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Requesting examples in psychodiagnostic interviews: Therapists' contribution to the sequential co-construction of clients' change

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Abstract

As part of a larger research paradigm on understanding client change in the helping professions from an interprofessional perspective, this paper applies a conversation analytic approach to investigate therapists' requesting examples (REs) and their interactional and sequential contribution to clients' change during the diagnostic evaluation process. The analyzed data comprises 15 videotaped intake interviews that followed the system of Operationalized Psychodynamic Diagnosis. Therapists' requesting examples in psychodiagnostic interviews explicitly or implicitly criticize the patient's prior turn as insufficient. They also open a retro-sequence and in the following turns provide for a description that helps clarify meaning and evince psychic or relational aspects of the topic at hand. While the therapist's prior request initiates the patient's insufficient presentation, the patient's example presentation is regularly followed by the therapist's summarizing comments or by further requests. Requesting examples thus are a particular case of requests that follow expandable responses regarding the sequential organization; yet, given that they make examples conditionally relevant, they are more specific. With the help of this sequential organization, participants co-construct common knowledge which allows the therapist to pursue the overall aim of therapy, which is to increase the patients' awareness of their distorted perceptions, and thus to pave the way for change.

Keywords: change; operationalized psychodynamic diagnosis; psychotherapy; requesting examples; sequentiality

1. Introduction

From a clinical point of view, change in the client is of utmost interest because change of some sort is the motivation for all psychotherapies (Weiste and Peräkylä 2015: 8; Peräkylä 2019: 265). The question of how the particular interaction between therapist and patient leads to the latter's change is thus highly relevant; yet it is extremely challenging to answer, due to the various internal and external factors that possibly contribute to patients' transformed way of talking and feeling about their concern(s) and/or experience (see Voutilainen *et al.* 2011; Peräyklä 2019) and to their transformed ways of acting (see Carey *et al.* 2007). Voutilainen *et al.* (2011: 348) claim that 'an analysis that focuses on sequences of talk that are interactionally similar offers a sensitive method to investigate the manifestation of therapeutic change'. Likewise, Peräkylä *et al.* (2008: 16) postulate that 'sequential relations of actions are a major vehicle in psychotherapeutic process' (see also Peräkylä 2019: 257).

Studies such as these focus on the therapeutic core work, i.e. intervening, whereas the current contribution focuses on interactional and sequential

aspects of diagnosing as an obligatory preparatory work for intervening and thus for change. As part of a larger research project on understanding change in psychotherapy and related formats from a qualitative-linguistic perspective (this issue; see also Graf *et al.* 2019), this paper investigates the interactive, sequential and thematic preparations for change in the context of the Operationalized Psychodynamic Diagnosis system (OPD Task Force 2009). Specifically, we focus on therapists' requesting examples (REs) in psychodiagnostic interviews and their specific interactional and sequential functions as therapeutic change potential via initiating thematic development and expansion as well as by prompting reflection. In our focus 'on identifying, describing, explaining and predicting the effects of the processes that bring about therapeutic change' (Greenberg 1986: 4) in the context of REs, we take a conversation analytic perspective (Deppermann 2008; Sidnell and Stivers 2013). The more general linguistic context of our research deals with triggers for therapists' action in psychodiagnostic intake interviews with patients: what do professionals single out from the patients' prior utterances as worth exploring and as potentially modifiable in the patients' description of their experiences (see Peräkylä 2011, 2013)?

According to the protocol of the OPD system (OPD Task Force 2009), the diagnostic conversations carried out on the basis of this manualized procedure help to assess the patients' psychodynamic profile: their underlying maladaptive interpersonal patterns, motivational conflicts and levels of personality functioning or integration. This diagnosis aims at the development of mid- and long-term therapy goals as well as other aspects of treatment planning. In summary, the material and the therapeutic action under scrutiny here lay the ground for patient change insofar as they carve out patients' problems, i.e. insofar as they highlight what needs to be changed in their feeling, thinking and acting, and predetermine what therapeutic steps must be taken to achieve this ultimate goal in therapy.

