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When and how patients' self-claims are challenged in psychotherapy

Abstract

The article describes the practices through which patients' self-presentations are challenged in psychotherapy. Based on the analysis of thirty-eight instances from psychodynamic psychotherapy and psychoanalysis, analyzed with methods of conversation analysis, narrative analysis, and coding, this article reports on how therapists challenge patients' self-conceptualizations in response to patients' self-presentations. Challenges mostly follow patients' descriptive, narrative, or evaluative accounts that include a strong claim about their self. Challenges to the self pertain to core issues of the therapeutic projects. They are mostly built in ways that show its sensitivity to probable rejection by the patient. Overwhelmingly, the challenge is accounted for by reference to shared knowledge built in the participants' shared interactional history. Arguably, psychotherapy is a particular setting where the organization of face-work is modified, as occasional challenging of the co-interactant's self-presentation is part of the institutional task of the professional participant. Data are in Finnish and German. (Self, psychotherapy, Goffman, conversation analysis)*

Introduction

While much of the interactional work that psychotherapists do is seemingly geared to maintain or re-establish affiliation (see e.g. Muntigl, Knight, Watkins, Horvath, & Angus 2013; Muntigl & Horvath 2014), it is also evident that disaffiliative actions, such as challenging (Voutilainen, Henttonen, Kahri, Ravaja, Sams, & Peräkylä 2018), are an equally important part of therapy. In this article, we focus on a particular kind of challenge: one where the therapist questions the description of 'self' that the patient has put forward in their talk. Extract (1) below is an

example of such a challenge. In lines 1–9, the patient tells the therapist that she feels guilty for bringing her dreams to the therapy sessions only rarely. Rather than affiliating with the patient, the therapist challenges the patient's self-description.

(1) Fragment of extract (3) below; line numbers not corresponding (PA: patient, TH: therapist)

1	PA:	I feel guilty because I so rarely have there to bring you.
		((Five lines omitted))
7	PA:	… 'cos proper analysands on a regular or irregular basis however bring
8		(3.0)
9	PA:	Some of their dreams.
10	TH:	So there also (is I think) again the extremely important thing that
11		how you live your life as if for others.
12		(1.4)
13	TH:	And you bring dreams for me and not for yourself.
14		(0.6)
15	PA:	That's how I guess it must be seen then.

In lines 10–13 the therapist interprets what the patient has just said: the patient's talk shows that she lives too much for others, forgetting herself. Thereby, the therapist treats as problematic the self that the patient's prior talk implied. In line 15, the patient responds to the challenge, with pro-forma agreement that is clearly marked as being less than wholehearted.

In what follows, we ask when and how the therapists issue such challenges. Before turning to our data, we present our theoretical perspective to self in interaction and in psychotherapy.

Self in interaction research

Self has been a cardinal theme of social psychology. Alongside James (1891), classical authors such as Cooley (1922) and Mead (1934) emphasized the social determination of the self: what the person considers themself arises from their interactions with others and calls for recognition and validation from others. More recently, social psychologists and philosophers have also clarified the concept of self: self is not part of the person, but rather 'the whole person considered from a particular point of view' (Zahavi 2014:3). In sociology, Goffman considered the self as a key node in social organization. He pointed out that the maintenance of positive images of the selves of participants—their 'faces'—is an omnipresent concern in interaction (Goffman 1955). Yet, despite the skillful practices of self-presentation (Goffman 1959), self is never secured (see also Rawls 1987). Social interaction brings about an inevitable vulnerability of the self, due to inconsistencies in self-presentation, discrediting information, and physical or psychological intrusions by others.

The reception of Goffman's conceptualization of the self has been ambivalent. Brown & Levinson's (1987) influential work on politeness took up Goffman's theory of face, suggesting linguistic strategies of face-work are associated with various social actions. The reception in conversation analysis (CA) has been more critical. Schegloff (1988) argues that Goffman's insistence on concerns about face as the driver of all interaction 'psychologizes' the study of interaction in a harmful way. In a text that focuses on the notion of identity, Schegloff (1991) proposes that for an identity category to be relevant in interaction, it needs to be locally made relevant and consequential through the participants' actions.

As theoretical notions, 'self' and 'identity' are close but not identical. In line with Goffman, we consider 'self' as something that is reflected upon and experienced, often emotionally, while we see 'identity' more as a social category defining a person. Generally, 'face' and 'self' only rarely figure in conversation analytic studies (see however Heritage & Raymond 2005). Conversation analysts tend to reject the analysis of self, because it tends to explain interactional events with assumed inner processes. Instead, conversation analysts call for an analysis of observable practices constituting identities: exploration of the ways in which status, rights, duties, and properties of persons are manifestly treated in social interaction (Antaki & Widdicombe 1998). This has been done mainly in studies of membership categorization, originating in Sacks's lectures (1992).

