Persuasive Argumentation in Systemic Therapy Interaction:
A Conversation Analytic Study

by

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Abstract

One of the core tasks of systemic therapy is to facilitate change which is largely considered to occur in an affiliative and non-interventionist manner. In this thesis I examine the role of an under-reported practice in the pursuit of 'change' in systemic therapy encounters, by focusing on a therapist's attempts to facilitate change in the client's perspective through persuasive argumentation.

An interactional account of argumentation is offered through the means of conversation analysis which is the primary methodological framework for the research. The data consists of 13 hours of recorded and faithfully transcribed interaction between a person living with HIV and a systemic psychotherapist.

I report three persuasion mechanisms that the therapist mobilises in the attempt to induce change. In the first, subsequently to a display by the client of a negative stance the therapist solicits the client's grounds (or strongest grounds) in support of this stance. Pragmatically the move invites a defeasible account which the therapist then challenges or rebuts. In the second, the therapist launches a series of questions which progressively uncover a contradiction in the client's understanding of her lived experience. In the third, the therapist delivers a concession to which she attaches an account or elaboration which in fact opposes the client's trajectory and which renders the concession a tactical one.

Based on the findings, I discuss some core characteristics of argumentation in therapy interaction. I also discuss the role of epistemic accessibility in the accomplishment of opposition in systemic therapy practice. Finally, I argue that argumentation in the data arises from the use of habitual systemic therapy techniques which reveals their argumentative potential and the under-theorised role of argumentation in facilitating psychotherapeutic change.

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Contents

Chapter 1: Introduction

1.1   The focus of the thesis

The ways in which therapists pursue or accomplish change in their encounters with their clients is an issue which has been a continuous preoccupation to the therapy community. This thesis, based on 13 sessions between a systemic therapist and her client in an HIV counselling setting and employing primarily the apparatus of conversation analysis, offers a contribution to this question by focusing on instances in which the therapist, faced with the client's troubles-tellings, attempts to facilitate a shift in the client's narratives and the opening up of multiple perspectives. The therapist's project does not proceed smoothly, as in the exchanges that will preoccupy us in the rest of this work the client in fact opposes the therapist's attempts.

The type of interaction which emerges is oppositional and involves attempts to influence one's interlocutor. Therefore the focus of the work is on persuasive argumentation in psychotherapeutic interaction. Importantly, the aim is to offer an interactional account of argumentation rather than treat it as the study of idealized structures of reasoning. Moreover, as will become evident in the analytic chapters, the argumentation in the data is very much shaped by the conventions of the talk in therapy interaction. This needs to be taken into consideration in the analysis of the data if one wants to avoid the risk of downplaying the argumentation aspect of the exchanges, particularly since this notion is neither part of the customary descriptions of systemic therapy textbooks nor a part of a lay understanding of how therapy is done. The work reveals the sort of interactional phenomena that emerge as the therapist attempts to persuade the client through verbal reasoning. Ultimately, this work exposes the interactional phenomena that emerge from attempts to implement perhaps contradictory systemic therapy mandates of, on the one hand, being collaborative and taking up the role of a catalyst, and on the other, achieving change.

Before proceeding any further however, it is important to stress that this work started in an exploratory manner, rather than with a set of predetermined questions. I began this journey by considering a number of issues about psychotherapy which I found particularly intriguing and which I lay out below.

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To begin with, psychotherapy constitutes a distinct type of interaction whereby a lay person shares intimate details of his or her personal life with a professional. The therapist needs to 'manage' the degree of intimacy with the 'client' (an interesting example - given the historical perspective - of the issues a professional considers arising from this type of interaction is given by Minuchin and Fishman (1981) in their description of the process of joining). Moreover, the interruption of the contact between the lay-person and the professional often requires careful negotiation and takes a certain degree of preparation to get accomplished, but when it does happen it is in most cases permanent, precisely because the client's progress or improvement entails the dissolution of this atypical human relationship.

Another aspect of therapy work that raises intriguing issues in the contact between professionals and their clients relates to the fact that clients are supposed to find their preferred solutions by themselves, despite the fact that they attend therapy to gain professional help for problems that they have difficulty resolving by themselves. What is interesting in this case is to examine how this aspect of the work is managed by participants and the issues that this raises in practice.

If these two issues are of the kind that we have largely learnt to take for granted as members of a society with psychotherapists and clients, there are further issues which render psychotherapy an intriguing practice and which this time relate to the fact that the therapeutic space houses conversations both about problems and about people's self-realisation, competencies and potential.

One such issue concerns the way that clients, in particular those accessing a public health service, go through a process of being labelled with diagnostic categorizations so that they will be able to gain the right to use the service, but on the other hand, in order for the therapy to be successful, these categorizations need to cease to exist. This is partly reflected in Cronen's and Lang's (1994: 31) observation that a professional might become instrumental in creating a grammar of suffering which nevertheless 'results in more difficult work in the consultation as what gets created then has to be resolved'. Burnham (1992: 14) also comments on some of the issues raised by these rather conflictual aspects of the psychotherapeutic work by noting that 'Professionals develop specialist shorthand and phrases to describe their clients and their reason for referral, eg "anorectics", a CSA case, addict and so on' ... 'While this may have some benefit of rapid communication between the professionals concerned, when used in conversation with clients it can close down space for them to describe their own emotional experience in the "local grammar" of

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their significant relationship systems.' A question that arises then concerns the ways through which both clients and therapists perform the transition from what White (1988) calls a 'problem saturated description', to other, problem-free ones.

These rather opposing features of therapy practice bring us to the broader and in fact more crucial issue of 'change' and to the way that this might be achieved. This constitutes a big issue for therapists and is an area clouded by controversy and debate. Should a therapist attempt to instigate change or should she or he refrain from exercising much influence at the expense of therapeutic impact? Envisaging a rather extreme scenario, if a client wants to commit suicide should s/he be prevented from doing so or should her/his wish to end her/his life be respected?

If the above issues though -particularly the one regarding the interventionist or not face of therapy- are controversial for therapists themselves, it might be all the more useful to take a step back and adopt a rather independent position vis-à-vis psychotherapy practice. This would allow one to observe how such issues or dilemmas are actually handled by psychotherapists and their clients in practice. Therefore, aside from what needs to happen in theory, the question about what character therapy actually has remains: is it an interventionist one which tends to impose the therapist's preferred world-view onto the clients, or a non-interventionist one which ignores the demand for 'change'? What balance do therapists strike in practice?

All of the above-mentioned aspects resurface in the context of my main research question which has in fact developed from my inspection of the data rather than starting from pre-existing questions. Going over my data-set revealed exchanges which could be described from a lay perspective as participants' attempts to influence each other. These instances in the data, which in fact fed my initial interest regarding the interventionist or not face of therapy, seem to reveal persistent attempts by participants to shape reality in particular ways. Researching this matter in an in-depth way has the potential for shedding some light on some little-examined aspects of therapy practice.

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1.2 In search of a research framework

An important next step has been to find out what tools and resources might be appropriate to use in order to look into psychotherapy practice. Below I consider three different possible paths that one could consider taking, namely therapy theory, psychotherapy process research and conversation analysis.

1.2.1 Therapy theory

In order to attempt to investigate the above questions a first port of call could be the baggage of interactional knowledge that psychotherapists themselves have in stock (Perakyla and Vehvilainen, 2003) and which they use to understand their interaction with clients. As there is an extensive array of therapy models, I will be narrowing the scope of my exploration down to a single approach, systemic psychotherapy. The name 'systemic' constitutes an umbrella term that historically has brought together a number of different models, all bearing the common denominator that they view problems as interpersonal rather than intrapersonal and that they emphasize the importance of context in understanding the issues that clients bring in the therapy room. The systemic approach is routinely being deployed with families and couples, but also with individuals, teams or institutions (Burnham, 1992).

Aside from a personal interest in systemic psychotherapy arising from my own professional training, I considered that it would perhaps be beneficial to explore further the insights emerging from systemic therapists' stock of interactional knowledge, as this particular approach has traditionally flagged up Bateson's (1973) idea that we cannot not communicate and as this has been placing the interconnections between the client and therapist at its forefront (one of the ways that this might be achieved can be seen in Cronen et al., 2009) particularly after a turn to a second order ideas through which systemic therapists acknowledged the impact of the observer on the observed (Von Foerster, 1982). This would mean that it would be possible that systemic therapy theories contain useful information regarding those aspects of the encounter between therapist and client that form the motivation for this piece of work.

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1.2.1.1   Systemic therapists' growing preference for a democratic, non-prescriptive practice

If one was to turn to some influential systemic therapy texts, one could find a number of potentially enlightening mentions on the issue of a therapist's influence on clients. What becomes immediately noticeable though is that even within the realm of the systemic approach one cannot talk about a unitary orthodoxy given the lively debates running through the systemic field.

In the beginning of the nineties, in a paper that critiqued depicting clients as resistant, Hoffman (1990: 9) was observing that '...family therapy has often presented itself as an adversarial model. Thus, you get terms like strategies, or moves in a game of chess, or maneuvers and countermaneuvers.' This formed part of a series of papers which criticised the so-called 'first order' systemic models and which promoted the use of a collaborative language in the therapy room (Andersen, 1992; Anderson and Goolishian, 1988; Campbell, 1997; O'Hanlon, 1992; Weingarten, 1998). Within this new turn of the systemic approach opposition between therapists and clients is largely being seen as negative; for instance Insoo Kim Berg (1991: 39) advices therapists '**Do not** confront directly or do things that will make the client defensive. Always avoid getting into debates or arguments with clients. It works better when you take a "one down" position and say you are "confused" or "don't quite understand", and ask for further clarification.'

The official story of systemic practice is thus becoming more and more firmly that the voice of the therapist should avoid becoming dominant in the psychotherapeutic interaction and that therapy practice should avoid being hierarchical, leading or prescriptive. As Jones (1993: 140) was noting 'the new systemic family therapy' has presented itself as democratic, co-constructive, neutral and value-free.' Opposing voices on the other hand become more isolated and defensive in view of the accumulating critiques (Minuchin, 1998; 1999).

This move had been embraced by a number of systemic practitioners. For instance Hoffman (1985: 393) wondering 'how one goes about influencing people within a "second order" cybernetic model' draws the conclusion that 'You don't strictly speaking, influence *people*- you only influence the *context*, maybe the only part of which you can control is yourself'. Tomm and Lannamann (1988: 41) comment that 'The goal of therapy is not to

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impose the therapist's view of particular changes but to enable clients to experience more freedom to make and act on choices in their lives'. Anderson and Goolishian (1992) in a seminal paper in which they encouraged therapists to adopt a 'not-knowing' position through which a therapist 'positions himself or herself in such a way as always to be in the state of 'being informed' by the client' (ibid.: 29), promoted the idea that the therapist's role is that of a 'participant-observer and a participant facilitator of the therapeutic conversation' (ibid.: 27). The activity therapists are supposed to undertake thus starts increasingly being characterized with terms such as 'facilitating' or 'enabling' (for instance enabling clients to achieve their goals); clients on the other hand were seen as needing to reach their own insights.

One of the main tools systemic therapists use to display their adherence to democratic principles is questions. As Glaser (1991: 156) notes 'Asking questions rather than making statements is a way of avoiding the trap of 'truths', whereas Rober (1999: 211) notes 'The therapeutic question is the primary instrument to facilitate the development of space for the not-yet-said'. Privileging questions over statements is also noted by Tomm and Lannamann (1988: 41) who claim that 'In contrast to assertions there is something in the grammatical form of questions that invites reflection and opens up alternative possibilities. Assertions often encourage closure while questions encourage exploration.' What transpires from such a claim is that one of the obvious benefits that questions present for systemic therapists is that they minimize the role of therapist and place the responsibility for the work that needs to be done onto the client who is supposed to reflect and explore different options; this can be seen more clearly in Tomm's (1988: 2-3) remark that 'A further advantage in therapist's asking mainly questions, and refraining from making statements, is that clients are thereby stimulated to think through their problems on their own. This fosters client autonomy and allows a greater sense of personal achievement for family members when therapeutic change takes place, rather than inducing dependency on the "special knowledge" of the therapist.'

A particularly influential concept which encapsulates systemic therapists' attempts to avoid becoming domineering and constitutes a clear display of non-interventionism is the therapeutic stance of neutrality (Selvini-Palazzoli et al., 1980: 11). Neutrality has been construed as the consequence of the therapist allying 'with everyone and no one at the same time'. The aim of adopting such a stance had been 'to observe and neutralize as early as possible any attempt towards coalition, seduction, or privileged relationships with the therapist made by any member or subgroup of the family' (ibid.). It is worth noting at this

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point that the therapist's stance of neutrality has later been heavily criticised, particularly from the feminist field (Imber-Black, 1986; Luepnitz, 1988; MacKinnon, 1993; MacKinnon and Miller, 1987), as constituting a way of perpetuating social injustices and the status quo.

In response to the emerging critiques, Cecchin, one of the authors of the initial paper on neutrality (Selvini-Palazzoli et al., 1980), rather than abandoning the concept re-defined it as a stance of curiosity which would permit the therapist to pursue his or her exploration of the different versions put forward by the clients attending therapy (Cecchin, 1987). In this way neutrality persevered as a theoretical concept despite the fact that this redefinition does not appear to have fully satisfied all critics, particularly those from the feminist group[1]. The extent to which the (re-defined) idea of neutrality has continued being deemed important by systemic practitioners becomes even more obvious when in subsequent years it has been used as a resource by practitioners dealing with cases of abuse; one such example is offered by Glaser (1991) who attempted to display that the concept continues having some therapeutic value in cases of child abuse.

1.2.1.2   Therapists' recognition of the potential for influencing clients

Systemic therapist's preoccupation with adopting an egalitarian, non-interventionist stance in essence constitutes an implicit admission of the therapist's power and his or her influential position. Indeed, second order systemic therapists made a point about acknowledging or 'noticing' power afresh[2], this time treating it not so much as a resource or as a therapeutic necessity but largely as something that needed to be managed, tamed or treated with caution.

To begin with, initially feminist and later on a larger population of therapists have started paying more and more attention to the ways through which a therapist might exercise power in their relationship with their client (Jones, 1993; 1995; McGoldrick, 1994). In contrast to proponents of the first order models though (Haley, 1976; Weakland

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[1] One such critic is Elsa Jones who 7 years after Cecchin's (1987) paper was noting 'This stance of curiosity (Cecchin, 1987) is one of the strengths of this approach, but is also perhaps one of the greatest sources of controversy and criticism' (Jones, 1993; p.145).
[2] The issue of power has been approached rather differently by first order systemic therapists (Haley, 1976; Weakland et al., 1974).

et al., 1974) therapists' power is considered potentially harmful and safeguards are put in place so that clients are protected. For instance Jones (1995: 11) notes 'the therapist acknowledges and takes responsibility for the imbalance of power which exists at the beginning of therapy and works in such a way as to 'shed power' and allow clients to empower themselves'. She later comments (ibid.: 19) that 'Recognising the power imbalance which exists – particularly at the beginning of therapy – between client and therapist makes it more likely that the therapist will avoid abusing this.'

Linked to the above, systemic therapists have started paying increasing attention to the ways in which therapists might influence clients through their personal characteristics (Falicov, 1995; Glaser, 1991; Jones 1993; 1995; McAdam, 1995). According to Aponte (1985: 327) 'value biases are pervasive in all aspects of therapy and the question is not one of *whether* the therapist's values will confront those of the family but *how*. The task that remains to be addressed is how therapists can work with their professional and personal values in ways that benefit the families they treat.**'** In addition, therapists are expected to make use of their selves in ways which might be helpful to clients (Hardham, 1996; Real, 1990).

As in the case of power, therapists consider necessary to put safeguards in place in order to protect clients from their own biases and so as to avoid influencing clients with their beliefs and preferred view points. One such safeguard is the concept of self-reflexivity which entails placing the therapist's own history, theory or cultural maps (Falicov, 1995) under scrutiny to avoid the unexamined import of what is considered as the therapist**'**s own biases. An illustration of reflexivity in action by a training group is offered by Burnham et al. (2008), whereas an example of a tool inviting self-reflexivity is given by Hardy and Laszloffy (1995) who propose the use of 'cultural genograms' in training; according to these authors this device **'**highlights culturally linked issues that may impede effective treatment' (ibid.: 233-235).

In addition, therapists increasingly started making references to the interventive character of questions (Tomm and Lannamann, 1988) which they argued can be used to influence clients (Tomm, 1988). Similarly to the issue of the therapist's power though, caution is required in order to avoid having a negative effect. For example Tomm (1988) creates a distinction between different types of questions, namely lineal, strategic, reflexive and circular. Only the last two types of questions are seen as having a positive effect on clients in terms of inducing change -namely generative and liberating respectively- whereas the first two types of questions are seen as having a conservative and constraining

effect respectively. Once more it is mostly up to therapists' skill and expertise to employ questions that will have a therapeutic effect and therapists need to continuously reflect upon the influence their questions might have on clients so as to avoid those with a negative impact.

The picture that is thus emerging from this brief look into the systemic therapy literature is far from black and white. Despite the fact that an egalitarian therapy has increasingly been favoured by a growing number of therapists, therapists' power and authority does creep into the picture, surfacing as something that needs to be managed and treated with cautiousness, or as something that needs to emerge in the therapy room in tentative and reflexive ways (as is the case with Mason's (1993) concept of safe uncertainty). The least that can be said according to the above reports in the systemic therapy literature, is that if avoiding influencing or leading clients constitutes an ideal (at least for some therapists), it seems that it is an unattainable one.

1.2.1.3   Limitations of therapy theory for investigating psychotherapy practices

Following a rather brief inspection of systemic therapist's theories regarding the extent to which therapists attempt to shape client's realities in particular ways, a rather complex picture has emerged. The question that is still left unanswered though is how such contradictions and dilemmas that are raised for therapists are being resolved or managed in action. A not particularly deep engagement with therapy texts reveals a number of reasons why therapy theories do not seem to be particularly beneficial in helping us investigate psychotherapy practices in an in-depth way.

The basic reason revolves around the fact that therapists' constructions would then need to be used as the measure against which therapy practice will be judged or understood. And whilst therapists' constructions contain therapeutically useful abstractions regarding the interaction between therapists and clients, they nevertheless also present a number of problems when taken as tools to investigate the process of psychotherapy. As will be explained below, these problems mainly relate to the ways in which such constructions are being produced.

To begin with, therapy theories have often borrowed conceptualizations, such as the theory on functionalism (Carr, 2000), general systems theory and cybernetics, from

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other fields. These broader conceptualizations then form the lenses that therapists apply to read or approach what is taking place in the therapy room. As one can imagine, there are bound to be problems of fit between these imported theories and what is taking place in the interaction between therapists and clients; aspects that do not fit these conceptualizations might remain unnoticed, or alternatively, the view of what is taking place might be intensely coloured by these larger metaphors.

Alternatively, a number of therapy theories have emerged from therapist's lived experience of working with the clients. The starting point in this case is therapists' own perspective and one can envisage a number of obvious problems with that, such as issues of stake, or partial view of the interaction, or the ways in which the clients' contributions are being included, which would render them unsatisfactory for measuring what takes place in the therapy room.

With regards to this last point about the clients' contributions, in the majority of therapy papers the clients' input is not being adequately represented; for instance in most cases they are presented in the format of reported speech in which case they are in fact co-authored by the therapist (Leudar and Antaki, 1996) and serve to validate the therapist's theoretical construction. An example –out of many- of this practice, can be found in a paper by Michael White (1986) which constitutes a narration of a single case study. Throughout the paper the clients' contributions are presented in quotes or indirect reported speech. Theories based on such inadequate representation of the clients' input do not constitute particularly reliable tools against which to examine the process of psychotherapy as this is jointly produced by therapists and clients.

Linked to that, as can be seen from a cursory examination of therapy journals, in therapy circles there is an established tradition of deriving or transmitting clinical knowledge through clinical vignettes, rather than alternative means such as recorded pieces of interaction between therapists and clients. An example (among numerous others) can be drawn from a paper by Lieberman (1995) in which he puts forward a theory on the behaviour of families of anorexics; the theory proposed by the author is exclusively based on clinical cases as these are retrospectively narrated by the practitioner. In that regard therapy theory as a genre of 'scientific'[3] theory bears a number of peculiarities, which largely relate to the ways in which it is drawn or validated from professionals' narratives of clinical encounters. As is the case with stories more generally, these constitute

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[3] Whereas therapists often strive to present therapy as a scientific discipline, according to authors such as Lowe (1990; p.8) therapists engage in 'literary productions, imaginative play and poetical invention'.

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reconstructions designed to address particular audiences, can be vague or leave out a great deal of information regarding what takes place in the encounter between clients and therapists. Once more one can imagine that therapy theories which rest upon evidential bases of this sort are bound to be inadequate when used as tools to examine the process of psychotherapy.

Another issue with therapy theories when taken as a framework for research, is that to a notable extent they are packaged in the form of idealized guidelines which distances them from actual therapy practice; despite the fact that theories by definition concern idealized practices, this is particularly striking in the domain of therapy. Examples of such idealized guidelines are the following: 'The basic premise is that *the therapist should attempt to exercise no more influence over the family's values than is required adequately to address the family's problems*' (Aponte, 1985: 335); 'therapists should employ four levels of description or explanation' (Jones, 1993: 154). The issue that this tendency raises is that we do not know what form such didactic principles actually take when implemented in the actual interaction with the clients, and the types of response that they tend to receive. Correspondingly, measuring the interaction between therapists and clients against such generic principles would leave a lot of room for arbitrary analytic comments.

In addition, even more concrete therapy techniques as is the case with different types of psychotherapeutic questions, are presented in isolation, outside of any context. Examples of this practice can be found in White's (1992) paper 'deconstruction and therapy' in which the author presents lists of different types of therapeutic questions. The difficulty that this raises is that when presented in isolation it becomes difficult to distinguish their actual role in the interaction with clients; and by implication, if used as tools to approach and investigate actual data one could find the task of fitting data within such categorizations challenging.

Finally, as became obvious from sections 1.2.1.1 and 1.2.1.2 above, even within the realm of one single psychotherapy approach such as systemic therapy, there are a variety of schools and theories that might stand in opposition to each other. This raises the need for a research approach employing an external descriptive language about therapy practices that will allow a more detached and nonaligned take on these practices.

Overall, all of the above points indicate that whereas therapy theories constitute invaluable resources in therapists' attempts to achieve their therapeutic objectives with clients and to communicate with their colleagues, they do not seem particularly fit for being employed as lenses that could adequately explicate psychotherapy practices.

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1.2.2   Therapy Process Research

The next path one could take in this search for an appropriate research framework for this study is that adopted by a number of researchers that investigate psychotherapy processes. It is perhaps useful commenting at this early stage that this corresponds to a somehow restricted part of research on psychotherapy, as a large proportion of it is geared to the effectiveness of different approaches and interventions (examples of which can be found in Carr's reviews (2009a; 2009b).

An obvious reason for this constitutes the number of benefits that seem to arise for practitioners from demonstrating that they deliver evidence based-practice, as these have been noted by Perakyla and Vehvilainen (2003) and as transpires from the recommendations of researchers-practitioners who advocate for the production of evidence testifying the effectiveness of particular schools of therapy (an example is offered by Rivett (2010)). This might account for the fact that even research on psychotherapy processes seems to at times constitute a stepping stone towards determining the outcomes of particular therapy approaches or interventions (such links between process and outcome research have been noted by Garfield (1990), Marmar (1990) and Stiles (1988) and also become evident in studies such as those by Knerr and Bartle-Harring (2010) and Lock et al. (2008)). Given the relatively limited number of studies on psychotherapy processes that focus on the systemic approach and given the fact that the points that will be raised in this section concern broader issues of research design, in the following section I will be drawing from pieces of research on therapy processes from different therapeutic orientations.

A cursory examination of different studies in the domain of psychotherapy process reveals a great deal of heterogeneity in terms of the ways that such studies are being designed throughout the different stages of the research endeavour, which in turn reflects a diversity in the epistemological assumptions underpinning these studies. What I will consider below is a limited number of basic dimensions along which these studies might vary. One or more of these dimensions might feature in a single piece of research.

One such dimension concerns what the study takes as the focus of the research and the extent to which this draws from particular theories. On one side of this dimension one could situate pieces of research that set out to investigate aspects of the client's or

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therapist's verbal or paralinguistic conduct in a therapy session. Examples of such studies are offered by Braswell et al. (1985) who examined client and therapist verbal activities in three different types of treatment and also by Stiles' (1988) study on therapists' and clients' verbal responses in therapy sessions of two different theoretical orientations.

On the other end of this dimension there are studies which attempt to investigate conceptual categories (examples can be drawn from the studies of Ryan and Carr (2001) and Pandya and Herlihy (2009) which focus on the concept of the therapeutic alliance). It is not infrequent that such conceptual categories originate from therapy theories postulating that such 'processes' tend to feature in the process of psychotherapy. In this latter case it is possible that many of the issues applying to research that takes as its framework therapy theories (as these have been outlined in section 1.2.1.3 above) become relevant in this type of research too. Alternatively though, even studies that do not directly take as their starting point particular therapy theories, as appears to be the case with studies belonging in the former category above, might fail to adopt a more independent stance. An example of how this might come about can be found in the above-mentioned study by Braswell et al. (1985), where the authors devised a coding scheme of process-categories arising from the data, some of which describe psychological processes in the language of particular psychological approaches- an example being the category 'therapist verbal positive reinforcer' which seems to have been drawn from the behaviourist approach and which thus seems designed to in some ways validate it.

Another important dimension concerns the type of data that is being employed to study psychotherapy processes and how this has been produced. Researchers might use transcribed audio or video material of therapy sessions, notes taken during the sessions, or clients' and/or therapists' open-ended accounts of what took place in a therapeutic encounter. Descriptive material of what took place in a therapy session might also be elicited through the medium of interviews, questionnaires or scales. These different sets of data reflect a differing degree of immediacy of the research encounter; whereas audio or video material contains a large part of what actually takes place in a therapy room, this is less so the case with retrospective accounts of aspects of the psychotherapeutic encounter. Moreover, these varied types of data entail a differing degree of involvement on the researcher's part in terms of their production. One could make the case that the more researchers' are involved in the production of the data, the more the gathered material risk to reflect researchers' pre-conceived ideas or theories regarding the area of study.

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For instance, measuring instruments such as questionnaires or scales might carry aspects of the researchers' -or ultimately therapists'- privileged theory. To take one example, in the study by Lemmens et al. (2009) on therapeutic factors in a systemic multi-family group for depression, subjects completed questionnaires which included items on the types of therapeutic factors, thus implicitly directing or pre-determining participants' responses.

An additional example of the researchers' impact on the type of data produced can be drawn from a controlled clinical trial by Dozier et al. (1998), designed to examine the impact on the therapeutic alliance of particular types of questioning, as these have been devised by a prominent systemic therapist, Karl Tomm (1987; 1988). The study involved showing families videotaped instances of simulated therapy sessions, each of which was devised to portray a particular type of therapy questioning. In this case researchers had a significant input in the type of data that has been gathered, not only through their use of a particular scale which pre-empted the range of acceptable answers, but also, indirectly, by devising particular scripts of therapy sessions. In this way the collected data was importing in the research not just the authors' pre-conceptions, but also the assumptions of the particular theory that these scripts were designed to exemplify, given that the scripts had been based on Tomm's examples of the different questioning styles and had also been validated by him.

In case researchers employ standardised tools such as questionnaires, it is not only important how such tools have been devised, but also the way that these are actually being administered to participants. The reason for that is that this could have an impact on the data that is ultimately collected. This has been demonstrated by a number of studies from neighbouring fields. For example, a study by Houtkoop Steenstra and Antaki (1997) on the quality of life of people with a learning disability brought to the surface the transformation by interviewers of interview questions in ways that jeopardised the questionnaire's validity. In addition, Antaki (1999; 2001) found that interviewers assessing the quality of life of people with learning disabilities transformed the questions in ways which portrayed their respondents as limited along a variety of dimensions such as linguistic, cognitive or social. In this case, the ensuing results were not so much telling for respondents' quality of life as they were reflections of the interviewer's viewpoint on it. Moreover Rapley and Antaki (1996) equally employing data from interviews assessing the quality of life of people with learning disabilities found evidence that challenges the idea that the outcomes

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of research employing such data collection methods are independent of the research situation.

Aside though from methods of data collection that involve a large input on the researcher's part (for instance in the construction of the tool), problems have also been reported with interviews, a device which does not involve a structured procedure and which is routinely used in the research on psychotherapy process (examples can be seen in the studies of Bowen et al. (2005) and Pandya and Herlihy (2009)). Potter and Hepburn (2005) offer a comprehensive review of a number of problems arising from the use of interviews, a particularly salient one being 'flooding the interview with a social science agenda and categories' (ibid.: 16). The authors observe that there is a likelihood that 'a piece of interview research is chasing its own tail, offering up its own agendas and categories and getting those same agendas and categories back in a refined or filtered or inverted form' (ibid.: 19). Similarly, Speer (2002) has demonstrated from the analysis of interviews in the field of feminist research that even when a researcher attempts to minimize his or her input in the production of the data through the use of non-directive techniques such as prompts, he or she might end up having the opposite effect.

A third basic dimension along which many therapy process studies can be situated concerns the way that the data are being treated (which obviously also is interlinked with the types of data collection techniques that have been employed and the epistemological assumptions underpinning a piece of research). In case the research is of quantitative nature or involves quantitative components researchers identify relevant variables that might potentially appear in the data, represent them numerically and then implement a number of measuring operations. Examples can be found in the study of Lemmens et al. (2009) who investigated therapeutic factors in a systemic multi-family group treatment for people suffering from depression or in the study of Holzer et al. (1996) who analyzed psychotherapy transcripts implementing computer-based analysis of the material. As psychotherapy is based on talk, by transforming talk into numbers and quantifying interaction a lot of the richness of the therapeutic encounter is lost.

This constitutes ample grounds for opting for a qualitative methodology. However, even qualitative pieces of research involve procedures which result in reductionist accounts of the richness of the psychotherapeutic process. For instance, much of the research on psychotherapy process that is performed from within a qualitative research framework involves coding observable features of the interaction between therapists and clients in process categories (e.g. Bowen et al., 2005; Pandya and Herlihy, 2009). However, as

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Heritage and Maynard (2006: 361) notes regarding process research in medical interaction 'coding expunges the context of utterances and actions. The location of utterances and actions in a phased activity within an encounter such as history taking or counseling and their placement in a specific and autocthonously intelligible sequence and course of action are precisely the aspects of context that give utterances and actions their meaning'.

So far, from this brief exploration of psychotherapy process research arise a number of potential shortcomings attached to different aspects of a variety of types of research that investigate how therapy works. These raise the need for a research framework which would allow one to conduct research that would largely be independent of pre-determined therapy theories, which would permit the collection of data that minimize the researcher's involvement in their production and which would thus allow for the richness of the psychotherapeutic encounter to be captured in the research. Also it raises the need for a research framework that studies talk between therapists and clients in the context in which it is being produced.

These features seem particularly important for a piece of research that takes as its starting point broad areas of interest rather than clearly defined research question. Also they seem very important for a piece of research which takes as its task to investigate contradictory or dilemmatic aspects of therapy work and which aspires to allow some space for the emergence of aspects of therapy practice which might not form part of prevailing psychotherapy theories. Finally, they seem particularly important for a piece of work which seeks to avoid being driven by idealized accounts of therapy practice and which instead seeks to examine how particular issues, paradoxes or dilemmas are being managed in action.

1.2.3 Interactional approaches to the study of psychotherapy practice

The next port of call in the search for a research framework from within which to conduct this research consists of analytic approaches which focus on social action and pay attention to the interactional detail of how participants manage their business, namely conversation analysis and discursive psychology.

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1.2.3.1 Conversation analysis

Conversation analysis, an empirical approach developed by Harvey Sacks (1992) is dedicated to the study of the '*interactional organization of social activities*' (Hutchby and Wooffit, 2005: 14). According to Ten Have (2007) conversation analysis could be considered a paradigm on the basis that it constitutes a unique way of studying the social world.

In contrast to many other approaches which adopt a referential view on meaning, conversation analysis views language as a means of performing actions and offers an empirical approach to the study of social action through the detailed investigation of participants' talk. From a conversation analytic perspective conversational phenomena are not just linguistic occurrences which could be bracketed off so as to only distil their supposed 'essence' (which would be the information they transmit). They do in fact constitute the very social actions that people perform and are thus very telling and revealing about social life itself. Thus, from such a perspective, to analyse the conversational phenomena occurring in therapy sessions would lead us to the heart of psychotherapy and could provide a methodologically disciplined way of describing how therapy is done in all of its revealing details and multifaceted dimensions.

The approach maintains that participants possess as resources a multiplicity of ways of accomplishing actions, for instance by varying the design, lexical choice, or delivery of their turns in interactionally meaningful ways. In this manner, participants manage to constantly construct themselves, the others and the world. Therefore the analysis attempts to illuminate all these minute features and details of the talk that are significant for participants themselves and to explicate what participants achieve by mobilizing them.

Meaning is seen as emerging from an utterance's placement in the particular interactional environment in which it is produced and therefore the approach underlines the indexical (Garfinkel, 1967) properties of utterances and the occasioned nature of talk. This means that utterances do not as much have a static meaning independently of the context in which they are produced, but rather, they draw their significance from the particular interactional circumstances which give rise to their occurrence. To take one example, the invocation of problems of self-esteem by a client will draw its meaning from having for instance emerged as part of an account for the non-taking of a course of action, rather than

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being taken as an intrinsic or invariable psychological feature that will be attributed to the client in a general manner. One can also imagine that the use of such an account will be particularly suitable in the context of a psychotherapy session where a clients' psychological state of being is a central consideration.

From a conversation analytic perspective interaction is organized in a sequentially organized manner as participants collaborate in the production of sequences which constitute 'courses of action implemented through talk' (Schegloff, 2007: 3). An action produced by a speaker projects or makes relevant a next action or a number of possible next actions by the next speaker. This initial action thus constitutes the local context for the second speaker's ensuing action, which in turn becomes the context for a next action. The second speaker monitors the prior speakers talk for the type of action it implements and designs his or her talk in a way that orients to it. Simultaneously by producing a relevant next action, the second speaker displays his or her understanding of the first speaker's action, thus building a mutual understanding of the interaction. If a relevant next action is not forthcoming this can be treated as meaningful in itself; for instance it can be understood as a way for performing a different type of action or it might potentially be treated as an accountable matter. What the last point also indicates is that from a conversation analytic perspective, whatever takes place in the course of interaction (even the lack of a relevant next action) is particularly telling for how participants manage their business and is worthy of an analyst's attention.

Overall, conversation analysis shows a commitment to avoiding drawing analytic inferences from the application onto the data of pre-existing theories or categories, resisting going up the ladder of abstraction in terms of the analytic concepts employed. Critics have pointed out the impossibility of studying participants' talk in their own terms (Billig, 1999a; 1999b), but conversation analysts maintain there are virtues in following a principled way of analyzing data which avoids the imposition of concepts or categories that do not seem relevant to participants' concerns (Schegloff, 1992; Schegloff, 1999). In the case of research on psychotherapy, this would mean that conversation analysis would be in a position to offer what Madill et al. (2001: 416) characterize as 'a data-driven perspective from outside the institution of psychotherapy'.

One of the main ways that conversation analysts attempt to satisfy the above principle is by examining participants' orientation to their co-participant's prior talk, to any categories that they consider that this makes relevant and to the type of actions that they diagnose that this performs. The analyst's task is to prove that any analytic insights are

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drawn from the issues that participants make relevant in their talk, and that any analytic categories recruited (including those about participants' institutional identities in the case of institutional data (Drew and Heritage, 1992; Schegloff,1992)) demonstrably matter for participants themselves. In that regard conversation analysis embraces the principles of ethnomethodology (Garfinkel, 1967) which views members' practices and commonsense knowledge as the subject matter of the study.

The above enterprise is also made possible by the fact that conversation analysts employ naturally occurring talk as data. In this way the role of the researcher in the production of the data is minimal or even, on some occasions, inexistent. This type of data also permits the researcher to come close to actual members' practices as opposed to idealized ones (Heritage, 1984a); moreover, in the case of research on psychotherapy it promises to keep alive for the researcher all the richness, complexity and infinite detail of a social encounter as the psychotherapeutic one.

1.2.3.2 Discursive Psychology

Discursive psychology (Edwards and Potter, 1992), could broadly be characterized as 'the application of ideas from discourse analysis to issues in social psychology' (Potter, 1998: 234). Two of the most central areas that this empirical approach focuses on is cognition and reality; both of these domains are examined as discursive constructs featuring in participants' talk, that are recruited as means of attending to practical business of all kinds.

Before proceeding any further it is worth noting that discursive psychology draws heavily on conversation analysis, highlighting the action-orientation of discourse and its situated nature. Moreover, although discursive psychology is not so much preoccupied with the structural organization of talk, it is equally committed to studying talk in its local context, paying attention to its detailed features and basing analysis on recorded interaction. Furthermore, discursive psychology operates from within an ethnomethodological framework and analysts limit their analytic claims to aspects of the talk that demonstrably matter for participants and to which they appear to orient in their talk.

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Discursive psychology also draws insights from Billig's (1996) rhetorical psychology as it acknowledges the rhetorical nature of descriptions. According to Billig (1989: 206) 'Holding a view on a social issue involves taking an argumentative stance in relation to counter views'. Participants' efforts to present a version as factual and convincing could thus be rather telling of the potential that their version might be discounted or treated as disputable and might be revealing of participants' efforts to attend to such eventualities.

From a discursive psychology perspective, discourse is considered both as constructed (through its sequential ordering, rhetorical devices, accounts and other features of language) as well as constructive (Potter, 2004), in the sense that it builds versions of the world. The task of the analysis is thus to examine the ways in which descriptions construct the world, particularly in relation to alternative or competing versions and to identify the resources participants mobilise to this end.

One of the most central contributions of the approach is that it offers an interactional approach to the analysis of psychological concepts in action. It re-examines psychological notions that have traditionally been analysed in the abstract, such as memory, emotions, claims of knowledge or intentionality (Edwards, 1995; 1997; 1999; 2006; Edwards and Potter, 1992; 2005; Locke and Edwards, 2003) investigating their practical uses in interaction. These psychological concepts in action are not treated as deficient or partial indications of external and objectively defined processes, but as means that people use to undermine or support particular versions, to account for their conduct and to accomplish actions more broadly. Discursive psychologists have thus taken as their task to respecify notions featuring in cognitive approaches such as cognitive distortions (Auburn and Lea, 2003) scripts, perceptions, emotions (Edwards, 1997), bringing to light their situated nature as discourse practices and critiquing the assumptions upon which rest traditional studies of the mind.

Another important area of study for discursive psychologists is the way in which participants might construct descriptions as factual and what this accomplishes in action (Potter, 1996). Participants might thus use a number of discursive devices to portray a version as independent of the speaker. Alternatively participants might draw from a number of available discursive resources to portray a version as subjective; subjectivity in this case could be used to undermine a particular description (Edwards, 2005), or to achieve a variety of other interactional effects. Overall, discursive psychology offers detailed accounts of the ways in which participants construct the world, support or

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undermine particular versions, and also of the ways in which descriptions about the mind or reality accomplish actions.

To conclude, the above characteristics of both conversation analysis and discursive psychology render them an appropriate research framework for the present study. Among their advantages, two seem particularly prominent for studying psychotherapy practices: firstly, the fact that they both pay attention to detail in the study of participants' talk, and secondly, that they are both weary of imposing onto the practices they investigate analytic categories that are distant to participants' concerns.

1.3   Outline of the thesis

The thesis is structured as follows. In chapter two the focus is on the primary methodological framework of this study, conversation analysis. This is approached from two different angles: initially by investigating how conversation analysis can be applied to psychotherapeutic interaction and the type of descriptions of therapy practice that might ensue. This is achieved by giving a brief account of a number of studies on psychotherapy talk which reveal that this method succeeds in offering interactional accounts of great detail. This exploration offers us a preliminary conceptual context before proceeding to the analytic chapters.

The second angle from which I approach the conversation analytic framework is by investigating how this approach can apply to the study of argument. In this section we enter into rather subtle methodological issues, which focus on the study of argument from an interactional perspective. The basic component of argument talk is taken to be the action-opposition sequence. In addition argument is examined as a practice which obtains some of its basic characteristics from the local conventions which become pertinent in particular types of interaction. This allows for a degree of variation in the characteristics of argument talk in different types of interaction. Moreover, a reference is made to the dual meaning of the word argument (as this might be used is in the sense of a dispute or of building a case), noting the possibility of overlap between the concepts, the possibility that participants might display or orient to both aspects of the term in their talk and that on different interactional occasions a single, or both aspects of the term might be illuminated.

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These observations prepare us for discovering features and forms of argumentation in a setting where normatively argumentation might seem an improbable activity.

Chapter three offers an account regarding the type of data that have been gathered, which consist of thirteen hours of recorded therapy talk between a systemic psychotherapist and a person living with HIV. Moreover, it presents some information regarding the service from which the data for the study has been drawn including the different types of clinical work performed in this service. What is also explicated is the process of obtaining ethical clearance for the study and of securing permission from the different NHS Research and Development departments, whereas I also discuss how these processes impacted on the amount of data collected. I also present some of the main ethical principles that have been followed in the study as well as information regarding the transcription procedures and the selection of the extracts.

Chapter four, the first analytic chapter, focuses on a practice which potentially triggers or initiates episodes of argumentation. The practice involves the solicitation of the client's strongest grounds in support of a negative stance that the latter previously displayed; the question is formulated in ways which invite a defeasible response; therefore in case the client delivers grounds in support of her stance the therapist proceeds to counter them thus performing an initial oppositional move (which in the data is first in a series of such moves). It thus transpires that in this case it is the therapist who opens up the space for opposition which at times is performed in a fairly systematic way. It could be argued that in case the therapist's move adheres to systemic principles, argument might have a justified place within this particular approach.

In chapter five the therapist initiates a series of questions which invite the client's supposedly spontaneous contributions through largely leading questions. Interestingly, the therapist's line of questioning uncovers a contradiction in the client's utterances and culminates in a challenge or a disagreement on the therapist's part at the conclusion of this lengthy sequence. The contradiction that the therapist exposes in this way largely revolves around the client's personal domain of experience; in contrast with other phases of the therapy work in this case this appears to be mobilised for oppositional purposes.

Chapter six focuses on a practice which at first, without the close inspection of the talk or of the interactional context in which this emerges, appears as an instance of affiliation. The client displays a standpoint and the therapist issues a concessionary statement which on the surface appears to go along with the client's version in a rather striking way, as this also includes a positive assessment or valorisation of the client's

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standpoint. Close inspection of the talk though reveals that the therapist's concession is a tactical one as it is followed by an account or elaboration which permits the therapist to carry out an oppositional move.

Finally, in chapter seven, the concluding part of the thesis, I start with a summary account of the phenomena in the data. In addition, I describe some main characteristics of the episodes of argumentation in the data which might also be applicable to incidents of argumentation in psychotherapeutic interaction more broadly. Moreover, based on the findings in the three analytic chapters, I appraise the role of epistemic accessibility in the accomplishment of opposition in systemic therapy practice. I then draw links between the practices in the data and systemic therapy theoretical concepts; these links underscore the absence in theoretical accounts of systemic practice of the potential role of persuasive argumentation when therapists attempt to achieve change. It is noted that this absence could be accounted for by contradictory mandates in systemic therapy theory which might also account for the form that argumentation takes in the data. There follows a section which treats the thesis as a constructed text, whereas the conclusion ends with a brief outline of some main contributions of the thesis.

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Chapter 2: Conversation analysis, psychotherapy and argumentation

2.1   Conversation analysis and psychotherapy

Having identified a framework for the research, we will now have the opportunity to appreciate conversation analysis in more depth, by viewing some applications of this approach. These applications will be drawn from key conversation analytic studies on psychotherapy. This review, which is by no means exhaustive, will, on the one hand, reveal an expanding field and, on the other, will illustrate what conversation analysis can achieve when employed to analyse psychotherapeutic interaction. One could distinguish these studies according to whether they mostly focus on a client's or a therapist's action; in the latter case one could distinguish between initiating therapist's actions or actions which are responsive to a prior action by the client.

2.1.1   Therapists' moves which initiate a course of action

A number of conversation analytic studies on interaction in counselling or psychotherapy settings focus on courses of action which are initiated by the therapist. One such phenomenon is the practice of perspective display series that was first described by Maynard (1991) in medical interaction. The sequence is initiated by the practitioner who elicits the client's perspective; this then allows the practitioner to introduce his or her perspective in third position, appearing to have taken into account that of the client. Hutchby (2007) who systematically studied this type of sequence in child counselling observed that it might be used as part of a counsellor's efforts to attain two potentially conflicting psychotherapeutic targets: to enable children to profess their own perspective whilst simultaneously guiding the talk towards therapeutically relevant matters.

However, the instances that Hutchby (2007) investigated demonstrated that the device fails to open up the space for therapeutically relevant talk. In particular, following solicitation of the child's perspective, the child at best offers a noncommittal response. In response to that the counsellor proceeds to issue a therapeutically relevant perspective,

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which once more gives rise to a noncommittal response by the child that brings the sequence to a close.

In this way the counsellor not only fails to produce a perspective that would have been sensitive to the child's; but rather, when delivering his or her own perspective this is 'based on the counsellor's interpretation' (ibid.: 77). What this reveals is that for such sequences to materialise and to accomplish a therapeutically relevant trajectory, the client, in this case a child, needs to collaborate in their production. This is also a phenomenon which reveals that clients (i.e. children) might avoid aligning with the institutional agenda, and therefore forms part of a number of studies which touch upon the issue of client resistance (Antaki et al., 2004; Hutchby 2002; MacMartin, 2008; Madill et al., 2001).

Another phenomenon that has been identified in interactions between clinicians and clients is that of hypothetical questions (Perakyla, 1995). Perakyla has observed that HIV counsellors of systemic orientation employed future-oriented hypothetical questions to bring to the table and address difficult issues such as dying. Similarly to the above practice, such questions reflect counsellors' attempts to accommodate conflicting professional mandates, namely avoiding being directive whilst simultaneously channelling the talk towards challenging future situations.

These future-oriented hypothetical questions manage to open up the space for difficult issues precisely because of their hypothetical structure and conditionality. On one hand they invite the clients to comment on scenarios that might possibly realise, permitting the counsellor to achieve his or her institutional aims. Simultaneously their hypothetical structure renders the task of securing a response from the client more feasible as it permits him or her to come up with an answer which is equally hypothetical, non-definite and somehow removed from his or her current circumstances. Although these questions render the task of answering difficult questions less threatening for participants, clients are also in a position to use the hypothetical nature of the question as a resource to leave the question unanswered on the grounds that they lack epistemic certainty about the future.

MacMartin (2008) studied a different type of questions appearing in therapy sessions of narrative and solution focused orientation. In particular, the author identified the use of optimistic questions which embedded a number of presuppositions regarding the client's strengths or other positive personal characteristics. These questions were mostly wh-questions which renders the task of contesting the embedded presupposition more difficult, as one would then have to respond 'in a manner that refuses to answer the question agenda' (ibid.: 83). The therapist appears to ground these questions in the client's

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preceding talk; this establishes their relevance at that moment in time and creates 'a common ground for the optimistic presuppositions they contained' (ibid.: 85).

Despite these features of optimistic questions they largely appear to receive disaffiliative responses by the clients who opposed the optimism embedded in these questions. The author notes that this has been less the case with hypothetical questions thus confirming Perakyla's (1995) findings regarding the potential of hypothetical questions to attract a response. Such responses by the clients principally triggered attempts by the therapist to recycle their optimistic questions.

2.1.2   Therapists' actions targeting a client's prior action

Conversation analysts have illuminated a number of intriguing actions performed by therapists which are responsive to a prior action by clients. In many cases these actions seem to somehow modify aspects of the client's prior talk either explicitly or in more implicit ways, or to offer a novel perspective in relation to the client's prior utterances.

Rae (2008) has described a practice encountered in a counselling psychology psychotherapy session which he termed 'lexical substitution' through which the therapist indicates to the client the appropriate level of feeling that the latter should exhibit. In particular the therapist proposes an alternative lexical item for a description previously issued by the client. Whilst this move seemingly imposes a 'minimal' change to the client's prior description and constitutes the therapist's display of understanding of the client's prior utterance, it simultaneously constitutes an explicit correction which promotes a different perspective to that put forward by the client. Interestingly, despite the fact that this type of correction corresponds to a particularly 'authoritarian' (ibid.: 69) form of repair, and also, despite the fact that the correction which the therapist issues concerns matters which epistemically belong principally within the client's realm of knowledge, it appears that the correction is subsequently being accepted by the client.

Another key conversational phenomenon is 'reinterpretation'; a practice identified by Bercelli et al. (2008b) in cognitive behavioural and systemic therapy. Reinterpretations constitute a medium through which therapists introduce their perspective in relation to the client's experience; this perspective might differ to that previously put forward by the client. What is distinctive about this practice is that the therapist does interactional work to

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display that she or he offers her or his own perspective in relation to the client's utterances up to that moment in time. According to the authors (ibid.) these utterances are thus routinely preceded by markers which display that the version offered is that of the therapist.

Reinterpretations make relevant an array of different responses by the clients. These range from agreement, that might be either minimal or more substantial as is the case with offers of evidence in support of the therapist's reinterpretative statements, to sheer disagreement. In cases where the client proceeds to display his or her agreement to the therapist's reinterpretation, this might be realised in ways which portray the client's insights as having emerged from the therapist's utterances; as noted by Bercelli et al. (ibid.: 60) such changes of perspective are 'precious stuff in psychotherapy especially when manifestly triggered by therapist's interventions'. The authors have also observed that in case the novel perspective introduced by the therapist is met with lack of response by the client, therapists might pursue this particular thread until they finally secure a response.

In the psychoanalytic field conversation analysts (Perakyla, 2008; Vehvilainen, 2003a) have described the practice of interpretation which presents some similarities with reinterpretations. In particular, through the medium of interpretation an analyst proposes a diagnosis of the patient's mental experience. According to Vehvilainen (2003a: 580) interpretation 'functions as an explanation' of a puzzle that has been constructed gradually in the course of a session. Therefore, interpretations are often the culmination of an interpretative trajectory that has been built progressively in the course of a session. In cases where patients do not collaborate in the build-up of this trajectory, the ensuing interpretations might be resisted by the patient.

Part of this trajectory has been illuminated by Vehvilainen's (2008) study on ways in which analysts identify instances of patient resistance to the analytic work. The author identified two distinct ways that might happen: firstly, the analyst might render the patient's prior actions the focus of the talk, using it to build a puzzle. Secondly, the analyst might characterize the patient's prior action as evidence for an interpretation that the analyst puts forward. In the course of doing so the analyst raises accountability issues for the patient and can also open up the space for argumentative sequences. Vehvilainen (ibid.) notes how such moves on the analyst's part serve to construct an asymmetry between the analyst and his or her patient given that the analyst does not treat the patient as the owner of his or her experience.

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Interpretations and reinterpretations constitute means through which therapists explicitly put forward their perspective, even though in the course of doing so they might take care in presenting this perspective as somehow grounded in the client's preceding talk (this has for instance been noted by Vehvilainen (2003a) in her analysis of interpretations). However, there are instances where therapists employ considerably more subtle means of introducing a psychotherapeutic perspective, namely extensions (Vehvilainen, 2003a) and formulations (Davis, 1986).

Formulations have frequently been identified as a key resource that therapists employ in order to pursue their institutional aims. On the surface of things they constitute a way that therapists have of summarizing or drawing the implications of the client's prior talk. By doing so however therapists select segments of the client's version and delete some other parts; what emerges is thus a modified version in relation to the original that had been produced by the client. According to Davis (1986), this phenomenon, which she termed re-formulations is a strategic means through which therapists transform a client's prior version to 'a suitable problem for therapy' (ibid.: 46); as the author notes, this also constitutes a means through which therapists might psychologise a client's version. Interestingly, formulations have been noted (Heritage and Watson, 1979) to function as first pair parts which project agreement. By doing so they promote the acceptance of this hybrid or modified version that the therapist implicitly puts forward.

