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DIALOGIC DISCOURSE ANALYSIS OF PSYCHOTHERAPEUTIC DIALOGUE: MICROANALYSIS OF RELEVANT PSYCHOTHERAPY EPISODES

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ABSTRACT. This paper shows a microanalysis of episodes of therapeutic change and ruptures of the alliance using *Dialogic Discourse Analysis* as a method that makes it possible to detect discursive strategies in psychotherapeutic dialogue. Four relevant episodes, two of therapeutic change and two of ruptures of the alliance, from different sessions of a long-term psychoanalytic psychotherapy were analyzed using a qualitative methodology. Results showed linguistic features of change and rupture. In the latter, linguistic markers were identified, which highlighted the connection between the rupture of the alliance, its resolution, and change. The use and advantages of this microanalytic method are discussed.

Keywords: Dialogic discourse analysis, microanalysis, psychotherapy process research

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, 1800-1803/1863*)

Process research in psychotherapy focuses on the phenomenon of change in the context of therapeutic interaction. Studies based on this approach have shown that, rather than being a homogeneous process, psychotherapy is made up by a series of segments, periods, or phases whose causal and temporal relations tend to be complex, and not necessarily linear (Krause, 2005; Orlinsky, Helge & Willutzki, 2004).

Besides, as a result of such a heterogeneous notion of the process of psychotherapeutic change, researchers have centered their efforts on identifying relevant episodes leading to the construction of psychic change (Greenberg, 2007;

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Krause, 2005; Orlinsky, Helge & Willutzki, 2004). This is grounded on a theoretical framework about what *change* is and what *non-change* is in this specific context (e.g. Gonçalves, Matos, & Santos, 2009; Krause, et al., 2007). This study specifically deals with episodes of change and episodes of ruptures of the therapeutic alliance.

A change episode is an interaction segment in a psychotherapeutic session in which a representational-level change is observed in the patient. The method for determining change episodes, derived from this definition, is based on the notion of *generic change* of subjective theories (Krause, 2005; Krause et al., 2007). Therefore, an *episode of change* is an interaction segment where a patient's microchange[1] takes place and corresponds with some generic change indicator. In the rating procedure to demarcate a change episode, this microchange moment is used to mark the end of the episode. From this point, and according to a thematic approach, a rater reviews the text of the session backward in order to identify the beginning of the topic discussed by the patient and the therapist that deals with that specific microchange moment (Krause et al., 2006; Valdés et al, 2010).

Several studies have shown that utterances belonging to a moment of change are characterized by the use of the first person singular, the present tense, and the presence of self-referential content (Aristegui et al, 2004; Reyes et al., 2008; Stiles, 1992). This has been interpreted as the patient being the protagonist and author of his or her own change. For instance, in a moment of change, the patient is expected to express this change verbally with an utterance which includes something like "*now, I, about myself*". From a dialogic perspective, this linguistic construction connects "who speaks" (subject of enunciation) with "who is in charge" of what is being talked about (subject of the utterance). Such a linguistic construction is a position of the self which establishes his/her authorship of utterance (Bakhtin, 1986). At this point, a question to ask is: *how does therapist - patient dialogue help cement the patient's authorship of his/her own change?* Here the aim was to explore, in episodes of therapeutic change, specific verbal interaction performed by the participants for the patient to be the author of his or her own change.

With regard to episodes of rupture, following Safran & Muran (1996, 2000, 2006) we will understand these "processes of rupture" of the therapeutic alliance as a disruption in the process of intersubjective negotiation. That is, as ruptures in patient-therapist communication which manifest themselves through two thematic, behavioral,

[1] The notion of microchange makes reference to a level of analysis, specifically a microscopic level. This level refers to the immediate consequences of therapeutic intervention. In this level, if the analysis focuses on the outcome, then in-session impacts or microchanges are studied. If the analysis focuses on the process, then moment-by-moment or microanalytic strategies are performed (Orlinsky, Helge, & Willutzki, 2004). This study integrates both approaches.

and communicational markers: *a) Withdrawal or distancing, and b) Confrontation*. Both markers reflect the ways in which each member of the dyad approaches the tension between self-regulation and mutual regulation in the intersubjective field -that of interactive regulation-. An optimal level of regulation is a balance between self-regulation and mutual regulation, with the middle range resulting in the most satisfactory degree of flexibility between both dimensions of the interaction. If mutual regulation is interrupted, participants will focus their attention on their own regulation and neglect their mutual link (Beebe, 2006).

In spite of this temporary rupture in communicative negotiation, the tension becomes–according to Safran & Muran (2006)–the intersubjective field for the construction of change. A question that comes up at this point is *how does the therapist-patient dialogue configure the development and resolution of an episode of rupture of the alliance?* Here the aim was to explore, in episodes of rupture of the therapeutic alliance, specific verbal interaction performed by the therapist to reestablish the relationship.

