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Susanne Kabatnik
University of Greifswald
Christoph Nikendei
University of Heidelberg
Johannes C. Ehrenthal
University of Cologne
Thomas Spranz-Fogasy
Leibniz-Institute for the German Language Mannheim

Relationship management by means of solution-oriented questions in German psychodiagnostic interviews

The article addresses *Solution-Oriented Questions (SOQs)* as an interactional practice for relationship management in psychodiagnostic interviews. Therapeutic alliance results from the concordance of alignment, as willingness to cooperate regarding common goals, and of affiliation, as relationship based upon trust. SOQs particularly allow for both: They are situated at the end of a troublesome topic area, which is linked to low agency on the patient's side, and they reveal understanding of and interest in the patient. Following the paradigm of Conversation Analysis and German *Gesprächsanalyse* this paper analyzes the design and functions of SOQs as a means for securing and enhancing the relationship in the process of therapy. Our data comprise 15 videotaped first interviews following the manual of the Operationalized Psychodynamic Diagnostics. The analyses refer to all SOQs found but will be illustrated by means of a single conversation.

Keywords: relationship, therapeutic alliance, solution-oriented questions, psychodiagnostic interview, psychotherapy

1. Introduction

Psychotherapy is to a large extent shaped and supported by the relationship between the participants, which is fundamental for common interactional work as well as for obtaining the institutional goals. The establishment and maintenance of the therapeutic relationship or alliance is crucial for the success of therapy (Muntigl and Horvath 2018). As many researchers have argued, the working alliance is the most effective success factor in therapeutic interaction: "The strength of the alliance is arguably the

best and most reliable predictor of outcomes […] and is generally considered one of the most important common factors in therapy" (Ribeiro et al. 2013: 295; see also Horvath and Greenberg 1994; Horvath 2006; Ardito and Rabellino 2011; Lambert 2013; Flückiger et al. 2012). Psychotherapy as a co-constructed treatment format primarily relies on structural characteristics of communication: the fundamental sequentiality of verbal interaction (Deppermann 2008), i.e., the sequence of utterances of at least two speakers provides and guarantees the production of intersubjectivity and thus forms the basis of therapeutic effectiveness (Peräkylä et al. 2008) – also in terms of relationship management. However, it is difficult to investigate relationships because they are usually not explicitly addressed (cf. Mandelbaum 2003) and can often only be analyzed on the basis of how interactants communicate with each other (for online communication cf. Kabatnik in this volume).

The topic of interpersonal relationship has a long tradition in pragmatics research. In language theoretical approaches from Humboldt via Schütz, Mead, Bakhtin to Linell, dialogicity is emphasized as central (Mandelbaum 2003). Bühler's (1934) functions of expression and appeal are relationally indicative and constitutive as well as Jakobson's (1960) phatic function or the functions of illocution and perlocution in speech act theory. Watzlawick et al. (1967) emphasize the relational aspect in addition to informative content. Special impulses for linguistics, however, have come primarily from the sociology of interaction, for example with Goffman's concepts of role and face, or from the politeness-theory of Brown and Levinson. Davies and Harré (1990) developed the concept of positioning, which focusses on the dynamic aspects of interpersonal encounters. Based on these concepts, Holly (2001) characterizes relationship in interaction as elementary, ubiquitous, and common, but also as potentially superficial, delicate, and explosive, and therefore mostly implicit. Bucholtz and Hall (2005) outline a framework for the construction of identity generated in linguistic interaction. Locher and Watts (2008) highlight that relational work includes the whole spectrum of the interpersonal aspects of social practices, i.e., both politeness and impoliteness. Arundale (2010) extends the face concept to a cross-cultural and culture-specific dimension and conceptualizes face as a relational phenomenon. The ethnomethodologically-based Conversation Analysis (Sidnell and Stivers 2013) highlights the construction character of interaction and thus also of relationships-in-interaction. Participants in the conversation themselves, with their interrelated actions, constitute what they are doing at the moment, which action goals are being pursued, and the relationship between them. Mandelbaum (2003: 217) in her study "Interactive Methods for Constructing Relationships" describes relationships from this perspective "as collections of communicative practices, or things that we do through communication, in contrast to thinking of them as social structural things that we *have*" (emphasis by Mandelbaum).

While psychological and psychotherapeutic research usually conducts extensive studies on the topic of relationship within and outside the therapeutic setting, systematic linguistic analyses remain rare (Linke and Schröter 2017), although many relationship-relevant phenomena such as theme setting, variation of expression, intonation or lexical modification are of a linguistic nature. On the interactional micro-level, Conversation Analysis distinguishes two central practices of micro-managing the interpersonal relationship or the alliance between patient and therapist: alignment and affiliation (e.g., Muntigl and Horvath 2014; Muntigl et al. 2012). Alignment and affiliation are two key qualities of interactional interpersonal relationship that form "an infrastructure of therapy" (Peräkylä 2019: 273), which enables patient and therapist to attach to each other. Alignment characterizes the mutual willingness and intention to cooperate, to pursue a common goal willingly, and to work together in a cooperative process. Affiliation, on the other hand, characterizes a more fundamental quality: the emotional agreement and the relationship and bond based on trust between patient and therapist (Lindström and Sorjonen 2013; Steensig 2019). While alignment refers to the more structural characteristics of the sequential organization, e.g., the observance of the right to speak or the fulfillment of conditional relevance, affiliation is associated with the factual and substantive agreement of the epistemic attitude of the interlocutors and their emotional-empathic support.

