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Original Contributions - Originalbeiträge

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Seeing the Situational Gestalt - Movement in Therapeutic Spaces

'Our aim cannot be to characterize the utterance as an isolated structure, presuming that it may later be slotted into a context. The utterance is inherently emergent within a contingent sequence, pointing on the one hand a step back in time to its social-contextual-psychological motivation (that which brings it about) and on the other hand a step forward to its social-contextual-psychological consequences (that which is brought about by it).' (Enfield, 2011a, p. 59)

1. Introduction – Learning to 'See'

The situation in psychotherapy process research is somewhat surprising. High level empirical research has demonstrated that its former enemy, the so-called camp of 'humanistic' or 'hermeneutic'-oriented methods in research and professional practice has won. I will start with some observations of this ironic situation. Under the battle noise of these two strong opponent camps with deep roots in various traditions of philosophy and scientific theory, the tradition of gestalt theory gradually vanished. During my training as a psychoanalyst, I had the fortune to meet teachers who guided me to understand that the most of 'doing psychotherapy' is an ability to 'see'. Orlinsky and Ronnestad (2005) could find that many colleagues after some years of work found this 'ability to see' as the centre of professional skills. 'To see' means to be gone through a sufficient number of theories with intensive study of each, practicing in their horizon, going to the next and achieve a state where the ability to easily alternate from one to the other becomes part of a professional competence to quickly acknowledge what is required and what should be done. This is not only described for psychotherapists, but also for teachers or nurses. Some describe how the loss of theoretical interests might endanger the whole profession (Benjamin, 2007; Levy & Anderson, 2013). My aim here is to describe 'seeing' in more precision drawing on conversation analysis (CA) which is one of the scientific endeavours which seems to have valuable tools for description of what and how happens in the treatment room and I think a description of 'situations' that can be 'seen' is useful. But I do not claim to have exhausted the number of therapeutic 'situations'.

The ability to 'see' is a common heritage of clinicians with CA. Gail Jefferson, daughter of two psychoanalysts, had a clear idea of that problem:

> That is, there is in the first place a problem about *seeing* these things. They inhabit otherwise ordinary talk ... There are phenomena which only emerge when the surface 'plausibility' is pierced. (Jefferson, 1996, p. 5)

This meant, someone who would not see how a plausibility is pierced could not even do a good transcription. And Gail Jefferson was praised by many for her enormous sensitive perfection of transcribing. Another micro-analytically working sociologist made a similar observation:

> Our ability to see goes in tandem with the expansion of our theories of what processes are out there to be seen. (Collins, 2008, p. 24)[1]

'Seeing' is, of course, a misleading metaphor, wrongly overvaluing the eye and excluding the third ear as it was termed in psychoanalysis (Reik, 1976). The eye controls, the hearing person can be told something. Seeing establishes, hearing immerses. Seeing confronts me with the world, hearing lets me experience a different environment; the environment is perceived spherically. The eye can search, the ear can only wait. Seeing sets things, hearing is set.

Although one can differentiate seeing and hearing in phenomenological reasoning, we find that 'seeing' (in Jefferson or Collins) was meant in analogy to 'hearing' figures of talk emerging across various topics and times, with different materials and opportunities. In German psychoanalysis, Alfred Lorenzer and Herrmann Argelander theorised this observation as 'scenic understanding' (Bohleber, 2013; Buchholz, 2019; Hamburger, 2015; Lorenzer, 2016) which they proclaimed to be the methodological core of psychotherapeutic understanding. However, on the one hand, to take a metaphor ('scene') from the world of theatre was not mandatory; on the other hand, this metaphor had been extremely well established in Erving Goffman's work (1971). Goffman, one of the founding fathers of CA made rich observations of human interactions with a fine eye for details and integrated his observations in coherent theorising. In the 1980s Goffman was widely excluded in the German speaking psychosocial world while gestalt theory led a shadowy existence at the periphery of mainstream psychology. However, both survived under the radar.

[1] And one could add more: "You don't see something until you have the right metaphor to perceive it" (Bowers (1990, p. 132); "What characterizes creative thinking, apart from the intensity of the interest in the problem, seems to me often the ability to break through the limits of the range - or to vary the range - from which a less creative thinker selects his trials. This ability, which clearly is critical, may be described as 'critical imagination'. It is often the result of culture clash, that is, a clash between ideas, or frameworks of ideas. Such a clash may help us to break through the ordinary bounds of our imagination" (Popper (1976, p. 47).

By avoiding constraining implications of theatre-metaphors (Wilshire, 1982) a concept of Situational Gestalt (SG) comes close to 'Scenic understanding', nevertheless SG creates the connection to the world of CA as a powerful tool for the study of therapeutic talk. To replace 'scene' by 'situation' and to define 'situation' with gestalt conceptual tools frees one's thinking from the false opposition between 'positivism' and 'hermeneutics' and offers an experiential base for generating data (human talk) including imagination, as Lakoff wrote:

> ...experientialism focuses on the way we use our imaginative capacities to comprehend what we experience. (1987, p. 210)

Inevitably, studying therapeutic talk turned my interests more and more to linguistic domains. Among others, I studied the work of George Lakoff and Mark Johnson and brought it to the German therapeutic world, while I turned my interests to CA, too. Here, I will introduce the concept of SG as an integration of CA and psychotherapy. I start with some observations in psychotherapeutic process research.

2. How Psychotherapy Process Research Rediscovered Conversation

I start with a short overview of the actual state of the art in psychotherapy process research. The reasons are: First, to demonstrate the enormous potential of CA in offering empirical, theoretical and practical solutions for some problems in analysing psychotherapeutic process. Second, to get a rough outline of theoretical weaknesses of CA for this purpose. When process researchers discover the role of the individual person, this points to a theoretical weakness of CA. I will come back to this in analysing extracts 6–8 and in other analyses of transcripts.

In psychotherapy process research, over many years, a paradigm prevailed which named psychotherapists as 'people changers'. Since this term was coined (Jay Haley in 1971) in nearly every paper on psychotherapy research, the measurement of 'change' tacitly was viewed as the entire goal of research efforts. This situation begins to change. Today, some authors (Goodman, 2016) think psychotherapy has become a colonialistic endeavour and others maintain it 'makes us all crazy' (Watters, 2010). Research attempted to change people from worse to better by application of *technical* tools. A kind of technological optimism in research prevailed over many years. Today, although all kinds of psychotherapy outcome research are positive, we can observe some doubts.