In order to sketch an answer for these questions about episodes of change and ruptures, we have chosen to use a microanalysis method based on the contributions of the *dialogic perspective* of discourse analysis (Bakhtin, 1986; Hermans, 1996; Holquist, 1990). There is a small body of literature about discourse analysis or conversational analysis in psychotherapeutic dialogue (e.g., Antaki, Barnes, & Leudar, 2005; Gunn, 2004; Peräkylä, 2004). The dialogic perspective contributes to this line of research by studying a therapeutic process focusing mainly on the relationship between the *self* and the *other* (alter). In this study, we will consider the *self* as fundamentally dialogic: as a relationship between a self and an alter (Hermans & Lyddon, 2006, Marková, 2006). In psychotherapy, this *other* is thought to have at least two levels. It is a therapist (or patient) *other* with whom the patient (or therapist) establishes a real dialogue and, at the same time, multiple and diverse *others* which are present in the discourse of both participants (Marková, 2006). These *others* are a part of the self, but their presence in the narrative structure of the self is vivid as if they were other people, *imaginal figures* (Hermans, Rijks, & Kempem, 1993) who keep different positions or perspectives regarding the same situation.

Any dyad taking part in a dialogue, including the therapeutic dyad, is mutually responsible for the multiple meanings of such dialogue, and of being the addressee of each other's meanings, including the *others* who are not physically present, but who are referred to in the dialogue. From this perspective, we will differentiate two dimensions in the psychotherapeutic dialogue. One of them refers to the *real* dialogue between the participants involving the rules pertaining to conversation, which we will call *dialogal exchange*. The other dimension, which takes into account the dialogue established between the multiple voices or positions that the *I* adopts in the self and that manifest themselves in the discourse of each of the participants, will be referred to as *dialogic*

exchange (Grossen & Salazar, 2006). For example, Dimaggio and collaborators (Dimaggio, Salvatore, Azzaras & Catania, 2003; Dimaggio, Fiore, Salvatore & Carcione, 2007) have conceptualized this internal dialogue between the patient's positions as *dialogical relationship patterns*, stressing the idea that these patterns constitute the building blocks of personality.

The first dimension of dialogue, or *dialogal exchange*, is analyzed by means of Conversational Analysis (CA) tools that enable us to illustrate real patient-therapist exchanges (for an example, refer to Forrester & Reason, 2006, or Peräkylä, 2004)). The second dimension, the *dialogic exchange*, is analyzed via a microanalysis system that seeks to mark this multivocity and its influence on the construction of shared meanings (intersubjectivity) in a linguistic manner. Both analytical tools are part of the Dialogic Discourse Analysis (DDA) method (Larraín & Medina, 2007, Martínez & Medina, 2009), a form of discourse analysis based on Bakhtin's ideas about dialogism, and which sees discourse as permanently marked by subjectivity (Larraín & Medina, 2007).

The purpose of this paper is to present this microanalytic method applied in an ongoing study about dialogical regulation in psychotherapeutic dialogue. Specifically, its aims are to show the use of DDA as a productive microanalysis strategy in the evaluation of relevant psychotherapy episodes, and to illustrate the application of DDA in two episodes of change and two episodes of rupture of the therapeutic alliance.

In order to illustrate the DDA method, we propose two objectives. As mentioned above, they were: first, *in episodes of therapeutic change,* to explore specific verbal interaction performed by the participants for the patient to be the author of his or her own change; and second, *in episodes of rupture of the therapeutic alliance,* to explore specific verbal interaction performed by the therapist to reestablish the relationship.

Method

Participants

In order to gather data, we recorded a long-term psychoanalytic therapy with weekly sessions, which started in October 2005 and ended in March 2009 after 120 sessions, considering holiday breaks. The patient was a 37-year-old woman, while the therapist was a 50-year-old man with a vast clinical experience and with formal psychoanalytic training. The patient came to psychotherapy due to depressive symptomatology and several interpersonal conflicts. Her therapeutic history includes a period as psychiatric inpatient and two suicide attempts. The diagnostic hypothesis at the onset of the treatment was a borderline personality disorder based on Axis II of the Diagnostic Statistical Manual of Mental Disorders (American Psychiatric Association, 1994). The treatment was evaluated by means of two perspectives: A self report outcome measurement using the Outcome Questionnaire 45.2 (OQ-45.2, Lambert & Burlingame, 1996) that was applied to the patient before every session, and an

evaluation of the process of therapeutic change using the Generic Change Indicators (GCI; Krause et al., 2006b, 2007) that was applied to the session transcripts.

The OQ45.2 subscale of disease symptoms showed a slight improvement in the measurements at the end of the treatment with respect to the beginning of therapy. However, the interpersonal relationship and social role subscales remained unchanged throughout the entire process. From the point of view of GCIs, the therapy was successful, considering the number of changes and their high level in the whole process (Martínez, 2010). GCIs constitute a hierarchy of indicators that can be divided into three levels reflecting the phases of the psychotherapeutic change process (Altimir et al., 2010; Echávarri et al., 2009). The initial level (Level I) is referred to as an initial consolidation of the structure of the therapeutic relationship; the second level (Level II) is considered an intermediate stage and is referred to as an increase in patient's permeability towards new understandings; the third level (Level III) is referred to as a construction and consolidation of the patient's new understandings (see Krause, et al., 2007). As it is shown in Figure 1, the percentage of Level I changes decreased during the process (phase1-phase3 = 33%, CI [0.06-0.55], $p< 0,05$), whereas the percentage of Level III changes increased towards the end of the therapy (phase3-phase1= 54%, CI [0.29-0.71], $p<0.05$). These significant differences support the notion that this therapy displayed a positive evolution from the point of view of GCIs.

