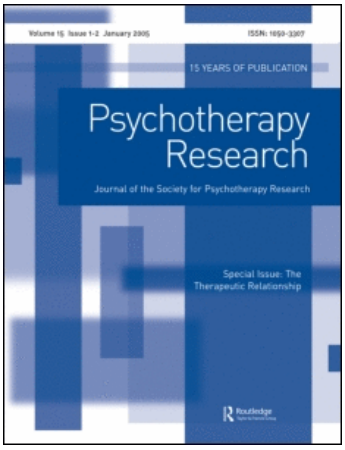

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Therapeutic change in interaction: Conversation analysis of a transforming sequence

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Therapeutic change in interaction: Conversation analysis of a transforming sequence

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Abstract
A process of change within a single case of cognitive-constructivist therapy is analyzed by means of conversation analysis (CA). The focus is on a process of change in the sequences of interaction, which consist of the therapist's conclusion and the patient's response to it. In the conclusions, the therapist investigates and challenges the patient's tendency to transform her feelings of disappointment and anger into self-blame. Over the course of the therapy, the patient's responses to these conclusions are recast: from the patient first rejecting the conclusion, to then being ambivalent, and finally to agreeing with the therapist. On the basis of this case study, we suggest that an analysis that focuses on sequences of talk that are *interactionally similar* offers a sensitive method to investigate the manifestation of therapeutic change. It is suggested that this line of research can complement assimilation analysis and other methods of analyzing changes in a client's talk.

Keywords: process research; qualitative research methods; conversation analysis; cognitive-constructivist therapy

A central aim in psychotherapy process research is to describe and understand therapeutic change. This is often achieved through a qualitative analysis of recorded and transcribed therapy sessions. In this article we suggest that conversation analysis (CA) offers a useful perspective and methodology that is complementary to the qualitative process research on psychotherapeutic change. Through a case analysis, we suggest that CA can be used to study therapeutic change in terms of a transformation in *interactional sequences*.

A number of qualitative studies have located therapeutic change in the transformation of clients' talk (on a theme / experience) over the course of therapy. For example, assimilation analyses have traced how a problematic experience becomes recognized, worked through and finally resolved through eight stages (see e.g., Honos-Webb, Surko, Stiles, & Greenberg, 1999; Leiman & Stiles, 2001; Stiles, 2002; Stiles et al., 1990); narrative analyses have traced changes in how clients move between external, internal and reflexive narrative modes (see e.g., Angus, Levitt & Hardtke, 1999; Laitila, Aaltonen,Wahlström, & Lynne, 2005); and studies on change moments (e.g., Krause et al., 2007; Reyes et al., 2008) have traced the development of new forms of interpretation and representation and the result has been the creation of new subjective theories. In this study we also focus on transformation in talk over the course of a therapy process. However, unlike the studies referred to above, our analytical focus is not primarily on an intra-psychic process, but on sequences of social interaction.

In terms of this interactional focus, CA has similarities with dialogical sequence analysis (DSA) (Leiman, 1997; Leiman & Stiles, 2001) that focuses on the positions that the speaker adopts in relation to the other (i.e. the co-participant of the interaction), as well as to the object that they are talking about. However, compared to DSA, CA goes in some ways a step further in emphasizing the relevance of the interactional context of an utterance. In this paper we suggest that the particular benefit of CA for psychotherapy process research is the research procedure that as it were standardizes the interactional context of talk.

Conversation analytical methodology is based on a particular theory on the organization of social interaction (see Heritage, 1984). Thus, unlike most other methods used in psychotherapy process

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research, the theory of CA does not focus primarily on psychotherapy, but on social interaction in general. CA examines talk as social action. It proposes that social interaction in face-to-face encounters is organized according to the expectations or norms that the participants orient to, concerning their behavior during interaction. These norms are on a very general level, for instance, that people talk one at a time and monitor certain signs in each other's behavior in order to decide when it is appropriate to take their turn (see Sacks, Schegloff and Jefferson, 1974); or that there are certain relevancies that a type of action raises for the next possible action, so that a question makes relevant an answer or that an assessment makes relevant another, agreeing or disagreeing assessment (see Schegloff, 2007). The norms can be broken, but such breaches are always accountable, and warrant an explanation. These norms are not only restrictive in nature, but constitute a fundamental prerequisite of social order: They make it possible to achieve a shared understanding between the participants about the nature of the ongoing situation and activity. According to CA theory, the default environment of social interaction is an everyday conversation between friends and acquaintances, and talk in institutional encounters consists of variations on this basic theme (Drew & Heritage, 1992). In institutional encounters such as psychotherapy, the basic organization of interaction is adapted to the institutional tasks and roles that are specific to the institution in question. As CA provides a general theory of the organization of social interaction, it is applicable to various environments, helping to distinguish the specific characteristics of talk-in-interaction in each environment.

In recent years, a number of CA studies have taken up psychotherapy as topic (e.g., Lepper & Mergenthaler 2005, 2007, 2008; Peräkylä, 2004, 2010; Peräkylä, Antaki, Vehviläinen, & Leudar, 2008; see also Boothe, 2001; Buchholz, 1995; Streeck, 2001, 2008). These studies have explicated recurrent sequences of utterances through which the therapeutic work, in different therapies, is accomplished. For example, they have unpacked the ways in which therapists reformulate the clients' utterances (i.e., restate in their own words what they suggest the client has just said, see Antaki, 2008; Antaki, Barnes, & Leudar, 2005; Buttny 1996; Davis, 1986; Peräkylä, 2004; Vehviläinen, 2003), extend the clients' utterances so as to produce collaborative descriptions (e.g., Vehviläinen, 2003) or offer interpretations to the clients (e.g., Peräkylä, 2004, 2005). Some other CA studies have focused primarily on the clients' actions, for example, by explicating the ways in which clients, in their responses to therapist's interventions, collaborate with (Bercelli, Rossano & Viaro, 2008; Peräkylä, 2005, 2008) or resist (Hutchby, 2002; McMartin, 2008; Vehviläinen, 2008) the therapist's interpretations and agenda. The current study will expand the scope of CA of psychotherapy. Instead of seeking to explicate some recurrent practice or practices of psychotherapeutic interaction (as CA studies thus far have done), the current study adopts a longitudinal approach and seeks to describe change in one such practice (cf., Leudar et al., 2008; Muntigl & Horvath, 2005, and studies on learning as interaction by Lave & Wenger, 1991; Martin, 2004; Melander & Sahlstrom, 2009; Mondada & Pekarek Doehler, 2004; Sellman, 2008; Vehviläinen, 2009, pp. 186–187; Wootton, 1997; Young & Miller, 2004).