Membership categorization is explicitly performed by assigning social category labels to persons, thereby treating them as members of a certain social group. Schegloff (1997), Stokoe (2012) and others insist on a rigorous sequential approach which shows that participants actually use categories in a certain interactional moment to index some property, action (disposition), or evaluation of their incumbents (or the category as such) and vice versa.

While membership categorization captures many facets in which identities become relevant in everyday talk, a more complex approach is needed especially for narratives in which the biographical dimension plays a role and in which several temporal layers of the past, present, and sometimes also future self are related to each other (Deppermann 2013, 2015). This point is particularly important for the analysis of therapeutic discourse, in which narratives about the patient's past experience play a primary role. The positioning approach developed by Bamberg (1997; Bamberg & Georgakopoulou 2008) tries to reconcile conversation analytic insights concerning the displayed relevance of self and identity with insights from narrative analysis.

We focus on one interactional environment where issues of self are made manifest and treated in a consequential way: psychotherapy. Even though our data and analysis does not offer evidence for or against the idea of omnipresence of self, it touches upon 'Goffmanian' themes. We zoom in on moments where the patients explicitly or implicitly make claims about who they are, and the therapists call into question these claims. The claims involve emotionally relevant self-attributions. Yet our approach also attends to the 'Schegloffian' requirement

regarding the observable relevancy of categorization. By challenging patients' self-claims, therapists display their orientation to the patient having made such claims. In our data, participants put 'identity' in service of 'self': when presenting their (experiential and emotional) selves, participants also employ identity-categories. Yet, selves transcend these identity-categories by, for example, psychological, evaluative, attitude, and action -related descriptions. Finally, our work is informed by narrative analysis, as we examine the participants' ways of relating the patients' past and present selves.

Psychotherapy as social interaction

Psychotherapy stands out among medical and therapeutic practices, as it operates almost entirely through language and social interaction. Perhaps for this reason, it has become one key topic of social scientific and linguistic interaction research, and especially of CA. Typically, CA studies have taken up therapists' actions, such as formulations, interpretations, and questions, seeking to specify their composition, sequential environments, and interpersonal functions. Furthermore, the studies have explored the interactional management of the therapeutic relation, for example, in terms of affiliation and resistance (for overviews of CA studies on therapeutic interaction, see Peräkylä 2019). In spite of the centrality of the experience of self in psychotherapeutic process (see the section below), the interactional management of self-experience and self-presentation have only rarely been addressed in CA studies. Focusing on therapists' and clients' choices of person reference forms in Finnish psychotherapies (active, passive, or zero person), Wahlström (2022) explored how the client's positioning of themselves as agentic or non-agentic was negotiated in therapeutic talk. In a similar vein, the recent study of Deppermann, Scheidt, & Stukenbrock (2020) on narrative and performative self in psychotherapy shows how the therapists, in receiving the patients' stories, typically shift from responses through which they affiliate with the self conveyed through the content of the narrative, to comments inviting the patient to reflect upon the 'performative' self that is presented through the action of telling the story and through embodied affective displays. We continue this line of research by investigating systematically the ways in which the therapists challenge the patients' self-presentations.

Self in clinical theories of psychotherapy

According to Mahoney (1991:235), 'all psychotherapies are psychotherapies of the self'. If a therapy is successful, the patient's understanding of themself undergoes a process of change (Purkey & Stanley 2002:484). The psychoanalyst Donald Winnicott described the process of psychotherapy as one in which 'the patient will find his or her self, and will be able to exist and to feel real' (Winnicott 1971:5).

It is assumed in clinical theories that acceptance—be it called 'positive regard', 'validation', or 'empathy'—is a key facilitator of the client's self-related processes

(see e.g. Rogers 1961; Kohut 1971; Linehan 1997). With an empathizing therapist, 'clients feel safe to explore the nature of the self'. Thereby, it becomes possible for the clients to accept themselves, their 'self-definition becomes more crystallized, and the discrepancy between self and self-ideal tends to be reduced' (Purkey & Stanley 2002:484).

