analysis proceeds a ‘data driven’ way: the research foci and specific research questions are not determined in advance, but they arise from the contact with data. Previous research and CA concepts are, however, used as resources through out the process of data analysis: from the very beginning of the analysis, the data are articulated in terms of turn-taking, sequences, turn design, and so on. The data analysis starts with transcribing (see Jefferson, 2004) and unmotivated exploration of the data, after which the interactional phenomena to be examined are identified. Next phases involve collecting instances of the phenomenon and determining the variation of it. Finally, the wider implications, e.g. in terms of professional practice or social relations, of the investigated phenomenon are discussed. (Peräkylä, 2004c; ten Have, 1999) In what follows I will describe the research process in this study.

2.3. Data and research process

The data corpus of this study consists of 57 audio recorded therapy sessions from one therapist-patient dyad. The recordings cover a time period of (last) 18 months of a therapy process of two years. The therapist is an experienced private practitioner of cognitive-constructivist therapy, and the patient is a young adult who is recovering from depression. Informed consent was obtained from the participants.

In the early phase of the research process data were collected also form three other therapist-patient dyads. Since it became possible to have the longitudinal data from the first dyad we however decided to focus on this one process, aiming to track changes in the interaction over time. At that point it felt difficult to me to manage the data from different dyads to find the focus of the analysis. This was also a question of resources for transcribing. The recordings from the other dyads were very rich data and it is a pity that we were not able to include them to this study.

From the corpus of 57 sessions, 14 sessions were transcribed as whole and 12 sessions partly. The transcribed data from these 26 sessions covers approximately 20 hours of audio recordings. After transcribing systematically the first 7 sessions, data to be transcribed were selected on the basis of topics of talk in the sessions. These focus themes were the patient's (negative) experiences with people close to her, and partly overlapping with this, her conception of herself. I chose these rather intuitively as somewhat 'emotionally relevant' themes in the therapy after preliminary analyses of the first recordings. Additionally, one session was selected for transcription because in that particular session the participants talk about problems in their current interaction, which sounded interesting from the CA perspective. In the data that were not transcribed the participants talked about for example future events and issues considering the patient's work.

The overall topical organisation of the sessions is flexible; most talk during a session can be focused on a distinct theme, or the themes can vary during a session. Typically the sessions begin with the patient telling about how she has felt during the week and what has happened to her. This discussion about current or recent experiences can continue, or it can lead to (or intertwine with) discussion on other themes (e.g. patient's past experiences, her relations to others, her hopes or fears). Towards the end of some of the sessions, the therapist formulates a kind of conclusion or suggestion on the basis of the discussion. Development of recurrent themes can be traced from the data.

The overall sequential organisation of the sessions was not studied systematically, but it appears to me as more fluid than what was reported from cognitive therapy by Bercelli & al. (2008: 44-45), who characterize the turn-type distribution and turn order in cognitive therapy as consisting of series of question-answer sequences and question-answer-statement-response patterns. In my data, the patient's turns at talk are long and there are lots of perspective shifts. The therapist responds actively to the patient's talk, in a manner that adapts to, rather than seeks to control, the patient's perspective shifts.

Various perspectives to the data emerged in supervision and project meetings, in data sessions, and when analysing the data on my own. From the beginning of the project, my research interest was broadly management of emotion, which guided me to search for

sequences that seemed to involve affect in one way or another. The data being audio only set restrictions to what kinds of phenomena were available, thus I tried to find sequences where the 'emotion' was somewhat verbalised. I started from evaluations of stories, tried to find assessment sequences – and ended up noting that most of the data were not organised as clearly distinguishable activities (such as storytelling or complaining), nor as clear cut adjacency pairs (such as first and second assessments). Rather, the discussion appeared to me as a stream of 'topic talk' in which most turns at talk had equally responsive and initiative elements (cf. Bercelli & al., 2008: 44-45). The participants were involved in institutionally specific actions: the patient told about, and reflected upon, her experiences, and therapist made interventions that reformulated the patient's disclosures and suggested new perspectives. The initial analyses however encouraged me to make collections of cases where the patient's tellings and the therapist's initial responses to them had *some features* that in earlier CA studies have been shown to be associated with 'affective practices' such as evaluating stories, assessment sequences and complaining. Such features of talk that I found also from my data included extreme case formulations and other kinds of intensifiers, as well as prosodic and lexical expressiveness.

Despite the fact that the focus of my analysis is on verbal actions, it should be acknowledged that the analysis inevitably suffered from the lack of visual data. Especially problematic was the lack of visual information on therapist's and patient's actions that took place while the other was speaking.

