Exploring clients' meta-comments in psychotherapy using conversation analysis

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Thesis Abstract

Asking clients about shifts in their moment-to-moment experience - for example, when they laugh, smile or make a comment to themselves - is done in a variety of different ways in different therapeutic approaches. However, the various therapies do not necessarily specify what might be happening for the client when a shift occurs, and are instead more interested in the therapist's response to those events. Method of Levels (MOL) therapy does however, make a series of claims about what is occuring for the client during those shifts, termed 'disruptions'. Disruptions are proposed to be short responses, offering comments on a client's own talk, which are not spontaneously elaborated on. Asking about disruptions in MOL is one of the two over-arching goals of the therapy (Carey, 2006). As MOL emphasises these disruptions so heavily, instances when shifts occured during clients' talk were assessed against MOL's proposals.

Conversation Analysis (CA) was used to explore a corpus of recordings from a university counselling service for possible "disruptions" (as defined above). Due to the breadth of potential disruptions, clients' explicit comments on their own talk were prioritised for exploration. Instances of clients referring to their own talk with the format "sounds [X], but [Y]" (SBs), e.g. "it sounds so bad … but it's the truth", were collected and reviewed. SBs were used by the clients to disclaim a named negative hearing of their talk (sounds [X]), to create a favourable interactional environment to disclose a sensitive issue to the therapist (but [Y]). It is argued that the "sounds [X]" component represents a potential hearing for both the client and the therapist. A range of therapist responses to SBs are discussed, including responses which are affiliative and non-affiliative, alongside the client's subsequent response.

The study has two main implications. Firstly, it provides a detailed account of clients' actions when they attend to issues of immediacy, inter-subjectivity and making a disclosure, which are of interest beyond MOL, and typically explored from the therapists' perspective. In discussing and exploring the range of therapist responses using CA (which is non-cognitive), a contrast is provided with psychotherapies' typically cognitive approach. The contrast in approaches provides an opportunity for reflection on whether therapists' actions are aligned to their own therapeutic goals

when a client uses an SB. Secondly the study supports a number of MOL's proposals: potential disruptions were transitory; and without therapists asking about SBs, clients resumed their prior talk. However, MOL's account of disruptions does not highlight the social actions of talk that CA emphasises.

A brief unstructured exploration of disruptions was also undertaken prior to the CA study. The exploration included looking at the disruptions highlighted by MOL therapists during therapy, the types of disruptions identified by the author from example videos, and whether there were frameworks from literature other than MOL that could inform the identification of disruptions as attentional shifts. No clear framework was identified, but Poyatos' (1983) proposition of language consisting of language, paralanguage and kinesics was informative.

The systematic literature review reflects an alternative quantitative approach to exploring MOL's propositions. A design using this approach was abandoned due to a combination of the low association found in the meta-analysis and feasibility of testing this; discussion with my supervisors; feedback on submitting the paper to *Personality and Individual Differences;* and the ensuing development of my thinking and interest.

Acknowledgements

I would like to thank Marco Pino for his invaluable help and encouragement with the project and for being so generous with his time. I could not have hoped for better support and guidance with Conversation Analysis and in shaping the project. I would also like to thank Nima Moghaddam and Thomas Schröder for their assistance and supervision.

I have benefited from comments and discussion from the Discourse and Rhetoric Group (DARG) at Loughborough University, in particular Charles Antaki and Paul Drew. I have also benefited from exchanges with Warren Mansell and Tim Carey on Method of Levels, and from Caitlyn Cannon in sharing her data and write-up with me. Thanks also to Mike Rennoldson who started me down the road with MOL.

Thank you to my parents and Anwen for your ongoing support and encouragement.

I am grateful also to the anonymous peer reviewers of the Systematic Literature Review for ensuring that the nail was finally in the coffin of the quantitative design – I am grateful.

Good Morning!" said Bilbo, and he meant it. The sun was shining, and the grass was very green. But Gandalf looked at him from under long bushy eyebrows that stuck out further than the brim of his shady hat.
"What do you mean?" he said. "Do you wish me a good morning, or mean that it is a good morning whether I want it or not; or that you feel good this morning; or that it is a morning to be good on?"
"All of them at once," said Bilbo.
…
"Good morning!" he said at last. "We don't want any adventures here, thank you! You might try over The Hill or across The Water." By this he meant that the conversation was at an end.
"What a lot of things you do use Good morning for!" said Gandalf. "Now you mean that you want to get rid of me, and that it won't be good till I move off."

J. R. R. Tolkien, The Hobbit

Statement of Contribution

1. Project Design

Mark Burdett (with supervision from Marco Pino, Nima Moghaddam and Thomas Schröder)

2. Applying for ethical approval

Mark Burdett (with supervision from Thomas Schröder)

3. Writing of the systematic literature review

Mark Burdett (with supervision from Mike Rennoldson and Nima Moghaddam)

4. Writing the review of literature

Mark Burdett (with supervision from Marco Pino, Nima Moghaddam and Thomas Schröder)

5. Transcription

Mark Burdett (with supervision from Marco Pino)

6. Data analysis

Mark Burdett (with supervision from Marco Pino)

7. Write up

Mark Burdett (with supervision from Marco Pino, Nima Moghaddam and Thomas Schröder)

The clinical data used in the study were collected as a part of a study with Sue Wheeler as the Chief Investigator. The data had ethical approval for secondary data analysis and was kindly released for the current study by Sue Wheeler.

Data referred to in the study, but not submitted for publication at the time of writing was collected by Caitlyn Cannon, supervised by Jo Meredith, Sue Speer and Warren Mansell (Cannon, 2014). I am grateful to Caitlyn for kindly providing me with a summary of her extracts of therapist's questions about disruptions.

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1. Systematic Literature Review

Goal conflict and well-being: A meta-analysis reviewing the associations found with the strivings instrumentality matrix

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1.1. Abstract

Conflict between people's goals is thought to affect their well-being. However, the findings are inconsistent, have limited statistical power, are potentially subject to publication bias, and a number of other factors have been found to affect the association. A meta-analysis was undertaken to review the evidence for a particular measure of goal conflict, the Striving Instrumentality Matrix (SIM), and measures of wellbeing and distress. 11 studies were included in the analysis. A positive correlation between goal conflict and 'negative well-being' (measures of distress and negative affect) was found r = .10, 95% confidence interval .01 to .18. A negative, non-significant correlation r = -.10, 95% confidence interval -.01 to -.21 was found between goal conflict and positive well-being (positive affect or life satisfaction). The findings are discussed in relation to the SIM's ability to measure goal conflict and whether conflict at the lower level will necessarily have an impact on wellbeing.

1.1 **Introduction**

1.1.1. Goal Conflict

Conflicting goals are thought to decrease a person's well-being (Emmons, 1986; Palys & Little, 1983). However, the research is at a confluence between personality, cognitive, clinical and motivational approaches to psychology. As such there are different conceptions of goals, their salient aspects, how they might be measured and what might affect them. Similarly, there are different types and components of well-being and distress. Whilst most studies indicate a positive association between conflict and people's distress, or conversely a negative association with well-being, the effects are not fully consistent (for narrative reviews see Michalak, Heinreich, & Hoyer, 2004, Michalak & Holtforth, 2006, Kelly, Mansell, & Wood, 2015, Riedeger 2007). Therefore a meta-analysis of a cohesive part of the literature would provide a clearer estimate of the association.

A range of findings is unsurprising given methodological limitations and the number of factors that may influence an association between goal conflict and well-being – such as whether goals are mutually exclusive or whether conflict is the result of limited resources with which to pursue goals (Segerstrom & Solberg Nes, 2006). Optimism (Segerstrom & Solberg Nes, 2006) and ambivalence about achieving goals (Kelly, Mansell, & Wood, 2011) amongst other factors have also been found to mediate and moderate the association with well-being. Further, conflicts may also be outside of conscious awareness, creating additional complications in measurement (Kleiman & Hassin, 2011). The variety of influences and null findings creates uncertainty in the basic association between goal conflict and well-being and in ascertaining an underlying mechanism that might explain the relationship.

In a helpful systematic review of studies on the association between goal conflict and well-being, Kelly et al., (2015) conceptualised a hierarchy incorporating the different approaches to examining goal conflict consistent with Perceptual Control Theory (PCT, Figure 1). PCT proposes that at the top of the goal hierarchy are abstract, fundamental values like being a good person, which control lower-level concrete

goals, which in turn enact the higher-level goals in a particular situation (Powers, 2005).

1.1.2. Perceptual Control Theory and MOL

PCT has been developed into a therapeutic approach called Method of Levels (MOL, Carey, 2006; Carey, Mansell, & Tai, 2015). MOL and PCT propose that people's behaviour is driven by their perceptual goals. As in the fairy-tale of Goldilocks there is a perceptual goal of what porridge, bed or other perceptual experience is "just right". Conversely, distress is caused by "enduring unwanted perceptual activity" (Carey, 2006, p56). The enduring activity is the result of conflicting goals; making progress towards one goal undermines the other, and therefore both cannot be "just right" (Carey, 2006). For example in social anxiety a typical conflict is between a desire to form a good impression and wanting to avoid a negative evaluation (Kashdan, 2007) – resulting in indecision and neither goal being met. MOL operates on the principle that for the conflict to be resolved the person needs to become aware of these conflicts, allowing the goals to be adjusted so that they are no longer incompatible (Carey, 2006). The therapist highlights occurences where the client's attention briefly shifts to higher levels of their hierachy, and the therapist tries to maintain the client's awareness at the higher level through discussion and noticing any further shifts in awareness (Carey, 2006). MOL is deliberately a minimalistic therapy, proposing that goal conflict is the key transdiagnostic process, eschewing a variety of tools and techniques in favour of focusing on attentional shifts and awareness (Carey, 2006).

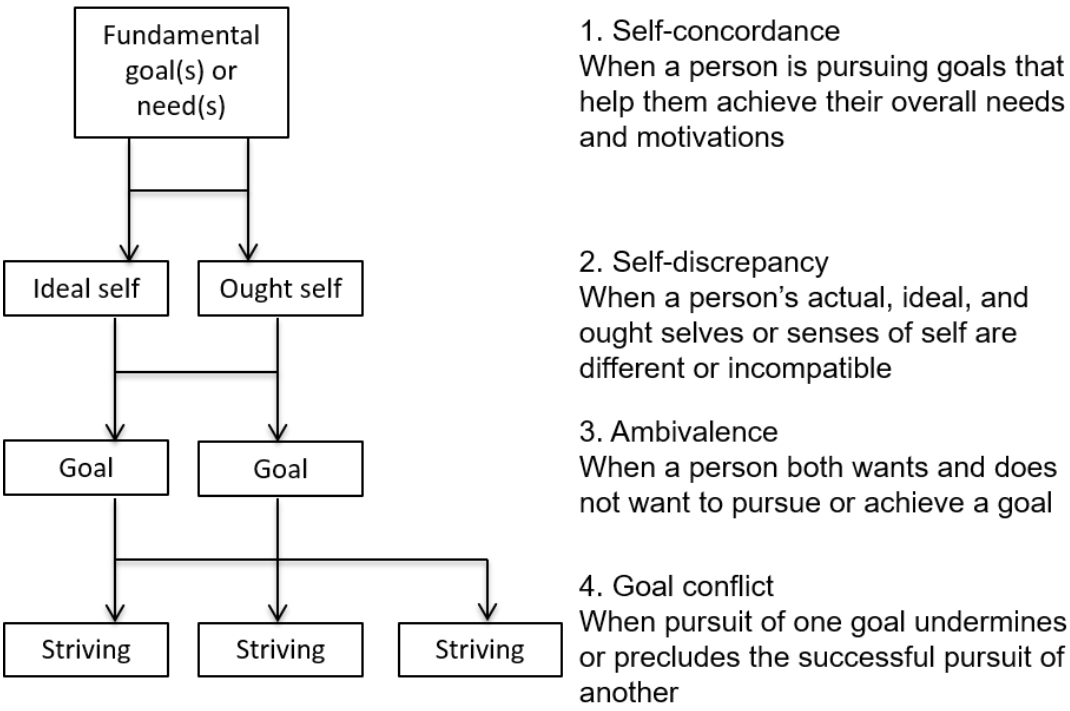

Figure 1. A hierarchical model of goal conflict from Kelly et al. (2015)

There is evidence that MOL is an effective individual (Carey & Mullan, 2008; Carey, Carey, Mullan, Spratt, & Spratt, 2009; Carey, Tai, & Stiles, 2013) and group (Morris et al., 2015) intervention, showing moderate to large effect sizes on standardised measures for a variety of diagnoses – although the studies are limited to case studies and prospective studies. Accounts of hearing voices (Varese, 2014), and the experience of reducing distress by those who have resolved their difficulties through, or without therapy (Gianakis & Carey, 2011; Higginson & Mansell, 2008) have also been found to be consistent with PCT. However, findings that MOL might be effective are not the same as confirming that the mechanism of action is the proposed one. Only a limited number of studies have been conducted and found a decrease in goal conflict after therapy (e.g. Hoyer, Fecht, Lauterbach, & Schneider, 2001). Therefore for MOL it is important to explore the association between goal conflict and distress in order to test or develop the theory, and to ascertain whether there are differences in the type and strength of conflicts.

1.1.3. Methodological Hierarchies

Kelly et al's (2015) proposal for their hierarchy concluded that the evidence is weakest at the lowest level, where one goal undermines or precludes the attainment of another, such as 'I want to work long hours to get ahead, but I also want to see my friends'. Kelly et al., (2015) note inconsistent findings in general, and between measures, such as Michalak et al., (2004), who found a low correlation (r = .07) between the implicit Computerised Intrapersonal Conflict Assessment (CICA, Lauterbach, 1996) and the explicit Strivings Instrumentality Matrix (SIM, Emmons & King, 1988) which is the most frequently used measure for low-level conflict, although the sample size was only 24.

Kelly et al. (2015) proposed two explanations for the inconsistent findings at their lower level. Firstly, explicit conflict may be more amenable to change (citing Higginson et al., 2011); as lower level conflict is easier to observe it is more likely to be reorganised. Secondly, lower level conflict may have less effect on well-being, as it may be offset by an overall set of conducive goals (Sheldon & Kasser, 1995), and that goal conflict can even have positive effects (Cropanzano, Citera, & Howes, 1995). The use of bipolar scales like the SIM has also been highlighted as a source of inconsistencies (e.g. Boudreaux & Ozer, 2013). Riediger (2007) and Riediger and Freund (2004) suggested and found evidence that interference is negatively related to well-being and facilitation is unrelated, and that instead facilitation is related to goal pursuit. The methodology of individual studies has also been highlighted. Freitas, Clark, Kim, and Levy, (2009) proposed that Sheldon and Kasser's (1995) questions on motivations as well as conflicts potentially confounded their results. A further consideration is the lack of statistical power analysis considered in the literature, with varied sample sizes, and consequent benefits of using larger samples to establish a more reliable estimate of a correlation (Cohen, 1992, Schönbrodt & Perugini, 2013).

1.1.4. Rationale

As the literature is inconsistent at a conceived lower level of conflict, it is therefore difficult to ascertain the degree of the association between goal conflict and well-being from narrative reviews such as Kelly et al. (2015). The *degree* of the

association is theoretically important for MOL, and also of consideration for clinical practice in general. In this context a meta-analysis would complement the narrative reviews in producing an estimate of the upper and lower boundaries of the association of goal conflict and well-being – for example, as measured by the SIM and well-being. Another advantage of a meta-analysis is exploring the effect of publication bias. A meta-analysis would also contribute to establishing whether a goal conflict measure would be helpful to include in clinical work, alongside measures of other constructs that are related to distress and well-being.

1.2 **Goal Conflict Measure Selection**

The SIM was found to be the most frequently used measure at the lowest level, used by 9 out of 23 studies categorised in Kelly et al.'s (2015) review. The CICA was the next most commonly used measure, used in six studies, with the third most commonly used measure only used in two studies. The analysis carried out in this review is only based on the SIM because it was the most commonly found measure and because of the low association of r = .07 found by Lauterbach (1996) indicating that pooling the data would be inadvisable. Further the CICA and SIM study samples are also not necessarily comparable, as the SIM is almost exclusively used with non-clinical samples and the CICA with clinical samples. The CICA is also an implicit measure of goal conflict administered using a computer; it is not freely available, and therefore the potential for using it in further studies is limited.

1.2.1 **The SIM**

To complete a SIM respondents list a number of personal strivings, defined as “an objective that you are typically trying to accomplish or attain” (Emmons & King, 1988, p. 1042) – typically listing 10 or 15 strivings. These are then copied to a 10x10 or 15x15 matrix listing the goals on the vertical and horizontal axes. Respondents are then asked to rate “Does being successful in this striving have a helpful, a harmful, or no effect at all on the other striving?” (Emmons & King, 1988, p. 1042). The rating is on a scale ranging from very harmful (-2) to very helpful (+2), with 0 representing neither unhelpful nor helpful. A rating is completed for each goal pair. For ease of scoring the -2 to +2 scale is then recoded to a 1 (representing *very helpful*) to 5 (representing *very harmful*) conflict score. A score of 3 represents the neutral midpoint. A total score, or a mean of the conflict scores can then be calculated.

The split-half reliability of the SIM has been found to be r_s = .91 (Emmons & King, 1988), r = .92 and r = .94 (both Hall, Oates, Anderson, & Willingham, 2012), and a one year test-retest reliability of r_s = .58 was deemed satisfactory (Emmons & King, 1988). Aside from the poor correlation reported in 1.1 with the CICA, the authors are unaware of published associations between the SIM and another measure of goal conflict.

1.2.2 **Well-being and distress**

Discussion of well-being concepts is somewhat limited within the goal conflict literature, with a variety of measures adopted, alongside clinical measures of distress. Hedonic, subjective well-being – which is conceived as related to happiness – is used throughout the literature. It is thought to consist of an emotional side, comprised of positive affect and negative affect; and a cognitive judgement of life satisfaction which is felt to be more trait-like and stable (Diener, Emmons, Larsen, & Griffin, 1985; Diener, 2000; Lucas, Diener, & Suh, 1996). Various interacting factors are associated with hedonic well-being, as with distress, due to the overarching nature of constructs and complexities of individual experience, such as personality, age, gender, socioeconomic status and physical health (Diener, Oishi, & Lucas, 2003; Dolan, Peasgood, & White, 2008; Wiest, Schüz, Webster, & Wurm, 2011). Given the number of factors that are associated with hedonic well-being, and the influence of other processes such as habituation to circumstances, correlations tend to be modest (Diener, 2000). For example demographic factors such as age, occupation, education and gender have been associated with positive affect and negative affect and distress, with correlations around r = .05 to .20 (Crawford & Henry, 2003, 2004; Diener & Ryan, 2015), which is lower than a specific factor such as unemployment (r = .27, Paul & Moser, 2009).

Eudaimonia, which is related to fulfilment and achieving one's potential is less considered within the research. However, a discussion of hedonic and eudaimonic theories (such as Huta & Waterman, 2014; Waterman, 1993) is beyond the scope of this article, but does represent a limitation of the literature for review as the studies included only one measure of hedonic well-being.

1.3 **Method**

1.3.1 **Inclusion/exclusion criteria**

Studies were included that:

a) Used the SIM and:
    i. a bidirectional rating of goal pairing conflict
    ii. the participant listed more than five strivings
    iii. strivings were 'typical' for the individual concerned
b) Used a measure of distress, which was valid and reliable
c) AND/OR used a multi-item measure of hedonic well-being with published reliability
d) Were written in English

1.3.2 **Literature search**

Keyword searches were performed using the PsycARTICLES Full Text, PsychINFO (1806 to current) and Ovid MEDLINE® Daily Update in July 2015. Two strategies were used; firstly searching for the SIM by keyword ("Striving$ Instrumentality Matrix") and secondly as Emmons and King (1988) is the standard reference for the SIM, citations listed on Google Scholar, Web of Science and via the OVID platform were reviewed for inclusion in July 2015.

All of the articles that were retrieved were reviewed solely by the author. If the title did not provide sufficient information to exclude the article the abstract was reviewed. If the abstract did not provide enough information then a full copy of the paper was downloaded and reviewed. References of the papers that met the inclusion list were also reviewed for further articles and the same review process followed. A summary of the search is provided via a QUORUM diagram (Moher et al., 1999, Figure 2).

Monzani et al., (2015) only asked participants to rate four goals, and pairings were only rated in terms of harm. Simons and Carey (2003) rated conflict between strivings and pre-specified levels of marijuana use in a student sample and, with the limited marijuana use in the sample, it was not felt to be a 'typical striving' as most participants were not using marijuana. Conversely, Hall et al., (2012) enquired about

strivings related to mother's careers and their parenting responsibilities, which was felt to be sufficiently broad and likely to be typical.

Given the time span covered, and the periods at which particular well-being measures were developed, the inclusion criteria for this study were pragmatic, to discuss measure quality and to include data despite a lack of validation against another measure. For example the measure used by Emmons, (1986) has published reliability (Diener & Emmons, 1984) but no published validity. Only including studies using the SIM meant that two studies Wallenius (2000) and Palys and Little (1983), which used a measure similar to the SIM were excluded. Wallenius (2000) reported no association but Palys and Little (1983) did report one. However, both studies used a single item measure of well-being, and Wallenius (2000) also used a single item measure of depression. Single item measures have been described as "adequate" if a very brief measure is required, but ignore the multiple components of well-being (Diener, 1984, p. 544). It was judged that a more than brief measure was required, and all of the studies used either a single measure which was reliable and valid or multiple measures. Only one of the studies (Romero et al., 2009) included an explicitly eudaimonic well-being measure. A variety of other measures, such as the Rosenberg Self-Esteem Inventory (Rosenberg, 1965) were used in some studies, but not included due to differences with eudaimonic wellbeing, and its treatment as a personality variable in some literature (e.g. Diener & Diener, 1995). Although measures of subjective well-being and self-esteem have been found to have different patterns of association, overall they correlate to $r = .58$ (Lyubomirsky, Tkach, & DiMatteo, 2006). Further discussion is included in 4.1 including a brief summary of a analysis including broader criteria.

Three studies, one published (Hötzel et al., 2012) and two unpublished (Michalak, 2002; Puschel, 2000 - which did find an association, both referred to in Michalak et al., 2004) were in German, and unfortunately could not be incorporated.

1.3.3 **Critical Appraisal**

The Crowe Critical Appraisal Tool (Crowe & Sheppard, 2011, Crowe, Sheppard, & Campbell, 2012) was used as it was specifically been developed to apply to a wide number of study designs and attempts have been made to explore its validity and

reliability, in contrast to most other appraisal tools. Other critical appraisal tools were considered, but generally they apply to randomised control trials, or between-group designs, whereas the studies included are all correlational single group designs. The construction of an esoteric measure was considered, but a formalised approach was chosen for transparency.

1.3.4 **Meta-Analysis**

The methodology and statistical process outlined in Field and Gillett (2010) was followed. The analysis was undertaken as a random-effects model, assuming that the effect size estimates of the populations for the studies vary (Field & Gillett, 2010). Hedge's and Vevea's random effects model is primarily reported, due to it having more accurate confidence intervals when applied to a small number of studies (Field, 2005).

1.3.5 **Effect Size**

Pearson's correlation coefficient, *r*, was used in the review. It is a standard effect size and measure of the covariance between two variables (Field & Gillett, 2010) and *r* values were reported in all of the studies. In addition *r* has several advantages for computations and comparison, such as r^2 aiding interpretation relative to *d*, and being more widely understood (Rosenthal & DiMatteo, 2001).

1.4 **Results**

1.4.1 **Study Characteristics**

Summaries of the papers are provided in Table 1 and 3. For negative well-being the total sample size was 1,239, for positive well-being it was 1,143. Therefore, both sample sizes are above the level required to have sufficient power to detect a small effect size (Cohen, 1992). The studies commonly used a cross-sectional correlational survey design, predominately with student samples. Most of the studies had limited (Anglo-American) ethnic variation, although two of the studies took place in Spain and Germany. There is an over-representation of women, who formed 70% of the sample, exaggerated by Hall et al. (2012). Therefore the representativeness of the studies is limited. Studies typically found low levels of goal conflict, and few

found a significant association between goal conflict and either positive or negative well-being.

1.4.2 **Critical Appraisal**

The respective ratings are shown in Table 2. The overall quality of the papers was generally good in terms of the theoretical introduction, context and how the results were written and interpreted. Sampling was in general adequate, noting moderate sample sizes and brief descriptions. However, no rationale was offered for the particular sample sizes used, beyond presumed convenience. Nor are any power analyses reported; most studies investigated and analysed multiple variables and this is a considerable shortcoming. Cohen (1992) suggests that, to detect a small effect size (r = .10) with a power of .80, a sample of 783 is needed, and for a medium effect size (r = .30), a sample of 85 is needed (both with α = .05). Five of the samples have an n below 85, with the seven remaining samples falling between 85 and 783. Therefore, five of the studies are clearly underpowered for even a medium effect, and the consequent validity of interpretation of their effect size can only be limited.

A variety of measures of well-being, or clinical measures of distress were employed, with better reliability than validity in some cases due to the less widely used measures, for example Kehr (2003) used items with αs > .90, but no published validity. The items as listed in Table 3 did not necessarily consider all three components of hedonic well-being, although some only refer to ratings of mood and Kelly et al., (2011) only used a measure of distress. The variance in measures is partially attributable to the age of some of the papers and that some of the papers were not conducted in English-speaking countries. For example Emmons (1986) and Emmons and King (1988) predated publication of the PANAS, but used similar measures. As mentioned in 2.5 whilst certain studies were better at specifying particular hypotheses, when multiple measures were used, no preference was indicated. Data collection was also generally described in broad terms, whilst ethical issues were generally not mentioned (and were therefore scored as 0 or 1). Overall, however, the range of scores is reasonably narrow, ranging from 63% to 78%. Therefore – and also due to the modest number of studies, a sub-group analysis was

not undertaken. It is noted that critical appraisal tools are often limited, as they tend to focus on a study's report rather than conduct (Higgins & Green, 2011).

1.4.3 **Effect Size Estimates**

Three of the studies used a single psychometric measure to compare with the SIM score. The intercorrelations between the various measures were not available in most studies to calculate an effect size which would account for them. Therefore the simple mean of the items was calculated (Rosenthal & Rubin, 1986). Using the mean ignores dependence between measures and can produce a slightly higher or lower estimate than composite weightings (Marín-Martínez & Sánchez-Meca, 1999; Rosenthal & Rubin, 1986). However, it can still produce suitable estimates when homogeneity of nonindenpendent effect sizes is assumed (Marín-Martínez & Sánchez-Meca, 1999); as shown in Table 3 the means were often similar. Similarly PANAS positive and negative affect scores are not completely independent, but it has been proposed that they are relatively independent (Crawford & Henry, 2004).

Measures of positive affect, life satisfaction and self-esteem were collated as "positive well-being". They were separated from negative affect or distress which were collated in to "negative well-being" in the analysis. The separation was done pragmatically, given the directions of scoring for the two areas. It was also not possible to separate positive affect and life satisfaction due to the limited number of studies using them. The amalgamation therefore conflates a number of important constructs. This is a limitation, however, the practical importance of this is limited, as there are significant correlations between the constructs. For example the BDI has been found to correlate to .56 with negative affect (NA) from PANAS, (Watson, Clark, & Tellegen, 1988), and the BAI (.54, .64 and .81) and BDI (.74, .58 and .60) to DASS sub-scales (Lovibond & Lovibond, 1995). Studies did not necessarily publish a full matrix of zero order correlations, and therefore the respective correlations could not be reported or analysed. The studies also explored the association with a number of factors between well-being, distress and goal conflict, such as personality (Romero, Villar, Luengo, & Gómez-Fraguela, 2009). There was however, considerable variety in these other factors, and it was not possible to include them due to the limited number of studies looking at their effects.

Several of the studies reported the SIM conflict score in different ways. Not all of the studies reported their methodology explicitly and in some studies an instrumentality score was reported rather than a conflict score. Therefore some of the *r* value's directions are reported based on the wording of the conclusions. Segerstrom and Solberg Nes (2006) do not explicitly report a correlation between their psychometrics and the SIM, but note that no relationship was found. Although conservative as it tends to underestimate the magnitude of any effect size (Rosenthal, 1995), the correlation was entered as 0 in the current analysis.

Authors	Sample	n	Age Mean (SD)	Age range	Design	Gender m:f (%)	Ethnicity White:Other
Emmons (1986)	Undergraduates	40			Longitudinal, cross-sectional	30:70	
Emmons and King (1988) study 1	Undergraduates	40			Cross-sectional	30:70	
Emmons and King (1988) study 2	Undergraduates	48			Cross-sectional	27:73	
Sheldon and Kasser (1995) study 1	Undergraduates	161			Cross-sectional	42:58	
King, Richards, and Stemmerich (1998)	Students	80	21.09 (2.28)		Cross-sectional	22:78	85:15
Kehr, 2003	Managers (German)	99	39.8 (8.83)	21-62	Cross-sectional	75:25	
Segerstrom and Solberg Nes (2006) study 2	Undergraduates	77	20	17-71	Longitudinal, cross-sectional	17:83	87:13
Freitas et al. (2009) study 2	Undergraduates	91	20.18	18-31	Cross-sectional	27:73	
Romero et al (2009)	Part student, part general population (Spanish)	405	31.87 (7.97)	21-55	Cross-sectional	36:61	
Dickson and Moberly (2010)	Secondary school students	119	Mode: 17	16-19	Cross-sectional	38:62	
Kelly, Mansell, and Wood, (2011)	Students	120	19.84 (2.93)		Cross-sectional	18:82	
Hall et al. (2012)	Mothers in work with a degree or qualification	200	39.69 (6.92)	26-58	Cross-sectional	0:100	81:19

Table 1. Demographics and designs of the studies
Missing cells indicate values not reported in the articles.

	Preliminaries	Introduction	Design	Sampling	Data Collection	Ethics	Results	Discussion	Total	%
Emmons, (1986)	5	5	4	2	4	0	5	4	29	73%
Emmons and King (1988)	5	5	4	2	3	0	5	4	28	70%
Sheldon and Kasser (1995) study 1	4	4	4	2	3	1	3	4	25	63%
King, Richards, and Stemmerich (1998)	3	4	4	3	4	1	4	4	27	68%
Kehr (2003)	5	4	4	3	3	1	4	4	28	70%
Segerstrom and Solberg Nes (2006), study 2	4	4	4	3	4	1	4	4	28	70%
Freitas et al (2009) study 2	4	4	4	3	4	0	4	4	27	68%
Romero, et al. (2009)	4	5	4	4	3	0	3	4	27	68%
Dickson and Moberly (2010)	4	3	4	3	4	1	4	4	27	68%
Kelly, Mansell, and Wood (2011)	5	5	4	3	3	1	5	5	31	78%
Hall et al. (2012)	4	3	4	4	4	1	4	3	27	68%

Table 2. CCAT ratings by study
5 marks awarded per heading, out of a possible total of 40 per study

				Negative Affect				Positive Wellbeing				
Study	n	%	Conflict M (SD)	1	2	Mn *r*	N x r	1	2	3	Mn *r*	N x *r*
Emmons (1986)	40	3%		.33**[i]		.33	13.20	-.21[j]	-.34**[f]		-.28	-11.2
Emmons and King, (1988) study 1	40	3%	3.50 (0.89)	.28*[k]	.30*[l]	.30	12.00	-.13[k]	-.18m		-.16	-6.40
Emmons and King, (1988) study 2	48	4%	3.63 (0.92)	.21[k]	.20[l]	.20	9.6	-.11[k]	-.07[m]		-.09	-2.40
Sheldon and Kasser, (1995) study 1	161	12%	1.47 (0.57)+	-.03[h]		-.03	-4.20	.08[h]			.08	12.88
King, Richards, and Stemmerich (1998)	80	7%	2.30 (0.38)	.01[e]		.1	8.00	-.05[f]			-.05	-4.00
Kehr (2003)	99	9%	2.60 (0.56)+	.08[a]	.21*[a]	.15	14.35	-.07[a]	-.18[a]		-.13	-12.87
Segerstrom and Solberg Nes (2006) study 2	77	7%		[c]		0						
Freitas et al. (2009) study 2	91	8%	2.35 (0.45)+	-.09[h]		.09	8.19	-.29**[h]			-.29	-26.39
Romero et al. (2009)	405	35%		.01[h]		.01	4.05	.09[h]	.04[f]		.07	28.35
Dickson and Moberly (2010)	99	9%	2.40 (0.4)	-.33***[b]	-.40***[c]	.37	-36.14					
Kelly, Mansell, and Wood (2011)	120	10%	2.84 (0.35)	-.05[d]		-.05	-6.00					
Hall et al. (2012)	200	17%	2.25 (0.62)			N/A		-.22**[g]			-.22	-44.00

Table 3. Effect sizes by sample

+ denotes conflict scores re-scaled according to Emmons & King (1988) with 1 representing “very helpful”, 3 representing no effect and 5 representing “very harmful”. * $p < .05$

Measures: [a]16 item measure from (Brunstein, Schultheiss, & Grässmann, 1998), [b] Beck Anxiety Inventory, [c]Beck Depression Inventory, [d] Depression, Anxiety and Stress Scale (DASS-21), [e] Beck Depression Inventory Short Form, [f] Satisfaction with Life

Scale, [g] Positive and Negative Affect Scale (reported as well-being, no breakdown reported), [h] Positive and Negative Affect Scale, [i] Idiosyncratic 5 adjective negative affect, [j] idiosyncratic 4 adjective positive affect, [k] Bradburn Affect Balance Scale, [l] Hopkins Symptom Checklist (Mean of Somatization, Anxiety and Depression scale, for study 1 r = .28, .29, .34, for study 3 r = .24, .17, .19 respectively), [m] Wellbeing scale of the Differential Personality Questionnaire

1.5 **Publication Bias**

In reviewing the available literature it is a general concern that papers without significant effects tend to be unpublished, with a number of factors contributing to the effect (Begg & Berlin, 1989). There are a variety of ways of estimating and reporting publication bias. Rosenthal's fail-safe *N* was calculated, this is the number of unpublished non-significant studies that would need to exist for the obtained probability value of the population effect size to be non-significant. For negative well-being, the fail-safe N was 30 and for positive well-being it was 18. Rosenthal (1979) suggests a conservative tolerance for N of five times the number of studies plus ten, which would be 65 for positive well-being and 55 for positive affect, both larger than the fail-safe N, indicating a risk of publication bias. However, the fail-safe N is only indicative, and does not adjust the estimate of the effect size.