Psychotherapeutic conversations are characterized by narratives of the patient and interventions of the therapist, which are intended to guide the patient's explanations. In addition to the therapists' supporting actions, challenging actions promote the therapeutic process, too (Marciniak et al. 2016). Conversational analysis has identified four key types of therapeutic speech actions: questions, formulations, extensions, and interpretations (Weiste and Peräkylä 2015). In this paper we focus on formulations and questions. Weiste and Peräkylä (2013) differentiate four types of formulations: *highlighting, rephrasing, relocating,* and *exaggerating formulations*. All of these action formats aim to promote awareness and expand and restructure the patient's knowledge and thus ultimately bring about change (see Peräkylä 2019).

In addition to their cognitive content, verbal actions also imply different attitudes towards the patient, relationship offers, and support (see Watzlawick et al. 1967: 4; Konerding 2015: 234). It is about gaining trust and establishing a relationship based on trust, getting patients to cooperate, and establishing common goals. Therapeutic issues are also strongly relationship-implicative in this respect. However, in terms of relationship management, questions have often been viewed critically; they are considered to be too invasive in such a sensitive relationship context due to sequential constraints and therefore lead to patients being blocked in their willingness to talk about their emotional needs. Nevertheless, questions in psychotherapeutic conversations are endemic, and many formulations are

treated as (declarative) *questions* too by both therapists and patients (see Marciniak 2016: 6; Spranz-Fogasy 2010). In a study by Mack et al. (2016) on questions, all functions identified for formulations could also be determined for questions. In addition, the following other question types were identified: *Requesting Example* (cf. Spranz-Fogasy et al. 2020), *Questions for Collaborative Explanation Finding* (cf. Mack et al. 2016) and *Solution-Oriented Questions* (cf. Kabatnik et al. 2019; Spranz-Fogasy et al. 2018; Läpple et al. 2021). While the first type requires a broader, content-related presentation of the patient by asking for examples (= clarification of problem issues), the second aims at causes for symptoms or mental disorders (= explanation), the latter type – on which we focus here – aims at patients' treatment expectations, wishes or life perspectives (= solution). These subjects of *Solution-Oriented Questions* (SOQs) imply possible changes or therapeutic goals and can therefore be analyzed as a specific change-enabling interactional and therapeutic practice (see Kabatnik et al. 2019; Spranz-Fogasy et al. 2018). The desire for change is the central motivation of any form of psychotherapy (Weiste and Peräkylä 2015: 8) and thus also for the change of relationship and relationship behavior. In the following we therefore analyze relationship implications of SOQs in their immediate sequential context and across the course of the conversation. First, however, we will present the data on which the analyses are based.

2. Data and method

The data of the research comprise 15 videotaped psychodiagnostic interviews with 15 patients (8 female / 7 male) with diagnoses of depressive disorders, and five psychotherapists (1 female / 4 male). The interviews follow the concept and manual of the OPD system (OPD Task Force 2009). On average, the interviews last for about 75 min (a total of 18 hours 43 minutes). Data was collected at the Department for General Internal Medicine and Psychosomatic at the Heidelberg University Clinic (2008 to 2015). 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 is in German.[1]

The OPD system was first developed in 1992 by psychoanalysts and experts in psychosomatic medicine and in psychiatry. The central idea is that a psychic problem is not sufficiently operationalized by its categorization within a descriptive classification system for symptoms. To understand all dimensions, the symptoms must be enriched by a psychodynamic dimension, and understood in relation to a

1. We only present the English translation; the original German data are placed on the book's web page.

patient's individual biographical background and psychodynamic characteristics. Thus, OPD represents a diagnostic method that helps to assess the patients' psychodynamics via conversation in terms of a specifically designed interview. The interview thereby functions as a manualized instrument that allows for drawing a precise and individualized pattern of the patients' suffering and specific underlying problems. OPD allows therapists to classify patients' problems according to a manual and applies categories and scales to assess the findings; this guarantees the comparability of the diagnostic results (cf. Sachse 1999). Psychotherapists thereby diagnose patients' conditions and their underlying psychodynamic constraints along five axes (cf. Ehrenthal and Benecke 2019), which allow the therapist to define a therapeutic focus in respect to underlying psychodynamic conflicts, patients' personality function, and particular dysfunctional relationship patterns (Schauenburg et al. 2020).

As the data were derived from a time-limited diagnostic interview session, it does not allow us to draw any conclusions about psychodynamic psychotherapy as a whole. Nevertheless, the data is valuable for investigating the context of certain question types and their sequential organization as well as their relationship conditions and relationship building implications.

The 'target action' (Peräkylä 2019: 7) of our analysis are *Solution-Oriented Questions* (SOQs). In our corpus we found 27 SOQs in twelve interviews. Other question types not discussed here were 33 explicit *Requesting Examples* and 57 *Questions for Collaborative Explanation Finding* (Spranz-Fogasy et al. 2020). The SOQs were analyzed by means of Conversation Analysis (Sidnell and Stivers 2013) and German *Gesprächsanalyse*[2] (Deppermann 2008).