In further analyses of the 'affective' segments in supervision meetings, we noted that some of the therapist's responses to the patient's disclosures conveyed interpretations of the patient's mind, while other responses referred to the 'outer world issues' such as other people or events. I reorganised the collections of cases to 'inner experience' and 'outer world' cases on the basis of the therapist's focus referent in her responses to the patient's potentially affective disclosures. These collections are the basis of the articles 1 and 3: the practices described in the first article were found from the 'experience' collection and the practices described in the third article from the 'outer world' collection. However, it should be noted that the practices reported in the articles do not cover all the initial collections. The article 1 does not discuss cases where the participants talk about feelings of depression or anxiety, nor cases where the therapist's response to the patient's disclosure is a 'mere *candidate* understanding' (that does not imply access to the experience). These cases seemed to be organised differently than the cases that were included to the article. The article 3, in turn, discusses only cases where the 'outer world' referent is a person (so not cases where the referent is an event or a thing).

Besides the collections, we worked with a single session, which appeared as deviant in the data (that is the session that I mentioned above, where the participants talk about their interactional problems). Many perspectives to the session were taken during the process (in Helsinki and York), which probably reflect the complexity of the case. Moreover, I had difficulties in applying a method that focuses on details (i.e., CA), to the study of the course of a whole session: there were lots of things going on, which could not be standardised in similar way as in analyses that are based on collections of similar sequences. However, the study was finished and is reported in the article 2.

The work that resulted as articles 1 and 3 was rather long and complicated as well, taking up different perspectives and building collections, and changing them again after analyzing new data. It was over 18 months into the research process when I had the first thought of the findings that were later reported in the first article. However, and perhaps accordingly, the latter phases of the research were easier. After writing the manuscripts of the articles 1, 2 and 3, I returned to the segments of data that I had worked with in the beginning; and the phenomenon that is reported in the fourth article 'just appeared' to me. This probably had to do with a tacit (ethnomethodological, I would like to think) conception that I had developed considering the main issues in the therapeutic process that I was studying. These intuitions were tested through a collection of cases that is described in the introduction of the fourth article.

The reports of the empirical results – the articles – were co-authored by Anssi Peräkylä and Johanna Ruusuvuori. The writing process of the articles went in the order of authors: I wrote the first versions, whereafter they were first edited by Peräkylä and then by Ruusuvuori (and then finished by me); except from the second article (*Misalignment as a therapeutic resource*) which was edited first by Ruusuvuori. Having acquired responses from the journals, we made the revisions of the manuscripts in the same order as we produced the original manuscripts. While Peräkylä is my supervisor and his insights have contributed to the analyses from their very beginning, in the phase of writing the articles his contribution was above all conceptual: he brought to the introduction and concluding sections both conversation analytical and psychotherapeutic concepts and discussions, especially in the first and third articles (*Recognition and interpretation* and *Professional non-neutrality*). Ruusuvuori, in turn, edited especially the data analyses in the articles, clarifying the use of CA concepts and pointing to features of turn design that were missed in the initial versions. Ruusuvuori's contribution was especially important for the formulation of the argument in the article 2, as well as for the discussions on features of troubles-tellings (in the first and second article) and complaints (in the third article) in the therapeutic activities – which has become a central theme in this study.

As this study focuses on interactions between one therapist and one patient, the practices found in this study are not as such genearlizable to all cognitive-constructive therapies, let alone other types of psychotherapy. The ways in which the therapist in the data works are probably dependent not only on her personal style and approach, but also on the contributions that this particular patient makes, and on the particular problems that are discussed. However, this study shows in detail ways in which cognitive-constructivist psychotherapy works (in relation to emotion) in this particular instance. Thereby, the study explicates *possible* ways in which the participants make systematically use of the sequential organization of interaction to 'talk psychotherapy into being'. The conclusions that this study draws about cognitive therapy or psychotherapy in general are based on the discussion with earlier empirical or theoretical literature, and are hypothetical in nature. (Peräkylä, 1997.)

3. Summary of the results of the articles

3.1. Recognition and interpretation

The first article describes two kinds of responses to the patient's descriptions of an emotional experience, named as recognition and interpretation. In recognition, the therapist displays that she understands the patient's experience and sees it as real and valid. In interpretation, the therapist points at something that can be heard as implicit in what the patient expressed: she offers the patient a new angle or connection to consider the experience in question, though heavily drawing upon the patient's preceding description of it. The paper shows that these two actions are *combined* in specific ways in the therapist's turns at talk.