All kinds of bona fide therapies – those with many years of experience, a differentiated theory and teachable treatment competencies – achieve a strength of effect of $d = 0.8$ or higher. This is impressive, compared to many psychiatric pills that

are licensed by the American NIMH with effect strengths of 0.35. So, one might really say, that psychotherapy is an influential endeavour.[2]

However, researchers are not content because they encounter the so-called equivalence paradox – equivalent results are achieved by very heterogeneous processes. And, what is worse, these processes lack unified description. Former editors-in-chief of the field's leading journal *Psychotherapy Research* concluded:

> The disappointing results of our time-intensive process-outcome research (described earlier) challenged our beliefs in the importance of therapist techniques and the value of detailed process research. (Stiles, Hill, & Elliott, 2015, p. 287)

Others (Barber, 2009) uttered similar critics and described the failure (Kazdin, 2009) as something of the richness and specifity of what therapists are doing was overlooked. Bohart and Tallman (2010) provoked by describing clients as 'the neglected common factor in psychotherapy research'. Others demanded to give up diagnoses (Timimi, 2014), and an open-minded behaviourally oriented researcher informs that the NIMH has given up the policy of prioritising research based on formal diagnostic categories such as ICD (International Classification of Diseases) or DSM (Diagnostic and Statistical Manual) (Goldfried, 2019). What guides clinicians' assessment of clients are 'transdiagnostic measures' such as age, gender, spiritual orientation, class, race, and affinity to aesthetics poetry (Norcross & Wampold, 2019). This orientation enables clinicians to create individualised therapies for each client anew (Norcross & Wampold, 2018). The strongest critic came from today's SPR[3]-president, Bruce Wampold, who in 2001 summarised the results of his meta-analysis as worldwide available meta-analyses by a warning:

> In this book, the scientific evidence will be presented that shows that psychotherapy is incompatible with the medical model and that conceptualizing psychotherapy in this way distorts the nature of the endeavor. Cast in more urgent tones, the medicalization of psychotherapy might well destroy talk therapy as a beneficial treatment of psychological and social problems. (Wampold, 2001, p. 2)

A purely technical understanding of psychotherapy (which he names as 'medical'), I repeat, 'might well destroy talk therapy'. A few years later comes a hint to what is considered as helpful:

> The intervention we discuss in this book is still mostly a human conversation—perhaps the ultimate in low technology. Something in the core of human

[2] Doubts come from Leichsenring, Steinert, and Ioannidis (2019).

[3] SPR = Society for Psychotherapy Research.

> connection and interaction has the power to heal. (Wampold & Imel, 2015, p. 2)

What best research finds out is that 'low-technology' approaches, conversation, helps; psychotherapy is a human endeavour realised by a cycle of talk-in-interaction.

It is worth to remember that 'conversation' was something done in salons like in Warsaw, St. Petersburg, Paris, Berlin and in many other cities. The two most important rules in salon-conversation were that 'things should go one' and that every participant should be included. Think of the starting chapter in Tolstoj 'War and Peace', it is a wonderful recapitulation of salon conversation.[4] From the salon, psychotherapists acquired the necessity not to close with a last word, but to find a next one that opens conversation up. In opposition to salon conversation, we have scientific discourse whose participants want to decide certain questions in order to turn to new ones (Miller, 2006). Both origins were combined in Freud's famous formula that therapeutic conversation be a junction of Healing and Researching. Healing in vast dimensions meant to mobilise the memory in order to include the forgotten parts of one's life, this was the salon tradition: to re-member those who were excluded, even to re-mind them. What is to be included is the scientific tradition that forces us to acknowledge that sometimes things can be closed.

Freud brought scientific and salon tradition together in his famous formula that there is no healing without research. Today, too many clinicians overestimate their doing in the treatment room as 'research'. 'Doing psychotherapy' is not research. It is professional work with a high-level conversational art. The art of therapeutic conversation can be researched – e.g. by CA. Of course, one can hope that the study of therapeutic conversation will increase therapist's art and lead to more precisely understand how it is done.

3. Theory and Method – Modelling Therapy as a Social Situation

Goffman once wrote that psychology is interested in men and their situations, whereas sociology must describe 'situations and their men' (Goffman, 1964). Obviously, this is not a matter of fact. Unintendedly, Goffman plays with the possibility to change background and gestalt. You have two elements. Seeing one in the foreground relegates the other into the background – and this can alter from moment to moment. In talk therapy, we cannot imagine a situation *without* men

[4] The term "Gesprächsmaschine" ("machine of talking") was created by Leo Tolstoj (2010, pp. 19–20) for his description of what people in a salon do. CA-author Levinson (2006) described the 'interaction engine', he has not taken it from Tolstoj – but he might have. Both concepts fix a relevant observation of conversation in the same term.

or a man *not* in a situation. However, *conceptually* we can distinguish psychology and social science.

In order to conceptualise 'situation', both attitudes – psychological or social in the foreground – are best thought of as in a chain, linked by expectations participants have (Huron, 2006). Musicologist David Huron sees expectations based on 'imaginative scenarios' producing 'tensions,' which lead to 'predictions' of what will happen next. The 'reaction' then is 'appraisal' – I say 'hello' to my friend passing along and I feel a little tension if and how he will greet back, my prediction is that he will and if he does, I am happy – if not, I will have to change my imaginative scenarios. In listening to a piece of music, I enter an imaginative scenario hearing melody and beat and I am surprised if things suddenly change rhythm and musical gestalt. I realise that I have to change my imaginative scenario that guided me to this point of my listening and, after some experience of that kind, I come to understand that composers aim to surprise. Observable actions give reasons to make inferences. This theory comes close to Nick Enfield's theory of 'enchrony' – 'a generic mechanism that yields sequence, relevance and accountability' (Enfield, 2011b, p. 303). Here, it suffices to see that expectation is a focal element for conceptualising a situation. 'Situation' is a term too often used without any definition of beginning or ending or altering.

Here is a theoretical offer:

> Situations begin when mutual monitoring occurs, and lapse when the second person has left. (Goffman, 1963)

One crucial element is mutual monitoring, which from the start operates recursively:

> Persons must sense that they are close enough to be perceived in whatever they are doing, including their experiencing of others, and close enough to be perceived in this sensing of being perceived. (Goffman, 1963, p. 17)

The recursive effect can take two ways: two people decide not to go beyond 'sensing of being perceived' (think of two people in an elevator) – even then, they have to execute a minimum of cooperation: mutually observing to avoid recognition with gazes to feet and rushing to leave if possible. Another imaginative scenario was described by Harvey Sacks: both can

> … show each other that whatever it is they're doing together, they're just doing together to do together. (Sacks & Jefferson, 1992/1995, p. 147)

Situations present options, participants have choices. 'We know how our actions will be taken by others, and this is how our communicative actions are shaped' (Enfield, 2011, p. 60).

These observations can be made in a double fashion, describing observable 'doings' or describing expectations. Both are equivalent parts of a situation. Many CA-authors described how adjacency pairs (greetings, saying thanks, etc.) are steered by expectations which, if violated, cause 'trouble'. Expectations are elements of situations. My empirical question now is: how do things go on in a therapeutic conversation? Is there something that we can use to enrich the concept of a situation for further purpose? I will try answers tentatively.