3. Analyses

Solution-Oriented Questions (SOQs) are verbal interventions by therapists to find solutions for patients' problems that have been discussed or to determine patients' expectations for their future life or for therapy (Mack et al. 2016). The problems addressed always refer to the patients' reduced agency (Deppermann 2015; Kook 2015; Marciniak 2017). SOQs play a key role in psychodiagnostic interviews, especially for depressive patients with limited agency and prospects. The primary goal of this question format is to discuss and work out a solution for the problem discussed (see Mack 2016; Spranz-Fogasy et al. 2018). Solutions that are negotiated as a result of such questions are always hypothetical; in the protected space of the

2. *Gesprächsanalyse* is a German research paradigm based on CA that also draws on pragmatics, discourse analysis, and linguistic text analysis.

psychotherapeutic setting, patients can experiment with different ideas of possible solutions without fear of consequences.

The following analyses refer to the investigation of all 27 SOQs. To make the analyses easier to understand, we will first illustrate SOQs by means of a single conversation in which the therapist articulates a total of five SOQs and a development in the search for a solution as well as in the therapeutic relationship becomes clear. We also refer to this interview regularly in subsequent property- and structure-related descriptions which will apply to all occurrences of SOQs in our corpus. Thereby we analyze the design of SOQs, describe the position of SOQs within the overall interaction, and analyze their sequential processing locally and also within the whole interview with respect to the formation of relationship during the interaction. The patient in our reference interview suffers from depression and has already made several attempts for therapy. Her main problem of accepting help is addressed right at the beginning of the interview. The patient shows a skeptical and resistant attitude towards the therapeutic agenda. The aim of the interview is to build a trust-based relationship with the patient, to get her to cooperate and to work out common (therapeutic) goals. Because SOQs ask about the patient's goals, solutions, wishes, and hopes, and offer support in the search for them, they seem to be predestined for the purpose of building a trustful relationship (further practices of relationship cf. Muntigl in this volume and Graf and Jautz in this volume).

In interview T3_2 we identified the following five SOQs, presented here with their content reference points and thematic context:[3]

Extract 1. SOQ 1: Therapy hopes/desires (00:34:11)

T: i mean (.) what do you hope for or what (0.5) would you wish for (.) if you allowed yourself to wish for anything

Extract 2. SOQ 2: Balance between own needs and the needs of others (00:42:16)

T: how could you create a balance where you don't feel that others (0.28) ehm come off badly but where your own needs could also be considered

Extract 3. SOQ 3: Good quarreling 1 (00:56:16)

T: could you imagine that (.) how that **[i.e., good quarreling; the authors]** (.) could look like or how you want it

Extract 4. SOQ 4: Good quarreling 2 (00:56:23)

T: and if you'd fantasized a little bit **[i.e., about good quarreling; the authors]**

Extract 5. SOQ 5: Accepting help (01:19:33)

T: could that be a topic for you (0.56) which you would like to deal with here

3. Transcription conventions follow Selting et al. 2011.

SOQs offer support for collaborative reflection and planning (cf. Thurnherr in this volume also sees clients as active participants in the therapeutic alliance). Thematically, SOQs refer either to the therapy (see Extracts (1), (5) above) or to the patients' lives (Extracts (2), (3), (4)) and address the patients' wishes (Extract (1)), ideas (Extracts (3), (4)), concrete perspectives (Extract (2)), or goals (Extract (5)) (see Spranz-Fogasy et al. 2018; Kabatnik et al. 2019). SOQs can also contain explicit relationship topics, such as the balance of needs (Extract (2)) and the patients' conflict behavior in relationships (Extracts (3), (4)). For patients, answering such questions means to distance themselves from familiar, albeit dysfunctional, interpersonal regulatory patterns and correspondingly stressful intrapsychic affects, and to explore solutions that aim at gaining freedom of action and overcoming patterns of dysfunctional self- and relationship regulation. SOQs thus aim at the epistemic-emotional state of consciousness of the patient and exert high interactive pressure on the patient to act.

Design

SOQs have several common features regarding their formulation design, often associated with delays (Extracts (1), (3), (5)) or terminations and repairs (Extract (2)) (19 of 27). This suggests that SOQs are not an easy undertaking for therapists either:[4] Concerning the patient's problem, their emotional and mental state and the potential sensitivity of the therapeutic relationship, these interventions must be treated with caution. In addition, subjunctive forms (see Extracts (1)–(5); 16/27) with reference to the future are usually used (see Extract (5); 23/27), which opens the space for speculation and at the same time marks the tentativity of the issues to be negotiated. The therapist thus places him-/herself on the same epistemic level as the patient, as he does not know the solution to the problem either but is prepared to accompany the patient in developing solutions (cf. Džanko in this volume points out that the demonstration of epistemic equivalence ensures stronger commitment).

Regarding the semantic-grammatical question type, *wh*-questions are significantly more frequent (Extracts (1), (2); 20/27). *Yes/no* questions are also possible but occur almost exclusively as integrated *wh*-questions (see Extract (3)). Thus, basal categorical information is asked, such as person, time, and place, and the patient's problem is at the center of the therapeutic intervention. The presuppositions of the questions, i.e., the existence of hope and wishes (Extract (1)), the balance between

4. In the remaining 8/27 SOQs the questions are prepared by the therapist; see also Extract (4), which follows Extract (3) almost immediately.

needs (Extract (2)), the possibility of good conflict (Extract (3) and (4)), and the acceptance of help as a possible therapy topic (Extract (5)) suggest thinkable solutions and thus also define a framework for answers. These presuppositions make such questions interactionally delicate and at the same time challenging for establishing relationship between the participants. The patient's problems discussed above can be expected to lead to deficits in the patient's ideas and strategies for solutions and face-threatening repair initiatives on the part of the therapist (Brown and Levinson 1987) – which is also reflected in our data (cf. Kabatnik et al. 2019; Spranz-Fogasy et al. 2018).