The analysis focused on the therapist's initial responses to the segments of the patient's talk where the patient describes *how she feels about somebody or something* or *how somebody or something is like.* In many cases, these two kinds of actions – describing an affective experience and evaluating an object – intertwine in the patient's talk. In broad terms, the accounts can be heard as expressions of the patient's as it were 'immediate experience': with them the patient describes the way she feels with regard to important people or events in her life, how she relates to them. The therapist's responses in focus have the patient's inner experience as their referent, rather than referring to other issues such as the (external) situation that the patient might be worried about, and they are designed to indicate availability of the patient's experience to the therapist.

Recognition and interpretation were the basic types of therapist's experience oriented responses to the patient's descriptions. The article shows two ways in which these two actions are intertwined. In one, the recognition of the experience *as the patient told it* precedes interpretation as a separate act. The recognition invites agreement from the patient and this way also builds grounds for the therapist's next action, which is an interpretation. In the other way of combining the two actions, recognition is done, for example by prosodic means, *within* interpretation. In this case, what is affectively recognized in the therapist's initial response is somehow beyond the experience that the patient described.

The article suggests that recognition (emotional responsiveness) is a prerequisite of therapist's more interpretive actions that imply access to the patient's experience. This is connected to general psychotherapeutic debate on 'cognition-centred' vs. 'emotion-centred' approaches: it is concluded that they might not represent two distinguishable psychotherapeutic ways of working, but rather involve theoretical idealizations which foreground one or the other basic psychotherapeutic actions.

The reported practices are discussed through comparison to medical interaction. It is suggested that the difference between the psychotherapist's and the medical doctor's ways of responding to the patient's emotional experiences reveals, in the details of interaction, some institutional particularities of psychotherapy. Psychotherapy, unlike medical interaction, is characterized by the professional participant's orientation to the patient's

problematic experiences as a central issue, and by the professional assuming a more direct access to the patient's experience than what can be found in medical care.

3.2. Misalignment as a therapeutic resource

The article reports an analysis of a single therapy session, explicating some ways in which interactional problems are managed. During this single session, interactional misalignment between the therapist and the patient emerges, culminates and is mitigated. The misalignment arises as the therapist pursues investigative orientation in relation to the patient's experience under discussion, whereas the patient maintains orientation to troubles telling. The diverging projects of the participants amount to overt misalignment. Eventually, the therapist brings up as a topic the relationship between herself and the patient, in ways which turn the misalignment into a resource of therapeutic work.

The article shows that in the latter part of this particular session, the participants end up in more complementary positions, exploring their relationship. The therapist manages to redirect the discussion in such a way that serves the prevalent therapeutic task of helping the patient to reflect upon her experience. The reflection in this case focuses on the the patient's contradictory feelings and her ways of interpreting the therapist's and other people's reactions to what she does or does not do. Still, in the details of the interaction, both the participants also retain their diverging projects. Throughout the session, the therapist maintains the separateness of hers and the patient's perspectives whereas the patient invites affiliation from the therapist.

The article suggests that interactional misalignment is a key aspect of what in psychotherapeutic literature is called 'ruptures of the therapeutic alliance'. The case study offers an example of how conversation analysis can be used to study the interactional emergence and management of such ruptures.

3.3. Professional non-neutrality

The article describes the therapist's actions that convey a critical stance towards a third party whom the patient has experienced problems with. The data analysis revealed two practices of this kind of critique: 1) the therapist can confirm the critique that the patient has (implicitly or explicitly) expressed in her previous turn or 2) she can return to critique which the patient has focused away from. These actions are shown to build grounds for the therapist's further, more challenging actions.

The article shows that the therapist's responses have similarities with everyday talk where participants respond with affiliation to complaints towards third parties: like the complaint recipients in everyday conversations, also the therapist shares the patient's implied or explicit critique, and indicates that the third party has transgressed moral standards. Thus, it is concluded that one context, which the therapy interaction can invoke, is that of the 'everyday social world' with its affective practices and moral codes.

The therapist uses these resources of ‘mundane non-neutrality’ to a therapeutic purpose: to drawing a line between healthy and dysfunctional reactions to mistreatment. She uses the third party critique (complaint) as a tool for confronting the patient’s tendency to react with self-blames instead of anger. The article suggests that in the case of psychotherapy, actions that as such might be seen as apparent lapses away from the neutral professional role can in their specific context perform the very task of the institution at hand. The findings presented in this article are to a degree in contrast with Parsons’ idea on affective neutrality in medical and psychotherapeutic interaction. Hence, the article is concluded by a discussion on pockets of non-neutrality in institutional interaction.