3.1. Illustration

In the 1970s Amalia was a patient who suffered from hirsutism, a malady that made her body, especially her face, look haired. She was desperate as no medical treatment could help and she was sent to psychoanalytic treatment, conducted by Prof. Dr. Helmut Thomä in Ulm, Germany. This treatment is documented as very successful; Amalia could overcome her fear of men, to expose her body to the interested gaze of others when she has left treatment after more than 500 sessions. All sessions were audiotaped and transcribed in Ulm. I take a segment of session 152:

3.1.1. Extract 1 (Amalia, session 152)

P: das hab ich (1) vielleicht im Studium mal getan [(-) da hatt
I did this (1) perhaps during my studies [(-) there I had
T: [Ja
P: ich so ne Zeit [(1.2)
Such a time [(1.2)
T: [Ja
[Yeah
P: und das kam jetzt auch wieder (..) eben durch Sie ausgelöst worn
And this possible now again (..) was triggered by you
T: hm hm
hm hm
P: und DA! =will=ich=so ein GANZ (.) kleines bIßchen (.) n Loch
And THERE!=I=want=so=quite (.) a little bit (.) hit a hole

in den Kopf (.) in den
in the head (.) in the

T: °mhm°
°mhm°

P: Kopf! In den Kopf (.) schlagn=
Head! Hit in the (.) head=

T: =mhm ja=
=mhm yeah=

P: =und da ein bißchen was von=von °meinen Gedanken rein tun°
=and insert a little bit of=of my thoughts °in there°

T: mhm
mhm

P: °°so°°. Das kam mir neulich (..) ob ich nicht ein bißchen
°°so°°. This crossed my mind recently (..) if I couldn't

P: IHR=Dogma (.) gegen MEINS austauschen kann
YOUR=Dogma (.)exchange a little bit against mine

T: mhhhh.=mm ((ansteigende Intonation))
Mhhh.=mm ((rising intonation))

Three times it is rhythmically repeated: Amalia wants to hit a hole in the therapist's head. She diminishes the value of this statement twice: a little bit. While she speaks of hitting a hole her rhythmic speaking demonstrates that she is using a hammer. One can hear this. But her voice is soft and tender. Her intention is clearly pronounced: she wants to insert some of her thoughts in the therapist's head. The implication of this utterance needs not to be said, but she reformulates it: to exchange 'a little bit' his dogma against her's. The semantics of hitting a hole is aggressive which is underlined by the joyful spoken repetitions, but her voice is tender and her idea can be understood if one takes into account that psychoanalysts are said to be shrinks with hard heads – metaphorically speaking. She formulates that he is too attached to his dogmas. What she says is undoubtedly something where Amalia wishes to open the therapist's mind. She concludes her move with a typical deontic 'so', closing the main part of her message, which indicates that the therapist is to take the turn. However, a short subsequent statement ('this crossed my mind recently') downgrades the actuality of her utterance

disposing the origin of her thoughts to a former time. Here is how the therapist conceptualised this situational expectation:

3.1.2. Extract 2 (Amalia, Session 152)

Th: it's certainly about (.) err actually also (.) so (.)
Th: es geht ja (.) öh wirklich auch (.) so (.) much >about about< thoughts >and (.) and< err
sehr >um um< Gedanken >und (.) und< äh was is in the head [even is
das was im Kopf ist [im Kopf
A: [yeah
A: [JAha
Th: in the head err what you think what I think [and much
Th: auch ist äh was Sie denken was ich denke [und sehr
A: [yeah
A: [ja°ha°
Th: more to come over these thoughts to who you are and who I am
Th: viel mehr über die Gedanken zu dem zu kommen was Sie sind und ich bin

This is a rare example of what Goffman describes ('perceiving being perceived'), articulated in words. These words transgress the embodied dimension of 'perceiving' by an important procedure: Not only do participants *see* each other mutually with their eyes exchanging gazes. This embodied experience of 'seeing and being seen' is transposed to the sphere of two minds: 'It is about thoughts … and what is in the head … what you think that I think' in order to step 'through thoughts' to a new perception 'what you are and who I am'. The embodied Goffmanian Situational Gestalt is preserved *and* transformed into another sphere in three steps:

a) bodily exchange
b) mind-to-mind (think),
c) person-to-person (encounter)

The embodied 'perceiving being perceived' serves as template to model the following two levels. The phrase 'to come through thoughts' uses a bodily metaphor

of walk as imaginative scenario for a trajectory[5] – via spheres of meeting minds, then each other as person. The Situational Gestalt remains the same, transforming the verb 'to see' in an extended metaphorical use, which the patient can follow without difficulties. This step into some empirical data shows how a therapeutic situation beginning with Goffmanian 'perceiving being perceived' proceeds not only in time but in building-up additional levels of meaning which are negotiated by both; these levels are not fixed from the beginning, they are process and result of conversation. The therapist responds to the patient by delivering a 3-step-frame with higher potential to integrate the patient's thoughts and to propose new targets; a response is delivered in a form as if it takes the target-component as articulation of the patient's unsaid-but-meant imagination.

Is 'understanding' a sufficient description for what therapists do? The answer is no, if we think guided by an equation like 'understanding = decipher'. This is the widely used self-understanding of 'understanding understanding' (Brinkmann, 2020), or, as can be found in Dilthey, 'higher' forms of understanding. In hermeneutics (Detel, 2011) and phenomenological traditions (Waldenfels, 2007) new equations relevant for therapy were developed (Gallagher, 2009). Brinkmann (2020) proposes the equation 'Understanding = response to the other's request' (in German: 'Antwort auf den Anspruch[6] des Anderen'), which seems useful for therapeutic purpose. My next question is:

3.2. Can we define 'Situation' in abstract Terms?

I want to add some further dimensions of situations, taken from philosophy and phenomenology. There are at least three general dimension of a situation (Markowitz, 1979):

3.2.1. Opening up options – creating expectations

Social scientists often use the term 'horizon', conceptualised as *opening* of unlimited possibilities. However, one of them can be realised only if it is broken down in sequences of steps. The moment you *select* one, a horizon loses its quality as 'universe of possibilities' (Markowitz, 1979, p. 72 ff.); you cannot simultaneously go towards and away from it. You must take your choice and control the steps. Nevertheless, horizon remains in the background as 'imaginative scenario' (as Huron might say), the foreground being determined by the object or topic or project that two people want to do together doing together. E.g., doing 'pointing to' or 'talking about' or 'walking along' or 'proceeding to'. How such projects are formulated has far-reaching effects, which are by

[5] See Deane (2005) for an analysis of the image-schema for over.

[6] The German word *Anspruch* has a double meaning as 'claim' and as 'feeling addressed'.

no means always clear for the participants. The definition of project, object or topic must somehow be achieved, Enfield (2011b) describes relevant asymmetries. The possibility to exclude other options creates bifurcations in every step: A situation delivers an option to participate – or not, participants can name elements as limitation – or as opportunity, as unparalleled or often met; with reference to participants' agency (Enfield, 2017), you can find yourself 'in' a situation or experience and describe as coming over you. What your choice is – you co-determine what follows.