Another striking feature is the dominant, sometimes multiple, direct addressing (24/27) of patients despite individual therapy (cf. Günthner in this volume for addressing as a relationship-building instrument). On the one hand, this direct addressing activates patients' personal knowledge (cf. Spranz-Fogasy et al. 2018). On the other hand, despite clear identification, such person references indicate patient-centeredness and can thus be interpreted as an expression of affiliative activities (cf. Schwitalla 2010: 192). Thus, not only is the patient in the focus of the therapist's attention, but also his or her problem, ideas, wishes and conceptions on emotional and interpersonal issues. SOQs allow for both cognitive and emotive-volitional projections, which are also expressed in the cognitive (Extract (3)), emotional (Extract (1)) and volitional (Extract (5)) lexicon of the predicates of the questions (see Extracts (1)–(5)). By querying wishes, hopes, and concrete ideas, the patient's entire spectrum of experience is covered and thus acts as a precursor to the negotiation of common goals in terms of alignment. The use of the respective verb type also indicates which reactions therapists assume to elicit through their questions. Cognitive verbs such as "to imagine, think, believe" already aim at concrete solutions, while emotional verbs such as "to hope, wish, want" trigger a solution orientation in the first place (Reinicke 2018). From a clinical perspective, cognitive verbs operate simultaneously at a greater emotional distance, while emotional verbs tend to be closer to the delicate and "painful", similar to Wachtel's (2011) description of effects of rational vs. experiential strategies and wordings.

Regarding the requirements for contextualization, SOQs show different degrees of complexity – from short initiatives, previously prepared utterances (see Extract (4), prepared by Extract (3) and the patient's following answer) to increasingly complex utterances with inserted and/or deferred clarifications of the framework conditions as well as an often long lead time as in the following extract:

Extract 2′. SOQ 2 with presequences (00:41:49)

T: and I believe that this is also happened to you (0.25) is (0.21) has also happened to you in all these years (0.31) that you actually °h (0.45) the area of needs and desires and the °h (0.21) feelings ((incomprehensible)) (0.64) for really (0.28) yes for good (0.64) very good reasons (.) to have deposited or deposited somewhere (.) °hh (1.0) and which of course (.) is under pressure as a steam boiler and and you just h° (0.29) probably have little (.) handling for how can one (0.2) **how can you achieve balance where both °h you don't have the feeling that other °hh (0.28) um ((clicks)) come off badly but where your own needs are seen**

The frequent high complexity of SOQs with long lead times, insertions as well as the intermediate and subsequent clarification of framework conditions also point to the delicate nature of these questions. Therapists thus document their awareness of the patient's difficult mental state, which is addressed in the preceding interactional negotiation of low agency in the reference interview in connection with the patient's relationships. In addition, this way of formulating documents that therapists consider the psychological state of patients when formulating the intervention and tailor their statements to suit the addressee (cf. Clark 1992), so that the patient's understanding of the intervention can be made easier and possible misunderstandings can be avoided from the outset.

Beyond that, SOQs can also be used to implicitly criticize the patient's previous behavior (Bröcher 2017), as for example in Extract (4), which shows the connection to the insufficient response to SOQ in Extract (3) and calls on the patient to undertake further solution-finding activities. This type of criticism can also represent an activity that endangers the relationship due to its potentially face-violating character.

In the context of OPD interviews, however, SOQs are primarily a diagnostic tool, as the therapist implicitly asks whether or where the patient already sees possibilities for action and shows willingness to cooperate. Thus, an important function of SOQs is to test (cf. Bröcher 2017; Oelschläger 2017) whether the patient is ready for developing common goals or projections for them. In addition, responsibility can be transferred and its handling by the patient can be observed (Oelschläger 2017). Transfer of responsibility with simultaneous support then also documents confidence in the patient's ability to find solutions and at the same time presupposes a secure basis of trust between patient and therapist.

Positioning and context

SOQs usually appear in the last third of the interviews (18/27). However, they can also – as in our reference interview – appear in the first (3/27) and second third (6/27) of the interview, but then always at the end of a complex problem negotiation (9/27). This specific position of SOQs at the end of the conversation and/or of complex topics indicates on the one hand that SOQs require a basis of trust and relationship, due to their invasive character in terms of content and interaction with which they address the patients' level of experience and demand a reaction. On the other hand, they can also create a relieving change of perspective from problem elaboration and the past to the alignment of goals and the future. Due to the preceding problem elaboration, a patient's low agency is documented and addressed in all 27 SOQs of our corpus (cf. Marciniak 2017). A problem or conflict is indicated retrospectively, for which possible solutions are sought. In the way it is formulated, the offer of support is expressed by asking for possible solutions, but these are marked as hypothetical so that patients can carry out thought experiments in the protected space without fear of real consequences. This is explicitly formulated in SOQs 3 and 4, in which the therapist addresses the patient's imagination and fantasy, but also in all other cases, e.g., through the subjunctive (cf. Mack et al. 2016). The therapist can thus initiate ideas for solutions, develop them together with the patient, but also correct them if necessary.