3.4. Therapeutic change in interaction

The article describes a change process in the interaction between the therapist and the patient during the 18 month period that we have data from. The focus is on the patient’s responses to particular kinds of therapist’s interventions in different phases of the therapy. In the interventions, the therapist investigates and challenges the patient’s tendency to transform her feelings of disappointment and anger into self-blame. Over the course of the therapy, the patient’s responses to these interventions are recast: from rejection through ambivalence to agreement.

The therapist’s interventions in the focus sequences are conclusions of two kinds: ones where the therapist brings out the patient’s critical stance towards a third party (a stance which the patient has expressed more indirectly) and ones that call into question the patient’s self-blame,on the basis of what has been agreed upon in the preceding interaction. In the beginning part of the therapy, the patient responded to such conclusions with silence, which was followed by explicit resistance. In the middle of the therapy process, the patient first confirmed but then backed off from the conclusion. Eventually, towards the end of the therapy, the patient confirmed the conclusion and displayed strong agreement. Throughout the process, in most of the cases the patient was collaborative with the therapeutic agenda: she did not resist working as such with the issues that the therapist brought up in her conclusions, but rather, she resisted the therapist’s specific understandings and suggestions regarding them, thus conveying that she was not ready to agree with them until the issue is worked through.

It is concluded that transformation of the patient’s actions in recurrent interactional sequences incorporates therapeutic change, and that CA offers useful tools to investigate such change. The article also suggests that CA perspective can provide useful additional understanding to approaches in psychotherapy research that focus primarily on intra-psychic processes of change.

4. Discussion

4.1. Therapeutic modifications of everyday talk

The four articles of this study described interactions where the patient and the therapist talked about the patient's negative emotional experiences. These exchanges had both thematically and sequentially similarities with troubles telling and complaining in everyday talk (Jefferson, 1988; Drew & Walker, 2009)[1]. On the other hand, the talk was in service of institutional aims, orientation to which was incorporated in the turn design and sequential organisation of the participants' actions.

In their discussion on convergence of troubles telling and service encounter Jefferson and Lee (1992: 535) suggested that in the everyday activity of troubles telling, the focal object is *the teller and his/her experiences* while in a service encounter, the focal object is *the problem and its properties*. In everyday troubles telling, the tellers invite the recipients to focus on the experience as such and they reject advice that is offered too early in the troubles-telling sequence. The clients of service encounter, on the other hand, resist the focus on the experience and orient to the problem solving activity; or in the case of medical encounters, might invite an affiliating response but treat the focusing on the experience as an side issue and orient to quick return to the business, i.e., to solving the medical problem (Jefferson & Lee, 1992; Ruusuvuori, 2007). In the case of psychotherapy, however, these aspects might be seen as fundamentally interwoven, as psychotherapies by and large aim to change in the patients' and clients' relation to their experiences (see Peräkylä & al., 2008: 16). To put this in very simplified words, in psychotherapeutic encounters, the problems under discussion are the patient's experiences. Thus it is an institutional context in which the patient's emotional experience (at least in the sense of topic of talk) cannot be treated as irrelevant or as a side issue (cf. Jefferson & Lee, 1992; Ruusuvuori, 2007).

Through recognizing the patient's emotional experience (article 1) and by confirming the patient's critique of a third party (article 3), the therapist takes a position which is like that of an affiliating troubles (in the latter case also complaint) recipient: she displays understanding, compassion or agreement with the (potentially) emotional material that the patient offered (Ruusuvuori, 2007: 598-600). On the other hand, by interpreting the patient's emotional experience (article 1) and by challenging the patient's beliefs (article 3), the therapist orients herself to a kind of problem solving, which might be called

[1] *My understanding is that the CA concepts of troubles telling and complaining overlap, and that most the actions described in the articles 1 and 3 were located within this overlap (so the speaker conveys both a problematic experience and a transgression by a third party). This troubles telling / complaining, then, also overlaps with the more institution-specific activities. Because of this complexity, in the article 3 we used the term 'critique' instead of 'complaint' with the aim to avoid confusion with more bounded complaint sequences (Drew, 1998). Retrospectively, this perhaps would not have been necessary, as also other studies on complaints in institutional settings have pointed that the complaint is often embedded in other activities (e.g. Ruusuvuori & Lindfors, 2009; Vöge, 2010).*

