Final published version: Smoliak, O., MacMartin, C., Le Couteur, A., Hepburn, A., & Elliott, R. (in press). Authority in therapeutic interaction: A conversation analytic study. *Journal Marital & Family Therapy.*

Authority in Therapeutic Interaction: A Conversation Analytic Study

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Abstract

A paradigmatic shift toward postmodern, collaborative practice in family therapy raises questions about how therapists can use professional authority to facilitate change and how clients can assert their knowledge and agency. We used conversation analysis to investigate how the authority to know and to determine here-and-now action (i.e., who does what, and how, in therapy) was negotiated and accomplished in 10 sessions of emotion-focused therapy involving chair work. Therapists were observed to rely on a particular interactional sequence structure: *stepwise entry into a directive*, in which directives were preceded by a question-answer sequence. We show how instances where clients' views were elicited *prior to the delivery of a directive* resulted in different interactional consequences from instances where therapists straightforwardly directed clients to perform some action. The study offers evidence concerning how therapists can facilitate chair work collaboratively and responsively.

Keywords: authority, power, conversation analysis, chair work, emotion-focused therapy, epistemics, deontics

Authority in Therapeutic Interaction: A Conversation Analytic Study

The topic of therapist authority or power has been a central and much-debated issue family therapy (e.g., Atkinson, 1993; Guilfoyle, 2003). Indeed, it was the critique of the therapist's ultimate authority vis-à-vis clients that marked a paradigm shift in family therapy toward postmodern ideas and practices (e.g., Anderson, 1997; McNamee & Gergen, 1992). Postmodern therapists challenged the notion of an expert practitioner and highlighted the importance of client-therapist collaboration, respect for clients' knowledge, and co-creation of meanings. These ideas about collaboration in therapy, coupled with other influences (e.g., humanistic, feminist, common factors, alliance), have had a profound impact on the contemporary practice of family therapy, which is becoming increasingly collaborative and less hierarchical (Tuerk, McCart, & Henggeler, 2012). Despite the shift toward more collaborative practice, there is little guidance on *how* therapists' expertise might be balanced with, rather than overpower, clients' subjective knowledge. Emotion-focused therapy (EFT) has been at the forefront of developments in collaborative therapeutic practice (e.g., Greenberg, 2014; Watson, 2019). EFT is a well-known humanistic approach aimed at deepening and transforming clients' emotional experience (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2015). EFT practitioners seek to balance *directivity* (which they refer to as process guiding) and *non-directivity* (which they refer to as fostering client personal agency and collaboration). Whereas directivity highlights therapists' professional knowledge and agenda and involves active guidance of clients toward change, non-directivity is about offering opportunities for clients to find their direction and voice (Elliott & Greenberg, 2007).

A hallmark of EFT (Goldman, 2019), chair work, involves a dialogue facilitated in therapy between the client and the client's non-present significant other, or between two aspects or parts of self (understood as an internal system of self-aspects). It is an intervention rooted in gestalt therapy (Perls, Hefferline, & Goodman, 1951) that has been expanded and advanced by EFT practitioners (Greenberg, 2015). Chair work comes in three forms. *Empty-chair dialogue* is used to work on unresolved interpersonal issues with a family member or significant other. Clients are asked to imagine a significant other in an empty chair, express their feelings and needs to the imagined other, and then switch chairs and respond (Elliott & Greenberg, 2007). *Two-chair dialogue* is used when clients experience inner conflict. Clients are instructed to move back-and-forth between the chairs, taking turns speaking as different parts of the self. Often, they are instructed to enact a critical part of the self to criticize another part (referred to as "the experiencer") and then switch chairs to express the experience of being criticized (Elliott, 2013). A new form of chair work—*compassionate self-soothing*—involves a nurturing part of the self (or an imagined significant other) supporting a vulnerable part of the self (Elliott, 2013; Goldman & Greenberg, 2013). Chair work is not only the most well-known EFT intervention but is also the most directive. To establish imaginary chair dialogues and guide clients toward change, therapists rely extensively on process directives (Greenberg & Paivio, 1997; Muntigl, Chubak, & Angus, 2017; Sutherland, Peräkylä, & Elliott, 2014). As a highly directive environment, chair work is an ideal EFT intervention for investigating tensions between professional and subjective authority.

Despite its origins in individual therapy, chair work can be used with couples and families (e.g., Goldman & Greenberg, 2013; Smith & Quirk, 2017). Emotion focused couple therapy is a systemic approach focused, in part, on interactional patterns in couple relationships. In contrast, emotion-focused therapy has conventionally been seen as an individual approach (i.e., does not

theorize distress in relational terms). Having said this, we see a relational aspect to chair work. EFT practitioners using chair work draw on attachment theory (Bowlby, 1969), among other influences, to conceptualize and address clients' distress relationally. It is the relationship (to other aspects of the self or to a significant other) that is re-enacted, explored, and transformed through chair work (Soth, 2018). Individuals are seen as internally enacting relational dynamics previously enacted between them and their significant others. Although the study examined the use of chair work in individual therapy, it can offer valuable insights to systemic practitioners about important matters, like emotions and how to work with them therapeutically, excluded from systemic theorizing.

The EFT literature has focused on what attitudes of directivity and non-directivity, and the tension between them, might entail in principle. The interactional enactment of these attitudes deserves further investigation to offer greater clarity and detail to practitioners seeking to influence clients in collaborative ways. To address this gap, we used conversation analysis (CA) to examine the authority to know and define reality and to determine another's future action in therapy. We analyzed recorded sessions of EFT involving chair work. We approached authority interactionally, that is, as accomplished and negotiated (e.g., asserted, ratified, challenged) through the back-and-forth of interaction in therapy.