By addressing low agency in the forefield of SOQs, in our reference interview interpersonal relationships of the patient were discussed before each SOQ. Prior to SOQ 1, the patient's recurring suicidal thoughts are discussed, where she claims not to commit suicide because of her mother. The therapist calls this behavior a *dangerous deal* because the patient makes herself dependent on another person. After his observation of the great inner distress of the patient and the question of her attitude towards therapy, with SOQ1 follows a question concerning therapy hopes and wishes, with which the therapist addresses the subjective dimension and implicitly asks how he can help her.

Prior to the second SOQ, the focus is on earlier therapy attempts of the patient. She admits that she has not always been honest with her therapists. On the one hand, this may mean that the patient has not been able to build up enough trust with her therapists to confide her feelings, thoughts, and experiences in them. On the other hand, it may indicate a behavior that endangers the relationship,[5] which is also criticized by the patient as *false honesty*. Nevertheless, the therapist deals

5. In the case of malicious deception, exposure can have far-reaching consequences for the relationship. Certain contexts, such as therapy situations or relationships, can encourage such deception (Goffman 1977: 98).

with these self-reproaches of the patient understandingly, that she had neglected the emotional sphere for years for good reason, which is a face-saving activity of the therapist.

This is followed by the second SOQ for establishing balance, in which the therapist implicitly asks how the patient can trust him without neglecting her need for protection (see Extract (2)' with presequences). SOQ 1 and 2 are interlinked, because both questions deal with the subjective dimension of the patient, marked in SOQ 2 by *feel*, so that the second SOQ is not a general question about establishing balance. Given the contextualization with past therapeutic behavior, this SOQ can also be related to the patient's behavior in the current therapy, which is marked by the very general subject *others*, with whom both therapeutic and non-therapeutic relationships are addressed.

The third and fourth SOQ follow almost immediately after each other and deal with the previous topic of the patient, her father and her parents' dispute behavior. She then describes her own argumentative behavior as *I am one of them (.) I can (.) nothing can discuss (.) nothing can't argue if I have a fight I am gone* (00:55:14). The self-attribution of this quarrelling behavior by *I am also such a one* points to a manifest conflict behavior of the patient. After the question of the therapist, if the patient does not know *other disputes […], where people have argued well*, the negation of the patient and the rephrasing formulation of the therapist *that means that you do not know how to argue well*, the therapist asks in SOQ 3 for good arguing. With this he asks whether the patient has any ideas about good arguing behavior, and furthermore, how she would like to shape arguing situations in the future. With the volitional lexicon of the question (*want*) the subjective dimension is also addressed here. Due to the lack of a with-whom-addition, the patient's general conflict behavior is addressed, including that in therapy, which is essential for the ability to argue because patients are also confronted in therapy with unpleasant contents and assessments to which they must respond (cf. Marciniak et al. 2016: 4).

Before SOQ 5, the relationship with a former partner of the patient is discussed. The patient reports the escalation of a dispute at a party, for which border violations by a guest are cited as the trigger. As the dispute escalates, the patient wants to flee. After the therapist praises the patient for her strength and the patient continues with her self-reproaches, the therapist interrupts her self-deprecation by means of an *exaggerating formulation* and takes up the initial topic of accepting help again with SOQ 5. Topically, the previous SOQs are continued here, because the balance between the patient's own and other people's needs from SOQ 2 is dealt with, as well as the conflict behavior from SOQ 3 and 4 and the therapy wishes from SOQ 1.

In the context of the SOQs, different relationships of the patient, e.g., with her parents, partner or other therapists, are negotiated with regard to reduced agency of the patient, on the one hand, and relationship-relevant behavior, e.g., honesty, the

expression of feelings or argumentative behavior, on the other. The context analysis shows that each SOQ in our reference interview has relationship implications and thus also deals with relationship-relevant aspects, not only between the patient and her family members and friends, but also between the therapist and the patient.

Sequential organization and global development of relationship

Positions 0–2

Based on the data of the 15 OPD interviews, we have created a step-by-step model of the sequential organization of SOQ, which we would like to demonstrate using the five SOQs in our reference interview. The model comprises five sequence positions of therapist- and patient-side utterances. With respect to the SOQs throughout the interview, the sequence varies in the second, third, and fourth position. Nevertheless, it is possible to derive a pattern for the sequence organization of solution negotiation, summarized schematically here:

0-Position	P/T:	discussion of relationship
1-Position	T:	SOQ with relationship implications
2-Position	P:	dispreferred answer/disalignment
		non-answer/answer-like/partial conform response
3-Position	T:	expansion initiation/repair initiation
		or: topic change and subsequent therapeutic action
4-Position	P:	preferred answer/(improved) alignment/repeated resistance
5-Position	T:	ratification; subsequent therapeutic action

Figure 1. Sequence pattern of Patient (P)/Therapist (T) with SOQ as target action

In the following we discuss in parallel the sequential development of all five SOQs in our reference interview. In the **0-position** the first SOQ is preceded by the topic of the patient's repeated suicidal thoughts and the role of her mother, the second SOQ is preceded by discussions about years of suppression of the patient's feelings, the third and fourth SOQs are preceded by the topic of deficient argumentative behavior and before the fifth SOQ, low agency is shown in the patient's deficit to accept help (Extracts (1)–(5), see Table 1 below).