In this paper, we will show how the method of CA yields a description of therapeutic change. Data from a single process of cognitive-constructivist therapy will be analyzed by means of CA. More specifically, we will examine how the patient's responses to a particular kind of therapist's intervention become transformed over time. We will apply CA's general understanding of social interaction on our psychotherapy data, by describing how the patient's actions in a *particular sequential context*—after a specific type of intervention by the therapist—change over time, from the early phase of the therapy through to the end. In other words, we describe how the relation between two adjacent utterances (composing a sequence that recurs in this therapy) is transformed during the therapy process. In this way, we aim to demonstrate the usefulness of CA perspective in the research of therapeutic change.

Method

Data

The data of this study consist of 57 hours of audiorecordings from an individual cognitive-constructivist therapy. The recordings cover the latter 19 months of a 2-year weekly therapy, except for one month during which the recordings failed. The therapist is an experienced, female cognitive therapist. The patient is female, in her early twenties, and living in a relationship. During the therapy process, the patient studied and worked as an intern. This therapy was chosen for our study on the basis of availability: The participants recorded their sessions for our CA project on therapeutic interaction (for other publications on these data, see Voutilainen, Peräkylä, & Ruusuvuori 2010a, b). Informed consent was obtained from the patient and the therapist. Any identifying information

about the participants has been changed in the text and data excerpts.

The patient suffered from recurrent spells of anxiety and depression. During the therapy process, her problems were discussed in terms of a lack of security and her tendency to transmute aggression she felt towards others to herself. No standardized measures were undertaken to assess the outcome of this therapy. Our impression, and the view of the therapist in question, is that the therapy process was very successful. Through its course, the patient's anxiety and depression become alleviated, and she seems to adopt a more positive image about herself and becomes more assertive in relation to people who are important to her.

Analytic strategy

CA research procedure starts from transcription. A detailed transcription of the recordings is an important part of the data analysis. Besides the words that are said, the transcripts indicate the voice qualities of the speakers, the length of pauses within and between utterances, and the overlapping talk. This level of detail in transcripts makes it possible for the researcher to attend to such phenomena as the speaker's (affective) stance to what he or she is saying, the places where a speaker could change and whether something (for example the turn of the co-participant) is treated as being problematic. The data analysis involves consulting the transcripts alongside the audio or video files. Readers who are familiar with this notation can reconstruct the interaction as it were 'alive' through reading the transcript. (See Jefferson, 2004, and transcription symbols in the appendix).

After the transcription, the data analysis proceeds as an inductive exploration of the data. This involves recurrent listening and reading of the data, usually in small segments, without adapting any a priori hypothesis. The aim of this inductive exploration is to identify the recurrent interactional phenomena (sequences) in the data. The next phase is to create collections of the recurrent phenomena identified in that inductive exploration and analyze the instances of the collection case-by-case to specify the nature and variation of the phenomenon in question (Peräkylä, 2004). The basic question in the analysis is how utterances are related to each other: What kind of interpretation the current utterance offers regarding the previous utterance, how it responds to that previous utterance, and which implications it has for the next utterance (see Heritage, 1984). The analysis focuses on surface-level phenomena in the interaction, and it does not require an interpretation of the participants' inner experiences. The exploration phase and preliminary analyses are often carried out in group meetings and consensus is sought among the CA analysts. However, the standard CA methodology does not require analyses of all of the data instances by more than one trained analyst. In other words, the validity of the analysis is controlled on the basis of representative examples of the instances.

Although the analysis is data-driven and focuses exclusively on what can be observed in the interaction, towards the end of the research procedure there is a place for broader theorizing and interpretation. The interactional phenomena that have been found through the data analysis will, during the last stages of the research procedure, be discussed in relation to relevant theories (Peräkylä, 2004; Peräkylä & Vehviläinen, 2003).

Procedure

Our research question was: Can we locate a therapeutic change to sequences of interaction that are collected and analyzed using the method of CA.

Out of the 57 recorded sessions, 14 sessions were transcribed in their entirety and 12 sessions were transcribed partly. The data to be transcribed were chosen on the basis of the content of the talk. Themes of discussion were selected to be "emotionally intensive" for purposes of our wider research project that focused on the therapist's responses to the patient's emotional expressions (see Authors 2010a, b). This paper analyzes one of these themes: The patient's problematic experiences with her mother. The transcribed data involve all the extensive discussions on this topic in the data. There were seven sessions in which the topic of mother was extensively discussed, taking place, into the therapy at 6 months, 9 months (two sessions), 11 months (two sessions), and at 18 and 23 months. This topic was possibly discussed also before the recordings started 6 months into the therapy and in the month during which the recordings failed.

One of the main themes of this patient's therapy has been her inability to express her feelings of anger or disappointment towards other people, especially towards her mother. Our overall impression was that there was a positive change in the patient's ways to relate to other people and to herself, and that change is detectable in the discussions on the patient's problematic experiences with her mother. We decided to try to determine whether this change

can be located in the sequences of interaction by applying conversation analysis.

The phase of inductive exploration was carried out during the weekly meetings between the first and second author, but also in a larger research group and by the first author individually. In this phase, we focused on the longer instances of interaction that we heard as being emotionally intensive. From these instances, recurrent sequence types were identified, including the sequence type that was analyzed in the current study. The collection and analysis of the instances (25) of this sequence was carried out by the first author.

The sequence type analyzed in this study consisted of the therapist's conclusion and the patient's response to it. By conclusion, we refer to a conversational action that suggests something on the basis of the preceding discussion. The term "conclusion" does not therefore refer to a type of therapeutic intervention, but to the conversational "format" of the action. Compared to more tentative suggestions, these conclusions are delivered in a manner that, in conversational terms, invites the patient to confirm and to agree. Two kinds of conclusions were collected. The first were those in which the therapist brings out the patient's critical stance towards her mother that the patient has expressed more indirectly. The second conclusion involves those instances that question the patient's self-blame. These conclusions seem to be interconnected in terms of the therapeutic work that they accomplish. Through both kinds of conclusion, the therapist dealt with the patient's tendency to transform her feelings of disappointment or anger (in this case towards her mother) into self-blame. The collection includes all the 25 instances of these conclusion-response sequences that were found from the discussions dealing with the patient's relation to her mother: 15 instances where the therapist brings out the critical stance that the patient has expressed and 10 instances where she questions the patient's self-blame.