The paper first gives an overview of the key concepts for the current analysis, discussing psychotherapy in the context of conversation analysis (CA) and *Gesprächsanalyse*, a German research paradigm based on CA that also draws on pragmatics, discourse analysis and linguistic text analysis (see Deppermann 2008). It then introduces REs as the action type under scrutiny, OPD as the relevant therapeutic protocol and psychodiagnostic interviews within OPD as precursors for therapeutic change. Next, the data and method are discussed, followed by the analysis proper. Here we first present a case study, followed by details of the overall formal organizational structure. We conclude with a discussion of the findings, in particular with a focus on the change potential of requesting examples in the context of OPD.

2. Literature review

2.1. Psychotherapy in Conversation Analysis and Gesprächsanalyse

The analysis follows the well-established research paradigm in CA and *Gesprächsanalyse* that investigates the sequential organization of recurrent practice(s) of psychotherapeutic interaction (for CA see e.g. Peräkylä *et al.* 2008; Bercelli *et al.* 2013; Voutilainen and Peräkylä 2014; Weiste and Peräkylä 2015; Peräkylä 2019; and for *Gesprächsanalyse* and psychotherapy see e.g. Scarvaglieri 2015; Mack *et al.* 2016; Marciniak *et al.* 2016). More specifically, researchers working in this field have recently started to focus explicitly on the sequential and interactional change potential and change efficiency of particular therapeutic strategies within and across therapy sessions (see Voutilainen *et al.* 2011; Voutilainen *et al.* 2018; Marciniak *et al.* 2016; Kabatnik *et al.* 2019; Spranz-Fogasy *et al.* 2019).

At the same time, the current study forms part of a research paradigm interested in how knowledge is co-constructed in professional or therapeutic interaction; that is, how epistemic asymmetries represent the primary motivation for patients to seek professional help (Kallmeyer 2000; Lalouschek 2005; Weiste *et al.* 2016; Pick 2017; Graf and Spranz-Fogasy 2018). Analyzing types of relevant knowledge as well as interactive practices of knowledge construction and knowledge transfer are of core interest for research on the helping professions. The success of therapeutic interactions 'depends in some measure on the client's willingness and ability to talk about self and other's experiences' (Muntigl and Zabala 2008: 188) and thus therapists' actions often center on eliciting or trying to elicit additional or different

information from their patients (Pino 2015). REs thereby function as one of these actions.

2.2. Requesting examples

From a therapeutic perspective, therapists' REs are an interactional means to shed light on patients' mental problems. These may include distorted perceptions due to past experiences, disordered emotional and behavioral reactions to these experiences and their mental representations (Weiste 2015), or a patient feeling not in control or lacking capacity to act (Scarvaglieri 2013). OPD may also address neuroscientific issues (Kessler *et al.* 2013).

From a technical point of view, REs are a specific form of clarification. Although clarification is applied universally in different schools of therapy, from a psychodynamic perspective it can be defined as 'the therapist's invitation to the patient to explain and explore any information that is unclear, vague, puzzling, or contradictory' (Yeomans *et al.* 2002: 138). Clarification aims at deepening either the patient's or the therapist's understanding of a given topic and at identifying regulatory defensive mental strategies that hinder therapeutic or diagnostic progress by avoiding painful memories or insights. Another aspect of clarification as a technique concerns its interpersonal impact. Clarification is often perceived as a genuine interest of the therapist for the patient that strengthens the bonding aspect of the therapeutic alliance. At the same time, it may also stimulate ambivalent feelings or impulses in the patient toward the therapist, as familiar evasive patterns are challenged by the clarification request. To clarify therefore always means to co-construct through communication, which is an important principle, and often a more or less conscious motivation for engaging in psychotherapy.

From a general interactional perspective, REs by therapists explicitly or implicitly mark the patient's prior turn as insufficient regarding its epistemic or experiential content (Muntigl and Zabala 2008). By opening up a retro-sequence (Schegloff 2007), such actions provide for a description that both helps clarify the semantic vagueness and evinces psychic or relational aspects of the topic at hand. While the therapist's prior request initiates the patient's insufficient presentation, the patient's example presentation is regularly followed by the therapist's summarizing comments or by further requests focusing on the patient's problem. With the help of this sequential organization, both participants co-construct elements of common and new knowledge (Keselman *et al.* 2016: 656). Such an 'interplay of understanding' (Voutilainen and Peräkylä 2014) allows the therapist to pursue the overall aim of therapy, which is to increase the patients' self-awareness of distorted perceptions in order to pave the way for change.