While clinical discussions about self tend to revolve around empathy, it is acknowledged that for psychotherapy to be successful, challenge is needed alongside empathy (Bänninger-Huber & Widmer 1999; Voutilainen et al. 2018). Challenge involves that 'the therapist, sometimes overtly but often discreetly, questions the client's beliefs about self, the world and his or her ways of being with others' (Voutilainen et al. 2018:1). The ways in which the therapist might challenge clients' self-experiences and beliefs about the self has not been much described in the clinical literature. Discussing narcissistic patients, Kohut (1971:192) describes a process where the therapist gradually confronts the client's grandiose fantasies 'with a realistic conception of the self'. How such confrontation happens interactionally is not known. In this article, we present an analysis of therapists' ways of challenging patients' self-presentation.

It is distinctive for psychotherapy that patients' accounts and more generally their conduct in the therapeutic session are treated by the therapist not in terms of their validity, social evaluation, similarity to own experiences, and so on, as is usual in other social encounters, but as a window to how the patient conceives of their (emotional, cognitive, social, normative) self. In our article, we set as our research question the following: when, how, and with what consequences do the therapists challenge patients' self-presentations in psychotherapy? We answer the 'when' question by examining the interactional environments of the challenges, the 'how' question by examining the design features of the challenging turns, and the 'with what consequences' question by examining the patients' responses to the challenges. By answering these questions, our article is the first to describe interactionally the challenges of self-descriptions in psychotherapy.

Data and Method

Three sets of data were used in this study. One set consists of German psychodynamic therapies with three therapist-patient dyads with twenty-five sessions each (recorded 2017–2018), another of Finnish psychodynamic therapy with five therapy-patient dyads with six sessions each (recorded in 2012–2013), and the third of Finnish psychoanalytic therapy (classical psychoanalysis) with three therapist-patient dyads with eighteen to twenty-one sessions each (recorded in 1999–2000). All patients were adults (seven female and four male). Two therapists were in their advanced training, the others had long work experience; four therapists were female and six were male. The patients' problems involved mostly depression and anxiety. The German data collection was accepted by the Ethical Board of the University of Freiburg. As for the Finnish data, at the time of its collection, there

was no relevant ethical board for this type of research. All participants in all datasets gave their written informed consent for the use of the data in scientific research and publications. The data are stored in data storage platforms and in hard disks protected by passwords. In transcripts, all identity-related information has been anonymised. In our study, we use conversation analysis (see e.g. Sidnell & Stivers 2013) as the primary methodology, amended by narrative analysis and coding. The transcripts of thirty-eight instances of challenges to the self in our collection were translated into English and analyzed sequentially and narratologically in joint data sessions by all authors. In our initial analysis, we outlined for each case the aspect of the self that is being challenged, the steps by which the challenge is brought about, the resources used to create the challenge, and the patient's response to it. In the second phase of the analysis, we analyzed the talk prior to the challenge, relevant aspects of the interactional history of the therapy that provide a backdrop for the challenge, the ways in which therapists attend to patients' 'face' in challenging, and how the patient engages with the challenge. After systematizing our case analyses according to recurrent phenomena and analytic categories, we devised a coding scheme for checking the generality of what struck us as being recurrent observations. The coding scheme consisted of fourteen categories. The categories 'strong self-related statement of the patient before the challenge', 'challenge refers to shared knowledge', 'challenge contributes to pursuing therapeutic core project', 'orientation to sensitivity in the design of the challenge', and 'patient's response to challenge' proved to be particularly relevant for describing constitutive features of the challenges and their sequential context (see next section). Each case of our sample was coded first by one of the authors and then reviewed by the other authors. Disagreements were resolved in discussions involving all authors.

Analysis

Overall view of challenges

Relying on existing transcripts of parts of the corpus amounting to 123 hours of audio and video-recorded therapy sessions overall, we identified thirty-eight instances, where the patient's self is challenged by the therapist. Being convinced that a more systematic reading of our data would yield more instances, we consider thirty-eight cases enough as representation of key characteristics of the phenomenon. The challenges in our data occur in the context of a three-part sequence. It roughly consists of (i) the patient's claim about themselves (ii) the therapist's challenge of the patient's self-claim, and (iii) the patient's response to the challenge. Importantly, the self-claims, challenges, and responses are conveyed by variety of actions. In other words, these other actions, which we specify below, serve as 'vehicles' (see Schegloff 2007:73–78) of self-claims, challenges, and responses.

The three-part sequence starts with patients' turns that, in broad terms, involve a narration, a description of the self or the world, or an assessment of the self or the world. Often patients' turns preceding the challenge consist of more than one action type, for example, a narration followed by an assessment of the self.