Begg and Mazumbar's test, similarly to funnel plots explores the correlation between effect size estimates and their variances as publication bias will tend to induce a correlation between the two factors (Begg & Mazumdar, 1994). For negative well-being Begg and Mazumbar's rank correlation was not significant $\tau(N = 11) = .43$, $p = .072$ as was the figure for positive well-being $\tau(N = 9) = -.19$, $p = .463$. However, the test has a lower power for meta-analysis with a small ($k = 25$) number of studies (Begg & Mazumdar, 1994), and therefore bias cannot be ruled out. Therefore funnel plots of the effects found in each study against the standard error for visual inspection and sensitivity analysis suggested by Vevea and Woods (2005) are reported. For the funnel plots an unbiased sample will be symmetrical around the population effect size, with the funnel reflecting the variation in effect sizes found by studies with different properties.

1.5.1 **Negative Well-being**

8 out of the 11 samples found a positive correlation, although only 4 studies found a significant one. Homogeneity of variances was non-significant, $\chi^2 (10) = 10.37$, $p = .409$ and therefore the effect-size parameters are similar in the studies. The effect sizes are also shown in Table 4, showing a relatively symmetrical distribution around .1. Table 6 shows the overall meta-analysis estimate and confidence interval, with the mean just under, but rounding to

Cohen's (1992) boundary of a small effect size. Negative well-being was positively related to goal conflict, sharing 1.0% of the variance in goal conflict score.

Figure 2 shows a funnel plot of the effect sizes for negative well-being. Interpretation of funnel plots is challenging (Vevea & Woods, 2005), and as there are only a small number of studies it is difficult to determine whether bias might be one or two-tailed. To explore this further both one and two-tailed publication-bias corrected estimates were calculated using Vevea and Woods (2005) sensitivity analysis for random effects. A one-tailed estimate models the existence of more correlations near zero, whilst a two-tailed estimate models more significant correlations in either direction of the effect. Compared to the estimate in table 6 of r = .10, the models assuming a moderate publication bias produced a small amount of change, with a one-tailed population estimate of r =.07 and a two-tailed estimate of r = .09. The severe one-tailed weight function was r = .01, with a two-tailed estimated of r = .08. Therefore all of the estimates assuming publication bias are below the cut-off of r = .10 for a small effect size (Cohen, 1992), but only show a small degree of change, unless a severe one-trailed publication bias is assumed.

Stem	Leaf
-.5	
-.4	
-.3	
-.2	
-.1	
-.0	5
.0	0, 3, 9
.1	0, 1, 5
.2	0
.3	0, 3, 7
.4	
.5	

Table 4. Stem-and-leaf plot of mean negative well-being effect sizes

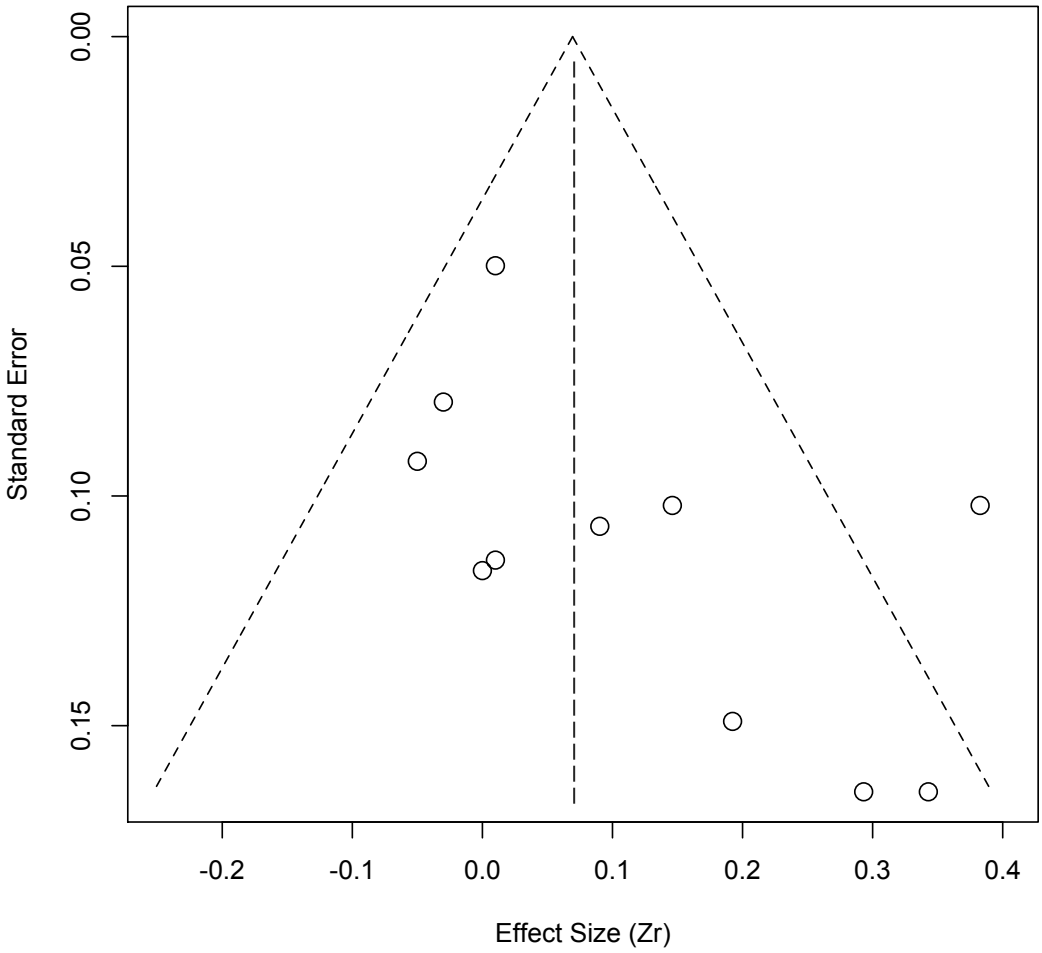

Figure 2. Funnel plot of negative well-being.

The vertical line represents the population effect size and the diagonal lines the 95% confidence intervals.

1.5.2 **Positive Well-being**

7 out of the 9 samples found the expected negative correlation, although only 3 of the studies found a signification association. Homogeneity of variances was non-significant, χ^2 (9) = 6.14, p = .631, and therefore the effect-size parameters are similar across the studies. The effect sizes are also shown in Table 5, illustrating a relatively symmetrical distribution around -.1. Table 6 shows the overall meta-analysis estimate and confidence interval, with the effect size just over the threshold for small effect, but non-significant.

Stem	Leaf
-.5	
-.4	
-.3	
-.2	2, 8, 9
-.1	3, 6
-.0	5, 8, 9
.0	7, 8
.1	
.2	
.3	
.4	
.5	

Table 5. Stem-and-leaf plot of mean positive well-being effect sizes

Figure 3 shows a funnel plot of the effect sizes, which is more one-sided. Again, estimates corrected for publication-bias were calculated using Vevea and Woods (2005) sensitivity analysis for random effects. Compared to the estimate in table 6 of -.10 the models assuming a moderate bias produced a one-tailed population estimate of r =-.13 and a two-tailed estimate of r = -.09. However, the severe one-tailed weight function increased to r = -.22. The severe two-tailed estimate was r = -.08. Therefore, if the severe publication bias is present the effect is underestimated, and otherwise the estimate shows a small amount of change.

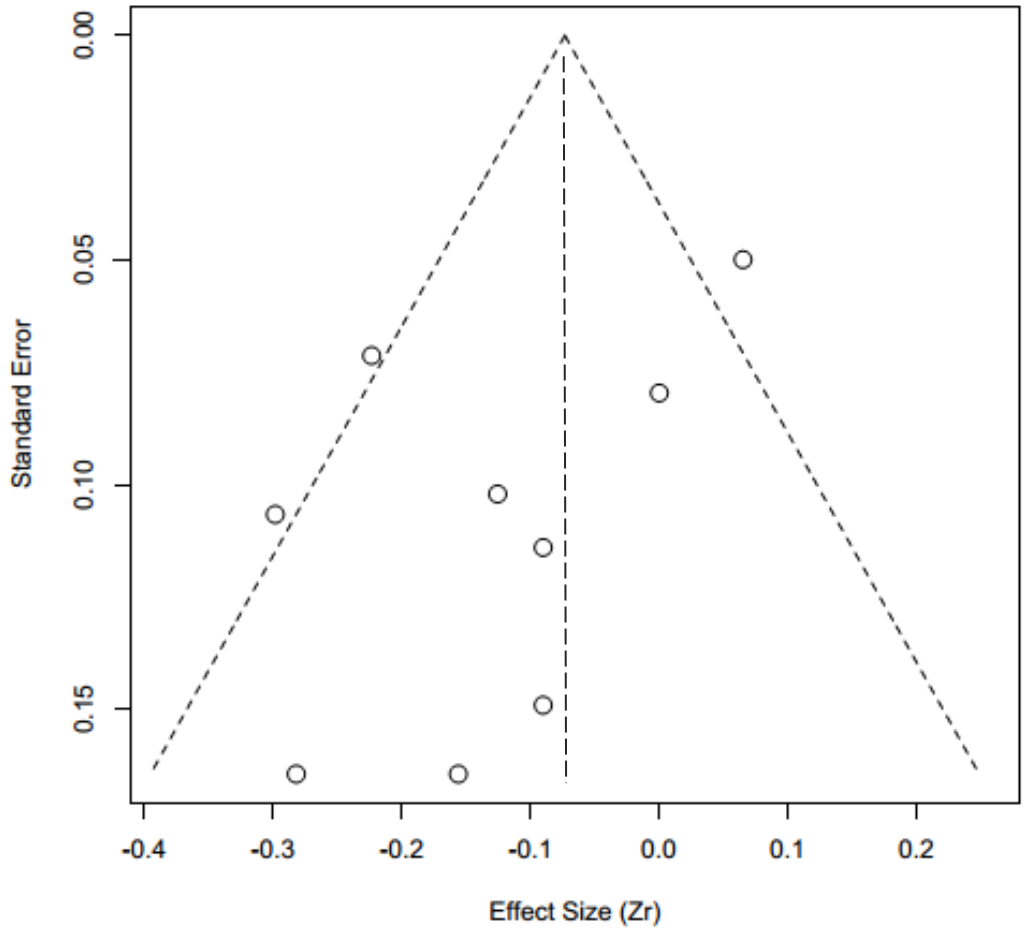

Figure 3. Funnel plot of positive well-being.

The vertical line represents the population effect size and the diagonal lines the 95% confidence intervals.

	K	τ^2	*p*	95% confidence interval for *r*			*z*
				Lower	Mean	Upper	
Negative Affect	11	.01	.028	.011	.098	.183	2.20
Positive Wellbeing	9	.02	.064	-.206	-.101	-.006	1.86

Table 6. Meta-analysis results for negative and positive well-being

1.6 Discussion

This meta-analysis summarises the results of the association between goal conflict, specifically as measured by the SIM, and measures of well-being and

distress. It includes data from 11 studies. Overall the results demonstrate a small association, showing that goal conflicts associated with increased positive well-being (r = .10), and decreased negative well-being (r = -.11) are at the boundary of a small effect size. Whilst there was some indication of publication bias, estimates correcting for the bias preserved the results presuming a moderate bias. The confidence intervals of the effect size ranged from approximately .00 to .20 for both negative and positive well-being and therefore at most account for 4% of the shared variance. As such and in relation to other correlations with distress and well-being the finding is lower compared to a factor such as unemployment (r = .27, Paul & Moser, 2009), but in line with some other significant control variables' associations with components of well-being, such as age, geographic area and partner status (e.g. Wiest et al., 2011). The overall result, however, suggests that goal conflict as measured by the SIM does not show a high degree of association with either well-being or distress.

The result is consistent with the narrative reviews (e.g. Kelly et al., 2015; Michalak et al., 2004; Michalak & Holtforth, 2006), with some uncertainty in the effect. Further, Kelly et al. (2015) note that effect sizes higher in the hierarchy tend to be small or medium and until a synthesis is undertaken for conflict at the other levels and accounting for publication bias it is difficult to ascertain whether there is a stronger effect at a particular level, although it would appear likely. As discussed in 1.3 several reasons have been suggested for the weaker association at lower levels of conflict, including a number of mediating factors like optimism and ambivalence, the bipolar scoring on the SIM, and the overall importance of low-level conflict. The current analysis is unable to contribute to whether it is a measurement artefact or a true effect, although the methodological constraints of assessing goal conflict are evident given the number of factors that are implicated.

This analysis has only looked at the SIM's bipolar rating of conflict and facilitation. A bipolar scale prevents a separate rating of one goal facilitating and conflicting with another goal. The lack of this separation makes interpretation of the SIM results ambiguous (Riediger, 2007), there are

insufficient studies to explore a contrast of this, and this separation is worth further exploration. However, whilst a separation is likely to be more technically accurate, unfortunately this would immediately double the burden on the respondent. Similar to Michalak et al.'s (2004) conclusions the current review found seven out of nine reported mean SIM scores were helpful, rather than harmful, and therefore the SIM score might be better conceptualised as measuring the degree of integration of a person's goals. More helpful SIM scores may be a representation of the largely student sample, and that conflict may be less prevalent in non-clinical samples. An alternate measure is likely to have advantages, and the CICA's association with well-being and distress is an area for further investigation to build on the current studies.

The findings do not undermine MOL, as there are a variety of reasons why the SIM might not correlate strongly with well-being and distress. For example, it may not be a robust measure of the type of conflict that MOL would consider problematic. MOL is somewhat unspecific about quantifying the degree of conflict, and no specific goal conflict measure is seen as more central to the approach, or a standard measure that is used for conflict, and it is therefore difficult to produce an unambiguously inconsistent result. However, the findings suggest that the SIM conflict score has at best limited utility in a clinical context. In that sense, therefore the current analysis does little to make the case for PCT and MOL. For MOL to demonstrate its effectiveness via the proposed mechanism of reducing goal conflict, or at an association at a population level, it is likely that other measures will need to be utilised.

1.6.1 **Limitations**

Most of the studies were conducted with students and had limited ethnic variation. Additionally there is an over-representation of women, who formed 70% of the sample, exaggerated by Hall et al., (2012). Therefore the representativeness of the studies is limited. As the studies are of correlational design, an association does not imply causation, or indeed preclude distress preceding goal conflict. A time-series analysis would provide stronger evidence for the degree and nature of an association. Another limitation with correlational design is the potential impact of some third variable which truly

explains the association. Such a third variable may take the form of a number of the constructs explored in the various studies, or it may be something different. The measurement of these variables was not consistent enough to be included in this current review, but further variables would certainly be expected to have an effect, reflecting the variety of factors that have been found to influence well-being and distress. As such there are areas for further research. However, it is also important to be realistic about the end goal of the research, given the resources required and the extent of progress in developing models of well-being and distress.

The use of meta-analysis and the approach taken also have limitations. As highlighted in 2.1 a number of papers were excluded, and the pragmatic conflation of well-being and distress constructs discussed in 2.5 is a particular limitation necessarily adopted because of the limited data available. The use of measures and their properties was also heterogeneous, with a eudaimonic measure, a measure of self-esteem and another measure of goal conflict excluded, although this primarily affected positive wellbeing. A more inclusive analysis was also undertaken for positive wellbeing, including these excluded measures, which found a similar, but significant correlation, just above a small effect size with a similar confidence interval. As outlined in 3.2 meta-analyses are subject to publication bias. On testing for this, both positive and negative associations were held relatively stable assuming a moderate publication bias, giving some confidence in the results. However, the negative well-being association was essentially eliminated under a severe one-tailed bias, and the positive well-being association doubled under the same conditions.

1.6.2 **Conclusion**

The analysis suggests that the association between goal conflicts (as measured by the SIM) on the one side, and distress and well-being, on the other is on the boundary of a small effect size. The inconsistent findings that account for this have been discussed in narrative reviews. The overall weighting of this association and the extent of publication bias has not been evaluated before, which is the unique contribution of this paper. The current meta-analysis suggests that there is limited utility in assessing goal conflict using the SIM in

non-clinical samples to explore well-being or distress. Future research should consider exploring the results in clinical samples, separating the helpful and harmful scoring for the SIM, or using the CICA.

1.7 References

Begg, C. B., & Berlin, J. A. (1989). Publication bias and dissemination of clinical research. *Journal of the National Cancer Institute*, *81*(2), 107–115. http://doi.org/10.1093/jnci/81.2.107

Begg, C. B., & Mazumdar, M. (1994). Operating characteristics of a rank correlation test for publication bias. *Biometrics*, *50*(4), 1088–1101. http://doi.org/10.2307/2533446

Boudreaux, M. J., & Ozer, D. J. (2013). Goal conflict, goal striving, and psychological well-being. *Motivation and Emotion*, *37*, 433–443. http://doi.org/10.1007/s11031-012-9333-2

Brunstein, J. C., Schultheiss, O. C., & Grässmann, R. (1998). Personal goals and emotional well-being: the moderating role of motive dispositions. *Journal of Personality and Social Psychology*, *75*(2), 494–508. http://doi.org/10.1037/0022-3514.75.2.494

Carey, T. A. (2006). *The Method of Levels: How to do Psychotherapy without getting in the way*. Hayward, CA: Living Control Systems Publishing.

Carey, T. a. (2011). Exposure and reorganization: The what and how of effective psychotherapy. *Clinical Psychology Review*, *31*(2), 236–248. http://doi.org/10.1016/j.cpr.2010.04.004

Carey, T. A., Carey, M., Mullan, R. J., Spratt, C. G., & Spratt, M. B. (2009). Assessing the Statistical and Personal Significance of the Method of Levels, (April), 311–324. http://doi.org/10.1017/S1352465809005232

Carey, T. A., Mansell, W., & Tai, S. J. (2015). *Principles-based counselling and psychotherapy: A Method of Levels Approach*. Hove: Routledge.

Carey, T. a., & Mullan, R. J. (2008). Evaluating the method of levels. *Counselling Psychology Quarterly*, *21*(October 2014), 247–256. http://doi.org/10.1080/09515070802396012

Carey, T. a., Tai, S. J., & Stiles, W. B. (2013). Effective and Efficient: Using Patient-Led Appointment Scheduling in Routine Mental Health Practice in Remote Australia. *Professional Psychology: Research & Practice*, *44*(6), 405–414. http://doi.org/10.1037/a0035038

Cohen, J. (1992). A power primer. *Psychological Bulletin*, *112*(1), 155–159.

http://doi.org/10.1037/0033-2909.112.1.155

Crawford, J. R., & Henry, J. D. (2003). The Depression Anxiety Stress Scales (DASS): normative data and latent structure in a large non-clinical sample. *The British Journal of Clinical Psychology / the British Psychological Society*, *42*, 111–131. http://doi.org/10.1348/014466503321903544

Crawford, J. R., & Henry, J. D. (2004). The positive and negative affect schedule (PANAS): construct validity, measurement properties and normative data in a large non-clinical sample. *The British Journal of Clinical Psychology / the British Psychological Society*, *43*, 245–265. http://doi.org/10.1348/0144665031752934

Cropanzano, R., Citera, M., & Howes, J. (1995). Goal hierarchies and plan revision. *Motivation and Emotion*, *19*(2), 77–98. http://doi.org/10.1007/BF02250564

Crowe, M., & Sheppard, L. (2011). A general critical appraisal tool: An evaluation of construct validity. *International Journal of Nursing Studies*, *48*(12), 1505–1516. http://doi.org/10.1016/j.ijnurstu.2011.06.004

Crowe, M., Sheppard, L., & Campbell, A. (2012). Reliability analysis for a proposed critical appraisal tool demonstrated value for diverse research designs. *Journal of Clinical Epidemiology*, *65*(4), 375–383. http://doi.org/10.1016/j.jclinepi.2011.08.006

Derogatis, L. R. (1986). Symptom-Check-Liste (SCL-90-R) [Symptom-check-list (SCL-90-R)]. In Internationale Skalen fur Psychiatrie (Ed.), *Collegium Internationale Psychiatrieae Scalarum*.

Dickson, J. M., & Moberly, N. J. (2010). Depression, anxiety, and reduced facilitation in adolescents' personal goal systems. *Cognitive Therapy and Research*, *34*(6), 576–581. http://doi.org/10.1007/s10608-010-9307-1

Diener, E. (2000). Subjective well-being. The science of happiness and a proposal for a national index. *The American Psychologist*, *55*(1), 34–43. http://doi.org/10.1037/0003-066X.55.1.34

Diener, E., & Diener, M. (1995). Cross-cultural correlates of life satisfaction and self-esteem. *Journal of Personality and Social Psychology*, *68*(4), 653–63. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/7738768

Diener, E. E. (1984). Subjective well-being. *Pyschological Bulletin*. http://doi.org/10.1037/0033-2909.95.3.542

Diener, E., & Emmons, R. A. (1984). The independence of positive and negative affect. *Journal of Personality and Social Psychology*, *47*(5), 1105–17. http://doi.org/10.1037/0022-3514.44.3.644

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction With Life Scale. *Journal of Personality Assessment*, *49*(1), 71–75. http://doi.org/10.1207/s15327752jpa4901_13

Diener, E., Oishi, S., & Lucas, R. E. (2003). Personality, Culture, and Subjective Well-Being: Emotional and Cognitive Evaluations of Life. *Annual Review of Psychology*, *54*(1), 403–425. http://doi.org/10.1146/annurev.psych.54.101601.145056

Diener, E., & Ryan, K. (2015). Subjective well-being : a general overview, *39*(4), 391–406.

Dolan, P., Peasgood, T., & White, M. (2008). Do we really know what makes us happy? A review of the economic literature on the factors associated with subjective well-being. *Journal of Economic Psychology*, *29*(1), 94–122. http://doi.org/10.1016/j.joep.2007.09.001

Emmons, R. a, & King, L. A. (1988). Conflict among personal strivings: immediate and long-term implications for psychological and physical well-being. *Journal of Personality and Social Psychology*, *54*(6), 1040–1048. http://doi.org/10.1037/0022-3514.54.6.1040

Emmons, R. A. (1986). Personal strivings: An approach to personality and subjective well-being. *Journal of Personality and Social Psychology*, *51*(5), 1058–1068. http://doi.org/10.1037/0022-3514.51.5.1058

Emmons, R. a. (1986). Personal strivings: An approach to personality and subjective well-being. *Journal of Personality and Social Psychology*, *51*(5), 1058–1068. http://doi.org/10.1037/0022-3514.51.5.1058

Emmons, R. A., & King, L. A. (1988). Conflict among personal strivings: immediate and long-term implications for psychological and physical well-being. *Journal of Personality and Social Psychology*, *54*(6), 1040–1048. http://doi.org/10.1037/0022-3514.54.6.1040

Field, A. P. (2005). Is the meta-analysis of correlation coefficients accurate when population correlations vary? *Psychological Methods*, *10*(4), 444–467. http://doi.org/10.1037/1082-989X.10.4.444

Field, A. P., & Gillett, R. (2010). How to do a meta-analysis. *The British Journal of Mathematical and Statistical Psychology*, *63*(Pt 3), 665–694. http://doi.org/10.1348/000711010X502733

Freitas, A. L., Clark, S. L., Kim, J. Y., & Levy, S. R. (2009). Action-construal levels and perceived conflict among ongoing goals: Implications for positive affect. *Journal of Research in Personality*, *43*(5), 938–941. http://doi.org/10.1016/j.jrp.2009.05.006

Gianakis, M., & Carey, T. A. (2011). An interview study investigating experiences of psychological change without psychotherapy, *0871*, 442–457. http://doi.org/10.1111/j.2044-8341.2010.02002.x

Hall, M. E. L., Oates, K. L. M., Anderson, T. L., & Willingham, M. M. (2012). Calling and conflict: The sanctification of work in working mothers. *Psychology of Religion and Spirituality*, *4*(1), 71–83. http://doi.org/10.1037/a0023191

Higgins, J. P. T., & Green, S. (2011). *Cochrane Handbook for Systematic Reviews of Interventions Version 5.1.0 [updated March 2011]*. *The Cochrane Collaboration* (Vol. 4).

Higginson, S., & Mansell, W. (2008). What is the mechanism of psychological change? A qualitative analysis of six individuals who experienced personal change and recovery. *Psychology and Psychotherapy*, *81*, 309–328. http://doi.org/10.1348/147608308X320125

Higginson, S., Mansell, W., & Wood, A. M. (2011). An integrative mechanistic account of psychological distress, therapeutic change and recovery: The Perceptual Control Theory approach. *Clinical Psychology Review*, *31*(2), 249–259. http://doi.org/10.1016/j.cpr.2010.01.005

Hoyer, J., Fecht, J., Lauterbach, W., & Schneider, R. (2001). Changes in conflict, symptoms, and well-being during psychodynamic and cognitive-behavioral alcohol inpatient treatment. *Psychotherapy and Psychosomatics*, *70*, 209–215. http://doi.org/10.1159/000056255

Htzel, K., Michalak, J., Striegler, K., Drries, A., Von Brachel, R., Braks, K., … Vocks, S. (2012). Explizite lebensziele von patientinnen mit anorexia und bulimia nervosa. *Verhaltenstherapie*, *22*(3), 173–180. http://doi.org/10.1159/000341538

Huta, V., & Waterman, A. S. (2014). Eudaimonia and Its Distinction from Hedonia:

Developing a Classification and Terminology for Understanding Conceptual and Operational Definitions. *Journal of Happiness Studies*, *15*(6), 1425–1456. http://doi.org/10.1007/s10902-013-9485-0

Kashdan, T. B. (2007). Social anxiety spectrum and diminished positive experiences: Theoretical synthesis and meta-analysis. *Clinical Psychology Review*, *27*(3), 348–365. http://doi.org/10.1016/j.cpr.2006.12.003

Kehr, H. M. (2003). Goal conflicts, attainment of new goals, and well-being among managers. *Journal of Occupational Health Psychology*, *8*(3), 195–208. http://doi.org/10.1037/1076-8998.8.3.195

Kelly, R. E., Mansell, W., & Wood, A. M. (2011). Goal conflict and ambivalence interact to predict depression. *Personality and Individual Differences*, *50*(4), 531–534. http://doi.org/10.1016/j.paid.2010.11.018

Kelly, R. E., Mansell, W., & Wood, A. M. (2015). Goal conflict and well-being : A review and hierarchical model of goal conflict , ambivalence , self-discrepancy and self-concordance. *Personality And Individual Differences*, *85*, 212–229. http://doi.org/10.1016/j.paid.2015.05.011

King, L. a, Richards, J. H., & Stemmerich, E. (1998). Daily goals, life goals, and worst fears: means, ends, and subjective well-being. *Journal of Personality*, *66*(October 1998), 713–744. http://doi.org/10.1111/1467-6494.00030

Kleiman, T., & Hassin, R. R. (2011). Non-conscious goal conflicts. *Journal of Experimental Social Psychology*, *47*(3), 521–532. http://doi.org/10.1016/j.jesp.2011.02.007

Lauterbach, W. (1996). The measurement of personal conflict. *Psychotherapy Research*, *6*(213-225).

Lauterbach, W., & Newman, C. F. (1999). Computerized Interpersonal Conflict Assessment in Cognitive Therapy. *Clinical Psychology & Psychotherapy* , *Vol 6(5)* , 357–374.

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the depression anxiety stress scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy*, *33*(3), 335–343. http://doi.org/10.1016/0005-7967(94)00075-U

Lucas, R. E., Diener, E., & Suh, E. (1996). Discriminant validity of well-being measures. *Journal of Personality and Social Psychology*, *71*(3), 616–628.

http://doi.org/10.1037/0022-3514.71.3.616

Lyubomirsky, S., Tkach, C., & DiMatteo, M. R. (2006). What are the Differences between Happiness and Self-Esteem. *Social Indicators Research*, *78*(3), 363–404. http://doi.org/10.1007/s11205-005-0213-y

Marín-Martínez, F., & Sánchez-Meca, J. (1999). Averaging dependent effect sizes in meta-analysis: a cautionary note about procedures. *The Spanish Journal of Psychology*, *2*(1), 32–38.

Michalak, J. (2002). [Conflicts and psychological symptoms]. Unpublished research data.

Michalak, J., Heinreich, T., & Hoyer, J. (2004). Goal Conflicts: Concepts, Findings, and Consequences for Psychotherapy. In W. M. Cox & E. Klinger (Eds.), *Handbook of Motivational Counseling: Concepts, Approaches, and Assessment* (pp. 83–98).

Michalak, J., & Holtforth, M. G. (2006). Where do we go from here? The goal perspective in psychotherapy. *Clinical Psychology: Science and Practice*, *13*, 346–365. http://doi.org/10.1111/j.1468-2850.2006.00048.x

Moher, D., Moher, D., Cook, D. J., Cook, D. J., Eastwood, S., Eastwood, S., … Stroup, D. F. (1999). I m p r oving the quality of reports of meta-analyses of randomised controlled trials: the QUOROM statement. *The Lancet*, *354*, 1896–1900.

Monzani, D., Steca, P., Greco, A., D'Addario, M., Pancani, L., & Cappelletti, E. (2015). Effective pursuit of personal goals: The fostering effect of dispositional optimism on goal commitment and goal progress. *Personality and Individual Differences*, *82*, 203–214. http://doi.org/10.1016/j.paid.2015.03.019

Morris, L., Mansell, W., Emsley, R., Bates, R., Comiskey, J., Pistorius, E., & McEvoy, P. (2015). Prospective cohort feasibility study of a transdiagnostic group intervention for common mental health problems: The Take Control Course. *Psychology and Psychotherapy: Theory, Research and Practice*, n/a–n/a. http://doi.org/10.1111/papt.12070

Palys, T. S., & Little, B. R. (1983). Perceived life satisfaction and the organization of personal project systems. *Journal of Personality and Social Psychology*, *44*(6), 1221–1230. http://doi.org/10.1037/0022-3514.44.6.1221

Paul, K. I., & Moser, K. (2009). Unemployment impairs mental health: Meta-analyses. *Journal of Vocational Behavior*, *74*(3), 264–282.

http://doi.org/10.1016/j.jvb.2009.01.001

Powers, W. T. (2005). Behavior: The control of perception. In *Behavior: The Control of Perception* (New Canaan). Benchmark.

Puschel, O. (2000). *Auswirkungen von Motiv-Ziel-Diskrepanzen auf Volition und Symptombelastung [Impact of discrepancies between motives and goals on volition and symptoms]*. Ruhr-University, Bochum, Germany.

Riediger, M. (2007). Interference and facilitation amoung personal goals: age differences and associations with well-being and behavior. *Personal Project Pursuit: Goals, Action, and Human Flourishing.*, 119–43.

Robins, R. W., Hendin, H. M., & Trzesniewski, K. H. (2001). Measuring Global Self-Esteem: Construct Validation of a Single-Item Measure and the Rosenberg Self-Esteem Scale. *Personality and Social Psychology Bulletin*, *27*(2), 151–161. http://doi.org/10.1177/0146167201272002

Romero, E., Villar, P., Luengo, M. Á., & Gómez-Fraguela, J. a. (2009). Traits, personal strivings and well-being. *Journal of Research in Personality*, *43*(4), 535–546. http://doi.org/10.1016/j.jrp.2009.03.006

Rosenberg, M. (1965). Rosenbery self esteem. In *Society and the Adolescent Self-Image*. Princeton, NJ: Princeton Univeristy Press.

Rosenthal, R. (1995). Writing Meta-Analytic Reviews, *118*(2), 183–192.

Rosenthal, R., & DiMatteo, M. R. (2001). Meta-analysis: recent developments in quantitative methods for literature reviews. *Annual Review of Psychology*, *52*, 59–82. http://doi.org/10.1146/annurev.psych.52.1.59

Rosenthal, R., & Rubin, D. B. (1986). Meta-analytic procedures for combining studies with multiple effect sizes. *Psychological Bulletin*. http://doi.org/10.1037/0033-2909.99.3.400

Schönbrodt, F. D., & Perugini, M. (2013). At what sample size do correlations stabilize? *Journal of Research in Personality*, *47*(5), 609–612. http://doi.org/10.1016/j.jrp.2013.05.009

Segerstrom, S. C., & Solberg Nes, L. (2006). When goals conflict but people prosper: The case of dispositional optimism. *Journal of Research in Personality*, *40*, 675–693. http://doi.org/10.1016/j.jrp.2005.08.001

Sheldon, K. M., & Kasser, T. (1995). Coherence and congruence: two aspects of personality integration. *Journal of Personality and Social Psychology*, *68*(3),

531–543. http://doi.org/10.1037/0022-3514.68.3.531

Simons, J. S., & Carey, K. B. (2003). Personal strivings and marijuana use initiation, frequency, and problems. *Addictive Behaviors*, *28*(7), 1311–1322. http://doi.org/10.1016/S0306-4603(02)00247-2

Varese, F. (2014). *Voices, conflict and personal goals: A Perceptual Control Theory perspective on auditory verbal hallucinations*. University of Manchester.

Vevea, J. L., & Woods, C. M. (2005). Publication bias in research synthesis: sensitivity analysis using a priori weight functions. *Psychological Methods*, *10*(4), 428–443. http://doi.org/10.1037/1082-989X.10.4.428

Wallenius, M. a. (2000). Personal project level of abstraction and project conflict: Relations to psychological well-being. *European Journal of Personality*, *14*, 171–184. http://doi.org/10.1002/(SICI)1099-0984(200003/04)14:2<171::AID-PER352>3.0.CO;2-D

Waterman, A. S. (1993). Two conceptions of happiness: Contrasts of personal expressiveness (eudaimonia) and hedonic enjoyment. *Journal of Personality and Social Psychology*, *64*(4), 678–691. http://doi.org/10.1037/0022-3514.64.4.678

Watson, D., Clark, L. a, & Tellegen, a. (1988). Development and validation of brief measures of positive and negative affect: the PANAS scales. *Journal of Personality and Social Psychology*, *54*(6), 1063–1070. http://doi.org/10.1037/0022-3514.54.6.1063

Wiest, M., Schüz, B., Webster, N., & Wurm, S. (2011). Subjective well-being and mortality revisited: differential effects of cognitive and emotional facets of well-being on mortality. *Health Psychology : Official Journal of the Division of Health Psychology, American Psychological Association*, *30*(6), 728–35. http://doi.org/10.1037/a0023839

2 Journal Article

"That sounds so bad… but it's the truth": A conversation analysis of disclaiming and disclosing using reflective talk in psychotherapy.