2.3. The Operationalized Psychodynamic Diagnosis system

The therapeutic protocol the study focuses on is the OPD system, which was first developed by psychoanalysts and experts in psychosomatic medicine and psychiatry in 1992 and revised in 2006 (Arbeitskreis OPD 2006; trans. OPD Task Force 2009). It centers on the idea that a categorization of psychic problems, based solely on a descriptive classification of symptoms, must be enriched by a psychodynamic dimension. In this vein, OPD represents a diagnosing technique or method that helps to assess patients' psychodynamics in and through conversation. The OPD psychodiagnostic interview thereby functions as a tool that allows drawing a precise and individualized picture of a patient's suffering and specific problems. As found across the majority of therapeutic diagnostic interviews, OPD proceeds according to a manual and applies categories and scales to assess the findings, which guarantees the comparability of the diagnostic results (cf. Sachse 1999: 98; see also OPD Task Force 2009). Psychotherapists diagnose patients' conditions and their underlying psychodynamic constraints along five axes, which allows for a parallel understanding of the various aspects of a patient's psyche and living conditions and enables drawing a holistic picture of a patient's situation.

The OPD system lends itself to the study of linguistic patterns in therapeutic interactions. On the one hand, it follows a semi-structured pattern where the interviewing therapist is always required to ask about, among other things, relationship episodes, how the patient experiences and sees himself or herself and how the patient experiences and sees significant others (Ehrenthal 2012; Ehrenthal and Grande 2014). It is therefore also a setting where, in contrast to regular psychotherapy, the aims of

the conversation and general content are more controlled. As noted above, this facilitates comparability, and ultimately it helps deduce patterns as described below. On the other hand, while asking the related questions, the OPD interview is more similar to actual therapy than other standardized interviews, as the techniques used by the interviewer are similar to a therapeutic conversation, in that they contain clarification, confrontation and interpretation. This serves to verify the diagnostic hypotheses, to give the patient an experience of how actual therapy might feel, and to set shared treatment goals. By assessing the patient and his/her problem, the OPD system in its psychodynamic approach co-constructs therapeutic change potential on the basis of which an individualized therapeutic process is developed and carried out via therapeutic operations (Orlinsky 2009; Lambert 2013).

2.4. Psychodiagnostic interviews as precursor for change

Diagnostic interviews in psychotherapy settings usually serve several purposes. Primarily, they establish if there is a need for psychotherapy treatment, and how psychotherapy may contribute to recovery. Secondly, they help to identify and foster agreement about treatment goals, and create specific therapeutic tasks which are aimed at reaching these goals. Lastly, these treatment formulations ('formulation' here used in a general sense rather than in a CA sense – Heritage and Watson 1979) concerning tasks and goals may serve as a means for the evaluation of psychotherapy treatment in individual patients or clients. In other words, diagnostic procedures always serve the treatment itself (OPD Task Force 2009).

To correctly diagnose a patient's problem – together with formulating a goal and deducing appropriate next steps in therapy – is part and parcel of the therapeutic process and its success, i.e. the *sine qua non* for patients' change. To rephrase, the results of the diagnosis determine the procedure and interventions in therapy (cf. Mack *et al.* 2016: 19; OPD Task Force 2009).[1] As outlined by Sachse (1999: 95), there are different types of diagnostics: intake or entrance diagnostics, process diagnostics and success diagnostics. Given that the entrance diagnostics lay the ground for all future therapeutic procedures, this type of diagnostics is of particular relevance for the whole therapy process. Based on the assumption that therapy has to take into consideration patients' different conditions and circumstances in order to be effective, a differentiating diagnosis of individual preconditions of the patient is of absolute necessity (cf. Sachse 1999: 94, OPD Task Force 2009).

3. Data and method

The data for the present study comprise 15 videotaped first interviews with 15 patients (8 female, 7 male) with diagnoses of depressive disorders involving five psychotherapists (1 female, 4 male). On average, the interviews last for about 75 min (a total of 18 hours 43 minutes). The data were collected at the Clinic for General Internal and Psychosomatic Medicine at the Heidelberg University Clinic. The study was approved by the ethics committee of the University of Heidelberg (S-195/2014) and all participants gave their written informed consent in accordance with the Declaration of Helsinki. The original data are in German.

