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THERAPY INTERACTIONS: SPECIFIC GENRE OR "BLOWN UP" VERSION OF ORDINARY CONVERSATIONAL PRACTICES?[1]

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Over the last decade, therapy interactions have become a common field for linguists, interaction analysts, psychologists and clinicians alike. On the one hand, some linguists and conversationalists have turned their attention to the subject as a field of inquiry leading to questions which are then also posed and elaborated on in other contexts. It was in this way, for example, that the pioneering work of Labov and Fanshel (1977) led to their developing a general model for discourse analysis. From this standpoint, therapy interactions are just one kind of social interaction among others, where, while respecting the specificities of their institutional and professional context, dynamics which can then be generalized are observed (the fact that Labov and Fanshel's work, mentioned above, is subtitled *Psychotherapy as Conversation* is not coincidental). On the other hand, psychologists' and clinical practitioners' perspectives on therapy interactions aim not simply at describing the ways in which this type of interaction is organized, but more at structuring this description using questions linked to the assessment and improvement of therapy methods. The latter approach leads, for example, to an improved understanding of patients and thence to a better diagnosis, or to more accurate assessment of the effects of therapy (see, for example, Gale 1991). The specificity of the therapy context is fundamental in this case.

The analyses of therapy interactions collected in this issue also reflect the different trends mentioned above, a tendency which can be observed in the diversity of the literature concerning this interdisciplinary field. Given the number and diversity of the types of corpora studied, together with the analytical approaches and the objectives aimed at, the articles published here indeed raise questions as to the specificity of these interactions – presupposing the existence of a certain homogeneity in their form and structure – and as to their relationships with other kinds of interaction. The question is, therefore: what are the results and the consequences, both theoretical and descriptive, of analyses of specific therapy interactions (analyses such as those presented in this issue)?

• Are we dealing with analyses which point the way towards a sufficiently unified corpus so as to be considered to belong to a particular and specific genre, that of therapy interaction? Or are we dealing with a series of examples whose very diversity leads us to give up all hope of ever defining any common characteristics?

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• What are the relationships between this kind of interaction and other interactional genres in a professional and institutional context?

• Does the functioning of this type of interaction clearly differ from that of everyday conversation, or is this functioning so similar to everyday conversation that it "enlarges" it, as would a zoom lens?

We will now identify and elaborate on some possible research orientations in an attempt at getting principles of analysis and reflexion to emerge, which will in turn help to answer the above questions. This will enable us to accurately localize work already carried out in this field, with particular emphasis on the contribution of conversational analysis.

1. Therapy interaction and other kinds of interaction

Therapy interaction can be described in terms of its relationships both of similarity and of difference with other kinds of interaction, whether ordinary conversation or other institutional and professional interactions. The following comparative analysis focuses on the procedures by which the organization of interaction is jointly accomplished by all the participants, be they therapists or clients. This is notably the case for procedures such as handling the asymmetry of turn-taking, negotiating the formulation of problems and jointly constructing utterances.

1.1. *Interactional asymmetry and turn-taking management*

Turn-taking management constitutes the basic structure of interactive exchanges. Although the interactional formats of therapy sessions vary considerably according to different schools and trends – whether they concern individuals or groups, whether the therapist has a firm control over the interaction or whether he/she is mostly silent – they are generally considered as being characterized by an interactional asymmetry between the therapist's activity and that of the patients. This asymmetry is also a feature of other institutional interactions, such as that taking place between doctor and patient (Maynard 1991a; Fele 1994), judge and witness, lawyer and defendant during questioning in a court of law (Drew 1992), or again, between policeman and suspect during an interrogation (Watson 1990), etc. This asymmetry is created by specific turn-taking procedures, especially when it is the therapist who decides on the attribution and distribution of turns, as well as introduction and control over the topics which are brought up (Fele 1990; Leonardi & Viaro 1983).