therapeutic problem solving. (As such, 'problem solving' is not a proper term to describe therapeutic work, and therefore I use here the expression 'therapeutic problem solving' to refer to the *investigative line of action* that is comparable to discussing "the problem and its properties"[Jefferson & Lee, 1992: 535] in other institutional contexts.) Thus, when interpreting and challenging the patient, the therapist seeks to promote an understanding of mental processes that are connected to the patient's problematic experiences and her ways of relating to these experiences. The articles 1 and 3 showed that this kind of therapeutic problem solving activity took place after (in the case of interpretation, also simultaneously with) the affiliating actions. This resembles Jefferson's (1988; Jefferson & Lee, 1992: 531) template of troubles-telling sequence in which "work up" of the trouble (e.g. advice or diagnostic considerations) occurs only after orientation to the experience as such. However, unlike in the troubles telling sequence, the therapist's "work up" is not close-implicative but it launches further therapeutic problem solving activity: the therapist invites the patient to further reflect her experience in relation to the therapist's suggestions[2].

Then again, the therapist's affiliation is not only affiliation as such (as in troubles telling) but it serves the therapeutic problem-solving. First of all, it has an intrinsic therapeutic purpose, as empathy (see discussion in the following section) is regarded as an essential part of a successful psychotherapy (Rogers, 1957; Bohart & Greenebrg, 1997). Moreover, the data analyses showed how the therapist's affiliating turns (recognition or confirmation) *built grounds* for the interpreting/challenging actions. In the context of psychotherapy, the everyday practices of troubles telling are thus used and modified for institutional purposes.

The article 2 then showed a case of misalignment between the frames of troubles telling and therapeutic problem solving: the patient invited the therapist to the position of a troubles recipient whereas the therapist oriented to the diagnostic line of action. This is where the mismatch between the frames of *the teller and her experiences* and *the problem and its proprieties* (Jefferson & Lee, 1992) came up. Nevertheless, that this kind of continuing mismatch is *possible* suggests that these two frames – troubles telling and therapeutic problem solving – are both inherent parts of psychotherapy – or were at least in this particular case.

Besides discussing the relation between troubles telling and problem solving, the articles dealt also with questions pertaining to epistemic rights (Peräkylä & Silverman, 1991; Heritage & Raymond, 2005) and institutional neutrality (Drew & Heritage, 1992) in the psychotherapeutic context. In article 1, we pointed out that, as compared to medical professionals (Ruusuvuori, 2005, 2007), the psychotherapist referred more directly to the patient's inner experience, implying that this experience is somehow similarly available to

[2] *Article 4 showed how the patient responded to this "work up" invitation in one sequential context: she reflected the ways in which she could not confirm the therapist's suggestions. She also oriented towards working further on the issues in question. Finally, the patient responded to the therapist's suggestion in close-implicative ways and indicated that there was no need for further "problem solving" on the issue in question: the "troubles-telling sequence" could have been closed in an everyday way.*

both participants. This kind of epistemic position might be particular to psychotherapy: it has also been reported from psychoanalysis (Vehviläinen, 2003; Peräkylä, 2008; cf. interaction between infants and caregivers, Kahri, 2007). When it comes to (non-) neutrality, article 3 showed that the practices of therapeutic interaction can look fairly similar to practices of everyday talk: the therapist's actions resembled those of a recipient of everyday complaints, as she shared the patient's affective and moral stance.

To summarise, the psychotherapeutic practices that were found in this study shared similarities with everyday practices of troubles telling and complaining. In terms of affiliating with the patient's affective and moral stance, they were perhaps closer to norms of everyday talk than some other institutional interactions are (Jefferson & Lee, 1992; Ruusuvuori, 2005, 2007; Drew & Heritage, 1992). On the other hand, these practices were modified and used for therapeutic purposes: they were designed and placed so that they built grounds for further therapeutic interventions. In the case of epistemic rights in referring to the patient's experience, then, the therapeutic interaction seemed to be as it were more 'institutional' (in the sense of being different from the what seem to be more generic norms of interaction) than interaction in other institutions (Peräkylä & Silverman, 1991; Ruusuvuori, 2007; Vehviläinen, 2003; Peräkylä, 2008).

Whether the specific features of interaction that were found in this study actually are typical to psychotherapies in general is a question for future (comparative) research on different psychotherapies. For example, future studies should explore the ways in which the therapist's investigative or challenging actions in other kinds of psychotherapy occur with or without the preceding or simultaneous affiliation (cf. article 2).

4.2. Types of empathy

The basis of the first and third articles is a collection of cases where there is a distinction between two kinds of response by the therapist: those that focus on the patient's inner experience and those that focus on the 'outer world'. In the 'experience-oriented' responses (discussed in the first article) the therapist 1) displayed empathetic recognition of the patient's experience, and 2) interpreted the experience e.g. by suggesting links between it and the patients' childhood experiences. In the responses shown in the third article the therapist focused on the 'outer word', by sharing the patient's criticism towards a third party. This built the ground for subsequent challenging of the patient's dysfunctional beliefs.