3.2.2. Selection of options – situational asymmetries and 'doing contrastivity'

A CA-term that applies here is 'deontic authority' (Ekberg & LeCouteur, 2015; Stevanovic, 2018; Stevanovic & Peräkylä, 2012), as a 'weak' form of authority suggesting further actions while staying dependent on agreement or refusal. It is the moral commitment – always to be acquired – to propose, but not to command. Articulating expectations you expose yourself to unexpected resonances (against which some ritual practices grant some protection in order to increase the opportunity of next steps). You cannot escape the power of this interactive field; affectively[7] and epistemically you contribute with more or less high levels of engagement. The more you focus on central topics the more you weaken your attention for others. Situations create a gestalt-distinction between 'topic' and 'side issues' resulting in interactional 'asymmetries' (Enfield, 2011b). To select an option is a risky endeavour, which can be counterbalanced by using other means. It was an early observation (Jaffe, Beebe, Feldstein, Crown, & Jasnow, 2001) that high levels of embodied synchrony (head nodding among adults) are shown among people who do not know each other well. Desynchronisation can be observed if some relaxation in the relationship occurred. In talk, the same holds for rhythm and other phonological aspects that become relevant in order to balance asymmetries (Bazan et al., 2019). In CA-literature, the term 'doing contrastivity' applies here. I take it from a CA-paper on interaction with children (Tarplee, 1996), where mothers were observed correcting their young children's incorrect language use – not by corrections 'but as re-elicitations' (p. 426). 'Doing contrastivity' can be used in order to understand how people sometimes topicalise a meaning while at the same time use other conversational means to articulate contrast *against* other meanings which are *not* meant. Multimodal synchrony serves as regulation for asymmetries in situations.

[7] '…emotion, as emergent in a social situation, is taken as a phenomenon that is presumed to be orderly and consequential to the ensuring course of interaction...Thus, a potential display of emotion, that is, an action that is interpretable as affective, is something that can be and often is notified or addressed in succeeding talk or other activity' (Ruusuvuori (2007, p. 598).

3.2.3. Controlling options – 'my mind is with you'

What follows as third element of a situation is that participants try to gain control – next steps, the situation in general or with respect to self-regulation. People try to assess their 'effectiveness': how strongly move A influences a respondent's move B is 'forward direction' of timeline. Enfield (2011b) points to the further aspect of 'appropriateness': Speaker A assesses if B's move is appropriate in quality to move A. The timeline of this move is directed backwards. The response to inappropriateness is from *surprise* to *sanction* (Enfield, 2011b). Both aspects, effectiveness and appropriateness, are summarised as 'enchronic', adding relevance to the time structure of a situation.

Whatever it is, a noise production, a smile, a glance – the interaction recursively installs a 'second level': not only doing together but doing together to do together, to assess effectiveness forwardly and appropriateness in a backward direction, to move into a situation and to assess and think and have emotions influenced by the situation. In all these aspects, participants are doing together to do together and unavoidably have to keep in mind the other person's mind. And more:

> …there are enormously elaborated ways in which we bring off that 'my mind is with you' - I use that rather loose sounding phrase and you might figure that it could get shot down, but we'll see in due course that people really can achieve showing that 'my mind is with you.' (Sacks & Jefferson, 1992/1995, 166 ff.)

How is it that one party shows 'my mind is with you' to the other? Formulas as 'doing together to do together' and 'my mind is with you' name the field of study, they do not precisely describe or even explain what takes place. Here, I want to describe the steps two participants take in a therapeutic setting when they come to what Karl Bühler (1934) has called the 'Deixis am phantasma'. Bühler knows three modes of pointing. The first he calls pointing to something in the space of immediate perception (*demonstratio ad oculos*); the second is pointing to spoken elements in the context of speaking (*anaphora*); the third requires a transposition of the *origo* as embodied starting point of our orientation to an *imagined* place in the mental space. This is the entire *Deixis am Phantasma* (Bühler, 2011 (1934))[8]. Huron's 'imaginative scenario' can be viewed as describing something very similar found in musical, not in linguistic tradition.

Phantasmatic deixis generates what was aptly named 'mental space' (Ehmer, 2011). Ehmer (2011, p. 51) argues that cognitive linguists consider meaning as generated by conceptualisation whereas CA views 'social meaning' produced by

[8] The glossary added to the English edition of Bühler's book states by way of explanation: "The particular point of Bühler's construction is ... that the demonstrator does not just point at the phantasy product, but can also show the hearer around it in imagination" (Bühler, 2011 (1934), p. 487).

ethnomethodical acting. Ehmer's strong argument is that CA has the potential to analyse mental space too. Mental spaces can be created by what he describes as animating speech, using practices such as 'embedding a figure', changing from symbolising to *phantasmatic* demonstrations (pointing) in local repetitions, fictionalising practices building up *fictional* spaces, evocations and metaphors. Animating practices of speech can put participants in a whole other world shared imaginatively while absolutely realising to share an acoustic world of talk. To control for that mental or even fictional spaces remain shared in the therapeutic session is the responsibility of therapists.

4. The Material

The material is taken here from various resources. One is 'the student', a psychodynamic short therapy of 28 sessions. This treatment is well known (Buchholz, 2014). Another source is Amalia, the patient described above. The whole treatment impressed many researchers (Buchholz, Spiekermann, & Kächele, 2015) by the therapist's skilful talk, his ability making hearable turning his attentiveness to his patient and his tone, very rich in modulations. He makes hearable what he is doing. A third source is the CEMPP-Project, conducted at International Psychoanalytic University (IPU) during 2014–17 under my leadership[9] and that of Horst Kächele. We had under study 15 complete therapies of psychoanalytic, psychodynamic and behavioural (CBT) orientation,[10] from which we extensively studied early and end sessions and of the middle phase of treatment. In order to create comparisons between these treatments we distinguished various types of therapeutic situations.

5. Results – Three Therapeutic Situations

5.1. Co-constructed utterances

A co-constructed utterance (CCU) is very often observed; in everyday observation we hear people talk like out of one mouth. The most obvious phenomenon is that people mutually complete their sentences or that they seem to operate as prompters. The effect of which is that suddenly they seem to have acquired the ability of mind reading. They take each other's turn without hesitation and no 'trouble' seems to happen.

Here is a clear definition of CCU:

> In the most frequently studied type of collaboratively constructed utterance, one speaker begins an utterance in a way that projects possible completions.

[9] This project was promoted by a generous grant from the Köhler-Stiftung (Germany).
[10] Thanks to Prof. Dr. Dorothee Huber from the Munich Psychotherapy Study (Huber and Klug, 2016).

> Another speaker then contributes utterance elements that are incorporated into a jointly produced utterance. The acceptance by participants of a collaboratively constructed utterance is strong evidence for the establishment of common ground understanding. (Hutchins & Nomura, 2011, p. 29)

Auer et al. (1999, p. 57) add that rhythmic cues guide the 'inference making machine' (Sacks and Jefferson, 1992, vol 1, chapter 14) of conversationalists: what will still follow? Can I take the turn? Others (Gotsbachner, Mroczynski, & Ziem, 2015) speak of 'concurrent experiences' (p. 76) and these linguistic authors add something close to therapeutic experience:

> Through a collaborative completion, the communicative act of claiming to be able to 'read' someone else's mind, which is rather risky in other forms of realisation, becomes acceptable and even an expression of empathy and intuition. (p. 80, my translation, Buchholz)[11]

These definitions are clear. Here are extracts of these situations from our material: at first an example of an ambiguous CCU.

