2017

A Conversation Analysis of Therapist-Client Interactional Patterns in Single Session Therapy: A Researcher's Interpretation

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A Conversation Analysis of Therapist-Client Interactional Patterns in Single Session Therapy: A Researcher's Interpretation

by

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A Dissertation Presented to the

College of Arts, Humanities, and Social Sciences

In Partial Fulfillment of the Requirement for the Degree of

Doctor of Philosophy

Nova Southeastern University

2017

Nova Southeastern University
College of Arts, Humanities, & Social Sciences

This dissertation was submitted by Nozomu Ozaki under the direction of the chair of the dissertation committee listed below. It was submitted to the College of Arts, Humanities, and Social Sciences and approved in partial fulfillment of the requirements for the degree of Philosophy in the Department of Family Therapy at Nova Southeastern University.

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Acknowledgements

It feels like forever since I started the doctoral program. At first, it felt that the path forward is very long, challenging, and intimidating because of my ability to believe in myself and my English language skills. I thank Dr. Christine Beliard, my dissertation chair, for keeping guiding and encouraging me to the completion of this dissertation. Your timely feedback was very reliable and valuable for composing the dissertation. Dr. Ron Chenail, a committee member of this dissertation, taught me how to approach data like a clinical qualitative researcher. You rigor and metaphors for research have tremendously shaped this dissertation. Dr. Jim Hibel, another committee member, consulted me and gave me nuggets for keeping cybernetic appreciation and inspiration in mind in the process of analysis. This dissertation is a culmination of my journey.

Once, upon my graduation from an undergraduate program, I gave up on my aspiration to become a therapist in the United States, because of my worry for my language proficiency to practice therapy in English, let it alone my writing skills to excel in classroom. My lost aspiration was rekindled by a few professors in Japan who encouraged me to pursue my dream in U.S. One thing led to the other. A couple of articles on systems approach to family therapy ended up in my hand. My journey began.

Dr. Douglas Flemons, a faculty of the family therapy program and a former chair of this dissertation, responded warmly to my email inquiry to his approach, a relational approach to family therapy. My path was set and I found myself at Nova Southeastern University several months later, pursuing a Master of Science in Family Therapy and, later, a Doctor of Philosophy in Family Therapy. Along the way, many people inspired me, challenged me, and guided me through the journey.

Needless to say, I can't express enough appreciation for Dr. Flemons for charting my path, and continuously inspiring me with his rigor in clinical practice, supervision, teaching, and writing. Another faculty member and his wife, Dr. Shelley Green has taught me how to blend the rigor for clinical practice, supervision, and teaching with her relaxed letting-go.

Dr. John Miller, another former chair of this dissertation, invited me to his single session therapy consultation services and really opened my eyes for the potential of single session therapy. Your commitment for the SST inspired my passion for the field. You also taught me how to galvanize my effort toward a completion of this dissertation, which I call a SST approach to dissertation.

Other faculty members, particularly Drs. Anne Rambo, Chris Burnett, Pat Cole, and Tommie Boyd in the program taught me, inspired me, and challenged me to think rigorously and differently in classes, supervisions, and practicums, while communicating me to remain true to myself. You all gave me my aspiration for the family field and helped me cultivate a new epistemology to look at the world differently. The experience has been truly life-changing! For that, thank you so much!!

Dr. Arlene Gordon, the director of Brief Therapy Institute, and her partner and a fellow at Writing Center, Richard Toumey, have encouraged me to stay pursuing my dream, while Dr. Gordon supervised my clinical work for many years and Richard consulted me on my writing.

My colleagues in the program have contributed to a wonderful learning environment in and out of classes in which we wrestled with and digested challenging ideas and practice in our own ways. Particularly, Mike Rhodes, and Drs. marcela

polanco and Jeff Cotton met me frequently for breakfast and dinner to chat and support each other in our own journey in the doctoral program. Marcky St. Fort, and Drs. Shawyna Murray, Yolle-Guida Dervil, and Isaac Farin kept in touch with me for occasional encouragement and support for each other's dissertation.

Needless to say, I thank my parents, Satoshi and Takako Ozaki, for having always been there for me and supporting me in my endeavor, literally from thousand miles away. Without your belief in me and continuous encouragement, I wouldn't have been here! And my warm 'thank you' to my wife, Alyson Montovani-Ozaki for your daily support, tremendous patience, and deep belief in my ability to move through and complete this dissertation. You graciously agreed with me to put aside our life together, until the completion of this dissertation. Lastly, my appreciation goes to my friends for their heartfelt support for this dissertation and their understanding of my holding of our social life for the time-being.

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Abstract

In response to the growing awareness of the issue of accessibility to mental health services (World Health Organization, 2013), single session therapy (SST) has been implemented in various settings throughout the world. (Hoyt &Talmon, 2014b; Miller, 2008; Miller & Slive, 2004; Talmon, 2014). Although there has been much advancement in the knowledge and application of SST, an understanding of therapist-client interactional patterns that enfold in SST is extremely scarce. In this study, I investigated how therapists collaboratively improved the talk in SST turn by turn in such a way that promoted therapeutic improvement. I utilized conversation analysis (Sacks et al., 1974) to analyze a video-recording of a SST consultation within a single instrumental case study format (Stake, 2005). The findings of this study provide an interactional understanding of the collaborative practice, valued in SST literature (e.g., Campbell, 2012; Miller & Slive, 2004; Slive et al., 2008). Specifically, the therapists' collaborative manner is exemplified in how the therapists oriented to the moment-to-moment interaction with the client within and across various interactional practices to coordinate their interaction, form and maintain the therapeutic relationship with the client, invite therapeutic change, and negotiate advice with the client. The findings of this study offer SST therapists and supervisors a potential interactional repertoire that they can utilize in their SST consultations and SST trainings. This study also presents a method of psychotherapy research that can address the research-practice gap (Strong & Gale, 2013).

CHAPTER I: INTRODUCTION

> In most books, the I, or first person is omitted; in this it will be retained. . . . We commonly do not remember that it is, after all, always the first person that is speaking. I should not talk so much about myself if there were anybody else whom I knew well. Unfortunately, I am confined to this theme by the narrowness of my experience.
>
> —Henry David Thoreau, *Walden or life in the woods, n.d.*

Personal Note on the Use of "I"

Throughout the study, I will use the first person particle, I, instead of the conventional use of the third person (e.g., researcher, author, etc). I am well aware of the potential criticism that my use of the first person will color the current research and its findings. I understand this position from the traditional objectivist or rationalist tradition, wherein a researcher has to separate him or herself from that which he or she investigates in order to discover the truth, from the independently existing universe (Steier, 1991a).

On the other hand, I believe that I cannot separate myself from that which I am examining, for I am the one who makes a decision at every step of the way in the process of composing the research study based on my assumptions, bias, experience, knowledge, and so forth.

Taking a constructionist perspective, Steier (1991b) asserted:

> Whether we concern ourselves with what we call a family, or a work team, we, as researchers, invent those very systems we claim to study. . . . It is the researcher who specifies the questions that characterize the domain in which familiness or

> teamness is displayed, and who creates (her or his) 'order' from the orderly, or even 'disorderly' world. (p. 178)

It is within this paradigm that the processes of generating data themselves become a part of the research. For this reason, I will make every effort to share what is guiding my decision throughout the study so that the readers can make a judgment on the quality and legitimacy, not for the objective truth, of the study.

The current study seeks discursive understandings of therapeutic interactional patterns in single session therapy (SST). In particular, I set my research question as "How do therapists collaboratively improve the talk in SST turn by turn in such a way that promotes therapeutic improvement?" In the following session, I will describe SST, social background in which SST has become viable option, and purpose of the current study.

Phenomenon of Interest

Throughout the years I have practiced family therapy, I have come to view that psychotherapy industry is often another means of maintaining the social status quo; those who can afford to pay for the services are able to get professional help, while those cannot afford it are left out from the services. This was a shocking for me since I came into the field aspiring to make a difference in the lives of people who need professional assistance. Even when people gain access to mental health services, the treatment is set up in favor of the insurance provider's needs, rather than the needs of the clients: Insurance providers get to determine the number of sessions, length of treatment, and sometimes even the modalities of treatment will be necessary. In this rigid structure, many clients fall through the cracks. Even when they stay in treatment, they are

diagnosed and treated according to the so-called best practices in order to justify the need for treatment. They are often pathologized because of the diagnosis by their family, friends, and sometimes the very mental health professionals who treat them. Their behaviors become attributed to their diagnoses—"She is manipulative because she is borderline," "Oh well, he is schizophrenic." Over the years, the clients may become institutionalized to the extent that their diagnoses become their identity of their diagnoses. This paints a pretty grim picture for me. At the same time, the rigid structure of mental health services is understandable in a context of competitive economy in which mental health agencies are under tremendous pressure by the entire industry to minimize the cost and maximize the benefit of services provided.

Because of my disappointment in the current state of the mental health system, I was drawn to single session therapy (SST), a modality of mental health services that seems to be more geared toward the needs of clients than those of providers and therapists. Talmon (2014), who has practiced SST over two decades, described SST this way:

> I see each session as a whole, complete in itself. This approach enables me to allow room for the full potential of that session, and to allow the client and outcome to dictate what may come next. . . . It is our clients who should be the main source of guidance for us, letting us know when to stop and when to continue with our sessions. (p. 38)

In fact, SST emerged decades ago as a new paradigm that privileged "clients' ways of knowing, and their competencies to help them achieve outcomes they defined as successful" (Hoyt & Talmon, 2014b, p. 6). As part of brief therapy movement (e.g., de

Shazer, 1985; 1988; Fisch, Weakland, & Segal, 1982; Haley, 1977; O'Hanlon & Weiner-Davis, 1989; Ray & Keeney, 1993; White & Epston, 1990), therapist conducting SST have paid attention to client's strengths and resources over weakness and problems (Hoyt & Talmon, 2014a). Within this paradigm, clients are viewed as partners for change (Miller, 2008; Miller & Slive, 2004; Slive, McElheran, & Lawson, 2008).

Social Background

Mental health is a tremendous global issue. The World Health Organization (WHO; 2013) refers to mental disorder as a range of mental and behavioral disorders that meet conditions in the International Statistical Classification of Disease and Related Health Problems, Tenth Revision (ICD-10; World Health Organization, 2016). For instance, those conditions include depression, bipolar affective disorder, schizophrenia, anxiety disorders, dementia, substance use disorders, intellectual disabilities, and developmental and behavioral disorders common among children and adolescents. According to this definition, about 20 % of children and adolescents in the world suffer from mental disorders or problems.

People with mental disorders tend to have a higher rate of disability and mortality than people without them. For instance, persons with major depression and schizophrenia tend to die prematurely 40 to 60 % higher than the general population, due to untreated physical issue (e.g., cancers, cardiovascular diseases, diabetes, and HIV infection) and suicide. In fact, suicide is the second leading cause of death among young people in the world. In addition, a correlation has been pointed out between mental disorders and other diseases (e.g., cancer, cardiovascular disease and HIV/AIDS).

Furthermore, there is a high co-occurrence of mental health disorders and substance use disorders (WHO, 2013).

Mental disorders often lead individuals and families into poverty. In fact, people with mental disorders have a higher frequency for homelessness and unfair incarceration (WHO, 2010). Because of the stigmatization and discrimination against people with mental disorders, they are deprived of human, civil, and political rights, as well as being denied access to economic, occupational, educational, social, and cultural opportunities. They may also be subjected to unhygienic and inhuman conditions, and physical and sexual abuse, neglect, or harmful treatments in health facilities. All of those factors may contribute to the marginalization of the individuals. As a result, the sum of mental, neurological and substance use disorders represents 13% of the total global burden of disease in 2004 (WHO, 2013). In fact, the issue of mental disorders comes with tremendous economic consequences: The loss of economic productivity as a result of mental disorder will amount to US $16.3 trillion between 2011 and 2030 (Bloom et al., 2011)

Despite the dire situation, WHO (2013) concludes that the health care system has not adequately responded to the burden of mental health issues: The gap between the need for mental health care and its current provision is large throughout the world. Between 76 % and 85 % of people with severe mental disorder do not receive treatment in low-income and middle-income countries. In high-income countries, between 35% and 50% of those with the same condition do not receive treatment. WHO (2013) also reports that 67% of allocated funding is spent for stand-alone mental health hospitals that are associated with poor treatment outcome and human rights violations of their clients.

Due to this situation, WHO (2013) suggests a re-allocation of the funding for integrated health care system, comprehensive of mental and general health care, including maternal, sexual, reproductive, and child health.

The consumers of mental health services and their families still face barriers when attempting to access mental health services for a number of reasons: (a) the lack of understanding about the process, (b) the stigmas attached to the use of services, (c) the challenge of cultural beliefs, (d) the intimidating process of scheduling appointments (e) unavailability of transportations, (f) issues with work schedules, and (g) the high cost of child care services (Slive & Bobele, 2014). Further, people are reluctant to wait for mental health services in places where walk-ins for many other services are common (Hoyt &Talmon, 2014b).

On the side of the mental and health care system, WHO (2013) points out five barriers to mental health services:

- unrecognized need for mental health and corresponding funding,
- lack of public mental health leadership,
- the current mental health service system,
- lack of integration within primary care, and
- insufficient human resources for mental health.

Specifically, mental health providers in developed courtiers (e.g., community mental health centers, health maintenance organizations) and public or large-scale organizations (e.g., managed health care, employee assistance programs, and the national health services) are often trapped by issues of under-staffing, low-budget, lengthy waiting lists,

and other concerns regarding the cost and effectiveness of psychotherapy services. This is in spite of the recent increase in available mental health services and providers.

In response to those barriers to mental health services, WHO (2013) outlines the principles and approaches to address the mental health disparities: (a) an access to mental health services without the financial burden; (b) an establishment of evidence-based practice; (c) an implementation of mental health care for addressing the developmental needs throughout the life span; (d) the coordination among multiple public sectors (e.g. health, employment, judicial, housing, social, and other sectors) and private sectors; and (e) the empowerment of people with mental disorders through service provision and monitoring of treatment, among other aspects of the mental health services.

SST may be a viable option for those people for whom mental health needs are not being met (Hoyt &Talmon, 2014b; Miller, 2008; Miller & Slive, 2004; Talmon, 2014). In fact, various types of SST, including walk-in services and SST with appointment, have been implemented mostly in Western countries as a cost-effective, labor-effective alternative to, or as a complementary service to the traditional service delivery model. Those courtiers include the United States (Bobele & Slive, 2011; Schoener, 2011), Canada (Clements, McElheran, Hackney, & Park, 2011; Harper-Jacques & Leahey, 2011; Young, 2011), Australia (Boyhan, 2014; Rycroft &Young, 2014), China (Miller, 2014), Mexico (Platt & Mondellini, 2014), and the United Kingdom (Iveson, George, & Ratner, 2014).

Purpose of the Study

Numerous literature reviews on SST (Bloom, 2001; Cameron, 2007; Campbell, 2012; Gee, Mildred, Brann, & Taylor, 2015; Green, Correia, Bobele, & Slive, 2011;

Hoyt &Talmon, 2014a; Hymmen, Stalker, & Cait, 2013) have attested that SST delivers clients satisfaction, and promotes the resolution of various presenting problems for adults, children, and families In addition, outcome studies of SST indicate that most clients believed the single session sufficiently addressed their issues such that they did not need to return for follow-up sessions.

While the majority of the studies took a quantitative and anecdotal approach to examining the effectiveness of SST, I observe a considerable lack of qualitative research exploring the various processes of SST. An exploration of the basic patterns of interactions that produce satisfying outcomes in SST seems imperative to the field of SST, due to its commitment to client-centered service delivery. I believe that researchers need to accumulate "the difference that makes a difference" (Hoyt & Talmon, 2014a, p. 514) in the process of interaction between therapist and clients in SST (Campbell, 2012). Due to the initial stage of process research to SST, I decided to set my research question as "What are the patterns of interactions in successful SST?" in general. In particular, it is "How do therapists improve the talk in SST turn by turn in such a way that promotes therapeutic improvement?" Due to SST's emphasis on collaborative therapist-client relationship, I paid a particularly attention to how the idea is played out in therapist-client interaction.

CHAPTER II: LITERATURE REVIEW

To see a World in a Grain of Sand

And a Heaven in a wild flower,

Hold Infinity in the palm of your hand,

And Eternity in an hour.

—William Blake, *Auguries of innocence and other lyric poems, 2014*

In this chapter, I discuss the field of single session therapy, and offer an overview of the existing literature on psychotherapy research, in general, and single session therapy, in particular. Then, I introduce the focus of the current research study by pointing out the gap in the existing literature on SST.

Single-Session Therapy (SST)

Brief therapy approaches, which "challenge the idea that enduring change must come through long and laborious interventions" (Slive & Bobele, 2011b, p. 12), have evolved tremendously over the last several decades. As a form of brief therapy, SST is centered on the idea that a small number of sessions, or even a single session, can bring about significant changes in clients (Slive & Bobele, 2014). In fact, research studies on psychotherapy have shown that clients make the most improvement in the initial sessions, with further improvements slowing in subsequent sessions (Battino, 2006; Hubble, Duncan, & Miller, 1999; Seligman, 1995). In addition, a collaborative therapeutic relationship that utilizes clients' strengths and contextual resources can improve the likelihood of immediate positive results (Amundson, 1996; Bloom, 2001, Duncan, Miller, & Sparks, 2011).

SST as a New Paradigm

For Hoyt and Talmon (2014b), "privileging clients' ways of knowing, and their competencies to help them achieve outcomes they defined as successful" (p. 6) meant a shift in paradigm. Looking back at the history of single-session therapy and walk-in therapy, Hoyt and Talmon (2014b) commented that they shared a fundamental idea with other therapists (e.g., de Shazer, 1985; 1988; Erickson, 1980; Fisch et al., 1982; Haley, 1993, 1994, 2010; Hubble et al., 1999; O'Hanlon & Weiner-Davis, 1989; Ray & Keeney, 1994; Wampold, 2001; White & Epston, 1990) that therapists utilize clients' strengths and resources, instead of their deficits, for helping them solve their problems. The new orientation toward clients has led SST therapists to take a "consumer" driven position, in which therapists view clients as partners in the change process. They utilize the clients' strengths, resilience, resources, and motivation in helping them achieve their goals (Miller, 2008; Miller & Slive, 2004; Slive et al., 2008).

To address the question of "how to know when enough psychotherapy has been done" (p. 83), Bloom (2001) contended more than a decade ago that "attention to this issue transforms the entire debate in short-term psychotherapy from one in which time is the central concept to one in which therapeutic sufficiency is the fundamental issue" (p. 83). In this paradigm, termination takes on a new meaning:

> The term "termination" has begun to refer not to psychotherapy but this episode of psychotherapy. This point of view leads to a distinction between the treatment episode and the treatment relationship. It is the relationship that can endure over time. Productive treatment episodes of varying lengths, including a single

> interview, may occur within this enduring treatment relationship. (Bloom, 2001, p. 84)

The new conceptualization of therapy and its termination presents a stark contrast to the common view among conventional clinicians and researchers; that client self-termination is a "problem" requiring special attention and preventive efforts by mental health professionals. The view stems from their perception that the clients who terminate therapy early in the process do so without receiving an "'adequate dose' of therapy" (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008, p. 248) for the resolution of their problems, or "gaining the full benefits" (Swift & Greenberg, 2012, p. 547). In fact, a debate on "dose-effect" (Howard, Kopta, Krause, & Orlinsky, 1986; Kopta, Howard, Lowry, & Beutler, 1994), or "dose-response," (Hansen, Lambert, & Forman, 2002; Harnett, O'Donovan, & Lambert, 2010) has arisen in the psychotherapy field. Efforts to determine the adequate amount of psychotherapy to treat specific diagnoses are similar to those made in pharmacological studies. Hoyt and Talmon (2014a) comment on the debate and pointed out the term, dose, is inappropriate to describe SST:

> "Dose" is often the wrong metaphor. Borrowed from the medication-for-medical-illness pharmaceutical research realm . . . , to date the dose-effect research literature has been based largely on some admixture of cognitive-behavioral and psychodynamic interventions . . . conducted by therapists more-or-less lacking specific training in deliberately resource-focused, time sensitive therapy. . . . Most planned brief therapies, including single session, do not attempt or wear down "pathogens.". . . Rather, single session (and other brief) therapists endeavor to help clients access and activate overlooked resources, reframe situations, shift

> meanings and narratives, modify interactional patterns, and spark imagination and inspire creative problem-solving. (pp. 512-513)

Scamardo, Bobele, and Biever (2004) brought forward clients' perspectives to the discussion of who, when, and how to terminate therapy. The study, using a qualitative method, explored how nine clients made a decision to terminate therapy. As a result, Scamardo et al. suggested that clients may have set and followed their expectation for the length of therapy without ever sharing that expectation with their therapists. Six of the nine participants reported that they had terminated therapy because it had helped them; the remaining three participants decided to terminate therapy due to personal circumstances. None of the clients reported negative perceptions of therapy.

More recently, Simon, Imel, Ludman, and Steinfeld (2012) conducted a study with a total of 2,666 patients covered by a health plan of a prepaid health system. The researchers studied their experiences of psychotherapy visits between March 10, 2008, and September 30, 2010. Specifically, the researchers employed statistical measures in order to compare survey results of patients who went back for a second visit and patients who did not. Among those patients who did not return for a second visit, one third gave the highest possible satisfaction rating. Over 60 % of the clients gave the highest possible rating to the therapeutic alliance, and more than 40 % reported significant improvements in their presenting problems. However, some of the patients who did not go back for a second visit reported dissatisfaction with the visit, and 25 % of them indicated problem deterioration. The results of Scamardo et al. (2004) and Simon et al.'s (2012) studies suggestion the importance of considering that some clients make a decision not to return to therapy because the therapy was helpful.

Types of SST

Green et al. (2011) make a note of Talmon's classification of three different types of SST: planned, unplanned, and consensual termination. In a planned single session, the client and therapist agree to meet potentially just one time. The client may come to a clinic with appointment—that is, SST with appointment—or without previous appointment—that is, walk-in services (WIS). In an unplanned SST, the client does not return for a follow-up appointment after the first session. The unplanned SST is often described in various terms, including premature termination, drop out, and treatment failure. Consensual termination occurs between the clients and therapist at the end of the first session; both agree to terminate the therapy, despite not having previously planned to do so. In addition, Miller (personal communication, February 2016) adds two more types of SST, including SST with intentionality and SST by necessity. SST with intentionality occurs where therapist and clients do not contract for a one-time session, but the therapist approaches the session as if it will be the first and last meeting. In contrast, SST by necessity occurs when a situation preclude the therapist from being able to meet again after the first session (e.g., a natural disaster).

Paul and van Ommeren (2013) note that SST may mean something different from one group to the other. While the original SST researchers and therapists (Bobele & Slive, 2014; Hoyt & Talmon, 2014a, etc.) view SST as a modality with guiding assumptions for a wide range of client problems, an emerging group of researchers and therapists seem to approach SST as a unifying manual geared toward addressing certain problems using various protocols. These protocol include behavioral exposure treatment (Başoğlu, Şalcioğlu, & Livanou, 2007), cognitive behavior therapy (Başoğlu, Şalcıoğlu,

Livanou, Kalender & Acar, 2005), Eye Movement Desensitization and Reprocessing (Jarero, Artigas & Luber, 2011), motivational interviewing (McCambridge & Strang, 2004), and psychological debriefing (van Emmerik, Kamphuis, Hulsbosch & Emmelkamp, 2002). For the purpose of the current study, I will focus on planned SST, including SST with appointment and WIS, within a paradigm viewing SST as a modality, due to their relevance to the current study.

With respect to the various usages of SST terminology, *client* connotes egalitarian and mutual therapy relationship in which therapists consult with clients to help them utilize their own resources and strength to resolve problems. In contrast, *patient* seems to refer to a hierarchical therapy relationship in which therapists treats patients' illness and suffering (Hoyt & Talmon, 2014b). Bobele and Slive (2014) use a word, *consultation,* to refer to their SST work:

> As a consultation process where the therapist offers ideas . . . and the client decides whether to accept them, reject them, or put them on hold. A consultation stance helps therapists to resist the temptation to take responsibility for client change. . . . Clients are in the best position to evaluate the ideas generated during the session. Our job is to create a context that enables the clients to discover those resources and teach us how to be their guide. (p. 101)

In the current study I generally use the terms *clients*, *therapists,* and SST *consultations* to emphasize the egalitarian and mutual SST context, unless I am quoting authors who use different terms.

Myths on SST

Young and Rycroft (2012) clarify the myth that clients are only given one session of therapy as the name implies. However, Young and Rycroft explain that approximately half of the clients in SST will return for further therapy. The authors go on to note that the field has not found a term that describes an approach to therapy, characterized by therapists' dual belief that a single session may be sufficient and clients may need following sessions. In fact, Keeney and Keeney (2014) caution against being bogged down by the number of sessions or any other constraints in practice since a therapist cannot predict how a session will evolve.

Modality of SST

Although SST has been adapted in forms and services specific and unique to each setting, they tend to share things in common. Those shared elements include (a) the basic assumptions about the human nature and the corresponding nature of therapeutic relationship, (b) the emphasis on pragmatics over adherence to specific theoretical orientations, (c) the clinical guidelines of conducting SST, and (d) the structure of SST service delivery.

Assumptions

Because of the particular influences of post-modern, social constructionist, systemic, and Ericksonian ideas (Slive & Bobele, 2011a), the principles of single session therapy are congruent with the brief therapy models in the family therapy and systemic therapy traditions (Campbell, 2012; Miller & Slive, 2004; Slive et al., 2008). Campbell (2012) connects the principles of brief therapy and those of SST, contrasting them to the principles of traditional psychotherapy:

> The whole field of brief therapy challenges many of the assumptions of traditional therapies, which tend to locate responsibility for change in the expertise of the therapist and conceptualize change as a long-term and difficult business. . . . By way of contrast, single session therapy considers that change is an inevitable process in life and that clients often need the support and assistance of therapists only for brief periods, to enable them to utilize their own resources to solve their problems. (p. 15)

In this framework, the therapists at those settings share the basic tenets of SST: Change can happen rapidly and has the greatest potential early in therapy (Bloom, 2001; McElheran, Stewart, Soenen, Newman, & MacLaurin, 2014). Although various therapeutic approaches have been employed, those approaches tend to focus on the present instead of the past (Bloom &Tam, 2015). According to Talmon (2014), SST does not require therapists to maintain a strong theoretical or ideological stance. Rather, the therapists believe and expect that "a whole therapy can occur in one hour and that a single hour of therapy can lead to a significant change, even for long-lasting issues" (Slive & Bobele, 2011b, p. 12). A single session needs to be treated as a whole, comprising of a beginning, middle and end (Ray & Keeney, 1993), regardless of whether the clients come back for another session or not. Each session is treated as a new case (Bobele & Slive, 2014).

Another assumption of SST is about clients' capacity for change. As Hoyt and Talmon (2014c) state, "the fundamental assumption of all forms of deliberate brief therapy, including SST, is an attitude and expectation . . . that clients/patients have the capacity to alter their thoughts, emotions, and behaviors in order to bring about

significant and beneficial changes" (p. 471). The authors contend that once clients have made a change, it can be magnified and reinforced by subsequent life experiences, causing a positive cascade of "ripple effects" (Hoyt &Talmon, 2014c, p. 471). The therapists' expectation is passed down to clients explicitly and implicitly (Bobele & Slive, 2014; Scamardo et al., 2004).

Pragmatism

In SST, the structure of the service—that is, a whole therapy in one hour—result in the pragmatic approach to addressing clients' presenting problems (Amundson, 1996). It is grounded in a belief that no one model or approach will work for every client (Clements et al., 2011). In fact, SST is not a "rigid or structured therapeutic model, but a highly flexible, integrative, and creative one" (Talmon, 2014, p. 34) to which therapists can apply their choice of models and/or techniques (Young, Weir, & Rycroft, 2012). In fact, therapists have conducted SST informed by a single or combination of various therapeutic orientations: Solution-Focused Brief Therapy (e.g., Iveson et al., 2014; Lamprecht et al., 2007; Sharma, 2012; Sommers-Flanagan, Polanchek, Zeleke, Hood, & Shaw, 2015), Mental Research Institute brief therapy (Bobele & Slive, 2014; Slive, & Bobele, 2011a; Slive et al., 2008), and Narrative Therapy (Ramey, Tarulli, Frijters, & Fisher, 2009; Ramey, Young, & Tarulli, 2010; Young, 2008, 2011). In describing their SST work, Slive and Bobele (2014) cite Fisch (1994) who proposed commonalities of brief therapy models, including Ericksonian approach (Erickson, 1980), strategic approach (Haley, 1963, 1977), Mental Research Institute model (Fisch, et al., 1982; Watzlawick, Weakland, & Fisch, 1974), solution focused therapy (de Shazer, 1985, O'Hanlon & Weiner-Davis, 2003), and narrative therapy (White & Epston, 1990).

Accordingly, those therapists make therapy briefer and more efficient by (a) narrowing down the scope of therapy by conceptualizing clients' problems occurring in their present interaction, (b) staying away from formulating underlying cause of the problem, and (c) galvanizing therapeutic effort toward a clearly defined goal in behavioral term (Fisch, 1994).

Regardless of the theoretical orientations informing them, therapists who practice SST fundamentally aim to provide clients with a "clearly identifiable outcome" (Miller & Slive, 2004, p. 97) guided by the clients' stated goals for the session. Amundson (1996) asserted:

> We believe that if any goal exists implicitly or explicitly for therapy, it is to bring theory to its proper home in language, in frank and useful conversations with the people we treat. At this program, then, therapy is offered in a single session walk-in format; the emphasis is upon brief and pragmatic contact aimed at rapid resolution of problems. (p. 5)

Toward this end, the therapists put pragmatic considerations into actions by (a) initially taking a neutral stance on any ideas, (b) utilizing the clients and therapists themselves' resources and strengths, (c) determining possibilities for a change in the progression of the therapy, (d) taking into account the effectiveness of therapeutic actions as determined by the clients, (e) taking into account the value of theory by virtue of its ability to shape the therapy for the resolution of clients' presenting issues (Amundson, 1996).

As I have mentioned here sparingly, SST also hones into the meta-analysis of psychotherapy outcome research, known as the common factor research (Duncan, Miller, & Sparks, 2004; Duncan, Miller, Wampold, & Hubble, 2010). The body of research

supports therapy that prioritizes clients' contribution, as well as collaborative therapeutic relationship that utilizes clients' strengths and contextual resources for improving the likelihood of immediate positive results (Amundson, 1996; Bloom, 2001; Bobel & Slive, 2014). Their client-centered stance is reflected in Bohart and Tallman's (2010) assertion:

> It is clients who make therapy work. . . . They actively operate on therapists' inputs, transforming bits and pieces of process into information and experiences which, in turn, are used to make change occur. Their effort, involvement, intelligence and creativity enable them to accommodate and metabolize different therapeutic approaches and achieve positive outcomes. (p. 94-95)

Based on the imperative, Bohart and Tallman (2010) lists clinical implications for therapists: (a) utilize clients' strengths, resource, and motivation for change; (b) believe in clients' motivation and capacity for change; and (c) collaborate with clients in making change privilege clients' experiences and ideas on problems and solutions through careful listening, solicitation of their feedback and tailoring services to their sensibilities. While sharing some of the implications with Bohart and Tallman (2010), Norcross (2010) suggests additional implications for therapists: (a) request clients feedback on the therapy relationship in the process of therapy; (b) keep away from critical or derogatory remarks toward clients; (c) inquire clients the most helpful element in therapy; (d) pass on your understanding of clients' situation for developing empathy; (e) develop strong alliance with clients early in treatment through communication skills, openness, consensual and collaborative decision-making on goals and tasks; and (f) communicate positive regards toward clients.

Guidelines

During SST, therapists allow clients to lead the session in terms of their problems and goals, organizing the session so that the clients will leave the session with a sense of having being heard, and an increased recognition of the resources and strength they can utilize to resolve their problems (Bobele & Slive, 2014; Slive & Bobele, 2011a). Hoyt (2014) describes the essence of effective brief therapy, explaining that it "involves developing an alliance, having achievable goals, and evoking relevant resources" (p. 3). He went on to emphasize: "Language matters. . . . Smart therapists strategically amplify and utilize patients' existing healthful resources and responses" (p. 66).

More specifically, Hoyt and Talmon (2014b) re-introduced the "Clinical Guidelines" for SST originally proposed by Talmon, Hoyt, Rosenbaum, and Short (1990):

1. "Seed" change through induction and preparation.
2. Develop an alliance by co-creating, with the client, obtainable treatment goals.
3. Allow enough time for the session to be complete process or intervention.
4. Look for ways to meet clients in their worldview while, at the same time, offering a new perspective and hope about the possibility of seeing and acting differently.
5. Go slowly and look for the clients' strengths and resources.
6. Focus on "pivot chords," ambiguous or conflictual situations that can be reframed in therapeutic ways.
7. Practice solutions experientially, using the session to rehearse solutions, thus inspiring hope, readiness for change, and forward movement.

8. Consider taking a time-out, break, or pause during the session to think, consult, focus, prepare, and punctuate.
9. Allow time for last-minute issues, to help the clients to have the sense that the session has been complete and satisfactory.
10. Give feedback, emphasizing the client's understanding and competency to make changes.
11. Leave the door open, follow up, and let client to decide if the session has been sufficiently helpful or if another session (or more) is needed. (Hoyt & Talmon, 2014b, pp. 4-5)

Still, in all methods of SST, it is of the utmost importance to meet clients where they are and mobilize their resources and skills (Slive & Bobele, 2011a).

Structure

The service structure of SST is usually set simple for efficiency and brevity of service delivery. For instance, at the Eastside Family Center, Wood's Homes in Calgary, clients are given two forms upon arrival. One form asks about their primary concern on that day, the people who are affected by the concerns, the solutions they have attempted, their identified internal and relational strengths, their previous and current involvement with other therapy, their goals for the session, and a sign of improvement they envision as a result of SST session. The form sets the tone for a collaborative therapeutic relationship between the clients and therapist (McElheran et al., 2014); it is also designed to elicit solution-focused thinking (de Shazer, 1988, Miller, 2008).

Some SST sites utilize Milan model's team approach (Boscolo, Cecchin, Hoffman, & Penn, 1987). It consists of three to six therapists and a supervisor. A

therapist or a set of co-therapists works directly with the clients while the other members observe the session behind a one-way mirror (Miller, 2008). The team approach—which is minimally consisted with a therapist being immersed in interaction with clients while the other therapists observe the session—was originally developed as an enactment of Gregory Bateson's idea of binocular vision (Boscolo et al., 1987). Bateson (2002) noted that since "information for the two descriptions [on a phenomenon] is differently collected or differently coded" (p. 66), it produces extra "dimension" or "depth" in a metaphoric sense.

Each of the single usually lasts 50 minutes and follows a particular sequence:

1. The team starts hypothesizing about the client(s)' goals from the session prior to the session based on a brief questionnaire filled out by the clients.
2. The therapist works with client(s) for 30 minutes (session).
3. The therapist takes a mid-session break and consults with the team for feedback.
4. The therapist delivers the feedback to the client(s).
5. The team processes the session after it concluded (postsession) (Bobele & Slive, 2014; Miller, 2008).

Originally, the therapists constructed a systemic hypothesis that connected an identified client for the presenting problem to other people who have noticed the presented problem, and professionals helping the family, resulting in hypothesis. The Initial hypothesis evolves over time with added information gleaned from the session. As Boscolo et al. (1987) pointed put:

> The act of hypothesizing is best described using the concepts of cybernetic feedback loops, for as family's response to questioning modifies or alters one

> hypothesis, another is formed based on the specifics of that new feedback. This continuous process of hypothesis construction requires the therapist to reconceptualize constantly, both as an interviewer and as a team member. (p. 94)

In this team format, the therapist and team approach a single session so that the clients leave the session with a "sense of emotional relief and some sort of positive outcome" (Slive et al., 2008, p. 12). Toward this end, the therapists focus on the following ideas (Slive et al., 2008):

- Ask what the clients want from the session so that the client guide the therapy and get what they want.
- Understand the clients' problems in context by asking the reason why the clients are seeking therapy now.
- Aim for directing the conversation so that the clients can utilize their resources and strengths for problem-solving.
- Consider the belief that the problem is the attempted solution (Watzlawick et al., 1974). The therapists should aim to understand what the clients previously tried, unsuccessfully, in an effort to resolve the problem.
- Take responsibility for building therapeutic relationship and attending closely to the client's motivation for attending the session.
- Think of the small changes that are already happening, and offer a small solution based on the idea that the small change will lead to a big change.
- Borrow the interview techniques from Solution Focused Therapy (Berg & Dolan, 2001; de Shazer, 1985) (e.g., exceptions to the problems, future oriented questions,

scaling questions, coping questions, etc.) which are designed to shift the clients' focus from their problems to solutions.

- Invites the clients to lead and make the most out of the session by asking what they want from the session, what they believe about the problem, what ideas they have for solutions.
- Take an intersession break, then return to deliver solution-oriented ideas from the therapy team. Generate and deliver positive statements about the clients that are designed to underscore resources that they may not have noticed. Correct clients' potential assumptions that therapists would criticize their mistakes. Those strategies are designed to let the clients guard down, making them more accepting of the team's suggestions.

The Current Status of SST

SST has been implemented in various locations, including the U.S. (Bobele & Slive, 2011; Schoener, 2011), Canada (Clements et al., 2011; Harper-Jacques & Leahey, 2011; Young, 2011), Australia (Boyhan, 2014; Rycroft & Young, 2014), China (Miller, 2014), Mexico (Platt & Mondellini, 2014), the United Kingdom (Iverson et al., 2014). IT has been delivered in various settings, including disaster mental health (Miller, 2011), medical family therapy (Rosenberg & McDaniel, 2014), and equine therapy (Green, 2014).

The choice of brief therapy is understandable in various types of organizations and programs in countries such as Canada, England, Australia, and others, since SST offers a cost-effective, labor-effective option for treatment providers. In fact, a review of

research studies on the effectiveness of SST (Goodman & Happell, 2006) concluded that SST is an efficient entry point for family based treatment to address adolescent mental health issues. This is due to the timely manner in which services can be accessed, the eliminated need for telephone screenings, and the flexibility with which treatment is implemented.

In addition, SST is rewarding for therapists for several reasons:

- Clients are likely to be ready for change.
- There are no "no-shows."
- 50 minutes of a session leaves enough time for the therapists to complete a session note.
- There is no need for further case management beyond the session and session note.
- If practiced in a team format, the therapists can learn from each other (Slive & Bobele, 2011a).

Implementing SST as standard practices can sometime pose challenges due to the complexity of cases. This is especially true at facilities such as cancer clinics, domestic violence shelters, psychiatric hospitals, and inpatient medical hospitals. Another challenge is that SST may not be profitable for independent private practitioners since they provide services on a fee-for-time basis (Hoyt & Talmon, 2014c). Yet another barrier sometime comes from the belief among therapists that "deeper is better" (Hoyt & Talmon, 2014c, p. 467). Despite those potential challenges, there seems to be continued interest in adapting the SST modality. Rycroft and Young (2014) commented on a SST training offered at the Bouverie Centre, Australia for diverse professionals working in

outreach programs, hospital ward social work settings, homeless shelters, palliative care settings, and others:

> They no longer needed or wanted to be "persuaded" by the research on the efficacy of SST—they wanted to know what needs to happen to make a single-session approach as effective as possible and how to implement it into their organization. (p. 150)

Single Session Encounter in Other Disciplines

The same principles and assumptions underlying SST has been reviewed for their potential applications in hospital social work (Gibbons & Plath, 2006, 2012), school psychology (Jones, Kadlubek, & Marks, 2006), and sports psychology (Pitt, Thomas, Lindsay, Hanton, & Bawden, 2015). In addition, the idea of a single session as a valid treatment has also explored in the field of career counseling (Barrett, Lapsley, & Agee, 2012), and practiced in music therapy (Rosenow & Silverman, 2014).

The SST Consultation Services at Brief Therapy Institute

The Brief Therapy Institute (BTI) is a clinic that is part of the Department of Family Therapy, accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), at Nova Southeastern University. The clinic includes a program that offers Single Session Therapy (SST) consultation services. The SST consultation project was designed to run from January 8, 2016 through April 1, 2016 with sessions conducted every Friday evening from 3:00 to 9 p.m. The program, which was offered to all members of the local community free of charge, was funded by the President's Faculty Research and Development Grant from Nova Southeastern

University. Its aim was to determine the overall effectiveness and level of client satisfaction with SST.

Dr. John Miller, a faculty member in the Department of Family Therapy, and Melissa Schacter, a doctoral student in the program supervised and oversaw the services conducted within the SST project at BTI. Dr. Miller has conducted SST for the last 20 years in various contexts and settings, including a community mental health center in Calgary, Canada (Miller, 2009; Miller & Slive, 2004); the American Red Cross providing disaster relief mental health services in Louisiana, U.S. (Miller, 2011); and a university clinic in China (Miller, 2014). Melissa Schacter has conducted SST at her private practice and remained abreast of the latest developments in the SST literature. Dr. Miller and Melissa applied for and secured the grant for the SST project. They added three doctoral students to the project, of which I was one, to help implement and manage the services. An additional two doctoral student researchers were hired to conduct the interviews with clients at the end of their consultation sessions. Before the launching of the project, Dr. Miller hosted a training workshop in which he recruited master's level students to deliver the services.

In order to determine the overall effectiveness and level of client satisfaction with the SST consultation, the designated therapists of consultations asked clients if they would be willing to participate in a short interview when their consultation session concluded. The interviews included a combination a survey—Client Survey of Clinical Services (CSCS) (Appendix C)—and a semi-structured interview—Post-Session Video/Audio Recorded Structured Interview Protocol (Appendix D). One of the student researchers asked about various aspects of clients' experience with the consultation

session—satisfaction, usefulness, sufficiency, and helpful aspects of the session—as well as their perceptions of mental health services in the local community in terms of accessibility, affordability, stigma, and barriers.

At the end of the service period, the project team will analyze the data collected from the interviews. They will use qualitative analysis to examine the narratives of client response and quantitative analysis to assess the Likert scale survey items in order to understand cultural issues and identify themes. Lastly, the lead members of the project will survey the participating student clinicians and researchers in order to understand their experiences in project and gain suggestions for future projects.

The project served the local community by offering prompt access and assistance to at risk and underserved populations. Further, the project also provided training opportunities for the graduate level family therapy students who participated. Since the department predominantly emphasizes postmodern and systemic approaches, the student who took part in the project had an easier time conducting SST. This was because of the fact that SST has evolved out of a brief, systemic tradition of psychotherapy (Campbell, 2012; Hoyt & Talmon, 2014a; Slive et al., 2008; Miller & Slive, 2004; Slive & Bobele, 2014).

The SST services at BTI were advertized for the full term of the project through the university's radio station; electronic newsletter; local, independent media including newspaper and radio stations, and flyers at local cafés etc. Clients called the BTI and made an appointment at one of the designated times. During the initial phone call, they answered basic questions from the Drop in Therapy Telephone Intake (CUTI) (Appendix A) (e.g., name; phone number; address; presenting concerns; other participants' names;

ages; and their relationships to the initiating client). The clients could attend the session in any configuration—individual, couple, or family—depending on their preferences.

Project Guidelines

The SST consultation services at BTI followed the SST guidelines articulated by Miller and Slive (2004):

- "Therapy Begins When Clients Walk In the Door" (p. 96);
- "Pragmatics versus Model" (p. 97);
- "More is not Better; Better is Better" (p. 98);
- "Timing is Important" (p. 98); and
- "Relationship with the Service Versus an Individual Therapist" (p. 98).

I present each guideline below, in chronological order in relation to the sequence in which services are delivered.

Timing is important. Although the project did not include drop-in services, it was still accessible to potential clients since it is cost-free, obligation-free, and convenient. There is no waitlist for the program due to the recent initiation of the project. According to Miller and Slive (2004), family therapy researchers have pointed out the importance of utilizing client readiness (Berg, 1989), or motivational readiness (Hubble et al., 1999; Prochaska & DiClemente, 1992), as well as their intensity (Minuchin & Fishman, 1981) for change.

Therapy begins when clients walk in the door. The clinic was well maintained and well furnished, with particular attention paid to client privacy, making it appropriate for adults and children. Upon arrival, clients filled out intake and informed consent. These

include the Lobby Intake Forms (Appendix B) which contains a series of brief, nonintrusive questions with a solution-focused bent. Questions on the form include: What is the single most important concern that you wish to share today? What inner strengths would it be useful for us to know about? What will be the smallest change to show you that things are heading in the right direction? Clients who are unable or unwilling to complete the form have the option of leaving the forms blank and discussing the questions with their therapists during the session (Miller & Slive, 2004).

Pragmatics versus model. The therapists in the SST program approach consultations mostly from systemic and postmodern orientations: Solution Focused Brief Therapy (Berg & Dolan, 2001; de Shazer, 1985, 1988), Mental Research Institute model (Watzlawick et al., 1974; Fisch et al.,1982), Narrative Therapy (White, 2007; White & Epston, 1990), Postmodern Collaborative Language Approach (Anderson, 1995, 1997) and so forth. However, in order to achieve a goal identified by clients at the end of their consultation session, these therapists value in utilizing what is determined to be useful at each moment of interaction with the clients, instead of strictly adhering to particular therapeutic model(s) (Amundson, 1996; Miller & Slive, 2004; Miller, 2008). To this end, it is important to give a clear message to the clients about the nature of the service at the beginning of the session (Miller & Slive, 2004). A typical message communicated to the client in the SST is as follows:

> As you know, this service is a single session consultation, so this may be the first time and the last time we meet. However, you would be welcome to come back in the future if you need it. After we've talked for a half-hour or so, I will take a break to consult with my team about our conversation. Then I will return and

> share our feedback and ideas about what you have presented to us today. I hope that we can work together in the next hour or so to figure something out about what you brought today. Do you have any questions?

After addressing any potential questions, the therapist would usually open the session by asking a variation of the following question: "What is one thing that you would like to have accomplished today, given that this may be the only time we work together?" The responses to this question would be likely to help the clients and therapists frame a solvable problem with clear sense of direction to follow (Miller & Slive, 2004).

More is not better; better is better. An adaptation of the "consumer-driven" view (Miller & Slive, 2004, p. 98) creates an egalitarian therapeutic relationship: The clients tell the therapists their goals, and the therapists guide the process, giving the clients feedback at the end of the session without providing more than what is asked for. The therapy team prioritizes and acts on potential risks of harm to self or others by informing the appropriate authorities and/or providing clients with potentially useful resources (e.g., information on abuse cycle, patriarchal social structure, resources for safety in case of domestic violence) (Miller & Slive, 2014).

Maintaining the consumer-driven mindset, the therapists in the SST team utilize the Milan team model (Boscole et al., 1987), in which two therapists meet with client(s) in a room, while the rest of the team observe the session in the next room through a one-way mirror. The team usually consists of Dr. Miller and/or Melissa, both of whom are AAMFT (American Association for Marriage and Family Therapy)-approved supervisors, along with doctoral and master's student therapists. The two rooms are connected through inter-phones, which members of the team may call in to the session to

offer feedback to the assigned therapists during the session as necessary. Two cameras in the therapy room feed video and audio material to a television in the observation room. Once the clients signed consent form, the sessions are video-recorded using two cameras in the therapy room. Following the session format of the Milan model (Boscole, et al), the SST team takes the following steps in each session:

1. The team starts hypothesizing about the nature of the case based on the phone and lobby intake forms.
2. The assigned therapists see the clients for 30 minutes.
3. The therapists take a mid-break and consults with the supervisor(s) and therapists in the observation room, generating feedback from the team.
4. The therapists deliver the feedback to the clients.
5. The team processes the session after the clients leave (Bobele & Slive, 2014; Miller, 2008).

In most cases, the assigned therapists ask clients for permission to work with a reflecting team (Anderson, 1987) behind the mirror. The therapists ask a variation of the following question: Would it be okay if the team behind the mirror comes over here and we discuss about the session. The therapists generally follow the question with the following instruction: However, I would like you to pretend as if there is an invisible wall between you and us." This content was modified from the original ideas and format characterizing Anderson's (1987) reflecting teams. With the clients' permission, the observing team enters the therapy room to talk about the case with the assigned therapists. The therapists discuss their speculative impressions on and understanding of the clients' relational dynamics and process from different points of view without

pathologizing the clients. The aim of the reflecting team is to generate multiple descriptions and explanations of the clients' problems, some of which may fit for the clients. Sometimes, the team members comment on how clients drew distinctions as they described the presenting problem. After the discussion, the team returns to the observation room, and the assigned therapists initiate a conversation with the clients about what may have stood out for them from the reflecting team discussion (Anderson, 1987).

Immediately after the consultation, the assigned therapists complete a session summary. The summary covers a description of the presenting problem, the therapists' assessment of the clients' readiness for change, and any interventions and/or suggestions delivered during the session (Miller & Slive, 2004).

Relationship with the services versus an individual therapist. Since the therapy team in the SST program at BTI consists of only a few therapists, it is highly likely that returning clients will encounter some of the same therapists they worked with in the initial session. However, the team made an effort to form a relationship with the program, in general, as opposed to getting attached to individual therapists.

The Previous Literature Reviews of SST

Up to this point, researchers studying SST have attempted to prove its effectiveness mostly by examining clients' subjective experiences. In 2001, Bloom (2001) conducted a comprehensive review of the clinical and research literature on SST from the previous 20 years. The author commented that the field was worthy of further investigation due to its ability to produce the same client satisfaction and desired

outcomes as long-term psychotherapies. Bloom concluded that a variety of theoretical approaches may be equally effective for myriad of clinical goals.

In their short review of research studies on effectiveness of planned SST, Goodman and Happell (2006) contended that SST is a suitable and efficient initial door for family based treatment dealing with adolescent mental health issues, due to its timely access to the services, mitigating the need for telephone screenings, and its flexibility for implementation.

Six years later, Cameron (2007) included some more recent literature in his review of SST, and came to a conclusion: SST is a "pragmatic approach to the provision of psychotherapeutic services" (p. 248) for its ability to satisfy clients with diverse presenting problems. Green et al. (2011) concluded that SST cam produce effective, satisfying, and long-lasting results in treating children adolescents. In more recent years, Campbell (2012) published an updated literature review and confirmed that "the field is moving forward" (p. 23). Hymmen et al. (2013) made a reserved conclusion that the majority of clients found SST as "sufficient, helpful, and satisfactory" (p. 69) and leading to perceived betterment in presenting problems in general, as well as specific problems, including depression, anxiety, distress level, parenting skills and possibly self-harm.

In their review of SST for its potential application to humanitarian situations, Paul and van Ommeren (2013) commented that SST's framework has a potential for "flexible, creative and dynamic responses" (p. 17) to mental health issues. Similarly, Hoyt and Talmon (2014a) posit:

> When given the right condition and right clinical methodology, a single session of therapy can yield significant and enduring positive effects . . . . And many

> patients, with wide variety of presenting problems and diagnoses, benefit from such one-session experiences—especially when client and clinician are open to the possibility. (p. 515)

Most recently, Gee et al.'s (2015) brief review of SST concluded that SST holds a promise for treating mental health problems impacting children, young people, and their caretakers. In addition, the authors emphasized the potential SST has to provide more cost-efficient and timely mental health services to a greater number of clients.

At the same time, there is a pressure to provide more conclusive evidence for the effectiveness of SST: Most of the researchers who have conducted literature review on SST (Bloom, 2001; Cameron, 2007; Campbell, 2012; Hymmen et al., 2013; Gee et al., 2015; Paul & van Ommeren, 2013) have pointed out that the majority of studies are descriptions of cases with qualitative methods or in uncontrolled settings. In this account, Hymmen et al. (2013) itemize methodological limitations among the existing studies on SST: few randomized controlled trials; an inconsistency in measurements used to assess clients' problems and their improvements; potentially skewed results due to the research design in which therapists collected data from clients; other research designs in which client may have felt pressured to give favorable responses; and small and homogenous sample size. Because of the methodological limitations among the existing studies on SST, those authors of the previous literature reviews (Bloom, 2001; Cameron, 2007; Campbell, 2012; Gee et al., 2015; Hymmen et al., 2013; Paul & van Ommeren, 2013) have suggested empirical studies be conducted to further establish the effectiveness of SST. Specifically, Campbell (2012) pointed out that it may be "'culturally' necessary" (p. 24) for studies of SST to compare the SST intervention with the existing 'evidence-

based' interventions using randomized controlled trial designs. Hymmen et al. (2013), who called for "evidence of the appropriateness and effectiveness" (p. 70) of SST, asserted that studies should employ rigorous research designs (e.g., large sample sizes, standard measurements, randomization of participants, or comparison groups, and longer term follow-up), using diverse participants, and conducting in-depth interviews with them.

Taking a different perspective, Hoyt and Talmon (2014c) acknowledged the movement toward evidence-based protocols for certain groups of clients due to the growing pressure for "industrialization and cost-effectiveness of psychotherapy services" (p. 477). However, they argued, "We strongly believe that any attempt for 'one-size-fits-all' detailed manuals are most likely to hinder both effective as well as creative and surprising elements of each first session and each first encounter" (p. 478).

Literature Review for the Current Study

For the current study's literature review, I kept the publication date from 2004 to 2016 in order to update the previous literature reviews on SST (Bloom 2001; Cameron 2007; Campbell 2013; Gee 2015; Gee 2015; Green 2011; Hoyt 2014; Hymmen 2013; Paul 2013). I found a total of twenty five quantitative and qualitative studies that focused on various aspects of SST, including clients' experiences, practitioners' experiences, and therapy process. Among those studies I found, many illustrated or investigated WIS (Barwick et al., 2013; Clements et al., 2011; Correia, 2013; Gibbon & Plath, 2006; Green 2012; Harper-Jaques & Foucault, 2014; Harper-Jaques & Leahey, 2011; Harper-Jaques et al., 2008; Miller, 2008, 2014; Miller & Slive, 2004; Ramey et al., 2009, 2010; Sharma, 2012; Stalker, Horton, & Cait, 2012; Young,

2011; Young & Cooper, 2008); only four of the studies focused on SST with appointment (Fry, 2012; Nuthall & Townend, 2007; Perkins, 2006; Perkins & Scarlett, 2008). In addition, I found four qualitative investigations on the process of life style consultation (Massfeller & Strong, 2012; Strong & Nielsen, 2008; Strong & Pyle, 2012; Strong, & Turner, 2008). I categorized all the studies as either case studies or quasi-experimental studies, depending on the degree of control placed on variables in each study. In presenting the results, I separately mention WIS and SST with appointment, due to the difference in the service setting between them.

Case Studies

First, I present two case studies on SST with appointment. Lamprecht et al. (2007) conducted a pilot study on the outcome of single-session Solution-Focused Brief Therapy (SFBT: Berg & Dolan, 2001; de Shazer, 1985; 1988) in combination with the standard psychosocial assessment for self-harm with 40 patients who admitted to the hospital with a tendency for self-harm. The researchers used a standard psychosocial assessment for self-harm at the James Cook University Hospital in Middlesbrough, UK. The therapists for the study provided SST, along with a biopsychosocial assessment, and utilized miracle question to have participants picture the way their problems might be resolved. In addition, they asked a scaling question using a 10-point scale in and after the session. The participants were given a break near the end of the session. Lamprecht et al. reported that 78% of the patients indicated a post-session change on the scaling question. In addition, the researchers reported that two of the participants (6.25% of 40 participants) had repeated self-harm after one year. This is compared with 40 patients (13.2% of 302 patients) who had presented self-harm

at the hospital during the time of the study. Based on the results, Lamprecht et al. (2007) concluded that the single session SFBT did not appear to conclusively deteriorate self-harm tendencies. The researchers suggested that SST may be used to complement other established interventions for self-harm.

Fry (2012) conducted a review of Alfred CYMHS, a mental health service facility that serves children and adolescents from 0 to 24 years old, in Melbourne, Australia. The SST program at the facility invites entire families into session—regardless of their configurations—to address a wide range of problems, excluding psychosis, autism, and acute crisis. The program mainly utilizes Solution-Focused Approach, and includes the reflecting team approach (Miller, 2008). Since the inception of its SST program in 2006, they have collected data on 144 families through the Scott Miller session rating scales (Miller & Duncan, 2000) at the end of each session. Those Likert scales have four domains "(1). Individual (personal wellbeing); (2) Interpersonal (family, close relationships); (3) Social (work, school, friendships); and (4) Overall (general sense of wellbeing)" (Miller & Duncan, 2000, p. 62). According to the data, 56 % of the families reported that a single session alone was sufficient in handling the presenting problems, while 21 % of them needed one or more follow-up sessions.

There have been numerous studies on WIS in recent years. Miller and Slive (2004) examined clients' experience with walk-in therapy services at the Eastside Family Center and the Westside Family Center of Wood's Homes in Calgary. The centers provide approximately 2200 sessions each year to 3000 clients. Of those clients, approximately 50 % attend a WIS without returning for follow-up sessions, 25 % is referred to community-based mental health agencies, and 10% is referred to outpatient

mental health clinics or their family doctors (Clements et al., 2011). The walk-in single session service at the two centers utilize a team approach of Milan model (Boscole et al., 1987), consisting of three to six therapists and a supervisor, in which a therapist or co-therapists see clients, while other members observe the session behind a one-way mirror (Miller, 2008). Miller and Slive used a questionnaire that included a mix of open-ended questions, scaling questions, "yes/no" questions, and other quantitative-oriented questions to gather information about clients' experiences with the center's services. The number of generated reports indicated (a) general satisfaction with the services for the majority of clients—74.4%, (b) improvement situations for the majority of the clients'—67.5 %—as a result of the services, in comparison to small deterioration of situations for a small percentage of clients—7%, and (c) and no change for the rest of the clients'—25.6% — situations. In addition, a significant percentage of the clients—44.3% — indicated that SST adequately addressed their issues. Interestingly, the therapists, who worked with the clients, highly rated their clients' readiness for change.

Several years after Miller and Slive's (2004) study, Clements et al. (2011) studied the same center. The researchers reported that overall satisfaction among their WIS was between 4.3 and 4.5 on a 5-point Likert scale ranking the services in terms of responsiveness and accessibility of the services. In addition, a report showed an average decrease in clients' level of distress between 20 % and 25 % on the measurements administered before and after SST. Due to the statistical significance of these findings, Clements et al. concluded that a single session may have helped those clients to "find a method to frame or structure their problems in ways that provided hope for change" (p. 117). In addition, in their satisfaction survey conducted with clients who had returned for

services at the center, Clements et al. found that (a) 90 % of them had generally satisfactory and positive experience, (b) 42 % of them felt that they had been heard and understood, and (c) 38% of them appreciated the site staff members' professionalism.