The target utterances (Peräkylä 2019) of the following analysis are REs. As discussed above, they can be defined as retrospective requests from the therapist to the patient to elaborate their directly preceding utterance via an exemplary concretization. In our analysis we restrict the collection to cases where the word 'example' (German *Beispiel*) is explicitly used. There are also many indirect or implicit cases such as 'can you describe a typical situation?' or 'which topics make you desperate?', which we excluded from this first analysis (see Blöcher 2017). In our corpus we found 33 explicit REs in 12 interviews, while in two other interviews there were only synonyms or variants without the word 'example'. One interview did not contain any such request at all; in this particular case the therapist was acting very carefully, due to the patient's extreme traumatization caused by family members. The data is transcribed according to GAT 2 (minimal transcript) (Selting *et al.* 2009; see Appendix). The REs found were analyzed by means of conversation analysis with regard to the context of the conversation, their design, the sequential structure and their functions.

In what follows, we first present a case study to illustrate and detail the change potential of requesting examples. Next, we discuss the overall formal and organizational structure of requesting examples and their theoretical change potential as they have emerged from our data.

4. Analysis of requesting examples

REs are a particular type of reference clarification; yet, as we will see, they are regularly more loaded with affective meaning than requests for persons, time or space. We here present a case study taken from the corpus, before a more general analysis of REs derived from the corpus.

4.1. Case Study

The following case study illustrates an example, which can be regarded as prototypical of requesting examples as well as RE sequences. The extract analyzed here lasts for 4 mins 26 secs; due to space limitations it is necessary to considerably shorten (and therefore partly paraphrase) the respective sequence. We first describe the context of the RE sequence and then analyze the whole sequence from its beginning, which is prior to the proper RE action.

Context for the RE sequence (patient)
In a factual manner, the patient speaks about the beginning of his panic attacks. He reports to the therapist that while he was dressing for the current OPD interview, he remembered that he had worn the same shirt when his panic attacks initially had begun. He also tells the therapist that he is convinced that he is now in better control of his fears most of the time.

Rephrasing utterance (therapist)
In her response, the therapist uses a rephrasing question, as shown in Extract 1

Extract 1

T: °h ham sie diese anspannung eigentlich schon mal bemerkt wenn sie sich irgendwie geärgert ham oder wenn sie sich sorgen gemacht haben um ne beziehung oder um einen menschen
have you already [particle (PRT)] noticed this tension before when feeling angry or when worrying about a relationship or about a person

With this, the therapist focuses on the patient's inner experience and emotions in various ways. She talks about tension, about being annoyed and worrying about a relationship or a concrete person; she thereby draws the attention away from the patient's person to relationships and other people. Her question is followed by a marked silence of 15 secs.

Explanation (patient)
In his delayed response to the therapist's question, the patient answers in a reluctant way, as shown in Extract 2.

Extract 2

P: (15.0) °hh h° also ich merk eigentlich dann wenn ich äh (.) streite (0.5) ((schmatzt)) dass dann die körperlichen symptom (.) me schwerer werden (0.26) ((schmatzt)) oder (.) beziehungsweise stärker werden
15.0) well I notice PRT when I uhm (.) fighting (0.5) ((smacks)) that the physical symptom (.) ms put on weight (0.26) ((smacks)) or (.) respectively become stronger

In a lengthy elaboration (1 min 30 secs), he then details different situations where he gets tense, thus focusing on himself and others, e.g. parents or his girlfriend. He reports that he feels extremely uneasy when disputing with people particularly close to him. He adds to this in Extract 3.

Extract 3

P: da fühl ich mich dann schon (.) sehr angespannt un_ möchte das ganze eigentlich gern abbrechen un_dann fi kann i nich weider (.) diskutieren (.) weil ich des gefühl habe es schadet mir
I do feel very tense and really want to cancel the whole thing and cannot go on dis-cussing things (.) as I have the feeling it really harms me

As can be seen in his explications, the patient does not precisely address the point the therapist was aiming at, i.e. being annoyed and worrying about a relationship or about another person.