This phenomenon appears to be used broadly by therapists; indeed it has been identified in a number of different therapy approaches (such as psychoanalytic sessions (Vehvilainen, 2003a), cognitive behaviour therapy (Antaki et al., 2004; 2005), or child counselling (Hutchby, 2007)) and appears to serve diverse institutional aims. A canonical usage of this practice is to transform clients' accounts in ways which are consistent with core therapy objectives such as interpretation, the construction of psychotherapeutic hypotheses and the transformation of the meaning ascribed to clients' problems (Antaki, 2008; Hutchby, 2007; Kurri and Wahlstrom, 2007; Vehvilainen, 2003a). Antaki (2008) also noted that this practice is at times used to advance the progress of a session. In addition, Antaki et al. (2005) and Antaki (2008) observed that formulations are used in the course of history taking, shaping the client's talk in ways that render it amenable to further psychotherapeutic interventions at a later stage of the work.

Aside from formulations, another method of introducing a therapy-laden perspective has been noted by Vehvilainen (2003a) who observed the use in psychoanalytic psychotherapy of a practice which she termed 'extensions'. Through this

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particular practice therapists collaboratively complete patients' talk. In particular, extensions have been described as turns that are responsive to a patient's immediately preceding talk and which are offered as its continuation. These utterances, which cannot stand on their own, are often introduced with various connectives that link them with the client's prior talk. Extensions display the therapist's understanding of the client's preceding talk, but simultaneously introduce new elements which might even contradict the client's version. According to Vehvilainen (2003a: 581) 'using devices, which imply the availability of the other speaker's meaning, while also including new elements, is a way to read psychoanalytic relevancies into the patient's talk. It is a way for analysts to imply that the patient's talk contains *a meaning that he or she is not (yet) aware of*'.

2.1.3 Clients' actions

Conversation analytic studies which focus principally on clients' actions appear to be fewer. Many of those seem to centre on actions which resist the therapist's trajectory. For instance Hutchby (2002; 2007) has displayed how the utterance 'I don't know' has been used systematically by a very young child in child counselling as a means of obstructing the counsellor's line of questioning. The sequential analysis of these utterances demonstrated that they appeared in specific moments in the interaction which involved the counsellor raising delicate issues. According to Hutchby (2007) the child's strategy proved to be remarkably powerful as on one hand it could 'be produced in response to virtually any prior turn' (ibid.: 121) and simultaneously it removed any accountability issues for not answering the counsellor's questions.

This resistance strategy has also been observed by MacMartin (2008) as a response to the optimistic questions that narrative or solution focused therapists employ. In that case it featured as part of non-answer responses which the author contrasted with answer-like responses. The latter supposedly affiliated with the therapist's trajectory but nevertheless were subsequently 'treated as problematic' (ibid.: 85). More specifically, these consisted of 'downgrading the optimism of therapist's questions, joking and sarcastic responses and refocusing responses' (ibid.: 91).

One of the explanations offered by the author on the issue of the clients' resistance relates to the possibility that, were clients to accept the presuppositions of these questions,

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they could be seen as engaging in self-praise which is routinely avoided in ordinary interaction. Alternatively, this resistance could reveal a tension between clients' need to focus more on problems and the mandate of narrative or solution focused therapies which aim to help clients construct more fulfilling stories about themselves and their significant others.

Moving away from the topic of resistance brings us to a study by Bercelli et al. (2008a) who studied clients' personal narratives in individual sessions run by cognitive and systemic therapists. The authors have identified two sequential environments in which such narratives appear: firstly, following solicitation and secondly following therapist's reinterpretations which make clients' responses relevant given that they constitute B-event (Labov and Fanshel, 1977) statements. It appears that clients' personal narratives take different forms in these two distinct environments.

In particular, in case they appear following solicitation by the therapist they seem to contribute to the therapist's agenda. The reason for that is that in this case it is the therapist who decides which parts of the clients' talk are worthy of further development and who might have a decisive role in shaping the form of this narrative, in the course of its progression. As noted by Bercelli et al. (2008a: 294) 'therapists, by pursuing their inquiry, elicit aspects of clients' events and experiences that possibly escape previously set perspectives'.

Alternatively, in case personal narratives are occasioned by therapists' reinterpretative statements they appear to serve as evidence which supports or counters the therapist's reinterpretations. In these cases personal narratives are volunteered by clients and therapists' influence on the shape of these narratives is rather minimal. Clients might thus develop narratives in ways that are unforeseen by therapists, and therapists may allow clients to make contributions that might not only bolster their reinterpretations but might also modify them. One of the key issues that this study highlights is the 'interactional complexity of personal narratives' (Bercelli et al., 2008a: 300) in a psychotherapeutic setting.

To conclude, despite the fact that this presentation of a number of key conversation analytic studies in the field of psychotherapy is not exhaustive, it nevertheless shows that through the sequential turn-by-turn analysis of interaction between therapists and clients it is possible to examine closely significant aspects of the therapeutic process. It appears that this approach has the potential of providing detailed interactional accounts that cannot be produced by professionals' stocks of interactional knowledge (Perakyla and Vehvilainen,

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2003). In particular it permits analysts to view how therapists' and clients' contributions prompt or further one the other and how they co-create the practice of therapy. The end product is a very elaborate account of the moment-by-moment construction process of psychotherapy practice, resulting from the consideration of the minute details of the interaction. In addition, it becomes apparent that conversation analysis permits the identification of common conversational practices (as is the case with the phenomenon of formulations or with particular resistance strategies) across competing types of therapy as well as the use of a common descriptive language that is applicable to many different psychotherapeutic modalities.

2.2   Conversation analysis and argumentation

From a conversation analytic perspective arguments are interactionally accomplished in a turn-by-turn manner. Arguments are seen as jointly produced by co-participants and involve following culturally familiar patterns of disagreeing with each other (Antaki, 1994). An important moment in the journey of treating arguments as interactionally managed was marked with the work of Scott Jacobs and Sally Jackson (Jackson and Jacobs, 1980; Jacobs and Jackson, 1981), who were nevertheless coming from the tradition of speech act theory. Although Jacobs and Jackson maintained speech act theory as their overarching analytic framework, they nonetheless incorporated in their work on arguments many of the insights of the conversation analytic approach that had taken off ground in the previous decade. By doing so, they planted some important seeds for an interactional approach to argument-talk, which were later reworked and advanced in a more rigorous way by conversation analysts.

Jackson and Jacobs applied to the study of argument the conversation analytic ideas of adjacency pair, and thus saw arguments as arising when 'one party issues a proposal or other FPP … which is then rejected, objected to or countered by the other party … and then resupported by the first party' (1980: 254). One benefit of examining arguments as organised in the form of adjacency pairs was that it permitted researchers to apply to the study of arguments characteristics pertaining to adjacency pairs, such as their possibilities for expansion or the preference for agreement. As Jackson and Jacobs (1980: 257) noted 'A recipient of a FPP may treat it as arguable in order to justify an upcoming dispreferred

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SPP, or to obtain a backdown. An SPP may become arguable in order to obtain a more preferred substitute. Authors of a FPP or SPP may imply the arguability of their own turns by providing unsolicited support for issuing the turn.' Analytically this broadening of the study of arguments with a number of basic conversation analytic insights would permit analysts of conversational arguments to capture the oppositional or argumentative flavour of turns which otherwise might have remained un-noticed with the use of more inflexible analytic lenses.

Jacobs' and Jackson's (1981) account of argument-talk was not far from Coulter's (1990) more distinctly conversation analytic account of argument structure ten years later, which described argumentative sequences as being organized in two-pair parts, and an ensuing third turn. The first pair part would consist of an assertion, which could potentially be followed by a disagreement token or a counter-assertion (as opposed to the alternate choice of agreement). Such response to the first pair, would have the effect of prolonging the topic instead of closing it (as agreement would have done) and could open up the possibility of the first speaker responding with a type of third turn (in Coulter's terms a reassertion), that would maintain the argumentative nature of the sequence. Such types of second and third turns would be dispreferreds in contrast with alternative types of turns that would have displayed agreement. Subsequent conversation analysts have been referring to Coulter's description of an initial adjacency pair followed by a third turn, as a three-part sequence.

According to Coulter (1990) what people argued against was 'adversary positions ("or theses") with respect to some topic' (ibid.: 185). Nevertheless Jackson and Jacobs (1980), had argued for including within the range of things that somebody in a conversation could take issue with, a variety of other possible arguables such as someone's right to make a particular claim. This was an important contribution because it paved the way for locating the source of a dispute in any feature of a turn: according to Maynard (1985) and Antaki (1994) practically anything in what someone might say and not just assertions carry the potential of becoming an arguable.

The idea that the backbones of argumentative sequences are formed from adjacency pairs was later criticised by Hutchby (2001) who nevertheless maintained these authors' emphasis on arguments as interactionally achieved and as emerging in a sequential manner. Hutchby (ibid.) claimed that in contrast with first pair parts which make conditionally relevant a second pair part, what defines a sequence as argumentative is the second move. As Hutchby (2001: 128) noted 'Coulter confuses the strongly prospective

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constraints involved in adjacency pair sequences with the much weaker retrospective constraints of the action-opposition sequence.' Despite placing the emphasis on the recipient's move Hutchby (1996: 23) acknowledged that it is still possible that 'persons can "go looking" for an argument, for instance by trying to needle a coparticipant, making blatantly controversial claims and so on'.

Instead of the three-part argument model Hutchby (1996) proposed the notion of action-opposition sequences as the structural basis of argument sequences. In essence this concept extended Maynard's (1985) idea that any action can be opposed, considering that oppositional moves can subsequently be treated as arguables themselves, thus contributing to the construction of a series of oppositional moves and ultimately to the construction of an argument sequence. According to Hutchby (2001) a single action-opposition sequence would not necessarily be sufficient for argument to take place. The notion of action-opposition sequences emphasises the role of opposition in arguments, and the resources upon which participants draw to oppose or undermine a prior action and to construct arguments more generally.

Interestingly, Hutchby claimed that it is not only the sequential placement of participants' moves which is significant for the production of argument, but also other features of their talk which work jointly with their sequential position to reveal the talk's argumentative nature. According to Hutchby (1996) one such feature is the manner in which oppositional moves are delivered. For instance, one could emphasize or alternatively play down the contrary nature of an oppositional move. A different feature relates to the format of oppositional moves, as participants might produce 'certain hearably argumentative utterance types' (Hutchby, 2001: 126); in these cases the hearability of these utterances as oppositional will also relate to their sequential position in the interaction. Examples of such utterance types are the 'you say X, but what about Y' which is employed to instigate controversy (Hutchby, 1992; 1996) as well as utterances prefaced by 'Oh' and accompanied by a proposition that is hearably ironic (Hutchby, 2001).

Paying attention to such features opens the way for the investigation of other culturally familiar ways in which participants might perform opposition or argument. One such device has been identified by Antaki and Wetherell (1999) which comprises a three part structure of proposition, concession and reassertion through which participants make a show of conceding a point for oppositional or rhetorical (in the sense of bolstering one's position against competing ones) purposes. One intriguing issue noted by Antaki and Wetherell regarding this device is that recipients might collaborate in its production.

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Similarly, in the case of the 'you say X, but what about Y' device identified by Hutchby (1992) recipients at times recognize its oppositional character before a speaker articulates it fully, in which case they seek to counter the other speaker's scepticism by rushing to reformulate their initial claim. These instances demonstrate that when participants employ such devices, they mobilize culturally familiar ways of doing opposition which are hearable as such by their interlocutors.

Applying the insights of conversation analysis to the analysis of argument yields very subtle accounts of how arguments are accomplished. For instance, it shows that these are at times carried out by mobilising conversational phenomena which might not commonsensically be associated with the accomplishment of arguments. An example is offered by the work of Osvaldsson (2004), who drew attention to the use of laughter in the course of argument sequences as a way of displaying dominance, or of siding with one participant whilst opposing another. Conversation analysis also allows for very subtle accounts for the form that arguments might take. For instance, one can distinguish between aggravated and mitigated opposition (Hutchby, 1996). In the latter case disagreement -and by implication argument- might realise in ways which mark it as disagreement only minimally and all by maintaining the preference for agreement.

Linked to that, conversation analysis allows the analysis of argument which is sensitive to the differing ways that arguments might develop in ordinary as opposed to institutional interaction, and also to the differing ways that arguments might develop in different types of institutional interaction. This permits analysts to investigate the sequential patterns and resources upon which participants draw when displaying opposition and engaging in argumentation in these diverse interactional occasions.

For instance Goodwin and Goodwin (1987) demonstrated the lack of mitigation in children's arguments. Although similar findings have been reported in other types of interaction too, as is the case with disputes between professors and students in academic environments (Kotthoff, 1993) or in disputes in interview panels (Greatbatch, 1992), this finding does not have generalised applicability. As Dersley and Wootton (2000: 376) note 'the shape of the arguments about the preference for disagreement has been influenced particularly by studies of children and of interaction in particular kinds of institutional settings, circumstances in which a good deal of direct confrontation can take place, but from which it is difficult to make extrapolations into more normal interaction among adults.'

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In fact on many occasions the study of argument seems to be shaped by the particularities of the type of interaction concerned and the identities of the people involved as these become relevant by participants themselves in the course of the interaction. For instance in interaction in court room settings the business in which 'attorneys and witnesses are engaged (accusing, discrediting, rebutting, defending, challenging, etc.) has to be fitted to the sequential environment which the specialized speech-exchange system allocates to each participant' (Drew, 1992: 477). Witnesses might thus rebut a challenge but might do so whilst appearing to simply offer a description and without displaying in any overt, explicit or marked way that they dispute the version embedded in the attorney's question (Drew, 1992). Similarly, Greatbatch (1992) has reported that disagreements occurring in interview panels between interviewees take the form of responses to the interviewer's questions instead of arising immediately after an interviewee has displayed a particular viewpoint.

On different interactional occasions participants might put into practice a variety of conversational conventions. These might concern the time when somebody is allocated a conversational slot, specialized or not forms of turn-taking systems and the distribution of speakers' rights. Instances of argumentation emerging on different interactional occasions (i.e. in different settings) will thus take their flavour from the local conversational conventions that become relevant in that particular setting.

By implication, in case therapists and clients engage in argumentation this is likely to be shaped by the local conventions applying in psychotherapeutic interaction. Psychotherapy settings are considered as non-formal ones (Drew and Heritage, 1992) as participants do not engage in a highly formalized turn-taking system. Despite the relative fluidity of the form that the talk might take though (as opposed to that emerging in formal settings such as courtrooms), participants still tend to privilege particular conversational conventions (as this has become apparent through the inspection of pieces of research in psychotherapy in section 2.1). For example, therapists might often appear to ask questions whereas clients might frequently appear to respond to them. Therefore, in cases where therapists and clients engage in argumentation it wouldn't be implausible to assume (although this still remains to be tested against actual data) that this might be brought about through rather familiar means that have been reported to occur rather routinely in psychotherapeutic interaction.

Moreover, according to Hutchby (1996: 32) the fact that in institutional settings 'opposition is constrained within these specialized turn-taking systems means that actual

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person-to-person opposition is systematically mitigated.' This observation is particularly interesting as it is also meant to apply to interaction in talk radio (together with other types of institutional interaction), where there appears to be an institutional mandate for creating controversy. If one extrapolates this principle to interaction in psychotherapy settings, which is customarily perceived as being affiliative, one would perhaps expect an even greater deal of mitigation in this case (although once more this needs to be tested against actual data).

All the above conversation analytic insights apply mostly (but not exclusively) to the notion of argument as a dispute. This brings us to the fact that the term argument has a dual use: on one hand the term might be used to signify a dispute and on the other in the sense of building a case. Several authors though have noted that there might be a larger or smaller overlap between the two notions of the term.

More specifically, Billig (1996) from the field of rhetorical psychology treats the two uses of the word argument as interconnected. Interestingly Billig attributes to the notion of argument as reasoned discourse an individual meaning, whereas to the notion of argument as a dispute a social one. The implication of treating these two usages of the term as tied together is that 'any individual argument is actually, or potentially, a part of a social argument' (ibid.: 74). This last point might prove to be relevant in the analysis of systemic therapy talk as this is a field which supports the view that there is not a single reality but multiple ones that are socially constructed and where therapists take as their task the facilitation of the construction of realities that are beneficial to their clients.

The conversation analytic angle on the other hand appears to draw a somewhat greater distinction between the two usages of the term argument, but also notes the possibility of overlap between the two. More specifically according to Jacobs and Jackson (1981: 121), although making arguments and having arguments might occur separately one from the other, 'Instances of having an argument by making arguments do appear to be the prototypical case of argument'. Hutchby (1996) also makes a distinction between the two uses of the term, but also notes the likelihood of a point of intersection. Indeed he notes that in the case of a dispute participants might recruit rhetorical arguments, and also that rhetorical arguments 'are produced in some interactional context' (ibid.: 21).

It would perhaps be plausible to assume that on different interactional occasions one or both from these two notions of argument might come alive. For instance in the case of interaction between children, analysts have reported arguments in the sense of a dispute (examples are offered by Maynard (1985)). Alternatively, in court hearings participants'

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talk might contain pieces of reasoning whilst simultaneously taking part in a dispute. For the purpose of this study it might be sensible to allow for both of these uses of the term argument to potentially become pertinent in the data. This can take place whilst simultaneously respecting the conversation analytic principles of examining how these notions become relevant for participants themselves and how therapists and clients display or orient to what emerges interactionally as part of an argument either in the sense of a dispute or in the rhetorical sense of the term.

It should be noted at this stage that in this case one faces the question of whether analysts' characterisations of their topic of analysis is close enough to the actions that participants are engaged in. This question is raised by Edwards (2005) on the issue of defining an action appearing in the data as a complaint. As Edwards (ibid.: 7) notes 'But it is a feature of complaining, as an actual conversational activity (rather than a topic for conceptual analysis), that the word itself is seldom used. The same stretch of talk might also be glossed over as criticism or accusation, troubles-telling, or merely story-telling or factual reportage, which are potentially relevant alternatives for speakers when characterising their activities. Speakers may even work against the notion that what they are doing is complaining, rather than simply reporting some observations.' Similarly, participants might not actually term what they do as an argument. Nevertheless, they can still show that they engage in opposition or orient to a previous utterance as being of an oppositional nature. Equally, they might display that they engage in the production of a stretch of reasoning or in the production of other aspects of rhetorical arguments. In that case, the role of analysis will be to remain attentive to such aspects of participants' talk.

It might be worth mentioning at this stage that, as previously noted, the notion of opposition on its own might not be sufficient to describe argumentative interaction. We have previously seen how Hutchby (1996; 2001) also introduces additional aspects revolving around the mitigated or aggravated way in which opposition is being conducted as well as around the format of utterances that perform opposition. Indeed, simply a description of a piece of interaction as chains of action-opposition sequences might result in a limited or restricted story regarding argument talk in the data. Therefore, it might be worth allowing some room for the emergence of aspects of argument that may enrich the analysis of argument in a domain where the study of argument is in fact elementary, namely psychotherapeutic interaction.

Chapter 3: Data and Ethics

This study has been based upon a number of audio recorded therapy sessions that have been derived from an HIV community service. These data has been gathered for the purpose of this study but has, thereafter, been used by participants themselves for clinical purposes as they decided that it was a useful resource that permitted the client who took part in the study to revisit the conversations that took place in this particular service so as to use them as a source of reflection and support.

A total of thirteen sessions of clinical work were gathered; although the routine length of a session was roughly an hour, a few of them were substantially longer or shorter in duration; nevertheless the number of hours of talk that were ultimately collected were approximately thirteen. All these recordings were derived from the clinical work conducted between an HIV specialist counsellor and systemic psychotherapist based in this HIV community service and an adult living HIV (Human Immunodeficiency Virus).

The participants had already established a lengthy therapeutic relationship before the start of the research as they had already been meeting over a period of a year and a half on a weekly basis (this renders this data set different to the one gathered by Silverman (1997) which is based on pre-test counselling and on the initial meeting of post-test counselling). This had created a basis of trust which permitted the collection of the material for research purposes. This was an extremely delicate endeavour as the data is sensitive in two respects: firstly because it is based on psychotherapy sessions, which means that it contains a lot of very personal or intimate information. In addition the data is sensitive because of the client's medical condition which is deemed as potentially stigmatising and might involve a great deal of privacy. These issues affected the type of material gathered; although I had received ethical clearance to gather video material in addition to the audio recordings, only audio recordings were deemed appropriate by participants.

What is important to note is that although the sessions are conducted in English, neither of the participants has English as their mother tongue as each of them comes from a different ethnic background. This accounts for some misspeakings in the data; interestingly though there are also times when this difference is used as a resource, particularly in the

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course of exchanges of an argumentative nature when being precise and finding the right word is treated as significant by participants themselves.

The practitioner in this corpus provides HIV specialist counselling that is offered after diagnosis with the condition (post-test counselling). The post-test counselling can take place in a single session and involves focusing on newly-diagnosed people's worries regarding their health, protecting their family members or other people they know from the condition and reflecting on who they need to disclose this information to. At the conclusion of this phase of the work, newly-diagnosed people are offered long term emotional and therapeutic support, in case they find that useful. If they proceed, they are initially offered six sessions, at which point an assessment is performed in order to establish whether they need further support. People might thus attend a single time, but there are also people who might be followed over a number of years (the maximum having been two and a half).

What becomes obvious is that in this particular service practitioners enjoy the luxury of being able to offer long term work, in contrast to other clinical services. This perhaps accounts for the fact that the recorded sessions, collected in the second year of this clinical encounter, do not only revolve around the client's medical condition, but also a range of other issues affecting the client's life are being discussed. This might be also be explained by the fact that at the time of the recordings the client's viral load was low and her condition did not raise any pressing issues.

Linked to this, whereas referrals for post-test counselling concern newly diagnosed people, referrals for long-term counselling and therapeutic support might concern people that have been diagnosed years ago. In this case, people can consult a professional for a number of potentially unrelated to HIV issues, such as relationship problems, depression or anxiety, although the main referral criterion is still that that they live with HIV. In this instance the practitioner draws largely from her broader clinical and psychotherapy skills[4].

The practitioner's systemic orientation means that at times significant others are invited to the sessions; however in the course of the thirteen sessions that constitute these data, such invitations on the therapist's part were declined by the client. In addition, this approach values viewing clients within their social context and potentially intervening on a number of contextual levels (Bertrando, 2000). Therefore, several issues regarding the

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[4] It might be worth noting at this stage that given that the specific systemic model favoured by this therapist is the narrative one, terminology drawn from this model has been privileged in the course of making connections between theory and practice in the analytic and conclusion chapters.

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client's broader circumstances become relevant in the course of the work, for which the therapist links with a number of other services.

The thirteen sessions constituting the data have been gathered in the course of a six-month period; the therapy work came to an end because of the therapist's departure from the service. In the preparation for the end of the work the client had been offered the option to continue the sessions with a different professional, which the client declined. Gathering data from the end of a two year period meant that the sessions largely revolved around the client's strengths and around the changes achieved in the course of the clinical encounter, in accordance with the therapy model privileged by the therapist (Epston and White, 1992). It is probable that this has a direct bearing on the number or extent of the episodes of argumentation in the data. The reason for that is that in this corpus these tend to follow from troubles tellings by the client, which might have been relatively infrequent at the final stage of the work. In fact the extracts upon which the analytic work has been based have all been derived from four out of the thirteen sessions; this denotes that the episodes of argumentation occupy a relatively limited part of the total amount of the recorded talk.

The data collection process for the thesis has proved a rather demanding task that stretched over a period of eighteen to twenty-four months. The extent of the time required is explained by the sensitive nature of the material and the slow nature of the process of receiving ethical clearance and approval from NHS trusts in order to conduct the research at their sites.

To take things more gradually, I started looking for data by making contact with a number of clinicians whom I invited to take part in the study. Although I was inviting clinicians from diverse professional backgrounds, my specific interest in the systemic approach which emanates from my training in this modality, meant that many of my initial contacts were systemic practitioners. The contacts were primarily made in workshops, conferences and other training events for clinicians. In this way I initially recruited seven practitioners from diverse organisations who expressed an interest in taking part in the study. Once I had the practitioner's agreement to take part, my next step was to proceed to secure ethical clearance and approval by the Trust or other organisation in which the clinician was based.

In this way I sought and successfully received ethical clearance to conduct research at multiple NHS sites and at one psychotherapy institute, in addition to the ethical clearance I had initially received from Loughborough University (see relevant documents in the appendix B). For the NHS sites I also required approval from the research and

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development departments of each trust. This proved to be a particularly time consuming process, given the delays in some of these Research and Development departments to process the required paperwork. Finally, some Research and Development departments imposed requirements which were not feasible within the time and resources allocated for the study, such as recruiting an independent person to obtain informed consent from participants. Moreover, on one occasion the appropriateness or quality of the study was measured against the criteria established by research on the effectiveness of psychotherapeutic interventions, which resulted in the initial rejection of the study and in subsequent meetings in which I attempted to clarify methodological issues pertaining to this study and to secure the department's approval.

Given the length and the difficulties of the process of obtaining approval, I kept the recruitment process open for a long time as I was uncertain about the end result of my efforts in terms of obtaining access to some data. Importantly, the obstacles I encountered and the length of the process of receiving approval meant that on a number of occasions the study failed to receive the relevant Trusts' permission to go ahead (only two Research and Development departments granted me access to their Trusts). In addition, in some cases, this meant that after a period of time, the initially recruited practitioners could no longer take part in the study given that some left their jobs and some faced life cycle events that meant that they took a break from their professional activities. Therefore out of the seven practitioners that I initially recruited, I managed to secure data from only one.

All participants who were initially interested in taking part in the study were given more than twenty-four hours to decide whether they agreed to take part. In addition, following an initial display of interest on their part, potential participants were offered detailed information on the study and were invited to ask questions. The client that was recruited in the study had been selected as a potential candidate for the research by the practitioner organising the sessions, as it was left up to her to judge whom among her clients could take part and whether inviting a particular client was clinically appropriate. The practitioner offered to the client preliminary information about the study and gave her the opportunity to meet me and to ask questions. It was made clear to the client that the study was entirely voluntary and that strict anonymity and confidentiality would be observed at all times. Moreover, it was explained to her that she had the right to change her mind and withdraw from the study at any time without having to offer an explanation and that this would have no impact on the service she was receiving. The client was also offered the opportunity to read the information sheet regarding the study and was asked to

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take a period of more than twenty-four hours to consider whether she wanted to take part. Once the client agreed, she gave her informed consent by signing the relevant form.

Strict confidentiality has been maintained throughout the project, by anonymising entirely the transcribed material and by taking out any other revealing details of participants' identities. Participants offered their informed consent that transcripts of their conversations with all identifying details removed could be used in the thesis, in research meetings and professional publications and that audio records of their conversations with all identifying information removed and voices disguised could be used in research meetings. Finally, all information was kept confidential and was locked safely in the University or on a password-protected computer.

In preparation for analysis of the data, the audio-recordings from all thirteen sessions have been transcribed in a verbatim manner. This allowed me to greatly familiarize myself with the data. The first step towards the analysis of the material was to transcribe a large number of segments using the Jefferson (2004) transcription system (for the transcription conventions used in the thesis please refer to the appendix). The main benefit of employing this transcription system is that it allows an analyst to include in the transcript many features of participants' talk that are interactionally relevant for participants themselves. However, according to the methodological framework employed in this study which is that of conversation analysis, such transcripts are only considered as an aid to the analysis as this is primarily based on the audio material.

The analysis of segments of talk from the data started in an exploratory manner, as already mentioned in the introduction. Progressively this led to the current corpus as I started identifying patterns of talk and the collections of phenomena that formed the basis of the analytic chapters of the thesis. Inevitably, a number of the initially selected segments were not incorporated in this current work as they have not informed it.

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Chapter 4: Questions soliciting defeasible accounts

4. 1 Initial presentation of the phenomenon

This section investigates a practice discovered in the data which appears to open the way for argumentative exchanges. This practice involves a question or a series of questions and their answers which set up a sequence where disagreement (and therefore potentially argument) might ensue following response to the question. The questions in the data enquire about a scenario, eventuality or state of affairs, regarding which one's interlocutor has already expressed a negative stance, either implicitly or explicitly. More specifically these questions appear to be inviting one's interlocutor to comment or elaborate on an adverse or worst case scenario of a negative state of affairs that he or she has previously talked about, which in the case of this data, corresponds to an invitation for the delivery of an account.

This practice broadly relates to conversation analytic literature on questions which are employed to perform subsequent disaffiliative moves (such as those reported by Monzoni (2008)), on practices for eliciting accounts about questionable matters (Robinson, 2009) and on questions that show that a prior stance is overly exaggerated (Halonen and Sorjonen, 2008). The key issues discussed in this chapter revolve around the function of such questions in the data, as this is derived from the study of their design and sequential position in the interaction, and around the kind of sequential trajectories and argumentative possibilities that these open the way for.

Before proceeding further, it might be useful to show an instance of the practice appearing in the data. This can be viewed in extract 1 below but, before that, it is worth giving a brief gloss of what this is about. The start of this extract is the concluding part of the problem telling that the client has been producing for already some time concerning an incident that she described as shocking. This revolved around having accidentally bumped into a person that she and her relatives knew, whilst attending a group for HIV sufferers. This person had been unaware of her medical condition, as were also some of her relatives. The client became fearful that this person would disclose that she was affected by HIV -to her relatives in particular- and felt forced to leave abruptly this support group, despite previously being enthusiastic about attending it. What is of interest in the extract is the

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therapist's question in lines 19-23 and the subsequent interaction. Through this question, the therapist invites the client to give her strongest reasons for feeling uncomfortable about this encounter.

Extract 1 [S2.00:04:02]

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1    Cl:  =I want to be in a plac:e where [I fee]l
2    Th:                                   [mhm ]
3    Cl:  I will be comfortable,
4    Th:  mhm
5    Cl:  you know I'll be PROTECTED (0.5) but. (.) to see someone I
6         know, [an
7    Th:         [mm:::
8    Cl:  that person is part of the: family I am always with
9    Th:  [mhm ]
10   Cl:  [and t]hey don't know anything about my lif:e,
11        (.)
12   Th:  mhm
13        (.)
14   Cl:  that was really hu:ge shock to me and I
15        [think] [ye]ah
16   Th:  [  mm:]::[: ]
17   Th:  .pt .hhh right
18        (0.8)
19   Th:→.hhh what was your: main worry (0.9)
20        ((noise))
21   Th:  about you know what would be:: the thing that would make you
22        most uncomfortable wh- wh- when you would be:: (0.2) in the
23        room with this man
24        (0.8)
25   Cl:  U:::H I don't know what he will thi:nk
26        (.)
27   Th:  (.pt) [what    ] he will think?
28   (Cl):      [(what he)]
29   Cl:  =yeah I know what he will think
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In line 14 of the extract we can see the client stating that she felt deeply shocked by the incident previously described ('that was really hu:ge shock to me...'). The therapist responds by issuing a hypothetical question regarding the client's main worry about the imaginary scenario of attending the same support group as this man ('what was your: main

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worry (0.9) ... ab<u>ou</u>t you know what would b<u>e</u>:: the th<u>i</u>ng that would make you m<u>o</u>st unc<u>o</u>mfortable wh- wh- when you would be:: (0.2) in the room with this m<u>an</u>', in lines 19-23)[5]. Whilst this question, when removed from its interactional context, could be treated either as an innocent or as a rhetorical one, detailed analysis of the extract (presented in sections 4.1.1 and 4.3 below) demonstrates that it is designed to bring forth a questionable response, which would either reveal to both participants the problematic grounds for the client's stance, or at least, would allow the therapist to argue against the client's initial utterances (in line 1). As it will be shown below (in sections 4.1.1 and 4.3), in this particular instance the client evades providing such an answer.

The practice appearing in this excerpt is actually evocative of a mundane conversational practice whereby when somebody says 'what's the worst thing that can happen' concerning a given scenario, this is idiomatically understood as a rhetorical question designed to challenge the claims made by another speaker that something bad could in fact happen. The recognisability of such an idiomatic formulation as an actual members' category, seems to boost the particular reading of the instances found in the data (which emerged from their detailed analysis and which will be presented in section 4.3 below), that questions such as that in lines 19-23 of the above extract are in fact of challenging nature.

At this point, though, it is worth differentiating between rhetorical questions which are entirely unanswerable and questions which are still of a challenging nature but which are answerable. Rhetorical questions have often been described as questions which strongly imply a particular answer and which simultaneously are being treated as unanswerable (Koshik, 2003; Schaffer, 2005). To pass to a concrete example of a rhetorical question so as to briefly examine how these features are talked into being, one could consider the following extract drawn from Heinemann (2008):

Extract 2 Heinemann (2008: 65-66)

(6) [TH/F4/HH/10–1] 'Don't you look at the bag'

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11    Bente:  >.hhh< Men så ha'e jeg købt nye kartofler de
              >.hhh< But then I'd bought new potatoes they
12            smagte li' a' helve't te',
              tasted like hell,
13    Maren:  Gjorde de det?
              Did they?
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[5] The dots signify an omitted part of the actual transcript. This also applies to the rest of the thesis.

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14              (0.2)
15    Maren:    Hvor var de fra?
                Where did they come from?
16    Bente:    De var så vanded' hh
                They were so watered hh
17    Maren:    (n)Hvor var de fra¿
                Where did they come from¿
18    Bente:    Omme fra Brugsen¿
                From the Coop¿
19    Maren:    Jahm' hva' var det for no'en¿ = Dan[ske? ]
                Yes but what kind were they¿  = Dan[ish? ]
                                                  [     ]
20    Bente:                                      [Døv- ]
21              (0.6)
22    Bente:    Det ve' jeg ikk',
                That I don't know,
23    Maren:    Nahm'- Det' jo det.
                Nyeahb- That's ADV it.
                Nyeahb- That's the thing you know.
24              (0.6)
25    Bente:    Aner ikk' om det var danske,
                I have no idea if they were Danish,
26              (2.0)
27 => Maren:    Ser du ikk' på posen¿
                Look you not on bag-the¿
                Don't you look at the bag¿
28              (0.4)
29    Bente:    Nej det var de al'så ikk'.
                No they really weren't.
30              (2.5)
```

The target question is situated in line 27 of the exchange ('Don't you look at the bag¿'). The question is delivered in the context of an implicit disagreement between participants regarding the relevance of the provenance of the potatoes one is buying for establishing their quality; Maren insists on the importance of knowing where they come from whilst Bente implicitly rejects it. Maren's question in line 27 is presumptive, implying that Bente does not look at the bag. Given that the question is asked in the context of Maren having previously presented it as necessary that one knows where potatoes come from, it raises accountability issues for Bente. Importantly, the question places Bente in a

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challenging position as, were she to answer with the type of response projected by the question (in this case a 'no') she would have conceded a point which would portray her in an unfavourable light. The above seem to account for Bente eventually not answering the particular issue of whether she looks at the bag or not (in lines 28-29) and commenting instead on the issue of the provenance of the potatoes ('no they really weren't').

What the above example also manifests is that what establishes the question in line 27 as unanswerable, and in fact rhetorical, is the sequential context in which this is being produced. Similar observations are also reported elsewhere in the literature concerning rhetorical questions (Koshik, 2003) and are also more broadly in line with the conversation analytic principle of the sequential context largely determining the nature of a particular turn. In that sense, the same question (for example the 'what's the worst thing that can happen' type of question analysed in this chapter) could have potentially been delivered as a rhetorical one, but could have also been delivered as an answerable type of challenge.

Interestingly, the questions in the data, unlike rhetorical ones, and despite their challenging and to some extent presumptive character are delivered in such a way so as to actually secure a response -albeit a defeasible one. This dimension of this practice and the institutional aims this seems to fulfil will be explained in more detail later (in section 4.4.2). One distinction worth drawing at this point though is that, whereas entirely rhetorical questions such as the 'Don't you look at the bag¿' seen in extract 2 come with an immediate interactional cost of some kind (which is in fact what renders them unanswerable), in the case of the questions in this data as will be discussed later there is still a price to pay for the recipient which however is deferred for later.

4.1.1   Grounding the disaffiliative nature of such questions in the talk

The therapist's question in lines 19-23 of extract 1 above, which is topically related to the client's problem telling, and which prompts the client to talk about the essence of her problem, could easily be seen as a sign of attentiveness and curiosity (Cecchin, 1987) towards the client's hardship and an empathic move on the therapist's part, designed to simply get a better understanding of the problem. However, there is evidence from the interaction that this is not the case. Systematic analysis of the data shows that the features of the talk which reveal that such questions in the data -like the therapist's question in the

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above example- are in fact disaffiliative moves, are the following three: firstly, the sequential position in which the questions come, secondly, the questions' design, and thirdly, the way that the questions are being treated by the client.

In the above example (part of which is reproduced in extract 3 below), analysis of the question's discursive context, demonstrates that prior to the question there is already some interactional mismatch.

Extract 3 [S2.00:04:02]

```
1    Cl:  =I want to be in a plac:e where [I fee]l
2    Th:                                   [mhm  ]
3    Cl:  I will be comfortable,
4    Th:  mhm
5    Cl:  you know I'll be PROTECTED (0.5) but. (.) to see someone I
6         know, [an
7    Th:        [mm:::
8    Cl:  that person is part of the: family I am always with
9    Th:  [mhm  ]
10   Cl:  [and t]hey don't know anything about my lif:e,
11        (.)
12   Th:  mhm
13        (.)
14   Cl:  that was really hu:ge shock to me and I
15        [think] [ye]ah
16   Th:  [  mm:]::[: ]
17   Th:  .pt .hhh right
18        (0.8)
19   Th:→.hhh what was your: main worry (0.9)
20        ((noise))
21   Th:  about you know what would be:: the thing that would make you
22        most uncomfortable wh- wh- when you would be:: (0.2) in the
23        room with this man
24        (0.8)
25   Cl:  U:::H I don't know what he will thi:nk
26        (.)
27   Th:  (.pt) [what     ] he will think?
28   (Cl):       [(what he)]
29   Cl:  =yeah I know what he will think
```

The client had been engaged in a problem telling of which lines 14 and 15 are the concluding part ('that was really hu:ge shock to me and I think yeah'). One can see that the client produces a doubly upgraded ('really hu:ge') manifestation of her emotional reaction to the trouble, which on one hand adds to the seriousness of the trouble, and on the other, offers indications to the recipient as to the type of response that would be appropriate to her narrative. Despite that, the therapist positions herself as a troubles-recipient only minimally with the elongated and emphasised 'mm::::' (in line 16) and a display that the client's trouble has been heard ('right', in line 17). The therapist's question therefore occurs as an alternative to a more empathic response on the therapist's part, which would position her as sufficiently aligned to the client's troubles-telling, as according to Drew and Holt (1988: 410) 'In telling about a grievance or trouble, a speaker may expect or seek (as a preferred response) the recipient's sympathy.' and as Jefferson (1984) reports that the display of sympathy is a response of a properly aligned troubles-recipient.

In addition, the therapist designs her question in a way that minimises the client's problem description. The terms that the therapist selects to talk about the client's trouble are 'worry' (in line 19) and 'thing' (in line 21), whereas the term employed for the client's emotional reaction to her trouble is 'uncomfortable' (in line 22). These terms downgrade the client's own description that the event that she was talking about was a 'hu:ge shock'(in line 14), and by doing so display the therapist's stance on the matter (Heritage, 2004).

Crucially, there is evidence from the client's ensuing to the question talk that she treated the therapist's interactional move as a challenging one. Her response that her main worry would be what this other person would think ('U:::H I don't know what he will thi:nk' in line 25) is formulated as a dispreferred, with a delay of 0.8 of a second prior to the start of her turn and with the 'pre-pausal' (Schelgoff, 2007: 68) 'U:::H' which further delays satisfying the therapist's query. In addition, the 'I don't know' (in line 25) which could partly work as a display that the client fleeing the scene was a rather instinctive reaction on her part that did not require much thought, could equally be a display of resistance to collaborate in producing an immediate and straightforward response (Hutchby, 2007). Finally her account in line 25, that she did her best to avoid this encounter with this person because she was fearful of what he would think after seeing her in a group for people affected by HIV, is rather minimal and more or less normative, portraying her reaction as commonsensical and ultimately adding to the legitimacy of her worries. This is in accord with Locke's and Edwards' (2003: 245) observations that 'Accounting for actions involves locating them with regard to a normative backdrop, itself discursively definable, in

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terms of which specific actions (also as defined) can be identified as typical, usual, conventional'.

As the interaction unfolds the client proceeds to show her hand a bit more, revealing a rather upfront lack of collaboration. In particular, as the therapist proceeds with a follow-up question requiring the client to elaborate on this upgraded problem description ('what he will think?', in line 27), the client resists making any speculations about this person's thoughts and instead goes on to produce a response ('yeah I know what he will think' in line 29) which presents the answer to the question as an (at least to her) obvious matter which does not necessitate further expansion. Through this response the client not only resists the trajectory of the therapist's talk, but simultaneously, by presenting herself as knowledgeable regarding this third person's thoughts in this given scenario, portrays what this third person could have thought of as definite, thus adding weight to her previous problem description and by implication buffering it against potential disagreement or criticism. It is plausible to assume that the client would not have deemed such a move necessary, had she not treated the therapist's questions as opening the way for the potential weakening or disconfirmation of her version. It is worth noting that the therapist's follow up question in line 27 ('what he will think?') was inviting the client to produce a description of a state of affairs on which the therapist would have had equal epistemic rights with the client, and by implication, would have offered the therapist the possibility, should she wish to, to dispute the client's version. And it seems that it is precisely such a course of action that the client's response ('yeah I know what he will think' in line 29) seems designed to block.

In summary, the therapist's questions (in lines 19-23 and 27), despite appearing as affiliative ones, when positioned in their interactional context, and analysed in relation to their internal design and in relation to the client's preceding as well as subsequent talk, appear to invite the client to produce a response of the sort that can be treated by the therapist as challengeable or disputable. As the exchange up to this moment (and indeed as it proceeds later on) has revealed, these questions (in lines 19-23 and 27) have not been treated by the client as an opportunity to elaborate further on her problem. Rather, they seem to have caused a substantial degree of interactional turbulence, to the extent that, the more the interaction unfolded, the client attempted to sabotage the therapist's project and was temporarily successful in doing so.

Further empirical analysis below based on detailed examination of the data, demonstrates that these discursive moves play a central role in the elicitation of material

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which allows the therapist to question or argue against aspects of the client's talk the therapist might wish to challenge.

4.2   A basic outline of the practice of questions soliciting defeasible accounts

The constituent parts of the practice described in this section are the following:

A) <u>Negative Stance</u>: A speaker expresses, either implicitly or explicitly, a negative stance on a particular issue, which his/her interlocutor shows signs of not endorsing. (This move by the first speaker makes relevant a number of alternative next actions; the sequential trajectory which is sketched below, together with its variations, is one out of several other possibilities; any other trajectories escape the scope of this work).

B) <u>What are your (strongest) grounds</u>: The second speaker issues a question which takes the form of an invitation to issue a description of either the biggest disadvantage or of the disadvantages more generally, of that issue or eventuality, on which the first speaker has revealed a negative stance. In other words, this question invites a description of the first speaker's beliefs or reasons in support of this stance (or even of his/her strongest beliefs or reasons). Pragmatically, this move invites the issuing of an implausible or challengeable belief, or of material which would allow the second speaker to question or undermine the first speaker's case. A characteristic feature of the questions' turn design which places the second speaker in an argumentative advantageous position is the use of extreme case formulations or other terms through which the recipient is invited to offer his or her 'strongest' grounds. This paves the way for the second speaker later beating the first speaker's sturdiest argument in support of his/her stance. Another characteristic feature concerns the solicitation of the first speaker's subjective take on the matter as opposed to facts.

C) <u>Either evasion in providing account, or provision of account</u>: The first speaker might resist providing any grounds, or, alternatively, there might be response by the first speaker providing a description of the negative aspects of the issue on which the speaker had initially revealed a negative stance, which brings forth challengeable material.

D) <u>Delivery of challenge or disagreement</u>: In case that the first speaker provides an account, there is an utterance by the second speaker of argumentative nature such as a

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challenge, or disagreement through which she or he contests the first speaker's response in part C.

Variations to this action sequence might involve a series of interlinked question-answer pairs such as those featuring in parts B and C, which invite potentially a series of elaborations on the initially requested description, prior to the therapist actually issuing a challenge or a disagreeing turn in the third position. This possibility will be considered in more detail later.

Moreover, one can envisage the prospect that this practice might also occur after a first speaker displays a positive stance (in part A of the sequence), in which case part B could concern an invitation for that speaker to talk about the (greatest) advantages of the stance which this speaker supports. However, as in the case of this data all instances occur after a speaker displays a negative stance, the above outline has been written to capture the nuances of the existing material. In both scenarios though, the second speaker would not be in favour of the stance or of the course of action that the first speaker advocates.

4.3   A detailed illustration of this action sequence

To get a better grasp of the phenomenon let us look at one such instance in more depth:

Extract 4 [S2.00:10:12]

```
1      Cl:  [she ↑didn't expl]ain but when I ta-
2            talked to (the) auntie Melanie >auntie
3            Melanie say< it's because maybe, .h she
4            know so many people  so many some of them
5            people she did her work her work
6            colleagues, and .hh (0.4) they went maybe
7            to the same uni:,
8      Th:  mh[m[mhm            ]
9      Cl:    [s[omething like] that,
10           (0.6)
11     Cl:  yea:h and most of them they work (.) in
12           the Hevestoft so it's like you know
13           (0.3)
14     Th:  mhm
```

Negative stance

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```
15    Cl:  yeah
16    Th:→ mhm .pt=.hhh and:: from what you
17         understand,(0.5)
18         ((noise))
19    Th:  .hhh if:: (0.2) any of these people was
20         to:: e::m (0.45) to learn that you live
21         with eitchaivi ((HIV)), what do you
22         think would be the consequences?
23         (0.8)
24    Cl:  u:::h the th↑ing wi- with us its: like
25         it's very very different because (0.5)
26         >I remember< Sophie say is u:h (1.4) no
27         matter wha:t, it's like we black we always
28         (remember that we are)
29         bla:ck (0.2) so when these white people
30         talk about confidentiality
31    Th:  mhm
32    Cl:  the black people don't take it so serious
33    Th:  okay
34    Cl:  and it really doesn't bother (me)=so when
35         they get to their own crowds, they talk a
36         different thi[ng       ]
37                      [((noise))]
38         (0.4)
39    Th:  hm[::] ((intonation of doubt))
40    Cl:    [ye]ah?
41         [so:::]
42    Th:  [okay ]
43    Cl:  the white people they (.) that's: that's
44         the ground ru:le but when it comes to
45         black people it's a different thi:ng
46         (.)
47    Th:  mm::
48    Cl:  yea[h  ]?
```

What are your grounds

Provision of account

53

```
49     Th:     [.pt]=.hh I am not so su:re.=I will put
50             a questionmark here okay?=because I've I
51             know black people who don't. who respect
52             confidentiality and don't talk about it
53             .hh and:: like two people that you also
54             know it's Brunette and Elaine.
55     Cl:     mm
56     Th:     yeah? and I know them, and .hh (0.2) e:::h
57             you know and we've had a lot of discussions
58             about how in their community, they wouldn't
59             disclose somebody's
60             information=so::
61             ((noise))
62     Th:     they are blacks, (0.4)
63             ((noise))
64     Th:     (0.35) but the- and they don't belong to
65             (.) the rule that you just said=so I am
66             sure there are other blacks .hh (.)
67             that do[n't talk          ]
```

Delivery of disagreement

To give a brief description of the above extract, in lines 1-12 the client displays a negative stance towards the possibility of people who she knows finding out about her medical condition if she were to attend a support group for people living with HIV. In response to that, the therapist issues a question through which she invites the client to provide grounds for supporting the position that her social acquaintances becoming aware of her condition has negative consequences (in lines 16-22). In lines 24-45 the client provides an account in support of her stance, namely that in case her social circle was to find out that she attends such groups, this would result in breach of confidentiality regarding her condition. In the final position (in lines 49-67), the therapist delivers a disagreement with the client's grounds, which had been presaged by her question located in lines 16-22.

To take things more gradually, at the start of the extract (lines 1-12) the client, despite appearing as simply animating a claim her auntie Melanie has made, she actually produces an inferable stance that attending support groups where her medical condition might become known to others is a negative thing[6].

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[6] Very briefly, the client's stance is discernible through the following three features of the talk. First through her non-conforming response ('u::h she ↑didn't explain but ...', in line 1) and secondly through the use of

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The analytic interest lies in lines 16-22 where the therapist proceeds, through the initial component of a perspective display series (Maynard, 1991; 1992) to solicit the client's perspective on the (implicitly negative) consequences of the people that the client mentioned in her account finding out about her medical condition ('... if:: (0.2) any of these people was to:: e::m (0.45) to learn that you live with eitchaivi ((HIV)), what do you think would be the cons<u>e</u>quences?').

This question, treated outside of its context, could be seen as a seemingly affiliative move on the therapist's part. To begin with, the way the turn is initiated ('<u>and</u>:: from wh<u>at</u> you underst<u>an</u>d' in lines 16-17)' presents what comes next as a request for elaboration or clarification emanating from the client's prior talk. Importantly, it is designed as an open question which would allow for a broad range of answers in the second position. Finally, the intonation in which it is delivered does not convey any critical tone on the therapist's part.

In fact, Perakyla (1995) reports similar-looking open-class questions inviting descriptions of drawbacks of particular state of affairs, which are equally employed by AIDS counsellors working with the systemic therapy approach and which appear to be used rather affiliatively. One such example from Perakyla's (ibid.) corpus can be viewed in the extract below:

Extract 5 [Perakyla (1995: 114 & 221-222)]

((Lines 1 to 35 below have been derived from two extracts appearing in Perakyla's text (ibid.): firstly from extract 12 (E4-46) on page 114 and also from part of this extract's extension which is extract 15 on pages 221-222)) [7].

((P is the person undergoing treatment, whereas C1 and C2 are the two counsellors conducting the session)).

```
1   P:        =I don't know: I- I just go th- er through stages of
2             uh:m (1.1) you know I mean I've had a really (0.2)
```

reported speech ('... >auntie Melanie say< it's because m<u>ay</u>be, ...', in lines 2-7), both of which allow her to produce an explanation when there hasn't been any by auntie Sophie, and by implication, to articulate obstacles preventing her from attending support groups. Thirdly, her stance is evident through the expansion in lines 11-12 ('yea:h and most of them ...') where the client shifts footing (Goffman, 1981) and aligns herself to auntie Melanie's reported thought. In other instances in the data the client's stance might be displayed a lot more strongly.

[7] The line numbering, font, location of the beginning or ending of turns as well as any signs showing the part of the extract that requires the reader's attention (arrows preceding a line), have been modified in this reproduction of Perakyla's (1995) original text.

`

```
3            sort of a quite hectic weekend, quite a busy
4            ti:me,=and it's not as though I've been sitting down
5            moping again. (0.6) But you know it's just sort of
6            like as though- as though it just clicks:. (0.5) And
7            then I think it will all
8            (        ) what's going to happen (wi:th) (.)
9            (so and so) if you know what I mean.
10 C1: →     Can I (s[ay) what's your greatest (0.6) fear for=
11 C2:           [(                    )
12 C1:        =th- what might happen.
13           (0.3)
14 P:        My greatest fear:?
15 C1:       Mm
16           (0.7)
17 P:        Uh::m (1.5) Well obviously at the moment I mean I
18           don't (.) particularly want to get AIDS or nothing
19           like that. (0.5) You know (.) but I still suppose
20           there's- there is that on the back of your mind
21           still. And I know I've got the er HIV, (.) but I
22           don't know how far (0.5) into AIDS I a:m. (0.6)
23           yet.=So:
24           [I don't know. (I don't [like to be)
25 C2:       [Does-                  [s-
26 C2:       How much does (0.2) Michael want to know about
27           (0.8) how far he's (in[to AIDS)
```

In lines 1-9 the client (P), following an invitation by C2 to disclose his personal experience on the issue of his medical condition, 'cooperates with this enquiry' as Perakyla (1995: 226) notes, and, in the course of doing so, displays a negative stance regarding a future eventuality which relates to his medical condition ('And then I think it will all ( ) what's going to happen (wi:th) (.) (so and so) if you know what I mean'). In response to that C1 invites the client to talk about her greatest fear regarding this future eventuality ('Can I (say) what's your greatest (0.6) fear for=th- what might happen.', in lines 10 and 12).