Young (2011) studied Reach Out Centre for Kids (ROCK) in Ontario, which provides services to any families with children age 18 and under who reside within the agency's catchment area. A walk-in single-session service acts as an entry point for further referral services including ongoing therapy, treatment groups, and psychology services (Young, 2011). Young collected data from the evaluation given to the clients who completed the SST service at the ROCK. The results indicated that 89 % of the clients were satisfied with their problems, and 90 % of them created plans of actions by the end of the session. The majority, 92%, of the clients indicated that they would seek the services again if necessary in the future. Further, Young reported that half of the clients who received SST did not return due to their perception that the single-session was sufficient at that time. The other half was referred for further services, and 27 % of them returned for therapy more than once.

Harper-Jaques and Leahey (2011) studied the Mental Health Walk-In Program (MHWI) at the South Calgary Health Centre (SCHC) in Calgary, Alberta, Canada. The program delivers services including urgent care, laboratory, mental health, community health, medical rehabilitation, and management of chronic health concerns. The service at the MHWI is offered on a walk-in basis at no charge to anyone of any age with any problem. In a typical mental health session, a therapist will consult a client for 30 to 45 minutes using a solution-oriented framework, listening for and highlighting the client's strengths (Harper & Foucault, 2014; Slive et al., 2008). According to a report on the

evaluation of services rendered at the MHWI between April 2006 and March 2007, the clients reported satisfaction with the WIS in general, along with a significant reduction in stress. Similarly, an evaluation conducted between September 2007 and February 2008 concluded a significant reduction in clients' distress levels (Harper-Jaques & Leahey, 2011).

Harper-Jaques and Foucault (2014) conducted another study to measure the effectiveness of the MHWI program by statistically analyzing accounts of client satisfaction from 98 participants. The clients rated their satisfaction with the WIS before the session, after the session, and one month after the session using standardized self-administered questionnaires. The results indicated general satisfaction with the services among the clients, which carried through to the one-month follow-up. Among the items on which the clients reported satisfaction were "knowledge and skill of staff," "respect of client rights," and "information provided" (Harper-Jaques & Foucault, 2014, p. 43). In addition, clients indicated overall improvements of their problems on multiple measures in terms of a decrease in distress level and problems severity, and an increase in solutions and coping. Furthermore, Harper-Jaques and Foucault (2014) highlighted the importance of therapeutically engaging clients, which may potentially lead to successful outcomes in single sessions.

Stalker et al. (2012) conducted a pilot study to assess effectiveness of Walk-In SST at Kitchener-Waterloo Counselling Services in Canada. Specifically, the researchers assessed and compared the participating clients' level of distress, general functioning, and motivation for change. In addition, the researchers inquired the clients' frequency of being precluded from daily activities due to their mental health conditions, as well as

their use of health care services and other community service agencies. Therapists were informed by various approaches (e.g., Solution-Focused Brief Therapy, Brief Narrative Therapy, Cognitive-Behavioral Therapy) and worked together with clients to create a written plan that the clients will be invited to complete, with an option of the coming back for following sessions.

Initially, a number of participating clients decreased from 225 at the baseline to 28 at the one month follow up, to 8 at the two-month follow-up. However, the number increased to 24 at the time of four-month follow-up, speculatively due to the incentive given to them. Prior to the SST consultation, the clients indicated various mental complaints: depression/anxiety (28%), couple relational problems (21.6%), depression/anxiety and another problem (15.6%), and depression/anxiety and two or more of other problems. In regards to their choice of health care in case of absence of walk-in clinic, they identified the emergency department of a local hospital (19 %), their physician (8%), not knowing options (24%), another therapy provider (21%) and other alternatives (28%).

After the WIS, the participating clients indicated decrease in distress, improvement in general functioning, and less use of health services at a month follow-up and even further betterment at a four months follow-up. At both follow-up points, significantly fewer clients reported a less preclusion from usual activities than the month prior to SST consultations. In addition, more clients accessed other community services, speculatively due to the guidance on the community resources provided at WIS. The result on the speculated relations between the clients' level of motivation and their treatment improvement was mixed.

Miller (2014) reported clients' feedback on walk-in SST offered at the training clinic at the Institute for Developmental Psychology at Beijing Normal University in China. The program employed a systemic, collaborative, 5-step team approach with a central goal of making the single session the first step in a process of creating change in clients' problems (Miller, 2008; Slive & Bobele, 2011a). The participants in the study completed a survey and participated in an interview after the session. Among the clients who took part in the study, 81% reported that the session met their expectation. On a separate question, 79% of the participants indicated that the single session was useful, while 21 % rated it as neutral. In response to a question regarding the sufficiency of SST, 56 % of them indicated that the single session was enough to address their problem; the remaining clients reported a need for further help.

Quasi-Experimental Studies

Perkins (2006) conducted an experimental study of planned SST using a solution focused approach with 5 to 15 years old who were admitted to an out-patient mental health clinic in Melbourne over a 14-month period. The clients who were assigned to the treatment group were assessed by their parents on the frequency and severity of their psychopathology using a non-statistical scale. Their parents and teachers also rated the participants on the types of psychopathology using a standardized multi-dimensional measurement. Finally, the participants received two hours of single solution focused therapy session that included their caretakers and siblings. In the session, an assigned therapist rated the client' global functioning, and the caretakers rated their satisfaction with the SST at the time of the service. A month later, the clients were assessed with the same measurements. The clients who were assigned to the control group were assessed

on the same aspects of their problems by their parents and teachers, but did not receive SST at the time of the initial assessment. The participants in the control group were assessed again 6 weeks later by their parents and teachers on the same aspects of their problems using the same scale and measurement; they also received the solution focused SST at that time.

The parents and teachers of the participants in Perkins' (2006) study diagnosed the participants with various types of problems (e.g., parent-child relationship problems, oppositional defiant disorder, anxiety disorder, ADHD; adjustment disorder with mixed disturbance of emotions, disruptive behavior disorder, separation anxiety disorder, etc.). The results of statistical analysis on the data collected from the measurements revealed statistically significant improvements among the treatment group in terms of the level and the frequency of their presenting problems relative to the control group. In addition, parents' ratings of the severity of psychopathology of their children in the treatment group improved at clinically and statistically significant levels relative to the control group. Teachers' ratings of the same items revealed improvements without clinical or statistical significance relative to the control group. In addition, the therapists' ratings of the participants' the global functioning improved at clinically significant levels between the time of treatment and one month after the treatment. Further, 95.2 % of parents of the participants in the treatment group were satisfied with the service right after the treatment, and 87.6% of them remained satisfied a month later. Perkins concluded that solution focused SST is an effective treatment for children and adolescents with various presenting problems.

Perkins and Scarlett (2008) followed up with the clients from Perkins' (2006) study using the same questionnaires 18 month after the initial SST. Almost a half of the clients responded to the questionnaires; among them 40 % had engaged in follow-up sessions after the initial SST. The researchers conducted a statistical analysis to assess the long-term effects of SST. Their results showed a continuous improvement in the participants' presenting problems—in terms of their frequency and intensity—for both the treatment and control groups. However, the results were statistically significant. Around 60 % of the participants indicated that a single session was sufficient, while the remaining 40 % required more than one session. Perkins and Scarlett concluded that SST seems to produce long-term effects over time for children and adolescents with various presenting problems. In addition, they noted that the inclusion of entire family in the SST may have been partially responsible for the maintenance of the positive effects after the initial session.

Nuthall and Townend (2007) conducted a quasi-experimental study in which participants in the experimental group received a Cognitive Behavior Therapy (CBT: Craske, Barlow, & Meadows, 2000) based, planned SST for panic disorder, and participants in the control group completed a CBT assessment without SST. The participants were clients from the Accident and Emergency Department at the two District General Hospitals in Shropshire in the United Kingdom. The therapist conducted the SST and helped the patients deal with their experiences of panic and cope with other related symptoms by providing education on topics including hyperventilation, exposure to fear-inducing situations, and the origin of panic, and stress-management techniques. Experimenters then administered a measurement of panic disorder and agoraphobic

symptoms—which included items on the frequency of panic and distress, anticipatory anxiety, avoidance of panic-inducing situations and sensations, and work and social impairment—to both groups before the treatment, one month and three months after the initial treatment. The researchers reported a significant reduction in the panic-related symptoms among participants in the control group between the initial contact and the two follow-ups; however, they did not find a significant difference between the groups at those follow-ups.

Barwick et al. (2013) evaluated the WIS at West End Walk-In Counseling Centre at Yorktown Child and Family Centre (YCHFC). The WIS was designed for children and youth with psychosocial problems. In a quasi-experimental design, the researchers compared a group of children between 4 to 18 years old who utilized the WIS and another group of clients who utilized usual care. Both groups were accessed at intake, post-treatment, and three-month follow-up on demographic characteristics, behavioral and emotional adjustment and functioning, service satisfaction, and service utilization. The researcher did not find any significant differences between the two groups on those variables.

The result showed more improvement in behavioral and emotional adjustment and functioning among the children who had WIS than the children who utilized usual care. Client of WIS identified the efficiency of the service, cultural inclusiveness, and empowerment by therapists' availability in comparison to clients who utilized usual care with a wait for the service. The children who utilized WIS indicated less willingness to wait to use service mental health help. At post-and three-month follow-up, children in both groups indicated that they sought mental health services more at mental health and

education services than at the general medical sectors and child welfare programs. In addition, the children who received WIS indicated greater satisfaction, than the children who received usual care, with the mental health help. They included the sufficiency of WIS to address their concerns, the counselors' respect for their cultural values, and the accessibility of the service.

Qualitative Studies on Clients' Experiences

I found two qualitative studies exploring the subjective experience in WIS. Due to the nature of qualitative methodology, which produces participants' rich accounts and thick descriptions of the phenomenon, these studies are invaluable to the SST literature. In her dissertation study, Correia (2013) conducted a phenomenological exploration of Latino clients' subjective experiences in WIS which were provided, using three systemic approaches: Narrative Therapy, Solution-Focused Brief Therapy, and Mental Research Institute model. The researcher conducted two interviews with the participants to find out what they deemed helpful, unhelpful, satisfying, or dissatisfying about their WIS experience.

Correia (2013) reported several thematic categories under which the participants' accounts were grouped in terms of the most helpful aspects of WIS. Those categories included (a) the readily available access to therapy, (b) their need for services, (c) their effort to go on their lives without further help, (d) the possibility of self-harm if it was not for the WIS, (e) meeting with therapists who genuinely cared for them, (f) being heard, (g) been able to let go of their stress and negative emotions, (h) receiving therapists' helpful advice, (g) receiving therapists' direction or feedback, (h) therapists' assurance

that they were on the right track, (i) leaving the problems at the sessions, and (j) feeling more hopeful, positive, or confident after WIS.

The clients also indicated several areas in which the WIS could potentially be improved. They reported that more time would have allowed the therapists to know them better and more advice or direction would have been helpful. They also indicated that they would have liked being more engaged by their therapists. In addition, they indicated that they would have liked meeting with therapists whom they had already known. However, the clients indicated that they would be willing to meet a new therapist in the future.

Correira (2013) compared the results of the study with the existing literature on SST and made the following conclusions:

- The severity of the problem did not mean longer treatment.
- Extra-therapeutic factors affected the outcome of SST and clients' satisfaction with it.
- Therapists' commendations of what clients were already doing bolstered the clients' existing strengths.
- SST increased the clients' hope encouraged the release of emotion.
- Having someone hear their stories contributed to positive outcome of SST among the clients.
- The therapeutic relationship mattered to the clients' improvement.
- The clients would have appreciated been given more direction and advise from the therapists.

- The clients may have held preconceptions about the length of therapy and beliefs that they would need lengthy therapy to get satisfaction.

Young and Cooper (2008) examined themes of significant and meaningful experiences among clients in Narrative Therapy based WIS. The results of the study revealed several themes and implications for this form of WIS:

- Therapists having a respectful posture and checking in with clients to discuss sensitive matters seems to have invited clients to open up.
- Utilizing and reviewing clients' words seems to have allowed them to open up about their preferences, ideas, commitments, knowledge, and so on, which led to new realizations about themselves and/or others.
- Recalling the single session for the research purpose seems to have facilitated the clients' learning by having them view their experiences from someone else's perspectives.
- Externalizing conversations seem to have allowed the clients to talk about and better understand their problems.

Qualitative Studies on Practitioners' Experiences

Two qualitative studies have shed a light on the practitioners' subjective experiences with SST. Given the growing popularity of SST and the need for staying informed of trainees' accounts with SST for training purpose, Green (2012) interviewed several doctoral level student therapists on their training experience of learning, practicing, and being supervised in WIS form of SST. The researcher reviewed and analyzed the interview data using phenomenology in order to capture the student

therapists' lived experiences. The results of the study indicated that SST training challenged the student therapists' preconceived notions of psychotherapy and skepticism about SST; furthermore it left them with a new understanding of therapeutic change. As they saw positive therapeutic changes in SST, they developed appreciation for its efficacy and usefulness. The student therapists reported that during the training, they felt supported by their supervisors as they experienced the practice of SST, and were able to deliver culturally competent therapy services to clients.

Gibbons and Plath (2006) added to the qualitative literature on SST from the field of social work. The researchers conducted focus groups with hospital social workers to explore their experiences using single session consultation with clients at their respective hospitals. The type of SST is not clearly described in the article, but the authors mention that their SST encounters are planned or unplanned. The social workers in the study indicated that they do not always give credit to their single encounters with clients. They acknowledged that a certain expertise is necessary for conducting such single encounters. Gibbons and Plath (2006) also identified a number of characteristics of single session social work, including setting clear goals and parameters, quickly developing a therapeutic alliance, assessing the clients' major issues and making necessary referrals, and providing information while following the social work principle of self-determination.

Qualitative and Quantitative Therapy Process Studies

A handful of process studies have contributed to a nuanced understanding of micro-changes in the dynamic and reciprocal process of interaction between the therapist and client in SST. With the exception of one quantitative study, most of

process studies in the existing literature are qualitative studies that explore the various aspects of the SST process. Ramey et al. (2009) conducted a quantitative study using a sequential analysis to examine the conceptualized process of change, or "map of scaffolding" (White, 2007) in Narrative Therapy based WIS with children who had various complaints. The map scaffolds movement from the known and familiar to possibilities and plans in regards to clients' problems or resources (Ramey et al., 2009). These movements include:

1. Naming and characterizing clients' problem or initiative.
2. Associating between the problem or initiative and its consequences.
3. Reflecting on the chains of the associations.
4. Generalizing clients' learning from specific circumstances to other areas of their lives.
5. Making plans of action based on the newly understood associations.

Ramey et al. (2009) explored whether the children in the study followed the development of change according to the map, whether the therapists initiated the development of change according to the map, and whether the clients' development corresponded with the therapists' initiatives at the same level of development in the map. The researchers coded videotaped single sessions of narrative therapy using a coding system based on the map; they then conducted a sequential analysis. The results of their analysis revealed that the children followed the therapists' initiatives at the same level in the order descried in the map.

In a follow-up study, Ramey et al. (2010) conducted a qualitative study to investigate the same research questions explored in Ramey et al.'s (2009) study. The researchers transcribed the session and coded each therapist and child's speech turns

according to a qualitative observational coding system based on the map. The researchers coded their speech turns in terms of the frequencies of types of actions taken by the therapists, the correspondences between of therapists' invitations for certain types of movements and the clients' responses to those invitations, and the overall movement of their interactions. The results showed that the children in the study responded to the narrative therapists' scaffolding initiatives at the same level of the map, and the change at the level of language occurred in accordance to the steps of the map.

In response to the lack of studies on language as a change agent in psychotherapy, Sharma (2012) conducted an exploratory study to better understand the linguistic mechanisms of change processes in SFBT of a WIS. The researcher used conversation analysis to analyze the transcript of a video-recorded session and examine therapeutic encounter in an in-depth, microscopic fashion. In particular, the researcher paid attention to shifts in the therapeutic conversation to capture transitions from problem talk to solution talk during the course of the session. The analysis revealed seven principles of SFBT:

> 1). Encouraging problem elaboration, 2) Using humor, 3) Maintaining a present and petite focus, 4) Ignoring exploration of past and other problems, 5) Pursuing exception eliciting responses over many turns, 6) Interrupting problem talk with solution talk, 7) Using the client's language and paralanguage. (Sharma, 2012, p. i)

Those identified principles helped shape the conversation, moving toward solution building from problem talk. In addition, the results of the study revealed an ever shifting

and dynamic exchange of meaning-making between the client and therapist. In particular, the therapist and client engaged with each other based on their interpretations of one another's responses.

Several research studies have contributed to an understanding of different aspects of lifestyle single consultation session (e.g., career contemplation) that are conducted using the principles of constructionist approach to therapy. The nature of SST is unclear in those studies. Although the life style single consultation sessions those studies examined are not therapy in nature, I included them in this section of the literature review because those study investigated the principles of constructionist approach that underlie the life style single session consultation.

In one such study, Strong and Turner (2008) used conversation analysis to analyze sequences of conversations between therapists and clients in single lifestyle consultation; they then used a videotaped replay procedure to supplement the results of the analysis with the clients and therapists' comments on their analysis. The purpose of the study was to examine how the therapists identified and expanded on the clients' resource and competencies in the consultations. The researchers selected and micro-analyzed segments of the single consultation sessions, in which the therapists and clients came to a resolution of dialogue about the clients' competencies or resources. Strong and Turner contended that interactions between the therapists and clients can be viewed as "negotiations" in which the therapists invited the clients into a resourceful dialogue, and the clients responded to the invitations. The clients' commented that they appreciated and benefitted from those therapists' invitations in the single session consultation.

Responding to a lack of research on clients' and therapists' experiences of engaging in resourceful conversations in constructionist therapy, Strong and Nielsen (2008) examined the clients' and therapists' experiences in using and responding to social constructionist inquiries in lifestyle single session consultations. In particular, the researchers interviewed the clients and therapists separately and reviewed selected video clips in which the therapists introduced social constructionist rhetoric techniques (e.g., deconstruction questions, exception questions, miracle questions, externalization questions, scaling questions, goal-oriented questions, introducing new discourses, probing understandings). The interview questions were formed so that both clients and therapists would comment on the same interventions. The researchers then transcribed and analyzed the recordings of the clients and therapists' comments using the constant comparison procedures from grounded theory. The results indicated that the therapists explored problems and solutions within the clients' perspectives and use of language; invited alternative perspectives by negotiating clients' strengths, possibilities, and preferences for solution; and reached shared understandings.

Strong and Pyle (2012) used conversation analysis to explore how therapists negotiated exceptions to clients' problems, and later elaborated on the exception talk in single session lifestyle consultations. In particular, the researchers analyzed the transcriptions of single consultation sessions using conversation analysis in order to examine the rhetorical features of discussions about exceptions. They found several episodes of negotiations between the therapists and clients in which the clients responded to the therapists' rhetorical invitations to discuss exceptions to their concerns.

Discursively oriented therapy approaches (e.g., Narrative Therapy, Solution-Focused Brief Therapy, etc.) understand that clients and therapist engage each other in a collaborative negotiation of meaning and conversational process. Massfeller and Strong (2012) examined the way in which clients shaped the content and direction of lifestyle single session lifestyle consultations through conversational correctives and initiatives. Furthermore, the researcher explored how constructionist therapists responded to those clients' correctives and initiatives. Massfeller and Strong (2012) discursively micro-analyzed transcribed segments of consultations to explore how clients initiated topic shifts or corrected the therapists' misunderstandings, as well as how the therapists responded to them. The results of the analysis revealed that clients contributed to the content and course of their conversations with the therapists by correcting, interrupting, or expressing positions that were different from those of the therapists.

Summary of the Current Literature Review

I synthesized them according to the following criteria:

- Client-reported sufficiency of SST;
- Client-reported satisfaction with SST;
- Client-reported problem improvement through SST;
- Client-reported helpful and unhelpful aspects of SST;
- Therapist-assumed variables associated with SST outcomes;
- Clients' meaningful or significant experiences in SST;
- Practitioners' experiences with SST; and
- In-session processes of change within SST.

I expand on each of these criteria in the following sections, along with the corresponding results of the previous literature reviews.

Client-Reported Sufficiency of SST

The results of the studies I reviewed indicated that for 44.3% and 60 % of clients, SST was enough to address their problems (Fry, 2012; Miller, 2014; Miller & Slive 2004; Perkins & Scarlett, 2008) without a need for further sessions (Miller & Slive, 2004; Young, 2011). Barwick et al. (2013) reported greater sufficiency of WIS among a group of children who received WIS that another group of children who received usual care. The results of these studies somewhat reflect Hymmen et al.'s (2013) conclusion that, from the clients' perspective, SST is a sufficient treatment intervention approximately 60.9% of the time, as most clients do not return for further sessions (Boyhan, 1996; Denner & Reeves, 1997; Harper-Jaques et al., 2008; Miller & Slive, 2004; Perkins & Scarlett, 2008; Price, 1994; Slive et al., 1995). Similarly, Harper-Jaques and Foucault's (2014) review revealed that between 12% and 58% of families found SST to have sufficiently addressed their concerns (Boyhan, 1996; Hampson et al., 1999; Kaffman, 1995; Miller & Slive, 2004; Perkins & Scarlett, 2008; Price, 1994; Talmon, 1990).

Client-Reported Satisfaction with SST

High percentage of clients in each study—74.4% (Miller & Slive, 2004), 89% (Young, 2011), 90% (Harper-Jaques & Leahey, 2011), 95.2% (Perkins, 2006)—expressed their satisfaction with SST or WIS right after the treatment. In Perkins's (2006) study, 87.6% of clients reported satisfaction a month after SST, and participants in Clements et al.'s (2011) study rated their experiences between 4.3 and 4.5 on a 5-point Likert scale. Participants in other studies reported a general satisfaction with SST

(Perkins, 2006; Harper-Jaques & Leahey, 2011), and continued satisfaction one month later (Harper-Jaques & Foucault, 2014). Further, a group of children who received WIS indicated greater satisfaction with the mental health service than the children who received usual care (Barwick, 2013).

These findings closely echo the ones found by Hymmen et al. (2013) in a review of the SST literature, which showed that the majority of clients who participated in research studies—between 90% and 100% (Harper-Jaques et al, 2008; Perkins, 2006; Perkins & Scarlett, 2008) or between 74% and 90% (Hampson et al., 1999; Harper-Jaques et al., 2008; Miller 2008; Miller & Slive 2004; Slive et al., 1995)—were highly satisfied with SST.

Client-Reported Problem Improvement through SST

Studies reported a reduction in clients' level of stress regarding their problems (Clements et al., 2011; Harper-Jaques & Foucault, 2014; Harper-Jaques & Leahey, 2011; Stalker, 2012), level of presenting problems, (Harper-Jaques & Foucault, 2014; Perkins, 2006; Young, 2011), the frequency of their problems (Perkins, 2006), preclusion from daily activities (Stalker, 2012), and use of health services (Stalker, 2012). Some studies reported improvements in clients' general functioning (Stalker et al., 2012), behavioral and emotional adjustment and functioning among children (Barwick et al., 2013), and unspecified improvements in clients' lives (Miller & Slive, 2004). Still other studies found an increase in clients' solutions and coping (Harper-Jaques & Foucault, 2014), clients' confidence in their ability to resolve their problems, along with increased knowledge about resources (Young, 2011). Dealing specifically with the issue of self-harm, Lamprecht et al. (2007) reported a change in clients' perception of their problems,

along with a significant decrease in the number of self-harming episodes compared with other patients at the same facility.

The findings of the current literature review is consistent with findings of Hymmen et al.'s (2013) literature review that revealed that clients generally perceived an improvement in their presenting problems, as well as with respect to specific problems. Those problems include anxiety, depression, and psychiatric disorders (Denner & Reeves, 1997), distress level and parenting skills (Sommers-Flanagan, 2007; Sommers-Flanagan et al., 2015), and possible self-harm (Lamprecht et al., 2007).

Therapists-Reported Variables Associated with SST Outcomes

Hymmen et al. (2013) mention, in their literature review, that studies they reviewed identified two variables that may affect results of the SST: clients' problem severity and their motivation for change. The researchers itemized types of clients' mental health issues based on which several previous studies excluded clients. Those mental health issues include risk of suicide or homicide (Littrell et al., 1995; Perkins, 2006); past sexual abuse, brain injury, mental illness, and HIV/AIDS (Boyhan, 1996), psychosis, risk of suicide, and mood disorders (Campbell, 1999), and domestic violence, child abuse or neglect (Campbell, 1999; Hampson, et al., 1999; Perkins, 2006; Price, 1994).

Of the studies I reviewed for the current study, many sites (Clements et al., 2011; Green, 2012; Harper-Jaques & Foucault, 2014; Harper-Jaques & Leahey, 2011; Miller, 2008; Miller, 2014; Miller & Slive, 2004; Sharma, 2012) of those studies did not set clients' exclusion criteria in terms of severity or types of presenting problems for the service of SST at those sites. At a site reported by Stalker et al. (2012), the researchers

screened clients on suicidality, homicidality, addictions, and intimate partner violence prior to SST consultation and referred those who were associated with those conditions to additional sessions within the agency. In contrast, one study set exclusion criteria on clients who presented issues of psychosis, autism, and acute crisis (Fry, 2012). Two studies specifically targeted specific issues: self-harm (Lamprecht et al., 2007) and panic disorder (Nuthall & Townend, 2007). Some sites (Perkins, 2006; Perkins &Scarlett, 2008; Ramey et al., 2009, 2010; Young, 2011) in the studies delivered SST for mental health issues specific to child and adolescent. For instance, issue that were identified among participants in Perkins's (2006) and Perkins and Scarlett's (2008) studies included parent-child relationship problem, oppositional defiant disorder, anxiety disorder, ADHD, adjustment disorder with mixed disturbance of emotions, disruptive behavior disorder, and separation anxiety disorder. Correia's (2013) study recruited only Latino adult clients because of the researcher's interest to explore Latino clients' experience with SST. Four qualitative therapy process studies (Massfeller & Strong, 2012; Strong & Nielsen, 2008; Strong & Pyle, 2012; Strong & Turner, 2008) were focused on single session consultation on lifestyle issues (e.g., career exploration, etc.)

Based on the SST delivery at those sites, it seems to imply an assumption held at those sites that SST is a viable service to a wide variety of mental health issues for a wide range of clients. As Harper-Jaques and Foucault (2014) asserted, this situation comes in a stark contrast to previous literature that claimed a utilization of SST only for minor problems. Cameron (2007) drew a similar conclusion that SST can deliver satisfying results for clients with diverse presenting problems. Hymmen et al.'s (2013) made a note that it is not clear whether SST does not produce desired results for clients

with severe presenting problem due to the mixed results from their literature review. At the same time, Hymmen et al. reported a tentative impression that clients dealing with psychotic illness, suicidal thoughts, child protection issues and domestic violence issue may not be suitable for SST.

Some researchers have identified other clients' characteristics that are associated with outcome of SST. Cameron (2007) in a literature review commented that SST may be suitable for clients who are ready for change. However, the relation is not clear due to the lack of studies; only in Miller and Slive's (2004) study, therapists evaluated the clients' readiness for change as high at the time of sessions. Hymmen et al. (2013) reached the same conclusion that the relation is not clear due to the lack of studies attesting to this relation. Harper-Jaques and Foucault (2014) reported on other predictors of successful SST: therapeutic relationship (Hampson et al., 1999); clients' sense of helpfulness (Boyhan, 1996); family's sense of pride (Campbell, 1999); family's level of hopefulness and confidence (Perkins, 2006); and service being offered at the time of need (Boyhan, 1996; Miller & Slive, 2004; Price, 1994). Lastly, Perkins and Scarlett (2008) commented that the inclusion of the entire family in the SST may have partially accounted for the maintenance of the effects from the initial session.

Client-Reported Helpful and Unhelpful Aspects of SST

Numerous studies reported on specific aspects of SST or WIS that clients appreciated. They include

- gaining immediate and easy access to therapy (Correia, 2013; Harper-Jacques et al., 2008; Miller, 2008; Barwick et al., 2013);

- staff members' knowledge, skills, and respect of client rights (Harper-Jaques & Foucault, 2014);
- cultural inclusiveness (Barwick et al., 2013);
- professionalism among staff members (Clements et al., 2011);
- therapists' taking a time and paying attention to their problems (Nuthall & Townend, 2007);
- therapists' genuine concern and care (Correia, 2013);
- therapists' characteristics (Miller, 2008);
- having gained opportunity to talk about their problem and felt supported (Sommers-Flanagan, 2007);
- having feeling that they had been heard and understood (Clements et al., 2011; Correia, 2013; Miller, 2008);
- having been informed of an available treatment for their problems (Nuthall & Townend, 2007);
- having been told that they are on the right track (Correia, 2013);
- receiving helpful advice or feedback about the problem (Correia, 2013; Miller, 2008; Miller & Slive, 2004; Nuthall & Townend, 2007; Sommers-Flanagan, 2007);
- having practiced skills in session and experienced relieve of symptoms (Nuthall & Townend, 2007);
- having released stress and negative emotions (Correia, 2013);
- having been referred to other resources (Miller & Slive, 2004);
- therapists' saving clients from hurting themselves (Correia, 2013);

- leaving their problems at the session (Correia, 2013); and
- achieving a feeling of hope, positivity or confidence (Correia, 2013).

Those helpful aspects of SST expanded the helpful aspects identified in Hymmen et al.'s (2013) literature review. Those aspects identified in their review include: receiving useful advice about the problem (Boyhan, 1996; Hampson et al., 1999; Miller, 2008; Miller & Slive, 2004; Nuthall & Townend, 2007; Sommers-Flanagan, 2007); therapist characteristics (Boyhan, 1996; Hampson et al., 1999; Miller, 2008); having heard about their problems and feel supported by the their therapists (Boyhan, 1996; Coverley, Garralda, & Bowman, 1995; Hampson et al., 1999; Sommers-Flanagan, 2007).

Clients' Meaningful or Significant Experiences in SST

Young and Cooper's (2008) collaborative study with clients of SST produced thick and nuanced descriptions of clients' subjective accounts of the therapists' respectful posture and utilization of their own words, which seemed to have allowed them to open up and discover new insights about themselves and others. The results from this study also indicated that a particular technique in narrative therapy, externalizing conversations, seemed to have invited clients to process their problems. The clients reported that participating in interviews with the researchers about their experiences in SST seemed to have given them new opportunities to learn by viewing things from someone else's perspectives. I could not locate the equivalent findings within the existing SST literature reviews.

Practitioners' Experiences with SST

Green's (2012) study on trainees' experiences with SST indicated the trainees' transformational experience in which conducting SST challenged their skepticism about SST and led to their perception and appreciation of SST as viable therapy form. The trainees also reported maturation of their practice skills in SST. This may point to Gibbons and Plath's (2006) findings that hospital social workers' indication of necessary skills to conduct SST. Those identified skills included setting clear goals and parameters; quickly developing a therapeutic alliance; assessing the clients' major issues and making necessary referrals; and providing information while following the social work principle of self-determination. Campbell (2013) commented that the most of publications on therapist characteristics necessary for SST are based on experiences and opinions without verification from systematic studies. However, the researcher pointed out a shared perception among therapists that therapists who practice SST should be able to utilize a wide range of interventions.

In-Session Processes of Change within SST

Reports from in-session process studies illuminate nuanced, process-based evidence for change within a narrative approach (Ramey et al., 2009, 2010), a solution-focused approach (Sharma, 2012), and a constructionist approach (Massfeller & Strong, 2012; Strong & Nielsen, 2008: Strong & Pyle, 2012; Strong & Turner, 2008) to SST. This is because most of the studies I reviewed utilized systemic, brief, constructionist therapy approaches: solution-focused, strength-based approach with a single therapist (Perkins, 2006; Perkins & Scarlett, 2008); solution-focused, strength-based approach with a team approach (Correia, 2013; Fry, 2012; Green, 2012; Harper-Jaques & Foucault,

2014; Harper-Jaques & Leahey, 2011; Miller, 2014); Narrative Therapy with a single therapist (Ramey et al., 2009, 2010; Young & Cooper, 2008); Narrative Therapy including a co-therapist, or an outsider witness group (Young, 2011); and Solution-Focused Brief Therapy including a co-therapist and a team (Sharma, 2012). In one study (Lamprecht et al., 2007), a solution-focused single session was provided adjacent to a biopsychosocial assessment.

The SST process studies seem to point to principles and ethics of a constructionist approach: reciprocal and mutual process of meaning-making or negotiations between clients and therapists (Massfeller & Strong, 2012; Ramey et al., 2009, 2010; Sharma, 2012; Strong & Nielsen, 2008: Strong & Pyle, 2012; Strong & Turner, 2008); emphasis within constructionist approaches on clients' resources, strengths, and possibilities of clients instead of their deficits and pathologies (Sharma, 2012; Strong & Nielsen, 2008; Strong & Pyle, 2012; Strong & Turner, 2008); and therapists' adaptation of a client-centered stance and utilization of client language (Massfeller & Strong, 2012; Sharma, 2012; Strong & Nielsen, 2008). The study of SST in the field of social work (Gibbons & Plath, 2006) revealed the principle of self-determination, which seems to overlap with the constructionist principle of a client-centered stance. Those principles and ethics of constructionist approach in SST have not been identified in the existing SST literature reviews. However, Campbell (2012) commented that it is "the nature of a single-session intervention itself" (p. 24) that makes SST efficient, aside from the frameworks of therapy models. Thus, those principles and ethics of constructionist approach in SST may exemplify factors present in the nature of SST intervention.

The Gap in the Existing Literature

The current quantitative and qualitative literature suggests that SST delivers satisfaction to clients and promotes the resolution of various presenting problems for adults, children, and families, along with decreasing their distress associated with those problems. In addition, it seems that most clients perceived SST to have sufficiently addressed their issues such that they did not need to return for follow-up sessions. In terms of variables associated with SST outcomes, the results are mixed. While some researchers advocate for the use of SST with clients who present with only certain types of issues, most others do not set any exclusion criteria. Those conclusions are consistent with earlier reviews of studies on SST (Bloom, 2001; Cameron, 2007; Campbell, 2012; Hoyt & Talmon, 2014a; Hymmen et al., 2013).

In regards to research design of SST studies, I draw the same conclusion with the most of the previous literature reviewers (Cameron, 2007; Campbell, 2012; Hymmen et al., 2013; Gee et al., 2015; Paul & van Ommeren, 2013) that there has been little progress in methodological design of SST studies; more than half of the outcome studies I reviewed relied on the changes in the clients' narratives using non-statistical analyses. This trend may reflect the SST's belief in the collaborative relationship in which clients are seen as partners for change (Amundson, 1996; Bloom, 2001, Miller, 2008; Miller & Slive, 2004; Slive et al., 2008). As Campbell (2012) points out, it may make sense for SST researchers to employ more rigorous research designs (e.g., large sample sizes, standard measurements, randomization of participants, or comparison groups, and longer-term follow-up), since it is how psychotherapy field gets acknowledged within the current culture of scientific disciplines.

The recent studies, mostly qualitative research, have elucidated subjective experiences of SST, including client-reported helpful and unhelpful aspects of SST, meaningful or significant experiences among clients in SST, and practitioners' experiences with SST. These studies are useful since they tend to capture more nuanced and complex experiences of clients and therapists that cannot be captured through quantitative research. In addition, a small number of studies have examined in-session processes associated with outcomes of SST. These studies can offer practical descriptions of therapist-clients interactions that can guide therapists and trainees of SST to conduct SST. As Campbell (2012) suggested, I believe that researchers need to continue exploring "the difference that makes a difference" (Hoyt & Talmon, 2014, p. 514) in the process of interaction between therapist and client. In another words, the researchers of SST needs to continue investigating a question, "What is happening in a single session therapy that is leading to change? (Campbell, p. 24)

This question seems to be particularly relevant to the SST field since SST researchers and therapists seem to have eschewed the question due to their pragmatic focus over adherence to a particular theory or theories. While I share Hoyt and Talmon's (2014c) caution against manualization of SST, I believe that a conceptual map of interactions in SST will benefit the field. Such map will inform therapists how to interact with clients without being confined to particular theories. For those reasons, I decided to explore a flow of interactional patterns in a successful SST. In particular, I will explore, "How do therapists improve the talk in SST turn by turn in such a way that promotes

therapeutic improvement?" In the next chapter, I discuss how I will pursue the research question in this study.

CHAPTER III. METHODOLOGY

> Any study which throws light upon the nature of 'order' or 'pattern' in the universe is surely nontrivial.
>
> —Gregory Bateson, *Steps to an ecology of mind, 1972*

The current study explores the flow of interactional patterns in single session therapy. In particular, I set my research question as, "How do therapists improve the talk in SST turn by turn in such a way that promotes therapeutic improvement?" In order to address the question, I used a conversation analysis (Heritage, 2001; Peräkylä, 2007; Sacks, Schegloff, & Jefferson, 1974; ten Have, 2007), a qualitative discursive research method (Gale & Lawless, 2004).

In this chapter, I describe and explicate the reason for my use of conversation analysis, a qualitative research method, from constructionist research paradigm. Then, I illustrate the steps and procedures—the selection of case and segments of analysis, the methods of data collection, the research design, and other import aspects of conducting the current study—I followed when conducting the current study. I then discuss the trustworthiness of the analysis, the ethics of the research, my role as a researcher in composing the current research, and the potential implications of the research.

Qualitative Methodology

Over the years, qualitative research has evolved into "legitimate, critical, comprehensive component of human sciences" (Munhall & Chenail, 2008, p. x) and has permeated disciplines, fields, and subject of interest (Denzin & Lincoln, 2005). As such, its contribution to the human sciences is acclaimed (Munhall & Chenail, 2008). Qualitative research holds various ideas and assumptions (e.g., foundationalism,

positivism, postfoundationalism, postpositivism, poststructuralism) as well as methods and approaches (e.g., case study, politics and ethics, participatory inquiry, interviewing, participant observation, visual methods, interpretive analysis). Since its inception, qualitative research has constantly evolved and embraced tensions and contradictions, including disagreements over its methods and the forms of its findings and interpretation. Therefore, it is hard to define qualitative research due to its non-commitment to any theory or paradigm, and methods or practices (Denzin & Lincoln, 2005). However, Denzin and Lincoln offered a generic definition:

> Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. . . . Qualitative research involves interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. (p. 3)

The aim of qualitative researchers is to develop an understanding on how people construct the social world (McLeod, 2011) within the situated context (Munhall & Chenail, 2008).

Qualitative research and quantitative research are often compared. Each of them adheres to different types of methods, epistemologies, and forms of representation (McLeod, 2011). Denzin and Lincoln (2005) clarified qualitative research in this regards:

> The word qualitative implies an emphasis on the qualities of entities and on process and meanings that are not experimentally examined or measured . . . in terms of quantity, amount, intensity, or frequency (p. 10)

While quantitative researchers pose close-ended questions to discover cause and effect between variables in order to test or confirm theories (McLeod, 2011), qualitative research poses open-ended questions, and analyze phenomenon by grounding data in the empirical materials (e.g., statement, transcript) of social interactions. Following the empirical data, the analysis entails an exploratory process (Burck, 2005; Denzin & Lincoln, 2005; McLeod, 2011), which may lead to "new insights into old problems" (McLeod, 2011, p. 1).

The two different styles of approach to phenomena are based on different assumptions about the world. While quantitative researchers tend to believe in the existence of the objective truth in the world, the new generation of qualitative researchers aligns with the postmodern idea that people actively construct the nature of reality in social interaction (Denzin & Lincoln, 2005). For their pursuance of the objective truth, quantitative researchers use statistical measures to interpret a large number of participants' accounts into numbers in order to generalize the findings. In contrast, qualitative researchers attempt to capture participants' local, intimate, and situated subjective experiences within their context (Denzin & Lincoln, 2005), producing "rich descriptions of the social world" (McLeod, 2011, p. 9).

Because qualitative research situates the researchers in the interpretation of phenomenon, reflexivity takes the central role the interpretation process. Researchers critically reflect on their role in shaping the very inquiry as both an inquirer and respondent (Lincoln, Lynham, & Guba, 2011). In another words, the phenomenon of the research becomes "not just as an external entity, but as an entity-in-relationship with the researcher[s]" (McLeod, 2011, p. 50). Qualitative research can contribute to an

improvement on people's quality of live, impact on the public policy, and generate evidence-based practice (Munhall & Chenail, 2008).

A various disciplines utilize qualitative research to interpret phenomenon, guided by a set of assumptions about the world and methods to understand and study the world. Each interpretive paradigm orients researchers to shape their research by asking certain questions and making certain interpretations. Those general paradigms include positivist and post-positivist, constructive-interpretive, critical, and feminist-poststructural. Further, these general paradigms are branched into more particular practices (Denzin & Lincoln, 2011).

Clinical Qualitative Research

In clinical qualitative research, clinicians study their own or someone else's approach, in order to examine the "nature of the therapy process" (Maione, 1997, "Introduction" section, para. 3). Researchers conducting clinical qualitative research often incorporate their own perspectives, as well as those of the participants (Chenail, 1992; Chenail & Maione, 1997; Maione, 1997). In this manner, clinical qualitative research is viewed as a means of maintaining integrity of therapeutic practice and rigor of research. Chenail (1992) compared the approach to other types of qualitative research—scientific and artistic qualitative research—and elaborated:

> On one hand, these clinical projects share many similarities with other types of qualitative research . . . in the way description, interpretation, discovery, observation, and questioning are stressed. On the other hand, clinical qualitative research differs greatly from the scientific and artistic types in that, where scientific qualitative research is based upon a scientist's way of thinking and

> doing, and artistic qualitative research embraces an artist's way in the world, clinical qualitative research may be conducted from a therapist's way of acting and knowing, or may be focused on learning more about a therapist's way of practicing and thinking in the world. ("Clinical Qualitative Research" section, para. 1)

Because clinical qualitative researchers embed themselves in a cycle of knowing and analysis, while drawing "practical distinctions" (Chenail, 1992, "Clinical Qualitative Research" section, para. 1), clinical researchers are able to capture clinicians' experiences in therapy. In the process of conducting a clinical qualitative research, a researcher will make an effort to fit "the metaphor of the therapy or therapist with the metaphor of the research or researcher" (Chenail, 1992, "Clinical Qualitative Research" section, para. 2). In addition, the research method should be congruent with the researcher's interest, research question, and epistemological stance (Maione, 1997). Maione (1997) described the way a chosen method of analysis organizes the analysis phase of the research:

> Analysis tools are simply ways of organizing data into meaningful units. They help you manage the data so that you can begin the process of meaning construction. Basically, what you are doing with any data is drawing distinctions in the data. After drawing some initial distinctions, you will be in a better position to comment on what you are finding and whether or not you are moving in a productive direction ("Choice 7" section, para. 2)

For these reasons, the clinical qualitative research is directly relevant to clinicians.

Although some clinical qualitative research studies produced clinically meaningful and practical studies for clinicians, the approach has been underutilized (Chenail. 1992). Some studies have been conducted in which researchers and therapists explored and employed the clinical qualitative research approach to study clinical practice and theory (Chenail, 1990/1991). Four such studies include the Double Bind Project- Mental Research Institute work of Gregory Bateson and this colleagues (Bateson, 1972, 2002), Richard Bandler's and John Grinder's Neuro-Linguistic Programming (Bandler & Grinder, 1975, 1979; Grinder & Bandler, 1976, 1981); the Milan Therapy-Coordinated Management of Meaning (CMM) conference (McNamee, Lannamann, & Tomm, 1983); and Bradford Keeney's cybernetic project (Keeney, 1983, 1987, 1990; Keeney & Ross, 1985; Keeney & Silverstein, 1986).

Finding an Appropriate Research Paradigm and Method

As I described previously, Chenail (1990/1991; 1992) suggested that the world view of clinical practice matches that of clinical qualitative research. Similarly, Maione (1997) asserted that the methods researchers choose should be congruent with their research interest, research question, and epistemological stance. My intention in this section is to share my efforts to adhere to the Chenail and Maione's suggestions. Since the SST approach under examination is pragmatic in nature, a therapist may flexibly employ any single therapeutic model or a combination of several (Amundson, 1996; Miller, 2009; Miller & Slive, 2004); each orientation and practice calls for different means of inquiry. For this reason, I decided to focus on the basic orientation of the SST, which is systemic and social constructionist in nature, without claiming any particular models of therapy (Miller & Slive, 2004; Slive & Bobele, 2011a; Slive et al.,

2008). The systemic and social constructionist aspects of the SST approach that are relevant to choosing the methodology and method of analysis include

- interactional—that is, the therapist engages with clients in back-and-forth interactions;
- contextual—that is, the therapist aims to understand clients' issues in their idiosyncratic contexts (Slive 2008);
- relational and process-focused—that is, the therapist frequently intervenes in clients' relational systems at the level of client interactional processes (Slive, 2008); and
- social constructionist-oriented—that is, the therapist invites clients into to resource-focused dialogue (Hoyt, 2014; Miller, 2008; Miller & Slive, 2004; Slive, 2008; Slive & Bobele, 2011a; Slive et al., 2008).

In order to study the basic patterns of interaction between therapist and clients in SST, I contend that my research methodology and method for this study needs to be

- interactional—that is, the unit of analysis is the recursive patterns of therapists' and clients' verbal and non-verbal interactions;
- textually and contextually sensitive—that is, the method needs to be able to capture dynamic and circular interplay between the clients' and the therapists' verbal and non-verbal behaviors and corresponding contextual shifts;
- relationally focused—that is, the method needs to be able to track shifts within the relational and interactive contexts of clients' issues; and
- constructionist—that is, the method needs to be equipped with sensitivity to the negotiation in constructing therapeutic reality between clients and therapists.

The second point of crafting clinical qualitative research is concerned with congruency between my research interest, research question, and epistemological stance (Maione, 1997). To reiterate, I am conducting the current study to extrapolate basic interactional patterns of therapist and clients in successful single session therapy. As a researcher and therapist, my epistemological stance is social constructionist in nature, as I have been trained in and utilized various approaches to therapy (e.g., Mental Research Institute model, Solution-Focused Brief Therapy, Milan Systemic Family Therapy, etc.) within a social constructionist framework. I acknowledge that I, as a researcher, will draw distinctions in the data and organize them in meaningful units in order to construct basic patterns of interactions between therapists and clients in SST consultation.

Constructionist Paradigm

Constructionism emerged in social sciences in 1960s. The paradigm sits on the foundational principles: "The world we live in and our place in it are not simply and evidently 'there,' but rather variably brought into being. Everyday realities are actively constructed in and through forms of social action" (Holstein & Gubrium, 2011, p. 341). Implied in the principles is an assumption that people are active agents in meaning making. Social constructionists seek to provide an understanding of socially-created life through social interaction, particularly language (McLeod, 2011). In this sense, meaning of our world comes through relational and dialogical use of language (Anderson, 1999; Gergen, 1994, 2009). In this vein, constructionism orients researchers to a "distinctive way of seeing, and questioning the social world" (Gubrium & Holstein, 2008, p. 5). Constructionist research has focused on the dynamic form of social reality—what— and the process—how— through which the social reality is

created and assigned meaning (Gubrium & Holstein, 2008). In specific, it questions "What is being accomplished, under what conditions, and out of what resources" (Holstein & Gubrium, 2011, p. 342) in "the agentic processes—the hows—by which social realities are constructed, managed, and sustained" (p. 342).

The principles and dual-focuses of constructionism have direct bearing on how researchers in disciplines orient and conduct research (Gubrium & Holstein, 2008). In study of interpersonal communication, communication is viewed as involving patterns and sequences of interactions, along with the activities of studying them (Foster & Bochner, 2008). Implied in the latter part of the claim is the nature of researchers' relationship to their research: Constructionist research directs a researchers to address the nature of relationship they have with the research participants and the "transformative potential" of [the] research for the researcher[s]" (p. 100).

In regards to analysis of communication from the constructionist perspective, Foster and Bochner (2008) asserted:

> It has become clearer and clearer that communication is not about quantity but about patterns (Bateson, 1981) and therefore needs to be grounded in the epistemology of interacting human beings. . . . It is not widely understood that communication is not merely a mode of representing, but also a means of constituting reality. Communication creates the webs of belief and meaning to which human beings become attached, and these webs have far-reaching, recursive consequences. (p. 86)

Due to the dual-focuses of constructionist attention on social interaction and its process, as well as its view on people as active meaning-making agents, qualitative research fits well within constructionism (McLeod, 2011).

Constructionist Qualitative Research to Therapy

Miller and Strong (2008) introduced a perspective about therapy which views therapy as institutional discourse (Miller 1994; Miller & Fox 2004). The perspective assumes that a therapeutic reality is formed by social interactions in therapy, in conjunction with two levels of contexts; local context within which the therapy happens, and the socio-historical context within which various forms of therapy emerged. While the latter context shapes the purposes and goals for the therapy, the immediate interactional context in therapy contributes to the formation of those purposes and goals in concrete term. The view on the immediate context is consistent with "postmodern discursive turn" which exists within the postmodern movement in therapy; the movement views that the experience of a reality is shaped by people's use of language (Haene, 2010; Strong & Gale, 2013).

Within the framework that views therapy as institutional talk, therapy is not about using interventions designed to treat clients' diagnosed disorders. Instead, it is an interactional process of "working up" (Miller & Strong, 2008, p. 618) the definitions of social reality, which make sense to clients and therapists, and point the clients to practical actions to change their lives. With this idea in mind, constructionist therapists pay attention to the way clients' troubled sense of reality is maintained by the way they use language (Miller & Strong, 2008; see Anderson1997; de Shazer, 1994; White & Epston, 1990). In this definition of therapy, therapists' use of langue is no longer a reflection of

the nature (Rorty, 1979), nor innocent (Anderson, 1997; Tomm, 1988). Because of the assumptions about therapeutic reality, constructionist researchers attend to observable patterns of interaction through language between therapists and clients, along with their relationship in therapy. From the discursive analytic point of view, Gale and Lawless (2004) similarly asserted:

> "If researchers view "the real world" as being discursively created, then all of "reality" is a meaning making performance negotiated between people. To understand this performance, language must take center stage" (p. 129).

In addition, the researchers pay attention to immediate contextual factors impacting therapy practice and the therapist-client relationship, and the cultural assumptions informing the therapy approach used by the therapists (Miller & Strong, 2008).

For those researchers, qualitative research provides "empirical and interpretive frameworks for knowing therapy" (Miller & Strong, 2008, p. 611). Those discursively-oriented qualitative researchers value the local and intimate knowledge construction of participants (Strong & Gale, 2013). Miller and Strong (2008) divided the constructionist qualitative research to therapy into "microinteractional approaches" (p. 611), "ethnographic approaches" (p. 613) and "philosophical-historical approaches" (p. 613). These means of analyzing therapy come with their own concerns and emphases, while sharing things in common at the same time. Using the ethnographic approaches, researchers are able to observe therapy setting and interview participants in order to find out how the social and cultural settings affect the therapeutic interaction that occur within them. The philosophical-historical approach involves analyzing various therapy-related texts using various methods from the humanities in order to extract their significance

Microinteractional approach pays attention to talk and social interaction (Arminen, 1998; Bavelas, McGee, Phillips, & Routledge, 2000; Edwards, 1995; Gale, 1991). Researchers using the microinteractional approach consider therapy as "series of interactional encounter" (p. 611) and, accordingly, utilize audio or video recordings to explore the interactional process of therapy. Its examination of "how forms of knowledge, actions, and relationships are constructed or sustained" has contributed to a "discursive wisdom" (Paré, 2002), equivalent to Schőn's (1983) notion of reflective practice. Conversation analysis (Atkinson & Heritage, 1984; Boden & Zimmerman, 1991; Sacks et al., 1974) is a microinteractional approach.

Discourse Analysis

I have identified conversation analysis (CA), a qualitative, discursive approach to studying social interaction as the most appropriate method for the current study. Discourse Analysis (DA) is considered as a methodology or theoretical perspective rather than a method (Nikandar, 2008). There are various schools and approaches with different definitions of DA and understandings of "discourse," as well as different philosophies, research interests, and epistemological stances, that range from a realist to a relativist orientation (Rapley, 2012), within and across various disciplines (Hepburn & Potter, 2007b; Nikandar, 2008).

Despite the differences among them, Nikandar (2008) pointed identifies common themes in the various DA traditions. The first theme is the "habit of attending to discourse and in a multitude of interactional contexts and texts and focusing on the close study of language use" (Nikandar, 2008, p. 415). The second theme is the "action orientation of discourse" (Nikandar, 2008, p. 415), which means that people use words to

construct social reality. Accordingly, DA research focuses on the use of language in social interactions becomes the focus of study, rather than on psychological constructs. As Gale and Lawless (2004) explain, "If researchers view 'the real world' as being discursively created, then all of 'reality' is a meaning making performance negotiated between people. To understand this performance, language must take center stage" (p. 129). The third common theme within the DA tradition is the emphasis on "rhetorical organization" (Nikandar, 2008, p. 416), which refers to how speakers strategize language and words in order to sway the conversation. Expanding on these common themes, Nikandar (2008) described that "DA interrogates the nature of social action by dealing with how actions and/or meanings are constructed in and through text and talk" (Nikandar, 2008, p. 415).

Gale and Lawless (2004) identified three discursive analyses within the DA tradition, including critical discourse analysis (CDA), textual analysis, and conversation analysis (CA). Despite differences between these analyses, they share assumptions on identity, interactions, and context. According to Gale and Lawless (2004, p. 127),

> identity is viewed as an active discursive accomplishment that is maintained and transformed within joint social interactions. . . . From this perspectives, context is not a bucket that contains our actions and identities, but rather, a performance that is accomplished through practical interpretative practices of how two(or more) people makes sense of each other's communication (ethnomethodology) (Garfinkel, 1967; Heritage, 1984). These identities are organized within a social structure that is constituted within face-to-face interactions that are reflexive and refer back to the immediate and proximal context (Maynard & Clayman, 1991).

The DA tradition distinguishes between two contexts; the *distal* and *proximal* contexts (Schegloff, 1992a). Distal context is a sociopolitical context that shapes social interactions. It includes elements such as skin color, work status, media discourse, and many others. Proximate context refers to the context shaped by particular aspects of participants' interactions –for example, how what is expressed was informed by the previous turn of the interaction in the conversation, and so on. Most research studies focus exclusively on one or the other context (Gale & Lawless, 2004). Based on those assumptions and constructs, researchers examine microinteraction of talk, including turn taking, pauses, overlaps of turns, misspoken words, and paralinguistic features (Gale & Lawless, 2004).

Researchers performing CDA and textual analysis seek not only scientific advances but also social and political change. They consider "discourse analytical enterprise . . . as a political and moral task of responsible scholars" (van Dijk, 1997, p. 23). Textual analysis prioritizes how individuals' identities are constructed and maintained through a use of text. By contrast, CDA analysts pay attention to the sociopolitical context that shapes the individuals' local interactions and their temporal identities because of their assumption that individual interactions are influenced by dismal context (Gale & Lawless, 2004). In this sense, CDA is a macro-analytic and grounding of interactions within a preexisting theoretical framework (Tseliou, 2013).

Conversation Analysis (CA)

In the early 1960s, Harvey Sacks, Emanuel Schegloff, and Gail Jefferson (Sacks et al, 1974) developed the CA. They were influenced by the intersecting perspectives of two social scientists: Erving Goffman and Harold Garfinkel (Heritage, 2001, 2004;

Peräkylä, 2007). Both Goffman and Garfinkel paved the way for the development of CA by asserting that details of ordinary conversation are orderly and thus a meaningful subject to study (Heritage, 2001).

Goffman established an idea that social interaction is a "form of social organization in its own right" (Heritage, 2001, p. 48). This is because social interaction is a social institution, like any other institutions (e.g., family, education, religion, etc.), that is comprised of a "distinct moral and institutional order" (Heritage, 2001, p. 48). Goffman (1983) referred this as interaction order. As an institution, it has a moral component. Social interactions are normative in a sense that individuals are expected to interact with others in accordance to socially expected manner and a deviation from the social expectation will be deemed immoral. Goffman further asserted that the interaction order mediates transaction in all other institutions in society (e.g., politics, economics, education, law, etc.). The institutional order exhibits the choices each participant in interaction made from available alternatives, which leads to the persons' immediate identity within the interaction (Heritage, 2001). In other words, people negotiate their identities through interactions. Goffman's ideas on interaction order reflects the aspect of CA that involves uncovering institutionalized practices and their organization, which shape the ordinary interactions (Heritage, 2001, 2004).

From Garfinkel, the developers of CA took away the notion that practices and procedures with which participants in social interaction form talk are communicational resources, or ethnomethod. Garfinkle (1967) assumed that participants in social interaction are able to "make shared sense of their circumstances and act on the shared sense they make" (Heritage, 2001, p. 49) by using "shared commonsense knowledge and

shared methods of reasoning" (Heritage, p. 49) ('ethno-method')" in their interaction. This refers to intersubjectivity of every day interaction. His project, ethnomethodology, was designed to understand how people use those shared knowledge and methods of reasoning in their daily interaction of sense making. Since people share those knowledge and methods of reasoning, they can form actions to each other and understand each other's actions in a given interaction. In addition, people use those shared knowledge and methods of reasoning to understand an event within the event's context. This means that when an understanding of the context changes, it will change the understanding of the event and the vice versa—reflexive relationship between sense making in a context and the context of sense making (Heritage, 2001).

In contrast to CDA and text analysis, CA examines the proximate context of naturally occurring conversations without referring to sociopolitical factors (Gale & Lawless, 2004). On this account, Sidnell (2014) asserts that CA researchers acknowledge the difference among people in accessing power, privileges, resources; however,

> They [CA researchers] do not assume that such differences are necessarily consequential to the production of a particular bid of talk or other conduct in interaction. They may be certainly consequential, but . . . that should be demonstrated rather than assumed. (p. 86)

Still, the results of the analysis may be placed within a sociopolitical context (Gale & Lawless, 2004).

The CA's focus on the sequential aspects of interaction points to Garfinkel's emphasis on the intersubjective nature of interaction, role of context in an understanding social interaction, and reflexivity between an understanding of social interaction and the

context of the social interaction (Heritage, 2001). Specifically, CA assumes three fundamental ideas that are interrelated. First, CA researchers understand that both participants in dialogue contributes to the structure and immediate context of the conversation by his or her turn, depending on the way they interpret the preceding turn of the other (Heritage, 2001, 2004; Sacks, 1992; Sacks et al., 1974). In this sense, their talk is "context-shaped" (Heritage, 2004, p. 223) at each turn of the talk. Second, the current action requests the next action by the other participants in the conversation (Heritage, 2001, 2004; Schegloff, 1992b). In this sense, participants' actions "create (or maintain or renew) a context" (Heritage, 2004, p. 223) for the next actions. Third, participants show their understanding of the previous actions by their next actions in various ways (Heritage, 2001, 2004). For instance, a participant can show acceptance by assuming that the prior turn was an invitation directed toward the participant.