Requesting example (therapist)
The patient's evasive explanation then elicits an RE by the therapist, as shown in Extract 4

Extract 4

T: ham sie ein beispiel dafür
do you have an example for that

This request, an immediate and unmodified question addressing the patient, refers to the patient's latest descriptions and marks a particular action as relevant. As a third-position statement the therapist's utterance criticizes the patient's prior turn – i.e. his response – as she treats the patient's explication as an 'expandable response' (Muntigl and Zabala 2008). Yet, with the RE she defines or restricts the particular content of the patient's follow-up turn to an example, thereby suggesting *ex negativo* that the patient's descriptions up to now have been too general or inaccurate in some way and therefore need at least some concretization.

Example given – or not (patient)
Apparently, the patient has difficulties with this request at first and in Extract 5 seems reluctant to give an adequate answer.

Extract 5

P: (1.05) pf es gibt so viel dispute (0.32) ((brummt)) (0.43) wenn einfach ähm der partner die eltern mit ner gewissen situation net zufrieden sind (1.4) ich hätte das tun sollen habe es nich gemacht (0.67) oder ähm was auch immer es es jetz ganz (.) ganz zu konkretisieren fällt mir einfach schwer des sin_alltags (.) sachen kleine streitereien sag ich mal aufgrund von (.) °h kleinen gegebenheiten (1.21)
(1.05) pf there are so many disputes (0.32) ((humming)) (0.43) when simply uhm the partner the parents are not satisfied with a certain situation (1.4) I should have done that haven't done it (067) to entirely (.) entirely concretize is PRT difficult for me that are everyday (.) matters little little arguments I would say due to (.) °h little circumstances

Yet, after his initial refusal to provide explanations, a pause of 1.21 secs and some hesitation signals (*uhm m m*), the patient in Extract 6 comes out with an initially irritable report.

Extract 6

P: ähm m m warum hast du heut nich eingekauft ich war den ganzen tag arbeiten jetz muss ich wieder mit ich würd gern heim lieber jetz was essen jetz muss ich noch einkaufen gehen hab ich kein bock drauf °hhh und so sachen (.) ähm wo man da einfach kleinichkeit streitet (0.32) ich hab eigentlich keine lust (1.19) zu streiten momentan
why haven't you shopped for groceries today I was working the whole day now I have to come along again I rather would PRT go home eating something now I still have to shop for groceries myself […] °hhh and such things (.) uhm where you simply are fighting about peanuts (0.32) I PRT don't feel like (1.19) arguing at the moment

After a short side sequence, in which the therapist and the patient discuss that the patient had quoted his significant other, the patient affirms that he had reported an example (explicitly framed as 'for example') and begins with a longer elaboration. He talks about his partner's expectations and her understandable anger. He admits that he could have gone shopping for groceries, but that he had not managed this because of his illness.

At this point, the patient's elaboration is very lively, containing fine-grained details that illustrate his and his partner's emotions and how they deal with the situation. He also elaborates his own incapacity to fulfill his partner's expectations.

Response/further action (therapist)
At this point the therapist steps in again, as shown in Extract 7.

Extract 7

T: wie gehts ihnen dabei wenn sie das so zu ihnen sagt
how do you feel when she says this PRT to you

The therapist thus focuses on the patient's feeling within this particular relationship and forces the patient to engage in a deeper level of self-reflection, self-disclosure and self- and other-awareness in a close relationship, all of which are preconditions for change (Voutilainen *et al.* 2011). The therapist's third-position response then ratifies the patient's description or explanation as sufficient; her ratification and response are offered in the form of a question that builds on the patient's finally offered example (after he refused to come up with a concrete example in the first place).

Further context (patient and therapist)
Although the RE sequence formally ends here, the therapist's RE initiative entails further psychotherapeutically relevant consequences, as the patient reports his feelings of rage against himself and his significant other because of her lack of consideration, even though he admits that he understands his partner's behavior. The patient continues to explain how he enters a negative train of thought and how panic, fear and hypochondriac disturbance become virulent.

In Extract 8 the therapist, in her next question following the patient's report, sketches an alternative scenario of the patient's example telling.