As Perakyla (1995: 226) observes, the action performed through the counsellor's question (in lines 10 and 12) is the 'elicitation of P's experience'. In response to this question the client proceeds to outline his worries (in lines 17-24), which in turn, provides C2 the opportunity to enquire further about one of the issues introduced by the client ('How

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much does (0.2) Michael want to know about (0.8) how far he's (into AIDS', in lines 26-27)). From an institutional perspective, such enquiries on the counsellors' part (in lines 10 and 12 as well as in lines 26-27) seem to be attempts to open up the space for talk on topics '*potentially threatening*' for the client (Perakyla, 1995: 215). The client appears to collaborate in the production of talk on such matters.

To return to the question of our main example though (extract 5, lines 16-22), the action that this carries out significantly differs from the counsellors' actions in extract 5 or in other similar-looking instances reported in the literature, despite the fact that they all appear to enquire about the negative aspects of a particular state of affairs. Crucially, despite the seemingly affiliative nature of this question as previously noted, extensive analysis of the data at hand strongly suggests that this question, as well as the rest of such questions in this corpus, are not innocent or affiliative ones, unlike the question of extract 5.

As already mentioned in the introductory example above, (see analysis of extract 3), the evidence for this analytic claim is threefold. The proof for the disaffiliative nature of this question is grounded in the question's sequential position in a particular discursive context, in the question's internal design, and thirdly and perhaps most decisively, in the client's own reading of this question as this becomes apparent in her response to it.

a) the evidence arising from the question's sequential position in the interaction

Close inspection of the local discursive context in which the question in extract 4 (lines 17-23) is produced reveals some interactional discord, before the actual question, even though this is rather minimal. The relevant part of extract 4 is reproduced below (in extract 6):

Extract 6 [S2.00:10:12]

```
1      Cl:  [she ↑didn't expl]ain but when I ta-
2           talked to (the) auntie Melanie >auntie
3           Melanie say< it's because maybe, .h she
4           know so many people  so many some of them
5           people she did her work her work
6           colleagues, and .hh (0.4) they went maybe
7           to the same uni:,
8      Th:  mh[m[mhm          ]
9      Cl:    [s[omething like] that,
```

`

```
10          (0.6)
11    Cl:  yea:h and most of them they work (.) in
12          the Hevestoft so it's like you know
13          (0.3)
14    Th:  mhm
15    Cl:  yeah
```

More specifically, immediately before the start of this extract the therapist had issued a question enquiring about the reasons as to why the client's auntie, Sophie, had not wanted her niece to attend support groups for people affected by HIV. This move was making relevant as a next action the issuing of an account, which could be tested for its sufficiency (Buttny, 1987). Following the client's issuing of this account (located in lines 1-12 of the extract) the therapist, did treat it as inadequate by withholding any display of approval of the worth of the account on several occasions: in line 8 the therapist only produces a continuer ('mhmmhm'), in line 10 an interactionally long silence (of 0.6 of a second) elapses prior to the client coming in in line 11, whilst in line 14 the therapist only produces a continuer ('mhm') after another interactionally noticeable pause of 0.3 of a second. The question, in lines 16-22 is therefore being asked whilst the issue of the worth of the account is still left hanging.

Moreover, it is worth noting that at the time of placing her question, (in lines 16-22) the therapist already has some knowledge of the types of issues that the client would consider as damaging were other people to find out about her medical condition. This arises from participants' talk up to that point, which demonstrates that the therapist had already information about the client's attitude towards third parties finding out about that fact that she was affected by HIV. This suggests that this question is different from a simple information-seeking one.

Another example of the therapist's informed state of knowledge regarding the issues she is enquiring about and by implication of the sequential context in which the question is being delivered playing a role in the question being understood as a non-innocent move, appears in the extract below (7). In this extract the therapist invites the client to outline her obstacles in attending a support group for people living with HIV:

`

Extract 7 [S3.00:13:34]

```
1  Th: →  .hh .pt u:::m:: bec- I I understand that u::m  (0.3) you
2         know your your biggest how how would you sa- how would
3         you describe your biggest obstacle in going back?
```

The therapist's question above, despite the fact that it emerges in an affiliative type of context, re-opens a conversation from the previous session, where the client had rebuffed the therapist's attempts to encourage her attendance to this support group and exchanges of disputatious nature had ensued as a result. Therefore, this re-opening of a matter which the client had attempted to close on numerous occasions in previous interaction, not just occurs in the context of prior interactional turbulence, but in itself marks this move as a disaffiliative one given that it brings up an issue which the client has persistently been treating as a closed matter.

Examination of the sequential context of such questions in the data reveals the non-innocent character of this discursive move in the rest of the examples in the corpus. We've already seen that in extract 3 above, the therapist's question is issued following the therapist resisting to position herself as a troubles-recipient to the client's problem-telling (Jefferson, 1984). The relevant part of the extract is reproduced below:

Extract 8 [S2.00:04:16]

```
1   Cl:  that was really hu:ge shock to me and I
2        [think]  [ye]ah
3   Th: [  mm:]::[: ]
4   Th:  .pt .hhh right
5        (0.8)
6   Th:→.hhh what was your: main worry (0.9)
7        ((noise))
8   Th:  about you know what would be:: the thing that would make you
9        most uncomfortable wh- wh- when you would be:: (0.2) in the
10       room with this man
```

To give a concluding example, in extract 9 below, similarly to extract 4 above, the therapist's question (situated in lines 12-15) follows on from a client account. This time, instead of the therapist merely withholding approval of the client's account at the time of placing her question, the therapist proceeds to an outright dismissal of it.

`

```
1    Th:   .hhh .pt what would you think about telling eh uncle Mike about
2           ey:- (.) e:m (.) living with eitchaivi ((HIV))
3           (.)
4    Cl:   (and) that's something I would never tell him
5           (0.3)
6    Th:   why not?
7    Cl:   (°no°)
8           (3)
9    Th:   can you find a good explanation why not?
10          (.)
11   Cl:   ↑I ↑don't ↑need to tell him that
12   Th:→  .hh no I am I am not suggesting that you need to, but I am just
13          uh I am just thinking what would be the positive things if
14          you tell him and what would be the negative things if you
15          [tell him]
```

Briefly, at the start of the extract the therapist delivers an 'advice implicative interrogative' (Butler et al., 2010) ('... what would you think about telling eh uncle Mike about ey:- (.) e:m (.) living with eitchaivi ...', in lines 1-2). The client treats this move as a preliminary (Schegloff, 2007) to what seems like an invitation to adopt a particular course of action and responds by issuing a blocking response ('(and) that's something I would never tell him', in line 4). The therapist meets this rejection with the challenges 'why not?' (in line 6), and 'can you find a good explanation why not?' (in line 9), thus treating the client's response as problematic or accountable. The challenges were making relevant an account as a next action, and in line 11 the client delivers it ('↑I ↑don't ↑need to tell him that').

At that moment in the interaction the most affiliative trajectory that the therapist could have taken would have been to accept the validity of the client's account (Buttny, 1987). However, as presaged by the request for not just any explanation but for a 'good' one (in line 9) which sets the standards particularly high, with sole judge of their quality the therapist, the therapist dismisses the client's grounds. In line 12 the therapist initiates her turn by discounting the client's account, alleging that this has been built upon an erroneous interpretation of her question ('no I am I am not suggesting that you need to,'). The ensuing question ('... what would be the positive things if you tell him and what would be the negative things if you tell him', in lines 12-15) thus occurs as an alternative to a more

affiliative trajectory, and in particular as a correction of the client's supposedly erroneous interpretation of the therapist's initial interrogative.

To summarise, the fact that in all of the relevant extracts in the data, the delivery of the question 'what are your (strongest) grounds?' occurs in a discursive context which to a larger or lesser degree is characterised by some interactional turmoil and also the fact that the question occurs as an alternative to a more affiliative response that the client's prior move is making relevant, strongly suggests that this is a non-innocent move on the therapist's part.

b) The evidence arising from the question's internal design

In addition to the sequential context of the question ('what are your (strongest) grounds') its internal design also reveals its oppositional character. To return to extract 4 above (the relevant part of which is reproduced in extract 10 below), analysis of the design of this question leads to the following observations.

Extract 10 [S2.00:10:32]
```
16      Th:→ mhm .pt=.hhh and:: from what you
17           understand,(0.5)
18           ((noise))
19      Th:  .hhh if:: (0.2) any of these people was
20           to:: e::m (0.45) to learn that you live
21           with eitchaivi ((HIV)), what do you
22           think would be the consequences?
```

In fact, through this question's design the therapist brings in the possibility of rendering the client liable to challenge. To begin with, the solicitation of the client's thoughts ('what do you think' in lines 21-22) as opposed to the solicitation of the consequences of the course of action put forward by the therapist's hypothetical question, highlights the client's input in the construction of this particular version and by implication opens up the possibility of the client's utterances in the second pair part becoming more amenable to challenge (Potter, 1996).

In addition, although the client has previously provided as a response (in lines 1-12) a vague and inferential explanation consisting of a series of characterizations regarding Sophie's social circle which could not be challenged by the therapist, the therapist now

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with her question formulates a hypothetical scenario and enquires about the potential consequences of such an imaginary situation taking place. Enquiring about a specific situation seems designed to force the client to abandon the vagueness that was evident in her prior turns (in lines 1-12). Crucially, by doing so, the therapist delimits the client's forthcoming talk to an area which is epistemically accessible to both speakers; by implication the client is being pushed to more unsafe ground, where she might potentially be confronted by the therapist.

It is worth noting at this point, that the lexical choice of the emphatically uttered extreme case formulation (Pomerantz, 1986) 'any' (in line 19) invites the client to potentially speculate about the event that would prove the most damaging for her or for whoever else would be suffering these consequences. This means that were the therapist to proceed to a challenging move in the third position, she would have targeted and potentially undermined the client's biggest objection towards keeping her identity secret from the people that she mentioned in lines 4-12.

In addition to introducing accountability issues, and despite appearing as simply soliciting the client's perspective, the therapist does not design her question neutrally in relation to the description that the client had previously put forward (in lines 1-12) and to the particular issue on which the client's viewpoint is being sought. Through the terms 'any of these people' in line 19, the therapist drops the references regarding the nature of Sophie's relationship to the people previously mentioned by the client, thus sketching a more impersonal relationship between these people and the client's family, and taking the focus away from the accountability issues the client's inferential description drew upon in order to portray her family's close relationship with these people as hindering her attendance to support groups. Finally the characterization 'that you live with HIV' (in lines 20-21) distances the person from the condition (in contrast to alternative ones such as that of 'HIV positive'). These features seem designed to promote the construction of a reality which neutralises any negative effects on the client's life of other people finding out about her condition, which the client's description was making inferentially available.

This non-neutral design of the therapist's question (in lines 16-22) reveals another facet that characterizes this interactional moment. These features involve choices that portray the therapist as displaying, albeit implicitly, a personal stance on the matter of how damaging such a scenario of people finding out about the client's medical condition might be (Heritage, 2004). As we have seen there is some evidence for that in the design of the question which works non-neutrally, that is, in a way so as to minimise the client's

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emerging problem description (regarding the problematic to the client aspect of her condition becoming known). In addition, given that the question concerns a hypothetical scenario of something that could potentially happen to anybody affected with HIV and also, given that the therapist was a specialist in counselling people with HIV, one can assume that as a competent member of her professional community, the therapist would have already had a view on the matter.

The design of the rest of these sorts of questions in the collection, also reveals the non-neutrality of the therapist's project. For example, we've already seen how in the case of extract 3 above (the relevant part of which is reproduced in extract 11 below) the lexical choice of the terms of the question (in lines 1-5) significantly downplay the client's preceding problem description:

Extract 11 [S2.00:04:22]

```
1     Th:→.hhh what was your: main worry (0.9)
2          ((noise))
3     Th:  about you know what would be:: the thing that would make you
4           most uncomfortable wh- wh- when you would be:: (0.2) in the
5           room with this man
6          (0.8)
7     Cl:  U:::H I don't know what he will thi:nk
8          (.)
9     Th:  (.pt) [what     ] he will think?
```

Moreover, similarly to the previous example (extract 10), enquiring about the client's 'main worry' (in line 1) or about the thing would make her 'most uncomfortable' (in line 4) allows the therapist to potentially undermine the client's biggest objection to going back to the group, subsequently to the client's response. Also, as already argued in previous analysis of the extract, the therapist's follow-up question ('what he will think?', in line 9) is designed in a way so as to induce material of the sort the therapist would be epistemically equipped to dispute (see analytic comments regarding extract 3 above).

In the following extract the therapist ostensibly appears to maintain some form of neutrality by enquiring both about the positives of a course of action previously rejected by the client ('↑I ↑don't ↑need to tell him that', in line 1), and about the negatives:

```
1    Cl:  ↑I ↑don't ↑need to tell him that
2    Th:  .hh no I am I am not suggesting that you need to, but I am just
3         uh I am just thinking what would be the positive things if you
4         tell him and what would be the negative things if you
5         [tell him]
```

However, this very display of neutrality seems to work in a way that overcomes the client's prior resistance to the therapist's interactional project as this is manifested in line 1 of the extract, by downplaying any personal stake on the therapist's part (Edwards and Potter, 1992). Simultaneously though, one can observe certain features of the talk in action similar to those observed in the previous extracts, through which the therapist appears to invite material of the kind that might subsequently allow for a challenging move on her part. In particular, the therapist appears to be enquiring about states of affairs regarding which not just the client but she too would be in a position from an epistemic point of view to express an opinion, due to their generalised and hypothetical nature ('what would be the positive things if you tell him and what would be the negative things if you tell him', in lines 3-5).

Similar features of the talk can also be observed in the following extract in which the therapist enquires about the effects on the client's life of her departure from the service, following the client having expressed devastation by this turn of events:

Extract 13 [S4.00:22:31]

```
1    Th:  what would be:: the worst thing that could  happen
2         (3)
3    Th:  (.pt/.h)=or (0.7) ((noise)) (1) what would be: (0.3) ((small
4         noise)) the bad things that could happen
```

In the initial version of the therapist's question appearing in the extract (in line 1) one can observe the therapist asking about the 'the worst thing' that could happen, which like in other examples in the collection, would allow the therapist to beat the client's strongest reasons for displaying this particular stance, in case that she proceeds to perform a challenging or argumentative move in the third position. The therapist's recycled question which enquires about 'the bad things that could happen' (in lines 3-4), invites talk on general and hypothetical states of affairs (the latter feature is also observed in the initial

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version of the question in line 1) on which the therapist too would be deemed epistemically able to express an opinion, to evaluate the client's take, and perhaps even counter it.

Overall, analysis of the design of the therapist's questions in the collection reveals their non-innocence as the terms of the question are chosen in a way which reveals that the therapist not only does not share but even attempts to undermine the client's initially expressed negative stance. In addition, this lack of neutrality appears to be accompanied by discursive moves which allow the emergence of talk by the client that might be vulnerable to challenge or disagreement in the third position, in ways which will be also be elaborated later on in the chapter.

c) The evidence arising from the client's way of treating the question

The analytic reading regarding the disaffiliative nature of the therapist's question ('what are your (strongest) grounds') which so far has been based on the examination of its sequential position and internal design, is significantly strengthened when inspecting the client's own take of the therapist's move. Returning to extract 4 above (the relevant part of which is reproduced in extract 14 below) one can make the following observations regarding the client's response in lines 16-22.

Extract 14 [S2.00:10:46]
```
23          (0.8)
24    Cl:   u:::h the th↑ing wi- with us its: like
25          it's very very different because (0.5)
26          >I remember< Sophie say is u:h (1.4) no
27          matter wha:t, it's like we black we always
28          (remember that we are)
29          bla:ck (0.2) so when these white people
30          talk about confidentiality
31    Th:   mhm
32    Cl:   the black people don't take it so serious
33    Th:   okay
34    Cl:   and it really doesn't bother (me)=so when
35          they get to their own crowds, they talk a
36          different thi[ng        ]
37                       [((noise))]
38          (0.4)
```

`

```
39      Th:   hm[::] ((intonation of doubt))
40      Cl:     [ye]ah?
41            [so:::]
42      Th:   [okay ]
43      Cl:   the white people they (.) that's: that's
44            the ground ru:le but when it comes to
45            black people it's a different thi:ng
46            (.)
47      Th:   mm::
48      Cl:   yea[h  ]?
```

To begin with, the client's second pair part is formulated as a dispreferred with a delay of 0.8 of a second (in line 23) and the pre-pausal 'u:::h' (in line 24). Importantly, prior to answering the therapist's question, the client engages herself into an attempt to back the claim that she is about to present in lines 29-30 and 32 ('when these white people talk about confidentiality ... the black people don't take it so serious'), and in that way to defend it against potential criticism. Therefore, it seems that the client displays some orientation to the fact that what she is about to say could be disputed. This might well relate to the actual claim that she is about to make, but could also be related to the therapist's question having created a rather inauspicious environment for what is to follow.

Through the 'the th↑ing wi- with us' (line 24), the client treats the therapist as lacking some knowledge on something. Although she does not make clear at that point who the pronoun 'us' includes and this only becomes explicit shortly afterwards (through the 'we black' in line 27), the fact that the therapist is not included in the 'us' is prefigured by the client having to explain what 'the th↑ing' is to the therapist. The client builds further on the contrast between 'us' and all those excluded from it, through the upgraded assessment 'it's very very different' (in line 25). Therefore, this aspect about 'us' that the client then goes on to introduce, she constructs it as outside of the therapist's knowledge. Simultaneously, she constructs herself as having epistemic priority (Heritage, 2002a; Heritage, 2008) to express an opinion or to evaluate this issue, as she presents herself speaking from an insider's position. By implication, through this device, the client denies the therapist any grounds for professing expertise on the matter; any potential disagreement on the therapist's part is thus being undermined in advance.

In lines 26-29 the client shifts footing (Goffman, 1981) and reports something that another black person, with the same category entitlement (Potter, 1996) as her, has

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supposedly said on the matter ('Sophie say is u:h (1.4) no matter wha:t, it's like we black we always (remember that we are) bla:ck'). According to Pomerantz (1984a: 613) 'In giving sources, participants may attempt to convince sceptical recipients that there are good grounds for accepting their version as right'. This reported utterance therefore works in a way so as to corroborate the client's perspective making it sound more factual (Edwards and Potter, 1992). Also this utterance is presented in an axiomatic way, which seems an attempt to crystallise its legitimacy. It includes two extreme case formulations ('no matter what' and 'always' (in lines 26-27) which according to Pomerantz (1986: 222) are often being used when 'interactants … anticipate or expect their co-interactants to undermine their claims and when they are in adversarial situations'.

There are further analytic points about the client's response, but the following points can be made so far. The client presents the drawbacks of Sophie's acquaintances finding out about her medical condition, only after having built a case for their legitimacy and after having attempted to disarm the therapist from making any counterclaims, thus orienting to the therapist's preceding question (in lines 16-22) as carrying some critical overtones and also orienting to the possibility that the therapist disputes her version in the third position.

The client appears to orient to the non-innocence of the therapist's questions in all of the available extracts, doing interactional work to discourage any forthcoming undermining of her version. This is the case even in the extract below, where the displays of dispreferrence of the client's response are kept to a minimum, and where the response appears to be the most straightforward or else, the client appears the least troubled to provide a persuasive account. At the start of the extract, the therapist asks the client to describe her biggest obstacle in going back to a group from which she hurriedly fled following an unexpected and unpleasant encounter with a person she knew:

Extract 15 [S3.00:13:34]

```
1      Th:  .hh .pt u:::m:: bec- I I understand that u::m  (0.3) you know
2           your your biggest how how would you sa- how would you
3           describe your biggest obstacle in going back?
4           (0.2)
5      Cl:  .pt .hh u:::h to bump into somebody I knew agai(h)n heh heh
```

In line 5 ('... to bump into somebody I knew agai(h)n heh heh') the client appears to be doing work to boost her version in the following ways: To begin with, the laughter tokens work as a display that the client's 'obstacles in going back' are self-evident and

therefore more realistic and insurmountable. The brevity of her response also seems to work to the same end. In addition, the client's current description of what stops her from returning to this support group, when juxtaposed to the previous problem descriptions that the client put forward regarding this same episode (in interaction not appearing in this extract), appears upgraded. This new version of the trouble is generalised to any person whom she knows ('somebody I knew') and that she might bump into whilst attending the group, rather than being restricted to the actual person that made her flee the group in the first place. These features seem designed to strengthen her version regarding the seriousness of her fears and the necessity to discontinue attendance to this group.

A yet different way of dealing with the therapist's question which however, like the rest of the client's responses, shows that she does not take it to be an innocent move has been presented in extract 3 at the start of the chapter. In this extract, as previously demonstrated, the more the interaction progresses the more the client refuses to collaborate with the therapist's interactional project. The continuation of the exchange which lies from line 17 onwards of the following excerpt (16), testifies even greater resistance on the client's part as the therapist persists in her attempts to solicit an answer of the sort that would further her institutional interests:

Extract 16 [S2.00:04:16]

```
1    Cl:  that was really hu:ge shock to me and I
2         [think]  [ye]ah
3    Th:  [  mm:]::[:  ]
4    Th:  .pt .hhh right
5         (0.8)
6    Th:  .hhh what was your: main worry (0.9)
7         ((noise))
8    Th:  about you know what would be:: the thing that would make you
9         most uncomfortable wh- wh- when you would be:: (0.2) in the
10        room with this man
11        (0.8)
12   Cl:  U:::H I don't know what he will thi:nk
13        (.)
14   Th:  (.pt) [what     ] he will think?
15   (Cl):       [(what he)]
16   Cl:  =yeah I know what he will think
17   Th:  mhm
18   Cl:  yea:h
```

`

```
19   Th:   .pt .hh (0.3) like can you make some guesses what
20   Cl:   I reall[y
21   Th:          [(what)
22   Cl:   can't make guesses because, all that time I really went out of
23         questions=asked myself what
24   Th:   ↑u:[:h ] ( [)        ]   [yeah yeah yeah]
25   Cl:      [( )]   [all I wa]s [(thinking) was] protecting myself=
26   Th:   =yes yes
27   Cl:   I know what [I am] going through and .hhh
```

We've already examined the interaction between the therapist and the client up until line 16 (in the analysis of extract 3 above). After having faced a rather explicit display of resistance towards her interactional project to get the client to elaborate on her strongest grounds for adopting a negative stance on a specific matter (in line 16), the therapist proceeds to recycle her previous question located in line 14 ('what he will think?'). She does so by inviting the client to 'make some guesses' ('...like can you make some guesses...', in line 19), which works as an attempt to circumvent the client's prior resistance. By employing the term 'guesses' the therapist deletes the client's prior claim that she knows what this third person will think (in line 16) and, together with that, all the interactional implications which accompany this claim (which have been outlined in the analysis of extract 3). This manoeuvre not only bears no fruit, but in fact escalates the client's resistance further.

In particular, from line 20 to 27 the latter responds with a stream of turns which are delivered in a way which almost prevents the therapist from taking the floor unless in overlap with the client (in line 24). Importantly, the client overtly refuses to collaborate with the therapist's project ('I really can't make guesses', in lines 20 and 22). She then backs up her move with an account ('all that time I really went out of questions', in lines 22-23), which stresses her state of shock at the time of her encounter with this man, and therefore supports her initial version regarding the troubling nature of the encounter. The continuation of this account ('all I was (thinking) was protecting myself', in line 25) implicitly treats the therapist as if having attempted to hold the client accountable or even to blame her for her way of dealing with the situation. Interestingly, the client's use of the past tense ('went out' in line 22, 'asked' in line 23, 'all I was (thinking) was' in line 25) moves the conversation to the past and by doing so helps her to avoid providing her present perspective on the matter. Finally, her utterance 'I know what I am going through' (in line

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27), apart from exonerating her from the therapist's supposed accusations for her reaction, implicitly accuses the therapist of lack of empathy. Overall, the client's increasingly argumentative manner suggests that in the case of this extract she treats the therapist's project not just as disaffiliative but in fact as oppositional or even threatening to her own endeavours.

The same tactic on the client's part of refusing to collaborate with the therapist's project is repeated in the following extract (17), although this time the resistance is performed in a non oppositional manner:

Extract 17 [S4.00:21:15]
```
1     Th:   mm::: (1.9) .pt .HHHH HHH eh what do you think the effects
2           might be: if if Julia e-
3     (Th):((noise))
4     Th:   (.) if I go, when I go (.) o- or
5           ((noise))
6     Th:   what effects this might have in your life
7           (1)
8     Cl:   °mm::°
9           (3.9)
10    ( ):  ((noise))
11          (0.9)
12    Cl:   °mm°
13          (0.6)
14    Cl:   ((small cough))=.hhh u::m it's really hard to tell because you
15          know it's only when you start to be in that situation then, you
16          can see the effect
17          (0.65)
18    Cl:   but as of now you can't really tell what is gonna happen
```

The exchange is situated in a session where the therapist announces that she will be leaving her job and the client treats this news as particularly troubling. At the start of the extract the therapist enquires about the potential impact upon the client of her absence ('...what effects this might have in your life', in lines 1-6).

The client's response bears the familiar signs of dispreference (Schegloff, 2007). She allows for a number of lengthy pauses (1 second in line 7, 3.9 of a second in line 9, 0.9 of a second in line 11 and 0.6 of a second in line 13), on two occasions she produces barely audible contributions which delay the delivery of her turn (' °mm::° in line 8 and ' °mm° in

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line 12) as also does the cough, the inbreath ('.hhh') and the prepausal ('u::m') at the start of line 14. In addition, when she produces a lengthier turn it is to provide an account about her inability to answer the question ('it's really h<u>a</u>rd to t<u>e</u>ll', in line 14). Thereafter, the client proceeds to back this up with another account ('because y<u>ou</u> know it's only when you start to be in that situ<u>a</u>tion then, you can see the <u>e</u>ffect', in lines 14-16), whilst in line 18 she appears to recycle her initial account about not answering the question ('... you can't really tell what is gonna happen').

The client's talk contains several rhetorical features which are designed to boost her action of not answering the question. For instance, the client formulates her claims as a generalised state of affairs which applies to her case simply as an instance of a general pattern that would pertain to everybody (Edwards, 1997); this is achieved through the use of 'you' (in lines 15 and 18) as opposed to an 'I', the present tense and the maxim 'it's only when you start to be in that situ<u>a</u>tion then, you can see the <u>e</u>ffect', (in lines 15-16). The extreme case formulation (Pomerantz, 1986) 'only' (in line 15) together with the hypothetical construction 'when X then Y' set the standards impossibly high for the client to produce an answer at that moment in time. The client presents herself not as refusing to answer, but in fact as being reasonable and not wishing to make unfounded speculations about the future. Such rhetorical features in the client's talk seem to be designed not only to support the line that the client is taking regarding not answering the therapist's question but also to block any similar questions on the therapist's part which could be forthcoming and which could force her to provide an answer (as indeed seems to be the case later on in the interaction).

Overall, throughout her response the client manages to remain vague, and to avoid answering the question despite actually being responsive (a distinction made by Schegloff and Lerner (2009) and also by Muntigl and Zabala, (2008)). This vagueness which she achieves and defends quite elaborately, is a display that the client treated answering the therapist's question as a treacherous enterprise, and seems to have been put together to protect her version against criticism were she to attempt to talk about specific effects of the therapist's departure on her life (Edwards and Potter, 1992).

Crucially, the client's response presupposes that there will actually be an effect on her life from the therapist's departure: 'you can see the <u>e</u>ffect' (in lines 15-16) presupposes that there will be an effect and 'what is gonna happen' (in line 18) presupposes that something will in fact happen; the client just can't tell what these will be. This move is a

way of boosting her initial position about the therapist's departure being a particularly troubling occurrence for her.

On the whole in this extract the client avoids answering the therapist's question, whilst simultaneously strengthening the validity of her initial position. Both of these moves are displays that she treats the trajectory that the therapist's talk invites her to take as unhelpful to the actions that she has previously been performing through her talk.

To summarise the available evidence arising from analysis of the client's responses to the therapist's question in this data, shows a range of discursive tactics on the client's part, which roughly extend from providing material which could be cast as challengeable by the therapist, whilst simultaneously defending her original standpoint to a lesser or greater degree, to, on the other hand, avoiding to answer the therapist's question, either argumentatively or tactically. In addition, in all extracts in the data the client implicitly or explicitly responds in a way which defends her initial version against potential undermining. These features of the client's talk offer vital evidence regarding the challenging character of the therapist's prior move.

4.3.1 The delivery of challenge or disagreement in the third position

In those cases in the data where the client does provide an account that pragmatically can be challenged, the therapist proceeds to deliver a disagreeing or challenging move. For example this is what happens in extract 4 above, the relevant part of which is reproduced in extract 18 below:

Extract 18 [S2.00:10:56]

```
27        matter wha:t, it's like we black we always
28        (remember that we are)
29        bla:ck (0.2) so when these white people
30        talk about confidentiality
31   Th:  mhm
32   Cl:  the black people don't take it so serious
33   Th:  okay
34   Cl:  and it really doesn't bother (me)=so when
35        they get to their own crowds, they talk a
36        different thi[ng        ]
37                     [((noise))]
```

`

```
38            (0.4)
39    Th:    hm[::] ((intonation of doubt))
40    Cl:      [ye]ah?
41             [so:::]
42    Th:    [okay ]
43    Cl:    the white people they (.) that's: that's
44             the ground ru:le but when it comes to
45             black people it's a different thi:ng
46             (.)
47    Th:    mm::
48    Cl:    yea[h  ]?
49    Th:      [.pt]=.hh I am not so su:re.=I will put
50             a questionmark here okay?=because I've I
51             know black people who don't. who respect
52             confidentiality and don't talk about it
53             .hh and:: like two people that you also
54             know it's Brunette and Elaine.
55    Cl:    mm
56    Th:    yeah? and I know them, and .hh (0.2) e:::h
57             you know and we've had a lot of discussions
58             about how in their community, they wouldn't
59             disclose somebody's
60             information=so::
61             ((noise))
62    Th:    they are blacks, (0.4)
63             ((noise))
64    Th:    (0.35) but the- and they don't belong to
65             (.) the rule that you just said=so I am
66             sure there are other blacks .hh (.)
67             that do[n't talk        ]
```

     For the sake of brevity not much will be said about the therapist's response in the third position, apart from underlining, that through this move the therapist displays her disagreement, as presaged by the therapist's preceding question in lines 16-22. In particular, as the client keeps pursuing the thread on the consequences of other people finding out about her condition, the therapist receives it with pre-disagreements which work as harbingers of a forthcoming dispreferred response (Schegloff, 2007). In lines 33 and 42 she only provides acknowledgement tokens ('okay'); in line 38 she resists taking the floor for an interactionally long time (for 0.4 of second) and when she does she produces a token

clothed with an intonation of disbelief ('h<u>m::</u>', in line 39). Following a micropause (in line 46) the therapist only provides a minimal continuer ('mm::' in line 47) which masks the silence and the lack of agreement. Indeed, when the therapist finally comes in with a lengthier turn, it is to openly question the client's version ('...I am n<u>ot</u> so su:re.=I will put a questionmark here <u>okay</u>? ...', in lines 49-67), even though this disagreement is mitigated as the therapist simply claims to withhold absolute agreement and to only provide exceptions to the generalised claims previously made by the client ('because I've I know black people who <u>don't</u>. who respect confidentiality and <u>don't</u> talk about it...' in lines 50-67).

To recapitulate what we've seen so far, taking extract 4 as our departure point for illustrating the main parts of the sequence, at the start of the extract the client expresses, rather implicitly, a negative stance on other people finding out about her condition. In response to that, and in the first position of the three-part action sequence described in this chapter, the therapist issues an ostensibly affiliative question asking the client to elaborate on the drawbacks of people finding out about it.

However, this question, rather than simply seeking information on an issue regarding which the therapist is neutrally positioned, seems designed to force into the public domain a version of the client's views that the therapist is already negatively positioned towards, and which would make possible the undermining of the client's case that she should make every effort to protect the secrecy surrounding her medical condition, including keeping herself away from support groups. Importantly, this move, together with the type of client response that it invites (mainly an epistemically accessible response and also one which could be classified as subjective), set-up the basis for a disagreeing response by the therapist in the third position. This in turn can open the way for an argumentative sequence in case that, subsequently to the third position, the client also proceeds to disagree with the therapist (this is what actually happens in the client-therapist exchange following the end of the presented extract).

In the second position the client provides a response which she attempts to protect from criticism or disagreement, thus displaying an orientation to the therapist's question as being of a challenging nature, and also orienting to the possibility that her response could subsequently be disputed. Indeed, in the third position, the therapist proceeds to contest the client's response, as this has been projected by her question in the first position of the three-part sequence.

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4.4 Observations on the interactional use of such questions

4.4.1 The role of these questions as stepping stones to a challenging move in relation to preceding talk

So far, the focus has been to demonstrate that there is a particular practice in the data consisting of non-innocent questions which invite accounts that are vulnerable to challenge or disagreement in the third position of the sequence. Parallel to that, an attempt has been made to present in detail the different segments of this three-part sequence as well as evidencing the questions' disaffiliative nature in the face of examples of similar-looking questions which are however of an affiliative nature. Now the emphasis will be placed on the interactional use and argumentative potential or function of these questions.

To better understand the role of questions soliciting defeasible accounts, one could turn to the discursive context in which they arise. In case the therapist's project is to challenge the client on a particular issue, she might need to overcome a number of stumbling blocks in relation to the client's talk up to that point. This can be illustrated by examining the following two extracts:

Extract 19 [S2.00:04:16]

```
1     Cl:  that was really hu:ge shock to me and I
2          [think]   [ye]ah
3     Th:  [  mm:]::[: ]
4     Th:  .pt .hhh right
5          (0.8)
6     Th:→.hhh what was your: main worry (0.9)
7          ((noise))
8     Th:  about you know what would be:: the thing that would make you
9          most uncomfortable wh- wh- when you would be:: (0.2) in the
10         room with this man
```

Extract 20 [S2.00:32:31]

```
1     Cl:  ↑I ↑don't ↑need to tell him that
2     Th:  .hh no I am I am not suggesting that you need to, but I am just
3          uh I am just thinking what would be the positive things if you
4          tell him and what would be the negative things if you
5          [tell him]
```

`

In the above extracts what precedes the therapist's question is an A-event ('that was really <u>hu:ge</u> sh<u>o</u>ck to me ...' in line 1 of extract 19, and '↑I ↑don't ↑need to t<u>e</u>ll him th<u>a</u>t' in line 1 of extract 20). Such A-events are events that are known to the client but not to the therapist (Labov and Fanshel, 1977), and therefore cannot be disputed by the latter. Although particular conversational devices might be used to circumvent such A-events, as is the case of '...I am not suggesting that you n<u>ee</u>d to ...', in extract 20 (line 2), it appears that the questions studied in this chapter are then employed, serving as a stepping stone towards the extraction of material which the therapist can in fact challenge or dispute.

These questions though do not only follow the issuing of A-events: in the following extract the complication encountered by the therapist seems to be of a different nature:

Extract 21 [S3.00:13:24]

```
1     Th:   a- anybody can refer her there, I c<u>ou</u>ld refer  her there y[es,
2     Cl:                                                                   [˚mm:˚
3     Th:   mhm
4           (.)
5     Th:   .hhh[hh  ]
6     Cl:       [˚mm˚] hheh heh)
7     Th:   <u>mm:::</u>
8           (0.2)
9     Th:   ye:s so::
10          (0.6)
11    Th:   .hh .pt u:::m:: bec- I I underst<u>a</u>nd that u::m  (0.3) y<u>ou</u> know
12           your your b<u>i</u>ggest how how would you sa- how would you
13           describe your b<u>i</u>ggest <u>o</u>bstacle in going back?
```

In this case it appears that the talk preceding the question situated in lines 9-13 does not directly concern the issue that the therapist treats as worthy of challenge (as the forthcoming interaction as well as interaction from a previous session testifies) and the question seems to facilitate the transition to such talk. More specifically, the talk preceding the question in lines 9-13 concerned the possibility of the therapist referring a third person to a support group ('a- anybody can refer her there, ...', in line 1), whereas the therapist's question ('...how would you sa- how would you describe your b<u>i</u>ggest <u>o</u>bstacle in going back?...' lines 12-13) not just turned the talk back to the client's business, but also it served to revive the issue of the client herself going back to this support group which had been

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discussed in a previous session, and together with it to revive the argument that had been surrounding it.

In the detailed example that I analysed previously (extract 4, the start of which is being reproduced in extract 22 below) the client's talk (in lines 1-12) which preceded the question (situated in lines 16-22) was not offering itself for challenge for yet other kinds of reasons.

Extract 22 [S2.00:10:12]

```
1      Cl:  [she ↑didn't expl]ain but when I ta-
2           talked to (the) auntie Melanie >auntie
3           Melanie say< it's because maybe, .h she
4           know so many people  so many some of them
5           people she did her work her work
6           colleagues, and .hh (0.4) they went maybe
7           to the same uni:,
8      Th:  mh[m[mhm            ]
9      Cl:    [s[omething like] that,
10          (0.6)
11     Cl:  yea:h and most of them they work (.) in
12          the Hevestoft so it's like you know
13          (0.3)
14     Th:  mhm
15     Cl:  yeah
16     Th:→ mhm .pt=.hhh and:: from what you
17          understand,(0.5)
18          ((noise))
19     Th:  .hhh if:: (0.2) any of these people was
20          to:: e::m (0.45) to learn that you live
21          with eitchaivi ((HIV)), what do you
22          think would be the consequences?
```

As we have seen previously, at the start of the extract the client was responding to a request for an explanation as to why her auntie Sophie (referred to as 'she' in line 1) had not wanted her to attend any support groups, which from a therapeutic perspective could be deemed as an obstructive restriction imposed by Sophie onto the client. The client's account (in lines 1-12) issued in response to this question, comprised a series of characterizations regarding Sophie's social circle, designed as factual information, which the therapist would have no grounds and no interest to dispute as such. Importantly,

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although the account that the client put forward was seemingly providing diverse pieces of information through the construction of a list (Jefferson, 1990) (in lines 3-7), on the other hand, the client refrained from providing a sufficient cause for the restriction prescribed by Sophie. Therefore, the account that the client put together was inferential and vague and all but fully articulated, as she refrained from explicitly spelling out the consequences for any of the family members of auntie Sophie's multiple acquaintances. For example the client could have said that Sophie might have suffered from the stigma surrounding the relatives of people living with HIV, or that the client herself would risk suffering from social exclusion. These vague formulations employed by the client in this particular stretch of talk seem to work in ways as to prevent 'easy undermining while at the same time providing just the essentials to found a particular inference' (Edwards and Potter, 1992: 162). Last but not least, the client's account (in lines 1-12) concerned a third person's beliefs and actions which would not be of any particular interest for the therapist to challenge, given that the focus of the therapist's work is the client's own beliefs and actions. In contrast to the client's account (lines 1-12 above), the therapist's question (in lines 16-22 above) as we've already seen in the detailed analysis of extract 4 above, managed to extract from the client a rather pronounced version regarding the dangers of others finding out about her medical condition and by implication on what previously (in her initial account in lines 1-12) was a not very easily discernible personal stance on the issue of attending support groups (where her secret regarding her condition could become known).

What we've seen up to now is that, a particular exchange might not constitute particularly fertile ground for a challenging move, in which case questions such as those described in this section facilitate transition to or extraction of such talk.

4.4.2   Creating the pre-conditions for arguable talk

Crucially though, a more general point to make is that, irrespective of the argumentative possibilities offered by the stretches of talk which precede such questions, these questions seem to perform the business of bringing forth such descriptions of a particular state of affairs, that could be amenable to challenge. This effect is brought about through particular features of the talk which will be outlined below and which relate both to

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the question's design and to its sequential position which determines the way that the move is being understood and responded to.

One way of bringing forth challengeable material is by talking about the client's affairs in such way which renders them epistemically accessible to the therapist, in a similar way that they are to the client. Were the client to be the sole person with epistemic access to a particular topic, the therapist not only would have had to manage talk on the matter carefully to potentially attend to issues of epistemic subordination on her side (for example Heritage and Raymond, (2005) and also Raymond and Heritage (2006) analyse how such issues are managed in assessment sequences), but she would have found herself in a particularly unfavourable position to display disagreement. According to Drew (1991: 30) 'the use of a version employing one speaker's authoritative access to knowledge puts the other in an asymmetric position if he or she is to challenge what has been said'.

In the data drawn from the collection, epistemic access seems to be secured through a number of interactional moves. At times the therapist enquires about other people's thoughts or actions or about generalised states of affairs that are on the public domain and about which the therapist can have a view, in contrast to things such as the client's feelings or statements of personal intentions which can be only known to the client. Examples can be drawn from the following extracts:

Extract 23 [S2.00:10:32]
```
1       Th:→ mhm .pt=.hhh and:: from what you
2            understand,(0.5)
3            ((noise))
4       Th:  .hhh if:: (0.2) any of these people was
5            to:: e::m (0.45) to learn that you live
6            with eitchaivi ((HIV)), what do you
7            think would be the consequences?
```

Extract 24 [S2.00:32:34]
```
1    Th:→.hh no I am I am not suggesting that you need to, but I am just
2        uh I am just thinking what would be the positive things if you
3        tell him and what would be the negative things if you
4        [tell him]
```

`

Note that in the above extracts the therapist is enquiring about matters that can potentially be known to her too, through their generalised nature, her familiarity with the client or her professional expertise.

In case where the therapist has formulated her question in a way which solicits something which can only be known in an authoritative way by the client (Drew, 1991), such a client response does not constitute particularly fertile ground for a disagreeing move by the therapist immediately after the client's response. Examples of such questions that are also drawn from the collection can be seen in the following extracts:

Extract 25 [S2.00:04:22]
```
1     Th:→.hhh what was your: main worry (0.9)
2          ((noise))
3     Th:  about you know what would be:: the thing that would make you
4          most uncomfortable wh- wh- when you would be:: (0.2) in the
5          room with this man
6          (0.8)
7     Cl:  U:::H I don't know what he will thi:nk
8          (.)
9     Th:  (.pt) [what     ] he will think?
```

Extract 26 [S3.00:13:34]
```
1   Th: → .hh .pt u:::m:: bec- I I understand that u::m  (0.3) you
2          know your your biggest how how would you sa- how would
3          you describe your biggest obstacle in going back?
```

In these cases, even if the therapist has already some idea regarding the type of client response that is in order, her question is formulated in a way which invites as a response a state of affairs which are only knowable to the client (unless the client proceeds to boost her answer with claims regarding general states of affairs that the therapist would be epistemically equipped to dispute). It is thus not insignificant that in these examples in the data, subsequently to the client's response, the therapist does not signal the end of the matter but encourages further talk by issuing more questions which are on the same trajectory as the initial one. And it appears that it is this further talk that progressively moves the conversation to an area which is epistemically accessible to the therapist too. So for instance, in extract 25 above, following the client's response to the therapist's initial question ('U:::H I don't know what he will thi:nk' in line 7) the therapist proceeds to issue

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a follow-up question ('<u>wha</u>t he will th<u>i</u>nk?', in line 9) which unlike the therapist's initial question (in lines 1-5) concerns the thoughts of a third person in a given situation and it is this new question which allows the extraction of material that can be disputed by the therapist -as already mentioned in the analysis of extract 3.

In the second such extract above (26), disagreement and argument arises following the third such question on the therapist's part. The whole exchange can be viewed in extract 27 below:

Extract 27 [S3.00:13:34]

```
1    Th:  .hh .pt u:::m:: bec- I I underst<u>a</u>nd that u::m  (0.3) y<u>ou</u> know
2         your your b<u>i</u>ggest how how would you sa- how would you describe
3         your b<u>i</u>ggest <u>o</u>bstacle in going back?
4         (0.2)
5    Cl:  .pt .hh u<u>:::h</u> to bump into somebody I knew ag<u>ai(h)</u>n heh heh
6    Th:  <u>o</u>kay the s<u>a</u>me person or somebody else?
7    Cl:  £somebody£ else because that was like y<u>ou</u> know (.) <u>i</u>f I can
8         find <u>o</u>ne person I know, so that means I can find m<u>o</u>re
9         surprising pe<u>o</u>ple here .hh an to give m<u>o</u>re shock to me and I
10        don't want to be shocked <u>e</u>very t<u>i</u>me so::
11        (0.9)
12   Th:  <u>mm:</u>[::            ]
13   Cl:     [and it's r<u>ea</u>lly] a hard feeling knowing that everybody
14        you'll be bumping into someone you kn<u>o</u>w
15         (0.4)
16   Th:  m:::hm
17   Cl:  yeah?
18   Th:  .hh (0.6) u:::m hhh
19        (0.8)
20   Th:  .pt
21        (1.2)
22   Th:  would you be (.) more e::h sh<u>o</u>cked (0.3) if you m<u>ee</u>t somebody
23        (1.2) because of <u>you</u>? e- or because of e::h Sophie, and because
24        of uncle Mike, .h
25        (0.2)
26   Th:  like=
27   Cl:  =u<u>::</u>h f<u>i</u>rst it would be (.) because of m<u>e</u> (.) and the:n (1)
28        they'll come s<u>e</u>cond but, mainly it's m<u>e</u> [(I'm only)] u<u>::</u>h
29   Th:                                        [okay      ]
30        (0.4)
```

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```
31   Cl:  now (the new) ( ) (could)(can be) also disturbin you know so
32        that al- it's not that
33        [I (kindov)/(find that)]
34   Th:  [so it'll be also    ] can be also?
35   Cl:  yeah can be also this person like because if someone sees you
36        that they definitely know that you know you're positive (and
37        they'll be like) ( ) yea:h=huh
38   Th:  I'm not I'm not su:re that they, they need to make this
39        assumption (.) straight away
```

In this stretch of talk the therapist issues not one but three questions, which nevertheless appear to work towards the same end. The first which we've already seen lies in lines 1-3 ('...how would you describe your biggest obstacle in going back?'), the second in line 6 ('okay the same person or somebody else?') and the third in lines 22-24 ('would you be (.) more e::h shocked (0.3) if you meet somebody (1.2) because of you? e- or because of e::h Sophie, and because of uncle Mike,'). These three questions are topically related, as they all attempt to establish the client's biggest objection for continuing her attendance to a support group; also the last two seem to elaborate on the client's response to the therapist's initial question. Crucially, these three questions form an interlinked series of sequences which are all designed to carry out the same type of action[8] (Schegloff, 2007).

Despite the amount of questions issued by the therapist and the relative length of the extract, there are scant opportunities for the therapist to challenge the client's version as, epigrammatically, the client's talk largely comprises of reports about the client's own sentiments regarding her attendance to this group. The most distinct departure from a type of talk which would be rather inaccessible to the therapist from an epistemic point of view, occurs at points where the client produces pieces of reasoning in the form of 'if X then Y' constructions; the first lying in lines 7-9 ('because ... if I can find one person I know, so that means I can find more surprising people here') and the second in lines 35-37 (because if someone sees you that they definitely know that you know you're positive (and they'll be like) ( ) yea:h=huh').

It's thus not surprising that the therapist's disagreement ('I'm not I'm not su:re that they, they need to make this assumption (.) straight away') emerges after one of these two pieces of reasoning; more specifically after the second. This seems to confirm the key role

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[8] Perhaps the most decisive sign in the data evidencing the similarity in terms of the action type of these three questions, relates to the client's way of treating all the three of them as challenging moves on the therapist's part.

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of epistemic accessibility for disagreement to become possible. If this is the case though, an obvious question is why the therapist missed the first such opportunity of delivering a disagreeing third turn, at the completion of the first 'if X then Y' construction (in lines 7-9).

Looking more closely at the client's talk reveals that the first argument that the client puts forward ('because ... if I can find <u>o</u>ne person I know, so that means I can find m<u>o</u>re surprising p<u>eo</u>ple here', in lines 7-9) embeds as evidence a segment of the client's own experience, namely that the client has already found one person she knew in the support group, prior to the client moving inductively to a more general claim about the possibility of finding more 'surprising p<u>eo</u>ple' in the group. This seems to warrant the evidentiality of her claims, rendering her argument more factual. The second piece of reasoning (because if someone s<u>ee</u>s you that they definitely know that y<u>ou</u> know you're p<u>o</u>sitive (and they'll be like) ( ) yea:h=<u>huh</u>', in lines 35-37) is very general as it concerns what anybody would think in a given situation; therefore the therapist would be fully equipped from an epistemic point of view to evaluate its validity, with the possibility of offering an alternative to the client's version. This would thus render it a slightly better candidate for a challenging move on the therapist's part, but still this does not seem to properly explain why if the therapist's questions (in lines 1-3 and 6) project a disagreeing third part, this has not arrived at that moment in time when it could have done.

What seems to comprise a more robust explanation as to why the therapist did not come in with a challenging or disagreeing third turn following the first piece of reasoning ('because ... if I can find <u>o</u>ne person I know, so that means I can find m<u>o</u>re surprising p<u>eo</u>ple here', in lines 7-9), seems to relate to this device's sequential position in the interaction. Immediately after its delivery the client occupies the possible transition relevance place with an inbreath ('.hh', in line 9) and proceeds to outline the emotional effects of such a hypothetical scenario on her as well as her stance to such an eventuality ('an to give m<u>o</u>re shock to me and I don't want to be shocked <u>e</u>very t<u>i</u>me so::'). These utterances, which are designed to add to the validity of the case that the client has been building, and which approximate A-events (Labov and Fanshel, 1977), placed at the end of the client's talk guard her prior utterances from immediate commentary. This could explain why despite the client's initial 'if X then Y' construction making it possible (in relation to issues of epistemic accessibility) for the therapist to perform a challenging move at that stage (which is projected by the therapist's previous questions in lines 1-3 and 6), this actually does not happen until the next such opportunity arises.

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All these analytic observations confirm that the therapist's disagreement ('I'm not I'm not su:re that they, they need to make this assumption (.) straight away', in lines 38-39) comes at a point in the interaction where the ground for such a move is most fertile. Incidentally, that disagreement is anticipated at that point in time when it does arise is also visible from the interaction immediately preceding it. Very briefly, there are many features of the client's response which show that she treats the therapist's previous question ('would you be (.) more e::h shocked (0.3) if you meet somebody (1.2) because of you? e- or because of e::h Sophie, and because of uncle Mike,', in lines 22-24) as projecting a disaffiliative third part, which relate to the complexity of the account that the client is building ('first it would be (.) because of me (.) and the:n (1) they'll come second but, mainly it's me ... now (the new) ( ) (could)(can be) also disturbin', in lines 27-32). However, the most striking feature concerns the client's response to the other-initiated repair (Schegloff, et al., 1977) issued by the therapist ('so it'll be also can be also?', in line 34). It is rather obvious from the way that the therapist formulates her repair that, whatever her reasons for issuing it, she treats as worthy of repair the part of the client's account located after 'also' (in line 31), given the repeats of parts of the client's prior utterances up until that point, and given the questioning intonation in which these are delivered ('so it'll be also can be also?', in line 34) (Schegloff, et al., 1977).

Interestingly, the client does not restate the target terms (from 'disturbin' in line 31 onwards), but proceeds to strengthen her version with an account which incorporates the hypothetical 'if X then Y' construction. It thus appears that the client does not treat the therapist's repair as a mishearing, but as evidence of misalignment (Schegloff, 2007). Indeed, the therapist's ensuing turns ('I'm not I'm not su:re that they, they need to make this assumption (.) straight away', in lines 38-39) confirm the client's take.

On the whole, apart from illuminating the role of epistemic accessibility for disagreement and argument to arise, what the last two exchanges also show (extracts 25 and 27 above) is that if the initial question-answer pair is not particularly favourable for a challenging move on the therapist part, the latter might keep issuing further such questions which solicit defeasible accounts, until the opportunity for the delivery of a challenging third part finally arises. In other words, these exchanges confirm the non-haphazardness of the disagreeing third part in sequences initiated by the questions described in this chapter; instead the therapist appears to be in pursuit of an opportune moment for its delivery.

`

To return to the ways in which epistemic access, and by implication challengeability is secured, another way is through the use of hypothetical constructions which feature in most of these questions as can be seen in the following extracts:

Extract 28 [S2.00:32:34]

```
1    Th:  .hh no I am I am not suggesting that you need to, but I am just
2         uh I am just thinking what would be the positive things if
3         you tell him and what would be the negative things if you
4         [tell him]
```

Extract 29 [S4.00:21:15]

```
1    Th:  mm::: (1.9) .pt .HHHH HHH eh what do you think the effects
2         might be: if if Julia e-
3    (Th):((noise))
4    Th:  (.) if I go, when I go (.) o- or
5         ((noise))
6    Th:  what effects this might have in your life
```

Extract 30 [S4.00:22:31]