The challenges in our data are produced through various actions that include formulations (e.g. Antaki 2008), interpretations (e.g. Peräkylä 2004), or evaluations (therapists disclosing their own point of view towards something in the patient or in their world; cf. Voutilainen, Peräkylä, & Ruusuvuori 2010a). In the challenges, the therapists address directly or indirectly the patient's self-presentation and convey that the patient is not what they claim to be, or that they are something else, or that what they claim to be is a problem. Challenges in our data are not implemented by WH-questions (which Koshik 2003 associates with challenges), while (when being formulations) they can adopt the shape of a request for confirmation (see also Küttner & Ehmer 2023).

Finally, patients' responses to challenges can involve agreement or disagreement. The patients sometimes also avoid responding to the challenge by focusing their talk elsewhere. The three-part sequence of self-challenges is depicted in Figure 1 below.

We identified some key characteristics in the sequences of self-claims, challenges, and responses. The characteristics include (i) strength of the patient's self-presentation, (ii) the challenge's embeddedness in the therapeutic project, (iii) orientation to sensitivity in the design of the challenge, (iv) references to shared knowledge, and (v) lack of agreement in the patients' responses. The case analyses presented below are organized around these characteristics. First, we present a quantitative overview of them.

Challenges typically occur after strong self-presentations (in 87% of the cases). By strong we mean that the patient displays strong epistemic certainty and a clear stance about the self that they are presenting. These are unmitigated, categorical statements by which the patient attributes to themselves certain personal characteristics by using a categorical predicate, usually a noun, an adjective, or a self-attribution of habitual ways of acting by a verbal phrase, by contrasting their own stance or behavior with others, or by telling a story designed to give evidence of certain personal characteristics.

Challenges draw on shared knowledge about the patient (in 79% of cases), which has been built in the earlier interactions between the participants.

Challenges concern issues that are at the heart of the therapeutic project (in 76% of the cases). By therapeutic project (see Peräkylä 2019), we mean the main topical thread (Schegloff 2007) in the therapeutic talk that extends over several sessions. Such topical thread can be understood to reflect the aims that the participants (often especially the therapist) strive towards through their interactions.

Therapists attend to the sensitivity of the challenge, that is, the invalidation of the patient's self-presentation (in 71% of the cases). Sensitivity is indexed by displaying empathy and (partial) agreement with the patient's account before producing

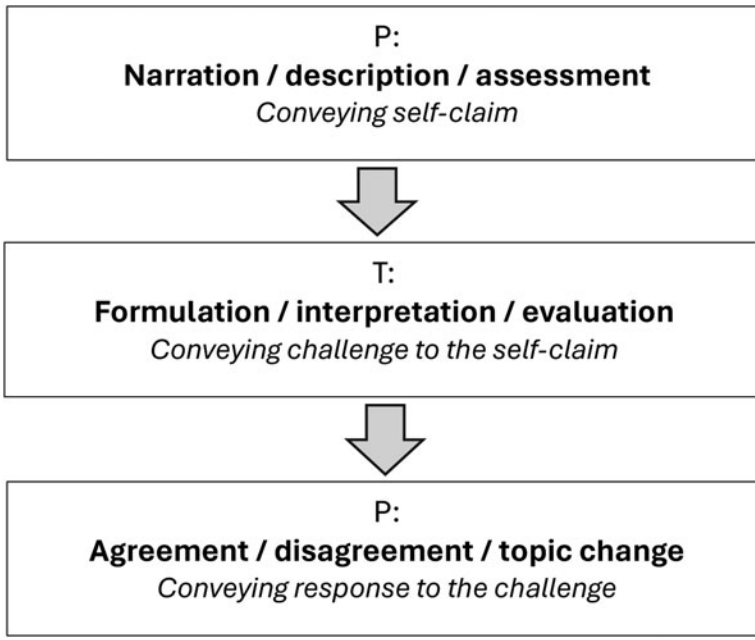

FIGURE 1. Actions that convey self-claims, challenges, and responses to challenges. The vehicular actions (shown in boldface) convey the self-claims, challenges, and responses to the challenge.

the challenge (Vehviläinen 2003; Voutilainen, Peräkylä, & Ruusuvuori 2010b; Deppermann et al. 2020), and by a dispreferred turn-design (Pomerantz 1984), for example, by hesitation, mitigation, self-repairs, cut-offs, and/or additional accounts for the challenge. Orientation to sensitivity is absent only in particular environments, for example, in challenges in response to self-deprecations, in challenges in the context of an ongoing argument, or in challenges repeating the patient's own words.