We found instances of the conclusion-sequence from all of the seven sessions that involved extensive discussion of the patient's relation to her mother. It should be noted that the conclusion-response sequences that we investigate in this paper amount to only a very small part of the on-topic data. Most of the discussions on this topic consist of the patient's narration and of the therapist's empathetic or interpreting responses and reformulations, and of different kinds of question-answer sequences. We chose to focus on the conclusion-response sequences because they involve a "standardized" reoccurring sequential environment in which the patient's account of her relation to her mother, as well as the therapist's effort to recast this relation, are articulated in a concise and clear way.

When analyzing the variation of this sequence, we found that the sequence becomes transformed over the course of the therapy. We linked these findings to the assimilation model, and especially to the version of the assimilation model that incorporates Vygotsky's ideas of "zones of proximal development" proposed by Leiman and Stiles (2001). This will be elaborated on later in the discussion section of this paper.

In what follows we will report on the change process in these 25 instances through eight data excerpts. These eight excerpts include the very first and the very last instances of the conclusion-response sequences. The rest of the excerpts were selected on the basis of their clarity and on their power to illustrate the key phenomena. The data were transcribed according to the CA convention (Jefferson, 2004; see appendix for key to the symbols). It should be noted that we have simplified the transcription of the excerpts in this paper. The excerpts have been translated from Finnish by the authors.

Results

The change process in both kinds of the conclusion-response sequences is similar: In the early phase of the therapy (in the phase when the recordings started 6 months into the therapy), the patient resists the conclusions, later the responses are more ambivalent, and finally the patient confirms the conclusion and displays agreement. All the examples of resisting responses are from the same session that occurs at the beginning of the recordings. The phase of ambivalent responses then lasts 16 months, and we have instances from five sessions from this phase. The month in which the recordings failed was unfortunately between the session containing the resisting responses and the session containing the first instances of ambivalent responses so we were not able to determine exactly the transformation from the resisting responses to the ambivalent ones. The instances of agreeing responses occur at the end phase and these are again from just one session.

Table I below shows the number of instances in each phase by the type of the therapist's conclusion in the sequences.

We will describe this process through the eight data excerpts below.

Table I.

	Bringing out the P's critical stance	Questioning P's self-blame	Total
Resistance (one session)	1	5	6
Ambivalence (16 months, sequences from 5 sessions)	9	4	13
Agreement (one session)	5	1	6
Total	15	10	25

Rejection of the Conclusions

The first excerpt shows the starting point to the process we describe. This is the only instance in the session of the sequence in which the therapist brings out the patient's critical stance. Before this excerpt, the patient has talked about a movie, and how she had felt lonely and rejected after seeing it. The therapist has asked if the movie brought up memories from the patient's childhood. As an answer to this, the patient recounted a recent event with her mother, in which her mother ignored what she had told her about her own success in work. Just before the excerpt, the therapist and the patient have started to discuss this event. They have both noted that the mother did not say what one could have expected from a recipient of such news—i.e., she did not congratulate her, give her praise, or respond in a positive way. In the beginning of the excerpt, the patient moves on to repeat how she reacted to her mother's lack of response: She left the scene.

Excerpt 1

1 P: Then I went away from there. mhe[hh
2 T: [So that she did
3 T: not express like a̲ny kind of interest.
4 P: No,
5 (1.3)
6 P: .No no I have not mmmm, mhhh
7 (1.0)
8 P: mhh
9 (2.0)
10 T: Hmmm.
11 (1.5)
12 P: .hhh .hhhh kry̲hmm
13 T: It feels really b[ad.
14 P: [M̲mm. mh
15 (11.0)
16 T: **It's no wo̲nder that you feel (.) rejected**
17 **and .hhhh (1.3) like no one cares.**
18 (4.0)
19 ?: .hff
20 (2.3)
21 T: **I guess that does make one feel like that.**
22 (12.0)
23 P: .hfhhhh kryhh-kry̲hmm hmhhhhhhh Then it's that I
24 have a̲lways like (0.3) but if I speak to Ville
25 about those then he starts to .hh (0.4) rail at her
26 or berate or (1.5) say bad things about her and then
27 I defend her to death and .hfff (.) so that no one
28 is like (0.5) allowed tosay anything bad about her

The patient's story about being dismissed by her mother is a response to the therapist's question about the origins of the patient's negative feeling. The patient implies that her negative feeling arises from this unpleasant encounter with her mother. In lines 2–3, the therapist formulates the mother's lack of interest (she did not express any kind of interest) and the patient confirms this in line 4. Starting in line 5, the patient has the opportunity to continue her utterance, for instance by explicating the feelings that the mother's ignorance evoked. She continues in line 6, but then cuts off her utterance. The impression given by the audiotape is that the patient is close to tears, if not crying (lines 5–12). This is also how the therapist interprets the patient's preceding actions as she says 'it feels really bad' (line 13).

The therapist's focus conclusion follows in lines 16–17, after a gap of 11 seconds. In her conclusion, *It's no wonder that you feel rejected and like no one cares*, and further in the expansion of that statement in line 21 *I guess that does make one feel like that*, the therapist explicates and validates the connection between the negative feelings that the patient described earlier and the event that she discussed. Through this utterance, the therapist makes it possible for the patient to express her negative feeling towards her mother more directly. However, the patient resists this invitation. She neither confirms the therapist's conclusion, nor responds to it in any way during 12 seconds of silence. Following that silence, the patient starts to describe how she reacts when her partner talks negatively about her mother, and indicates that she does not wish her mother to be talked about negatively (lines 23–28). Thus, the patient, quite strongly, retreats from the stance that she indirectly expressed in her story about the event with her mother.

Excerpt 2 is taken from the same session, and it shows an instance in which the therapist questions the patient's self-blame. Before this excerpt, the therapist has started a project that she has also launched earlier in the session: Through a series of questions (Socratic dialogue), the therapist points out that the negative attitude of the patient's mother towards her can be seen as a trait of her mother and not as something that the patient should blame herself for. The therapist has asked the patient what the patient's descriptions of her communications with her mother reflect about her mother. The patient has answered hesitantly that her mother is a negative person and a pessimist. Just before the excerpt, the therapist has paraphrased this attribution, which the patient has confirmed hesitantly. In the beginning of the excerpt, the therapist continues to describe the patient's mother (lines 1–2), and the patient confirms the description more decisively (line 4).

Excerpt 2

1	T:	Who seldom sees the bright sides of things or
2		good or ( ).
3	P:	Mmm,
		(1.0)
4	P:	That's what she is indeed.
5		(2.0)
6	P:	hhh
7		(10.7)
8	T:	**Well does it then mean that you are bad**
9		(2.0)
10	T:	**If mother tends to see everything as bad**
11		(1.3)
12	**T:**	**Negatively.**
13		(13.0)
14	P:	It did not necessarily mean that ( ) but
15		I do feel like ( ). .hff
16	T:	[Mm.