5.1.1. Extract 3 – CCU (CEMPP, Psychodynamic therapy, beginning)

P: das wa:rn (-) ne ganz große: (-) Entlastung;
This was (-) a huge (-) relief;
T: mh=[hm,]
Mh=[hm,]
P: [°so] als wie so als wär mir ein Felsblock vom Herz
[°so] as if as so a boulder from my heart
[gefallen;°]
[had fallen]
T: [°ah=ha°] .h des AUSSPRECHEN zu können;
[°ah=ha°] .h being able to speak that out
P: mh=hm,
mh=hm,
T: mh=hm;
m*h=hm;*
(--)

The patient delivered a narrative finished with a metaphoric coda. The metaphor of the boulder serves as an emotional intensifier; it is an often-used phrase from

[11] Original in German: "Durch eine kollaborative Ergänzung wird die in anderen Realisierungsformen eher riskante kommunikative Handlung, zu behaupten, jemandes anderen Gedanken ‚lesen' zu können, akzeptabel und sogar zu einer Bekundung von Empathie und Einfühlungsvermögen."

cultural knowledge. This is why the therapist can deliver his change-of-state-token (Heritage, 1984) while the patient is ending the phrase; the therapist can predict the end of the patient's words. Delivered as 'parallel-speaking' both co-construct this utterance with the effect as if the 'boulder'-metaphor has changed something for the therapist. He takes the task to document his correct understanding in a special way. On the one hand, his re-translation of the metaphor downgrades the metaphorically produced intensifying effect. On the other hand, emotional downgrading implicates a correction which is buffered by the prosody (°ah=ha°) of a 'change-of-state'-token (Heritage, 1984). Both elements do not fit neatly together. The therapist is 'doing contrastivity': trying to sustain a participating emotional relationship and trying to correct the emotional intense boulder metaphor. The tokens do not allow to assess the 'effectiveness' but mutually confirm 'appropriateness'. Thus, closing the situation by mutually 'mh=hm'-exchange is not a sign of deep mutual agreement, but a silent consent not to discuss here the contrastivity provoked by the therapist's remark. This is an example for an ambiguous CCU.

5.1.2. Extract 4 – CCU-entrainment (Amalia 152)

A more complicated gestalt of a CCU in the next example is subdivided into a phase of entrainment, followed by a groove. Unavoidably, entrainment is not referred to as agreement in factual or technical terms, but on a personal level, which anticipates a higher risk of a derailment. In *entrainment* a 'shared attentional space' is to be prepared, which is expected to be filled in *groove* when both speakers produce utterances 'out of one mouth' manifesting their shared intentionality.

A: °oh, you know sometimes (1) I feel like (1)
°ach, wissens manchmal (1) hab ich das G'fühl (1)
I should rush up to you and seize your neck and
ich müsste auf Sie zustürzen und Sie am Hals packen und ganz
hold it tight and then?
festhalten und dann?

Th: mhm
mhm

A: then I think he won't cope with it, he won't stand it
Dann denke ich, das schafft der gar nicht, das hält der gar nicht aus

Th: mhm
mhm
A: then I see somehow how you (2.4) BURN
dann seh ich wie Sie auch irgendwie (2.4) BRENNen

Beginning with an injection (°oh,), her 'you know' indicates that something of interest will follow and that the recipient is expected to respond with increased attention. Amalie directly seizes her therapist's attention whom she perceives as perceiving her informing him about her feelings to rush up to him and seize his neck ending with a questioning prosody. The therapist's continuer token indicates that he won't take the turn. With 'then' Amalia continues telling about her feelings and that she thinks the therapist won't stand it. Not in interrogative morpho-syntax her question is delivered: will he cope with her and stand her attack? The risk of a possible derailment is clearly marked. She describes her imaginative scenario, her tension, makes a prediction, expects his reaction and in just the fourth position of Huron's scheme (see above) she stops (pause of 2.4 sec) as if reminding herself not to give up with a negative assessment, but that her therapist has better qualities. The effect is that she downgrades the risk of negative assessment (and severe disappointment) by remembering herself that she sees him 'burning', a metaphor aimed to describe her view of his therapeutic engagement for her. The use of 'I see (you)' might be viewed in another terminology (Fonagy & Allison, 2014) as indicating the existential question of 'epistemic trust'. The story continues:

5.1.3. Extract 5 – CCU-groove (Amalia 152)

Th: that I don't stand it that I [err
Dass ichs nicht aushalte dass ich's [äh
A: [YES
[JA
(1)
(1)
Th: >that I don't bear it, can't bear you< a::nd=
>nicht ertragen kann, Sie nicht ertragen kann< u::nd=
A: =yes: that I hold you tight
=ja: dass ich Sie festhalt
Th: mhm
mhm
A: mhm
mhm

The therapist reformulates Amalia's intention and Amalia co-constructs this formulation by filling the 'slot' with her injections and fast turn-connections. The therapist starts with an incomplete sentence: 'that…', where something like '*You think*, that I…' is omitted (Scarvaglieri, 2013). After reformulating 'don't stand' to 'don't bear it' and then to 'don't bear you' (with focal accents on the final syllables) he slows his talk leaving it unfinished with an extended 'a::nd' – Amalia fills the gap, completing what she thinks the therapist intended to say: That he might fear not to bear being hold tight by her. The sequence ends by a mutual exchange of agreement tokens. Alignment is altered without trouble, the hearer becomes speaker, 'perceiving being perceived' is realised by 'speaking out of one mouth' as if both had the same intention. Everything is talked about in a metaphorical state of deixis, again. She does not really 'hold him' with her real hands. No decision is required if her 'holding him' might originate from love or aggression. This type of motivational topicalising would distract attention from the skilful arrangements of conversational steps: from creating a 'shared intentional space' to 'shared intentionality' (to continue working) to a kind of 'we-intentionality' which responds to Amalia's open question for 'epistemic trust'. One might conclude with far greater certainty that Amalia herself does not know if her imaginative scenario of 'holding tight' her therapist might be rejected by him? This is the existential 'question' to which a 'response to the other's request' is to be given in therapy as 'understanding' and empathy. If 'to understand' means 'to respond to an unformulated question' we can in a subtle fashion follow how the risk of interactive derailment is mastered by both; the question is answered by raising it to a higher level. The answer gains its persuasive power from the therapist's participation.