Analysts of CA presume that it is through socially shared practices by which those three fundamental features of interaction are achieved (Heritage, 2001, 2004). As the interaction continues, the participants develop a shared context, leading to a mutual understanding of intersubjectivity (Heritage, 2004; Sacks et al., 1974). Eventually, a pattern emerges from the conversation and participants continue re-orienting themselves to the emerging pattern. In this evolving conversation, the participants' behaviors reflect and mark that pattern (Liddicoat, 2007).

Gale and Newfield (1992) elaborated on this process:

> All aspects of social action and interaction exhibit organized patterns of stable, recurrent structural features. . . . A person's action is not independent of the actions of the others, but rather, is patterned in relationship to others. Indeed,

> meanings are conveyed and maintained precisely because there are patterned structures to interactions.

Through this process, the sequential organization of interaction dynamically creates the social context (Heritage, 2004). In summary, CA entails the "analyses of action, context management, and intersubjectivity because all three of these features are simultaneously . . . the objects of the participants' actions" (Heritage, 2004, p. 224).

When it comes to researching the order found in social interaction, CA asserts that this order be located in naturally occurring interaction, instead of artificially created materials (Heritage, 2001). Sidnell (2014) describes the CA's preference as participants' orientations and noted that "We must examine what persons actually do, and, from this, discern the analyses they have produced of the circumstances in which they find themselves" (p. 79). In addition, since it is in the details of interaction in which the orderliness embodies, these materials should be audio or video recorded, instead of being written down, coded, recollected, or imagined. As a result, CA represents the social science that is as close as the natural science (Peräkylä, 2007).

CA of Institutional Talk. When it was being developed in the 1990s, the field of CA diversified from initial attention to ordinary conversation to institutional talk (Heritage, 2001) (e.g., legal proceedings, doctor-patient interaction, news interviews, classroom interaction, etc.). In analysis of institutional talk, Goffman's idea of an "institutional order of interaction" (Heritage, 2004, p. 222) is still a central issue; institutional "practices . . . make social action and interaction, mutual sense making, and social reality construction possible" (Heritage, 2004, p. 222). In addition to the institutional order of interaction, there is "social and institutional orders in interaction"

(Heritage, 2004, p. 223). That is means that institutional imperatives are evident and constructed in and through interaction. Field of psychotherapy has been no exception; it is in and through interaction with clients through which therapists create change (Strong & Turner, 2008). Thus, it seems a natural flow to study therapist-client interaction in therapy for evidence of therapeutic change given the constructionist understanding that therapist participate in conversation with clients (Strong, Busch & Couture, 2008).

Psychotherapy Research

In the field of family therapy, the so-called research-practice gap has been a long-standing issue (Sprenkle & Piercy, 2005). Clinicians argue that researchers do not comprehend clinicians' practical wisdom (McWey, James, & Smock, 2005); researchers criticized clinicians for not employing empirically justified approaches (Gurman, 2015). Referring to this issue, Strong and Gale (2013) pointed out the parallel relationship between the two groups: "Each group was developing its own genre of professional discourse, with particular cultural mores. While both sought to improve groups the human condition, each did so from very different philosophical premises and values" (p. 47)

The gap between practice and research seems to stem from epistemological differences between the systems approach and traditional, individually oriented psychotherapy approach (Sutherland, 2008). Conventional psychotherapy researchers apply evidence-based medicine (EBM: see Wessley, 2005), an approach to medicine, in psychotherapy research to examine if a different set of interventions change pre-determined clients' quantified variable(s), operationalized by the researchers (Peräkylä, Antaki, Vehviläinen & Leudar, 2010). EBM "treats psychotherapeutic interactions

themselves as given, or as a black box" (p. 24). In contrast, systemic approach emerged in contrast to the individually oriented approach and offered a new method of inventing clients' conundrums (Greenberg & Pinsof, 1986). Due to the difference between the individual approach to psychotherapy and the systemic approach in family therapy, traditional research methods investigating individual psychology seem to be irrelevant to research systems approach due to its "linear, atomistic, mechanistic, individualistic, and decontextualizing" (Couture & Sutherland, 2004, p. 4) nature.

For instance, randomized clinical trials, the gold standard of outcome research, do not take into the uniqueness of clients, their problems, and their contexts, although they aim to investigate the efficacy of family therapy (Sexton & Datchi, 2014). In reference to research methodology, Sutherland and Strong (2011) assert that quantification does not address the "interactive dynamics in therapy. . . . [since] the use of coding systems tends to answer questions about whether, and to what extent, certain phenomena . . . occur in discourse" (pp. 273-274). Similarly, Oka and Whiting (2013) claim that most statistical methods employed by family therapy researchers seem to be incapable of "understating the complexities of relationships and personal dynamics" (p. 18) due to their focus on individuals.

Adding to the research-practice gap, therapists have criticized that the setting in which researchers conducts family therapy research is far removed from the actual practice of family therapy (Oka & Whiting, 2013; Strong & Gale, 2013; Tilsen & McNamee, 2015). In addition, Sexton and Dacthi (2014) have argued that "change mechanisms are part of a complex set of purposeful interventions in therapy, and

understanding them outside of the context in which they occur may neither be practical nor sensible" (p. 423).

Although several process studies have been conducted, most researchers have focused on the therapists' intervening efforts with little attention to clients' "preceding and subsequent responses to those efforts" (Sutherland & Strong, 2011, p. 273). The previous studies have generally centered on a view of problems and their resolutions as "entities or specific blocks of interventions rather than as conversational or interactive process" (Couture, 2005, p. 12). This way of looking at therapy is limiting, as it does not account for the evolving nature of change in interaction (Sutherland & Strong, 2011).

CA of Psychotherapy

In contrast to traditional methods of research, discursive approaches have attracted systemic and constructionist family therapists because of their alignment with the social constructionist approach to therapy (Avdi & Georgaca, 2007; Strong et al, 2008; Sutherland & Couture, 2007; Tseliou, 2013), in which the therapist locates and explores knowledge in dialogic practices with clients (Burr 2015; Gergen, 2009; McNamee & Hosking, 2012). Gale (2010) asserts a further implication for applying discursively approaches to constructionist-oriented approach to therapy: "Therapy, through participating in clients' interpersonal and intrapersonal talk-in-interaction, helps them construct new understanding and expressions of their identity (e.g., accounts of resiliency, hope, capabilities, moral valuing, etc.)" (p. 14).

In addition, CA centers on "issues of meaning and context in interaction" (Heritage, 2004, p. 223) by connecting both meaning and context to the idea of sequence of interaction. Particularly, applied CA is "the study of the local rationality of member's

practices, why it makes sense, for participants, locally, in their practical context, to do things as they were done" (ten Have, 2007, p. 196). This resonates with a fundamental assumption of the systemic family therapist's focus on the clients' observable behaviors in interaction in their context, rather than focusing on their past and internal psychological constructs (Fisch et al., 1982; Watzlawick et al., 1974).

Further, the CA method elucidates complex micro-interactions between the clients and therapist in terms of "how such talk occurred—given that listeners respond simultaneously to both semantic and performed aspects of a message" (Strong & Turner, 2008, p. 188); it involves both the content and the process of the dialogue (Sutherland & Strong, 2011). In CA, it is crucial is to attend to how conversational invitations or proposals are expressed and responded to, or not (Strong & Turner, 2008). The inductive and discovery-oriented characteristic of CA (ten Have, 2007) to social interaction under examination seems appropriate for theory building in SST. In this regard, Bertrando and Gilli (2010) contended that, despite the commonly belief that the practice of therapy is dictated by a therapist's chosen model, the therapists appear to do more than just what can be contained by the any model and more than they can describe. Similarly, Flaskas (2014) asserted that "in the generation of knowledge about practice, it is the practice capacities of knowledge that define good theory, and it is the practice that challenges theory, not the other way around" (p. 284). The CA method allows researchers to elucidate, examine, and produce descriptions of how therapists and clients design sequentially organized social actions in ways that constitute certain relations between their utterances (Peräkylä et al., 2008). On this account, Strong and Turner (2008) asserted that '''use' [of conversational moves explicated] in CA is not necessarily

conscious or intentional; indeed, part of CA's analytic power comes with making evident such taken for granted aspects of communication" (p. 193). In this sense, CA exposes and links taken-for-granted micro-details of conversation in therapy—utterances, breaths, pauses, overlaps, sequences, and changes in intonation—that build toward the creation of therapeutic change (Couture & Sutherland, 2006). As a result, CA can bring accountability to therapists on their part of the mutual accomplishment with clients in constructionist-oriented therapy (Strong et al., 2008). At the same time, the inductive and discovery-oriented nature of CA may activate reflexivity from researchers and clinicians in practice (Roy-Chowdhury, 2003), closing the research- practice gap (Tseliou, 2013).

Strong et al.'s (2008) recently argued for "conversational evidence" (p. 388) of psychotherapy. In addition to the evidence of therapy outcome based on clients' self-reports after therapy, Strong et al. (2008) highlight another type of evidence for change: clients' evaluation of therapy in dialogue of therapy itself. The authors elaborated on this type of outcome evidence:

> At a mundane level we believe therapists are constantly guided by conversational evidence. Their choices of question, response, even posture, are part of their responsive ways of being with clients. These choices, however, are not simply guided by theoretical models of change (as if therapists could put textbooks on their eyes and ignore clients), but by what happens as therapists use their theories in interacting with clients. (p. 390)

Peräkylä et al. (2010) propose a similar idea, "internal outcome of psychotherapy interventions" (p. 24). The idea is that sequence of therapist-client interactions (e.g., questions and answers, formulations and responses, etc.) makes impact for clients within

each interactional context. As a result, CA can bring accountability to therapists on their part of the mutual accomplishment with clients in constructionist-oriented therapy (Strong et al., 2008). At the same time, the inductive and discovery-oriented nature of CA may activate reflexivity from researchers and clinicians in practice (Roy-Chowdhury, 2003).

Pointing out the analytic CA ability, Peräkylä and Vehviläinen (2003) called for a fruitful dialogue between various practitioners and CA researchers. Various professionals, including psychotherapists, use "their own 'language'" (p. 727) to discuss about their practices. In fact, "the practitioners view their practice and their own actions through and in terms of them (p. 728). Peräkylä and Vehviläinen (2003) referred the professional 'language' as 'professional stocks of interactional knowledge (SIK)'; that is a "organized theory (theories or conceptual models) concerning interaction, shared by particular professions or practitioners" (p. 730). SIKs come with normative assumptions about health and pathology, as well as different levels of descriptions in terms of clarity and sophistication. Peräkylä and Vehviläinen (2003) went on to say that

> in cases where the SIK is very general and abstract, . . . CA can provide the missing link between the professional SIK and the actual interaction by suggesting the ways in which abstract goals might be oriented to in the interaction. CA may also end up showing that participants orient also to other aims than those described in the SIK. (p. 746)

The gap between the two levels of description provides utility of juxtaposing them side by side (Peräkylä & Vehviläinen, 2003):

- "CA falsifies and corrects assumptions that are part of an SIK" (p. 731);
- "CA provides a more detailed picture of practices that are described in an SIK" (p. 731);
- "CA adds a new dimension to the understanding of practices described by an SIK" (p. 731); and
- "CA expands the description of practices provided by an SIK and suggests some of missing links between the SIK and the interactional practices" (p. 732).

Recently, a small but increasing number of researchers have contributed to CA research on various aspects of dialogue in therapy (e.g., Charlés, 2012; Couture, 2005, 2006, 2007; Couture & Strong, 2004; Couture & Sutherland, 2006; Harvie, Strong, Taylor, Todd, & Young, 2008; Kurri & Wahlström, 2005; Stancombe & White, 2005; Strong, 2008; Sutherland, 2008; Sutherland & Couture, 2007; Sutherland & Strong, 2011). Of particular interest for the current study are studies that have been conducted in the context of single session lifestyle consultation. Strong and Turner's (2008) study explored the way therapists identified and expanded on the clients' resource and competencies. Strong and Pyle (2012) examined the rhetorical features of discussions on exceptions to clients' presenting problems between therapists and clients. Massfeller and Strong (2012) took a look at the way constructionist therapists responded to clients' conversational correctives and initiatives. Sharma (2012) investigated the linguistic mechanisms of change processes in a single session SFBT in order to explicate building blocks, or patterns of interaction of solution focused brief therapy. However, no study

has investigated the basic interactional patterns of SST that evolve between therapists and clients.

Discursive understanding of collaboration. In psychotherapy, the collaborative relationship is the heart of the therapeutic process and outcome (e.g., Hovath, Del Re, Flűckiger, & Symonds, 2011) and is a topic of research. Some view collaboration as the clients' ability or willingness to cooperate with therapists in terms of their level of engagement and homework completion (see Tryon & Winograd, 2011); the others characterize it as the therapist's and clients' willingness to cooperate together in therapy (e.g., Bordin,1994). In contrast, for constructionists and discursive researchers, collaboration becomes an interactive accomplishment, jointly coordinated and negotiated between therapists and clients (Anderson, 1995, 1997; Strong, Sutherland & Ness, 2011; Sutherland & Couture, 2007; Sutherland & Strong, 2011). Strong et al. (2011) illustrate the difference between the conventional view and an interactional understanding of collaboration:

> Commonly, counselors are culturally expected to offer professional knowledge that clients 'receive' and make use of. We see collaborative relations between counselors and clients as involving commitments to agreed-to initiatives in counseling (Critchley, 2008) that are revisited when either party identifies them as a concern (Roy-Chowdhury, 2006). Thus, collaboration . . . involves shared intentions, relational commitments and a dynamic and reciprocal process involved in keeping interactions collaborative. . . . Collaboration, or working together, is for us an *ongoing* process guided by shared judgments and modifications worked out 'on the fly', as it were. (p. 27)

In this view of therapeutic collaboration, clients' "resistance" and therapists' responses to the resistance takes a whole different meaning: It is an indication of the clients' desire to assert their voice in the decision process in psychotherapy (Strong et al., 2011). Thus, the collaboration between therapists and clients should be reflected in the manner they coordinate and negotiate differences in each other's preferences (e.g., meanings, intentions, proposals, conversation style, etc.) on shaping the process and content of their evolving interaction (Ness et al., 2014; Strong et al., 2011; Sundet et al., 2016; Sutherland & Strong, 2011). In this sense, clients and therapists mutually offer their expertise and competencies on change moment-by-moment (Strong et al., 2011). However, therapists need to initiate this collaborative process due to their perceived power in the context of psychotherapy.

CA offers a fitting method to investigate such collaborative process, since it can illuminate on the therapist-client moment-to-moment interaction, negotiating the content and process of therapy (Sutherland & Strong, 2011). Based on the discursive and constructionist understanding of collaboration, several researchers (e.g., Couture, 2006, 2007; Couture & Strong, 2004; Couture, & Sutherland, 2006; Roy-Chowdhury, 2006; Strong, 2008; Strong & Nielsen, 2008; Strong & Pyle, 2012; Strong & Turner, 2008; Sutherland & Couture, 2007; Sutherland & Strong, 2011) have conducted studies on various aspects of constructionist therapy.

For instance, Roy-Chowdhury (2006) identified a strong therapeutic engagement within an interactional sequence in which a family therapist's constructed turns, incorporating the client's language when communicating the understanding of the client's account, while providing minimal acknowledgements and questions. This manner of

listening and responding seems to encourage clients to elaborate. In addition, the researcher identified the therapist's flexibility to adapt a variety of conversational styles, including advice giving. Further, the researcher identified that the therapist, at times, allowed the clients to express their preferences on the session structure.

Couture and Sutherland (2006) reported that Karl Tomm, a renowned constructionist therapist, utilized a step-wise entry into advice giving. In the cyclic process, the therapist invited the family clients to negotiate a middle ground within the family's conflicting positions about issues at hand in order to move forward at the time of impasse. Then, the family evaluated the proposed middle ground and offered acceptance or rejection. When it was rejected, the therapist extended his invitation until the family tentatively accepted the proposal, before moving forward to advice giving.

In his study, Strong (2009) showed the ways constructionist-oriented counselors packaged their turns in asking for clients' goals by using the client language and in open-ended questions. The process was, accordingly, a circular negotiation process in which (a) the counselors posed a question, asking session goals, (b) the clients provided goal descriptions, (c) the counselors asked for clarifications or specifications, and (d) the clients offered responses. In addition, Strong (2009) showed the manner in which the counselors responded to and legitimized the clients' initiative to contest or modify the counselors' descriptions. In this process, the therapists utilized questions and response to allow the clients to tailor their goals, while shaping agreeable goals themselves.

Massfeller and Strong (2012) discursively micro-analyzed transcribed segments of the consultations in which clients initiated topic shifts or corrected the therapists' misunderstandings, as well as how the therapists responded to them in singe lifestyle

consultations. The result of the analysis indicated that clients contributed to the content and course of the conversations with the therapists by correcting, interrupting, or expressing from their positions that were contrary or different from those of the therapists.

Sutherland and Strong (2011) identified several interactional, collaborative practices Dr. Karl Tomm used in a couple therapy session. First, the therapist engaged the clients to evaluate his therapeutic initiatives. In a cyclic process, the therapist kept adjusting subsequent responses in answer to the clients' disagreements, refusals, and minimal agreements with his initiatives until they arrived at mutually satisfying descriptions of the matter on hand. The researchers also found that the therapist utilized candidate answers (Pomerantz, 1988) to elicit the clients' preferences on the process of the therapy. The therapist also used *reciprocal editing* (Kogan & Gale, 1997), a set of practices, including uncertainty markers (e.g., "maybe" or "I guess"), pauses, and hesitations (e.g., "uh" or "um"), in order to downgrade his expert status. In addition, the therapist approached delicate topics by composing his turns with impersonal constructions (Aronsson & Cederborg, 1996) (e.g., "some people" or "the others"). Further, the therapist prefigured activities and topics of conversation in therapy through *pre-sequence* (Schegloff, 1980).

Rational for Examining a Single Case

In therapy research, case studies are invaluable since they produce experience-near data that are practical and relevant for clinicians (Dattilio, 2002, 2006; Dattilio, Edwards & Fishman, 2010; Dattilio, Piercy & Davis, 2014; Edwards, Dattilio, & Bromley, 2004; Wolfe, 2011). McLeod (2010) argues that case studies can "capture,

describe, and analyze evidence of complex processes" (p. 9) of therapy within their natural context. Context-dependent knowledge produced by case studies takes a primary importance in examining professional activities. Flyvbjerg (2011) asserts:

> Context-dependent knowledge and experience is at the very heart of expert activity. Such knowledge and experience lie also at the center of the case study as a research and teaching method . . . or . . . as a method of learning. . . . it is only because of this experience with cases that one can move at all from a beginner to being an expert. (p. 303)

The intimate descriptions of case studies are important for learning since it brings forth a "nuanced view of reality" (Flyvbjerg, 2011, p. 303), along with a view that theories cannot fully encompass. As a result, they can be used to establish "a pragmatic evidence base, consisting of information on the assumptions, strategies and interventions" (McLeod, 2010, pp.10-11) that therapists use in therapy.

In looking for a type of case design for the current study, I deemed that single case analysis will be an appropriate one. According to ten Have (2007), CA is considered as a "cumulative enterprise" (p. 162) in which researchers start off by analyzing few cases intensely, instead of a large collection of cases, complemented by thorough reading of CA literature in general and in particular to their research topic. This is because CA researchers want to track, in detail, how participants use various rhetorical devices and strategies (Hutchby & Wooffitt, 2008) in order to establish particular relationships between the utterances that make up the conversation (Liddicoat, 2007). For instance, Hutchby and Wooffitt (2008) commented that one of the founders of CA, Harvey Sacks often used single case studies in his early writings (1992), recognizing that

crucial purpose of CA is to "describe, adequately and formally, singular events and event-sequences" (Hutchby & Wooffitt, 2008, p. 114).

A careful and sensitive single case analysis also makes sense in the context of psychotherapy. Weakland (1987) asserted that

> effective therapy involves considering and dealing with a number of factors which are interrelated more systemically than hierarchically—all are fundamental, in a sense. To see the fundamental factor in therapy is like seeking the cause of a problem. (viii)

In the same manner, I believe that there are multiple factors working together within a single session all of which contribute to the overall gestalt of experience of a session. Similarly, Couture (2005) views that change in psychotherapy can be better captured as an "ongoing conversational process than as an isolated shift" (p. 80). Likewise, I view change in SST happening over the course of interaction, rather than at some specific points in the session. This view is exemplified in Strong et al.'s (2008) idea, c*onversational evidence*:

> By using words, metaphors, discourses, gestures, tones of voice, and so on, both clients and therapists construct ways of talking, understanding, feeling, and acting from within their dialogue. In our view, these accomplishments in their dialogues are *evident* to the speakers in terms of client accounts and in evidence of shifts in meaning and ways of talking. (p. 400)

A method that enables researchers to maintain the evolving nature of interaction in therapy is conversation analysis because of its emphasis on embedding participants'

interactions within the evolving sequence and its context of the interaction (Heritage, 2001, 2004; Sacks, 1992; Sacks et al., 1974). In this regard, Gale (1991) stated:

> With conversation analysis, context is seen as endogenous, as "generated within the talk of participants and, indeed, as something created in and through that talk" (Heritage, 1984, p. 283). This view of an endogenous context necessitates the detailed analysis of the conversation itself rather than examination of verbal chunks removed from their natural context. (pp. 3-4)

In case of the current research, the interactional patterns cannot be accurately described without accounting the progression of interaction in the session as a whole: Strings of interaction need to be embedded within the whole ecology of interactions in the session. This means that when analyzing the evolving interactions between therapists and clients in SST, I will need to keep the whole system in mind by analyzing extended sequences of their interactions. Single case analysis is particularly useful technique to analyze extended sequences of talk (Hutchby & Wooffitt, 2008). Hutchby and Wooffitt elaborate:

> In contrast to analysis of collections, this technique involves tracking in detail the production of some extract of talk, which can be drawn more or less at random from any interactional context, to observe the ways in which particular conversational devices are used in its production. (p. 113)

In addition, single case analysis is looked as a "starting point" (Liddicoat, 2007, p. 10) for any analysis. Findings from single case analysis can be used later to build a collection of similar interactions (Liddicoat, 2007; ten Have, 2007). Liddicoat (2007) went on to argue that a researcher then will use the collection of similar interactions to

refine the description of the interactions by identifying the interactions across different cases. Since discursive investigation of SST is in the initial stage, the current study will serve as a spring board for further discursive investigations of SST in the future.

In this careful case-by-case analysis of interaction, a single case of interaction represents a complete set of data as it is and needs to be treated as such. Liddicoat (2007) stated:

> A single case of talk is a single case of achieved orderly interaction, which can be examined as such and which can reveal much about the procedures used to create this order. . . . As such, a single case is not like a sample drawn from a pre-existing collection of such cases and representative of those cases, but rather an entire, self-contained instance of produced order. (pp. 9-10)

This point seems particularly relevant to analysis of SST, since a case of SST is viewed as a whole in itself (Talmon, 2014). By using a single case analysis, I will be able to explore and track in detail how therapists and clients use their utterances, leading to orders of interaction in a SST session. Several dissertations have been based on the singe case design of CA (e.g., Couture, 2005; Gale, 1991; Sharma, 2012; Sutherland, 2008).

Self of the Researcher

My position on the self of the researcher stems from the constructionist idea that a researcher cannot set himself apart from that which he or she is investigating, nor can he claim objective truth in his findings (Holstein & Gubrium, 2011). Instead, as a researcher I actively contributed to the construction of the current research from choosing the relevant research paradigms, research methodology, and research methods to conduct analyses of the data and presenting the result (Leeds-Hurwitz, 1995). As a

constructionist researcher, I embraced and paid attention to the idea that my analysis itself contributes to that which I will construct (Foster & Bochner, 2008). As an active contributor of the research, my immersion in the research is imperative. Flyvbjerg (2011) comments on immersion of researchers in their own research:

> If one assumes that the goal of researcher's work is to understand and learn about the phenomena being studied, then the research is simply a form of learning. . . . it then becomes clear that the most advanced form of understanding is achieved when the researchers place themselves within the contexts being studied. Only in this way can researchers understand the viewpoints and the behavior that characterizes the social actors. (p. 310)

In the current study, my choice of SST for the subject of the current study stemmed from my personal curiosity about SST. Reflexivity is of central importance, as I stayed aware of myself "as both inquirer and respondent" (Lincoln et al., 2011, p. 124) in the research process itself. This translates to another idea that the process of research itself is another realm of social construction (Steier, 1995). Therefore, I will share the assumptions informing my interpretation of the data, as well as the context of the study itself, in order to reflect my commitment for reflexivity in terms of my role as an interpreter and inventor of the study. I am aware that my knowledge of and experience with SST as a doctoral student therapist at the site of the study, Brief Therapy Institute, Nova Southeastern University, have shaped the way I initiated and designed the study and guided the research process.

Selection of a Case

The video recordings of a single case of SST served as the primary data for this study. While the principal aim of a case study is to "understand its complexities" (Stake, 2005, p. 444), Stake (2005) categorizes case studies based on their intent. The type of case study I employed for this study is single instrumental case study. It aims to provide "insight" (Stake, 2005, p. 445) into a phenomenon of interest: the case supports the researcher's understanding of his or her interest. In addition, an instrumental case study can be used for teaching and training.

In a single instrumental case study, a researcher will pick a bounded case that illustrates the researcher's interest (Creswell, 2007), then examines the case in depth in terms of its context and patterned activities (Stake, 2005). A case study is "both a process of inquiry about the case and the product of that inquiry" (Stake, 2005, p. 444). For this reason, Stake (2005) described the steps of conducting a case study. Following the steps, I first identified a case. Since I aim to explore patterns of interactions particular to SST setting, my choice of data source needed to come from that setting (ten Have, 2007). In particular, I chose a single case from the SST consultation program offered at BTI, as I described earlier. In choosing a case, I used the criterion sampling method to find a case that embodies the essence of the phenomenon under investigation, providing rich information (Morrow & Smith, 2000). Since the phenomenon of interest for the current study is the basic interactional patterns in successful SST, I decided to take the following criteria into an account:

- Video recording of the session is available for detailed analysis of the change process.

- Clients have given permission for the case to be used for educational research purposes.
- Dr. John Miller conducted the session alone or in conjunction with a student therapist.
- Dr. Miller accounted for the case as a typical example of SST.
- Clients in the case rated the session as successful in the post-session interview forms.

I decided to choose a case conducted by Dr. Miller primarily because of his expertise of having practiced SST for the last 20 years, as well as his numerous SST related publications (Miller, 2008; Miller, 2011; Miller, 2014; Miller & Slive, 2004). For the same reason, I decided to refer to his opinion as to determining a case as a typical of SST.

Researchers using case studies draw from multiple data sources in order to allow for "multiple facets of the phenomenon to be revealed and understood" (Baxter & Jack, 2008, p. 544). Yin (2003), and Baxter and Jack (2008) suggest several types of information be collected including documents, archival records, interviews, direct observations, and participant observation. For this study, I collected case note information, the telephone intake and lobby-intake forms, as well as descriptions of the SST project and its service setting. I synthesized those multiple sources of information in the analysis process, since "each data source is one piece of 'puzzle,' with each piece contributing to the researcher's understanding of the whole phenomenon" (Baxter & Jack, 2008, p. 554). In the current study, I integrated the CA's findings from the video-recording of a chosen case with the information mentioned above by comparing and contrasting those information sources. At the same time, I protected the client's confidentiality by de-identifying and de-selecting the client's identifying information.

Data Collection and Data Management

I started off by gathering relevant, non-identifiable information from the case note of the chosen case, as well as a consumer satisfaction survey and interview about the client's experience with the SST consultation services she completed right after the SST consultation. Although I was a part of the therapy team that observed the case through one-way mirror at the BTI, reviewing the case note information refreshed my memory. The case note information include various data: (a) occupation; (b) age range; (c) ethnic or cultural background; (d) the client's idea about how the service may be useful; (e) presenting problems; (f) the client's strengths and resources; (g) living arrangement and relations among people within the arrangement; (h) history of past physical and mental abuse if applicable; (i) the client's opinion on usefulness, sufficiency, and helpful aspects of the session to address the presenting problem; and (j) the client's opinion about mental health services in general.

The relevant, non-identifying information contained within the survey and interview included another set of data: (a) the client's satisfaction with the services; (b) ease of access to and affordability of counseling services in the local community; (c) any negative stigma associated with counseling; (d) sufficiency of the consultation; (e) reasons for seeking the type of services; (f) helpful and unhelpful aspects of the services; (g) recommendations for improving the services; (h) barriers to accessing therapy services; and (i) suggestions for improving access to therapy services. Those pieces of information gave me a contextualized picture of the case. Sidnell (2014) commented on the importance of gathering contextually relevant information for CA study, although analysis of the recorded date is the primary method of analysis:

> Analysis of a particular fragment of conversation . . . requires as much contextual information as possible—the more we know about who the participants are to one another and how they feel and bout the matters they are talking about, the better we can understand what they are doing in talking in the particular ways they do. (p. 85)

The information provided me with the client's basic information, the context for seeking SST consultation, her initial concern, and her feedback on the SST consultation.

In order to secure the open mindedness, I followed ten Have's (2007) suggestion to write down and set aside my "expectations" (p. 40) about potential interactional patterns in SST. My expectations came from my knowledge of the SST, as well as my own experience of having been observed and conducted SST consultations in the SST consultation services at BTI. My expectations was that the collaborative, client-centered, and strength-focused stance of therapists, as well as the shared assumption between therapist and clients that a single session can lead to meaningful a change, shape their interactions and lead to the sense of completion and resolution at the end of SST consultation. In specific, I assumed that the collaborative, client-centered stance of the therapists is exemplified through therapists' various interactions: collaborative problem and goal setting; careful listening and speaking; sharing of therapists' understanding of clients' situations; therapists' utilization of clients' words and frames of reference; and tentative suggestions and advise-giving. In regards to formation of shared expectation for the brevity of SST, I assumed that it is formed and maintained through the marketing of the service, the explicit session opening, the way therapist and client move through in the session, and the explicit closing of the session. The assumption is embodied overtly and

covertly in and through their interaction (e.g., therapists' ways of managing the interaction, comments, formulations, and questions and clients' responses to those interactions).

Practice of CA calls for a "close, careful examination of the actual spoken/acted details of the interaction" (Psathas & Anderson, 1990, p. 76). This means that a researcher needs to record the details of interaction for repeated listening and viewing. ten Have (2007) suggests a general outline for CA project: (a) making recording of natural interaction; (b) transcribing the video-recording in whole or in part; (c) analyzing selected segments of interaction; and (d) reporting the research. I first reviewed the video recorded session several times, while paying attention to shifts in contexts, themes, topics, language, intonations and any other significant conversational moments that may represent signs of therapeutic improvement (e.g., from problem saturated to strength, resource focused). The choice of the term, therapeutic improvement, was based on the body of SST studies attesting that clients make the most improvements in initial session of psychotherapy (Battino, 2006; Hubble et al., 1999; Seligman, 1995). Other foci of analysis include the basic elements of brief therapy (Amundson. 1996; Fisch, 1994; Miller & Slive, 1995; Talmon, 1990) and the collaborative, client-centered therapeutic relationship that utilizes clients' strengths and contextual resources (Duncan et al., 2010, 2011) in SST (Amundson, 1996; Bloom, 2001; Bobele & Slive, 2014). At the same time, I remained open to other types of potential shifts because therapists in the SST consultation program may have employ discursive techniques from various therapy approaches that make sense at each moment of interaction with the client (Amundson, 1996; Miller & Slive, 2004; Miller 2008).

While reviewing the video recording, I took brief notes about those interactions within the general progression of the session. The note included: the therapists' attempt to establish expectation for the brevity of the SST consultation through explicit language use; the therapists' structuring of the consultation from a singular goal setting over the course of the consultation; therapists' exploration of family dynamic around presented problem; therapists' suggestions and advise giving over several turns; and the therapists' client-centered and strength-focused approach through langue use in forming questions and comments, utilization of client's language and the world view, and repeated pursuits of client's strength within the problem situation over several turns.

I then transcribed the entire case in conventional English language based on the video-recording. I spend roughly 50 hours for transcribing. Over time, I divided up the entire session of the chosen SST consultation into phases based on an objective or topic in each phase based on the understanding that an entire single event comes with somewhat of distinctive states (Heritage, 2004; Robinson, 2014). I asked myself, 'What is that they are trying to accomplish in this sequence of interaction?' Initially, I derived 30 phases that evolved over time and became 23 phases at the end. I kept reminding myself that the division was artificial.

Regarding transcription, ten Have (2007) cautions that it should not be treated as data; instead, "a transcription might be best seen as a translation, made for various practical purposes, of the actually produced speech into a version of the standardized language of that particular community, with some selective indication of the actual speech production" (p. 94). Transcription allows "a repeated and systematic 'access'"

(Psathas & Anderson, 1990, p. 90) to the reader. In CA, a transcription can be viewed as an interpretation of social interaction based on the sequential focus of CA.

This makes the process of transcription an important part of analysis for CA: the transcription process "provides the researcher with a way of noticing, even discovering, particular events and helps focus analytic attention on their socio-interactional organization" (Heath & Luff, 1993, p. 309). Gale (2010) described that transcribing of talk-in-interaction is an important process of immersing researchers in talk-in-interaction and practice for the researchers to acquire open-mindedness to the data without pre-conceived notions about the data. In addition, a transcript gives a researcher an immediate access to a wide range of interactional sequences (ten Have, 2007).

Following ten Have's (2007) suggestion, I added notation symbols (Appendix E), using a transcription notation system outlined by Voutilainen, Peräkylä, and Ruusuvuori (2011), and Kogan (1998) after having completed a conventional transcription of the recording. I spend roughly 200 hours in this process. Throughout this process, I took journal about the process, as well as any thoughts and insights that emerged in the process. The journaling helped me to stay consistent in adding CA notations to the transcript. For efficiency, I used a computer software program, Transana (Version 3.01, 2015), to add CA notations to the conventional English transcription. Transana is a commercially available software program developed by researchers at the Wisconsin Center for Educational Research, the University of Wisconsin. The program utilizes a split screen design that allows users to review audio or video-audio material, while transcribing and analyzing it simultaneously. The program allowed me to capture micro-details of therapist-client interactions listed in the CA notation system. Those include

symbols that account for paralinguistic features—utterances, breaths, pauses, overlaps, sequences, and changes in intonation— as well as nonverbal features of interactions—gaze, gestures, and postural shifts. Over time, I decided to make note of one category of the CA convention at each round of review: (a) timing of interaction; (b) intonation and speech delivery; (c) audible in-breath and out-breath; and (d) clarifying information and non-verbal and choreographic elements.

In the stream of the interaction, "a movement [of nonverbal features] . . . may be used to accomplish particular tasks in face-to-face interaction" (Heath, 1986, p. 10); thus, the visual movements may be significant in coordination with the progression of actions and activity (Health & Luff, 2014). Since there seems to be no equivalent unit (e.g., turn-by-turn, speaker-by-speaker, etc.) to those nonverbal features (Heath, 2004; Health & Luff, 2014; ten Have, 2007), I first treated vocalizations as a baseline, to which I added nonverbal features in order to supplement the linguistic and paralinguistic elements of conversation (ten Have, 2007). This created a more comprehensive picture of the face-to-face interaction in the session. As Heath (2004) noted, "the utterance, and the way in which it is understood, is the outcome of a complex interaction that includes both visual and vocal contributions by the participants during the very course of its production" (p. 271). Health (2004) went on to assert that "it is important to consider the sequential organization of the participants' conduct even though next actions may occur prior to next turn [of vocal interaction]" (p. 271) (e.g., a speaker's gesture in a stream of interaction may prompt the hearer's next utterance). I repeated the transcription process and revised the transcript until I captured the range of interactional features specific to the CA notation system.

In dealing with specific transcription issues, I consulted with Psathas and Anderson's (1990) guideline. I noted time, data, and location of the original recording of SST for data recording purposes. I identified participants in the consultation in the transcript using "categorical identification" (p. 97), including C for client, T1 for primary therapist, and T2 for secondary co-therapist. Each letter code was placed in the left column.

Although the numbering of line may seem a mundane activity, it has particular consequences in the analysis. Psathas and Anderson (1990) claimed that

> the line of type/transcription is itself a 'unit' on the page. . .—first and primarily a unit bounded by the width (margins) of the printed page, but secondly, and more problematically, as significantly related to interactional units such as turn, utterance, or breath-length utterances. (p. 85)

Consequently, researchers can order numbering of lines to draw attention to particular interpretation of the data. Among various choices, I decided to assign lines to distinct phases or clauses as semantic units by breaking lines at the end of each semantic unit. For this reason, I caution the reader of this research not to equate the number of lines in the transcript to the temporal length of the transcript (Psathas & Anderson, 1990).

Psathas and Anderson's (1990) suggest transcribing "actual words spoken . . . . [since] the assumption here is that the interactants are engaged in the use of conventional linguistic forms grounded in a common language with semiotic and syntactic conventions" (p. 80-81). Researchers need to determine whether they use conventional English by correcting actual words spoken, describe actual words as they are spoken by participants, or vary between the two options depending on particular circumstances. ten

Have (2007) comments that the decision needs to be based on the researcher's purpose and audience and that the researcher needs to follow the chosen method consistently. I decided to transcribe words just as closely as spoken by the participants since therapists' utilization of clients' words are highly valued in SST (Massfeller & Strong, 2012; Sharma, 2012; Strong & Nielsen, 2008) in joining with their world views. When I determined that a word would be hard for the readers to determine the spoken word, I added a conventional word within a single parenthesis, "( )" right after the spoken words.

Although sounds uttered may not always form conventional words, they may carry "meaning and interactional import" (Psathas & Anderson, 1990, p. 81), so researchers need to capture sounds produced as closely as possible. For this reason, I added sounds that may have contributed to the development of interaction (e.g., 'tch' for 'tisking' the tongue against the roof of the mouth, 'pt,' for lips parting, '.h' for in-breath and 'h' for out-breath, 'eh,' 'uh,' and 'mhm' etc.) Other vocal sounds, including laugher and crying, will be described within double parentheses, "(( ))" to mark their non transcript status. As for incomprehensible and inaudible sounds (e.g., a clearing throat, a cough) I made my best guess and inserted them within a single parentheses, "( )." Similarly, I inserted inaudible and incomprehensible stretches of talk by dots within parentheses "(…..)" in which each dot corresponds to the length of the stretched talk. ten Have (2007) suggested that those sounds be included since they "contribute to 'the picture' of the rhythm of the talk" (p. 100).

Spaces and silences between and among words and sounds seem to be important in interaction as much as words and sounds themselves (Psathas & Anderson, 1990; ten Have, 2007). Pauses happen when one person stops speaking and no one takes the next

turn immediately within the natural flow of interaction. When the previous speaker continues speaking, it becomes a "within-turn pause" (ten Have, 2007, p. 101). If another speaker picks up a turn after the silence, the silence is noted as a "between-turn pause" (ten Have, 2007, p. 101). I made note of pauses and silence in terms of a measured interval (i.e., "(0.4)" for four tenths of a second, "(1)" for one second, "(.)" for a pause less than one tenth of a second or less). Though the timings are rarely objectively accurate, they need to be consistent within an individual transcript (Psathas & Anderson, 1990). This is because "it is the relative differences between timed pauses within the same transcript that is significant" (Psathas & Anderson, 1990, p. 87) {e.g., the difference between pauses noted as "(0.5)" and "(1.5)," or between pauses noted as "(1.5)" and "(3.0)"} since the transcript needs to capture the participants' experience of those pauses or silence. By paying attention to the pace of the interaction, I was able to "catch the local significance of the pauses" (ten Have, 2007, p. 102). For measuring lengths of pauses, I used the wave form representation of the audio recording captured within Transana.

For overlapped speech and sounds, Psathas and Anderson (1990) suggested displays of the following indications: (a) the start point of the overlap; (b) the point in the previous speaker's speech or sound that was overlapped; (c) the end point of the overlap; and (d) the both speakers' speech or sound contents within the overlapped segment. I noted the overlapped speech and sounds by inserting a single bracket, "[" for the start point and "]" for the end point of the overlap. Following Gail Jefferson's occasional practice mentioned in ten Have (2007), I stretched the display of one of the overlapped

parts by inserting extra spaces so that the length of the duration of both parts of overlapped speech were matched up with each other in the transcript.

In addition, I aligned the location of the overlapping speech or sounds to the overlapped speech or sounds by inserting the overlapping speech or sounds in the next line right below the overlapped speech. In regards to denotation of pace, stretches, stresses, and volume of speech and sounds, I refer the readers to the notation system (Appendix E). However, I inform of the readers that the use of punctuation in the transcript is "not used to demark sentences or clauses in any grammatical sense" (Psathas & Anderson (1990, p. 84). Instead, it is used to "display intonation" (Psathas & Anderson, 1990, p. 84) (e.g., "?" for rising intonation, "." for downward intonation, etc.).

In regards to display of visual, nonverbal elements of interaction, ten Have (2007) noted that each researcher needs to find a way toward "a contextually relevant analysis" (p. 166) of visual elements of interaction. After transcribing vocal features of utterances in each numbered line, I inserted a corresponding continuous choreographic element (ten Have, 2007) within a "{ }" and assigned it to the line right below the corresponding vocal features of utterances in the transcript. The location of "{" marks the beginning of the choreographic element in proportion to the vocal features of the utterance, whereas "}"marks the end of the element in proportion to the corresponding vocal utterance. If the choreographic elements ended sooner than the length of description of the element in proportion to the verbal utterance, I placed "}" at the point corresponding to the verbal utterance and continued inserting description of the choreographic element. If the description of the choreographic element ended sooner than the temporal length of the element in proportion to the verbal utterance, I inserted spaces in order to match the "}"

to the corresponding verbal utterance. I adjusted the choreographic description's level of detail depending on my imagination of the significance of the choreographic elements for the participants in the stream of the therapy interaction.

In summary, all of the choices researchers make in displaying various elements of interaction on a printed page make a difference in the analysis. As Psathas and Anderson (1990) noted, "the seemingly simple matter of how interaction is presented in a line-by-line format should be carefully considered when interpretations of interactional phenomena are based on the 'display conventions' rather than the 'actualities' of the phenomena" (p. 89-90). For this reason, Psathas and Anderson (1990) suggest that researchers return to the original recording of the interaction. This meant that I returned to the video recording of the SST consultation every time I inspected the transcript.

Data Analysis

According to ten Have (2007), CA researchers aim to find "'patterns of interaction' or 'sequential structures'" (p. 120) within its context by inductively approaching data, as well as explicating the logics of the interaction. Sidnell (2014) similarly describe the goal of CA study as "to identify the actions that participants in interaction do and to describe the particular practices of conduct that they use to accomplish them" (p. 78). Practice carries a particular connotation in CA. According to Heritage (2011), it is "any feature of the design of a turn in a sequence that (i) has a distinctive character, (ii) has specific locations within a turn or sequence, and (iii) is distinctive in its consequences for the nature or the meaning of the action that the turn implements" (p. 212).

Although there is no best strategy of pursuing such practice, unmotivated examination of data (Schegloff, 1996; ten Have, 2007), or an inductive, discovery-oriented position (Couture, 2005; Gale, 1991; Sharma, 2012) is recommended. This means that researchers examine naturally occurring interactions without any preconceived ideas about "what [the] data 'are' or 'represent'" (ten Have, 2007, p. 6). Schegloff (1996) continue on to describe the examination process:

> The trajectory of such analyses may begin with a noticing of the action being done and be pursued by what about the talk or other conduct—in its context—serves as the practice for accomplishing that action. Or it may begin . . . with the noticing of some feature of the talk and be pursued by asking what—if anything—such a practice of talking has as its outcome. (p. 172)

On the other hand, CA studies have accumulated a collection of conversational logic over the years that a current researcher can attend to. Therefore, the researcher can take a balanced approach of inductive, discovery-oriented examination of audio-visual recording of naturally occurring social interaction and its transcript, while attending to fundamental interlocking interactional devices and practices, as well as interactional practices specific to psychotherapy (ten Have, 2007). I first turned to those explicated fundamental interlocking interactional devices and practices accumulated by the previous CA researchers in the field.

Fundamental Interactional Devices and Practices in CA

ten Have (2007) suggested four fundamental types of interlocking interactional organizations that researches can attend to for analysis of naturally occurring everyday face-to-face interaction. Those interactional organizations include: turn taking, sequence

organization, repair organization, and the organization of turn design. Along with these organizations, I also wove in other fundamental interrelated organizations I found in CA literature.

Turn taking is a sequentially organized activity (Stivers, 2014; Sacks et al., 1974). In every moment of a face-to-face interaction, one person speaks while the other picks up the turn; this takes place with minimal gaps and overlaps. In each turn, a speaker has a right to the conversational floor until certain junctures where the recipient of the conversation can pick up the floor—*transition-relevance place* (TRP: Clayman, 2014; Sacks et al., 1974). In this fashion, turns are composed of a series of *turn-constructional units* (TCU: Clayman, 2014; Sacks et al., 1974) (e.g., sentences, clauses, phrases, and words). In this fashion, the participants of the talk contribute to the sequence of conversation at each turn (Clayman, 2014; ten Have, 2007)—that is, turns-at-talk (Hayashi, 2014). The turn-taking is an outcome of people methodically orienting to normative social practices (Hayashi, 2014).

Not only does the completion of a turn become obvious at its occurrence, but also it is projected by the speaker through various means (e.g., unfinished TCU, slowing down and stretching of the last syllable, a brief rise in intonation before the completion, the construction of a turn in a question format, a speaker's gaze toward the recipient of the talk near the end of a turn, addressing or indirect gaze at a next speaker, etc.). At the same time, a speaker can prevent a turn of speakership by various means (Clayman, 2014; Hayashi, 2014) (e.g., rushing through the turns; bridging multiple turns using an item of the talk, etc.). On the other hand, the recipient of the talk can self-select to take the next turn at or near the end of a turn or by projecting his or her initiation of the next

turn by an audible in-breath, and so forth. Overlaps happen when a participant starts his or her turn before another participant completes his or her on-going turn. Overlaps are usually considered a problem and in need of repairs, except in some contexts where choral participations are considered appropriate, since they deviate the normative assumption behind the social conversational practices (Hayashi, 2014).

Repair occurs when a participant(s) initiates an effort to correct mishearing or misunderstanding by interrupting an ongoing course of action. Any participants in the conversation can initiate the repair, including the misheard or misunderstood speaker and/or recipient(s) of the message (Kitzinger, 2014; ten Have, 2007). A common repair takes a form of one or both of the speakers dropping out. After an overlap, the participants can choose to continue the turn taking, or pick up the utterance that was overshadowed by the overlap (Hayashi, 2014).

Through turn-taking, each participant fine-tunes each turn in sequential order (Clayman, 2014) in order to adapt to the other participant(s) involved, reflexively constituting the participants as members of the conversation (ten Have, 2007). The assumption on the sequential organization of talk leads to another interactional organization, the organization of turn-design. This means that a speaker adjusts his or her turn progressively, according to his or her understanding about the context of the conversation, as well as understanding about the other participant(s) by utilizing linguistic and other conversational resources (Drew, 2014; Pomerantz & Heritage, 2014; ten Have, 2007)—that is, *recipient design* (Pomerantz & Heritage, 2014). For instance, a speaker usually utilizes a particular reference to the person about whom the speaker is talking about when the speaker knows that the recipient knows of the person. In forming

and interpreting actions, repair, turn-taking, and the sequential progression of actions, participants in an interaction show their preferences as they follow principle(s), often implicitly (Pomerantz & Heritage, 2014).

Turn-taking is shaped by the location in sequence, the actions taken within the design of the turn, and the recipient of the turn (Drew, 2014). In a progressive manner, each utterance refers to the previous utterance and forms a context for the next (Stivers, 2014; ten Have, 2007). In other words, an utterance (second pair part) produced by a participant following a previous utterance (first pair part) produced by another participant is viewed as a legitimate response to the previous utterance. Together, the paired utterances form an *adjacency pair* (e.g., "question-answer," "greeting-greeting," "offer-acceptance/refusal") (Schegloff & Sacks, 1973). Drew (2014) elaborates on the process:

> The contingent connection between a turn and its prior, and the contingencies one turn creates for a subsequent (responsive) turn, generate strings or sequences of connected turns in which we each 'act,' and in which the other's—our recipient's—responses to our turn relies upon, and embodies, his/her understanding of what we were doing and what meant to convey in our (prior) turn. (p. 131)

The initial pair of turns can be expanded in various ways by incorporating additional sequences of interaction (Stivers, 2014; ten Have, 2007). Stivers (2014) notes that sequence expansion can occur prior to, during, or after the basic sequence. When *adjacency pairs* are formed together in a meaningful manner, they form *activities*: "Activities are achieved across more than one sequence of action 'which are nonetheless

being managed as a coordinated [or coherent] series that overarches its component pairs' (Heritage & Sorjonen, 1994: 4; see also Lerner, 1998)" (Robinson, 2014, pp. 259-260). Activities involve *overall structural organization* (Robinson, 2014) which gives the activities coherence to their subcomponents. The size of activities varies from small sequence (e.g., that of *opening* interaction) to large sequences (e.g., medical consultation) and so does the size of corresponding overall structural organization. Within each activity, an overall structural organization emerges and reflexively, as an interactional context, gives their interaction coherence "that shapes and constraints participants' production and understanding of behavior in interaction" (p. 278). Participants in social interaction understand and produce social action by taking into a holistic account those aforementioned interrelated interactional devices and practices. In this interactive process, overall structural organization gives a sense of progression through the structure and components of the interaction toward completion (Robinson, 2014).

An *Opening* (Schegloff, 1986) interaction, relatively small activity, consisting of a small number of adjacency-paired sequences, and provides the participants in an interaction with how to start their interaction based on the interactional goal (Schegloff, 1986). As I mentioned above, the overall structural organization does not unilaterally dictate the interactional nature of the participants at each stage of the interaction; rather, as the interaction unfolds between them, the overall structural design emerges and reflexively shapes their interaction (Robinson, 2014). The opening usually comes to an end with anchor position which is marked with the participants' first topic of discussion (Schegloff, 1986) (e.g., reason for the interaction).

In comparison to a small activity, a *project* (Levinson, 2014) can involve a large number of sequences of action and corresponding overall structural organizations of sequences of actions (Robinson, 2014). According to Levinson (2014):

> A project is an action plan, and like any plan of moderate complexity, it will have steps to be taken on its way to completion: to make the coffee, I have to, say, find a filter, fill the water up, find the coffee, ready a cup, and so on, observing which, you might step in and get the cups. (p. 126)

In interaction, then, participants negotiate on projects in terms of its initiation, maintenance, termination, diversion, and preclusion. In this sense, actions serve to projects and the projects themselves are actions to be pursued (Levinson, 2014). What is implied here is that projects are collections of interactions.

When it comes to an entire, single occasions of interaction, they entail distinct components of *opening* (Schegloff, 1986), *closing* (Schegloff & Sacks, 1973), and *topics* (Schegloff, 1986) that come between the opening and closing (Robinson, 2014). For instance, a primary care visit may be divided into interactional components between a physician and a patient: greeting; problem presentation; information gathering; diagnosis; treatment; and closing. It is noted that a physician and a patient orient to each component in the service of the following component (Robinson, 2014). While forms of interaction, or topics (Schegloff & Sacks, 1973) that fall between an opening and a closing may be pre-determined in both ordinary and institutional interaction, participants themselves can propose topics. The activity of closing is marked with terminal sequence (e.g., the exchange of "bye") (Schegloff & Sacks, 1973). For the terminal sequence to be accounted as such, the participants have to establish an appropriate context for the

terminal sequence. In this phase, the participants can propose other topics to be discussed before the closing.

The consideration of those different levels of interactions within a SST consultation in this study—that is, interactions; *activities* composed of interactions; *project* encompassing *activities*; and an entire, single occasion of interaction encompassing *projects*—was crucial for me, since it is my assumption that every interaction are interrelated systemically (Weakland, 1987) and contributes to the overall gestalt of the therapy, thereby client's experience of the therapy session. Robinson (2013) refers to a metaphor of a matryoshka doll, Russian nested dolls, on the systemic nature of the production and understanding of interaction through the lens of CA:

> [The production and understanding of social action are] influenced by multiple, simultaneous orders of interactional organization, with the recognition that those orders are themselves organized relative to each other (Sacks & Schegloff, 1979). All relevant orders reflexively (Heritage, 1984b) inform each another" (p. 278).

Particularly in SST, "it is the whole session itself that is the novelty (J. Miller, 2016, April, 2016)." This meant to me that I needed to embed the therapists' and client's actions and activities within the evolving sequence and its context of the interaction (Gale, 1991). However, the consideration of overall structural organization in CA studies is rarely central focus, as Robinson (2014) noted. The majority of the studies has analyzed individual sequences of action, as well as their subparts—turns and turn constructional unit. Robinson (2014) continues expressing his concern: "As Sacks (1992 [1971a]) argued, the enterprise of analyzing individual sequences of action completely ignores how they are, in some cases, part of larger, coherent matters" (p. 258).

Interactional Devices and Practices in Applied CA

Since the current study will investigate institutional interaction of therapy, its analysis demands special considerations. Institutional interaction is characterized by the following (Drew & Heritage, 1992; Heritage, 2004):

1. Participants are oriented toward a particular goal, which is tied to their institutional identities (e.g., doctor and patient);
2. Institutional talk places restraints on the range of interactions, contributing to the institution's goal; and
3. Institutional talk provides "inferential frameworks and procedures" (Heritage, 2004, p. 225) that are specific to the institutional contexts.

Due to the unique characteristics of institutional interaction, Heritage (2004) encouraged that researchers take the following six ideas into consideration in probing "'institutionality' of interaction" (p. 225):

- Turn taking organization;
- Overall structural organization of the interaction;
- Sequence organization;
- Turn design;
- Lexical choice, and;
- Epistemological and other forms of asymmetry (p. 225).

In describing each interactional devices or practices, I rearranged their order starting from micro to macro level, except the turn taking organization and epistemological and other forms of asymmetry. While these different dimensions of institutionality are divided,

Heritage (2004) clarified that they are interrelated in such way that each of these dimensions is a part of the next encompassing level; "lexical choice is a part of turn design; turn design is a part of sequence organization; sequence organization is a part of overall structural organization" (Heritage, 2004, p. 241). I advise the readers of the current study that there are some overlaps between this set and the interlocking interactional devices and practiced suggested by ten Have (2007).

Turn taking organization. While institutional talk shares basic turn taking organization with everyday talk, some institutional talks represent very specific systematic organization. It is important to pay attention to these organizations, since they may pre-determine available actions and interpretation of each action of activities that happens within the context. On the other hand, every day conversation is rarely pre-determined (Heritage, 2004).

Lexical choice. Speakers select descriptive terms depending on the institutional settings or their roles within it (Drew & Heritage, 1992; Heritage, 2004). For instance, a person who may use a term, cop in regular conversation may choose to use police officer in a court room. The lexical choice can contribute to a shape of whole sequences, and overall pattern of the interaction. For instance, below is a segment of a phone conversation between a school teacher and a mother. The transcript right below is the version of CA's transcript notation system used for the analysis of the excerpt.

1 Mom: Hello

2 (0.5)

3 Teacher: Hello, Mister Wilson?

4 (0.8)

5 Mom: Uh: this is Missus Wilson.

6 Teacher: Uh Missus Wilson I'm sorry. This is Miss Matalln

7 from Arroyo High School calling?

8 Mom: Mh hm

Transcript conventions

Symbol	Indicates
→	Arrows in the margin point the lines of transcript relevant to the point being made in the text.
( )	Empty parentheses indicate talk too obscure to transcribe. Words or letters inside such parentheses indicates the transcriber's best estimate of what is being said.
hhh	The letter "h" is used to indicate hearable aspiration, its length roughly proportioned to the number of "h"s. If preceded by a dot, the aspiration is an in-breath. Aspiration internal to a word is enclosed in parentheses. Otherwise, "h"s may indicate anything from ordinary breathing to singing to laughing, etc.
[	Left-side brackets indicate where overlapping talk begins.
]	Right-side brackets indicate where overlapping talk ends or marks alignment within a continuing stream of overlapping talk.
°	Talk appearing within degree signs is lower in volume relative to surrounding talk.

> <	"Greater than" and "less than" symbols enclose talk that is noticeably faster than surrounding talk.
((looks))	Words in double parentheses indicate transcriber's comments, not transcriptions.
(0.8)	Number in parentheses indicate periods of silence, in tenths of a second – a dot inside the parentheses indicate a pause of less than 0.2 seconds.
:::	Colons indicate a lengthening of the sound just preceding them, proportional to the number of colons.
becau-	A hyphen indicates an abrupt cut-off or self-interruption of the sound in progress indicated by the preceding letter(s) (the example here represents a self-interrupted "because").
____	Underlining indicates stress or emphasis.
dr^ink	A "hat" or circumflex accent symbol indicates a marked pitch rise.
=	Equal signs (ordinarily at the end of one line and the start of an ensuing one) indicates a "latched" relationship—no silence at all between them.

Source: adapted from Heritage (2004, p. 368-369)

By using the formal lexical choice, the teacher sets a tone that it is a conversation about school business. The smooth transaction of the following sequences originated from the clear projection of the conversational context through her lexical choice (Heritage, 2004).

Turn design. Turn design is a crucial place to examine "institutionality" of interaction and points to two distinct selections that a person's speech embodies; "(a) the action that the talk is design to perform, and (b) the means that are selected to perform the action" (Heritage, 2004, p. 231). The design quality of interaction becomes apparent in the selection of action that a participant wants to accomplish in a turn at talk. Below is a conversation between a heath visitor (HV) and a father (F) and a mother (M) who have a new born baby.

1 HV: He's enjoying that [Isn't he.

2 F: → [°Yes, he certainly is=°

3 M: → =He's not hungry 'cuz (h)he's ju(h)st (h)had

4 'iz bo:ttle .hhh

5 (0.5)

6 HV: You're feeding him on (.) Cow and Gate Premium. =

(HV:4A1:1)(Heritage & Sefi, 1992, p. 367)

In this segment of the conversation, the mother interprets the health visitor's remark that the baby is enjoy sucking something because he is hungry, as evidenced by the mother's response rejecting the interpretation. In contrast, the father simply agrees with the visitor. Thus, the mother and father elected to choose different responses both of which are relevant as the next actions. What is implied here is that the father treated the remark as innocent observation of the baby whereas the mother treated it as a comment referring to her duty as a mother who needs to provide the baby with a proper care.