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2.1 Abstract

Objective: To explore examples of clients' "talk about their talk" during psychotherapy, its interactional features and how therapists responded.
Method: Conversation Analysis was used to explore a corpus of recordings from a university counselling service. Twenty-one instances of clients referring to their talk with "sounds [X], but [Y]" were reviewed, and contrasted with propositions from Method of Levels therapy.
Results: "Sounds [X], but [Y]" (e.g. "it sounds so bad … but it's the truth") was used by clients to voice, and disclaim a self-identified social concern. In addressing their concerns, the clients worked to create a favourable interactional environment for disclosing a sensitive issue. A range of therapist responses are discussed, including variable levels of affiliation with the clients' statements, and how the clients subsequently responded.
Conclusion
The clients' use of "sounds [X], but [Y]" potentially demonstrates competence in a range of cognitive skills – including mentalization or a shift in clients' perspectives – of interest to different therapies. Conversation Analysis provides a detailed account of clients' and therapists' interactions through their talk, and allows for consideration of whether these interactions are congruent with therapeutic goals or interests. Support was also found for a number of propositions from Method of Levels therapy.

Key Words

Conversation Analysis, Method of Levels, Disclosures, Immediacy, Meta-communication

Clinical or Methodological Significance of this article

A detailed account is provided of client-initiated 'talk about their talk', immediacy and disclosures, and addressing a limitation in the therapist-centric literature. The alignment between the client's and therapists' actions provides a space for considering the different actions therapists might pursue. Support is also provided for several of Method of Levels' propositions about disruptions, which have not been explored previously.

2.2 Introduction

Asking clients what was happening for them a moment ago, when something caught the therapist's eye; getting clients to attend to the present; and exploring issues in the therapeutic relationship or other immediacy, are features of many different therapeutic approaches. Cognitive Behavioural Therapy (CBT) encourages asking about shifts in a client's affect in order to identify maladaptive thoughts (e.g. Beck, 1976; Padesky & Greenberger, 1995). More broadly attention is brought in to the present moment in Bugental's existential psychotherapy (Kondratyuk & Peräkylä, 2011); attentiveness to emotional experience is important in Emotion-Focused Therapy (Greenberg, 2004); exploring resistance, transference and pressure is used in Intensive Short-Term Dynamic Psychotherapy (Davanloo, 2001); and there is the concept of innovative moments in Narrative therapy (Gonçalves, Matos, & Santos, 2009). Such a shift in affect, or transition from discussing the past to the present might also be observable in clients' talk. However, these therapies are often not sufficiently specific to suggest *what* is occurring in clients' talk that produces these shifts. Instead, how therapists initiate or respond to these shifts has received more attention than the clients' talk itself (Kondratyuk & Perakyla, 2011), with different theoretical approaches proposing different responses.

The dynamics between the client and therapist are often understood in terms of the 'therapeutic relationship' (Muntigl & Horvath, 2014). This has typically involved correlating a client's or therapist's ratings of the therapeutic alliance (a subset of the therapeutic relationship) with outcome measures, rather than how the relationship is managed 'in the moment' by the therapist and client (Muntigl & Horvath, 2014). Such an exploration of 'in the moment' experience has also been termed immediacy (Kondratyuk and Peräkylä, 2011) and relates to inter-subjectivity, "what is occurring between two minds" (Beebe, Rustin, Sorter, & Knoblauch, 2003, p. 806). The current study sought to explore potential shifts in clients' talk from an interactional perspective, to explore *when* and *why* a shift might occur, and *how* such as shift is orientated to by the clients and therapists.

Therapists' and clients' actions (i.e. what actions their talk or other utterances achieve in conversation) have been explored as interactional practices using Conversation Analysis (CA, for reviews see Peräkylä, 2013; Peräkylä, Antaki, Vehviläinen, Leudar, 2008). For example, CA can be used to examine *how* clients construct disclosures as voluntary, significant and personal reports through their talk (Antaki, Barnes & Leudar, 2005), rather than focusing on *what* is disclosed. Despite this, most CA psychotherapy research has typically focused on therapists', rather than clients' actions (Vehviläinen, Peräkylä, Antaki, & Leudar, 2008). Further, CA research has rarely examined occasions where people spontaneously comment on their own talk (also known as meta-language, Lucy, 1993) or where their affect or attention shifts. To the authors' knowledge there are no studies exploring the use of explicit reflective talk or meta-language in an individual therapy setting.

In contrast to the other therapy approaches mentioned, Method of Levels (MOL, Carey, 2006; Carey, Mansell, & Tai, 2015) proposes that a therapist should only have two goals: to get the client to talk about their difficulties, and to ask the client about moments when the client's talk becomes disrupted. In doing so MOL eschews formulation and other specific therapy interventions (Carey, 2006). There is growing evidence that MOL is an effective therapy (e.g. Carey, Carey, Mullan, Spratt, & Spratt, 2009; Carey, Tai, & Stiles, 2013) – indicating that attending to disruptions or shifts in client-talk is not merely *important* for

therapeutic outcomes, but (MOL would suggest) obviates the need for other therapeutic practices (Carey, 2006). However, MOL's evidence-base is limited, with the majority of its practice-based evidence coming from primary care, without any published controlled trials. Despite this, MOL's proposals are explored in the current study as MOL so specifically focuses on disruptions in client's talk and makes a series of claims about the client's actions as well as the therapist's. The proposals are not explored within MOL sessions as MOL proposes that disruptions occur in *all* talk, and in this report it is the potential disruption itself rather than the MOL-specific response, that is the primary research interest.

2.2.1 **MOL**

MOL (Carey, 2006; Carey, Mansell, & Tai, 2015) is based on Perceptual Control Theory (PCT, Powers, 2005, see 3.1.1 for more on PCT). PCT proposes that people control their perceptual inputs through their behaviour – behaviour *is* the control of perception. As in the fairy-tale Goldilocks, people have a perceptual goal of what is "just right" and people try to achieve their "just right". MOL proposes that distress arises when two or more goals are mutually incompatible and those differences are insuperable. For example, in social anxiety a typical conflict is between a desire to form a good impression and wanting to avoid a negative evaluation (Kashdan, 2007). With MOL proposing that to resolve a goal conflict a person needs to become aware of the conflicts, which allows the goals to be adjusted so that they are no longer incompatible (see 3.1.2 for more on MOL). Goals are thought to be organized hierarchically, from more concrete practical goals at the bottom of the hierarchy, to more abstract fundamental goals at the top.

People are thought to become aware of higher goals via "disruptions" (see 3.2.2 for a brief exploration of disruptions):

"When people talk from time to time their flow of dialogue is punctuated by *brief* interruptions… they might smile wryly to themselves, or shake their head, or look away, or pause… they might even keep talking but make a kind of meta evaluative comment such as, 'does this make sense at all' or, 'that sounds

stupid when I say it like that'… or, *something else that indicates that, in some way, they have been listening to what they have been saying and now they are commenting on that*. Often, people do not even seem to notice that their dialogue has been disrupted and, *in the blink of an eye, they resume the story*"

(Carey et al., 2015, p. 62-63 – emphases added)

MOL proposes that disruptions represent a switch in attention, between what a person was saying – their "foreground thoughts" – and their "background thoughts", an evaluation of the foreground thought. From this description, three proposals about disruptions are apparent: firstly, disruptions mark a comment on the client's talk; secondly, disruptions are brief; and thirdly, that afterwards clients often resume their prior talk. MOL does not outline a comprehensive list of possible disruptions, nor provide evidence for them other than stating they are observable in both therapy and non-therapy talk. MOL does not suggest that disruptions serve a function for the client, and the possible functions of the disruptions have not been explored elsewhere to the authors' knowledge. Within MOL, the content of the client's talk is not thought to be important per se; as talk is seen as "a means to an end" to get the client to shift their attention to higher levels where the conflict occurs so that it can be resolved (Carey, Mansell, & Tai, 2015).

After a disruption MOL therapists are encouraged to ask a client a simple, clear question, such as "what's making you smile", in order to maintain the client's attention on the background thought (Carey, 2006). The types of questions that MOL therapists ask have previously been explored using Conversation Analysis, with the timing and phrasing of the question affecting the clients' response (Cannon, 2014).

2.2.2 **Conversation Analysis**

Conversation Analysis (CA) is a qualititative approach to investigating social interaction. CA is well suited to the study of psychotherapy (e.g. Madill, Widdicombe, & Barkham, 2001, see 3.2.1 for more on the thesis's epistemology , 2.2.3 for more on methodological choice, 3.2.4 for more explanation of CA) as CA explores the actions performed by talk. CA proposes that talk is

fundamentally structured, and it is through conversation's structure and organization, its devices and apparatuses, that participants organize a conversation and handle any problems that may arise (Drew, 2004; ten Have, 2007, see 3.2.5 for more on CA's epistemological perspective, 3.2.6 for more on epistemology). CA focuses primarily on how practical social actions are accomplished via different forms of utterances (Hutchby & Wooffitt, 2008). Inter-subjectivity (Sacks, 1995) is displayed and managed through talk; one person proves to the other that they are hearing and understanding what has just been said by how they respond. CA also explores how talk over multiple turns by different speakers achieve actions, such as telling stories or complaining (e.g. Holt, 2012; Mandelbaum, 2013; Schegloff, 2007). *A priori* theories or arguments such as psychotherapy theories are avoided, as CA is cognitively ascetic, and favours an inductive approach of looking at what a person does, rather than imposing an external order derived by other theories (Markee, 2000; ten Have, 2007).

2.2.3 **CA and Psychotherapy**

As indicated, there is a contrast in the current study between CA's "bottom-up" methodology, and a therapist's or MOL's theoretical "top-down" approach, where therapists "do therapy" by putting a theoretical model into practice (Peräkylä & Vehviläinen, 2003, see 3.2.8 for more on CA and MOL's differences). MOL's description of disruptions is not a specifiable unit of analysis for exploration using CA (e.g. Schegloff, 1996) as there is no evidence "disruptions" are performing a similar interactional action in talk. Disruptions are instead a collection of possible actions, proposed by a "top-down" a-priori therapy (MOL). However, a collection of explicit meta-comments or a client's "talk about talk" can be built from the "bottom-up" to explore the use and actions of one possible type of disrupton, which would be compatible with CA. Explicit meta-comments' actions, and how the client and therapist orientate to them can therefore be explored using CA.

Peräkylä and Vehviläinen (2003) argue that a dialogue can also be constructed between CA findings and practitioners' therapies, such as MOL – termed Stocks of Interactional Knowledge (SIK). CA's therapeutically agnostic approach can

be used to critique or test the assumptions of a therapy's SIKs, or provide more detail or add new practices to those SIKs (Peräkylä & Vehviläinen, 2003).

2.2.4 **Research Aims**

The current study aims to explore several of MOL's SIKs. The study sought to explore the following MOL SIKs concerning disruptions:

- Disruptions indicate a comment on the client's own talk
- Disruptions are brief
- After disruptions clients will often resume their prior talk

The study also sought to elaborate on the clients' and therapists' actions in these instances, and to review their potential therapeutic implications beyond MOL. Therefore, the study used non-MOL therapy sessions to review how non-MOL therapists responded to potential disruptions. The broader aspects were considered by exploring:

- In what context a potential disruption occurs, and what social action the client appears to be performing
- How therapists and clients subsequently orientated to the potential disruption

2.3 **Data and Method**

CA research is undertaken in several steps (Hutchby & Wooffitt, 2008; ten Have, 2007). The data are explored using "unmotivated looking" (Hutchby & Wooffitt, 2008; Schegloff, 1996), without pre-conceived ideas about what the data represent (ten Have, 2007). Unmotivated looking does not preclude a prior interest, but the instances should emerge after noticing a potentially interesting phenomenon (Hutchby & Wooffitt, 2008; Sacks, 1984). Collections of recurrent actions and patterns are then built, and transcribed using the Jefferson system (symbols included as appendix 2). The cases within the collection are then analysed in more detail to cross-compare and analyse the trajectories of the talk and to establish the shared and divergent features (ten,

Have, 2007). CA does not use comprehensive sampling to explore the most frequent type of utterance within the recordings. Instead collections are built using case-by-case analysis on a cumulative basis, where there are shared features, and a case is then built for the pattern that emerges from listening to the collection (ten, Have, 2007). CA is therefore not concerned with external validity. The analysis was undertaken collaboratively by the first and second authors.

The analysis was conducted using a corpus of audio recordings collected for a therapy study at a university counselling service that provided support to staff and students. Therefore, clients of the service did not necessarily have to have an identified mental health problem. Ethical approval was granted by the University of Nottingham to analyse recordings from a previous study, collected with prior consent for secondary analysis. The corpus consisted of 19 different clients' complete therapies, with each session typically lasting 50 minutes. In total 57 different sessions were reviewed to build a corpus of examples, representing three sessions per therapy, which were randomly selected from the available sessions.

The screening of the data sought to review explicit comments by clients on their own talk, so that there is less ambiguity about their reflexive nature. CA has established literature looking at a range of disfluencies such as "erms", "laughs", or "oh" which *may* be reflexive in nature, but are potentially ambiguous. Whilst these disfluencies will be discussed in extracts, they were not included as potential disruptions because of the ambiguity about whether they were potential disruptions. Specific comments about a person's own talk are less likely to be ambiguous because of the nature of the comments (i.e. a laugh may or may not be reflexive, but a statement of "it sounds" is more clearly reflexive).

Talk about talk has also been referred to as meta-language or meta-pragmatics (Lucy, 1993), or narrative reflexivity (Auburn, 2005). Therefore, there is an overlap in some of the terminologies, although MOL's conception of disruptions and meta-comments as outlined include other disfluencies. It is not proposed that the examples are necessarily illustrations of MOL's disruptions, as befitting

CA's approach, but that the examples of reflective talk would likely be judged a disruption by MOL as outlined.

In the data analysis stage, instances of "sounds [X], but [Y]" were collected. 21 instances were identified, which is in line with many CA studies and came from 12 different sessions, representing 9/19 clients, and 7/12 therapists. The extracts presented here best illustrate the issues discussed. Other possible disruptions were considered and provisionally explored (e.g. 'I don't know' [cf Beach & Metzger, 1997] and comments on emotions, but showed more variability in their use and therefore did not successfully accumulate in to one particular practice. "Sounds [X], but [Y]" emerged from the initial screen for possible disruptions and were cumulatively collected in to a practice of interest for further analysis. Unfortunately, as the data came from a study that had taken place several years prior to the current analysis, the original data about the therapists' theoretical orientations were not available. Due to MOL's relatively recent development (2006) and limited uptake, it is presumed that the therapists were not using MOL – confirmed by listening to the recordings.

2.4 **Results**

21 instances of psychotherapy clients talking about their own talk were identified, for example saying that it "sounds [X] but [Y]", (henceforth abbreviated to SB), such as "that sounds so bad… but it's the truth" (Extract 1), or "it sounds pretty grotesque… but I get applauded" (Extract 5). In all of the instances the "sounds" elements were negative hearings that were first proposed by the client. It is argued that SBs are a practice to address two predominant, interlinked client concerns. Firstly, the clients voice both their own reaction to their talk and attempts to defuse a potential social criticism, by explicitly acknowledging a potentially problematic hearing of their talk. For example, in "that sounds so bad… but it's the truth" (Extract 1) the speaker is nominating a negative hearing of their talk, and showing an awareness that that negative hearing might be attended to. Who it "sounds [X]" to is ambiguous, and "sounds" is potentially designedly ambiguous. The SB can be used before (prospectively) or after (retrospectively) the statement to be disclaimed,

although references were often ambiguous. Secondly, the clients used "but [Y]" to disclose, justify and support an issue and the interactional action which they were completing. In addressing their own concerns and possible social concerns, the client worked to create a favourable interactional environment for disclosing a sensitive issue to the therapist. The sensitivity of the issues is corroborated by other features associated with sensitive issues, such as laughter and disfluencies, which were also associated with SBs. The SBs were often used at a conclusory part of talk about a problem, stating the issue more clearly, before the client moves to close the problem or talk about a related issue. (See 3.3 for extended results)

SBs will be discussed in three sections; firstly, outlining their sequential position and orientation; secondly, outlining the features associated with SBs; and thirdly, their interactional consequences.

2.4.1 **Sequential Position and Orientation**

Three extracts are presented and discussed in more detail to highlight where the SBs were positioned within clients' talk and the orientation the client showed to the SBs. Extract 1 is from the middle of the fifth therapy session, with a female client discussing feeling low in confidence. The extract illustrates the reflective nature of the SB, and highlights the client's attempt to disclaim a nominated hearing ("sounds so bad"), whilst justifying their perspective. The extract also illustrates the potential use of a prospective SB, and a retrospectively positioned SB in relation to a problematic part of talk.

Extract 1, 5-9616, 33:51[1]

```
01     C     I remember(h)r hhh erm (.) hhhh (0.3)
02           getting a C:: in maths  (.) for my school
03           report once, .hhh. (.) and I was so:::: (.)
04           >I was< cry::ing::, (0.3) my friends said
05           £oh (.) what happened (.) I said I got
06           a C::£ (0.2) .hh £in maths£ (0.2)
```

[1]5: session number within the therapy. 9616: client identifier code. 33:51: extract start time within the session. Therefore, extract is from the 5th therapy session, with a client whose ID is 9616 and the extract commences at 33:51.

>an' an'< they said (.) erm, (0.9)
((lip smack)) (0.4) >they said< (0.3)
so what (.) .hhhh (.) an' I said, (0.4)
no::: <my Mum told me-> >I mean I must used
been< (a told no g n) no I my Mum says .hhhh
(.) my Dad's gonna take it really badly cos-
(0.6)>a bit like-< (0.4) maybe a- (0.2) ov- a
year or two before he had a bypass? (0.4)
So erm. (0.3) >We used to try and not stress
her-< I mean this is another thing, (0.3)
my dad's so fra(h)gile, (0.4) <he's so
fragile-> I don't feel like feel like (.)
→ erm (0.4) I've had (.) a b- hhhh it sounds
→ so b(h)a(h)d h (>be- like<) (0.2) don't really
feel that I've had a <man around £the house?£>
.hhhh (.) um.
(0.8)
→C £ °That sounds so° £b(h)a(h)d(h) h h (.) I
→ mean it feels really bad saying that,£ .hhhh
→ (.)erm,(0.2) >but it's the truth,< (.) .
hhh he's- (0.2).hhh he's he e's <really
fragile> (.) I mean >he's always< it's all
about protecting my da:d.
(0.7)
C You know?
(0.3)
C >It-< so I don't <feel> (.) I mean this is
(0.2) probably why (.) I've got in the wrong
relationships (.) y'know (.) erm, (0.3)
C I'm- I was always looking for a fath:er:? Hhh
erm, (0.4) I- I had one friend (0.4) .hhh
C £a(h)n(h)d I always used to always say he
was£ like my mother,

The client's narrative moves through several related statements without a break before stopping at line 22 ('.' Indicating a final intonation, showing that she has stopped her talk; e.g. Clayman, 2013) with the conclusion that she does not feel that she has had "a man around the house" (line 21). The client's expression of this point is started from line 18, with the "I don't feel like", which is stopped with the "erm (0.4)" at line 19. This is then restarted, with a potential aborted SB across lines 19 and 20, which is prospectively addressed, but at line 20 it is unclear to a listener what "sounds so bad". The sensitive issue is then produced in lines 20-21: she does not feel that she has "had a man around the house". She then repeats but references retrospectively that it sounds bad (line 24), which is changed to a more personal ownership of "it feels really bad". The use of "sounds" is ambiguous, and the client's use of "it feels bad" is a rare identification by a client with the "sounds" component. At the end of line 29 the client stops again: the SB has been used to bring the complaint to a grammatical close and to summarize the client's experience.

The effect is to make the statement that she does not feel that she has a "had a man around the house", and "it's all about protecting my dad" as a disclosure. In this context the use of disclosure is meant as a *process* of "revealing something of oneself", rather than the more conventional therapeutic understanding of a statement revealing intimate information (Antaki, Barnes, and Leudar, 2005, p. 44). Antaki, Barnes and Leudar (2005) propose that disclosures are brought off in interaction, and are voluntary, significant and personal reports – that disclosures are context dependent and how they are managed shows the sensitivity of the disclosure. Confirming your details with a bank would not be a disclosure and would not be managed as such, but telling those same details to a stranger in a park would be. The client states that her father is fragile at lines 17, 18 and 28 and that she has got into the wrong relationships (lines 34 and 35) without the delicacy she shows in her talk around the SB.

The SB acts as a *disclaimer* which can be used when a speaker might anticipate and attempt to ward off doubts about their claims (Hewitt & Stokes, 1975). The SB component in Extract 1 is a sub-type of a disclaimer, proposed

to “credentialize” the speaker’s talk – she is aware of the potential criticism, and attempts to head-it-off by naming and acknowledging the criticism (Hewitt & Stokes, 1975). A more well-known phrasing might be “I’m not racist, some of my best friends are x, but…” (Hewitt & Stokes, 1975). Disclaimers are similar to Potter's (1996) concept of *stake inoculation*, whereby speakers try to show that they do not have a particular motivation in holding their opinion, as having a motivation for holding an opinion can be seen as undermining the basis of that opinion (Edwards & Potter, 2005).

Naming a possible hearing of their talk via an SB shares an aspect of the client’s intersubjective experience with the therapist– that in Extract 1 part of the talk sounds “bad” to the client and further that the client feels bad saying it. In saying “bad” the client names their hearing of the talk, out of a range of possible hearings. Previous research has shown that people attend to two main concerns when discussing their problems: aligning the listener to the trouble, and aligning the listener to the speaker’s perspective (Jefferson, 1988). Auburn in extending Jefferson’s description of a speaker attending to intersubjectivity proposed that reflexivity is a specific point where the speaker explicitly attends to intersubjectivity. Auburn (2005) suggests that a particular role of narrative reflexivity is to direct listener’s inferences by attempting to defease or nullify one available inference and to propose another. In Auburn (2005) this was explored in the context of a sex offender treatment programme, where offenders attempted to deny a threatening implication of their talk, and instead suggested a mundane explanation of their actions. Narrative reflexivity was positioned both before and after potentially problematic talk (Auburn, 2005). The SB seems to be performing a similar function in Extract 1. Although, in contrast to Auburn’s data, in the SBs the client specifically names the face-threatening inference in an attempt to defease and disclaim it (see 0 for more on Extract 1).

Extract 2 comes from the beginning of the 11th therapy session, with a male client who has some knowledge of mental health issues, mentioning that he had been counting the windows during his journey to the session and that he was wondering why he had done so. The extract further highlights the reflective nature of the SB, and highlights the client’s reaction to his talk, which is

emphasized by his response to the therapist's question. In the corpus of data reviewed, this is the only instance in which the therapist asks about the "sounds" element.

Extract 2, 11-7623, 2:35

```
01     C     .hhhh So I thought I'd mention that heheh h h
02           h h.hhhh (.) cos I'm wondering if I am, (1.9)
03           I wouldn't say I- I do it obsessively
04           >whatever that< means but (.) I I certainly
05           (0.4) >it's not< (0.5) uncommon for me to,
06           (0.4).hhhh count (1.3) something, (1.4) .hhh
07           like (.)the rings °of- in° the curtains
08           ((clears throat)) (0.4) e::r:r (1.0) you
09           know I might do that: (1.2) .hhhhhh four
10           or five times in a ro:w, hhhh (.) say °a
11           couple° of times a we:ekk?
12           (0.9)
13     C     °When I wake up?°
14           (0.6)
15     C     .hhhhh
16           (1.4)
17     C     .hhhhh <So (.) it doesn't really> (1.9)
18           bother me (.) but now I've heard meself say it
19     →     (.) °it sounds a bit,° (1.3) ((lip smack))
20     →     (0.3) .hhhhhh more worr(h)y(h)i(h)n(h)g heh
21     →     heh. Hhhhh (0.3) but e:::r:::::m,
22           (0.6)
23     T     What's the worry?
24           (1.7)
25     C     <hmm <the worry is e:r,> (0.7) that is sounds
26           as if >I've- I a<  °sounds like° some kind
27           of, (0.7).hhhhhhhhh
28           (0.6)
29     C     °That° there's something wrong with me (.)
```

like I've got some kind of (.) ((clears throat)) (0.8) ((lip smack)) errrrr (1.2) °you know (.)compulsive disorder or something.° .hhhh Which I'm sure I haven't (.) but the worry that (.) <it could get worse> or::: I could be labelled as °<of- er as a- a- something,>° (1.1) .hhhhh I think is a (.) worry (0.3) or that it's a worry that, (0.2) .hhh (0.2) in that it (0.2) makes- indicating something might be wrong (.) but I'm not sure:, (2.2) e::rr:,

(2.4)

C What it is:: (.) or it- it's a worry (.) <in the sense that erm,> hhh (1.4) °I'm just° doing it.

(1.7)

C .hhhhhh erm, hhhh

(4.5)

C °<I doubt it's good.>°

(0.5)

C .hhhh Uncomfortable. Hhhh I think (.) I think it's a bit uncomfortable, (0.2) e:r:m,

(4.0)

C .hhhhhhh (0.8) You know you're >doing it< (0.6) well, not so much doing it, but realising I'm doing it.

(0.8)

T (Maybe if) the worry's also about not knowing why you're (0.2) doing it.

The client volunteers the first segment from lines 1-11, but there is a silence at line 12 where the therapist could have spoken. The client subsequently volunteers a further detail at line 13, which also does not elicit a verbal response from the therapist. The upwards intonation at the ends of lines 11

and 13 are “try markings” (Sacks & Schegloff, 1979). Try markings are where a person uses questioning intonation, but they do not necessarily indicate an interogative. As with Extract 1’s “you know?”, at line 31, these instances are indicative of the client seeking an acknowledgement from the therapist. The “so” at the start of lines 1 and 17 are uses of “so” as a marker to preface talk which has been pending (Bolden, 2006, 2009b). In Extract 2 the client’s use of “so” links the two aspects of aspects of whether the counting is obsessive and whether he is actually concerned about it – overall indicating that the client had an aim in bringing up his counting which took multiple turns of talk to complete (Schegloff, 2007). As with Extract 1 the SB helps to bring the client’s talk to completion, to the extent that the therapist speaks at line 23. Compared to Extract 1 the conclusion is presented as somewhat more surprising to the client and is an explicit change from the talk of “obsessively, whatever that means” and “it doesn’t really bother me” to the client disclosing that it now “sounds a bit more worrying” – with the change apparently due to the client’s talk (“now I’ve heard myself say it”).

The SB includes a proposal about the client’s “mental state” (worrying) – descriptions of “one’s own thoughts and feelings” (Edwards & Potter, 2005), as do many of the extracts. Within CA mental states are seen as an interactional object that participants orientate to, rather than an inner psychological object (Edwards, 1997; Hepburn & Potter, 2007; Potter, 1999). Speakers invoke mental states and manage them in conversation as they do with other topics (Edwards, 1997). The client raises the prospect of “worry” and the therapist then responds by asking about the worry, which results in the client talking further about their worry. The therapist then proposes a formulation (Antaki, 2008) of the client’s worry at lines 57 and 58. (See 0 for more on Extract 2)

Extract 3 is from a first therapy session. The male client has been discussing struggling to meet his course’s demands whilst dealing with the emotional effects of being stabbed before university. The extract highlights a prospective use of an SB, before a sensitive issue is disclosed.

Extract 3, 1-1842, 20:46

C And you need your full focus (.) and obviously that's not something that I've been able to do.

(0.3)

C Even though (.) as much as I've tried to do that (.) I've not been able to (.) an's it's, (.).hhh and that's what- that's what's irritating me quite a lot as well (.) because, (.) .hhhh (.)part of the big thing for me to come here (.) was to get away from all the distractions, (.)>y'know< that were holding me back? (.).hhhh and yet, since I've been here, (.) it's like? (0.3) I've had more if anything

→ (.) and it's like °k .hhh° (0.6) I don't want

→ to sound (.) really ungrateful (.) 'cos' I

→ love my family but, (0.2) .thhhhhh (0.4) they always like, (0.7) pull me in (.) n, make me, (0.2)I dunno, not make me feel (.) >cos obviously they're my family< and I'd do

→ anything for them but, .hhhhhhh (0.3) y'know

→ >but they- it's like they< put the pressure on me t- to be: the responsible one and:, (.) hhhh (.) y'know to be there to help sort things out: (.) and it's like k (0.4) I

→ don't mind doing that (.)but right now I have all this other stuff that I'm trying cope with (.) and y'know.=

T =Mmmm.

C How can I- (.) how can I dedicate my time (0.2).hhh to them (.) and to myself, (0.2) and- like cos I have to work and stuff as well: it's like (.) .hhhhhh (.) °I don't have no fre- very much free time for myself:: (.)'nd,

```
35              (0.6)
36      C       Y'know,
37              (0.3)
38      C       .hhhh The lady I spoke to before (.) She was
39              like (.) y'know (.) >you you< didn't just come
40              here to burn yourself out (.) she goes you
41              came here to have the whole uni experience?=
42      T       =Mmmmm.
```

The SB in this instance is negatively phrased – "I don't want to sound" (line 14 and 15), whereas most other extracts in the corpus do not explicitly express reluctance. The SB again acts as a disclaimer. As with Extract 1, the client shows sensitivity to producing the complaint and how it is understood in the context of "love" (line 16), before they raise the problematic complaint. The phrasing is changed throughout lines 16-23 to try and express his perspective and outline what his problems with his family dynamics are. As with Extract 1's first partial SB, it is also initially ambiguous what he might be "ungrateful" about at line 15 – although this later receives some clarification at line 19: that it is about his family. As with Extract 1 (lines 4-12) the client reports another person's speech (see Clift, 2006), at lines 39-41, presumably from the therapist who assessed him for the service. The reported speech highlights the ambiguousness of whom the SB is directed to, i.e. who might judge the talk 'ungrateful'. The ungratefulness appears to be salient to the client in Extract 3 as he is acting to defease it. Yet the client has already had his viewpoint corroborated by the previous therapist. However, he still supports his claim to the current therapist by adding the corroboration from his previous therapist. In the circumstances of him having difficulties after being stabbed, the "unreasonableness" of his perspective may be more salient to the client than the therapist. (See 0 for more on Extract 3)

2.4.2 **Associated Features**

In this section, other features of the clients' talk which were associated with the SBs and supported the SBs' actions are discussed.

Delicate issues are often delayed by pauses and disfluencies (such as “er”, also called perturbations, Silverman & Peräkylä, 1990; Weijts, Houtkoop, & Mullen, 1993). Pauses and disfluencies are seen across the extracts, supporting the argument that SBs are associated with delicate talk. In Extract 1 there are multiple instances of the client starting and stopping trying to articulate a point in lines 13 and 19. The client’s laugh during “bad” at lines 20 and 24 is a feature found in the majority of the corpus, where laughter was associated with SBs. Laughter is a complex activity (Jefferson, Sacks, & Schegloff, 1987). Laughter is frequently seen in complaints, where it illustrates that the complainer is able to show some resilience to the difficulty, or more broadly the complainer is attempting to avoid being seen as whining, or seeking sympathy (Edwards, 2005; Potter & Hepburn, 2010; Sacks, 1995). Patients often use laughter when addressing delicate issues or trouble regarding their health in medical consultations (Beach & Prickett, 2016; Haakana, 2001). Laughter can also be used by speakers to display that they are stalling (Pomeroy & Weatherall, 2014), and as a way of obscuring delicate talk such as using an obscenity (Jefferson, 1985).

In Extract 1 the laughter appears to be associated with the reflective “badness” element of the talk, with the client laughing at herself. The asymmetric nature of the laughter is also common, with the client showing that they are resistant to their difficulties by laughing whilst the therapist does not laugh, showing that the therapist is receptive to hearing about the difficulties and takes them seriously (Jefferson, 1984). The client’s description of a “man around the house” is also idiomatic. Drew and Holt (1988) argued that idioms are often used at the end of complaints to summarize the complaint in a way that enhances their legitimacy, and to initiate the close of a topic. The use of “it” (line 19) is a gloss, where an item generalized which obscures some asepct of it (Jefferson, 1985). In this case “it” refers to the “man around the house” (line 21) which is said later, and glosses have been found to be associated with delicate items (Silverman & Peräkylä, 1990).

In Extract 2 there are elements of laughter (also known as laughter particles, shown by “h”) throughout line 20, when the client mentions “worrying” and the

client's talk is halting and hesitant. As with Extract 1 there is also a "quiet voice" (° symbol) used as a part of the SB. In Extract 2, the quiet voice is also used when the client mentions "compulsive disorder" at line 32, "labelling" at line 35 and "doubting it's good" at line 48. The quiet voice, or *sotto voice* delivery can also indicate that talk is delicate (Lerner, 2013). The client's talk also has a number of disfluencies – the end of the client's talk at line 21 is brought about through hesitancy, with an elongated "erm", which is often treated as a filler or hesitancy marker.

In Extract 3 the client's positive sentiments about his family are added through a series of restarted sections of talk, or alterations (Schegloff, 2013), which can serve to adjust meaning. The number of positive features of his family are indicative of the complainant demonstrating their reasonableness in making a complaint (Madill et al., 2001). They are however, matched with four "but" parts, at lines 16, 20, 21 and 24 which also adjust the meaning by saying he does not feel able to act as he might do. In contrast to many of the other extracts, the client does not use humour in addressing his difficulties. The lack of laughter fits the more exasperated and down-beat tone of the client, and their more direct orientation to their problem which is evident in other parts of their talk (not included here) where they discuss dropping out of university.