Conversation Analytic Study of Authority and Power

Conversation analysis is the leading approach to the study of talk and social interaction across disciplines (Sacks, Schegloff, & Jefferson, 1974; Stivers & Sidnell, 2013), having been developed by sociologists in the United States in the 1960s. CA investigates naturally occurring interaction in everyday and professional settings. Interactions are recorded and transcribed in minute detail (e.g., overlapping talk, intonation, emphasis, precise length of pauses). CA's key premise is that social interaction is orderly, and that this order is ongoingly, incrementally, and jointly achieved by the participants. Participants in an interaction jointly rely on culturally available methods of acting and reasoning to produce an orderly and mutually understandable interaction and to accomplish a range of social activities (e.g., jointly prepare a meal, conduct a surgery, or formulate a problem in therapy). CA aims to identify and describe these methods in fine detail. Sequentiality of actions is the key aspect of this interactional order. CA researchers have described how actions are sequenced in particular ways, often as paired actions (e.g., answers are produced in response to questions). Conversation analysts study how actions are linguistically designed, responded to, and sequenced in the flow of interaction. Participants not only act, but they also interpret each other's actions and work to maintain mutual understanding. Each utterance displays an interpretation of a preceding utterance and is a way for participants to ensure that they understand each other, or to signal misunderstanding (Sidnell, 2010). Because this interpretive work is mutually displayed by interactants, meaning-making is amenable to detailed analysis.

The conversation analytic study of psychotherapy is a rapidly growing field. Since the first CA study of psychotherapy (Davis, 1986), there have been more than a hundred works published (for an overview see Madill, 2015; Peräkylä, 2013, 2019), including in family therapy (see Tseliou, 2013). CA of therapy talk can offer critical insights to practitioners about options for action and potential action trajectories (if I design an utterance like this, this is how a client may respond; before I do X, it may be helpful to do Y). CA seeks to identify generalities and patterns in how talk is done through a bottom-up analysis of collections of specific instances of interaction. The focus is thus on talk in naturally occurring situations - in the present case, on

recordings of actual therapy sessions. As a context-sensitive and naturalistic approach to the study of therapy, CA can offer knowledge that is close to real-life practice and, as such, is argued to be practically meaningful (O'Reilly & Lester, 2019). It offers a means of elucidating how phenomena (e.g., identity, blame, diagnosis) are constituted interactionally. Therefore, there is a social constructionist (Gergen, 2015) undercurrent to CA, although this has been debated (e.g., Speer, 2012; Whelan, 2012). Most CA studies of authority and collaboration have focused on postmodern, collaborative therapies (e.g., Couture & Sutherland, 2006; Sutherland & Strong, 2011), necessitating the study of authority in other approaches.

From a CA perspective, authority is conceptualized as a dynamic, multifaceted, and interactive process rather than as a static variable (Zur, 2009). For example, in medical encounters, Maynard (1991) described power discrepancies as not simply "being imposed", but as being "interactively achieved" (p. 449). Rather than seeing therapists as inherently and invariably possessing expert authority that they can impose on fragile and passive clients, Maynard and others (e.g., Heritage, 2013; Peräkylä, 1998) have approached authority as interactionally negotiated. Both therapists and clients may claim or assert (superior) authority and challenge each other's claims of authority. Accordingly, it is important to study *sequences of talk* or the recipient's response and the subsequent conversational trajectory (Maynard, 1991).

Authority has been examined within CA using the concepts of epistemics and deontics. Whereas *epistemics* addresses how knowledge is distributed among speakers in a specific interaction or how speakers treat each other as more or less knowing about certain matters (Heritage, 2013), *deontics* concerns authority to determine one's own or another's immediate or remote action (Stevanovic & Peräkylä, 2012). Existing CA studies of epistemics and deontics in therapy have shown that clients are routinely treated as having greater access and rights to describe and evaluate their experience relative to professionals (Peräkylä & Silverman, 1991; Weiste, Voutilainen, & Peräkylä, 2016), including in chair work (Muntigl et al., 2017). Epistemic authority has been studied in therapists' formulations/summaries and interpretations (Weiste et al., 2016), questions (Muntigl & Chow, 2010), and proposals (Ekberg & LeCouteur, 2015). Muntigl and Chow (2010) examined couple therapy, showing how clients used 'no memory' epistemic claims to resist ascriptions of blame. Ekberg and LeCouteur (2015) studied the link between epistemics and deontics. They showed how clients resisted therapists' proposals by issuing "inability claims" (e.g., this won't work because I've tried it before) that evoked their epistemic primacy and deontic authority to determine the changes they implemented (or not) in their lives. Cumulatively, this work highlights how participants in therapy treat as relevant epistemic and deontic rights and obligations and shows that authority to know, and to determine action, is accomplished alongside other social and therapeutic activities (questioning, formulating, blaming, etc.). In this study, we sought to address the research question of how epistemic and deontic authority is asserted, claimed, and negotiated during chair work in EFT.

The growing body of therapy literature that suggests flexibility in treatment approaches is beneficial and facilitates clients' engagement (e.g., Constantino, Boswell, Bernecker, & Castonguay, 2013; Owen & Hilsenroth, 2014). Therapists are called to be responsive to clients (their preferences, understandings, values, characteristics, etc.), providing each client with a different, individually tailored treatment (e.g., Stiles & Horvath, 2017). The present study fits within, and contributes to, this body of literature by examining *how* therapist responsiveness and displays of clients' preferences are done in actual interaction.