In lines 8, 10 and 12 the therapist states the conclusion in the form of a question: If the negative attitude is the mother's trait, does it mean that the patient should blame herself for being inferior. The conclusion strongly invites a response that disapproves of the supposition that the patient is inferior. However, the patient answers only after a pause of 13 seconds. She gives a partial confirmation to the therapist's conclusion (*did not necessarily mean that*, line 14), and indicates that she nevertheless feels like that (line 15). After what is shown in the excerpt, the patient adds that she has tried to think sensibly and not blame herself, but the feeling of being at fault is stronger than her reasoning.

These two instances from the same session were similar in terms of the patient's resistance to the therapist's conclusion: The conclusion was followed by a silence (12/13 seconds) that is rather long in these data, after which the patient diverged from the point that the therapist had offered. On the other hand, however, while the patient resisted the conclusion, she did not resist the therapeutic agenda in terms of discussing the problematic theme: Instead of merely disconfirming the therapist's conclusion, she reflected upon her inability to confirm it and thus made relevant further discussion on these issues. In the instances shown above, the patient's account of how she thinks that one should not say negative things about her mother (excerpt 1) evoked a discussion on this imperative and its grounds (part of which was shown in excerpt 2). The patient's account about her feeling in the second excerpt, in turn, evoked a discussion on the patient's experience

and needs, which then again turned back to the theme of not wanting or being able to criticize her mother.

Ambivalent Responses

We will now turn to describe the second phase of the change process in the conclusion-response sequence. The next excerpt occurs 16 months into the therapy, so a year later than the previous excerpts. It shows an instance where the patient's response to the therapist's conclusion is not as strongly resistant as in the previous excerpts, but is rather ambivalent. The therapist and the patient have talked about the patient's depressed mood. The therapist has asked what the patient would change in her life if she could. The patient has first suggested that she would like to have a new "head" or "mind," which the therapist has not accepted as a proper answer. Thereafter the patient has pondered about how she might change her childhood. In the beginning of the excerpt, the patient responds to the therapist's question about what aspects of her childhood she would change.

Excerpt 3

1	P:	.hhhhh ts mhhhhhhhhhhhhhhhhhhhhhhh Well mmmmm
2		.hhhhhh (1.2) sss (0.4) ermhhhhhhhhhhhh mmaybe
3		that very thing (.) that one would feel more
4		safe and that one would have (1.7.) have erm
5		like that ca- care and love and
6		such (0.5) tenderness (2.3) more.
7		(0.4)
8	T:	Received.
9		(.)
10	P:	Yes.
11		(0.7)
12	T:	**So then you (.) would alter (.) ↓mother.**
13		(.)
14	P:	.hhhhhhhh Ehh yeah.
15	T:	**To be different.**
16		(0.5)
17	P:	Yeah (0.5) £perhaps£.
18		(.)
19	T:	Or.
20	P:	.hhhh (1.2) Yeah (6.3) and mmmmmmmm I guess
21		(.) father too
22		(.)
23	T:	Yeah.
24		(7.0)
25	P:	But I don't know then (2.5) whether that
26		would help in any way £hheh heh£ (.) .hhhh like
27		whether I would feel any better.

The patient reflects on changing her childhood to a time of feeling secure, being cared for, and loved. In line 12, the therapist concludes (through an upshot formulation, see Heritage & Watson, 1979) *So that you would alter mother*. This conclusion again brings out the critical stance towards the mother that was implicit in the patient's turn (the patient's childhood memories that have been talked about in the therapy have mainly focused on her relationship with her mother). In line 14, the patient confirms that conclusion, albeit somewhat hesitantly (there is a long inbreath and some kind of sneer before the confirming *yeah*). After the therapist's expansion of the conclusion in line 15, the patient starts to waver by qualifying her stance with *perhaps* (line 17) and by adding that she would also change her father (lines 20–21). In lines 25–27, the patient moves further away from the conclusion by challenging the assumption that the hypothetical change would make her feel better.

So, in the excerpt above, the patient again retreated from the critical stance towards her mother after the therapist had explicated it. However, unlike in the first excerpt where the patient backed off from the critique after a silence, here the patient first confirmed the therapist's conclusion, though hesitantly. This can be seen as a change in the patient's manner of responding to the therapist in this context. As was mentioned above, this excerpt occurred a year later than the first two excerpts. We should note that this is not the first instance of this kind of response in the therapy process. Similar kinds of responses had occurred, as had responses in which the first confirmation was not hesitant. The first instances of ambivalent responses occur already in a couple of months after the session from which we had the instances of resisting responses (excerpts 1 and 2). In all these instances, however, following the confirmation, the patient eventually retreats from the critical stance.

During the session that the above excerpt occurs in, immediately following what is shown in that excerpt, the therapist came to a similar kind of conclusion about the patient's self-blame as was shown in excerpt 2. This is evident in the next excerpt (4), which continues directly from excerpt 3. In the beginning of the excerpt 4, the therapist refers to their earlier discussion, where the patient pondered upon whether the therapist is disappointed in her, because she still feels depressed despite the therapy. The therapist has pointed out that the patient might actually be disappointed at the therapy/therapist, and later suggested that the patient might try instead to convert her thought that somebody is disappointed in her into a feeling of her being disappointed in that same person.

Excerpt 4

1		(0.8)
2	T:	.hhh But then earlier you said that .hhhhh
3		(.)krh kryhm that you that then you maybe
4		just think that like if you are a disappointment to
5		me so then it ↑just is the way it is that you are so
6		faulty .hhhhhh I mean .hhhhh (5.3) hhhhhhhhhh
7		so that if you would have received more love and
8		acceptance and security so .hhhhh so like if
9		mōther and father would have been different (.)
10		.hhhh (1.0) then I mean I'm thinking about your
11		faultiness so ↑ar- are you that fau[lty ↑so.
12	P:	[↑Yeah (.) yeah
13		(0.5) ↓yeah.
14		(.)
15	T:	So has it been your fault originally or.
16	P:	You mean that in other words that I am (.) I
17		am disappointed at my £parents£ kind of.
18		(0.4)
19	T:	↓Yeah.
20	P:	Yeah.
21		(0.5)
22	T:	**They have been what ↑they ↑have ↑been**
23	P:	Yeah.
24		(1.4)
25	T:	**But you have started to think that yōu are**
26		**somehow faulty.**
27		(2.0)
28	P:	Y-yeah.
29		(5.8)
30	P:	Mmm but as I still don't want to and somehow
31		I'm not able to (1.0) able to accuse (1.2)
32		or to be disappointed in my parents (.) well
33		with father yes but erm not with mot her.
34		(9.2)
35	P:	↑I don't know.