In the articles we discussed the actions of recognition of experience (article 1) and confirmation of critique (article 3) in terms of the psychological (and mundane) concept *empathy*. I would like to suggest that 'experience-oriented' recognition and 'outer word oriented' confirmation might involve two different types of empathy. Recognition primarily communicates that the speaker *perceives* the other person's subjective experience, while confirmation of critique communicates that the speaker *can feel in a similar way* as the other towards an object in the outer world. These two kinds of 'empathies' might have different interactional loci e.g. on the basis of whether the previous speaker brings to the foreground the inner or outer aspects of experience, and on

the basis of the epistemic resources that are provided for the empathizing party. Articles 1 and 3 suggest that these different types of empathy can be used also strategically in the therapeutic context: they build grounds for further actions that arise from the 'experience' or 'outer word' orientations.

Even though the concept of empathy has its 'home base' in psychology, in this study it is used to refer to social action (empathetic displays) and therefore, I use it rather interchangeably with the more common CA term affiliation (see also Ruusuvuori & Voutilainen, 2009). In psychological literature, empathy (as an attitude) is often defined in a more specific way, through the distinction between it and the more "projective" feelings of sympathy or compassion (Bohart & Greenberg, 1997, 7; Duan & Hill, 1996; cf. Ruusuvuori, 2005; see also Linehan 1997 on empathy/validation). According to Rogers's paradigmatic definition (1959: 201), empathy is an ability to "perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the 'as if" condition". In this study, displays of this kind of 'pure empathy' were perhaps most apparent in the action of 'pure recognition' that was described in the first article: she as it were spoke from within the patient's experience by adding details to the patient's description of it (cf. Vehviläinen, 2003; Ruusuvuori, 2005, 2007). On the other hand, when the therapist combined recognition with interpretation (article 1), it is possible to argue that she did not display Rogersian empathy (but performed another kind of therapeutic task) in the sense that she, within the interpretation that pointed to something that the therapist heard as implicit (perhaps unconscious) in the patient's experience, mixed her frame of reference with that of the patient's (Rogers, 1959; cf. Stiles, 1992). In confirming the critique (described in article 3), the therapist might be seen as giving up the 'as if' condition and rather displaying sympathy, as she states her own opinion on the third party instead of purely reflecting that of the patient's (cf. Linehan, 1997; Stiles, 1992).

Whether these actions actually did overstep the patient's inner frame of reference, or lose the 'as if' condition, are eventually questions of the participants' experiences in ways which are not transparent in the data, and are beyond the object of this study.

However, in terms of communication of empathy, the two aspects in the Roger's definition on empathetic attitude: 1) perceiving the other's frame of reference and 2) feeling as *if* one were the other, seem to lead towards the *directions* of what the therapist conveyed in interpretation (i.e. that she is able to offer descriptions of the patient's experience that the patient did not offer as such) and confirmation (i.e. that she is able to take a similar stance). The actions of interpretation and confirmation appear to be means to display more access to (so empathetic understanding of) the patient's experience than would do merely paraphrasing the meaning of her words – which may even connect to the organisation of repair (see Schegloff, Jefferson & Sacks, 1977; cf. Rae, 2008).

In fact, the different kinds of therapist's apparently empathetic responses (recognition, interpretation and confirmation) were, basically, different types of combinations of linguistic means of *paraphrasing* and *interpreting* the patient's expressed experience and

displaying affect[3]. Thus, I would like to suggest that empathy as an *action* consists of these components (paraphrasing, interpreting and displaying affect) and that they are combined in different ways in different types of empathetic responses.

The empathetic responses that were described in articles 1 and 3 were recurrent in the therapy that we studied. Article 2, in turn, showed a deviant case in which misalignment between the participants emerged and was mitigated. Compared to the interactions described in articles 1 and 3, this case was different in many respects: the therapist's responses took more distance from the patient's emotion; the patient expressed acute anxiety; and in the latter part of the session, the participants topicalized explicitly the emotion between them. In article 2 we referred to the therapist's ways of maintaining the *separateness* of her own and the patient's experience. The therapist did not talk from within the patient's experience (cf. article 1) or share the patient's stance (cf. article 3) but took epistemic distance to the patient's emotion and talked about her own emotions and perceptions instead (cf. Vehviläinen, 2008 on resistance and confrontation in psychoanalytic interaction).