Method

We used CA to examine 10 (five video and five audio) recordings of EFT containing chair work (approximately 8 hours total). The sessions were selected by the fifth author from a larger collection of recordings of EFT for social anxiety, collected in the United Kingdom, except for one recording that was developed by the American Psychological Association for training purposes. EFT sessions were selected where chair work was extensively used within a session (for a total of 209 chair work directives), consented by clients and therapists to be used for research purposes, and illustrated the use of chair work by different therapists. Participants were mostly speakers of British English, with one therapist and one client speaking North American English, and one therapist speaking a blend of South African and Canadian English. Seven out of 10 recordings were examined in their entirety and ranged from 54 to 85 minutes in length. The first author was able to get access only to short segments (around 10 min each) representing chair work in the remaining three sessions. All 10 sessions represent sessions that occur later in the treatment (ranging from 4th to 38th session). The sessions involved three therapists (one female and two male) and nine clients (two male and seven female). All except one client were white, middle-class, and resided in the United Kingdom, with ages ranging from 20 to 56 years. For two of the segments, it was the first instance of chair work; for the rest, there had been multiple previous episodes of chair work in earlier sessions. All 209 directives were issued by therapists and addressed here-and-now (in-session) physical, verbal, or mental actions of clients (e.g., *look in the eyes*, *push*, *ask*, *tell*, *give compassion*, *feel*, *imagine*). Out of all directives, 123 were highly prescriptive. They were grammatically formatted as imperatives (*move, imagine*, *tell*, *hug*) and were not mitigated (e.g., using *could you*, *would you be willing to*, *a little*, *perhaps*).

The data were transcribed according to CA conventions (Table 1; Hepburn & Bolden, 2013). Analytically, we sought to identify patterns in language use and interaction. The first author conducted the data selection and analysis following the steps outlined in practical guides to CA (e.g., Hutchby & Wooffitt, 2008; Sidnell, 2010). Other co-authors commented on and edited the conclusions. The first author located a potentially interesting phenomenon, namely questions sequentially preceding directives. She built a collection of instances of the phenomenon (N=43). She then sorted instances based on clients' responses to questions and directives, and analyzed each subset of instances in terms of turn-taking organization, turn-design, sequential positioning of turns, repair organization, and the overall organization of interaction. The goal was to clarify what interactional work was accomplished through the use of the identified sequential pattern (i.e., questions preceding directives). Particular attention was paid to participants' interpretations of each other's actions, using the *next-turn proof procedure* (Sacks et al., 1974). This procedure in CA treats the next speaking turn as evidence of what the prior turn is doing. Codes and observations were made in a separate column of each instance's transcript. General observations were then formulated and supported by examples. Deviant case analysis (i.e., instances that challenge the proposed pattern) was used to further support generated conclusions.

We are an interdisciplinary and international (Canada, Australia, the United States, the United Kingdom) team of practitioners and language-and-social-interaction scholars who have contributed to the CA study of therapy. We have examined therapists' advice, directives, proposals, and questions in professional encounters (AUTHOR CITATIONS). The study was approved by the University of X and the University of Y Research Ethics Boards.

Results

Therapists were observed to rely, recurrently, on a particular sequence structure: *stepwise entry into a directive*, in which a directive is prefaced by a question-answer sequence. The question is used to elicit a particular kind of response, and the directive is then grounded in this response. Straightforwardly directing clients to perform specific actions during chair work might engender various troubles. Clients may not understand what they are asked to do. They may question the relevance of actions or refuse to comply, disrupting the smooth progression of chair work. They may also call into question therapists' right to know what they can say to (or as) their non-present significant others or aspects of self. Stepwise entry serves to create a favorable environment for a directive. It allows therapists to elicit clients' perspectives, gain access to their inner experience to be able to work with it, and work to minimize clients' reluctance to perform directed actions. The structure of stepwise entry can be presented as follows:

T: WH-QUESTION (e.g., what, how, who) – requests information
C: ANSWER – supplies requested information
T: DIRECTIVE – tells a client to say or do something in a chair dialogue
C: COMPLIANCE – performs directed action

An optional third-position turn (following an answer) can be used to acknowledge the receipt of information, display understanding, or evaluate the client's performance of an action. Most directives in the corpus mobilized or re-used the content conveyed in the clients' *immediately preceding* answers or confirmations. There were also instances of directives drawing on content that had been established as shared, gradually, *over many speaking turns* (i.e., over the preceding 10 minutes of talk). We considered the entry into these directives to be stepwise as well.

We identified two patterns involving this structure. In instances where clients produced therapeutically relevant responses (i.e., provided requested information and performed the directed actions), chair dialogues progressed smoothly. In these cases, clients' perspectives on their experience, once elicited, became the basis of imaginary chair dialogues. By contrast, in instances where clients struggled to respond to wh-questions in therapeutically relevant ways (i.e., where they did not answer or comply), the smooth progression of chair work was disrupted. In such cases, clients used epistemic disclaimers (e.g., I don't know, I'm not sure) that challenged their presupposed access to subjective knowledge. Clients' claims of no knowledge initiated a shift in therapists' epistemic stance from less knowing to more knowing. In these environments, it was therapists' knowledge, as confirmed by clients, that became the basis of chair dialogues. We describe each pattern with four illustrative examples and conclude by presenting an example of a therapist directing a client straightforwardly, rather than taking the stepwise route. Conclusions in the examples we discuss are representative of the results of our analysis for the entire dataset (209 directives). Table 2 reports on the frequencies of directives in each session, stepwise entries into a directive, and instances of clients' non-compliance with directives. Out of 11 instances of client non-compliance, five appeared to be related to a lack of stepwise entry into a directive (i.e., the therapist abruptly introducing the directive content or action without having first negotiated it with the client). Other examples of clients' non-compliance seemed to relate to clients not understanding what they were asked to do. Throughout the corpus, chair work was mostly organized as a back-and-forth between question and directive sequences. In two out of the 10 sessions, therapists did not use directives to facilitate chair work, instead relying on other means (e.g., questions, formulations, observations, clients' reports of imagining, or doing something in relation to a non-present other); neither of these therapists was engaging in standard EFT practice. (In one session the client had

consistently refused to do chair work and was instead talking to an empty place in the room; in the other session the therapist was a Gestalt therapist practicing chair work in a non-EFT way.)