In lines 2–11 and 16 the therapist starts to question the patient's conception of herself as being faulty, using the preceding talk about wanting to change the parents as a resource. The therapist reveals her chain of reasoning in lines 9–11 where she questions the patient's belief of being faulty. The patient indicates with her *nii* responses (line 12) that she understands the therapist's line of reasoning. The therapist subsequently restates her previous question (line 15) as to whether it is the patient's fault, and then offers the patient a place to add the opposite option (by her *or*-preposition at the end of her utterance). The patient formulates her understanding of the therapist's point (that it is in fact she is the person who is disappointed in her parents) in lines 16–17. The statement *I am disappointed at my parents* is produced in literary, correct Finnish, and partly in a smiley voice. Furthermore, the patient displays that she formulates the therapist's understanding (not necessarily her own) as she prefaces her turn with *You mean/So in other words (Nii että toisin sanoen*, in the original data*)*. These features can be heard to index a type of irony and to refer to the therapist's earlier suggestion of converting the thought of being a disappointment to somebody into a feeling of being disappointed in someone else. In spite of this possible irony, and unlike excerpt 2, by showing that she understands what the therapist means (lines 16–17) and by then accepting her reasoning (line 20), the patient now follows the therapist's project of questioning the patient's self-blame.

In lines 22 and 25–26, the therapist explicates the point that has been made. These utterances can be seen to complete the therapist's conclusion that she started in line 2. The therapist points out that the patient's parents *have been what they have been* (line 22), which is confirmed by the patient (line 23). However, the therapist's next turn, in which the patient has *started to think* that she is *somehow faulty* (lines 25–26) gets a delayed and disfluent (albite agreeing) response (line 28). In lines 30–33, the patient then retreats from the conclusion by noting that she still does not want to, and is not able to, blame her parents, or, more precisely, her mother.

As in the previous excerpt (3), here the patient's response to the therapist's conclusion is also ambivalent: The patient first agrees with the therapist but then withdraws from the conclusion. Compared to the first two excerpts in this paper, where there was first a delay of 12–13 seconds, and then a resisting response, the patient's responses in examples 3 and 4 are yet more aligning with the therapist's suggestion. On the other hand, what is similar to the latter excerpt (4) and the instances in the early phase of the therapy (excerpts 1–2) is that the patient, while withdrawing from the therapist's conclusion, does not resist the *therapeutic agenda* but indicates that there is still need to work on this issue by stating *I still don't want to and I'm not able to blame* (lines 30–33), and ambivalence, *I don't know* (line 35). The patient therefore responds to the therapist's conclusion with self-reflective talk (excerpt 3 was different in this respect).

We now mention two more excerpts from this "ambivalent phase." They are both from a session that took place 11 months into the therapy, so 5 months after the session with the resisting responses (8 months before the excerpts 3 and 4). Again, in the first excerpt (5), the therapist brings out the patient's critical stance (here in terms of the patient's emotion, i.e., anger) towards her mother and in the second one (excerpt 6), she questions the patient's self-blame. Before excerpt 5, the patient has described how she tends to feel frightened and defenseless when her mother gets angry at her. In line 1, the patient describes a past event in which her mother disapproved of her choices, and the patient was not able to defend herself.

Excerpt 5

1		I was not able to although I THOUGHT damn
2		it so (0.3) so I did what I feel is like best
3		or me [.hhhh and IT DID like (.)
4	T:	[Mmm.
5	P:	AND I GUESS I FELT (.) I mean I often felt only
6		AFTERWARDS like .hhhhh had a kind of
7		(.) rebellious ↓mm-m feeling (.) but I mean in
8		that moment I was totally like (.)
9		floored like .hhhhhh I was [not even able to
10	T:	[↓Mmmm.
11		look at her and.
12		(0.3)
13	P:	.hf I was not [able to say how I feel

14 T: [↓Mmmm.
15 P: I mean .hhh [I was like mm-hh £↓yes ↓mother
16 T: [↓Yeah.
17 P: heh heh heh .hhhhhhhhh£.
18 (0.5)
19 T: **So afterwards you however began to**
20 **feel a bit [angry like I do what I want.**
21 P: [YES (.) YES
22 P: (.) AFTERWARDS I FELT (.) YES.
23 T: Mmm.
24 P: And so angry at myself and so to all that
25 not being able to say to her that .hh
26 anything against her or .hh fight against her
27 so.
28 (0.6)

Starting from line 1, the patient describes, with some hesitation (see pauses and repairs in lines 3, 5, 6 and 7) how she *felt rebellious* (line 7) afterwards, but in the moment when her mother was angry at her she was completely floored and unable to even look at her mother (lines 7–9, 11, 13, 15 and 17). The therapist receives the patient's telling with acknowledgments (lines 4, 10, 14 and 16), and then in lines 19–20, shifts the focus from the patient's defenseless feeling (at this point the patient ended her description) back to her rebellious feeling (that the patient described in the earlier part of her utterance), and formulates this feeling as anger (*so that afterwards you however began to feel a bit angry so that I do what I want*). The therapist draws the conclusion in which she explicates that the feeling that the patient was referring to in lines 3–7 was anger. The patient subsequently confirms the therapist's conclusion (lines 21 and 22). The latter part of the confirmation, however, is designed as one that foregrounds not the anger itself, but the delay in its occurrence (*Afterwards* I felt yes) and thus rekindles what the patient pointed out at the end of her previous utterance: The defenseless feeling at the moment of the conflict. Then again, in lines 24–27, the patient moves away from the anger towards her mother and describes how she was angry at *herself* for not being able to defend herself. The patient's response is therefore similar to what was shown in excerpt 3: The patient first confirms the therapist's conclusion, but then moves away from the negative emotion towards her mother. In this instance, however, after what is shown in this excerpt, the patient turns back to describe her angry feelings that come afterwards—and then again turns to a self-critical stance (this continuation of the patient's response is shown in the next excerpt below). While resisting focusing on the feeling of anger as such (which was made relevant by the therapist's formulation) the patient again elaborates on her problematic experience, on her emotions that create a dilemma and so orients to the therapeutic agenda and collaboration.

The next excerpt shows how the therapist, by directly continuing the interaction above, addresses the patient's tendency to redirect her anger to herself and to blame herself. This instance is different from the other instances in which the therapist questions the patient's self-blame, as here the therapist comments directly on the patient's way of talking during the therapy session (cf., Vehviläinen, 2008), and in this way the therapist guides the patient to reflect upon her current reactions.