In response to the challenges, in about half of the cases, patients agree with the therapist; however, equally often (in 47% of the cases) the patient's response is other than agreement (disagreement, irony, or avoidance).

In our data, there are cases where the self-claims and self-challenges are readily observable in the design of the manifest actions; in others, self-claims and challenges are more implicit. We present four cases from our data, exploring the characteristics of self-claims and challenges. We start from a case in which the patient's self-presentation and the therapist's challenge are straightforward and explicit, observable in the design of the manifest actions. Afterwards, we move towards cases in which the self-claims and challenges are more implicit, and where the sequence 'self-claim—challenge—response' is also more complex and extended.

Case analyses

Extract (2) is from a psychodynamic focal therapy with a female patient in her twenties suffering from psychogenic seizures. In this case, the patient's self-claim is straightforward and the therapist's challenge is explicit and overtly part of the manifest actions that their turns accomplish.

Before the extract, the patient described the ways in which she experiences and handles her seizures in the social context, saying that she talks about them with her boyfriend, but hides them from her relatives. The patient then claims that her seizures are not part of her real self (lines 7–35). The therapist challenges her view by suggesting that the seizures belong to a part of her that usually does not surface (lines 38–47). The patient rejects this interpretation and reinforces the position she has already taken before (lines 49–73).

(2) 'Seizures' (Therapy_C9, 29:05) (PA: patient; TH: therapist)

1	PA:	ja:,=und für mich is: (0.2) glaube ich auch wenn
		'yes:,=and for me it is: (0.2) I guess also if'
2		ich (.) ähm: (1.4) das erzähle.=dass ich h. die:
		'I (.) erm: (1.4) tell this.=that I h. the:'
3		irgendwie dann nen anfall hatte oder so dann
		'somehow then had a seizure or so then'
4		(0.8)
5	PA:	ja:,
		'yes:,'
6		(1.0)
7	PA:	ich (.) vom wesen her bin ich eigentlich (0.3)
		'I as far (.) as my nature is concerned I am actually (0.3)'
8		würde ich sagen (0.3) ähm: (0.3) ähm: (0.7)
		'I would say (0.3) erm: (0.3) erm: (0.7)'
9		ja nicht hilflos.=und nich (.) irgendwie verletzlich.
		'y'know not helpless.=and [not] (.) like vulnerable.'
10	TH:	[hm hm,]
11	TH:	hmhm,
12	PA:	so: also
		'so: I mean'
13		(1.4)
14	TH:	hmhm,
15	PA:	sondern eher ähm (0.8) ja:; (1.2) schon irgendwie stark.=
		'but rather erm (0.8) well:; (1.2) like strong indeed.='
16	PA:	[=und lustig.]=und (.) fröhlich. hm::: hilfsbereit,=
		'[=and funny.]=and (.) cheerful. erm::: obliging,='
17	TH:	[hmhm,]
18	PA:	=und für andere da.[=und,] (0.4) äh:m des is dann
		'=and there for others.[=and,] (0.4) er:m this then is like'
19	TH:	[hmhm,]

20 PA: so komplett das gegenteil.
'so completely the opposite.'
21 TH: hmhm,
22 PA: wie ich mich auch selber nicht fühl[e;]
'as I do not feel like myself eithe[r;]'
23 TH: [HM]_hm,
24 PA: und ich glaube ich (0.5) möchte dann auch einfach
'and I guess I (0.5) then simply just don't like'
25 nicht dass die anderen des mitbekommen. [=dass ich]
'that the others witness this either. [=that I']
26 TH: [hmhm,]
27 (1.2) hilflos verunsichert,
'(1.2) helpless insecure,'
28 hmhm,
29 PA: (0.2) und dann da liege und (1.5) ja. (.) mein körper
'(0.2) and then lie there and (1.5) yes. (.) my body'
30 (.) abspackt.
'(.) throws a fit.'
31 PA: h. ((laughs)) .h
32 TH: hmhm, hmhm,
33 (2.4)
34 PA: weil ich so dann auch einfach (0.5) im wesen gar
'because I am then just simply (0.5) not like that'
35 nicht bin.
'in my nature.'
36 TH: hmhm,
37 (6.5)
38 TH: is vielleicht des was ganz wichtiges. (.)
'(this) is perhaps something very important. (.)'
39 vielleicht könnte man ja sagen (0.3)
'perhaps y'know one could say (0.3)'
40 dass ein teil von: ihrem selbst oder ihrer (.)
'that a part of: your self or your (.)'
41 persönlichkeit (0.5) zum (0.9) tragen komm.
'personality (0.5) comes (0.9) to bear.'
42 oder zum vorschein kommt. (1.1) die sonst zu ihrem
'or is revealed. (1.1) which otherwise to your'
43 (0.5) leben gar nicht so dazu gehört.=
'(0.5) life does not belong so much.='
44 =und den sie auch nicht so gern (0.9) mit
'=and which you also do not so much like (0.9) with'
45 sich selbst (0.5) °machen.°
'yourself (0.5) °do.°'
46 (1.5)
47 TH: diese hilfslosigkeit und diese (1.1) abhängigkeit.
'this helplessness and this (1.1) dependency.'