2.4.3 **Therapist and Client responses to SBs**

The three extracts that have been discussed so far have primarily considered how, when and why the client says the SB, not how they are responded to by the therapist. The therapist's response to the client's talk illustrates the interactional consequences, i.e. the actions which the therapist pursues and how this is carried out. Does the therapist ignore the SB, or do they interpret it in a particular way? In the corpus, there were a variety of different interactional responses to the SBs and disclosures, which will be outlined. In brief, in disclosing the issue with a disclaimer, the client often implicitly seeks an affiliative response or acknowledgement from the therapist, which the therapist often does not make explicitly. An affiliative response is where the recipient displays that they support the affective stance expressed by the speaker (Lindström & Sorjonen, 2013). The lack of a verbal response was not

necessarily treated as problematic by the clients. Without a verbal therapist response, the clients typically minimally pursued a response or acknowledgement from the therapist (i.e. they did not ask the therapist for one, but did indicate one might have been preferred), or otherwise moved topic with or without acknowledgement. The positioning of the SB, whether it was prospectively used (e.g. Extract 3, 4 and 6) or retrospectively (e.g. Extracts 5, 7 and 9), did not appear to alter the therapist's response to the SBs.

Response Withheld by the therapist

One possibility is of a "non-response", where the therapist withholds a response. A withheld response in CA terminology is the non-occurrence of particular actions that are sequentially relevant, which were not produced in the relevant expected sequence (Chevalier & Moore, 2015; Schegloff, 2007). Speakers may hold the listener responsible for not producing the expected response (Chevalier & Moore, 2015). Previous literature indicates that withholding is associated with both asymmetries of power in an institutional context, such as within therapy, where there are asymmetries of knowledge or experience (Chevalier & Moore, 2015). Withholding a response can be purposeful for institutional tasks, rather than obstructive (Chevalier & Moore, 2015), such as encouraging expansion of the client's previous talk (Muntigl & Zabala, 2008; Pomeroy & Weatherall, 2014).

Client pursues a response

In Extract 1, after the gap where the client could speak at line 30, there is a silence; and, at line 31, the client says "you know?" "You know" is potentially ambiguous; it can be an appeal to shared knowledge, highlight an inference for the listener to align to (Fox Tree & Schrock, 2002; Schiffrin, 1980), or be part of a speaker's discourse style (Erman, 2001; Macaulay, 2002). At line 31 the client appears to be attempting to gain an affiliative response from the therapist. However, the therapist does not reply. The client then discusses her own formulation of her behaviour, which is sequentially related to the prior talk, but does not directly address the SB. In Extract 3, there are also indications that the client wishes to elicit a stronger response from the therapist than the "mmm" at line 28 –the client further substantiates his reasonableness by highlighting

the assessing therapist's agreement with his perspective, which also ends with a try marking at the end of line 41.

Response not pursued

Extract 4 is from the second therapy session with a male client – the prior talk is about career aspirations and hobbies. The extract starts with a formulation by the therapist based on the prior talk – this is a rare occurrence in the extracts evaluated in this study. The extract also highlights the role of SBs in addressing social norms, and the orientation of the client to social norms in general. References to social norms also seen in Extracts 1 and 3 where the clients report what someone else has said to them to substantiate their claims, and in Extract 2 through the use of "obsessively" at line 3. In Extract 4, channelling aggression is discussed positively, whereas "sadomasochism" and wanting to shoot people (the client had previously discussed wanting to be a sniper), is discussed negatively when they did not necessarily have to be:

Extract 4, 1-2653, 45:05

```
01     T     It sounds like some of these things, (.) the:
02           the [army,] the cage fighting are wh- wh:ere:
03     C         [((coughs))]
04     T     you can channel your aggression.
05     C     Yeah (.) I absolutely lov:e: it. I mean,
06           (0.4) because it all(.) >it's all< built
07           up (.) I mean, .hhhhh (0.3) I- I can't
08           think of any (0.8) other way to vent it. (0.2)
09           U:m:, (1.1) I me:an:, (1.0) I can't just out
10           in the street and just- pick a fight with
11           anybody, (.) e:rr:r (0.8) s:port (.) >I mean,<
12           (0.7)wiv- without doing, (1.5) so I mean (.)
13           >when-  whe-< when (.) I mean (.)it's got to
14           be maybe not everyone but ninety nine percent
15           of people when they get angry they want
16           to hit something, .hhhhhh e::r:r: (0.3)
17           most of us don't do it (.) and it just sort
```

of >builds up and builds up< inside, and
then (.) like when (.) when I go to
training (.) when I go to competition (.)
.hhhhh I can just let it loose (.) I can-
.hhhhh (0.4) I get applaud- I mean (.) it
do(h)e(h)s hhh so(h)un(h)d (pretty)
→ £grotesque to be quite honest£, heh (.) but
→ I get applauded for hurtin' somebody:, (0.2)
but e:r:, (0.6) <not in so much of
a sadomasochist way but>, (.) getting
punched would spur me on (.) >I mean< (0.2)
>it's like if somebody's hitting me £I'm
gonna to hit 'em back£. <.hhhhh errm, (1.8)
I just, I dunno (.) >I reckon< (.)that's
definitely a way to channel aggression.
(0.4)
C Um:,
(1.5)
C As for going in to the armed forces, (.) I've
thought about that a lot (.) as in (.) whether
or not it is just me trying to channel my
aggression (.) as in why would I want do it
(.) I mean (.) .hhhhhh(0.3) If somebody walked
up to me (.) and told me that their life
ambition was to go out somewhere (.)
get a gun (.) point it at someone and shoot
them (.) I would think they were °a bit of
a fuck°:ing weirdo £to be quite h(h)onest,£
h h h.hhhh And so that's what I've been- (.)
I've been- thinking about myself (.) about
thinking hhhh why do I want to do this.
C And, ((taps)) >ye- I- I've< <no idea why
I do>.

As with Extracts 1, 2, and 3, after the SB aspect is completed there is a point for the therapist to speak – at line 33, and again at line 35. However, the client does not explicitly seek a response from the therapist. The client then starts to talk about the second issue (the army), which whilst still relevant to the subject of being "grotesque", it moves away from the point raised by the SB. (See 0 for more on Extract 4)

Therapist asks about the SB

Extract 2 is the only extract in which the therapist asks about the SB. The therapist's question can be seen as an attempt to un-package the glossed issue of "obsessively whatever that means" (e.g. Weijts et al., 1993). Hesitancy within the client's talk creates a space at the end of line 21 where there is an opportunity, but not an obligation, for the listener to complete the speaker's turn (in CA, a semi-permeable space) and promote affiliation (Lerner, 2013). The client gives some indication that responding to the therapist's question is not welcomed or disliked (in CA terms dispreffered). The client's repeat prefaced reply to the question at line 25 ("the worry is…") can indicate a difficulty in retrieving the information requested, and is often associated with silences, as there are at lines 24 and 28 (Bolden, 2009a). The pause of 1.7s in replying also indicates a dispreferred turn (Antaki & Jahoda, 2010; Jefferson, 1988). Further there are multiple instances of hedged and delayed talk in the client's response to the question, which are also indicative of a dispreferred response (Pomerantz & Heritage, 2013). The therapist's theoretical orientation, and their own SIKs potentially contribute to the question, which is possibly a CBT informed question (See 3.3.11 for more on therapist's theoretical orientation and questions). In contrast to the other extracts, the client's talk then discusses the "sounds" aspect of the SB in more detail.

Formulate and Affiliate/Validate

Extract 5 and the subsequent extracts are presented as partial extracts (see appendix 2 for full extracts). The full extracts are provided in the supplementary material, and the line numbers are preserved at their respective places to reflect this. Extract 5 is from a client discussing avoiding people as he finds it awkward if people do not reciprocate when he says hello.

Extract 5, 1-7623, 11:52

37			Or I'll cross the road, (0.2) or I'll (0.2)
38			.hhhhhhhhhh (.) >°take°< take >my phone out
39			me pocket or I'll do kind< of something, (0.4)
40	→		.hhhh If it sounds very childish when I (.)
41	→		°sort of° try and explain it but (0.2)
42	→		it pr- probably is childish but, (0.4)
43		T	Sounds like that:'s a way thut (0.2) that
44			you've got of dealing with that (.) difficult
45			situation.
45			(0.7)
46		C	Yeah
47			(0.3)

The therapist in this case responds with a formulation of the client's way of coping with the issue at hand, and validates it being a "difficult situation" (line 44). Antaki (2008) highlights the inherently cooperative role of formulation in linking the talk of the client and therapist by summarizing the discussion and allowing the client to confirm or refute the therapist's evaluation. The client agrees with the formulation with an emphatic "yeah" (underlining shows emphasis) at line 46. There were few therapist formulations in the corpus, and as noted by Antaki (2008) formulation can perform several interactional roles, with the extract illustrating one of those possible roles.

Therapist Completion

In Extract 6, the female client has been discussing coming to terms with the death of her father who had been unwell for some time:

Extract 6, 10-8011, 29:31

37		=Yeah (.) it's like y'know? It's another stage
38		of like (.) accep:tance (.) and I'm real:ly
39		unwilling to accept that this has happened (.)
40		still.

41 (1.9)
42 →C Like it sounds insane (.) I know it’s been
43 → like (.) four months but,
44 (3.6)
45 T °But you’re not ready yet.°
46 (3.7)
47 C N::y::o:o,
48 (4.7)
49 C I keep thinking about like (.) to other people
50 (.) it’s been, (0.2) four months, (0.3) to
51 m:e? (2.2) It kind of >$almost hasn’t
52 happened?$< (0.5) Yet.

The therapist’s completion of the client’s phrase at line 45 is a compound turn in CA (Lerner, 1991; 1996). Compound turns are where the prior speaker’s talk (client lines 42 and 43) allows for the anticipatory completion of the talk by the listener (Lerner 1996). The therapist completes the client’s phrase, and the client agrees with the therapists’ statement (line 47). In doing so, the therapist shows affiliation with the client as they demonstrate their understanding (Lerner, 1991). As with previous extracts, the SB invokes the ideas of social norms: the client states that four months is too long to be unwilling to accept a bereavement (e.g. Penman, Breen, Hewitt, & Prigerson, 2014).

Therapist Tease and Client Resistance

In contrast to Extracts 5 and 6, Extract 7 highlights a non-affiliating therapist response to the SB. The client has been discussing feeling as though she is not good enough to accept any accomplishments as her own work.

Extract 7, 1-1425, 19:31

24 C And there’s like (.) <one massive big gap> cos
25 the person I am is this person (0.3) not (0.2)
26 that per(h)s(h)o(h)n >I(h) m(h)e(h)a(h)n
27 i(h)f<yo(h)u un(h)ders(h)tand(h) th(h)e
28 → con(h)ce(h)pt (.) £I make that sound weird£

```
29   →C     >.hhh But you think? Did I really do that?<
31    C     >An' I think I did?<
32    C      >It must have been some good luck.<
33          (0.4)
34    C     >Or some coincidence< or something happened on
35          the day (.) or eeerrrmmmm (0.2) it's cos they
36          helped me out (.) O::r (.) >y'know< (.) .hhhh
37    T     It couldn't possibly be becau[se (     )]
38    C                                  [Oh it c]an't be
39          me cos I'm this person.
40          (.)
41    C     I'm that person who got told off. And this
42          person here >who did this, who did that.<
```

The therapist's response is non-serious tease. Teases often feature exaggerated versions of events to make them recognisable as a tease ("couldn't possibly", line 37, Drew, 1987). Rather than being about social control (Drew, 1987) the tease appears to be trying to test the strength of the client's belief. As is common with teases the client responds with a "po-faced" response (where the respondent treats the tease seriously, Drew, 1987): she denies that her accomplishments could be anything to do with her, interrupting the therapist's talk at line 37. The exchange is not treated as a therapeutic rupture; but illustrates the client defending their position and disagreeing with the therapist's optimistic proposition (MacMartin, 2008). (See 0 for more discussion on the issue raised of sounding "weird" or "silly)

Minimal Encouragement

Extracts 8 and 9 highlight therapists using "mmm" and "yeah", which can be used to different effects. In Extract 8 the client is talking about having been to a bad school.

Extract 8, 10-1766, 42:19

```
66     C     An' (1.3) like the whole thing is just
67           completely tainted.
```

68 (0.5)
69 C Like erm,
70 T °Mmmmm°
71 (2.0)
72 C °I am.°
73 (1.0)
74 →C °Like sounds quite° (0.7) trivial but.
75 (2.0)
76 C Even that (0.7) like just (.) puts (0.8) just
77 like (1.3) erm,
78 (0.4)
79 C Doom and gloom B(h)as(h)ic(h)ally.
80 T Mmmmm.
81 (0.4)
82 C Yeah
83 (2.1)
84 C And then again. °>I couldn't (0.2) probabl-
85 I'm probably quite.<° (0.3) .hhhhh bitter
86 about it (.)°>there was like° five years of my
87 C childhood (.) that was (.) supposed to be
88 (0.2) good (.) Hhhhh.hhhh and erm. (0.8) it
89 feels like a bit of an injustice really,=
90 T °=Mmmmm°

In Extract 8 "mmm" (line 80) is used as a continuer (e.g. "mm hm", "uh huh"; Muntigl & Zabala, 2008; Schegloff, 1981) which can encourage the client to expand – the therapist does not expand on the "mm" through a question or a longer response. Afterwards, there are some features which suggest that the client is pursuing a more affiliative response from the therapist, as the client re-articulates and escalates that the experience being tainted is non-trivial, with the client being "bitter", and that it "feels like a bit of an injustice" (line 85).

Minimal Receipt

Extract 9 highlights a different use of a continuer. Extract 9 is from the same session as in Extract 8, with the client discussing being bullied.

Extract 9, 10-1766, 50:31

42	C	But, (0.4) They made me feel like I was, (0.2)
43		hhhhh inferior to them.
44		(0.2)
45	C	>An' that I wasn't< (0.4) £wasn't cool::£ that
46		kind of thing, HHHHhhhh
47	T	Mmmm
48	→C	(h)Wh(h)ic(h)h .hhh (0.4) >£sounds silly now£<
49	→	but (.) is (.) like, (0.5) <important> (0.2)
50		then (.) I sup[pose,]
51	T	[Yeah].
52		(1.2)
53	C	Like, (0.2) it's amazing like, coming to
54		university an' (0.6) >just like< (0.2) nobody
55		cares, (.) nobody cares (.) no-one cares what
56		you look like (.) what you do:, (0.6) like,
57		(0.6) there's just too many people an' you just
58		(0.2) you have your friends an' >that's that.<
59		(0.9)
60	C	Erm,
61		(2.3)
62	C	>Which is good.<
63		(0.9)
64	C	hhhh
65	T	We're going to have to end there for today.

"Yeah" (line 51) can be used to indicate continuation, agreement or alignment, and differentiating uses can be ambiguous (Lambertz, 2011). Afterwards, the client changes topic slightly to emphasize how much better it is at university. After doing so there is another opportunity for the therapist to speak at line 59 and 61 which the therapist does not do. In contrast to using "yeah" and "mm"

as continuers, Antaki and Jahoda (2010) proposed that these minimal receipts, where the listener produces a response to show that they are listening, but where the response does little more than this, can be used to encourage clients to stay "on track". A possible reason for the therapist's less affiliative or encouraging response is not clear until line 62 when the therapist says that they have run out of time.

2.4.4 **MOL's SIKs**

Having analysed the instances of talk (SBs) in a data-driven, inductive approach using CA, the findings can be entered into a dialogue with the outlined MOL SIKs:

Disruptions indicate a comment on the client's own talk

There is an acknowledged tautology in how potential disruptions have been implemented in the study and MOL's conception of them – as the study specifically sought to find examples of self-reflective talk. Therefore, the self-reflective aspect of disruptions cannot be directly contradicted by the current study. However, the study can expand on this SIK. The MOL quotation illustrated relatively straightforward examples of disruptions, such as laughs, or smiles. As has been outlined in the associated features section, the SBs were associated with several concurrent or consecutive features of talk, such as laughter, changes in intonation, and starting and stopping talk. Therefore, the SBs illustrate that a potential disruption is potentially not limited to just one single "disrupted" feature – that potential disruptions may have multiple features.

Disruptions are brief

Consistent with MOL's SIKs, none of the recordings in the corpus featured the client using an extended period of narrative reflexivity. Extract 3 is the most protracted, but even then, the client is trying to repair their meaning, rather than the SB leading to a further turn at talk which is a continued meta-comment.

After disruptions clients will often resume their prior talk

After an SB, clients talked about a related topic, as would be expected from other CA literature indicating that talk is ordered and interactionally interlinked (e.g. Schegloff, 2007). For example, in Extracts 1 and 3, the subsequent talk is a formulation related to the prior talk, but does not elaborate on the 'sounds' aspect. It was only in Extract 2 where the client was asked about the SB that his talk was sustained on the SB.

The two further aims of expanding on MOL's SIKs can also be reviewed:

In what context a potential disruption occurs, and what social action the client appears to be performing

SBs were examined as one potential disruption, and their use by clients to disclaim and disclose an issue has been outlined. PCT proposes that behaviour controls perception – that perceptual variables or experiences are controlled by a person's actions, and those actions are controlled to bring about the desired perceptual state. In line with CA findings at large, the current corpus indicates that clients are sensitive to the internal acceptability of their talk, its social acceptability, and maintaining a shared intersubjective experience with the therapist, which were attended, or controlled for by the SB. The results also indicate that clients are apparently being "open and honest" with the therapist if the client is disclosing issues (see 3.4.11 for more discussion on MOL's SIKs)

CA proposes that talk is orderly, which therefore raises the prospect that other potential disruptions would show some orderliness. For example, laughter is one potential disruption, and whilst CA has shown that laughter is complex, CA has shown that its use is orderly, such as laughter's use when talking about medical issues (e.g. Beach & Prickett, 2016) or in complaining (e.g. Potter & Hepburn, 2010). Therefore, a logical consequence of CA's proposed orderliness is that people's talk might be "disrupted" at similar points. CA's perspective is contrasted with MOL proposals that the content of the talk is not

of interest per se, as the important factor is getting the client to focus on disruptions. MOL does propose that clients might modify their talk due to social concerns, or to maintain the quality of the therapeutic alliance (Carey, Kelly, Mansell, & Tai, 2012). However, MOL's account is based on the client needing to be able to talk about their difficulties, and the potential for the therapist and client to have conflicting goals about what they want to discuss – not the finer detail of how this is done in the talk itself. The potential for the client to use their own talk to create the "just right" environment for a disclosure receives less attention in MOL, and the presumption is made that evaluation occurs "after the ideas have been expressed" (Carey et al., 2012, p1), whereas the current study's extracts found that SBs can occur prior to the problematic talk (e.g. Extracts 1 and 4). The analysis of SBs elaborates on the micro-level at which this regulation occurs, within specific moments of talk and what other factors might be being controlled for. The CA account is not necessarily incompatible with MOL's accounts, but there is a difference in emphasis (see 3.4.2 and 3.4.8 for more).

SBs appear to be a marker of openness in therapeutic relationship – representing disclosures and showing that the therapeutic relationship is being attended to. Issues of client self-monitoring are present in MOL, with the client regulating their perception of what is "just right" to talk about. The results pose some challenge for MOL's somewhat straightforward account of a disruptions representing a transition between a client's foreground thoughts (i.e. thoughts that are currently in the person's awareness, or their current point of view) and their background thoughts (thoughts about what they are currently doing, or various points of view about what they are doing). The CA analysis suggests that clients are attending to multiple factors in their talk, such as its coherence, whether they are describing an event properly, whether the listener appears to be following, and what inferences the listener might draw. All of these issues are attended to in some part by the SBs, and CA shows the level of sensitivity with which talk is managed. To an extent these sensitivities and issues could still covered under the idea of 'background' thoughts, but MOL does not elaborate on the variety of these background thoughts, and how much might be controlled for during talk as a moment-to-moment activity.

How therapists and clients subsequently orientated to the potential disruption

A variety of different therapist and client responses have been outlined in the results section. Disruptions are not discussed in interactional terms by MOL, and there is no discussion in the MOL literature of whether a client might pursue a response from a therapist. In the current study, several extracts highlighted the clients pursuing a response from the therapist, or a stronger response than the therapist gave, whereas other extracts had the therapist completing the client's talk (Extract 6). It was only when the therapist asked about the SB in Extract 2 that the SB was addressed directly by the client.

Overall the CA finding are indicative that not only do some therapists not ask about possible disruptions or SBs, but that SBs can also be insufficiently attended to from the client's perspective. Conversely, none of the clients held the therapist explicitly accountable for this lack of attentiveness by questioning the therapist about it. How the therapists and clients orientated to the SB is explored more broadly is in the remaining discussion.

2.5 **Discussion**

The current study aimed to explore the interactional features of clients reflecting on their own talk. The study collected instances of clients saying 'sounds [X] but [Y]', which was used to disclaim a possible hearing of their talk, build up to a disclosure, and to attend to issues of intersubjectivity. The findings also provided broad support for, and expanded on, several of MOL's SIKs. The findings will be considered in the context of the broader therapeutic and CA literature on disclosures, intersubjectivity and immediacy.

SBs were associated with client disclosures (see 3.4.22 for more on disclosures), where the SB contributed to voluntary, significant and personal reports brought about in an interaction (Antaki et al., 2005). Therapeutic research on client disclosures has typically not explored how disclosures are carried out, instead focusing on why clients might withhold information; the

association between disclosure and therapy outcome; and therapists' self-disclosures (Henretty, Currier, Berman, & Levitt, 2014; Knox & Hill, 2016). Literature on disclosures more commonly frames disclosures as a statement of particularly significant thoughts or feelings, such as sexual abuse (Graham-Bermann, Kulkarni, & Kanukollu, 2011). The SBs resulted in a variety of different therapist responses. CA does not take a position on which response is "better", but some examples indicated the clients sought a different response, and the results afford an opportunity for therapists to reflect on what is appropriate within their own approach's SIKs. The SBs were relatively fleeting, however, and given the limitations of a therapist's potential reply there are limitations on what can be said in response and which aspect to respond to, if at all.

SBs also attended to intersubjectivity (see 3.4.33 for more), with the client naming a potential hearing of their talk through the "sounds [X]" component. However, it was potentially designedly ambiguous who the hearer was – as it may refer to both parties. Quite what this means depends on the perspectives taken, and how intersubjectivity is understood. Intersubjectivity has considerable overlap with other therapeutic concepts such as mentalization (e.g. Fonagy & Bateman, 2006) and Theory of Mind (ToM e.g. Baron-Cohen, Leslie, & Frith, 1985). A therapeutic perspective might be that the clients are sharing their internal experience ('I think it sounds') or projecting a concern (I'm worried you think I sound), displaying some competence at mentalizing or ToM. CA's cognitive asceticism does not afford the exploration of these issues as might typically be understood therapeutically – instead in CA intersubjectivity is treated as a more diffuse problem managed in a variety of ways through talk (Potter, 2012). The SBs highlight one such explicit way of attending to intersubjectivity and the discussion herein offers a CA exploration of the ways the client and therapist negotiate the issues, beyond intersubjectivity merely being an appraisal of the client's or therapist's internal state. Several of the extracts showed a collaborative response from the therapist to the client's intersubjective expression (e.g. Extracts 5 and 6) whereas Extracts 8 and 9 do not (Perakyla, 2008).

The SBs also represent the clients' move in to immediacy (3.4.4 for more on immediacy). Immediacy has a number of different meanings, but is most broadly related to the here-and-now of the therapeutic relationship (Kondratyuk and Peräkylä, 2011, see 3.4.55 for more on the therapeutic relationship). CA research on immediacy has predominantly explored how the therapists guide the client in to immediacy (Kondratyuk & Peräkylä, 2011), rather than when the clients initiate it a move to immediacy themselves. The SBs' move in to immediacy is done to name and defease a possible negative hearing of the clients' talk. Similar shifts in to immediacy were seen in a study examining narrative reflexivity in a sexual offender treatment programme, where offenders used immediacy to defease a possible negative hearing of their talk and how they understood their offence (Auburn, 2005). After the potential hearing of talk had been defeased, the offenders resumed their narrative account of their 79ehavior. As there are only two studies exploring self-initiated moves in to immediacy, it is premature to conclude whether it is primarily done to disavow negative hearings. It is however, interesting that this is the pattern so far.

The exploration of SB has two interlinked implications. Firstly it has elaborated on apparent shifts in clients' moment-to-moment experience highlighted by several different therapies at the outset. A detailed account of the actions performed by clients with SBs has been discussed as disclaiming and disclosing an issue. The account also addresses a limitation in the literature by focusing on how, when and why clients might produce a shift in their talk. These aspects are of broader interest beyond MOL, and can be understood in different ways using other therapeutic approaches. Secondly, it has provided some exploration of MOL's SIKs, and highlighted SBs as one possible form of disruption – describing its interactional features, and how it might be responded to by therapists who are naïve to MOL. MOL's outcomes evidence suggests that asking clients about these shifts can be an effective therapeutic intervention (e.g. Carey et al., 2009; Carey, Tai, & Stiles, 2013). The two aspects are worth considering during training and development, including when a therapist reviews their own recordings and example sessions. There can be no one 'correct' response for a therapist to a shift in a client's talk, or indeed to any client activity, given the number of competing demands in therapy (see

Cannon, 2014 for MOL suggestions), but SBs are a potentially interesting practice for therapeutic consideration of how to respond to them (see 3.4.66 for more on therapist responses). (See 3.4.88 for more on clinical implications, 3.4.9 for future research implications)

A limitation of the study is that the data were obtained from audio recordings, and therefore non-verbal behaviour such as nodding which can be used to reinforce affectual bonds or affiliate in psychotherapy (Muntigl, Knight, & Watkins, 2012) is not available (see 3.4.7 for more on strengths and limitations). As indicated previously, unfortunately the theoretical orientations of the therapist were not available, although the discussion in relation to their therapeutic approaches is limited due to CA's approach. Whilst the advantages of CA have been outlined, the approach also has limitations due to its ascetic approach to cognitive issues. (See 3.5 for critical reflections)

2.6 References

Antaki, C. (2008). Formulation in psychotherapy. In A. Perakyla, C. Antaki, S. Vehvilainen, & I. Leduar (Eds.), *Conversation Analysis and Psychotherapy* (pp. 26–42). Cambridge: Cambridge University Press.

Antaki, C., Barnes, R., & Leudar, I. (2005). Self-disclosure as a situated interactional practice. *The British Journal of Social Psychology*, *44*(2), 181–199. http://doi.org/10.1348/014466604X15733

Antaki, C., & Jahoda, A. (2010). Psychotherapists' practices in keeping a session "on-track" in the face of clients' "off-track" talk. *Communication and Medicine*, *7*(1), 11–21. http://doi.org/10.1558/cam.v7il.ll

Baron-cohen, S., Leslie, A., & Frith, U. (1985). Does the autistic child have a "theory of mind"? *Cognitive Development*, *21*, 37–46. http://doi.org/10.1016/0010-0277(85)90022-8

Baumann, E. C., & Hill, C. E. (2016). Client concealment and disclosure of secrets in outpatient psychotherapy. *Counselling Psychology Quarterly*, *29*(1), 53–75. http://doi.org/10.1080/09515070.2015.1023698

Beach, W. A., & Prickett, E. (2016). Laughter, humor, and cancer: Delicate moments and poignant interactional circumstances. *Health Communication*, 32(7), 1–12. http://doi.org/10.1080/10410236.2016.1172291

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

Beebe, B., Rustin, J., Sorter, D., & Knoblauch, S. (2003). An expanded view of intersubjectivity in infancy and its application to psychoanalysis. *Psychoanalytic Dialogues,* 13(6), 805-841. http://doi.org/10.1080/10481881309348769

Bolden, G. B. (2006). Little words that matter: Discourse markers "So" and "Oh" and the doing of other-attentiveness in social interaction. *Journal of Communication*, *56*(4), 661–688. http://doi.org/10.1111/j.1460-2466.2006.00314.x

Bolden, G. B. (2009a). Beyond answering: Repeat-prefaced responses in conversation. *Communication Monographs*, *76*(2), 121–143. http://doi.org/10.1080/03637750902828446

Bolden, G. B. (2009b). Implementing incipient actions: The discourse marker

"so" in English conversation. *Journal of Pragmatics*, *41*(5), 974–998. http://doi.org/10.1016/j.pragma.2008.10.004

Cannon, C. (2014). *A Conversation Analysis of Method of Levels Psychotherapy*. *Unpublished MRes Dissertation*. Manchester: University of Manchester.

Carey, T. A. (2016). The Method of Levels: A transdiagnostic approach to effective and efficient patient-perspective treatment. Manchester: Presented at an MOL training course.

Carey, T. A. (2006). *The Method of Levels: How to do Psychotherapy without getting in the way*. Hayward, CA: Living Control Systems Publishing.

Carey, T. A., Carey, M., Mullan, R. J., Spratt, C. G., & Spratt, M. B. (2009). Assessing the Statistical and Personal Significance of the Method of Levels. *Behavioural and Cogntive Psychotherapy,* 37(3), 311–324. http://doi.org/10.1017/S1352465809005232

Carey, T. A, Kelly, R. E., Mansell, W., & Tai, S. J. (2012). What's therapeutic about the therapeutic relationship? A hypothesis for practice informed by Perceptual Control Theory. *The Cognitive Behaviour Therapist*, *5*, 47–59. http://oi.org/10.1017/S1754470X12000037

Carey, T. A, Mansell, W., & Tai, S. J. (2015). *Principles-based counselling and psychotherapy: A Method of Levels Approach*. Hove: Routledge.

Carey, T. A, & Mullan, R. J. (2008). Evaluating the method of levels. *Counselling Psychology Quarterly*, *21*, 247–256. http://doi.org/10.1080/09515070802396012

Carey, T. A., Tai, S. J., & Stiles, W. B. (2013). Effective and efficient: Using patient-led appointment scheduling in routine mental health practice in remote Australia. *Professional Psychology: Research & Practice*, *44*(6), 405–414. http://doi.org/10.1037/a0035038

Chevalier, F. H. G., & Moore, J. (2015). Producing and managing restricted activities: An introduction to avoidance and withholding in institutional interaction. In F. H. G. Chevalier & J. Moore (Eds.), *Producing and managing restricted activities: Avoidance and withholding in institutional interaction* (pp. 1–44). Amsterdam: John Benjamins Publishing Company.

Clift, R. (2006). Indexing stance: Reported speech as an interactional evidential. *Journal of Sociolinguistics*, *10*(5), 569–595. http://doi.org/10.1111/j.1467-

9841.2006.00296.x

Davanloo, H. (2001). Intensive short-term dynamic psychotherapy: extended major direct access to the unconscious. *European Psychotherapy*, *2*, 25–70. http://doi.org/ 10.7717/peerj.548

Davison, T. E., McCabe, M. P., Knight, T., & Mellor, D. (2012). Biopsychosocial factors related to depression in aged care residents. *Journal of Affective Disorders*, *142*(1–3), 290–296. http://doi.org/10.1016/j.jad.2012.05.019

Drew, P. (1987). Po-faced receipts of teases. *Linguistics*, *25*(1), 219–253. http://doi.org/10.1515/ling.1987.25.1.219

Drew, P. (2004). Conversation Analysis. In L. Fitch, K & R. E. Sanders (Eds.), *Handbook of Language and Social Interaction* (pp. 71–102). Mahwah: Lawrence Erlbaum Associates

Drew, P., & Heritage, J. (1992). Analyzing talk at work: An introduction. In P. Drew & J. Heritage (Eds.), *Talk at work: Interaction in Institutional Settings* (pp. 3–65). Cambridge: Cambridge University Press.

Drew, P., & Holt, E. (1988). Complainable matters: The use of idiomatic expressions in making complaints. *Social Problems*, *35*(4), 398–417. http://doi.org/10.1525/sp.1988.35.4.03a00060

Edwards, D. (1997). *Discourse and Cognition*. London: Sage.

Edwards, D. (2005). Discursive Psychology. In K. L. Fitch & R. E. Sanders (Eds.), *Handbook of Language and Social Interaction* (pp. 257–273). London: Erlbaum.

Edwards, D. (2005). Moaning, whinging and laughing: the subjective side of complaints. *Discourse Studies*, *7*(1), 5–29. http://doi.org/10.1177/1461445605048765

Edwards, D., & Potter, J. (2005). Discursive psychology, mental states and descriptions. In H. te Molder & J. Potter (Eds.), *Conversation and Cognition* (pp. 241–259). Cambridge: Cambridge University Press.

Erman, B. (2001). Pragmatic markers revisited with a focus on you know in adult and adolescent talk. *Journal of Pragmatics*, *33*(9), 1337–1359. http://doi.org/10.1016/S0378-2166(00)00066-7

Fonagy, P., & Bateman, A. W. (2006). Mechanisms of change in mentalisation-based therapy with BPD. *Journal of Clinical Psychology*, *62*(4), 411–430. http://doi.org/10.1002/jclp.20241

Fox Tree, J. E., & Schrock, J. C. (2002). Basic meanings of you know and I mean. *Journal of Pragmatics*, *34*(6), 727–747. http://doi.org/10.1016/S0378-2166(02)00027-9

Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature Of "innovative moments" in the construction of change. *Journal of Constructivist Psychology*, *22*(1), 1–23. http://doi.org/10.1080/10720530802500748

Graham-Bermann, S. A, Kulkarni, M. R., & Kanukollu, S. N. (2011). Is disclosure therapeutic for children following exposure to traumatic violence? *Journal of Interpersonal Violence*, *26*(5), 1056–1076. http://doi.org/10.1177/0886260510365855

Greenberg, L. S. (2004). Emotion–focused therapy. *Clinical Psychology & Psychotherapy*, *11*(1), 3–16. http://doi.org/10.1002/cpp.388

Haakana, M. (2001). Laughter as a patient's resource: Dealing with delicate aspects of medical interaction. *Text & Talk*, *21*(1). http://doi.org/10.1515/text.1.21.1-2.187

Hall, D. A., & Farber, B. A. (2001). Patterns of patient disclosure in psychotherapy. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *29*(2), 213–230. http://doi.org/10.1521/jaap.29.2.213.17262

Henretty, J. R., Currier, J. M., Berman, J. S., & Levitt, H. M. (2014). The impact of counselor self-disclosure on clients: A meta-analytic review of experimental and quasi-experimental research. *Journal of Counseling Psychology*, *61*(2), 191–207. http://doi.org/10.1037/a0036189

Hepburn, A., & Potter, J. (2007). Crying receipts: Time, empathy, and institutional practice. *Research on Language & Social Interaction*, *40*(1), 89–116. http://doi.org/10.1080/08351810701331299

Hewitt, J. P., & Stokes, R. (1975). Disclaimers. *American Sociological Review*, *40*(1), 1–11. http://doi.org/10.2307/2094442

Holt, E. (2012). Using laugh responses to defuse complaints. *Research on Language & Social Interaction*, *45*(4), 430–448. http://doi.org/10.1080/08351813.2012.726886

Hutchby, I., & Wooffitt, R. (2008). *Conversation Analysis* (2nd ed.). Cambridge: Polity.