5.2. Agenda-Transforming Utterances

An agenda-transforming utterances (ATU) is a quite different scenario in interaction. Imagine a situation in which a teller reports an event. The recipient would respond with: 'What do you want to sell?', thus, categorising the telling as a deal with a certain degree of untruthfulness. The whole agenda or scenario were transformed as if it was bordering on dishonesty or even fraud. Local roles rapidly change: the teller is named a seller, the recipient becomes a customer who feels uncomfortably touched by being expected to believe in doubtful or untrue things. Many therapeutic interactions are of this kind, however in a positive direction. When a patient says furiously, 'I am so angry', many therapists reformulate (Antaki, 2008) this by using 'indignance', e.g. 'when you were so indignant you could not think clearly'. It is easy to see how the agenda changes. A more simple case is a technique of downgrading, when a depressed patient talks to be 'always so completely despaired' and the therapist

uses the next opportunity to talk of the patient's state as being 'sometimes cast down'. Such a re-formulation alters the agenda: desperation is a state within the individual, being cast down opens the path to an interactive event. Here is an example:

5.2.1 Extract 6

```
Cl: I am surviving and I am
Th: But it feels (.) doesn't feel right
Cl: It feels a little uncomfortable
Th: Or a lot uncomfortable.
Cl: It feels a l(hoh)ot unc(huh)omfortable actu-
    ally (Rae, 2008, p. 64)
```

Rae speaks of 'lexical substitutions' that have the effect that a patient can admit to have downgraded his feelings in his utterances. Such lexical substitutions show that not only therapists do 'understand' (Madill, 2015) that therapists are not simply 'empathic', but they 'challenge' their clients' self-descriptions (Voutilainen et al., 2018). Challenging is the other pole of the continuum. Therapists can help after adequately naming feelings.

5.2.2. Extract 7 – ATU ('Student', first interview, self-description of symptomatic behaviour)

Altering a verb of a patient's self-described activity transforms the agenda. In the first minute of his first interview the 'student'-named patient self-describes his obsessive-compulsive behaviour:

```
P:  =also so °Kontrollzwang° (-)
    =thus so compulsory control (-)
P:  Verhalte also so Kontroll zum (..) also
    wenn=i=also zum
    =behave thus so control at (..) so when=I=so
    for
    Beispiel aus der Haustür rausgeh dann net
    aber
    example go out of the house door then not but
    wenn=i=rEIngeh [dann=
    when=I=go into [then=
T:                 [H:m=H:m
                   [h:m=H:m
P:  =guck=i=hi:n (.) nach hinten=
    =I=look=towards (.) towards behind=
```

T: °mmh=mmh°
°mmh=mmh°
P: =un kontrolli:er ob=i=au=nix vergesse hab oder so
=and I contro:l that=I=haven't forgotten anything or so

5.2.3. Extract 8 – ATU ('Student', first interview, therapist's agenda-transforming proposal)

At the end of the same first interview, the therapist changes the agenda with a proposal:

T: dann haben Sie keine Ahnung, was dieses Gucken bedeuten könnte.
then you do not have a hunch of an idea what this looking could mean
P: nee, (lacht etwas)
Nay (laughing a little bit)
T: das müssen wir rausfinden. was Sie da eigentlich gucken, wozu Sie da gucken,
this is what we must find out. What you entirely look, what you are looking for
P: also, ich hab mir schon immer überlegt, bin ich so materialistisch orientiert daß ich Angst habe daß ich was, liegen lasse was vergeß, aber das glaub! ich nicht weil ich das ja, im Schlafanzug mach oder in der Badehose, das ist was anderes äh,
well, I've always wondered, is it that I am so materialistically oriented that I fear I leave something behind or forget, but I don't! believe as I do this in pyjama or swimming trunks, it's something different err,
T: hmhm
hmhm
P: es ist; steht in keiner Rea- Relation da mit dem was ich über- überwachen kontrollieren, könnte und wollte, äh wie, also so stark wie sich das äußert gell,
it is in no rea- relation with what I could or would guard or control, err how, well how strong this makes itself felt very strongly

T: hm ja also das wird uns dann beschäftigen was Sie da gucken, was Sie da suchen, suchen?
hm yeah well this will keep us busy then what you are looking, what you seek, seek?

P: hm suchen kann man schon sagen ja, (lacht leicht) net nur, kontrollieren sondern schon suchen.
hm seeking one can say, yes (slight laughter) not only controlling but already seeking.

The change of agenda from 'control' to 'look' and 'seek' has the following aspects: The patient complains of his behaviour as controlling and he seeks support for better control of his controlling behaviour. Within this complaint-frame, he controls not to forget anything and mandates the therapist to remove control – but then, it would follow, that he prefers to forget things. The control-frame is contradictory in itself; he tries to cast out the devil of control with the Beelzebub of super-control. If a therapist could help him to give up control, he would soon complain that he now forgets things, more than before. This is a well-known trap (Arden, 1984; Bateson, 1978) for psychotherapists. Therapists cannot simply fight a symptom as it might be expected in medicine. The complaint-frame is to be changed because it implies to fight.

From the moment the patient realises that his behaviour is better described as 'seeking', the control-frame is removed. Seeking is an activity necessary if you miss something. Within the seeking-frame his doing becomes acceptable for the patient. However, new questions arise: What is it he looking for? Why at the house entry? When leaving or coming home? These questions cannot be fought against, a new frame is implied: not to control, but to find out something.

What is it that enables the therapist to deliver a re-formulation? Therapists hear a narrative (the patient's complaint) and they request patients to tell in a as-rich-as-possible fashion complaint-scenarios. These scenarios, imaginative or interactive, enable them to find new descriptive terms with the effect that they acquire new meanings within new frames.

5.2.4. Extract 9 (28. Psychoanalytic session, female patient, actualised translation from German)

A quite similar gestalt of a situation could be described (Buchholz & Reich, 2015) in the analysis (including prosody) of the first 10 minutes of a female obsessive-compulsive patient. She begins her 28th psychoanalytic session in presenting her

mental state as improved, she confirms to her therapist that she had no obsessive-compulsive thoughts (OCTs); here is the beginning of the session:

(37)
P: I managed to while away the hours really well yesterday (2) and (3) I don't remember (-) having any obsessive thoughts? (2) nor when I was somehow driving home (2) and then (2) <I was at home for some time> and um (2) then I drove to Landsberg with a (girl)friend (3) a:nd (-) there we met two kind of :: (1) old friends of ours and went to the swimming pool for a bit and (1) after the weather wasn't so good then um (1,5) went into town for a bit as well <got something to eat> and then um (..) an ice cream afterwards an::d (1,5) yeah and I was really (1) able to switch off well again.
(4)
P: well, I::
T: °>mhm<°
P: didn't notice, that somehow something was coming (2) something somehow was creeping up on me, that was all
T: °good°
P: somehow really=really far away
(15)
T: you didn't actually while away the hours, you ENJOYED it (smiling voice).
P: yeah exactly haha (laughs) that's right! That was bad wor(h)d(h)ing [haha (laughs)]

The patient's report is prefaced with the patient's frame for her telling: She managed to while away the hours of the day. The pleasing information that no OCTs showed up should not lead one to overlook that these reports are delivered with a very flat voice (see our PRAAT-Analysis in Buchholz & Reich (2015)) and that she does not present a narrative heading for a climax of tension (Peräkylä et al., 2015) but a report-format where each element is chained to the next by elements like 'and then', which fits to the impression of emotional flatness or vagueness. Turning attention to the way how she presents her symptoms, one can see that she reports in a fighting-frame: she didn't notice 'that something was coming', that nothing was 'creeping up on me'. Speaking, she points in a phantasmatic deixis to her symptoms as if these were active, hostile agents and she unfolds

her scenario that the enemy was 'really=really far away'. To my knowledge, this phenomenon of a fight-frame (not interpersonal, but intra-personal) has not yet been described in CA-literature dealing with psychotherapy. But it is well known in texts analysing the use of metaphors describing experiences as persons (Asch, 1955; Fiksdal, 1999; Fitzgerald, 1993; Hobson, 1985; Shotter, 1985). The fighting-frame implies that she has not won the war nor ever could.