Another aspect is that participants can say or perform the same actions differently. In the following segment of interaction among the same visitor, mother and father, the aspect is evident.

1 HV: →It's amazing, there's no stopping him now, you'll be
2 Amazised at all the different things he'll start doing.
3 F: [(Hnn hn)
4 (1.0)
5 M: →Yeh. They [learn so quickly don't they.
6 F: → [We have noticed hav'nt w-
7 HV: That's right.
8 F: →We have noticed (0.8) making grab for your bottles.
9 (1.0)
10 F: Hm[::.
11 HV: [Does he: (.) How often does he go between his feeds?

(HV:4A1:2) (Drew & Heritage, 1992, p. 34)

In the excerpt, the mother and the father agree with the health visitor's remark about the child development differently. The mother's response refers to the infancy development in general, whereas the father responded by supplying their observation on the particular baby. The mother's response may be in response to her interpretation of the motive of the health visitor—an initiative for "expert-novice" relationship; the father's response seems to prove to the visitor of their care of the baby (Heritage, 2004).

Sequence organization. By looking at the sequence of interaction, CA researchers can observe how participants initiate and progressed together through the

particular courses of actions, while they open up and activate, or prevent particular action opportunities from happening. All of these transactions are beyond the reach of the participants; they use whatever transpires at each turn as a basis of inference about the character and situation of their co-interactants (Heritage, 2004). Below is an instance of a phone conversation between a teacher and the mother of a student, along with the transcript convention used.

9 Teacher: [.hhhhh Was Martin home from school ||| today?=

10 Mom: =U:::yes he was * in fact * I'm sorry I- I didn't ca:ll*

11 because uh ::h I slept in late * | (.) haven't been feeling

12 well either. .hhhh And uh .hhh (0.5) u::h he had uh y|h

13 know, uh fever:

14 (0.2)

15 Mom: this morning.

16 Teacher: U::h Hu:h,

Source: adapted and modified from Heritage (2004, p. 230)

In this segment of the interaction, the mother answers and apologizes to the teacher with laborious explanations for the situation. The line 10 to 12 shows her attempt to skip pauses at sentence boundaries. In addition, her attempt to continue talking is evident at the line 11 at which her sentence was complete (marked with an asterisk), where the teacher could have interjected. In addition, the mother did not fall in intonation at the end of sentences (that would have marked with a period), and moved

straight to the next sentence without a break. Based on the design of her actions, an analysis would infer that she did not want to create opportunities for the teacher to intervene or add another observation. It is only after she spelled out that she had not been feeling well that she takes a breath (marked with "hhhh"). From this short exchange, it seems that the mother inferred the teacher's question as an initiative making the mother accountable for not calling the teacher. Her treatment of the teacher's initial questions represents the particular understanding of its relevance (Heritage, 2004).

Overall structural organization of the interaction. When a researcher figured out that a special turn-taking organization is at work in the presented data, the researcher would build an "overall 'map' of interaction in terms of its typical 'phases' or 'sections" (Heritage, 2004, p. 227). For instance, a telephone call between a teacher and a mother of a student can be mapped out as (a) opening of conversation in which they establish their roles to each other (the teacher and the mother of the student), (b) problem initiation stage in which they initiate and set a problem of the student missing from the school, (c) disposal section in which the teacher describes his or her next actions in response to the problem, and (d) closing phase in which both of them manage the exit from the conversation.

Each section comes with a sub-goal (Heritage, 2004). In this way, each section is accomplished though joint-actions of the participants. Identifying these sections of institutional talk bring forth other features important to analysis of the institutional talk: (a) a number of agenda at each stage, (b) the incremental movement between participants in setting task and goals, (c) the way the parties progressively co-construct the sense of joint goals and tasks, as well as roles each plays (or not), and (d) the way participants

agree or do not agree on the movement from one section to the other. However, the overall structural organization is not a rigid framework; instead, it is only relevant to the extent that it organize the parties in constructing interaction (Heritage, 2004).

Interactional asymmetries. Institutionality in interaction embodies various asymmetries, including: (a) participation; (b) interactional and institutional knowhow; (c) knowledge; and (d) rights to knowledge (Heritage, 2004). The asymmetries of participation is evident in most professional-lay person interaction in which professionals initiate and retain the right to: (1) shape a new topic by designing opening questions; (2) determine when a topic is explored satisfactorily; and (3) decide what the next topic will be (Drew & Heritage, 1992; Heritage, 2004; Mishler, 1984). The asymmetries of interactional and institutional knowhow arise from the gap between professionals who treat each interactional encounter as a routine practice and lay persons for whom the encounters are very personal. The gap can become a source of stress to the lay persons because of not knowing the professionals' objectives behind the encounter.

Epistemological caution refers to professionals and institution's tendency to avoid making claims, because it is sometime prohibited (e.g., news interview, court hearings, etc.) (Heritage, 2004). The asymmetries of knowledge embody knowledge claims made by professionals for their specialized expert knowledge. It is renewed variously in talk (Gill, 1998; Jacoby & Gonzales, 1991, Peräkylä, 1998, 2002; Raymond, 2000; Silverman, 1987). Other asymmetries of knowledge occur when people do not have rights to access to certain knowledge. For instance, a person calling to an emergency service about an accident does not have an access to know about the incident.

Interactional Devices and Practices in CA of Psychotherapy

The imposition of sequential organization of CA on psychotherapy makes the CA studies of psychotherapy distinctive enterprise. According to Peräkylä (2014),

> This organization entails that anything a therapist or patient does is, done and understood in the context of the other participant's previous turn. . . . Thus through their adjacent utterances, therapist and client inevitably create an intersubjective field—an emergent field of shared understandings regarding each other's actions and the worlds of momentary experience that these actions embody. (p. 552)

To this day, CA researchers have examined different psychotherapy practices separately, which has led to little understanding on the commonalities among different practices. Peräkylä et al. (2010) pointed out reasons for this: (1) the CA of psychotherapy is still developing; and (2) the multitude of psychotherapy schools warrants multiple psychotherapy principle; and (3) some psychotherapy approaches are not organized in terms of distinct phases of treatment. I hoped that the current study would contribute to CA research body by providing interactional map of SST.

I reviewed interactive devices and practices general in psychotherapy and ones particular to systemic, constructionist oriented therapy, due to SST's origin and orientation to those practices. The previous researchers have investigated various aspects of interactional practices within psychotherapy and systemic, constructionist oriented therapy: *transition relevant place* (Couture, 2005; Gale, 2000); *adjacency pairs* (Gale, 2000, 2010); *turn taking sequences* (Gale, 2010); *discursive markers* (Bangerter & Clark, 2003; Schiffrin, 2001); *accounts* (Gale, 2000, 2010); *formulation* (Antaki, 2008; Gale,

2000); *lexical substitution* (Rae, 2010); *preliminaries* (Gale, 2000); *construction of delicate object* (Silverman, 1997, 2001); *quasi-conversational turn-taking* (Peräkylä, 1995); *circular questioning* (Peräkylä, 1995; Peräkylä & Silverman, 1991); *live open supervision* (Peräkylä, 1995); *addressing "dreaded issues"* (Peräkylä, 1995); *hypothetical questions* (Peräkylä, 1995); *advise-giving and advise reception* (Silverman, 1997); *optimistic questions* (MacMartin, 2010); clients' responses to therapists' *reinterpretations* (Bercelli et al., 2010); *exteriority* (Kogan, 1998); *the disciplining of narratives* (Kogan, 1998); *locality* (Kogan, 1998), and so forth.

Clark's (1996) Interactional Theory of Communication

I decided to refer to Clark's (1996) interactional theory of communication and other related ideas, as I found these ideas fitting with the analysis of this study. In turn, the theory supplied me with a lens with which to organize the data. Accordingly, people engage in joint activities that require the participants use language to communicate to share understanding and coordinate their interaction to accomplish such activities, while renewing their intentions and commitment for the activities at each moment. At the same time, the communication itself is a joint activity that people need coordinate on a moment-to-moment basis (Bangerter & Mayor, 2013; Holtgraves, 2002).

Through such interaction and coordination of interaction, participants contribute to creation of conversational intersubjectivity through grounding (Bangerter & Mayor, 2013; Clark & Brennan, 1991). Clark and Brennan (1991) elaborated on the process:

> It takes two people working together to play a duet, shake hands, play chess, waltz, teach, or make love. To succeed, the two of them have to coordinate both the content and process of what they are doing. . . . They cannot even begin to

> coordinate on content without assuming a vast amount of information or common ground—that is, mutual knowledge, mutual beliefs, and mutual assumptions (Clark & Carlson, 1982; Clark & Marshall, 1981; Lewis, 1969; Schelling, 1960). And to coordinate on process, they need to update their common ground moment by moment. All collective actions are built on common ground and its accumulation. (p. 127)

In such activities, participants show each other that they have understood the other participants enough to continue being engaged in the on-going process (Bangerter & Mayor, 2013; Clark & Brennan, 1991). Participants show their lack of understanding through asking the other participant to repeat what he or she just communicated.

Clark and Schaefer (1989) posited five ways recipients of communication can show their understanding to the sender of communication, from least to most explicit:

- continued attention to interaction;
- relevant next turn in which a contributor produces a first pair part of adjacency pairs (e.g., a question) to which a conversation partner responds with a relevant second pair part to the first part (Schegloff & Sacks, 1973);
- acknowledgement, or *continuers* (Schegloff, 1982) (e.g., use of "uh huh," or head nod); and
- demonstration that a recipient understood a speaker's turn (e.g., paraphrasing or repeating of the speaker's partial or entire turn.).

Within such projects, participants coordinate specific aspects of communication, including (a) coordinating reference in turns, (b) coordinating turn taking, and (c)

coordinating transitions within and between parts of joint activities (Bangerter & Mayor, 2013).

Coordinating references in turns. Participants systematically design their messages to reflect what their addresses know—that is, *audience design* (Clark & Carlson, 1982), or *recipient design* (Pomerantz & Heritage, 2014) in CA's term. More elaborately put, a speaker adjusts his or her turn progressively, according to his or her understanding about the context of the conversation, as well as understanding about the other participant(s) by utilizing linguistic and other conversational resources (Drew, 2014; Pomerantz & Heritage, 2014; ten Have, 2007). A principle of CA postulates that a speaker should select a reference that a recipient knows (Pomerantz & Heritage, 2014; Sacks, 1992). This shows to the recipient that "you know that they know what you're talking about" (Sacks, 1992, p. 149). Over time, participants come to reuse the same expressions—that is, *lexical entrainment* (Bangerter & Mayor, 2013). As a result, they use lesser set of references in progression to describe objects involved in the activities, which is evident to the idea that the object has become part of their common ground (Bangerter & Mayor, 2013). In summary, the use of reference design and emergence of lexical entrainment leads to more economical transactions between participants in joint activities.

Coordinating turn taking. Participants in joint projects coordinate turn-taking by following set of interactional rules, as I touched on in an earlier section on fundamental interactional devices and practices in CA. In their influential paper, Sacks et al., (1974) descried the rules. First, the current speaker can select the next speaker (e.g., through asking a question to a recipient) until the turn comes to a juncture—that is, *transitional*

relevant place (TRP). The recipient can self-select the next turn in TRP. In this fashion, the participants of the talk contribute to the sequence of conversation at each turn (Clayman, 2014; ten Have, 2007)—that is, *turns-at-talk* (Hayashi, 2014).

The speaker can project the completion of a turn through various means (e.g., unfinished TCU; slowing down and stretching of the last syllable; a brief rise in intonation before the completion; the construction of a turn in a question format; a speaker's gaze toward the recipient of the talk near the end of a turn; addressing or indirect gaze at a next speaker, etc.). At the same time, a speaker can prevent a turn of speakership by various means (Clayman, 2014; Hayashi, 2014) (e.g., rushing through the turns; bridging multiple turns using an item of the talk, etc.). On the other hand, the recipient of the talk can pick up the next turn before or near the end of a turn—that is, *overlaps*. Overlaps are usually considered problematic (Hayashi, 2014). Thus, the recipient can project his or her initiation of the next turn through an audible in-breath, an acknowledgement of the current turn, and so forth.

Coordinating transitions within and between parts of joint activities.

Participants divide up joint activities into hierarchical projects and subprojects, and navigate through them using *project markers* (Bangerter & Clark, 2003; Bangerter, Clark, & Katz, 2004). In particular, they use two types of *project markers* to manage two types of transitions in projects: (a) vertical transitions when entering and exiting joint projects, and (b) horizontal transitions for continuing current projects. Vertical transitions are signaled with project markers, including "okay" and "all right"; horizontal transitions are signaled with project markers, including "uh-huh" and "m-hm," "yeah," "yes," "yep," and "right."

For instance, duet dancers first need to agree with each other that they are going to dance together. Once they agree, they may decide on a type of dance they perform, from which subsequent projects will emerge. In this sense, the subsequent projects are nested within their initial agreement on the joint activity, as well as their agreement on the type of dance. They may then perform actual dance together. At the end of the performance, they may agree to end the duet, which is hierarchical to the performance of dance. Throughout the entire joint activity, they use project markers to transition through the projects and subprojects.

Bangerter and Clark (2003) and Bangerter et al. (2004) classified these project markers within a conventional system of contrasts for marking location and progress in projects. These include (a) *acknowledgment tokens* (e.g., "yes," "yeah," "yep," "un-huh," "m-hm," etc.) for acknowledging that recipients have received and understood senders' utterances and allow the conversation to continue; (b) *agreement tokens* (e.g., "right," "sure," and "of course" for aligning with other senders' positions; and (c) *consent tokens* (e.g., "okay," "sure," "fine," "all right," etc.) for giving permission on an undertaking of a project requiring the partner's permission.

Acknowledgment and agreement tokens are used for horizontal transitions; consent tokens are used for vertical transitions. In addition, *assessment tokens* (Goodwin, 1986) (e.g., "fantastic," "terrible," etc.) are used to give assessment of an undertaking project. Participants produce these project markers as a second pair part to a first pair part of adjacency pairs (Schegloff & Sacks, 1973) in order to ground horizontal or vertical transitions to the body of the conversation (Bangerter et al., 2004). Participants

make stronger commitments within a project as they move from acknowledgment, to agreement, to consent tokens (Bangerter & Clark, 2003).

I believe that therapy is not an exception to this ongoing and mutual process between therapist and client. As Strong (2006) mentions, therapy can be looked at as a joint activity between therapist and client in which they work out "understandings, preferred outcomes and the means to enact them" (p. 255). Therapist and client use language and non-verbal language to coordinate their turn-takings in therapy session. They move through, within, and across these different parts of therapy—that are, joint activities and projects—together by exchanging project markers and conversational tokens to accomplish identified goals over the course of therapy. Over time, they come to share references to refer to the same objects. It is this lens of join activity through which I am going to describe and explain patterns of interaction.

Adapted Procedures and Steps of Analysis for This Study

I remind the readers that this study is an applied CA: The aim of such a study was to generate new ideas and insights of interactional practices that emerge from a local context. As ten Have states, applied CA is

> the study of the *local rationality* of members' practices, why it makes sense, for participant, locally, in their practical context, to do things as they are done, even if this is at odds with how these practices are planned, evaluated, or accounted for 'elsewhere,' 'in theory,' or at higher hierarchical levels in an organization. (p. 196)

As such, the purpose of this research was to find interactional patterns in SST. In particular, I was interested in how co-therapists respond to a client so as to improve the talk collaboratively turn by turn in such a way that encouraged therapeutic improvement.

The process of analysis evolved over time as I experimented with different ways of approaching data (see Figure 1). The process was not linear; instead it was a cyclic process in which I played with and mulled over the data and their interpretations. Throughout the entire process, I consulted with the existing CA literature to be informed by previously identified interactional practices that are relevant to my data. After transcribing the entire consultation with the CA transcription notation, I created a

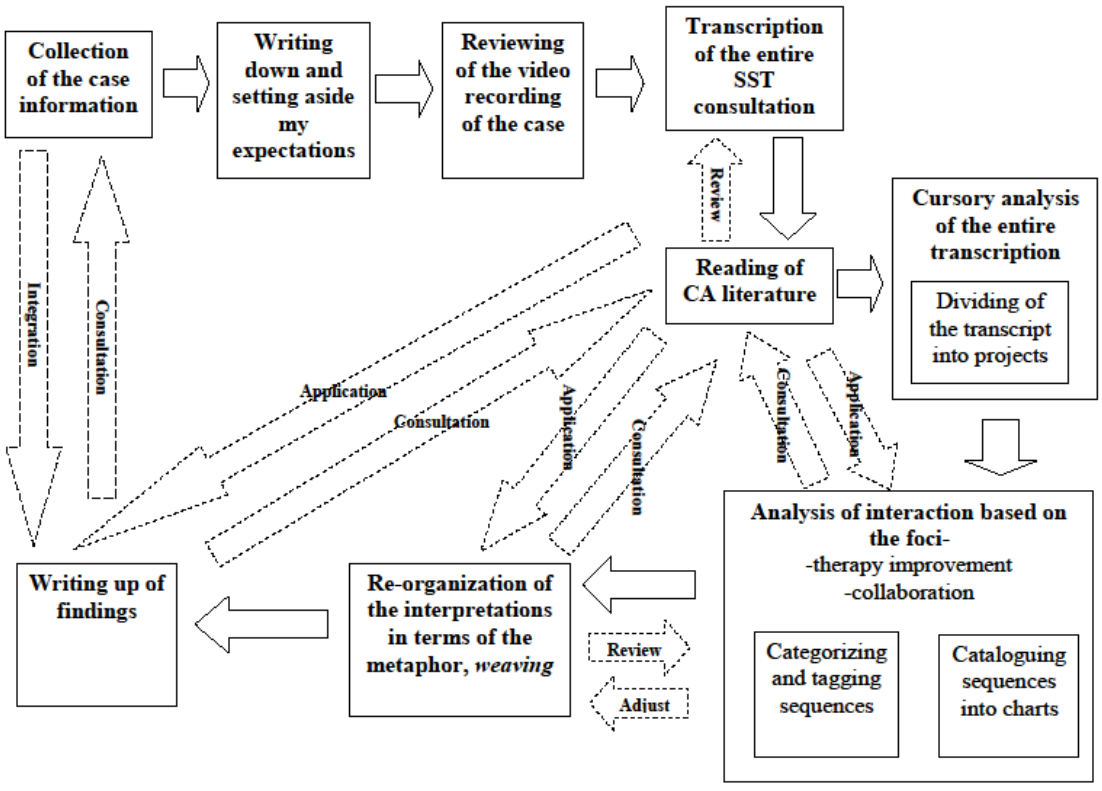

Figure 1. The cyclic process of my analysis.

collection within Transana and sub-collections, dividing the entire consultation into a series of phases. Each sub-collection contained a relevant video-recoded segment and a corresponding transcript. Further, I created smaller collections within each sub-collection, containing video-recorded segments of relatively large interactional sequences (e.g., account expansion, circular questioning, pointing out client's contradiction, etc.) and relevant transcripts.

For the foci of my research, I incorporated a discursive understanding of collaboration and improvement in therapy. Particularly, the view is to *see* and *hear* "small changes, or adjustments, happening at the level of micro interaction between therapists and client, which led to the overall flow of progression and the outcome of the session" (Chenail, August 10, 2016, personal communication) (see Figure 2). In this micro interaction, a therapist initiates an initial inquiry by asking a question, the client responds to the question or objects to the initiative, and the therapist adjusts his or her responses grounded in the client's response or objection. Throughout the sequence of the interaction, the therapists utilize a various set of interactional practices. The therapist may further the inquiry, or move onto a new inquiry both of in which the therapist and client follow the same or similar sequential interaction. Over time, those micro adjustments, made at the micro level, lead to therapeutic improvement.

The process of therapists' and clients' engagement, negotiating and coordinating the differences in their views on those small changes, or adjustments reflect the idea of collaborative practice (Ness et al., 2014; Strong et al., 2011; Sundet et al., 2016; Sutherland, Sametband, Silva, Couture & Strong, 2013; Sutherland & Strong, 2011). I hoped to produce a clinically relevant and locally contextualized interactional map of

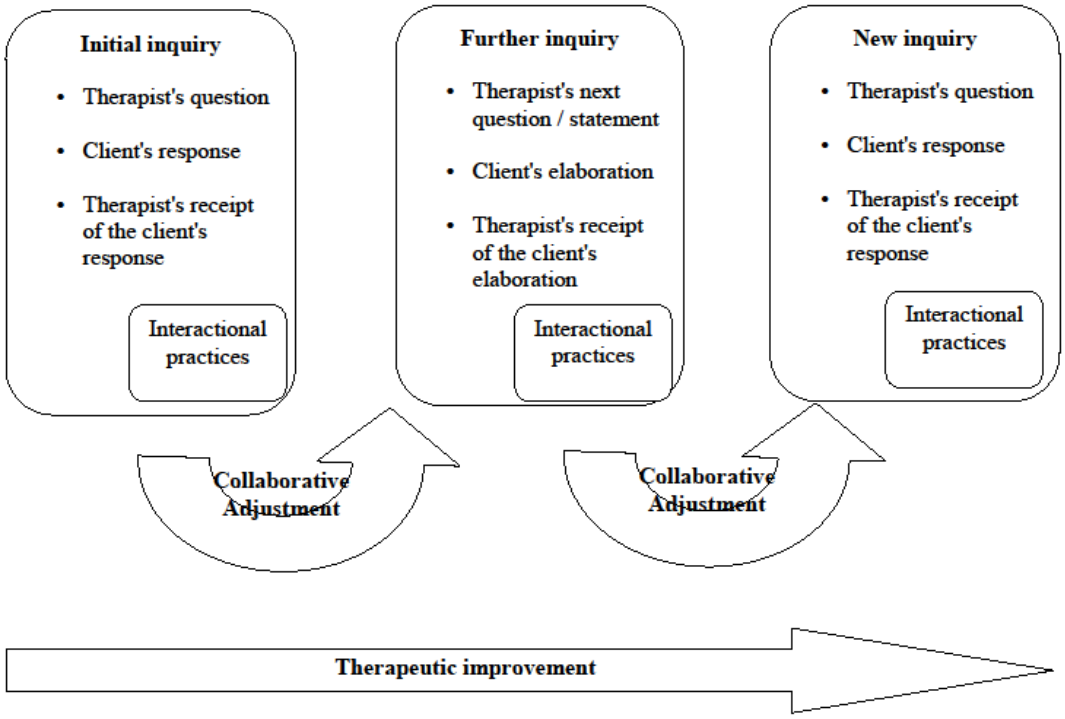

Figure 2. Collaborative adjustments at micro level.

SST that other SST therapists can refer to in their own setting. My clinical focus let me to pay attention to clinically relevant distinctions throughout the analysis.

I identified and tagged them with key words, identifying smaller interactional sequences (e.g., asking for clarification, formulation, allowing client to take time responding, etc.). However, I realized that Transana did not allow me to compare each segment of identified interactional sequences side by side. In addition, I realized that the identified sequences were taken out of their natural context—that is, the surrounding interactional sequences, leading up to and following the sequences under examination. For these reasons, I transported CA transcriptions of each phase into Microsoft Word to analyze each phase using an analytic strategy suggested by Pomerantz and Fehr (1997).

Generally, I followed ten Have's (2007) suggestion to examine transcript systematically in a "'series of 'rounds' of prespecified analytic attention" (p. 122). In the first round of the analysis, I selected sequences of interest. Since my research interest was on interactional patterns within the overall flow of the interaction that encourage therapeutic improvement, I had to reconcile with *unmotivated* examination of data (Schegloff, 1996; ten Have, 2007). I accomplished it by drawing a conceptual boundary around data that appeared to represent signs of clinically meaningful interaction within the overall flow of interaction, while maintaining inductive, exploratory approach to the data within the boundary.

Once I identified an interactional segment, I attempted to derive interactional understanding of the segment from the therapists' and client's views by following Pomerantz and Fehr's (1997) suggestions. In particular, I characterized the segment in the sequence by asking a question, "What is the therapist(s) doing in this turn and sequence?" by considering the surrounding turns and sequences into account. Then, I considered how the packaging of actions within the sequence may have provided the other participant a particular understanding of the actions performed and or matters discussed. Similarly, I looked at how the timing and taking of turns within the sequence may have provided the other participants a particular understanding of the actions performed and matters discussed. Lastly, I examined how the ways actions within the sequence were accomplished may imply particular roles and or relationship between the therapists and client (Pomerantz & Fehr, 1997). I worked on this process of analysis on the entire transcription of the case.

Due to my discursive conceptualization of therapeutic improvement, achieved through the collaborative negotiation between therapists and clients at each turn, the overarching outcome of the SST consultation became the focal point for my analysis. First, I determined a therapeutic outcome by asking myself a question. "What did the client and therapists achieved by the end of the session?" I determined that the therapeutic outcome of the consultation to be "*Finding her problem: How to balance her personal life and her family problems*." Once I determined a therapeutic outcome, I started working backward through each phase of the session to find "artifacts of interaction that were consistent throughout the session" (Chenail, August 10, 2016, personal communication) that may have contributed to the overall progression and the outcome of the session. For this task, I asked myself, "What happened in this phase that led to the progression in the following phase of the consultation?" This gave me a conceptual boundary within which I looked for clinically meaningful distinctions within the entire transcript. In this process, I utilized both semantic and pragmatic analysis, as I followed the progression in the talk between therapists and client. In particular, I paid attention to shifts in themes, topics, language, intonations and any other significant conversational moments that may represent signs of therapeutic improvement (Battino, 2006; Hubble et al., 1999; Seligman, 1995) (e.g., from problem saturated to strength, resource focused) and collaborative therapeutic relationship, utilizing clients' strengths and contextual resources (Amundson, 1996; Bloom, 2001, Duncan et al., 2011).

In this phase of the analysis, my attempt was to track how the therapists initiated, oriented to, and negotiated each interactional practice with the client (Hutchby & Wooffitt, 2008). CA's ability to elucidate discursive aspects of therapy interaction

allowed me to capture potential shifts in description, without being confined by theoretical descriptions of practices, ascribed by particular therapy approaches. I classified and categorized the patterned sequences of interaction into interactional practices, based on my interactional understanding of the sequence in terms of my foci I described above. Then I referred them as exemplars—that is, instances in which a particular use of language leads to an intended response from the recipient(s) (Gale, 2010; ten Have, 2007).

To accomplish those tasks, I used the comment function of the Review tab in Microsoft Word to highlight sections of utterances and make note of interactional understanding of the utterances. Then, I assigned different font colors for the different types of interactional sequences I identified, based on my research foci. Within each type of sequences, I differentiated between relatively small and large sequences by using lowercase letters for small sequences and uppercase letters for large sequences in Word. Whenever applicable, I attached previously researched interactional devices on exemplars (Gale, 2010; ten Have, 2007). At the same time, I remained aware of ten Have's (2007) cautions for beginning CA researchers, not to treat the previously explicated CA's concepts as coding instruments. Instead, ten Have (2007) suggests that researchers view them as "descriptions of possible normative orientations of participants, available for various usages as they [participants of the interaction under examination] see fit" (p. 38). Following this advice, I maintained the inductive, discovery-oriented examination of data (Gale, 1991, 2010; Sharma, 2012; ten Have, 2007).

I also looked for *deviant cases* in which previously observed patterns of interaction break down (ten Have, 2007). Specifically, the recipient in these cases "does

not answer the question [requested by the person posing a question] but nevertheless shows that s/he should have" (Sidnell, 2014, p. 80). This is the case in which participants interact with the same assumptions as the cases exemplars (Clayman & Maynard, 1995). For instance, the recipient may (a) express apology for not providing the answer, (b) justify not answering by stating that she or he does not know the answer, or (c) justify their lack of answer by giving a reason. In return, the inquire can respond by (d) following up with another question, (e) acknowledging the absence of an answer, or (f) providing a potential reason as to why the answer is not given (Sidnell, 2014). As ten Have (2007) explains, "by comparing instances with each other, and with general experience and expectations, their formatted properties, sequential placement, and local functionality can be related and explicated" (p. 24).

If the deviant case fell out of the assumption working in the regular cases, the researchers would need to re-formulate the description of the interactional practice to encompass both the regular and deviant cases (Clayman & Maynard, 1995). For instance, a departure from the regular pattern of interaction within the deviant case can actually be part of a more encompassing interactional pattern that the participants normally orient to. If those first two approaches fail, researchers then can treat the deviant cases as another interactional practice that encompasses the previous interactional practice, but accomplishes different activity from the practice (Clayman & Maynard, 1995). When a juxtaposition of exemplars and deviant cases produced new insight on my understanding of sequences of interactions, I made note of them within their corresponding interpretation in Microsoft Word.

In the process of analysis, a metaphor, *weaving*, emerged, which led to re-categorization of interactional sequences based on the metaphor. In weaving, weavers create patters by cross-weaving two different types of collections of threads: *warp* and *weft*. Warp is strung over one direction and weft is woven over the warp across another direction. Both warp and weft are made up of *fibers*. The metaphor allowed me to *see* and *hear* the therapy interaction in terms of warp and weft, woven together to create patterns of interaction and an overall gestalt of the SST consultation—that is, *tapestry*.

Over time, I realized that it is not the sequence by itself that determines the classification, but a particular placement of the sequence within the surrounding interaction that determines the classification. For instance, the same interactional sequence can be designed to introduce change, or weave common ground, depending of its sequential placement. This meant letting go of my own assumptions about each interactional sequence. Gale (2010) describes this process: "It is learning to reposition one's point of view and staying open to see and hear in a manner that privileges each speaker's orientation and meaning-making practices, centering on what each utterance mean to the speaker, in their context" (p. 19) without resorting to psychological constructs or ideas.

I composed a list of identified interactional sequences for each category. Within each list, I differentiated between relatively small interactional practices and relatively large interactional practices that often encompass these small sequences. In making each list, I reviewed the transcription to assign relevant interactional sequences into each list to determine patterns across the consultation and within each phase of the consultation.

One way of data selection and analysis process for CA is to employ theoretical sampling (ten Have, 2007), initially coined by Glaser and Strauss (2012) in grounded theory, a qualitative approach to research. Particularly calling it as a constant comparative method, Glaser and Strauss (2012) describe that:

> Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory *as it emerges* [emphasis added]. (p. 45)

The constant comparison method made sense for the current study since I aim to extrapolate interactional patterns within a SST consultation from its video-recording, guided by minimal theoretical attention to the data. I created a chart, documenting and counting small and large interactional sequences to thoroughly inspect and review the entire transcription. Following the idea of saturation from the grounded theory (Glaser & Strauss, 2012), I continued the process until I no longer found any new patterns of interaction that could add more information, or inspire new ideas to the collection of the data (ten Have, 2007). Once I felt that the saturation point was reached where I could not come up with any more revisions of the interactions and their categories, I stopped the review of the transcription.

Then, I started writing the findings of this research, while incorporating the case information of the chosen SST consultation. Whenever it made sense, I went back to the earlier stages of the data management. Throughout the process of review, I kept the identified patterns of interactions within the broader sequence of evolving interactions in the session (ten Have, 2007). This was particularly important since "the session in its

entirety is viewed as novelty" (J. Miller, April 26, 2016, personal communication) in SST. In this process, initially unnoticed gestalt, encompassing the order of interactions emerged in this process. The oscillation between the micro—that is, process—and macro—that is, progress—levels of interaction created an overall flow of interaction that may have worked as a whole (R. Chenail, April 26, 2016, personal communication).

Trustworthiness of the Analysis

Since validity and reliability are the ultimate goals of conventional inquiry, qualitative researchers have devoted much time trying to develop methods in the same way conventional researchers do (Atkinson et al., 1991). In fact, social science shares the similar attitude as the conventional science about the relation between phenomenon of research and results of the research. According to Peräkylä (2004), "the aim of social science is to produce descriptions of a social world – not just any descriptions, but descriptions that in some controllable way correspond to the social world that is being described" (p. 283). This seems to have led to various methods for assuring the credibility of qualitative research: member checks, triangulation, persistent observation, audit trails, peer review, negative case analysis, and careful inductive analysis (Piercy & Benson, 2005; Sprenkle & Piercy, 2005).

However, Piercy and Benson (2005) rejected the existence of the objective reality separate from the observer who can access and discover it by applying certain methods. Instead, they asserted that social interactions produce one description among many other ways of interpreting and describing events in the social world. In this sense, there seems to be mismatch between the methodologies employed in qualitative research studies and the way they are evaluated. As Patton (2002) argued, qualitative research should be

evaluated based on the research paradigm, as well as the purpose of the research. Within the constructionist research, bias takes on a completely different meaning and role within the constructionist paradigm. In fact, qualitative researchers acknowledge and share their biases; they believe that those biases are inevitable (Maione, 1997), or even "greatest asset[s]" (Maione, 1997, "Choice 8" section, para. 4) as they contribute to the interpretation of the events. Therefore, transparency is an important aspect of the constructionist research, to the extent that "others have access to the actual data of a study" (Maione, 1997, "Choice 8" section, para. 5). In the context of constructionist-oriented case studies, Chen and Pearce (1995) asserted:

> Open-endedness is an essential criterion for a case study. The pragmatics tradition sees meaning as a social product that is always unfinished and incomplete. . . . Rather, it provokes readers to think beyond what the text provides and invites them to offer a different interpretation. (p. 149-150)

In this way, researchers ensure the credibility and trustworthiness of their interpretations; readers become the ones who will judge the quality of constructionist research (Piercy & Benson, 2005).

For case studies, several measures need to be taken into consideration:

- a formulation of clear research question;
- a substantiation of appropriateness of case design for the research question;
- an application of purposeful sampling strategies suitable for the case study type;
- a systematic collection and management of data; and
- a correct analysis of the data (Russell, Gregory, Ploeg, DiCenso, & Guyatt, 2005).

Although CA is situated within the social science of interpersonal interaction, it takes a unique position on the issue of objectivity (Peräkylä, 2004). The unique stance seems to stem from CA's "specimen perspective" (ten Have, 2007, p. 35) when it comes to its assumption about the relation between phenomenon of research and the results of the research. ten Have (2007) clarified that "A specimen as a form of research materials is not treated as either a statement about or a reflection of reality; instead, specimen is seen as *part of the reality* [emphasis added] being studied" (p. 35). Still, the kind of knowledge CA seeks is different from the conventional scientific pursuit for the universal knowledge; it is focused on "the commonalities that exist across a relatively small number of cases" (Ragin, 1994, p. 190). In this vein, CA researchers attempt to explicate "the inherent theories-in-use of members' practices as lived orders, rather than trying to order the world externally by applying a set of traditionally available concepts, or invented variations thereof" (ten Have, 2007, p. 32).

Because of CA's view on objectivity, CA is particularly rigorous among other qualitative research methods; the CA researchers ground their analytic interpretations in empirical materials— recording of naturally occurring social interaction and its transcript (Peräkylä, 2004; ten Have, 2007). In this sense, the transcript gives the readers an "independent access" (ten Have, 2007, p. 32) to the data analyzed. In addition, several characteristics of CA reflect its adherence to the analytic rigor: (a) its obsession with micro-details of interactions—e.g., noting of pauses, overlaps, inhale and exhale; (b) its refusal to incorporate available theories of human conduct in its analysis; and (c) its refusal to construct theories general to all social interactions (ten Have, 2007).

However, as ten Have (2007) admitted, transcript is not neutral; it is an *interpretation* of social interaction based on sequential focus of CA. ten Have (2007) elaborated in this regard as following:

> Transcripts are unavoidably incomplete, selective renderings of the recordings focusing at first on the text of the verbal stream, and adding various kinds of particularities of the ways in which the words were spoken later. . . . The purpose of a CA transcription is to make what was said and how it was said available for analytic consideration. . . . Transcribing recordings gives the analyst a "feel" for what has been recorded. (pp. 31-32)

In addition, researchers' role in their interpretation seems to be evident in CA's analysis phase. When grounding their analyses in transcript, researchers adhere to the CA's principle that participants express their understanding of each others' utterances in their next uptake (ten Have, 2007). However, the researchers seem to take an active role in the process. ten Have (2007) commented on the process that "the researcher's own comprehension, 'as a member,' so to speak, is also and inevitably involved" (p. 33). This means that the trustworthy of analysis depends on the degree to which the researchers have become members of the conversation at the time of the analysis.

Therefore, I maintained a balanced view of the tension between the CA's view of objectivity and the constructionist idea of subjectivity. As the researcher of the current study, I played an important role in shaping its research design and understanding aspects of video-recorded social interactions in SST. Rather than referring to the reliability and validity in universal sense, I refer to the reliability and validity within the context of my

study. In this regard, Chen and Pearce (1995) commented on the evaluation of case studies from a constructionist view:

> As our interests in doing case studies are not to predict and control but to enlighten and illuminate while acknowledging the complexity and contingency of communication, a case study should also be judged by how probable and plausible the interpretations are within the context of inquiry. (p. 149)

I established the plausibility of my interpretation within the context of my study by rigorously treating empirical material—video recordings (Peräkylä, 2004), while keeping my research design and analysis visible (Maione, 1997), or open-ended (Chen & Pearce, 1995) to the readers of the current study so that the readers can judge the results of the study (Piercy & Benson, 2005).

In this vein, I adapted relevant various strategies for securing the reliability within this study. As I described, the video recordings are considered as "raw material"; thus their quality has a great implication for my analysis, as well as for readers of the research (Peräkylä, 2004; ten Have, 2007). I provided the readers with segments of the transcript, along with the notation coding system based on which I interpreted therapeutic interaction between therapists and client(s). In this sense, I and the readers of the current study have a "shared focus" (ten Have, 2007, p. 32).

Second, I maximized the inclusiveness of recorded data by giving an account of ethnographic materials (Peräkylä, 2004), including the site information and the guidelines for the SST consultation service at BTI. I also maximized the inclusiveness of recorded data by incorporating written document (Peräkylä, 2004) (e.g., non- identifying case note information and clients' responses to a semi-structured questionnaire.) Further, I

incorporated non-verbal interactions in the video recordings, or "different layers of social actions" (Peräkylä, 2004, p. 287), to supplement my primary use of verbal interaction.

Since SST is viewed as a complete in itself (Slive & Bobele, 2011a), and I used a single case, the volume of the recordings was sufficient to capture "the variation of the phenomenon" (Peräkylä, 2004, p. 288)—that is, a variation of basic interactional patterns of SST in this study. Further, the use of audio-video recording equipment at the BTI provided a high technical quality of recordings (Peräkylä, 2004). In the transcription phase, I captured as many aspects of vocal expressions as possible (Peräkylä, 2004) so as to be able to focus on any potential aspects of therapy conversation.

A central question of validity in CA research is "What grounds does the researcher have for claiming that the talk he or she is focusing on is in any way 'connected to' some institutional framework?" (Peräkylä, 2004, p. 294). My ground for claiming institutionality of SST is based on the use of single case of SST consultation; a single session is viewed as complete and whole in itself (Slive & Bobele, 2011a). Another level of validity comes from a sense whether my analytic claim seems apparently valid in the transcript (Peräkylä, 2004).

A strategy for securing validity of my analytical claims is use of exemplars. I first aimed at establishing and formulating regular patterns of interaction (Peräkylä, 2004; Heritage, 1995), or relations between actions, through displays of the corresponding segments of the transcript and their analysis (Schegloff, 1996). I then looked for and examined deviant cases, where a part of suggested pattern is not associated with other expected parts. The comparison of deviant cases with exemplars enabled me to explicate how therapists and clients designed their language in order to have intended responses

from the other in the conversation (ten Have, 2007). As I described in the previous sections, reflexivity was woven throughout the current study (Finlay & Gough, 2003; Lincoln et al., 2011; McLeod, 2011; Steier, 1995).

Another strategy for establishing validity is use of *next-tern proof* (Wooffitt, 2005). This is based on research studies on talk-in-interaction that each participant of an interaction shows, through his or her turn, each other their understandings of the previous turn by the other participant. In another word, the validity of analytic claim made by researchers is evidenced by the participants' subsequent conversation turns (Peräkylä, 2004; Schegloff, 1996; ten Have, 2007). In this sense, CA seeks to ground formulations of actions or actions in the "'reality' of the participants" (Schegloff, 1996), or the "frame of reference" (Sutherland & Couture, 2007, p. 213). In this study, I investigated and demonstrated the next turns subsequent to the interactions of interest in order to establish my analytic claims on the participants' previous utterances.

Implications of the Research Findings

CA's choice of case-by-case analysis is related to the purpose of CA. According to ten Have (2007), CA's aim is to gain "a theoretical grasp of interactions' underlying 'rules' and 'principles'" (p. 150). In other words, CA seeks for a "set of formulated 'rules' or 'principles,' which participants are demonstrably oriented to in their natural interactions" (ten Have, 2007, p. 150). Thus, researchers first examine single instances, paying attention to "priori structures, rather than on contingent ones" (p. 150), and formulates rules. ten Have (2007) went on to describe that

> each case should be considered in detail, in order to make an accountable decision that it is indeed a case of the phenomenon one is looking for, as a specimen of . . .

> [a particular type of interactions] . . . in its context, and for the participants. (p. 162)

Later, the researchers will test the specimen of a particular type of interactions in other comparable cases. In studies of ordinary conversation, their findings are generalizable to the whole aspect of ordinary conversation (Peräkylä, 2004) because it is presumed that fundamental features of interaction are generally shared among people within the particular culture or society (ten Have, 2007).

When studying institutional interactions, the results of the study have very limited generalizability outside of the particular institutional contexts (Peräkylä, 2004); however, the concept of "possibility" (p. 297) becomes important. Peräkylä, (2004) contended as follows:

> Social practices that are possible, i.e. possibility of language use, are the central objects of all conversation analytic studies on interaction in particular institutional settings. The possibility of various practices can be considered generalizable even if the practices are not actualized in similar ways across different settings. (p. 297)

In the current study, the findings of my study do not describe what other therapists in SST consultation do; however, the detailed descriptions of how therapists responded to clients in interaction can contributed to the practice and training of SST. I believe that the interactional patterns, derived from the actual course of SST consultation, inform practitioners, supervisors, and trainees on how to evoke, maintain, and potentially change interpersonal constructs in and through their interactions (Gale, 2010) without sacrificing the pragmatic nature of SST (Amundson, 1996; Clements et al., 2011; Miller & Slive,

2004). This is the case, assuming that the therapists in these sites have the same set of interactional competencies as the therapists in the SST consultation services at BTI (Peräkylä, 2004). For instance, other therapists in SST can incorporate the way the therapists in this study accomplished setting a manageable session goal in interaction with clients.

The derived descriptions of interaction in SST became the *conversational evidence* (Strong et al., 2008) of psychotherapy. As Strong et al. (2008) argue, the conversational evidence complements the outcome-based psychotherapy research by providing clients' evaluation of therapy within the process of therapy itself. Clients' moment-to-moment evaluation guides therapists in how to respond in a therapeutic manner, which creates the stream of therapeutic interaction. In this sense, CA exposed and linked taken-for-granted micro-details of conversation in therapy—that are, utterances, breaths, pauses, overlaps, sequences, and changes in intonation—that build toward the creation of therapeutic change (Couture & Sutherland, 2006). This comes with interactional responsibility on the therapists' part (Strong et al., 2008), while potentially activating clinical reflexivity among therapists (Roy-Chowdhury, 2003).

In addition, a juxtaposition of CA's interactional descriptions in SST and the interactional knowledge of SST, or SIKs (Peräkylä & Vehviläinen, 2003), within the existing SST literature leads to a fruitful dialogue between the two. As I described in the previous section, the dialogue may result in the following outcomes according to Peräkylä and Vehviläinen (2003):

- "CA falsifies and corrects assumptions that are part of an SIK" (p. 731);

- "CA provides a more detailed picture of practices that are described in an SIK" (p. 731);
- "CA adds a new dimension to the understanding of practices described by an SIK" (p. 731); and
- "CA expands the description of practices provided by an SIK and suggests some of missing links between the SIK and the interactional practices" (p. 732).

Because of SST's persistence on pragmatics over adherence to particular theory (Amundson, 1996; Clements et al., 2011 Miller & Slive, 2004), I find that theory building has been undervalued and eschewed by SST practitioners and researchers. While I agree with Hoyt and Talmon's (2014c) stance against the manualization of SST, I believe that formulation of interactional principles in SST that are possible will be useful for SST practitioners, supervisors, and trainees. In addition, the findings of CA can play socio-political role for the field of SST (Peräkylä & Vehviläinen, 2003) (e.g., claiming professional legitimacy, efficacy, identity, etc.).

Furthermore, the findings of CA can contribute to generation of evidence-based practice (EBP), as set forth by the American Psychological Association (APA) Presidential Task Force on Evidence-Based Practice (APA, 2006). Accordingly, EBP is defined as an "integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences'' (p. 273). In their recommendation, the task force acknowledged multiples types of research evidence, including qualitative data, for the evaluation of psychotherapy outcomes and processes. The findings of CA studies are result of an integration of rigorous qualitative research

method with clinical expertise of SST therapists within the natural context of their interactions with clients.

Ethical Considerations

I protected the participants' confidentiality and emotional wellness in the current study by implementing several measures: (1) reviewing the case related materials, including the video recording, case chart, and consumer surveys at the premise of BTI, and safeguarding the research related data in a locked file cabinet at all times; (2) de-identify the transcript containing personally identifiable information by using pseudonyms, etc; and (3) keeping the transcript and write-up of the study in my password-protected personal computer.

CHAPTER IV: RESEARCH FINDINGS

You can find out how to do something and then do it

Or do something and then find out what you did.

—Isamu Noguchi

To think about phenomena incisively, one must be able to combine imaginative and rigorous thinking.

—Arthur P. Bochner, *Rigor and Imagination: Essays from the Legacy of Gregory Bateson, 1981*

In this study, I aimed to examine recursive patterns of interactions between co-therapists and a client in a SST consultation. In particular, I was interested in elucidating an interactional map of SST that describes how the co-therapist collaboratively improved, if applicable, the client's talk turn-by-turn in such a way to encourage therapeutic improvement. CA was an ideal method to extrapolate their interaction at a micro level, while embedding each interaction within the overall sequence of the interaction.

Following Couture's (2005) use of tense in her CA dissertation study, I used present tense when referring to each exemplar, as it is a common practice in CA research. The present tense allowed each relevant interaction to feel like it was happening in the moment. In contrast to Couture (2005), however, I also used present tense to discuss the integration of the collection of integrations within the overall sequence of the consultation. I believe that the overall structure of interaction shaped their interactions, as much as each interaction reflexively contributed to the emergence of the structure.

The Case Information

The case I picked for this study was an individual client's case. I used a pseudonym, April, for protection of privacy. April is a female, a student at a local college in her early 20s who identified herself as a Caucasian. She was referred to the SST consultation services by her roommate for her family issues. She hoped to "talk through problems with a third party." She identified her strengths and resources in herself or her relationship as "resilience."

According to April, her father was "mentally abusive" to her and her older and younger sisters. Despite her attempt to stop him, the father had made derogatory comments toward her and her sisters for years because he was "jealous" of them and wanted their "attention." After having suffered serious injuries and health issues, he stopped working, while her mother became the sole financial provider for the family. April explained that while her mother knew about her husband's treatment of their daughters, she had not intervened in the situation, nor had she left him because of his health issues. Since the situation was "out of control," April moved out of her home when she was at a middle teen age with the help of her aunt, but had kept frequent contact with her family.

April described that her older sister had issues with drug use, lying, stealing, borrowing money, and the inability to keep her jobs. Her younger sister had an issue with dating a man who treated her badly, as their father did. According to April, her sisters hated each other. In the meantime, her father did not seek medical help for his physical issues, while her mother did not make him do so. April noted that everyone in the family relied on her and talked to her about the other family members. Having been

stressed and worried about them, April had an issue concentrating at school, although she had excelled at school earlier despite the family issue.

Collaborative Adjustments at the Micro Level

In reviewing and analyzing the transcript of the SST consultation, I determined that the turn-taking pattern between the co-therapists and client is uniform and asymmetric throughout the consultation in that the therapists initiated the start, end, and transitions of conversations to which the client responded:

- The therapists asked questions—that is, first pair parts of adjacency pairs (Sacks et al., 1974; Schegloff & Sacks, 1973)—at any time about the client's view on problem, family dynamics, her strength, and so forth;
- The client provided answers—that is, second pair parts of adjacency pairs—to the therapists' questions in forms of accounts and / or conversational tokens, including acknowledgement, agreement, or consent tokens (Bangerter & Clark, 2003);
- The therapists responded to the client's answers to their questions with conversational tokens (Bangerter & Clark, 2003), along with another question, or statement—that is, another first pair parts of adjacency pairs;
- The client regularly responded to such therapists' responses with conversational tokens (Bangerter & Clark, 2003), and /or further elaborations of her accounts—that is, second pair parts of adjacency pairs;
- The turn-taking pattern shifted, at the discretion of the therapists, to advice giving toward the end where the primary therapists presented and re-presented reflecting team's advice , along with their own advice; and

- The client did not ask questions usually, except for asking for the therapist's clarification of their utterances.

This type of turn taking is called quasi-conversational (Bercelli et al., 2010; Peräkylä, 1995) and characterized by uni-formal turn-taking patterns. Without formal rules put in place, unlike other institutional contexts (e.g., mediated and structured exchanges between prosecutors and defendants) this turn-taking pattern evolves spontaneously in and through the therapist-client interaction. Quasi-conversational turn-taking pattern comes with two features: inquiry and elaboration (Bercelli et al., 2010). Inquiry is where a therapist gleans information about the clients' view of their problems and solutions through a series of question-answer sequences; elaboration is in which the therapist further elicit information about the clients' view through reinterpretation and / or formulation. This turn-taking pattern has implications for topical development: The therapist can start a new topic, whereas clients generally cannot do so (Bercelli et al., 2010).

However, engaging in this turn-taking pattern meant that the therapists needed to adjust each utterance based on the client's responses at each moment of their interaction. Only after having gained the client's acceptance of the therapists' adjustments, did the therapists advance a matter at hand, or initiate a new inquiry. As I indicated in chapter three, I conceptualized that collaborative adjustments are reflected in the manner in which the therapist attended to the client's responses and adjusted their next utterances, while employing various sets of interactional practices. Across time, the micro adjustments led to the therapeutic improvement, as depicted in Figure 2.

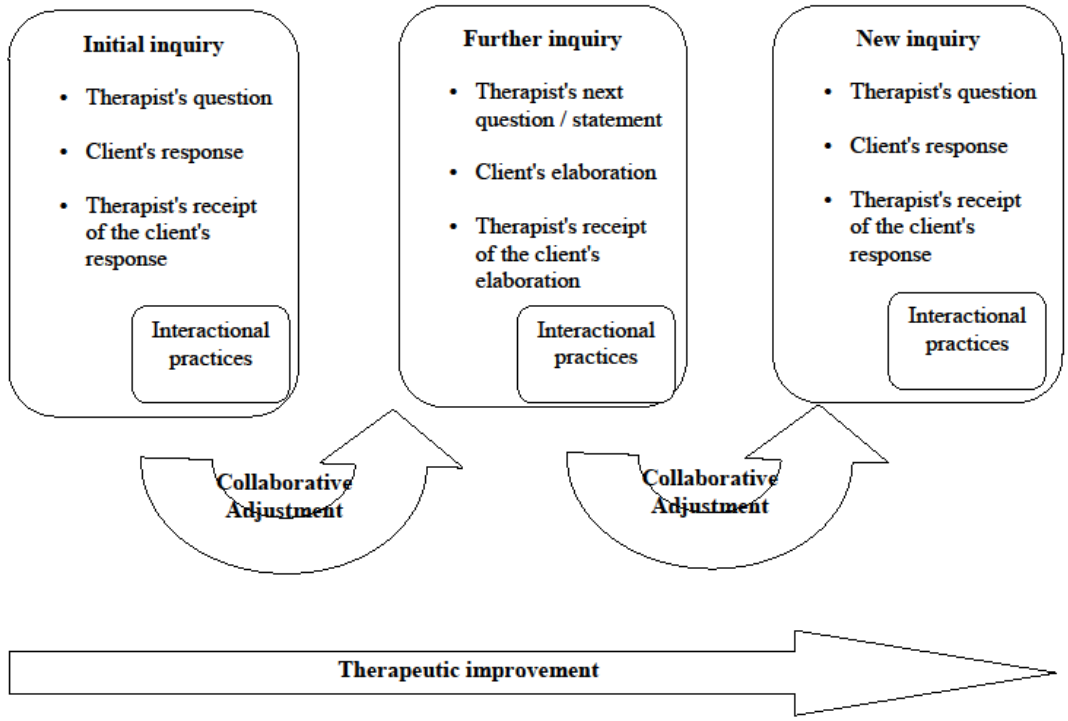

Figure 2. Collaborative adjustments at micro level.

The sequence below happens when Dr. Miller initially starts eliciting April's problem description.

13 T1: So:: the things I: I noticed from this is and I would just have you tell us
14 about it is you wanted a third opinion ((looks up to see C)) about whatever
15 goin'on and you talked about family issues.{C: Yeah.} a::h:,
16 .h Tell me little more about that.
17 (.)What does that mean? {T2: ((shifts gaze from T1 to C))}
18 C: So my dad {T1: moves a hand to chin)) is .h very (0.2) mentally abusive.
.

.

(0.8)°Ahm: °((looking up in the air)) I moved out when I was like eighteen
like seven- ((mouthing)) pt seventeen.
(0.7) A::nd- he's like <u>out of ↑control</u>
Like he didn't like- hit us or anything really it's like (jus-) mentally ((hand
gesture)) like abu<u>sive</u>. ((wipes eye))
So now it's happening with my sisters like tweni one {T1: °yea°} .h
An- like ((wipes eye)) he like (that's) to my older sister too but they both
live with ↑him (.4) and my ((wipes eye)) ↑mom
But it's just like <u>out</u> of control.{T1: ((nodding head))}

After sharing his observation on the case chart (lines 13-15), he asks two consecutive questions (lines 16-17). The set of questions elicits her answer over the next several turns (lines 18-31). Throughout her turns, both Dr. Miller and Melissa provide acknowledgement tokens (Bangerter & Clark, 2003) (lines 15, 28, 31).

T1: .hh ((empathic tone)) Ahm whata:h- wha- <u>with your ↑dad</u> I get a sense
that like the source ((making a circle with hands in front of himself)) of
what's going on with (0.4) your dad when you described as like he's a-
<u>abusive</u>.
Tell me more about that.=
=What is- how long has that'been going on?
What does that look like?.hhh

After a while, Dr. Miller offers reinterpretation (Bercelli et al., 2010) of what she has accounted (lines 84-86) and follows up with another set of questions (lines 87-89) about

specific aspects of what she has accounted. This leads to her elaboration on her view of her father and family dynamics.

91 C: Just like (to say) negative thing (.hh) (.hh) like (0.7) since(h) ↑<u>forever</u>
92 He's just like the (ty-) I mean I know ((pointing at herself)) <u>it</u>.
93 That's why I moved out.
94 I'm not <u>stupid</u> ((hand gesture)). ((sobs))
95 Like- he jus- like (0.8) thinks (0.6) he seems like super <u>jealous(hh)</u> (0.8) of
96 like ((hand gesture)) my sisters and ↑I. .hh {T1: Yea}
97 It's like an <u>attention seeker</u> but he's also like (0.9) <u>sociopath</u> in a sense
98 that .h it's like lot of issues like ((wipes eye)) he has like heart disease, he
99 doesn't take care of himself, just like (0.2) the <u>alpha</u> ((hand gesture)) {T2:
100 ((nodding head))} of my mom. {T1 / T2: ((nod heads))}
101 ((sobs)) Like doesn't let her do ↑anything like puts her down.
102 And then when <u>I</u> ((hand gesture)) <u>say</u> <u>something</u> she's- my dad
103 lik- .snih <u>yells</u> <u>at ↑me</u> lik- yells my ↑mo::m
104 T1: ((empathic tone)) ↓Yeah {T2: °mm°((nodding head))}
105 C: It's (lik) <u>out</u> of control.

Both therapists offer acknowledgement tokens (line 104), followed up by April's reiteration of her view of the situation (line 105). In the following section, I describe each group of threads, using exemplars from the transcription.

An Organizing Metaphor for the Therapist-Client Interactional Patterns

Over time, a metaphor of *weaving* emerged and helped me capture the interactional patterns across the session and within each phase of the session. On a loom,

a weaver strings a group of threads, the warp, on the frame, usually horizontally. The weaver interweaves another group of threads, the weft or woof, across the warp at a right angle, loosely or tightly. Threads are made up of various fibers. The weaver chooses the types and number of threads, and the patterns of weaving to make various fabrics or tapestries. This metaphor helped me to conceptualize therapist-client interactional patterns that are interwoven across different levels of abstraction. As a whole, those micro and macro patterns of interwoven interactions created a larger pattern of interaction that contributed to the progression and outcome of the SST consultation—that is, a *tapestry* of the overall patterns of therapist-client interaction.

Within the transcription, I identified three sets of systemically related interactional practices, as shown in Figure 3:

- *Fiber*—that is, a group of interactional practices through which the therapists managed therapist-client interaction, and other interactional agendas;
- *Warp*—that is, a series of interactional sequences and two interactional practices through which the therapists structured the SST consultation into a series of projects, involving a number of sequences of actions in order (Robinson, 2014); and
- *Weft*—that is, a group of interactional practices through which the co-therapists (a) developed and maintained therapeutic relationship with the client, (b) invited changes in the way the client talked about herself and her relationship to her family, and (c) negotiated advice over many turns with the client.