Stepwise Entry into a Directive

Smooth Progression of Chair Work

The following two fragments demonstrate stepwise entry into a directive – how therapists can use information-eliciting questions to involve clients in co-shaping what they can say or do to (or as) non-present others. Client consistently comply (e.g., enact directed actions, produce answers to questions) and chair work progresses smoothly. The first fragment is taken from two-chair dialogue for self-criticism. The interaction is between a white, male therapist and a white, female client. One part of the client (the inner critic) is in dialogue with the other part (the experiencer). The client is directed to imaginatively suspend an ordinary (client-therapist) participation framework and enter a self-critical participation framework (Goffman, 1981; Sutherland et al., 2014). The information elicited and supplied in the ordinary participation framework (lines 1-11) becomes the basis for the critic-experiencer dialogue (lines 12-13).

Fragment 1 (SA-097, 30:04 minutes into session 4)

1	T:	How do you feel about that part (.) the critic,	WH-QUESTION
2		(1.0)	
3	T:	°How do you feel about he:r°	
4		(.)	
5	C:	Kind of a↑nno::yed at her be[ing th]e::re a::nd,	ANSWER
6	T:	[Okay]	
7		(1.0)	
8	C:	Just wish it would go to one si::de or be more under contro:::l,	
9	T: →	O↑kay (0.4) tell her (0.6) I'm annoyed with you:,	DIRECTIVE
10	C:	Yea:::h you you've no place ↑he:::re, (.) right no::w,	COMPLIANCE

The client is mutually treated as having superior epistemic authority (being more knowledgeable than the therapist) in the domain of her subjective experience. The therapist's utterance at line 1 ("How do you feel about that part (.) the critic") elicits the client's feelings about, or attitude toward, the inner critic. The question is heard by the client as *requesting* information about her experience, as evident in her *supply* of that information. The information-seeking wh-question (Wh-Q) affirms the client's epistemic primacy; it positions the therapist as an unknowing (K-) questioner and the client as a knowing (K+) recipient (Heritage, 2013). The information supplied ("anno::yed", line 5) is then recycled in the therapist's subsequent directive ("tell her (0.6) I'm annoyed with you:", line 9, marked with an arrow; recycled material is highlighted in grey). The stepwise entry into a directive establishes the client's experience as shared knowledge, and increases the likelihood that the client will enact the chair dialogue as directed (i.e., convey the directed speech to the critic).

The therapist enacts superior deontic authority (Stevanovic & Peräkylä, 2012), evident in him *directing* the client, and in the client *complying* with the directive by performing the directed action. The imperatively formatted directive (tell her…) is relatively prescriptive. It expects immediate compliance from the client and does not orient to any potential unwillingness or inability to comply. There are no devices that soften or mitigate the prescriptive force of the directive (e.g., would you be willing…, could/can you…, maybe, a little, try it). The client

complies by reproducing, in paraphrased form, the directed speech to the inner critic. In so doing, she temporarily relinquishes her autonomy, and allows the therapist to guide her through the chair dialogue.

Although therapists routinely sought clients' perspectives on their inner experience (privileging clients' epistemic authority), on some occasions, therapists sought clients' input regarding the process of chair work, or shared deontic authority with clients. Clients were asked to identify a soothing or critical agent/role to enact at a specific moment of chair work (e.g., whether to speak to, or as, the imagined other). Fragment 2 is an example of a therapist eliciting and incorporating the client's preferences for chair work. The dialogue is between a white female client and a white male therapist. The client (adult part of her self) is asked to imagine a sad, lonely child in the empty chair (not shown) and to talk to the child. The EFT assumption is that the child is a vulnerable part of the client longing for validation, recognition, and support. The compassionate self-soothing task is used to facilitate corrective attachment or relational experiences, and help clients develop their self-soothing capacities.

Fragment 2 (SA-276, 41:06 minutes into session 13)

1	T:	What can you say to her,	WH-QUESTION
2		(1.4)	
3	C:	I'd a- I'd ask her what was wro::ng	ANSWER
4		(0.4)	
5	T: →	Go ahead ask her (0.4) yeah	DIRECTIVE
6	C:	What's wro:ng are you okay	COMPLIANCE
7	T:	Okay	
8		(1.0)	
9	C:	Do you want someone to talk to:	
10		(2.2)	
11	T:	Oka::y (0.4) good, (0.4) do you wanna be he::r or	ALT-QUESTION
12		you wanna just (.) talk to he::r	
13	C:	U:m (.) just talk to her	ANSWER
14	T:	That's fine okay alright (.) alright	

We see the recurrent structure of Question-Answer (Q-A, lines 1-3) followed by Directive-Compliance (D-C, lines 5-9). The therapist's evaluation of the client's telling concludes the D-C sequence ("Oka::y (0.4) good", line 11). The client is mutually positioned as more knowledgeable about her own experience, and the therapist as having greater authority to determine the client's here-and-now actions. The therapist then issues an alternative question (Alt-Q) that offers the client a choice between two candidate answers ("do you wanna be he::r or you wanna just (.) talk to he::r", lines 11-12). The client responds by selecting one of the options ("U:m (.) just talk to her", line 13). We highlighted "talk to her" in the transcript in the same way we highlighted the verbal content that gets recycled in therapists' directives. This is because the client's preference to talk *to* the child (rather than *as* the child) informs how the chair work proceeds, namely, the client is asked to talk to and hug the child, among other relational/soothing actions (not shown).