Jefferson, G. (1984). On the organisation of laughter in talk about troubles. In J. M. Atkison & J. C. Heritage (Eds.), *Structures of Social Action: Studies in Conversation Analysis* (pp. 346–369). Cambridge: Cambridge University Press.

Jefferson, G. (1985). An exercise in the Transcription and Analysis of Laughter. In T. A. Van Dijk (Ed.), *Handbook of Discourse Analysis Vol 3: Discourse and Dialogue* (pp. 25–34). London: Academic Press.

Jefferson, G. (1985). On the interactional unpackaging of a "gloss." *Language in Society*, *14*(4), 435. http://doi.org/10.1017/S0047404500011465

Jefferson, G. (1988). On the sequential organization of troubles-talk in ordinary conversation. *Social Problems*, *35*(4), 418–441. http://doi.org/10.1525/sp.1988.35.4.03a00070

Jefferson, G. (1988). Preliminary notes on a possible metric which provides a "standard maximum" silence of approximately one second in conversation. In D. Roger & P. Bull (Eds.), *Conversation* (pp. 166–196). Clevedon: Multilingual Matters.

Jefferson, G., Sacks, H., & Schegloff, E. A. (1987). Notes on laughter in the pursuit of intimacy. In G. Button & J. Lee (Eds.), *Talk and Social Organization* (pp. 152–205). Avon: Multilingual Matters.

Kashdan, T. B. (2007). Social anxiety spectrum and diminished positive experiences: Theoretical synthesis and meta-analysis. *Clinical Psychology Review*, *27*(3), 348–365. http://doi.org/10.1016/j.cpr.2006.12.003

Knox, S., & Hill, C. E. (2016). Introduction to a special issue on disclosure and concealment in psychotherapy. *Counselling Psychology Quarterly*, *29*(1), 1–6. http://doi.org/10.1080/09515070.2015.1095156

Koivisto, A., & Voutilainen, L. (2016). Responding to what is left implicit: psychotherapists' formulations and understanding checks after clients' turn-final *Että* ("That/So"). *Research on Language and Social Interaction*, *49*(3), 238–257. http://doi.org/10.1080/08351813.2016.1198195

Kondratyuk, N., & Perakyla, A. (2011). Therapeutic work with the present moment: A comparative conversation analysis of existential and cognitive therapies. *Psychotherapy Research : Journal of the Society for Psychotherapy Research*, *21*(3), 316–330. http://doi.org/10.1080/10503307.2011.570934

Lambertz, K. (2011). Back-channelling: The use of yeah and mm to portray engaged listenership. *Griffith Working Papers in Pragmatics and Intercultural Communication*, *4*(1), 11–18.

Lerner, G. H. (1991). On the syntax of sentences-in-progress. *Language in Society*, 20(3), 441–458. http://doi.org/10.1017/S0047404500016572

Lerner, G. H. (1996). On the "semi-permeable" character of grammatical units in conversation: conditional entry into the turn space of another speaker. In E Ochs, Schegloff, E. A., & Thompson, S. A (Eds.), *Interaction and Grammar*. Cambridge: Cambridge University Press.

Lerner, G. H. (2013). On the place of hesitating in delicate formulation: a turn-constructional infrastructure for collaborative indiscretion. In M. Hayashi, G. Raymound, & J. Sidnell (Eds.), *Conversational Repair and Human Understanding* (pp. 95–134). Cambridge: Cambridge University Press.

Li, X., Jauquet, C. A., & Kivlighan, D. M. (2016). When is therapist metacommunication followed by more client collaboration? The moderation effects of timing and contexts. *Journal of Counseling Psychology*, *63*(6), 693–703. http://doi.org/10.1037/cou0000162

Liddicoat, A. J. (2007). *An introduction to Conversation Analysis*. London: Continuum.

Lindström, A., & Sorjonen, M.-L. (2013). Affiliation in Conversation. In J. Sidnell & T. Stivers (Eds.), *Handbook of conversation analysis* (pp. 350–369). Oxford: Wiley-Blackwell.

Lucy, J. A. (1993). Reflexive language and the human disciplines. In J. A. Lucy (Eds.), *Reflexive Language: Reported Speech and Metapragmatics* (pp. 9-32). Cambridge: Cambridge University Press.

Macaulay, R. (2002). You know, it depends. *Journal of Pragmatics*, *34*(6), 749–767. http://doi.org/10.1016/S0378-2166(01)00005-4

MacMartin, C. (2008). Resisting optimistic questions in therapies. In A. Perakyla, C. Antaki, S. Vehviläinen, & I. Leudar (Eds.), *Conversation Analysis and Psychotherapy* (pp. 80–99). Cambridge: Cambridge University Press.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, *91*(1), 1–20.

http://doi.org/10.1348/000712600161646

Madill, A., Widdicombe, S., & Barkham, M. (2001). The potential of conversation analysis for psychotherapy research. *The Counseling Psychologist*, *29*(3), 413–434. http://doi.org/10.1177/0011000001293006

Mandelbaum, J. (2013). Storytelling in conversation. In J. Sidnell & T. Stivers (Eds.), *Handbook of conversation analysis* (pp. 492–508). Oxford: Wiley-Blackwell.

Markee, N. (2000). *Conversation analysis*. Mahawah: Laurence Erlbaum Associates.

Muntigl, P., & Horvath, A. O. (2014). The therapeutic relationship in action: How therapists and clients co-manage relational disaffiliation. *Psychotherapy Research*, *24*(3), 327–345. http://doi.org/10.1080/10503307.2013.807525

Muntigl, P., Knight, N., Horvath, A. O., & Watkins, A. (2012). Client attitudinal stance and therapist-client affiliation: A view from grammar and social interaction. *Research in Psychotherapy: Psychopathology, Process and Outcome*, *15*(2), 117–130. http://doi.org/10.7411/RP.2012.012

Muntigl, P., Knight, N. K., & Angus, L. (2014). Targeting emotional impact in storytelling: Working with client affect in emotion-focused psychotherapy. *Discourse Studies*, *16*(6), 753–775. http://doi.org/10.1177/1461445614546255

Muntigl, P., Knight, N., & Watkins, A. (2012). Working to keep aligned in psychotherapy: Using nods as a dialogic resource to display affiliation. *Language and Dialogue*, *2*(1), 9–27. http://doi.org/10.1075/ld.2.1.01mun

Muntigl, P., & Zabala, L. H. (2008). Expandable responses: How clients get prompted to say more during psychotherapy. *Research on Language & Social Interaction*, *41*(2), 187–226. http://doi.org/10.1080/08351810802028738

Padesky, C. a., & Greenberger, D. (1995). *Mind over Mood*. Ney York: Guildford Press.

Penman, E. L., Breen, L. J., Hewitt, L. Y., & Prigerson, H. G. (2014). Public attitudes about normal and pathological grief. *Death Studies*, *38*(8), 510–516. http://doi.org/10.1080/07481187.2013.873839

Peräkylä, A. (2013). Conversation analysis in psychotherapy. In J. Sidnell & T. Stivers (Eds.), *The Handbook of Conversation Analysis* (pp. 551–574).

Chichester: Wiley-Blackwell.

Peräkylä, A., Antaki, C., Vehviläinen, S., & Leudar, I. (2008). Analysing psychotherapy in practice. In A. Peräkylä, C. Antaki, S. Vehviläinen, & I. Leudar (Eds.), *Conversation Analysis and Psychotherapy*. Cambridge: Cambridge University Press.

Peräkylä, A., & Vehviläinen Sanna. (2003). Conversation analysis and the professional stocks of interactional knowledge. *Discourse & Society*, *14*(6), 727–750. http://doi.org/10.1177/09579265030146003

Pomerantz, A., & Heritage, J. (2013). Preference. In J. Sidnell & T. Stivers (Eds.), *The Handbook of Conversation Analysis* (pp. 210–228). Chichester: John Wiley & Sons.

Pomeroy, L., & Weatherall, A. (2014). Responding to client laughter as therapeutic actions in practice. *Qualitative Research In Psychology*, *11*(4), 420–434. http://doi.org/10.1080/14780887.2014.933919

Posner, M. I. (2008). Measuring alertness. *Annals of the New York Academy of Sciences*, *1129*, 193–199. http://doi.org/10.1196/annals.1417.011

Potter, J. (1996). *Representing Reality: Discource, Rhetoric and Social Construction*. London: Sage.

Potter, J. (1999). Beyond cognitivism. *Research on Language & Social Interaction*, *32*(1-2), 119–127. http://doi.org/10.1080/08351813.1999.9683615

Potter, J., & Edwards, D. (2013). Conversation Analysis and Psychology. In J. Sidnell & T. Stivers (Eds.), *The Handbook of Conversation Analysis* (pp. 701–725). Chichester: John Wiley & Sons.

Potter, J., & Hepburn, A. (2010). Putting aspiration into words: “Laugh particles”, managing descriptive trouble and modulating action. *Journal of Pragmatics*, *42*(6), 1543–1555. http://doi.org/10.1016/j.pragma.2009.10.003

Powers, W. T. (2005). Behavior: The control of perception. (New Canaan). Benchmark.

Rapley, M. (2012). Ethnomethodology/Conversation Analysis. In D. Harper & A. R. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy* (pp. 177–192). Oxford: Wiley-Blackwell.

Sacks, H. (1995). *Lectures on Conversation. Volumes I and II*. (G. Jefferson, Ed.). Oxford: Blackwell.

Sacks, H., & Schegloff, E. A. (1979). Two preferences in the organization of refrence to persons in conversation and their interaction. In G. Psathas (Ed.), *Everyday Language, Studies in Ethnomethodology* (pp. 15–21). New York: Irvington Publishers.

Sacks, J. (1984). Notes on methodology. In J. Heritage & M. Atkinson (Eds.), *Structures of Social Action: Studies in Conversation Analysis* (pp. 2–27). Cambridge: Cambridge University Press.

Schegloff, E. A., Sacks, H. (1973). Opening up closings. *Semiotica*, *8*, 289–327. http://doi.org/10.1515/semi.1973.8.4.289

Schegloff, E. (1997). Practices and actions: Boundary cases of other-initiated repair. *Discourse Processes*, *23*(3), 499–545. http://doi.org/10.1080/01638539709545001

Schegloff, E. A. (1981). Discourse as an interactional achievement: some uses of “uh huh” and other things that come between sentences. In D. Tannen (Ed.), *Analysing Discouse: Georgetown University Roundtable on Languages and Linguistics* (pp. 71–93). Washington, DC: Georgetown University Press.

Schegloff, E. A. (1996). Confirming allusions: Toward an empirical account of action. *American Journal of Sociology*, *102*(1), 161–216. http://doi.org/10.1086/230911

Schegloff, E. A. (2005). On complainability. *Social Problems*, *52*(4), 449–476. http://doi.org/10.1525/sp.2005.52.4.449

Schegloff, E. A. (2007). *Sequences Organization In Interaction: A Primer in Conversation Analysis*. Cambridge: Cambridge University Press.

Schegloff, E. A. (2013). Ten operation in self-initiated, same-turn repair. In M. Hayashi, G. Raymond, & J. Sidnell (Eds.), *Conversational Repair and Human Understanding* (pp. 41–70). Cambridge: Cambridge University Press.

Schiffrin, D. (1980). Meta-talk: Organizational and evaluative brackets in discourse. *Sociological Inquiry*, *50*(3–4), 199–236. http://doi.org/10.1111/j.1475-682X.1980.tb00021.x

Silverman, D., & Perakyla, A. (1990). AIDS counselling: the interactional organisation of talk about “delicate” issues. *Sociology of Health and Illness*,

12(3), 293–318. http://doi.org/10.1111/1467-9566.ep11347251

ten Have, P. (2007). *Doing Conversation Analysis: A Practical Guide* (2nd ed.). London: SAGE Publications.

Vehviläinen, S., Peräkylä, A., Antaki, C., & Leudar, I. (2008). A review of the conversational practices of psychotherapy. In In A. Perakyla, C. Antaki, S. Vehviläinen, & I. Leudar (Eds.) *Conversation Analysis and Psychotherapy* (pp. 188–197). Cambridge: Cambridge University Press.

Weijts, W., Houtkoop, H., & Mullen, P. (1993). Talking Delicacy: Speaking about Sexuality during Gynaecological Consultations. *Sociology of Health and Illness*, *15*(3), 295–314. http://doi.org/10.1111/1467-9566.ep10490531

3 Extended Paper

3.1 Extended Introduction

3.1.1 Perceptual Control Theory

Perceptual Control Theory (PCT) is a theory of behaviour explaining the phenomenon of control (Powers, 2005). PCT proposes that all organisms need to be able to control key variables such as food and warmth in order to survive. To control properties like temperature in variable circumstances, behaviour needs to vary with the circumstances. When someone gets warm they might take a layer off or open a window, whereas when someone gets cold they might put a layer on or put the heating on. It is the perceived level of warmth that is controlled for, rather than a behaviour.

In order to control people need to be able to perceive, compare and act (Carey, 2006). PCT proposes that control is achieved via a negative feedback loop (Figure 4). To control how much water to put in to a glass someone needs to be able to perceive how much water is in the glass, compare it to an idealised version of how much water they want in the glass (a glass level reference value or goal), and then act to turn the tap on and off at the appropriate time. The process of perceiving, comparing and acting runs simultaneously whilst the task is being completed, and often people are not aware that they are doing the different steps (Carey, 2006). A key part is that it is the “perception” of the environment that is controlled for, rather than an objective reading of the environment (Powers, 2005).

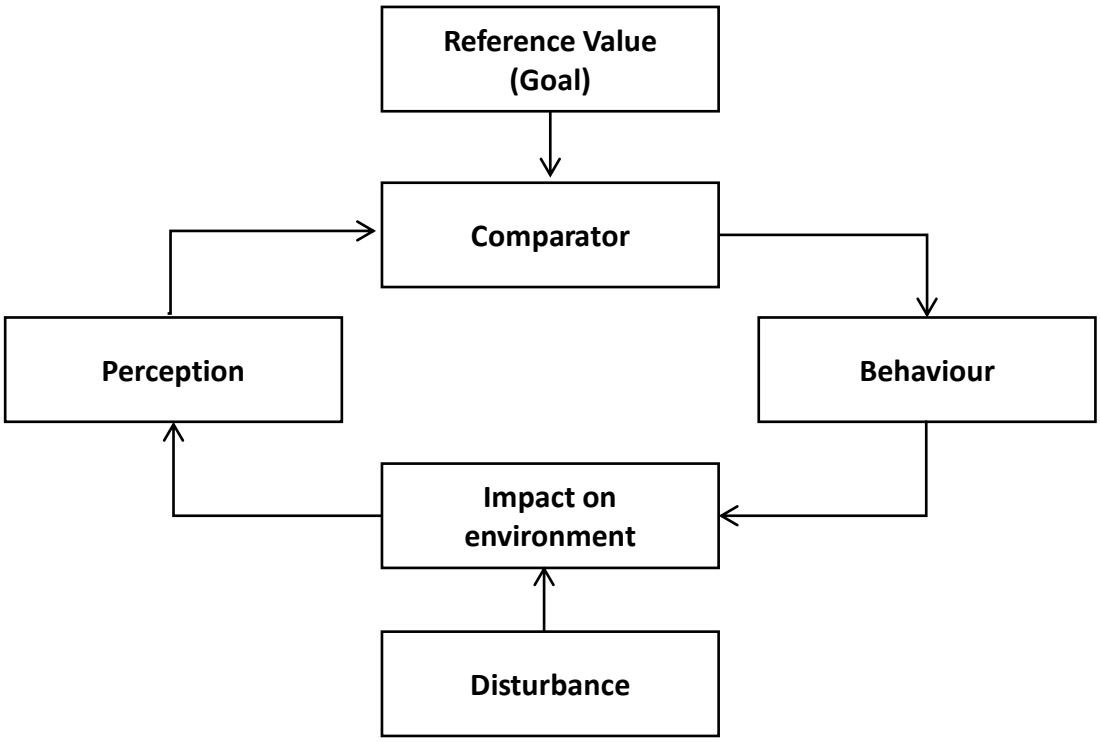

Figure 4. PCT's negative feedback loop.

PCT proposes that negative feedback loops are organised in a hierarchy (Powers, 2005). Higher level loops set the reference value or goals for lower level systems within the hierarchy, which in turn set the goals for even lower level loops. Higher order loops control more abstract perceptions or goals, such as beliefs and morals, whereas the lower level become more concrete and specific. Ultimately the lowest level in the hierarchy controls physiological properties, such as muscle contractions (Carey, 2006; Mansell, 2005; Powers, 2005). A high-level goal might be to "be a good person", and this could result in a lower level goal such as "being polite", which could result in the various muscle contractions which result in holding a door open for someone else. As such negative feedback loops can have multiple reference values set by higher order loops, as it is only possible to have one's arm or person in one place, or to say one thing at a time. If negative feedback loops are trying to achieve two different goals, it is possible to have conflicts between goals. One goal might be to be good at your job, which might indicate that you go to bed to get a good night's sleep for work, whereas another goal, to enjoy yourself, might indicate

that you stay up and watch another episode of something on TV. As long as two incompatible goals are being specified, conflict exists.

Distress in psychopathology is the result of insuperable goal conflict (Carey, 2006; Mansell, 2005). It is not problematic to have goal conflict for a short period of time if it is resolved, but if that conflict perpetuates and goals are not met, then distress arises. Awareness of goal conflict, or at least parts of conflict can also perpetuate distress (Carey, 2006). For example people might seek to supress certain thoughts or people might believe that certain safety behaviours work, when they may in fact be counterproductive. However in doing so people do not take into account the other goal that is not being met. If someone tries to control their thoughts it might meet a goal to have some control over their thoughts, but it might mean that a goal of not being rigid fails to be met.

Within PCT a process called reorganisation resolves conflict (Carey, 2006; Mansell, 2005; Powers, 2005). Reorganisation works by making random changes within the goal system by changing the properties of some of the goals. Usually the process of reorganisation occurs quickly and with little difficulty (Carey, 2006). The goals are adjusted, and conflict is reduced – for example you might watch half an episode of something on TV and then go to bed. However, the changes that reorganisation makes can make control worse. For example, when you drive a different car where the controls for the indicator and windscreen wipers are reversed it can take some time to adjust to the change and the process is not necessarily smooth. The reorganisation system is only purposeful in that it reduces conflict by trial and error, it does not know whether those changes are necessarily good or bad and only seeks to reduce conflict. Often the simplest way to reorganise is to escape a situation altogether such as in a social anxiety, which can temporarily reduce conflict, as such conflict can also be reorganised or escaped at different levels. Reorganisation can also occur at the wrong level in the hierarchy, the lower level goals might be reorganised, but they are not necessarily the ones generating the conflict. Resolving the conflict at a lower level might mean that a feared situation is always avoided. However, the conflict of wanting to be in the feared situation is never resolved at the higher level. The process of reorganisation does not

occur on its own. Awareness can guide reorganisation, and it can also be used to change the goals that someone is trying to meet. Awareness can also be used to guide reorganisation of goal conflicts to occur at the right level.

PCT proposes that the loss of control and goal conflict is the transdiagnostic mechanism of psychological distress, and that reorganisation is the solution. Each person's conflict goals may be different, but they are maintained and solved by the same mechanism. MOL was developed to target reorganisation and resolve goal conflicts. MOL and PCT are strongly interlinked – "MOL is what it is because of PCT" (Carey, 2006, p. 63).

One criticism is that PCT does not distinguish between pursuit and avoidance goals (Mansell, 2005). For example conflict would seem more likely if an individual is attempting to meet one goal and avoid another (Mansell, 2005). The rate of change in perceptions is also less fully articulated by PCT. It has been proposed that there is a further reference value and negative feedback loop system for monitoring the rate of change in errors (Carver & Scheier, 1990). Carver and Scheier (1990) suggested that if the rate of error reduction was greater than the reference signal it would result in positive affect, or if the rate was lower in negative affect.

3.1.2 **Method of Levels**

MOL proposes that conflicting goals outside of someone's awareness result in them coming to therapy, and MOL is intended to bring those goal conflicts in to the client's awareness (Carey, 2006). One of the main goals of MOL is to help clients shift their awareness up the levels of their control hierarchy – leading to the name. Once clients are aware of their conflicts they can then begin to reorganise their goals. However, awareness is thought to be limited, and MOL compares awareness to exploring a cathedral in the dark by torchlight (Carey, 2006). The cathedral is still there, but only some of it can be seen by the torch's beam, equivalent to awareness. Awareness is thought to be limited, so that a person can only be aware of certain thoughts at one time. MOL proposes that the "background" and "foreground" thoughts are there, but that only one of them can be in awareness at one time. However, as with the torch beam, awareness

can move throughout the hierarchy and awareness can be brought to focus on different goals.

MOL proposes that clients will often be aware of their conflicting goals to a certain extent, but that the awareness may be at the wrong level. MOL and PCT propose that conflicts occur across at least three levels of the control hierarchy (Carey, Mansell, & Tai, 2015; Powers, 2005). For example, at the top level there might be a goal to be popular and be respected. Being popular and respected would then control two goals at the middle layer; to be liked, and to be assertive. Being liked and being assertive might then specify different goals for talk in a conversation, which are managed by the lowest level. Being more assertive in a conversation might mean that the person is less likely to be liked, and therefore moves that goal further away from completion. Similarly, trying to be liked might make the goal of being assertive less likely. The conflict might be evident in the person's talk as they try and be both "liked" and "assertive", and a person might be aware of this conflict. However, it is the highest-level goal of being popular and respected which is creating the conflict by specifying the contradictory goals to the middle level. Therefore, conflict cannot be resolved until the client becomes aware of the top-level goal and it can be reorganised.

The MOL therapist therefore has two goals, to get clients to talk about their problems, and to ask about disruptions when they occur (Carey, 2006; Carey, Mansell, & Tai, 2015). The first goal is to explore the issues with the client in an uncensored way, so that the client can develop their awareness of their current problems. The goal is not to persuade the client of another perspective, or to offer a solution to their difficulties. The questioning does not take aspects of the client's experience for granted, and asks about the different aspects of client's difficulties. MOL proposes if therapists take what the client is talking about for granted, then they may inadvertently stop the client from exploring the issue themselves.

The second goal of MOL therapists is to ask about disruptions (see journal paper, MOL).

MOL's evidence base is limited, and its outcome data are primarily from its proponents' clinical work (Carey & Mulan, 2008; Carey, Carey, Mullan, Spratt, & Spratt, 2009; Carey, Tai, & Stiles, 2013). There has been little independent published outcomes data from MOL, and there are no published controlled trials evaluating its effectiveness against waiting list controls or treatment as usual (although there is an ongoing trial ('Next Level') exploring MOL's effectiveness in early intervention in psychosis). MOL's outcomes data is predominantly from primary care clients, with fewer patients seen in secondary care, or for longer-term therapy, with the mean length of therapy in published studies frequently below five sessions. Although the approach to appointment setting is conceptualised differently in MOL, as a once-a-week format is not seen as necessary, and clients are encouraged to book appointments when they want (Carey, 2006). In total over 500 clients' outcomes have been included in MOL's outcomes literature , and whilst replication in different settings (with evidence from the UK and Australia and in primary and secondary care) aids MOL's literature (Carey & Stiles, 2016), it is still not well-established. There is also no evidence pertaining to the association between how often clients are asked about disruptions and therapy outcomes, and whether being asked about disruptions more often within MOL is associated with better outcomes.

There has also been a program of qualitative studies examining change accounts following therapy, and change occurring without any therapy, which has produced findings consistent with MOL and PCT (Carey, Mansell & Tai, 2015). In particular, several studies explored accounts of change, linked with both (1) "aha" moments of insight (i.e., sudden gains) and (2) gradual change (Higginson & Mansell, 2008, p.319), finding similar change processes occurring in those who have received therapy versus have not (Higginson & Mansell, 2008). The qualitative findings were interpreted as routine change being associated with the usual process of attaining goals, and sudden insight associated with the process of reorganisation of the goals, such as that which might occur in disruptions in MOL (Carey, Mansell & Tai, 2015). Research has also been undertaken from a more PCT orientated perspective, looking at whether people's motor skills and behaviour match that predicted by PCT (e.g.

Marken & Mansell, 2013), or whether the degree of control affects outcomes in exposure to peoples' phobias (Healey, Mansell & Tai, 2017).

The developer's and proponents' approach to studying MOL is creditable given the small number of authors publishing on MOL and the variety of evidence that has been produced. However, there are shortcomings with the available evidence of MOL's effectiveness, in particular whether it is suitable or effective for interventions with secondary care clients.

3.2 **Extended Methodology**

3.2.1 **Epistemology**

The current study was undertaken within a critical realist perspective. Critical realism proposes that the world consists of more than events, experiences and discourses, and that structures, powers and tendencies shape the course of events (Patomaki & Wight, 2000). Contrary to scientific realism, critical realism proposes that there is an inherent subjectivity in the production of knowledge which depends partly on our beliefs and expectations (Madill, Jordan, & Shirley, 2000). Critical realism is methodologically and epistemologically pluralist, and it is compatible with epistemological opportunism; using a variety of approaches that are suitable to address a research question to advance knowledge (Patomaki & Wight, 2000). Critical realism is accepting of a partial nature of all perspectives, which can then be incorporated into a more comprehensive account (Patomaki & Wight, 2000).

3.2.2 **Exploring Disruptions**

MOL does not propose a comprehensive list of possible disruptions. The approach taken to identifying disruptions is to propose a general definition, because keeping an updated exhaustive list of “approved” disruptions would be counterproductive (Carey, Personal Communication, May 4, 2016). One of the reasons for this is that MOL does not propose that it is desirable to ask about every disruption because it would involve interrupting the client too often, or that each disruption necessarily relates to an important background thought (Carey, 2006). For example staring out of the window and noticing a cloud and being reminded about getting the washing in would not be therapeutically relevant (Carey, 2006). Similarly asking about disruptions is seen as untroublesome if they do not appear to be salient, as the MOL therapist can just ask about the next disruption, or try to return to the problem at hand (Carey et al., 2015). However, the lack of specificity poses some challenges in testing the proposals made by MOL. There is no literature exploring whether MOL therapists routinely identify the same disruptions or whether MOL therapists’ practice of identifying disruptions has reasonable validity or reliability.

Disruptions are discussed in the MOL publications (e.g. Carey, 2006; Carey, Mansell, & Tai, 2015), but quite what they represent in PCT is unclear: MOL or PCT do not specify why a switch from a background to a foreground thought results in a disruption, and neither is it explained why a disruption looks like it does. Accordingly, the boundary of what is, and what is not a disruption is vague. The suggestions made by Carey and colleagues make it easier to "rule in" what a disruption looks like, but it is less easy to "rule out" what is not a disruption. Both Carey (2006) and Carey, Mansell and Tai (2015) refer to clients' disruptions occurring when clients are talking however, it would seem possible that a disruption can occur in a train of thought, without the thought needing to be verbalised. Due to MOL's narrow focus of identifying and asking about disruptions the issues with the conception of disruptions are more focal than in the broader range of claims and interventions used in other therapeutic approaches. MOL makes it explicit what the mechanism of change is and pursues that in a singular manner.

Other theories have their own issues, such as a consistent finding that depressed individuals are more realistic in their perceptions than non-depressed individuals, which is contrary to a simplistic interpretation of cognitive theory (Beck, Rush, Shaw, & Emery, 1979), that depressed people would be more negatively biased (Moore & Fresco, 2012). In part some of the issues of concepts and reliability and validity are obscured by evidence for clinical effectiveness, such as various outcomes studies, reviews and clinical guidance (e.g. Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; NICE, 2010). If the therapy appears to work, then the theoretical issues that might be apparent within the approach are somewhat less problematic. For example studies looking at the reliability of CBT case formulation have indicated some issues with reliability (Kuyken, Fothergill, Musa, & Chadwick, 2005), although case formulation is a multi-faceted skill. Whether the proposals about CBT for depression or formulation are necessarily true are not directly of issue in the current study. However, they illustrate that proposals as a part of one model of depression which has a good an evidence base as any therapy and is used broadly, has failed to find convincing straightforward evidence for some of its claims. A further issue as highlighted in the journal paper is that the evidence

base for MOL is merely emerging, rather than it being well established, both in terms of MOL's age, and limited research.

To explore the issues around disruptions as a part of the current study several different approaches were undertaken to explore different possible methodologies. The unstructured approach was undertaken to use what resources were available to the author to inform the rest of the thesis as a part of its development. The review looked at how therapists ask about disruptions; whether there is other research that looks at markers of attention, and what the author thought they were by looking at video recordings.

Cannon (2014) reviewed instances of clients asking about disruptions in MOL therapy. The therapists' responses took the form of questions or noticings following disruptions. The therapists' responses were reviewed to determine whether a feature was noted as a part of the disruption – for example "what made you smile just then". The review sought to determine whether features were consistently noted by therapists, or whether a range of different features were identified. The two most commonly named features were laughing (18 instances) and smiling (12), representing 30/47 named behaviours. The next most common feature was a repetition in speech (6 instances). In 11 therapist responses to an apparent disruption no features were named. The total of 58 examples varies slightly from the 56 discussed in Cannon (2014), due to other selection criteria that were used in the broader analysis of the instances by Cannon (2014). Overall it appeared that smiling and laughing were named particularly frequently by therapists when commenting on disruptions, and therefore they may be particularly salient. Although it does not preclude there being other features being noted by the therapist, or that smiles and laughing are merely the features that therapists named.

An unstructured review of attention literature was undertaken to explore whether there might be a framework of signs of shifting attention which could be adapted for the current study. However, research into attention has tended to focus on narrower research looking at particular markers of a particular system, such as visual attention (e.g. Carrasco, 2011; Gu & Badler, 2006), and then

exploring particular facets of that system, including the neurological basis (e.g. Nummenmaa & Calder, 2009), rather than an overall approach. Within the literature it was found that there was no generally agreed taxonomy of attentional operations (e.g. Posner, 2008).

A broader approach was therefore used to look at communication literature, to see if there were frameworks for looking at disfluencies in communication. The most helpful framework found was proposed by Poyatos (1983), who proposed a triple structure of language, consisting of language, paralanguage and kinesics. Language is the "words" or lexical element of talk and paralanguage constitutes the other features of speech, such as pitch, rhythm and other sounds or silences. Kinesics includes the body's movements and posture. The three systems of language combine to make sense in communication, with Poyatos (1983) proposing that language needs paralanguage and kinesic information to make sense. However, in so doing there is redundancy or overlap amongst the different channels, which convey similar information, whilst being distinct. The features noted by Poyatos (1983) fit proposals for three broad types of disruptions presented but not published by Carey (2016) at an MOL training day:

- Up-a-level comments e.g. "That sounds ridiculous doesn't it?"
- Change in speech pace or volume e.g. speeding up or slowing down

Changes in physical state e.g. looking away or smiling

With Carey's 'changes in speech' being similar to Poyatos' paralanguage, 'changes in physical state' similar to kinesics and 'up-a-level comments' similar to language. Carey was unaware of the crossover (Carey, Personal Communication, May 4, 2016). Whilst the structure was helpful, it did not resolve the issue of whether there were certain features indicative of attentional shifts with research evidence for them. Poyatos' triple structure also has a low uptake given its age, as it has few citations (31 via google scholar at time of writing), potentially due to what appears to be an intuitive structure.

To reflect on what actions I thought were disruptions I reviewed two recordings of therapy-type sessions. One was from the classic recording of Carl Rogers and Gloria (1965) demonstration of Person Centred Therapy, and secondly a recording of an MOL exercise with Tim Carey, included as a part of Carey (2006, available at: http://www.livingcontrolsystems.com/mol/mol_contents.html). In reviewing the recordings of a similar length (33 minutes for MOL, 30 minutes for Person Centred Therapy), 32 were noted for MOL and 31 for CT. The supposed disruptions were felt to be caused by a range of behaviours, such as the client commenting on their talk, having difficulties in articulating their ideas or otherwise having broken speech, laughing, nodding, grimacing, cringing, pausing, trailing off and moving their eyes, closing their eyes or looking away. The client actions appeared broadly similar in both videos. In the MOL session 20 apparent disruptions were followed up, whereas only five were in the Person Centred Therapy session. In the MOL session disruptions were highlighted by the therapist, whereas in the Person Centred Therapy session disruptions appeared to be treated by the therapist as a pause where a summary or interpretation was offered. In the MOL session the client would respond by explaining their thinking about the disruption, whereas the client in the cognitive session might agree and expand on the topic or lead to another related topic. The MOL recording also features a "Sounds [X] but [Y]": "the word plan sounds a bit daft there, but I certainly think a lot about it" at 17:40.

Comparing the two video recordings with little structure beyond looking at what disruptions I rated, and whether they were followed up was a limited approach. The possibility of following up by asking MOL therapists or others to indicate when they thought disruptions was considered, but it was not pursued because of the direction the rest of the project took in using Conversation Analysis, rather than exploring quantitative issues.

3.2.3 **Methodological Choice**

The aim of the study was to explore potential disruptions. Of principal interest was the interactional nature of the disruption – when did it occur and what did the therapist and the client do after a potential disruption and what were the

consequences. There were several qualitative designs that could be used to complete parts of the study's aims. For example, narrative and discourse analysis have been used within psychotherapy to look at meaning and human experience as interactionally constructed (Georgaca & Avdi, 2009). Interpretative Phenomenological Analysis or Grounded Theory were also potentially of relevance to understanding issues around disruptions. However, CA was favoured because it investigated the interactional processes through which therapeutic work is accomplished in practice (Georgaca & Avdi, 2009). CA affords a framework to explore talk in a turn-by-turn approach, and how therapist and client orientate to, and accomplish actions in talk. CA was felt to be the best approach to study the interaction between the client and therapist leading up to, during and after a disruption, and to discuss the client's and therapist's actions. Discursive psychology, which often draws heavily on CA (Edwards & Potter, 2005), and critical discourse analysis (e.g. Edwards, 2005) were also possibilities, but the current study sought to focus on the interactional aspects favoured by CA, rather than the discussion of mental states or cognitive models.