In the **1-position** the therapist utters a SOQ with a concrete offer of help. Due to the strong interactive pressure to react to the question, the patient's individual resources are activated to find a solution and an interactive negotiation phase is initiated. Since SOQs set a certain answer conditionally relevant, which aligns with the question in terms of form and content, we were able to establish a typology based on MacMartin (2008) and Voutilainen et al. (2011) according to different degrees of (dis)preference of patient answers in the **2-position**: With *answer-like responses*, patients shift the focus of the questions (cf. Winkler in this

volume sees "semi-response" answers as a source of information and a challenge). In *non-answer-like responses*, patients show their resistance in a more open way, e.g., by complaining about the question (= not wanting to) or expressing their inability to answer (= not being able to). *Partially conforming responses* are responses that are partially consistent with the question, but still contain characteristics of dispreferred responses, such as delay signals or explanations (see Spranz-Fogasy et al. 2018, Kabatnik et al. 2019; on preference organization in general see Pomerantz and Heritage 2013). Thus, dispreferred answers may indicate disalignment and deviating positions. All SOQs in our corpus and thus also in our reference interview are followed by dispreferred answers:

Table 1. Sequence position 0–2 in case T3_2

Sequence position // Timeline of extracts	**0-low Agency**	**1-SOQ T**	**2–Response P**	**P response type**
1:00:32:37–00:34:26	Suicidal thoughts, mother, great need of P	**Therapy hopes/wishes**	uhm that (0.26) does not work at all because it was taken from me ((laughs)) hh° i actually came with the wish or things (.) in my brain (1.08) uhm (0.26) that I can forget (0.32)	answer-like refocusing & non-answer, sarcasm
2:00:39:37–00:42:26	Shaking attack, earlier therapy tries, suppression of feelings for years	**Creating a balance between your own needs and those of others**	i have tried sports (0.47) but (0.25)	answer-like refocusing
3:00:55:14–00:56:21	Deficits in dispute behavior	**Desired image about good quarrelling**	uhmuhm (0.31) i wouldn't know	non-answer
4:00:56:23–00:56:40	Deficits in dispute behavior	**Desired fantasy for good quarrelling**	(2.15) uh argue well (0.25) uhm_uhm (2.24) yes i think arguing well is simply uh (.) °h (0.24) to stay objective just (.) uh to stay in a certain tone and not to step out there and simply (.) °h discussing (0.46) and then of course to find a common denominator	optimized answer, partly refocusing
5:01:16:58–01:19:42	Dispute with partner, inability to accept help	**Therapy topic/ desire**	(2.33) yes (0.29) somehow +++ yeah but somehow i do not know how to edit it	Partially conforming response

In our reference interview, the patient responds to the first SOQ on therapy hopes or wishes as a change of topic and positive reorientation with a *non-answer response* by denying the wish qua *extreme case formulation* (*not at all*; cf. Pomerantz 1986) and shifting the focus via *answer-like refocusing response* to an unrealistic wish, thereby expressing that she is not yet ready for common therapy goals.

The patient responds to the second SOQ for establishing a balance between her own and other people's needs – also in therapy – by shifting the focus to solution attempts that have already failed, thus rejecting the therapist's attempt to support her in developing balance.

The third and fourth SOQs follow each other and are related to each other as well as to their answers: At first, the patient is resistant to the SOQ on good arguing behavior. After feedback signals and long pauses, the patient then globally rejects knowledge about good conflict behavior via an *extreme case formulation* (*I wouldn't know*), to which the therapist reacts with a fourth and insistent SOQ to fantasize about constructive conflict behavior. On the one hand, the therapist thereby indicates that the patient's previous answer was insufficient, i.e., the therapist criticizes the first answer to the question. On the other hand, the therapist asks the patient for more willingness to cooperate by *if you'd fantasized a little bit* and asks the patient to think beyond any responsibility or duty to act. This is a specific support of the psychotherapeutic setting, in which the patient is encouraged to experiment. The insistent SOQ is highly successful here because the patient reformulates and optimizes her first response: After a short hesitation and a repetition of the question, the patient develops a concise and reasonable concept of good arguing, which enables the therapist to go deeper into the emotional level of quarreling. She answers the question in detail and responds with an – at this point surprisingly – elaborate conceptualization of good conflict behavior. By answering the therapist's question in this way, the patient shows an increased willingness to cooperate, which is elicited by the therapist's sensitive and personalized insistence. The sequences of SOQs 3 and 4 follow the ideal-typical sequence of the local solution negotiation 'low agency – SOQ – disagreed answer – therapeutic intervention – preferred answer'. Thereby, via recursion, changes in knowledge, attitude, ability to act, resistance as well as the willingness to cooperate and joint agreement on objectives can be achieved (cf. Kabatnik et al. 2019; Spranz-Fogasy et al. 2018).

The setting of common goals finally succeeds – at least partially – at the end of the conversation, as shown in the patient's response to SOQ 5 to accept help. The patient's response to the fifth and final SOQ on her initial therapy wishes and acceptance of help is finally partially-conforming. She first follows the therapist's agenda affirmatively, but then openly addresses deficits in the implementation and gives the following reasons: *well, I would like to say yes, I (.) so in the (moment) yes,*

I would really be that one hundred percent without (secondary thoughts I would like the) help and I would like to accept it (01:19:44–01:19:44).