Excerpt 6

1 P: .hf So: #mmmmmmmm# -mhh .hh I know more about
2 my life than (.) like that mm how I
3 £should (.) ac- (.) how I must act and
4 do so that what£ feels good so she cannot
5 judge but I mean all that is always
6 afterwards then like anger and the kind of
7 fury so.
8 T: Mmmm.
9 P: AND TOWARDS MYSELF (.) towards myself most of
10 all so why can't [I just .hhhhh °mm°.
11 T: **[It's curious**

12		**enough that you .hhhhhh almost g- can be angry**
13		**at mother (.) but then you right after**
14		**say [but it is towards myself**
15	P:	[YEA:H
16	P:	YEAH (.)
17	T:	**£after all heh heh£ [.hhhhhhh hhhhhhh.**
18	P:	[Yeah I somehow am not
19	P:	and then .hhhhh (.) YES IT IS AWFULLY
20		↓DIFFICULT (.) still just that (0.7) I would
21		be angry at her for something ↑or ↑bitter
22		↑or (.)↑or ↑furious ↑or mmm so that I
23		always EXPLAIN it on her behalf (.) [somehow.
24	T:	[Mmmm.

In lines 9–10, after the therapist's acknowledgment of what the patient said about her angry feelings towards her mother, the patient emphatically points out that the anger that she feels is mostly focused on herself (for not being able to defend herself). At this point, the therapist formulates and assesses the patient's previous action by stating that *it's curious enough how you almost can be angry towards mother but then right after you say that it is about myself after all* (lines 11–14 and 17). This utterance illustrates the therapeutic agenda that in our understanding is also present in the other focus conclusions: As an alternative to reacting with self-blame, the therapist encourages the patient to recognize and to express (in the therapeutic interaction) her negative emotions towards mother. In this instance, the therapist particularly invites the patient to reflect on her tendency to shift from anger to self-blame.

In her response in lines 15, 16 and 18–23, the patient confirms the therapist's point and elaborates on it by stating how difficult it still is for her to be angry at her mother. The patient is thus aligning with the therapist. However, the patient slightly shifts away from what the therapist suggested as focus (cf., Peräkylä, 2005): While the therapist's utterance deals with the patient's tendency to transform anger into self-blame, the patient talks about her difficulty to be angry at her mother, thus shifting her focus from the transformation and inversion of the affect. Nevertheless, after the therapist's comment, the patient reflects on her inability to become angry in a less self-accusatory way than she did in lines 9–10.

So, in the phase of ambivalent responses from which the latter four excerpts were taken, the patient's responses to the focus conclusions were ambivalent: The patient first agreed with them but then withdrew from them. In most of the instances, however, the patient did not resist the therapeutic agenda as such, but rather seemed to resist the *solution to the problem* that the therapist's conclusion implied. In other words, through her responses to the therapist's conclusions, the patient conveyed that she was not (yet) able to completely agree with them and that there was still need for work on the issue.

Confirmation and Agreement

We will next turn to excerpts from the the "end point" of the process that we are describing. As we mentioned in the beginning of this article, this end point is one session from the end phase of the therapy, and it is the last one in which the patient's relationship with her mother is discussed. In the session, the patient now confirms the therapist's conclusions and displays agreement.

The next excerpt again illustrates an instance where the therapist brings out the patient's critical stance towards her mother. As in the previous two excerpts, here the patient has also described her reactions to her mother's angry reactions, and told the therapist about the previous time when the patient's mother got angry at her. The excerpt begins from a point where the patient moves to evaluate her mother's angry behavior in general.

Excerpt 7

1	P:	Mm 0.5) .hhhh it was (quit-) it was a bit
2		tough situation .really .hhhhhhhhhhh but I mean
3		those kind of scenes and besides mmm she can
4		get one from a quite minor reason if she has a
5		bad day ba- mhh (.) wrong moment.
6		(0.7)

7	T:	Mm-hm.
8	P:	so then she can get quite a heavy
9		like (.) .hhhhh.
10		(2.0)
11	T:	**Pt so she is un[predictable.**
12	P:	[an outburst.
13		(.)
14	P:	Ye[ah.
15	T:	[Mmm.
16		(.)
17	T:	Mmm-m.
18		(1.5)
19	P:	And that's what she's ↑always b↑een.
20		(.)
21	T:	Mmm-m. .hhhh so that in a way ((continues))

In this excerpt, the patient explains how her mother can have quite fierce outbursts [of anger] over minor matters when she has "a bad day" or "a wrong moment" (lines 1–5, 8–9). The patient thus indicates that her mother's reaction is not appropriate to the situation, and it depends on the mother's mood. In line 11, the therapist brings this out by formulating the patient's point as an assessment on her mother: *So that she is unpredictable*. The patient confirms this formulation (line 14) and after the therapist's acknowledgment/agreement (lines 15 and 17), the patient extends it by stating that *and that's what she has always been* (line 19). This turn both confirms and reinforces the therapist's conclusion (through the "categorical" *always*). In other words, the patient no longer backs off from the critique that the therapist brought up, but displays strong agreement (on agreeing with assessments, see Pomerantz, 1984). This kind of agreement also has elements of closure: The patient indicates that there is no need to expand on this issue, treating the matter at this moment as one that has been settled and no longer in need of further reflection The therapist, however, continues the topic by asking if the mother still is as unpredictable as before (the beginning is shown at the end of the excerpt, line 21).

Later in this same session, the therapist again draws a conclusion on the irrationality of the patient's self-blaming. This is shown in the next excerpt. Before that excerpt, the therapist and the patient have elaborated further on the tendency of the patient's mother to have outbursts of anger, and on how the patient becomes nervous before she should see her mother because she is afraid of her mother's angry reactions. After this, the patient moves on to talk about the positive experiences she has had with her mother, which she glosses in lines 1–2 of the excerpt. From line 4, the therapist directs the focus back to the mother's outbursts and makes a conclusion of a similar kind to that in excerpts 2 and 4.