```
1    Th:  what would be:: the worst thing that could  happen
2         (3)
3    Th:  (.pt/.h)=or (0.7) ((noise)) (1) what would be: (0.3) ((small
4         noise)) the bad things that could happen
```

Extract 31 [S2.00:04:22]

```
1    Th:  .hhh what was your: main worry (0.9)
2         ((noise))
3    Th:  about you know what would be:: the thing that would make you
4         most uncomfortable wh- wh- when you would be:: (0.2) in the
5         room with this man
```

Extract 32 [S2.00:10:32]

```
1     Th:  mhm .pt=.hhh and:: from what you
2          understand,(0.5)
3          ((noise))
4     Th:  .hhh if:: (0.2) any of these people was
5          to:: e::m (0.45) to learn that you live
6          with eitchaivi ((HIV)), what do you
7          think would be the consequences?
```

`

As can be seen in the above extracts, these questions enquire about the disadvantages of an (undesired by the client) eventuality materialising. Interestingly, in all but one extract in the collection, the hypothetical aspect appears to qualify not just the scenario that the therapist enquires about, but crucially its consequences (for instance, 'what effects this might have in your life', in line 6 of extract 29 above). By doing so, the therapist not only avoids portraying these disadvantages as definite or factual, but also, invites the client to produce speculations of the sort that anyone might be in a position to do, even if that person is not in the situation. In other words, by employing the hypothetical form in this particular way the therapist invites talk which is epistemically accessible not only to the client but also to the therapist. This creates the preconditions for the therapist to disagree with the client's version in the second position, despite the fact that these scenarios concern aspects of the client's life which the therapist would have otherwise been in a relatively disadvantageous position to express an opinion on or effectively to disagree with the client.

To expand on the ways through which the therapist's question attempts to invite challengeable material in the second position, in some cases she formulates her question in a way which contextualises what is to come as the client's subjective take on a matter (that is enquiring about the client's thoughts). This is the case in the following extracts:

Extract 33 [S4.00:21:15]
```
1    Th:  mm::: (1.9) .pt .HHHH HHH eh what do you think the effects
2         might be: if if Julia e-
3    (Th):((noise))
4    Th:  (.) if I go, when I go (.) o- or
5         ((noise))
6    Th:  what effects this might have in your life
```

Extract 34 [S2.00:10:32]
```
1      Th:  mhm .pt=.hhh and:: from what you
2           understand,(0.5)
3           ((noise))
4      Th:  .hhh if:: (0.2) any of these people was
5           to:: e::m (0.45) to learn that you live
6           with eitchaivi ((HIV)), what do you
7           think would be the consequences?
```

`

Note the difference between 'wh<u>a</u>t do you th<u>i</u>nk the effects might b<u>e</u>:?' (derived from lines 1-2 of extract 33 above), as opposed to the invented 'what might be the effects?': comparatively the initial formulation anticipates an even less objective version than the second one, given that this would simply be the product of someone's thoughts. From a discursive psychology perspective such a version could be discounted more easily (Potter, 1996). Therefore the therapist's manoeuvre works to display that the client's ensuing version will not necessarily be received uncritically.

In a similar way, in extract 35 below the use of the modal 'would' situated in a position which characterizes the client's anticipated talk, alludes to the possibility of a series of alternative descriptions ('... how would you describe your...', in lines 2-3).

Extract 35 [S3.00:13:34]

```
1   Th: →  .hh .pt u:::m:: bec- I I underst<u>a</u>nd that u::m  (0.3) y<u>ou</u>
2          know your your b<u>i</u>ggest how how would you sa- how would
3          you describe your b<u>i</u>ggest <u>o</u>bstacle in going back?
```

Such modals studied by Edwards (2006b) in the course of interrogations of police suspects have been analysed as portraying an action as dispositional and as displaying a 'back-dated predictability' (ibid.: 497) of somebody's actions. Characterizing the client's forthcoming description as dispositional has the effect of portraying it as one out of many potential descriptions that people with different dispositions might produce, thus undermining its uniqueness. This is also consonant with systemic therapy guiding principles aiming to promote a 'multiverse' (Pearce, 1989) or else a range of possible but equally valid descriptions, which perhaps explains the pervasiveness of this practice in the data.

In general, simply the issuing of these questions in the particular discursive context in which they are being asked, as well as the terms from which these questions are composed when compared with the client's preceding descriptions of the same state of affairs, work as displays that the therapist is on a disaffiliative trajectory towards the client's emerging version. For example, these questions might occur as an alternative to an empathic response towards a problem-telling which would have revealed the therapist as fully aligned as a troubles-recipient, or as an alternative to a display of acceptance of a given account. Or for instance, the use of hypothetical forms could portray the client as

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having a choice between different courses of actions, despite the fact that the client has already expressed a stance on a matter, as is the case in the following extract:

Extract 36 [S2.00:32:34]

```
1    Th: .hh no I am I am not suggesting that you need to, but I am just
2        uh I am just thinking what would be the positive things if
3        you tell him and what would be the negative things if you
4        [tell him]
```

Therefore these questions once more could appear to have been issued in defiance of the client's pre-existing position thus equally pre-figuring a potential challenge by the therapist.

All these can be signs that the client's second pair part regarding an issue on which her stance is already known and towards which the therapist has shown signs of disafiliation, will be arriving in an inauspicious environment. Although this in itself does not directly set in place the prerequisites for a challengeable response, nevertheless, pragmatically, it seems to lead the client to defend her response against challenge, through devices such as extreme case formulations, generalizations, or maxims, in a similar way that in Drew and Holt's data disafiliation by a co-participant 'generates the production of multiple idioms by the speaker/(troubles) teller' (1995: 130), or that speakers might 'summarize their grievance in an idiomatic complaint, to anticipate an unsympathetic response;' (Drew and Holt, 1988: 407) or alternatively, that one might resort to extreme case formulations 'in anticipation of non-sympathetic hearings,' (Pomerantz, 1986: 227). Such devices though, might end up facilitating or opening the way for disagreement through the sheer fact of their hearably excessive or generalised character; according to Edwards (2000: 352) 'ECFs are factually brittle, in that an extreme or universalizing statement ... risks easy refutation by a single exception', whilst Kitzinger (2000: 141), talking about the generality and vagueness of idioms, points that 'resistant co-conversationalists can use the same vagueness to refuse affiliation by pointing to the existence of specific concrete details (individual differences or particular circumstances) that are taken to render the idiom inapplicable'. Examples of how the client's use of extreme case formulations, maxims and generalised statements generate disagreement can be seen in the following excerpts (for detailed analytic comments of these extracts see previous analysis of extracts 14 and 27 respectively):

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Extract 37 [S2.00:10:47]

```
1    Cl:   u:::h the th↑ing wi- with us its: like
2          it's very very different because (0.5)
3          >I remember< Sophie say is u:h (1.4) no
4          matter wha:t, it's like we black we always
5          (remember that we are)
6          bla:ck (0.2) so when these white people
7          talk about confidentiality
8    Th:   mhm
9    Cl:   the black people don't take it so serious
10   Th:   okay
11   Cl:   and it really doesn't bother (me)=so when
12         they get to their own crowds, they talk a
13         different thi[ng        ]
14                      [((noise))]
15         (0.4)
16   Th:   hm[::] ((intonation of doubt))
17   Cl:     [ye]ah?
18         [so:::]
19   Th:   [okay ]
20   Cl:   the white people they (.) that's: that's
21         the ground ru:le but when it comes to
22         black people it's a different thi:ng
23         (.)
24   Th:   mm::
25   Cl:   yea[h  ]?
26   Th:      [.pt]=.hh I am not so su:re.=I will put
27         a questionmark here okay?=because I've I
28         know black people who don't. who respect
29         confidentiality and don't talk about it
30         .hh and:: like two people that you also
31         know it's Brunette and Elaine.
```

Extract 38 [S3.00:14:43]

```
1    Cl:  yeah can be also this person like because if someone sees you
2         that they definitely know that you know you're positive (and
3         they'll be like) ( ) yea:h=huh
4    Th:  I'm not I'm not su:re that they, they need to make this
5         assumption (.) straight away
```

To summarise, the central point sketched so far is that whatever the particular way in which they do so, the questions examined in this section open up the space for the undermining of a particular position. Implicitly, it is as if these questions invite some kind of transformation of the client's prior talk on a particular issue, such as a problem-telling or a blocking response, by attempting to extract such descriptive versions of the client's problem-tellings or of her grounds for opposing a particular idea that could be challengeable.

However, this effect cannot take place without the client's participation, given that it is the client who provides the challengeable or disputable material. This becomes particularly obvious in those cases where the client blocks the therapist's attempts by avoiding to answer, as we have already seen that it is the case in the extract below:

Extract 39 [S4.00:21:15]

```
1     Th:  mm::: (1.9) .pt .HHHH HHH eh what do you think the effects
2          might be: if if Julia e-
3     (Th):((noise))
4     Th:  (.) if I go, when I go (.) o- or
5          ((noise))
6     Th:  what effects this might have in your life
7          (1)
8     Cl:  ˚mm::˚
9          (3.9)
10    ( ):  ((noise))
11          (0.9)
12    Cl:  ˚mm˚
13          (0.6)
14    Cl:  ((small cough))=.hhh u::m it's really hard to tell because you
15          know it's only when you start to be in that situation then, you
16          can see the effect
17          (0.65)
18    Cl:  but as of now you can't really tell what is gonna happen
```

It thus appears that the therapist's project relies upon the client herself to provide responses of the sort that could carry it out. For the sake of comparison, it is worth noting that this would not be the case with other types of conversational devices which largely rely upon one's interlocutor preceding turns to achieve their aims (although even such devices could be open to disconfirmation in a next turn). An example of such a practice, where the

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material is already available, is that of formulating a prior speaker's talk and by so doing, editing and transforming it in ways which serve specific institutional purposes as these have been outlined by Antaki (2008).

The fact that for completion of her project (that is for her to be able to issue a third turn of the sort that has been described in the outline of the phenomenon's structure), the therapist relies rather heavily upon the client's participation in the second position, could perhaps account for the covertness of these questions' oppositional character. As already mentioned this seemingly affiliative character is manifested in a number of ways. For example, all of these questions are open questions thus appearing to permit a wide range of responses in the second position (this freedom though, as previously analysed, is rather deceptive given that the terms in which the question is formulated guide the client towards specific paths, which in reality facilitate the therapist's interactional project of questioning a particular version previously supported by the client). Another crucial feature which could have betrayed the kind of project carried out through these questions is the intonation in which they are being delivered. However, despite the questions' challenging nature, all of the instances featuring in the collection seem to be delivered in a neutral intonation as if the questions are simply information-seeking ones, which again conceals their oppositional character.

One could imagine though that in other cases, particularly in ordinary interaction, the device could in fact be delivered in openly disaffiliative ways that would manifest fairly explicitly the interactional project in action. Such a more overtly disaffiliative use of the device could perhaps bring a different set of responses. In the absence of real-life openly disaffiliative examples, and to be able to make this point more markedly, one could examine a rather similar device in the data, which is that of challenges.

Challenges are not the focus of this section, but nevertheless it is worth noting that there are several similarities between them and the phenomenon studied in this chapter. To begin with, the challenges in the data also appear in the first position of a three-part question answer disagreement type of sequence. Importantly though, there is some similarity in terms of the action performed through these devices. Challenges on one hand invite a prior speaker to warrant the grounds, truthfulness or evidentiality of his/her claims. These questions on the other hand, as already mentioned in the outline of the structure of the phenomenon, implicitly invite a description of the prior speaker's (strongest) beliefs or reasons in support of a stance that they previously displayed.

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Inspection of a collection of challenges in the data reveals that the most openly disaffiliative challenges tend to get more openly disaffiliative responses in the second position. The contrast could be seen in the following two examples:

Extract 40 [S3.00:15:33]

```
1      Th:    [ok]ay .hhh so:, (.) wh↑y do you assu:me that anybody who
2             would £see you£, (0.9) would assume ↑o::h she's
3             p[ositive]
4      Cl:     [hhheh h]eh heh .hhh u::h
5             £ (I don't know) it's just that you know .hh when you
6             know that you're thief, and somebody sees you holding
7             something,£
8      Th:     yes,
9      Cl:    £so they'll (just/most) (definitely) know you've stole
10            it   so it's like£=
```

Extract 41 [S2.01:02:10]

```
1   Th:    mm::: ((displaying disagreement)) .pt who says that you
2          don't have any choice
3   Cl:    me
4          (2.6)
5   Th:    can you explain to me to me a bit
6          (1.5)
7   Th:    you said I have no choice
```

Many analytic comments could be made about these extracts but the point of interest at this stage, is that whereas the therapist's challenge in extract 40, whose challenging character is mitigated with smiley voice ('... wh↑y do you assu:me that anybody who would £see you£, (0.9) would assume ↑o::h she's positive...', in lines 1-3), receives a fairly elaborate answer ('... when you know that you're thief, and somebody sees you holding something, ... so they'll (just/most) (definitely) know you've stole it...', in lines 4-10), this is not the case in extract 41. In this last excerpt, the therapist issues a presumptive question which assumes that the best grounds the client has for claiming that she has no choice on the matter of attending a support group, is that she was told so ('... who says that you don't have any choice') thus treating the client as if having no entitlement to make such a knowledge claim herself (Drew, 1991). Therefore the therapist employs an ironised format which receives an equally ironised second pair part ('me', in

line 3) that does not get the therapist very far in terms of her project and requires two toned-down re-issued first pair parts ('can you explain to me to me a bit' in line 5 and 'you said I have no choice' in line 6) to finally get a response by the client that the therapist treats as acceptable (for the sake of brevity the client's response has not been reproduced here).

To return to the questions examined in this section, the supposed neutrality which the therapist conveys intonationally whilst delivering her question or through the use of an open question would not be attributed to chance, but could have been designed to have a more forceful effect upon the client in terms of getting the client to actually produce an arguable account, the delivery of which could have been jeopardised by a move issued in an explicitly disaffiliative manner. Such an orientation to the potential success of a particular conversational move by its architect would not be an unfamiliar practice, as participants orient to the possibility of different sorts of interactional outcomes being attached to different ways of designing their turns in all sorts of action sequences; for example Curl and Drew (2008: 130) have demonstrated that participants' selection of request forms display speakers' 'orientations to their entitlement to make the request and to the contingencies that may be involved in the recipient granting the request.' Although in this case no issues of entitlement arise for the therapist, nevertheless the therapist displays a strong orientation to the type of outcome that might come up with different forms of delivering her question. It thus appears that in the case of this data the therapist's institutional aims would best be met by actually getting the client to issue the type of response which could permit her to proceed to the third part of the sequence.

Of course, one could imagine that an even more convenient response for the therapist would be for the client to simply drop the claim that she has previously made (such as a problem-telling, or a blocking response to a preceding action by the therapist). Had the client given such a response there would have been no need for the therapist to disagree in the third position. In the absence of these types of responses though, and as the client issues responses which attempt to block the therapist's trajectory or to defend her original stance, the therapist in the data appears to do her best to receive challengeable material, by toning down the challenging character of the question, or by continuing to issue a series of questions which are in pursuit of challengeable or arguable material, until the client finally provides such a challengeable response.

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4.5   A few concluding observations

4.5.1   Reflections on the argumentative force of the device

These observations bring us to the issue of the argumentative 'success' of these
questions in the data. As we have already seen there are instances where these moves prove
to be rather 'advantageous' for the therapist from an argumentative point of view. This is
when the therapist is in fact successful in bringing into the open material which she is then
in a position to challenge. However, we've equally seen that in some cases the potential for
disagreement does not materialise, and furthermore, that at times these questions might
even come with a certain interactional cost, as it is the case with extract 43 below
(reproduction of extract 17; for analytic comments refer to the latter), which is one of the
few cases in the entire corpus where the client's attempts to block the trajectory of the
therapist's moves reaches its greatest intensity.

Extract 43 [S2.00:04:16]

```
1     Cl:  that was really hu:ge shock to me and I
2          [think]  [ye]ah
3     Th:  [  mm:]::[: ]
4     Th:  .pt .hhh right
5          (0.8)
6     Th:  .hhh what was your: main worry (0.9)
7          ((noise))
8     Th:  about you know what would be:: the thing that would make you
9          most uncomfortable wh- wh- when you would be:: (0.2) in the
10         room with this man
11         (0.8)
12    Cl:  U:::H I don't know what he will thi:nk
13         (.)
14    Th:  (.pt) [what     ] he will think?
15    (Cl):      [(what he)]
16    Cl:  =yeah I know what he will think
17    Th:  mhm
18    Cl:  yea:h
19    Th:  .pt .hh (0.3) like can you make some guesses what
20    Cl:  I reall[y
21    Th:         [(what)
```

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```
22   Cl:  can't make guesses because, all that time I really went out of
23        questions=asked myself what
24   Th:  ↑u:[:h ] ( [)        ]  [yeah yeah yeah]
25   Cl:     [( )]  [all I wa]s [(thinking) was] protecting myself=
26   Th:  =yes yes
27   Cl:  I know what [I am] going through and .hhh
```

From the different types of client responses that become relevant following a question which solicits a defeasible account, the most successful in blocking the therapist's trajectory appears that of avoiding to give an answer, although this might be only temporarily successful, given that thereafter the therapist might insist on extracting an answer by recycling her initial question. The other main type of client response observed in the data, which is that of producing an answer that the client nevertheless attempts to defend against doubt, appears, sooner or later, to lead to challenge, disagreement or some form of undermining of the client's version by the therapist.

As previously mentioned, oddly enough, it might be the client's attempts to defend her initial stance, and in particular her efforts to portray her version as definite or all-applying, that might facilitate the therapist's task by laying the client open to challenge or disagreement (see analytic comments of section 4.4.2). In this case, the client appears to attempt to avoid one trap, which is that of offering a self-defeating response, but ends up falling into another. Either way, she is not on the winning side. These findings are in line with Hutchby's (1992: 681) analytic insights from the study of argument on talk-radio, that 'while bald statements of putative fact may be routinely exploited to lend versions their sense of authoritativeness in certain interactional environments, in others, and particularly in environments where 'argument' is being done, controversy being pursued, such statements are conversely exploitable by a sceptical party to present as fallible the very positions they are designed to legitimise'.

This brings us to the issue of the types of discursive resources used to combat argumentative moves which are available to the client; among other things one can in this case make a broad distinction between talk regarding A-events (Labov and Fanshel, 1977) and talk regarding what is constructed as logical or objective. The practice of questions which solicit defeasible accounts demonstrates a move between the two, given that in the data the therapist appears to attempt to shift the talk to issues which are presented as generaliseable, belonging to the realm of logic, or that can be evaluated objectively. Whenever the client barricades herself behind A-type of events she appears to be on safer

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ground – at least temporarily. On the contrary when she resorts to a range of discursive resources that supposedly depict the objective world she lays herself open to confrontation and possible defeat. This point can surely be generalised to other types of argumentative exchanges in the data; indeed the client appears to often resort to talk about A-events as a discursive resource to elude challenging moves or disagreement on the therapist's part. Aside from what might be the case in other exchanges though, this palindromic move is particularly striking in the case of this phenomenon as previously developed (in section 4.4). Therefore, one of the strengths that this particular phenomenon presents for the therapist is that it allows for a move away from talk where the client is the only person enjoying epistemic accessibility, as previously developed (see section 4.4).

It could be argued that such a move between these two types of talk would be characteristically a participants' resource in the course of psychotherapeutic interaction (and by implication in the course of argumentative exchanges in this type of setting), given that it is customary for clients to be talking about their personal world, experiences and aspirations and that therapists cannot have direct knowledge of these things. For the sake of comparison, one could speculate that talk regarding such matters would be relatively unusual in other types of institutional interaction such as political interviews. Therefore in such settings this move between talk regarding A-type of events and talk regarding matters which can be known by both participants could not be an argumentative resource in a similar way that it is in this data. It thus appears that this phenomenon of questions soliciting defeasible accounts, aside from other things, illuminates a quality of argument talk which would nevertheless to a large extent be particular to argument talk in psychotherapeutic interaction (as opposed to interaction in other sorts of institutional settings).

4.5.2   Reflections on what the phenomenon reveals about systemic therapy practice

This previous observation has brought us to the issue of what is revealed about therapy practice by the details of participant's talk when they are engaged in exchanges involving the phenomenon investigated in this chapter. It has been argued throughout that the questions in the data are designed to bring forth challengeable or arguable material. One could imagine that challenge or disagreement with someone's version can occur spontaneously, with one participant saying something and the other issuing the challenge or

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the disagreement. In the case of these exchanges in the data though, it appears that the way for disagreement is being opened up progressively in rather skilful ways. If we assume that these questions are in line with systemic therapy theory principles, this leads to the conclusion that challenge or disagreement have their rightful place within the institutional practice of systemic therapy. Therefore in this case one could talk about institutional disagreement -and also about institutional arguments – not in the sense of disagreement simply occurring in the course of institutional interaction but in the sense of being designed to happen, or else, of being an accepted part of systemic therapy practice instead of occurring haphazardly.

In addition, the fact that the therapist designs her questions in an affiliative manner indicates that she does not risk not getting an answer, as it could have been the case with an explicitly disaffiliative design of the question (for more details see parallel with affiliatively and disafiliatively issued challenges in section 4.4.2). Indeed, given the intensity of the resistance that the client already exhibits in some of her responses (as is the case in extract 16), one could imagine that a more openly oppositional manner by the therapist at the delivery of her question could have greatly jeopardised her project. The therapist in the data appears to show an orientation to this possibility, which emphasises the importance for the therapist of the client actually producing an answer, and ultimately, for her institutional project materialising. This is also shown by the therapist's repeated attempts to get a response of the kind that would facilitate her project, by issuing follow-up questions whenever the client response in the second position does not immediately offer itself to challenge.

If the arguments initiated with the questions examined in this chapter have been brought about progressively, then it is of great interest to examine the context in which these three-part sequences emerge. The data reveal that these questions follow troubles-tellings, or alternatively, the rejection by the client of a course of action (of course this does not exclude other types of actions potentially preceding such questions). In the first case the questions soliciting defeasible accounts appear to attempt a transformation of part of the client's troubles telling to challengeable material – which, as one could imagine, radically departs from the client's expectations from psychotherapy. In the second case the questions appear to be employed to bring forward the client's objections to a course of action which allows their transformation to arguable material. It is as if, during the time that the client talks about a problem or rejects a course of action, the therapist identifies or diagnoses an 'arguable', or else a problem (i.e. the client's stance on a matter), which is though a

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problem from an institutional perspective, and which differs from the client's problem, both in its nature and in terms of how it gets resolved. Therefore, through these questions, the therapist appears to initiate a process which permits her to eventually become challenging and indeed corrective of the client's own utterances and actions.

In addition, the way that the therapist's move is being performed, offers the client the opportunity not just to provide grounds for her negative stance, but equally, to drop some or all of her claims 'spontaneously', as it would also be the case with challenges (for instance this likelihood is mentioned by Monzoni (2008) in the case of wh- questions in complaint sequences) or with the practice of uncovering a contradiction (see chapter 5). In this case, the therapist's input towards this outcome would have remained covert, what would have been visible would be that the client reached this outcome or insight on her own; the therapist would have supposedly 'just been asking questions', which would theoretically fit with the therapeutic principles of non-directiveness (Cecchin et al., 1993; Mason, 1993).

A final observation relates to the way that these questions, viewed on their own, might appear as if having been issued for diagnostic purposes, or, the therapist might appear as if having been driven by what Cecchin (1987: 411) calls 'curiosity'; a principle which is particularly valued by systemic practitioners and which refers to the continual search for 'different descriptions and explanations'. In other words, these questions, treated outside of their context, could be considered similar to the relatively affiliative question appearing in extract 5 above, which is drawn from Perakyla's (1995) material. Given the importance of context though for understanding the disaffiliative nature of these questions, this stresses the need to situate therapeutic interventions within their discursive context in order to study their orientation and the actions they perform.

4.5.3   Observations on the scope of this phenomenon

The above observations indicate that the discursive practice analysed in this chapter allows for some significant reflections regarding argumentative exchanges in a psychotherapeutic institutional environment. One question that comes to mind then is how broad this practice is in the data. My collection comprises five extracts which at first sight appears a rather small number. However, prior to making such a claim, certain parameters need to be taken into consideration.

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To begin with, the corpus of data comes from the end of a two year period. The end of a therapeutic encounter, where the systemic approach is employed, is supposed to mostly involve celebration of the changes made (Durrant, 1987; Epston and White, 1992) -indeed this principle seems to be largely put into practice in this current corpus as well, as, for example, at the very last session the client is being awarded a certificate for the things that she has managed well throughout the therapy work. The instances of the practice described in this chapter though, occur either after troubles tellings as well as after client-resistance of some kind; these activities appear to be infrequent in this corpus; this most probably relates to the fact that the sessions have been drawn from the concluding part of the therapist-client encounter. Had the corpus of data been derived from the beginning or middle of these encounters, a different story might have been told regarding the frequency of this practice. In addition, argumentative exchanges in the data only appear in four out of a total of thirteen sessions; moreover, even when they do appear they do not occupy the whole of a session. In this context expecting a large number of instances of this practice would have been entirely unrealistic. All things considered, five instances appear to be not as infrequent an occurrence as initially thought.

Linked to that, it appears that this practice features elsewhere in the literature on interaction in a counselling setting. In particular Perakyla (1995) cites the following extract, which, despite being employed to illustrate very different analytic points, appears to bear some notable similarities with the extracts comprising this present collection:

Extract 44 (Perakyla, 1995: 164-165)

(18)   (N-41)

        ((Talking about the GP's role))

```
1    P :         Haemophilia: I (.8) don't want him to ge[t=
2    C1:                                            [No
3    P:          =involved wit[h haemophilia:.=I want to=
4    C1:                    [O:kay.
5    P:          =come up here,
6                (.)
7    P:          Er:::m
8                (.5)
9    C1:         But w[hat would it be–
10   C2:              [Mrs Heller how much information does a
11               GP need to f[unction adequately.
12   C1:                     [*I'll a:sk later that.*
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13   C1:              I was just wondering: (.) (yeah) ( ) (.3)
14                    how: (.2) I mean what would be: (.2) the worst
15                    effects do you think of the GP knowing.
16                    ((continues))
```

This extract is not complete for our purposes, in the sense that the turns which have been identified as approximating the practice described in this chapter, correspond to only a segment of the three-part sequence described in this chapter. A second, although not as important difference from this current collection, concerns the presence of two professionals which alternate in delivering the questions. Nevertheless, even within these constraints, there appears to be a match with the practice featuring in the data.

Initially, (in lines 1 and 3) P expresses a negative stance regarding his GP's involvement with his condition ('I (.8) don't want him to get= involved with haemophilia:.'). In response to that C1 issues a question which is initiated with the disjunctive 'but' (in line 9); this indicates some dissonance with the client's stance. C1's question though overlaps with a question issued by C2 ('Mrs Heller how much information does a GP need to f[unction adequately.', in lines 10-11). The overlap results in C1 abandoning her initial query as line 12 shows (*I'll a:sk later that.*).

What is of interest is C1's ensuing question in lines 13-16 ('I was just wondering: .... what would be: (.2) the worst effects do you think of the GP knowing.'). Given that there is evidence of C1 not embracing the client's stance prior to that point (arising from C1's initial question in line 9), one could assume that C1's ensuing question would equally be on a disaffiliative trajectory with the client's initial stance. Interestingly, through this question C1 appears to be seeking the client's strongest grounds in support of her stance, in the same way that the questions of this current collection do. These features point to the direction that in fact through her question in lines 13-15 C1 attempts to bring forth challengeable material regarding an issue about which she seems to be in opposition with the client. The client's response to C1's question in the second position as well as the therapist's response in the third position would have been particularly valuable in claiming with certainty the commonality between Perakyla's extract and those comprising this current collection, but even in the absence of this material there is rather strong evidence that they all form part of the same practice. This would suggest that the practice of soliciting defeasible accounts could be a common practice of professionals embracing the

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systemic approach (as both the professionals from this corpus as well as from Perakyla's one embrace this therapeutic modality).

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Chapter 5: Uncovering a contradiction: eliciting the client's reports of her experience for oppositional purposes

The inspiration for this chapter arose after observing in the data a form of activity initiated by the therapist which could roughly be characterized as attempting to persuade the client by means of reasoning and appeals to evidence. This type of talk observed in the data exposes the use by participants of argumentation in order to accomplish some form of psychotherapeutic enterprise. The method which the therapist employs to carry out her project is solicitation of particular aspects of the client's experience which oppose the client's proposed version. The analysis of these instances in the data will attempt to illuminate how the therapist engages the client in such a process which exposes incongruities in the client's reports of her experience.

5.1   Background

My starting point for this chapter has been some instances which I found in the data, which exhibit participants engaging in a process of gathering evidence to build a logical case. Such processes have preoccupied a number of philosophers or scholars working within the fields of logic, rhetoric and argumentation theory. It might as well be noted at this stage that the work presented in this chapter has nothing to do with the study of idealised structures of reasoning such as those devised by scholars from the field of formal logic. Such structures have very little to say about the way people reason whilst talking amongst themselves and have hardly any application to ordinary arguments (Antaki, 1994), in opposition to informal logic which is concerned with natural language arguments (Fisher, 1988; Rips, 1998).

It appears that the concept of argument as a set of premises leading to a conclusion appears to have some relevance for the analysis of this data, insofar as instances in the data reveal that participants themselves package their talk in the form of evidence in support of a particular claim and in the form of ensuing conclusions, thus making argumentation relevant in their talk. In fact it has even appeared to be of some use to at times cast the arguments constructed by participants in the data in a syllogistic format, in the manner of informal

logicians. The principal reason for that is that it helps bring out the fact that participants themselves appear to construct their talk as reasoned arguments with premises and conclusions. However, unlike informal logic the analysis is not preoccupied with the investigation of participants' reasoning strategies, nor with the evaluation of the arguments that they produce.

What is at the centre of the analytic interest in this chapter is precisely the fact that argumentation seems to have some interactional relevance in a systemic therapy setting. What also appears worthy of analytic investigation is the resources employed by the client and the therapist in order to bring their argument off or to rebut a case. Constructing claims as logical or as the result of processes of reasoning is treated as one of the resources participants have at their disposal, which they mobilise in an attempt to achieve their persuasive or other interactional aims. Similarly, the validity of such claims is not an analyst's concern as it is the participants' business to evaluate a claim's validity, to leave it unnoticed, or even to construct irrationality as an interactional and argumentative resource – in fact the latter appears to be the case in one of the instances in the data.

A number of authors have noted that speakers present particular versions in a syllogistic form for rhetorical purposes; for example, Edwards and Potter (1992) and Swan and McCarthy (2003) offer examples of monological arguments. The use of argumentation as a resource in psychotherapeutic interaction has been observed by Antaki et al. (2004) who presents an instance of a dialogical argument mobilised by the therapist to normalise and effectively deal with a problem-telling produced by the client.

In antiquity, practices of dialogic argumentation similar to the instances found in the data have been recorded by Plato in his dialogues (Plato, 1961) where he documented Socrates' maieutic or dialectic method of questioning through which Socrates was attempting to investigate a variety of issues of concern to the citizens of Athens. Socrates was making a parallel between his method of questioning and the practice of midwifery (Theaetetus, 151), at a time when Athenian midwives were imposing a test onto the newborns that they were helping deliver, namely immersing them in cold water so as to maintain in life the fittest. Similarly, Socrates was claiming that he was on one hand employing a method of questioning which was giving birth to ideas, but also that he was submitting these ideas to the test of critical enquiry, so as to only retain those resistant to critique. Interestingly, as Edwards' (1997) analysis of an excerpt of the Socratic dialogue with Meno demonstrates, Socrates, whilst claiming to be ignorant and whilst giving the appearance of simply asking questions, was 'eliciting' particular versions about certain

states of affairs. These versions seemed to be in support of an implied argument, if not publically that of Socrates (as Socrates was pretending to only be conducting an unmotivated enquiry), then at least that of Plato himself, who was 'reporting' these dialogues.

5.1.1 Initial reflections on the argumentation in the data and two initial instances from the data

To return to the material upon which this analysis is based, the way that the dialogical arguments in the data are performed reveals a notable aspect of psychotherapeutic interaction that has not really been remarked upon so far. It appears that in almost all the instances of these dialogical arguments in the data, the therapist mostly invites the client to provide reports of her own experience. These are derived not for any other normatively established therapeutically-relevant purpose but in order to put together the evidence for a claim which in fact goes against the client's version. And, although the solicitation of the client's experience is a rather normative aspect of the psychotherapeutic work throughout all different phases of the psychotherapeutic encounter, extracting such reports for argumentative aims appears rather remarkable. It thus transpires that the analysis of this practice might offer us the opportunity to explore rather intriguing aspects of systemic therapy practice.

The discovery of the practice described in this chapter arose after encountering in the data exchanges between the therapist and the client such as the one presented in the extracts below (1, 2 and 3). These extracts have been derived from one single dialogical argument, which cannot be presented in its entirety as it runs over several minutes of talk. The parts that will be presented constitute some core components of this argument which have been drawn from its beginning, middle and concluding part.

The extracts have been derived from a session situated towards the end of the psychotherapeutic encounter and it is worth noting that on this occasion the end of the therapy had been prompted by the therapist's decision to leave her job. Throughout the session the client has been displaying a stance against the termination of therapy at that point in time. The client's stance on this matter becomes evident at different points of the session, one of which appears in lines 1 to 6 of extract 1.

Extract 1 [S11.00:42:20]

((The symbol | in line 2 corresponds to a tapping sound occurring through the production of the emphatically uttered part of the utterance 'go:ing' in line 1)).

```
1    Cl:  =but this one is different like you're go:ing a[way and] I
2                                                     |
3    Th:                                                  [mhm   ]
4    Cl:  wasn't you know (0.3) ready for that as ye:t [so    ]
5    Th:                                               [alright]
6    Cl:  it's something that I have to take in (0.45)
7    Th:  mm:[::]
8    Cl:     [ye]ah
```

One can see that the client not only opposes the end of the therapy, but in fact appears to be managing the possibility that what she says regarding the therapist 'go:ing a[way' (in line 1) might be hearable as a complaint. This is in line with Edwards' observations (2005: 24) that at times complaining is 'likely to be a subtle business'. Features of the client's talk that portray her as managing such a possibility is the attempt to establish a shared understanding for her claims ('you know', in line 4) and the mitigation 'as ye:t' (in line 4) in the course of making the case that she is not ready to stop therapy. In addition, despite portraying the therapist as being the agent of an action that inconveniences the client ('it's something that I have to take in', in line 6), the client refrains from presenting any more serious or detrimental implications of the therapist's departure from the service that would portray the therapist as failing the client.

Shortly afterwards the therapist initiates a series of questions examples of which can be seen in the following segment:

Extract 2 [S11.00:43:37]

((The symbol | underneath a letter signifies a tapping sound which appears to be provoked by the therapist as she speaks and which corresponds to the part of the transcript appearing above it)).

```
1    Th:  so can s- you give me specific examples what would be:
2         happening? what signs would you notice .hh (0.3) on you that
3         would tell you (0.3) that you don't need to be seeing me
4         (0.7)
5    Cl:  [↑u:::h acceptin that (no matter/I'm better)
6         [((noise))
7           [I'm living a positive life and you know
```

```
8            [((noise))
9         (0.5)
10        ((noise))
11   Cl:  I'm doing well for £mys↑elf,£
12        (0.3)
13   Th:  mhm
14   Cl:  £y↑e:ah,£
15   Th:  .pt that sounds to me quite
16        theoretic[cal an abstract
17   Cl:           [HEH HEH HEH HEH HEH HEH HEH
18   Cl:  heh heh heh
19   Th:  I [want ex[amples
20                   |


     ((21 lines have been omitted))

40   Cl:  £like eh doing the application (  )£?
41   Th:  [yes:        ]
42   Cl:  [heh heh heh] heh heh
43   Th:  yes
44   Cl:  £oka:y£
45        (.)
46   Th:  [uha]
47   Cl:  [£al]right£
48        (0.3)
49   Th:  could we take this as a si:gn?
50        (.)
51   Th:  [u- like as]
52   Cl:  [( yeah   )]
53   Th:  an example that actually, .hhh (0.5) this has has start
54        happening that you're able to manage things on your own
55   Cl:  mm
56   Th:  without relying on the help of the others
57   Cl:  yeah
58        (.)
59   Th:  okay=so: that's one precious example, .hh (0.3) any other
60        example?
61        (1.2)
62   Cl:  ↑u:::[:m  ]
63   Th:       [from] the last couple of months if you think
```

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One can see that the therapist launches a series of questions through which she is attempting to engage the client in enumerating aspects of the client's experience that would, in the case of a hypothetical scenario of the client continuing to attend therapy, signal to the client that she does not need therapy (the second in the line of such question is that appearing in lines 1-3 'so can s- you give me specific examples what would be: happening? what signs would you notice .hh (0.3) on you that would tell you (0.3) that you don't need to be seeing me'). It is worth noting that although the therapist's question is formulated in the hypothetical, at different points of the interaction (preceding and subsequent to the question in lines 1-3) the therapist invites the client to draw from existing examples derived from her lived experience which demonstrate that she has managed well up to that moment in time (an instance of that can be seen in line 63 at the end of the extract '[from] the last couple of months if you think').

The client proceeds by providing an answer ('... acceptin that (no matter/I'm better) [I'm living a positive life...'), which is nevertheless treated as inadequate or resistant by the therapist ('that sounds to me quite theoretic[cal an abstract' in lines 15-16 and 'I [want ex[amples', in line 19). Following further resisting responses by the client and cues (Edwards and Mercer, 1987; Gumperz and Herasimchuk, 1975) offered by the therapist guiding the client towards a particular type of response (in intervening talk not cited in this extract), the client finally comes up with a candidate answer ('£like eh doing the application ( )£?' in line 40). The client delivers her response in a questioning intonation thus inviting the therapist's confirmation and this time the therapist treats the client's response as appropriate ('yes:', 'yes' and '[uha]' in lines 41, 43 and 46 respectively).

Interestingly, on this occasion, the therapist also uses this opportunity to attempt to establish afresh a joint understanding of what this aspect of the client's experience evidences ('could we take this as a si:gn?' ... '[u- like as] an example that actually, .hhh (0.5) this has has start happening that you're able to manage things on your own', in lines 49, 51 and 53-54). By doing so though she transforms the significance attached to it. Therefore the therapist attempts to secure the client's agreement that the information the client has just provided will not only be evidencing that the client would not need the client's professional input in a hypothetical scenario, but also in the here and now of the psychotherapeutic interaction. Ultimately, through this subtle manoeuvre the therapist attempts to secure the client's co-operation in recruiting evidence against her own claim that

she needs more therapy (as articulated in lines 1-6 of extract 1, but also at various other points of the session).

Following a confirmation by the client ('yeah', in line 57) the therapist proceeds with a third turn receipt that is accompanied by a display that this report of the client's experience is one out of many ('okay=so: that's one precious example,', in line 59) and proceeds to re-invoke a modified version of her initial first pair part ('any other example?', in lines 59-60). In this way the therapist appears to attempt to engage the client in the assembly of a list of such reports of her private experience which the therapist constructs as indications that the client can manage without the therapist's support.

After several minutes of attempting to elicit several other such reports of the client's experience (in ways similar to those observed by Edwards and Mercer (1987) and Gumperz and Herasimchuk (1975) in classroom interaction), the therapist proceeds to bring this lengthy exchange to a close as can be seen in extract 3 below:

Extract 3 [S11.00:54:47]
```
1    Th:  bingo
2         (.)
3    Cl:  ye:[ah?]
4    Th:     [so ] six thi:ngs that you did .hh eh?
5         (0.3)
6    Th:  you: you managed to do yourself
7         wi[thout relying on] o[thers]
8    Cl:    [mm::            ] [  mm:]::
9         (0.3)
10   Th:  .pt=.hh so it ↑is a sign to me:, (.) actually that, you know,
11        (.) althou::gh, if I was to s:tay here for longer, .hh (.) you
12        would have stayed (unt-/and-) .hh you know, you would have
13        stayed (.) you wou- (0.3) eh you would have continued
14        counselling maybe less frequently,
15   Cl:  mm
16   Th:  (.) and the signs that would tell you that you don't need (0.5)
17        counselling anymore, you said you would be if you understood
18        that .hh (.) you can manage yourself without relying on others
19   Cl:  ˚ye:ah˚
20   Th:  .h an I think you already have a lot of signs that
21        s[ay that]
22   Cl:   [hhhheh ] hheh heh
23   Th:  so maybe: [you know i]f I was
```

```
24  Cl:                [mm        ]
25  Th:  to continue I would tell you .pt w↑ell Mary, I think that you
26       know there're there are enough reasons, (0.9) why you can
27       manage yourself without relying on others, so: maybe I think
28       that I can become redundant,
```

Following a positive evaluation of the progression of the project initiated by the therapist and of the jointly built version ('bingo', in line 1), the therapist proceeds to issue a formulation (Heritage and Watson, 1979). This purportedly summarises the essence of the talk up to that moment in time ('[so] six thi:ngs that you did ...' in line 4), that stretches right from the initial report of the client's experience that has been treated as evidence for the client's self-reliance and autonomy vis-a-vis the therapist (featuring in line 40 of extract 2) till the final one, located a few lines before the start of extract 3.

This material, packaged in a condensed way in this formulation becomes the context upon which the therapist is drawing upon to make her subsequent claims, acquiring the status of evidence which would justify the discontinuation of the therapy work ('...so: maybe I think that I can become redundant,', in lines 20-28). In this way the therapist opposes the client's initial claims regarding requiring more therapy whilst presenting herself as making a reasoned claim that is based on factual evidence, that is on concrete events drawn from the client's own experience. In addition, this evidence has either been provided by the client or at least with some degree of co-operation by the client, which maximizes the chances that the client will come up with an agreeing response to the therapist's reasoned claims (which however is not forthcoming).

It is worth noting that the task that the therapist undertakes by mobilising this dialogical argument is a rather delicate one as she attempts to undermine claims which belong within the client's domain of experience and which the therapist would not be epistemically equipped to dispute in a direct manner (Drew, 1991) (examples are the client's utterances 'I wasn't you know (0.3) ready for that' in lines 1 and 4 and 'it's something that I have to take in' in line 6 of extract 1). The delicacy of this task is evident in the therapist's manoeuvres when delivering her claim at the final part of the device (extract 3).

More specifically, when initially constructing the inference purportedly arising from the material gathered, the therapist does not present it as a conclusion available to all but instead restricts it to her own judgement ('so it ↑is a sign to me:,' in line 10). It is possible that on this occasion, the therapist avoids producing a generalized, all-applying claim that

she would present as obvious to everybody on the issue of the client's needs, therefore displaying an orientation to the client's greater epistemic authority on this particular matter.

Moreover it is rather intriguing that prior to delivering her conclusion which in fact revolves around the client's need for therapy, the therapist relinquishes authorship of part of the argument that she puts together to the client herself ('the s<u>ig</u>ns that would t<u>e</u>ll you that you <u>don't</u> need (0.5) counselling anymore, you said you would be if you understood that .hh (.) you can manage yourself without relying on <u>o</u>thers', in lines 16-18). This is achieved through the use of direct reported speech that can be employed precisely for its pretence to offer an exact reproduction of someone's utterances (Holt, 2000). This practice has been reported in a systematic way by Perakyla (1995) who observed that, instead of reporting directly other people's experience, participants often reproduce earlier descriptions by the person owning the experience in order to qualify such descriptions. In this particular instance this allows the therapist to then draw her inference without having to make a direct mention to a domain which pertains to the client's epistemic realm of knowledge ('an I think you already have a l<u>o</u>t of signs that s[ay that]' in lines 20-21). Finally, it allows the concluding part of the therapist's inference which this time contains explicit references to a domain in which the client has epistemic priority ('there are en<u>ou</u>gh r<u>ea</u>sons, (0.9) why you can manage yourself without relying on <u>o</u>thers, so: m<u>a</u>ybe I think that <u>I</u> can become redundant,', in lines 26-27) to be brought in more smoothly.

To conclude the presentation of this lengthy exchange, the therapist's manoeuvres in the above extracts seem designed to reveal a contradiction as the therapist recruits reports from the client's experience which run against the client's initial stance that she is in need of more therapy. The conversational mechanism mobilised by the therapist seems designed to persuade the client and to extract her agreement with a claim which the client resists. Overall, we see that the therapist resorts to reasoning and argumentation principles to achieve her institutional aims.

A second instance of this practice, which lends itself more easily to in-depth analysis due to its restricted length can be appreciated in the following extract:

Extract 4 [S3.00:14:55]

```
1    Cl:   £↑you d↑on't kn<u>o</u>w (but) you know I think that you know when you
2          are,£ that's what you're g<u>o</u>ing through it's like when you kn<u>o</u>w
3          somebody sees you that's the first thing they'll have in their
4          h<u>ea</u>d
```

```
5              (.)
6     Th:  >okay<. .h so when you first saw this person,(0.6) eh ye- e::m
7              (0.3) two weeks ago, (0.7) what was the first thing that came
8              to your min- mind
9     Cl:  o::h it was like oh my god he's going to know that I'm
10             £positive£
11    Th:  okay
12    Cl:  hhheh heh .hh
13    Th:  so what did you think about <him> did
14             yo[u think ]
15    Cl:   £[I didn't] think about him (0.2) at all£
16             (0.3)
17    Cl:  £it was <me> it was me who [(knew)]£
18    Th:                             [hm::  ]
19             (.)
20    Th:  .hhh okay:
21             (0.5)
22    Th:  .hh so:: (.) you didn't did you not think that ↑oh my g↑od ↑he
23             is p↑ositive t↑oo:
24             ((in a theatrical voice))
25    Cl:  no(h):
26    Th:  no.
27             (.)
28    Cl:  [no]
29    Th:  [ok]ay .hhh so:, (.) wh↑y do you assu:me that anybody who would
30             £see you£, (0.9) would assume ↑o::h she's p[ositive]
```

   To briefly identify the phenomenon, at the start of the exchange the client produces a
generalised claim (in lines 1-4) through which she argues that when one is seen in a support
group for people living with HIV he or she is automatically identified as an HIV sufferer.
The therapist then engages the client in the production of a counter-argument which has
premises and a conclusion. The case that the therapist builds goes as follows: when the
client herself met someone she knew in this support group she did not think of him as an
HIV sufferer. Therefore the client's initial claim that whoever sees her in a support group
for HIV sufferers would assume that she lives with HIV would be defeasible or
challengeable one. The therapist achieves to build this case by initiating a series of question-
answer pairs (in lines 6-28) which engage the client in the production of evidence that
contradict and effectively discount the client's initial claim. Thereafter (in lines 29-30),

based on the 'evidence' gathered through her questioning, the therapist delivers a challenge to the client's claim.

To take things more gradually, prior to this exchange the client and the therapist have been debating whether one becomes stigmatised when being 'seen' in a group for people living with HIV; the client argued that it is highly probable, whilst the therapist disagreed with this claim. The start of the extract shows the client attempting to evidence her prior claim (in lines 1-4) and her assertion, given that it constitutes the third oppositional move in a series portrays the sequence as a disputatious one as according to Hutchby (2001) arguments emerge from a series of action opposition sequences. To substantiate her version, the client constructs a claim regarding a third person's mental state in a given situation ('... when you kn<u>o</u>w somebody sees you that's the first thing they'll have in their h<u>e</u>ad...', in lines 1-4). This type of claim, given its generalised nature and given that it concerns a third person's thoughts concerns matters that are epistemically accessible to the therapist in the same inferential way that they are to the client (for a distinction between first-hand, authoritative versus inferential knowledge see Drew (1991)). The implication of that is that the therapist would be fully in a position to challenge it or treat it as an arguable should she wish to do so.

In such a discursive context, where an argumentative episode has already been initiated, it would not be odd for the therapist to respond with an argumentative move; in fact according to Kotthoff (1993: 193) in some cases, when a 'dissent-turn-sequence' has been initiated, 'opponents are expected to defend their positions'. The therapist's move consists of initiating a series of questions (in lines 6-8, 13-14 and 22-23), which in fact suspends the delivery of challenge or disagreement. These questions though attempt to elicit the client's own response in a similar situation to that initially described by the client. The implication that the therapist's move makes inferentially available is that any departure of the client's own experience from what she reports to be the other people's experience in the same situation, raises accountability issues for the client for contradicting herself.

The sequences initiated through the therapist's questions, each concluding with an 'okay' (in lines 11, 20 and 29) in the position of a sequence-closing third (Schegloff, 2007), form part of an interlinked series of sequences, each of which appears to implement a successive part of a course of action (Schegloff, 2007). In this instance, these consecutive steps are those that establish the different components of what the therapist constructs as a logical trajectory, designed to undermine the client's version; to begin with that the first thing that came to the client's mind when she bumped into an acquaintance of hers whilst

attending a support group for HIV sufferers was the concern that this person would find out that she herself lives with HIV, secondly, that the client thought nothing of this other person and thirdly that one of the things that the client failed to consider was in fact the possibility that this other person could be HIV positive himself. In this way the therapist proceeds to progressively establish more and more firmly that the client's own stance was an exception to the axiom stated by the client in lines 2-4; not only the first thing that came to the client's mind was something different to what the client claimed is would have been the case in general, but in fact, as it turns out in the unfolding interaction, she did not even consider such a possibility.

The sense that the therapist is following a trajectory is also conveyed through the use of the marker 'so', the role of which will be developed extensively in section 5.5.2. In addition, this sense is conveyed through a reprise by the therapist of the client's initial version ('when you kn<u>o</u>w somebody sees you that's the first thing they'll have in their h<u>e</u>ad', in lines 2-4), which the therapist now formulates in an extreme and quasi-theatrical way that displays the therapist's negative stance to the client's version ('so:, (.) wh↑y do you ass<u>u:</u>me that <u>a</u>nybody who would £s<u>ee</u> you£, (0.9) would assume ↑<u>o::</u>h she's p[<u>o</u>sitive]', in lines 29-30). Therefore through this utterance the therapist appears to return to the client's initial claim (in lines 2-4) to address it with a challenge. In this way the adjacency pairs (in lines 6-29) that the therapist initiated following the client's initial claim (in lines 1-4) approximate[9] an insert expansion (Schegloff, 2007), that delay the delivery of the therapist's challenge (in lines 29-30).

We've seen in the previous paragraph that when the therapist does display her opposition to the client's claim she does it in a way that constructs the client's version as improbable. This is partly achieved through the transformation of the client's 'somebody' to the emphatically uttered extreme case formulation (Pomerantz, 1986) '<u>a</u>nybody', which makes the client's version appear extreme and irrational, particularly in the context of the exception to the rule asserted by the client that the therapist just uncovered (similar use of extreme case formulations in the course of reformulations which attribute exaggeration to a co-interactant's version has been noted by Edwards (2000) and Hutchby (1992)). In addition, the active voicing (Hutchby and Wooffitt, 2005) '↑<u>o::</u>h she's p[<u>o</u>sitive]', is prosodically uttered in such a pronounced or caricaturing way that would make it a

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[9] Insert expansions consist of adjacency pairs that are positioned between a first pair part and its response (Schegloff, 2007). In this case, the segment of talk between lines 6 to 28 does not constitute a proper insert expansion as it is not positioned between two adjacency pairs, but between a disagreeing turn and its rebuttal.

reprehensible and excessive thing to do. In this way the therapist further ironizes the client's version, whilst displaying her own stance, in a similar way to what Holt (2000) reports to be the case with episodes of direct reported speech. Such a use of humour is consonant with Buttny's (2001) findings that therapists use humour as a resource in episodes of retelling the client's tellings particularly when these occur in sequential environments of disagreement and misalignement. Thirdly, as noted by Clayman and Heritage (2002), the sheer fact of inviting one to give grounds for one's stance or actions as the therapist does in this instance, portrays the behaviour as unusual or even problematic.

This concluding utterance on the therapist's part (in lines 29-30) reveals that the therapist has been working towards the business of exposing a contradiction, by bringing to light what she constructs as an inconsistency in the client's version. In fact, examination of similar challenging or disagreeing manoeuvres at the final part of the device in the data, reveals that the therapist at times amplifies the critique that her utterances convey, as is the case in this extract (4). Alternatively, the therapist has the choice of presenting her concluding, disagreeing turn as merely a factual type of deliberation that is derived from the therapist simply having perused the evidence on some matter and from having followed a logical procedure.