This asymmetry results in structuring the sessions in keeping with specific interactional formats such as that of interviews based on question/answer adjacency pairs. Although such pairs are also possible in ordinary conversation, they are organized differently in this case. In fact, in therapy interactions, these pairs are not followed by a third turn, constituted by a commentary, an opinion, or an evaluation of the answer, as being surprising or as introducing a new piece of news, for instance. On the contrary, the therapist displays a neutral position towards his/her client's response, just as a judge or a certain category of journalist does (Heritage 1985; Clayman 1992), before moving on to

procedures aimed at eliciting further information, or to procedures which reiterate, develop, and elucidate the information which has been collected (Fele 1993). These features distinguish therapy interactions from those of ordinary conversations, considering that the latter are characterized by symmetrical participation, and by third turns which tend to be expressions of affiliation, of alignment, or, on the contrary, of disagreement.

Conversation has in fact often been considered a basic model for studying other types of interaction – a basic organization of which institutional and asymmetrical exchanges would then be a variant (Sacks, Schegloff & Jefferson 1974). However, a different perspective is possible – a perspective clarified by Fele (1993), and which states that every interaction involves asymmetry. The ordinary conversation model, therefore, runs the risk of being an idealization, whereas the analysis of therapy interaction, as one kind of asymmetrical interaction among others, facilitates investigation of the mechanisms which provide it with its socially ordered and regulated characteristics. This, in turn, then allows us to shed light on procedures by which the asymmetry emerges, is locally accomplished and maintained by the participants engaged in the interaction.

1.2. *The emergence of "problems" as an interactional accomplishment*

One of the fundamental activities of the participants involved in therapy sessions consists of formulating, reformulating and negotiating the patient's "problem" (Apothéloz & Grossen 1995) – the very reason for being in contact with the therapist in the first place. This "problem" is in fact worked on jointly by the different parties concerned during the therapy exchange. These parties employ procedures which produce and elicit descriptions, which are specific to therapy interaction and analogous to what happens in other types of interaction (Wodak 1981).

On the one hand, interactional analysis allows the analyst to follow the emergence and progression of a description which, once expressed by the patient, is reformulated, redefined and reinterpreted by the therapist (Davis 1986; Buttny 1996). In the course of this process, a transformation takes place, since the therapist offers an alternative version of the problem, which, while utilizing elements provided by the patient, reframes it and draws different conclusions. The reformulating activity of the therapist is thus a focal point of his/her specific professional competence as an analyst, as well as negotiation, argumentation and co-construction with the patient.

On the other hand, this formulation of the problem raises the question of how it is to be managed through interactional procedures which are both specific and general. As a result, although the session takes on the form of an interview, formulation of the problem is often solicited in formats displaying "circumspection" (Peyrot 1987) or "discretion" (Bergmann 1992) on the part of the therapist, especially when the problems are complicated or embarrassing to talk about (Silverman 1994; Peräkylä & Silverman 1991; see also Grossen & Apothéloz in this issue). In preference to a direct question, these formats tend towards a suggestion (Peyrot 1987) or an invitation to speak (through "information-eliciting telling" Bergmann 1992), giving the patient the possibility of being in control of the information and descriptive elements which he/she then provides. In this case, the procedures adopted by the therapist are not unlike those described in ordinary conversation by Pomerantz (1980) as "fishing devices". The first speaker displays incomplete, indirect

and limited knowledge about an event or a situation relating to a second speaker. The latter can then pick up on this and offer further information which now comes from a direct and authorized source. These devices are widely used in psychiatry (Bergmann 1992) since they enable therapists to recycle information which they already have at their disposal from other sources (other doctors, medical files, social workers, or the patient's family) and to explore the methods by which the patient constructs his/her own version. This includes when a patient lies, where, in this case, the "fishing device" is in fact a "lie-detecting device", a technique which can also be used in police or judicial contexts.