Excerpt 8

1	P:	Erm m-m (1.0) so every now (.) now and then
2		she can be like that though .hhhhh.
3		(0.9)
4	T:	**So then mother is like this kind of (0.5)**
5		**hh unpredictable impulsive hhhhhhhh (0.4)**
6		**short-tempered (.) person who can have**
7		**even outbursts of rage [so (0.7) then**
8	P:	[Mmmm.
9	T:	**as she now however ↑is like that kind of person**
10		(0.5)
11	P:	Mmm-m .hh[hhhh.
12	T:	**[Isn't she so:[.hhh (.) the fault [is not**
13	P:	[Yea-ah. [Yeah.
14	T:	**yours.**

15 (.)
16 P: .hhhh (0.6) ↓Yeah.
17 (0.9)
18 P: Yeah.
19 (0.6)
20 T: .hhh.
21 (.)
22 P: .hhhh.=
23 T: **=If she happens to be that kind of person.**
24 (.)
25 P: Yeah:.
26 (0.6)
27 P: That's the way it is indeed heh hẹh (.).hhhhh
28 £that's the way it is£ I MEAN I have never (.)
29 I can't .hhhh e: (.) m-m I mean I don't (.)
30 understand wh-(.) #mmmm# I mean if I tried to like
31 find something within myself (.) like I don't know
32 what that would be .hhh[hh I mean I nevertheless
33 T: [Mmmm.
34 P: see myself as a quite (0.9) quite decent
35 daughter like
36 [I mean I have not [thou- (.)
37 T [Mmmm. [Yeah.
38 P: not (.) been in trouble I mean or anything
39 like that what could be .hh[hh (.) so
40 T: [Mmmm.
41 P: mm .hhh (.) mm (0.5) so then mmm
42 there's no other choice than to (.) thin[k that
43 T: [Mmmm.
44 P: it is mother (.) she has that kind of pers-
45 personality so she is what she is £hh [.hh£
46 T: [yeah
47 (.) so no [matter ↑what kind of person
48 P: [(-).
49 T: was in her .hhhhhh surroundings
50 shẹ still is the way she is.

In lines 4–7, 9, 12, 14 and 23, the therapist again points out, drawing on what has been mutually agreed upon, that the mother's reactions are due to the mother's personality and not something that the patient should blame herself for. The patient confirms the therapist's notions in lines 8, 11, 13, 16, 18 and 25, and subsequently in lines 27–28, displaying strong agreement through the repeated phrase *that's the way it is*. Thereafter the patient points out that her own observations support this: She cannot find the fault in herself (lines 28–32, 34–36, 38–39) so the only possible conclusion (*there's no other choice than to think*, lines 41–42) is that the reason for the mother's behaviors is in the mother's personality (lines 44–45). The patient ends this elaboration with the phrase *she is what she is*. This phrase is somewhat similar in its inevitability to the phrase *and so she has always been* from the previous excerpt and thus how it indicates the closure of the theme, and furthermore, how it may be heard as conveying resigned acceptance regarding her problematic experiences with her mother.[1]

The two excerpts above showed the "end point" to the process we describe. At this point, in her response to the therapist conclusions, the patient decisively maintained the critical stance that she expressed (excerpt 5) and elaborately agreed with the therapist's point that questioned the patient's resorting to self-blame (excerpt 6). Through displays of agreement and closure (and resigned acceptance), the patient indicated that no further therapeutic work was needed on this issue.

To sum up, the eight excerpts mentioned above showed a process in which the patient's responses to the therapist's conclusions (that bring out a critical stance that questions the patient's self-blame)

transform over time. In the beginning of the therapy, the patient, after a silence, resisted that conclusion. In the phase that lasted 16 months, the patient first confirmed, but then backed off from, the conclusion. During these phases, while the patient resisted the therapist's conclusions, most often, however, she did not resist working with the theme in question. Instead, she reflected on her inability to confirm the therapist's conclusion and this allowed her to work further on her problematic experiences and ways she reacts to them. The patient subsequently confirmed the conclusion and displayed strong agreement.

Furthermore, it may be the case that the patient is not the only one who changes here. If we reflect on the therapist's talk in the instances that we have been examining, it appears that there in the end point of the process, the therapist's conclusions may also have changed somewhat from what they were in the early stages. The difference is nevertheless very subtle. In the two instances from the early stage, the therapist uses rather extreme formulations (see Pomerantz, 1986). In excerpt 1, she says *It's no wonder that you (.) feel rejected and . . . like no one cares* (lines 14–15), and in excerpt 2, *mother tends to see everything as bad . . . negatively* (lines 9–12). The mother in these descriptions is out of the ordinary, beyond the limits of acceptance. It should be noted that these expressions as such (*no one cares*, *everything as bad*) were used by the patient herself in the earlier discussion. Yet, the patient resisted the conclusions in which these expressions were explicitly linked to her experiences with her mother and to questioning her self-blame. At the end point of the process, the therapist's conclusions are somewhat milder and, to a degree, even understanding or conciliatory towards the patient's mother, which again reflects the patient's mode of talk. In excerpt 7, *she is unpredictable* (line 11) and in excerpt 8, *mother is like such . . . unpredictable impulsive . . . short tempered person who can have even outbursts of rage* (lines 4–7). These descriptions depict a mother who is far from any ideal mother, but nevertheless she has characteristics that a number of people tend to have. These conclusions are in contrast to the conclusions drawn in the beginning part of the process in that they reflect a different way of making relevant the resigned acceptance that the patient indeed conveys through her responses at this final phase. If this tentative understanding of ours regarding the change in the design of the therapist's conclusions is correct, then it appears that the change that we have been describing in this paper is not only a change in the patient's actions, but rather it is a change in the joint actions and understandings that the patient and the therapist produce together.

Discussion

In their account on CA research of psychotherapy, Peräkylä et al. (2008, p. 16) suggest that "sequential relations of actions are a major vehicle in psychotherapeutic process." They point out that the utterances of the therapist, as well as those of the patient, inevitably convey understandings of the patient's (as well as the therapist's) experience. Utterances that convey understandings are organized as sequences: One utterance follows another, and this sequentiality matters a lot. As Schegloff (2007, p.15) observes, in any interaction, an utterance is understood to display the speaker's understanding of the just-prior utterance, and to embody an action that is responsive to the just-prior utterance so understood. It is for this reason that anything a therapist or a patient says is said and understood in the context of the previous utterance of the other participant. In consequence, the participants inevitably have to orient to and work with the understandings that they each bring about through their utterances. It is, according to Peräkylä et al., this sequential interplay of the understandings that advances the therapeutic process. Conversation analysis offers a particular method for the study of this interplay.

In this paper, we hope to have shown the potential of CA in documenting therapeutic change.

CA can identify and unpack pairs of utterances that recur in the course of therapy. By analyzing observable changes in these pairs of utterances, it is possible to describe the gradual process in which a therapeutic transformation occurs in the patient's relation to her problematic experiences. As limitations of this study, it should be noted that this was a case study that involved only one therapy process, and the outcome of the therapy was not assessed by any standard method. We concentrated on only one topical and sequential context and on the change only in the latter turn of the conclusion-response sequence. We can thus offer only a tentative and partial description of the therapeutic change process in question. However, our study shows that changes can be located to recurrent sequences of interaction, and thus opens way for further, more extensive research designs.