3.2.4 **Conversation Analysis**

CA is a qualitative empirical analysis, building its evidence from specimens of naturally occurring talk, looking at examples of recurrent patterns or features (ten Have, 2007). CA takes an "emic" perspective to data, in that a case example is seen as a demonstration of that individual's "knowledge-in-use" (Markee, 2000; ten Have, 2007, p. 34). These patterns are seen as specimens of a class as demonstrated by the talker, rather than representing a comprehensive understanding of that class (ten Have, 2007), with an analysis of an instance or a collection of instances only being convincing to the extent that it can be justified by the data presented for the analysis (Markee, 2000).

CA's literature provides a collection of potential structures and practices of people's talk which can be identified in most samples of talk (Peräkylä, Antaki, Vehviläinen, & Leudar, 2008). The most basic structure is the "adjacency pair" (Schegloff & Sacks, 1973), where the first speaker's talk strongly projects a certain type of response – for example a question projects an answer. A

speaker's question shows the listener what they are doing and constrains the listener's potential responses. CA research has identified a series of other structures and practices that are used in conversation, which can be used as a framework to look at other aspects of talk (Hutchby & Wooffitt, 2008; Peräkylä, Antaki, Vehviläinen, & Leudar, 2008).

CA's structures and concepts include aspects of people correcting their own talk, how turn-taking is managed, how participants' "knowledge" is managed and principles around preference (Stivers & Sidnell, 2013). For example, whilst the categorisation of some aspects, such as a "question" might be superficially clear, their action, and how that is managed over the course of a conversation can vary. Similarly, how a person responds with an "answer", and what they say increases the complexity, given the variety of possible permutations and what knowledge they have and choose to convey. The question "do you know who is going to the party?" might be an interested factual enquiry, a precursor to another question, or used by the speaker to imply they know something the listener does not (Hutchby & Wooffitt, 2008). The listener may also be unable to deduce the speaker's meaning, such as if the listener is going to several parties, or if there is a person that they are trying to avoid. Therefore, there are a range of possible ways of responding as the listener, such as responding with "no who?" or "Jim's not going, I know you can't stand him" (Hutchby & Wooffitt, 2008). The analysis is not just "lexical", as it includes verbal characteristics such as intonation, pace and laughter. The recipient's interpretation of the turn becomes available to the analyst in the recipient's next turn which demonstrates "some analysis, understanding or appreciation of the prior turn" by the recipient (Heritage, 1984, p. 255).

After a phenomenon has been noted it should be described using a CA approach. One of the central questions of CA enquiry is "what interactional work is the phenomenon, or device, being used to do?" (Hutchby & Wooffitt, 2008, p. 93). Afterwards the data should be returned to, to search for other instances of the phenomenon that fit with the original phenomena (Hutchby & Wooffitt, 2008). As more cases are found the phenomenon's description is iteratively refined. The identification and explanation of the shared practices

within the collection enables the researcher to make claims about the phenomena of interest (Hutchby & Wooffitt, 2008). Collections may be based around formal features, or a construction such as “you say [X]”, or on its sequential positioning to some other turn or action (e.g. a question or a reaction), as long as the analysis focuses on the similarities in how the items in the collection achieve the identified actions (Hutchby & Wooffitt, 2008).

A particular branch of enquiry within CA research has been into “institutional talk”. The nature of the talk that individuals produce is seen as representing an orientation to that institution and particular institutional actions such as a police interview or a telephone call to a suicide line (Hutchby & Wooffitt, 2008; Peräkylä et al., 2008). The institutional aspect of the conversation is seen as “restricting” or “altering” the conversation and who gets to say what and when (Peräkylä et al., 2008). In that context CA aims to analyse these different types of interaction and to show how the individuals use the rules to transact their actions (Hutchby & Wooffitt, 2008). Psychotherapy is one such “institution” which has been researched, with studies looking at the structures, practices and organisations of talk to try and achieve psychological change (Fitzgerald, 2013; Peräkylä et al., 2008). Institutions can adjust interactional practices, such as expectations around who gets to ask and answer questions, which is generally the person from the institution, and the visitor respectively (Heritage, 2004). One aspect of psychotherapy as an institution is the asymmetrical relationship between the client seeking help and the trained therapist seeking to provide it (Heritage, 2004). Another issue with psychotherapy and institutions more broadly is the concept of particular “inferential frames” (Drew & Heritage, 1992), that in the different institutions listeners hear contributions in institutionally specific ways. An aspect of psychotherapy in particular is that the listeners often understand and infer what is said “beyond” its communicative intent (Peräkylä, 2013). The different ways of interpreting, or formulating clients’ actions, or what is “beyond” the communication varies between different therapies; for example cognitive or psychodynamic therapists will likely interpret and enact ideas differently with clients (Peräkylä, 2013).

3.2.5 **CA’s epistemological perspective**

Conversation Analysis (CA) was originally developed by Henry Sacks and colleagues at the University of California in the 1960s and 70s (ten Have, 2007). CA developed as a product of Sacks' work to determine whether it was possible to develop an observational science of social action, and therefore of society (Drew, 2004). CA's development was influenced by, and associated with ethnomethodology and attempts to show how social organisation is organised from the "bottom-up", through showing how social organisation emerges from the efforts of the members, rather than a pre-existing framework (Liddicoat, 2007; Maynard & Clayman, 2003). Social organisation was seen as a problem for the individual (ten Have, 1999); everyone organises their own impressions and experiences into a coherent pattern. These patterns are then used to inform their own understanding and actions in the social world (Liddicoat, 2007). As such the patterns are not accessible directly, instead, they can be understood through the person's actions. In an interaction between people, each person will necessarily convey their own understanding, and monitor discrepancies between their understanding and the other person's (Liddicoat, 2007). As each person is making their own interpretations, meanings are therefore subjective. Whilst CA was informed by ethnomethodology, and vice versa, CA has emerged as an independent approach (Maynard & Clayman, 2003).

CA uses instances of the actions to look at *how* the actions are performed and responded to through the words used, their intonation and syntactic structures; what kind of presumptions participants share, or agree on, and whether the participants' actions are either aligned or misaligned (Peräkylä, Antaki, Vehviläinen, & Leudar, 2008). CA proposes, and treats interaction and language in three specific ways (Madill, Widdicombe, & Barkham, 2001). Firstly, speech is envisioned as activity focused, all speech performs an activity. Secondly, CA looks at a turn-by-turn sequences of utterances, which are explored in terms of the actions that the utterances perform. Thirdly the analysis is of the participants' orientation to the actions that are being conducted. No a-priori hypothesis is brought about how the participants interact, as the analysis is of how the participants orientate themselves to their interpretation of what the other person has said, and how their responses are

shaped by it (Madill et al., 2001). Conversation analysis examines language in its own right, rather than as a means of exploring the underlying psychological phenomenon, with CA explicitly uninterested in mental life (Potter & Edwards, 2013). As with other qualitative approaches, quantification within CA is contentious, and generally avoided beyond brief descriptions, due to issues such as determining what other talk which might represent an appropriate denominator or be in some way be comparable (ten Have, 2007 see 3.2.7).

3.2.6 **Methodology and Epistemology**

As outlined the overall approach of the current thesis is a critical realist perspective, whereas CA is broadly a constructionist approach (Rapley, 2012). CA does not fit easily in to a "realism-relativism" continuum, as CA claims are grounded in data, but they are relativist in that claims are indicative of action and what is accomplished and they are not a fixed facts (Rapley, 2012). Whilst there are some attempts to argue for critical realism within more discursive approaches (e.g. Sims-Schouten, Riley, & Willig, 2007) they are in the minority, and it is acknowledged that CA has its own epistemological perspective and that for CA to be employed appropriately CA's approach needs to be respected. Therefore, claims need to be compatible with CA's epistemology and standards, as CA is felt to be the appropriate methodology for the current study. As such not all of CA's claims are accepted as a world view by the author of the thesis, but the current author believes CA's views need to be respected for the approach to be used. Rapley (2012) proposes that high-quality CA shows and documents competencies that ordinary speakers use in mutually intelligible and socially organised interaction, using an extensive corpus of examples of real speech to support the claims made.

3.2.7 **Quantification and representativeness in CA**

As indicated in 2.2.5, the extent to which quantification is used within CA is contentious, as it has generally been resisted for both epistemological and practical reasons (ten Have, 2007). CA looks at specific examples which could potentially be counted and categorised as is done in other qualitative approaches. In CA studies quantifying expressions (e.g., "frequently" "some", "rarely" or "often") are frequently used, whilst explicit quantitative information

such as how often or how frequent practices appear is often not considered or reported (ten Have, 2007). There is however, a rationale for the approach within CA. Schegloff (1993) in discussing quantification in CA used the helpful conception of numerator and denominator for exploring an objects proportionality, although the two are related as a product of determining the activity and its environment. Schegloff (1993) discussed the denominator as the 'environment of possible *relevant* occurrence' (p. 103). For disruptions or meta-comments determining when one might *relevantly* occur is problematic. For example, there are a variety of responsive activities, such as full-talk, laughter, or utterances like 'uh huh'. Whether they are relevantly present can only be determined by understanding the interaction – which may also be constituted in part by that response itself, as it shows how the participants in the conversation understand it. To the author's knowledge there is not a typical sequence in which a meta-comment might usually be expected to occur (compared to Jefferson's (1988) outline structure of troubles tellings), therefore the absence or presence in a sequence of talk is difficult to determine. In order to operationalise a numerator there needs to be clear understanding of what *should* count – and consequently, with a good enough denominator, where its non-occurrence would count as an absence – and determination of the different types of possible numerators and their context. For example, the action of 'uh huh' will vary depending on its environment, and there are issues of whether something else which functions similarly to 'uh huh' is used, or whether the participant pursues a different response. A similar utterance might also perform a different action in a different context. Therefore, whilst a similar utterance might be used, its action might be different, and a similar action might be performed by a different utterance. Some more quantitative CA has been done, such as on the delivery of a diagnosis in a medical consultation, and consequent responses to it (Peräkylä, 2006) where the talk is more standarsied (ten Have, 2007). However, the business of commenting on one's own past and present experiences in a psychotherapy session has less of a standard format than a medical consultation (Peräkylä, 2013) which makes quantification problematic.

Alongside CA's epistimological perspective, this approach means that concepts of representativeness of the object of analysis is not a typical CA concern as it would be for more postivist enquiries. Typical positivist concerns about external validity are also not a concern for CA, as it has its case-by-case cumulative approach built from the data as discussed in 2.2.4 and 2.2.5, and CA does not seek to make broader claims – the collections are collections of 'specimens' that are not thought to be thoroughly representative. The rigour of the analysis can be reviewed by looking at the extracts that are provided in the study and whether the analysis appears credible. As discussed in 2.2.7 the current study was therefore not specifically intending to find the most numerous meta-comment, or one that might be represented in each of the different sessions. To do so would not be consistent with the design and aims, which was to be explorative about the use of a possible disruption.

3.2.8 **CA and MOL**

There is a disparity between the type of theory MOL is, its proposals and CA's methodology. MOL does not discuss disruptions as having an interactional effect in therapy per se. There is some consideration within MOL of a discussion between two people being an interaction of two control system, with both individuals trying to control the shared environment so that they both see it as "just right" (Carey, Kelly, Mansell, & Tai, 2012). Discussion of what the "just rights" are, are discussed in terms of goals, rather than conversational practice, as talk or the conventions of conversation would be seen by PCT and MOL as a behaviour, and therefore something that is not controlled for per se. Therefore, for MOL the therapeutic relationship is discussed in terms of its role in being able to facilitate the client exploring their difficulties and being able to focus their attention on background difficulties. As with the content of sessions, the therapeutic relationship is not of interest per se, and whilst qualities like "warmth" are important, they are a means to an end of the two goals of MOL (Carey et al., 2015). Whether the client says "that sounds stupid" or "I don't know why I said that", or laughs is not of interest to MOL per se, and therefore there is no consideration that they might have different interactional actions. MOL would not suggest that the therapist respond differently to these different client actions, as the MOL therapist would follow-up a potential disruption with a

MOL appropriate enquiry such as “what occurred to you when you [X] then” (Carey et al., 2015, p. 63). As CA is not interested in cognitive events, MOL’s account of foreground and background thoughts is not accessible through CA.

CA’s rejection of a-priori hypothesis precludes CA from directly looking at “disruptions” because they are a specific MOL proposal, and group together a range of different phenomena that are not necessarily related. Additionally MOL’s proposals about disruptions treat them as objects or events of interest, but for CA it is the interactional work being accomplished by those objects or events via turns at talk that are of interest (Hutchby & Wooffitt, 2008). It is not apparent that possible disruptions like meta-comments, a laugh, or a smile have the same interactional function, as there is no evidence that they do. CA accounts are built on a case-by-case basis, and each instance is treated in its own right (Hutchby & Wooffitt, 2008). CA accounts look at whether an action is being performed and what practices are used to accomplish that action, or conversely through noticing a feature of talk and considering the outcome of that talk (Schegloff, 1996). CA phenomena have to have a boundary of what is, and what is not within the boundary of the candidate practice, which is established by the collection of examples, and how participants orientate to the examples (Schegloff, 1997). Although when described, multiple cases do not have to be exactly the same, there does need to be common set of properties and regularities shared by the accounts (Hutchby & Wooffitt, 2008).

3.3 **Extended Results**

The overall structure of the clients' talk is related to several CA issues, structures and topics, principally storytelling (e.g. Mandelbaum, 2013), Jefferson's (1978, 1988) concept of troubles telling, and of complaints (e.g. Schegloff, 2005). The clients are giving accounts of their problems and do so in an orderly way. Jefferson (1978, 1988) outlined a structure that the telling of people's troubles are often sequentially organised, beyond the general principles of CA. The description of someone's troubles or stories takes place over multiple turns of talk, which requires the suspension of some of the normal turn-by-turn rules of talk, so that the troubles teller can speak for extended periods of time (Mandelbaum, 2013). However, stories are told interactively, and co-constructed between the teller and the listener (Mandelbaum, 2013). Jefferson (1988) outlined a structure that is not always fully featured in each description of someone's troubles. The structure included types of utterances for both the troubles teller, and the listener, often, but not always found in building up to and discussing a person's troubles. For example, Jefferson (1988) outlined that the opening of a trouble might be started by the recipient enquiring after the troubles teller ("how are you?"), who replies with a downgraded response ("fine"), which the recipient acknowledges ("uh huh") before the teller then leads in to their story ("So, I've been to the doctor"). During the stories and complaints, a response is typically due from the recipient, and the lack of a response noted by the speaker (Stivers, 2013). It is also typical for the listener to adopt the same stance that the story teller adopted (Stivers, 2013).

Extract 1

The "you know?" at line 31 is potentially ambiguous, as "you know" has a range of discourse functions, which may relate to appeals to shared knowledge or addressing inferences which the listener should align to (Fox Tree & Schrock, 2002; Schiffrin, 1980), or instead as a part of a speaker's discourse style (Erman, 2001; Macaulay, 2002). However, at line 31 the client appears to be attempting to pursue an affiliative response, with the "try markings" (Sacks & Schegloff, 1979), indicative of the client seeking an acknowledgement from the

therapist. A limitation of the current study is the use of audio data, and therefore nods which can be used to reinforce affectual bonds or affiliate in psychotherapy (Muntigl, Knight, & Watkins, 2012) are not available. Stivers (2008) found that nods are used to support the teller's affectual stance by their positioning whereas alignment is displayed through vocal continuers.

The client's description of a "man around the house" is figurative or idiomatic, and leads to an implication, but the precise meaning of this is unclear, but has a number of possible implied meanings. One possible hearing is of the lack stereotypical male role-model, such as someone who is able to "put up shelves", or act as a protective figure. Another possible hearing is as a complaint from the client that the family has to protect her dad at the expense of the client, who is unprotected and therefore vulnerable. There is also a potential broader emasculating element, with the father failing to provide a suitable role model of masculinity. The meaning is not specified at line 21, and although alluded to somewhat at lines 33-41 it is still unclear. It is characteristic of talk for its implication and inference to be implicit (Heritage, 1967), however, in everyday talk it is not usual to make the implicit explicit, whereas it is more usual in psychotherapy (Koivisto & Voutilainen, 2016) where it might be reformulated back to the client (Antaki, 2008).

Extract 2

The SB includes a proposal about the client's "mental state" (worrying), descriptions of "one's own thoughts and feelings" (Edwards & Potter, 2005). Mental states overlap with emotion, although within CA the use of emotion is broader, akin to "folk psychological terms" (Ruusuvuori, 2013), rather than more formal psychological terms. A discussion of mental states raises epistemic issues, which are prevalent in CA – which refers to participants in conversation having different rights to certain knowledge. It is difficult for the therapist to make a direct claim about the client's mental state, as it is something the client "knows" (Heritage, 2013). The therapist's formulation addresses epistemic issues by leaving room for the client to disagree with the "maybe if" prefaced formulation at lines 57 and 58 (Hepburn & Potter, 2007). Conversely the client's statement that he is "sure" (line 33) that he does not have OCD, but he is aware

that he might be “labelled” (line 35) is weighted differently due to the institutional imbalance of power and the difference in experience and expertise between the therapist and client (Heritage, 2013). It is in this unbalanced environment that the client is asked to expand on their worry, with the client being treated as accountable for their prior talk.

Extract 3

The client in Extract 3 also appears to pursue a more affiliative or expansive response from the therapist - there are try-marking in lines 12, 13 and 41, as well as the two “y’knows” at end of lines 27 and 36. The client also explicitly references the previous therapist’s agreement, further showing his reasonableness. In Extract 1, the client references their friends not understanding what getting a C meant as they did not understand the role the client has in protecting her dad – that without this constraint the client and their friends would see the “C” in maths as unproblematic. Reported speech has been associated with both providing further evidence for one’s complaint, and also showing the speaker’s implicit comment upon that utterance (Clift, 2006; Holt, 1996, 2000). Compared to the client’s apparent appeals in Extract 3 there is little overt therapist response – with the therapist using continuers at lines 28 and 41.

Extract 4

The excerpt starts with a formulation by the therapist, which is a rarer instance in the corpus. As with disclosure a formulation is discussed using a CA perspective (Antaki et al., 2005), rather than from the psychological sense. The client responds initially in a preferred form, with a quick, non-disfluent agreement at line 5, but in expanding upon this the his talk becomes disfluent and more broken with multiple stops and starts to the talk. The client’s channelling of their aggression into martial arts is described as being functional, as the term of channelling aggression implies, whereas the armed forces role, or at least his view of wanting to be a sniper, is more clearly described as abnormal.

The SB again has the features of the client adjusting his speech prior to a problematic issue and possible hearing by the therapist – as indicated by the client trying to disclaim the negative hearing of being a sadomasochist (which is implied as bad). The SB has some retrospective elements as it addresses the "applaud" in line 22, but it is not clarified until line 25 what the applause is about. Several of the extracts in the corpus display this mixed feature where the SB functions as an inserted part of talk to preface an upcoming comment. The SB appears before the disclosure that the client feels spurred on by being punched, but they are clear that this is not in a sexual manner – again defeasing a concern. This then leads to a conclusory statement again about a way of channelling aggression. As with Extracts 1, 2, 3 the concept of "normalcy" is available, for both the client, but also for other people's perspective on the client's views.

Extract 10

Extract 10 is from the twelfth therapy session. The client has been talking about how she has become less socially outgoing. She had previously been happy to dance with other people when they asked, but more recently she has been saying no to people. The extract illustrates another aspect of SBs, compared to the previous examples the "sounds" aspect relates to "silliness", rather than a failing or a particular concern for the client like being "bad" or "grotesque".

Extract 10, 12-3605, 47:27

1	C	I felt worse in myself because >I kept saying
2		no y'know?< Like what was the harm in saying
	Appendix 2.	ye:s.hh (.) really? And it's- .hhh it's just
	Appendix 2.	one of them things (.) wh:er:e, (0.6)
	Appendix 2.	it's like the first day of uni (.) I thought (0.2)
6		well I need to go make friends, (.) S:O
7		I just kind of chucked myself in to the deep
8		end=
9	T	=yeah

(1.6)
C >Cos I think (.) I think that's< what I've been thinking for a while (.) that,
(1.4)
→C I know n that this may sound really weird, (.)
→ (.) >or< stupid or silly or something (.) but,
(2.5)
C But it's (0.3) sah (0.8) because I'm a good swimmer,
(1.2)
C ((ike))
(0.7)
C I don't,
(0.8)
C You know when anyone says (0.3) y'know (.) °li:ke-like° they'll chuck yourself in the deep end or [somethi]ng?
T [mmmmmm]
(1.2)
C It feel- (.) I fe:el (1.8) like I can handle it (.) because (.) >you know like, I can swim in any- <you know like.=
T =yeah=
C =£Strong enough to swim in any water£ (.) so it's like well. ((sniffs))
(0.2)
C £why ↑not?£
T Yeah=
C =y'know.

The client's SB is prospectively phrased. Compared to the other extracts there are less perturbations, which would suggest that the issue of expression may be less problematic. The client's tone is more up-beat in the discussion in that it is a more positive characterisation of someone who is making progress with their

difficulties, contrasted to Extract 2 where the client is unsure about them. The use of the SB is in-line with Hewitt and Stokes (1975) suggestion of cognitive disclaimers, where the speaker thinks that they might be challenged on whether they are making sense or are out of touch with reality. In this case the client appears to be orientating to their use of an analogy to compare their social difficulties to being like their confidence with swimming. Extract 7 has a similar quality to it, with "sounds weird" (line 28), where a quality of the speech is that it sounds "odd", rather than it reflecting badly on the character of the client as Extract 1 or 4 might. As with Extract 1 there is a use of idiomatic language ("man around the house" and "chuck yourself in to the deep end"). Previous literature has found that idioms are positioned at the end of complaints to bring them to a close in a way that is less contestable (Drew & Holt, 1988). The SB disclaims the "weird" (line 14) or "stupid" or "silly" (line 15) hearing of their upcoming analogy and allows the client to use the analogy to summarise her change in thinking.

There is also more explicit agreement from the therapist, showing some orientation to a preference organisation of the client's tentativeness in using the analogy, with the therapist's "yeahs". "Yeah" can be used in multiple ways, to both indicate continuation, agreement or alignment and differentiating them can be ambiguous (Lambertz, 2011). In Extract 10, "yeah" is indicating agreement and alignment on behalf of the therapist, which the client orientates as affiliative by continuing with their analogy across several turns, rather than abandoning the topic despite the client's apparent hesitancy. The therapist appears to respond more encouragingly to an issue of understanding someone's concerns about whether their talk is "silly", to encourage the client's talk. In Extracts 1-4 the therapist's orientation to the shared intersubjectivity is less clear and there are fewer minimal encouragers and fewer instances of latched speech compared to Extract 10 (lines 32 and 38). Ruusuvuori (2005) similarly found that affiliation was generally not offered by professionals, and both parties orientate to institutional restrictions in offering affiliation. When professionals did affiliate they did so in a way to preserve the patient's experience and to keep the focus on the patient (Ruusuvuori, 2005), as appears to be the case in Extract 10.

3.3.1 **Therapists' SIKs and theoretical orientation**

The CA design did not seek to explore the therapist's theoretical orientation, as it was not known which approach individual therapists ascribed to, let alone put into practice. It is acknowledged that SIKs from different therapies are likely to have influenced therapists' responses in general, and the extent to which they may have influenced the responses to SBs is unclear. A discussion of therapists' SIKs and theoretical orientations within the study is limited by two factors. Firstly, there is a limited amount of therapist talk during the SB extracts, without the therapists' talk their actions are not directly accessible via CA. Secondly, as indicated it was not known what theoretical approach therapists ascribed to.

A withheld response, or a more neutral response is potentially more indicative of the greater emphasis within psychodynamic therapies on the therapist as a 'blank screen' (e.g. Lemma, 2003) – whereas a CBT therapist might place more emphasis on questioning to access thoughts. However, with the limited therapist responses in the corpus it is not possible to substantiate whether there are clear differences. The use of continuers has also been found to vary with therapeutic approach (Fitzgerald, 2013), although quite what the effect is was not articulated by Fitzgerald, other than that continuers might be used to support client utterances in line with the therapist's work, which varies with the therapeutic approach. Fitzgerald (2013), further argued that the therapist's use of continuers can also illustrate their own perspectives on what the client was discussing – arguing that changes in the intonation of continuers can be used to: show affiliation with the client's perspective; indicate that the therapist has a positive view when the client has not articulated their own perspective yet; and direct the client to keep talking as the therapist view the talk as constructive. The current study makes a similar argument that different therapist responses show different therapist orientations to the clients' talk, which are then responded to differently by the clients.

3.4 **Extended Discussion**

The current study sought to explore clients' comments on their own speech and how therapists responded to them. The analysis focused on examples of "sounds x, but y", which clients used to disclaim a negative hearing of their talk, and as a practice to try to create a suitable interactional environment to disclose an issue to the therapist. SBs were found alongside several other practices which have been identified by CA studies indicating the delicacy and sensitivity of talk. It is not, however, argued that SBs are sufficient for a client to make a disclosure. SBs are discussed in relation to several therapeutic concepts. First, SBs' relation to MOL's SIKs are discussed. Second, SBs are discussed in relation to disclosures, and how disclosures are conventionally understood within therapeutic approaches. Third SBs' roles in attending to intersubjective experience and the contrast between a more therapeutic explanation and an interactional perspective of intersubjective experience are discussed. Fourth, SBs are discussed in how they illustrate the therapeutic relationship and rupture and repairs.

3.4.1 **Method of Level's SIKs**

The introduction included a number of MOL's SIKs about disruptions which will be discussed in turn. 'Disruptions are brief' has already been discussed in sufficient detail in the journal paper.

Disruptions indicate a comment on the client's own talk

The SB extracts illustrate that a number of features potentially indicative of a disruption occur at a similar point: laughter, the use of 'quiet voice', starting and stopping talk, and pauses are all present at various points in multiple SBs. MOL understandably gives disruptions as relatively straightforward examples, such as looks away, laughs, or self-directed talk, whereas disruptions may have multiple interlinked features occurring in combination with each other. However, the current study expands on the conception of a disruption as it indicates there might be multiple features to a disruption, and it is not isolated to just one aspect of a person's talk or communication. The finding is in line with suggestions by Poyatos (1984, 2002) of three different mutually supportive but

inseparable channels for communication. Although in practice MOL therapists may only ask about a single feature like a smile or laugh (Cannon, 2014) it may be a gestalt of the person's communication that indicates a disruption.

After disruptions clients will often resume their prior talk

SBs were often used towards the end of a section of client's talk to bring a topic to conclusion. If the therapist did not respond the clients would talk about a related topic as would be expected by other CA literature, indicating that talk is ordered and interactionally interlinked (e.g. Schegloff, 2007). Therefore, the current study expands one of MOL's SIKs, which focuses on the client's talk, but does not highlight at what point within talk a disruption might occur, although the finding cannot be extended to other potential disruptions without further studies. So far MOL has also not presented evidence that clients often resume their prior talk following a potential disruption, which this study addresses.

The positions of SBs is somewhat similar to Cannon's (2014) finding in MOL sessions, that disruptions which were queried mostly occurred near the end of a section of client's talk. Cannon (2014) found that therapists often asked about a potential disruption at a suitable point of speaker transition, without interrupting the client. However, the comparison is limited as Cannon (2014) only reviewed therapists asking about disruptions.

In what context a potential disruption occurs, and what social action the client appears to be performing

The CA results indicate that the clients are attending to certain social actions with their talk. As outlined laughter, continuers, and phrases such as "you know" and SBs are used to perform particular actions in particular places, such as using laughter to manage delicate medical issues (e.g. Beach & Prickett, 2016) or in complaining (e.g. Potter & Hepburn, 2010). Therefore, there is some potential that disruptions might occur at similar points during similar talk because the potential disruption is related to a common social action. As

discussed in 2.2.2, Cannon et al (2014) found that laughter and smiling were the most frequently named disruption in therapist's questions about disruptions in MOL sessions. The current study found that laughter was commonly found in SB instances. However, the CA of laughter has shown that it is a complex activity and may perform multiple functions (e.g. Jefferson, Sacks, & Schegloff, 1987). Therefore, whilst commonly cited, the social action or potential disruption might be doing different things with laughter. Overall the results suggest some potential overlap between CA's analytic approach and exploration of various features of talk, and the type of disruptions suggested by MOL. The overlap is limited though, as CA and MOL as discussed in 2.2.8. are rather 'chalk and cheese'. CA is cognitively ascetic, whereas MOL is a cognitive theory, and therefore a reconciliation of the two aspects is problematic. At the same time their propositions are not mutually exclusive so they do not directly contradict each other. It is possible that a similar type of "background thought" comes in to clients' awareness when they are at similar points describing their difficulties.

From a more MOL and PCT perspective, the SB would be seen as a function of the client trying to make the interaction "just right"; the SB is one possible way to achieve goals of being open/honest by making the disclosure, maintaining intersubjectivity, and preserving face/goodness by disclaiming negative hearings of the clients' talk. MOL acknowledges that clients will be controlling for "a number of goals simultaneously e.g. for the therapist to like them…which might impact on the way in which they speak about the problem" (Carey et al., 2015, p. 61). The SB indicates that potential disruptions may emerge as a part of the client controlling for conversational variables, alongside other factors, and how inseparable the content of the talk may be from the disruption. The CA account and MOL account are not mutually incompatible. PCT may explain how someone produces disfluencies and other behaviour – because it meets a perceptual goal. However, the current study expands aspects of MOL's SIKs and provides some evidence to support some of MOL's SIKs, although CA itself cannot discuss the cognitive aspects of MOL.

How therapists and clients subsequently orientated to the potential disruption

It was rare for the non-MOL therapists in the examples to ask about SBs. When the therapist did ask about the SB they did so in a way which was not in line with MOL's SIKs, where a response might have been "what went through your mind then?". The findings suggest that MOL's SIKs are different to the therapists' practices in the current study, and that MOL questions about disruptions potentially do not occur spontaneously, or are otherwise replaced with another therapy's SIKs. However, in asking about the SB (Extract 2) the therapist did maintain the client's talk about the issues raised by the SB; although the client's response was then matched to the therapist's question about what the worry might be.

MOL does not make any proposals about clients pursuing responses following a disruption. Several extracts indicate that the clients pursued a response from the therapist, or a stronger response than the therapist gave (Extracts 1, 3 and 9). The client's responses have been described as minimally pursuing acknowledgement or affiliation, and will subsequently be discussed in relation to the therapeutic relationship. Therefore, some SBs were not attended to sufficiently from the client's perspective. However, none of the clients explicitly sought a response or appeared to hold the therapist accountable for their lack of response, such as by asking what the therapist thought (e.g. Chevalier & Moore, 2015). It was unclear from the examples whether it was the SB itself or part of the disclosure that some of the clients appeared to minimally pursue a response to, given the minimal nature of the response. However, for a client to follow up an SB there is some indication that the client is pursuing a relevant action, and therefore there is a potential that the client has attended on some level to the SB.

The extracts do not indicate that the therapists responded to SBs with the SIK, or preferred response indicated by MOL. A therapist asks about the SB in only one of the extracts. The result is interesting in highlighting the difference between the therapists' responses and MOL's preferred approach – the null finding does however limit what can be said about MOL. It does highlight that

MOL's preferred response does not appear to occur spontaneously, in this sample at least.

3.4.2 **Disclosures**

The use of CA to explore disclosures, and CA's perspective on disclosures contrasts with much of the distinct psychotherapy literature pertaining to disclosures, as much of the research into disclosure in psychotherapy has reviewed disclosures content, its associations such as with therapy outcome, rather than how the issues are disclosed by clients (Antaki, Barnes, & Leudar, 2005). The empirical designs also adopt the conventional psychotherapy conception of disclosure, relating to particularly significant thoughts or feelings, such as sexual abuse (Graham-Bermann et al., 2011). Clients have been found to be more likely to disclose issues in therapy when they feel that they can trust their therapists and when they believe that they can benefit from the disclosure (Baumann & Hill, 2016). Clients report commonly concealing sexual issues (Baumann & Hill, 2016; Farber, 2003) and being more likely to discuss disliked characteristics of themselves or others (Farber, 2003). The SBs' topics are broadly in-line with clients disclosing more relational issues, and issues about themselves, as the issues are primarily about relationships.

Psychotherapy literature exploring the interactional features that facilitate or encourage disclosure is limited. A process analysis of a disclosure of sexual abuse found that the therapist's actions facilitated the disclosure, and linked the disclosure with other topics discussed in the therapy (Balmforth & Elliott, 2012). Antaki, Barnes and Leudar (2005) found that disclosures not just in a psychotherapy setting were in part a response as a summary of a speaker's prior turn, and seen as a reciprocal action by the person disclosing the information which served to maintain or enhance intersubjectivity – people disclosing information often "take up the opportunity to confess" (p. 192). Extract 4 partially illustrates some collaboration, with the client responding to the therapist's formulation, although most of the SBs do not clearly support this claim due to them largely being monologues. However, the SBs illustrate that clients carry out work through their own talk to create a suitable interactional environment to disclose an issue.

As noted by Peräkylä, Antaki, Vehviläinen and Leudar (2008), CA can illustrate how therapist or client actions in particular contexts can produce particular effects, or CA can explore how those actions change over time. The current study addresses a shortcoming in the psychotherapy literature in exploring client disclosures and highlights the interactional practice of disclosures. The interactional approach highlighted the features of disclosures as discussed by Antaki, Barnes and Leudar (2005), who proposed that a disclosure is not just a single piece of verbal behaviour. Instead they proposed that disclosures are a social action which must be completed interactionally, and that disclosures were personal, significant and voluntary. The extracts from the current study were predominantly a client monologue, with the therapist using continuers and rarely asking questions or otherwise talking in the segments of talk reviewed. CA provides a way of discussing and reviewing how clients and therapists carry out a number of therapy relevant constructs, like disclosures, and the therapeutic relationship through their talk. CA highlights that whilst the disclosure are delicate and significant, they can also be fleeting, as might MOL partially suggest. The clients did not elaborate on the disclosure itself, as with the SB, after it had been raised. As indicated there are difficulties in interpreting a withheld response in CA, but from a practice perspective it indicates the need for therapists to consider their responses.