48 (0.5)
49 PA: <JA: obwohl ich (.) glaube dass es nicht unbedingt
'<YE:S although I (.) guess that it does not necessarily'
50 zu mir gehört,= =sondern> (0.5) des is so gekommen.
'belong to me,= =but> (0.5) this has come this way.'
51 =mit dem: (0.9) nachde:m die äh ähm:
'=with the: (0.9) after: the er erm:'
52 das abi (.) und da die
'the high school diploma (.) and then the'
53 ausbildung des wurd immer schlimmer.
'professional training this became increasingly worse.'
54 (0.6) äh:m: (0.5) weil frü:her überhaupt war ich (.)
'(0.6) erm (0.5) because in fo:rmer times I was (.)'
55 gar nich (.) [so:;=]
'not at all (.) [like that:;=]'
56 TH: [hmhm]
57 PA: =also es is: (0.9) es fühlt sich auch nicht
'=I mean it is: (0.9) it doesn't feel either'
58 so an als wäre ich des dann.= =wenn ich da (.) aufm
'as if it was me then.==when I there (.) lie there on the'
59 bett liege und; (0.5) ähm meinen anfall be[komme.]
'bed and; (0.5) erm get my seizure.'
60 TH: [HM_hm,]
61 (0.3)
62 PA: sondern eher so: wenn s mir gut geht wie am wochenende-=
'but rather like: when I feel well as last weekend-='
63 =>des war n bisschen stressig, aber es ging mir trotzdem gut,
'=>that was a bit stressful, but I felt well nevertheless,'
64 es wir hatten spaß,<
'it we had fun,<'
65 TH: HM_hm,
66 (0.4)
67 PA: äh:m: sondern eher dass da merke ich ja- (0.8) das (0.3) bin ich.
'er:m: but rather that then I realize yes- (0.8) that (0.3) is me.'
68 (0.2)
69 TH: hmhm.
70 (1.7)
71 TH: [also es lässt sich (.) ja:,]
'[so it lets itself (.) yes:,]'
72 PA: [aber des andere is dann so wie so n an]deres wesen.=
'[but the other one then is like kinda different being.='
73 =wie so ne andere (.) christine die des so
'=like kinda different (.) Christine who this like'

Strong self-presentation. In lines 1–35 the patient is engaged in narration of her experiences of the attacks. In and through this narration, she conveys what she

considers herself to be. The patient produces a categorical, generalizing self-presentation, making a sharp distinction between her nature (*wesen*; lines 7, 34), that is, her real, core self, and the experiences associated with her seizures. She uses a list of dispositional predicates (strong, funny, cheerful, obliging; lines 9, 15–16) to characterize the former, contrasting them with the seizure experience, which she categorizes as the opposite (lines 18, 20) of how she feels ordinarily (line 22). The feelings of helplessness and insecurity (line 27), in contrast, are not attributed to herself as traits, but as state predicates (cf. e.g. Mischel 1968), which only apply in the context of the seizures (lines 24–30). Again, she mentions that she wants to avoid others perceiving her exhibiting these (temporary) properties (lines 24–25). Thus, the patient takes care that only those aspects of herself that she considers to be part of her true self and that are positively valued become socially visible, while the seizure-related, negatively valued impressions are excluded from her social self.

The therapist's challenge. The therapist challenges the patient's self-conceptualization by stating that in the seizures, an aspect of the patient's self becomes visible that usually does not belong to the patient's life (lines 39–43). This view explicitly contradicts the account emphasizing the positive aspects of her self that the patient gave in lines 9–16 and 34–35. In his turn-continuation (lines 44–45), the therapist (in an ungrammatical statement) rephrases the patient's dislike of this side of her self, which he then reformulates as 'helplessness and dependency' (line 47), echoing the words which the patient used herself in line 27. The therapist thus makes clear that his challenge concerns the issue that the seizure experiences, which the patient treats as unrelated to her self, are to be integrated into the patient's self-concept.