I determined that the interactional practices of the *fiber* are foundational as I observed them consistently throughout the consultation. The therapist utilized the interactional practices of the *warp* to structure the consultation into a series of projects for and in

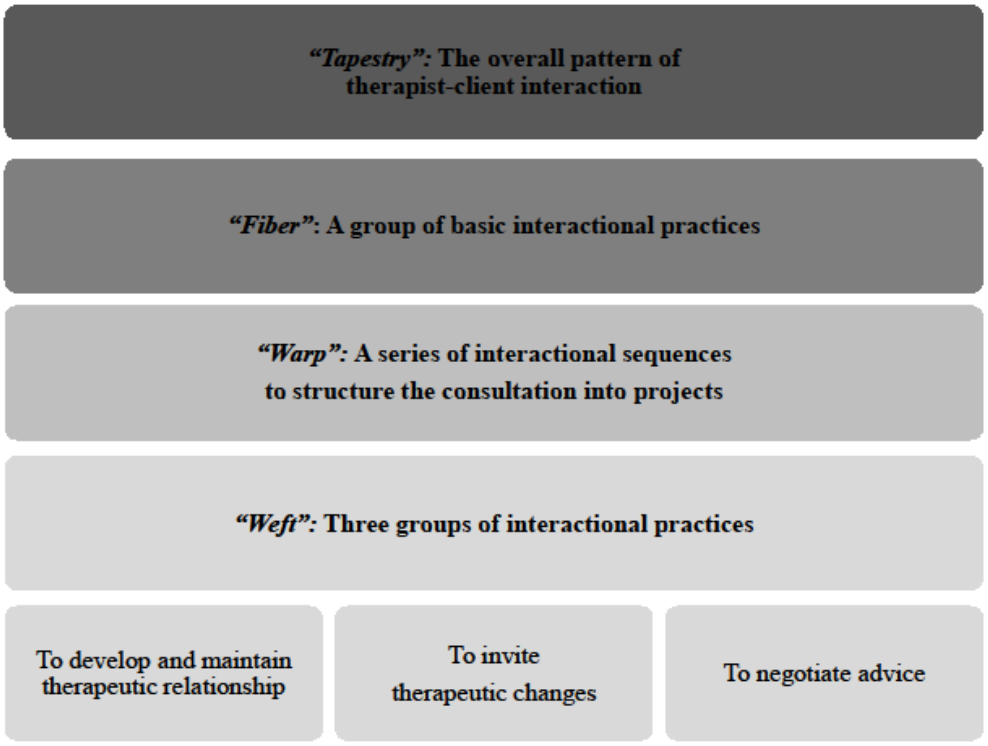

Figure 3. An organizing metaphor for the therapist-client interactional patterns

which the therapists utilized the interactional practices of the *weft* to accomplish the three interrelated purposes. In this sense, those three sets of practices seem to have operated at three different levels of abstraction. I gathered these distinctions from the analysis of the data, as well as my knowledge about and existing literature on SST and psychotherapy: one informed the other and vice versa. Despite differences in levels, these threads as a

whole contributed to the *tapestry*, the overall patterns of interaction, or *overall structural organization* (Robinson, 2014) in CA's term.

Fiber: A Group of Basic Interactional Practices through Which the Therapists Managed the Therapist-Client Interaction

I observed that the therapists utilized the basic practices consistently throughout the consultation. Therefore, the practices seem to be the foundational elements of the therapist-client interaction. Among the practices, I identified a set of three practices to manage specific aspects of the therapist-client interactions, and one versatile practice for various purposes. The set of three practices include: (a) project markers to coordinate transitions within and between parts of the consultation; (b) adjacency pairs and conversational tokens to coordinating turn taking; and (c) use of silence to coordinate the turn-taking. The one versatile practice is turn design.

Project Markers to Coordinate Transitions within and Between Parts of the Consultation

To reiterate, participants separate joint activities into hierarchically nested projects and subprojects, as they use dialogue to move through them (Bangerter & Clark, 2003; Bangerter & Mayor, 2013; Bangerter et al., 2004). In particular, they use project markers to move within and across different parts of activities. They use a group of project markers, including "uh huh," "m-hum," "yeah," for continuing on-going projects; they use another group of project markers, including "okay," "all right," when entering and exiting joint projects. As such, use of the two groups of project markers is essential in a SST consultation, as the therapist and clients work together to move through projects, from setting a context for the consultation to negotiating problems and goals for the

consultation, to achieving the goal by the end of the consultation. Below is an exemplar where Dr. Miller uses a project marker, "so" to transition out of the previous project and move into the next project of eliciting the problem description from April.

13 **So::** the things I: I noticed from this is and I would just have you tell us
14 about it is you wanted a third opinion ((looks up to see C)) about whatever
15 goin'on and you talked about family issues.{C: Yeah.} a::h:,
16 .h Tell me little more about that.
17 (.)What does that mean? {T2: ((shifts gaze from T1 to C))}
18 C: So my dad {T1: moves a hand to chin)) is .h very (0.2) mentally abusive.

His added emphasis and elongation of the word "So::" (line 13) allowed him to move smoothly into his observation of the client's note, along with the couple of questions asking her to elaborate on her accounts of the note. His turns successfully elicited a response that fell into the theme of the project.

The exemplar below happens when April has started accounting her view of the family problems.

25 (0.7) A::nd- he's like out of ↑control
26 Like he didn't like- hit us or anything really it's like (jus-) mentally ((hand
27 gesture)) like abusive. ((wipes eye))
28 So now it's happening with my sisters like ((the younger sister's age))
29 **{T1: °yea°}** .h
30 An- like ((wipes eye)) he like (that's) to my older sister too but they both
31 live with ↑him (.4) and my ((wipes eye)) ↑mom
32 But it's just like out of control. **{T1: ((nodding head))}**

.

.

37 C: An:: like she's like having trouble herself with her ↑boyfriend. **{T2:**

38 **((nodding head))}**

39 (0.6) Like, just really stressful **{T1: °Yeah° / T2: ((nodding head))}**

40 I'm trying like- concentrate on school= **{T2: ((nodding head))}**

.

.

51 C: =Like I feel like (0.2) all of the- like mom like doesn't ((hand gesture))

52 take care of anything just like lets my dad ((hand gesture)) do whatever he

53 wants.

54 **{T1: °Yeah.°} {T2: Um hum.}** She's like enables ((forms a parenthesis

55 with fingers)) ↑him

56 T1 / T2: **((nodding head))**

57 T1: .hh Wel- you said you have two ↑sisters one ↑older **{C: ((nods head))}**

58 you're the ↑middle **{C: ((nods head))}** and one younger↑ **((nods head))**

58 And they are still at ↑home

59 C: Yeah.

60 T1: **↑O↓kays**

61 C: Like my older sister like- doesn't like to keep a job. .h

62 We're like really close to in age.

Throughout this interactional sequence, both therapists use many forms of project markers for letting April know to continue to provide her account of the family problems.

One form is their use of a variation of "yeah" (lines 28, 39, & 54). Another form is a head nod (lines 31, 38, 39, 40, 56, 57, & 58). The last form is "um hum" (line 54). Their delivery speaks self-evidently to their functions: All of them, except one (line 56), occurred in the background of the client's speech so as not to interrupt the flow of her speech. After a small inquiry into the age order of April's sisters, Dr. Miller uses a project marker, "↑O↓kays" (line 60) to indicate that his inquiry has just finished. This is supported by April's returning to her account of her sisters, to which he presents no objection.

Adjacency Pairs to Coordinate the Turn-Taking

Smooth coordination and allocation of turn-taking is essential for successful execution of any joint activities, including psychotherapy. Both therapists used adjacency pairs (Sacks et al., 1974; Schegloff & Sacks, 1973) in questions-answers sequences, and project markers (Bangerter & Clark, 2003; Bangerter & Mayor, 2013; Bangerter et al., 2004) to coordinate turn-taking between them throughout the consultation. Below is an exemplar of a simple question-answer sequence.

63 → T2: What're the ages ((C: turns toward T2)) of everyone?

64 → C: My sister's ↑((mid 20s)) {((T2: °um hum° ((nods head))} ↑ ((early 20s))

65 ((early 20s)), my younger one **{((T2: nodding head)) / T1: °m: okay.°}**

Melissa's question asking her and her siblings' ages elicits April's answer. Upon their receipt of her answer, both therapists provide project markers (line 65) in the background to let April to take turns.

The exemplar below is a sequence of Dr. Miller's statement, in a form of reinterpretation (Bercelli et al., 2010), and April's corresponding response.

51 C: ((wipes face)) My ↑mom I feel like she's never gonna like- leave him.

52 He like doesn't do anything positive.

53 Like all he does is complain an like yells.

54 He doesn't even do anything all ↑day

55 I'm like my mom's like working hard. **{T2: °mm° ((nodding head))}**

56 She won't leave him now 'cause he's sick.

57 She would never.

58 And my younger sister's like learning from that you know.

59 She's lik- has a boyfriend but she's like broke ((wipes face)) up with 'cuz

60 he's like ↑insane, just like my da::d.

61 → T1: ((nodding head))

62 C: (.H) (.HH) ((mouthing)) °just-° ((shrug shoulders))

63 → T1: That's your wo- It's a worry for her:.

64 C: ↑Yea:h [(lik.)

65 → T1: ((empathic voice)) [(....) she would pick someone like your dad.

66 C: Yeah she already has, but they broke up because he was insane and she's

67 like kept going back to him. (.H) (.H)

April mostly continues to hold the conversation floor (lines 51-61) with occasional encouragements to do so by Melissa (line 55) and Dr. Miller (line 61) in forms of discourse markers. Then, he supplies a reinterpretation pointing out April's worry for her sister (line 63), which elicits her acknowledgement token (line 64). Overlapping her turn at the end, he picks up the next turn to put words into her worry (line 65). April responds with an agreement token, "Yeah" and provides elaboration on the account (line 66).

Use of Silence to Coordinate the Turn-Taking

Throughout the consultation, both therapists utilized noticeable silence between turns for two types of occasions: right after their questions for signaling speakership change, and while April is taking turns as project marker (Bangerter & Clark, 2003; Bangerter & Mayor, 2013; Bangerter et al., 2004) for letting her to continue her turns. After such silence, either the client or one of the therapists picked up the speakership.

Below is an exemplar that contains both uses of silence.

1	T1:	I'm wondering whatyu' are <u>hopeful</u> about with them.
2		You said several times you feel like tch can't change people can't change
3		them but .hh what'reyu <u>hopeful</u> about?
4 →		(2.1)
5	C:	In general?
6	T1:	((empathic voice)) Yeah.
7		(0.4) Just to get to know you a little bit h .hh
8 →		(0.5)
9	C:	mmmm:(1.8) ↑Graduating
10 →		(0.5)
11	T2:	[[((nodding head))
12	T1:	[[((nodding head)) You ↑career {C: °yea°} ↑school {T2: °um°}.h
13	T1:	((empathic and firming voice, nodding head)) That's <u>go:od.</u> {T2: °um 14
		hum° ((nodding head))}
15	T1:	What'else?

16 C: Ah::m I have a girl friend {T2: ((nodding head))} that lives in ↑Brazil.

17 She's coming.

18 → (1.3)

19 T1: She's gonna come visit?

20 C: °yea.°

Dr. Miller and Melissa use silence right after his question (lines 4 & 8) to communicate April that it is her turn, both of which elicit her answers. Similarly, they use silence after April's answer to his questions (lines 10 & 18) to encourage her to keep the speakership. After a brief silence to encourage April to retain the speakership (line 10), Dr. Miller fills in the silence with accounts for April (line 11).

In other cases, April continues to hold her speakership when being encouraged by the therapist's silence.

103 C: Lik- (0.8) there's a reason that they're coming to me (0.4) you know.

104 ((wipes face)) {T2: °um hum° ((nodding head))}

105 (0.7)

106 T2: What's the (.) reason?

107 → (0.9)

108 C: < > ((hand gestures in sync with the speech)) Because I know. I know

109 what's happening.<

110 T2: °um hum° ((nodding head))

111 T1: °um hum°

112 → (0.6)

113 T1: .h[h

114 C: [Lik- but putting like all th- like oh like she shouldn't do that because of
115 that (0.3) not jus- I mean not just feeding ((hand gesture)) into like (0.7)
116 the lies (0.3) and the (0.9) enabling of (.) letting people do things. {T2:
117 °um hum°}
118→ (1.4)
119 C: ((hand gesture in sync with the speech)) I do- I don't do <u>bad</u> <u>things</u> but-
120 like (0.5) make mistakes you know but (1.4) like- doing one thing bad like
121 knowing it's bad and doing it ↑again (0.2) >you know like-< that's the
122 <u>wrong</u>.=
123 T1: That's ((nodding head)) what they do. {T2: °yeah°}

After April states that she knows the reason why her family members visit her to consult about their family problems (lines 108-109), both therapists provide project markers (Bangerter & Clark, 2003; Bangerter & Mayor, 2013; Bangerter et al., 2004), "°um hum°" (lines 110 & 111), along with Dr. Miller's head nod. Then, both of them use a brief silence to further indicate their intent (line 112). A moment before Dr. Miller may have taken the next turn (line 113), April picks up the speakership again and continues to elaborate (line 114). After the turn, Melissa further supplies a project marker, which is followed by a brief silence (line 118). This invites April to continue her account of her family (line 119).

Turn Design

Turn design refers to how a speaker constructs a turn-at-talk (Drew, 2014). Particularly, a speaker selects and utilizes linguistic and other resources in such a way that the recipient of the turn would understand what the speaker intend to do with the

turn. Turns are made up of components—that are, *turn-constructional units* (Drew, 2014). For instance, therapists used the client's words, emphasized certain words, varied the rise and fall of the pitch of their utterances, slowed down or speeded up a portion of their utterances, nodded their heads, and so forth. As such, turn designs became elemental conversational practices with which the therapists assembled a various combination of turn-constructional units to construct turns for a myriad of purposes.

Below is an exemplar in which Melissa constructed a turn, using April's own words to elicit her experience. This interactional sequence occurred right after Dr. Miller attempted to elicit her main concern, but she could not point it out.

17 C: Jus(hhh)t .hh hh He's like so:: mentally abusive like my old sister like
18 instigates like yelling at my younger sister.
19 .h My dad like calls her like hoar. {T2: ((nodding head))}
20 .h Like (0.9) I'm like me standing up for ↑ that and they just don't (0.2)
21 >°hum°< They just don't do anything.
22 She's like- oh I haveta stay here. ((sobs))
23 (0.6)
24 → T2: ((empathic voice)) How was it like {T1: ((turning toward T2))} for you to
25 see (0.2) a::hm them not standing up to themselves and just staying?
26 C: It hurts me a lot.
27 T2: ((empathic voice)) °Yeah.°

The first sentence (lines 17-18) seems to reflect April's emotional intensity and concern for her sisters, as evidenced in her combustible aspirations and the emphasis and

stretching of the word, "so::." She provides an example of her father's "mental abuse" by referring to his name calling of her sister (line 19). Then, she compares herself with her sisters by juxtaposing her and their views of his behaviors by emphasizing the words, "standing up for ↑that" (line 20) and "don't" (line 20) of his father's behavior. She then emphasizes a form of her emotional expression about the situation by providing a full sentence of the account and emphasizing, "don't do anything." (line 21). At the end of the next line, she sobs (line 22). After a brief pause (line 23), Melissa constructs a question with April's own words, "not standing up to themselves" (line 25) and "staying" (line 25) to elicit her meaning about the situation. April provides the description of her meaning (line 26) and Melissa acknowledges it (line 27). Although I may not mention those basic practices in describing other interactional practices, they are the basic fabrics of any practices.

Warp: A Group of Interactional Practices and Sequences Designed to Structure the SST Consultation into Projects

Throughout SST consultation, the therapists utilized two interactional practices and a series of interactional sequences to structure the consultation into projects. First, I turn to the two interactional practices.

Use of Pre-Sequences and Preliminaries to Preliminaries to Negotiate the Consultation Arrangements and Courses of the Consultation

Dr. Miller often utilized *pre-sequences* (Schegloff & Sacks, 1973) in interactional sequences designed to structure the therapist-client's upcoming interaction. Speakers use pre-sequences to coordinate entries into the next course of interaction. Through pre-sequences, speakers can assess and establish elements necessary for the

upcoming interaction. Pre-sequences come in various forms, including pre-questions, pre-announcements, and pre-invitations. For instance, a speaker asks a recipient, "What are you doing tonight?" in order to know the person's availability and decide whether to ask him or her to go out together. If the recipient indicates his or her availability, the speaker can assume that he or she would accept the upcoming invitation. In this study, Dr. Miller used pre-sequences to comment about the consultation arrangements and upcoming process to gauge and secure April's permission to proceed.

In addition, Dr. Miller used *preliminaries to preliminaries* (Schegloff, 1980). Through preliminaries to preliminaries, speakers show recipients that speakers negotiate with recipients on a departure from the current course of conversation and a move to the next course of conversation. As such, the speakers show their respect for what they have developed in conversation up to the point (Peyrot, 1995). In her study, Sutherland (2008) points out that a frequent use of preliminaries to preliminaries can open up a space for the recipients to insert their agreement or disagreement, leading to a shared decision making process. In this study, Dr. Miller used preliminaries to preliminaries to initiate a project (Levinson, 2014), while closing a previous project. As I described in chapter three, a project involves a large number of sequences of actions, as well as a goal for which participants direct their interactions. In the relevant interactional sequences, I am going to describe how the therapists' used a combination of pre-sequences and preliminaries to preliminaries to negotiate the consultation arrangements and transitions between projects.

The interactional sequences designed to structure the SST consultation included

- setting the single session nature of expectation,

- negotiation for employment of a therapy team,
- soliciting problem description,
- first attempt to focalize a problem for consultation,
- second attempt to focalize a problem for consultation,
- focalizing a problem for advice-giving,
- focalizing a problem for advice-giving and articulation of consultation break,
- describing reflecting team process,
- initiating discussion on reflecting team,
- giving recommendations,
- checking with the client for topics left out from the consultation, and
- closing of consultation.

I point out to the readers of this research that I selected those sequences since I determined that they thematically and pragmatically contributed to setting contexts for, and were thus hierarchical to, the following therapist-client interaction and overall progression of the consultation. Those above sequences reflect an institutional interactional context in which professionals follow routine practice to achieve institutional objectives (Drew & Heritage, 1992; Heritage, 2004).

In the following sections, I explicate interactional sequences through which Dr. Miller structured the SST consultation by describing or negotiating the nature of, or providing the agenda for the forthcoming projects and subprojects. These sequences set a context for the upcoming interaction between the therapists and the client. This means that the sequences in this section are organized in terms of their unique utilities, rather

than their recurrent patterns in the consultation. I incorporated interactional sequences that I determined semantically and or pragmatically contributed to the progression of therapeutic interaction and achievement of meaningful changes, and excluded interactional sequences that I determined clinically non-consequential in my observation. I remind the readers of this study that there are considerable overlaps in my analysis across different threads of therapist-client interactional sequences. This is, because I imposed artificial boundaries on the therapist-client interaction in the SST consultation for the purpose of this study. In actuality, therapy interaction flows seamlessly.

Setting the Expectation for Single Session Nature of the Consultation

This interactional sequence begins right after the client's introduction to the therapy room. Dr. Miller seems to project to April a clear expectation about the single session nature of the consultation. Right at the beginning, Dr. Miller asserts his professional right to initiate this project (Levinson, 2014) in a preliminary to preliminary (Schegloff, 1980) format, ".h Let me tell you few things before we start." (line 1). In this turn, he communicates to her that he will continue to have the conversation floor while the few items are being talked about. In institutional interaction, professionals initiate and retain the right to (1) shape a new topic by designing opening questions, (2) determine when a topic is explored satisfactorily, and (3) decide what the next topic will be (Drew & Heritage, 1992; Heritage, 2004; Mishler, 1984).

Then, Dr. Miller projects to April clear expectations about the single nature of the session. The entire sequence seems to a pre-sequence (Schegloff & Sacks, 1973) to the proposal of the single session nature of the consultation. He accomplishes this task by communicating about it over many consecutive turns (lines 8-18).

8 T1: Ah:m ((looks away from C)) tch so: ah this is unique ((looks down and up
9 to see C)) in a way this thing we're doing a:hm this service.=
10 An then we're just meeting with you just once =
11 = It's like a consultation ={C: =↓Yeah} essentially =
12 =So we're try to: .hh The INTENT of this is to tell you as much as we can
13 about whatever you're interested in this <one> meeting °you know.°<
14 >Doesn't mean you can't come back. =
15 = You can come back as much as you↑want to: ((shifting sitting
16 position)) you know=
17 =We'll welcome you ↑too:
18 but .h that's just the intent of it for <today.>

In the first turn (lines 8-9), Dr. Miller emphasizes the unique nature of the service by stressing the word "unique." This turn seems to set up an importance of the forthcoming turn. With no gaps in between, he provides two sentences to state the single nature of the meeting with added emphasis on the word "once" (line 10) and "consultation" (line 12). This does not seem to leave a room, or transition-relevance place (Sacks et al., 1974), for April to take up a turn in between, except her acknowledgement token, "{C: =↓Yeah}" (line 11). In CA, turn-taking takes place with minimal gaps and overlaps in face-to-face interaction, and a speaker has a right to the conversational floor until certain junctures where the recipient of the conversation can pick up the floor.

He then starts sharing the intent of the meeting. At the beginning of the turn, he immediately uses *self-initiated repair* (Kitzinger, 2014) and fine-tunes the turn by placing

the word, "INTENT" (line 12) at the top of the turn with increased volume and emphasis on the word. In addition, he slows down the delivery of the word, "<one>" (line 13) with added emphasis on the word. With this repaired formation, he seems to stress an idea that the consultation is driven by her needs, while reiterating the single nature of the session.

The location of goal sharing is consistent with Bangerter and Mayor's (2013) account that project partners enter joint activities by identifying the purposes and social roles in the interactional context. Sharing activities' goals allows them to interpret each other's actions. Haslett (1987) articulated about the dynamic between communication and its goals being the context in which participants' actions and utterances are produced and interpreted: "As speakers, we utter statements we believe to be *relevant to the purposes at hand (i.e., goals); as listeners, we interpret utterances by determining their relevance to our general sense of what is going on in the interaction*" (p. 125).

With no gap in between, he adds three sentences, one after the other: (a) ">Doesn't mean you can't come back.=" (line 14); (b) "=You can come back as much as you ↑want to: ((shifting sitting position)) you know=" (lines 15-16); and (c) "=We'll welcome you ↑too:" (line 17). While the first two sentences seem to communicate in two different ways, the last sentence adds a favorable judgment to her potential returns for the service. With these three turns, he seems to try to avoid a potential misunderstanding and encourage her to come back at her own needs. At the end, Dr. Miller brings April's attention back to the single nature of this meeting by using the word, "but" (line 17) and slower delivery of the word, "today" (line 18). Overall, Dr. Miller seems to have set a

clear expectation for the single session nature of the consultation through constructing and timing his turns in the interactional sequence.

Negotiation for the Employment of a Therapy Team

This project occurs somewhat after the first phase. In this phase, I determined that Dr. Miller negotiates for the use of a therapy team over many turns, utilizing effective turn design (Drew, 2014) to receive permission from April. Turn designs refers to the way a participant designs components of a turn—that are, turn-constructional units (Drew, 2014) — to accomplish what it is designed for by utilizing various linguistic and other resources.

At the beginning of the sequence, Dr. Miller uses a vertical project marker (Bangerter & Clark, 2003; Bangerter et al., 2003), ".hh >So" (line 1).

1 T: .hh >So one another ((looks back, points the one-way mirror behind him))
2 thing that I will tell you about< is thata::h we have a: (.) team of therapists
3 who are watching.

CA researchers postulate that a participant shows another participant his or her readiness to initiate a conversational floor with inhales right before their turn (Clayman, 2014). Dr. Miller's rushed initiation of the turn also indicates his willingness to continue to keep the conversational floor. In forming the statement, he uses a preliminary to a preliminary (Schegloff, 1980), "one anther ((looks back, points the one-way mirror behind him)) thing that I will tell you about" (lines 1-2), to prefigure the upcoming course of conversation. The use of the preliminary to a preliminary seems to show his intent to transition into the next project, while leaving a space for April to protest the direction of the conversation if she wishes.

In the next turn (line 4), he assumes that April may be intimidated by the team approach for being watched from behind. In the first turn (line 5), Dr. Miller frames team approach as a "consumer deal" (line 5), implying that it is her who will benefit from this arrangement.

4 T1: .hh Andah >Don't be intimidated by that<↑thi:s

5 I would just advise you to look at a good consumer deal=

Dr. Miller delivers the next consecutive turns (lines 6-10) without any TRP (Sacks et al., 1974), making it difficult for April to interject. He describes the team's aim as "giving as many ideas as possible" (line 6), and adds that April can meet the team members if she wishes (line 7). Taking the interactional context into account, he seems to communicate that there is nothing to hide from her about the team approach. In the following turn, he clarifies that the team is advising therapists to serve her, while seeking an agreement from Melissa by turning towards her (lines 9-10). Melissa agrees with an acknowledgement token (Bangerter & Clark, 2003), "°um hum° ((nodding head))" (line 10).

6 T1: =They are here to give us as many ideas as ah possible=

7 ((points a nod to the back)) You can actually meet them if you want

8 but- .hhh (...) we can do that later if you want as well.=

9 =Ahm: they are here to advice us ((turning toward T2, points themselves))

10 {T2: °um hum° ((nodding head))} essentially.

In the following turns, Dr. Miller uses a *self-initiated repair* (Kitzinger, 2014) to fine-tune the turns in the service of projecting that it is both therapists who will take a break and get ideas from the team (lines 11-13). The sequence up to this point seems to

work as a set of pre-sequences (Schegloff & Sacks, 1973) to propose the use of therapy team.

11 T1: They are listening and then I take a break, we take a break {T2:
12 ((nodding head))} in about in about thirty or forty five minutes after we
13 talked for a bit .hh and try to get as many ideas as we can from them.
14 And ah: So does that sound okay for you?= {T2: ((turns toward C))}
15 =<They should've told you when you .h [°called in.°
16 C: [°It's okay°((flips her hand in the
17 air)) {T2: ((nodding head))}

Then, he builds a question to show his preferred answer (Pomerantz & Heritage, 2014; Sacks, 1992), "And ah: So does that sound okay for you?=<They should've told you when you .h [°called in.°" (lines 14-15). In these turns, not only does he build the initial question in a way that shows his preference on her answer, but also justifies his preference with the second turn without a gap between these turns by communicating that the arrangement for the therapy team should have been discussed and approved by April at the time of her initial phone call to the clinic. The principle of CA in responding to such yes-no questions is, "if possible, avoid or minimize explicitly stated disconfirmations in favor of confirmations" (Pomerantz & Heritage, 2014, p. 213). In fact, April overlaps (Hayashi, 2014) his latter turn and provides his preferred answer with a consent token (Bangerter & Clark, 2003).

Then, Dr. Miller uses *other-initiated repair* (Kitzinger, 2014) of repeating essentially the same question to resolve his momentary trouble hearing her turn due to the

overlap (line 18). To her previous agreement (line 16), he acknowledges her response, following up with attributing a positive value to her response (lines 19-20).

18 T1: Is that okay?

19 Al↓right ((nods his head)). {C: Yeah.}

20 .hh ((nodding head)) Okay good.

Overall, Dr. Miller used various interactional practices that are sophisticatedly woven in order to obtain April's permission on the arrangement of the team approach.

Soliciting the Client's Problem Descriptions

This brief sequence occurs sometime after the negotiation for the therapy use and right after a description of the use of video-recording of the session. In this brief sequence, Dr. Miller elicits April's problem description, using her words written in the lobby intake form.

13 → T1: So:: the things I: I noticed from this is and I would just have you tell us

14 about it is you wanted a third opinion ((looks up to see C)) about whatever

15 goin'on and you talked about family issues.{C: Yeah.} a::h:,

16 .h Tell me little more about that.

17 (.)What does that mean? {T2: ((shifts gaze from T1 to C))}

18 C: So my dad {T1: moves a hand to chin)) is .h very (0.2) mentally abusive.

After using "So::" (line 13) as a vertical project marker (Bangerter & Clark, 2003; Bangerter et al., 2004), he uses a pre (Schegloff, 1980), "I would just have you tell us about it" (lines 13-14) to negotiate a move to this current project, inquiring April's problem. In doing so, he uses her words written in the Lobby Intake Form, "a third opinion" (line 13) and "family issues" (line 14). This elicits April's confirmation,

"Yeah." (line 15). A principle of CA postulates that a speaker should select a reference that a recipient knows (Pomerantz & Heritage, 2014; Sacks, 1992). This shows to the recipient that "you know that they know what you're talking about" (Sacks, 1992, p. 149). In management of joint activities, participants progress to reuse the same expressions—that is, *lexical entrainment*, which builds further common ground (Bangerter & Mayor, 2013). He follows up with two questions (lines 16-17), using the latter question to clarify the first one. In psychotherapy literature, the manner portrayed through attentive listening of clients' accounts, along with tentative responses or questions about clients' accounts are exemplified in a therapists' position, *not-knowing* (Anderson, 1990, 2005; Anderson & Goolishian, 1992). According to Anderson (1995),

> *Not-knowing* refers to the attitude and belief that the therapist does not have access to privileged information, can never fully understand the other person; and always need to learn more about what has been said or not said . . . not-knowing means the therapist is humble about what she or he knows. (p. 34-36)

In CA literature, an idea of *epistemics* (Heritage, 2014) is relevant. CA researchers refer it as "the knowledge claims that interactants assert, contest, and defend in and through turns-at-talk and sequences of interaction (p. 370). Normally, conversation participants normally maintain the congruence, in and through interactions, between what they know and what they tell the other participants that they know. However, participants can purposely *upgrade* or *downgrade* their knowledge claims in order to initiate or expand interactional sequences (Heritage, 2014). In this case, Dr. Miller downgraded his understanding of the client's description, which may have led to an upgrading of April's upcoming turn. Taking the interactional context into account, it

seems that Dr. Miller is attempting to elicit April's own description of the family problem, without imposing his assumptions. As a result, this sequence elicits her initial problem description. Overall, Dr. Miller used several interactional practices to effectively establish a context in which April started describing her problem accounts in her own words.

Continually Adjusting Questions to Solicit a Focus for the Consultation

Over the course of the consultation before they take a consultation break, I observed that therapists continued to adjust their questions four times, focalizing a problem to be discussed in the consultation, to solicit a type of response they were looking for from April. This is due to the fact that she initially did not have an answer to the question. In addition, she did not believe that the SST consultation will change her family, given her account of attributing the problem to her family. The manner of therapists responding with April seems very valuable in structuring the consultation in which the therapists adjusted their questions and responses to April's lack of knowledge and challenge to the therapists' assumptions embedded in their questions.

First attempt to focalize a problem for the consultation. The initial solicitation of April's problem description leads to her account of the multitude of her family issues and the family dynamics. April makes a conclusive statement.

37 C: Everyone has problems. Jus- I'm not really sure .hh just feel stressed.

38 ((hand gesture))

39 T1: ((empathic tone)) Yeah of ↑course. {T2: °um hum°}

At this point, Dr. Miller poses a question, attempting to focalize a problem to be solved.

1 → T1 Would'yu think back on ((looks down on the case chart on the table))

what's going on with your family, (..) give me a sense of- what is it that you're- ((looking up to see C)) ?
.hh What's the main concern you have of of- the situation you described?=
=It sounds really hard. {T2: ((turning toward C))}
.h And there's lot going on and we're kida getta a glimpse of {C: (....)} it but what's your main- hh ((empathic voice)) What's your main concern abouta: (0.7) what's happening in your family right now?
(0.6)
T1: <I head yu talk about your sisters ((hand gesture, nods head)).=
=It sounds to me like you are worried about them.= {T2: °um hum.°}
C: =I feel like the biggest problem is just my dad not him not wanting to get help for himself, .hh like (0.3) trying to get my sister-
<I MEAN, (0.8) a(h) I'm not really sure.
I'M NOT SURE. {T2: ((nodding head)) °um hum°}
(1.2)

Dr. Miller starts forming a question by referencing her account of the family problem as "what's going on with your family" (lines 3-4), while refining the question by *self-initiated repair* (Kitzinger, 2014) and attempting to have her pick the "main concern" out of all of the issues that they can discuss (lines 3-5). This seems to communicate to her that he is having her pick a single focus for the consultation, while presenting his understanding of the multiplicity of her issues. Looking through the idea of epistemics (Heritage, 2014), Dr. Miller downgraded his knowledge about which one may be her primary issue, in service of upgrading April's upcoming response.

With no gap in between, he takes the next turn with which he seems to align with her emotional difficulty through a *reinterpretation* (Bercelli et al., 2010), "=It sounds really hard." (line 6). In reinterpretation, a therapist offers his or her own interpretation of clients' accounts of their events, based on the clients' accounts. In offering his or her own interpretation, the therapist replaces the clients' interpretation with his or her own, or presents an alternative interpretation. The reinterpretation is signaled in his tentative tone through the use of "It sound" (line 11).

Dr. Miller continues to hold the conversational floor and gives a *formulation* ".h And there's lot going on" (line 7). In formulation, a speaker presents a mere summary of the previously speaker's event or account, while transforming one part to a degree and deleting another part (Antaki, 2008; Heritage & Watson, 1979). In this case, he acknowledges the complexity and multitude of her family problems, while shifting the direction of the conversation. According to Antaki, Barnes, and Leudar (2005), formulation helps therapists to manage the progress of the session by gently shaping and re-shaping ebb and flow of the session in therapeutically meaningful manner. He then minimizes his own and Melissa's knowledge about the full extent of the problems (lines 7-8). Together with the formulation, he acknowledges the multitude of her problem, while having her choose a focus for this consultation.

In the latter part of the turn, he repeats a similar question as the previous turn, while adding "right now" at the end of the question (lines 7-9). This addition further narrows down the range of April's legitimate response to his inquiry. In this sense, the series of his questions works as the first pair part of an adjacency pair (Sacks et al., 1974;

Schegloff & Sacks, 1973) for which April is expected to provide a response as a second pair part.

After a brief gap, he provides her with a *candidate answer* (Pomerantz, 1988) (line 11). Pomerantz (1988) described that participants in interactions seek responses from one another and candidate answer is a strategy for that purpose. Pomerantz noted:

> When interactants incorporate Candidate Answers in their inquiries, they give the co-interactants *models* of the types of answers that would satisfy their purposes. In providing a model, an interactant instructs a co-interactant as to just what kind of information is being sought. (p. 366)

In this case, Dr. Miller provides April a potential response for the question, while pursuing some kind of response from her. In addition, he adds a reinterpretation (Bercelli et al., 2010) without any gap in which he puts forth an idea that she may be worried about her sisters (lines 10-11). April provides a response, pointing out her father as the primary problem, disagreeing with his *candidate answer* with added emphasis on "<u>just</u>" and "<u>dad</u>" (lines 13-14); however, she quickly withdraws her response, "<I MEAN, (0.8) a(h) I'm not really sure. I'M <u>NOT</u> SURE" (lines 15-16). The louder vocal delivery and repeat of the same statement seems to communicate her confusion about the topic.

The sequence becomes a further inquiry into her family issues, along with their relational dynamics, while the therapists start exploring April's strength that she "did not put up with bullshit" and persevered at her home, and eventually moved out of her family house and into her own apartment. In addition, the therapists came to find out that she kept grade As s at school.

Second attempt to focalize a problem for the consultation. This interactional sequence happens after the co-therapists' inquiry about April's perception of family dynamics and her strength within the family context, as well as an inquiry into her worry for her family members. In this sequence, Melissa tries again to establish a focus on the client's family problems.

1 T2: ((empathic voice)) .hh Sounds like you have (.) really have so much staff
2 going'on ↑right.=
3 = I'm hearing that .h a:hm, you're worried about your ↑dad ((hand
4 gesture)), you're worried about his ↑safety ((hand gesture)) and his ↑
5 health ((hand gesture)).
6 (.) It sound like you're worried about your ↑sister ((hand gesture)).
7 She might be- you know she sounds very ↑volatile, perhaps she's doing
8 drugs ((hand gestue)) an: you know you're ((hand gesture)) worried about
9 her ↑too and then you have a issue concentrating at ↑school, rightfully
10 ((hand gesture, nodding head)) ↑so.
11 So sounds like you have a:l (0.2) LOT OF stuff
12 < >I'm ((hand gesture)) sure there are stuff we didn't even hear about.<

Initially, Melissa offers a series of reinterpretations (Bercelli et al., 2010) (lines 1-10), using the same format to itemize April's worry. After the series of reinterpretations, she reinterprets in a form of conclusion, after a *self-initiated repair* (Kitzinger, 2014), to stress April's multitude of problems by louder delivery of her voice, "LOT OF stuff" (line 11). She then jump-starts her fast-paced next turn, minimizing her and Dr. Miller's knowledge about her problems (line 12).

This turn seems to acknowledge her multitude of problems, while creating a smooth transition for which she now has April pick a focus for the consultation.

13 → T2: .hh But I'm curious to know (0.2) if this time together ((turning toward T1
14 briefly, hand gesture)) a:h:m was most useful (.) for you, .hh a:h:m what
15 would we have to (.) focus on and what- what would have to (.) happen
16 (0.2) for this to be most useful for you?
17 C: mmm: >I donno< just talkin.
18 Like- one session thing is jus- mostly just talking.
19 T2: Um hum. ((nodding head))
20 C: (.H) (.H) Just getting it out there. {T2: °okay° ((nodding head))}
21 T1: pt. That's fine.
22 That's actually-{T2: °yeah°}it can be really helpful.=
23 =I'though it was really wise what you wrote {C: (hh)h} on the form you
24 talked- about talking to a third party a(h) (h)m ((smiley voice))
25 {T2: °mm°}
26 You know sometimes that is(hh) (0.2) really helpful.

In this sequence, Melissa starts out with a preliminary to a preliminary (Schegloff, 1980), meta-commenting on what she is about to say, and asks a question to focalizing a problem and a goal in a hypothetical format, "if" (lines 13-16). In response, April disagrees with Melissa's embedded assumption in her question that they need to take actions to make this consultation useful by added emphases on words, "talkin" (line 17), "mostly," and "talking" (line 18). Melissa responds with an acknowledgement token (Bangerter & Clark, 2003), while April continues to communicate the same message (line

20). Melissa uses a consent token (Bangerter & Clark, 2003), along with a head nod, "°okay° ((nodding head))" (line 20), to show April that she is satisfied with April's response. In this sense, the therapists did not receive a type of response they were looking for. Instead, this sequence leads to further inquiry into April's perception of the family problem and her strength within the family context.

Third attempt to focalize a problem for the consultation. This interactional sequence happens after the co-therapists' previous inquiry into April's perception of the family problem and her strength within the problem context. Dr. Miller returns to an inquiry into types of advices she is seeking for the third time around.

1 T1: .hh ↑O↓kay

2 .hhh ((looks down)) <u>WELL</u> WE WILL ah: TRY TO GIVE YOU as many

3 options ((looks up to see C)) and opinions as we can=

4 =and I do believe it's just helpful to get'it out.=

Dr. Miller utilizes April's previous accounts, getting third party "opinions" (line 3) about her family problem on the utility of the consultation. At the same time, he uses various methods to transition projects, including a project marker (Bangerter & Clark, 2003; Bangerter et al., 2004), ".hh ↑O↓kay" (line 1), and non-verbal behavior of looking down at and stressing the beginning of the following turn (line 2). With no gap, he adds a turn, legitimizing her account, "get'it out" (line 4). This seems particularly useful since April partially rejected Melissa's embedded assumption in the previous question that client and therapists need to do something to make the consultation useful. Looking through the idea of grounding in project (Clark & Brennan, 1991; Bangerter & Mayor, 2013),

legitimizing April's account may have served to re-align the therapists' position with her position, thus regaining the common ground.

Then, Dr. Miller further legitimizes her account by backing it up with a reinterpretation (Bercelli et al., 2010).

5 T1: = ((empathic voice)) It seems to me that you've been carrying a lot (.) for a
6 while {C: °yea°}and this is ((hand gesture pointing the therapy room))
7 this is why we built this place for you to be able to come and talk {T2:
8 ((nodding head))}here {T2: ((nodding head))}so (..)
9 (0.2)

In response to his turn, legitimizing her account (lines 5-6), April agrees with it with an agreement token (Bangerter & Clark, 2003), "°yea°" (line 6). Although Bangerter and Clark (2003) identify the use of "yeh" as acknowledgment token, its use in this interactional context seems to be as an agreement token. He continues the turn further, legitimizing her view on the use of SST consultation with an added emphasis on the word, "built" (lines 6-8).

Then, Dr. Miller returns to an initiation for determining types of advice April is looking for.

10 → T1: A::hm{T2: ((turns toward T1))} a::h: BUT BACK to what Melissa was
11 asking about like if you think of what's going on ((turns toward C)) in
12 your family, .hhh so like one thing that rise to the top maybe we- I also- I
13 get ((points a nod to the therapy team behind his back)) team to help us
14 think about this too.=
15 =It's like a ((looks down to a side, nodding head)) question.

16 Like that ((knocks on the table)) thing.

17 .hhh I:- I need to help knowing what to do this ((points a finger in the air))

18 ↑way or that ((moves the finger)) way ((looks up to see C)) o:r: .hh and

19 you'VE ALREADY SAID four or five things that I can guess without that

20 buta:: I say it to you.

Dr. Miller reiterates the same message as Melissa's using different turn constructional unit (Drew, 2014). He delivers the turn, emphasizing a return to the topic with a pre- (Schegloff, 1980), "BUT BACK" (line 10) in a louder voice and "one thing" (line 12) with an added emphasis. He then elaborates his account by comparing it with a "question" (line 15) and calling it as "that thing" (line 16). Then, he enacts sample types of advice (lines 17-18). He then initiates candidate answers (Pomerantz, 1988) by emphasizing that he has heard her accounting possible areas of concerns. He accomplishes this through a louder turn delivery and added emphases on some words: "you'VE ALREADY SAID four or five things that I can guess without that" (line 19). At the end, he uses a preliminary to a preliminary (Schegloff, 1980), "buta:: I say it to you" (line 20).

In the following sequence, he gives candidate answers (Pomerantz, 1988) in a form of itemization.

21 → T1: It's yo- but (..) you tell me if this is one of those, or something else.

22 .hhh One of the them is that essentially you're worried about your older

23 sister and her safety.= {T2: turns toward C, nodding head))}

24 =She's sending out signals (0.2) which people do when they are troubled.

25 {T2: °um hum°}

.hh And (..) just whataI'm ((hand gesture)) hearing is that sounds like ((nodding head)) (0.3) you're <u>onto</u> something there that makes this a concern.= {T2: ((nodding head))}

= ((looks down to the side and up to see C)) <u>The other</u> is about your mother(0.4) .hh an she seems like she's give up a lot for her happiness and whatever's happening to her even though she's going to therapy. (0.2) .hh so that's another one.=.hhh

= <u>Another</u> is <u>your ((shifts the direction of his face)) own</u> (0.3) h work school.=

= You made straight As last term but I couldn't help (that you're in the state) that you cannot focus {T2: ((nodding head))} this term so,

C: °yea° [I mean just started.

T1: [((.....))

T2: °um hum°

T1: ((smiley voice)) Yeah (just .....) It's been a week yeah ((small laugher)) .hhh=

C: =Just started.

(0.4)

He uses a preliminary to a preliminary (Schegloff, 1980) to shape the current sequence so as to have her pick topics that may be in her most interest (line 21). In itemizing candidate answers, he uses the same turn design (Drew, 2014) in which he first points out an area of potential concern and supplies his understanding of each concern as evidence. For instance, he utters, "<u>One</u> of the them is that essentially you're worried about your

older sister and her safety.=" (lines 22-23). He accompanies his understanding of the topic, justifying her accounts with added emphases on few words, "She's sending out signals (0.2) which people do when they are troubled." (line 24). He further justifies her accounts as he continues to state, "you're onto something there" with added emphasis on the word, "onto" (line 27). He then uses the same turn-constructional units (Drew, 2014) to construct the following turns about her mother (lines 29-32) and her (lines 33-36). This use of the same turn-constructional units for each turn may have effectively communicated April that he has understood her accounts on the family problems. April does not add any tokens in response until the end of his last turn, itemizing her account on herself. In this turn, she uses an acknowledgement token (Bangerter & Clark, 2003), "°yea°" (line 37), along with a partial correction of his account of her account, "[I mean just started." (line 37). In response, Melissa acknowledges his accounts and her correction of his accounts with an acknowledgement token, "°um hum°" (line 39). Dr. Miller self-repairs with a paraphrase of her correction, "It's been a week yeah" (lines 40-41). With no gap, April re-asserts her account (line 42). Through the negotiation and adjustment of his own accounts in response to April's accounts, he seems to continue the process of grounding (Bangerter & Mayor, 2013; Clark & Brennan, 1991) with her.

After a brief pause (line 43), he picks up a turn to state that the previous turns were meant to suggest potential areas of concerns for April.

44 T1: SO ANYWAY those types ((turns toward C)) of thing.=

45 =Is there one in particular you feel like (0.2) yeah ((nodding head)) I'd like

46 some advise, opinions about those- that thing.=

47 C: =WELL I feel as like it's(hh) just hopeless (.hh) (til) like (0.4) because like
48 I said like you can't make ((hand gesture)) someone like do ((hand
49 gesture)) anything.

He delivers the first part of the turn, "SO ANYWAY" (line 44) with a lauder voice, and "types"(line 44) with an added emphasis. With no gap, he asks her if there is one topic that she wants to pursue (lines 45-46). She starts off her turn with "WELL" (line 47) and continues to state, "just hopeless" (line 47). The use of "well" in a lauder voice delivery seems to signal her disconfirmation with his embedded assumption that they can help her improve her family problems. In CA literature, disconfirming responses to polar questions (i.e., question projecting "yes" or "no") often accompany delays, prefaces, accounts, and so forth (Lee, 2014; Pomerantz & Heritage, 2014). She goes on to justify her account, "you can't make ((hand gesture)) someone like do ((hand gesture)) anything." (lines 48-49). This sequence evolves into April attempting to convince the co-therapists that there cannot be any solutions, since it is her family that is the problem and they are not willing to change themselves.

Fourth attempt to focalize a problem for the consultation. This sequence happens after the co-therapists explored April's view on the family dynamics and her hope for herself. Before taking a consultation break with the therapy team, Dr. Miller asks if there are any topics or inquiries the therapist did not initiate with her up to that point.

1 → T1: .h I do wanna >think about< Is there any (.) question I haven't asked you
2 about ((looks up to see C)) or thing we haven't asked you about you feel
3 like (.) it's good for us to know about you or something.

4 °You:: °.hhh thought of ((hand gesture)) as you came here >it's like<

5 ((pretending as if C)) I wanna ((nodding head)) get their opinion about

6 thi::s↑ or tha::t↑

7 C: No.

8 T1: Is that it? Pretty ((nodding head)) much the things you've talked ↑about.

9 Those are the main concerns?

10 C: Just what- I don't know maybe ((hand gesture)) like what to do that's

11 ((hand gesture)) jus(h) what I'm looking ((hand gesture)) for.

12 T1: What to do? Both with yo::u: and your fa::mily?

13 Those are the two main spheres? .hh

14 C: I mean-

15 T1: Or something else.

16 C: I I honestly ((hand gesture)) don't know. {T1: °okay°}

17 I ((hand gesture)) don- I don't know.

18 T1: ↑O↓kay {T2: °um hum°} .hh >WE CAN DO THAT.<

He uses a preliminary to a preliminary (Schegloff, 1980), "I do wanna >think about<" (line 1) to initiate the current project, making sure if there is any topic of her interest that they have not addressed (lines 1-3). Then, he elaborates on the question by pretending as if he was her (lines 4-6). In answer to April's response (line 7), he re-attempts to confirm the types of problems for which she wants their advice (lines 8-9). In response, she starts out with a hesitation—that is, weak agreement (Pomerantz 1984), "I don't know maybe" (line 10) and provides a type of advice, "what to do" (line 10), she is looking for. In CA, weakly stated agreements, exemplified in "yeah," or "uh huh" with hesitation, are

reported to be used to show disagreement or refusal in interaction. Dr. Miller repeats her account and asks for another confirmation on the type of problems she wants their advice for with an added emphasis on each word, "yo::u: and your fa::mily*"* (line 12) in a form of candidate answers (Pomerantz, 1988). In seeking information, a speaker provides a recipient with potential answers in order to communicate the types of information he or she is looking for. In addition, he adds another question, asking for a confirmation. Together, this sequence of inquiries seems to solicit her confirming response in this interactional context. Despite his effort, April communicates that she does not have an answer, "I I honestly ((hand gesture)) don't know." (line 16), or *non answer response* (Fox & Thompson, 2010), and communicates the same idea in the following turn (line 17). Dr. Miller then supplies a vertical project marker (Bangerter & Clark, 2003; Bangerter et al., 2003), "↑O↓kay" (line 18), followed up with an acceptance of her responses with added emphasis to communicate that her weak agreement and absence of her answer have nonetheless satisfied his inquiry and that he is about to transition into an adjacent project of describing and explaining about the consultation break.

Articulation of the Consultation Break

In this project, Dr. Miller articulates the process and objectives of the consultation break.

19 T1: We- we- that's we work- ((hand gesture)) w'l- w'l- w'l- w'l ((looks up in
20 the air)) >we'll come up with as many things as we can. ((hand gesture)) =
21 =I I'll tell you what's gonna happen next ((looks down)) if it's okay with
22 you.= (.....it's our..) it's up to you.<

23 .hhh I'm gonna take a break ((points the one-way mirror behind himself))
24 we'll ((turns toward T2)) gonna take a break ((points the one-way mirror))
25 to go trying to get information from the team.=
26 = They ('ve been) listening ((hand gesture)) an- .h THEY <u>SORTA</u> WORK
27 FOR US ((hand gesture)) they work for you <u>too</u>. = ((hand gesture))
28 = They're like ((turning around a finger in the air)) thinking about
29 {T2: °mm°}trying to answer this question about things ((hand gesture))
30 to recommend ((hand gesture)) for you to go home with.

After referring to the objective of the consultation (lines 19-20), he uses a preliminary to a preliminary (Schegloff, 1980), " =I I'll tell you what's gonna happen next ((looks down)) if it's okay with you.= (.....it's our..) it's up to you.<" (lines 21-22). It seems that he is projecting the upcoming sequence, while negotiating with April on the direction of the conversation (Sutherland & Strong, 2011). Then, he refines his turn with self-initiated repair (Kitzinger, 2014) to communicate that both of the therapists are going to take a consultation break (lines 23-25).

He then explains the purpose of having the therapy team observing the consultation (lines 26-30). In particular, he initially stresses that the therapy team will work for the therapists, while adding that it will also work for her (lines 26-27). With no gap, he designs his turns, "things ((hand gesture)) to recommend ((hand gesture)) for you to go home with." (lines 29-30) to show the arrangement will contribute to the consultation's objectives. During the delivery of this sequence, he effectively held the conversational floor by leaving no gap between the turns.

Then, he initiates a negotiation on the use of the reflecting team (Andersen, 1987), while projecting his preference on its use. It seems that the entire sequence is a pre-sequence (Schegloff & Sacks, 1973) to negotiate with April on the use of the reflecting team.

31 T1: .hh Anda::h ((hand gesture)) ah THERE'S A THING ((hand gesture)) WE
32 CAN DO:: with them if you're up for it.=
33 = I- I think ((hand gesture)) you may like it ((hand gesture)) (.....)
34 interesting for you is thata:: I might (..) suggest that they come back in
35 here ((finger gesture)) .hhh
36 a:::nd they ((looking up to a side, hand gesture)) talk to me.
37 A:::h >they talk to us< ((turns toward T2)) about their ideas and you can
38 jus(h) sit back and ↑listen
39 C: ↑Sure

At first, he stresses parts of the first turn in louder voice and with an added emphasis, "THERE'S A THING" and "WE CAN DO::" (lines 31-32). At the end of the statement, he adds that it is up to her to decide (line 32). Taken together, the first and second statements seem to show his willingness to negotiate with April on the decision making. Then, he adds his speculation that she may like the arrangement (lines 33-34). In the following turns (lines 34-38), at the same time, he seems to communicate his preference over the arrangement by stating that she will not have to do anything in particular (lines 37-38). This successfully elicits April's affirmative consent token (Bangerter & Clark, 2003) for the arrangement, "↑Sure" (line 39).

In the following sequence, Dr. Miller describes the process of a reflecting team (Andersen, 1987) by framing it as "wired" (line 40).

40 T1: And it's almost like (.) it sounds wired. ((hand gesture))=
41 =I tell you (about it) now.
42 .h Ju- like- pretend like you're watching a TV ((drawing a wall before him
43 with open palms))
44 .hh anda:: they they'll once you meet them ((hand gesture)) when they first
45 come in ((pretending as if greeting, hand gestures in sync with speech))
46 you say hi you know, you meet them ah::
47 They can- we'll ask you to pretend ((sticks out arms forward)) there's an
48 invisible wall ((drawing a wall with open palms before him)) between us
49 {T2: Mm.} and we can see and hear you, (0.2) .hh but
50 j(h) a::h: you can see and hear us ((drawing the wall in the air)) but we
51 can't see an- hear you. ((drawing the wall in the air)) {C: °Okay°}

The unfavorable evaluation of the reflecting may seem to work to preempt April's negative response about the use of the reflecting team. After the consecutive turns that describe its procedures, he designs his turn (Drew, 2014) by using a comparison in order to describe a difference between themselves and April, "you can see and hear us ((drawing the wall in the air)) but we can't see an- hear you. ((drawing the wall in the air))" (lines 50-51). In response, she gives a consent token (Bangerter & Clark, 2003), "°Okay°" (line 51).

In the next sequence, Dr. Miller provides consecutive turns, providing rationale for the reflecting team.

52 T1: Right↑and it's to PRESERVE what would've been ((points to the one-way
53 mirror behind himself)) the conversation (0.2) back there.=
54 =So we- we have no secrets ((finger gesture)) from you.=
55 =We jus- want'yu to hear everything ((finger gesture)) we are thinking.

In the first turn, he delivers the word, "PRESERVE" (line 52) with a lauder voice to emphasize the purpose. He then declares with added emphasis that they do not have any secrets from her (line 54). He goes further to state that they prefer that she hears their thoughts about the consultation (line 55). Throughout this sequence, he effectively maintained the conversation floor by leaving no TRP between the turns. Taking all together, he seems to create a convincing argument that the therapy team is willing to share their thoughts with her.

Then, he continues to speak about the procedures and asks for her permission for the use of the reflecting team.

56 T1: .hh So we talk ((hand gesture)) with them for a bit and we do that thing
57 you just sit back ((hand gesture)) and listen and they'l leave ((points to one
58 side with a hand)) and we'll ((points to the side of T2 with another hand))
59 finish up .hh like with you talking with you (that which you heard.)
60 C: °sure.°= {T2: ((nodding head))}
61 T1: =Does that sound okay?
62 ↑Al↓right

In response, April gives a consent token (Bangerter & Clark, 2003), "°sure.°" (line 60). Dr. Miller realizes her response right after his question asking for her permission (line

61), and initiates a vertical transition (Bangerter & Clark, 2003; Bangerter et al., 2003) with "↑Al↓right" (line 62) into a consultation break.

Describing the Reflecting Team Process

This sequence happens after the consultation break and the co-therapists, along with some of the team of therapists came back to the therapy room from the observation room. Dr. Miller reiterates the procedures and purpose of the reflecting team (Anderson, 1987).

1 T1: .hh So like I said ((hand gesture)), sit back and just a:::h (0.4) °just ((hand
2 gesture)) listen° .
3 And we're gonna pretend like there is an invisible ((drawing a wall in
4 the air with a palm)) wall=

In this brief sequence, he prefaces a redundancy with ".hh So like I said ((hand gesture))," (line 1) and re-uses the same references as when he initially described about the reflecting team procedure, "sit back and just a:::h (0.4) °just ((hand gesture)) listen°" (lines 1-2). The selection of shared references shows that he knows that she knows what he is speaking about (Sacks, 1992b). In the following turns, he shares the purpose of the reflecting team arrangement, while initiating humor.

5 =So it's <u>wired</u> ((hand gesture)) we talk about like you're <u>not</u> in the room.
6 (.).hh But it's <u>not meant to be ru::de</u>.(.) ((small laugher)) {T?: ((small
7 laughter))}
8 .hh It's just like to <u>preserve</u> what was the conversation ((points to the
9 room behind the one-way mirror)) we just had back there.

In the first turn, he re-uses the same reference term as before, "wired" (line 5) to describe the arrangement, perhaps to preempt her unfavorable receipt of the arrangement. At this point, he initiates humor by adding emphasis on the combination of words and stretching the last word, followed by self-inducing laughter, "not meant to be ru::de.(.) ((small laugher))" (line 6). His initiation of humor brings forth laughter of unknown person in this interactional context. Then he states the purpose of the reflecting team by emphasizing the word, "preserve" (line 8).

In the following sequence, Dr. Miller negotiates with April, in a pre-sequence format (Schegloff & Sacks, 1973), on the procedure of the reflecting team.

10 T1: (.) .hh So:a::h I LOG WHAT THEY SAID ((hand gesture)) and thena:::h
11 if you hear ((finger gesture)) like anything stands out for you thenah:: I'll
12 talk ((hand gesture)) with you- we'll ((turns toward T2, hand gesture))
13 {T2: ((nodding head))} about it with you {T2: °um hum°}after they
14 le:ave.= ((hand gesture))
15 =°So we'll talk like five minutes and then-°
16 .hh Sound okay?
17 C: ((hand gesture)) °Sure.°
18 T1: Okay ((nods head))

After clearly assigning a note-taking role to himself, he asks her to pay attention to anything that will stand out for her by adding emphasis on the words, "stands out" (line 11). He refines his turn with a self-repair (Kitzinger, 2014) to communicate that the post-discussion will continue to be a collaborative effort between April, Melissa, and himself (lines 11-14). He designs the turn to show his preference, ".hh Sound okay?" (line 16),

which elicits April's consent token (Bangerter & Clark, 2003), "((hand gesture)) °Sure.°" (line 17). With her consent, he initiates a move into the reflecting team process with a vertical project marker (Bangerter & Clark, 2003; Bangerter et al., 2003), "Okay ((nods head))" (line 18).

Initiating a Discussion on the Reflecting Team

This brief sequence happens right after the completion of the reflecting team. Dr. Miller initiates a discussion with April about the reflecting team.

11 → T1: .hh<u>Well</u> <u>a::hm</u> (0.3) usually what I ask you ((hand gestures in sync with
12 the speech)) is like <u>of all the stuff</u> ((hand gesture)) that you heard what
13 <u>stood out</u> for you?=
14 =You don't think about it too much but like <stuff they said what .h (0.4)
15 just what intuitively (0.3) stood out for you?> =
16 C: =I mean (0.5) ((shifts seating position)) I <u>care about myself</u> you know.

Using "<u>Well</u>" (line 11) as a vertical marker (Bangerter & Clark, 2003; Bangerter et al., 2003), he describes a routine procedure after reflecting team, using a preliminary to a preliminary (Schegloff, 1980), to initiate a smooth transition to the upcoming project. In this turn, he makes a clear distinction between "<u>of all the stuff</u> ((hand gesture))" (line 12) she has heard and what "<u>stood out</u>" (line 13) for her with added stress on these words. Without no gap in between, or TRP (Sacks et al., 1974), he adds an instruction on the way he wants her to itemize what stood out for her and emphasize intuitive selections of items by slowing down a section of the sentence "<stuff they said what .h (0.4) just what intuitively (0.3) stood out for you?>" (lines 14-15). This inquiry elicits April's response and the new phase that encompasses the inquiry begins.