Despite the mentioned deficits in the implementation, a clear increase in the patient's willingness to cooperate can be seen when comparing the initial and final state. The initial manifest(ed) resistance to the therapist's agenda decreases over the course of the conversation and the development of common (therapeutic) goals in terms of alignment is thus prepared for.

Positions 3 and 4

The patients' answers, which are always dispreferred in our entire data, form a starting point for further therapeutic treatment. The patients have not yet developed a solution concept for their own problems and are not (yet) prepared to follow the therapist's agenda. Thus, the patients' dispreferred answers represent a critical moment in and for the interaction. Alignment must therefore first be accomplished in the third and fourth sequence position. Therapeutic responses to the patients' resistance are insistence to expand, repair initiation or change of topic (see Figure 2; cf. Läpple et al. 2021.).[6] While repair initiation addresses the patient's dispreferred answer as a problem of alignment and change of topic even ignores the lack of alignment, insistence marks the patient's lack of affiliation with the implications of a SOQ. In any case, at this sequential position the current status of the relationship becomes virulent and assessable for the therapist. This also helps us to observe changes in the relationship in the course of the interaction.

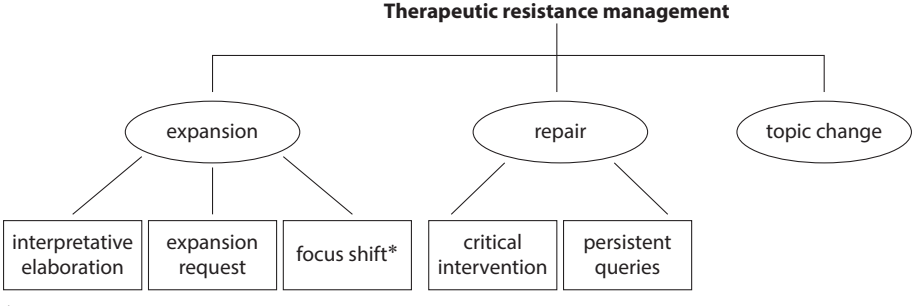

Figure 2. Therapeutic resistance management

6. In recent analyses of psychotherapy sessions, we found a further type of resistance management: topicalization of resistance. We assume that this type does not occur in OPD interviews, because this is not necessary for the rationale of these interviews (i.e., assessment) and could be counterproductive in this context due to time constraints and the depth of intervention. Explicit topicalization of resistance is discussed in Vehviläinen 2008.

In the following we discuss the sequential development of all five SOQs in our reference interview for positions 3 and 4 in parallel as above (continuation of Table 1 with positions 3 and 4).

Table 2. Sequence position 0–4 in case T3–2

Sequence position // Timeline of extracts	**0-low Agency**	**l-SOQ T**	**2-Response P**	**3-Reaction T**	**4-Response P**
1:00:32:37–00:34:34	Suicidal thoughts, mother, great need of P	Therapy hopes/ wishes	does not work, wish was taken away immediately, being able to forget	**Expansion with interpretative elaboration**	h° yes I just don't know (really) how to deal with it (.) um I don't know how I could build it up
2:00:39:37–00:42:40	Shaking attack, earlier therapy tries, suppression of feelings for years	Creating a balance between your own needs and those of others	trying to solve the problem with sport	**Topic change**	yes (.) ((laughs)) ((incompre-hensible)) ((laughs)) yes (.) she was quite funny
3:00:55:14–00:56:21	Deficits in dispute behavior	Desired image about good quarrelling	Rejection	**SOQ4**	Response 4
4:00:56:23–00:56:52	Deficits in dispute behavior	Desired fantasy for good quarrelling	stay objective and debate, find a common denominator	**Expansion request**	don't know(.) ((sniffles)) I have no idea
5:01:16:58–01:19:44	Dispute with partner, inability to accept help	Therapy topic/ desire	Consent on notification of implementation deficits, side issues	**Focus shift**	neither do I, but I want to get this ((laughs))

The therapist responds to the patient's first answer to SOQ 1 about therapy hopes and wishes (2 – Response P: does not work, wish was taken away immediately, being able to forget, see Tables 1 & 2) with understanding and empathy for her unrealistic wish:

Extract 1′. postsequences: 3 – Reaction T – Expansion with interpretative elaboration (00:34:35)