Both participants signed informed consents to participate in this study and to be recorded audio-visually.

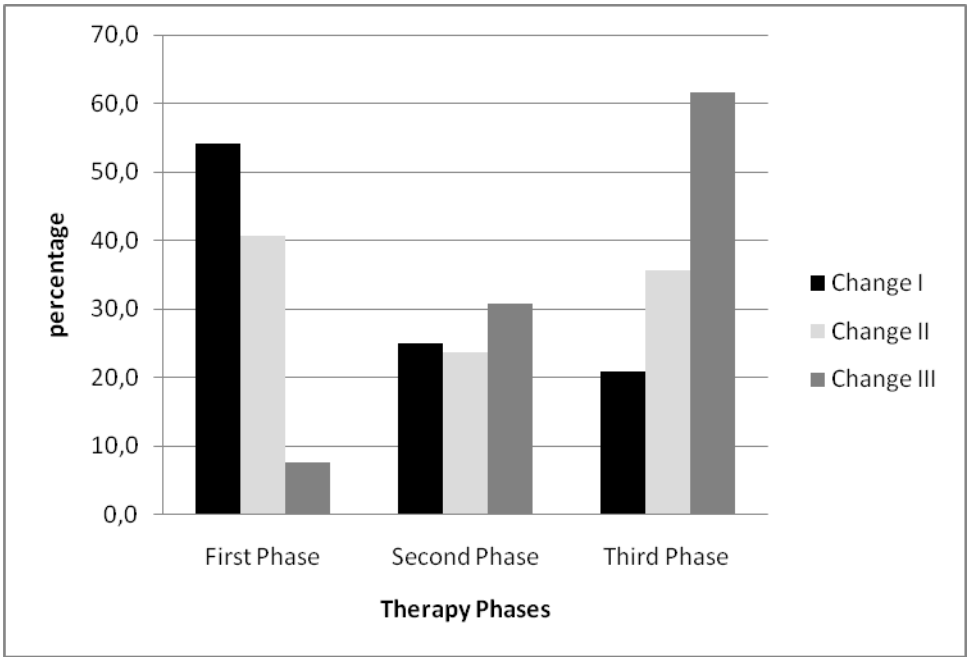

Figure 1. Distribution of change episodes in the therapeutic process.

Procedure to select episode sample

Because of accessibility reasons only 60 of the 120 videorecorded sessions were analyzed. These 60 sessions covered the entire therapeutic process (see note at Figure 2).

The identification of microchange moments (see above) and delimitation of episodes of change was carried out with the *Generic Change Indicators* (GCI, see Table 1) and the criteria developed for that end (Krause et al., 2006a; Krause et al, 2006b; Reyes et al., 2008). Episodes of change are interaction segments starting when a microchange takes place. This moment marks the end of the episode and each of them must be classified as a type of GCI. This classification is a hierarchical one and, in a broad manner, it distinguishes three levels (see Table 1).

Also, this procedure to select episodes of change was validated intersubjectively[2] through direct (by means of the one-way mirror) and indirect observation (through the analysis of transcripts) of the sessions. Microchange moments in which the observers did not reach an agreement were eliminated. With respect to the temporal delimitation of the episode of change, its end is signaled by the change moment and its beginning is established by a thematic criterion, that is to say, at the point when the participants begin discussing the topic regarding which the change occurs (Krause et al., 2006a).

The identification of episodes of rupture of the alliance was carried out applying to the transcripts of sessions the *Rupture Resolution Rating System Manual* (Eubanks-Carter, Muran, Safran, & Mitchell,2008) which specifies communicational markers derived from the two main types of rupture of alliance indicated by Safran & Muran (1996, 2000, 2002, 2006): Withdrawal and Confrontation. With respect to the temporal delimitation of episodes of rupture, their beginning was signaled by the very first communicational hints of rupture as listed in the manual, and their end was established by the very first hints of its resolution or overcoming. The same aforementioned intersubjective criterion was used to validate the selection and temporal delimitation of the episodes of rupture of the alliance.

Following these criteria, from 143 relevant episodes (see Figure 2 and Table 2), four episodes were selected to apply the microanalysis. Two of them correspond to episodes of therapeutic change from sessions 2 and 7. The other two correspond to episodes of rupture of the therapeutic alliance, taken from sessions 9 and 33. These

[2] Intersubjective validation is a process in which the observations by a researcher or rater are compared with the independent observations of other researchers or raters. The validation of observation is attained through consensus or agreement between these different perspectives (see Flick, 2004).