Giving the Client Advice

This sequence happens right after the therapists and client discussed about the therapy team's accounts from the reflecting team. In this sequence, Dr. Miller and Melissa share with April their own reflections on the reflecting team.

1 → T1: [[Okay.=.hhhh
2 p(hh)- Well we're getting close on time and I wanna <u>leave</u> you with some
3 ideas ((the screen turns back on))
4 you know <u>everything</u> like the team all we know is this ((hand
5 gesture)) °you know° forty minutes of what we heard. {C: yeah.}
6 So we're .hhh working hard to think as many things so you leave here with
7 some ideas some in your <u>pockets</u>. =
8 =An some of the things that you hear about that I found .hhhhh people
9 come back they don't (0.2) <u>stick</u> immediately but then they think about
10 them later and they so that (0.2) that ((hand gesture)) happens to you,
11 that's fine.=
12 =So (....) <u>take</u> ((flipping palms before his face)) <u>it all in</u> so little bit of
13 information (0.2) overload sometimes buta:h .hhh a::h (0.4) yeah I wanna
14 give you some sense of recommendations about what to do.

In the first turn, Dr. Miller seems to accomplish three things: vertical transition (Bangerter & Mayor, 2013; Clark & Brennan, 1991), the time management of the consultation, and the projection of the current project's objective. He accomplishes the vertical transition with a project marker (Clark & Brennan, 1991; Bangerter & Mayor, 2013), "[[Okay." (line 1). He continues to hold the conversational floor with audible in-

breath and out-breath "=.hhhh p(hh)-" (lines 1-2) with no gap after the project marker. Then, he manages the time of the consultation, while initiating a transition into the next project, using a preliminary to a preliminary (Schegloff, 1980), "I wanna leave you with some ideas" (lines 1-2), and projecting the objective of the project by stressing the word, "leave" (line 2).

Then, he downgrades (Heritage, 2014) the therapists' and the therapy team's knowledge about her situation by emphasizing the word, "everything"(line 4), followed by the utterance that they are doing their best to come up with advice for her (lines 6-7). Together, these two turns seems to moderately set expectations for the upcoming advice. Then, he lays out possible scenarios for April's reception of upcoming advice by using the word "may" and referring to other clients' experiences (lines 8-11). The message here seems to be that she may not find their advice fitting right away, but may find it fitting later on. This turn legitimizes his next turn in which he can now suggest her to take them all in (line 12). He delivers the turn with added stress on "take ((flipping palms before his face)) it all in" (line 12). He concludes with a reiteration of this project's objective to give recommendations (lines 13-14) in the form of a preliminary to a preliminary (Schegloff, 1980).

Checking with the Client for Topics Left Out from the Consultation

This project happens after the therapists gave April advice based on the reflecting team process. Dr. Miller asks her if there are any topics of interest they did not explore.

1 → T1: TODAY WE'RE GETTIN' CLOSE ON TIME ((looks up to see T2))
2 {T2: ((looks at T1))} and .hhh is there anything else we didn't tell you
3 about that (..) seems like we:ah you wanted to know about?

4 (0.8)

5 C: No.

6 (1.2)

7 T1: .hhh °Okay.° =

8 C: =Do you feel like just making break ((hand gesture)) (0.4) just like leaving

9 ↑((hand gesture)) them (0.9) {T2: ((nodding head))} you know. {T1:

10 Um hum.}

He first manages time in the consultation in the form of a preliminary to a preliminary (Schegloff, 1980), "TODAY WE'RE GETTIN' CLOSE ON TIME" (line 1), while asking if they left out any topics she may have wanted to pursue with added emphasis on the words, "know about?" (lines 2-3). He and Melissa then allow April to contemplate her response briefly (line 4). She then replies with "No." (line 5). In response, he produces a turn, ".hhh °Okay.°" (line 7) which serves as an acknowledgement token (Bangerter & Clark, 2003) to acknowledge her response, and a project marker (Bangerter & Clark, 2003; Bangerter et al., 2003) for a vertical transition into the next project. However, April adds another turn with no gap, pointing out her area of interest that has not been explored enough (lines 8-9). Melissa acknowledges her account with a head nod (line 9), whereas Dr. Miller produces an acknowledgment token (Bangerter & Clark, 2003), "Um hum." (lines 9-10). Then, this sequence evolves into an inquiry about the topic of interest.

Closing of the Consultation

This final project happens after completion of the previous inquiry into April's topic of interest that had not been explored enough. In this final project, Dr. Miller clearly verbalizes that the consultation has come to an end.

1 → T1: .hhhh ((looks down)) Wellahm hhh ((looks up to see C)) a::h we gonna-
2 we're running out of time here buta:h .h that's as much as we can do
3 today.=

He uses looking down and "Wellahm" (line 1) as signals to communicate a vertical transition (Bangerter & Clark, 2003; Bangerter & Mayor, 2013; Bangerter et al., 2004) into the final project of closing the consultation. He then reminds her of the time limit for the consultation, in the form of a preliminary to a preliminary (Schegloff, 1980), and attempts to close off their interaction (lines 1-3). This sequence leads to Melissa's and his reiteration of the open-door policy of the clinic, followed by the co-therapists' exit from the therapy room.

In summary, Dr. Miller and Melissa structured the consultation with frequent uses of adjacency pairs (Sacks et al., 1974; Schegloff & Sacks, 1973), reinterpretation (Bercelli et al., 2010), turn design (Drew, 2014), project markers (Bangerter & Clark, 2003; Bangerter & Mayor, 2013; Bangerter et al., 2004), and conversational tokens (Bangerter & Clark, 2003). At the same time, they seemed to maintain their collaborative stance with their uses of pre-sequences (Schegloff & Sacks, 1973) and preliminaries to preliminaries (Schegloff, 1980) through which they negotiated with April on the consultation arrangements and upcoming courses of conversation. When April rejected their initiations of the particular type of conversation, the therapists accepted the

initiation and followed the thread of conversation. In case of focalizing a problem, the co-therapists initiated the attempt several times before April finally provided them with the type of response they were looking for. Overall, the back-and-forth exchange of their turns contributed to common ground (Bangerter & Mayor, 2013; Clark & Brennan, 1991) between them.

In this section of the analysis, I have focused on interactional sequences that helped structure the subsequent sequences within the progression of the consultation. I hope that this section has illustrated how therapists and clients contributed in tandem to the flow of the interactional sequences. While the co-therapist, particularly Dr. Miller, structured the process of the consultation, the client provided the content of each phase.

In the following section, I illustrate interactional practices the co-therapists utilized *in coordination with* the client by their patterns, instead of within the progression of the consultation. I hope to illustrate the readers of this study, particularly who are clinicians or clinically-oriented researchers, the manner the co-therapists oriented to moment-to-moment interactions with the client within and across various interactional practices in order to coordinate their turn-takings and develop and maintain therapeutic relationship, while inviting changes in the way the client talked about her problems and their solutions.

***Wefts*: Three Types of Interactional Practices**

Within the contexts set forth by the interactional sequences negotiated between the co-therapists and client, they weaved interactional patterns of SST at the micro level of interaction and the macro level of overall flow of interaction. I found the metaphor of *weaving*, along with the distinctions I made on the different types of interactional

sequences provided me with *eyes* and *ears* to keep the therapy interaction organized throughout the process of analysis. In this section, I will attempt to untangle those interwoven threads for the purpose of this research. To repeat, the distinctions between these threads are artificial and made sense for me in the context of my research.

I point out to the reader of this study that I will not conduct a formal analysis of the reflecting team (Anderson, 1987) itself, although the reflecting team process was an integral part of the SST service at BTI. This is because the unique interactional properties of the reflecting team in which primary therapists and therapy team members discussed their speculative impressions on and understanding of the clients' relational dynamics and process from different points of view before the clients' presence in the room. Although those impressions, understandings, and advice are directed to the clients, the primary therapists arranged with clients prior to the start of the reflecting team that the client can hear the therapists, but the therapists cannot hear the clients. As a result, the group of therapists in the therapy room did not have direct interaction with clients. Therefore, I will describe the interactional sequences of the reflecting team to the extent that they became a focus of discussion between the client and primary therapists after the reflecting team process. For a detailed explication of the reflecting team, I refer the readers to Peräkylä (1995).

Weft 1: Interactional Practices through Which Therapists Developed and Maintained the Therapeutic Relationship with the Client

As in any psychotherapy, the therapeutic relationship is a necessary condition for change in SST (Hoyt, 2014; Hoyt & Talmon, 2014b; Slive et al., 2008). A body of research supports therapy that prioritizes a clients' contribution and the collaborative

therapeutic relationship which utilizes clients' strengths and contextual resources for improving the likelihood of immediate therapeutic change (Amundson, 1996; Bloom, 2001; Bobel & Slive, 2014). Particularly in SST, therapists need to form a therapeutic relationship with clients effectively and efficiently due to the duration of a single encounter. In this section, I am going to focus on the interactional sequences through which the therapists formed and maintained a therapeutic relationship with the client.

Audience Design and Lexical Entrainment

As I described in a previous section, participants in joint projects systematically design their messages to reflect what their addresses know—that is, audience design (Clark & Carlson, 1982), or recipient design (Pomerantz & Heritage, 2014). In addition, they come to use the same expressions to refer to the same objects or ideas—that is, lexical entrainment (Bangerter & Mayor, 2013). This is a testimony to the idea that conversation participants have come to share common ground (Bangerter & Mayor, 2013). In the general counseling field, therapists match clients' way of talking to form rapport with them and engage them in the on-going interaction (Cormier & Hackney, 2011). As such, audience design and lexical entrainment are means for therapists to match clients' idiosyncratic way of talking and world view.

A number of lexical entrainments evolved over the course of the consultation. One of them is an expression, "don't put up with bullshit." It was first introduced by April and later used and referred by both her and the therapists as her sources of strength in the family problem context. In fact, the therapists noted the expression as one of the client's resources in the case note they completed after this consultation. Recipient design expresses itself in those interactional sequences.

T1: = I'm- there's this- strength that gather that (0.7) <you ha::ve somehow that, I'm just guessing filling in the pieces here somehow you were ((nods head)) able to leave the situation=where I get a sense your- both of your sisters and your mother, and in a way ((tilts head from one side to the other)) your dad can't.=

C: =hhhYeah they feel trapped.

T1: How is it [you ((tilts head)) were able to do that?

C: [(.H) (.H) (.H)

T1: That's {T2: °um hum°} this- just seems like something amazing there: .h T[ell me about that.]

C: [**Don't put up with bul]shit.**

T1: **Don't put up with a bulshit** ((nodding head))?

C: °at's it.° hhh

T1: That was it?
((firm voice)) When did- tell me {C: ((sobbing))} about that=and you- how did you ((shifts upper body)) learn how to do that?.hh

C: I don' know.
I just see my sisters like seeing people are doing wrong. ((wipes nose)) (Li..) [make] me a good person ((reaches out to tissue from the tissue box on top of the table)). (.Hh) (.Hh)
Just seeing people doing stupid things. .h (HHH) ((wipes nose))

In the initial sequence above, Dr. Miller verbally communicates to her that his utterance is his interpretation based on her previous accounts of her family problems—that is,

reinterpretation (Bercelli et al., 2010). He continues his turn by framing the fact that compared to her family members, April's leaving the family home was a sign of her strength (lines 2-6). This elicits April's immediate response confirming part of his reinterpretation (line 7). Then, he asks how she was able to leave the home, and follows up with a turn complimenting her action (line 10). Sequentially, he placed his reinterpretation first based on her previous accounts, along with his acknowledgement that it is his interpretation. Only after her affirming confirmation of his interpretation did he inquire about her strength. The sequential placement of the series of those turns reflects his understanding of her previous account—that is, recipient design—, while framing his action as her strength. In response, she phases it as '[**Don't put up with bul|shit.'** (line 12). He repeats the expression (line 13) and re-uses it to inquire about a different aspect of her strength (lines 16-22).

His inquiry about another aspect of her strength continues in the sequence below (lines 28-38).

28 T1: So: when- [when did that start?=

29 C: [(.HH) (.HH) ((sobbs, wipes nose))

30 T1: =When did you [(1.0)] realize like, I'm **notgonna put up with this**

31 **bullshit**

32 C: [°ha:::°]

33 T1: and I am getting outta here. (.)

34 You said seventeen.

35 Holy cow. {T2: ↑Um ↓hum ((nods head))}

36 Is that when it happened?

37 C: I mean it's what happened in my <u>whole</u> lif(h)e but-: I <u>can'</u> <u>do anything</u>
38 you know. {T1: ↑Um ↓hum} (.H) (.H) HHHA::))

Sometime later, he brings up the expression to inquire more about her strength, despite the relational dynamic in her family.

27 I getta sense your family ((making and holding a round shape with both
28 fingers in front of himself)), .hh >I get a sense-<<u>except for you,</u> somehow,
29 but the three of them four of them, {C: °yeah°} I call four of them .h that
30 they are ((rotating and counter-rotating the shape)) very much in this [(..)
31 prison.
32 C: [They
33 are in all <u>cahoots</u> ((hand gesture)) with each other ye[ah.=
34 T1: [They're all ((rotates
35 the shape)) <u>cahoots</u> ↑right. {T2: um hmm ((nodding head))} (0.7) <u>except</u>
36 <u>for you</u> (0.3) h somehow. and I am still like trying to figure that:out.=
37 = How, how you were able to ah: (0.2) [there's something to that] I think
38 worth looking in.
39 C: [(I .....)]
40 T1: .hh **Not taking {T2: ((turns toward T1))} any bullshit**. {T2: ↑Um
41 ↓hum.}
42 That's one thing. pt.

In the sequence above, Dr. Miller uses the same sequence placement of turns in which he first offers reinterpretation (Bercelli et al., 2010) of her family dynamics, while comparing April with the rest of the family (lines 27-36). This successfully elicits her

affirming agreement, along with a particular word and accompanying gesture, "cahoots ((hand gesture))" (line 33). He quickly offers self-repair (Schegloff et al., 1977) in his turns by adapting the expression, while re-empathizing the comparison between April and the rest of the family (lines 34-36). Without any gap, he introduces another turn in which he refines his turn to make it a compliment (lines 37-38). In doing so, he continues to hold the speakership despite her initiation of a turn (line 39). Then, he uses the expression, "not taking any bullshit" as a candidate answer (Pomerantz, 1988) (lines 40-42) to shape the direction of the conversation.

Later in the consultation, at a time of giving advice to April, he brings up the expression again to underscore her strength.

86 T1: .hhh So HOWEVER you figured out this thing to make straight As at
87 school despite all this is happening is (.) amazing. {T2: °yeah°((nodding
88 head))} That's- THAT'S THE WORD THEY USE and I think that's
89 amazing too.=
90 I think that's ((nodding head))
91 (.)
92 .hhh A::h whatever's going on there is worth study for you. =
93 =It's like <that's good.>
94 DON'T LET GO OF THAT 'cause that can be the sanity (0.2) keeper (.)
95 for you (..) into futures like that one thing ((hand gesture)) that you figured
96 out how to do you knew how to do it somehow you and your family when
97 you were seventeen you knew .hhh it sounds like **not to put up with bull**
98 **shit** that way you know so g[ood for you.

99 C: [(It's) true. It's like the only word to use. {T1:

100 Yeah. / T2: °yeah°}

101 T1: No I::((turns face to a side)) agree completely. {T2: °yeah°}

102 (.)

In the above sequence, the sequential placement of Dr. Miller's turns are different from the earlier sequences since he and April have established common ground about her strength within the context of her family. At this time, he first shares his understanding of her strength and then mentions the problematic context. Together, they form a compliment (lines 86-93). He then follows up advice to hold onto her strength, while making a reference to the expression (lines 94-98). This set of turns elicits April's affirming agreement (line 99). In response, both therapists provide acknowledgement tokens (Bangerter & Clark, 2003) (lines 99-100), followed up with their affirming agreement (line 101). From the view point of grounding (Bangerter & Mayor, 2013; Clark & Brennan, 1991), this sequence is a sign to both therapists and the client that they share common ground about her family dynamics and her strength within the dynamic.

Matching the Client Non-Verbally

As I described earlier, a therapist matches clients' way of talking to form rapport with them and engage them in the on-going interaction (Cormier & Hackney, 2011). In Clark's interactional theory of communication, the non-verbal matching seems to address the audio dimension of face-to-face interaction through which participants can form the common ground (Clark & Brennan, 1991). In the current study, I observed the practice occurring through various mediums over and over in the SST consultation. These mediums include gestures, voice level and tone, the length of turns, and within-turn gaps.

Matching the client's voice level. Within the sequence below, Dr. Miller seems to match April's voice level.

101 C: The problem is her not doing anything about it.=

102 → =Like I KNOW ALL THESE THINGS. (wipes nose))=

103 =There's jus- nothing I can do about it.

104 It's just stressful((sobs)).

105 → T1: .hhhhh H(H)H(H)=

106 = I'm- there's this- strength that gather that (0.7) <you ha::ve somehow

107 that, I'm just guessing filling in the pieces here somehow you were ((nods

108 head)) able to leave the situation=where I get a sense your- both of your

109 sisters and your mother, and in a way ((tilts head from one side to the

110 other)) your dad can't.=

Through the series of turns (lines 101-104), April expresses that she is upset with the family situation. This seems to be particularly reflected on her louder volume delivery, wiping her nose (line 102), sobbing (line 104) and added stress on a turn. In return, Dr. Miller produces a stretched inhalation and combustible exhalation (line 1).

In the following exemplar, Melissa delivers an acknowledgement token in lower volume than the surrounding in response to April's preceding turn in lower volume.

16 C: Ah::m I have a girl friend {T2: ((nodding head))} that lives in ↑Brazil.

17 She's coming.

18 (1.3)

19 T1: She's gonna come visit?

20 → C: °yea.°

21 T2: Did you meet her in your trip?

22 Oh or before.

23 → C: °yeah.°

24 → T2: °okay.° ((nodding head))

25 C: .hhh She's great.

After April's first mention of her girlfriend (line 16), there is a significant length of pause (line 18). Dr. Miller picks up the speakership and repeats what she has just said (line 19). The long pause seems to indicate her reluctance to talk about her girlfriend, while Dr. Miller seemed to have waited for her to continue. She responds to his question with an agreement token in lower volume (line 20) without any elaboration. Then, Melissa follows up and inquires about where April met her (line 21). Again, April supplies a simple agreement token in lower volume (lines 20 &23). In return, Melissa supplies an acknowledgment token in lower volume (line 24).

Matching gaps within the client's turns. In the following sampler, Dr. Miller matches April's gaps within turns.

8 C: =Do you <u>feel like</u> just making break ((hand gesture)) **(0.4)** just like leaving

9 ↑((hand gesture)) them **(0.9)** {T2: ((nodding head))} you know. {T1:

10 Um hum.}

11 I <u>feel like</u> really <u>that's</u> the only thing **(0.5)** but then like I said >it's like<

12 they're still doing the same thing **(1.2)** like putting distance.{T2: Um

13 hum.}

14 → T1: pt .hh You're ((client's age)) **(0.9)** ↑Yes. **(0.8)** and you moved out when

15 → you were seventeen. **(0.7)** (>Is- that-<) Did I get the facts right?

16 C: ((nods head))

17 T1: And- so you started making that break already.

In the series of turns (lines 8-13), April shows gaps within those turns. In return, Dr. Miller produces his first turn with similar gaps within the turn.

Responding to the client's crying empathically. In contrast to a dominant conception of emotions as individual experience psychology, conversation analysts view emotional expressions as "social signal[s]" (Ruusuvuori, 2014, p. 332). In this view, indications of crying are thought to be signs of a person being upset, which alerts the conversation partners to respond empathetically (Hepburn & Bolden, 2014). In the SST consultation, the therapists seemed to have shown their empathy with the client through their empathic voice tone and lower volume, and the gaps in their turns.

In the exemplar below, therapists respond to April's various indications of crying when talking about her family problems.

18 C: So my dad {T1: moves a hand to chin)) is .h very (0.2) mentally abusive.

19 I don't wanna cry 'cuz ((moves a hand)) °**kind of emotional.**° =

20 T1: =Yeah.

21 C: Like ((hand gesture)) (what makes..) **((mouthing))** emotional.

22 Sorry ((**sobbing**, slaps her thigh with a hand)).

.

.

31 But it's just like out of control.{T1: ((nodding head))}

32 Like ((shifts position on the couch)) I don't know like I jus- have told my

33 sister that she can like live with ↑me but **(1.5)** I'm not really I don't really

34 want her to <u>but</u> (.3) ((**wipes eyes with shoulder**)) ((**mouthing**)) probably

35 (...her not) live ↑there

36 → T1: **°Yeah↑°**={T2: **°um hum:°** ((nods head))}

In the above sequence, April presents a number of indications of crying, including lower voice volume (line 19), mouthing (lines 21, 34), sobbing (line 22), and wiping eyes (line 34). Dr. Miller and Melissa respond with delivering acknowledgment tokens in lower voice volume (line 36).

Below is another exemplar at another point of their interaction.

17 C: Jus**(hhh)**t **.hh hh** He's like <u>so</u>:: mentally abusive like my old sister like

18 instigates like yelling at my younger sister.

19 .h My dad like calls her like <u>hoar</u>. {T2: ((nodding head))}

20 .h Like **(0.9)** I'm like me <u>standing up for ↑that</u> and they just <u>don</u>'t (0.2)

21 >°hum°< They just <u>don't do anything</u>.

22 She's like- oh I haveta stay here. **((sobs))**

23 (0.6)

24 T2: **((empathic voice))** How was it like {T1: ((turning toward T2))} for you to

25 see **(0.2)** a::hm them not standing up to themselves and just staying?

26 C: It hurts me a <u>lo</u>t.

27 T2: **((empathic voice))** °Yeah.°

28 **(1.5)**

29 T1: **((empathic voice))** They know you are worried about?

30 C: ↑<u>Ye</u>ah but they won't- They're like oh I can't leave.

31 I can't <u>do</u> anything about it. > **(.H) (.H)**

32 Like my older sister (as) like she's like ((wipes face)) really into

33 drug(h)s and like she doesn't have like (1.0) <u>friends</u> you know. **(.HH)**

34 {T1: **°mm°** ((nodding head))}

35 Like **(0.5)** she's like always asking ((wipes face)) for like money. =

36 =It's just like the <u>family</u> **(.h) (.h)** like dynamic of things.

37 I feel like everyone has to like rely on me ((wipes face)). {T2:

38 **((empathic voice)) °mm.°**}

39 It's ↑stressful. {T1: **((empathic voice))** <u>Yea</u>h.}

40 **(0.4)**

In this sequence, April presents another set of indications of her being upset, including combustible aspirations (lines 17, 31, 33, 36), silence where she was expected to continue her turns (lines 20, 35) or pick up a turn (line 28), and sobbing (line 22). In return, the therapists respond with delivering turns in empathic voice tone (lines 24, 29) and providing acknowledgement tokens (Bangerter & Clark, 2003) in lower volume (lines 27, 34, 38, 39).

Although I may not mention those subtle ways the therapists showed their understanding of April's account in the rest of analysis, they seem to work in tandem with the rest of the interactional practices that are more obvious.

Formulations as Empathic Communication

A model of empathic communication in medical settings by Suchman, Markais, Beckman, and Frankel (1997) characterizes empathic communication as the accurate understanding of the other's experience and the presentation of the understanding back to

the person in such a way that the person feels understood. In family therapy field, Flemons (2002) postulated a similar conceptualization of empathic communication: A therapist needs to communicate "not only the content of their [clients] experience, but also something of its emotional intensity and quality" (p. 62). Such empathic communicate can encourage the clients' trust with the therapist, or rapport for therapeutic change. In the SST field, Norcross (2010) emphasizes developing therapeutic alliances with clients through therapists' active demonstration of their understanding of clients' situations. In a discursive study, Hepburn and Potter (2007a) analyzed empathic communication in the context of crying and stated that a respondent can offer a formulation of a crying person's experience tentatively as an empathic response.

In similar fashion, I observed that the co-therapists used formulations as empathic communication. In formulation, speakers present mere summaries of the previous speakers' account of events, while transforming one part to a degree and deleting another part (Antaki, 2008; Heritage & Watson, 1979). Speakers insert formulations relatively after the first speakers, which come across as if they are extensions of the previous speakers' account. As a result, the speakers project the first speakers' agreement. Because of the characteristics, formulation helps therapists to manage the progress of the session by gently shaping and re-shaping ebb and flow of the session in a therapeutically meaningful manner (Antaki, Barnes, & Leudar, 2005). Formulation also helps therapists for gathering therapeutically relevant information from clients by deleting some parts of what the clients have said.

Below is a short exemplar in which Dr. Miller uses a formulation to respond empathically to April.

43 C: (.H)h (.H)h Like my dad's sick .H and my mom doesn't ((bends backward
44 to the back of couch)) like make him go to doctor years HHHH ((sits
45 upright)).
46 (1.3)
47 → T1: ((empathic voice)) You think she should (.) make him go↑
48 C: You can't make him do anything {T1: °yeah.° / T2: °um hm° ((nodding
49 head))}

In response to April's account of her mother not making her father visit a doctor for his sickness (lines 43-45), Dr. Miller provides a formulation in a form of question (line 47), asking for April's confirmation or disconfirmation. She provides an account, disconfirming Dr. Miller's speculation and claiming that nobody can force him to do anything (lines 48-49).

Below is another exemplar in which Dr. Miller uses a formulation to respond to April.

51 C: ((wipes face)) My ↑mom I feel like she's never gonna like- leave him.
52 He like doesn't do anything positive.
53 Like all he does is complain an like yells.
54 He doesn't even do anything all ↑day
55 I'm like my mom's like working hard. {T2: °mm° ((nodding head))}
56 She won't leave him now 'cause he's sick.
57 She would never.
58 And my younger sister's like learning from that you know.
59 She's lik- has a boyfriend but she's like broke ((wipes face)) up with 'cuz

60 he's like ↑insane, just like my da::d.

61 T1: ((nodding head))

62 C: (.H) (.HH) ((mouthing)) °just-° ((shrug shoulders))

63 → T1: That's your wo- It's a worry for <u>her:</u>.

64 C: ↑<u>Yea:h</u> [(lik.)

65 → T1: ((empathic voice)) [(....) she would pick someone like your dad.

66 C: Yeah she already <u>has</u>, but <u>they broke up</u> because he was insane and she's

67 like kept going back to him. (.H) (.H)

April elaborates on the point through a series of statements on her family dynamics (lines 51-62). The therapists continue to provide acknowledgment markers (lines 55-61) during this time, until Dr. Miller's formulation, pointing out her worry for her sister (line 63). This elicits her agreement token (Bangerter & Clark, 2003). With her agreement, he continues another formulation that her sister would pick someone resembling her father (line 65). She agrees with the formulation and elaborates on the account (lines 66-67). Through this series of formulations, Dr. Miller seems to have shown his grasp of her account, while bringing forth her primary issue in the situation.

In an elaborative sequence below, April expresses her worry for her older sister. Some turns later, Dr. Miller responds with a formulation, refining his understanding of her account.

34 C: My older sister ((hand gesture)) is one who like- she really can't ((hand

35 gesture)) keep a ↑job.

36 She always finds ↑excuses ((makes parentheses with fingers)). {T1: °

37 yeah°}

38 Like just tell her to keep ((wipes nose)) a ↑job you know.
39 Stop stealing.
40 She like feels like she always doesn't have <u>anything</u>.
41 She takes ((makes parentheses with fingers)) Pay Day Loans.
42 Always telling lies.
43 I'm not really sure what she's up to, (0.5) but when she's like crying ((hand
44 gesture)) and .hh (0.5) like always asking for ↑money. {T1: °yeah°}
45 Like making ↑excuses {T2: °um hum°((nodding head))}like good
46 reasons ((hand gesture)) for ↑it {T1: °yeah°} like (0.7) I <u>can't</u> say no
47 ((hand gesture)).
48 (.)
49 T2: [[°sure.°
50 T1: [[°yea.°

While April gives an elaborate account of her worry for her older sister (lines 34-36, 38-47), the therapists respond with acknowledgement tokens (Bangerter & Clark, 2003) (lines 36-37, 44, 45. 46). After a brief pause (line 48), Melissa provides an agreement token (line 49), while Dr. Miller provides another acknowledgement token (line 50).

51 C: You know ['cuz]
52 T1: [Are you loaning] her the money? ((moves a palm on cheek))
53 (0.6)
54 C: Yeah she says like (0.7) ((wipes nose)) like oh you know money's just
55 temporary. ((reaches out to get tissue on the table and wipes nose)) (0.5)
56 you know.=

57 T1: That's what she says to you?=

58 C: =NO I KNOW IT ((shrug shoulder)) you know.

59 She's like ohh need this like (0.2) Ten years from now you know like (0.7)

60 (loaning) her money ((hand gesture)) (.) is gonna be nothing.

61 You know just money ((hand gesture)).

62 T1: So you-[

63 C: [But like- she's making a big deal (0.2) because she feels like

64 ((making parentheses with fingers)) stressed about it.

65 Like she always ((hand gesture)) owe people money.

66 (0.3) She probably owns like pay day loans ((wipes nose)) like.

67 (0.7) She'll go to jail ((hand gesture)) [(... not) paying (those) back.

68 {T2: °um hum°((nodding head))}

69 T1: [(..-)

70 C: [[Like she owes people money.

71 T1: [[(...)

72 → ((looking at C)) Are you worried she's ruining her future?

73 (0.4)

74 C: Definitely.=

75 T1: = (That's what is). That's what it is. {T2: °yeah°} ((nodding his head))

76 (0.6)

77 C: Definitely.=

Following the previous sequence, Dr. Miller asks if April loans her sister money (line 51). After a brief pause (line 53), she continues on her accounts of her sister (lines 54-56,

58-61). Although Dr. Miller tries to insert his response (line 62), April overlaps and continues on with her account of her sister, pointing out the consequences of her sister's issue with money (lines 63-67). After two more attempts to take a turn (lines 69, 71), Dr. Miller looks up to see April and asks if she is worried that her sister is ruining her own future (line 72). After a brief moment of silence (line 73), she supplies an affirming response, "Definitely." (line 74). In return, he confirms his receipt of her confirmation with an emphasis, "That's what it is." (line 75). This, along with a short gap (line 76) elicits April's repeat of the same affirming confirmation of his previous formulation (line 77).

Re-adjusting Own Position in Response to the Client's Disconfirmation of the Therapist's Position

Particularly in SST, a collaborative therapeutic relationship is emphasized in which therapists center clients' experiences and ideas on problems and solutions through careful listening, solicitation of their feedback and tailoring services to their sensibilities (Bohart & Tallman, 2010; Norcross, 2010). Similarly, Hoyt and Talmon (2014b) underscore the importance of meeting clients' world view, while offering new perspectives. In the SST consultation, those ideas seem to be reflected on the therapists' continuous effort in adjusting their understanding of the client's views when the client challenged the therapists' views embedded in their questions.

Acknowledging the client's nonconforming responses. Questions are divided into two types: polar questions and *wh*-questions (Hayano, 2010; Lee, 2010). Polar questions confine the recipients of the questions on the type of responses: "yes" or "no" (Boyd & Heritage, 2006; Clayman & Heritage, 2002; Heritage, 2010). Because of the

sentence structure of such questions (e.g., "Have you mailed the package yet?") polar questions project the questioners' preferences (Pomerantz & Heritage, 2014) on one alternative over the other: "Yes I have" is preferred over "No I haven't." These two types of answers conform the type of responses projected by such polar questions, and are called *type-conforming* responses (Raymond, 2003). On the other hand, recipients can contest to the terms and constraints projected by polar questions by providing *nonconforming* responses (Raymond, 2003). As a result, nonconforming responses can jeopardize the progression and expansion of the sequence in progress, whereas type-conforming responses tend to encourage progression and expansion of the sequence in progress (Raymond, 2003). Therefore, the way participants manage polar questions and their responses locally can have significant impact on the progression of joint activities.

In the SST consultation, I observed that therapists acknowledged the client's occasional nonconforming responses with acknowledgement. Here is an exemplar.

158 T1: Have they <u>ever</u> tried going to a counseling? =

159 = I mean I get a sense that something happened when you were eleven. =

160 C: =.HHH [(..)

161 T1: [and they came in.=

162 T1: =Do you think they go for it?:or:

163 C: My mom does, like by herself.

164 T1: She does she still does?

165 C: Yeah.

166 T1: °oh°>you think it helps?

167 (0.8)

168 C: Problem (.) is like <u>doing things about it</u>. (.HH .HH) {T1: **°yeah°**

169 **((nodding head))**}You know.

170 .snih Like you can do whatever you want ((hand gesture)).

171 Like going to therapy((hand gesture)) but if you don't like <u>FOLLOW</u>

172 WHAT PEOPLE SAY ((hand gesture)), (.H) (H) (.H) (H) NOTHING

173 HAPPENS(h) ((hand gesture)). hh {**T2: °yeah°**}

174 (0.6)

In this sequence, Dr. Miller poses a polar question, asking if her family have tried counseling for their family issues (line 158). With no gap in between, he adds another turn, recalling the family's history of utilizing counseling in the past (line 159). Overlapping April's initiation of a turn, he adds another question without any gap if they would try counseling at this time (line 162). The addition of "or:" (line 162) at the end of the question seems to be a sign of his readjusting of his preference on her "yes" answer, and opening up the room for a "no" answer. Taken all together, the series of his turn seem to imply his suggestion for the family's use of counseling. In response, she states, "My mom does, like by herself." (line 163). This response is nonconforming response, since it challenges his presumption that her family have not been in counseling since the last episode. Dr. Miller repeats her partial turn in a form of question, asking for April's confirmation of the information (line 164).

Upon her confirmation (line 165), he expresses his surprise with "°oh°" and asks if her going to counseling helps in the form of a polar question (line 166). After a moment of delay (line 167), she provides a nonconforming response, "Problem (.) is like <u>doing things about it</u>. (.HH .HH)" (line 168). Through this turn, she seems to contest

against his assumption embedded in the question that use of counseling helps to deal with the family problems, while implying that her mother has not applied what she may have taken from counseling into their family problems. Dr. Miller acknowledges her contestant through an acknowledgment marker and nodding head. She continues on her accounts about therapy in which she emphasizes the difference between her idea and Dr. Miller's idea through delivery of her turn in higher volume and an added stress on a word, along with hand gestures: "FOLLOW WHAT PEOPLE SAY ((hand gesture)), (.H) (H) (.H) (H) NOTHING HAPPENS(h) ((hand gesture))." (lines 171-173). In response, Melissa gives an acknowledgment token (line 173). The silence after this sequence (line 174) seems to indicate a consequential stall in the progression of their interaction. By acknowledging her contestant against Dr. Miller's advice and his assumption, the therapists may have avoided a potential breakdown of the sequence in progress.

Legitimizing the client's clausal responses. In contrast to polar questions, *Wh*-questions solicits a type of responses specified by the questioners (e.g., persons for "who," objects for "what," places for "where," manners for "how," times for "when," etc.). In response to *wh*-questions, a conversation partner can respond with *phrasal* or *clausal* responses (Fox & Thompson, 2010). In phrasal responses, conversation partners respond in phrases (e.g., nouns or noun phases). For instance, a partner can respond, "Right now" in response to a question, "When are you going to clean up the room?" By providing the answer, the partner accepts the relevance of the question (Lee, 2010) and the presupposition embedded in the question (Hayano, 2010): The partner is going to clean the room at some point.

In contrast, clausal responses usually come after delays and prefaces (e.g., "well") and take a shape of clausal units (Lee, 2010). Unlike phrasal responses, clausal responses question the relevancy of the questions being asked, or suggest that answers are somehow not straightforward. For instance, a person asks, "What do you think is the best way for the trauma survivors to move forward?" The recipient may respond, "Well, the matter is not to move forward or not. It's about their healing right now." Similar to nonconforming responses, clausal responses hinder the progression or expansion of the on-going sequences.

Below is a sequence where Melissa asks a *how*-question to elicit the focus of the consultation.

1	T2:	((empathic voice)) .hh Sounds like you have (.) really have so much staff
2		going'on ↑right.=
3		= I'm hearing that .h a:hm, you're worried about your ↑dad ((hand
4		gesture)), you're worried about his ↑safety ((hand gesture)) and his ↑health
5		((hand gesture)).
6		(.) It sound like you're worried about your ↑sister ((hand gesture)).
7		She might be- you know she sounds very ↑volatile, perhaps she's doing
8		drugs ((hand gestue)) an: you know you're ((hand gesture)) worried about
9		her ↑too and then you have a issue concentrating at ↑school, rightfully
10		((hand gesture, nodding head)) ↑so.
11		So sounds like you have a:l (0.2) LOT OF stuff
12		< >I'm ((hand gesture)) sure there are stuff we didn't even hear about.<
13		.hh But I'm curious to know (0.2) if this time together ((turning toward T1

14 briefly, hand gesture)) a:h:m was most useful (.) for you, .hh a:h:m what
15 would we have to (.) focus on and what- what would have to (.) happen
16 (0.2) for this to be most useful for you?
17 C: mmm: >I donno< just talkin.
18 Like- one session thing is jus- mostly just talking.
19 → T2: Um hum. ((nodding head))
20 C: (.H) (.H) Just getting it out there. {T2: **°okay° ((nodding head))**}

In this sequence, Melissa provides a reinterpretation (Bercelli et al., 2010) (lines 1-2) of items of April's concern (lines 3-10), and acknowledgement of other potential topics that have not been brought up in the consultation (line 12). I refer the readers of this study to my previous detailed analysis of this sequence in an earlier section of this study. At the end of the series of the accounts, she poses a hypothetical question, asking the topic necessary to be discussed and the process necessary to happen to make the consultation most useful (lines 13-16). In return, April responds with a series of units (line 17), containing a preface, "mmm:" (line 17), a non-answer response ">I donno<" (line 17), and a phrasal response, "just talkin." (line 17). Taken all together, it seems that April is questioning the relevancy of her question in this interactional context, while proving a type of answer solicited by the question at the end. Then, she adds a series of elaboration, "Like- one session thing is jus- mostly just talking." (line 19) and "(.H) (.H) Just getting it out there." (line 20). In response, Melissa supplies an acknowledgement token (line 19) and a consent token (line 20), endorsing April's objection and her account of simply talking to the therapists to process her issues.

At this point, Dr. Miller picks up the speakership and confirms her account.

21 → T1: pt. That's fine.
22 That's actually-{T2: °yeah°}it can be really helpful.=
23 =I'though it was really wise what you wrote {C: (hh)h} on the form you
24 talked- about talking to a third party a(h) (h)m ((smiley voice))
25 {T2: °**mm**°}
26 You know sometimes that is(hh) (0.2) really helpful.
27 I getta sense your family ((making and holding a round shape with both
28 fingers in front of himself)), .hh >I get a sense-<<u>except for you,</u> somehow,
29 but the three of them four of them, {C: °yeah°} I call four of them .h that
30 they are ((rotating and counter-rotating the shape)) very much in this [(..)
31 prison.
32 C: [They
33 are in all <u>cahoots</u> ((hand gesture)) with each other ye[ah.=

Dr. Miller confirms her account (line 21) and provides a series of elaborations, attesting to her account. At first, he acknowledges the incongruence between Melissa's embedded assumption and April's account about utility of the consultation, while describing that talking things out can be helpful (line 22). He then delivers a compliment in a smiley voice, pertaining to a note April made on the lobby intake form (lines 23-24). Melissa acknowledges his account (line 25).

After a repeat of his earlier account (line 26), he goes back to a discussion about her family dynamics (lines 27-31). This engages April and elicits her correction of the reference term, from "prison" to "cahoots" (lines 32-33). In summary, Dr. Miller's agreement and endorsement of her account seems to have allowed a smooth transition

back to another inquiry into April's strength in the context of her family dynamics, while maintaining the therapeutic alliance between them.

Weft 2: Interactional Practices through Which the Therapists Invited the Change in the Ways Client Talked about Herself and Her Relationship with Her Family

I now turn to interactional sequences in which the therapists invited change in the way April talked about herself and her relationship with her family. I remind the readers of this study that I artificially separated the flow of therapist-client interaction for the purpose of this research. In the flow of the SST consultation, the group of interactional sequences—that is, the *warp*— created interactional contexts for the therapist-client interaction. Within each interactional context, the therapists invited therapeutic changes, while developing and maintaining the therapeutic relationship with the client by weaving the group of the basic interactional practices—that is, *fiber*, and three groups of interactional practices—those are, *wefts*. In other words, I cannot describe the therapeutic changes without accounting for an integration of all the practices. In describing the current section, I will keep this complexity in mind. First, I turn to the three interactional practices through which the therapists attempted to expand the client's temporal and conceptual domains.

Expanding the Client's Temporal and Conceptual Domains

As Hoyt and Talmon (2014b) identified, it is imperative for SST therapists to introduce new perspectives to clients, while meeting their world view. Since SST therapists fundamentally assume that clients have necessary resources and strengths for therapeutic change (Hoyt & Talmon, 2014c), it seems natural that therapists introduce

new perspectives through inviting clients to expand their perspectives through interaction.

I observed the therapists in the SST consultation utilize three interactional practices in their effort to expand the client's temporal and conceptual domain of her situation. At the same time the therapists engaged clients and gathered relevant information about the client and others involved, and their situations. Those practices include reinterpretations, circular questions, and hypothetical questions.

Reinterpretations. As I mentioned in a previous section, through reinterpretation (Bercelli et al., 2010), therapists offer their own interpretations of clients' accounts of their events, based on the client's accounts of the events. The utility of reinterpretations is that therapists can replace clients' interpretation with their own, or present alternative interpretations (see Bercelli et al., 2010). Reinterpretations often accompany various markers (e.g., "I think," "in a sense," "maybe," "perhaps," etc.), suggesting to the recipients that they are the speakers' interpretations of the recipients' previous accounts. In a sense, therapists downgrade (Heritage, 2014) their own knowledge claim in service of upgrading the upcoming clients' responses. As such, reinterpretations project recipients' agreement or disagreement, along with their accounts explaining their stances with the reinterpretations. As a result, therapists can bring forward clients' experiences that are implied in their accounts but yet expressed (Antaki, 2008). The therapists' tentative manner portrayed through attentive listening of clients' accounts and tentative responses to clients are exemplified in a therapists' position, *not-knowing* (Anderson, 1990, 2005; Anderson & Goolishian, 1992), as I described earlier in this chapter.

I observed that the therapists in the SST consultation used reinterpretation throughout the consultation in order to elicit April's elaboration of her accounts of matters at hand. In the following sequence, Dr. Miller uses a reinterpretation and a series of questions to elicit April's elaboration on her account of her father.

18 C: So my <u>dad</u> {T1: moves a hand to chin)) is .h very (0.2) mentally abusive.

.

.

23 (0.8)°Ahm: °((looking up in the air)) I moved out when I was like eighteen
24 like seven- ((mouthing)) pt seventeen.
25 (0.7) A::nd- he's like <u>out of ↑control</u>
26 Like he didn't like- hit us or anything really it's like (jus-) mentally ((hand
27 gesture)) like abu<u>sive</u>. ((wipes eye))
28 So now it's happening with my sisters like tweni one {T1: °yea°} .h
29 An- like ((wipes eye)) he like (that's) to my older sister too but they both
30 live with ↑him (.4) and my ((wipes eye)) ↑mom
31 But it's just like <u>out</u> of control.{T1: ((nodding head))}

.

.

84 → T1: .hh ((empathic tone)) Ahm whata:h- wha- <u>with your ↑dad</u> I get a sense that
85 like the source ((making a circle with hands in front of himself)) of what's
86 going on with (0.4) your dad when you described as like he's a- <u>abusive</u>.
87 Tell me more about that.=
88 =What is- how long has that'been going on?

89 What does that look like?.hhh

90 C: Just like (to say) negative thing (.hh) (.hh) like (0.7) since(h) ↑<u>forever</u>

April describes about her father who used to verbally "abuse" her and who were doing the same with her sisters who live with him and her mother (lines 18-31). During her account, Dr. Miller provides acknowledgement tokens (Bangerter & Clark, 2003) (lines 28 & 31) to signal his receipt of her utterances, while encouraging her to continue. After more of her turns, Dr. Miller takes up the speakership and offers a reinterpretation of her account, using her word, "abusive" (line 86), while downgrading (Heritage, 2014) his interpretation through the use of "I get a sense" (lines 84-86). Then, he follows up with a series of questions asking about different aspects of the word. This elicits a series of her elaboration on her account of her father being "abusive."

95 C: Like- he jus- like (0.8) thinks (0.6) he seems like super <u>jealous(hh)</u> (0.8) of
96 like ((hand gesture)) my sisters and ↑I. .hh {T1: Yea}
97 It's like an <u>attention seeker</u> but he's also like (0.9) <u>sociopath</u> in a sense
98 that .h it's like lot of issues like ((wipes eye)) he has like heart disease, he
99 doesn't take care of himself, just like (0.2) the <u>alpha</u> ((hand gesture)) {T2:
100 ((nodding head))} of my mom. {T1 / T2: ((nod heads))}
101 ((sobs)) Like doesn't let her do ↑anything like puts her down.
102 And then when <u>I</u> ((hand gesture)) <u>say</u> <u>something</u> she's- my dad
103 lik- .snih <u>yells</u> <u>at ↑me</u> lik- yells my ↑mo::m
104 T1: ((empathic tone)) ↓Yeah {T2: °mm° ((nodding head))}
105 C: It's (lik) <u>out</u> of control.

During her series of elaboration, Dr. Miller and Melissa provide a number of acknowledgement markers (lines 96, 99-100, 104) to acknowledge their receipts of her utterances.

In the following exemplar, April takes a series of turns about her father who is ill.

43 C: (.H)h (.H)h Like my dad's sick .H and my mom doesn't ((bends backward
44 to the back of couch)) like make him go to doctor years HHHH ((sits
45 upright)).
46 (1.3)
47 T1: ((empathic voice)) You think she should (.) make him go↑
48 C: You can't make him do anything {T1: °yeah.° / T2: °um hm° ((nodding
49 head))}

In response to April's account about her father and expression of being upset about the situation (lines 43-45), Dr. Miller provides a formulation (Antaki, 2008; Heritage & Watson, 1979), pointing out her expectation. However, the client rejects the formulation by giving a contradictory account (line 48). In response, Dr. Miller and Melissa acknowledge her account with acknowledgement markers (Bangerter & Clark, 2003) (line 48).

62 → T1: .h Sounds like there's a bit o- worry about what's gonna happen with your
63 dad too. {T2: °↑um ↓hum°}
64 C: °m:yeah.°
65 T1: >That he's gonna get-< I get the sense that his health is really in a
66 jeopardy.
67 C: Yeah.=

Some turns later, he provides another reinterpretation, tentatively pointing out her worry for her father by downgrading his interpretation (Heritage, 2014) (lines 62-63), which elicits her agreement (line 64). With her agreement, he furthers his reinterpretation, suspecting that the father's health is critical (line 65). This elicits another agreement from her (line 66).

67 T1: =Is that right?
68 So there's sort of a pressure to the situation right now.=
69 =Did things got worse recently ((tilts upper body, nods head)). {T2?: °um
70 hm°}
71 Something happened recently?
72 (1.2)
73 C: My sister's, my older my sister's just asking for money. (.HH)
74 >You know-< she's like always ask for money.
75 T1: From you?={T2: °um°}
76 C: From everyone.
77 T1: From everyone. {T2: ((nodding head))}
78 C: She won't- she gets loan from people.
79 It's just stressful on my mom.

With a quick confirmation of his receipt of her agreement (line 67), he furthers his formulation, pointing out the tense family situation due to his physical conditions (line 68). With no gap, he suspects in a form of a question if the family situation got worse recently (line 69). He adds another question, paraphrasing his own question (line 71).

This series of turns elicits another inquiry in April's account of the recent issue with her older sister (lines 73-79).

Circular questions. Circular questions are subjects of numerous family therapy literature (e.g., Fleuridas, Nelson, & Rosenthal, 1986; Penn, 1982; Selvini, Boscolo, Cecchin, & Prata, 1980; Tomm, 1988, etc.) and are associated with Milan systemic family therapy (Selvini, et al., 1980; Boscolo et al., 1987). The question stems from Gregory Bateson's (1972) circular assumption that information emerges from a difference, or change in perceptions of an object (e.g., persons, objects, phenomena, ideas, events, etc.) gleaned from comparing the object from one time to the other. As such, circular questions "reveal recurrent circular patterns that connect perceptions and events" (Tomm, 1988, p. 5). In delivery, a therapist asks clients differences between different persons' perceptions of something (e.g., problems, persons, feelings, events, etc.) in the presence or absence of the persons.

The structure and embedded assumption behind the questions can have clients formulate their perceptions about a matter at hand in a circular manner, which often differs from how the clients may have formulated the matter previously. This effect seems to be the interactional utility of this type of questions, as Peräkylä (1995) noted in his CA of circular questioning. In their study, identifying patterns of interactions following introductions of circular questions, s and Tseliou (2014) contend that the circular questions, asking the problem definition (e.g., "What is the problem in your opinion?") seems to spur different views of the problem among family members, and honor the multiple viewpoints associated with different positions of each member. Similarly, circular questions, asking for explanation of other's behavior seems to set a

stage for deconstructing an accusation among the family members, replacing liner punctuation of events with more circular punctuation of events associated with the identified problem (Diorinou & Tseliou).

Below is an exemplar from the SST consultation that happens after the previous exemplar in which the therapists explored April's worry for her sister, within the context of the family dynamics.

68		Like I told my mom like ↑o::h you know it's the same exact ↑thing.
69		My mom like stayed with my dad and they're married for like (.) thirty
70		something years.
71	T2:	↑Um ↓hum.
72		Lik- ((hand gesture, shrugs shoulders)) she's not gonna leave ↑him.
73		My sister sees that. .hHH h
74	T1:	((empathic voice)) Yeah.
75	C:	Jus- (0.9) really (.....) ((wipes nose))
76	T1:	((nods head))
77 →	T1:	((empathic voice)) If your- {T2: ((turns toward T1))} if your (.) sisters
78		((tilts head)) were here and I was talking to them, what would they say is
79		the::: .h problem with what's going on? (..)
80	C:	My da::d.
81	T1:	((empathic voice)) They would say (.) it's your dad↑=
82	C:	=My li- younger sister hates my older sister.
83	T1:	Really= ((tilts head, nodding head))}
84	C:	(Think it's just) sister fights.

85 T2: ↑Mh ↓hmm. ((nodding head))

86 C: >You know-< it's like <u>always</u> (0.2) jealous of each other.

87 T2: ↑Um ↓hm

88 C: Like steal each other's cloths.

89 My older sister's like steals everything (0.3) from her ((T2: °Mhh.°)) like

90 her car keys an <u>everything</u> ((shrugs shoulder)).

91 T1: ((empathic voice)) °ye[ah.° ((nodding head))

92 T2: [°m:°

93 (0.4)

April continues accounting her family dynamic and her worry for her sister (lines 68-75). After occasional acknowledgment tokens (Bangerter & Clark, 2003) (lines 71, 74, 76), Dr. Miller picks up the speakership and asks a circular question (lines 77-79) in empathic voice tone, inquiring what her sisters would identify as the family problem. This elicits April's response identifying her father as the problem from her sisters' point of view (line 80). He responds by repeating her turn, with raised pitch at the end, which makes it a question asking for her confirmation. In the next several turns, April elaborates on the relational dynamics between her older and younger sisters. During this time, the therapists provide minimal acknowledgement tokens (lines 83, 85, 87, 89, 91, 92).

After a brief between-turn pause (line 93), Melissa continues the inquiry using another circular question.

94 → T2: ((empathic voice)) And what would'your mom {T1: ((turns toward T2,

95 nodding head))} say {C: ((turns toward T2))}the problem is?

96 C: She doesn't- she's (letting) she's so <u>passive</u> about <u>everything.</u> ((wipes

97 face))

96 T2: < >So she wouldn't say there's any problem?<

97 C: (.h) (.Hh) She'd say my older ↑siste::r.

98 My younger sister for not keeping her mouth shut. {T2: ((nodding head))}

99 It's lik- (.h) (.h) ((shrugs shoulder)){T1&2: ((nodding head))

100 T1 ((empathic voice)) °yeah°}

101 C: The problem is her not doing anything about it.=

102 =Like I KNOW ALL THESE THINGS. (wipes nose))=

103 =There's jus- nothing I can do about it.

104 It's just stressful((sobs)).

Building on Dr. Miller's initial circular question's structure, Melissa asks her what her mother would identify as the problem (lines 94-95). In response, April provides an account identifying her mother's character (lines 96-97). Melissa follows up with a reinterpretation (Bercelli et al., 2010) in a form of question, soliciting April's confirmation (line 96). However, April states that her mother would identify her older and younger sisters as problems (lines 97-98). April follows up with a partial statement and shrugging of her shoulders, implying the complexity of the family problem. During this time, the therapists respond with minimal acknowledgement tokens (lines 98-100). Then, April points out that it is a problem that her mother has not intervened in the situation, despite knowing that there is a problem (line 101). With no gap in between, she claims that she knows those family dynamics and the multiple points of views about the family dynamics among her family members in a louder voice than the previous

turns. With no gap, she states that she cannot solve the problems for them (line 103), along with its impact on her (line 104).

In the following exemplar, Dr. Miller provides a reinterpretation from which a further inquiry about April's family dynamics is revealed.

43 C: I'm not really sure what she's up to, (0.5) but when she's like crying ((hand
44 gesture)) and .hh (0.5) like always asking for ↑money. {T1: °yeah°}
45 Like making ↑excuses {T2: °um hum°((nodding head))}like good
46 reasons ((hand gesture)) for ↑it {T1: °yeah°} like (0.7) I <u>can't</u> say no
47 ((hand gesture)).
48 (.)
49 T2: [[°sure.°
50 T1: [[°yea.°
51 C: You know ['cuz]
52 T1: [Are you loaning] her the money? ((moves a palm on cheek))
53 (0.6)
54 C: Yeah she says like (0.7) ((wipes nose)) like oh you know money's just
55 temporary. ((reaches out to get tissue on the table and wipes nose)) (0.5)
56 you know.=
57 T1: That's what she says to you? =
58 C: =NO I <u>KNOW</u> IT ((shrug shoulder)) you know.
59 She's like ohh need this like (0.2) <u>Ten years from now</u> you know like (0.7)
60 (loaning) her money ((hand gesture)) (.) is gonna be <u>nothing</u>.
61 You know just money ((hand gesture)).

62 T1: So you-[

63 C: [But like- she's making a big deal (0.2) because she feels like

64 ((making parentheses with fingers)) <u>stressed</u> about it.

65 Like she always ((hand gesture)) owe people money.

66 (0.3) She probably owns like <u>pay</u> <u>day loans</u> ((wipes nose)) like.

67 (0.7) She'll go to jail ((hand gesture)) [(... not) paying (those) back.

68 {T2: °um hum°((nodding head))}

69 T1: [(..-)

70 C: [[Like she owes people money.

71 T1: [[(...)

72 → ((looking at C)) Are you worried she's ruining her future?

73 (0.4)

74 C: Definitely.=

75 T1: = (That's what is). That's what it is. {T2: °yeah°} ((nodding his head))

76 (0.6)

77 C: Definitely.=

78 T1: =.h And you're working ((nodding head)) on your future.

79 (0.3)

80 C: °yea.°{T2: °yeah°}

81 She doesn't wanna help herself.

82 She feels like stuck in the past. (0.8)

83 Can- doesn't change her ways. {T2: °um hum°}

84 Continues ((hand gesture)) to lie.

85 T1: ((moves a palm from chin to cheek))} .h[hh

In this sequence of the exemplar, April gives her detailed account of her sister's issue with money (lines 43-70). During this time, the therapists remain listening to her account with minimal acknowledgement tokens (lines 44, 45, 46, & 48) and agreement tokens (lines 49 &50), along with occasional questions, simply asking her confirmation of information (lines 51 & 57). Then, after his initial attempt (line 71), Dr. Miller supplies a reinterpretation, pointing out her worry for her sister (line 72). After a brief pause, she agrees with the reinterpretation with affirming tone (line 74). He responds with a turn recognizing his receipt of her agreement (line 75). After another moment of silence (line 76), she repeats the same response as her previous turn, "Definitely" (line 77). Latching right after her turn, he adds "=.h And you're working ((nodding head)) on your future" (line 78), emphasizing her resilience by comparing her and her sister. She agrees with the account (line 80) and continues on with her account on her sister (lines 81-84).

Some turns later, April makes a pronouncement after which Dr. Miller poses a circular question.

93 C: [Everyone (0.3) <has a

94 problems.> {T2: °um°}

95 T1: °true.° =

96 → =Of the three in your {T2: turns toward T1))} .hh or four ((hand gesture))

97 really in your family, {C: ((wipes nose))} which one are you worried

98 about the most? {T2: turns toward C))}

99 C: My mom.

100 T1: Your ((inquisitive voice, tilts head to a side)) <mom>. {T2: °um

101 → hum°}Why?

102 C: 'Cuz she's the one that (holds) everything together.

103 T1: Yeah. {T2: ((nodding head))}

104 (0.3) She's- she's the str[onges]t one even though

105 C: [She'-]

106 (.)

107 C: She's paying the rent.

108 She's doing ((wiping eyes)){T2: ((nodding head))}everything.

109 She's doesn't even make that much money but she's like still like take care-

110 takes care of my ↑dad, {T2: Um hum} makes some breakfast, lunch,

112 dinner.

113 (0.3)

114 T1: Is he working?

115 C: No. (0.3) He hasn't worked in like such a long time. {T2: ((nodding

116 head))}

117 I can even- I don't even know how long. {T2: °um hum°}

April makes a pronouncement that everyone has problems (lines 93-94). Melissa acknowledges it (line 94), while Dr. Miller agrees with it (line 95). Without any gap, he poses a circular question (lines 96-98), asking her whom she is most worried about. In return, April simply names her mother (line 99). He repeats her turn from his view point in inquisitive voice tone, while tilting his head (line 100). Then, he asks another circular question about the reason of her previous response (line 101). The combination of the circular question, his acknowledgement token, along with a non-verbal gesture, and the

question elicits April's elaboration of her account of her mother's role in the family (lines 102-112). Then, this elaboration leads to an inquiry about the difference in her perception between her mother and father in the family (lines 114-117). As Peräkylä (1995) suggested, circular questions seem to have dual functions: bringing forth the circular nature of a matter at hand, and eliciting an elaboration of accounts.