Whether this kind of maintenance of 'separateness' is a recurrent practice in moments of acute anxiety and intensive emotions in the therapeutic relationship, is a question that might be studied further. In this study, moments where the participants talk about feelings of depression and anxiety, or where they orient to the emotion in the current interaction, were not studied systematically. My overall impression of the data is, however, that in these cases therapist's initial responses to the patient's disclosures of problematic experiences are different from the responses studied in the articles 1 and 3. Studying moments of acute anxiety and intensive emotions in the therapeutic relationship would perhaps reveal further modifications of empathy, as well as those of confrontation, in the therapeutic context.

4.3. Social action and therapeutic change

Articles 1, 3 and 4 were based on data in which the participants discussed particular themes: the patient's problematic experiences with persons close to her, and her conceptions about herself. Whereas the first and third articles reported the therapist's recurrent practices of working with these themes, the last article took a longitudinal approach to one aspect of these discussions by describing a change process in specific kinds of sequences.

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[3] *This disturbed me when I made collections of the therapist's responses to the patient's disclosures: it was not easy to label the therapist's actions in CA terms (cf. Vehviläinen & al., 2008). As sequential actions, the responses were (in some cases paradoxical) mixtures of syntactic and pragmatic features of candidate understandings / formulations (Heritage & Watson, 1979), extensions (Vehviläinen, 2003), direct statements (Bercelli & al., 2008) and second assessments (Pomeranz, 1984). The solution at that point was to divide the cases in more topical terms to "inner experience" and "outer word" references. Working with only clear case actions would perhaps have resulted finding other kinds of practices but in that way I might have lost the most typical empathetic responses in the data.*

In the article we discussed the ways in which a transformation in the patient's verbal actions (in her responses to the therapist's suggestions) can be seen as embodying a therapeutic change. For a conversation analysts, focussing on what is manifest in interaction is a basic methodological choice: CA does not offer means to assess an intra-psychic therapeutic change. However, the social process of change that was manifest in the interaction can, in more theoretical terms, be linked to internal changes in the patient. In a way this is the whole idea of psychotherapy: changes in inner experiences and relating to oneself are achieved through interaction in the therapeutic relationship; in other words, as Peräkylä & al. (2008:16) pointed, through *sequential relations between actions* (see the discussion in the conclusions of the article 4).

Bearing this perspective in mind, and by drawing upon conversation analytical studies on learning (e.g. Young & Miller, 2004; Martin, 2004), as well as upon recent developments in psychotherapeutic process research (Leiman & Stiles, 2002), we made a linkage between our findings, and Vygotsky's (1978) concept of zones of proximal development. The therapist and the patient constructed first jointly the actions that the patient, in the end phase of the therapy, became able to accomplish by herself.

The change in the patient's actions can also be seen as a change in the patient's participation in the therapeutic relationship (cf. Lave & Wenger, 1991). Some theories of psychotherapy (e.g. Warner, 1997; Stern, 2004) suggest that therapeutic change takes place through new experiences of emotional expression and response in the therapeutic relation. In the cases shown in the article, through her conclusions, the therapist can be seen to offer recognition and validation of the patient's emotions and self. The patient's changing actions, in turn, might be seen as changing position in relation to the therapist: the patient first resists, then treats ambivalently and later accepts the recognition and validation that the therapist offers. This change might convey new kind of relational knowledge by the patient (see Streeck, 2008: 183-184).

Furthermore, Peräkylä (2009) has recently suggested that the relation between manifest interaction and inner psychological processes can be re-articulated in the light of theories that see self-regulation and interactional regulation of emotion as a system. According to this view, any means of acting upon or with the co-participant in interaction, are simultaneously means of self-regulation in the individual (Beebe & Lachman, 2002; Peräkylä, 2009; cf. Scheff, 1990, 67; Mead, 1934). Following this route it is possibly to argue that when responding to the therapist's suggestions, the patient also, necessarily to some extent, regulated her inner experience in new ways. So, while the idea that the change in the patient's interactional expression also involves a change in her inner world is not empirically demonstrated in this study, it is a reasonable possibility, not only on basis of common sense, but also when considered in the light of relevant (social-) psychological theories.

As it was pointed above, articles 1, 3 and 4 describe segments of therapeutic discussion that share broadly the same topic. The collections which these papers were based on, were partly overlapping. For example, conclusions that questioned the patient's self-blame were studied in both the third and the fourth article. Assumingly the practices described in the articles 1 and 3 were connected to the change process that was shown in the last article. Perhaps future research on psychotherapeutic interactions could make more of these kinds

of connections, i.e. relations between therapist's practices and change processes in sequences. One aspect that was only briefly referred to in article 4, but could be looked at more in future research, is the changes in the therapist's interventions over time, and how they reflect the changes in the patient's talk. Perhaps also the (by no means categorical) distinction between 'inner' and 'outer' referents, applied in articles 1 and 3, could be a practical tool in future research on therapeutic work and change.