3.4.3 **Intersubjectivity**

Intersubjectivity was attended to explicitly by the clients through their SBs, highlighting and nominating a potential hearing of their talk. Quite what this means depends on the perspectives taken, and how intersubjectivity is understood. From a more typical therapeutic perspective SBs would appear to show some competence of the speakers to mentalise, have a ToM and to be mindful. However, this again highlights the difference between CA and more typical therapeutic interpretations.

As briefly alluded to in the results in the discussion of mental states in Extract 2 CA, and Discursive Psychology (DP), which draws from CA, has critiqued mentallization (e.g. Davidsen & Fosgerau, 2015) and ToM (e.g. Antaki, 2004), and whether they are compatible with CA or DP ideas, or in their own right.

Antaki (2004) argued that the “mind reading” aspirations of mentalization or ToM are too high – that in principle the ToM or mentalization claims could be checked against a known object. For example in Extract 4 where the client says that their talk sounds “grotesque”, the client could be proposing that they think that the therapist is actually thinking “that sounds grotesque”. However, in Extract 4 the client may be responding to aspects of the therapist’s question about their ways of channelling anger; a difference in the client recognising what is being displayed, compared to being able to “read” the therapists mind. In the speech preceding Extract 4 the client had been talking about mixed martial arts, which is a somewhat different term to “cage fighting” which the therapist uses in their question at line 2, and may emphasise “grotesqueness”, even if mixed martial arts may take place in a cage.

The difference between an observational approach and a “mind reading” approach has been explored to a limited extent using CA. For example, a common proposition is that those with psychosis or schizophrenia may have compromised phenomenological experience concerning the self and others (Brüne, 2005; Stanghellini & Lysaker, 2007). However, a CA exploration of clinical interactions of those with schizophrenia found that the clients with schizophrenia spontaneously demonstrated and successfully expressed beliefs about their own state of mind and that of others (McCabe, Leudar, & Antaki, 2004). Similarly, in the classic Sally-Anne test a child has to answer where Sally would look where she left an item before she left a room, or whether it is in the place that Anne moved it to when Sally had left. Children with autism are classically expected to do badly at the Sally-Anne test. A CA study exploring the test administration (Korkiakangas, Dindar, Laitila, & Kärnä, 2016) found that children with Autism Spectrum Disorder were adjusting their responses based on the tester’s talk, which involved some of the children’s responses being changed from apparently correct to incorrect responses.

The current study cannot provide a determination on which perspective is correct as CA is unable to address the cognitive perspective directly. The more conventional clinical psychology approaches and CA are illustrative of the different backgrounds of the approaches. Given the current study’s CA

methodology, the current study highlights and explores the interactional and sequential aspects of talk, which can be overlooked when a mentalisation or ToM perspective is used.

3.4.4 **Immediacy**

Another aspect of the SBs is the shift that they mark in the client's talk from a description of an event, story or feeling, to talk about the present, making a proposal about how their talk might sound to themselves or the therapist. A number of therapeutic concepts are related to "talk about talk" and discussing the present moment withinin psychotherapy. "Immediacy" has a number of different meanings, but is most broadly related to the here-and-now of the therapuetic relationship (Kondratyuk and Peräkylä, 2011). Metacommunication is also used to refer to the client and therapist discussing the therapeutic relationship (Li, Jauquet, & Kivlighan, 2016; Safran & Kraus, 2014). The therapeutic relationship will be discussed in the following section.

As with disclosures, research on immediacy has predominantly looked at how the therapist guides the client in to immediacy, or explicitly asks about immediacy, rather than immediacy being initiated by the client (Kondratyuk & Peräkylä, 2011; Li et al., 2016). Although client initiation may be less common, as Hill et al., (2014) found that immediacy was initiated by the therapist in 85% of instances. The theoretical approach of the therapist has been found to affect how therapists bring clients in to the present (Kondratyuk & Peräkylä, 2011), although the data were limited. In a comparison of cognitive therapy and existential therapy, the existential therapists' questions guided the client towards, and achieved further co-construction of their subjective experience, whereas the cognitive questions produced a response from the client, which the therapist then expanded upon before moving on to another therapeutic task (Kondratyuk & Peräkylä, 2011).

The SB instances relate to immediacy as they include both a movement in time, and also both therapist and client responses. As indicated, only one of the SBs resulted in a therapist response that asked about the "sounds" component brought up in the SB part, therefore there was limited explicit discussion of "the

feeling in the room" at the time of the SBs. Discussion of meta-communication or immediacy has been found to have mixed results, as it may be helpful on some occasions, have no effect on others, or even be harmful (Hill et al., 2014). When immediacy is beneficial it can help therapists and clients negotiate issues in the therapeutic relationship, express feelings and facilitate correction in the relational experience and help clients feel validated (Hill et al., 2014). Research has suggested an interaction between number of sessions, meta-communication, and the dominance or submission of the therapist within the session, and the consequent effects on client-therapist collaboration (Li et al., 2016).

Auburn (2005) reviewed narrative reflexivity in the context of a group setting, where offenders were due to be challenged about cognitive distortions in discussing their offending behaviour. Prisoner's narrative reflexivity was designed to discount listeners' negative inferences (Auburn, 2005). Therefore there was a potentially difficult interactional context for the prisoners to use narrative reflexivity to discount the cognitive distortions which might be threatening to the client, and have an impact on their ability to succeed in the program. The institutional setting of a university counselling service is likely to be different from Auburn's study, and whilst there appeared to be some overlap in defeasing a possible hearing of people's talk the potential interpretation may have different consequences in the different settings.

Conversely, Weiste (2015) reviewed interactions within cognitive therapy and psychoanalysis, where the therapist disagreed with the client's description of their personal experiences. The disagreements could be done supportively, where the therapist worked to finding congruence between their perspective and the client's, and validated the client and respected their perspective, prompting confirmation and elaboration. Alternatively, the disagreement could be unsupportive, where the divergence in perspectives was highlighted, which promoted a more negative interactional response from the client, which resulted in the therapeutic relationship being the focus of the conversation, (Weiste, 2015). The foregoing illustrates that disagreement or challenging the client's

account should not be seen in purely negative terms, even if the client appears to be trying to avoid it.

CA has been used to explore how clients convey their stance through storytelling, and how the therapist responds, and how this affects the client-therapist relational bond in the present (Muntigl, Knight, Horvath, & Watkins, 2012, with one of the extracts, Bonnie, featuring an SB; Muntigl, Knight, & Angus, 2014). The studies found that stance and affiliation were negotiated interactionally, with the therapist's responses as the "key element in the expansion of talk" (Muntigl et al., 2012, p 122) and played an important part in moving the interaction in a therapeutically relevant direction (Muntigl et al., 2012). This is potentially observed in some of different therapist responses to the SBs, which display different levels of affiliation. The therapists' responses were found to be affiliative and disaffiliative, and when focusing on the client's emotions either elicited, named or illustrated the client's emotional experience more vividly (Muntigl et al., 2014).

3.4.5 **Therapeutic Relationship**

The therapeutic relationship is one of the factors that has been found to affect disclosures, alongside length of therapy (Hall & Farber, 2001; Kahn, Achter, & Shambaugh, 2001). Therapeutic alliance (a subset of the therapeutic relationship) is also one of the better predictors of outcomes in different treatments (Horvath, Symonds, Horvath, & Symonds, 2011), with moderate associations (Ardito & Rabellino, 2011). Again, much of the research is quantitative, using measures to look at the association between alliance repairs or ruptures, and outcomes, rather than exploring how they are managed as an interaction through talk (Muntigl & Horvath, 2014). Different theories have different perspectives on the therapeutic relationship, and have different perspectives on responding to strains (Hill & Knox, 2009; Safran & Kraus, 2014).

The SBs indicate some attentiveness to the therapeutic relationship. The clients voluntarily disclosed information, yet at the same time they had to do specific work to create a suitable interactional environment to disclose that

information. The SBs could be seen as protecting the therapeutic relationship by forestalling a rupture if the therapist were to in CA terms "heckle" the speaker by interrupting them (Sacks, 1995). Conversely as has been discussed the SBs were an attempt to defease a social concern for the client, which may have implications for how the clients think they might be viewed by the therapists. Muntigl, Knight, Horvath, and Watkins (2012) explored how therapists and clients convey their stances during discussions and maintain affiliations. They found that Person Centred therapists might try to reflect the client's stance during discussions, although the client may reject the therapist's construction of their stance. As a result the therapist would then retreat from their prior position to preserve the affiliative level and track of therapy, the therapist would then try to re-affiliate with the client. The previous research and the current research highlight the iterative nature of interactions, and branches of possibilities that arise for clients and therapists in interactions. They illustrate the potential choices that can be made, and the potential dilemma between affiliating with the client and therapeutic tasks – agreeing with the client about their difficulties would be unlikely to resolve them. Whilst there were no outright ruptures, there are indications that clients are orientating to therapists' responses as non-preferred. Extract 7 provides the clearest example of this. Even though it is argued that the therapist's action in Extract 7 is a tease it contrasts with the other more affiliative response in Extract 6. Similarly, the level of affiliation offered by the therapist varies across the extracts.

3.4.6 **Therapists' Responses**

As highlighted by Antaki and Jahoda (2010), in responding to client's talk, therapists are constantly making decisions about what to do. The responses outlined in the results section and MOL's suggestion of a particular type of question cannot be judged as "better" solely from a CA perspective. The different approaches highlighted in the introduction have their own SIKs and goals which they seek to achieve during therapy. The current study contributes where and when clients might use an SB, and seeks to highlight to therapists a range of possible responses to SBs, which is not presented as an exhaustive list, but rather as illustrative. The therapists in the examples may be using the

client's talk to inform their formulation, or more unconsciously to inform their practice – such cognitive work is outside of the scope of CA.

3.4.7 **Strengths and Limitations**

A strength of this study is that it keeps the proximal end point for talking therapies, the client's behaviour and talk, the central issue in exploring the data. Whatever therapeutic goal or approach is being used in therapy the focus is on helping the client change. CA is a useful methodology for exploring what clients and therapists appear to be doing within therapy, and to show how their actions are orientated to by both parties. It is both a strength and a limitation that the approach is cognitively ascetic. CA removes an overlay of therapeutic theory which can alter interpretations depending on the perspective taken. CBT therapists might draw different interpretations from psychodynamic therapists (or from other CBT therapists). As CA claims can only be grounded in what the therapist and client appear to be doing and the broader CA literature, claims have to be built individually with evidence to support them. Such claims are built from the bottom-up, rather than a top-down imposition of possible narratives on a client's action. Frequently claims in therapeutic literature are built from within the therapy of interest's own practice, which limits the generalisability of the research. Conversely the cognitive ascetism of CA potentially limits broader understanding, as it is a different approach to what most therapists do, and therefore the ability of CA to engage with therapy theory is more limited. The proposition of SIKs and CA's ability to explore SIKs is helpful, but it still maintains a certain distance between CA and therapy theory, which as indicated has benefits and costs. Importantly the approach maintains the client's agency in therapy and contributes to the literature about what clients actually do during therapy, rather than what therapists do to clients.

There were several limitations to the current study. The study used audio recordings, and therefore non-verbal behaviour such as nodding which can be used to reinforce affectual bonds or affiliate in psychotherapy (Muntigl, Knight, & Watkins, 2012) are not available. As indicated unfortunately the theoretical orientations of the therapist were not available, although the discussion in relation to their therapeutic approaches is limited. MOL's conception of

disruptions, and the range of possible self-talk by clients is broad, and the current study could only explore one such type of utterance. Similarly, the demographic information for the clients is not available, and the sample is unlikely to be representative of the "clients" who are accessing therapy, as they are not necessarily from a "clinical" sample, and they will be disproportionately more educated if they are university students or staff. Although CA itself does not seek to establish representativeness or validity or reliability in the typical approach, it might limit the uptake of the current study from those not familiar with CA.

3.4.8 **Clinical Implications**

The study has elaborated on apparent shifts in clients' moment-to-moment experience, which are highlighted by a number of different therapies. The SBs that were reviewed have some overlap with disclosures, intersubjectivity, immediacy and the therapeutic relationship, which are often understood using a more outcomes or correlational approach, or from the therapists' actions, rather than understanding *how* they are managed in practice by clients. Using CA provides a detailed analysis and addresses this shortfall within the therapeutic literature, and provides concrete examples of these issues being managed – with exploration of the context in which they arise, and how the clients manage them. This is in contrast to the mentalistic approach that typifies most psychotherapies, and CA's cognitive asceticism offers a different perspective on some of these issues which can help to complement therapy's own approaches or terms which have entered the common understanding within therapy. The discussion of ToM, mentalisation, or mindfulness in 2.4.4 raises these issues – therapists might presume that the SB is the client demonstrating these skills, however the CA discussion illustrates that the client may be doing something else, and that ToM or mentalisation are not necessarily required for CA to discuss the clients' actions. Even so, the clients were ambiguous about to whom they thought their talk might 'sound [X]' and therefore it is not clear whether it is a proposed hearing for the therapist, client or both. To whom it might 'sound [X]' to might be understood to display different cognitive skills by the client from a broader approach.

CA's methodology and approach does not provide a way of directly assessing what might be a 'better' therapist response. However, it does provide a point for reflection for different therapists about what they might want to achieve with different responses or actions within therapy, and whether they are achieved. There are a variety of different therapist actions that are available and not affiliating with the client may be a deliberate, or reflect a desire by the therapist to pursue some other action. However, it may not be, and the understanding of the different actions is likely to be based on the preferred therapeutic approach of the therapist. It is possible that the therapists are not aware of the apparent client actions, as it is only through the detailed use of CA that these patterns emerge and can be explored from a collection of recordings. Other client actions, or the general work of conversation may have many apparent similarities, but these may only have face validity until they are explored using a method like CA, that allows the similarities and differences to be discerned. The current study argues that the SBs outlined perform similar action for the clients, but they appear to be responded to differently by therapists, and those different therapist responses produced different client responses in turn. Whilst the requirements to transcribe and explore a transcript and recording using CA are impractical in day-to-day practice, reviewing recordings for a more general discussion of clients' actions is feasible in supervision and personal reflection. CA does demonstrate the value in not exploring client action purely through a psychotherapeutic lens can avoid taking certain theoretical perspectives that may obscure the client's actions, or restrict them to the therapeutic account.

A secondary implication is the exploration of MOL's conception of disruptions. The findings are broadly supportive of MOL's account, and this study is the first study to the author's knowledge to explore disruptions affording the client's actions primacy in the research, and to directly look at the disruptions themselves, as opposed to therapists' responses to them (as in Cannon et al., 2014). The current study provides evidence for several of MOL's claims, which have not been substantiated directly in MOL's current literature. If MOL's claims about potential disruptions were unsupported and clients freely elaborated on their own disruptions, the logic for the therapy would be undermined. Instead, the study found that clients did not spontaneously

elaborate on disruptions, and that clients would move on to talk about something else, and therapists rarely asked about them directly. The study also extends on several aspects of MOL's SIKs to include aspects which are not directly articulated, such as whether possible disruptions occur before or after parts of talk, and the orientation the clients show to the SBs themselves.

Whilst there are limitations to MOL's evidence as an effective therapy, the outcomes evidence from MOL does suggest that asking about disruptions can lead to improvements in client's ratings of distress, as asking about disruptions is one of only two goals within MOL. Given that the recordings come from non-MOL sessions the contribution to MOL is an exploration of a counterfactual, exploring what happens if potential disruptions are not necessarily explored.

3.4.9 **Future Research**

The current study is one of a few studies exploring clients' reflective talk, and the role that it has within therapy. Therefore, there are questions about how broadly applicable the SB's narrative is to other instances of clients commenting on their own talk given the limited literature. Further research to explore other instances of reflective talk is warranted from both within therapy and in non-therapy settings. Given the nature of reflective talk it is difficult to see that it could not attend to issues of immediacy, therapeutic relationship and intersubjectivity, but its use by clients in different places in therapy may vary. It may not only be used in disclaiming and disclosing of sensitive issues, it may be used in moments of insight. Within therapy sessions exploration of other reflective talk would be helpful to explore some of the issues that clients explicitly pursue within therapy and whether this is facilitated or frustrated by therapists, and why. The broader narratives about empowering clients and away from professionals as experts imposing their perspectives also needs to be reflected in practice considerations. Issues of clients' disclosures, the therapeutic relationship, immediacy and intersubjectivity warrant further articulation beyond the therapists' actions.

MOL is an emerging therapeutic approach. The current study explores one possible disruption out of a broad range of possible disruptions. As disruptions

are central to MOL, further research is warranted to explore disruptions using different approaches. For instance, the claim that disruptions represent foreground to background thoughts is not clearly substantiated, although this is difficult to evidence. The current study, in line with CA, argues that an apparent disruption performs a social action as a broader part of the client's talk. A challenge for MOL is to provide evidence that disruptions are in line with MOL's accounts of disruptions.

3.5 **Critical Reflection**

This section offers my reflections on the research process

3.5.1 **Methodology**

The original project to look at MOL was envisioned as a single case experimental design looking at change on measures of goal conflict and distress over the course of therapy. That project was discontinued for a mixture of practical reasons and the limitations of measures of goal conflict. The current study therefore is rather different to the original idea I spent several months working on. At the beginning of the project I had also never heard of CA. I am not sorry that the project changed and adapted, and in CA I have found a methodology that I find interesting and rewarding. For me it is a methodology that is grounded in what people "actually do" in psychotherapy, rather than trying to quantify issues or asking them about it after the fact, or collect talk into themes. As such CA has a lot of appeal, and I feel that it is a shame that it is not more widely used, especially with Peräkylä and Vehviläinen's (2003) conception of SIKs, even if CA is only able to address therapy issues in a particular way.

The process of learning about CA and putting it in to practice has been challenging. As CA is non-cognitive it is challenging when I spent most of my time being cognitive to be "less cognitive" about issues. In becoming more familiar with CA it has provided a useful counterpoint to cognitive explanations and looking at what action someone might be doing. On the other hand, between MOL and CA I seem to have picked relatively minority concerns with clinical practice, and I wonder whether this is due to my own contrariness, or a desire to do something distinctive and the niches you can find yourself in with academic work. I am cognisant of the toothbrush problem (psychological theories are like toothbrushes – everyone wants their own) within clinical psychology and part of the appeal of MOL is that it is a transdiagnostic approach.

3.5.2 **CA and practice**

The essence of CA, and Sacks' quote of "order at all points" (Sacks, 1984, p. 22), that interactions are orderly, is a proposal that I had not considered prior to the current study. In retrospect, it feels like an assertion that as a psychologist I should have been more mindful of. I suppose I was at a general level, but CA has made me appreciate how much detail and order there is. Much like MOL's assertion that people control perceptions, not behaviour, it is difficult to "unsee" social interaction as ordered. CA has affected my therapeutic practice, and not just thinking about smaller components of what a laugh might be doing both therapeutically and socially. It has also affected my thinking more broadly through the ideas from ethnomethodology about how I put clinical psychology, and myself as a person in to practice. However, being aware of the issues from CA does pose the dilemma of what you do about it, both within therapy and outside of it. Do I merely notice what appears to be normal for people to do from parts of the literature, or do I do something about it? I do not have a specific answer to the issue, but it has certainly made me consider how I phrase things, and whether that's being done for my benefit or the other person's. For example, one issue that has been highlighted by CA is the issue of epistemics (Heritage, 2013), which has helped me think about the classic therapy phrase of "I wonder if…", and how I phrase proposals. Similarly, it has also made me reflect on how I manage the transition from "trainee" to "qualified" (and what action I might have in including "hopefully" there, and whether it needs to be in brackets, with an exclamation, or whether it comes across as assured/arrogant/over-confident if I remove "hopefully").

3.5.3 **MOL and practice**

In contrast to CA, MOL and PCT have a different world view – that it is our perceptions that we control and not our behaviour. I do not see the two perspectives as mutually conflicting, as CA's orderliness might be brought about through negative feedback. However, CA and MOL/PCT are both different in their composition and perspectives and the issues that they are addressing. Trying to hold the different perspectives in mind during the current study has been challenging to do justice to the approaches and to fairly critique MOL without misrepresenting it. I continue to see the appeal of MOL, and I like the clarity of approach that it offers. MOL's approach has significant appeal for me

with its two clear goals for a therapist during sessions. The clarity of those goals is something I find helpful, as other theoretical approaches are often overwhelming with their scope in both theory and practice, whereas MOL cuts through most of this. The clarity of MOL is both a strength and a potential threat to how I see myself as a therapist and the level of training I have, and how much training someone might need. I do not think that MOL is "easy". As a trainee clinical psychologist, I have been able to use elements of MOL in practice, although I would not suggest by a long way that I use MOL. Through this project, I have spent a lot of time engaging with MOL, and for that time I do not find that I have become disenfranchised with MOL. From my clinical placements, I have thought about the temptations to seek exceptions where MOL might seem harder to do than suggest some behavioural activation. I feel that "What went through your mind just then" is a helpful question. I am interested to see where the MOL research goes and how well MOL establishes itself as an effective intervention.

3.5.4 **Epistemology and Methodology**

A longer-term trend for me is moving away from a quantitative positivist perspective, and being more comfortable with quantitative designs and methods, to using a qualitative approach for my MSc and DclinPsy. The current study has again reiterated the value of qualitative approaches, even if their summary is never as neat as the promise that quantitative designs offer in my mind – though rarely deliver. The qualitative approaches have been helpful in exploring the detail of issues and I have gained much from doing qualitative work. Critical realism is a broad church methodologically and epistemologically, and I feel that I've made movements within it to appreciate the benefits of both qualitative and quantitative work. In part the change is a result of increased exposure to more constructionist ideas and what they offer, rather than being distrustful of what can seem like "woolly" answers. In part however, it is about being able to capture and reflect complexity and to present an alternative view which reflects the difficulties that we live and work with. I have worked in different service settings, and in different mental health teams, as well as in a physical health team. CA has made me think more about issues from a constructionist perspective, including issues around discourse, such as the

difference between diagnosis in physical health and mental health. Constructionist ideas have helped me to reflect on the differences in settings, and how I use language differently.

3.6 **References**

Antaki, C. (2004). Reading minds or dealing with interactional implications? *Theory & Psychology*, *14*(5), 667–683. http://doi.org/10.1177/0959354304046178

Antaki, C. (2008). Formulation in psychotherapy. In A. Perakyla, C. Antaki, S. Vehvilainen, & I. Leduar (Eds.), *Conversation Analysis and Psychotherapy* (pp. 26–42). Cambridge: Cambridge University Press.

Antaki, C., Barnes, R., & Leudar, I. (2005). Self-disclosure as a situated interactional practice. *The British Journal of Social Psychology, 44*(2), 181–199. http://doi.org/10.1348/014466604X15733

Antaki, C., & Jahoda, A. (2010). Psychotherapists' practices in keeping a session "on-track" in the face of clients' "off-track" talk. *Communication and Medicine*, *7*(1), 11–21. http://doi.org/10.1558/cam.v7il.ll

Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: Historical excursus, measurements, and prospects for research. *Frontiers in Psychology*, *2*, 1–11. http://doi.org/10.3389/fpsyg.2011.00270

Balmforth, J., & Elliott, R. (2012). "I never talked about, ever": A comprehensive process analysis of a significant client disclosure event in therapy. *Counselling and Psychotherapy Research*, *12*(1), 2–12. http://doi.org/10.1080/14733145.2011.580353

Baumann, E. C., & Hill, C. E. (2016). Client concealment and disclosure of secrets in outpatient psychotherapy. *Counselling Psychology Quarterly*, *29*(1), 53–75. http://doi.org/10.1080/09515070.2015.1023698

Beach, W. A., & Prickett, E. (2016). Laughter, humor, and cancer: Delicate moments and poignant interactional circumstances. *Health Communication*, 32(7), 1–12. http://doi.org/10.1080/10410236.2016.1172291

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York, NY: The Guildford Press.

Brüne, M. (2005). "Theory of mind" in schizophrenia: A review of the literature. *Schizophrenia Bulletin*, *31*(1), 21–42. http://doi.org/10.1093/schbul/sbi002

Cannon, C. (2014). *A Conversation Analysis of Method of Levels Psychotherapy*. *Unpublished MRes Dissertation*. Manchester: University of

Manchester.

Carey, T. A. (2016). The Method of Levels: A transdiagnostic approach to effective and efficient patient-perspective treatment. Manchester: Presented at an MOL training course.

Carey, T. A. (2006). *The Method of Levels: How to do Psychotherapy without getting in the way*. Hayward, CA: Living Control Systems Publishing.

Carey, T. A., Carey, M., Mullan, R. J., Spratt, C. G., & Spratt, M. B. (2009). Assessing the Statistical and Personal Significance of the Method of Levels. *Behavioural and Cogntive Psychotherapy,* 37(3), 311–324. http://doi.org/10.1017/S1352465809005232

Carey, T. A., Kelly, R. E., Mansell, W., & Tai, S. J. (2012). What's therapeutic about the therapeutic relationship? A hypothesis for practice informed by Perceptual Control Theory. *The Cognitive Behaviour Therapist*, *5(2-3)*, 47–59. http://doi.org/10.1017/S1754470X12000037

Carey, T. A., Mansell, W., & Tai, S. J. (2015). *Principles-based counselling and psychotherapy: A Method of Levels Approach*. Hove: Routledge.

Carey, T. A., & Mullan, R. J. (2008). Evaluating the method of levels. *Counselling Psychology Quarterly*, *21(3)*, 247–256. http://doi.org/10.1080/09515070802396012

Carey, T. a., Tai, S. J., & Stiles, W. B. (2013). Effective and efficient: Using patient-led appointment scheduling in routine mental health practice in remote Australia. *Professional Psychology: Research & Practice*, *44*(6), 405–414. http://doi.org/10.1037/a0035038

Carrasco, M. (2011). Visual attention: The past 25 years. *Vision Research*, *51*(13), 1484–1525. http://doi.org/10.1016/j.visres.2011.04.012

Chevalier, F. H. G., & Moore, J. (2015). Producing and managing restricted activities: An introduction to avoidance and withholding in institutional interaction. In F. H. G. Chevalier & J. Moore (Eds.), *Producing and managing restricted activities: Avoidance and withholding in institutional interaction* (pp. 1–44). Amsterdam: John Benjamins Publishing Company.

Clift, R. (2006). Indexing stance: Reported speech as an interactional evidential. *Journal of Sociolinguistics*, *10*(5), 569–595. http://doi.org/10.1111/j.1467-9841.2006.00296.x

Davidsen, A. S., & Fosgerau, C. F. (2015). Grasping the process of implicit

mentalization. *Theory & Psychology*, *25*(4), 434–454. http://doi.org/10.1177/0959354315580605

Davison, T. E., McCabe, M. P., Knight, T., & Mellor, D. (2012). Biopsychosocial factors related to depression in aged care residents. *Journal of Affective Disorders*, *142*(1–3), 290–296. http://doi.org/10.1016/j.jad.2012.05.019

Drew, P. (1987). Po-faced receipts of teases. *Linguistics*, *25*(1), 219–253. http://doi.org/10.1515/ling.1987.25.1.219

Drew, P. (2004). Conversation Analysis. In L. Fitch, K & R. E. Sanders (Eds.), *Handbook of Language and Social Interaction* (pp. 71–102). Mahwah: Psychology Press.

Drew, P., & Heritage, J. (1992). Analyzing talk at work: An introduction. In P. Drew & J. Heritage (Eds.), *Talk at work: Interaction in Institutional Settings* (pp. 3–65). Cambridge: Cambridge University Press.

Drew, P., & Holt, E. (1988). Complainable matters: The use of idiomatic expressions in making complaints. *Social Problems*, *35*(4), 398–417. http://doi.org/10.1525/sp.1988.35.4.03a00060

Edwards, D. (1997). *Discourse and Cognition*. London: Sage.

Edwards, D. (2005). Discursive Psychology. In K. L. Fitch & R. E. Sanders (Eds.), *Handbook of Language and Social Interaction* (pp. 257–273). London: Erlbaum.

Edwards, D. (2005). Moaning, whinging and laughing: the subjective side of complaints. *Discourse Studies*, *7*(1), 5–29. http://doi.org/10.1177/1461445605048765

Edwards, D., & Potter, J. (2005). Discursive psychology, mental states and descriptions. In H. te Molder & J. Potter (Eds.), *Conversation and Cognition* (pp. 241–259). Cambridge: Cambridge University Press.

Erman, B. (2001). Pragmatic markers revisited with a focus on you know in adult and adolescent talk. *Journal of Pragmatics*, *33*(9), 1337–1359. http://doi.org/10.1016/S0378-2166(00)00066-7

Farber, B. A. (2003). Patient self-disclosure: A review of the research. *Journal of Clinical Psychology*, *59*(5), 589–600. http://doi.org/10.1002/jclp.10161

Fitzgerald, P. E. (2013). *Therapy Talk: Conversation Analysis in Practice*. London: Palgrave Macmillan.

Fonagy, P., & Bateman, A. W. (2006). Mechanisms of change in mentalisation-

based therapy with BPD. *Journal of Clinical Psychology*, *62*(4), 411–430. http://doi.org/10.1002/jclp.20241

Fox Tree, J. E., & Schrock, J. C. (2002). Basic meanings of you know and I mean. *Journal of Pragmatics*, *34*(6), 727–747. http://doi.org/10.1016/S0378-2166(02)00027-9

Georgaca, E., & Avdi, E. (2009). Evaluating the talking cure: The contribution of narrative, discourse, and conversation analysis to psychotherapy assessment. *Qualitative Research in Psychology*, *6*(3), 233–247. http://doi.org/10.1080/14780880802146896

Graham-Bermann, S. a, Kulkarni, M. R., & Kanukollu, S. N. (2011). Is disclosure therapeutic for children following exposure to traumatic violence? *Journal of Interpersonal Violence*, *26*(5), 1056–1076. http://doi.org/10.1177/0886260510365855

Greenberg, L. S. (2004). Emotion–focused therapy. *Clinical Psychology & Psychotherapy*, *11*(1), 3–16. http://doi.org/10.1002/cpp.388

Gu, E., & Badler, N. I. (2006). Visual Attention and Eye Gaze During Multiparty Conversations with Distractions. *Computer*, *4133*, 193–204. http://doi.org/10.1007/11821830_16

Hall, D. A., & Farber, B. A. (2001). Patterns of patient disclosure in psychotherapy. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *29*(2), 213–230. http://doi.org/10.1521/jaap.29.2.213.17262

Hepburn, A., & Potter, J. (2007). Crying receipts: Time, empathy, and institutional practice. *Research on Language & Social Interaction*, *40*(1), 89–116. http://doi.org/10.1080/08351810701331299

Heritage, J. (1967). *Studies in ethnomethodology*. Englewood Cliffs, NJ: Prentice Hall.

Heritage, J. (1984). *Garfinkel and Ethnomethodology*. Cambridge: Polity Press.

Heritage, J. (2004). Conversation analysis and institutional talk. In R. E. Sanders & K. E. Fitch (Eds.), *Handbook of Langauge and Social Interaction* (pp. 103–147). Mahawah: Erlbaum.

Heritage, J. (2013). Epistemics in Conversation. In T. Stivers & J. Sidnell (Eds.), *Handbook of Conversation Analysis* (pp. 370–394). Blackwell.

Hewitt, J. P., & Stokes, R. (1975). Disclaimers. *American Sociological Review*,

40(1), 1–11. http://doi.org/10.2307/2094442

Hill, C. E., Gelso, C. J., Chui, H., Spangler, P. T., Hummel, A., Huang, T., … Miles, J. R. (2014). To be or not to be immediate with clients: The use and perceived effects of immediacy in psychodynamic/interpersonal psychotherapy. *Psychotherapy Research*, *24*(3), 299–315. http://doi.org/10.1080/10503307.2013.812262

Hill, C. E., & Knox, S. (2009). Processing the therapeutic relationship. *Psychotherapy Research : Journal of the Society for Psychotherapy Research*, *19*(1), 13–29. http://doi.org/10.1080/10503300802621206

Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: a review of meta-analyses. *Cognitive Therapy Research*, *36*(5), 427–440. http://doi.org/10.1007/s10608-012-9476-1.The

Holt, E. (1996). Research on language & social interaction reporting on talk : The use of direct reported speech in conversation. *Research on Language and Social Interaction*, 29(3), 219-245. http://doi.org/10.1207/s15327973rlsi2903

Holt, E. (2000). Reporting and reacting: Concurrent responses to reported speech. *Research on Language and Social Interaction*, *33*(4), 425–454. http://doi.org/10.1207/S15327973RLSI3304

Holt, L. (2012). Using laugh responses to defuse complaints. *Research on Language & Social Interaction*, *45*(4), 430–448. http://doi.org/10.1080/08351813.2012.726886

Horvath, A. O., Symonds, D., Horvath, A. O., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy*, 48(1), 9-16. http://doi.org/10.1037/a0022186

Hutchby, I., & Wooffitt, R. (2008). *Conversation Analysis* (2nd ed.). Cambridge: Polity.

Jefferson, G. (1984). On the organisation of laughter in talk about troubles. In J. M. Atkison & J. C. Heritage (Eds.), *Structures of Social Action: Studies in Conversation Analysis* (pp. 346–369). Cambridge: Cambridge University Press.

Jefferson, G. (1985). An exercise in the Transcription and Analysis of Laughter. In T. A. Van Dijk (Ed.), *Handbook of Discourse Analysis Vol 3: Discourse*

and Dialogue (pp. 25–34). London: Academic Press.

Jefferson, G. (1985). On the interactional unpackaging of a “gloss.” *Language in Society*, *14*(4), 435. http://doi.org/10.1017/S0047404500011465

Jefferson, G. (1988). On the sequential organization of troubles-talk in ordinary conversation. *Social Problems*, *35*(4), 418–441. http://doi.org/10.1525/sp.1988.35.4.03a00070

Jefferson, G. (1988). Preliminary notes on a possible metric which provides a “standard maximum” silence of approximately one second in conversation. In D. Roger & P. Bull (Eds.), *Conversation* (pp. 166–196). Clevedon: Multilingual Matters.