Disrupted Progression of Chair Work

Whereas Fragments 1 and 2 demonstrate a more typical progression through the Q-A-D-C structure, Fragments 3 and 4 represent a departure from this structure, which can take two forms:

1. T: WH-QUESTION (e.g., what, how, who) – requests information
   C: NON-ANSWER – does not supply requested information
   T: DIRECTIVE – tells a client to say or do something
   C: COMPLIANCE – performs directed action

or

2. T: WH-QUESTION (e.g., what, how, who) – requests information
   C: ANSWER – supplies requested information
   T: DIRECTIVE – tells a client to say or do something
   C: NON-COMPLIANCE – does not perform directed action

Instances of clients' reluctance in complying and answering were marked using a range of practices. Most frequently, clients used *epistemic disclaimers* (Lindström & Karlsson, 2016) or "no-access responses" (Fox & Thompson, 2010) (e.g., *I don't know*, *I am not sure*) to account for missing answers. We also observed clients asserting different perspectives (i.e., disagreeing), reasserting their previously asserted perspectives, and not taking up aspects of therapists' prior turns. When clients struggled to produce expected responses, sequential progressivity or movement through sequences of actions (Schegloff, 2007; Stivers & Robinson, 2006) was halted. To restore progressivity, therapists foregrounded their professional expertise, typically using *accounts* or explanations of how the mind works or how to address distress therapeutically. They made available to clients their professional reasoning, justifying the relevance and significance of these initiatives. Therapists also reformulated their open-ended Wh-Qs (for discussion see Fox & Thompson, 2010) into closed-ended polar (Yes/No) questions (see Raymond, 2003). Rather than seeking *information* from clients, polar questions seek *confirmation*. They offer candidate answers to clients to (dis)confirm when clients themselves struggle to generate answers. Overall, we noted the following pattern: when clients claimed to know less about their experience, therapists drew more on their professional expertise, and offered their knowledge to clients for confirmation or consideration. Fragment 3 exemplifies this pattern and represents two-chair work for self-criticism. In EFT, clients are encouraged to recognize that self-criticism is an attempt to avoid the pain of social rejection or invalidation, or that the inner critic's intentions are positive (Elliott & Shahar, 2019). In Fragment 3, the therapist talks to the client's inner critic, inquiring about her intentions in criticizing the experiencer.

Fragment 3 (SA-276, 27:51 minutes into session 13)

1	T:	Yeah that's the <u>me</u>ssage that you give her ri:ght yeah and	WH-QUESTION
2		what you're trying to <u>do</u> i:s (0.6) what (.) keep he::r in	
3		her pla::ce? I mean what's this pa:rt doing?	
4		(5.8)	
5	T:	.hhhh [See]	
6	C:	[It's] like I do:n't know she's been, (.) I don't	NON-ANSWER
7		kno:w (0.4)	
8	T:	Yeah (.)S<u>e</u>e the critic is always trying to <u>help</u> in some	
9		wa::y	
10		(0.4)	
11	C:	↑Yeah	
12		(0.6)	

13	T:	While ma:king (.) creating the problem (.) but what are	
14		you:, (.) (what) are you ↑trying	
15		(3.8)	
16	T:	Are you trying to pro↑tect he::r are you trying to, (0.4)	
17		wha:t	
18		(0.6)	
19	T:	U:m::	
20	C:	I think ↑it's trying to protect he::r but I'm not ↑really	
21		su:re what from	
22		(0.4)	
23	T: →	Okay (.) try it I'm trying to protect say tha:t	DIRECTIVE
24		(0.6)	
25	T:	[Just say]	
26	C:	[I'm tryi]ng to protect you:	COMPLIANCE
27		(0.6)	
28	T:	From (.) something	
29	C:	Yep from [something]	

When the client does not answer the therapist's Wh-Q (see the delay and *I don't know* epistemic declaimers, lines 4-7), the therapist offers an explanation that invokes his professional knowledge of how inner critics *in general* operate (note "the critic" refers to the generic critic, lines 8-9). The therapist explains that inner critics have positive intentions ("is always trying to help in some wa::y", lines 8-9). This presupposition gets embedded in the therapist's resumed Wh-Q directed to *the client's* critic ("what are you:, (.) (what) are you ↑trying", lines 13-14). Whereas the therapist is configured as K+ in the domain of inner critics in general, the client is positioned as K+ in the domain of her own inner critic.

We see another example of the client struggling to answer a Wh-Q (note a pause of 3.8 seconds at line 15). "Are you trying to, (0.4) wha:t" could be seen as a hybrid between a polar question and wh-question. It does not just leave the polar element out there, which would prefer a Yes or No response but offers a candidate for confirmation without pushing it. The therapist replaces the Wh-Q with a polar question, advancing for confirmation the notion that the client's inner critic is trying to protect her ("Are you trying to protect he::r are you trying to, (0.4) wha:t", line 16-17). (In EFT terms this is an example of an empathic conjecture.) The account, and polar question, help restore sequential progressivity. The client confirms, though weakly (delay, *um*, *I don't know*), the notion that the critic protects her but claims uncertainty about the source of danger ("I'm not really su:re what from", lines 20-21). The therapist orients to the weakness in the clients' uptake of his idea and mitigates (with "try it") his subsequent directive. He defers to the client (inner critic) to determine if she deems acceptable the proposed speech ("try it I'm trying to protect say tha:t", lines 23). The directive is presented as optional (a suggestion). By mitigating the directive, the therapist shares deontic authority with the client, involving her in determining what she does in therapy. The term "protect" is supplied by the therapist (line 16), endorsed by the client (line 20), and recycled in the directive (line 23). It becomes the basis of the chair dialogue, that is, it is integrated into the inner critic's speech to the experiencer (line 26). The fragment illustrates the link between epistemics and deontics (how access to knowledge relates to directivity). Therapists avoid importing into chair dialogues experiential material that has not been established as shared knowledge. They display

cautiousness in getting clients to communicate material within chair dialogues that has not been mutually endorsed.

Fragment 4 shows two-chair work for self-criticism. It shows instances of the client both not answering the Wh-Q and not complying with the directive.