In their continuity and specificity, these collaborative procedures for the co-construction of the problem also bear a "family resemblance" to other procedures, those of announcing bad news (Schegloff 1988; Maynard 1991). When the doctor gives his/her patient bad news, he/she does not do so directly, but by first eliciting from the patient his/her own opinion of the situation (using a procedure termed by Maynard as a "perspective display series"). The doctor does so, even if this means then transforming the patient's version by reformulating it, the reformulation being, in turn, accepted, negotiated or rejected by the patient. Announcing news also happens to be one of the procedures used in ordinary conversation to introduce a new topic (Button & Casey 1984).

The patient's problem is thus interactively accomplished by the patient and the therapist, who, for some aspects, uses procedures similar to those found in thematic development and in the management of troubles (Jefferson 1988) in everyday conversation. For other aspects, the therapist adopts procedures found in other types of interview (with, for example, a prospective employer, a journalist, a doctor, an attorney, etc.).

1.3. *Joint production of sentences*

This co-constructing concerns not only turns and topics, but also the syntactical shaping of the turns. In the therapy setting, it has thus been observed (Ferrara 1992, 1994) that a high number of sequential formats are present, where a first speaker, either the patient or the therapist, begins a formulation which is then completed by the second participant. These formats were first identified by Sacks in the 1960's (Sacks 1992), notably on the basis of an analysis of psychotherapeutic sessions conducted with a group of adolescents. His analyses, however, did not focus on the therapeutic effects of these sessions, but more generally on the interactional work constituting these sessions. These sequences display a "recipient-designed" trajectory, which enabled Sacks to show that the orientation of the speaker towards the addressee shapes the syntax of his/her utterances and of the interaction in a specific way. In this way a collaborative space is defined within units such as the sentence, which, until then, had been considered as monologically controlled by the speaker alone (Goodwin 1979; Goodwin & Goodwin 1992; Mondada 1995; Schegloff 1996).

Sacks's analyses lead to similar analyses of ordinary conversation, where these joint productions of sentences are also very frequent (Lerner 1991; Coates 1994; Jeanneret 1995). They have often been considered an indication of a cooperative relationship, even one of intimacy between the speakers. It would appear that this property of intimacy is especially present in the empathetic relationship between therapist and patient (Ferrara 1992, 212). Joint productions would thus seem to demonstrate the mutual orientation of the participants, motivated by a relationship of trust and by a common quest for deep reciprocal

understanding. Going beyond the idealized situation that such an approach may result in, these joint productions of utterances can be considered procedures of construction and of verification of understanding, since, by the very fact of B's completing the utterance initiated by A, he/she displays his/her interpretation of what A means, with the possibility of A's ratifying this interpretation (by a repetition, for example) or rejecting it. This kind of consideration would account for the interactional work done in these sequences without using the rather vague notion of "empathy".

1.4. *Therapy as co-construction*

The collaborative dimension of interaction management is a fundamental property of the organization of interaction in general. For many years, this collaboration was underestimated because of a "monological" approach to language activities, which has been now criticized within different fields of analysis. For some time now, this collaborative dimension has enabled us to define the problems posed in a number of disciplines by showing that these phenomena do not arise from the intentional and rational mastery of the subject alone, but that they are locally co-constructed within the framework of the interaction.

This changed paradigm is also mirrored in the field of psychotherapy, notably by those who have developed a constructivist approach to problems and to relationships within a therapy context. This approach, which has appeared in the last ten years in numerous areas related to the human and social sciences (e.g. Shotter 1993), has shown that the collectively-defining activities of social actors are not objectively linked in an independent way to pre-existing events or facts, functioning as causal determinations; these collectively-defining activities, in fact, contribute to establishing and shaping the realities to which these very activities pretend to correspond and refer. In the therapy field, this perspective (McNamee & Gergen 1992) has triggered off an interest in therapy as dialogue, and even as informal conversation (Anderson 1997). Such a recategorization of this professional activity can be viewed as an attempt to reduce asymmetry and to promote patterns of negotiation where the therapist acts more as a co-participant than as an expert (Anderson & Goolishian 1992).