Shared knowledge and sensitivity. Before his challenge, the therapist seemingly affiliates with the patient by first highlighting the importance of the patient's account (line 38). The challenge is prefaced by a mitigation projecting a hypothetical statement ("perhaps y'know one could say"; line 39), which, by using the modal particle *ja*, at the same time indexes that the upcoming statement builds on shared knowledge. While the content of the therapist's turn squarely challenges the patient's self-conceptualization, its linguistic design displays sensitivity to the invalidation of the patient's self-presentation and the possible rejection of the challenge by the patient: He presents his challenge as an insight to be inferred from the patient's own account. It is thus built counterfactually on shared knowledge, as if it confirmed the patient's account, mitigating thus the oppositional quality of the challenge.

Core therapeutic project. The challenge in extract (2) pertains to key issues dealt with in this therapy. The seizures are a major problem for the patient, and much of the therapeutic work is focused on understanding them.

Patient's response. The patient rejects the therapist's interpretation. Prefacing her turn with *ja: obwohl* (line 49), she indexes disagreement (Betz 2017); she insists that the seizure experiences "do not belong" to her (lines 49–50), because they developed only after her high school diploma (lines 51–52). The patient thus draws on the notion of an eternal, essential self, which is fixed from the very beginning as personality. In addition, she states that the seizure experiences feel alien to herself (lines 57–59) like a second, disjunct personality (lines 62–64).

In what follows, we go through three further examples of sequences in which the therapist challenges the patient's self-description. The cases exhibit largely similar characteristics as extract (2). We continue with another case (extract 3) where the self-claim and self-challenges are readily observable in the design of the manifest actions, and the sequence 'self-claim—challenge—response' is compact and transparent. Before extract (3), the participants had a long discussion about dreams of the patient. She adds that she actually had two dreams, but that she cannot remember the other one. She guesses that "perhaps there will be them [i.e. dreams] again at some point in time" and laughs (data not shown). The therapist comments, in a smiley voice, that the patient has a somewhat pessimistic attitude (lines 1–2). The patient joins in the humor by laughing (line 3), but then shifts to a more serious talk, saying that she feels guilty because she so seldom brings dreams to the therapist, while others regularly do (lines 4–5, 11–13, 15).

(3) 'Dreams as gifts' (KA1, 39:55)

1	TH:	() (m- s:-) .hh £suhtaudut vähä
		'() (m- s:-) .hh £you have a bit'
2		pessimistis['sti, £
		'pessimistic[attitude,£'
3	PA:	[Heh he he .hee:: £No vähä niinku varovaisesti
		'[Heh he he .hee:: £Well a little like carefully'
4		kun£ .hhh mä niin kovin tuntuu et #möy-# .h tunnen syyllisyyttä
		'because£ .hhh I feel so much like #muh-# .h I feel guilty'
5		kun > mulla niin< .hh harvoin on (0.3) tuoda sinulle.
		'because > I so< .hh rarely have there (0.3) to bring you.'
6		(1.6)
7	TH:	°Lahjaksi°.
		'°As gift°.'
8	PA:	N:ii:n.
		'Y:ea:h.'
9		(1.4)
10	TH:	Annat mulle harvoin lahjoja.
		'You give me gifts rarely.'
11	PA:	Niin tai niinku musta tuntuu että ku (.) kunnon (0.3) .nff
		'Yeah or like I feel like 'cos (.) proper (0.3) .nff'
12		analysandit (1.0) säännöllisin tai epäsäännöllisin väliajoin
		'analysands (1.0) on a regular or irregular basis'