4.4. Integrative therapeutic work

The therapist's work described in this study seems to involve integration of different professional theories of cognitive therapies. Integration indeed is one of the characteristics through which cognitive-constructivist therapy in Finland identifies itself (Toskala & Hartikainen, 2005; about CA and professional theories see Peräkylä & Vehviläinen, 2003; Arminen, 2005).

Confirming critique and questioning of beliefs are practices that come perhaps closest to the original ideas of Beckian cognitive therapy, which examines patients' irrational thinking, and tests correctness of beliefs (in terms of factual evidence, i.e. 'outer word') (Beck, 1976; see also Linehan 1997, 370-374). The cases where the therapist combines recognition with interpretation, in turn, can be linked to ideas of cognitive-constructivist therapy, which works with *personal meaning organisations*, i.e. how the patient's subjective experience is (historically) constructed (Guidano, 1991). The ways in which the therapist in our data combines recognition and interpretation also resonate with the cognitive-constructivist distinction between 'experiencing' and 'explaining' the experience in the therapeutic situation (Guidano, 1991; Toskala & Hartikainen, 2005). Furthermore, the therapist's ways of responding first empathetically to the patient's emotional talk, before taking distance from it, resonates with the central ideas of emotion focused therapy (Greenberg, 2004), which suggests 'accessing' emotional experiences that are seen as primary and adaptive, such as anger as a reaction to mistreatment, or sadness as a reaction to loss.

The therapist's work in the 'deviant session' (article 2) connects to writings on ruptures of the therapeutic alliance, which recommed management of ruptures through metacommunication (Safran & al., 2001). The therapist topicalised the problems in the interaction and so turned the misalignment between the participants into a resource of therapeutic work.

In her actual practice the therapist of the data thus seems to use flexibly – and at the same time, in CA terms: orderly – elements from different (cognitive) therapies, which in some respects are contrasted with each other in the literature. Furthermore, in more general terms of therapeutic work, this study has shown concrete ways in which 'cognitive' and 'emotional' sides of therapeutic work are combined. As was discussed in the article 1, these sides are emphasised differently in theories of psychotherapy. This study however suggests that in the details of interaction, psychotherapy recurrently performs a dual task of *empathy and challenging* in relation to the patient's ways of describing their experiences.

4.5. Sequential complexity

From conversation analytical perspective, the combination of empathy and challenging in psychotherapeutic interventions seems to result in sequential complexity: in the data of this study this dual task was often performed through ambiguous actions that for example start like formulations, continue like assessments and end like acknowledgements. Often it was not made clear at all whether the therapist was speaking her own mind or reformulating the patient's ideas. My contemplations with these actions evoked considerations of the very identification of *action*, and thus the "unit of analysis" in CA of psychotherapy.

First of all, in analysing the data, I had difficulties with the concept of formulation – which inevitably is a core action in psychotherapies (see e.g. Antaki 2008; Vehviläinen, 2003; Peräkylä, 2004a). When I took the concept in the broad sense, most of the therapist's utterances in the data could have been called formulations: in them the therapist communicated to the patient what she has heard her saying in the previous turn. On the other hand, when I used the term in the narrow sense (for actions that manifestly display reformulating the prior speaker's turn for example by prefaces such as *you mean*, in Finnish typically *et* or *eli*), there were lots of therapist's actions – most of the wide sense formulations – that were left unnamed in CA terms. (See Antaki 2008; Heritage & Watson, 1979.)

The management of the data became easier when I figured that *action* could be identified in somewhat less technical terms, in a manner that might be called 'semantic' or 'social-psychological'. In my way of identifying actions, the focus is in the ways in which the therapist in her turn treats the experience that the patient expressed in her previous turn. These kinds of actions were named as *recognition*, *interpretation* and *confirmation* and used as units of the analysis. Then, the "basic sequential actions", such as formulations, proposals and assessments, were treated as *possibly coexisting features of turn design* that form the therapist's actions, instead of definitive labels of utterances (cf. Vehviläinen & al., 2008).

So, in short, my methodological suggestion is that – perhaps especially in studies on psychotherapy and emotional aspects of interaction – CA should not focus on only sequentially 'pure' actions but tolerate working with the messy ones. I maintain that this makes the interaction look more complex but, nevertheless, not less dynamic and purposeful.

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