From a conversation analytical standpoint, this paradigm, while bringing dialogic-type logic to the forefront, presents the risk of adopting an abstract and idealized model of what conversation should be, instead of observing actual occurrences of interactions, and of analyzing them in the details of their sequential unfolding. In fact, it is from the very details – which are observable but not imaginable (Psathas 1990) – in which interaction is sequentially organized turn by turn that frameworks of participation are shaped and activities are structured. Such an analysis is therefore an indispensable prerequisite for characterizing forms of collaboration and co-construction – which do not in themselves guarantee symmetry. It also provides an indispensable basis on which to describe the constructed or, on the contrary, taken-for-granted character of the facts and problems, as it is socially and interactively accomplished by the participants (Mondada, forthcoming).

Turn-taking procedures, problems and situation definitions and comprehension repairs define possible sequences and participation forms which characterize therapy interaction, but are also present in other interactions, conversational and institutional. This

transversality of the organization modes of interaction not only allows us to establish a link between approaches used in psychotherapy and others used in the human and social science fields, but also makes it possible to analyze therapy settings for studying more general phenomena. Nevertheless, this transversal character does not provides an answer to the question of what makes therapy interaction a specific genre.

2. Therapy interaction as a specific interactional genre

Although the therapy session can be placed at the crossroads of several types of formal and informal interactions, it also possesses its own specificity, constituting a particular interactional genre. Questions pertaining to the generic aspects of the therapy session may be posed in different ways. First they can relate to the observer's point of view, as he/she sets up distinctive criteria and features. However, these questions can also relate to the participants' perspective, as they adjust to the situation such as they define it, and thus themselves contribute to shaping it. It is this second perspective which will be briefly presented below.

2.1. *Participants' orientation towards therapy as a distinct form of interaction*

Actors are oriented towards the type of activity they are taking part in, by producing formulations, by adjusting the way they behave, by expressing expectations as to what will happen and by producing interpretations of the way in which the activity is unfolding. These normative orientations thus bring a structuring as well as an evaluative dimension to the activity's progression.

In the case under study here – although individual and group therapy sessions may involve very different sequential organizations and even if these types of therapy are related to underlying theories which conceive of and structure their forms of participation very differently – it is important to note that patients orient themselves towards the specific characteristics of a therapy session. It is this orientation that sets the therapy session apart, differentiating it from ordinary conversation as well as from other types of institutional interaction. As ten Have (1989) points out with reference to medical consultations, the very fact that the participants orient themselves towards a normative and idealized sequence (making for the generic specificity of the exchange), constitutes in itself the device which organizes and establishes the activity as belonging to *that* specific genre. In other words, there is no typical sequence *per se,* instead we observe typifying actions on the part of the participants, who reflexively accomplish the correspondence between this typification and the actual interaction.

Exchanges which take place in the therapist's office or in a group therapy room are not all necessarily therapy interactions. The patients, in fact, orient themselves towards the session opening as a threshold, drawing a line of demarcation between ordinary talk (whose topic is neither therapy nor what happens during an actual therapy session and which takes place before the session begins – called by Turner (1972) "pre-therapy talk") and therapy interaction itself, where tellings are not processed, evaluated and scrutinized in the same way as they are in ordinary conversation. The patients recognize the fact that exchanges

during the session are organized in such a way as to structure the exchange as a therapy activity rather than as a conversation (in which case the patients might well question the legitimacy of the therapist's contribution and even of his/her very presence at the session!). For these reasons, patients and therapists alike are poised to begin the session, which marks a discontinuity, a starting point from which the patients' tellings are no longer considered ordinary talk and, as such, conforming to conversational routines, but rather as "data" produced within a particular participation framework, controlled by the therapist and listened to by him/her in a specific and professional manner. This "theory-governed hearing" shapes the session as a therapy interaction and designates the participants as belonging to such categories as "client-professional" or "patient-therapist" (Turner 1972: 396).