After 15 seconds of silence, the therapist takes up the preface that framed the patient's report. With a smiling voice the therapist actually replaced 'whiling away' by 'enjoyed it', with a strong focal accent – and the patient responds with a liberated laughter short and quickly followed by her self-criticism ('bad wording'), but her laughter endures.

ATUs were termed by the American linguist and conversation analyst Tanya Stivers (2007); they transform interpretations of the other's agenda, are powerful in therapeutic work and a cumulative set of agenda transformations holding powerful insights. They are conversationally used to mutually access the other's 'mental scenario' (Enfield, 2011a) or 'imaginative scenario' (Huron, 2006).

Turning attention from the conversational format (preface) to the fighting-frame and finally to her metaphorical self-description as a person who sees herself persecuted by something coming or even creeping, it is surprising to see that one clinical author includes a quote from Hippokrates, which is relevant here:

> I would rather know the person who has the disease than know the disease the person has (Hippokrates) (de Bilbao, 2011, p. 877)

This is echoed in the psychotherapeutic process research debate I mentioned. It is interesting that modern authors come to similar conclusions:

> As Sir William Osler (1906), father of modern medicine, wrote: 'It is much more important to know what sort of a patient has a disease than what sort of disease a patient has.' The accumulating research demonstrates that it is indeed frequently effective to tailor or match psychotherapy to the entire person. (Norcross & Wampold, 2018, p. 1890)

If these authors and their quoted elder authors are right, one future task for CA emerges: to invest theoretical energy in a CA-based theory of how a 'person' is to be conceptualised in CA. Obviously, this can be considered as relevant for understanding psychotherapeutic process (Buchholz & Kächele, 2017; Keselman, Osvaldsson Cromdal, Kullgard, & Holmqvist, 2018).

5.3. Typical Problematic Situations

Typical problematic situations (TPS) is a term recently introduced (Buchholz, 2016, 2017). Therapists know a lot about TPS, e.g. if a patient comes late, does

not pay the bill or threatens with suicide. Besides these macro-analytic descriptions, there is an unknown number of micro-analytically describable problematic situations.

5.3.1. Extract 10 – TPS 'asking the wrong person' (Amalia 152)

One of them is that therapists are asked questions they *cannot* answer (not: that they won't answer!). Here is an example; after Amalia's extended telling a dream and the therapist working with it, she asks:

```
A:  °glauben Sie das selbst, da:ss der Traum mir
    weiter hilft?° °°is noch so fremd jetzt doch
    noch°°
    do you believe that yourself, that the dream
    will help me?
    °°It's still so strange now after all°°
(2)
Th: Ja:: es ist [ja eine=eine
    Yeah: it is [yeah an
A:              [((?? °°ich will hab Ihn:°° ??))
                [((??  °°I want have it°° ???))
Th: äh ähm (-) m::h
    Err erm (-) m::h
(1)
```

After about 20 min of work with a dream told at the beginning of the session, she asks her therapist if he believes that the dream will help her. This question, taken literally, is unanswerable for the therapist. Only Amalia herself could answer this question. However, the therapist tries – and immediately begins with hesitation markers that have the effect of self-interruptions and trying to buy time by stalling. Imagine, Amalia had asked, if the therapist believes that their common working on the dream would have helped her; even then it is not the therapist who could answer this question. But he tries and quickly stumbles into a situation where the 'interaction engine' (Levinson, 2006) stutters and stops.

What makes this situation problematic? One may answer that even therapists do not easily admit to having no answers. This might be a psychological reason, which we don't need to follow. However, there is a conversational double meaning in Amalia's questioning. One reason, readable on the surface, for the therapist's confusion is that her question conveys doubt about whether the session itself was helpful – or not. Heard in this way, it's not a question, but a statement of doubt – hidden in a question format.

On the one hand, the therapist might tell the patient that it is not him who has to answer; her question is only for herself to decide. This amounts to responding with something like 'I don't know' or 'How can *I* know?'. On the other hand, because he senses her doubts, answering 'I don't know' or 'How can I know?' risks to be fatal for a fruitful continuation of the therapeutic relationship in the future. She could wrongly take it as his admission that he does not know whether what they are talking can help her. To answer the *question* in that way would enhance his epistemic authority, but the same answer conveys a downgrading of his authority if heard as response to the doubtful *statement* Amalia implies. The therapist's problem is not 'effectiveness', but 'appropriateness' (Enfield) depending if his answer is heard in this way or the other. He assesses in advance how his response might be heard in Amalia's ears and senses the risk for future work.

The clinical value of this analysis is that it might be helpful for therapists to oppose to questions of such a form that includes doubtful statements. This 'double meaning' obviously appears on the surface of the conversation and can be heard if the therapist's hearing is sensitized for this gestalt. While we have here a subtle doubt disguised in question format there are more complicated 'silent' transformations of the whole situational gestalt.

5.3.2. Extract 11 – TPS (CEMPP-project, beginning of a psychodynamic therapy, 'silent transformation of the situational gestalt')

In order to understand the following extract one must know that in German adults address each other with 'Sie', not with 'Du' – and both salutation formats are translated in English as 'you'. The German 'Sie' is used for professional relationships, between doctors and patients, among teachers and parents, in administrative customer service – but not necessarily between teachers of the same school faculty. 'Sie' is connected with addressing each other on surname basis, 'Du' with first names. However, in oral speech the 'Sie' can sometimes be heard as 'sie'. A German sentence 'Da habe ich s/Sie gehört' can be heard in a double fashion: 'There, I have heard them=sie' or 'There, I have heard you=Sie'. The first version tells something about external events, the second version addresses the recipient directly. This is to be observed in the following extract:

P: und und und<< wo is °h äh::m: was könnte es machen (0.9) beeinflussen >oder oder in in< die Wege leiten.=
and and and<< where is °h err::m what could it matter? (0.9) influence >or or in in< set it in motion=

→ T: =und überhaupt nur wirken bei jemand anderen [mit dem Sie

=and could only work on someone [you are
P: [ja,
[yeah,
T: wieder zu tun ham dann=
involved with again then=
→ P: =>ja=ja< m:anchmal merke ich dass sich Leute sehr unsicher fühlen (.) .h im Umgang mit mir.
=>yeah=yeah< sometimes I notice that people feel very insecure around me
(.)
(.)
T: hmhm.
hmhm.
(.)
(.)
→ P: also eh:::m:::es wo ich manchmal das Gefühl hab ich bin eigentlich der Stärkere? [(.) obwohl ich doch diese
I mean err:::m:: it is where I sometime have the feeling I am actually the stronger one [although it is me who's been
T: [.hh hmhm
[.hh hmhm
P: Situation durchgemacht habe,
through this situation
T: hmhm,
hmhm,
(.)
(.)
P: °h äh: weil S/sie einfach nicht genau wissen °h wie behandeln S/sie mich jetzt äh::m: bin ich der kranke Mensch für S/sie?
°.h err: because they/you simply do not know exactly how they/you treat me now, am I the sick person for them/you?