Fragment 4 (SA-276, 24:04 minutes into session 13)

1	T:	Okay so wha- >what is it< what is (.) what does happen	WH-QUESTION
2		(1.4)	
3	C:	I get anxious:: like (.) I find it really difficult to make (.)	ANSWER
4		eye contact (0.4) and I also find it difficult to like (.)	
5		remember things to say	
6	T: →	Okay (0.4).hh So make it (.)So tell her not to make eye	DIRECTIVE
7		conta::ct.	
8	C:	Don't make eye conta:ct	COMPLIANCE
9	T:	°Yeah° what How do you do that.= How do you get her	WH-Q & YES/NO Q
10		not to make eye conta:ct.	
11		(0.8)	NON-ANSWER
12	T:	Do you shame he:r?	
13	C:	Jus- so anxious: th't (.) can't make eye contact.	
14		(0.4)	
15	T:	((nods)) .hh n- no:w no- ma- n- not ma:king eye contact	
16		often (.) goes with sha:me. °right, (.)	
17		Cos when you feel shame you kind of wanna shrink in	
18		and hide yourself and look awa:y. (.)	
19		Is that what you do=Do you shame [her]	
20	C:	[Yeah] I think,	
21	T: →	Okay so shame her.	DIRECTIVE
22		(.)	
23	C:	↑s- (.) ↓hu:h .hhh I'm not £su:re how£ hhh	NON-COMPLIANCE
24		(0.4)	
25	T:	You should be ashamed of yourself you're (0.4) not	
26		worthy, you're no::t (°liked°)	
27	C:	Yeah you're not worthy you don't dese:rve (.) this,	COMPLIANCE
28	T:	You don't dese::rve this attention	
29	C:	Yeah	

Initially, we see the Q-A-D-C pattern (lines 1-8). The therapist addresses the client and elicits the description of her experience ("wha- >what is it< what is (.) what does happen", line 1). The elicited content then gets recycled in the therapist's directive turn and becomes the basis of the critic-experiencer dialogue (line 8). We then see another Wh-Q which gets reformulated into a polar question (lines 9-10). A direct answer to the question would accept the question's presuppositions (Heritage & Raymond, 2012; Raymond, 2003). The therapist's questioning turn presupposes that the inner critic is the source of the client's avoidance of eye contact and that the critic works through shaming. The client does not answer and instead repeats her previous assertion ("Jus- sort of like (.) can't make eye contact", line 11). Faced with the client's reluctance to take up the notion of inner shaming, the therapist issues an account that links shame

and the avoidance of eye contact (lines 13-16). He mobilizes his professional knowledge of the human mind (note "often (.) goes with" and generic "you") and concludes the turn with a re-issued polar question ("do you shame her", line 16). The client confirms, though not solidly (line 17). The subsequent directive recycles the confirmed content ("so shame her", line 18). The client does not comply; she accounts for non-compliance by claiming uncertainty concerning how to execute shaming ("I'm not $su:re how$ hhh", line 20). The therapist offers guidance by providing a candidate speech or demonstrating shaming ("You should be ashamed of yourself …", lines 22-23). Implied is his superior knowledge of how inner critics operate. The client complies by performing self-shaming (line 24). Fragments 3 and 4 thus illustrate how clients' reluctance to provide information initiates a shift in therapists' epistemic stance from less knowing to more knowing. It is therapists' professional knowledge ("shame" and "protection"), confirmed by clients, that becomes the basis of chair dialogues.

Straightforward Directing

Fragments 1-4 show therapists eliciting and incorporating clients' perspectives before directing clients to perform specific actions in therapy. The use of Wh-Qs serves to prepare the ground for subsequent directives in situations where cautiousness in making assertions may be warranted. When therapists' turns were not designed so as to minimize the epistemic asymmetry in the domain of clients' subjective experience, clients produced non-complying responses, as shown in Fragment 5 (an exchange between a white male therapist and a white female client). This example involves a compassionate self-soothing task. Here, god as enacted by the client is the soothing agent. Before line 1 the therapist has been addressing the client in the role of god.

Fragment 5 (SA-011, 43 minutes into session 8)

1	C:	And you don't try to hurt people .hhh u:::m (0.8) then	
2		I watch you someti::mes and, (.) and (.) you just make	
3		me (0.4) lau::gh when I see::: (.) or listen to your	
4		↑pla:ns	
5	T: →	Mmhm (.) tell her how she looks (.) °tell her how she	DIRECTIVE
6		looks°	
7		(0.4)	
8	C:	U::m, (3.6) er (5.6) I don't know I don't think god	NON-COMPLIANCE
9		see::s (.) me	
10		[as I] loo::k (.) ↑how I look I think	
11	T:	[O:kay]	
12	T:	Okay ( ) how does god see you:,	WH-QUESTION
13	C:	U:::m (2.6) I ↑think god just god sees me as a (.) u::m	ANSWER
14		(0.4)	
15	T:	Sees you:r (.) beautiful sou:l	
16	C:	(Yeah) as a feeling person,	
17	T:	Oka::y	
18	C:	(Certainly) (.) ↑tha::t's what u:::m (.) how go::d, (0.4)	
19		I >don't think<, (0.4) go::d is	
20	T: →	It doesn't matte::r (.) >°okay so< tell her (.) .hhh it	DIRECTIVE
21		doesn't matter how you look (.) [I accept] you a- as=	
22	C:	[(It does)]	

23	T:	=youlook	
24	C:	It ↑<u>doe</u>sn't ↓<u>ma</u>tter how you look,	COMPLIANCE
25		[and] it never ↑has=	
26	T:	[(Good)]	