Table 1

Generic Change Indicators (GCI)

Level I: Initial consolidation of the structure of the therapeutic relationship.	**Level II: Increase in permeability towards new understandings.**	**Level III: Construction and consolidation of a new understanding.**
Between Change Indicators 1 and 7:	Between Change Indicators 8 and 13:	Between Change Indicators 14 and 19:
• Acceptance of the existence of a problem • Acceptance of his/her limits and of the need for help. • Acceptance of the therapist as a competent professional. • Expression of hope • Questioning of habitual understanding, behavior and emotions. • Expression of the need for change. • Recognition of his/her own participation in the problems.	• Discovery of new aspects of self. • Manifestations of new behaviors and emotions. • Appearance of feeling of competence. • Establishment of new connections. • Reconceptualization of problems and/or symptoms. • Transformation of valorizations and emotions in relation to self or others.	• Creation of subjective construct of self through the interconnection of personal aspects and aspects of the surroundings, including problems and symptoms. • Founding of the subjective constructs in own biography. Autonomous comprehension and use of the context of psychological meaning. • Acknowledgment of help received. • Decreased asymmetry between patient and therapist. • Constructions of a biographically grounded subjective theory of self and others and of the relationship with surroundings.

Note. Based on Altimir et al. (2010)

relevant episodes were intentionally selected from the whole sample of episodes, because they constitute good examples of each kind of episode (see Table 2 for a description of episode frequency in the whole recorded psychotherapy).

The excerpt of session 2 is an episode whose moment of change corresponds to a Level I indicator named "questioning of habitual understanding, behavior and emotions". Specifically, in this episode the patient realized that her problematic interaction corresponds to an old pattern of behavior.

The excerpt of session 7 is an episode whose moment of change corresponds to a Level II indicator named "establishment of new connections". Specifically, in this

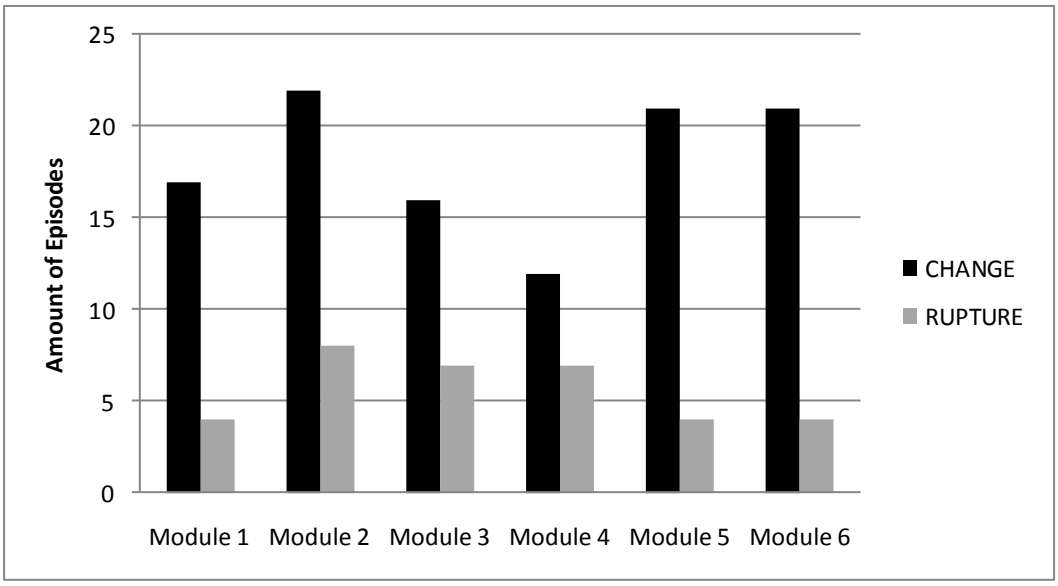

Figure 2. Frequency of relevant episodes in the entire therapy.

Note. The therapy was divided in six modules: Module 1 = Sessions 1, 2, 7, 8, 9, 12, 13, 14, 15, 16; Module 2 = Sessions 17, 18, 19, 20, 21, 22, 23, 24, 25, 26; Module 3 = Sessions 27, 28, 29, 30, 31, 32, 33, 34, 37, 38; Module 4 = Sessions 39, 40, 41, 44, 45, 47, 52, 56, 57, 58; Module 5 = Sessions 60, 64, 60, 70, 75, 76, 78, 79, 81, 82; and Module 6 = 87, 95, 98, 100, 103, 115, 117, 118, 119, 120.

Table 2

Frequency of relevant episodes

	Total	Session Mean
Episode of Change	109	1.02
Episode of Rupture	34	0.4
Total of Relevant Episodes	143	

episode the patient connected her symptomatology with her current biographical situation.

The excerpt of session 9 is an episode whose moment of rupture corresponds to a "confrontation" type. In this episode, the patient misunderstood an interpretation by the therapist and confronted him bluntly.

The excerpt of session 33 is an episode whose moment of rupture also corresponds to a "confrontation". In this episode, the patient got angry with the therapist because he did not answer some questions about his private life.

Data Analysis

As previously stated, DDA considers two levels:

Interpersonal level (dialogal). At this level, we qualitatively evaluated elements pertaining to conversation analysis, specifically turn taking / turn switching. Turn taking is a process of organization of the rules or principles for establishing who speaks, who listens, and who speaks next in a conversation (Calsamiglia, & Tusón, 1999; Schiffrin, 1992). The central principle that speakers follow in the turn taking process is to avoid gaps and overlaps in conversation (Sacks, Schegloff, & Jefferson, 1974). This could result in a more fluent and coordinate dialogue (Bernieri, Davis, Rosenthal, & Knee, 1994; Bernieri & Rosenthal, 1991).