Extract 8

T: wenn das (.) ihre ähm lebensgefährtin so zu ihnen sagt (.) °h merken sie sie dann auch manchmal dass sie sich wünschen würden (1.09) dass sie sagt ich (0.92) macht nichts ich geh jetz_einkaufen (0.68) (.) macht nichts dass du noch nicht äh einkaufen warst ich geh jetzt einfach einkaufen
when your significant other says PRT to you (.) °h do you you notice that you sometimes would wish (1.09) that she would say I (0.92) doesn't matter I go shopping for groceries now (0.68) doesn't matter that you haven't done the shopping I simply go shopping now myself

This scenario entails a new perspective on the patient's wishes concerning his significant other and their relationship, and possibly opens up the patient's mind to a more differentiated thinking and allows for greater agency. The patient affirms the therapist's scenario as desirable, but subsequently calls it 'unrealistic'. He reports that if he cannot understand something, his rage would grow and he would go berserk.

After a pause of 2.28 secs, the therapist again intervenes, asking the patient whether understanding helps him feel less annoyed. Thus, she – in a positive statement – turns the patient's focus from not understanding to the impact of his understanding. In what follows the patient talks about his early childhood experiences and his parents' education style as one important reason for his current being, thinking and doing.

The therapist and the patient next engage in a discussion that centers on the latter's need to better control his emotions as well as to grow up and to take care of his life. This insight, which is the most relevant result of the RE sequence, is the content-based concretization of the structural change potential of the RE sequence.

4.2. REs – Their structural and organizational build-up

This section describes more systematically the different action types REs can comprise, their format and verbal elements as well as the sequential implications as they have emerged in our data. We also describe the sequence type that REs establish.

Action types and sequential implications

REs comprise different linguistic action types such as questions, appeals, summons or even imperatives. Prototypical examples, as found in the data, are

– *do you have an example for that?*
– *please give an example*
– *example!*

All action types mentioned here set a particular type of reaction which is conditionally relevant in order to concretize one's prior insufficient or vague answer via presenting an example. This always means that patients have to come up with more than a yes/no-answer, i.e. nothing but presenting an example is a type-confirming (Raymond 2010) fulfillment of an expansion task, in Muntigl and Zabala's (2008) sense.

As regards another sequential implication, REs in our corpus immediately follow a patient's turn; sometimes they even intervene or interrupt the patient's ongoing turn. Normally, REs are short utterances with only one turn constructional unit (TCU), often referring to the material of the previous utterances in a straightforward manner. REs can thereby contain many different verbal elements that categorize the type of action (as question, appeal, summons etc.), accomplish addressing, modify the strength of a request, request the respective explanation or establish the reference. For example, in '*do you perhaps have an example for that?*' (from our corpus) the following aspects are realized:

– *do [you] have* marks the action type as a V1-question;
– *you* addresses the patient;
– *perhaps* modifies of the strengths of the request;
– *an example* requests the respective explanation;
– *for that* establishes the reference by pointing backwards to the patient's immediately preceding utterance.

Even though the RE in this example is very detailed, there are condensed versions of REs that contain these elements in more implicit forms: the imperative '*example!*' addresses the patient via its sequential positioning, participation constellation and action type, reveals a directly shaped request

and points to the patient's prior utterance as reference point.

The RE sequence

In pointing backwards, REs establish a sequence type which Schegloff (2007) calls a retro-sequence and which consists of at least two parts. In so doing, REs turns the patient's preceding utterance into the source of the RE and thus into the first position in the sequence. As argued by Muntigl and Zabala (2008) for requests for expansion, REs thereby entail a critical impetus: therapists point out to their patients that an utterance is insufficient and that an expansion, in particular an exemplarily concretization, is required.

While such insufficiency is rarely explicitly expressed in an RE, an analysis of the patient's prior utterance reveals vagueness, excessive complexity or other forms of lack of clarity as the source of the therapist's request. Furthermore, the critical impetus always indicates that the patient's utterance is an insufficient reaction to the therapist's request prior to the patient's explanation, i.e. the retro-sequence backwardly expands into a three-part sequence, defining the RE utterance as a third position disconfirmation action type (Schegloff 2007). Remarkably, in our corpus the therapist's first request in that sequence is always an action of the 'rephrasing' type as analyzed e.g. by Weiste (2015) and in Weiste and Peräkylä's (2013) study of psychotherapeutic interaction with particular respect to 'formulations'. 'Rephrasing formulations' are characterized by a transformation of a patient's presentation from a more factual focus to the patient's experiential dimension and even often her/his emotions (see also Pawelczyk 2011). As Mack *et al.* (2016) state, the rephrasing type of utterance is not limited to formulations, but is also realized in questions.