Hypothetical questions. In the family therapy literature, this type of question belongs to the Mental Research Institute's (MRI: e.g., Fisch et al., 1982; Watzlawick et al., 1974) approach to brief therapy. These therapists assume that the problems to be solved are clients' attempted solutions (see Fisch et al., 1982; Watzlawick et al., 1974). In describing a prominent MRI therapist, John Weakland's approach, Ray and Anger-Díaz (2007) explains that this type of question is essential for MRI therapists, since the type of questions elicit the presupposition, or context implicit in clients' attempted solutions. This type of question can potentially expand clients' temporal and or conceptual perceptions about what is being asked if clients' thoughts are constrained in particular views of their situations. In either case, the therapist would be able to utilize the information gleaned from this type of question in determining clients' world view.

In the SST consultation, the use of hypothetical question occurred shortly after the interactional sequence above in which Dr. Miller pursued to find out if there was any recent development that propelled April to seek the SST consultation.

62 T1: .h Sounds like there's a bit o- worry about what's gonna happen with your
63 dad too. {T2: °↑um ↓hum°}
64 C: °m:yeah.°
65 T1: >That he's gonna get-< I get the sense that his <u>health</u> is really in a

jeopardy.

C: Yeah.=

T1: =Is that right?

So there's sort of a pressure to the situation right now.=

=Did things got worse recently ((tilts upper body, nods head)). {T2?: °um hm°}

Something happened recently?

(1.2)

C: My sister's, my older my sister's just asking for money. (.HH)

>You know-< she's like always ask for money.

T1: From you?={T2: °um°}

C: From everyone.

T1: From everyone. {T2: ((nodding head))}

C: She won't- she gets loan from people.

It's just stressful on my mom.

T1: Do you think it's connected with her substance abuse problem?

{T2: °Um.°} Those two things sometimes go {T2: °Um.°} together.=

=What's you sense of [what's going on? =

C: [She swears she swore ((wipes nose)) she doesn't do it, but she's like a pathological liar.

T2: [[°um hum.°

T1: [[°(..) okay.°

(0.9)

88 C: °<u>ye</u>ah.°

After asking about her sister's potential drug issue, Dr. Miller asks a hypothetical question, asking for her fear of what may happen with the sister if the situation does not improve. This question elicits April's worry for the sister.

90 → T1: Whata you worried about what's gonna happen with your sister if nothing
91 changes?
92 C: Go to ↑jail.((wipes nose))
93 T1: She's gonna go to a jail? {T2: °yea:h.°}
94 C: Someone's gonna find that she owns ↑money
95 (0.2)
96 T1: °Yeah?°
97 (0.9)
98 C: (.H)h (.H)h HHA[::

The question (lines 90-91) elicits April's account that her sister may go to jail. After his repeat of her account (line 93), she provides an elaboration of her account (line 94). The combination of the between-turn gap (line 95) and his acknowledgement token (Bangerter & Clark, 2003) (line 96) in a form of question, and another between-turn gap (line 97) after the turn seems to indicate his further solicitation of April's account.

The sequence circles back to Dr. Miller's observation that something may have happened to her family recently such that the situation became dire.

126 T1: tch. (...-) Again ((hand gesture)) is this something that happens-
127 happening more <u>recently</u>, things ramping up a little bit?:or:: .h
128 C: I mean like- I am trying to go on (a trip to ...) with my ↑school {T2:

((nodding head))} .H (.H) and lik- my sister like asking ((wipes eye))
for ↑money .H like I keep giving into her because like I care her
((hand gesture)) {T2: ((nodding head))} and she like saying she wants to
like (.Hh) h KILL HERSELF ((hand gesture)) for like.
SHE'S LOOKING FOR ATTENTION.
an-(.H) (.H) It's jus(hh)- I don't want anything bad
happen to anyone. (.H) HHH:
(0.7)
T1: °Y[eah of course.° {T2: °um hum°}
C: [(.H) (.HH)h h
Like everything is so temporarily lik- ((gasps)) H WHEN SOMEONE
CAN LIKE- GET MAD LIKE ((gasps, hand gesture)) DRINK AND
DRIVE AN-KILL HIMSELF.
(.HH .HH) HHHH::
T1: Is that what you are worried< >it's gonna<possibly might happen with
your sister?
C: (.SNIH) H- ANYTHING CAN HAPPEN.
T1: Yeah. She's- sounds like she's sending off those signals (.) to you.
{T2: °um hum°}{C: HHH(H)}
When you have trouble ((looking down)) {T2: ((turns toward T1))}
concentrating at school, is that main thing that you are thinking about?
Or what is it that you're ((looks up to C)) thinking about?={T2: °um
hum°((turns toward C))}

151 C: Just the stress of them. {T2: °yeah°} Just everything that they are going
152 through. ((wipes eye))
153 T1: °yeah°((nodding head))
154 (2.6)
155 C: >I just feels like<nothing's ((hand gesture)) gon- can ((hand gesture))
156 change.
157 T1: Um:. ((nodding head))

In asking if there was any recent development in her family, Dr. Miller emphasized the newness of the potential development by adding an emphasis on the word, "recently" (line 127). In response to the direct question, April describes about the recent relational dynamics between her and her sister in which her sister told her that she would kill herself, due to the money issue (lines 128-132). April's direness for the situation seems to be expressed through her delivery of the phrase, "KILL HERSELF ((hand gesture))" (line 132) in a louder voice and accompanying hand gestures throughout her turn (lines 131-132). Although she suspects that it is her sister's way of asking for April's attention (line 132), she worries for the worst scenario (lines 133-134). This seems to be evidenced by her later account in a louder voice, along with the combustible and long aspiration (line 141), that someone who gets upset may drink and drive to kill him or herself (lines 138-140). After affirming April that her sister may, in fact, be sending a message to April (line 145) in a form of reinterpretation (Bercelli et al., 2010), he attempts to confirm if that is the source of her worry or anything else (lines 147-148). In response, April partially disconfirms his question format to state that it is her stress of knowing what her family is going through in general (lines 151-152). Dr. Miller provides

an acknowledgment marker, "°yeah° ((nodding head))" along with a long pause (line 154) to encourage her to continue to speak. This elicits April's further view that nothing is going to change her family situation (line 155). In summary, it seems that the interactional sequence that embeds the hypothetical question elicited April's elaboration on her views on potential consequences of the family situation. Within the elaborated view, her worry seems to make sense.

Next, I turn to two interactional practices with which the therapists shaped the topic of conversation on client's strengths: a combination of reinterpretations and optimistic questions, and candidate answers.

Shaping the Course of Conversation within the Client's Strengths

As I mentioned in chapter two, SST therapists hold a fundamental assumption that clients have already capacity and strengths necessary for therapeutic changes (Bohart & Tallman, 2010; Campbell, 2012; Hoyt & Talmon, 2014c) and interact with clients in such a way to utilize the capacity and strengths (Amundson, 1996; Bloom, 2001; Bobele & Slive, 2014; Slive & Bobele, 2011a). In particular, Hoyt (2014) comments on means of evoking clients' resources: "Language matters. . . . Smart therapists strategically amplify and utilize patients' existing healthful resources and responses" (p. 66). One such way without imposing therapists' assumption on clients is through shaping the course of conversation within their strengths. In doing so, the therapists' belief about clients' strengths is passed down to clients implicitly (Bobele & Slive, 2014; Scamardo et al., 2004).

A combination of reinterpretations and optimistic questions. As I mentioned in a previous section, through reinterpretation (Bercelli et al., 2010), therapists offer their

own interpretations of clients' accounts of their events, based on the client's accounts of the events. The utility of reinterpretations is that therapists replace the clients' interpretation with their own, or presents an alternative interpretation (see Bercelli et al., 2010). In the SST consultation, Dr. Miller used reinterpretations, providing an alternative interpretation that brought forth the client's agency, capacity or strengths. The interpretation, then, became a context in which it made sense for him to ask *optimistic questions* (MacMartin, 2008). This type of questions, mostly in a form of *wh*-questions (e.g., who, what, how, etc.) embeds assumptions, casting clients in an optimistic light. The questions are designed to solicit clients' answers, confirming their "agency, competence, resilience, abilities, achievements, or some combination thereof" (p. 82). In family therapy, this type of question is often associated with SFBT (Berg & Dolan, 2001; de Shazer, 1985, 1988) and narrative therapy (White, 2007; White & Epston, 1990).

In the extended exemplar below, Dr. Miller presents a reformulation, accompanied by an optimistic question to bring forward her strength within the family situation, in response to April's series of turns accounting her family problems and dynamics. Below is the first part of her accounts.

23 C: (0.8)°Ahm: °((looking up in the air)) I moved out when I was like eighteen
24 like seven- ((mouthing)) pt seventeen.
25 (0.7) A::nd- he's like <u>out of ↑control</u>
26 Like he didn't like- hit us or anything really it's like (jus-) mentally ((hand
27 gesture)) like abu<u>sive</u>. ((wipes eye))
28 So now it's happening with my sisters like ((the sister's age)) {T1: °yea°}
29 .h

An- like ((wipes eye)) he like (that's) to my older sister too but they both live with ↑him (.4) and my ((wipes eye)) ↑mom But it's just like out of control.{T1: ((nodding head))}

.

.

T2: What're the ages ((C: turns toward T2)) of everyone?

C: My sister's ↑((mid 20s)) {((T2: °um hum° ((nods head))} ↑ ((early 20s)) ((early 20s)), my younger one {((T2: nodding head)) / T1: °m: okay.°} Like she doesn't help with anything. She's like sits in her room all ↑day. .h She's like (0.4) not ((wipes eye)) clinically (I donno the word like). She's like really depressed because she like lives ((hand gesture)) with my parents like.

.

.

C: Like- he jus- like (0.8) thinks (0.6) he seems like super jealous(hh) (0.8) of like ((hand gesture)) my sisters and ↑I. .hh {T1: Yea} It's like an attention seeker but he's also like (0.9) sociopath in a sense that .h it's like lot of issues like ((wipes eye)) he has like heart disease, he doesn't take care of himself, just like (0.2) the alpha ((hand gesture)) {T2: ((nodding head))} of my mom. {T1 / T2: ((nod heads))} ((sobs)) Like doesn't let her do ↑anything like puts her down. And then when I ((hand gesture)) say something she's- my dad

103 lik- .snih yells at ↑me lik- yells my ↑mo::m

104 T1: ((empathic tone)) ↓Yeah {T2: °mm° ((nodding head))}

105 C: It's (lik) out of control.

106 I'm like but we can't make ((hand gesture)) him do anything. ((shrugs

107 shoulder))

108 (1.2)

.

.

113 C: .HHHhh [Just annoyin]g.

114 T1: ((empathic voice)) [How] Oh ↑yeah:

In the series of sequence above, April describes the dire family situations, as evidenced by her account, "It's (lik) out of control." (line 105), in which her father maltreats her sisters who live with her parents (lines 28-31). Despite the situation, her mother has not responded to the situation. Because of the maltreatment, one of her sisters feels depressed (lines 66-70). In addition, her father has serious health issues for which he does not consult with a doctor (lines 98-99). Further, April's and her mother's attempt to intervene in the situation does not seem to ameliorate the situation (lines 102-107). It is after this series of her elaborative accounts that Dr. Miller attempts to respond, but changes to provide agreement token, "((empathic voice)) [How] Oh ↑yeah:' (line 114)

Then, he provides a reinterpretation, choosing and bringing forward her strength within the family context among her other accounts of the family problems.

3 → T1: .h ((empathic tone)) How were you able to, sounds like you're the one of

4 your sisters {C: wipes eye with tissue)) that <got out >(0.4) {T2: °
5 Yeah°} of that.
6 I get that (.) sense.
7 → It's- How did that ha[ppen?]
8 C: [I mean]
9 T1: Tell me the story of that.=
10 C: = He like KICKED me out, not KICK me out, but he like TOLD me to
11 leave.
12 (0.4) (An-) like- threatened ((wipes eye)) to like take my motor cycle like
13 .hh I didn't let him↑obviously 'cause my only way to escape ((wipes eye))
14 him. .snih
15 An::d (0.5) so he like called the police on ↑me::=
16 =< >And I was like I'm not coming back here like,
17 < I MEAN I visit them because like they are my family and I
18 care, .HH .HH {T1: °yeah°}
19 But (there's-) I like- moved out seventeen, my aunt ((T2: nodding
20 head))} helped me, she let me stay at her hous(hh)e.
21 (0.5)

In the question delivery, he starts out the question by emphasizing "How" (line 3), but self-repairs (Kitzinger, 2014) and provides a reinterpretation that April seems to be the only one of the three sisters who was able to escape the home (lines 3-6). Consistent with MacMartin (2008), this statement seems to serve to set up a context for the upcoming optimistic question (MacMartin 2008), "How did that ha[ppen?]" (line 7), referring to

his reinterpretation that she was the only one of her siblings that was able to escape the home. He adds another request to have her account of the event (line 9). This series of requests elicits April's affirming response, highlighting her autonomy within the problematic situation. While her previous accounts of the event and family dynamics evolved around her family members, being impacted by the dynamics, the current account revolves around her sense of agency within the situation.

For instance, she self-repairs (Kitzinger, 2014) her first account from "He like KICKED me out," to "not KICK me out, but he like TOLD me to leave." (lines 10-11). She continues to state, "(An-) like- threatened ((wipes eye)) to like take my motor cycle like .hh I didn't let him↑obviously 'cause my only way to escape ((wipes eye)) him. .snih" (lines 13-14). The self-initiated repair and turn design (Drew, 2014) of "TOLD me to leave" (lines 10-11) and "I didn't let him↑obviously" seems to imply her sense of agency against her father's attempt to remove her from the house. This sense of agency seems to be implied in the turn design of her next accounts, "An::d (0.5) so he like called the police on ↑me::=" (line 15) and "=< >And I was like I'm not coming back here like," (line 16). In both sentences, she seems to assert herself as the determinant of the event. After another statement, she makes her agency clear by stating, "I like- moved out seventeen' (line 19).

Below is another exemplar in which Dr. Miller used a reinterpretation and an optimistic question to shape the flow of conversation into her strength within her family dynamics.

168 C: Problem (.) is like doing things about it. (.HH .HH) {T1: °yeah°

169 ((nodding head))}You know.

170 .snih Like you can do whatever you want ((hand gesture)).
171 Like going to therapy((hand gesture)) but if you don't like FOLLOW
172 WHAT PEOPLE SAY ((hand gesture)), (.H) (H) (.H) (H) NOTHING
173 HAPPENS(h) ((hand gesture)). hh {T2: °yeah°}
174 (0.6)

Initially in this sequence, April makes it clear that nothing will improve the situation unless her family members themselves take actions by asserting, "but if you don't like FOLLOW WHAT PEOPLE SAY ((hand gesture)), (.H) (H) (.H) (H) NOTHING HAPPENS(h) ((hand gesture)). Hh" (lines 171-173).

Some turns later, Dr. Miller comments on the family dynamics, while pointing out April as an exception to the problematic dynamics.

27 → T1: I getta sense your family ((making and holding a round shape with both
28 fingers in front of himself)), .hh >I get a sense-<except for you, somehow,
29 but the three of them four of them, {C: °yeah°} I call four of them .h that
30 they are ((rotating and counter-rotating the shape)) very much in this [(..)
31 prison.
32 C: [They
33 are in all cahoots ((hand gesture)) with each other ye[ah.=
34 T1: [They're all ((rotates
35 the shape)) cahoots ↑right. {T2: um hmm ((nodding head))} (0.7) except
36 for you (0.3) h somehow. and I am still like trying to figure that:out.=
37 → = How, how you were able to ah: (0.2) [there's something to that] I think
38 worth looking in.

C: [(I .....)]

T1: .hh Not taking {T2: ((turns toward T1))} any bullshit. {T2: ↑Um ↓hum.}
That's one thing. pt.

T2: Yeah it's pretty ((turns toward T1)) {T1: ((turns toward T2))}
[remarkable ↑right.] ((nods head))

T1: [there's- (.) there's something] there to that yeah (... look at that) {T2: ((turns toward C))
What helps you to do that? .hh {T2: ((nodding head))}
(1.0)

C: Focusing on what needs to happen. .h

T1: ↑Yeah I got a sense of that. I('m just) {C: .snih °hhhh°} imagining in my mind's eye like a home everybody's caught up in everybody else's stuff ((tilts head)) an; but you're able to (0.8) like do thing so that ((turns from one cheek to the other)) whatever needed to {T2: ((turns toward T1))} happen so that you can make {T2: ((nodding head))} straight As the last term, which is amazing.

T2: °yea that's amazing.°=

T1: =.hh A::hm and so what is it that about you that's <u>different</u>?

C: ((hand gesture))
hhh >I don'tno< just focusing on what needs to happen (.H) (.HH) not <u>dwelling</u> <u>the</u> <u>pa:st</u>.
(0.4)

63 T1: °mmm.° {T2: °um hm°((nodding head))}

64 C: °I don'know.°

65 (1.7)

First, he sets a context for the forthcoming optimistic question with a reinterpretation, while excluding April from the dynamics, "I getta sense your family ((making and holding a round shape with both fingers in front of himself)), .hh >I get a sense-<except for you, somehow, but the three of them four of them, call four of them .h that they are ((rotating and counter-rotating the shape)) very much in this [(..) prison." (lines 27-31). This elicits April's confirmation of the reinterpretation (line 29) and re-wording of the reference term from his word, "prison" (line 27) to her word, "cahoots" (line 33). Dr. Miller quickly picks up the reference term and fine-tunes his turn, "[They're all ((rotates the shape)) cahoots ↑right." (lines 34-35). Then, he adds, "except for you (0.3) h somehow." (lines 35-36), highlighting her autonomy away from her family. He adds a couple of statements, soliciting her responses (lines 36-38). Without waiting for her response, he provides a candidate answer (Pomerantz, 1988), ".hh Not taking {T2: ((turns toward T1))} any bullshit." (line 40) to shape the course of the conversation within April's strength. After Melissa's agreement with the candidate answer (line 40), he legitimizes the answer himself with, "That's one thing. pt." (line 42). Melissa jumps in and adds a compliment, "Yeah it's pretty ((turns toward T1)) {T1: ((turns toward T2))} [remarkable ↑right.] ((nods head))" (lines 43-44). Dr. Miller responds to her compliment and further the compliment (lines 45-46).

Then, he asks her what helps her "not to take any bullshit," which is accompanied by a pause (lines 48-49). This series of turns has built further expectation for April to

provide a response, confirming the assumption embedded in those accounts that she has autonomy of her own within her family situation. In fact, April provides a confirming response, “Focusing on what needs to happen. .h” (line 50). Dr. Miller responds with an elaborative interpretation, imagining her focusing on what needs to happen to excel at school in the midst of the family dynamics (lines 51-56). At the end of the turn, he turns it into a compliment and Melissa adds her agreement to it (line 57).

Using this elaboration as a context, he asks another optimistic question, “=.hh A::hm and so what is it that about you that's different?” (line 58). This question assumes that there is something different about April from the rest of her family, such that she is able to focus on what needs to happen to excel at school. In return, she seems to give a weak agreement (Pomerantz, 1984) in which she starts off with a non answer response, “>I don'tno<” (line 60), and repeats her previous answer, “just focusing on what needs to happen” (line 60), while adding a phrase, “not dwelling the pa:st.” (lines 60-61). As Pomerantz (1984) suggested, her weak response seems to indicate her hesitation with his question. Dr. Miller and Melissa seem to take up her weak agreement as it is by simply providing acknowledgment tokens (line 63). This is further followed by April’s non answer response, “°I don'know.°” (line 64)

Candidate answers. As I described in the previous section, speakers offer candidate answers (Pomerantz, 1988) in their inquiries to show the type of answers they are looking for from recipients. In institutional interactional contexts, speakers can utilize candidate answers to shape the direction of conversation. In these instances, candidate answers they provide are examples of a conversational topic they are looking

for. In the SST consultation, Dr. Miller used candidate answers to shape the conversation within the context of April's capacity and strengths.

In this exemplar below, Dr. Miller initially uses a reinterpretation (Bercelli et al., 2010) and an optimistic question (MacMartin, 2008) to bring forward April's strengths from within the family's problematic context.

T1: = I'm- there's this- strength that gather that (0.7) <you ha::ve somehow that, I'm just guessing filling in the pieces here somehow you were ((nods head)) able to leave the situation=where I get a sense your- both of your sisters and your mother, and in a way ((tilts head from one side to the other)) your dad can't.=

C: =hhhYeah they feel trapped.

T1: How is it [you ((tilts head)) were able to do that?

C: [(.H) (.H) (.H)

T1: That's {T2: °um hum°} this- just seems like something amazing there: .h T[ell me about that.]

C: [Don't put up with bul]shit.

T1: Don't put up with a bulshit ((nodding head))?

C: °at's it.° hhh

T1: That was it?
((firm voice)) When did- tell me {C: ((sobbing))} about that=and you- how did you ((shifts upper body)) learn how to do that?.hh

C: I don' know.
I just see my sisters like seeing people are doing wrong. ((wipes nose))

20 (Li..) [make] me a good person ((reaches out to tissue from the tissue
21 box on top of the table)). (.Hh) (.Hh)
22 Just seeing people doing <u>stupid</u> things. .h (HHH) ((wipes nose))

At the beginning of the sequence, Dr. Miller offers a reinterpretation (Bercelli et al., 2010), along with downgrading her knowledge claim (Heritage, 2014) that April has strength with which she was able to leave the problematic family home, while her sisters and mother, as well as her father, cannot do so (lines 2-6). This elicits April's instant confirmation with an adjustment on the reference term that her family members feel trapped in the situation (line 7). Dr. Miller uses this confirmation as a context for the upcoming optimistic question (MacMartin, 2008), "How is it [you ((tilts head)) were able to <u>do that</u>?" (line 8). Without waiting for her response, he adds a compliment, soliciting April's confirming response. When he is about to solicit her response verbally (line 11), she overlaps (Hayashi, 2014) his turn and provides an answer, "[Don't put up with <u>bul]shit</u>." (line 12). As I showed in a previous section of this chapter, the phase, "don't put up with bullshit" will become a shared phase between the client and therapists through a process of entrainment (Bangerter& Mayor, 2013).

After repeating her turn, Dr. Miller further solicits her accounts about the reference term and supplies another optimistic question (MacMartin, 2008), "how did you ((shifts upper body)) learn how to do <u>that</u>?.hh." (line 17). This question assumes that she learned how to "not put up with bullshit." Despite her initial weak agreement, she gives an account of how she learned how to persevere in problematic situations (lines 19-22).

After the next few turns, Dr. Miller further inquires about her strength by the reference term.

28 T1: So: when- [when did that start?=

29 C: [(.HH) (.HH) ((sobbs, wipes nose))

30 → T1: =When did you [(1.0)] realize like, I'm notgonna put up with this bullshit

31 C: [°ha:::°]

32 T1: and I am getting outta here. (.)

33 → You said seventeen.

34 Holy cow. {T2: ↑Um ↓hum ((nods head))}

35 Is that when it happened?

36 C: I mean it's what happened in my whole lif(h)e but-: I can' do anything you

37 know. {T1: ↑Um ↓hum} (.H) (.H) HHHA::))

38 Jus- you not'gonna sit down like watch people like (.HHH)h TEA(H)R

39 their lives apart you know. h h (.HH)

40 T1 / T2 : ((nodding head))

After the initial self-repair (Schegloff et al., 1977), he refines his optimistic question by reference term, “When did you [(1.0)] realize like, I'm notgonna put up with this bullshit and I am getting outta here. (.)” (lines 30-32). Despite her initiation of a turn in the middle of the question, he continued on with his question. Without waiting for her response, he supplies an answer himself in a form of candidate answer in which he adds an emphasis on her age. He expresses his surprise, “Holy cow” (line 34) and Melissa agrees with his reaction (line 34). Then, he asks for her confirmation (line 35). Although she confirms his candidate answer, she seems to reject the optimistic tone Dr. Miller has

presented about her situation with a statement that she cannot do anything about her family situation (lines 36-37).

Weft 3: Interactional Practices through Which the Therapists Negotiated Advice with the Client

Heritage and Sefi (1992) defined advice in institutional settings as sequential interaction in which a professional "describes, recommends or otherwise forward a preferred course of future action" (p. 368) to the client. In the context of counseling and psychotherapy, however, the relational implications of the definition pose a challenge (Heritage & Sefi, 1992; Kinnell & Maynard, 1996). On one hand, therapists are trained to empower clients' autonomy; on the other hand, they are expected to offer ideas or suggest interactions that are different, or sometimes contradictory to those of clients (Silverman, 1997; Vehvilainen, 2001). By virtue of giving advice to clients, therapists position themselves asymmetrically to clients as ones who have knowledge or wisdom that clients do not. The same dynamic applies to SST consultations: While advice-giving can be a means to introduce new perspectives to clients (Hoyt & Talmon, 2014b), therapists can potentially run a risk of stripping away clients' autonomy that they believe in (Bohart & Tallman, 2010; Campbell, 2012; Hoyt & Talmon, 2014c). It is therapists' duty to interact with clients so as to address the challenge (Vehvilainen, 2001).

Continually Modifying Advice over Many Turns to Make It Acceptable for the Client

I observed that the interactional nature of the SST consultation became advice giving in the reflecting team and the following discussion between the therapists and client thereafter. The change from mostly information gathering and expansion to advice

giving seems to be appropriate, due to April's somewhat weak request for advice on what to do with her family situations. Below is the relevant sequence.

1	T1:	.h I do wanna >think about< Is there <u>any</u> (.) question I haven't <u>asked you</u>
2		<u>about</u> ((looks up to see C)) or thing we haven't asked you about you feel
3		like (.) it's good for us to know about you or something.
4		°You:: °.hhh thought of ((hand gesture)) as you came here >it's like<
5		((pretending as if C)) I wanna ((nodding head)) get their opinion about
6		thi::s↑ or tha::t↑
7	C:	No.
8	T1:	Is that it? Pretty ((nodding head)) much the things you've talked ↑about.
9		Those are the main concerns?
10	C:	Just what- I don't know maybe ((hand gesture)) like <u>what to do</u> that's
11		((hand gesture)) jus(h) what I'm looking ((hand gesture)) for.
12	T1:	What to do? Both with <u>yo::u:</u> and your <u>fa::mily</u>?
13		Those are the two main spheres? .hh
14	C:	I mean-
15	T1:	Or somehting else.
16	C:	I I honestly ((hand gesture)) don't know. {T1: °okay°}
17		I ((hand gesture)) don- I don't know.
18	T1:	↑O↓kay {T2: °um hum°} .hh >WE CAN DO THAT.<

As I explicated in the previous section of this chapter, April and Dr. Miller agreed that the therapists would provide advice to her on what to do with the situation, despite her weak agreement (Pomerantz, 1984), "I don't know maybe" (line 10), and non answer

response (Fox & Thompson, 2010), “I I honestly ((hand gesture)) don't know.” (line 16). After advice giving in the reflecting team, Dr. Miller and Melissa engaged April in a discussion on the therapy team members’ advice and their own advice for April. In this process, I observed that the primary therapists needed to continually modify presentation of primary advice (i.e., self-care) numerous times over time so as to fit April’s perception, due to her initial rejection of the advice. At the end of the negotiating process, April accepted the advice.

Stepwise entry to advice giving. A *Stepwise entry to advice giving* (Vehvilainen, 2001) is a way of addressing the challenge. In stepwise entry to advice giving, advice givers first elicits advice recipients’ views on a matter at hand to fit their advice to the recipients’ view. Vehvilainen (2001) proposed two variations. In the first variation: (a) a speaker elicits a recipient’s view on a matter at hand; (b) the recipient describes his or her view of the matter; and (c) the speaker gives advice grounded in the recipient’s view. In the second variation: (a) an advice giver elicits a recipient’s view on a matter at hand; (b) the recipient describes his or her view of the matter; and (c) the advice giver evaluates the recipient’s view in a form of advice. In this latter variation, an advice giver poses advice as a means of evaluating and challenging the recipient’s views on topics at hand. The stepwise entry comes with interactional benefits of (a) avoiding establishing unilateral relationships and preserving a stance that the recipients are the experts in their lives, and of (b) gauging whether the speaker has had enough of a view of the recipient to give advice.

The overall structural organization of advice giving—variation 1. I derived overall sequential structure of therapist-client interactions in advice giving based on my

observation. In doing so, the idea of stepwise entry to advise giving was useful for me to discern the patterns. However, I expanded the unit of steps and their variations to accommodate the current study's data. I first present a figure, depicting the overall picture of the practice in steps. Then, I will explicate each step.

In Figure 4, I observed the following general steps: (1) a therapist presents April several pieces of advice as the reflecting team's advice and have her pick the ones that were meaningful to her, and her rejection of the advice; (2) the therapist evaluates her accounts of rejection through polar questions or challenge, and April's prompted elaboration of her previous accounts of rejection; (3) the therapist re-presents the reflecting team's advice through various interactive practices (e.g., minimizing their knowledge about the matter, compliments of clients, reframing of problem accounts, etc.) and April's corresponding rejection response; (4) the therapist evaluates her accounts of rejection through polar questions or challenge, and her elaboration of the previous accounts; (5) the therapist represents the advice through the various interactive practices, and she further expands her account; and (6) the therapist challenges the client, April partially accepts the advice, and the therapist acknowledges her acceptance. In the series of interaction, the therapists kept adjusting their advice so as to invite April to accept it at the end.

Before presenting a series of exemplars, depicting each step, I first present simple analysis of some advice proposed in the reflecting team. In the reflecting team process, most of the therapy team members shared with each other advice on the client's self-care, directing it toward the client.

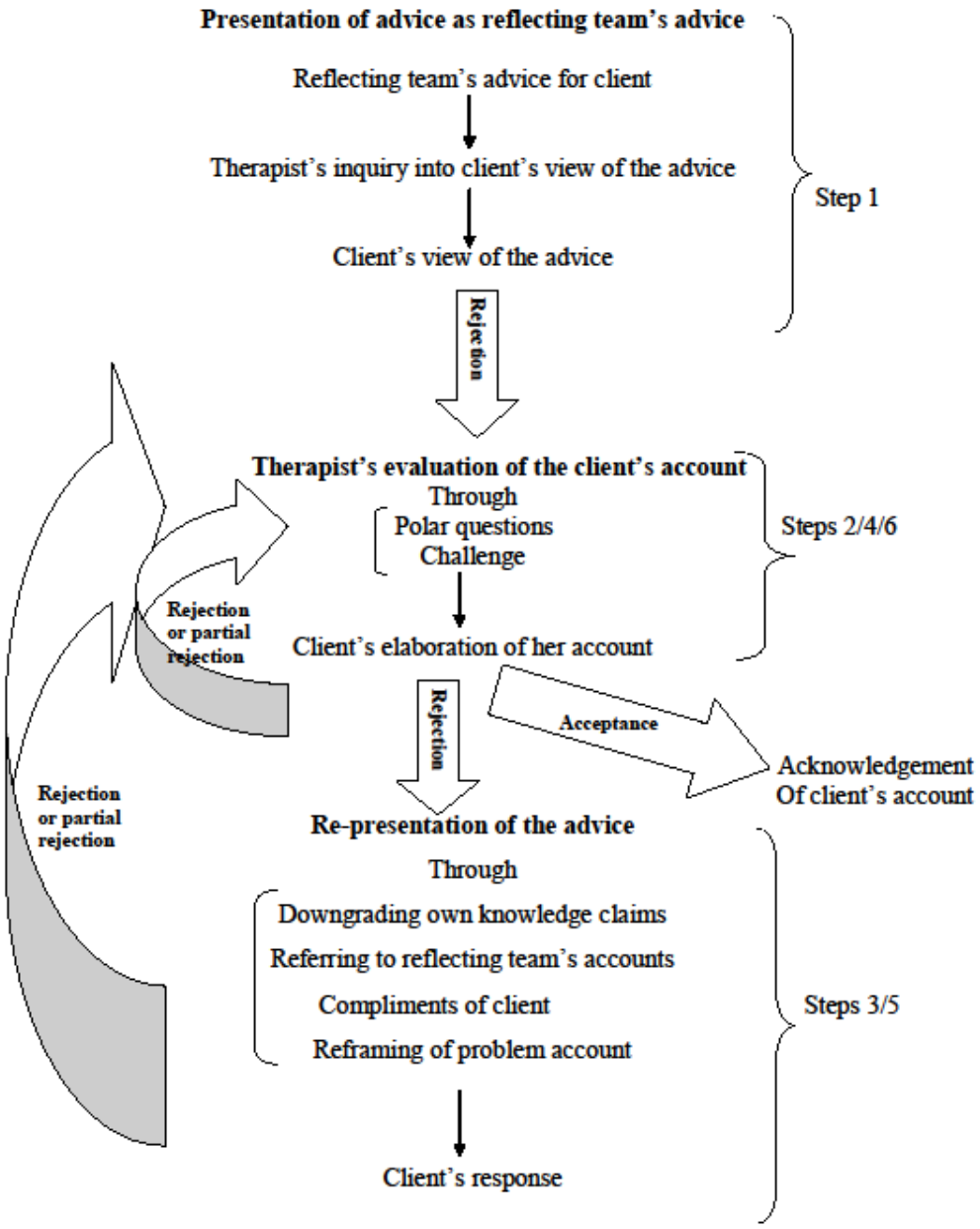

Figure 4. The overall structural organization of advice giving—variation 1.

43 T1: .hh ((turns toward T4, finger-points at T4) Yeah you had a similar idea

44 that that was very

45 (.)

46 T4: Yeah [it's almost like] (0.3) being able for her to give herself ((hand

47 T1: [(.....) e(HH)]

48 T4: gesture)) the <u>permission</u> to keep focusing on <u>herself</u>. {T3: Yeah (I saw

49 it.) ((nodding head))} (0.3)

50 Like taking a break from worrying so much about (0.6) a:::h her <u>family</u>

51 (0.2)

52 a::nd ahm to keep moving ahead and do what's working for her.

53 T2: °Yeah°

54 T1: °Good.°

In the sequence above, one of the primary therapists, Dr. Miller, appoints a therapy team member, Lisa, to share her ideas with the rest of the therapy team (lines 43-45). His use of bodily gestures, of turning toward her and pointing a finger at her, as well as the verbal encouragement, elicit Lisa's tentative advice for the client to give herself a permission to take care of herself, while stopping to worry for her family (lines 46, 48-52). The interspersed acknowledgment tokens (Bangerter & Clark, 2003) (lines 48-49, 53) and Dr. Miller's assessment token (line 54) seems to have worked to build up expectation for April to respond to the advice later on.

Below is another exemplar of an advice giving sequence later in the reflecting team.

69 T6: .hh But (0.2) with my history ((hand gesture)) (0.2) a:::h (u) watching

70 ((hand gesturing)) different kinds of illnesses and addiction, .hh < ((hand

71 gestures in sync with the speech)) I'VE OFTEN <u>HEAR:D</u> PEOPLE <u>SA:Y</u>

SOMETHING AKIN TO THE FOLLOWINGS.

.h <When I started ((points at himself with hands)) to take care of <u>myself</u>

(0.2) and I started put myself ((points at himself with a hand)) <u>first</u>, this

funny ((hand gesture)) thing happened that people ((points to the side with

a hand)) around me started to change.

.h And <u>often times</u> I heard that it's for the <u>better</u> that change like I didn't do

it for them most. {T?: °um hum°} (...for) ME. ((points to himself with

a hand)) {T2: °um hum°}.hhh

So there's no guarantee ((hand gesture)) there.=

In this sequence, a student therapist, Daniel shared a story to offer advice for April. In therapy, therapists can use storytelling to encourage clients to "think and behave in new, productive ways" (Crawford, Brown, & Crawford, 2004, p. 1). Particularly in Ericksonian psychotherapy and hypnotherapy, therapists use storytelling for various purposes, including making suggestions or points, embedding directives, reframing problems, modeling a new way of interactions and so forth (Zeig, 1980). In the present sequence, Daniel stresses key words, "<u>myself</u>" (line 73), "<u>first</u>" (line 74), "<u>often times</u>" (line 77), "<u>better</u>" (line 77), and "ME" (Line 78) to emphasize them. At the same time, he adds a tentative note at the end with, "So there's no guarantee ((hand gesture)) there." (line 80). However, I cannot gauge the interactional implications of their interactional sequences since the client was contracted to suspend her responses to those therapists' accounts till a later discussion with the primary therapists.

Step 1 and 2 of stepwise entry to advise giving. After the reflecting team, Dr. Miller opened up a discussion with April on those therapists' accounts in which he seems to utilize those accounts as a stepwise entry to advice giving.

T1: .hhWell a::hm (0.3) usually what I ask you ((hand gestures in sync with the speech)) is like of all the stuff ((hand gesture)) that you heard what stood out for you?=

=You don't think about it too much but like <stuff they said what .h (0.4) just what intuitively (0.3) stood out for you?> =

C: =I mean (0.5) ((shifts seating position)) I care about myself you know. {T1: leans forward, puts a palm on a side of chin, nodding head))} (0.3) I'm putting myself first. (0.2) you know I know that ((hand gesture in sync with the speech)) like (0.5) you know like I'm doing everything that I'm supposed to.=

=It's not that I like (0.3) worry (0.7) you know I put them first at any time.

Like I'm really putting((hand gesture pointing to herself)) myself first. {T2: °um hum°}

T1: You are↑

C: ↑Yeah ((hand gestures in sync with the speech)) just that they just- (0.4) there's always like sucking ((close a palm in air, moving it up and down)) things out you know {T2: °um hum°}

In response to Dr. Miller's inquiry as to therapists' accounts that stood out for her, April challenges, after a brief pause, embedded assumptions in the therapists' advice that she cares about her family at the expense of her self-care (line 16). Instead of responding to her account, Dr. Miller shifts his position, simply acknowledging her account (line 17). Taking the interactional context into account, it seems that he encourages her to account for her statement. This elicits a series of her more elaborative account on self-care (lines 18-24). While Melissa provides an acknowledgment token, "{°um hum°}" (line 25), Dr. Miller questions her accounts, "You are↑" (line 26). April further attempts to convince him that it is her family that is responsible for the family problems (lines 27-29).

Step 3 of stepwise entry to advice giving. April's account, pointing out her family as the source of the problem, continues for the next coming turns. Then, she makes a claim that the problem is the fact that she can recognize the family situation as an issue.

46 C: Problem is I <u>see:</u> what's happening.

47 T2: °(...)°

48 C: °yea[h° {T2: ((nodding head))}

49 → T1: [(Problem is a solution too.

50 .hh ((looks down)) I mean it's it's problem for <u>you</u>. (0.4)

51 I- I <u>wo</u>rry >jus' <u>getting</u> ((hand gesture)) to know you (.....)<=

52 =You're very clear about what's going on and I give you my .hh sense of

53 that is thata::h what I thought ((turns to a side to point the group of

54 therapists)) that I heard them saying was thata:h it's amazing what'yu're

55 doing.=

.

.

60 .hhh I think a lot of people are relying on you.=

In response to the April's account, Dr. Miller offers an idiomatic form, "[(Problem is a solution too." (line 49). He corrects himself and emphasizes with her that it is a problem for her (line 50). Then, he offers her emotional support, "I- I worry" (line 51), while quickly limiting his knowledge about her (line 51). He follows up with a compliment (Pomerantz, 1978; Pomerantz & Heritage, 2014) by referring to the therapy team members' accounts. He accomplishes this by turning to a side to signal the collecting account of the compliments (lines 53-54). He then makes a concluding remark in a form of reinterpretation (Bercelli et al., 2010) that her family depends on her (line 60).

Using the remark as a context, he re-offers the same advice as before. In this portion of advice-giving, Dr. Miller seems to utilize *reciprocal editing* (Kogan & Gale, 1997). The practice refers to a mutual process between therapists and clients of attributing and re-attributing new meaning to clients' initial account of their ideas, feelings, experiences, and so forth. This is achieved through their deliveries of their interpretations with various signs, showing their hesitation and uncertainty. Those signs include uncertainty markers, pauses, repeats, hesitations, questions within or after interpretation statement, and so on. Through this practice, therapists essentially achieve downgrading their knowledge claim (Heritage, 2014) about clients' ideas, feelings, experiences, contexts, and so on, which invites clients to co-edit the interpretation.

61 → T1: =And I heard that <their worry for you is that> (1.0) IN THAT TYPE OF
62 SITUATION YOUR OWN NEEDS seems very small= 'cuz you're very
63 competent.=

64 =You made straight ↑As,=you got out of the house at ↑seventeen= {T2:
65 ((nodding head))} =you you have something the others in your house (.)
66 <don't have.
67 .hh So you're very competent (.) is my sense of it. {T2: °um hum°}.hhh
68 and they're (.) no::t.
69 → And what can happen in that type of situation is what I heard the team
70 saying is ((looks up to see C)) there's worry about you taking care of
71 yourself ((points a nod at C)) .h 'cuz their needs seem <so much bigger.>
72 (0.3) What'yu ((points a nod at C)) think about that?
73 C: I do take care of myself.

Without any gap in between, Dr. Miller provides emotional support through the eyes of the therapy team, accompanied by reframing the context with added emphases on some words, "(1.0) IN THAT TYPE OF SITUATION YOUR OWN NEEDS seems very small= 'cuz you're very competent.=" (lines 61-63). In contrast to April's attribution of blame on her family, this reframing seems to attribute the source of the problem to the situation. His turn construction (Clayman, 2014) of placing "IN THAT TYPE OF SITUATION" (line 61-62) at the top of the sentence seems to add further emphasis on the reframed association. In addition, Dr. Miller downgrades (Heritage, 2014) his reframing with the word, "seems" (line 62) creating a space for mutual editing of the re-attribution of meaning to the context.

Further, he continues to provide detailed examples of her competency without any gap in between (lines 64-66), preventing her from responding at this point. He then makes another concluding remark that she is competent, in contrast to the rest of her

family, while making it tentative by using "my sense of it" (lines 67-68). He continues to bring up the same reframe with a more empathic tone at this time that the therapy team is worried about her not taking proper self-care, since her family's needs appears to be prominent (lines 69-71). Again, the implied message in this series of statements and reframe is that it is the situation in which she finds herself in that is the problem, instead of her. This series of the statements and reframing of the problem account, along with emotional support, seems to have created a condition for April's acceptance of the advice, as Feng (2009) suggests. With a short gap in between, he then asks for her response (line 72), which opens up a room for April to support or contest his reframing. However, April responds with a rejection, challenging the embedded assumption that she neglects self-care.

Step 4 of stepwise entry to advice giving. Due to April's rejection of the advice, the sequence circles back to another sequence in which Dr. Miller evaluates her account of rejection.

74 → T1: Do you?

75 → C: °ye°s (every-) I put my- I can pay like all the ((hand gesture)) bills and

76 without looking (0.2) like any handout =

77 = just (0.6) they (0.3) they're always like sucking it in ((closes a palm in

78 air, moves up and down)) like a::h: {T1: (....) / T2: °um hum°

As before, Dr. Miller challenges her account, "Do you?" (line 74). This prompts her detailed account, justifying her claim (lines 75-76). Without any gap in between, she again points out her family as the source of the family problem (lines 77-78).

This sequence further evolves into advice giving.

79 C: Lik- if I were to like jus- like she said like, jus break off ((drawing a curve
80 in the air with a hand)) and jus leave like she said like break off ((hand
81 gesture)) and jus leave, could. {T1: °yeah°}
82 It's always a possibility, but (0.5) I wouldn't do that. {T2: °um hum°}
83 It's like an (implosion) ((hand gesture)).
84 T1: °yeah.°
85 (.)

She presents her view that she will not abandon her family (lines 79-83). In return, Dr. Miller confirms his receipt of the view (line 84).

Step 5 of stepwise entry to advice giving. The sequence leads to another presentation of the therapy team's advice account.

86 → T1: So you heard that from (...) .hh so you- what Daniel says so (.) I hear you
87 saying you're still planning on staying connected with your family and .hh
88 you know the balance of how to take care of yourself (....) ((nodding
89 head)) {C: °yeah°} {T2: ((nodding head))}
90 She said ((points finger to the where T4 was sitting)) Lisa said the concern
91 that you have .hh that she maybe you need permission to take care of
92 yourself.
93 C: I I think I put myself first (0.1) in a sense that all my needs are taken care
94 of. {T2: °um hum° ((nodding head))}
95 Just they're like sucking all of me {T2: °yeah°} like brain power likeah
96 (0.7) coming to me like ((pretend as if her family)) oh what should I do?
97 {T2: °yeah°} [(like oh ..sister..)

He acknowledges April's intension to stay in touch with her family and represents the advice, "you know the balance of how to take care of yourself (....) ((nodding head))" (lines 86-89). This elicits April's acknowledgement token, "°yeah°" (line 89), Dr. Miller brings up a student therapist's speculation that April may need a "permission" (line 91) for self-care. This prompts her defending herself with a example (lines 93-94), while re-emphasizing the idea that the rest of her family is the source of the problems (lines 95-97). During this time, Melissa seems to go along with April by providing acknowledgement markers (Bangerter & Clark, 2003), "°um hum° ((nodding head))" (line 94) and "°yeah°" (lines 95, 97).

Step 6 of stepwise entry to advice giving. In contrast to Melissa, Dr. Miller, in return, challenges April's views of herself and the situation.

98 → T1: [When they do that, you have the capacity ((sticks an arm
99 forward)) to just say (0.2) <no.>
100 (0.2)
101 C: I mean I can listen ((hand gesture)) to it.
102 T1: Um hmm.

Dr. Miller straightforwardly challenges her, "[When they do that, you have the capacity ((sticks an arm forward)) to just say (0.2) <no.>" (lines 98-99). It seems that he poses advice through the polar question (Boyd & Heritage, 2006; Clayman & Heritage, 2002; Heritage, 2010). The short pause and pronunciation of "no" (line 99) brings the weight of his challenge. After a short pause, April responds with a partial confirmation (Raymond, 2003) of his advice. He acknowledges her account at this time (line 102).

The overall structural organization of stepwise entry to advice giving

variation 2. I observed that similar advice giving interactional sequence occurred later in the consultation. Since the order of steps involved is different from the earlier one, I distinguished the latter one as a variation 2. Below is Figure 5, depicting the overall structural organization of the variation 2. In this second variation, (1) Dr. Miler presented his advice through the various means as the ones used in the variation 1, and April's vague response; (2) he evaluated her account by asking for clarification on her vague account, and she gave her another vague response; and (3) he conducted another evaluation of her account by asking another question, and she gave another vague answer, as well as his acknowledgement of her vague answer.

Step1 of stepwise entry to advice giving—variation 2. Shortly after the sequence above, Dr. Miller describes about the SST consultation service's open door policy. After that, he re-presents the same advice as the previous one, in a different tone.

6 → .hh Seems like you have a plan for your life. (0.8) tch. a::h a future
7 you know ↑career ↑grades things like that. .hh ah:m
8 → That seems to be an anchor (.) to hold onto (0.2) as you're going into the
9 future.
10 .hh I didn't hear much about that.=
11 → =That's why I asked you what'yu're hopeful about 'cause .hh I HEAR
12 A LOT IN (THAT) THIS (..) YOUR STORY CAN GET MIRED
13 ((tilts head, draws hands outwardly)) WITH WHAT'S NOT GOING
14 RIGHT.

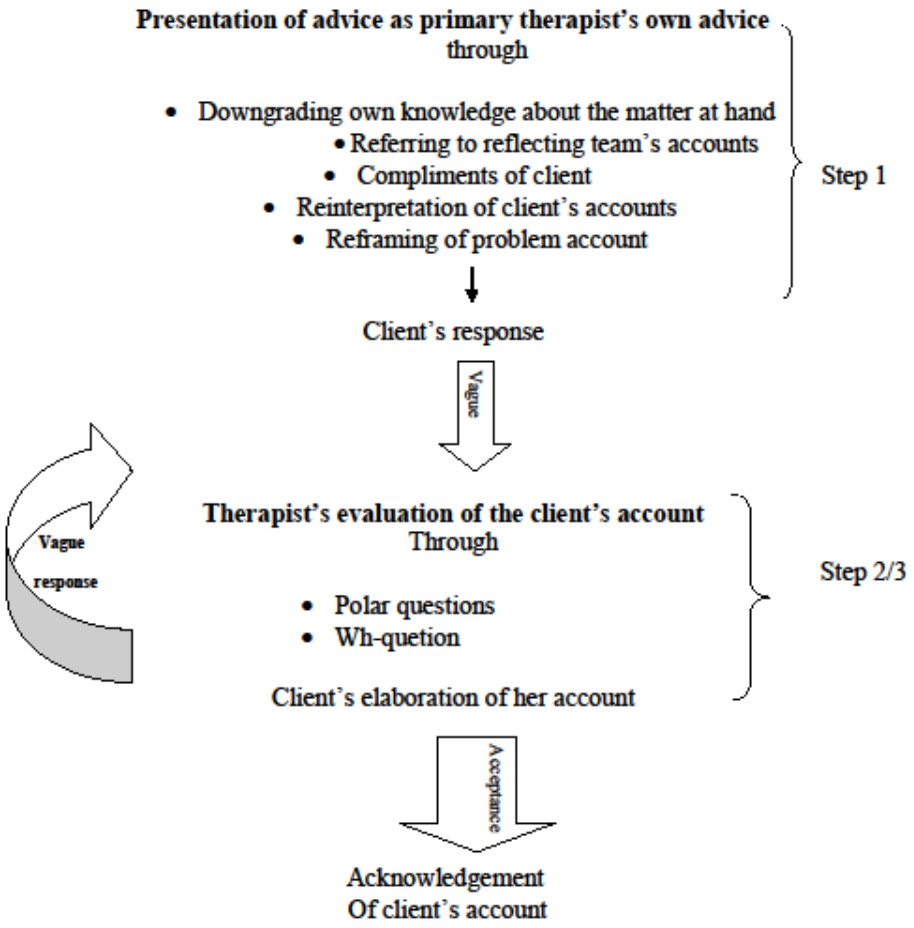

Figure 5. The overall structural organization of advice giving—variation 2.

First, he offers a claim that April has a plan for the future (line 6) and provides examples (line 7). He then attributes importance to the account (lines 8-9). After sharing his

observation of her (line 10), he provides an idiomatic phrase, ".hh I HEAR A LOT IN (THAT) THIS (..) YOUR STORY CAN GET MIRED ((tilts head, draws hands outwardly)) WITH WHAT'S NOT GOING RIGHT." (lines 11-14). Through using the ambiguous and oblique reference and presenting it as information, Dr. Miller seems to manage the misalignment between his and April's views in the course of advice giving (Silverman, 1997). Such use of oblique reference and presentation of advice in information format has allowed him to stabilize the advice, without necessitating her to confirm the advice or expand her perspective on the advice.

With the problem account laid out for April, he presents advice:

15 → T1: .hh And a::h I wanted to ask you an I would encourage ((points a hand to
16 C)) you to think about (.) as you see the bad things ((hand gesture))
17 happening in your family, (so also to think about) what do I ↑like ((hand
18 gesture)) what's going ↑well ((hand gesture)) what'am I hopeful
19 ((eyebrows go up)) about ((hand gesture)). .hhh ((tilts head))
20 (2.2)
21 C: ((hand gesture))

He quickly self-repairs (Kitzinger, 2014) himself and uses the word, "encourage" (line 15) with an added emphasis to turn this statement into an invitation. In the mid sentence, he switches his sentence construction from the second person to the first person format, perhaps to customize her advice particular to her situation so that she would be more receptive to the advice. Along the way, he seems to utilize conversational resources to elicit her response, including pointing a hand to her (lines 15-16), hand gestures timed with his speech, raising his eyebrows (line 19), and tilting his head (line 19), as well as a

long silence after the turn (line 20). However, this only elicits a minimal response from her (line 21).

Step 2 of stepwise entry to advice giving-variation 2. This sequence evolves into the step 2 of a stepwise entry to advice giving.

22 → T1: Can you say anymore about that tchh?

23 (0.5)

24 C: Jus- blooming my life you know. (.) Th[at's it. ((hand gesture))]

25 T1: [(....)]

26 C: (.) It's really it.

27 → T1: ((nodding head)) °yeah.°

28 → T2: ((nodding head)) °um hum.°

29 → T1: °okay.°

30 .hhh Well keep ((nodding head)) thinking about it=

31 C: =(HH[H) ((sobs, hand gesture))

32 T1: [Yeah HHH[H ((turns into a small laughter))

33 C: [You know ((hand gesture)) it's-hhh not it's not like a

34 ((hand gesture connoting "multi (....)")) (multi ....).

35 =Jus-hh living my life wherever ((hand gesture)) school takes me.

36 T1: °Yeah.°{T2: ((nodding head))}

In response to the unclear and weak response, he asks for clarification (line 22) and waits for her to pick up a turn (line 23). In return, April offers another vague response, "Jus- blooming my life you know. (.)" (line 24) and attempts to terminate the inquiry with "Th[at's it. ((hand gesture))]," (line 24) while overlapping his start of a turn (lines 24-25).

She repeats the similar phase to re-attempt to end the inquiry (line 26). He and Melissa acknowledge her attempt with tokens (Bangerter & Clark, 2003). He adds a consent token, "°okay.°" (line 29) to communicate the termination of the inquiry, while reminding her of the importance of the inquiry, in a form of suggestion that does not require her to respond further (line 30). This brings April into tears (line 31) and he responds with "Yeah HHH[H ((turns into a small laughter))" (line 32) to acknowledge her emotional expression and match her exhalation pattern. Taking her cry into the interactional context, it seems that April has accepted his advice at this point. After her another value response (lines 33-35), he acknowledges her account (line 36).

***Step 3 of stepwise entry to advice giving—variation 2*.** Then, he further pursues another line of advice in a question format (Silverman, 1997), "What makes you happy?" (line 37).

37 → T1: (0.3) What makes you happy?

38 (5.3)

39 C: °I: don't know.°

40 (0.4)

41 → T1: °(okay.)° ((nods head))=

42 = If you come back again, if you choose ((nods head)) to, I might ask you

43 that question again.=

44 =I just think about it little bit .hhhh buta: ((looks down))

After a long pause (line 38), April states that she does not know an answer. This is followed up by another short silence (line 40). He offers a consent token, "°(okay.)° ((nods head))" (line 41), while re-presenting the advice in a format, a *proposal of*

situation (Silverman, 1997). This format has allowed him to assert the advice again, without necessitating her to respond to it. In this sequence of interaction, it seems that April has accepted the legitimacy of the advice for her self-care.

This seems to be evidenced by their interaction toward the end of the consultation in which Dr. Miller asks April if there were any topics of interest that were not explored in the consultation. For more detailed account of his utterances in this sequence, I refer the readers to the previous section of this chapter. In response, she solicits advice as to whether she should break away from her family or pursue her life.

1 T1: TODAY WE'RE GETTIN' CLOSE ON TIME ((looks up to see T2))
2 {T2: ((looks at T1))} and .hhh is there anything else we didn't tell you
3 about that (..) seems like we:ah you wanted to know about?
4 (0.8)
5 C: No.
6 (1.2)
7 T1: .hhh °Okay.°=
8 C: =Do you feel like just making break ((hand gesture)) (0.4) just like leaving
9 ↑ ((hand gesture)) them (0.9) {T2: ((nodding head))} you know. {T1:
10 Um hum.}
11 I feel like really that's the only thing (0.5) but then like I said >it's like<
12 they're still doing the same thing (1.2) like putting distance.{T2: Um
13 hum.}

After the initial non answer response (Fox & Thompson, 2010), "No" (line 5), April solicits advice in a form of question whether she should break away from her family. While presenting it as seemingly the only way out of the problem, she displays hesitation (line 11-12).

In response, Dr. Miller poses a question, asking her confirmation of facts (line 14-15).

14 T1: pt .hh You're tweni two (0.9) ↑ Yes. (0.8) and you moved out when you
15 were seventeen. (0.7) (>Is- that-<) Did I get the facts right?
16 C: ((nods head))
17 → T1: And- so you started making that break already.
18 Which I- I think when they say admirable they say there's something
19 really good in you an about that. =
20 = That's what they're talking about that you .hh already have that capacity.
21 {T2: yeah.}
22 (1.2) So:: I yeah. So I think you- you're an adult. You're twenty two.
23 You're free to do what you want.
24 → I:-But my guess is it's more complicated than that with your heart (0.6)
25 {T2: um hum.}and your mind.

As she confirms the facts (line 16), he presents an alternative view that she has already started breaking away from her family when she moved out of their house (line 17), and follows up with a compliment on her competence of having done so at seventeen years old (lines 18-20). While advising her that she has freedom to choose to break away

further from her family (lines 22-23), he provides emotional support by describing her dilemma (lines 24-25).

Then, he offers a series of reinterpretations, pointing out April's worry for her family.

26 T1: .hhh a::hm (...) I would guess. (I ...) take a wild guess
27 >it would< be <worry> (0.4) for you (.) about what's gonna happen.=
28 =I heard'yu say a lot of things ((nodding head)) about what you're worried
29 about with them. {T2: °yeah°}
30 tch. Anda:: what would you've worried about if you are not around to (.)
31 be there when your mother ↑ called or:: loan your sister money when she
32 needed it=or hear your .hh younger sister complain about how the older
33 one's .hhh not doing something.
34 All those things (0.2) I think you're worried about that.

By framing his reinterpretations (Bercelli et al., 2010) as a "wild guess" (line 26), he downgrades his knowledge claim (Heritage, 2014) of this utterance. As I discussed before, his posture seems to be in line with SST's practice of centering clients' way of knowing (Amundson, 1996; Bloom, 2001; Bobel & Slive, 2014; Hoyt and Talmon, 2014b). After the initial concluding remark (line 27), he provides his detailed observation of her accounts (line 28-33).

Both-and questions. At the end of the sequence, he turns attention to Melissa, soliciting her accounts of April's dilemma. In response, Melissa asks *both-and questions*. This type of questions juxtaposes two seemingly contradictory ideas without

compromising one over the other. The idea is exemplified in a *both-and* perspective in family therapy literature (e.g., Auerswald, 1987). This idea was evolved in contrast to *either-or* perspective, or dualism in which an idea was either true or false. Therapists with the both-and perspective work with clients without needing to reduce problems to individuals, or being caught up in clients' dualistic thinking (Auerswald, 1987).

In the current interactional sequence, the question seems to invite April to free herself up from the dualistic thinking that she has to choose the option of self-care by breaking away from her family or the option of continuing to worry for her family by staying in touch with them.