Thus, whether through the way he/she manages turn-taking formats when imposing specific rules, or through the way he/she listens in silence, a silent listening which is very much part of the interactional dynamics while also differing from ordinary listening, it is the therapist who controls the interaction and structures it as a therapy session (as opposed to mere "chitchat", for example). As for the patients, they can orient themselves towards the interactional genre in two ways: By submitting to the sequential formats which they identify as relevant, thereby reinforcing them, or by *not* respecting them, thereby committing acts of "insubordination" (Leonardi & Viaro 1983). These acts can only exist as such and function because of a background which recognizes and invokes these rules. The identification of various forms of insubordination – such as concerning who brings up a topic, who summarizes the main points, who asks questions, who attributes turns, who interrupts, who refuses to answer – accounts for the rules recognized during the session in progress, even if this involves locally renegotiating and readapting these rules.

2.2. *Categorizations*

Orientation towards therapy interaction as a specific interactional genre goes hand-in-hand with recognizing the relevance of membership categories such as "client-professional" and in particular "patient-therapist" to the structuring of the activity. Whereas in informal conversations before the therapy session, these categories are not applied, they are made relevant as soon as the session begins, by assigning rights and obligations to each speaker. As in other kinds of interaction and activity, very well described by Sacks (1992), then by Schegloff (1992), membership categorization devices are not activated *a priori* by an institutional framework, but are made relevant by the participants' orientations, giving order and intelligibility to their activities.

In this sense, the specificity of therapy interaction is realized *in situ* through the participants' category-bound activities, accomplishing "doing being the doctor" or "doing being the patient", to quote an expression Sacks often used. This accomplishment concerns not only the sequential organization of the interaction, but also the various descriptive versions of the "problems" touched upon, and, more generally, the moral identities of the patients. Indeed, the therapist who chooses a certain way of describing the patient's problem contributes to associating him/her with a particular category of patients (Peyrot 1987) which the patient can either accept or refuse. The moral identity of the patient is thus constructed and negotiated (Silverman 1994) and even evaluated when the problem appears

to be "delicate" or "sensitive" and related to acts leading to inferences concerning the morality, the sense of responsibility and the seriousmindedness of the patient.

3. Conclusion: How to make specific and general features of interactional organization observable in the analysis of therapy interaction?

At the end of this brief overview of various possible interactional perspectives on therapy sessions, in terms of both specific and general features, two relevant methodological questions arise: how are the materials collected and how is the analysis carried out (what tools are used and on what aspects are they focused)?

On the one hand, particular analyses of therapy interactions pose questions as to the choice of the sessions to be recorded, the passages to be transcribed and the transcribing conventions to be adopted. These choices, instrumental in ordering the data on which the analysis will be based, also depend on the accessibility of particular situations, the possibility of recording sessions and the permission to use them for analysis. At the outset, these choices pose the question of categorizing situations as marginal or central to the observer's investigation, whether they are exemplary both in terms of their uniqueness and of their prototypicality.

On the other hand, once the data has been collected and transcribed, the question then arises of how to analyze it: How to identify and to point out the relevant and observable formal and sequential features accounting for the sessions' organization and its specificities/generalities? How to identify what can be considered traces or markers of the phenomena under study? Then, the relationship between the markers and what they refer to, not to mention the perspective from which these markers are to be considered, must also be defined. This perspective may be that of the analyst and his own theoretical framework, or that of the participants and their embodied and situated point of view (and it is clear that these two perspectives do not coincide).

As concerns the choices mentioned above, different types of interpretive knowledge will contribute to the analysis: The approach taken by a conversation analyst is not the same as that of a psychologist or a clinician, nor does it set the same purposes. Skills used for interpretation are in fact often overlapping and hybridized: this would be the case, for example, of a professional using methodological tools borrowed from conversation analysis, from discourse analysis or from pragmatics in order to better understand therapy sessions in which he/she is engaged as a participant.

If we consider that the definition of the situation, of the problems and of the solutions is accomplished during therapy interaction, these aspects are important not only within the methodological framework of the study; they even become fundamental to understanding how different, often irreconcilable, types of knowledge and factual accounts are exchanged during therapy sessions and to understanding the degree of specificity and generality of these interactional activities.

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