The client (as god) is directed to tell the client about the client's appearance ("tell her how she looks", line 5). There is no prior discussion of the client's appearance, nor questions posed about her appearance. The presupposition that the client's appearance is relevant to god has not been established as shared knowledge. There is no prior attempt to equalize the asymmetry or gain access to the client's (god's) perspective. Various markers that are indicative of the client's upcoming disagreeing response (e.g., delays, "u::m", "er", "I don't know", lines 7-10) can be seen. She comes out of chair dialogue to tell the therapist (as herself) that her appearance is not relevant to god. This telling marks the client's elevated access to her significant other's (god's) experience. The progressivity of chair work is suspended while the therapist clarifies the client's perspective on how god sees her. He issues a Wh-Q (line 12) and co-completes her answer when she observably struggles to answer (line 15). The therapist and client collaboratively unpack god's priorities (i.e., the client's soul, not her appearance) (lines 13-20), the material which becomes the basis of the therapist's subsequent directive (lines 23-26). The chair dialogue resumes as the client (as god) repeats the directed speech. Fragment 5 illustrates how clients are mutually treated as having primary epistemic access to the experiences of their significant others, and that clients hold therapists accountable for over-reaching into matters that are outside therapists' access.

Discussion

We investigated the conversational practices therapists use to balance their professional authority with clients' authority to know and determine their actions during chair work in EFT. Therapists used process directives to guide clients through therapeutic chair tasks. Therapists' knowledge of clients' experience can be questioned unless they attempt to gain access to clients' experience before they speak about it. Stepwise entry into a directive is a way for therapists to speak about clients' experience without undermining clients' epistemic primacy. Directives were routinely positioned after clients' perspectives had been obtained, and they were grounded in material supplied by clients in their prior talk. It is noteworthy that therapists' questions and formulations are not neutral tools to gather, or reflect back, information but are best viewed as interventive or co-constructive of the reality of clients' experiences and situations (Tomm, 1987). Questions often embed specific presuppositions about matters, and about what knowledge is relevant. Similarly, formulations tend to reshape clients' talk while appearing simply to reflect back what clients have said. Therefore, shared knowledge, although communicated by the client, can originate from the therapist, and reflect and advance therapists' professional agendas.

It is noteworthy, however, that chair dialogues were not based solely on clients' talk. Therapists actively co-shaped what was said or done in these dialogues. Although not the focus of this paper, these therapist practices included active voicing (speaking on behalf of clients), completing clients' speaking turns, formulations or summaries of clients' prior talk, closed-ended (alternative or polar) questions that advanced therapists' ideas, among other practices. These practices, while appearing merely to represent clients' talk, subtly advanced therapists' professional agendas. Therapists became particularly knowing, and guided or constrained clients' talk more, when clients observably struggled to enact chair dialogues or supply experiential

material to be used in chair dialogues. Clients' reluctance to respond in expected ways manifested both overtly (e.g., in disagreements) and subtly (e.g., in epistemic disclaimers). With these practices, clients resisted agendas and presuppositions generated by therapists' questions and directives. When faced with clients' reluctance to move forward in a chair task, therapists evoked their primacy in the domain of professional knowledge.

Our analyses point to: (a) clients having prime access and rights to describe and make sense of their inner experience and the appropriateness of such material for chair work, and (b) therapists having expert institutional knowledge about the clinical theory and procedures of effective chair work and the deontic authority to facilitate the enactment of chair work. Clients resisted therapists' *presuppositions* about their experience and significant others, but not the therapists' *agenda* to address clients' distress using chair work. In issuing directives, therapists routinely built on or incorporated material previously supplied by clients or "others" enacted by clients, underscoring the importance of clients not only asserting their general preferences for chair dialogues (identities, topics, issues) but being actively engaged in shaping the precise nature and content of chair dialogues moment-by-moment.

The current study provides an alternative conceptual and empirical foundation upon which to build research on authority in therapy. We offer an interactional approach to the study of authority that differs from conventional approaches that study therapists' authority, power, and influence as "variables" or unilateral, discrete acts of therapists or by retrospectively asking therapists and clients about it (e.g., McAuliffe & Lovell, 2011; McCarthy & Frieze, 1999). Accordingly, a CA lens reveals the complex and multidimensional nature of authority in practice, highlighting how authority varies in forms (epistemic and deontic), agents (clients and therapists), and domains (e.g., here-and-now and remote actions; professional and subjective knowledge). It also shows how authority is accomplished alongside other social and therapeutic actions and activities (e.g., directing, questioning, formulating).

Our conclusions support and extend prior work on epistemics and deontics in therapy contexts. Consistent with prior research, clients in our study were routinely treated as having prime access and rights to describe and make sense of their inner experience (Peräkylä & Silverman, 1991; Weiste et al., 2016). They evoked their subjective epistemic primacy to resist therapists' initiatives (e.g., Fragment 5) (Ekberg & LeCouteur, 2015). This is the first study of therapy that empirically demonstrates that people are treated as more knowledgeable than their other participants in the interaction about their significant others (e.g., relatives, friends, deity) (for everyday interactions see Raymond & Heritage, 2006). This relatively neglected epistemic domain may be especially relevant in family therapy that is focused on clients' relationships. The study also contributes to the literature on clients' resisting responses to professional initiatives (e.g., Koenig, 2011; Muntigl, 2013; Stivers, 2005). Clients used epistemic disclaimers (*I don't know*) to resist agendas and presuppositions generated by therapists' questions (for disclaimers in medical encounters see Lindström & Karlsson, 2016).

Finally, the study contributes to prior CA work on client involvement in professional initiatives, specifically stepwise entry into professional advice, diagnostic news, and proposals (e.g., Couture & Sutherland, 2006; Ekberg & LeCouteur, 2014; Maynard, 1991; Vehviläinen, 2001). We investigated stepwise entry into therapeutic *directives,* showing that the pattern of preparing for directives with information-eliciting wh-questions was used to involve clients in co-shaping the content and process of chair dialogues. Clients were more likely to perform directed actions when their epistemic primacy was recognized and when therapists' initiatives were grounded in clients' descriptions of their experience.