Intrapersonal level (dialogic). At this level, we qualitatively analyzed the following aspects which we have defined and illustrated for better comprehension:

1. Enunciators (voices/positions): points of view expressed in the utterance (enunciate), or an ideological position itself.[3] An utterance may contain more than a point of view, valuation, or position, which constitutes its polyphonic aspect (Larraín & Medina, 2007; Martínez & Medina, 2008).

2. Subject of the utterance (who is responsible of the utterance / who is in charge): it is understood as the protagonist of the narration, or the ideological center of reference from which it develops. It is the ideological foundation from which a subject enunciates (Larraín & Medina, 2007; Martínez & Medina, 2008).

3. Subject of the enunciation (who speaks): it is understood as the subjective aspect–not necessarily an objective one–whose impression on the utterance refers to the act of enunciation (Larraín & Medina, 2007; Martínez & Medina, 2008).

4. Modalizers and modalities (attitude and valuation): In this study, *modalizers* have been conceptualized as linguistic constructions, frequently adverbial in nature, which manifest the attitude and the valuation, either implicit or explicit, of the speaker with respect to what is uttered, and which tend to appear towards the beginning or the end to "color" or impregnate it with such attitude. From a dialogic point of view,

[3] The background, based on Bakhtin, Voloshinov, and Vygotsky, considers that language and discourse always entail an ideological position, because they are part of a broader social and cultural background (see Bakhtin, 1986; Vygotsky, 1962; Voloshinov, 1973). Therefore, an enunciator from the DDA point of view, always involves taking a position in the social and cultural scenario in which that conversation is performed.

modalizers acquire a functional social role, which allows them to regulate the dialogal and dialogic interaction (Larraín & Medina, 2007; Martínez & Medina, 2008). Concurrently, modalities have been conceptualized as the relationship between the speaker and the utterances that express him or herself –that is to say, the relationship between the propositional content and the speaker's point of view on it. Modalities can be marked using specific modal verbs and other linguistic elements. Alvarez (2001) classified them in: a) Alethic, which refer to a "could be", to situations that are probable or possible from the speaker's point of view; b) Deontic, which refer to a "must be", to situations that are obligatory, necessary, or forbidden from the speaker's point of view; c) Epistemic, which refer to "mental operations" such as to know, to believe, to think, etc.; d) Volitional, which refer to a "will" or to a "want to be"; and e) Appreciative or Axiologic, which refer to values or judgments expressed about persons, ideas or objects.

In the next excerpt[4] of the therapeutic dialogue we can see an example of discursive text with its dialogic elements in bold and with the aforementioned DDA elements, numbered in brackets after the utterance.

> T: .hhh Look ***I think that*** (2, 4b) when ***I was telling you*** (3) that ***I can tell you*** (3) how old I am and:: if I have children and if I am married or not (.) .hhh well actually look, ***I think that*** (2, 4b) what ***I hhh. am trying to explain*** (2) there is that um:: ***it is a type of question that has to do with a fact from reality*** (1) (.) right?, ***I mean, obviously, I mean*** (4) ***you um:: have every right to wonder who I am, what I do, right, outside these four walls,*** (1) right? (.) then ***what I am telling you*** (3) is ***that I think*** (2, 4b) ***your question is valid*** (1)

In this study, we have attempted to integrate both levels, dialogic and dialogal, doing a qualitative analysis in the selected episodes, in order to illustrate the DDA method and achieve the study aims.

Results

Change Episodes Analysis

To achieve the first objective regarding change episodes, we looked for a predominance of dialogic markers that placed the patient as author of the change, and dialogal markers that maintained conversational fluidity.

The results for these aims are the following:

The therapist favors the construction of a shared meaning throughout the psychotherapeutic dialogue. The next extract illustrates this result with dialogic markers

[4] See Appendix 1 for transcript notation

in bold and with DDA elements numbered in brackets (see Method section) after the utterance:

> T: .hhh I think **that if we** (2), in this job, manage to understand, for example, among other things (.) what makes you um::: (.) um::: **we could say** (2,4a), to position **ourselves** (2) like this (.) for example, I had the impression here with you um::: that:: (.) **if we** (2,4a) didn't do something for you to feel freer to speak your mind…" (Episode of change, session 7)

In this extract the therapist presents a common enunciation sharing the responsibility for the utterance with the patient by using the first person plural markers: "that if we"; "we could say"; "ourselves"; "if we". Notice that the therapist also uses the first person singular, but it is used less often than the plural form.