One such example comes from extract 3 above. In this exchange the therapist appears to reach a conclusion based on the evidence gathered from having questioned the client on aspects of her experience. In contrast with extract 4 in which the accountability issues for the client are emphasized, in this case when the therapist opposes the client's initial version she appears to simply state the facts ('you already have a lot of signs that s[ay that]', in lines 20-21) which she portrays simply as the result of logical deliberation ('so it ↑is a sign to me:, (.) actually that,' in line 10).

One of the features of the therapist's talk which is employed for persuasive purposes is the move between the present and the past. In extract 4 above, contrary to the client's initial claim (in lines 1-4) which is formulated as an all-applying maxim, the therapist's questions through which she elicits the evidence against the client's claim concern past events (in lines 6-8, 13-14 and 22-23). The use of the simple past tense has been reported to portray the activity it describes as complete or fixed (Bhimji, 2001), so by inviting the client to elaborate on events which she casts in the simple past tense, the therapist appears to base her ensuing challenge (in lines 29-30) into the concrete and the factual. In fact most of the therapist's questions in the course of the dialogical arguments encountered in the data are cast in the simple past tense. This has a double function: on one

hand, as it will be developed extensively in section 5.4.1.2 below, it is one of the mechanisms through which the therapist offers cues (Edwards and Mercer, 1987; Gumperz and Herasimchuk, 1975) that attract particular types of answers, but also, it allows the therapist to juxtapose facts against the client's generic and 'in principle' version.

The temporal element thus becomes a rhetorical tool through the therapist attempts to secure the client's agreement. The therapist appears to take the talk away from the client's general statements and to channel it towards the particular employing this as a rhetorical resource to substantiate her case, but then, by doing so she is then in a position to build a different kind of generalization. This seems congruent with Edwards (1994: 217) observations that 'script formulations set up a contrast with, or a generalization from, specific actions. But it is not that scripts must always normalize and breach formulations always pathologize. Script formulations may be used to pathologize too, just as exceptions can be used to excuse or praise.' In the case of this phenomenon the client's generalizations (as in lines 1-4 of extract 4) are being countered with the particulars of specific instances (as in lines 6-28 of extract 4), which then form the basis for new generalizations on the therapist's part (this is particularly obvious at the concluding part of extract 3).

Another important feature of this interactional snapshot is that throughout the exchange the therapist portrays herself as being in control of the game. This is largely due to the fact that the therapist is to a great extent leading the conversation to a territory that is familiar to her. The reason for this is that, despite the fact that the matters she enquires about belong to the realm of the client's personal experience, they have nevertheless been discussed in previous interaction and the client's responses to the questions are known to the therapist in advance. It appears that the therapist proceeds through what Edwards and Mercer (1987) have identified as 'cued elicitation', which they define as a process of the teacher asking 'a question while simultaneously providing heavy clues to the answer via bodily gestures and demonstrations' (ibid.: 110). Edwards and Mercer have argued that this process 'may also be done implicitly, by an unspoken appeal to shared knowledge' (ibid.: 142), which seems to be the case in this exchange.

To conclude the analysis of this exchange, through the series of the questions that the therapist issues, she achieves to engage the client in the production of the evidence against her initial claim, which she then proceeds to challenge. Importantly, given this evidence has been provided by the client herself and that it consists of reports of the client's own experience, the concluding challenge becomes particularly difficult for the client to counter.

5.1.2 The role of cued elicitation

As made apparent through the analysis of this extract, in order to put together the dialogical arguments in the data the therapist relies heavily upon the practice of 'cued elicitation' which Edwards and Mercer (1987) noticed occurring in classroom interaction. An example of this practice that has been drawn from Edwards' and Mercer's work can be seen in the following extract:

Extract 5 [Edwards and Mercer (1987: 142)]
Sequence 7.6 Cued elicitation: Galileo's pulse

T: Now he didn't have a watch/ but he **had** on **him** something that was a very good timekeeper that he could use to hand straight away/	T snaps finger on 'straight away', and looks invitingly at pupils as if posing a question or inviting a response.
You've got it. **I**'ve got it. What is it?// What could we use to count beats? What have you got? //	T points on 'You've' and 'I've'. T beats hand on table slowly, looks around group of pupils, who smile and shrug.
You can feel it **here.**	T puts fingers on T's wrist pulse.
PUPILS: Pulse.	(In near unison.)
T: A pulse. Everybody see if you can find it.	All copy T, feeling for wrist pulses.

The therapist employs cued elicitation in the course of building up the dialogical arguments under examination throughout all of the relevant exchanges in the data. However, the phenomenon in the data cannot be reduced to instances of cued elicitation. The main difference is that cued elicitation is not necessarily employed for persuasive or argumentative purposes through the accumulation of evidence for a counter-case. For instance, in the above example, the teacher does employ this conversational device but is

not attempting to argue a case; instead (s)he initiates a guessing game, guiding the students towards the 'correct' response by giving them a variety of indications as she goes along. Therefore, even though through cued elicitation a speaker might promote a particular version (i.e. that Galileo used his pulse to measure the time) which can in itself be considered as an arguable matter as a proposition might be in general (Billig, 1996), a speaker might still employ this conversational method for reasons different to arguing a case or outside the context of a dispute. For example a teacher might employ this conversational device in the course of teaching a class quantum mechanics, and whilst doing so might be seen as implicitly undermining the case against the erroneous view on physical processes that Newton mechanics incur when used to describe the microcosm, but this will not be synonymous to engaging in an argumentative exchange with the students. In addition, this would not necessarily involve the students being in support of a particular stance, attempting to argue a counter-case or having a stake in the matter, as it is the case with the recipient's (that is the client's) input in the data. Therefore, the phenomenon that will be presented in this chapter, whilst incorporating instances of cued elicitation, does not only amount to that, as a necessary feature of it is to argue a case and as it marks episodes of disagreement between the participants.

5.2   Structure of phenomenon:

The introductory section established that participants in the data employ argumentative reasoning to achieve a business of some kind. Initially we have seen two initial instances from the data, whose core features can also be extrapolated to the rest of the material in the data. We will now proceed to establish the bare bones of these dialogical arguments by identifying the basic components of their structure as these unfold progressively in the interaction:

A) The first speaker makes a claim about a state of affairs.

B) The recipient launches a series of largely leading questions through which s/he is recruiting the first speaker into providing evidence to be used against his/her initial claim.

C) At the conclusion of these question-answer pairs and if the first speaker has co-operated sufficiently with the second speaker's trajectory, the latter delivers a challenge or a

counter-claim to the first speaker's initial claim based on the evidence provided by the first speaker's response.

It might be worth observing that the solicitation of evidence in the second position of the device can be formulated in an unmarked way as is the case in extract 4 above, where the fact that the client's claims are later used as evidence against the client's initial claim becomes evident at the conclusion part of the exchange. However, there are also instances in the data where the therapist explicitly formulates her question as a request for evidence in support of a case. Examples of that can be seen in the following extracts:

Extract 6 [S11.00:42:57]

```
1      Th:   .hhh (0.7) a:nd=e:::h, (1) can you tell me? <what signs you
2            would see,> (0.5) to tell me (0.5) that Julia I don't need to
3            see you any more.
```

Extract 7 [S2.00:25:14]

```
1      Th:   mhm=.hh (.) eh wha- can you guess, whether like have you seen
2            any signs that tell you that maybe: (0.6) e::h the way she
3            thinks has changed?
```

It is worth mentioning at this point that, in many cases, the collection of evidence by the therapist in support of her case extends over several minutes of talk. For this reason only three extracts are presented in their entirety throughout the chapter, whereas the rest of the extracts presented throughout this piece of work constitute small segments extracted from larger episodes of dialogical arguments. Had the arguments in the data been shorter I would have at this point proceeded by presenting the range of different such extracts. However, the length of most such instances in the data renders this task unfeasible. Instead, I will proceed to examine an intriguing variation of the broader practice reported so far whereas thereafter I will present some basic moves that have been observed in the production of these dialogical arguments and which occur recurrently in the data.

5.3   A variant of the practice in the data: Questions that raise accountability by turning a claim on its head

There is a class of exchanges in the data which as well as forming part of the broader practice of dialogical arguments described so far, also bear a particularity of some sort which requires specific attention. One rough distinction between this type of dialogical arguments and the more generic ones in the data, is that in addition to bringing into the surface reports of the client's own experience to counter the client's claim, this time the therapist also mobilises in her questions aspects of the client's prior talk in an attempt to turn the client's very claim on its head. In the data, this way of initiating one's argumentative trajectory works as a type of challenge or as a move through which the therapist puts the client's claims to the test and more importantly as a way of raising intriguing and potent accountability issues that account for these moves' argumentative strength.

In fact, extract 4, which has been used to illustrate the broader practice in more detail, simultaneously falls within this subcategory of dialogical arguments appearing in the data. It is thus useful at this point to return to extract 4 and examine the distinct characteristics that this presents, which in fact are evident at the very start of the exchange (reproduced below):

Extract 8 [S3.00:14:55]
```
1     Cl:   £↑you d↑on't know (but) you know I think that you know when you
2           are,£ that's what you're going through it's like when you know
3           somebody sees you that's the first thing they'll have in their
4           head
5           (.)
6     Th:   >okay<. .h so when you first saw this person,(0.6) eh ye- e::m
7           (0.3) two weeks ago, (0.7) what was the first thing that came
8           to your min- mind
```

Some initial observations concern the fact that in her response to the client's generalized claim, the therapist incorporates some features from the client's prior talk, whilst simultaneously transforming some others. In particular, the therapist's question contains a partial repeat of the client's initial utterance 'the first thing' (in line 3). The therapist accompanies this repeat with the utterance 'that came to your min- mind' (in lines

7-8) which works as a paraphrase of the client's utterance 'they'll have in their head' (in lines 3-4). Simultaneously though, there is a change in the pronouns, as the client's all-applying 'you' and 'they', becomes transformed to a 'you' that pertains to the client.

By utilising the preceding talk in these ways the therapist manages to enquire about the same activity as that mentioned previously by the client, whilst simultaneously shifting the actors performing the activity. Ultimately, the therapist manages to enquire as to how the claim that the client issued previously applied to a different case and by so doing appears to perform a validity check for the client's assertion. This initial question then shapes the subsequent interaction, as the ensuing questions equally explore this new person's reaction in this particular scenario.

Similar features of the questions' design can be observed in other such instances in the data, such as the following one:

Extract 9 [S2.00:06:22]
```
1     Cl:   so: when he sees me that would be: (.) the thing that >is going
2           in< through his he:ad
3     Th:   okay
4     Cl:   ye:ah
5     Th:   .pt so what d- what was the thing that went: (.) through your
6           head when you saw him, about him.
```

In the above instance which equally marks the beginning of a dialogical argument in the data, the therapist also borrows some features of the client's preceding turn, given the partial repeat 'the thing that went: (.) through your head when you saw him' (in lines 5-6) which to a certain extent reiterates the client's 'the thing that >is going in< through his he:ad' (in lines 1-2). Once more a noticeable transformation of the client's talk concerns the change of pronoun, from 'he' or 'his' (in lines 1 and 2 respectively) to 'your' and 'you' (in lines 5 and 6). Again, the therapist appears to perform a validity check, regarding whether the client's claim applies in a different set of circumstances.

The re-employment of a prior speaker's talk in order to display disalignment or perform a disaffiliative action has been observed in a variety of exchanges. Examples are the use of partial repeats to construct a disagreeing turn (Pomerantz, 1984b) or the use of repeat prefacing to problematize a preceding question (Bolden, 2009a), or the practice of format tying observed by Goodwin and Goodwin (1987) in the context of children's arguments. The latter concerns the re-employment by a speaker of syntactic, semantic,

intonational, or even phonological features of the prior speaker's turns in an attempt to oppose his or her talk.

A somewhat similar principle[10] as in the case of format tying (ibid.) appears to be at work in the case of the therapist's questions in the data, which borrow part of the client's wording through partial repeats, or maintain a semantic continuity with the client's prior turn through paraphrases. In all instances in the data this restricts the talk to the same activity such as that mentioned by the client. Simultaneously though the therapist performs some transformations to features of the client's prior talk. One salient transformation concerns the person who appears to perform the activity. By maintaining the same activity but ascribing it to a different person, the therapist appears to be testing the client's claims in different circumstances where different actors are involved.

By designing her question in this way the therapist is in a position to temporarily alter the direction of the talk, whilst simultaneously raising intriguing accountability issues which constitute the foundation of these questions' persuasive vigour. For instance, in extract 9 above rather than pursuing the theme of what a third person would think of the client in a certain scenario, the therapist manages to turn the focus onto the client and on what she herself thought of this person on a similar occasion.

5.3.1   Accountability issues raised through this line of questioning

We've seen that through her questions the therapist implicitly invites the client to comment on the validity of the client's prior claim on a different occasion when different actors are involved -in most cases the new actor being the client herself. However, the therapist's questions are far from innocent, as their design and sequential position in the interaction invites the client to offer a response that would prove that in this different scenario introduced through the therapist's questions, the actors involved acted in a different way to the people featuring in the client's claim.

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[10] It is also worth noting that the practice in the data also presents differences from Goodwin's and Goodwin's (1987) concept of format tying, the most important being that whereas through format tying a participant attempts to alter the direction of the action in a permanent way as is the case with counters (Schegloff, 2007) more generally, the questions that raise accountability by turning a claim on its head do so only temporarily. The reason for that is that is that together with the responses that they invite they largely approximate an insert expansion (Schegloff, 2007) which will eventually come to an end and which ultimately serves to strengthen the therapist's ensuing challenge or disagreement to the client's initial claim.

One of the ways that this is achieved relates to the fact that in the data these questions follow on from a claim by the client which, through the reflexive qualities of the talk (Potter, 1996), makes inferentially available a negative attribution about other people[11]. According to Auburn (2005: 700) 'Interactants including speakers, continuously monitor talk and the inferences available from it as part of the ongoing accomplishment of a mutually meaningful intersubjective encounter'. In the data, the negative attributions made inferentially available through the client's talk seem to be used as a resource by the therapist in the construction of the line of questioning that questions the client's version. For instance in extract 9 above, the therapist's question occurs in the context of an assertion by the client that when an acquaintance of hers sees her in a group for people living with HIV he would be thinking of the client in a stigmatizing way, namely that the client is HIV positive ('so: when he se̲e̲s me that would be: (.) the thing that >is going in< through his he̲:ad', in lines 1 and 2 of the extract). Given that the therapist's ensuing question turns the focus onto the client and on what the client herself thought of this person when she met him in this support group ('so̲ wha̲t d- wha̲t was the thing that went: (.) through yo̲ur head when you saw him,' in lines 5 and 6), in case the client attempts to maintain that what she claimed to be the case for this person also stands for her, she risks to make a negative attribution about her own self. In other words, in case the client proceeds to assert the validity of her initial claim in these new circumstances, this would be synonymous to admitting that the client herself thought of this acquaintance of hers in a stigmatizing way.

We saw that one reason for the client to proceed with a response which proves that the client herself (or any other people invoked in the therapist's question) acted differently to the actors appearing in the client's claim, is the risk of making afresh a negative attribution. In addition though there are further compelling reasons. These have largely to do with a variety of cues (Edwards and Mercer, 1987; Gumperz and Herasimchuk, 1975) embedded in the therapist's question which lead the client towards particular types of responses that point to the direction that the client herself acts differently to how she mentions other people do (the ways in which the therapist's questions are leading requires more detailed examination and will therefore be presented in section 5.4.1 below). As will be seen later on, in case the client proceeds to defy the answer projected or favoured by the therapist's questions, she risks appearing as contradicting earlier claims of hers, or as unreasonable, or as being portrayed in a negative light more generally. Overall, the fact that

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[11] This is made apparent through the therapist's ensuing questions which to some extent serve to dissociate such negative attributions from the particular scenario described by the client in her initial utterance.

the above issues of accountability weight heavily on the client is largely visible in the fact that at no point in these exchanges does the client sustain that, what she originally claimed to be the case, also applies in the new scenario invoked by the therapist, despite the fact that she then pays a rather high interactional cost, as will be seen in a moment.

The above features explicate how the questions delivered by the therapist invite the client to respond with a version which in essence corresponds to an admission that what she claimed to be the case originally (for instance about other people), is not the case in the new circumstances invoked by the therapist (which most often concern the client's own experience). In effect though, such an admission weakens, not to say invalidates the client's original claim. To appreciate this more fully one can return to extract 4 (reproduced below):

Extract 10 [S3.00:14:55]

```
1     Cl:   £↑you d↑on't kn<u>ow</u> (but) you know I think that you know when you
2           are,£ that's what you're g<u>o</u>ing through it's like when you kn<u>ow</u>
3           somebody sees you that's the first thing they'll have in their
4           h<u>ea</u>d
5           (.)
6     Th:   >okay<. .h so when you f<u>irs</u>t saw this person,(0.6) eh ye- e::m
7           (0.3) two weeks ago, (0.7) what was the first thing that came
8           to your min- mind
9     Cl:   o::h it was like oh my god he's going to know that I'm
10          £p<u>o</u>sitive£
11    Th:   <u>o</u>kay
12    Cl:   hhheh h<u>eh</u>  .hh
13    Th:   s<u>o</u> wh<u>a</u>t did you th<u>in</u>k about <him> did
14          yo[u think ]
15    Cl:    £[I didn't] think about him (0.2) at <u>all</u>£
16          (0.3)
17    Cl:   £it was <<u>me</u>> it was me who [(kn<u>ew</u>)]£
18    Th:                                    [hm::  ]
19          (.)
20    Th:   .hhh <u>o</u>kay:
21          (0.5)
22    Th:   .hh so:: (.) you didn't did you not think that ↑oh my g↑od ↑he
23          is p↑ositive t↑oo:
24          ((in a theatrical voice))
25    Cl:   n<u>o</u>(h):
26    Th:   n<u>o</u>.
```

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```
27          (.)
28   Cl:   [no]
29   Th:   [ok]ay .hhh so:,(.) wh↑y do you assu:me that anybody who would
30          £see you£, (0.9) would assume ↑o::h she's p[ositive]
```

In this case the client's elicited version of what applied in her own case ('it was like oh my god he's going to know that I'm £positive£', in lines 9-10) undercuts her original, all-applying claim that when people see somebody else in a group for people living with HIV, they think that this person suffers from the condition ('when you know somebody sees you that's the first thing they'll have in their head', in lines 1-4). In turn this offers the therapist the opportunity to deliver a challenge ('so:, (.) wh↑y do you assu:me that anybody who would £see you£, (0.9) would assume ↑o::h she's p[ositive] (in lines 29-30). Effectively through this line of questioning, the client faces accountability issues for inconsistency or for maintaining double standards for herself as opposed to other people.

Finally, by admitting that what she claimed to be the case initially does not stand for the people invoked by the therapist, the client faces an additional accountability issue that this time relates to the negative attribution that becomes inferentially available from the client's initial claim. In case the client responds to the therapist's questions in a way which exonerates her from acting in the negative manner which she initially claims other people to do, she not only undermines her own claims but also faces accountability issues for making harsh claims about other people. Once more this reflects badly on the client's initial claim.

5.4 Four argumentative manoeuvres through which the dialogical arguments in the data derive their persuasive power

The dialogical arguments in the data constitute one of the main persuasive machineries that the therapist mobilises to convince the client of the worth of a particular version, and through which the client's version risks being discounted. It is thus all the more important to see how this is accomplished. In this section I will proceed to outline some recurrent argumentative moves employed by the therapist in her attempt to successfully engage the client in the production of a dialogical argument.

In particular, the therapist issues leading questions, offering a variety of cues which guide the client towards particular types of answers. The therapist also appears to confirm

the type of responses that are in line with the version that she promotes whilst also managing the client's opposition towards the therapist's unfolding project. Finally, as will be developed below, on some occasions the therapist invites the client to disconfirm a version which is closely related to the client's version, at strategic moments in the course of the dialogical argument. To illuminate these points I will be drawing upon a multiplicity of episodes of dialogical arguments in the data (it might be worth noting that given the length of most of these extracts I will only be citing segments of these instances rather than the whole episode).

5.4.1   Leading questions

To begin with, the questions the therapist employs to extract evidence in support of or against a particular claim are tendentious ones, inviting particular types of responses. In the conversation analytic field there are many mentions on the use of questions which are designed to attract particular responses (Heritage, 2002b; Koshik, 2002; Stokoe and Edwards, 2008 are some examples). This effect seems to be rather pronounced in the case of yes-no interrogatives; these questions might be formatted in ways so as to prefer particular answers (Raymond, 2003), the departure from which requires additional interactional work on the recipient's part. Participants appear to exploit these features of questions to advance their agendas; for instance Houtkoop-Steenstra and Antaki (1997) demonstrated that interviewers of people with learning disabilities might at times reformulate the interview questions in ways which attract optimistic responses. In fact, such formatting of the questions can be particularly powerful in shaping social realities, as demonstrated by Atkinson and Drew (1979) in courtroom interaction, where any additional features that witnesses might add to the expected yes or no can be eliminated from the record of the court proceedings. In addition, questions might be extremely tendentious and presumptive as is the case with questions which are used to convey negative assertions (Heritage, 2002c).

This is not just the case with yes-no interrogatives, as it can also happen with wh-questions; for example Koshik (2003) described the use of wh-questions in order to convey a negative assertion. In the case of the questions described by Koshik (ibid.) this might be done through the display of a stronger epistemic stance on the questioner's part. However, one can imagine that a variety of resources might be mobilized to this aim. For example,

Edwards and Mercer (1987) demonstrated that in classroom interaction teachers might embed cues as to the types of responses that are to be received. In classroom interaction these cues might be provided through non-verbal or paralinguistic means, but also through the questions' wording or appeals 'to shared knowledge' (ibid.: 142).

In a similar fashion, in the case of this data the therapist guides the client towards particular types of responses through the design of her turns and the lexical choice in the course of formulating her questions, appeals to shared knowledge or to the normative and the common-sense. Also, as will be demonstrated below, the therapist employs both wh-questions and yes-no interrogatives in ways which display an expectation for a specific type of response. Examination of the extracts below will demonstrate that even seemingly open questions, which supposedly allow for a wide range of possible answers, might work so as to narrow down the range of responses that the recipient can provide.

5.4. 1. 1 Offering cues through the turn design and the lexical choice of the terms of the question

One of the ways through which the therapist offers cues as to the types of responses that are expected, is the turn design and the lexical choice of the terms of her question. An example can be seen in the following extract (11) that contains a question through which the therapist elicits evidence against a claim made by the client:

Extract 11 [S2.00:55:09]
```
1     Th: .h=has anybody? (0.6) talked to you about their problems ever?
2         (2.3)
3     Cl: ↑mm:::: ↑ye::↓ah
```

One can see that the therapist designs her question as a yes-no interrogative which projects a yes type of response (Raymond, 2003). In this case the elicitation of an affirmative response is also achieved through the extreme case formulations (Pomerantz, 1986) 'anybody' and 'ever'. These lower the criteria that need to be fulfilled for the response to be an affirmative one, given that the therapist is asking for a single episode ('ever, in line 1) of a report of a trouble to the client by 'anybody' (in line 1).

The turn design and the lexical choice of the terms of the question are such powerful tools in the therapist's hands that in fact, if the therapist does not take this into consideration in how she designs her talk this might jeopardise the construction of the case that she is in the process of putting forward. Such an instance can be seen in the following exchange:

Extract 12 [S4.01:17:17]

```
1     Th:  mh]m .pt=.hhh would you would you say that you worry for
2          Sophie now that she: she looks stressed?
3          (0.3)
4     Cl:  yes I do worry [becau]se I want her to be
5     Th:                 [mm:: ]
6          happy
7     Th:  .pt would you worry more if you knew why she's worried?
8          (0.5)
9     Cl:  ↓y[e: ]↑ah
10    Th:    [bu-]
11         (0.6)
12    Th:  w- would you worry more? or would you worry the same?
13         (.)
14    Cl:  uh I think it will be the same [(because/just)] you know
15    Th:                                 [mm:::          ]
16    Th:  .hh so maybe, maybe you know=because .hhhh sometimes we don't
17         talk to people, because we don't want to make them worried.
18         (0.4) but people can see that ar- we're stressed, so they
19         worry anyway
20         (.)
21    Cl:  ye£::ah£=hh[uh]
22    Th:             [so] sometimes it's: it's just better to: tell
23         them why you worry, hhuh so that maybe (0.3) they don't
24         worry as much isn't [it?
```

In this exchange the therapist attempts to gather evidence against a claim reportedly issued by the client's relatives that it would be better to leave the client out of some problems that Sophie, another relative of hers, was facing. The extract reveals the therapist attempting to progressively build a case that it would be in the client's interests if Sophie were to reveal to the client the source of her worries as this would alleviate the client's worries for Sophie's well-being.

It therefore appears that it would be advantageous to the therapist to elicit from the client the version that the client would not worry as much if she knew the source of Sophie's problems. In line 7 of the exchange though the therapist issues the question 'would you worry more if you <u>knew</u> why she's worried?'. This question is a yes-no interrogative projecting an affirmative type of answer (Raymond, 2003). In other words this question projects a response which suggests that the client's relatives were right to want to protect the client from the weight of Sophie's worries; this in turn departs from the therapist's argumentative trajectory as this is constructed at the concluding part of her syllogism in lines 16-24.

That the trajectory projected by the therapist's question in line 7 is problematic for the therapist herself becomes visible subsequently in the interaction. To begin with, one can see an early attempt by the therapist to interrupt the client's emerging affirmative response ('↓y[e:]↑ah', in line 9) through the overlap at line 10 ('[bu-]'). Importantly, following the completion of the client's response there is an attempt by the therapist to initiate a repair, by reissuing a modified version of her initial question. The recycled question incorporates an alternative version 'or would you worry the same?' which the therapist places at the end of her turn thus making it immediately available for the client to comment on. According to Schegloff (2007: 102) 'other-initiated repair sequences can operate as pre-rejections and pre-disagreements – as harbingers of dispreferred base second pair parts', which seems to account for the client's revised response 'u̲h I think it will be the s̲ame ...', in line 14.

We saw that the therapist has not attempted to intervene immediately after she formulated her question but only when it was already visible that the client was in the process of providing an affirmative response. Therefore the interaction shows that the therapist has not initially treated her initial question as a mistake on her part. However, the subsequent repair ('w- would you worry m̲o̲re? or would you worry the same?', in line 12) shows that the therapist might have initially underestimated the force of the turn design and the lexical choice of the terms of her question (in line 7), which meant that following the projected by her initial question response she found herself in the position of having to take remedial action to redirect the talk towards her intended trajectory.

5.4.1.2 Enquiring about aspects of shared knowledge arising from prior interaction as a way of offering cues

Another means through which the therapist offers cues as to the type of response that would be appropriate is by invoking aspects from the client's world that the client shared with the therapist in previous interaction.

An example of that can be seen in the following extract (13):

Extract 13 [S2.00:06:22]
```
1    Cl:  so: when he sees me that would be: (.) the thing that >is going
2         in< through his he:ad
3    Th:  okay
4    Cl:  ye:ah
5    Th:  .pt so what d- what was the thing that went: (.) through your
6         head when you saw him, about him.
7         (0.3)
8    Th:  why was he there?
9         (1.7)
```

In lines 1 and of this exchange the client argues that when an acquaintance of hers sees her in a support group for people living with HIV he will realise that she suffers from this condition ('when he sees me that would be: (.) the thing that >is going in< through his he:ad'). The therapist's response is to enquire about the client's reaction when she herself saw this person in the group for people living with HIV. This question, despite being formulated as an open question which in a different context might have revealed the question to be an information-seeking one, in this context almost approximates a form of challenge. The reason for that is that this question is being delivered in the context of the client having previously divulged to the therapist her main thoughts when she met this person in the context of the support group, which in fact revolved around pressing fears that her condition would become known to him. The discursive context of the client's prior discussions with the therapist therefore becomes the backdrop for this current exchange, and is being invoked precisely through the therapist's question. Indirectly, what is being brought into the surface is the therapist's own knowledge of the event, as this has been presented by the client, as well as the possibility that the client could face accountability issues for lack of coherence were she to retrospectively significantly alter her story.

That the therapist attempts to invoke a specific point, becomes obvious from the way that she embeds in her question features that specify the exact point of the prior discussion that the client is to make connections with. To begin with the therapist incorporates a reference of a specific moment in time ('when you saw him,', in line 6) -this also works though to connect her interrogative to the client's prior turn in line 1 portraying the therapist's talk as drawing a parallel. Secondly and more importantly, the therapist completes her turn with a reference to a specific type of thought that the client could have made on that occasion and which the therapist is after ('about him.', in line 6). Not every thought that the client made on that occasion would constitute an appropriate response, as the client is invited to talk specifically about any thoughts that she might have made about this third person. Finally, after the client's lack of uptake (given the pause of 0.3 of a second in line 7), the therapist adds a further cue which this time guides the client towards sharing not just any thought that she made about this third person on that occasion, but specifically any thought that related to his reasons for attending the support group himself ('why was he there?' in line 8).

The significance of the prior discursive context for the successful elicitation of evidence in support of the therapist's argument becomes perhaps even more apparent when things do not go according to plan. This is the case in the following exchange (16):

Extract 14 [S2.00:17:57]
```
1    Th:  .hhh (0.6) do- has she ever attended support groups?
2    Cl:  n*o
3         (0.2)
4    Th:   no::?
5         (0.7)
6    Th:  NEVER?
7         (0.3)
8    Cl:  n::o
9         (1.1)
10   Th:  are you sure?
```

Immediately before the start of the extract the therapist had been promoting the view that the client's auntie could react positively to the idea that the client herself had been attending a support group. The client on the other hand had been resisting the therapist's trajectory. In response to that the therapist delivers a question through which she attempts to elicit

evidence in support of the case that she had been building ('...has she ever att<u>e</u>nded supp<u>or</u>t gr<u>ou</u>ps?', in line 1). One of the possible interactional implications of such a question could be that if the client's auntie had attended support groups herself then the therapist would be in a strong position to argue that the client's relative would not really be in the position to veto the client's decision to attend such groups herself.

This or any similar implication however does not appear to be drawn in this case, as in the second part of the adjacency pair the client comes up with a blocking move ('n*<u>o</u>', in line 2) which causes the collapse of the therapist's case. What is of particular interest in this case is the therapist's way of dealing with the client's response. In line 4 she makes an attempt for an other-initiation of repair (Schegloff et al., 1977) by issuing an emphatically uttered repeat of the client's response ('n<u>o</u>::?') which she delivers with a questioning intonation. Following a pause of 0.7 of a second (in line 5) there follows an upgraded second such attempt ('<u>NEV</u>ER?'; in line 4). The therapist's second negative interrogative is finally met with a confirmation by the client ('no::o', in line 8), but despite this, the therapist proceeds with a third attempt to initiate a repair ('<u>a</u>re you s<u>u</u>re?', in line 10). In fact another six such attempts follow in subsequent turns which all prove unsuccessful.

What such a sturdy insistence on the therapist's part reveals in a flagrant way is that the therapist had delivered her initial question ('has she ever att<u>e</u>nded supp<u>or</u>t gr<u>ou</u>ps?', in line 1) from a position of epistemic certainty even though if this later proved to be unfounded. The series of attempts to initiate a repair constitute endeavours to undercut the client's primary rights on the matter (Drew, 1991), despite the fact that the therapist would possess only second-hand knowledge on an issue concerning the client's relatives.

Overall what this instance shows is that this knowledge that the therapist possesses which she draws from her previous interaction with the client could occupy a crucial role for the progression of the therapist's argument as the therapist might rely heavily on it to extract a particular response and ultimately to direct the conversation towards a particular end point. Also, in case the client does not provide the projected response, there could be a policing of the client's answer by the therapist, as the therapist might allow herself sufficient epistemic rights to attempt to correct the client.

5.4.1.3   Offering cues by enquiring about normatively known issues

Another means that the therapist employs to shape the trajectory of the talk is by invoking normative descriptions, for example on the issue of what constitutes appropriate conduct. This is the case in the following exchange, which constitutes an attempt by the therapist to gather evidence against a claim made by the client that if she talks to other people about her problems they will be burdened by it:

Extract 15 [S2.00:56:04]
```
1      Th: so:: when somebody comes (.) up to you, (0.6) and talks to you
2          about their problems, (1.2) what do you do?
3          (0.6)
4      Th: how do you respond?
5          (0.3)
6      Cl: ↑u:::h it's: you comfort them an you give them advice
```

In this extract the therapist presents a habitual scenario of a troubles-telling and enquires about the client's reaction in such a case ('when somebody comes (.) up to you, (0.6) and talks to you about their problems, (1.2) what do you do?', in lines 1 and 2). The scenario is formulated as normative or scripted through features such as the present tense and the word 'somebody' (in line 1) which remove it from the particulars of a specific situation. According to Edwards (1994) formulating events as scripted serves rhetorical purposes and might also occur in episodes of explicit disagreement between participants. In this particular case, inviting the client to collaborate in the production of such a scripted scenario is designed to rebut the client's initial claim. If what is established as normative conduct in an episode of troubles-telling is that people comfort and advise the person with the trouble, then the hypothetical scenario that the client has previously built (that if she talks to her relatives about her problems they will get worried) appears out of the ordinary and ultimately improbable. As Edwards (1994: 218) points out, script formulations might establish 'a normative base against which some other actions, the ones at issue, stand out as anomalous and requiring an account'.

By formulating her scenario as normative or scripted the therapist invites the client to draw from common-sense knowledge as to how people respond to troubles-tellings. This is not just visible in the formulation of the therapist's question, but also in the client's response, who treats the question as eliciting conventional knowledge about what anybody

would do in a given situation ('you comfort them an you give them advice', in line 6). In this way the therapist succeeds in extracting a response about what is the case in general or in principle and circumvents the particulars of a specific case. The later could prove more unsafe for the therapist's trajectory as the therapist might more easily get things wrong, as is the case in extract 14 above where the therapist had the erroneous belief that the client's auntie had in fact been attending support groups herself.

The leading nature of these types of questions is better understood if one considers what other possible answers the client could come up with in response to such a question which is in pursuit of a normative answer. If the client were to deviate from the normative response of being an empathic listener to a person sharing his or her trouble, she could risk being regarded in a negative light. Therefore these questions could be considered as drawing their force from moral work which is performed implicitly (for a detailed instance see Drew (1998)).

However this raises a methodological question regarding how to make a claim of identifying a practice that remains covert (Drew, 1998; Stokoe and Edwards, in press). In this particular instance, what points to the direction that such moral constraints are at work is the client's response which unsurprisingly constitutes a normative answer of what action is appropriate in the circumstances of a troubles-telling ('↑u:::h it's: you comfort them an you give them advice.' in line 6). What is intriguing about this response is that it represents one of the rare instances throughout the course of the entire dialogical argument where the client collaborates with the therapist's project and that it is situated in an exchange which is full of persistent attempts by the client to dismantle the comparison that the therapist attempts to build between the client's own actions and those of other people when found in the position of listening to a trouble. This is rather telling about the constraints and implicit accountability imposed by such a question which clearly succeeds in a rather straightforward manner to invite an answer that then permits the therapist to undercut the client's initial assertion.

These aspects of the therapist's talk are perhaps even more obvious in the following exchange, in which the therapist again invokes a normative description of what constitutes an appropriate emotional reaction after having helped someone deal with a problem:

Extract 16 [S2.00:56:26]
```
1     Th:  after you've after you've comforted them and you've given
2          advice, (0.4) and they go away, and you go away, how do you
```

```
3           feel after that?
4           (0.6)
5    Cl: mm::::: (0.3) ↑I feel you know just happy that you know(I am)( )
6           (able to)
7           (1.3)
8    Cl:  at least give someone advice
```

Clearly the interactional cost for the client would not have been minimal if she were to say that she gets annoyed or bored when she has to go through such an ordeal. Therefore issues of accountability and morality also appear to be at work in such instances, which have a constraining effect on the range of answers available to the client.

5.4.2 Confirming the client's responses which are in line with the therapist's argument

In addition to delivering leading questions, what the therapist also does is to somehow formulate (Antaki, 2008) or confirm those client responses which are in line with her own argumentative trajectory. This tactic seems an attempt by the therapist to establish the version that she is promoting as valid and factual, whilst also indirectly undermining that of the client. One such example can be found in the following exchange:

Extract 17 [S2.00:56:04]
```
1     Th: so:: when somebody comes (.) up to you, (0.6) and talks to you
2          about their problems, (1.2) what do you do?
3          (0.6)
4     Th: how do you respond?
5          (0.3)
6     Cl:  ↑u:::h it's: you comfort them an you give them advice
7          (0.2)
8     Th:  you comforted them and you give them
9          advi[ce.
```

The analysis of extract fifteen demonstrated the leading nature of the therapist's question in lines 1-4. Let us now turn and see how the client's response in line 6 is being received by the therapist. Following its delivery the therapist repeats it in lines 8-9. Given that the repeated utterance is produced with clause final intonation, it appears to work as a

receipt token (Schegloff, 1997). In addition though, in this particular case, the emphatic intonation in which the therapist's repeat is being delivered seems to register a rather strong acceptance of the client's prior turn, given that it delivers the repeated turns in a more definite way than that of the client. This also seems to be achieved through the transformation of the client's 'c<u>o</u>mfort' (in line 6) to 'c<u>o</u>mforted' (in line 8) by the therapist. This modification of the tense works to present this scenario as something which has already happened, this time with the client being the principal actor, as opposed to the client's normative and removed from specific circumstances version. In this subtle way the therapist seems to upgrade this specific version attempting to render it more factual as she recruits the client's past actions to substantiate this claim.

An even more obvious attempt by the therapist to portray as factual those elicited client responses which are in line with her argument can be seen in the following exchange:

Extract 18 [S2.00:26:58]

```
1     Th:   so why has she not?
2           (0.6)
3     Cl:   £↑I don't know=maybe because >you know< she is sayin you know£
4           (0.7) it's up to me=I have to decide what's best for me=she
5           can't stop me from doing anything so:
6            (0.85)
7     Cl:   because now I'm a big person I can decide for myse:lf
8           (0.3)
9     Cl:   so: she's leaving everything to me to decide mm
10          (1.5)
11    Cl:   (˚mm/yeah˚)
12    Th:   mm. (0.3) .hh .pt (0.4) .pt that's very true I think
```

The exchange occurs in the course of a discussion about the attitude that the client's aunt has towards the client attending support groups. The therapist had been promoting the view that the client's aunt who had in the past been sceptical about the idea that the client attends support groups for people living with HIV, might have now changed and could even favour this idea and endorse the client's wish to attend such groups. To support this, immediately before the start of this extract the therapist successfully elicits the version that the client's aunt had never specifically prevented the client from attending such groups and thereafter (in line 1) invites the client to speculate on her aunt's reasons for doing so ('so why has she not?'). Despite this question being a fairly open one, it nevertheless is a further

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attempt by the therapist to elicit a version favourable to her claims, as whatever these grounds might be, they will be somehow evidencing the aunt's acceptance of such support groups. In lines 3-9 the client appears to align, at least temporarily, with the therapist's overall trajectory '...maybe because >you know< she is sayin you know£ (0.7) it's up to me=I have to decide what's best for me .'. What is of interest is the therapist's response in line 12 which in this case not only receives the client's account, but also validates it in an emphatic way. This is achieved through the upgraded characterization '...that's very true I think' which seems a straightforward attempt to underscore the factuality of the client's claims.

Once more, these sort of instances portray the therapist in control of the trajectory of the talk, whereas such unsolicited and upgraded confirmations of the elicited versions display the therapist asserting epistemic authority over the client's claims (in particular for the full modified repeat of extract 17 see Stivers (2005a)). Once more the therapist appears to have known the answer to her questions from the start, given that she is then in a position to confirm the appropriate responses. In addition, such emphatically delivered receipts or, more generally, such displays of endorsement of the version which the therapist promotes, bear great resemblance with practices employed by teachers in classroom interaction (Edwards and Mercer, 1987; Gumperz and Herasimchuk, 1975). For instance, Edwards and Mercer (1987) note that teachers might choose to make salient particular student contributions in a variety of ways, such as 'speech in unison' (ibid.: 141), repetitions, formulaic phrases and intonational shifts. According to these authors, 'Common knowledge is thus founded upon the establishment of the teacher's understandings as joint understandings...' (ibid.: 142). In a similar way, in the case of these specific exchanges, the advancement of particular versions, or else of psychotherapeutic "stories" seems to be performed through discursive manoeuvres initiated by the therapist which attempt to establish such versions as factual and shared. However, what also needs to be stressed is that unlike classroom interaction, these "stories" relate to the client's world and the client has a rather strong personal commitment to a particular view of events affecting her life. What one also needs to keep in mind is that in the data the therapist's attempts to establish these versions as dominant fall in the context of an overarching disagreement.

5.4.3 Overcoming the client's resistance to the therapist's trajectory

If one were to focus exclusively on instances of elicitation where the client aligns with the therapist's argumentative trajectory, this would result in a rather misleading picture regarding the client's stance to the therapist's overall interactional project. In fact all the dialogical arguments in the data are met with resistance from the client at different stages of their production. And perhaps, even the emphatic confirmations by the therapist following successful elicitation of particular claims as seen in extracts 17 and 18 (above), might in themselves be symptomatic of the high level resistance which the therapist faces in general as this might lead her to emphatically confirm the versions which she does manage to elicit. Among other things, this resistance often consists in employing vagueness (Edwards and Potter, 1992), resorting to minimization of the elicited versions, attempting to deny any parallels between the client's circumstances and those of other people, avoiding to volunteer the elicited evidence, as well as attempting to head off the implications of the therapist's trajectory.

For the dialogical arguments to materialize and reach their conclusion, the therapist needs to overcome such opposition. The therapist indeed shows an orientation to the existence of an overall project that needs to materialise by attempting to rebut the opposition that sidetracks her and the client from moving on with it. This she achieves in a number of ways, depending on the mechanism of resistance employed by the client. The following exchange demonstrates one such attempt to circumvent the client's resistance:

Extract 19 [S2.00:55:42]

```
1    Th:   tell me [one      ]
2    Cl:           £[it's just] (you know) minor things it's all about
3          the stress of ( ) or what's going on in their daily
4          li:f[e
5    Th:       [y::es,
6          (0.2)
7    Cl:   and you know it's (how) (they're) (strugglin) so::: tha[t's
8    Th:                                                          [okay
9    Cl:   these are the main problems
10   Th:   [okay      ]
11   Cl:   [that other] people talk about
12   Th:   mhm (.pt)=.h[h]
13   Cl:               [m]m ((tiny particle))
```

```
14    Th:   and:::=e:::h but the are they are real problems yeah? no matter
15          how big or small they are,
16          th[ey a]re problem[s        ]=.hh
17    Cl:     [(mm)]            [(mm/yeah)]
18    Th:   so:: when somebody comes (.) up to you, (0.6) and talks to you
19          about their problems, (1.2) what do you do?
```

The extract occurs in the context of the client having argued that if she talks to other people about her problems they will become stressed. In response to that the therapist attempts to engage the client in the construction of a counter-case, based on evidence drawn from the client's own experience of listening to other people's problems. The question in line 1 forms part of a series of questions eliciting this evidence. In particular this question invites the client to give a concrete example of an episode where other people shared their problems with her ('tell me [one', in line 1).

It is obvious from the client's response (in lines 2 to 11) that the client resists collaborating in describing a specific case of such an episode, and together with that resists providing the evidence required for the therapist to build her argumentative case. Simultaneously the client attempts to knock down any parallels that can be drawn between her case and that of other people. This she achieves by putting forward a particular description of other people's problems which works to disqualify the therapist's rival version as this emerges progressively; in particular the client's description is fraught with features which minimize the seriousness of the problems that other people talk about. To begin with, the client resorts to the upgraded minimization 'just ... minor things' (in line 2), whereas a supposedly fuller description about the problems' substance portrays them as solely related to psychological factors or to people's daily life ('it's all about the stress of ( ) or what's going on in their daily li:f[e' in lines 2-4). The reference to 'stress' occurs in the context of discussions about the client's medical condition; thus this implied contrast further minimizes the seriousness of the problems that other people encounter. In addition, through the reference to people's daily lives the client is trading on the common knowledge that hardly anything exceptional or dramatic can occur as part of people's daily routine.

There are further such rhetorical features in the client's talk which will not be developed at this stage because what also requires attention is the therapist's response to such resistance. The therapist's next move shows that the therapist herself treats such resistance as important in relation to the interactional project which she is trying to promote. Following a number of attempts to acknowledge receipt of the client's response -three of

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which occur in overlap with the client's talk ('[y::es,' (in line 5), '[okay' (in line 8) and '[okay]' (in line 10))- which equal attempts by the therapist to take the floor, the latter appears ready to proceed with her elicitation. This transpires from the use of the connective 'and:::' (in line 14) which the therapist employs routinely in such episodes of elicitation to preface her forthcoming question; according to Heritage and Sorjonen (1994: 24) an 'and' particle positioned as a preface to a question invokes 'the sense that the questions it prefaces are either routine, or agenda-based parts of some larger course of action.'. However, immediately after that the therapist attaches to the connective 'and:::' the sound stretch '=e:::h' which signals a perturbation and together with it 'the possibility of repair-initiation' (Schegloff et al., 1977: 367). Indeed, subsequently the therapist performs a self-repair changing the direction of her talk and this time disagreeing with the client's prior utterances ('but the are they are real problems yeah? no matter how big or small they are, th[ey a]re problem[s', in lines 14-16). The therapist's move reveals that it is more important for the therapist to deal with the client's resistance rather than proceed with her elicitation, and by implication that the therapist treats this resistance as in some way threatening her broader interactional project. Through her disagreement the therapist attempts to reinstate the importance of other people's problems and ultimately to restore the validity of the parallel that she is in the process of drawing between the client's situation and that of other people. After having dealt with the client's uncooperative move one can see that the therapist returns back to her project, as is demonstrated by the marker 'so::' through which the therapist prefaces her question (in line 18) and which is indicative of the therapist's overarching agenda (Bolden, 2009b). In addition, the therapist's shift back to her line of questioning succeeds in portraying the client's resistance and the therapist's response to it as parenthetical acts to a larger project.

The client's resistance might take a variety of forms, and unsurprisingly what also varies is the type of action that the therapist employs to circumvent this resistance. A different case of the client resisting the therapist's trajectory and of the therapist's way of dealing with such opposition can be seen in the following extract:

Extract 20 [S11.00:43:59]
((The symbol | underneath a letter signifies a tapping sound which appears to be provoked by the therapist as she speaks and which corresponds to the part of the transcript appearing above it)).