So far, we have identified a sequence with three parts that bears obvious psychotherapeutic implications. A factual presentation of the patient is interpreted by the therapist via a rephrasing utterance (first part) as an – implicitly – experientially and/or emotionally loaded description or representation, which in turn is replied to by the patient via an insufficient statement concerning the experiential and/or emotional load (second part). This, in turn, is followed by the therapist's action of trying to elicit an example as a concretization, i.e. an RE (third part); the therapist via his/her RE thereby again aims at the experiential and/or emotional dimension, given that this dimension was already addressed before by the therapist yet was only unsatisfactorily tackled by the patient. We can state that REs are a powerful resource for accomplishing thematic and psychodiagnostic work. As such they manage the progress of therapy by using patient's insufficiency or vagueness in giving an experientially and/or emotionally focused presentation as trigger or starting point for a more lively and concrete presentation.

However, as initiators of a three-part retro-sequence REs also work prospectively in setting an upcoming sequence as conditionally relevant: the RE functions as first position and the requested presentation of an example (or also a dispreferred reaction; see the case study above) is categorized as second-position action (see Muntigl and Horvath 2014). A sequence organized by an RE does not end with the presentation of an example (or other kinds of reaction) (concerning the necessity and value of the third position see Spranz-Fogasy 1986; Schegloff 2007; Stivers 2013). As an RE is a third-position assessment of the therapist's rephrasing utterance, the therapist's evaluation of the presentation of an example (or other kinds of reaction) later on is also sequentially organized by an RE. This sequential position regularly allows the therapist to deal with the patient's given example, focusing on its experiential/emotional implications; these may be the patient's agency within the described situation, her/his narrated or current thoughts or her/his relationship with other people, etc.

As shown in the previous section, in our corpus the sequence organized by RE contains five parts, where the two parts prior to the RE action are retrospectively organized by RE and the two following parts are prospectively organized by RE:

– rephrasing utterance (therapist)
– explanation (patient)
– RE (therapist)
– example given – or not (patient)
– response/further action (therapist)

We avoid numbering the single parts of the sequence because the organizing part is in the middle of the sequence and numbering would

suggest a consistent progress from the first part onwards. However, as the focal element in the middle of the sequence organizes the progress both retrospectively and prospectively, it is not projectable at the beginning of the sequence. The description of the sequence here might be confusing at first glance, but it again highlights how flexible the sequential organization and co-construction of mutual understanding works. The positional status of each single turn continuously changes, depending on the respective point of view. This allows for a subsequent evaluation and re-evaluation at every stage; as such it informs the following utterances as it simultaneously provides interpretations for the understanding of the previous utterances and shapes common ground and intersubjectivity.

This organizational structure marks reflections on the patients' side as conditionally relevant; i.e., we argue that the formal set up of RE sequences forces the patient to cognitively engage in a more concrete reflection as regards his/his distorted perception and/or behavior.

5. Discussion

The analysis evinced that the RE action is a powerful instrument to initiate psychotherapeutically meaningful conversations with patients. The question, though, remains: what exactly makes RE and RE sequences psychotherapeutically change-relevant? Within a thematic frame established by the therapists via a rephrasing request that addresses the patients' experiences and emotions, the therapists point backwardly to an insufficient explanation of the patient and demand for expansion via concretization and detailing. Implicitly, the patient's presentation is criticized as too vague, overgeneralized or unclear in some other way. The patients' offers of examples then provide concrete and insightful information regarding their experience and agency within a particular situation, their relationships and self- and partner-awareness, as well as self-reflection and investigation of the causes of their illnesses.