In psychotherapeutic situations we have two reference systems: patients tell trouble narratives from outside the treatment room; during the narration a relationship to the therapist unavoidably evolves. Both frames follow the gestalt principle so that gestalt and background can be referred to alternately.

The general expectation is that narrative frame and conversational frame are to be held apart; the conversation is meant to comment on the patient's life narrative in order to produce an answer or propose a better solution. CA can show that this expectation is too simple.

In Extract 11 one can precisely observe how these two frames intermingle. In his first utterance the therapist addresses the patient directly. However, the turn-organisation is very fast; both do not interrupt each other's talk and avoid 'trouble'. However, both deliver silent recipient tokens that can be heard as agreement *or* as signifying impatience. The therapist hurries to show that he has understood and, like in a CCU, seems to complete the patient's narrative (first arrow). The patient, then again very fast, joins the therapist's sentence with a quick 'Yeah=Yeah' (second arrow), which has the quality as if wiping aside the therapist's remark. Here starts a double meaning: The patient's remark about people who feel very 'insecure around him' can be heard in a narrative frame, but the conversational frame comes to the fore: the patient tells that he assesses the therapist's hurried remark as 'insecure' like those by people he knows. He adds to inform the therapist that he is 'actually the stronger one' (third arrow). It follows the remark where the German S/sie-problem comes to the fore, as the patient uses the word 'treat' – this can be heard as a hybrid element which fits into both frames. It is an element in a narrative of being 'treated' by other people as 'the sick person', but it is an element of the conversation, too. In this frame, the patient does not only pose a question to the therapist ('do you treat me as the sick person, too?'); his accusation is indirect, but hearably more: 'you simply do not know exactly how you treat me now'.

This intermingling of narrative and conversational frame, by the way, has been observed by Freud in his metaphoric recommendation to a patient:

> Act as though, for instance, you were a traveller sitting next to the window of a railway carriage and describing to someone inside the carriage the changing views which you see outside. (Freud, 1913, p. 135)

What Freud did not add here, is that what happens inside the railway carriage might become more interesting for the traveller than looking outside the window.

In a German conversation we have the possibility to make such double meanings unambiguous by uttering a remark. Disambiguation is the patient's task here, but he does not say word to this. This 'noticeable absence' (Sacks and Jefferson, 1992, vol. 1; p. 31) is left out and this must be considered an unspoken part of the conversation.

It is possible to add further examples where such double-framing are introduced by the therapist; in our CEMPP-material we have examples where therapists try to 'sell' something to the patient, e.g. that a certain practice of relaxation is

a wonderful training against stress and tinnitus. In other cases, conversational practices can be observed that remind of persuasive communication. Sometimes the whole situational gestalt is altered to a kind of police interrogation.

6. Conclusion

In my view, the shift of the situational gestalt can be analysed as follows. Enfield (2011) described the semiotic process (following Peirce) as a triadic relationship consisting of *a sign*, which signifies an *object* plus an *interpretant.* A problem arises when one of the three elements is used in two frames and, thus, becomes hybrid and acquires the ability to refer to more than one triad only. In extract 10, Amalia's question was more than a question – a doubtful statement. The therapist was not only addressed as interpretant of a question he could answer; he was also the *object* of the statement-part that doubted his epistemic authority. The same holds in extract 11. The same words like 'treat' and 'treatment' refer to the narrative frame *and* to the conversational frame; S/sie allows a similar double-hearing in both semiotic triads. Once the therapist is an interpretant for the story heard, then he is the object of a complaint.

I suspect that such complications have been termed as 'ruptures' (Muran, 2019), but such a metaphor is insufficient for what CA can observe and describe in detail. What we find termed as 'repair' should better be described as disambiguation of contradictory frames. To establish a typology of therapeutic disambiguation practices is a task for further CA-studies in process research.

My proposal to describe the Situational Gestalt of therapeutic conversations prepared three components: to open, to select and to control options. Herein lies the clinical opportunity for therapists to remind themselves that they have choices. The theoretical potential in this proposal is, in my view, to introduce two new concepts in CA of psychotherapy: shift-of-situations and double meaning of hybrid terms. It would be a practical asset if therapists were trained to sensitize themselves for these moments, not in order to 'repair' them, but in order to disambiguate them.

Summary

This paper starts with a short review of recent developments in psychotherapy process research and analyzes that a medical, or better, technical approach in process research – using words such as 'intervention', 'effect' and 'outcome' – is gradually acknowledged as only one side of psychotherapy; the other, more human or 'humanistic' side, is 'conversation', described by prominent authors as 'low technology'. Conversation analysis cannot study psychotherapy as a whole. Sessions are subdivided into 'situations'. What are situations? I make a proposal to answer this question by three components: open up, select and control options. Then, 11 transcribed extracts from psychoanalytical therapy sessions are used to describe three types of situations and the special kind of requirements they

demand from a therapist. Obviously, such situations appear during a session, they can be handled if therapists are sensitized for certain difficulties to arise. Shift-of-situation and double meaning are new observations in this approach to define the situational gestalt and train 'seeing' it.
Keywords: Conversation analysis, psychoanalytic therapies, Situational gestalt, shift-of-situation, double meaning.

Die Situative Gestalt Sehen - Bewegung im Therapeutischen Raum

Zusammenfassung

Diese Arbeit beginnt mit einem knappen Überblick über jüngste Entwicklungen in der psychotherapeutischen Prozessforschung. Analysiert wird, dass ein medizinisches, besser technologisches Modell der Psychotherapie(-forschung) – erkennbar an Worten wie „Intervention", „Effekt", „Outcome" – nur *eine* Seite des Ganzen der Psychotherapie abbilden könnte. Deren andere Seite, traditionell als „human" oder „humanistisch" beschrieben, wird von modernen Autoren zu recht als „wenig Technologie" beschrieben. Die Konversationsanalyse kann das psychotherapeutische Geschehen nicht vollständig beschreiben. Deshalb werden hier Sitzungen in „Situationen" unterschieden. Die Frage, was eine „Situation" sei wird zu beantworten versucht durch 3 Komponenten: Situationen öffnen, selektieren Möglichkeiten und kontrollieren Optionen. Elf transkribierte Extrakte psychoanalytischer Sitzungen beschreiben 3 Typen von Situationen und die besonderen Anforderungen, die sie an Therapeuten stellen. Solche Situationen geschehen in Sitzungen und sie können gehandhabt werden, wenn Therapeuten für die besonderen Schwierigkeiten sensibilisiert werden. Der „Situationswechsel" und die „doppelte Bedeutung" sind neue Beobachtungen in diesem Ansatz, um die Situationsgestalt zu beschreiben und sie zu „sehen" möglich zu machen.
Schlüsselwörter: Konversationsanalyse, psychoanalytische Behandlungstechnik, Situationsgestalt, Situationswechsel, doppelte Bedeutung.

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