```
1        Th:  I [want ex[amples
2                       |
```

```
3        Cl:      [.shih   [heh heh heh
4        Cl:      [↑hhheh heh heh
5        Th:      [hhheh
6        Cl:      .hhh £↑I don't know what kind of examp(h)olhhh£
7        Th:      like for example you could say something like what you said
8                 before that you're able to manage yourself without relying on
9                                              |              |
10                the help of the o[thers]
11       Cl:                         [ ye:]ah
12       Th:      .pt
13                (1.1)
14       Th:      well I can £th↑ink of couple of examples that you told me
15                last [time]
```

This is an instance where the therapist is in the process of eliciting evidence in support of the claim that the client does not need therapy any more as can be seen through the therapist's directive 'I [want ex[amples', in line 1), in the context of the client asserting the opposite. The therapist's directive in line 1 constitutes her second attempt to elicit this evidence (hence the client's laughter in lines 3 and 4 which is responsive to prior criticisms by the therapist about the unsatisfactory nature of her response to the therapist's initial attempt to elicit this evidence). One can see that in line 3 the client avoids satisfying the therapist's directive, with the utterance '£↑I don't know what kind of examp(h)olhhh£' (in line 6). Descriptions of mental states should be examined in their discursive context for their local interactional use (Edwards and Potter, 2005); in this particular case what takes the form of an assertion of ignorance is employed by the client as part of a justification for avoiding offering specific examples, managing to remain vague and by implication resisting collaborating with the therapist's larger interactional project.

This gives rise to an attempt by the therapist to offer the client some 'help' in answering the question ('like for example you could say something like ...', in lines 7-10) which after further resistance by the client to contribute to the therapist's project (given the lengthy pause of 1.1 of a second in line 13), culminates in the therapist eventually offering this evidence herself as can be seen in lines 14 to 15 ('well I can £th↑ink of couple of examples that you told me last [time]'). This practice of volunteering a clinically relevant response in the face of a client's resistance does not seem that uncommon as it has also been documented by Hutchby (2007).

We have previously seen (in section 5.4.1) that the therapist formulates her questions in ways so as to embed cues as to the type of response that would be appropriate on the client's part. We now see that in the course of episodes of elicitation, the therapist might also end up volunteering the appropriate response herself as a way of managing the client's resistance and progressing the case that she is putting forward. What is particularly noteworthy or even paradoxical is that what is volunteered by the therapist is not the therapist's own experience, or any other claim about the world but reports of the client's own experience. It is also worth noting that this episode (extract 20) marks the beginning of a series of elicitations of reports of the client's own experience in support of the claim the client is ready to be discharged, which interestingly are all being volunteered by the therapist herself rather than the client. And it is on the basis of this elicited evidence that the therapist finally concludes that the client would indeed be in a position to stop therapy.

Overall, what these instances (extracts 19 and 20) show is that these dialogical arguments do not run particularly smoothly, as the therapist often encounters substantial resistance on the client's part. Whereas these dialogical arguments are largely meant to be collaborative productions with the client volunteering the evidence in support of certain claims, the details of the interaction show that these exchanges might to a smaller or larger extent end up becoming battlefields as is the case in extract 19, or alternatively that the client's role might in actual fact be rather limited as is the case in extract 20. In addition, in many cases this resistance and the therapist's attempts to manage it seem to account for the lengthiness of such episodes, whereas in some other cases, the client's resistance eventually accounts for the collapse of the therapist's argumentative case.

5.4.4   Engaging the client in the disconfirmation of her version

In three dialogical arguments in the data, the therapist appears to deliver a question which solicits a disconfirmation of a particular claim which eventually amounts to inviting the client to issue a disconfirmation of her initial version. What this move achieves in terms of the unfolding argument is to 'twist the knife' prior to actually delivering the coup de grace. What is particularly noteworthy is the sequential position in which this move is performed as despite the fact that it precedes the therapist's challenge or disagreement at the third position of the device, it occurs at an advanced point of the interaction.

An instance of this practice can be seen in the following exchange:

```
1     Th: keep this in mind you feel happy: because you have been able to
2         give somebody advi[ce]=(.hh)
3     Cl:                   [mhm]
4     Th: (.) .hh but this somebody g- talked to you about their problems
5     Cl: yeah
6         (0.5)
7     Th: yeah?
8         (0.2)
9     Th: did they did they not worry you?
10        (1.4)
11    Cl: no I'm::: (0.8) I think my problem is more complicated than
12        th[eirs. mine is
```

This exchange occurs in the context of the client having claimed that she does not want to share her problems with her relatives as they will become stressed. In response to that the therapist attempts to engage the client in the construction of a counter-argument that when the client herself listens to other people's problems she feels happy rather than worried. The evidence solicited in this way, drawn from the client's own reports of her experience constitutes the grounds for invalidating the client's initial claim.

What is of interest, is line 9 'did they did they not worry you?'. Prior to moving any further though, a parenthetic but important observation is that the way that this question is formulated appears to be a misspeaking on the therapist's part which can be attributed to the therapist not being a native English speaker. One can see that it is in the therapist's interests to get the client to admit that when other people shared their problems with her this did not result in her getting worried. However, the format in which the therapist packages her question presumes that the client did get worried; as Heritage (2002c: 1432) notes 'negative interrogatives concerning matters about which there is shared knowledge are built to prefer 'yes' answers'. Despite the therapist's misspeaking in this case though, the client seems to treat the therapist's question for what it attempts to do, namely attempting to extract the version that the client did not become worried after listening to other people's problems.

At an earlier point of this dialogical argument the therapist has successfully extracted the version that when other people talk to the client about their problems she comforts them and gives them advice, and that this makes her happy. What the therapist appears to invite the client to do through the question in line 9, is to get the client to

disconfirm the version that this would actually worry her. The implications of such an admission for the client's initial claim are actually a lot more detrimental for the client's case than any of the other elicited claims that precede it. The new claim literally stands in sheer opposition to the client's initial one: if the client does not become worried after listening to other people's problems, chances are that the same will apply to other people when they listen to the client's problems, contrary to what the client claimed initially.

What is particularly interesting in this case is the sequential position in the interaction in which such a question is delivered. To begin with the question occurs after the therapist has secured a confirming response to questions which equally advance her line of argument although they are less damaging for the client's case from an argumentative point of view (such as 'when somebody comes (.) up to you, (0.6) and talks to you about their problems, (1.2) what do you do?' in lines 18-19 of extract 19 above). One could imagine that it would have been more challenging for the therapist to extract the client's agreement to what practically amounts to a straight rebuttal of the client's initial claim earlier on in the interaction, had it not been preceded by the previous questions which are argumentatively more innocent and easier to acquiesce to.

In addition, precisely because the therapist has already covered sufficient ground through her previous questions, such a question does not constitute a sine-qua-non step for the therapist's argumentative trajectory, as the therapist has already established that the client herself acts differently to what she claimed other people would do, were she to divulge her problems to them. In that respect, the therapist's question appears to be performed for the sake of registering publically this claim which almost amounts to a straight rebuttal of the client's initial claim.

Thirdly, with regards to the talk that is yet to come, such a claim prepares the ground for the therapist delivering her concluding disagreeing turn in the third position of the device. The final part of this particular dialogical argument (of which extract 21 is a segment) can be seen in line 3 of extract 22 below:

Extract 22 [S2.00:57:33]
```
1     Th:    [so ↑a]ctually
2     (Cl):  [(mm) ] ((unsure whether Cl. has at all spoken))
3     Th:    you're not burdenin them with any problem,
```

In this case, the client's prior admission that she herself does not get worried after other people talk to her about their problems ('n*o*'in line 11 of extract 21) offers the therapist more than ample grounds to claim a bit further in the interaction that other people will not be burdened by the client's problems.

What such manoeuvres in the midst of the dialogical arguments in the data demonstrate, is that the therapist designs the trajectory of these arguments in a strategic way, so as to ensure the maximum compliance on the client's part. Sequentially arranging the questions through which she elicits the required evidence (or else the steps of an argumentative manoeuvre which unfolds progressively), so as to initially position the less damaging questions and those which are more likely to be easily accepted, might not be such an uncommon practice in psychotherapeutic interaction. One of the other argumentative manoeuvres examined in this thesis, namely the tactical concessions in the data, also appear to mobilise a similar principle of maximising consensus and minimizing polarization between participants in the course of delivering an argumentative blow to the client's version. In the case of this practice the therapist first appears to issue a concessionary statement, and then proceeds to attach to her concession an additional component which brings into light the strategic and oppositional nature of her manoeuvre. The latter part of the device occurs after the therapist has offered the client the opportunity to already agree with her initial practically innocent -from an argumentative point of view- concessionary statement.

5.5   Participants' orientation to the unfolding interaction as constructing an argumentative case

What we have seen so far is that instances in the data which show that participants are engaged in the production of dialogical arguments. These comprise an initial claim by the client, a series of leading questions issued by the therapist which attempt to recruit evidence against the client's initial claim, and finally the delivery of a challenge or a disagreeing turn in the third position which opposes the client's initial claim and which is based on the evidence gathered through the question-answer pairs in the second position of the structure.

We have then turned to the second position of the device and examined some of the conversational manoeuvres which the therapist employs in order to build a version which counters that of the client, with, at least to some degree, the client's collaboration. However, even if the client does somehow collaborate with the therapist in the production of these dialogical arguments, she nevertheless does orient to the argumentative texture of the therapist's manoeuvres. Instances in the data show that the client treats the therapist's questions as part of a larger project, designed to eventually counter the client's own version.

To begin with, it is evident from the data that on numerous occasions the client opposes the direction of the therapist's talk. Examples of such opposition, which in fact takes a variety of forms, have already been presented in extracts 19 and 20 above. These as well as other instances in the data which portray the client as attempting to sabotage the therapist's unfolding project, demonstrate that the client treats the therapist's trajectory as disaffiliative displaying an orientation that this has the potential to invalidate the client's own version.

Importantly, in many instances the client appears to oppose what she diagnoses as the end point of the therapist's trajectory, displaying an orientation to the specific case being built by the therapist and to its potential to jeopardise or contradict the client's version. This demonstrates that the client's resistance targets specific interactional implications of the therapist's questions, which she treats as yet to come. Therefore not only does the client appear to treat the therapist's trajectory as being of argumentative nature, but also displays an orientation to the particular trap awaiting her if she collaborates with the therapist's project.

To see an example of that we can turn to the following revealing extract:

Extract 23 [S2.00:06:15]

```
1     Cl:  >↑maybe ( ) pointing at me< but. you know when somebody sees
2          you in that because he knows (for) who go there, what they're
3          going through:
4     Th:  mhm
5     Cl:  so: when he sees me that would be: (.) the thing that >is going
6          in< through his he:ad
7     Th:  okay
8     Cl:  ye:ah
9     Th:  .pt so what d- what was the thing that went: (.) through your
10         head when you saw him, about him.
```

```
11          (0.3)
12   Th:   why was he there?
13          (1.7)
14   Cl:   u::↑h I think he was there maybe to fac:state ((facilitate))
15         about something I don't know (about/but)= because it was only:
16         from nineteen to twenty five ( )=he's a very (0.45) u:::h older
17         than that. so I don- I r- I don't think he came there for tha::t
18   Th:   .pt .hh=uha=
19   Cl:   =>yeah< because I didn't ask the details [(so) (yeah)
20   Th:                                             [uha
21         mm:::
22          (.)
23   Th:   now: thinking about it, do you think you would have wished to:
24         ask the details?
```

In this exchange participants discuss an incident during which the client bumped into an acquaintance of hers in the course of attending a support group for people living with HIV. When this happened the client left the group hastily from fear of this person realising that she suffers from HIV. At the start of the extract the client claims that the specific context of a support group for people living with HIV will be revealing with regards to the reason why the client attends it ('...when somebody sees you in that because he knows (for) who go there,' ... ' that would be: (.) the thing that >is going in< through his he:ad,' in lines 1-6).

The therapist's subsequent question ('so what d- what was the thing that went: (.) through your head when you saw him,...' , in lines 9-10) alludes to the possibility that this person could also be suffering from HIV. Simultaneously, as presented in the analysis of part of this exchange in extract 13, the question is of a leading nature, as it invokes the client's prior reports of the incident, thus guiding the client to the type of response that would be appropriate. The version that the therapist attempts to elicit in this case is that at the time of the incident the client considered neither this person's reasons for attending the support group, nor the possibility that he too might live with HIV, as she was greatly pre-occupied with what this person would actually think of her. In case the client does provide such a response, this report of her own experience would contradict her prior claim (in lines 5-6) that when one is seen in a support group for people living with HIV what the other people present think about this person is that he or she lives with HIV.

In short, if the interaction so far were to be cast in a syllogistic format[12], this could look as follows:

Cl: *When somebody sees you in a support group for people living with HIV the person knows you attend because you live with HIV. I attend a group for people living with HIV. Therefore when person Z sees me in this group, he will think that I live with HIV.*

Th: *If what you say is true then when you attended the support group you would have thought of other people present as living with HIV. When you bumped into person Z whilst attending this group the idea that he himself might live with HIV did not occur to you. Therefore your initial premise (that when somebody sees somebody else in a support group for people living with HIV he or she will think that this person attends because this person lives with HIV) is false, which also invalidates your conclusion that when person Z sees you in this group he will think that you live with HIV.*

The client seems indeed to treat the therapist's question as a tendentious one. The client's response in lines 14-18 is packaged in a dispreferred format whereas it appears that the client refrains from falling into the trap of delivering the response that the therapist attempts to elicit. The client achieves that by providing an alternative account as to why this person was attending the support group, rather than the explanation conveyed indirectly by the therapist ('...I think he was there maybe to fac:state ((facilitate))...'). In addition, whereas the therapist's question is inviting a response about the client's past reaction to bumping into this acquaintance of hers ('... that went: (.) through your head when you saw him,' in lines 9 to 10), the client formulates her response in the present tense, offering her current viewpoint on the matter ('I think he was there maybe...', in lines 14 to 15). This allows her to offer a perspective that she could not have offered if she were to simply report her thoughts at the time of the incident, thus avoiding to lay herself open to accountability issues for contradicting her earlier version on the matter.

_____

[12] The aim of producing this syllogism is not to use it as a model in which to fit the exchange in the data, which is also reflected in the imperfection of the syllogism when compared with the rigour of Aristotelian logic. Rather, the aim is to facilitate the reading of the data, by bringing into prominence an attribute of the data: namely that participants themselves appear to put in motion argumentation principles in order to pull off some form of interactional business.

It is also noteworthy that the client proceeds to back her claim with a justification '= because it was <u>only</u>: from nineteen to twenty five ( )=he's a very (0.45) u:::h <u>o</u>lder than th<u>a</u>t.', in lines 15-17), which in itself seems to indicate that the client attempts to bolster her version against an alternative one. That the client's unfolding version is designed to do precisely that becomes in fact openly evident in the continuation of the client's talk ('so I don- I r- I don't think he c<u>a</u>me there for th<u>a</u>::t', in lines 17-18) through which the client disconfirms the alluded alternative, namely that this person might have attended the support group because he himself was living with HIV.

It is this final manoeuvre - and in particular the use of the deictic 'th<u>a</u>::t' which is employed in the context of the absence of an explicit formulation by the therapist - through which the client openly treats the therapist's prior utterances as alluding to a specific scenario and which portray the client both as predicting and as exposing the next step of the therapist's trajectory. Importantly, this also casts the client's initial opposition to the therapist's trajectory (in lines 11 and lines 13 to 18) not as coincidental, but as the outcome of the client diagnosing the interactional implications of the therapist's trajectory and the trap awaiting her were she to collaborate to provide the invoked response. By signalling to the therapist that she has diagnosed where the therapist is heading to and by disconfirming the alluded version which the client renders explicit, the client manages to block the therapist from delivering a challenge or disagreement at a later stage. Indeed, the subsequent interaction shows the therapist drop the issue and to shift to a different matter ('n<u>ow</u>: th<u>i</u>nking about it, do you think you would have wished to: <u>a</u>sk the d<u>e</u>tails?, in lines 23-24).

Overall, what this instance shows is that the client not only opposes the therapist's immediate trajectory, but also she orients to the existence of a larger project and to the detrimental interactional implications of the therapist's questions for the client's version. This is reminiscent of the tactics of witnesses in court proceedings who treat questions addressed to them as part of a series of questions which are designed to implement a bigger action, namely that of allocating blame (Atkinson and Drew, 1979). The client's response thus appear designed not only to address the therapist's preceding first pair part and the immediate project that this implements, but also, to impact on an anticipated, pending one. In fact, the client's resistance to this overarching project might be such that it may effectively result in the collapse of the therapist's case, as is indeed the case in this extract.

To conclude, so far I have made a case that the client does orient to the type of project that the therapist attempts to implement and to the strategic nature of her talk. However, what needs to be kept in mind is the dynamic nature of these exchanges; given that the

therapist's project extends over a number of turns at talk and that she relies heavily upon the client's collaboration for its accomplishment, there is a certain degree of fluidity involved not just in terms of second part of the practice but possibly in terms of the type of conclusion reached. One could imagine that, particularly in cases where the client exhibits a large degree of resistance to what she diagnoses as the end point of the therapist's trajectory, the therapist might be in a position to shift the goalposts according to the client's emerging responses.

5.5.1 Collaboration with the therapist's project might serve strategic purposes

In addition, analysis of instances of dialogical arguments in the data show that even if the therapist's project appears to run smoothly and even if the client appears to collaborate with the therapist in 'volunteering' the evidence solicited by the therapist, the client herself might exploit the unfolding version for her own argumentative purposes thus opposing those of the therapist.

One such instance can be found in extract 4 above which is reproduced below:

Extract 24 [S3.00:14:55]
```
1    Cl:  £↑you d↑on't kn_ow (but) you know I think that you know when you
2         are,£ that's what you're g_oing through it's like when you kn_ow
3         somebody sees you that's the first thing they'll have in their
4         h_ead
5         (.)
6    Th:  >okay<. .h so when you f_irst saw this person,(0.6) eh ye- e::m
7         (0.3) two weeks ago, (0.7) what was the first thing that came
8         to your min- mind
9    Cl:  o::h it was like oh my god he's going to know that I'm
10        £p_ositive£
11   Th:  _okay
12   Cl:  hhheh heh_ .hh
13   Th:  s_o wh_at did you th_ink about <h_im> did
14        yo[u think ]
15   Cl:  £[I didn't] think about him (0.2) at _all£
16        (0.3)
17   Cl:  £it was <m_e> it was me who [(kn_ew)]£
18   Th:                             [h_m::  ]
19        (.)
```

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```
20   Th:   .hhh okay:
21         (0.5)
22   Th:   .hh so:: (.) you didn't did you not think that ↑oh my g↑od ↑he
23          is p↑ositive t↑oo:
24         ((in a theatrical voice))
25   Cl:   no(h):
26   Th:   no.
27         (.)
28   Cl:   [no]
29   Th:   [ok]ay .hhh so:, (.) wh↑y do you assu:me that anybody who would
30          £see you£, (0.9) would assume ↑o::h she's p[ositive]
31   Cl:                                               [hhheh h]eh heh
32          .hhh u::h
33          £ (I don't know) it's just that you know .hh when you know
34           that you're thief, and somebody sees you holding something,£
35   Th:   yes,
36   Cl:   £so they'll (just/most) (definitely) know you've stole it
37         so it's like£=
38   Th:   =heh heh heh [heh ]
39   Cl:                [.hhh] [heh heh     ] heh
40   Th:                      [(yeah) right]
41   Th:   yeah but [in that case,  ]
42   Cl:            [heh heh heh heh] hheh
43   Th:   everybody £who's in this building£ is a thief
```

In contrast with other extracts of dialogical arguments in the data where the client strongly resists the therapist's unfolding trajectory, this is an extract where the client appears to offer rather unprobrematically the evidence solicited by the therapist, despite the fact that this provides the therapist the opportunity to deliver a challenge at the third part of the device. However, closer inspection of the talk reveals that the client does that whilst continuing to pursue her own line of argument.

In more detail, the contradiction that the therapist constructs with the help of the client through the use of this dialogical argument is that despite the fact that it did not occur to the client that an acquaintance of hers, whom she met in a group for HIV sufferers might have also been suffering from the condition himself, she nevertheless assumes that whoever sees her in this group would automatically find out about her condition. The term 'assu:me' (in line 30) which the therapist ascribes to the client in the third part of the device effectively portrays the client's judgement as subjective, unsubstantiated and deficient.

According to Edwards (2007: 31) 'By working up the subjective status of an account, generally somebody else's account, its objectivity is undermined.' In addition, 'subjectivity of various kinds (stake, prejudice, ulterior motives, etc.) is treated as a threat to a report's objectivity, reliability or truth' (Edwards, 2007: 46).

Interestingly, in the course of the therapist's solicitation of evidence, the client herself does flag up her judgement as subjective in the version which she 'volunteers' ('£it was <me> it was me who [(knew)]£', in line 17). Through this elliptic utterance, the client signals the impact of her own state of knowledge, implying that this had an effect on her judgement. In fact, this utterance, precisely because of its constraint and incomplete nature, relies heavily on an adjacent piece of talk for its meaning. In this case this adjacent piece is not so much the client's immediately preceding turn ('£[I didn't] think about him (0.2) at all£', in line 15), but the client's initial claim in lines 1 to 4 ('when you are,£ that's what you're going through it's like when you know somebody sees you that's the first thing they'll have in their head').

At that early point in the interaction the client appears to propose a mental state as a cause for an action or a particular occurrence, thus making an appeal to subjectivity to account for a particular claim. It just so happens that this utterance (in lines 1 to 4) establishes an episode of disagreement as it constitutes an oppositional move to a prior (equally oppositional) turn issued by the therapist (Hutchby, 1996) –not appearing in this segment. Therefore it transpires that prior to the therapist mobilizing a dialogical argument in order to uncover the double standards in the client's judgement and the 'subjective' nature of her claims, the client herself had mobilized subjectivity (Edwards, 2007), using it as a resource.

What the client effectively attempts to achieve by doing so is to legitimise a case which had already been questioned by the therapist. In particular, in prior interaction the therapist had disputed the client's claim that when one sees a person in a support group for people living with HIV, then one realises that the person attending the group is an HIV sufferer. The client's subsequent turns in lines 1 to 4 work as a warrant for the client's initial case but do so in an intriguing way.

In particular this time the client claims that one's identity as HIV sufferer and one's state of knowledge of being seen in the group for HIV sufferers influence other people's perception of the person living with HIV. Similarly to what Perakyla (1995) argues to be the case with the hypothetical-description part of hypothetical questions, the conditional that the client employs works as the presupposition for what comes next which in this case is

another conditional ('when you kn<u>o</u>w somebody sees you'). Eventually, both these conditionals, which foreground both one's identity as HIV sufferer and one's state of knowledge of being 'seen' in such a group, work as the background for the client's ensuing claim ('that's the first thing they'll have in their h<u>ea</u>d'), establishing some form of interdependence between the two.

One can imagine that from the perspective of a logician not to say of a lay person such an axiomatic claim would have difficulty being convincing, as it renders what other people think of a third person contingent upon this third person's mental state. This is reflected in the therapist's own way of treating the client's claim, as it appears that this aspect of the client's talk is not being treated by the therapist as a sufficient account, not to say even that it is deleted and remains unnoticed (the client's 'when you kn<u>o</u>w somebody sees you.' in lines 2 to 3, is subsequently transformed by the therapist to 'that <u>a</u>nybody who would £s<u>ee</u> you£,', in lines 29-30).

One could even suggest that this denotes some form of mistake on the client's part; however, subsequent interaction demonstrates that this is not the case and that the client designed her talk in this way to achieve a particular rhetorical effect. In fact, what the client does by constructing her claim in such a way is to portray aspects of one's experience and disposition as warrants of a claim that on its own had already come under attack ('that's the first thing they'll have in their head', in lines 3-4). And although she formulates her claim as applying to people in general, indirectly what resonates is her own entitlement to own such subjective experiences (Sacks, 1984) (given that participants' preceding talk concerns the client's own experience of living with HIV) in contrast with the therapist who does not share a similar entitlement.

That the client herself uses subjectivity as a rhetorical resource to support her line of argument is further evidenced at the conclusion of this dialogical argument. Following the therapist's challenge in lines 30 to 31 ('so:, (.) wh↑y do you ass<u>u</u>:me that <u>a</u>nybody who would £s<u>ee</u> you£, (0.9) would assume ↑<u>o::</u>h she's p[<u>o</u>sitive]) the client produces an account, which she designs as a metaphor, thus rendering her version more vivid ('when you know that you're th<u>ief</u>, and somebody sees you holding something,£ ... £so they'll (just/most) (definitely) know you've stole it' (in lines 34, 35 and 37).

There seems to be a similar type of mechanism at work in this piece of reasoning, as in lines 2 to 4 at the start of the extract. Once more the client claims in an axiomatic way that one's mental state will impact on other people's judgement. This claim is treated as irrational by the therapist as she meets it with laughter ('=heh heh heh [heh]', in line 39)

and a teasing ('yeah but [in th<u>a</u>t c<u>a</u>se,]'... '<u>e</u>verybody £who's in this building£ is a th<u>ie</u>f", in lines 42 and 43). One can imagine that a more plausible alternative for the therapist herself might have been that one's knowledge of being a thief and of being seen holding something could result in this person fearing being recognised as someone who stole something. However, similarly to lines 3 to 4, the client opts for a factual, non-subjective type of outcome ('they'll (just/most) (definitely) know you've stole it'), which she appears[13] to strengthen with a (potentially qualified given the use of '(just/most)') extreme case formulation (Pomerantz, 1986) '(definitely)'.

This brief analysis of the client's talk reveals that despite the fact that the dialogical argument mobilised by the therapist is designed to expose and challenge the client's subjective judgement, paradoxically, and given that the client had been using subjectivity as an argumentative resource, it aids the client to strengthen her own version and to argue against the therapist's initial version (that preceding line 1). It is thus no surprise that in this case the therapist finds no resistance in gathering the evidence needed to deliver a challenge at the concluding part of the argument.

Another, alternative reason for the client's collaboration, namely that on this occasion the client failed to diagnose the interactional implications of the therapist's trajectory, would be improbable as, aside from other indications (such as the smiley voice and the laughter tokens issued by the client at different points of her talk), this exchange occurs after another very similar one on exactly the same topic where the client was successful in diagnosing and in fact blocking the therapist's unfolding trajectory (this earlier exchange can be perused in extract 23 above).

5.5.2   The therapist's use of tokens which display that she is building a case

So far we have seen how the client orients to the therapist's moves as being of argumentative nature and how she diagnoses the end point of the therapist's trajectory. In addition though, the therapist also designs her talk in ways that display that the business she is up to is that of moving along a logical trajectory. There are two noticeable features of the therapist's talk that achieve this effect: first, features in her talk that display that she is

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[13] This is not a definite reading given that at this point of the transcript there might be a mishearing of what the client actually said.

constructing a logical case and secondly, features in her talk which display that she is following a trajectory.

5.5.2.1 Constructing a logical case

One of the ways through which the therapist portrays herself as reasoning is the marker 'so', which aside from other usages by the therapist in these instances in the data, appears to preface her challenge or disagreement in the third part of the device. A key function is that this marker has been reported to carry out (Raymond, 2004) is that of performing connections. It is thus plausible to assume that one of the factors which determines what this marker does interactionally relates to the parts of talk that this connects.

On these specific occasions in the data, the so-prefaced turns contain partial repeats or recyclings of the client's claims prior to the elicitation, which works as a display that what these turns are responsive to is the client's initial claim (in the first position of the device). Thus the marker so, placed in turn-initial position in these disagreeing or challenging turns appears to display that the therapist's disagreement or challenge targets the client's initial claim. This casts the intervening material, that is the material derived through the elicitation, as constituting the background information that has been deemed as essential for the disagreement to occur. Placed in such a sequential position the marker so seems to work so as to portray the therapist as drawing an inference from the intervening talk. This fits with mentions in the literature about the inferential functions of this marker (Raymond, 2004; Schiffrin, 1987). Therefore, it appears that on these occasions this marker (along with other features of the talk) portrays the therapist as being in the process of producing a piece of reasoning.

The inferential role of this marker in these exchanges can be seen in extract 25 below which constitutes the concluding part of an argument that runs over several minutes of talk:

Extract 25 [S11.00:54:48]
```
1    Th:    [so ] six thi:ngs that you did .hh eh?
2           (0.3)
3    Th:  you: you managed to do yourself
```

```
4            wi[thout relying on] o[thers]
5      Cl:     [mm:::            ]  [  mm:]::
6            (0.3)
7      Th:  .pt=.hh so it ↑is a sign to me:, (.) actually that, you know,
8            (.) althou::gh, if I was to s:tay here for longer, .hh (.) you
9            would have stayed (unt-/and-) .hh you know, you would have
10           stayed (.) you wou- (0.3) eh you would have continued
11           counselling maybe less frequently,
12     Cl:  mm
13     Th:  (.) and the signs that would tell you that you don't need (0.5)
14           counselling anymore, you said you would be if you understood
15           that .hh (.) you can manage yourself without relying on others
16     Cl:  ˚ye:ah˚
17     Th:  .h an I think you already have a lot of signs that
18           s[ay that]
19     Cl:   [hhhheh ] hheh heh
20     Th:  so maybe: [you know i]f I was
21     Cl:            [mm        ]
22     Th:  to continue I would tell you .pt w↑ell Mary, I think that you
23           know there're there are enough reasons, (0.9) why you can
24           manage yourself without relying on others, so: maybe I think
25           that I can become redundant,
```

In this extract the therapist appears to employ the marker 'so' to preface a claim that opposes the client's version that she is in need of more therapy ('so it ↑is a sign to me:, (.) actually that, ...', in line 7 and 'so maybe: [you know i]f I was to continue I would tell you .pt w↑ell Mary, I think that you know there're there are enough reasons, (0.9) why you can manage yourself without relying on others, so: maybe I think that I can become redundant,'in lines 21 and 23-25). Although the great length of this dialogical argument makes it impractical to present its initial part, it is worth mentioning that these so-prefaced turns contain recycled utterances from the client's own version at the start of the exchange as can also be presumed from the use of direct reported speech by the therapist in line 14 ('you said you would be...'). It thus transpires that the above mentioned so-prefaced utterances are responsive to the client's initial claims, which in fact they appear to oppose. The marker 'so' in these instances, positioned after the elicited material and introducing the therapist's disagreement to the client's earlier claims, present the therapist as drawing an

inference from the claims derived through elicitation. In turn, this portrays the therapist as drawing conclusions based on logical deliberation.

The marker 'so' employed in such a context appears to present the therapist as building a logical case even when prefacing an interrogative as is the case of extract 24 above (the relevant part of which is reproduced below):

Extract 26 [S3.00:15:33]
```
1     Th:  [ok]ay .hhh so:, (.) wh↑y do you assu:me that anybody who would
2           £see you£, (0.9) would assume ↑o::h she's p[ositive]
```

In this case despite prefacing an interrogative, this interrogative is strongly presumptive, as can be gathered from the analytic comments regarding extract 24 above, thus displaying the therapist's stance to the client's earlier claim.

5.5.2.2 Creating the sense of traversing a trajectory

In addition to displaying that she building a logical case, the therapist also displays that she is following a trajectory, which she appears to implement step by step. Some important features of the therapist's talk which achieve this effect are tokens that display a transition to a next step, as well as markers or utterances that construct a connection between different parts of the therapist's talk.

To begin with, there are instances in the data where the therapist employs the acknowledgement token 'okay' to display transition to the next stage of a trajectory. On these occasions this token is employed in the position of a third turn receipt following question-answer adjacency pairs that are initiated by the therapist and which effectively elicit a version favoured by the therapist (an example is extract 24 in section 5.5.1 above). Simultaneously these tokens are followed by a next-in-the-line such question, through which the therapist further attempts to advance the version that she is promoting. It thus transpires that in these instances the okay occupies the dual role described by Beach (1993), namely responding to prior talk whilst simultaneously signalling a transition to a next positioned matter. This becomes particularly evident in the following extract:

Extract 27 [S2.00:56:12]

```
1     Th:  how do you respond?
2          (0.3)
3     Cl:  ↑u:::h it's: you comfort them an you give them advice
4          (0.2)
5     Th:  you comforted them and you give them
6          advi[ce.
7     Cl:      [˚ye:ah˚
8          (0.2)
9     Th:  okay .hhh (.) and. how do you feel afterwards
10         (0.4)
11    Th:  after you've after you've comforted them and you've given
12         advice, (0.4) and they go away, and you go away, how do you
13         feel after that?
```

In this exchange the 'okay' in line 9 follows an adjacency pair initiated by the therapist. However, on this occasion the transitional character of this token is particularly evident given that the therapist has already registered receipt to the client's response to her question ('you comforted them and you give them advi[ce.', in line 5).

Importantly, the therapist displays that the different parts of the talk that is produced are interconnected, forming a coherent composition. What the therapist employs predominantly to achieve this effect are the conjunctive markers 'and' and 'so'. Instances of and-prefaced utterances can be seen in extract 28 below:

Extract 28 [S2.00:26:15]

```
1     Th:  mm:: so that's a very important factor isn't [it?
2     Cl:                                               [yeah
3     Th:  .hh .pt=.hh and th↑en (0.3) she has seen you go although you
4          don't attend regularly support groups, .hh she knows that you
5          have been to different events
6     Cl:  ye[ah  ]  [ y]eah
7     Th:    [isn't] i[t?]
8          (0.5)
9     Th:  where: she:: she can assume that there will be other people
10         living with eitchaivi ((HIV)) isn'[t it?
11    Cl:                                     [mhm
12         (0.3)
13    Th:  .pt=.hh so:: and has she ever told you: (0.5) no Mary you're
```

In the above extract the therapist employs the marker 'and' in turn initial position to preface utterances situated in the second position of the dialogical argument, which solicit evidence in support of a case that opposes the client's initial version. The first and-prefaced utterance is a B-event statement (Labov and Fanshel, 1977), that is an event situated within the client's epistemic realm ('and th↑<u>e</u>n (0.3) she has seen you go alth<u>ou</u>gh you don't attend regularly supp<u>o</u>rt groups, .hh she kn<u>o</u>ws that you have been to different ev<u>e</u>nts', in lines 3-5). Although such a statement does not have the intensity of an interrogative in terms of engaging the client in the interaction, it nevertheless is designed to ivite the client's confirmation (ibid.). This effect is also strengthened by the ensuing tag question ('[isn't] i[t?]', in line 7) which equally invites confirmation, as well as the subsequent tag question ('isn'[t it?', in line 10) which follows from an elaboration by the therapist. In addition, one can observe that subsequently in the interaction there follows an and-prefaced question 'and h<u>a</u>s she ever t<u>o</u>ld you: (0.5) <u>no</u> Mary you're staying at h<u>o</u>me you're n<u>o</u>t going there', in lines 13 to 14).

Heritage and Sorjonen (1994) have characterized instances of the marker 'and' prefacing questions as invoking a sense of agenda, or as portraying the ensuing question as a step into a larger activity. In a similar way, it appears that the markers 'and' appearing in this segment connect the therapist's utterances to each other whilst simultaneously portraying the therapist as progressing a particular agenda. Similarly to what Heritage and Sorjonen (1994: 6) note to be the case in the interaction between mothers and health visitors, 'while the *and*-prefacing serves to underscore a tie between the current and a prior question, each question also marks a forward movement within the trajectory of a larger activity'.

One can note that line 13 is in fact initiated with the marker 'so::'. It is probable that on this occasion the therapist treats this as a mistake and that the subsequent 'and' constitutes a repair although it is also possible that 'so' is also employed to mark a sense of continuity. This brings us to another observation drawn from examining the data, namely that the marker 'so' is another and in fact more frequently employed marker which the therapist utilizes to denote a sense of continuity and coherence among the questions that she delivers in the second position of the device.

An example of such a use of 'so' can be seen in the following extract, which constitutes a segment from a fairly lengthy dialogical argument:

Extract 29 [S2.00:55:26]

```
1     Th:   who who do you remember (0.8) one of the- who is one of them
2           who:: talk(ed) to you about their problems
3           (1.2)
4     Cl:   ↑mm ↑mm ↑mm so many


            ((nine lines have been omitted))


14    Cl:          £[it's just] (you know) minor things it's all about the
15            stress of ( ) or what's going on in their daily li:f[e
16    Th:                                                  [y::es,
17            (0.2)
18    Cl:   and you know it's (how) (they're) (strugglin) so::: tha[t's
19    Th:                                                    [okay
20    Cl:   these are the main problems
21    Th:   [okay      ]
22    Cl:   [that other] people talk about
23    Th:   mhm (.pt)=.h[h
24    Cl:               [m]m ((tiny particle))
25    Th:   and:::=e:::h but the are they are real problems yeah? no matter
26            how big or small they are,
27            th[ey a]re problem[s          ]=.hh
28    Cl:     [(mm)]            [(mm/yeah)]
29    Th:   so:: when somebody comes (.) up to you, (0.6) and talks to you
30            about their problems, (1.2) what do you do?
31            (0.6)
32    Th:   how do you respond?
```

The so-prefaced question ('so:: when somebody comes (.) up to you, (0.6) and talks to you about their problems, (1.2) what do you do?', in lines 29-32) follows from a rebuttal by the therapist of the client's display of opposition to therapist's previous question ('but the are they are real problems yeah? ... ', in lines 25-27). In that case, the marker 'so' appears to link this question to the therapist's previous topically linked questions (the question in lines 1-2 at the start of the extract and those preceding it). This seems consistent with Bolden's (2008) and Bolden's (2009b) observations that the marker 'so' at turn-initial position might

steer the addressee towards seeing the action it initiates as having been on the speaker's agenda.

In the following extract the therapist displays that she is following a trajectory by inserting a yet different feature in her talk:

Extract 30 [S2.00:56:34]

```
1    Cl:  mm::::: (0.3) ↑I feel you know just happy that you know (I am)
2         ( ) (able to)
3         (1.3)
4    Cl:  at least give someone advice
5    Th:  =okay
6         (0.3)
7    Th:  keep this in mind you feel happy: because you have been able to
8         give somebody advi[ce]=(.hh)
```

In this segment, following the client having offered a "no problem" response in terms of the progression of the therapist's project, the therapist meets that with the utterance 'keep this in mind' (in line 7). This utterance serves as a display that there is a final objective, which will be reached at a later stage. It portrays what the client has just said as the intermediate stage of an overall trajectory and also portrays what is to follow immediately after as simply a next rather than the final stage of the project.

In most cases the dialogical arguments in the data are pretty lengthy, particularly the part where the therapist attempts to gather evidence which counters the client's initial claim. In addition, as is the case in extract 29, the therapist's attempts to elicit such evidence are often met with opposition by the client. Therefore, one of the dangers for the therapist's project is that it might dissolve in the process as the talk might digress towards unrelated matters. It thus transpires that markers such as the 'so' and the 'and' can be particularly useful not just because they display a sense of progression but also to work to display connection and coherence across the different questions when this might be easily disturbed. To conclude, by employing the markers or utterances described in this section (5.5.2), the therapist displays that she is advancing an agenda, presenting herself as progressively proceeding from one step to the other and ultimately as delineating a series of logical, interdependent steps.

5.6   Discussion

This piece of work emerged after encountering in the data exchanges in which the therapist attempts to persuade the client over particular matters. These attempts involve asking questions which engage the client in bringing into the open previously neglected information which, when brought to the surface, will undermine the client's prior claim. In particular the therapist solicits reports of the client's experience that are incompatible with the client's preceding assertion. The solicited evidence is then used by the therapist as the basis upon which to draw a conclusion that opposes the client's initial version. In this way the therapist conveys the sense that she is producing a reasoned argument with the client's collaboration.

The majority of these dialogical arguments appear in exchanges where there is established dissent, although simultaneously their presence also marks the exchanges in which they feature as oppositional ones, given that they reveal the work that the therapist needs to do to secure the client's agreement with a particular viewpoint. According to Potter's (1996: 158) observations -which he bases on Latour (1987) and Pomerantz (1984b)- 'in situations of conflict in both scientific and everyday settings people will provide increasingly technical support for positions and can be increasingly concerned with giving a basis to their claims'. Indeed, the dialogical arguments in the data present the therapist as engaged in the business of fact construction (Potter, 1996) through appeals to reasoning that are devised for persuasive purposes. Linked to that, by employing reasoning as a resource the therapist manages to avoid being attributed subjectivity or stake (Edwards and Potter, 1992) which are some of the devices through which the client attempts to discount the therapist's contributions.

A number of manoeuvres have been identified as part of the delivery of the dialogical arguments in the data. These manoeuvres reveal that it is not as much the robustness of the therapist's reasoning that accounts for this phenomenon's persuasive potential, but the ways in which such arguments unfold interactionally and the work done by the therapist to guide the interaction towards particular paths.

Notable among the therapist's resources are the diverse accountability issues opened for the client through the therapist's line of questioning. These are particularly evident in the case of the variant of this practice, the questions that turn a claim on its head, as presented in section 5.3.1. Linked to that, what is also notable among the therapist's resources for

extracting the client's agreement and for advancing her overall project is the subtle invocation of what is normative and of the moral order (as detailed in section 5.4.1.2). This facet of the dialogical arguments in the data touches upon an open debate in the psychotherapeutic field as to whether therapy imposes a particular normative or moral order, with many therapists critiquing the processes through which normative assumptions and a dominant morality might be maintained by professionals (Malley and McCann, 2002; McGoldrick, 1998; Rivett and Street; 2003). What the data shows in that regard though is that the normative or the moral order might be revived through principally subtle manoeuvres that have been employed not as an end in itself but as a means to a larger psychotherapeutic project – this, paradoxically, might have even been launched in order to combat practices reflecting dominant values such as the stigma surrounding people that live with HIV, as is the case with some of the dialogical arguments in these data.

It is worth observing that if at some point in the interaction the therapist considers it advantageous to raise a contradiction, she can do so immediately after the client's initial claim. An example of the latter practice is for instance provided by Hutchby (1992) who observed that participants might employ the device 'you say X, but what about Y' subsequently to a prior speaker's turn in order to build a contrast and to instigate controversy or argument. Equally, if the therapist deems it advantageous to raise a contradiction in the form of a reasoned argument, she can of course produce a monological one, which will also make her trajectory less reliant upon the client's contributions. The therapist though seems to choose an alternative way, favouring questions over statements when building the premises of the argument, as can be seen for instance from the repair in the following segment of elicitation (where 'you didn't'' in line 3 becomes transformed to 'did you not'):

Extract 31 [S3.00:15:25]

```
1     Th:   .hhh okay:
2           (0.5)
3     Th:   .hh so:: (.) you didn't did you not think that ↑oh my g↑od ↑he
4           is p↑ositive t↑oo:
5           ((in a theatrical voice))
```

The fact that in the instances in the data the therapist designs her talk in a way that invites the client to produce the premises of the argument as well as the fact that the therapist suspends the delivery of the challenge or disagreement until the client has offered her

contribution to the piece of reasoning initiated by the therapist, seems designed to address a number of therapeutic, argumentative or interactional necessities.

To begin with, the inserted segments of elicited material aids the therapist to ground her ensuing challenge or disagreement upon material which is not only provided by the client herself but which also consists of reports of the client's own experience. This obviously is particularly advantageous from an argumentative point of view as it makes it harder for the client to resist the concluding part of the therapist's argument. There are additional argumentative advantages of this strategy, as the therapist is in a position to potentially address the client's emerging attempts to forestall what she diagnoses as the end-point of the therapist's trajectory. Being in a position to reply in the third position to elicited material has been documented as beneficial in a variety of institutional practices (Maynard, 1991; Maynard 1992; Vehvilainen, 2001); in this case the therapist is also in a position to progressively borrow, from the client's answers, material which she deems beneficial to her overall trajectory and to discard others.

Secondly, engaging the client in the production of evidence by eliciting reports from the client's own personal experience prior to delivering an oppositional move, offers the impression that the client to a large extent 'volunteers' the evidence that leads to the therapist's ensuing conclusion, whilst simultaneously it minimizes the therapist's role, who appears to simply facilitate this conversational process. The therapist thus appears to proceed like a modern Socrates, 'gently' opening the way for a perspective previously 'unnoticed' by the client simply by guiding the client to draw from a stock of knowledge derived from the client's own domain of lived experience.

This appears designed to embody psychotherapeutic principles which regard clients as carrying the resources and expertise to overcome the issues that lead them to seek professional help and which view the therapist as occupying the role of a catalyst that simply facilitates the conversational process through which new meanings are created (Anderson and Goolishian, 1992). This echoes findings about other practices observed in counselling settings which constitute attempts by professionals to embody similar counselling or psychotherapeutic principles. Examples are offered by Vehvilainen (2003b) who reports career training counsellor's strategies in response to advice requests as a way of adhering to the principle of self-directedness, by Hutchby (2007) who studied the use of perspective display series by child counsellors as a way of facilitating the counselling process instead of simply imposing their professional perspective on to the children and also by Butler et al. (2010) who identified the use by counsellors of advice implicative

interrogatives as a way of reducing the epistemic asymmetry between participants in a children's helpline.

There is a further necessity which could be the driving force behind the intervening instances of elicitation, which this time relates to issues of epistemic primacy and the delicate management that these might require. The claims that the therapist elicits through the questions in the second part of the device largely concern the client's own experience (examples can be drawn from extracts 2 and 3). Were the therapist to deliver the premises of the argument herself rather than engage the client in their production, she would have had to resort to B-event statements (Labov and Fanshel, 1977). An example of how the premises of such a monological argument could look can be seen in the invented syllogism featuring in the analytic comments of extract 23 above, the relevant part of which is also reproduced below:

> Th: *If what you say is true then when you attended the support group you would have thought of other people present as living with HIV. When you bumped into person Z whilst attending this group the idea that he himself might live with HIV did not occur to you.*

One can see that the premises of this argument constitute B-event statements and as such are a lot more vulnerable to disconfirmation by the client. One can also note that such statements multiply the accountability issues present for the client, given that it is the therapist herself who points entirely on her own towards aspects of the client's experience that have been overlooked by the client herself. Therefore, given that the topic of discussion -and by implication the topic of these arguments- concerns aspects of the client's experience, as it is customary to be the case in psychotherapy sessions, this seems to render the use of elicitation essential for building the premises of such an argumentative piece of reasoning. It thus transpires that through the instances of elicitation and the dialogical aspect of these arguments the therapist finds a way to overcome the unequal distribution of knowledge (Drew, 1991) between herself and the client, and to even turn it to her advantage given the argumentative leverage that the client's own reports of her experience constitute in this case.

Chapter 6: Tactical Concessions

6.1   An initial presentation of the phenomenon

This chapter is about a strategy employed by the therapist in the data which consists of tactically conceding a point in the course of argumentative exchanges between her and the client. When examining this practice in its local discursive context it becomes evident that unlike other concessions reported in the literature (Buttny, 1987; Kotthoff, 1993; Stivers, 2005b) the ones appearing in the data cannot simply be treated as a back-down from a previous claim. Instead, it appears that as the interaction unfolds the conceded point proves trivial in comparison to a larger contentious issue. In addition, it does not seem to deter the therapist from pursuing her line of argument in subsequent interaction. Importantly, the conceded point appears to serve as a vehicle which advances the therapist's argumentative agenda whilst simultaneously undermining the client's claims. Therefore this particular practice sits more comfortably with emerging reports in the literature about concessions employed by participants for rhetorical or argumentative purposes (Antaki and Wetherell, 1999; Lewis, 2005; Tileaga, 2005).

Before proceeding any further, it should be noted that the description of the phenomenon presented in this chapter is based on the analysis of three instances, which represent a small number of cases. However, these instances do form a rather robust conversational pattern which offers an intriguing view of the microcosm of therapy. As the chapter progresses each of these extracts will be commented upon multiple times, each time in order to illuminating a different aspect of the phenomenon.

An initial instance of a strategic concession that has been derived from the therapist-client interaction in the data can be seen in the following extract:

Extract 1 [S3.00:25:37]
```
1    Cl:   so::: I think that's why maybe I didn't because (0.6) when
2          uncle Mike came I was like should I ask him? and: >was like<
3          no I shouldn't do this
4    Cl:   [(something like this)]
5    Th:   [mm:::                ]
6    Cl:   so I said let me think about it .hhh CAUSE whenever I think
```

```
 7          that I am not ready to do something I am always ha- have to
 8          think about it more and more
 9          (.)
10   Th:    ↑m↓m[:::
11   Cl:       [*yeah
12          (0.3)
13   Th:    mhm
14          (0.7)
15   Th:    do you think that's a good good thing to do?
16          (0.3)
17   Cl:    y↑e↓ah
18          (0.3)
19   Th:    mm:::
20          (0.6)
21   Th:    yes
22          (.)
23   Cl:    hhe:h
24   Th:    I think it's a very good quality
25        (0.2)
26   Cl:    °mm°
27   Th:    to: to have to: when you are not sure about something (.) just
28          to:: think about it?
29   Cl:    yeah
30          (0.2)
31   Th:    and then make up your mind
32          (0.4)
33   Th:    mhm
34          (0.3)
35   Th:    .hhh so do you think you've had s↑ome time to think about about
36          it now?
37          (0.2)
```

Prior to moving to more detailed observations regarding this extract it might be worth highlighting the core parts of the tactical concession. At the start of the extract (in lines 1-8) the client takes the position that she is not ready to reveal the news about her condition to her uncle but instead has to think more about it (client's standpoint). The therapist then (in line 24) concedes that thinking things through is a very good quality (concession). She then (in line 31) attaches to her concession an additional feature that what

is also a very good quality is for the client to eventually reach a decision, which turns the concession to a tactical one (elaboration).

These three parts form the basic components of the phenomenon; in addition though, there is a fourth feature, which is not a defining part of a tactical concession but which is present in the extracts of the collection at hand: at the conclusion of the extract (in lines 35-36) the therapist issues a question, as to whether the client has already had enough time to think about revealing the news regarding her condition to the uncle (suggestion).

To take things more gradually, the talk at the start of this extract and in the turns immediately preceding it revolves around the possibility of the client ceasing to try to conceal from her relatives and other people that she lives with HIV. In previous interaction both the therapist and the client have openly manifested their respective stances towards this scenario, with the therapist opposing the secrecy surrounding the client's condition and the client being in favour of maintaining it. In lines 1-8, in response to a suggestion previously issued by the therapist that the client could ask her relatives' opinion regarding the possibility that she bumps into people acquainted to them whilst attending groups for people living with HIV, the client talks about having passed an opportunity to disclose her condition to her uncle ('so I said let me think about it', in line 6), justifying her decision with a scripted event formulation (Edwards, 1994; Edwards 1997) characterising her behaviour, which portrays it as normative and routine (namely that 'whenever I think that I am not ready to do something I am always ha- have to think ab<u>ou</u>t it m<u>o</u>re and m<u>o</u>re', in lines 6-8). In the context of the pre-existing debate on the issue of the secrecy surrounding her condition, the client's claims in lines 6-8 seem to be revealing of her preference to maintain the secrecy, at least as far as her uncle is concerned and at least for a certain period of time.

In response to this account, the therapist initiates a perspective display series (Maynard, 1991; 1992), soliciting the client's opinion regarding the merits of her scripted behaviour ('d<u>o</u> you think that's a g<u>oo</u>d good thing to do?', in line 15). This device manages to render even more explicit the client's argumentative interests by getting her to publically affirm that her scripted behaviour and by implication her reasons for not deferring talking to her uncle are appropriate (through her 'y↑e↓ah' in line 17). Importantly though it gives the therapist the interactional opportunity to come in with an assessment (Pomerantz, 1984b) in the third part of the device ('I think it's a very good quality' in line 24). Interestingly, the therapist's assessment is a positive one, despite the fact that the client's account regarding her need to take more time is equivalent to resisting the therapist's line of

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argument. Therefore by producing such a positive assessment in the context of having previously suggested that the client talks to her relatives, the therapist appears to make a concession.

However, the concession is short-lived as, in the course of formulating what the positively assessed behaviour consists of, the therapist incorporates a feature which in fact goes against the client's line of argument ('and then make up your mind' in line 31). The shift back to the therapist's line of argument is further crystallised through the ensuing question ('so do you think you've had s↑ome time to think about about it now?', in lines 35-36), which is pressing for a response in the context of the client having just offered one ('so I said let me think about it .hhh CAUSE whenever I think that I am not ready to do something I am always ha- have to think about it more and more', in lines 6-8), therefore treating the previous one as inadequate and implicitly deleting it. It thus transpires that this concession, instead of constituting a genuine back down, rather seems to be an attempt to establish some common ground between the two speakers prior to the therapist ultimately pursuing her own argumentative trajectory whilst dismissing the client's. This apparatus is put in motion at a point of the exchange where the therapist has already encountered resistance on the client's part, as the client's response in lines 1 to 8 testifies.

6.2 Common features in the way tactical concessions are being produced

The strategic concessions in the data bear some basic similarities in the way that are being fashioned, which in turn are indicative of the types of subtle interactional manoeuvres performed through this device. The main building blocks of the phenomenon are the following:

A) A standpoint taken by a speaker (in this data the client), through which one could lay himself/herself open to challenge, or on the contrary, which could receive someone's accord or ratification. In the data this point of view is expressed in defiance of an opposing view by the co-participant, but this feature would not in itself be necessary for the strategic concession to take place.

B) An utterance issued by the co-participant in the interaction (in this data the therapist) which is conceding the truth or adequacy of the first speaker's claim. This might be achieved through this utterance's sequential positioning in the interaction and/or through

markers which deliver it as hearably concessionary (such as '<u>actually</u>' or '<u>I just realised</u>'). A feature employed in the data to support the validity of the initial claim is the issuing of a positive assessment or valorisation of the other person's standpoint. It might be worth noting that the utterance performing the concession might at times be responsive to a claim made a lot earlier in the interaction rather than a claim located immediately before the concessionary statement.

C) An elaboration or account of the positive assessment issued by the second speaker (in the case of this data the therapist) which despite appearing as a natural or topically related continuation of the concession, marks a departure away from the initial speaker's claim and plants the seeds for a next action. This next move either weakens or directly contradicts the first speaker's initial claim; or, alternatively, attempts to diminish the first speaker's resistance to a claim previously made by the second speaker.

In order to explicate the way that each of these different components work and the actions that each performs in more depth, as well as in order to get a better grasp of the argumentative dimensions of the phenomenon, one could take a close look at the following example:

Extract 2 [S2.01:06:54]
```
1          (12.2)
2     Th:  .pt
3          (1.3)
4     Th:  so I understand tomorrow you're not going to go.
5          isn i[sit ]
6     Cl:       [mm::]
7          (0.5)
8     Th:  no
9          (0.5)
10         ((imperceptible noise))
11         (0.5)
12    Th:  .pt and actually I think I think this is a good idea
13         (0.9)
14    Th:  .hh e:::h because you need some ti- to give yourself some
15         time isn't it?
16         (0.9)
17    ( ): (.hh)
18         ((imperceptible noise))
19         (0.2)
```

```
20      Th:    and:=e::h think about it
```

Synoptically, the tactical concession in this extract runs as follows: the start of the exchange (lines 4-8) reveals the client's stance that she will not be attending a particular support group (client's standpoint). In line 12 the therapist concedes that this is a good idea (concession). Subsequently though (in lines 14-20) the therapist adds that the reason why this is a good idea is because the client needs to give herself time to think about this decision (account), which as will be explained below renders her concession strategic rather than genuine.

In more detail, this extract is situated towards the end of a session in the course of which the therapist and the client have been debating whether or not it would be problematic for the client to attend a particular group for people affected by HIV. In the course of the session the client has been claiming that it would be awkward for her to continue attending the group and the therapist has been questioning these claims. At the start of the extract the therapist issues a formulation (Antaki, et al. 2005; Antaki, 2008) through which she supposedly summarises the essence of the client's position up to that point, that she will not attend the group the day after ('so I understand tomorrow you're not going to go.', in line 4). In line 6, despite only producing a minimal response ('mm::'), the client confirms the therapist's understanding. Both the client's claims in the course of the session and her confirmation of the therapist's formulation in line 6 demonstrate the client's unwillingness to attend the group, and constitute the initial component of the strategic concession.

Prior to proceeding further to examine the subsequent parts of the phenomenon, it might be worth taking a moment to look at the client's responses at that moment in the interaction, in order to get a better grasp of participant's interests in the interactional instance in which the phenomenon occurs. As previously stated, this follows on from an argumentative exchange of which the long pauses in lines 1 (12.2 seconds) and 3 (1.3 seconds) seem to be symptomatic. Also, although the therapist's formulation[14] in line 4 'so I understand tomorrow you're not going to go.' together with the attached tag question 'isn isit' in line 5 (which seems to retrospectively transform what has been initially delivered as

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[14] The utterance in line 4 is delivered in terms of its intonation, as a complete turn. However, thereafter -as the therapist attaches the tag question (in line 5) - the definite tone is abandoned. This shift towards issuing a question rather than displaying the therapist's understanding of the client's talk, continues further with the therapist repairing the 'isn' to 'isit' which seems a move away from the certainty regarding the type of response that client will produce.

a statement into a question) project an agreeing response (Heritage and Watson, 1979) and in particular a type conforming one given the effect of the tag question (Raymond, 2003); they only receive a minimal non-conforming type of response by the client ('mm::' in line 6) without any further ratification, despite interactional opportunities for the client to do so (three pauses of 0.5 of a second each in lines 7, 9 and 11). These seem attempts on the client's part to end what in fact constitutes a relatively lengthy debate on the topic of her attending the support group. Given that the therapist has been trying for a certain amount of time to challenge the client's decision not to attend the group, were she to collaborate with the client in ending this particular sequence (lines 4-8), it could actually be synonymous to admitting defeat.

It is at this point that the therapist comes up with the turns 'and actually I think I think this is a good idea', (in line 12), which, given the therapist's previous argumentative position to encourage attendance at this group, constitutes a concession. The feature which also guides one to safely catalogue this action as a concession, is the 'actually' which works as a concessionary marker (Clift, 2001). Interestingly, this concession is being packaged in the form of a positive assessment. Initial assessments not only make relevant a second assessment but also, in many cases invite agreement as a next action (Pomerantz, 1984b). This seems to be the case in this example, given that the initial assessment is formulated in favourable terms and given that it performs an affiliative towards the client action (ratifying a decision previously taken by the client). One can imagine that such a positive initial assessment might be of particular usefulness in the context of an argumentative exchange where one's co-participant has already showed signs of attempting to bring the topic to a closure. In addition, from a systemic therapy perspective, employing appreciative language towards the client such as a positive assessment would be in harmony with psychotherapeutic imperatives to induce change by empowering one's client and by fostering positive narratives about one's self (Lang and McAdam, 1995; Madsen, 2009; McAdam and Mirza, 2009; Pearce, 2001).