What are the more general therapeutic implications of (giving) examples? Examples are single cases of a more general or global issue, which is prototypically represented by a sample of more examples of the same kind. When asked for examples, patients did not choose just any case, but chose examples which were significant cases for the general or global context. These are emotionally striking or loaded for the patient in some way, and therefore informative for the broader therapeutic context. This is due to the critical impact of the therapists' REs and due to the fact that more significant examples are easier to remember than less telling ones – since patients themselves choose them as significant. The presentation of examples then reveals structural elements of the general or global issue while also revealing the interrelatedness of these elements. Presenting and negotiating the impact of examples means *pars pro toto* 'working out the details' in a concrete case, and this is a means of discussing alternatives and, at best, a chance for introducing change.

Working with many exemplary cases may offer the therapist valuable insights into patients' perceptual patterns, which have become autonomous or automated and thus impair or direct the patients' (future) perceptions and agency. Discussing an example in therapy therefore will open up new opportunities for the patients to change these. Highly relevant for the purpose of reflection and change is the possibility of mutually relating concrete and more global descriptions in several 'rounds' and thereby developing alternative perceptions and discovering new and better forms of agency.

RE paradigmatically reveals psychotherapeutic courses of action in the following manner:

- immediate sequential linking to a patient's presentation;
- particular and recipient designed processing;
- immediate turn delivery back to the patient;
- request to exemplarily reveal underlying characteristics of the patient's experience and agency;
- inducement of reflection in and through the follow-up processing;
- creation of change potentials.

Scarvaglieri (this issue) addresses 'starting points' for therapeutic change in therapists' rewording of patients' experiences. He focuses on specific incremental changes introduced by the therapist via establishing a conceptually new perspective on the patient's experience, which – if accepted and elaborated by the patient – can serve as starting

points for therapeutic change given that they make different stocks of knowledge about the patient's experience accessible. The triggers or starting points analyzed in this study are of a different kind, functionally, thematically and sequentially. Firstly, as part of the OPD interviews, they primarily serve to diagnose the patients' problems in this particular therapeutic protocol, preparing the ground for therapeutic operations and thus, ideally, for change. Moreover, in their primary clarifying function they address the patients' stocks of knowledge, not the therapists'. And finally, the therapists' REs represent a third-position change-preparing element in a larger, five-part sequential interactional environment that aims at diagnosing patients' problems as a prerequisite for working on them via mediators and mechanisms of change (Kazdin 2009).

6. Conclusion

The current paper has focused on the action format 'requesting examples' (REs) and analyzed their particular interactional and sequential contribution to facilitating change in the patient, meaning a transformed way of feeling and talking about their concern(s) and/or experiences in the context of a therapeutic alliance with a therapist. Therapists' requesting examples are a routine action format in psychodiagnostic interviews, but they also relate to the technique of 'clarification' used in longer-term psychotherapies. Although psychodiagnostic interviews – the empirical basis for our analysis here – do not primarily aim at change via intervening strategies, they nevertheless prepare the ground for change via diagnostic strategies. As one of the key diagnostic strategies, REs generate important material as they interactionally elicit paradigmatic instances. These in turn reveal distorted perceptions and behavior patterns, allowing reflection and thus helping the client to develop alternative perceptions and behavior patterns.

From the perspective of psychotherapy practice and research, this linguistic approach sheds light on the interrelatedness of therapeutic technique (i.e., RE as a form of the psychotherapeutic intervention 'clarification') and the therapy process. It is important to note that none of the therapists conducting the OPD interviews in our corpus were aware of this line of research, but nevertheless produced similar patterns. In other words, linguistic analyses have the potential to reveal conversational patterns implicitly used by mental health professionals and their patients. In the long run, this may have the potential to help therapists to refine their interventions, but also to serve as a tool for further mixed-models research on psychotherapy processes and outcomes.

Appendix: Transcription conventions GAT

Transcription conventions Follow Selting *et al.* (2011).

Pauses

(.)	micropause (shorter than 0.2 secs)
(2.85)	measured pause

Other segmental conventions

und_äh	assimilations within units
äh, öh, etc.	hesitation signals, so-called 'filled pauses'

Breathing

.h, .hh, .hhh	inbreath, according to duration
h, hh, hhh	outbreath, according to duration

Other conventions

((coughs))	para- und extralinguistic activities and events

Note

1. Graf (2015, 2019) in her work on executive coaching, a related helping format, defines 'diagnosing' and 'intervening' (together with 'securing transfer') as the communicative core tasks of the basic activity 'co-constructing change'.

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