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T:  ((smacks)) °hh that would be nice if you could just start all over
    again and forget everything(.) again °hh what it is about (.)
    difficult things (.) about (.) insults to to °h
```

In doing so, he follows the patient's idea, but shows through the subjunctive and conditional sentence *that would be nice if one could simply start from the beginning again* that the patient's idea is unrealistic / impossible, while considering the idea to be generally legitimate. In this way, the therapist ratifies the patient's wish, while concurrently criticizing it. The therapist's reaction can be classified as an expansion with interpretative elaboration. In the **4-position**, the patient initially reacts in an affirmative way, but then refers to her ignorance or inability to deal with difficult issues.

The therapist reacts to the patient's answer to SOQ 2 (SOQ 2: creating a balance between your own needs and those of others, 2 – Response P: trying to solve the problem with sport, see also extract SOQ 2) with a critical intervention by pointing out the repeated misbehavior by *this is again the +++ fend for yourself* and then changing the topic: […] *°hhh you told about your grandma (0.21) where you said (as a child) you were there quite often and °hh*. The patient answers affirmatively, laughs and changes the topic to the positive relationship with her grandmother. The rapid change of topic prevents possible justifications and a loss of face of the patient. Change of topic (with 4/27 occurrences in all SOQs) can indicate that the therapist takes a step back and postpones his/her intervention through SOQs because he does not yet consider the therapeutic alliance to be sufficiently secured.

The therapist reacts to the processing of SOQs 3 and 4 on the patient's dispute behavior with a request for expansion, in which he asks the patient to include the subjective dimension in the discussion. Through the *and* in *and what do you do if then a feeling (comes) (0.97) and you ((incomprehensible)) the discussion (.) (but) no dispute* he ratifies the patient's answer on the one hand, but at the same time marks it as incomplete. The patient evades the call for completion on the subjective dimension by falling back into resistance. This example shows the patient's manifest resistance to the therapist's agenda. The willingness to cooperate, which was gained interactively before, is still fragile and the therapist must proceed in small steps and cautiously in order not to overtax the patient.

In the patient's partially compliant response to SOQ 5, the therapist then addresses the patient's concerns about her secondary thoughts (see above) with a focus shift. He recognizes the patient's secondary thoughts as a marker relevant for therapeutic progress, but characterizes the patient's concerns as unfounded, because he *would not know how to do this (.) that (0.38) can be approached one hundred percent without (zero thoughts)*. In this way he legitimizes the patient's

secondary thoughts, thereby addressing the reasons for the patient's resistance and trying to eliminate them so that the patient can engage in a relationship of trust and common goals. The patient agrees with the therapist but remains vague in her confession with *but I want to get this*; the reference point of *this* can be both the therapy and a therapy without secondary thoughts.

SOQs are relevant for the alignment of goals between therapist and patient, which are approached in this conversation by comparing the initial and final state. At the end of the interview, the patient's responses show a change towards a higher readiness to cooperate and a lower resistance. Dealing with this resistance also indicates that both the patient and the therapist regard the relationship as stable and that a possible conflict does or must not endanger future therapeutic work. Gradually, the use of SOQs leads to affiliation via alignment and intersubjectivity, thus strengthening and securing the therapeutic alliance.

4. Discussion

In psychotherapy, relationship building is a difficult endeavor even more in psychodiagnostic first interviews. A trustful relationship between people who do not know each other needs to be established, while at the same time a certain distance is required, e.g., patient and therapist will not be on first name terms or the therapist will not tell the patient about his/her own painful experiences. On the one hand then, the participants must maintain asymmetry in the conversation, and on the other hand the patient should feel understood and comfortable enough to be willing to share highly sensitive thoughts, experiences and feelings. SOQs elicit such sensitive thoughts in the form of, e.g., wishes or goals, and always have relational implications by thematizing relationships in the sequential forefield.

SOQs are thus frequently found in the data and appear at specific positions in the negotiation process: towards the end of topic developments and always in connection with depictions of patients' low agency in relation to the current topic or problem. With SOQs, the therapist expresses understanding for this and documents his or her interest in the patient. SOQs have a systematic value in the psychotherapeutic process: they serve to release the patient from his or her attachment to the problem and to open up for a – potentially better – future.

While hesitant formulations indicate that SOQs are interactively sensitive to the current relationship from a therapist's perspective, a conspicuous direct address shows an intense patient-centeredness and invites the patient to reveal her or his goals, wishes or hopes. The protected therapeutic setting and the formulation of SOQs in a hypothetical, speculative manner serve to relieve the patient of actual

duties or responsibilities and to stimulate the patient's self-reflection. SOQs thus lead to an expansion of the patient's agency, to the restructuring of knowledge, and thus to potential change.

With SOQs the therapist offers help and him-/herself as a "companion" who is willing to search for solutions together with the patient and to strengthen the willingness to cooperate. The patients' reactions are always primarily dispreferred – which in turn indicates the sensitivity of the issue – and at first sight it seems as if the relationship is endangered by this conflict; yet, the subsequent negotiation leads to overcoming the patients' resistance and to an increased cooperation. This corresponds to the therapeutic concept of challenging the patients, but not overburdening them.

By negotiating possible solutions, the therapist also receives information about the state of the therapeutic alliance and the patient's current therapeutic conditions. Design and sequence organization form the structural basis for the coordinated co-construction of intersubjectivity and the affiliative insight into the perspective and attitude of the respective interaction partner. Even in OPD first-interviews, the use of SOQs requires an already established and relatively stable / safe therapeutic alliance and SOQs can in turn reinforce and strengthen this alliance. SOQs are therefore not only an important practice on the content and thematic level, but also a therapeutically effective instrument on the relationship level.

Albeit the specificity of the underlying data, OPD diagnostic interviews, the limitation to patients with depression disorder, and the small data base greatly limit scope and validity of the analyses, the results of the present study are nevertheless informative for psychotherapeutic action. They provide clues as to which SOQs are relationship related regarding the constitution and maintenance of relationship and trust. In this sense, SOQs are to be seen as one particular communicative practice *doing* relationship in contrast of acting *in* relationship (Mandelbaum 2003).

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