However, it is also worth noting that, in terms of the way that the concession is being formulated in comparison with other competing ways of conceding a point, positively assessing a previously opposed version works differently to alternative ways such as admitting fault. It seems the therapist's chosen way of producing the concession minimises the sense that she has previously been in the wrong. Importantly, by making such an assessment the therapist maintains herself in a position of expertise to judge the quality of a

decision taken by the client (Pomerantz, 1984b). Therefore through this move the therapist still manages to display some epistemic expertise even at a point of making a concession.

Given the protracted disagreement between the therapist and the client on the issue of the client attending the support group, this shift in the therapist's position ('and actually I think I think this is a good idea', in line 12) would appear argumentatively odd had the therapist not accompanied it with an account, which is therefore projected by the sheer fact of the therapist making this concession. Moreover, the corrective ('actually') through which the therapist introduced the concession, equally projects an account given that it is used to 'counter a stance taken in a preceding turn' (Clift, 2001: 269). That an account is projected is perhaps evidenced by the fact that the client, despite the therapist's first assessment making relevant a second assessment (Pomerantz, 1984b), and despite being given the opportunity to come in in line 13 (where there is a pause of 0.9 of a second), refrains from occupying this conversational slot.

Having prepared the ground for an account, the therapist proceeds to perform a move that on a public level brings her back onto her argumentative trajectory which for a moment she appeared to have abandoned. This shift is achieved through the reasons that she offers in order to explain why she agrees with the client ('because you need some ti- to give yourself some time isn't it?' ... 'and:=e::h think about it' in lines 14-15 and 20). Despite the fact that such reasons (i.e. that someone might postpone taking some action because one needs thinking time) might at first sight appear a reasonable and thoughtful consideration on the therapist's part, for those aware of the issues at stake in that particular moment (for the participants themselves initially) they are in fact bound to be seen as bolstering the therapist's argumentative position whilst simultaneously deleting the client's version.

This is achieved in a number of ways. To begin with, the therapist's account departs from the client's position. The explanation that the client herself had previously given for not attending the group revolved around fearing to meet people that knew her relatives and worrying about breaches of confidentiality regarding her condition to her community. According to the therapist's account though ('because you need some ti- to give yourself some time isn't it?' ... 'and:=e::h think about it' in lines 14-15 and 20), the client would not attend the support group on the following day, not because of such obstacles but in order to give herself time to think about in fact going.

Moreover, there is a feature in the therapist's account which carries an element of opposition towards the client's position as this has developed so far. The client had

expressed a rather definite view that she did not think it was a good idea to attend the group any further. According to the therapist's account though, the client's lack of attendance at the group would not constitute a definite decision on the client's part[15]. Instead it appears restricted to the forthcoming session whilst the group was scheduled to keep running on a weekly basis for a number of months.

Thirdly, the therapist's account prepares the ground for a future action which is equally antagonistic to the client's position, as, in case the client agrees with the therapist's grounds that she needs to give herself time to think about the possibility of attending the support group, this would allow the therapist to re-open the issue in the future (i.e. in a next session). All things considered, it is obvious that the therapist's account not only departs from the client's position, but it also turns against it, as it would mean that, contrary to the client's deliberations up to that moment, the client's decision would not be a definitive one and could still in fact be overturned by the client herself. Pragmatically this allows the therapist to keep this particular argumentative thread hanging, ready to be taken up at a later stage, instead of allowing it to conclude. On the whole, it turns out that, through this account, the client's own argumentative position (not to attend the group) is being hijacked by the therapist, in order for the therapist to advance an opposing to the client's line of argument, proving her own previously stated concession ('and actually I think I think this is a good idea' in line 12) to be a tactical move on her part.

One could still argue at this point that despite all these features the therapist has in fact conceded that the client will not be attending the support group the day after the counselling session, so perhaps this concession is not so trivial after all. However, this back-down needs to be situated in the context in which it arises. The therapist's concession comes towards the concluding part of the session and up to that moment the client has been standing firm in her position not to attend, so it would be unrealistic for the therapist to be asking that she attends next day's group session. This battle has been lost, if not until the client effectively missed the forthcoming group session, at least in the dialogue between the therapist and the client. In these circumstances, the maximum outcome that the therapist can perhaps achieve is securing that the client would be accountable for reflecting on the possibility of attending the group at a future time (despite not attending the forthcoming group session), and creating an opportunity or the grounds to re-open the issue in the next

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[15] This deviation from the client's version has in fact first occurred when the therapist issued the formulation 'so I understand tomorrow you're not going to go.' (in line 4).

session (with chances of obtaining at that stage the client's agreement to eventually return to the group).

It thus transpires that the therapist concedes a point which in the course of previous interaction has developed into an argumentatively immaterial point. Simultaneously, the act of conceding a point allows her to appear reasonable, in a similar way to the concessions described by Antaki and Wetherell (1999) which are employed precisely to protect a speaker from appearing dogmatic. It also allows her to adhere to the systemic therapy principles of good practice that recommend following the client feedback (Campbell, 1999; Tomm, 1985) and, importantly, to create the conversational opportunities to advance her argumentative trajectory.

6.2.1   How the tactical concessions are occasioned

So far the focus has mostly been on the way that the third component of the concession, that is the account or elaboration part, blatantly shows the concession to be a tactical move on the therapist's part. Close inspection of the data though reveals an additional and perhaps more subtle feature of the talk which betrays the strategic orientation of the move, but which this time concerns the way that the concessionary part is brought about and therefore the talk immediately preceding it. In all of the instances in the data, it is largely the therapist rather than the client who opens up the opportunity for making the concession. In other words, the talk immediately preceding the concession does not show the therapist as being 'forced' into making the concession, but as actively creating the interactional opportunity for the concession to be performed. Before illustrating this point with examples from the data, it might be worth showing how a genuine concession is brought about in an extract derived from Kotthoff (1993):

Extract 3 [(from Kotthoff, 1993: 208-209)]
```
179    Tam:   if we could have yours then that might give us a
180           little help with – getting some other, it's pretty
181           important that we have faculty members who fell /like
182           us. /
183    Sch:   /Of course/ and I think there will be a lot of
184           faculty who will be willing to sign, – – but today
```

```
185            it's just a little, it's quite vague. Your pet the
186            statement of your petition is quite vague. I think,
187     Tam:   Yeah actually you know, I thought that too, but uhm
188            we're thinking of rewriting it if if if, what do you
189            see here that is vague, that we should rewrite.
```

This exchange occurs in the context of a dispute between a professor ('Sch') and a student ('Tam') on the issue of a petition put forward by the students. As the start of the extract shows, Tam insists on getting the professor to sign the petition (in lines 179-182), whilst the professor refuses to do so on the grounds of the petition's form ('...it's quite vague. ...', in lines 183-186). Tam's subsequent 'Yeah actually you know, I thought that too' (in line 187) despite claiming prior and independent access (Raymond and Heritage, 2006) to the negative assessment concerning the quality of the petition ('...it's quite vague. ...', in lines 183-186) concedes the validity of the point raised by the professor. The extract concludes with Tam seeking advice on how to improve the petition's form ('what do you see here that is vague, that we should rewrite.', in lines 188-189), which ultimately consolidates the fact that for the time being she drops her demand that the professor signs the petition. One can observe that in this extract the student's concession (in line 187) seems to immediately follow from the professor's criticism 'Your pet the statement of your petition is quite vague.' (in lines 185-186). The location of the concession in the interaction, that is the fact that it is positioned immediately after the professor's display of opposition, creates the sense that the student was in fact forced to admit the validity of the professor's point, in view of the argument put forward by the professor.

In contrast to that, the concessionary part of the tactical concessions in the data appears to immediately follow either from claims made by the therapist -and in particular from the therapist's display of a stance on a particular matter-, or alternatively, from a sequence initiated by the therapist which brings about the opportunity for the client to re-affirm a stance that she has previously displayed and regarding which the therapist then proceeds to make a concession. To take these ideas more gradually, below I cite an example of the first case scenario:

Extract 4 [S3.00:23:50]
```
1       Th:    .hh so:: (0.3) this person most probably wouldn't (0.3)
2              wouldn't go out to tell everybody else as (0.4) this person
3              wouldn't like ↑you to go out and tell everybody else.
```

```
4              (0.5)
5      Cl:    ˚yeah˚
6              (1.6)
7      Th:    .hhh an an now (0.2) I just realised something, you know
8              because:: e:::h (0.3) you said that this person knows Sophie
9              and knows Mike (0.3) auntie Mike yeah? .pt .hhh
10             (.)
11     Th:    and:: e:::m (0.3) .hhh (0.9) I think you did very well not to
12             tell (.) Sophie and Mi- uncle Mike that you met this person
13             becaus::e, m↑aybe you would be disclosing their status
```

In lines 7-10 of this extract one can observe the therapist backing down from previous claims that she had made in support of a particular course of action, namely that the client could reveal to her relatives (Sophie and Mike) that she had met an acquaintance of theirs whilst attending a support group for people living with HIV. This time the therapist renounces her previous position and praises the client for having kept secret from her relatives that she met this person, on the grounds that this would protect this person's confidentiality ('I think you did very well not to tell (.) Sophie and Mi- uncle Mike that you met this person becaus::e, m↑aybe you would be disclosing their status', in lines 11-13). Interestingly, not only the therapist's concession is sequentially dissociated from the client's prior argument (that she wished to keep this encounter secret from her relatives), but also it is sequentially positioned immediately after some claims made by the therapist on an entirely different matter, namely that the client should not worry about potential breaches of confidentiality from this third person. The sequential positioning of the concession does not portray the therapist as having been compelled to back down, for example after having heard the evidence of the client's countercase. Indeed, as will be argued in more detail later (in section 6.3), the concession in this context appears to work as evidence for the therapist's claims immediately preceding the concession (in lines 1-3), in the face of a weak uptake by the client (in lines 4-6).

In the two other cases in the data, the therapist's concessions follow from conversational devices initiated by the therapist and which are designed in such a way so as to invite the client to affirm the particular point which the therapist then proceeds to concede. One of them is the following extract, part of which has been presented in extract 3 above. In this instance the therapist's concession follows from a formulation (Antaki et al., 2005) and the client's response to it:

Extract 5 [S2.01:06:34]

```
1      Cl:  yea::h cause on that day I was really (no) (2)
2           it's (0.2) you know it was just a shock to me (0.2)
3      Th:  mm:[::]
4      Cl:     [ye]ah
5           (0.4)
6      Th:  mhm
7           (0.4)
8           ((noise in or out the room))
9           (1.1)
10     Th:  .pt=.hhhh h=mm:::
11          (1.2)
12     Th:  .pt=okay
13          (3.7)
14     Th:  e::m:
15          (12.2)
16     Th:  .pt
17          (1.3)
18     Th:  so I understand tomorrow you're not going to go.
19          isn i[sit ]
20     Cl:       [mm::]
21          (0.5)
22     Th:  no
23          (0.5)
24          ((imperceptible noise))
25          (0.5)
26     Th:  .pt and actually I think I think this is a good idea
```

The start of this extract constitutes the end of a sequence on the client's expectations from the therapist on a particular occasion (in lines 1-4). The therapist's formulation in line 18 ('so I understand tomorrow you're not going to go.') is not topically linked with this previous sequence in a straightforward manner; instead, it rather appears to summarise the essence of the client's talk throughout the session, driving the session to its close. It would be plausible to assume that this formulation is only one out of many other possible directions that the therapist's talk could take at that point, particularly given that it is somehow disjointed from the immediately preceding talk, and given that it supposedly

encapsulates a distillation of the talk produced throughout the session where a whole array of issues have been discussed.

In addition, whereas the talk throughout the session largely revolved around an undesirable encounter that the client experienced in the course of attending a group for people living with HIV, the therapist through her formulation chooses to focus on the client's decision to discontinue her attendance at this group in view of this traumatic event. In particular, as previously mentioned, rather than acknowledging the permanence of the client's decision, the therapist's formulation only acknowledges the client's wish not to attend the forthcoming group session, whereas the group would keep meeting on a regular basis. In that respect, the formulation greatly transforms the client's version regarding the particular matter it supposedly summarises, in a similar way to that reported in the literature on formulations (Davis, 1986; Antaki et al., 2005).

Moreover, the therapist's move is designed to attract the client's agreement. This is achieved firstly through the formulation given that this is what formulations routinely do (Heritage and Watson, 1979), and secondly through the retrospectively attached tag question ('isn i[sit]', in line 19). The client's response to this formulation, despite displaying the client's agreement, is a non-conforming one (Raymond, 2003) ('[mm::]', in line 20). Interestingly, faced with such a non-conforming response, the therapist proceeds to issue herself the type conforming version of the client's agreeing response ('no', in line 22), thus recording a more definite response than the one given by the client. It is at that point that the therapist proceeds to issue the concession ('.pt and actually I think I think this is a good idea', in line 26).

What we've seen so far is that the therapist guides the talk towards a particular topic which she formulates in such a way that it transforms the client's talk in ways that facilitate the therapist's trajectory. The client's weak response is not left as such but is being reissued more strongly by the therapist, despite the therapist having previously disagreed with the client's position on the matter. This small interactional exchange (the therapist's formulation and the client's response to it) then forms the basis upon which the therapist proceeds to make a concession, which (perhaps unsurprisingly after all) proves to be a strategic one. What all of these above points demonstrate is that the therapist is doing some interactional work before the actual concession, and it is this work which in fact creates the opportunity for the therapist to issue the particular concession in line 26. Once more, this departs from the normative concept of a concession as a forced admission of defeat which Kotthoff (1993: 209) articulates in the following way: 'In the case of an already established

controversy, concessions seem to be the dispreferred acts, because they threaten the need for a positive image in the sense of Goffman 1967 and Brown & Levinson 1987.'.

A similar case is that of extract 1 above, the relevant part of which is reproduced in extract 6 below:

Extract 6 [S3.00:25:46]

```
1    Cl:  so I said let me think about it .hhh CAUSE whenever I think
2         that I am not ready to do something I am always ha- have to
3         think about it more and more
4         (.)
5    Th:  ↑m↓m[:::
6    Cl:      [*yeah
7         (0.3)
8    Th:  mhm
9         (0.7)
10   Th:  do you think that's a good good thing to do?
11        (0.3)
12   Cl:  y↑e↓ah
13        (0.3)
14   Th:  mm:::
15        (0.6)
16   Th:  yes
17        (.)
18   Cl:  hhe:h
19   Th:  I think it's a very good quality
20        (0.2)
21   Cl:  °mm°
22   Th:  to: to have to: when you are not sure about something (.) just
23        to:: think about it?
24   Cl:  yeah
25        (0.2)
26   Th:  and then make up your mind
```


In this extract, although the standpoint supported by the client which constitutes the first part of the tactical concession is not explicitly re-introduced by the therapist as it was the case in the previous instance (extract 6), what is nevertheless notable is that, similarly to the previous example, the therapist very actively advances the particular version regarding which she then issues a concession. This is largely achieved through the question ('do you

think that's a g<u>oo</u>d good thing to do?', in line 10) with which the therapist meets the client's account ('whenever I think that I am not ready to do something I am always ha- have to think ab<u>ou</u>t it m<u>o</u>re and m<u>o</u>re', in lines 1-3), and the type of response that this projects.

In particular, one can observe that the therapist's question is designed in such a way so as to bring forth a positive evaluation (given that it is a yes/no interrogative projecting a 'yes' (Raymond, 2003)) of what the client previously portrayed as a scripted generalised pattern of her behaviour (Edwards, 1994; Edwards 1997). Through this move, the therapist does not simply prepare the ground for a mere acceptance of the client's patterned behaviour, but in fact for it to be described in positive terms. This becomes more obvious when one considers alternative moves on the therapist's part, still of concessionary nature, which nevertheless would not have portrayed the client's patterned behaviour in favourable terms (such as 'I can understand that'). Linked to that, through this question, which is designed in a way so as to project agreement, the therapist invites the client to affirm a stronger position than the one she previously put forward. It thus appears that through her question in line 10 and the response that this projects and ultimately through the transformation that this question incurs upon the client's version, the therapist performs some work prior to issuing her concession which ends up strengthening the forcefulness of the point that the therapist then proceeds to concede.

What I have argued so far is that careful examination of the talk immediately preceding the concessions in the data (and therefore of where these are situated in the interaction) reveals them to be strategic moves on the therapist's part, just as the account or elaboration part of the device does. The concessions might be situated after the therapist's own talk, or in any case, the therapist appears to take on a very active role in bringing forth or even strengthening the very version which she then proceeds to concede. This gives the impression that the concession has not really been devised in light of the case that the client put forward but that it rather serves different interactional purposes.

This is revealing of the importance of the sequential placement of a turn for it to be hearable as a concession. As Kotthoff (1993: 211) argues 'The local placement of a concession is essential for its being interpreted as one'. Although the tactical concessions in the data all follow on from the first speaker's (in the case of this data the client's) viewpoint like genuine concessions do as well, it nevertheless also appears that they are simultaneously somehow distanced from it and that there is other material that comes in between, which is to a smaller or larger extent initiated or produced by the author of the

concession and which does not present his/her back-down as instantaneously responsive to the case put forward by the first speaker.

6.3 The argumentative force of tactical concessions

It transpires from the analysis of the above instance that this conversational device performs a number of moves which can be particularly advantageous in the course of an argumentative exchange. To begin with, the way that the conceded point is formulated, that is, as positively assessing some formerly opposed state of affairs, portrays the therapist as owning epistemic expertise even at a time of making a concession, given that she displays herself as possessing knowledge and epistemic rights to produce such an assessment (Heritage and Raymond, 2005; Pomerantz, 1984b). In addition, this kind of formulation of the concession downplays the sense that there have previously been inaccuracies in the therapist's judgement, as it emphasises the client's qualities or achievements rather than stressing any fault on the therapist's part. This is perhaps indicative of a more general orientation towards admitting fault as a course of action that is not favoured by the speakers, as it also has been reported to be the case with regards to responses to some forms of complaints where as Dersley and Wootton (2000) point out, offering grounds which deny one being at fault is the most frequent type of response. In this data, the therapist displaying herself as being in the wrong in the course of making a strategic concession, occurs only once, and that is in the following example:

Extract 7 [S3.00:24:03]
```
1      Th:  .hhh an an now (0.2) I just realised something, you know
2           because:: e:::h (0.3) you said that this person knows Sophie
3           and knows Mike (0.3) auntie Mike yeah? .pt .hhh
4           (.)
5      Th:  and:: e:::m (0.3) .hhh (0.9) I think you did very well not to
6           tell (.) Sophie and Mi- uncle Mike that you met this person
7           becaus::e, m↑aybe you would be disclosing their status
8           (0.4)
9      Cl:  °yeah°
10     Th:  yeah?
11          (0.7)
```

```
12    Th:  had you thought that if you were to tell Sophie and uncle
13         Mike about (0.8) meeting (.) [this  ] guy,
14    Cl:                               [˚yeah˚]
15         (0.6)
16    Th:  you would be disclosing his status
17    Cl:  ˚mhm˚
18         (1)
19    Th:  mhm see I I hadn't (.) I hadn't really realised it when we
20         were .hhh thinking about: e:::m talking to Sophie and Mike
21         (0.6) about (1) potentially meeting somebody they know
22         [.hh
```

In lines 19-22 of the above instance the therapist admits a personal misjudgement ('... I hadn't really realised it ...'), relating to failing to make a particular realisation in the course of an exchange with the client during which the therapist had been promoting a particular course of action (that the client divulges to her family having met someone known to them whilst attending a group for people living with HIV). As the therapist claims in this extract, this course of action could have had adverse consequences on this third person's life as it would have potentially entailed disclosing this person's status. However, as can be seen in the extract, the concession in lines 19-22 ('I hadn't really realised it when we were .hhh thinking about: e:::m talking to Sophie and Mike (0.6) about (1) potentially meeting somebody they know') is in fact only a recycling of the one initially issued (in lines 1-7) which was in fact formulated as a positive assessment of a course of action taken by the client ('... I just realised something, ... I think you did very well not to tell ...'). What seems to have occurred between the two formulations of the conceded point, is that the client has hardly provided any displays of agreement with the therapist (there is only the imperceptible token of agreement ˚yeah˚ in line 9 and the continuer ˚mhm˚ in line 17) and has also missed a number of opportunities to fill in the available conversational slots as the pauses of 0.7 of a second; 0.6 of a second and of 1 second show (in lines 11, 15 and 18 respectively). It therefore appears that in this case the second formulation of the conceded point (in lines 19-22) works as an upgrade of the initial concession, adding (further[16]) to its weight and credibility by displaying that that the therapist is prepared to go against her personal interests by admitting inaccuracy in her judgement, in the face of the

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[16] In fact, as will be argued later, the initial concession (in lines 5-7) works precisely in the same way, therefore the recycling of the initial concession (in lines 19-21) simply intensifies this effect.

client's lack of uptake subsequent to the concession (that participants engage in careful management of issues of stake has been proposed by Edwards and Potter (1992)).

Another point of interest regarding the argumentative benefits of producing such concessions is that, not only the conceded point is minimised through the way that it is formulated, but in any case, by conceding the particular points that she does concede, the therapist loses nothing that might be of any substance with regards to larger issues which are at stake in her argument with the client[17]. The reason for that is that although the therapist makes concessions regarding issues that have previously been the subject of dispute, the conceded points have in fact proved in the course of the interaction to constitute a lost cause for her, as either the client has already displayed a firm opposition on the matter, or the allowance made by the therapist concerns a past event. The argumentative insignificance of the concession becomes even more apparent in subsequent to the strategic concessions interaction, where the therapist proceeds to issue questions that re-launch the same or other closely related issues. An example of that can be seen in the continuation of extract 7 above as this is illustrated in lines 24-28 of extract 8 below:

Extract 8 [S3.00:24:03]

```
1      Th:   .hhh an an now (0.2) I just realised something, you know
2            because:: e:::h (0.3) you said that this person knows Sophie
3            and knows Mike (0.3) auntie Mike yeah? .pt .hhh
4            (.)
5      Th:   and:: e:::m (0.3) .hhh (0.9) I think you did very well not to
6            tell (.) Sophie and Mi- uncle Mike that you met this person
7            becaus::e, m↑aybe you would be disclosing their status
8            (0.4)
9      Cl:   °yeah°
10     Th:   yeah?
11           (0.7)
12     Th:   had you thought that if you were to tell Sophie and uncle
13           Mike about (0.8) meeting (.) [this  ] guy,
14     Cl:                                [°yeah°]
15           (0.6)
16     Th:   you would be disclosing his status
17     Cl:   °mhm°
18           (1)
```

---

[17] This observation pertains to the initial part of the concession, which is located before the stage of the elaboration or account.

```
19    Th:   mhm see I I hadn't (.) I hadn't really realised it when we
20          were .hhh thinking about: e:::m talking to Sophie and Mike
21          (0.6) about (1) potentially meeting somebody they know
22          [.hh
23    Cl:   [mm
24    Th:   I hadn't really thought that you would (.) tell (0.4) th- them
25          look I met so and so, but .hh you could have a general
26          discussion and say .hh look Sophie when (0.2) when I go to
27          this: m- groups m↑aybe, I will meet (0.5) somebody that you
28          know (.) how will that be for you?
```

In the above extract it appears that after having made the strategic concession (that the client was in the right to disregard the therapist's prior encouragement to reveal to her relatives that she bumped into one of their acquaintances whilst attending an HIV support group (situated in lines 1-7 of extract 3)), the therapist goes on to issue a close approximation of the initial proposition which she had made before the concession in her prior interaction with the client. The newly formulated suggestion though is being produced in ways which address the points that the therapist has just identified as the weaknesses of the initially produced advice-relevant material; more specifically it addresses the issue that such a disclosure by the client to her relatives would jeopardise that person's confidentiality ('...you could have a general discussion and say .hh look Sophie when (0.2) when I go to this: m- groups m↑aybe, I will meet (0.5) somebody that you know ...', in lines 26-30). Therefore, the talk after the concession, demonstrates even further its weightlessness in terms of the broader issues at stake in the interaction.

Aside from the weight of the concession though, the most central of the moves performed through this conversational device, is the one carried out with the elaboration or account attached to the concession, through which the therapist attributes reasons or characteristics to the positive assessment she has just produced, which are in fact different to the client's take or reasons for having taken a particular action. Not only are these qualities or reasons different to the client's, but in fact they further the therapist's argumentative aims whilst simultaneously undermining the client's. It thus appears that this part of the device permits the therapist to carry out a significant oppositional manoeuvre.

Examination of the instances of the tactical concessions in the data reveals that the elaboration or account might vary in terms of the strategic purpose it might serve. To begin with, it could minimise the extent of the concession as is the case in extract 2 above, where,

although the concessionary part of the device signals the therapist's partial acceptance of the client's decision (to miss the support group's forthcoming session), the account part opens the way for a future reversal of the client's overall resolution (namely to discontinue her attendance at the support group for the whole of its duration).

Secondly, the elaboration or account part might open the way for a full renunciation of the conceded material as is the case in the following extract (some initial analytic comments of which have already been provided in extract 1):

Extract 9 [S3.00:25:46]

```
1    Cl:  so I said let me think about it .hhh CAUSE whenever I think
2         that I am not ready to do something I am always ha- have to
3         think about it more and more

     ((15 lines omitted))

19   Th:  I think it's a very good quality
20        (0.2)
21   Cl:  °mm°
22   Th:  to: to have to: when you are not sure about something (.) just
23        to:: think about it?
24   Cl:  yeah
25        (0.2)
26   Th:  and then make up your mind
```

Whereas at the start of the extract the client had produced an account backing up her resistance to a particular course of action (namely 'whenever I think that I am not ready to do something I am always ha- to think about it more and more', in lines 1-3), in the course of delivering her concession that such a scripted behaviour on the client's part is 'a very good quality', the therapist's progressively transforms the client's version. This is achieved through the elaboration part of the device (in lines 22-23). So the 'it' which the therapist initially employs to refer to the client's version (in line 19) is thereafter expanded to 'when you are not sure about something (.) just to:: think about it?' (in lines 22-23). At this stage there is already some important transformation occurring to the client's version given that the therapist drops the 'more and more' that the client had uttered (in line 3) and instead inserts the 'just' ('just to:: think about it?', in lines 22-23) which contrary to the client's version minimises the act of thinking. This progressive transformation culminates in the

complete reversal of the client's version through the increment 'and then make up your mind' (in line 26). This ties this utterance to the therapist's previous one supposedly clarifying it but simultaneously modifying it too, in what Lerner (2004: 155) calls 'an unmarked fashion' given that it simply presents the therapist's new utterance to be part of her previous turn-constructional unit. By doing so it shows that the quality that the therapist eventually evaluates in a positive way is actually the client reaching a decision rather than simply taking her time to think things through.

Thirdly, in the following extract, the third part of the tactical concession, which is located in line 13 of the extract below, reveals that the tactical concession serves a yet different strategic purpose, namely to boost a claim previously made by the therapist:

Extract 10 [S3.00:23:50]

```
1     Th:   .hh so:: (0.3) this person most probably wouldn't (0.3)
2           wouldn't go out to tell everybody else as (0.4) this person
3           wouldn't like ↑you to go out and tell everybody else.
4           (0.5)
5     Cl:   °yeah°
6           (1.6)
7     Th:   .hhh an an now (0.2) I just realised something, you know
8           because:: e:::h (0.3) you said that this person knows Sophie
9           and knows Mike (0.3) auntie Mike yeah? .pt .hhh
10          (.)
11    Th:   and:: e:::m (0.3) .hhh (0.9) I think you did very well not to
12          tell (.) Sophie and Mi- uncle Mike that you met this person
13          becaus::e, m↑aybe you would be disclosing their status
```

The concessionary part of the tactical concession lies in lines 11-12 ('I think you did very well not to tell (.) Sophie and Mi- uncle Mike that you met this person'), where the therapist backs down from a standpoint which she favoured in a previous exchange. Prior to that (in lines 1-3), the therapist has been building a complex argument that the client need not fear that an acquaintance of hers would reveal having met her in a support group for people living with HIV ('this person most probably wouldn't (0.3) wouldn't go out to tell everybody else', in lines 1-2). To back her claim the therapist used as evidence the client's own experience, appealing to the principle of 'being in the same boat', and thus exposing the client's and this third person's mutual stake (Edwards and Potter, 1992) in the matter ('as (0.4) this person wouldn't like ↑you to go out and tell everybody else, in lines 1-2).

The client's minimal response and the lengthy pauses work as displays that the client was not particularly in agreement with the therapist's claims in lines 1-3. Such an environment seems particularly suitable for a claim-backing to occur. Indeed the therapist proceeds to perform a fairly elaborate move to evidence her claim: she performs a concession through which she backs down from a position that she supported fairly vigorously in a previous session. Given that concessions are associated with losing face (Kotthoff, 1993), the therapist's concession seems to work as a public display that she is prepared to go to go to great lengths to vouch for her prior claims' authenticity (those located in lines 1-3). In this way this particular concession is recruited in the therapist's argumentative strategies for persuading the client for the seriousness and depth of her conviction concerning the stance she displayed in lines 1-3.

These accounts' or elaborations' argumentative force is greatly strengthened through the sheer fact of being sequentially placed subsequently to a positive assessment addressed to the client. This positive assessment of the client's actions or deliberations makes it particularly difficult for the client to oppose the therapist's subsequent elaborations or grounds for the assessment, despite the fact that these weaken or delete her own argumentative position. It therefore seems that this assessment disarms the opposition that could have else been expected from the client following a misrepresentation of her actions. This can be contrasted with other moves on the therapist's part; for example one could imagine that had the therapist articulated erroneous grounds for the client's actions in the course of producing an understanding check or even a formulation as defined by Heritage and Watson (1979) of the client's prior utterances, such a twist could have been a lot more exposed to disconfirmation by the client. This kind of alternative is being reported by Antaki et al. (2004) in their analysis of psychotherapy data, but can also be considered in the following extract:

Extract 11 [S1.00:04:12]

```
1      Th:  so you want to have one as well.
2           (0.2)
3      Cl:  N↑O N↑O=when I was looking at her I was like o:::HHHUH .HH
4           but  but you know that's non (0.5) something >I (want)<=when
5           you look at something it's like oh I also want one=
```

In line 1 of the above extract the therapist formulates her understanding of the client's previous talk (the latter has been omitted due to its lengthiness) 'so you want to have one as

well.'. By formulating a prior speaker's talk a recipient effectively deletes parts of it, selects some others and transforms it into something new (Antaki, 2008). Therefore a formulation involves an element of misrepresentation of the first speaker's version, in a similar way that the third part of the tactical concessions in this corpus also do. In the above example, one can see that the therapist's formulation, despite the fact that it projects the recipient's agreement as formulations canonically do (Heritage and Watson, 1979), is being strongly resisted by the client, as the repetition of the emphatically delivered disagreement tokens ('N↑O N↑O' in line 3) and the explicit disconfirmation ('that's non (0.5) something >I (want)'in line 4), demonstrate. This contrast between the way in which the client resists a misrepresentation of her version subsequent to a formulation issued by the therapist, renders her lack of resistance following the third part of a tactical concession which incurs a more obvious misrepresentation to her version, a lot more noticeable. Also, it demonstrates the disarming effect on the client's response of the account or elaboration part (which incurs the misrepresentation) being sequentially placed subsequently to a positive assessment.

To get a better grasp of what such strategic concessions in the data are being employed to do, one needs to understand them in relation to the talk surrounding them. As already mentioned in the analysis of the first and second extract, they come up at points in the data where the therapist and the client have already been engaged in an argumentative exchange for a period of time. In particular, in terms of the immediately preceding talk, the therapist makes these concessions at a point where she has failed to attract the client's agreement to particular claims. The client's lack of agreement is manifested primarily through justifications for not taking a particular course of action or long silences at transition relevance places (Schegloff, 2007). It appears that, at such moments, if the therapist had collaborated with the client in ending the topic, she would not have achieved the institutional goals that impelled her to engage herself in argumentation with the client in the first place. And it seems that by employing this conversational device, rather than dropping her case which could have been a possible alternative move at that stage, the therapist manages to prolong talk on particular topics and together with it her chances of securing the client's agreement; or even to boost her prior claims as already mentioned in the analysis of extract 10.

This brings us to the talk that follows the concessions; it emerges that the device not only works strategically in relation to the talk preceding it, but also in terms of the talk that

is yet to come, as it precedes prompts which instigate the client to take particular courses of action and which the client has so far been resisting. An example can be viewed below:

Extract 12 [S3.00:25:46]

```
1    Cl:  so I said let me think about it .hhh CAUSE whenever I think
2         that I am not ready to do something I am always ha- have to
3         think about it more and more

     ((15 lines omitted))

19   Th:  I think it's a very good quality
20        (0.2)
21   Cl:  °mm°
22   Th:  to: to have to: when you are not sure about something (.) just
23        to:: think about it?
24   Cl:  yeah
25        (0.2)
26   Th:  and then make up your mind
27        (0.4)
28   Th:  mhm
29        (0.3)
30   Th:  .hhh so do you think you've had s↑ome time to think about about
31        it now?
```

Lines 30-31 of the above extract is a recycling of a suggestion offered moments before the start of the extract, and which the client rejected in lines 1-3. This first pair part, which reiterates the therapist's solicitation of a response to her suggestion given that it deletes the client's prior response to the initial one, is situated right at the end of the tactical concession (located in lines 19-26). Such a move could not have been delivered immediately after line 3, but has only been made possible through the talk produced in-between.

What this feature points to, is that these strategic concessions could at times work in a way so as to present the client as being -at least temporarily- in line with the therapist, creating a context of (pseudo) agreement and consonance just before issuing a prompt or suggestion which the therapist has grounds from her interaction with the client to expect that will be opposed or rejected. On the whole, they seem to construct a conversational opportunity for the person employing them to issue such a prompt or suggestion. This is

accomplished through the account or elaboration part of the device, which greatly conceals the client's version regarding the matters under discussion whilst simultaneously putting in place the pre-conditions for passing to this prompt or suggestion.

6.4   Tactical concessions as displays of epistemic authority

The normative characterisation of a concession as a back-down would suggest that conceding a point would, to a smaller or larger extent, be associated with epistemic subordination on behalf of the person making the concession. However, this does not seem to be the case with the tactical concessions appearing in the data, as in fact, careful examination of the talk reveals that to a large extent this practice displays the therapist's epistemic expertise whilst at times it also assists the construction of epistemic asymmetry between the therapist and the client.

To begin with, as previously stated, part of the concession is delivered in the form of a positive assessment. According to Pomerantz (1984b: 57) 'with an assessment, a speaker claims knowledge of that which he or she is assessing'. Interestingly, in the case of the assessments in the heart of these concessions, the therapist's expertise might be displayed in relation to a domain which could very much be considered as the client's personal territory of knowledge, but which is also particular to the therapeutic profession, namely one's psychological make-up or state of being as this is constructed through talk. This is the case in extract 1 above, the relevant part of which is reproduced in extract 13 below:

Extract 13 [S3.00:26:02]
```
1    Th:  I think it's a very good quality
2         (0.2)
3    Cl:  °mm°
4    Th:  to: to have to: when you are not sure about something (.) just
5         to:: think about it?
6    Cl:  yeah
7         (0.2)
8    Th:  and then make up your mind
```

Here the therapist, through her assessment in line 1, which comprises the second part of the tactical concession, claims expertise about a psychological attribute which she ascribes to the client, thus displaying upgraded epistemic authority on the matter both as a member of a particular culture but also as a member of her professional community.

There is also evidence arising from the unfolding interaction that the therapist portrays herself as having thought about the conceded point independently or at least quasi-independently of the client's prior input, thus claiming primary epistemic rights. The first set of evidence arises from the sequential position of the concessions in the interaction (as already seen in section 6.2.1 analysing the talk preceding the concessions). As previously argued, the intervening talk between on one hand the client's display of a particular stance as well -as the evidence that the latter provides in support of her stance-, and the therapist's concession on the other, minimises the significance of the client's input for the therapist making the concession. The therapist in this case appears to be driven less by the forcefulness of the client's argument and more by her own independent judgement.

The second set of evidence arises from particular markers that the therapist employs in her talk. In particular, there are occasions in the data where the positive assessment of the tactical concession is being accompanied by displays of the therapist's change of mental state, namely 'I just realised' as well as 'and actually', in which case the third part of the tactical concession is brought about with an account rather than a simple elaboration. These instances can be viewed in the following two extracts:

Extract 14 [S3.00:23:50]

```
1     Th:    .hh so:: (0.3) this person most probably wouldn't (0.3)
2            wouldn't go out to tell everybody else as (0.4) this person
3            wouldn't like ↑you to go out and tell everybody else.
4            (0.5)
5     Cl:    °yeah°
6            (1.6)
7     Th:    .hhh an an now (0.2) I just realised something, you know
8            because:: e:::h (0.3) you said that this person knows Sophie
9            and knows Mike (0.3) auntie Mike yeah? .pt .hhh
10           (.)
11    Th:    and:: e:::m (0.3) .hhh (0.9) I think you did very well not to
12           tell (.) Sophie and Mi- uncle Mike that you met this person
13           becaus::e, m↑aybe you would be disclosing their status
```

Extract 15 [S2.01:07:08]

```
1     Th:   so I understand tomorrow you're not going to go.
2           isn i[sit ]
3     Cl:        [mm::]
4           (0.5)
5     Th:   no
6           (0.5)
7           ((imperceptible noise))
8           (0.5)
9     Th:   .pt and actually I think I think this is a good idea
```

Both these markers index the therapist's change of state (as this has been described by Heritage (1984b) with regards to the particle 'oh'), despite being at variance with regards to when they describe this change of state to have occurred: whereas 'I just realised' portrays the change of state as occurring almost concurrently to the time that the therapist is uttering these same words, 'and actually' on the other hand portrays the therapist to have already arrived at this conclusion some time ago (Clift, 2001)[18]. Irrespectively of this difference regarding the time that the change of state in the therapist's knowledge is reported to occur, they both portray the therapist to have reached this new state of knowledge independently of the client.

In particular, the 'I just realised in extract 14, presents the therapist's talk from lines 7 to 13 as a news report, with the therapist being the source of the insight; in fact the therapist is initially enigmatic regarding the nature of her 'realisation' by employing the vague formulation 'something' to describe what she realised which she only unpacks as she goes on. The client is not credited with any contribution to the therapist's change of state in extract 15 either. The therapist's new state of knowledge is presented as having occurred some time ago (Clift, 2001) (also see note 5), irrespective of the therapist-client exchange at that moment in time. The fact that the client's contributions when discussing the client's decision not to attend the support group (in lines 1-8) are kept to a minimal ('mm::' in line 3) attests this in an even more powerful way. Once more in both these instances through the

---

[18] According to Clift's (2001: 269) analysis of 'actually', when this lexical item is located in turn-initial position in the context of informings, it might work both as a display that the speaker revises a prior turn and also that the 'thought has just occurred to the speaker'. However, when it is employed after a TCU-initial conjunction as is the case in line 9 of the above extract ('.pt and actually'), 'although the *actually*-marked TCU is similarly used to counter a stance taken in a preceding turn, there is no claim made by *actually* that the thought has just occurred to the speaker. To the contrary, the conjunction prefacing *actually* characterizes the assertion being made as a conclusion arrived at some time before' (ibid.).

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particular markers of change of state that she employs, the therapist makes a claim regarding accessing the new state of knowledge independently of the client's contributions, thus asserting her epistemic priority on the issue of the conceded points.

Linked to the above, when the therapist offers grounds in support of the conceded point, these are new in relation to the client's previous grounds in support of her stance. An instance of the therapist offering new grounds has already been presented in the detailed presentation of extract 2 above; an additional one can be seen in extract 16 below:

Extract 16 [S3.00:24:03]
```
1      Th:  .hhh an an now (0.2) I just realised something, you know
2            because:: e:::h (0.3) you said that this person knows Sophie
3            and knows Mike (0.3) auntie Mike yeah? .pt .hhh
4            (.)
5      Th:  and:: e:::m (0.3) .hhh (0.9) I think you did very well not to
6            tell (.) Sophie and Mi- uncle Mike that you met this person
7            becaus::e, m↑aybe you would be disclosing their status
```

This exchange occurs following a session where the therapist had attempted to explore the possibility of the client revealing to Sophie and her uncle Mike that she met an acquaintance of theirs in a group for people living with HIV. During this same session the client had resisted this idea, offering a number of reasons which ranged from Sophie having previously been reluctant to allow her to attend such groups due to the stigma surrounding HIV and the possibility of others finding out that the client suffers from this condition, to, on the other hand not wanting to worry her uncle Mike who was so far unaware his niece was suffering from HIV. As can be witnessed in this example though the therapist's grounds for conceding the validity of the client's decision is evidenced on grounds not mentioned so far by the client, namely the need to protect this third person's confidentiality vis-à-vis the client's relatives.

Offering a novel account for why she concedes the appropriateness of the client's preferred course of action is an epistemically authoritative move on the therapist's part. The subtle paradox in this case is that whereas the client has first-hand knowledge of the particular issues revolving around the courses of action that she favours or rejects, the therapist's stretches of talk construct the therapist as on an equal or even a better position than the client from an epistemic point of view to comment on their validity or

appropriateness. This is consonant with Drew's (1991) observations regarding asymmetry as a practice that is constructed interactionally in talk, rather than as a given quality.

Further details of the talk throughout the extracts portray the therapist's talk as epistemically authoritative. In extract 17 below, the therapist's concession which legitimizes the client's behaviour is formulated in axiomatic terms 'it's a very good quality to: to have to: when you are not sure about something (.) just to:: think about it?' (in lines 19-23).

Extract 17 [S3.00:25:46]

```
1    Cl:   so I said let me think about it .hhh CAUSE whenever I think
2          that I am not ready to do something I am always ha- have to
3          think about it more and more
4          (.)
5    Th:   ↑m↓m[:::
6    Cl:       [*yeah
7          (0.3)
8    Th:   mhm
9          (0.7)
10   Th:   do you think that's a good good thing to do?
11         (0.3)
12   Cl:   y↑e↓ah
13         (0.3)
14   Th:   mm:::
15         (0.6)
16   Th:   yes
17         (.)
18   Cl:   hhe:h
19   Th:   I think it's a very good quality
20         (0.2)
21   Cl:   °mm°
22   Th:   to: to have to: when you are not sure about something (.) just
23         to:: think about it?
24   Cl:   yeah
25         (0.2)
26   Th:   and then make up your mind
```

Axioms are epistemically authoritative moves and in that respect it seems rather remarkable that the therapist would actually formulate in axiomatic terms a point which

signals a back-down on her part. It is also worth noting that what the therapist formulates as an all-applying principle (''it's a very good quality to: to have to: when you are not sure about something (.) just to:: think about it?', in lines 19-23) the client has previously merely presented as a scripted event (Edwards, 1994; Edwards 1997); it thus appears that the therapist upgrades the client's version which equally constitutes an epistemically authoritative manoeuvre on her part.

In extract 18 below what is particularly striking is the construction of epistemic asymmetry between the therapist and the client through the question 'had you thought that if you were to tell Sophie and uncle Mike about (0.8) meeting (.) [this] guy, ... you would be disclosing his status'(in lines 8-12).

Extract 18 [S3.00:24:14]

```
1      Th:   and:: e:::m (0.3) .hhh (0.9) I think you did very well not to
2            tell (.) Sophie and Mi- uncle Mike that you met this person
3            becaus::e, m↑aybe you would be disclosing their status
4            (0.4)
5      Cl:   ˚yeah˚
6      Th:   yeah?
7            (0.7)
8      Th:   had you thought that if you were to tell Sophie and uncle
9            Mike about (0.8) meeting (.) [this  ] guy,
10     Cl:                                [˚yeah˚]
11           (0.6)
12     Th:   you would be disclosing his status
13     Cl:   ˚mhm˚
14           (1)
15     Th:   mhm see I I hadn't (.) I hadn't really realised it when we
16           were .hhh thinking about: e:::m talking to Sophie and Mike
17           (0.6) about (1) potentially meeting somebody they know
```


Prior to issuing this question the therapist had produced a hypothetical version (in lines 1-3) which was making conditionally relevant the client's agreement regarding its plausibility. In response to that the client issued a delayed and barely audible weak agreement (˚yeah˚ in line 5) and failed to provide a stronger uptake following the therapist's ensuing question 'yeah?' in line 6 (given the rather lengthy pause of 0.7 of a second in line 7). In the face of the client's lack of uptake the therapist's next action was to deliver this question which seems designed to underscore the therapist's hypothetical

version as particularly remarkable, whilst at the same time pointing to a failure on the client's part, given that it treats the client as not having considered this possibility. Simultaneously, it appears to be seeking the client's collaboration for acknowledging the validity of the therapist's idea and for crediting the therapist for her contribution, but also for registering not having thought of this scenario as a failure on the client's part. This move appears thus not only to underline the therapist's epistemic expertise but also to place the client in a position of epistemic subordination.

It is worth noting that as the therapist keeps recycling her version, she also upgrades it from a hypothetical version to a more factual eventuality, thus progressively moving to a position of epistemic certainty. Whereas her initial version on the matter was not only qualified with the modal 'would' but was also with the emphatically uttered 'm↑aybe' ('m↑aybe you would be disclosing their status ', in line 3). The latter is dropped in the therapist's subsequent version 'you would be disclosing', (in line 12), whereas thereafter the therapist's hypothetical version is transformed to a more definite and palpable 'it' ('I hadn't really realised it', in line 15).

Finally, in the following instance in the course of accounting for her change of heart, the therapist asserts a B-event (Labov and Fanshel, 1977), (namely 'you need some ti- to give yourself some time', in line 3) in a way that is particularly authoritative from an epistemic point of view, given the use of 'you need' (in line 3) which also constitutes a habitual formulation for delivering directives.

Extract 19 [S2.01:07:14]

```
1     Th: .pt and actually I think I think this is a good idea
2          (0.9)
3     Th: .hh e:::h because you need some ti- to give yourself some time
4          isn't it?
```

Therefore through her turn in line 3 the therapist occasions asymmetry interactionally by asserting what the client needs; simultaneously such an utterance (in line 3) seems to fit particularly well with the therapeutic profession in terms of a therapist being normatively entitled to appraise his or her client's psychological needs. Given the high degree of epistemic authority that the therapist's utterance transpires, it is not surprising that on this occasion, the therapist attaches to her turn in line 3 the tag question 'isn't it?' (in line 4) which seems to mitigate the force of her prior utterance; similarly to Heritage's and

Raymond's (2005) findings who report that tag questions downgrade first position assessments. Overall though, the tactical concessions in the data, which as argued in this section are performed in ways that either exhibit the therapist's epistemic expertise or promote the creation of epistemic asymmetry between the two participants, are largely unmitigated.

One potential display of mitigation of the therapist's epistemic authority which is employed throughout all the tactical concessions in the data is the utterance 'I think'. From a discursive psychology perspective, reports of mental states are employed to perform actions (Edwards and Potter, 2005); in particular 'I think' could be used to present one's version as subjective. Linked to that, according to Raymond and Heritage (2006: 687) 'I think' could be used as an 'evidential' to downgrade an assessment performed in first position. An analytic principle that might also be decisive in order to determine the action that an utterance such as 'I think' carries out is the specific position that this might occupy within one single turn. In that regard, there might be multiple uses of 'I think' according to their position in a turn-at-talk, the display of subjectivity, or in this case the display of tentativeness on the therapist's part being one of them; but perhaps more work needs to be carried out across a number of cases to establish with certainty the differing uses of 'I think' and the degree in which this might act as a display of mitigation or not.

6.5   The success of the device as showed in actual interaction

The tactical concessions in the data, unfold progressively over a series of turns of talk and therefore the client is being given the opportunity to in some way collaborate in their production as the therapist goes along. For example, in all of the extracts the client is being given the chance to agree with the emerging account or elaboration, as can be seen in lines 4-7 of extract 20, in lines 2-4 of extract 21, and in lines 2-3 of extract 22 below:

Extract 20 [S3.00:24:14]

```
1     Th:  and:: e:::m (0.3) .hhh (0.9) I think you did very well not to
2          tell (.) Sophie and Mi- uncle Mike that you met this person
3          becaus::e, m↑aybe you would be disclosing their status
4          (0.4)
5     Cl:  °yeah°
```

```
6    Th:  yeah?
7         (0.7)
```

Extract 21 [S3.00:26:10]
```
1    Th:  and then make up your mind
2         (0.4)
3    Th:  mhm
4         (0.3)
```

Extract 22 [S2.01:07:25]
```
1     Th:  and:=e::h think about it
2          (0.5)
3     Cl:  (˚yeah/mm˚)
```

It is particularly noteworthy that in two of the three cases the therapist designs her talk in such a way so as to create an opportunity for the client to come in even before the account part or elaboration, that is immediately after the therapist's first assessment or positive valorisation (as can be observed in lines 2 and 3 of extract 23 and line 2 of extract 24 below):

Extract 23 [S3.00:26:02]
```
1    Th:  I think it's a very good quality
2         (0.2)
3    Cl:  ˚mm˚
4    Th:  to: to have to: when you are not sure about something (.) just
5         to:: think about it?
6    Cl:  yeah
7         (0.2)
8    Th:  and then make up your mind
9         (0.4)
10   Th:  mhm
11        (0.3)
```

Extract 24 [S2.01:07:14]
```
1     Th:  .pt and actually I think I think this is a good idea
2          (0.9)
3     Th:  .hh e:::h because you need some ti- to give yourself some
4          time isn't it?
```

```
5          (0.9)
6     ( ): (.hh)
7          ((imperceptible noise))
8          (0.2)
9    Th:   and:=e::h think about it
10         (0.5)
11   Cl:   (°yeah/mm°)
```

What is interesting about this is that the client is actually encouraged to offer her agreement, before the misrepresentation of her version occurs, at a moment in interaction where the therapist appears to merely positively evaluate the client's standpoint. This particular design of the therapist talk appears all but innocent, as in case the client does provide her agreement on this early occasion, it becomes more difficult or interactionally costly for her to retract it after the therapist finally delivers the account or elaboration which actually twists the client's version. The therapist thus appears to exploit the turn taking system in such a way so as to safeguard the client's agreement with her unfolding version, despite this opposing the client's own version.

As perhaps might be expected, even a cursory examination of the client's contributions in the data reveals that neither the second part of the device (that is the positive assessment) neither the third (that is that of the elaboration or account) are warmly received by the client. In fact the client at best issues imperceptible weak agreements or continuers and at worst remains silent at transition relevance places, both of which display her lack of agreement, and her orientation to the concession as a non-genuine one.

However, the third part of the device, which is the part performing the argumentative twist or misrepresentation of the client's version, is not being resisted in any intense way either. This seems to be rather revealing of the power that this device has to disarm explicit opposition. In addition, the device seems to be successful in permitting the continuation of the talk on a particular topic, at a point where this could have very well reached its end. In that regard, it seems that the device could be situated among a number of conversational practices employed in the course of argumentative exchanges of this kind that prevent a sequence reaching an end, despite one's interlocutor's efforts to do so.

6.6   Discussion

The argumentative strategy presented in this chapter is that of delivering concessions for tactical purposes. It involves initially assessing positively a state of affairs that featured among the argumentative claims of the opposition (and thus appearing as if making a concession), but subsequently attaching to it a seemingly innocent elaboration or account which in fact boosts one's own line of argument whilst simultaneously misrepresenting that of the other side. Such strategic concessions in the data, rather than actually signalling a genuine back-down, seem to be used in order to advance claims that have already failed to attract the other side's agreement in previous interaction. The tactic of employing a concession in the pursuit of agreement that has not been forthcoming might not be that uncommon a practice; Stivers (2005b) reports that physicians at times issue concessionary statements in an attempt to obtain parents' agreement with the physicians' treatment recommendations following previous failed attempts to do so. An important distinction however to be maintained between the concessions examined in this chapter and the concessionary statements featuring in Stivers' data, is that the former are employed to carry out oppositional manoeuvres, and to pursue one's argumentative line. In particular, they seem to be employed at a stage where an argumentative exchange could have reached its end, with the effect of not only reinstating argumentative claims in a way that disarms opposition, but in addition, of opening the way for the issuing of a prompt or suggestion for a course of action that has long been resisted.