The patient uses the first person singular to mark the *subject of the utterance*, thus being the author of the utterance reflecting the change. This result is illustrated in the next fragment:

> P: "This is what **I want** (2) deep down, the life **plan that I, I (.) need** and **I:: I want** (2) to have (3.0) **I am** (2) trapped in something **I don't**:: (2) (.) it's difficult **for me** (2) to escape…" (Episode of change, session 7)

This patient's utterance corresponds to the change moment that determines the end of the episode. In this utterance, the way in which the patient points herself as the author and protagonist of the change using the first person singular is highlitghed: "I want"; "...plan that I, I need"; "I...I want"; "I am"; "I don't"; "for me". Notice that in this very short utterance we found several "I's" used as *subject of the utterance*. Besides, this change moment met the criterion of the *first person singular, the present tense, and the presence of self-referential content,* discussed above (Aristegui et al, 2004; Reyes et al., 2008; Stiles, 1992).

The therapist attributes the authorship of the emergent meanings to the patient, making her protagonist of them. In the next excerpt we can see that:

> T: "… **you don't feel** (1) :: somewhat independent again (.) I remember that (.) there comes the image of being sort of trapped and sort of inserted into a rather closed system? (…) **these sensations that you** (1) have transmitted to me, these experiences **of yours** that I:: **that we can share** (1) here (.) are they recent experiences or has it always been like that? Has **your life** (1) been a bit like that?" (Episode of change, session 2)

In this fragment we can see the way in which the therapist highlights different positions (points of view) totally or partially attributing the authorship of them to the patient. In order to do that the therapist mainly used the second person singular or the first person plural: "you don't feel"; "these sensations that you"; "of yours"; "that we can share"; "your life".

Another result was that the therapist validates the patient's subjectivity as the author of the episode of change. In the next extract we can see this:

T: "… ↑ Because I had the impression that you suddenly made a gesture showing that **you had found an idea that you hadn't thought of before** (2) (.) this thing we are talking about…" (Episode of change, session 2)

In this utterance, the therapist highlights and validates the patient's subjectivity that takes part in her own change. The therapist does this using the second person singular associated with a mental content and underlining its emergence *here and now*.

Finally, at the interpersonal or dialogal level we found that turn taking follows the *adjacency pairs* pattern,[5] and there are examples of turn length compensation. As a whole, both dialogal markers could be interpreted as showing fluidity and coordination between the participants. In the next fragment of dialogue we can see this:

P1: (5,0) <Because my life became monotonous> (.) getting up, doing things ↓ doing things, >doing things, doing things, doing things, doing things < that I do again the next day and, that the next day I do again and the next day I ↑ do them again (3,0) they are the same things

T2: Sounds like a tedious:: routine (.) right?

P2: Yes

T3: (.) .hhh Would you agree with me that this aspect you expressed in the other interview, that suddenly> the experience of life becomes flat< , repetitive, BORING (.) without relevant motivations, that could be like a point::: um::: to study, like how to change it, for example? (Episode of change, session 2)

If we pay attention to the form of the dialogal exchange we can notice the fluidity of the turn taking, without gaps, overlapping or interruptions. Besides, at the beginning of the fragment, the patient presents a long utterance which is answered by the therapist with a short utterance. This is followed by a short utterance from the patient and then by a long utterance from the therapist. This kind of regularity, from our point of view, constitutes a compensation phenomenon that, together with fluidity, contributes to the coordination of the interaction.

[5] Adjacency pairs are a very typical exchange pattern from a turn taking analysis. Some pairs, such as *question-answer; invitation-confirmation; request-rejection*; etc., are typical examples of adjacent pairs (Schiffrin, 1992).

Rupture Episodes Analysis

To achieve the second aim regarding rupture episodes, we looked for dialogic markers that show the therapist's efforts to overcome the rupture, and dialogal markers that indicate a lack of conversational fluidity.

The results regarding both episodes of rupture of the alliance are the following:

In both episodes of rupture, the therapist tends to involve a third party as the *subject of the utterance* to give objectivity to the relationship. The next fragment, which illustrates this idea, is part of an episode of rupture, whose topic was that the patient does not want to talk about herself and wishes to quit the therapy because she says she feels better:

T1: "…I would have to be honest to tell you that, **in this jo::b(.) we sometimes see** (2,4a) with a certain frequency that, **when somebody** (2) feels better, just **like in medicine when one** (2) feels better one says it's ENOUGH, so to speak, right?..." bu::t but to me this not me::e:: I believe tha::t you are reproducing a mechanism of yours ok?(.) to be actually working and suddenly ok? You say (finger snap) I quit!!

P1 (10,0) Do you believe that I'm manipulating this situation?

T2 Manipulating?

P2 Mmm (3,0) or that I'm preparing it to be able to dismiss it later

T3 (.) Ok:: you understood me in that way, do you?

P3 Could be or not?

T4 hhh. I don't know how you think about it, I had never thought about manipulation

P4 I had the feeling tha::t you tried to say to me something like you want << to control the strings>> (.) of something:: (.) that actually is not so::=

T: (3,0) ok::

P: = (3,0) I'm not able to control the puppets yet

T5: able to what?

P5: to move the puppets

T6 : ok:: (3,0) hhh. well [when] (Episode of rupture, session 9)

In the first utterance (T1 in bold) the therapist brings to the dialogue a third party as the *subject of the utterance*. This party comes from outside of the relationship ("this job"; "in medicine") and has a generic form ("we sometimes"; "when somebody"). It is interesting to notice that, in the latter examples, the first person plural ("we") and the generic word "somebody" refer to neither the therapeutic relationship nor to the patient. Also, at the very beginning of this extract we can detect the use of a *deontic modality* ("I would have to be") and a *modalizer* ("to be honest"). Both have the effect of positioning the therapist as a trustful person that speaks from a "must be". This form could be similar to the episodes of change, but its particular use in these episodes of rupture has a very different effect: to give objectivity to the relationship.