Implications for Therapy Practice

Therapists using chair work may wish to consider preparing for directives with information-eliciting Wh-Qs and recycling clients' descriptive language in directives, rather than straightforwardly directing clients to perform specific telling, or other actions, during chair work. Therapists can also involve clients in determining how chair work is done by eliciting, with wh- or alternative questions, and incorporating clients' preferences for therapy. If clients struggle to supply experiential material, therapists might increase their content directiveness by relying on more closed-ended polar questions that advance *their* ideas. They can also give clients access to their professional reasoning by issuing accounts.

This study supports, and further clarifies and exemplifies, the existing body of knowledge on the importance of therapist flexibility and responsiveness (e.g., Constantino et al., 2013; Elkin et al., 2014; Owen & Hilsenroth, 2014; Stiles & Horvath, 2017). It does so by offering concrete evidence of specifically *how* therapists can be flexible in their delivery of chair work: how they can prepare clients for chair work, and tailor their ongoing interventions in light of clients' anticipated or actual responses. When interventions were adjusted to clients' responses, clients were more likely to engage in (and potentially benefit from) chair work. Stepwise entry into a directive tended to result in the client complying with the directive. In contrast, when a straightforward directive was delivered, clients were less likely to comply. Future CA work can help clarify how therapists using other approaches and specific interventions can be flexible and responsive, and also shed light on the immediate, interactional consequences of therapists being more or less flexible.

The notion of therapist "directivity" and its opposites "collaboration", and "non-directivity", "client-centeredness" have been heavily contested in family therapy (Anderson, 1997; Atkinson, 1993; Guilfoyle, 2003). Within EFT, the interactions we presented, although clearly directive, are also likely to be seen as flexible, collaborative, and client-centered. Proponents of postmodern or social constructionist family therapy practice may question these conclusions by highlighting that EFT therapists collaborate with clients *within the constraints* of their professional frames (e.g., they elicit and advance meanings that support their professional framing and therapy direction). Postmodern therapists may pose the following questions: To what extent can all therapy participants shape the direction of, and meanings generated in, therapy? How much space do clients have to contest and depart from therapists' professional frames and agendas? These are relevant and important questions. At the same time, we believe that rather than settling on specific, singular definitions of proper ways of working with clients and using professional authority, it may be useful to create space for multiple perspectives.

CA has a distinct approach to the study of the broader culture, and speakers' social locations. It cannot offer insight into group differences (e.g., directivity of male versus female therapists, compliance of female versus male, or variously classed, clients), or how speakers' other social locations may impact their linguistic conduct. These questions are best addressed using critically-informed discursive, sociolinguistic and other approaches to research. Future CA studies can however be used to clarify whether and how membership categories like gender, race, class, and so on, can be mobilized interactionally, and for what social, rhetorical purposes in directive-response sequences.

Conclusion

Talk is at the heart of therapy. Clients and therapists use talk to empathize, interpret, seek and provide information, complain, affiliate, and justify, among other actions. It is through talk

that participants in therapy formulate clients' concerns, form alliances, and generate therapeutic alternatives. If communication is the base of therapy, it is crucial to understand how therapeutic change and collaborative therapeutic relationships are accomplished *through* talk. We have presented one example of CA's potential to elucidate the communicative, interactional basis of therapy and the therapeutic relationship – specifically, therapy participants' more-or-less subtle ways of orienting to each other's authority to know and determine what is done in therapy.

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Table 1
Conventions for Transcription

Symbol	Indicates
(.) (.5)	A pause that is noticeable but too short to measure & a pause timed in tenths of a second
=	No discernible pause between the end of a speaker's utterance and the start of the next utterance
::	One or more colons indicate an extension of the preceding vowel sound
Underlining	Words uttered with added emphasis
.hhh/hhh	Exhalation of breath/Inhalation of breath
( )	Inaudible material
[ ]	Overlap of talk
?	Strongly rising inflection
.	A fall in tone
,	Slightly rising intonation
° °	Talk between is quieter than surrounding talk
> < or < >	Talk between is spoken more quickly or slowly than surrounding talk
↑ ↓	Marked shifts into higher or lower pitch in the utterance part immediately following the arrow
-	Cut-off
(( ))	Transcriptionist's comments
huh	Laughter
$ $	Smiley voice
* *	Descriptions of embodied actions are delimited between (therapist)
+ +	Descriptions of embodied actions are delimited between (client)
*--->	The action described continues across subsequent lines
---->*	until the same symbol is reached.
--->>	The action described continues after the excerpt's end.

Note. Adapted from "The Conversation Analytic Approach to Transcription" (pp. 59-67), by A. Hepburn and G. B. Bolden, 2013, in J. Sidnell & T. Stivers, Eds., The Handbook of Conversation Analysis. Malden, MA: Wiley-Blackwell; and from Conventions for Multimodal Transcription, by L. Mondada, 2014, Retrieved from https://franz.unibas.ch/fileadin/franz/user_upload/redaktion/Mondada_conv_multimodality.pdf

Table 2
Frequencies of Chair Work Directives by Therapists and Client Responses

Recording	Number of Directives	Stepwise Entry	Non-Compliance
SA187-06 (57 min)*	20	19	1
SA058-38 (56 min)	1	1	0
SA011-08 (20 min segment)	17	15	1
SA141-14 (1 hour, 25 min)	34	33	3
SA168-12 (59 min)	1	1	0
SA097-04 (55 min)	21	21	0
SA273-16 (56 min)	45	44	1
SA011-4 (8 min segment)	17	17	2
SA276-13 (58 min)	43	41	2
EFT Over Time-03 (7 min segment)	10	10	1
Total	209	202	11

* SA – Social Anxiety corpus of data; 187 – case number, and 06 – session number, ( ) – session length