These concessions' role in argument and opposition does not substantiate a distinction between partial agreement and concession made by Kotthoff (1993) which depicts concessions as a means of constructing consensus; according to this author 'It is necessary to distinguish between partial agreement and concession, because partial agreement stops only the debate on that specific point and keeps the general controversy going.' (ibid.: 210). Although Kotthoff's (ibid.) claim seems to apply to particular concessions, the claim cannot be generalised to all types of concessions as according to Antaki and Wetherell (1999: 11) 'Concessions have different rhetorical effects in different environments'.

In fact, concessions have been reported elsewhere in the literature to serve rhetorical and argumentative purposes; deserving a particular mention is Antaki and Wetherell's (1999) report of a conversational structure through which a speaker makes a show of

conceding a point in order to strengthen one's case and to weaken a countercase. According to the authors this device consists of a three-part structure of proposition, concession and reassertion; in particular it involves a speaker '(i) saying something vulnerable to challenge; (ii) conceding something to that challenge; then (iii) qualifying that concession and reasserting what one first said.' (ibid.: 8-9). Similarly to the concessions in the data, the rhetorical nature of these showcase concessions emerges progressively as the interaction unfolds and culminates as the speaker delivers the third part of the device. One of the main differences though between the phenomenon presented in this chapter and that reported by Antaki and Wetherell (ibid.) concerns the dialogical character of the former in the sense of a speaker conceding a point put forward by one's co-participant instead of the concession being authored by the same person throughout. However, despite their differences both these devices testify that concessions might feature among participants' resources for achieving certain rhetorical or argumentative aims.

What is particularly noteworthy about the tactical concessions in the data is that the therapist proceeds to perform an oppositional manoeuvre whilst simultaneously appearing to be in agreement with the client. What is also interesting, is that the device is designed in a way so as to disarm explicit opposition by the recipient, but does so precisely by offering the impression that the therapist is in accord with the client. This is mainly achieved through the positive assessment of the client's actions, as well as through the early opportunities for agreement whilst the argumentative character of the device is revealed towards its completion. Therefore, unlike other openly argumentative manoeuvres, the device does not offer to the client the opportunity for explicit resistance unless she is prepared to pay the cost of rejecting a positive valorisation of her actions. In that regard, the tactical concessions in the data appear to possess a feature that seems to a great extent to be characteristic of argument talk in a therapy setting more generally, namely the tendency for 'benign', non-quarrelsome disagreement, which nevertheless might be particularly forceful as section 6.3 demonstrates.

Despite the fact that the presentation of this practice is only based on three instances, these seem to constitute a representation on a small scale of the therapy world, as this can be captured when examining the details of the interaction between a therapist and the client, in a way that escapes an observer's attention when distancing herself/himself from the exact amount of talk. Among other things, what is particularly revealing is the way that the act of conceding a point might prove to constitute a tactical manoeuvre in the service of argumentation, the way that the turn taking system might be exploited to

construct an appearance of agreement between participants' as well as how issues of epistemic authority might be handled and constructed in the interaction between a therapist and her client. Also, taking into consideration that these concessions arise at a point in the interaction where there has already been some discord on some issue between the two participants, this device reveals the therapist's orientation to securing at least partial agreement by the client prior to proceeding to a different matter.

Such tactical concessions in the data are only being employed by the therapist. In that respect they seem to be revealing of the therapist's institutional agenda and they seem to be entwined with institutional necessities to achieve certain therapeutic outcomes, which could constitute the force driving the therapist to pursue an argumentative line even at a point when this might be fading out given the client's expressed opposition to it. One of the questions that spring to mind concerns the possible professional accounts that would have arisen from transcripts evidencing the presence of such a conversational device. Discrepancies are bound to arise by comparing the insights emerging from the close analysis of the talk with accounts derived from the therapy literature as according to Perakyla and Vehvilainen (2003) 'Practices are not accomplished merely by following theories, models or concepts. Theories and models are general idealizations, whereas practices are carried out in situ.'. With regards to this particular device, there does not seem to be any exact correspondence between such tactical concessions in the data and any therapy techniques featuring in therapy texts. However, the various subtle discursive manoeuvres that a tactical concession involves might relate to a number of therapy concepts.

To begin with, one could argue that by making a concession the therapist appears to follow the client's feedback, which has been a core principle of systemic family therapy since the early days of its development (Carr, 2000; Selvini-Palazzoli et al., 1980). Alternatively, following more recent developments in the field, the therapist's concessionary statements, could be described as moments where the therapist joins the client's grammar (Lang and McAdam, 1995). As the concession unfolds however, the therapist departs rather substantially from the clients' trajectory; what initially appears as a moment of co-creation of shared meaning, ends up as a different type of event. What this shows perhaps is that the details of the talk reveal a very complex and multi-faceted reality regarding the therapist-client interaction that might not be easy to capture unless one examines an instance closely and within the discursive context in which it arises.

In addition, another point of contact with systemic therapy ideas concerns the use of positive assessments such as those featuring in the heart of the tactical concessions in the data. As mentioned earlier, such positive assessments would be in line with theoretical imperatives to emphasise the client's strengths and achievements (Epston and White, 1992; Freeman et al., 1997; Lang and McAdam, 1995). However, when examined in the discursive context in which they are occasioned it appears that they are also put to a fairly different use, serving argumentative ends which in turn seem indicative of other perhaps more pressing institutional aims. In addition, the positive or empowering language employed by the therapist in these instances, seems to largely deny the client the opportunity for explicit opposition. By implication, in these particular instances, the empowering language might turn out to be more constraining rather than other, explicitly disputatious moves.

The emphasis on appreciative language (Lang and McAdam, 1995; Madsen, 2009; Pearce, 2001) would be associated with a post-modernist tradition within the field of systemic family therapy. One question that comes to mind is where the practice appearing in the data could be situated with regards to a broader argument regarding a post-modernist versus a modernist strand of thought in the field (as these are translated into therapy practice). Aside from the emphasis on language and in particular on the use of positive language with the aim of empowering clients, another important feature that would help us position this practice within one or the other tradition, concerns the therapist's level of expertise. According to Frosh (1995); 'when therapists call themselves 'postmodern', they seem mainly to be referring to their focus on language, often from within a social constructionist framework, and their concern to reduce or at least make obvious the asymmetries of power present in traditional therapeutic interactions'. Assuming a high level of expertise is associated more with the modernist tradition within the field, supporters of which espouse the display of benign authority by the therapist (Minuchin, 1999). On the other hand proponents of the post-modernist strand of thought often are in favour of a not-knowing position (Anderson and Goolishian, 1988; Anderson and Goolishian, 1992; Hoffman, 1992), advocating that the therapist embraces a rather tentative style of participation in order to allow clients to develop new narratives.

To attempt to examine the above question regarding which one of the two theoretical orientations these tactical concessions appear to reflect, it might be worth returning to the data. In the case of the exchanges previously analysed, despite the practitioner in the data appearing to adopt a non-expert position by making a concession,

the details of the talk as argued in section 6.4 reveal that in fact she displays a relatively high level of epistemic expertise towards the client. This in itself might have situated the therapist closer to a modernist tradition. In fact though, this does not turn out to be to be a straightforward matter. For example, it is noteworthy that the positive assessment in the heart of the concessions in the data, which as we've seen is one of the main ways through which the therapist displays her expertise - a characteristic largely linked with the modernist tradition in the field-, simultaneously testifies the use by the therapist of appreciative language which in turn is associated with a more post-modernist take on therapy. Such an example seems perhaps to reveal that contradictions might emerge when trying to fit the detail and complexity of the actual talk to larger conceptual categories. Also, it might be symptomatic of a potential contradiction arising when attempting to fulfil the psychotherapeutic mandates whilst also attempting to apply the lessons learnt by the post-modernist critiques. Frosh (1995: 189) articulates such a mismatch in the following way: '... 'postmodernist therapies' are not really postmodernist at all, but are, rather, modernist, with a heightened awareness of the slippery nature of 'truth' and of the dangers of abusive uses of power in the service of, for example, sexism and racism. This awareness is taken from postmodernism, but that does not make the approach itself postmodernist.'

To conclude, one of the most significant findings arising from the close examination of the data presented in this chapter and which is hardly at all represented in the systemic therapy literature, concerns the way that the recurrent practice of conceding a point for tactical purposes seems to work as a way for pursuing the therapist's line of argument as well as a way for weakening the client's case. This in itself is indicative of the type of means a therapist might employ to achieve certain institutional aims, of how therapeutic mandates might be performed in practice and finally of the role of an argumentative device such as the one presented in this chapter for performing routine therapy tasks.

Chapter 7: Conclusion

7.1   Summary of the practices in the data

Following the analysis of the three practices in the data we reach the end of this exploration of argument talk in psychotherapeutic interaction. The pieces of interaction forming the basis of this piece of work reveal that on a number of occasions the therapist attempts to secure the client's agreement with particular issues or alternatively to challenge particular aspects of the client's talk; the client on the other hand appears to oppose these attempts, tries to secure the therapist's agreement to her own version and to avert any further attempts at persuasion on the therapist's part. These instances where both participants engage in a series of oppositional moves testify to the existence of mutual opposition and of persuasive argumentation, which seem specific to the institutional occasion in which they emerge and which in fact get accomplished through very subtle conversational means.

Three mechanisms have been identified as means through which the therapist attempts to achieve swaying the client in particular directions. The first practice, termed questions soliciting defeasible accounts, occurs following the display by the client of a negative stance. Even though the therapist shows signs of disaffiliation to the client's standpoint, there are pragmatic reasons which prevent the therapist from proceeding to an immediate disagreement or challenge of the client's version. Rather, the therapist proceeds to a move which permits her to deliver an explicitly oppositional move at a later stage. In particular the therapist proceeds to deliver a question or a series of questions through which she invites the client to offer her strongest grounds in support of the negative stance that she previously displayed.

Pragmatically the therapist's move invites a defeasible response by the client which is subsequently contested by the therapist. The main mechanisms through which this is achieved is by displaying to the client that a challenge or disagreement is probable or imminent, for instance by framing the client's forthcoming version as subjective and by alluding to the possibility of alternative descriptions. Moreover, the therapist formulates her questions in ways which solicit such descriptions of the client's affairs which are accessible to the therapist too from an epistemic point of view and which therefore enable

the therapist to contest them should she wish to. This is largely achieved through the use of hypothetical constructions and also by enquiring about other people's thoughts or actions or about generalised states of affairs as opposed to the client's feelings or personal intentions.

These questions reveal instances where disagreement (and by implication argument) does not start spontaneously but after solicitation on the therapist's part. Moreover the exchanges in the data testify to the non-haphazardness of the therapist's ensuing challenge or disagreement as, in cases where the client evades providing a defeasible response but maintains her initial version, the therapist keeps pursuing with such questions until such a defeasible account is finally provided. In the data the therapist's challenge or disagreement in the final position of the sequence opens the way for a subsequent display of opposition by the client (not described in this work) and thus potentially for further action opposition sequences.

Another way through which the therapist attempts to persuade the client is that of exposing a contradiction in the client's utterances through the means of a dialogical argument. This practice entails engaging the client in the construction of a piece of reasoning designed to counter a prior claim that the client has made. Interestingly, this practice offers the impression that the therapist simply facilitates the conversational process, and that the client is actively participating in the co-construction of alternative meanings by volunteering new information from her own domain of experience.

In particular, following an initial claim by the client, the therapist initiates a series of leading questions which engage the client in the production of evidence that opposes the client's initial version. The evidence largely consists of reports of the client's experience and forms the basis upon which the therapist formulates a challenge or disagreement that is responsive to the client's initial utterances. A variant of this practice entails recruiting aspects of the client's prior claim, in an attempt to turn it on its head. This variant constitutes a way of putting the client's prior claim to the test and, in essence, is a way of raising crucial accountability issues for the client as a means of undermining the client's initial claim.

Although the therapist visibly employs logical constructions as a resource, this does not appear to be the main persuasive mechanism upon which these dialogical arguments rely. What is important is not as much the robustness of the unfolding piece of reasoning, but the fact that this logical case is jointly constructed by the two participants and that effectively it is the client herself who 'volunteers' the material upon which the therapist's

ensuing conclusion rests. In this way the therapist engages the client in providing the ammunition through which the client's initial utterances are subsequently rebutted. The persuasive power of the phenomenon also lies in the leading nature of the therapist's questions, in the mechanisms through which the therapist defuses the client's resistance to her unfolding project as well as in the accountability issues raised for the client through her line of questioning.

The third practice identified in the data involves the delivery by the therapist of a concession, which however, turns out to be strategic rather than genuine. In particular, following the display by the client of a standpoint, the therapist proceeds to make a concession which interestingly incorporates a positive assessment or valorisation of the client's standpoint. Thereafter though, the therapist attaches to her concession an elaboration or account, which to a smaller or larger extent opposes the client's version. In addition, in contrast with genuine concessions, in this case it is the therapist herself who creates the opportunity for the concession to take place, as this emerges from the close inspection of the details of the talk preceding the concession. Once more this feature of the concessions reveals their strategic nature.

Not only do these concessions not constitute a proper backing down but in fact serve as a means through which the therapist pursues her line of argument in the face of the client's opposition. Moreover, the tactical concessions in the data precede suggestions for courses of actions previously resisted by the client. The client displays her disaffiliation to the therapist's unfolding concessions, orienting to the oppositional nature of the therapist's move, but nevertheless she does not oppose the misrepresentation that these incur to her version in any overt way, which reveals the argumentative power of the device.

This last point brings us to the benefits of this device. As it transpires from the client's responses to the tactical concessions in the data, one of the main advantages of packaging an oppositional move in the form of a concession and of embedding in it a positive assessment is that it disarms the client's opposition. Simultaneously, it portrays the therapist as reasonable, and as adhering to systemic therapy principles of following the client's feedback, whilst the therapist advances her line of argument. Moreover, the way the concession is formulated portrays the therapist in a position of expertise or authority, even at a point where she seemingly backs down from her previous stand-point. Finally, these concessions succeed in prolonging the talk on a particular topic, despite the client's prior attempts to end the discussion on the matter.

7.2   Some characteristics of the arguments in the data

Most -although not all- of these instances of argumentation in the data revolve around the topic of HIV. The client is concerned about the possibility of becoming socially excluded because of a condition that she considers as deeply stigmatising and the therapist attempts to shift the clients' perspective on the matter and to recruit the client in a fight against the stigma associated with the condition and what she treats as uninformed views regarding HIV.

These conversations render this dataset rather different to the data that Perakyla (1995) gathered in the early to mid 1990s from a very similar HIV counselling service. Perakyla's extracts seem to largely revolve around dreaded issues such as loss and death. On the contrary, in this current data the therapist appears to argue against the view that HIV should prevent the client from having a normal life, including having healthy, non-HIV infected children. In addition, the therapist encourages the client to educate people around her who treat HIV as a fatal condition.

What seems to have greatly contributed to this difference between the two datasets is that a year later after Perakyla (1995) published his book 'AIDS counselling' there has been -in the western world rather than the developing world- a breakthrough in the treatment of the condition, consisting of prescribing a combination of antiviral medications as opposed to a single drug. This meant that people who had up to that point been on the verge of dying were able to recover and even able to enjoy the possibility of a long life. Meanwhile the classification of the disease, which was no longer considered as fatal, had changed from acute to chronic illness. Excessive or not, the new optimism surrounding the prognosis of this condition seems to have shaped the beliefs of the professionals at the frontline of the services for HIV and AIDS in the subsequent years, as this is evidenced by the discourse sustained by the therapist in this HIV counselling setting. It thus appears that approximately a decade later after these changes had taken place the therapist recruits these 'novel' social constructs regarding HIV in her conversations with the client, attempting to shape the construction of a different social reality in which the client could live with less constraints.

If the therapist promotes these more recent constructs regarding HIV and the meaning attached to it, the optimism is not being fully shared by the client. Moreover, the conversations that the client has with the therapist on this topic are far from being of

general interest and cannot be reduced to a simple exchange of views on the matter. It appears that from the client's perspective the nature of the condition and how this is being perceived more widely matter gravely and risk having an immediate impact on her day-to-day life. This seems to also explain the client's persistent lack of agreement with the therapist's take on these matters; whatever resources the therapist employs to persuade the client over the virtues of becoming confident regarding people's acceptance of her condition given the changing nature of the disease, these eventually prove unsuccessful in securing the client's agreement.

It transpires that the issues debated by the therapist and the client do not have a single answer. Participants cannot be considered as being right or wrong in an absolute way and the emerging arguments cannot be easily resolved. In fact all of the above aspects illuminate the social aspect of these arguments. This is consonant with Billig's (1996) take on the notion of argument; based on the insights of Protagoras, Billig notes that 'any individual argument is actually, or potentially, a part of a social argument' (1996: 74).

The above feature of the arguments in the data takes us to the characteristics of argumentation in psychotherapeutic interaction. The fact that the arguments between the therapist and the client can form part of social arguments potentially distinguishes them from arguments appearing in other types of interaction such as the interaction between children (examples can be found in Goodwin and Goodwin (1987) and in Maynard (1985)). What is also rather distinctive about them is that they appear to be systematically mitigated, unlike arguments appearing in other types of settings (Dersley and Wootton, 2001; Gruber, 1998; Kotthoff, 1993).

Linked to that, another crucial feature concerns the way that the therapist might be actively after her interlocutor's agreement and might also rely on her co-operation and contributions to bring off an argumentative move. This is particularly evident in the conversational practice of tactical concessions. In this case, the therapist offers the client the opportunity to display her agreement at different stages of the production of the concession (that is following the initial concessionary part and also following the account or elaboration part). Moreover, the therapist portrays herself –at least temporarily- as being in line with the client's version. The extent to which the client's agreement is deemed as important by the therapist becomes particularly evident through the use of the positive assessment or valorisation, which constitutes a remarkably intense way of displaying affiliation with the client's version. Both the opportunities for agreement that the therapist affords to the client, as well as the extent to which the opposition element of the device

remains covert, reveal how important it is for the therapist to avoid inciting the client's opposition and to get the client on her side at that particular point moment of the interaction. It thus transpires that in that case, promoting affiliation and securing an acceptance by the client of the transformation that incurs to her version by the therapist's move are valued as persuasive tools and are privileged over aggravated opposition.

The importance of securing the client's co-operation and agreement in the endeavour to progress a particular argumentative move is also evident in the second practice through which the therapist attempts to uncover a contradiction in the client's version. In this case the therapist relies heavily upon the client's contributions to carry out her argumentative project. This is designed to facilitate the acceptance by the client of the challenge or disagreement at the final part of the device, increasing the persuasive leverage that this exerts upon the client. Moreover, without the client contributions the therapist would have resorted to a particularly authoritative type of talk from an epistemic point of view given that she would have had to state what the client's experience was. In addition, because of the length of the sequences involved, without at least a partial co-operation on the client's part, the therapist would not have been in a position to deliver the final part of these dialogical arguments. It is thus not surprising that in addition to inviting the client's contributions the therapist recruits several conversational resources in order to amplify the 'appropriate' client contributions and to dismiss those opposing the emerging argument, thus actively forging the sense of a joint version.

Downplaying the challenging aspect of the therapist's opposition and privileging the client's co-operation rather than aggravated opposition seems also to be used as a resource in the practice of questions soliciting defeasible accounts, even though this device approximates to a challenge. We have already seen that despite the fact that these questions could have been delivered in openly disaffiliative or challenging ways – as could have been the case in ordinary interaction- the therapist delivers them in ways which conceal or downplay their oppositional character. In the case of this practice, this type of delivery appears to maximize the chances that the client delivers challengeable material in her response to the therapist's question which then permits the therapist to oppose the client's version. Concurrently, it permits the therapist to minimize the possibility that the client sabotages the therapist's project –as is in fact the case in some of the in the instances in the data where the client's resistance to the therapist's project is such that the therapist fails to deliver a challenge or disagreement at the end of the device.

Another feature of the instances of argumentation in the data is that participants accomplish them by mobilising rather habitual psychotherapeutic conversational resources. In the first and second practice developed in the analytic chapters opposition is realised through question-answer sequences. These are conversational resources which have been reported to perform a variety of actions both in the conversation analytic research on psychotherapy (examples are offered by Hutchby, 2007; MacMartin, 2008; Perakyla, 1995) and in the systemic therapy literature (Selvini-Palazzoli et al., 1980; Tomm, 1987a; 1987b; 1988; White, 1988). At the heart of the third practice of conceding a point for tactical purposes, lies a positive assessment which once more appears to be consonant with therapy practice as this transpires from the therapy literature (Epston and White, 1992; Freedman and Combs, 1996; Freeman et al., 1997; Lang and McAdam, 1995) and which sits comfortably with a normative understanding of what psychotherapists do.

In that regard it appears that the building blocks of the opposition and of the arguments appearing in the data are not practices which are alien or foreign to therapy practice as this is normatively understood; in fact the opposite appears to be true as these constitute familiar means through which therapy routinely realises. It thus transpires that argumentation in therapy interaction, like any other action performed by participants, relies heavily on the social conventions applying to the particular interactional occasion in which these are produced (which confirms the point that has been made more generally about argumentation by Antaki (1994) and Gumbertz (1992)).

A final point regarding the arguments in the data concerns the fact that both usages of the word argument have, to differing degrees, been made relevant in the analysis of the three practices in the data. In particular, the practice of soliciting defeasible accounts has been treated as illuminating primarily the notion of argument in the sense of opposition (this is the case even if the sequence is only pursued up to the first of a series of oppositional moves given that the emphasis in this case is placed on how such chains are in fact initiated). Simultaneously however, the therapist's move to solicit such defeasible accounts testifies to the therapist's attempts at persuasion, as the therapist endeavours (and at times manages) to elicit accounts in support of a particular viewpoint which constitute weak evidence in support of the client's version and which she can subsequently rebut.

The second practice in the data, namely the dialogical arguments, embodies primarily the rhetorical sense of the term argument. Simultaneously however, the therapist's move in itself constitutes an oppositional move as the sheer fact of resorting to building a case indicates a lack of agreement. Moreover, it appears that even if opposition

remains latent in the course of the series of question-answer pairs that form the second part of the device, the therapist's ensuing challenge or disagreement does constitute an oppositional move responsive to the client's earlier talk. In this case the intervening material might approximate an insert expansion, which not only contributes to the emerging rhetorical argument but which also forms the local discursive context occasioning the therapist's ensuing oppositional move (that is the challenge or disagreement at the final part of the device).

Finally, the practice of tactical concessions also illuminates both meanings of the word argument. In particular, these concessions have been analysed as potentially boosting the therapist's line of argument, for instance in the case of serving as evidence in support of a prior claim. In addition however, these concessions appear to occur in the context of an ongoing opposition between the therapist and the client and as they themselves mark an oppositional move (even if this is done covertly), they become a further component in this ongoing chain of action-opposition moves.

7.3   The role of epistemic accessibility in opposition in systemic practice

In the data, when the therapist engages in the production of oppositional talk, she assumes a position of analogous, if not superior, epistemic rights to those of the client. A detailed description of how this might happen has been given in section 6.4 of chapter 6 on tactical concessions where the therapist adopts an epistemically authoritative position whilst delivering her oppositional move, which in this case takes the form of a concession. Importantly, it appears that the therapist at times adopts a position of epistemic authority regarding issues which belong to the client's domain of personal expertise. This seems congruent with reports in the literature about breaches by clinicians of their clients' ownership of experience (Rae, 2008; Vehvilainen, 2008).

The data reveals two ways in which the therapist proceeds to oppositional moves which simultaneously place the therapist in a position of epistemic expertise or authority. On the one hand, there are cases where the therapist's oppositional move is immediately responsive to the client's prior talk; in this instance no intervening steps take place for opposition to be made possible. This appears to be the case in the tactical concessions;

although the therapist creates the opportunity for the concession to arise, this is responsive to the client's immediately preceding talk.

This contrasts with the other two practices in the data whereby in order for the therapist to proceed to the oppositional move at the concluding part of the device, she resorts to the solicitation of intervening material. In both these cases through this manoeuvre the therapist not only gathers material upon which her subsequent oppositional move is based, but also manages to accomplish a transition which renders the ensuing opposition possible from an epistemic point of view.

In particular, in the practice of questions which solicit defeasible accounts (in chapter 4) we have seen that the way in which the therapist's questions are formulated offers the therapist the opportunity to make a transition from an area of talk where the client enjoys epistemic priority to a domain where the therapist too has epistemic accessibility. This transition allows the therapist to proceed to an oppositional move thereafter. In addition, in the dialogical arguments examined in chapter 5 the intervening segments of elicitation allow for the premises of the argument, which are largely built from reports of the client's own experience, to be formulated by the client herself, thus sparing the therapist from resorting to B-event statements in case she had to produce these reports on her own. In both these cases, the intervening material, which is interposed between the questions issued by the therapist and the therapist's ensuing oppositional move, renders this oppositional move possible and less vulnerable to client disconfirmation.

Therefore, despite the different nature of these phenomena, in both cases the questions issued by the therapist seem particularly beneficial as, aside from any other affordances they present for the therapist, they also allow her to manage or overcome in some way the unequal distribution of knowledge between herself and the client. This might be particularly important in the case where the end-point of the therapist's trajectory is a challenge or a disagreement, given that epistemic asymmetries might put a person delivering an oppositional move at a distinct disadvantage (the importance of such asymmetries in the case of disagreement have been noted by Drew (1991)).

What emerges is that it is possible that such transitions, which allow the therapist to somehow manage or overcome the unequal distribution of knowledge between herself and the client, might be an important ingredient for the accomplishment of opposition by systemic therapists in psychotherapeutic interaction. Whereas disagreement and opposition might be performed in a straightforward manner in many other types of interaction that do not involve the sorts of epistemic asymmetries which exist between clients and their

therapists (given that the clients have first-hand knowledge of their personal experience which places therapists in a position of epistemic subordination), this might not be the case in psychotherapeutic interaction where such asymmetries might require careful management on the therapists' part (as is evidenced by the two practices in the data).

This point might be particularly relevant in this specific psychotherapeutic modality, as the official systemic therapy principles discourage practitioners from adopting authoritative positions through which the therapist's expertise overshadows that of the client (as this has been detailed in section 1.2.1.1 of the introduction). However, a similar principle might not apply in other types of therapy modalities where oppositional moves performed by the therapist and which also place the therapist in a position of epistemic expertise or which even incur breaches of the client's ownership of experience might serve particular psychotherapeutic mandates. In these instances such mandates might legitimate a straightforward breach of the client's ownership of experience, rendering a progressive transition unnecessary. This might for instance be the case in psychoanalytic interaction where analysts might undertake the task of comprehending the patient's unconscious. This task would legitimate describing the patient's experiences in ways which are foreign to the patient's own understanding of their experiences (Vehvilainen, 2008)).

If in systemic therapy practice oppositional moves performed by the therapist require a careful management of issues of unequal distribution of knowledge between a therapist and his or her client, which might often necessitate progressive transitions of the sort present in the two practices in the data (as described in chapters 4 and 5), one might wonder why, in the case of the tactical concessions, the oppositional move, which is performed in a way that places the therapist in an epistemically authoritative position, is carried out in a straightforward manner.

It is possible that this relates to the fact that in this case the therapist does not explicitly portray herself as engaging in opposition as this is performed covertly, but instead she portrays herself as performing actions which therapists routinely construct as belonging within the realm of their professional expertise. More specifically, the therapist presents what she does as appraising the client's psychological disposition or psychological needs and also as evaluating what is ethical or normative regarding issues of disclosure of sensitive information. It is probable that in this case these actions might render a straightforward display of epistemic expertise or authority of the sort observed in these instances as legitimate and unproblematic. Overall though, it is likely that in systemic therapy practice the display of opposition on the therapist's part towards matters which

might belong within the clients' domain of personal experience (which could easily occupy a large part of a client's talk in any therapy session) might require careful management and manoeuvres of the sort described in the practice of questions soliciting defeasible accounts (chapter 4) and the practice of dialogical arguments (chapter 5); although more research would be required in the field in order to establish such connections with more certainty.

7.4 Links between the practices in the data and therapy theory

From a systemic therapy perspective the three practices identified in the data seem to correspond with habitual aspects of therapy practice as these are described in systemic therapy papers and textbooks. In particular, the first practice 'what are your (strongest) grounds' consists of hypothetical or future oriented questions which allow the exploration of scenarios that clients might not have previously considered (Boscolo and Bertrando, 1992; Boscolo and Bertrando, 1993; Boscolo et al., 1987). As these questions allow clients to entertain different perspectives about their future or different possibilities altogether, they are seen as potentially having a reflexive effect (Tomm, 1987b). In addition, such questions are considered to have a continuous effect as clients might keep reflecting on them outside of the context of a session (ibid.).

Importantly, given that the questions at the heart of this practice invite the client to give her (strongest) grounds in support of a negative stance that she previously displayed, the questions in the data seem to correspond with questions which from a systemic therapy perspective are designed to explore catastrophic expectations. Tomm (1987b: 173-174) offers examples of such questions 'For instance, one might ask overprotective parents: "What are you worried might happen when your daughter stays out so late?... What is the worst thing that comes to mind?"; (to daughter) "What do you imagine your parents are most afraid of? . . . What terrible things do they expect might happen that keeps them awake at night?"'. As the author notes (1987b; 173) '*To explore catastrophic expectations is a way to facilitate the exposure of covert issues so that they can be dealt with more overtly.*'

This therapeutic usage of questions exploring catastrophic expectations seems indeed to correspond with the usage of the questions in the data, for a number of reasons. Firstly, the therapist in the data shows signs of disaffiliation to the client's initial version

which is the context in which the questions in the data are occasioned. One can imagine this to also apply in the case of the questions described by Karl Tomm given that what they explore is termed in a negative way (catastrophic expectations). Also, similarly to Tomm's description of their usage, through the questions in the data the therapist invites into the open a more pronounced version than the one initially put forward by the client. Thirdly, the solicited version allows the therapist to explain away the client's grounds in support of her stance. Although Karl Tomm does not explicitly mention in what way clients' catastrophic expectations might be 'dealt with' (ibid.), it is understandable that they are to in some way be undermined.

The second practice in the data through which the therapist uncovers a contradiction that largely revolves around the client's domain of experience, seems to correspond with the practice of unique outcomes (White, 1988), drawn from the narrative therapy model and also with the very similar to unique outcomes practice of finding exceptions in the client's talk (De Shazer and Dolan, 2007), drawn from the solution focused therapy model (given that the therapist embraces the narrative perspective it would be reasonable to mostly emphasize the parallels with the narrative concept of unique outcomes).

The concept of unique outcomes is based on the principle that 'the stories that persons live by are full of gaps and inconsistencies, and, as well, these stories constantly run up against contradictions' (White, 1992: 127). The therapeutic aim is to generate through the means of questions alternative knowledge which clients might have overlooked as they are overly organized by problem saturated descriptions. According to White (ibid.) 'As persons separate from the dominant or "totalizing" stories that are constitutive of their lives, it becomes more possible for them to orient themselves to aspects of their experience that contradict these knowledges'. Similarly, solution focused therapy aims to bring forward the strengths and abilities that clients possess and one way of doing that consists of finding and amplifying exceptions in the client's problem-laden descriptions. In both cases these tasks are achieved with the client's collaboration, rather than being imposed by the therapist upon the client. As Michael White (1988: 39) notes on the process of establishing unique outcomes 'Family members take an active rather than passive status in the generation of these new accounts and redescriptions'.

These two practices seem to present notable parallels with the practice of uncovering a contradiction in the data. Indeed, through this practice the therapist solicits into the open aspects of the client's experience which contradict her earlier problem-

saturated descriptions. Moreover the therapist actively engages the client in the process, to the extent that the client appears to in fact 'volunteer' the elicited information.

Finally, as detailed in the discussion section of chapter 6, the practice of tactical concessions in the data could be seen as adhering to a number of systemic therapy principles. Through the initial concessionary part the therapist appears to follow the client's feedback (Carr, 2000; Selvini-Palazzoli et al., 1980), or, according to more recent social constructionist developments in the systemic field, to join the client's grammar. Importantly, the positive assessment or valorization that the therapist incorporates in her concession attests the use by the therapist of appreciative language (Lang and McAdam, 1995; Madsen, 2009; McAdam and Mirza, 2009; Pearce, 2001) and is in line with systemic therapy mandates to highlight the client's strengths and achievements (Epston and White, 1992; Freeman et al., 1997; Lang and McAdam, 1995).

An important point to make is that all the above therapy concepts are in line with a second-order view of therapy which fits with social constructionist ideas and which has prevailed in the field following critiques against the initial systemic therapy models. Whilst the latter emphasize the possibility of exerting unilateral influence upon clients, second order practice treats therapists 'as part of what must change' (Hoffman, 1990: 5). The significance of that is that the above mentioned concepts cannot be considered as outdated as they are part of contemporary systemic therapists' resources for conducting therapy.

Overall, what transpires from these connections between the practices in the data and psychotherapeutic theoretical concepts is the unexceptional nature of the former. This would mean that such practices occupy a justified place within systemic practice. This is partially confirmed by the fact that the therapist does not orient to the moves that she initiates as a faux pas, despite their oppositional nature. This contrasts with some actions initiated in other types of institutional interaction which are oriented by institutional agents as actions that they would better refrain from engaging in (Butler et al., 2009; Vehvilainen, 2003b).

Moreover, as detailed in chapter 4, the practice of questions soliciting defeasible accounts not only demonstrates that the arguments in the data occur after solicitation on the therapist's part (as this is also the case with the practice of uncovering a contradiction), but also, that the space for disagreement (and therefore potentially for argument too) is opened up progressively by the therapist's manoeuvres and the types of actions that these invite. As proposed in the discussion section of the chapter, in this case one could talk about institutional disagreement (and thus potentially about institutional argument) as this

appears to be embedded in a routine therapy practice and importantly, as there are instances in which the client's defeasible responses appear to be pursued in a systematic way.

If the episodes of argumentation occurring in the data are triggered from routine aspects of contemporary systemic practice, if they are not oriented to as a faux pas, and if disagreement is at times pursued systematically by the therapist, one question that emerges, is why none of the theoretical concepts attached to these practices has so far been associated with the possibility of argumentation. What one is rightfully left to wonder is why this likely aspect of systemic therapy practice has not surfaced in any of the formal descriptions of how this type of therapy might be accomplished.

This is all the more surprising given the fact that in systemic therapy literature there are in fact mentions of therapists becoming challenging, despite the fact that overt opposition is seen as a feature of the earlier, first order models and is largely critiqued. These mentions thus differ from those appearing in texts on these earlier models, in a number of ways. To begin with, this time challenging can be performed whilst adopting a supportive and collaborative stance rather than in explicitly confrontational ways as was often the case with the first order models (examples of openly confrontational practice can be found in Minuchin (1974)). As Rober (1999: 220) mentions 'Challenging should always be accompanied by a containing, supportive attitude on the part of the therapist'.

Moreover, this might be performed from within a second order perspective. For instance, Tomm and Lannamann (1988: 39) report how Karl Tomm attempted to challenge a particular belief embraced by a client of his, through the means of reflexive questions (Tomm, 1987b), which are viewed as therapeutic means that potentially facilitate self-healing: 'My goal in the interview was to invite Glen to question the biological assumption a bit so that he could begin to entertain some other possibilities, possibilities that might prove more useful to him. At the same time, I didn't want to confront him directly and make him feel that he was wrong or silly for holding this belief. Picking up on my earlier question implying that the diagnosis might just be a belief, not necessarily a certainty, I asked: "who do you think believes the most strongly that the depression is biological?".'

Interestingly, in many instances mentions of challenging clients have become rather covert and impersonal, as can be seen in the following quotations:

- 'However, it was not only 'war' which made narratives of family life difficult for children but also deliberate silence, the elision of memory of the parent who had gone a

refusal to discuss their ongoing life in another place. A key function of the interviews was to challenge such silence.' (Gorell-Barnes and Dowling, 1997: 198).

- 'This approach promotes a therapy in which the perpetrator is invited to examine and challenge restraints that have stopped him from taking responsibility for the abuse' (Nylund and Corsiglia, 1993: 30).
- 'Others, hypothetical and future questions (Penn, 1985), challenge the clients' premises in the search for new solutions. Such questions introduce a premise for change into a frozen system' (Boscolo and Bertrando, 1992: 128).'

In the above segments the agent doing the challenging is largely deleted whereas what is being challenged is ideas, stories or particular positions rather than clients.

Interestingly, as emerges from the literature, challenging might be a necessary part of systemic practice as it fulfils important psychotherapeutic objectives revolving around the mandate for change. It would thus be plausible to assume that as long as challenging clients in an attempt to fulfil the mandate for change forms part of systemic therapy theory and as long as clients exert their right to oppose therapist's oppositional manoeuvres, it becomes possible that argumentation might emerge in participants' interaction. Interestingly, the likelihood that clients might oppose the therapist's challenging moves and that such challenging moves might end up instigating argumentation as is the case in this data set, is not really being mentioned in texts where therapists report becoming challenging. It is thus possible that in this way the possibility of argumentation is being left out of systemic therapy papers and textbooks.

A potential reason for this might be that an account regarding the potential role of argumentation in systemic therapy practice might not be easily considered as being in line with the prevailing ideas regarding the non-prescriptive, non-influential role of systemic practitioners. As detailed in section 1.2.1.1 of chapter 1, the role of the therapist is being described as enabling as he or she is positioned as a facilitator of therapeutic processes. Clients on the other hand are supposed to take a particularly active role in reaching the insights that better their lives. Simultaneously the language adopted by systemic practitioners, both in their practice with clients and in their descriptions of it, becomes more tentative and collaborative and inclusive of the client's voice (Hoffman, 1992; McAdam, 1995) to the extent that, as mentioned in the above paragraphs, this type of language also clothes the reports on challenging clients.

It could be argued at this point that ideas regarding an egalitarian, democratic and non-prescriptive therapy might clash with some potential consequences of the mandate for

change, such as mutual opposition, attempts at persuasion and argumentation. This could in fact lead to downplayed or even unsaid aspects of therapy practice and ultimately, to contradictory mandates for practitioners, although a thorough textual analysis of how such aspects feature in therapy papers and textbooks is required in order to substantiate these preliminary observations. Moreover, such contradictory aspects of therapy theory might account for the atypical form that argumentation takes in the data, as the therapist in the course of delivering her oppositional moves relies on client co-operation and contributions, attempts to create the impression of a jointly built version, privileges mitigated rather than aggravated opposition and, at times, even incorporates favourable remarks on the client's abilities or actions.

7.5 The text of the thesis as constructed of words and constructive of therapy worlds

One of the aims of this piece of work has been to produce a piece of research independent of particular therapy theories. Indeed, by identifying and analysing instances of argumentation in a systemic therapy setting we seem to have wandered into foreign territory in terms of the systemic therapy theories on offer.

However, the accounts that have been built, despite being interactional ones, throw the focus on what Vehvilainen et al. (2008: 191) call recipient activities 'in which the client's talk is in some particular way dealt with by the therapist' which could have traditionally been considered as a therapist's 'interventions'. In that regard the study has followed the example of CA studies which tend to 'focus on the talk of the institutional agent' (ibid.). One cannot help but note that by doing so some of the dominant assumptions about psychotherapy creep into the study, shaping the end product of the research. One is thus left wondering what research account might have been produced had there been a reversal of such basic assumptions and had the client's contributions been treated as the central focus of attention.

Following the presentation of the three practices I have made connections between the three practices in the data and systemic therapy principles, defending the routine nature of these practices and building a novel perspective about aspects of systemic therapy. A possible criticism at this point could be that by doing so I defied the critique initially raised (in section 1.2.1.3 of the introduction) regarding the potential for producing arbitrary

analytic comments when measuring the interaction between therapists and clients against generic therapy principles.

In defence perhaps of the validity of the links of the practices identified in the data and systemic therapy principles, it would be worth noting that the systemic approach can be classed among these therapy approaches which offer 'detailed and extensive descriptions and prescriptions concerning the interaction between professionals and clients' (Perakyla and Vehvilainen, 2003: 730). As the authors note 'In the case of Family Systems Theory, these descriptions and prescriptions concern the ways in which the professionals ask questions and deliver other interventions to the clients' (ibid.: 730-731). In addition, my own institutional identity as a systemic psychotherapist has aided the process of making such connections, rendering them less arbitrary. Moreover, in a feedback session with the practitioner who produced the data I had the opportunity to discuss the connections between the interaction in the data and particular systemic therapy theories, reaching a joint version on the therapy description that would be most appropriate for these interactional snapshots. However, even such 'safeguards' could not eliminate entirely the misty nature of links between therapy theory and practice; the unstable ground upon which such connections rest continues -at least to some extent- to be present.

The last point puts on the table my identity as a systemic psychotherapist which has shaped the text of the thesis in many other ways. One notable such way is the focus on the systemic perspective, particularly when producing connections between the identified instances of argumentation in the data and therapy practice. The exclusive focus on the systemic approach could be justified by the participant therapist's professional identity as a systemic psychotherapist. However, it might also be accounted for by my own interest in this specific approach and a perhaps unjustified tendency to maintain the theoretical divisions drawn by professionals. In actual fact it is probable that such instances of argumentation are generalizeable to other psychotherapy approaches too, that have not been included in this work. One such candidate approach is the cognitive behavioural approach which indeed makes open references to practices of disputing as can be seen from the work of practitioners such as Neenan and Dryden (1999).

Last but not least, one could question the use of the term argumentation as an umbrella term encompassing the instances described in the thesis, in comparison with other possible terms. An alternative, if not competing term that often features in conversation analytic texts that analyse interaction in institutional settings is that of 'resistance' (e.g. Hutchby, 2007; MacMartin, 2008; Stivers, 2005b; Vehvilainen, 2008). The term

argumentation has been preferred to the term resistance for a number of reasons, the main one being its dual meaning which captures both the 'building a logical case' aspect of the data, as well as the series of oppositional moves unfolding in the interaction. In addition however, opting for the term resistance could risk contributing to the depiction of the client as 'resistant' whilst simultaneously downplaying the therapist's contributions to such a portrayal. By contrast, the term argumentation captures the reciprocal aspect of the disaffiliation or opposition that occurs from both participants. Linked to that, the responsibility or the agency for the phenomenon's production tends to be shared rather than resting mostly upon the client. This cannot be described by the term 'resistance' as customarily one would not talk about 'resistant therapists'. Simultaneously, the use of the term argumentation does not rule out the occurrence of resistance on the client's part; rather this is seen as part of a broader phenomenon.

Before concluding this section, it would be appropriate to discuss some limitations of this piece of work. The phenomena presented in the analytic chapters have been drawn from conversations occurring between two participants only and also appear a small number of times. From a conversation analytic perspective this does not diminish the worth or the significance of the phenomena presented as, even if a conversational phenomenon occurs a single time, it still reveals a palpable aspect of the social world and the intelligibility by co-interactants of the conversational resources that they employ to perform actions. Nevertheless, the analysis could have been strengthened had there been a larger collection of the phenomena at hand, or had the data been drawn from conversations among different persons or from different sites, as this would have probably revealed a larger variation of the phenomena (Heritage, 1988) and would have yielded a more in-depth understanding of these psychotherapeutic practices.

7.6   Some basic contributions of the thesis

This journey on persuasive argumentation in systemic therapy interaction concludes by highlighting some of the main contributions of the thesis. Aside from describing three novel conversational practices[19] this piece of work offers an account of the

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[19] With regards to the practice of 'uncovering a contradiction', although similar dialogical arguments have been previously noted in the literature (Antaki et al., 2004) what is rather unusual in the arguments in the data is that the therapist largely elicits reports of the client's experience to construct the premises of the argument;

form that argumentation might take in psychotherapeutic interaction; this is particularly important as from a conversation analytic perspective the study on argument talk has largely been shaped by arguments in types of interaction where a great deal of aggravated opposition takes place (Dersley and Wootton, 2000). The practices described in this work depart from this trend, allowing us to envisage arguments in a type of interaction in which arguments are normatively considered as unlikely.

Linked to that, the thesis offers an interactional account of rhetorical arguments, whose study has to a large degree been appropriated by the fields of formal or informal logic; these disciplines tend to a larger or smaller extent to remove rhetorical arguments from their natural context and to elevate them to abstract or idealized processes. In this piece of work we had the opportunity to examine how pieces of reasoning (or in fact irrationality and subjectivity) are being recruited by participants as interactional resources, and how participants display or orient to a logical case in their talk as a way of advancing their interactional projects. The practices described in chapter five in particular, demonstrate that the study of rhetorical arguments in naturally occurring talk cannot be separated from how these unfold interactionally, from how they are being delivered or from how they are being received by one's interlocutor.

To move to a different issue, this thesis has focused on practices which from a systemic therapy perspective are described in rather different terms given that there is no mention of the particular interactional effects that these seem to have in actual interaction - as these emerge from the data. These external descriptions offered by the thesis not only supplement the psychotherapeutic ones, but also seem to have exposed a blind spot of systemic therapy theory, given that they have revealed a rather notable absence of any reference to the role of persuasive argumentation as a means for accomplishing change.

Finally, despite the fact that the thesis does not take the construction of HIV as its central topic, it offers a sociological imprint of how this illness is being constructed in the years that this work has been produced. What is notable is that the current constructions of professionals and of people living with the condition differ from those that were pertinent fifteen or twenty years ago as these are presented by Perakyla (1995). What is also notable with regards to how the illness is constructed at the time that the thesis has been produced, is the difference between the constructions of the illness by a front-line professional and a person living with HIV. Although constructions are fluid and differ according to the

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in addition, the variant of this practice, the questions that raise accountability by turning a claim on its head have not been previously described in conversation analytic studies.

interactional occasion in which they arise (Potter, 1996), it could be argued that in this data the therapist invites the client to embrace some relatively 'novel' constructs in a rather systematic way. In that regard the exchanges in the data seem to offer an interactional snapshot which reveals how the construction of the illness is progressively transformed as new medical advances emerge over the years and how new constructions might potentially be resisted given the cost that this transformation might have for people living with the condition.

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Appendix A: Transcription Conventions

The glossary of transcript symbols used in the present thesis is mainly based on descriptions provided in Jefferson (2004: 24-31).

[*A left bracket* indicates the point of overlap onset.

]   *A right branket* indicates the point at which two overlapping utterances end, if they end simoultaneously, or the point at which one of them ends in the course of the other. It also is used to parse out segments of overlapping utterances.

=   *Equal signs* indicate no break or gap. *A pair of equal* signs, one at the end of one line and one at the beginning of a next, indicate no break between the two lines.

, . ?   *Punctuation markers* are used to indicate 'the usual' intonation. The comma sign denotes a falling intonation, the period a terminal intonation, and the interrogation mark a rising intonation.

↑↓   *Arrows* indicate shifts into especially high or low pitch.

(0.8)   *Numbers in parentheses* indicate elapsed time in tenths of seconds.

(.)   *A dot in parentheses* indicates a brief interval (± a tenth of a second) within or between utterances.

::   *Colons* indicate prolongation of the immediately prior sound. The longer the colon row, the longer the prolongation.

⁻   *A dash* indicates a cut-off.

___	*Underscoring* indicates some form of stress, via pitch and/or amplitude. A short underscore indicates lighter stress than does a long underscore.
w<u>o</u>:rd	If a letter preceding a colon is underscored, the sound represented by that letter is 'punched' up.
wo<u>:</u>rd	If the colon is underscored, then the sound at the point of the colon is 'punched' up.
<u>wo</u>:rd	If underscoring occurs prior to the vowel preceding the colon, then the entire word is 'punched up'.
WORD	*Upper case* indicates especially loud sounds relative to the surrounding talk.
(word)	*Parenthesized words and speaker* designations are especially dubious.
°word°	*Degree signs* bracketing an utterance or utterance-part indicates that the sounds are softer than the surrounding talk.
hhh	A raw of 'h's indicate an outbreath.
.hhh	A dot-prefixed raw of 'h' indicates an inbreath.
wohhrd	A raw of h's within a word indicates breathiness.
(h)	*Parenthesized h* indicates plosiveness. This can be associated with laughter, crying, breathlessness, etc.
£	*The pound-sterling sign* indicates a certain quality of voice which conveys 'suppressed laughter'.
*	*The asterisk* indicates 'creaky voice'.

¿	*The inverted question mark* is used as a substitute for the question-mark/comma.
( )	*Empty parentheses* indicate that the transcriber was unable to get what was said. The length of the parenthesized space reflects the length of the ungotten talk.
(( ))	*Doubled parentheses* contain transcriber's descriptions.
<word	*A pre-positioned left carat* is a 'left push', indicating a hurried start; in effect, an utterance trying to have started a bit sooner than it actually did.
word<	*A post-positioned left carat* indicates that while a word is fully completed, it seems to stop suddenly.
> <	*Right/left carats* bracketing an utterance or utterance-part indicate that the bracketed material is speeded up, compared to the surrounding talk.
< >	*Left/right carats* bracketing an utterance or utterance-part indicate that the bracketed material is slowed down, compared to the surrounding talk.
.pt	Indicates a conventional representation of a slight lipsmack.
heh, huh	Indicate conventional 'little laughter' sounds.
.shih	Indicates wet sniff
		A vertical bar indicates a tapping sound produced simultaneously with the emphatically uttered part of the utterance.

APPENDIX B: CONFIRMATION OF ETHICAL CLEARANCE

LOUGHBOROUGH UNIVERSITY

ETHICAL ADVISORY SUB-COMMITTEE

RESEARCH PROPOSAL
INVOLVING HUMAN PARTICIPANTS

_____

Title: An analysis of psychotherapeutic practices

Applicant: Professor C Antaki, V Chrysikou

Department: Social Sciences

Date of clearance: 19 January 2006

Comments of the Committee:

The Sub-Committee noted that the proposal was thoughtful and thorough in its consideration of potential risks and difficulties, and agreed to issue clearance to proceed subject to the following condition:

- That telephone contact details for the investigators were included on the Information Sheet.

National Research Ethics Service

Nottingham Research Ethics Committee 2

1 Standard Court
Park Row
Nottingham
NG1 6GN

Telephone: 0115 9123344
Facsimile: 0115 9123300

26 July 2007

Ms Vasiliki Chrysikou
PhD student
Department of social sciences, Loughborough University
Room U4.11,
Department of Social Sciences,
Loughborough University, Loughborough, Leicestershire
LE11 3TU

Dear Ms Chrysikou

Full title of study:	A conversation analytic study of psychotherapeutic practice
REC reference number:	07/Q2404/62

Thank you for your letter of 28 June 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA. There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application		16 April 2007
Investigator CV		16 April 2007

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Protocol	1	13 December 2006
Letter from Sponsor		21 December 2006
Compensation Arrangements		01 August 2005
Participant Information Sheet: For parents / guardians	2	28 June 2007
Participant Information Sheet: For Children from 7 to 10 years old	2	28 June 2007
Participant Information Sheet: For children from 11 to 15 years old	2	28 June 2007
Participant Information Sheet: For psychotherapy clients	2	28 June 2007
Participant Information Sheet: For psychotherapists	2	28 June 2007
Participant Consent Form	5	13 December 2006
Response to Request for Further Information		28 June 2007
Assent form for children		
University Confirmation letter		17 May 2006
Allocation of Co-sponsorship		03 June 2006
Allocation of Co-sponsorship		03 June 2006
CV - Educational Supervisor		01 January 2007

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from http://www.rdforum.nhs.uk/rdform.htm.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Feedback on the application process

Now that you have completed the application process you are invited to give your view of the service you received from the National Research Ethics Service. If you wish to make your views known please use the feedback form available on the NRES website at:

https://www.nresform.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx

We value your views and comments and will use them to inform the operational process and further improve our service.

07/Q2404/62	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Dr M Hewitt/Ms L Ellis
Chair/Research Ethics Manager

Email: linda.ellis@nottinghamshirecounty-tpct.nhs.uk

Enclosures: *Standard approval conditions SL-AC2*

Copy to: Mr Peter Townsend, Loughborough University

Vasiliki Chrysikou
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Simons Court
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16 February 2007

Dear Vasiliki Chrysikou

Re: Your application for ethical clearance

Your application was discussed by the KCC Foundation Ethics Committee in December and I am pleased to be able to tell you that your application was approved.

Yours sincerely

Meg Carter
Acting Chair, KCC Foundation Ethics Committee