These episodes of rupture in the alliance seem to be solved once the therapist calls on and validates the patient's subjectivity. This is shown in an episode that begins when the patient asks the therapist about his private life: his marital status, if he has children, etc. The therapist did not answer her directly; instead, he answered by calling a third party as the *subject of the utterance* to give objectivity (T7: "…look (.) the way how we're working here (.) let say, allow us make ourselves this question (.) for example (.) why do you believe that it could be important for you to know that?..."). This answer makes the patient feel angry and the rupture starts. At the end of the episode, the therapist validates this patient's feeling:

T16: (3,0) .hhh **but this bothered you**,[obviously]

P18: [The tone DID both]er me, **it DID bother me**

T17: Why? **What did you feel? What, why do you think that**::

P19: Well **I felt what**:: I don't know, I mean, what many people may have felt, having set a definite limit, don't meddle in what I do... (Episode of rupture, session 33)

In this fragment the therapist stresses the patient's feeling about the moment of rupture ("this bothered you"). This facilitates and offers a way to repair the relationship by deepening in the patient's subjectivity ("What did you feel"; "…why do you think that"). At this point the patient takes the offer and amplifies her own feelings.

The resolution of both episodes of rupture analyzed results in a change in which the patient was the author of the meaning that had initially been part of the conflict. The following excerpt illustrates and explains this idea. The fragment corresponds to the continuation of the rupture of the ninth session showed previously:

P6. **It's [SO] COMPLICATED to discuss this topic**, I mean try: (.) meet: a person once a week, **talk about oneself** (.) it::s very complicated

T5. in which sense?

P7. because:: for starters, there are egocentric:: people and who speak about themselves all day (.) I DON'T, I mean, I'm the complete opposite, **I don't:: speak or:: express much (.) or feel much (.) also, right?,** ↓↓ in this sense I'm not very affectionate (.) but not because I don't feel anything but because that's the way I am (3,0) so I don't know:: (3,0) **it makes me somewhat (.) uncomfortable to be here and to try to tell you something**

T: hm::

P: (3,0) **to express what I think, to say what I want** (.) or::: I don't know:: (.) **to express that:: that I feel well, or maybe I'm assuming that I feel better and maybe I'm not so well …** (Episode of rupture, session 9)

In this fragment the crisis becomes an opportunity. The initial topic that motivated the rupture (the patient's wish to quit the therapy) is turned through the dialogue into the content of the patient's change, because in this case she realized that the true reason for leaving the therapy lied in her difficulties to express her feelings ("It's so complicated to discuss this topic… talk about oneself…"; "…it makes me somewhat uncomfortable to be here and to try to tell you something…"). Besides, the patient not only turned the rupture topic into a change content, but also established herself as the author of this change by expressing it in the form of the first person singular, in the present tense, and with a self-referential content ("… maybe I'm assuming that I feel better and maybe I'm not so well…").

Finally, from an interpersonal or dialogal perspective, in both episodes of rupture of the alliance, turn taking and switching were not very fluid and interruptions and overlapping took place. As a whole, these markers could show a mutual lack of coordination (mutual de-regulation) between the participants. In the next fragment of dialogue we can see this:

P10: >NO this is not a fantasy< it was just a (.) question that I think:: would be normal for you to answer

T9: I agree it seems natural to me (.) What I'm [showing] you

P11: [WHAT I REALLY] DON'T like is:: the:: the tone you used to tell me I can tell you this and not that (.) yes I know,[but it's also] legitimate=

T: [Tell me, how?]

P: =HOW YOU PHRASED IT

T10: (3,0) How I phrased it now

P: now

T: just now

P: just now mm

T: .hhh well I'd like [to]

P12: It [SOUND]ED A BIT AGGRESSIVE:: I can tell you yes yes (.) how old I am, when:: but I can also tell you nothing, (.) do you understand? (Episode of rupture, session 33)

In this dialogal exchange we can notice a lack of fluidity in turn taking, with overlapping and interruptions. In general, the patient and the therapist's phrases are shorter and the whole fragment looks like a rapid exchange, like a kind of fight to define the turn taking and the topic of the dialogue.

Discussion

The main purpose of this work was to show the DDA method for the in-depth study of relevant episodes in the psychotherapeutic process. Concurrently, through the rational and linguistic bases of this method, some insights about the agency of change and the reparation process of the rupture of the alliance were shown. Features of the DDA like *subject of the utterance*, *subject of the enunciation*, and *enunciators*, are coherent with the notions of authorship and being the protagonist of the change involved in both aims explored in this paper.