35 T1: A::h: .hh so hh what'yu ((points a nod at T2, keeps a gaze at T2)) think
36 about this? =>
37 → T2: =You know its- its- it sounds like you're doing what you need to do.=
38 =A::hm a:nd given the situation and your family is, .hh I am curious to
39 know (.) .hhh ((holds a hand in air)) HOW COULD (0.3) >you know<
40 (0.4) HOW COULD >you know< How could you continue on ((hand
41 gesture)) like how could there can and situation ((holds both hands in air))
42 for you where your family is hh (0.4) who they are ANDYU CONTINUE
43 TO ((hand gesture)) MOVE FORWARD IN LIFE, accomplishing the
44 things you wanna accomplish like ↑ school and this relationship.
45 A::hm (.)how could you have (0.7) both ((holding both hands in air)) in a
46 healthy way 'cuz (0.3) I'm not sure if you wanna cutoff your ↑ family .hh
47 right ↑ now.=

48 =So how- how could you just continue?

49 (0.5)

50 C: ((hand gesture)) That's probably the problem.

51 → T2: Um hum. ((nodding head))}

52 C: I don't know.

53 (1.0)

Melissa first offers a reinterpretation (Bercelli et al., 2010), legitimizing what April has done. With no gap in between, she offers a suggestion in a form of a question by juxtaposing side by side the two contradictory ideas provided by the client in the previous sequence: (a) she wants to stay in touch with her family (line 42); and (b) she moves forward in her life (lines 42-44). This juxtaposition connected is in contrast with the assumption embedded within April's dilemma that she has to choose either one. Thus, the juxtaposition frees her up without having to choose one over the other. In its delivery, she emphasizes the latter part of the distinction, "AND'YU CONTINUE TO ((hand gesture)) MOVE FORWARD IN LIFE" (lines 42-43), implying a pursuance of both sides of the distinction. Since Melissa used April's account of the dilemma, she has effectively set up an interactional context in which April is likely to accept her advice in the form of the question.

In response of the series of Melissa's turns, followed by the brief silence (line 49), April points out that not having an answer to the question is the heart of the matter (line 50). Melissa offers an acknowledgement token (Bangerter & Clark, 2003), "Um hum.

((nodding head))" (line 51) and April provides a non answer response (Raymond, 2003), "I don't know." (line 52).

After a moment of pause (line 53), Melissa asks a question, soliciting a confirmation of the account (line 54).

54 T2: Or could'yu? ((tilts head to a side))

55 (0.3)

56 C: I DON' WANT TO. {T2: °right°}

57 (1.4)

58 C: No. ((hand gesture))

59 (0.5)

60 T1: ((nodding head)) [[tch. .hh]

61 C: [[I jus-]don't want to cut them off.

62 T2: Right. ((nodding))

63 (1.3)

64 T2: pt. So how could you have them in your life AND continue to accomplish

65 your goals ((hand gesture)) (0.4) for the future?

66 (1.2)

67 C: ((hand gesture)) Not sure.

68 (1.0)

69 That's my problem.

70 T2: Right.=

After a brief moment of gap (line 55), April states in a louder voice that she does not want to break away from her family (line 56), followed up by another silence (line 57)

and her reiteration of her account (line 58). After providing an agreement token (line 62), Melissa allows a silence (line 63), seemingly waiting for April's further elaboration. Then, Melissa repeats the same question, "pt. So how could you have them in your life AND continue to accomplish your goals ((hand gesture)) (0.4) for the future?" (line 64-65). In this turn, she pronounces the word, "AND" (line 64) louder than the surrounding talk, implying that those two ideas can stand side by side. After another silence (line 66), April provides a non answer response (Raymond, 2003), followed up by another silence (line 68) and her admittance that not knowing the answer is her problem. Melissa agrees with her account (line 70).

Dr. Miller, then, picks up the conversation floor without any gap after Melissa's agreement token (Bangerter & Clark, 2003). First, he seems to communicate the importance of dealing with the question, while protecting April from potentially feeling ashamed with having struggled to come up with the answer.

71 → T1: =So it's a big question. {T2: Yeah. ((turns toward T1))}
72 You're- you're right that yu- identifying the big issue is sometimes really
73 important and (then) think about it for a while. =
74 =.hhh We talk about that a lot in here ((points a nod to the therapy room))
75 actually.=
76 =Don't feel feel alone in this.=
77 → =The balance and families between and give and take. {T2: Um hum.
78 ((nodding head))}

He starts off by stating that the question is "big" (line 71) with which Melissa agrees (line 71). This may have protected April from feeling inadequate for not knowing a response to the question. Then, he introduces the idea without any gap in between that it is important to deal with the question (lines 72-73), as evidenced by his observation of other clients dealing with the same question (lines 74-75). He further protects her by latching an explicit statement that she should not feel alone in dealing it (line 76), and latches another turn, describing the theme of the question in an idiomatic term, "The balance and families between and give and take" (line 77). This utterance seems to support the both-and perspective embedded in Melissa's previous question. In response, Melissa seems to support his intention by providing an acknowledgement token (Bangerter & Clark, 2003).

At this point, the interactional sequence seems to circle back to a step of evaluating the client's views about the advice.

79 → T1: .hhh pt Andah: seems to me that you're on the giving side ((tilts head)) a
80 lot right now and that's a dilemma. {T2: Um hum.}
81 → And knowing how to take a::h take back little for yourself ((pulling both
82 hands toward himself in circular motion)), take ((opens up his palms)) for
83 yourself what is needed out of your ↑ life so you can have a happy ↑ life
84 which is really ((nods head)) important.
85 .hh °t'swhat° ((points a hand to the direction where Lisa was sitting))
86 Lisa's saying it's really important ((points a hand to C)) April that you
87 would like (0.2) also enjoy your life. .hh [((points a finger to C)) [I =
88 T2: [For [your

89 <s(hh)hhh e- >]

90 → T1: donno if anybody's telling] you that{T2: °yeah°} but it's like ((points a

91 finger at C)) you matter and that's very important (.) that you (enj-) like

92 you find something that makes you happy in your life.

93 .hh I don't know if anybody's telling you that but .hh I'm telling you that.

94 S[o:

95 C: [I tell ((points a hand to herself)) myself that.

He starts off with a speculative evaluation of April in a form of reinterpretation (Bercelli et al., 2010) that she seems to give to her family more than to take care of herself, which he frames as a dilemma (lines 79-80). Melissa acknowledges this account (line 80).

At this point, he represents the advice by incorporating the both-and perspective that she needs to take back for herself as necessary to make herself happy (lines 81-84). He backs up the advice with a therapy team member, Lisa's account (lines 85-87). In its delivery, he seems to maintain the both-and perspective by emphasizing the word, 'also' (line 87). Overlapping Melissa's turn, he continues to point out that she needs to pursue her happiness, while speculating that no one may have told her the importance. In its delivery, he emphasizes key words, including "you matter" (line 91), "something" (line 92), and "happy" (line 92). He then repeats the same account (line 93-94), perhaps to emphasize it. In return, April accepts the advice and states that she tells herself the importance of pursuing her happiness (line 95).

The therapists' perception of the client's receipt of the advice is evident in the session note of this consultation. The therapists identified information delivered during the consultation as "balancing give and take with her family" and "giving herself

permission to continue taking care of herself." Similarly, they noted "identifying her source of happiness and what makes her hopeful" as intervention delivered during the consultation. In summary, the findings in this section demonstrates a collaborative process of advice giving in which Dr. Miller negotiated with April on her acceptance of the advice turn by turn through continually attending to her response, while utilizing various conversational resources and practices.

Tapestry: The Overall Structural Organization of the SST Consultation

Finally, I present the overall structural organization of the SST consultation. This is equivalent to a *tapestry* that is a collection of the *warp* and three types of *weft* all woven together in patterns. Although I observed some variations at each stage, I derived and depicted the general overall patterns of interaction between the co-therapists and client in Figure 6.

In the top left corner of Figure 5, the consultation begins with an opening in which Dr. Miller primarily set a single session expectation for April, along with other things (e.g., describing confidentiality and video recording of the consultation, negotiation for the use of a therapy team, etc.). The co-therapists structured the evolving interactional contexts through effective uses of conversational resources and two interactional practices—that are, preliminaries to preliminaries (Schegloff, 1980) and pre-sequences (Schegloff & Sacks, 1973). Throughout the entire consultation, the therapists also utilized the basic interactional practices (i.e., project markers, adjacency pairs, silence, audience design, etc) to manage and coordinate the therapist-client interaction.

Upon April's endorsement of the single session nature of the consultation, the co-therapists started inquiring about her problem descriptions, while developing and

maintaining the therapeutic relationship with her through the group of practices, the *warp* 1 (i.e., audience design and lexical entrainment, non-verbal matching, and formulations, etc.). At the same time, the therapists attempted to introduce new perspectives to the

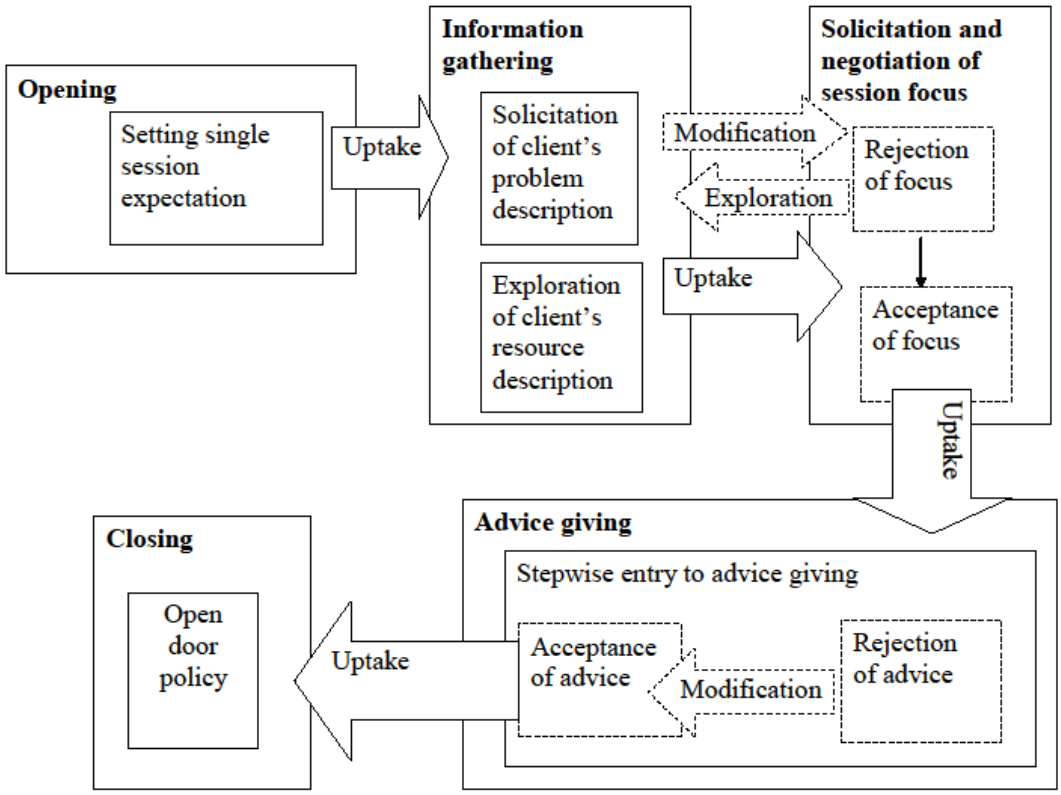

Figure 6. The overall structural organization of SST consultation.

client through the group of interactional practices, the *warp* 2 (i.e., circular questions, reinterpretations, candidate answers, etc.).

Once the therapists determined that they had enough descriptions of the family problems, and received confirmation from April that they understood those accounts accurately, they asked her to focalize a problem to be solved in the consultation. At each time of her rejection of the therapists' attempt to focalize a problem, the therapists

accepted her rejection and solicited further problem and resource description from her before making another attempt to focalize a problem. Over time, April provided a goal for the consultation.

Then, Dr. Miller negotiated with April for the use of a reflecting team and received her permission before taking a consultation break. In the reflecting team process, the group of therapists mostly offered advice for April. After the reflecting team process, Dr. Miller opened a discussion with April about the therapy team's accounts that stood out for her. Using the therapy team's accounts as a first step to stepwise entry to advice giving, Dr. Miller and Melissa negotiated the team therapists' pieces of advice by keep modifying the advice over many turn before they were accepted by April. This finally led to the closing of the consultation in which the therapist described an open door policy.

In summary, the group of basic interactional practices, or the *fibers* became the foundation of the therapist-client interaction. Using the foundation, the co-therapists punctuated the consultation through a series of interactional sequences, or the *warp* which became the contexts for the evolving therapist-client interactions. Within each interactional context, the therapists gathered the information about the family problems, and the client's strengths and resources, while developing the therapeutic relationship, inviting therapeutic changes, and negotiating advice by weaving three groups of interactional practices, the *weft* 1, 2, and 3. As a whole, the *fiber*, *warp*, and *weft* 1, 2, and 3 contributed to the *tapestry* in such a way that collaboratively improved the client's talk at each step of the way.

Juxtaposition of the Findings and Other Data Sources

The micro change that was played out in the therapist-client interaction and the macro change that emerged as a result of all groups of interactional practices being woven together seemed to have led to a meaningful outcome of the consultation. In the session note of the consultation, the therapists noted that the single session was sufficient enough to address the client's needs and estimated her level of satisfaction with the consultation as "very satisfied." In fact, the interview conducted with the client by a student therapist right after the consultation found the following:

- Her expectation for the consultation was met;
- The usefulness of the session was neutral;
- The session was sufficient to address her concerns and needs; and
- Discussing about her problem was helpful.

Conclusion

I analyzed a video-recording of a SST consultation, deemed successful by client report, as the primary source of data and other written documents of the case as the secondary source of data within a single instrumental case study (Stake, 2005). My analysis of the SST consultation's transcript, guided by the organizing metaphor of *weaving*, produced clinically relevant and contextually sensitive descriptions of therapist-client interactional sequences and patterns in the consultation. In particular, I derived the *fiber*—a group of basic interactional practices, the *warp*—a group of two interactional practices and a series of sequences to structure the consultation, and the *weft*—three groups of interactional practices to (a) develop and maintain the therapeutic relationship,

(b) invite changes in the way the client talked about herself and her relationship with her family, and (c) negotiate advice with the client. My integration of the interactional sequences and patterns generated the *tapestry*, an overall structural organization of the SST consultation.

The findings suggest the collaborative nature of therapist-client interaction through which they contributed to the incremental change at each turn. In each step of the way, the therapists and client collaboratively contributed to their evolving interactional, cyclic patterns. In general: (a) the therapists initiated an inquiry; (b) the client responded to the inquiry; and (c) the therapists acknowledged the client's response. The therapists utilized a variety of interactional practices in and through the interaction to engage in collaborative adjustment at the micro interactional level (Strong et al., 2008). Each cycle is a completion of the common ground (Bangerter & Mayor, 2013; Clark & Brennan, 1991). Those micro changes contributed to the overall flow of progression and the therapeutic improvement.

At this point, I revisit my research question: "How do therapists collaboratively improve the talk in SST turn by turn in such a way to promote therapeutic improvement?" I respond to this question by concluding that "The therapists collaboratively improved the talk in SST turn by turn by attending, responding to, and adjusting to the client's responses and objections to the therapists' initiatives in determining the process and content of the consultation."

In chapter five, I reflect on the findings of this study in the light of the existing family therapy, SST, and CA literature. In particular, I discuss the implications and

suggestions for the practice, research, and training of family therapy and SST. I also mention limitations of this study, as well as my personal reflection on this study.

CHAPTER V: DISCUSSION AND IMPLICATIONS

If you desire to see, learn how to act.

—Heinz von Foerster, *On constructing reality, 1973*

Collaboration . . . involves shared intentions, relational commitments and a dynamic and reciprocal process involved in keeping interactions collaborative.

—Strong, Sutherland & Ness, *Considerations for a discourse of collaboration in counseling, 2011*

In this study, I aimed to elucidate therapist-client interactional patterns in a successful SST consultation by utilizing CA, a discursive approach to face-to-face interaction. In particular, I explored how the therapists collaboratively improved the talk in SST turn by turn in such a way that promoted therapeutic improvement.

Guided by the organizational metaphor of *weaving*, my CA of a video-recording of a SST consultation, within a single instrumental case study (Stake, 2005), produced clinically relevant and contextually sensitive descriptions of therapist-client interactional patterns in the consultation. In particular, I derived the *fiber*—a group of basic interactional practices, the *warp*—a group of interactional sequences and two interactional practices to structure the consultation, the *wefts*—three groups of interactional practices to (a) form and maintain the therapeutic relationship, (b) invite the change in the way the client talked about herself and her relationship with her family, and (c) negotiate advice with the client. My integration of the interactional sequences and patterns generated the *tapestry*, an overall structural organization of the SST consultation.

Limitations of the Study

Since the study was a single case study, the findings will neither describe nor be applicable to all SST practices. Instead of generalization, the purpose of this study, utilizing CA within a single instrumental case study format was to provide context-dependent "insight" (Stake, 2005, p. 445) into interactional sequences and patterns between therapists and clients in a successful SST consultation. More elaborately put, I hoped to track and articulate how therapists used various rhetorical and interactional practices (Hutchby & Wooffitt, 2008) in order to establish particular relationships between the utterances that make up the conversation (Liddicoat, 2007). This careful and sensitive single case analysis made sense to me for exploring therapy, as Weakland's (1987) assertion that it is a number of interrelated factors that contribute to change in therapy.

Some readers of this study may criticize CA as a method. In the field of discourse study, CA has been criticized, for primarily two groups of reasons (Wooffitt, 2005). First, some researchers argue that CA cannot adequately analyze a particular type of interaction, manifesting power and inequality due to gender, ethnicity, or class (e.g., war, rape, abuse, etc.). Another group of argument against CA is that it fails to address the larger social, historical, cultural, and political contexts that are manifested in and expressed through participants' interactions (Wooffitt, 2005).

For instance, Wetherell (1998) and Billig (1999) contested Schegloff's (1997) depiction of CA that it is an empirical investigation of interaction in their own terms without preconceived assumptions. For Wetherell (1998) and Billig (1999), CA carries with it "frames of reference" (Wetherell, 1998, p. 387), or a set of "sociological and

ideological assumptions" (Billing, 1999, p. 544) that conversation analysts take for granted. In particular, Billing points out a group of specialist rhetoric (e.g., *adjacency pairs, receipt designs, self repairs* etc.) that are used in analysis of CA that CA researchers impose upon the analysis of interaction. At the same time, Wetherell (1998) acknowledged CA's contribution and suggested the synthesis of CA with other discourse approaches (e.g., ethnomethodology, post-structuralist analysis, or critical discourse analysis, etc.) that attend to and bring forward different factors, contributing to the formation of local interactions.

In response to those criticisms of CA, the proponents of CA responded that they do not assume the existence of those external influences, while acknowledging potential differences in accessing power, privileges, and resources. Instead, they support a view that such an equal power between participants should be evident and determined within their local interaction (Schegloff, 1999; Sidnell, 2014; Wooffitt, 2005). On the other point, Wooffitt (2005) defended that numerous CA studies provided an enriching analysis of highly contested interactions, and argued that an exclusive focus on the social contexts can shadow the intricacies of observable, local interactions. Wooffitt goes further to assert that the presupposition of discourses, impacting local interaction leads to a fabrication of such phenomena away from the empirical data.

While I refer the readers to the cited literature above for detailed elaborations of those points, I observe that the debate seems to stem from the dualism, except Wetherell's (1998) stance, in which one side claims the legitimacy of its own method, at the expense of the other. Instead of being caught in the dualism, I contend that the two methods can co-exist side by side. I believe that each method brings forth and highlights

some aspects of a phenomenon in investigation, while obscuring other aspects of the phenomenon. Embedded in my belief is my commitment to constructionism that social reality, including research, is brought into being by researchers (Holstein & Gubrium, 2011). Therefore, I take an approach to the issue that each method is valid and legitimate in its own right, if conducted with rigor. At the same time, I believe, as I argued in chapter three, that researchers should select their research methods based on their research questions and phenomena of interest. In this study, I chose CA since I sought to generate descriptions of interactional sequences and patterns through which the therapists engaged the client, in such a way that encouraged the improvement of the talk at each turn in a constructionist-oriented SST consultation. Holding the constructionist sensitivity meant the acknowledgment of my research findings as one version of multiple interpretations.

My Reflections as a Researcher

I acknowledge that it is through my way of approaching the data and utilizing CA, the research question, my knowledge, and assumptions about SST that produced analysis, interpretation, and representation of the data. This means that another researcher with a different research question and set of knowledge and assumptions about SST may produce different findings. As stated in chapter three, I adapted a constructional research paradigm whose purpose is to produce *an interpretation* of data within a particular research context. Therefore, it was imperative for me to share my assumptions and bias about SST, as well as the process of my research study itself. In this way, the readers of this study will be able to judge the trustworthiness of my interpretations. My findings are

invitations, not universal principles, for my readers to contribute to the analysis and its discussion.

After completing this study, I arrive at a conclusion that the traditional CA may be unfitting to study constructionist-oriented therapy interaction, if applied to analyze interactional practices without accounting for the overall interactional flow. To reiterate, the conventional CA's ultimate purpose is to identify principles of interactional devices that are context-specific and cross-contextual (ten Have, 2007). In my analysis, I focused on an exploration and explication of the therapist-client interactional sequences within the overall flow of their interaction. From my repeated analysis of the current transcription, I realized that it is not simply the interactional devices or sequences themselves that contributed to their interactional functions, but a combination of the interactional practices *and* its interactional context that embeds the practices which determines their interactional functions.

In addition, I observed that the interactional context evolved throughout the SST consultation through the therapist' and client's mutual and on-going participation. That is, the therapist and client contributed to an evolving context through their verbal and non-verbal utterances. Within the evolving interactional context, the meaning of their interaction is *temporarily* determined by the relations among their utterances. Over time, the layering of their utterances grew and become more and more complex. Sometimes, the initial layering of their utterances may later be folded within another layering of their utterances. That is, that the same two interactional sequences between the therapists and the client at two different points in time would have potentially meant something different, leading to two different findings of the same interaction.

For instance, in my analysis of the therapists' advice giving in the SST consultation, I would have captured their interactional sequence as the client's manner of repeated resistance to the therapist's advice had I limited my analysis to the sequence itself. It was only when I followed Clayman and Maynard's (1995) advice for CA researchers to expand the scope of sequence in examination, when faced with a deviant case, that I found that the therapists negotiated with the client's repeated resistance and represented the advice in a way that was more acceptable for the client. In a sense, I suggest that CA researchers take Clayman and Maynard's advice as the rule, not an exception, to the analysis of interactional sequence.

This conceptualization of interaction seems to be inconsistent with that of the traditional CA. I agree with Fusaroli, Rączaszek-Leonardi, and Tylén's (2014) criticism of the traditional conversation analysts' view of interactional patterns as "scripts" (p. 153) that are preconceived and shared by the participants of the interaction (see Sacks et al., 1974; Schank & Abelson, 1977). This may have to do with Robinson's (2014) observation that the majority of CA studies have analyzed individual sequences of action and their subparts. I agree with Fusaroli et al.'s alternative view that "interactional routines are dynamic, context sensitive structures in continuous evolution" (p. 153). This argument further warrants that, when studying a strip of interactional sequence in constructionist-oriented therapeutic interaction in SST, CA researchers need to take into account the overall progression of interaction that embeds the very interactional sequences under examination. Removing the interactional sequences from its surrounding sequences, or its natural context, creates a risk of casting the sequence as a static object that exists remotely from the evolving interactional context (Gale, 1991).

Reflections on the Study within SST Literature

As I mentioned in chapter one and two, there are numerous publications on SST. The findings from this study seem to be congruent with its assumptions, pragmatics, many of its guidelines, and structure. First, my findings seem to indicate that the therapists approached the SST consultation from the post-modern, constructionist, and systemic frame work (Campbell, 2012; Miller & Slive, 2004; Slive et al., 2008). This is evident in the way therapists positioned themselves to the client such that the client contributed to the nature of the consultation. Specifically, the therapists let the client determine her primary problems and the consultation goal through presenting and re-presenting their understanding of her problems and consultation goal. It seems that the way the therapist engaged the client also corroborate the findings of the common factor research (Duncan, et al., 2010, 2011) that points to an importance of a collaborative relationship in which a therapist prioritizes clients' contribution and utilizes their own resources to bring about therapeutic change. For instance, my analysis shows the co-therapists' tenacious attempt to adjust their understanding of the client's problem over many times, while exploring her resources and strengths within the family's relational context.

My findings seem to show the tenet of brief therapy that clients need a therapist's assistance for the period of the consultation to enable their resources to solve their problems (Campbell, 2012). This is exemplified in the manner in which the therapists explored the client's strengths and resources, while empathizing with the client on the significance of her family problem. In addition, the therapists' tenacious attempts to set a consultation goal seem to reflect the expectation that change can happen within one

consultation (Bloom, 2001; Bobele & Slive, 2014; Hoyt & Talmon, 2014c; McElheran, et al., 2014; Scamardo et al., 2004; Slive & Bobele, 2011b). While the therapists explored the past, it seems that the exploration was in service of knowing the current relational dynamics among the family members, which is consistent with Bloom and Tam's (2015) note that SST therapists focus on clients' present interactions more so than their interactions in the past. It seems that the structure of consultation seems to be of importance to the therapists, as they structured the consultation, through the interactional sequences I identified, from (a) setting the client's expectation for single consultation, (b) soliciting the client's descriptions of the problems and goal, (c) the reflecting team process, (d) advice giving, and to (e) closing (Ray & Keeney, 1993).

The findings from this study also seem to reflect the therapists' commitment to delivering of the client's goal (Miller & Slive, 2004) and their non-commitment to a strict adherence to any particular therapy models (Amundson, 1996; Clements et al., 2011; Talmon, 2014; Young et al., 2012). This is exemplified, for example, in their use of circular questions (Fleuridas, Nelson, & Rosenthal, 1986; Penn, 1982; Selvini, Boscolo, Cecchin, & Prata, 1980; Tomm, 1988), optimistic questions utilized by SFBT (Berg & Dolan, 2001; de Shazer, 1985, 1988) and narrative therapists (White, 2007; White & Epston, 1990).

My findings seem also to be fitting with interactional elements, designed to make therapy more brief (Fisch, 1994) and shared by brief therapy models, including Ericksonian approach (Erickson, 1980), strategic approach (Haley, 1963, 1977), Mental Research Institute model (Fisch et al., 1982; Watzlawick et al., 1974), SFBT (de Shazer, 1985, O'Hanlon & Weiner-Davis, 2003), and narrative therapy (White & Epston, 1990).

Those interactional elements include: (a) narrowing down the scope of therapy by conceptualizing clients' problems occurring in their present interaction; (b) staying away from formulating the underlying cause of the problem; and (c) galvanizing therapeutic effort toward a clearly defined goal in behavioral term (Fisch, 1994). For instance, the co-therapists' persistent attempt to set a clear goal for the consultation, despite the client's rejection of the therapists' initiative, seems to reflect the therapist's pursuance of the clearly identified goal. The therapists' persistent effort to negotiate through advice giving seems to reflect their commitment to providing the consultation outcome, identified by the client (Miller & Slive, 2004).

In addition, the therapists' way of engaging the client seems to be consistent with the guidelines represented by Hoyt and Talmon (2014b). For instance, the therapists (a) repeatedly attempted to find out the focal point of the family problem; (b) met the client's world view by asking for an elaboration of her account on her family's relational dynamics, while challenging her to be more firm with the family's request to rely on her for various things; (c) allowed for the last-minute issue to come up, (d) gave the client feedback, emphasizing her understanding of the situation and her competency to continue to pursue her future goals; and (e) left the door open for the client to return for another SST consultation.

Contributions to the SST Field

As I mentioned in the section above, SST therapists and researchers discuss the importance of various assumptions and ideas, methods, and guidelines in publications. For instance, they include post-modernism, social constructionism, the belief in rapid change and collaborative therapeutic relationship, the integration of various therapy

methods, narrowing down the scope of therapy, setting clear therapy goal, and meeting client's in their world view and offering something new. However, they offer little interactional descriptions to illustrate how SST therapists actually practice SST. The primary contribution of this study is the collection of the context-sensitive, nuanced, and sequential descriptions of interactional sequences and practices. My descriptions are clinically relevant and valuable, since professionals rely on such knowledge and experience in practice (Flyvbjerg, 2011). In addition, my description of the overall structural organization (Robinson, 2014) of the entire therapist-client interaction illustrates how the therapists weaved all of the interactional practices together. At this point, a juxtaposition of those interactional descriptions and the theoretical and prescriptive descriptions, discussed within SST literature, is fruitful (Peräkylä & Vehviläinen, 2003).

I found only one SST study that examined few aspects of the interactional practices. Sharma (2012) conducted a dissertation study on a WIS of SFBT. In this study, Sharma utilized CA to elucidate patterns of interactions to explore a linguistic change mechanism in SFBT. Her focus was on the interactional patterns of SFBT, instead of the ones of SST. In addition, Sharma paid attention solely to interactional practices that contributed to shifts at linguistic levels. In contrast, I paid attention, not only to the interactional practices that invited changes, but also to the type of interactional sequences, through which the therapist structured the therapist-client interaction, and two other types of interactional practices, through which the therapists coordinated the therapist-client interaction and formed common ground between themselves and the client. Further, Sharma presented seven interactional patterns without

synthesizing them. Without knowing how the therapist may have interwoven those practices, it is challenging for other therapists to utilize the interactional patterns.

Although the nature of study is different from my study, Sharma (2012) identified a few similar interactional patterns as I did in my study. They include the therapist's encouragement of the client's problem exploration, and the therapist's use of the client's language and paralanguage. Within the first pattern of interaction, Sharma observed that the therapist used conversational markers to encourage the client to elaborate on the problem. My study expanded the interactional utility of such conversational markers, since I identified that the conversation markers were used not only to encourage the client to elaborate on her problem, but also to negotiate a move from one phase to the next phase. Within the second pattern of interaction, Sharma noted that the therapist's use of the client's language and paralanguage allowed the therapist to engage the client. The findings from my study expanded the repertoire of paralanguage (e.g., use of silence to coordinate turn-taking, empathic and lower volume in turns to respond to client's emotional expression, lexical entrainment and use of audience design, etc.).

Implications for the Clinical Practice and Training of SST

In my analysis and presentation of the findings, I addressed Hoyt and Talmon's (2014c) caution against the manualization of SST, by providing a system of interactional repertoires that takes into account the evolving nature of therapist-client interaction. The juxtaposition of interactional practices and the overall flow of interaction keep SST therapists from falling into a partial view that therapeutic interaction is a set of stand-alone blocks. As I articulated in the previous chapters, I believe that therapy interaction

should be looked at as a series of therapist-client interactions that make a difference as a whole.

In a practical manner, the set of findings, generated from this study, offer SST therapists a potential interactional repertoire. This assumes that the SST therapists have the same set of interactional competencies as the therapists in this SST consultation (Peräkylä, 2004). The stream on micro interaction between the therapists and client showed a way the therapists responded to clients responsively (Strong et al., 2008). Every interaction matters in SST. Those exposed taken-for-granted micro-details of conversation in therapy as a whole creates the overarching gestalt of therapeutic experience for clients. Being aware of the micro-interaction may enable SST therapists' reflexivity of moment-to-moment interactions that enfold in SST consultations (Roy-Chowdhury, 2003).

SST supervisors and trainees may also determine that this study's findings are useful for them. For example, a supervisor can teach the metaphor, *tapestry*, as a way of organizing their SST consultation in general. SST trainees can also benefit from how the therapists in this study formed, expanded, and maintained common ground in their own SST consultations. Further, the two variations of the advice giving practice can be relevant to SST therapists, when faced with clients who keep rejecting their advice.

Throughout the process of my analysis for this research, the use of CA required me to learn how to ground my analysis in the observation of client-therapist interaction without resorting to psychological or mental constructs. I caught myself resorting to mental constructs a number of times along the way. While we cannot completely detach ourselves from those constructs or ideas, I believe that an ability to deal with actual

descriptions of interaction is essential to remain flexible and open to an ever evolving therapeutic process. For this reason, I suggest training for discursively-oriented therapists in which they practice grounding their observation and interpretations of their own and other therapists' interaction with clients.

Contributions to the Socio-politics of SST

The interactional knowledge derived from the current study serves as the "conversational evidence" (Strong et al., 2008, p. 388) of psychotherapy: clients' evaluation of therapy in dialogue of therapy itself. According to Strong et al., the conversational evidence complements the outcome-based psychotherapy research by providing clients' evaluation of therapy within the process of therapy itself. As such, the findings of CA can contribute to a generation of evidence-based practice (EBP), set forth by the American Psychological Association Presidential Task Force on Evidence-Based Practice (American Psychological Association, 2006).

The findings of CA studies are the result of an integration of rigorous qualitative research, combined with clinical expertise of SST therapists within the natural context of their interactions with clients. As such, the findings of this study can also play a socio-political role for the field of SST (Peräkylä & Vehviläinen, 2003). For instance, leaders in the SST field can claim the professional legitimacy and identity to other psychotherapy fields, as well as other stakeholders in the mental health industry (e.g., political lobbyists, community leaders, insurance providers, potential clients, etc.). The establishment of professional legitimacy and identity is necessary for preserving the field through a wider recognition of the profession, funding of SST programs, and allocation of research funding.

Contributions to the Discursive Approach to Psychotherapy Research

This study presented a method of psychotherapy research that can address the research-practice gap (see Gurman, 2015; McWey et al., 2005; Sprenkle & Piercy, 2005; Strong & Gale, 2013). The gap between practice and research seems to stem from an inconsistency between a choice of research method and psychotherapy in examination; traditional research methods, investigating individual psychology seem to be irrelevant to the study systems approach due to its "linear, atomistic, mechanistic, individualistic, and decontextualizing" (Couture & Sutherland, 2004, p. 4) nature. In addition, the settings in which researchers conducted research are far removed from the actual psychotherapy (Oka & Whiting, 2013; Sexton & Dacthi, 2014; Strong & Gale, 2013; Tilsen & McNamee, 2015). Furthermore, several researchers approached the psychotherapy process from a view that therapy interaction is made up of blocks of chained actions (Sutherland & Strong, 2011).

In contrast to the traditional methods of research, CA allowed me to capture, track, and analyze the therapist-client interaction on a turn by turn basis within sequence, without stripping the interaction away from its surrounding interactional sequences. The interactional view of CA also aligned well with systemic and constructionist oriented practices (Avdi & Georgaca, 2007; Strong et al, 2008; Sutherland & Couture, 2007; Tseliou, 2013), often utilized in SST. Within this interactional orientation, I was able to extract meanings of sequential interaction directly from its context (Heritage, 2004). In addition, the use of CA enabled me to attend to how conversational invitations or proposals are expressed and responded to, or not (Strong & Turner, 2008). CA's inductive and discovery-oriented manner (ten Have, 2007) also generated interactional

descriptions that seem to be highly relevant for initial theory building in SST. The interactional descriptions of SST seems to be also valuable for teaching and training SST, since therapists are not always aware of the micro aspects of therapy communication (Couture & Sutherland, 2006; Strong & Turner, 2008).

Further, the findings of this study seem to show therapists' commitment for collaborative practice in turn taking, explored in discursive research. Accordingly, therapists' commitment for collaboration should be reflected in the manner therapists and clients coordinate and negotiate differences in each other's preferences (e.g., meanings, intentions, proposals, conversation style, etc.) on shaping the process and content of their evolving interaction (Ness et al., 2014; Strong et al., 2011; Sundet et al., 2016; Sutherland & Strong, 2011; Sutherland, et al., 2013).

As I indicated in chapter four, the therapists and the client in this study collaboratively contributed to the evolving interactional, cyclic patterns of moment-to-moment interaction within and across the interactional practices. In general, (a) one therapist initiated an inquiry; (b) the client responded to the inquiry, accepting or rejecting the inquiry; (c1), if the client accepted the inquiry, the therapists acknowledged the client's response, and one of them followed up with a further inquiry, or (c2), if the client rejected the inquiry, the therapists acknowledged and legitimized the client's rejection. Either way, the therapists can follow up with the inquiry or start a new inquiry.

The manner the therapists in this study responded to and legitimized the client's rejections of their initiatives and advice seems to reflect idea of *delicate negotiation* (Massfeller & Strong, 2012; Wickman & Campbell, 2003). In such negotiation,

therapists embrace and utilize clients' responses and objections to therapists' initiatives in determining the process and content of therapy.

The interactive descriptions seem to resonate well with the findings of Sutherland and Strong's (2011) discursive study on a constructionist therapist, Karl Tomm's collaborative practice. Similar to their study, I found that the therapists in this study utilized a combination of pre-sequences (Schegloff & Sacks, 1973) and preliminaries to preliminaries (Schegloff, 1980) to prefigure upcoming courses of interaction, leaving a space for the client to contest if she had wished. The findings of this study also showed the way the therapists attended to the client's weak agreements (Pomerantz, 1984) and disagreements to come to mutual understanding of the client's account of the family problems and their potential solutions.

In addition, the findings of this study seem to represent the collaborative goal-setting Strong (2009) proposed in his study. Strong showed the ways constructionist-oriented counselors packaged their turns in asking for clients' goals by using the client language and in open-ended questions. The process was, accordingly, circular negotiation process in which (a) the counselor posed a question, asking session goals; (b) client provided goal descriptions; (c) the counselor asked for clarifications or specifications; and (d) the client offered responses. In addition, Strong (2009) showed the manner in which the counselors responded to and legitimized the clients' initiative to contest or modify the counselors' descriptions. For the process, the therapists utilized questions and response to allow the clients to tailor their goals, while shaping agreeable goals themselves. Those findings are consistent with the findings of this study. As Strong (2009) indicated, goal-setting is, for constructionist therapists, an opportunity for

clients to contribute to the direction of the therapy conversation. For this reason, therapists need to pay attention to how they invite clients to articulate therapy goals with which both of them agree.

The findings of this study also seem to corroborate Roy-Chowdhury's (2006) findings. In that study, Roy-Chowdhury identifies a strong therapeutic engagement within an interactional sequence in which a family therapist's constructed turns, incorporating the client's language, when communicating the understanding of the client's account by using minimal acknowledgements and questions. This manner of listening and responding seems to encourage clients to elaborate (Roy-Chowdhury). Similarly, the therapist in this study provided similar agreement tokens (Bangerter & Clark, 2003) and utilized the client's words in formulating re-interpretations (Bercelli et al., 2010) of the client's account to encourage the client's elaboration.

Dr. Miller's utilization of candidate answers to shape the topic of conversation within the client's strength seems to be similar to how a prominent solution-focused therapist, Bill O'Hanlon (O'Hanlon & Weiner-Davis,1989) used candidate answer to shape the context of his inquiry within a client's solution-oriented behaviors (Gale, 1991; Gale & Newfield, 1992). When it comes to advise giving, I showed the interactional sequence between the therapists and client. That is, (a) one therapist presented advice as reflecting team's advice; (b) the client rejected the advice; (c) one therapists evaluated the client's rejection by asking polar questions or challenging the client; (d) the client provided an elaboration of her account, further rejecting the advice; (e) one therapist re-presented the advice, while employing various means to modify the advice to make it more acceptable for the client; and (f) the client responded to the re-presented advice.

When the client rejected the therapist's advice, the therapists negotiated the rejection by evaluating it.

The particular manner in which Dr. Miller negotiated with April on her acceptance of advice seems to resemble the way a prominent constructionist therapist, Dr. Karl Tomm, managed delicate advice with his client (Sutherland & Strong, 2011). Specifically, the therapists in this study also utilized impersonal constructions (Silverman, 1997) (e.g., "what can happen in that type of situation" or "I heard a lot") when representing advice that the client initially rejected. The use of such vague and oblique construction of sentences seems to have allowed him to re-present the advice without necessitating April to respond to the advice.

Also, Dr. Miller used variations of the reciprocal editing that Kogan and Gale (1997) identified in therapy interaction of Michael White, one of the founders of narrative therapy (White, 2007; White & Epston, 1990). Those practices included uncertainty markers, pauses, and hesitations, to downgrade (Silverman, 2007) his knowledge claims so as to invite April to co-edit his reframing of her problem account. Furthermore, the overall manner the therapists engaged April in the cyclical stepwise process of interpreting and re-interpreting the advice is similar to the way Dr. Karl Tomm negotiated with a family to co-construct mutually agreeable positions in a cyclic stepwise process (Couture, 2006).

This study also produced new descriptions of interactional sequences and practices the therapists utilized in the SST consultation. They include (a) use of silence to coordinate the turn-taking; (b) the interactional sequences through which the therapists structured the consultation into a series of projects; (c) re-adjusting own accounts in

response to client's disconfirmation of therapist's accounts; (d) hypothetical questions; (e) a combination of reinterpretations and optimistic questions; (f) continually modifying advice over many turns to make it acceptable for the client; and (g) both-and questions. Both (b) and (f) are particularly important for SST consultations; other interactional practices are fundamental for many brief therapy approaches and psychotherapy in general.

In addition, the way I conceptualized the micro adjustments and the overall therapeutic improvement seems to be relatively new to the discursive research in psychotherapy. That is, I synthesized the interactional descriptions produced at the micro interactional level—that are, findings from CA—and the descriptive change emerged at the macro level—that are, the case note and the survey with the client. As such, the conceptualization may have a potential in bridging the moment-to-moment interaction between therapists and clients, and the overall therapeutic change in SST and psychotherapy.

The findings of this study demonstrate particular manner in which the therapists initiated a process of coordinating and negotiating differences between their and the client's preferences (e.g., meanings, intentions, proposals, conversation style, etc.) in shaping the process and content of their evolving interaction (Ness et al., 2014; Strong et al., 2011; Sundet et al., 2016; Sutherland & Strong, 2011). This points a concept of *discursive flexibility* (Strong, 2007), or the therapists' ability to engage clients collaboratively by using "client-responsive words and ways of talking" (Strong, 2009, p. 33).

It warrants a caution whether the discursive flexibility, exemplified in the collaborative practice I have described, is exemplified in all forms of SST and postmodern, constructionist approaches to therapy. Presumably, all so-called constructionist therapists (e.g., Anderson, 1995; 1997; Berg & Dolan, 2001; de Shazer, 1985, 1988; White, 2007; White & Epston, 1990) claim and practice elements that constitute the collaborative practice that are "more participatory, reflexive and client-driven practices" (Sutherland & Strong, 2011, p. 257). Similarly, SST therapists share ideas in common with those constructionist approaches.

However, I assert that the issue of claiming collaborative practice is a matter of empirical scrutiny, as asserted by Sutherland and Strong (2011). I would not claim any status of collaborative practice without referring to the discursive examination of therapy interaction by any therapists, captured in a turn-by-turn manner. I believe that the collaborative practice is brought into being by not only individual therapists' postures, but also their practices, reflecting their postures.

Comparison between SST and Other Brief Therapies

Juxtaposition of this SST consultation and the other brief therapy approaches bring forth the similarities and differences between the two. First, the clear difference is, as I mentioned in chapter two, that SST is a modality, comprehending the service delivery, assumptions held by the therapists, and a wide range of ways the therapists approach each case without being constrained by clinical theories (Amundson, 1996; Miller & Slive, 2004; Young et al., 2012). A clinical assumption held by every SST therapist is that a single session can bring about a long, lasting change when therapists assume and utilize clients' capacity and strengths to make such change (Bloom, 2001;

Hoyt & Talmon, 2014c; McElheran et al., 2014; Slive & Bobele, 2011b). As such, the groups of interactional practices I have described in this study are part of the SST repertoire.

In any case, it seems that this study illustrated the therapists' pragmatism of utilizing various clinical postures and techniques, and assumptions about clients' capacity and strengths explicitly through their statements about the length of the consultation and implicitly through their assumptions embedded in their questions. On the other hand, other brief therapy approaches prescribe particular assumptions about problem formation and resolution. Consequently, the therapists tend to interact with clients in particular ways, holding particular ideas in mind and or utilizing techniques.

At the same time, as I indicated above, it seems that the therapists in this SST consultation and therapists informed by other brief therapies in other discursive studies share many commonalities at the interactional, discursive level. The interactive descriptions between the therapists and client in this study seem to resonate well with the findings of Sutherland and Strong's (2011) discursive study on a constructionist therapist, Dr. Karl Tomm's collaborative practice in terms of the use of a combination of pre-sequences (Schegloff & Sacks, 1973) and preliminaries to preliminaries (Schegloff, 1980) to prefigure upcoming courses of interaction. Similarly, both therapists attended to the client's weak agreements (Pomerantz, 1984) and disagreements to come to a mutual understanding of the client's account of the family problems and their potential solutions.

The therapists in this study also seem to share commonalities with the constructionist-oriented counselors engaged with the clients in the collaborative goal-setting in Strong's (2009) study. The counselors' way of packaging their turns for goal

setting, as well as the manner in which the counselors responded to and legitimized the clients' initiative to contest or modify the counselors' descriptions seem to resemble the way the therapists in this study collaborated with the client in setting the consultation goal and adjusted their interactions in response to the client's contest against the therapists' initiatives.

Dr. Miller's utilization of candidate answers to shape the topic of conversation within the client's strength seems to be similar to how a prominent solution-focused therapist, Bill O'Hanlon (O'Hanlon & Weiner-Davis,1989) used candidate answer to shape the context of his inquiry within a client's solution-oriented behaviors (Gale, 1991; Gale & Newfield, 1992). In addition, the particular manner in which Dr. Miller negotiated with the client on her acceptance of advice seems to resemble the way a prominent constructionist therapist, Dr. Karl Tomm, managed delicate advice with his client (Sutherland & Strong, 2011).

Also, Dr. Miller used variations of the reciprocal editing that Kogan and Gale (1997) identified in the therapy interaction of Michael White, one of the founders of narrative therapy (White, 2007; White & Epston, 1990). Furthermore, the overall manner through which the therapists engaged the client formed a cyclical stepwise process of interpreting and re-interpreting the advice. This is similar to the way Dr. Karl Tomm negotiated with a family to co-construct mutually agreeable positions in a cyclic stepwise process (Couture, 2006).

Role of Expectations in SST

Other than the fundamental difference I mentioned in the section above, another aspect that distinguishes SST from brief therapy seems to be SST therapists' explicit

claim about the potential of a single session encounter. In the psychotherapy field in general, the role of clients' expectancy to the outcome of therapy is widely acknowledged. In their review of the role of clients' expectations in psychotherapy, Greenberg, Constantino, and Bruce (2006) concluded that clients' expectations make a vital contribution to the process of various forms of psychotherapy. Greenberg et al. (2006) also indicates that clients tend to have some sense of the duration of therapy necessary to resolve their complaints before the initiation of therapy. Similarly, Tambling (2012) reviewed previous studies and indicated that clients with an optimistic expectation of therapy—that is, therapy will help them resolve their complaints—are likely to experience more positive outcomes than those with neutral or pessimistic expectations of therapy. In fact, many psychotherapy approaches inherit methods to facilitate clients' expectancy (Greenberg et al., 2006)

Through the lens of the common factors approach to psychotherapy, Bohart and Tallman (2010) comment on the relationbetween client expectation for therapy and its effects on themselves: "One way of understanding the placebo phenomena [the benefits of client expectation for therapeutic change] is that the clientexpectation for change stimulates innate self-healing capabilities; in other words, the placebo effects represent the client's personal agency in action" (p. 86-87). Notably, solution-focused brief therapy embraces and utilizes this factor for therapeutic changes (see Reiter, 2010; Visser & Bodien, 2009).

In the same manner, it may be that SST therapists maximize the client's expectation for therapy and its self-healing capabilities explicitly through their statements and implicitly through their ongoing stream of interaction. SST therapists view the

expectation as the essence for SST practice and explicitly set the expectation with clients that the single session may sufficiently resolve their problems (Battino, 2014; Bobele & Slive, 2014). At the same time, the therapists' expectation is communicated to the clients through their interactions. (Bobele, López, Scamardo, & Solórzano, 2008; Bobele & Slive, 2014). This is exemplified in their statement: "Any session could be the last session. We do not conduct any sessions as if there will be another session. In other words, we do *one session at a time*" (p. 97-98). In this manner, it may be that the therapist's expectation is introduced, maintained, and shared by the clients in and through their on-going interaction.

Scamardo et al. (2004) reported a study in which participating clients at a walk-in clinic indicated that they had thought of a number of sessions necessary for resolving their problems based on their perception of the severity of their problems. That is, the more severe they had perceived their problems, the more sessions they had expected to resolve their problems. In the study, the clients' discussion with the therapists about the number of necessary session impacted their decision to terminate their sessions. Based on the findings, Scamardo et al. (2004) speculated that clients may have followed their plan and terminated their sessions according to their expectation. Thus, Scamardo et al. suggested that SST therapists address clients' expectation for a necessary number of sessions early in the session to contribute to their expectation and perception of improvement.

This idea points to a question: "How the perception of time, shared by both therapists and clients, may shape their expectations for change in SST?" There is little to no research on this area. Battino (2014) cites an anecdote of an experiment described by

Steve de Shazer, one of the founders of solution-focused therapy, and conduced at the Brief Family Therapy Center in Milwaukee. Accordingly, participating clients were randomly informed at the intake that it takes either five or ten sessions to resolve their particular issues. A follow-up a year later showed that the clients started taking significant actions toward the end of their expected number of sessions. Battino commented, "The client's *expectation* had a profound effect on how soon they got down to business" (p. 394). Drawing upon this experiment, it may be that both therapists and clients make significant contributions to the resolution of the clients' problems, knowing that the session has a potential to resolve their problems. Bobele et al.'s (2008) comment seems to support this hypothesis:

> In our work, we adapted the motto: "Every case has a potential to be a single session case." . . . We are acutely aware that over half of our clients would not return even if they rescheduled an appointment. We do our best to make each session self-contained" (p. 80).

If this is the case, it would challenge the commonly held assumptions of psychotherapy that psychotherapy has to happen over several sessions, progressing from the initial stage of information gathering and therapeutic development, the middle stage of problem and resolution development, and the last stage of resolving problems. A question becomes relevant: "Are we, as therapists, setting artificial constraints for ourselves on the duration of therapy based upon the traditional [psychotherapy] models we learn?" (R. Chenail, personal communication, November 29, 2016). Perhaps, other researchers can investigate the relations between the perception of time and the expectation for therapeutic change within SST to further comment on this question.

Suggestions for Future Research

The research findings have contributed to the interactional knowledge (Peräkylä & Vehviläinen, 2003) in the field of SST. In specific, the findings provided interactional understanding of practices used in the SST consultation. They also provided some missing links between the general descriptions of SST and practice of SST. That is, how therapists oriented to the ongoing and evolving interaction with the client, in managing therapist-client interaction, structuring the SST consultation, forming and developing therapeutic relationship, and inviting therapeutic change at a turn-by-turn basis.

As I indicated in chapter three, this study is a starting point for further CA analysis of SST. Using the findings from this study, other researchers can build a collection of similar interactions (Liddicoat, 2007; ten Have, 2007), contributing to the interactional knowledge in SST. The researchers will be able to use the collection of similar interactions to refine the description of the interactions by identifying the interactions across different cases. Finally, other researchers can investigate if they find the same interactional patterns in other SST consultations (ten Have, 2007). This is particularly relevant to the practice of SST since therapists approach SST sessions differently informed by various clinical orientations, while considering the idiosyncratic situation of clientsand the arrangements and settings of their practice settings (Bloom &Tam, 2015; Clements et al., 2011; Talmon, 2014; Young et al., 2012). For a fruitful dialogue between the general descriptions of SST practice and CA researchers, there needs to be open dialogue among the researchers, therapists, and educators in the field.

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Appendices

Appendix A

DROP IN THERAPY TELEPHONE INTAKE

(CUTI)-(J.K. Miller, 2015)

CLIENT CODE: _____

Date: _____ Time of call: _____ *Staff Taking Call:* **_____**

***The Drop In therapy clinic** strives to provide affordable, high quality individual, couple, and family therapy services. The clinic is staffed by graduate interns in the marriage and family therapy program at Nova who are supervised by the teaching faculty in the program. The service offers a free, one-hour private therapy consultation to individuals, couples and families. Therapists may work in teams, so the consultation session will be videotaped and may be observed by other therapists.*

Your Name:			
Your Phone Number:		*Alternative Phone Number(s):*	
Reminders: ☐ No - do not call. ☐ Yes - it is ok to call. ☐ No - do not leave message. ☐ Yes - ok to leave message			
Your Address:			
How did you find out about this event?			
Are there any concerns that you will want to address at your appointment? (record the caller's verbatim comments and use quotation marks)			
Will you be bringing anyone with you for the consultation?			
NAME	**AGE**	**RELATIONSHIP WITH CALLER**	
1.			
2.			
3.			
4.			
Which day and time of the event would you like to set the appointment			

We look forward to seeing you. Thank you for your call to us today.

Appendix B

Lobby Intake Forms

Welcome to the clinic. Please take a few minutes to complete this form before meeting with your therapist. When you are done filling out the information bring the form to the person at the counter or to your therapist. If you have any questions about form or don't know what to write, please feel free to leave the space blank until you meet with your therapist.

Information About You

<table>
<tr><td>Your Name:</td><td colspan="2">Phone:

❑ Check here if it is ok for us to call you at the above number for a follow-up interview.

❑ Check here if it ok for us to leave messages at the number above.

Is there anything we need to know about contacting you at this number?</td></tr>
<tr><td>Address:</td><td colspan="2">Emergency Contact Person:

Relationship:

Phone:</td></tr>
<tr><td>Employer or occupation</td><td>Your Date of Birth:</td><td>Highest Level of Education:</td></tr>
</table>

Your Ethnic or Cultural Background:	**Are you currently seeing another counselor or therapist? (If yes, please give the name or agency and phone)**
If you have been in counseling or therapy in the past, what do you remember as useful or difficult?	**How did you find out about us?**
What are your thoughts about how we might be of help today?	
Is there a specific problem that you would like to address today? If yes, please describe briefly.	
What are strengths and resources in yourself or your relationship?	

Other Information

Who lives in your home and what is their relationship to you?	
Name:	**Relation to you?**
1.	
2.	
3.	
4.	
In your current relationship, or in any previous relationships, have you ever felt threatened, been physically harmed, or put down or talked to in any other way that was hurtful?	
Is there anything else we have not asked you about that you would like your therapist to know?	

Thank you for taking the time to fill this out. Please bring this form to the person at the desk and your therapist will be out to greet you soon.

Appendix C

CLIENT SURVEY OF CLINICAL SERVICES

(CSCS) - (J.K. Miller, 2015)

Thank you for taking the time to complete this form. Your comments will be helpful in our future efforts to provide counseling services in our community. Your participation is optional and you can choose to not respond to any of the questions. A code will be tied to your responses. Your confidentiality will be preserved; your name will not be used in any written materials.

1. How did you hear about this clinical service (please check all that apply)?

☐ Radio ☐ Newspaper ☐ Friend/Relative

☐ Television ☐ Referral Other _____

2. The session met my expectations (circle one).

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

3. Counseling Services are easy to access in our community (circle one).

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

4. Counseling services are affordable in our community (circle one).

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

5. There is a negative stigma associated with counseling (circle one).

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

6. This one session was useful for me (circle one).

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

7. Did you find that your session was sufficient to address your concern or need?

☐ Yes ☐ No

8. What in particular attracted you to the service today?

9. What was particularly helpful for you?

10. What are your recommendations for improving the service?

11. What would increase the likelihood that you would seek counseling services in the future if needed?

Client Code _____

Appendix D

POST-SESSION VIDEO/AUDIO RECORDED STRUCTURED INTERVIEW PROTOCOL
(J.K Miller, 2015)

With your consent, we will ask you the following 5 open-ended questions. As above, your identity will not be revealed in any reports of this information. Do we have your permission to video and audio record your responses?

☐ Yes ☐ No

QUESTIONS:

1. **What in particular attracted you to the service?**

2. **What was particularly helpful and not helpful for you during the session?**

3. **What are your recommendations for improving the service?**

4. **What are your thoughts about some of the things that prevent you from accessing therapy services?**

5. What are some things that would make it more likely that you would seek help from a therapist in the future if you had a need?

Today's Date: _____ Therapist: _____ Client Code: _____

Appendix E

Transcription Notation

Symbol	Indicates
T:	Speaker identification; therapist 1 (T1), therapist 2 (T2) client (P)
[ ]	Brackets: onset and offset of overlapping talk
=	Equals: no gap between two utterances
(0.0)	Timed pause: silence measured in seconds and tenths of seconds
(.)	A pause of less than 0.2 second
.	Period: falling or terminal intonation
,	Comma: level intonation
?	Question mark: rising intonation.
↑	Rise in pitch
↓	Fall in pitch
!	Exclamation: animated tone
-	A dash at the end of a word: an abrupt cutoff
<	The talk immediately following is ‘jump started’: that is it begins with a rush.
> <	Faster-paced talked than surrounding talk
< >	Slower-paced talk than the surrounding talk
__	Underlining: some form of stress, audible in pitch or amplitude

CAPITAL	Capital: capital marks speech that is obviously louder than surrounding speech
:	Colon(s): prolongation of the immediately preceding sound
° °	Degree signs surrounding a passage of talk: talk at a lower volume than the surrounding talk
.hh	row of hs preceded by a dot: an inbreath; number of h's indicates length
hh	row of hs preceded without a dot: an outbreath; number of h's indicates length
( )	Indicates a back-channel comment or sound from previous speaker that does not interrupt the present turn.
(( ))	Double parentheses indicate clarificatory information, e.g. ((laughter)).
{ }	Non-verbals, choreographic elements.

Source: adapted from Voutilainen, Peräkylä, and Ruusuvuori (2011), and Kogan (1998).

Biographical Sketch

Nozomu Ozaki was born in Kyoto, Japan and has studies abroad to complete a Bachelor's degree in Psychology at Southeast Missouri State University, a Masters' degree in Family Therapy, and a Ph.D. in Family Therapy at Nova Southeastern University. Nozomu is a Registered Intern for Marriage and Family Therapy and is certified in clinical hypnosis in the state of Florida. He is a Pre-Clinical Fellow of the American Association for Marriage and Family Therapy (AAMFT), and is working toward becoming an AAMFT Approved Supervisor. Nozomu is a student member of American Society for Cybernetics.

Nozomu has practiced systemic, strength-based approach with individuals, couples, and families at various settings, including a school-based clinic, an outpatient psychiatric unit, a family strengthening program, a private practice, a homeless shelter, and a school-based program. He has conducted a teaching assistant position for numerous courses and a supervisor assistant for numerous clinical practicums. Nozomu has presented on the topic of brief therapy, single session therapy, an application of cybernetics to family therapy, and family therapy in international context at national and international conferences. He was involved with a grant-funded single session consultation services as a doctoral student therapist, offered at Brief Therapy Institute at Nova Southeastern University. Nozomu continues to explore advancement in clinical practice, supervision, and teaching, while exploring an application of systems approach and cybernetics in multidisciplinary and transdisciplinary contexts.