The way in which we have described therapeutic change is comparable to the descriptions of changes that are created by the assimilation model (e.g., Stiles, 2002). The patient's way of relating to her negative feelings towards her mother seem to move from a vague awareness to working with opposing perspectives, and finally towards an integration of the experience (Stiles, 2002; cf. also Rachman, 1980). Given this parallel between our results and those that might have been acheived through assimilation

analysis, we need to ask whether CA in general, and our analysis in particular, can yield results that add something to what could be achieved by an existing methodology (the assimilation model).

On a conceptual level, the difference between our approach and the assimilation model (as well as most other approaches to study therapeutic change) is that by applying the CA theory and methodology, we have shown how change takes place in the sequences of social interaction, while assimilation makes inferences about intra-psychic process, on the basis of what can be observed in interaction. Our interactional focus has consequences for the research procedure. A key difference between the assimilation model and our CA based approach is that while the assimilation model assesses *all* client talk that is topically linked to the problematic experience, we have focused only on a *particular recurrent sequence* where topically relevant talk takes place, leaving aside topical talk in other sequential contexts. This has made it possible for us to make more detailed, comparative observations on the design of the patient's utterances at the different stages of the therapy, as the sequential environment of these utterances is, as it were, standardized (they always follow the therapist's conclusions). Through this more detailed approach, we would like to suggest, our approach can complement the assimilation analysis. Conversely, assimilation analysis can also complement CA by accounting in more detail for the intra-psychic content of the client's talk in these specific sequential contexts.

The particular contribution that CA can make to understanding therapeutic change arises from the capacity of this method to unravel the turn-by-turn production of sequences of action. The relevance of turn-by-turn analysis has been highlighted by Leiman and Stiles (2001), who integrate the concept proposed by Vygotsky (1978) of the zones of proximal development into the assimilation model. They suggest that *in joint exchange with the therapist*, patients reach higher levels of assimilation than they reach in their *internal* assimilation. CA offers a particularly sensitive method to describe this kind of exchange, i.e., to reveal new ways of relating to an experience that are mutually achieved in interaction (cf., Peräkylä et al. 2008, p. 12). In the excerpts in this paper, this is perhaps most evident in instances from the "ambivalent phase" where the participants jointly, for a moment, achieved an expression of the patient's disappointment or anger: The patient offered material to the therapist that the therapist expressed more explicitly in her conclusion. The patient then confirmed that conclusion and then again, being again more "on her own," in a position where she could elaborate on the therapist's formulation in her own words, the patient moved away from what was just mutually achieved. In other words, what the therapist did in making that conclusion might be seen as adopting a position that was in the patient's zone of proximal development. Finally, the last excerpt above (excerpt 8) illustrated how the therapist's suggestions were accommodated in the patient's own account, which then might be seen as an internal assimilation of the problematic experience. Future research could analyze changes in both the therapist's and the patient's actions in a type of sequence, and so reveal how the change takes place as a change in joint action; how the therapist's actions change alongside the patient's actions. In these studies, CA and assimilation analysis could be combined in studying how the therapist's interventions fall into the client's zone of proximal development (cf., Leiman & Stiles, 2001). It would also be possible to combine this kind of approach with clinical measures indicating the outcome of the therapeutic process, and compare successful and unsuccessful therapies.

This study has offered an analysis of therapeutic change as it is embodied in the transformation of a particular sequence: By recasting the patient's responses to the therapist's conclusions in discussions on the theme of mother. In future studies, more than one recurrent sequential context could be included in the research designs, as well as more than one theme of discussion. That would probably help us to analyze the process of change in more detail, and to explore whether the changes are content dependent or display a more general change in the client. It is possible, however, that the assimilation process, as embodied in the *different* sequences (within discussion on the same topic), might not be synchronous. The data that we have examined for this paper suggest that the stage of assimilation might be seen *differently in different sequential contexts* in these sessions. In the "resisting" and "ambivalent" responses shown in this paper, after the therapist's conclusion, the patient shifted the focus of her response from the stance that she had expressed in her previous turn at talk. As we suggested in the analysis, the patient's resistance in this particular interactional context, that is, after the therapist's conclusion, might be directed towards the *making a conclusion* as an action, due to the "closure" that making a conclusion implies. In the sequential context of responding to the conclusion, the patient expressed that the issue was not worked through but was still ambivalent and therefore needed further

discussion. In other sequential contexts, which did not imply this kind of closure, the patient seemed to be more ready to express negative feelings towards her mother, or positive image about herself, than in earlier phases of the therapy. *The content of the patient's talk may thus indicate different levels of assimilation in different sequential contexts* during a period of time. Therefore, a future task for developing the CA methodology in investigating therapeutic change would involve research design that would investigate the transformation of different types of sequences (rather than of one sequence, as our study did). This kind of approach could specify further the ways in which different levels of assimilation overlap during the different phases of a therapy.

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Note

[1] An interesting point is that the patient's choice of words "*she is what she is*" can be heard as "echoing" the phrase "*they have been what they have been*," which was introduced by the therapist months earlier in the discussion about the patient's disappointment in her parents (shown in excerpt 4, line 22) and that she later in the same session also used this phrase in the form "she has been what she has been."

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Appendix : Transcription Symbols

T:	Speaker identification: therapist (T), patient (P)
[ ]	Brackets: onset and offset of overlapping talk
=	Equals sign: no gap between two utterances
(0.0)	Timed pause: silence measured in seconds and tenths of seconds
(.)	A pause of less than 0.2 second
.	Period: falling or terminal intonation
,	Comma: level intonation
?	Question mark: rising intonation
?	Rise in pitch
?	Fall in pitch
-	A dash at the end of a word: an abrupt cutoff
<	The talk immediately following is 'jump started': that is it begins with a rush.

> <	Faster-paced talk than the surrounding talk
< >	Slower-paced talk than the surrounding talk
____	Underlining: some form of stress, audible in pitch or amplitude
:	Colon(s): prolongation of the immediately preceding sound
° °	Degree signs surrounding a passage of talk: talk at a lower volume than the surrounding talk
.hh	A row of hs preceded by a dot: an inbreath
hh	A row of hs without a dot: an outbreath
##	Number signs surrounding a passage of talk: spoken in a 'creaky' voice (vocal fry)
£	Smiley voice
@	Animated voice