About our first aim, that is to say, to explore the predominance in the episode of change of dialogic markers that place the patient as the protagonist and author of change, and the presence of dialogal markers that maintain conversational fluidity, we found a particular use of *subject of the utterance* and the presentation of *enunciators* in both patient and therapist, which favors a common enunciation. This contributes to validating the patient's authorship of change. Besides, we observed a context of connection and coordination reflected through dialogal markers of fluidity. The latter could be an expression of the micro-regulatory process that occurs, verbal and non-verbally, inside the psychotherapeutic process. As is mentioned in the works of Tronick (1989), Stern (1985), and Beebe (2006), it is thought that both members of the therapeutic dyad are affected by their own self-regulation behaviors as well as by the others, which constitutes a process of mutual regulation. This process is believed to occur continuously, moment by moment, especially at a non-verbal level.

With respect to our second aim, the DDA method allowed us to depict some comprehensive issues about the rupture and its repair processes which were observed in both episodes.

Firstly, we found that the ruptures were characterized by both dialogic and dialogal markers. The former were represented by the presence in the dialogue of a third subject as *subject of the utterance*. This third party, which in this case was invited only by the therapist, has the effect of giving objectivity and legitimacy to the therapist's enunciators, but it does not contribute to rupture reparation. Related with this finding, Colli and Lingiardi (2009) have defined negative interventions of the therapists such as using technical jargon or "imposing" their world view, and have found that these interventions are positively correlated with patient's rupture markers. The latter, dialogal markers showed us a lack of fluidity and shared rhythm. Both markers seem to be an expression of a breakdown of the intersubjective field. This could be explained by the primacy of the self-regulatory process which serves as a shelter for each of the participants from the threat provoked by the rupture moment. As Safran and Muran (2000) have mentioned, the resolution of the tension between the need for agency and the need for relatedness is a dialectic which is always present in the psychotherapeutic process, just as self regulatory and mutual regulation is part of a permanent negotiation throughout the process.

Secondly, related with the episodes of rupture, we found two functions of the *enunciators* as dialogic markers in the context of the repair process in the analyzed episodes. The first one was the use of *enunciators* which have the effect of calling on and validating the patient's subjectivity. The second one was the shift of the patient's enunciator, but keeping the same topic of the rupture. These functions of the enunciators seem to work jointly within the repair process. Once the patient's subjectivity was convoked, her position became less defensive and allowed her to consider and adhere to the therapist's position with respect to the topic of the rupture. Coherent with this result, in the study of Colli and Lingiardi (2009), "positive interventions" were defined as therapist interventions that, in relation to previous patient communications, were emotionally attuned, focused on patient experiences, and linguistically clear. Also, they found a significant correlation between positive intervention of the therapists and collaborative processes from the patient. From a theoretical point of view, the effect of this kind of processes could restore the intersubjectivity field and, as Tronick (1998) states, dyadic regulation results in the expansion of the consciousness of the dyad's most vulnerable member.

In spite of some limitations, such as the small and homogeneous sample employed or the lack of statistical triangulation of its results, the exploratory design of this study make other facts come up which allow us to advance some hypotheses for future studies:

First, in relevant episodes (change or rupture) we will encounter *nuclear utterances* condensing all the elements (enunciators) that will be deployed during the conflict or the change. A *nuclear enunciator* corresponds to one particular *enunciator*, which is a dominant voice or position in the episode. These elements can be said to act as different voices or positions in the participants' discourse and, in rupture episodes, frequently get in conflict (Hermans, 1996) and become the focus of therapeutic work.

Second, in episodes of rupture, the patient's cooperation using the *first person singular* as a signal of his or her position as the author of the utterance (*subject of the utterance*), will result in a quicker resolution of the conflict.

Third, the patient's speaking turns during situations of change will be less fluid than those of the therapist in the same context. In turn, the opposite will happen in episodes of rupture, in which the patient's speaking turns will be more fluid than the therapist's. Considering the notion of authorship of the change, in this kind of episodes it is the patient who is in charge of elaborating his or her own change. In contrast, in episodes of rupture, it is the therapist who has the main responsibility to keep a good therapeutic alliance. So, this third hypothesis could be explained because of these different roles in the therapeutic process.

With respect to the microanalytic method shown in this study, and paraphrasing William Blake (1863): "To see a World in a grain of sand…", the value of an analysis of this type is that, on the basis of small events, it is possible to construct concepts and models that may be reproduced at higher levels of an interactive process. We think that this study is a small illustration of the possibility of a detailed account, in a conversational and discursive-linguistic manner, of the process of change and repair of the rupture in fragments of therapeutic interaction. In other words, this dialogic discourse analysis has shown to be a methodology that enables a productive and specific look at the processes of construction of therapeutic change, resolution of ruptures in the therapeutic alliance, and dialogic and dialogal regulation. Here, the distinction between the dialogal and the dialogic levels can be put forth as a model for therapeutic listening as well as for therapeutic work in general.

Finally, as discussed earlier, this methodology could be a coherent empirical contribution to the theoretical conceptualization of the intersubjective approach in psychotherapy. Language, in the form of conversation and discourse, constitutes an intersubjective space, a shared context of meanings and a dialectical field of tensions among people. Psychotherapy is built out of these moments of construction and struggle. Linguistic procedures can be an excellent method to illuminate that process and we think it is important to stimulate psychotherapy research with this kind of tools.

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