Jefferson, G., Sacks, H., & Schegloff, E. A. (1987). Notes on laughter in the pursuit of intimacy. In G. Button & J. Lee (Eds.), *Talk and Social Organization* (pp. 152–205). Avon: Multilingual Matters.

Kahn, J. H., Achter, J. A., & Shambaugh, E. J. (2001). Client distress disclosure, characteristics at intake, and outcome in brief counseling. *Journal of Counseling Psychology*, *48*(2), 203–211. http://doi.org/10.1037/0022-0167.48.2.203

Koivisto, A., & Voutilainen, L. (2016). Responding to what is left implicit: psychotherapists’ formulations and understanding checks after clients’ turn-final *Että* (“That/So”). *Research on Language and Social Interaction*, *49*(3), 238–257. http://doi.org/10.1080/08351813.2016.1198195

Kondratyuk, N., & Perakyla, A. (2011). Therapeutic work with the present moment: a comparative conversation analysis of existential and cognitive therapies. *Psychotherapy Research : Journal of the Society for Psychotherapy Research*, *21*(3), 316–330. http://doi.org/10.1080/10503307.2011.570934

Korkiakangas, T., Dindar, K., Laitila, A., & Kärnä, E. (2016). The Sally-Anne test: an interactional analysis of a dyadic assessment. *International Journal of Language and Communication Disorders*, *51*(6), 685–702. http://doi.org/10.1111/1460-6984.12240

Lambertz, K. (2011). Back-channelling: The use of yeah and mm to portray engaged listenership. *Griffith Working Papers in Pragmatics and Intercultural Communication*, *4*(1), 11–18.

Lemma, A. (2003). *Introduction to the Practice of Psychoanalytic*

Psychotherapy. *Chichester: Wiley*

Lerner, G. H. (1991). On the syntax of sentences-in-progress. *Language in Society*, 20(3), 441–458. http://doi.org/10.1017/S0047404500016572

Lerner, G. H. (1996). On the "semi-permeable" character of grammatical units in conversation: conditional entry into the turn space of another speaker. In E Ochs, Schegloff, E. A., & Thompson, S. A (Eds.), *Interaction and Grammar*. Cambridge: Cambridge University Press.

Lerner, G. H. (2013). On the place of hesitating in delicate formulation: a turn-constructional infrastructure for collaborative indiscretion. In M. Hayashi, G. Raymound, & J. Sidnell (Eds.), *Conversational Repair and Human Understanding* (pp. 95–134). Cambridge: Cambridge University Press.

Li, X., Jauquet, C. A., & Kivlighan, D. M. (2016). When is therapist metacommunication followed by more client collaboration? The moderation effects of timing and contexts. *Journal of Counseling Psychology*, *63*(6), 693–703. http://doi.org/10.1037/cou0000162

Liddicoat, A. J. (2007). *An introduction to conversation analysis*. London: Continuum.

Lindström, A., & Sorjonen, M.-L. (2013). Affiliation in conversation. In J. Sidnell & T. Stivers (Eds.), *Handbook of conversation analysis* (pp. 350–369). Oxford: Wiley-Blackwell.

Macaulay, R. (2002). You know, it depends. *Journal of Pragmatics*, *34*(6), 749–767. http://doi.org/10.1016/S0378-2166(01)00005-4

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, *91*(1), 1–20. http://doi.org/10.1348/000712600161646

Madill, A., Widdicombe, S., & Barkham, M. (2001). The potential of conversation analysis for psychotherapy research. *The Counseling Psychologist*, *29*(3), 413–434. http://doi.org/10.1177/0011000001293006

Mandelbaum, J. (2013). Storytelling in conversation. In J. Sidnell & T. Stivers (Eds.), *Handbook of conversation analysis* (pp. 492–508). Oxford: Wiley-Blackwell.

Mansell, W. (2005). Control theory and psychopathology: an integrative approach. *Psychology and Psychotherapy*, *78*, 141–178.

http://doi.org/10.1348/147608304X21400

Markee, N. (2000). *Conversation analysis*. Mahawah: Laurence Erlbaum Associates.

Maynard, D. W., & Clayman, S. E. (2003). Ethnomethodology and Conversation Analysis. In T. L. Reynolds & W. Creek (Eds.), *The Handbook of Symbolic Interactionism* (pp. 173–202). Walnut Creek, CA: Altamira Press.

McCabe, R., Leudar, I., & Antaki, C. (2004). Do people with schizophrenia display theory of mind deficits in clinical interactions? *Psychological Medicine*, *34*(3), 401–412. http://doi.org/10.1017/S0033291703001338

Moore, M. T., & Fresco, D. M. (2012). Depressive realism: A meta-analytic review. *Clinical Psychology Review*, *32*(6), 496–509. http://doi.org/10.1016/j.cpr.2012.05.004

Muntigl, P., & Horvath, A. O. (2014). The therapeutic relationship in action: How therapists and clients co-manage relational disaffiliation. *Psychotherapy Research*, *24*(3) 327–345. http://doi.org/10.1080/10503307.2013.807525

Muntigl, P., Knight, N., Horvath, A. O., & Watkins, A. (2012). Client attitudinal stance and therapist-client affiliation: A view from grammar and social interaction. *Research in Psychotherapy: Psychopathology, Process and Outcome*, *15*(2), 117–130. http://doi.org/10.7411/RP.2012.012

Muntigl, P., Knight, N. K., & Angus, L. (2014). Targeting emotional impact in storytelling: Working with client affect in emotion-focused psychotherapy. *Discourse Studies*, *16*(6), 753–775. http://doi.org/10.1177/1461445614546255

Muntigl, P., Knight, N., & Watkins, A. (2012). Working to keep aligned in psychotherapy: Using nods as a dialogic resource to display affiliation. *Language and Dialogue*, *2*(1), 9–27. http://doi.org/10.1075/ld.2.1.01mun

Muntigl, P., & Zabala, L. H. (2008). Expandable responses: how clients get prompted to say more during psychotherapy. *Research on Language & Social Interaction*, *41*(2), 187–226. http://doi.org/10.1080/08351810802028738

NICE. (2010). *Depression: the NICE guidelines on the treatment and management of depression in adults*. National Clinical Practice Guidelines 90.

Nummenmaa, L., & Calder, A. J. (2009). Neural mechanisms of social attention.

Trends in Cognitive Sciences, *13*(3), 135–143. http://doi.org/10.1016/j.tics.2008.12.006

Padesky, C. a., & Greenberger, D. (1995). *Mind over Mood*. Ney York: Guildford Press.

Patomaki, H., & Wight, C. (2000). After postpositivism? The promises of critical realism. *International Studies Quarterly*, *44*(2), 213–237. http://doi.org/10.1111/0020-8833.00156

Penman, E. L., Breen, L. J., Hewitt, L. Y., & Prigerson, H. G. (2014). Public attitudes about normal and pathological grief. *Death Studies*, *38*(8), 510–516. http://doi.org/10.1080/07481187.2013.873839

Peräkylä, A. (2013). Conversation analysis in psychotherapy. In J. Sidnell & T. Stivers (Eds.), *The Handbook of Conversation Analysis* (pp. 551–574). Chichester: Wiley-Blackwell.

Peräkylä, A., Antaki, C., Vehviläinen, S., & Leudar, I. (2008). Analysing psychotherapy in practice. In A. Peräkylä, C. Antaki, S. Vehviläinen, & I. Leudar (Eds.), *Conversation Analysis and Psychotherapy*. Cambridge: Cambridge University Press.

Peräkylä, A., Antaki, C., Vehviläinen, S., Leudar, I., & (Eds.). (2008). *Conversation Analysis and Psychotherapy*. (A. Peräkylä, C. Antaki, S. Vehvil*ƒ*inen, & I. Leudar, Eds.). Cambridge: Cambridge University Press.

Peräkylä, A., & Vehviläinen Sanna. (2003). Conversation analysis and the professional stocks of interactional knowledge. *Discourse & Society*, *14*(6), 727–750. http://doi.org/10.1177/09579265030146003

Posner, M. I. (2008). Measuring alertness. *Annals of the New York Academy of Sciences*, *1129*, 193–199. http://doi.org/10.1196/annals.1417.011

Potter, J. (1996). *Representing Reality: Discource, Rhetoric and Social Construction*. London: Sage.

Potter, J. (1999). Beyond cognitivism. *Research on Language & Social Interaction*, *32*(1–2), 119–127. http://doi.org/10.1080/08351813.1999.9683615

Potter, J., & Edwards, D. (2013). Conversation analysis and psychology. In J. Sidnell & T. Stivers (Eds.), *The Handbook of Conversation Analysis* (pp. 701–725). Chichester: John Wiley & Sons.

Potter, J., & Hepburn, A. (2010). Putting aspiration into words: “Laugh particles”,

managing descriptive trouble and modulating action. *Journal of Pragmatics*, *42*(6), 1543–1555. http://doi.org/10.1016/j.pragma.2009.10.003

Powers, W. T. (2005). Behavior: The control of perception. (New Canaan). Benchmark.

Poyatos, F. (1983). Language and nonverbal sign systems in the structure of face-to-face interaction. *Language & Communication*, *11*(1/2), 61–82. http://doi.org/10.1016/0271-5309(83)90010-1

Poyatos, F. (1984). The multichannel reality of discourse: language-paralanguage-kinesics and the totality of communicative systems. *Language Sciences*, *6*(2), 307–337. http://doi.org/10.1016/S0388-0001(84)80022-4

Poyatos, F. (2002). Language-paralanguage-kinesics: The basic triple structure of human communication. *Nonverbal Communication across Disciplines Vol I*, 103–132.

Rapley, M. (2012). Ethnomethodology/conversation analysis. In D. Harper & A. R. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy* (pp. 177–192). Oxford: Wiley-Blackwell.

Ruusuvuori, J. (2005). “Empathy” and “sympathy” in action: Attending to patients’ troubles in Finnish homeopathic and general practice consultations. *Social Psychology Quarterly*, *68*(3), 204–222. http://doi.org/10.1177/019027250506800302

Ruusuvuori, J. (2013). Emotion, affect and conversation. In J. Sidnell & T. Stivers (Eds.), *Handbook of conversation analysis* (pp. 330–349).

Sacks, H. (1995). *Lectures on Conversation. Volumes I and II*. (G. Jefferson, Ed.). Oxford: Blackwell.

Sacks, H., & Schegloff, E. A. (1979). Two preferences in the organization of refrence to persons in conversation and their interaction. In G. Psathas (Ed.), *Everyday Language, Studies in Ethnomethodology* (pp. 15–21). New York: Irvington Publishers.

Sacks, J. (1984). Notes on methodology. In J. Heritage & M. Atkinson (Eds.), *Structures of Social Action: Studies in Conversation Analysis* (pp. 2–27). Cambridge: Cambridge University Press.

Safran, J. D., & Kraus, J. (2014). Alliance ruptures, impasses, and enactments: A relational perspective. *Psychotherapy*, *51*(3), 381–387.

http://doi.org/10.1037/a0036815

Schegloff, E. A., Sacks, H. (1973). Opening up closings. *Semiotica*, *8*, 289–327. http://doi.org/10.1515/semi.1973.8.4.289

Schegloff, E. (1997). Practices and actions: Boundary cases of other-initiated repair. *Discourse Processes*, *23*(3), 499–545. http://doi.org/10.1080/01638539709545001

Schegloff, E. A. (1996). Confirming allusions: Toward an empirical account of action. *American Journal of Sociology*, *102*(1), 161–216. http://doi.org/10.1086/230911

Schegloff, E. A. (2005). On complainability. *Social Problems*, *52*(4), 449–476. http://doi.org/10.1525/sp.2005.52.4.449

Schegloff, E. A. (2007). *Sequences Organization In Interaction: A Primer in Conversation Analysis*. Cambridge: Cambridge University Press.

Schegloff, E. A. (2013). Ten operations in self-initiated, same-turn repair. In M. Hayashi, G. Raymond, & J. Sidnell (Eds.), *Conversational Repair and Human Understanding* (pp. 41–70). Cambridge: Cambridge University Press.

Schiffrin, D. (1980). Meta-talk: Organizational and evaluative brackets in discourse. *Sociological Inquiry*, *50*(3–4), 199–236. http://doi.org/10.1111/j.1475-682X.1980.tb00021.x

Silverman, D., & Perakyla, A. (1990). AIDS counselling: the interactional organisation of talk about “delicate” issues. *Sociology of Health and Illness*, *12*(3), 293–318. http://doi.org/10.1111/1467-9566.ep11347251

Sims-Schouten, W., Riley, S. C. E., & Willig, C. (2007). Critical realism in discourse analysis: A presentation of a systematic method of analysis using women’s talk of motherhood, childcare and female employment as an example. *Theory and Psychology*, *17*(1), 101–124. http://doi.org/10.1177/0959354307073153

Stanghellini, G., & Lysaker, P. H. (2007). The psychotherapy of schizophrenia through the lens of phenomenology: Intersubjectivity and the search for the recovery of first- and second-person awareness. *American Journal of Psychotherapy*, *61*(2), 163–179. http://doi.org/10.1080/17542860802173464

Stivers, T. (2013). Sequence Organization. In J. Sidnell & T. Stivers (Eds.), *The Handbook of Conversation Analysis* (pp. 191–209). Chichester: John Wiley & Sons.

Stivers, T., & Sidnell, J. (2013). Introduction. In T. Stivers & J. Sidnell (Eds.), *The handbook of conversation analysis* (pp. 1–9). Chichester: Wiley-Blackwell.

ten Have, P. (2007). *Doing Conversation Analysis: A Practical Guide* (2nd ed.). London: SAGE Publications.

Appendix 1. Jeffersonian transcription symbols

Symbol	Use
T/C	T denotes therapist speak. C for client
[ ]	Square brackets mark the start and end of overlapping speech.
↑ ↓	Vertical arrows precede marked pitch movement, over and above normal rhythms of speech. Pitch change is in the direction indicated by the arrow. They are used for notable changes in pitch beyond those represented by stops, commas and question marks.
→	Side arrows are used to draw attention to features of talk that are relevant to the current analysis.
Word	Indicates emphasis; the extent of underlining within individual words locates emphasis and also indicates how heavy it is.
WORD	Mark speech that is hearably louder than surrounding speech. This is beyond the increase in volume that comes as a by product of emphasis.
°Word°	‘degree’ signs enclose hearably quieter speech.
£Word£	Pound sign indicates that the talk was in a smile voice
*Word	Asterisks precede a ‘squeaky’ vocal delivery.
(0.2)	Numbers in round brackets measure pauses in seconds (in this case, 2 tenths of a second). If they are not part of a particular speaker’s talk they should be on a new line. If in doubt use a new line.

(.)	A micropause, hearable but too short to measure (<0.2s).
((coughs))	Additional comments from the transcriber, e.g. about features of context or delivery.
Wo::rd	Colons show degrees of elongation/stretching of the prior sound; the more colons, the more elongation.
Hhh	Aspiration (out-breaths); proportionally as for colons.
.hhh	Inspiration (in-breaths); proportionally as for colons.
Word,	'Continuation' marker, speaker has not finished; marked by fall-rise or weak rising intonation, as when delivering a list.
Word?	Question marks signal stronger, 'questioning' intonation, irrespective of grammar.
Word.	Full stops mark falling, stopping intonation ('final contour'), irrespective of grammar, and not necessarily followed by a pause.
Wor-	hyphens mark a cut-off of the preceding sound.
>Word<	Arrows in this direction show that the pace of the speech has speeded up.
<Word>	Arrows in this direction show that the pace of the speech has slowed down
=	The equal sign represents latched speech, a continuation of talk.
Heh hah	Voiced laughter. Can have other symbols added, such as underlinings, pitch movement, extra aspiration, etc.

`Wo(h)r(h)d`	Laughter within speech is signalled by h's in round brackets.

Appendix 2. Additional Transcript Material

Extract 5, 1-7623, 11:52-14:12

01	C	It generally makes me feel very uncomfortable,
02		(.) .hhhhh um- I'm not sure why, >but two of-<
03		(0.5) (tongue noises) (0.7) two or three
04		people in par:ticu:lar:?
05		(1.0)
06	C	.hhhhh I kind of (.) dread seeing (.) >well not
07		really dread seeing< but (.) .hhhh
08		(2.3)
09	C	there's something=
10	T	=uncomfortable (abadt).
11	C	Yeah.
12		(0.2)
13	C	.hhh >an then- an then-< they're coming towards
14		me so I've obviously seen them coming towards
15		me and I don't quite know::, (0.2) (lip noise)
16		(.) I don't react (.)particularly naturally,
18		(0.3).hhh I don't know whether to say hel:lo,
19		(0.7)or not:, (.) I don't know whether to- to
20		look at them or not, .hhh
21		(1.4)
22	T	>I'm just wondering what the< dreads about?
23		(0.8)
24	C	<We:ll (.) I don:t> really know (.) I th-think
25		it's cos I'm thinking they:'re (0.3)
26		>heh heh< .hhh £ignoring£ me, (0.2) err,
29		(1.7)
30	C	I >don-don't really know (.) you know (.) so<
31		they're walking back °and I'm kind of I dunno
32		>it's like ah↓°< (0.3) and then I'll do
33		something like, (02) .hhh just as they're about
34		to- (0.2) very close to me >I'll I'll< speak to

one of the boys.
(2.2)
Or I'll cross the road, (0.2) or I'll (0.2)
.hhhhhhhhhh (.) >°take°< take >my phone out
me pocket or I'll do kind< of something, (0.4)
→ .hhhh If it sounds very childish when I (.)
→ °sort of° try and explain it but (0.2)
→ it pr- probably is childish but, (0.4)
T Sounds like that:'s a way thut (0.2) that
you've got of dealing with that (.) difficult
situation.
(0.7)
C Yeah
(0.3)
C .hhhh but I- I don't know (0.2) you know (.) I
don't like myself for, (0.7) so there's me
(1.4) taking the boys to school, (.) which
really should be a very (0.5) I would have
thought pleasurable (.) normal (.) .hhhhhhh
thing to do, and >I'm< I'm grateful of the
opportunity to do that (.)cos I think I I
could be stuck in a job where, (.)ya'know (.)
I'm in a factory somewhere und (.) .hhh I
can't do that. And so I'm happy to do
that(.) and it's nice to sort of have
a chat with them on the way to (.) school (0.4)
and it's nice to meet↑ them (.) but instead of
kind of enjoying it I'm kind of lost in
this (0.2) .hhhhhhhhhh little world of
°not° (0.9) of of of of erm (lip smack) (.)
feeling uncomfortable (0.9) when I- when
I'm approaching certain people (.) which is
(1.7) er er feels errr (0.8) ridiculous (.)
ya'know I'm not (1.0) .hhh I don't know what

that's about Im Im Im not er (0.9) I don't know if everyone's (.) walking around feeling like that (.) but my su- (0.3) I'm thinking that they're not.

Extract 6, 10-8011, 29:31–31:57

C I think I need to relax a bit?
(4.8)
C I think I'm m:a:king myself more tense about this (.) like I think I am, (0.8) forcing myself to >let it< be more, (2.8) stre:ss:ed out? Than I should be?
(5.5)
C .hhh
T Maybe that has something to do with?
(2.4)
C hhhh
(1.1)
C .hhhhk
T Not wanting (.) to feel relaxed because you are no longer waiting for the phone call,
T Yeah.
(0.8)
C I think that is a big part of it (.) I think If I a:ll:ow myself to be relaxed I am either worried that something n:e:w (0.2) will happen (.) >that's really bad< like my grandmother dying (.)>or something like that (.)< (0.4) .hhh and or- like y'know? (0.5) The r:eal: fear which is that nothing will happen and it will just be li:f:e (.) .hhh (.) I think that's quite a scary thought for me (.) because it's like again the thing of, (0.9) like, (0.8) basically if I'm like (.) really

tense all of the time it kind of y'know? >it
hasn't happened (.) it hasn't happened.<
(1.4)
C Whereas if I just re:laxed in to it (.) and
y'know? (.) well (.) wha:t:ever? .hhh
(0.9)
T So it's letting [him go]=?
C [mmmmmm]=
=Yeah (.) it's like y'know? it's another stage
of like (.) accep:tance (.) and I'm real:ly
unwilling to accept that this has happened (.)
still.
→C Like it sounds insane (.) I know it's been
→ like (.) four months but,
(3.6)
T °But you're not ready yet.°
(3.7)
C N::y::o:o,
(4.7)
C I keep thinking about like (.) to other people
(.) it's been, (0.2) four months, (0.3) to
m:e? (2.2) It kind of >$almost hasn't
happened?$< (0.5) Yet.
(6.8)
C I think part of that (.) kind of, (0.7)
C accepting that (.) <it has happened> will be
(0.3) y'know? (1.8) Going home (.) and finding
C that he isn't there,
(5.0)

Extract 7, 1-1425, 19:31-20:56

T >If it (.) If if(.)< killed the pain bef:ore is
there a risk o:f it (.) being opened up again?
(0.3)

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04    C     <Doesn't matter if it i:s (.) as long as you
05          get to the bottom of it and make sure that the
06          confidence is sound.>
07    C     That's the thing.
08          (1.3)
09    C     Things have changed since two thousand, °I was
10          in a° factory then working part-time (.) now
11          I'm one of the highest qualified instructors in
12          the count:re (.) people rely on me, they depend
13          on me,.hhh there's people out there wanting me
14          to do presentations >all over the place.<
15          (0.7)
16    C     But the only trouble is (.) now I'm starting to
17          real:ly achieve (.) I can't appreciate the
18          achievements I'm doin'.
19          (1.2)
20    C     I can't appreciate it.
21    C     There's sorta like< (.) <me here> (0.4)
22          the achievements (0.2) here.
23          (0.3)
24    C     And there's like (.) <one massive big gap> cos
25          the person I am is this person (0.3) not (0.2)
26          that per(h)s(h)o(h)n  >I(h) m(h)e(h)a(h)n
27          i(h)f<yo(h)u un(h)ders(h)tand(h) th(h)e
28    →     con(h)ce(h)pt (.) £I make that sound weird£
29    →C    >.hhh But you think? Did I really do that?<
31    C     >An' I think I did?<
32    C      >It must have been some good luck.<
33          (0.4)
34    C     >Or some coincidence< or something happened on
35          the day (.) or eeerrrmmmm (0.2) it's cos they
36          helped me out (.) O::r (.) >y'know< (.) .hhhh
37    T     It couldn't possibly be becau[se (     )]
38    C                                  [Oh it c]an't be
```

me cos I’m this person.
(.)
C I’m that person who got told off. And this
person here >who did this, who did that.<
(1.1)
C So it’s- (.) c. (0.2) I can’t accept. >y’know<.
0.3
C Because, (.) there’s been a transition. (.)
>Sa Hell of a transition.<
(.)
C Between being, (0.2) >having no qualified-
qualifications back in oh four (.) and then
with all this lot now.< .hhhhh It’s very very
recent (.) For a.-< It’s happened >very, very<
quick.
C .hhhhh ((lip smack)) All of a sudden.
((sound from fiddling with an object))
C You’re not a factory worker.
C Roun:g:ing: ‘round in town.
(0.8)
C .hhhh With the- (0.3) People d- dossing on the
street.
(0.9)
C >All of a sudden (.) you’ve got a business< (.)
you go to university (.) you’re getting a
degree.

Extract 8, 10-1766, 42:19-45:02

T For some (.) reason we’re kind of like sponges
(.) and we ab[sorb] all this stuff.
C [yeah]
(0.4)
C y[eah]
T [unti]l we become saturated. (.) And we can’t

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07          absorb anymore,
08    C     Yeah.=
09    T     =((lip smack)) so I wonder, (0.3) if, (0.3)
10          .hhh you've kind of absorbed all that
11          negativity all the (.) crappy stuff,
12    C     °So there's not a space for any°=
13    T     =yeah=
14    C     =yeah.
15    T     °And and° so there wasn't space for you
16          to [kind]
17    C        [yeah]
18    T     of recall the (1.0)
19    C     yeah (0.4) the
20    T     ((cough)) [((cough))
21    C               [ I was definitely like (.)
22          completely dominates my memory of it.
23    T     mmmmm.
24          (0.5)
25    C     Like (.) .hhhh I know there was like, (0.3)
26          some like >a lotta good< times (.) and I had
27          some (.).hhh really good friends and like,
28          h(1.4) like hhh  I know there's days where I
29          was just (.)I was just in hysterics all day
30          (.) like laughing and stuff=
31    T     =Mmmmm[mm]
32    C           [And] it would be really fun but,
33          (0.7)
34    C     I just like.
35    C     >This seems totally insignificant.<
36          (0.8)
37    C     Like (.) compared to the five years there. (.)
38          An'.hhhhh An. (3.0) even like when I imagine
39          it (0.2) and picture it and remember it,
40          (0.6)
```

C It's like (0.9) It was- (0.7) like grey clou(h)d(h)s like all the time (.) the whole thing It's just like (0.4) dark and murky and miserable.

T Mmmmmmm=

C =Like (1.0) even if I (0.3) I-I I (0.5) >like cos my memory is like< (0.5) it's like °(obviously)° visual when you're remembering pictur[es kin]d of thing, (.) an'

T [Ye::s]

(0.9)

C So if I'm like.

(1.1)

C You know,

(0.5)

C Having some (0.2) .hhhh hhhhh l(h)i(h)k(h)e .hhh (0.3) erm (1.1) reminiscent (1.1) erm (1.1) y'know remembering it.

(0.7)

C For like (.) even (1.0) like (0.2) the weather is influenced (0.7) like remembering something outside.

(0.7)

C It's like it's grey.

(0.5)

C An' (1.3) like the whole thing is just completely tainted.

(0.5)

C Like erm,

T °Mmmmm°

(2.0)

C °I am.°

(1.0)

→C °Like sounds quite° (0.7) trivial but.

(2.0)
C Even that (0.7) like just (.) puts (0.8) just like (1.3) erm,
(0.4)
C Doom and gloom B(h)as(h)ic(h)ally.
T Mmmmm.
(0.4)
C Yeah
(2.1)
C And then again. °>I couldn't (0.2) probabl- I'm probably quite.<° (0.3) .hhhhh bitter about it (.)°>there was like° five years of my
C childhood (.) that was (.) supposed to be (0.2) good (.) Hhhhh.hhhh and erm. (0.8) it feels like a bit of an injustice really,=
T °=Mmmmm°
C Especially as those people that >I dunno< should have been there to (0.2) prevent it.
(0.7)
C When actually they (0.9) didn't (.) .hhhh erm,
(3.6)
C Errr
(2.7)
C Don't know. (0.2) Who was-
(2.1)
C I'm sure a lot of people had it $worse$,
(0.4)
C >At that time.<
(1.6)
C And like (.) at least I wasn't like (0.5) Erm (0.4)I dunno like (1.5) massively overweight or.hhhh (1.6) whatever else (1.7) people might (0.2) might [bully] you for.
T [Mmmm]

Extract 9, 10-1766, 50:31-52:18

C They obviously don't care because there's been
times when they've come up to me and been
like #oh it's so nice to see you# like
is it? .hhhh £really?£ an' hhh (.) erm,
(1.0)
C So it was obviously to them, (.) didn't mean
anything.
T Mmmmmm.
C Which is a bit (.) kind of like, (0.8) erm,
(3.1)
C °I don't know,° (.) kind of, (1.0) belittles
°the whole thing a bit?° (0.3) like erm, (1.3)
the fact that there wasn't even any like, (1.7)
>thing< (.) hhhhh significant enough for
them to even remember,
(0.8)
T That's (inci[dent to being true]
C [It was just like (.) f]or fun] (.)
yeah=
T =Mmmmm=
C =It was like, they were doing it for the <fun
of it> (.) an, (1.0) yeah (0.4) but, (1.8)
an I do like get upset about it it's like if I
(.) think about it too much (.) an (.) to feel
like °ashamed and humiliated and stuff (.) but,°
(.).hhhhh (.) I kinda think that, (2.0) I'm
like, (1.0) now I do think that I'm better than
them.
(0.5)
C And at the time (.) that's what they thought
(0.2)I thought (.) an (.) >I didn't< (0.4) .hhhh
an now £I do::£, (0.4) an', (0.2)

T °Mmm°
(0.8)
C <°I think that I was°> probably better than them as then as well (.) I wasn't, (0.8) erm, (0.4) upsetting anyone or anything (.) I was doing my work (.) I was, .hhhh (1.2) like, (0.5) <behaving> hhhhh
T Mmmmm
C But, (0.4) They made me feel like I was, (0.2) hhhhh inferior to them.
(0.2)
C >An' that I wasn't< (0.4) £wasn't cool::£ that kind of thing, HHHHhhhh
T Mmmm
→C (h)Wh(h)ic(h)h .hhh (0.4) >£sounds silly now£<
→ but (.) is (.) like, (0.5) <important> (0.2) then (.) I sup[pose,]
T [Yeah].
(1.2)
C Like, (0.2) it's amazing like, coming to university an' (0.6) >just like< (0.2) nobody cares, (.) nobody cares (.) no-one cares what you look like (.) what you do:, (0.6) like, (0.6) there's just too many people an' you just (0.2) you have your friends an' >that's that.<
(0.9)
C Erm,
(2.3)
C >Which is good.<
(0.9)
C hhhh
T We're going to have to end there for today.

Appendix 3. Ethics Approval Letter

The University of Nottingham

Faculty of Medicine and Health Sciences

Research Ethics Committee
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
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NG7 2UH

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16th May 2016

Mark Burdett
PhD Student/Doctorate in Clinical Psychology
c/o Dr Thomas Schröder, Associate Professor in Clinical Psychology
Director of Trent Doctorate in Clinical Psychology
Psychiatry and Applied Psychology
School of Medicine
YANG Fujia Building
University of Nottingham
Jubilee Campus
Nottingham University Hospitals
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Dear Mark

Ethics Reference No: I15032016 SoM DCP **– please always quote**
Study Title: Exploring Method of Level's conception of disruptions in clients' speech and their therapist's responses in therapy.
Chief Investigator/Supervisors: Dr Thomas Schröder, Associate Professor in Clinical Psychology, Psychiatry and Applied Psychology, School of Medicine,
Dr Marco Pino, Marie Curie Research Fellow, Department of Social Sciences, Loughborough University
Lead Investigators/student: Mark Burdett, Doctorate in Clinical Psychology student, School of Medicine.
Other Key Investigators: Dr Nima Golijani Moghaddam, Research Clinical Psychologist and Tutor on the Trent DClinPsy Programme, School of Psychology, University of Lincoln
Type of Study: PhD project, Secondary data analysis
Proposed Start Date: 16/3/2016 **Proposed End Date:** 31/03/2017 15mths
No of Subjects: n/a **Age: n/a**

Thank you for submitting the above application which has been reviewed on 15th March 2016 and responding to the requests made. The following documents were received:

Short Title: Disruptions in Therapy

- FMHS Research Ethics Application form version 1.0, Date: 5/03/2016
- REC application and letter of permission Professor Susan Wheeler, University of Leicester, 08/01/2016.
- Letter of permission from MRes thesis author Caitlyn Cannon, University of Manchester dated 18 March 2016
- Letter of permission from MRes supervisor, Dr Warren Mansell University of Manchester, dated 03 March 2016.
- Notice of Amendment no 1: 12 May 2016 – addition of Dr Marco Pino as second Supervisor.

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that the following conditions are observed:

1. You must follow the protocol agreed and inform the Committee of any major changes using a notice of amendment form (please request).

2. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix 4. Poster for Journal Paper

"That sounds so bad… but it's the truth": Exploring meta-comments in therapy using Conversation Analysis

Mark Burdett, Marco Pino, Nima Moghaddam, Thomas Schröder. Trent Doctorate in Clinical Psychology, University of Nottingham

Aims

- To explore examples of client's "talk about talk" during therapy
- To explore its structural and interactional features, and therapists' responses

Background

Asking clients about a shift in their affect, or other aspects of immediacy are prevalent in a number of therapies. However, therapies usually specify therapist responses, rather than proposing what the client might be doing at that point. Therapies do not specify when shifts in affect or attention might occur, and whether it might be linked to a social action by the client.

Method of Levels (MOL, Carey, 2006) proposes that "disruptions" in clients talk represent transitory shifts in attention.

Peräkylä and Vehviläinen (2003) propose that Conversation Analysis can be used to cmpare therapy theories with transcripts of sessions.

Sounds [x], but [y] (SBs)

Disclaims a negative hearing of the client's talk
Contributes to disclosing an issue to the therapist

Sounds [x]

The client identifies a problematic hearing [x]
Problematic hearing for both client and therapist

Disclaim

Mentioning negative "sound" of talk attempts to defuse the negative (Hewitt & Stokes, 1975)

But [y]

Justifies client's perspective
Discloses a sensitive Issue

Disclosure

Disclaiming negative hearing of talk creates a suitable interactional environment for client to disclose a sensitive issue

Delicacy

Also marked by other features:
Laughter, Quiet Voice, Halting Speech, Pauses, Stopping and Starting Talk

Interaction

Therapists rarely asked about SBs
Therapists commonly used continuers
Some clients pursued a response to SBs

Method

- Recordings of therapy obtained from a university counselling service
- Conversation Analysis was used to explore the data for instances of client's commenting on their own talk
- A collection of sounds [x] but [y] was collected
- Analysis explored the action of sounds [x] but [y] and its interactional consequences for the therapist and client

Discussion

- SBs display competence in Mindfulness, Theory of Mind and Mentalization
- SBs are potentially therapeutically relevant to a range of different theoretical orientations
- Therapists minimally attending to SBs and client disclosures in most cases
- Support was given for several of MOL's proposals
- Potential extensions to MOL's proposals are also made

"It does sound pretty grotesque to be honest, but I get applauded for hurting somebody"

"That sounds so bad. I mean it feels really bad saying that. But it's the truth"

"Which sounds silly now, but is like, important then"

"It sounds childish… but it probably is childish"

Carey, T. A. (2006). *The Method of Levels: How to do Psychotherapy without getting in the way*. Hayward, CA: Living Control Systems Publishing
Hewitt, J. P., & Stokes, R. (1975). Disclaimers. *American Sociological Review*, *40*(40), 1–11
Peräkylä, A., & Vehviläinen. (2003). Conversation Analysis and the Professional Stocks of Interactional Knowledge. *Discourse & Society*, *14*(6), 727–750.