13 kuitenkin tuo,
‘however bring,’
14 (3.0)
15 PA: #J:ota:kin uniaan.# h
‘#S:ome: of their dreams.# h’
16 TH: .mhh et siinäkin (on musta<) (0.2) taas se< .hh tavattoman
‘.mhh so there also (is I think<) (0.2) again the< .hh extremely’
17 tä:rkeä asia et kuinka sie .hh (.) elät elämääsi (0.3)
‘im:portant thing that how you .hh (.) live your life (0.3)’
18 ni ikään ku muille,
‘as if for others,’
19 (1.4)
20 TH: Ja tuot unia minulle etkä itsell°esi°.
‘And you bring dreams for me and not for your°self°.’
21 (0.6)
22 PA: .hhmt Nii (.) .hhmt Nii (.) kai se on nähtävä sit°te°.
‘.hhtch That’s (.) .hhmt That’s (.) how I guess it must be seen th°en°.’
23 (3.0)
24 TH: ‘Ttä jotenki semmonen (2.0) sanosko nyt uhrautuminen
‘Th’t somehow this kind of (2.0) would one now say sacrificing’
25 (se) (0.2) että oikeen< (0.2) .hh sinulla ei o #eo# (0.6)
‘(that) (0.2) that really< (0.2) .hh you have no #h’ve no# (0.6)’
26 oikeutta i- itsesi vuoksi nähdä un°ia°.
‘right to have dre°ams° for yo- yourself.’
27 (1.0)
28 TH: kaan. ((syllable added on to the previous word))
‘either.’
29 (2.0)
30 TH: Vaan se on: (.) sie näet niitä unia minun vuok°si°.
‘But it’s: (.) you have those dreams for my sa°ke°.’
31 (.)
32 PA: Niin no (0.2) tässä nyt on tietysti< #e:# jos nyt
‘Yeah well (0.2) there’s of course< #uh:# if one tries’
33 yrittää taas (0.3) selitellä (0.6) (.mhh) et ku minä
‘to give again (0.3) explanations (0.6) (.mhh) ‘cos like I’
34 en niitä osaa< (1.2) tulkita niin (3.0) mt nii m:itäpä
‘don’t know how to< (1.2) interpret them (3.0) tch so wha:t’
35 minä niillä tekisin.
‘would I have to do with them.’
36 (2.4)
37 PA: Ilman sinua.
‘Without you.’

Strong self-presentation. The patient’s talk in lines 4–13 involves a self-deprecation: an explicit negative evaluation of the self through disclosure of guilt and unfavorable comparison to others. The self-deprecation conveys a

pronounced, yet negative presentation of the self. The therapist receives the patient's self-deprecation with an increment (line 7) and formulation (line 10), which rephrase the 'object' that the patient does not bring to the therapist as 'gift' (cf. Weiste & Peräkylä 2013). After the formulation, the patient elaborates her self-deprecation (lines 11–13, 15) by the unfavorable comparison to others.

The therapist's challenge. In lines 16–20, the therapist produces an interpretation (cf. Vehviläinen 2003; Peräkylä 2004). It challenges the patient's prior self-attribution of being guilty for not bringing dreams (lines 4–5) as being an instantiation of her general tendency to live her life for others and not for herself.

Shared knowledge. By the clitic *siinä**kin*** (which could be translated **'also** there') and *taas* 'again' (line 16), the therapist indicates that the pattern he asserts is similar to something that the participants already know. This allusion to repetitiveness indexes shared knowledge, but also adds a quality of reproach to the therapist's interpretation.

Sensitivity. Unlike in many other cases in our collection, the therapist's challenge does not overtly orient to the sensitivity of the invalidation of the patient's self-presentation. His initial formulations (lines 7, 10) before the actual challenge convey collaboration and understanding. They, however, also prepare the challenge, by depicting the patient's 'altruistic' attitude. The actual challenge is upgraded, framing it as an "extremely important thing" (lines 16–17). Possibly the fact that the challenge follows the patients self-deprecatory talk makes this directness interactionally possible.

Core therapeutic project. Through the nineteen sessions that we recorded from this dyad, the therapist works to draw the patient's attention to her tendency to deny her own needs. Thus, challenging the patient's relation to dream-telling is one variation of a key theme—non-adaptive altruism—that the participants work with through the material that we have at hand. The therapist seems to emphasize the importance of this theme in lines 16–17 by characterizing it as "the extremely important thing".

Patient's response. The patient receives the interpretation by a pro-forma agreement which is clearly marked as being less than wholehearted ("That's (.) how I guess it must be seen th°en°"; line 22). After the patient's initial response, the therapist pursues further his challenge in lines 24–26 and 28. He reformulates again the patient's general attitude as 'sacrificing' (line 24), and once more points out that her relation to dreams not having dreams for herself, but for the analyst is an instantiation of it. In her response (lines 32–37), the patient defends her relation to dreams, by pointing out that she cannot interpret them herself without the therapist. She does not, however, address the more

general self-related attitude—sacrificing herself and living her life for others—that the therapist attributed to her.

While in extracts (2) and (3) the self-claims and self-challenges were readily observable in the design of the manifest actions, in extract (4) below, the patient's self-presentation is met by a challenge that engenders a more complex negotiation regarding the patient's self. While we can find the core sequence (self-presentation—challenge—response) here as well, the negotiation involves several expansions of it. Like in the previous extract, the therapist's intervention in extract (4) amounts to an interpretation.

The participants talk about the consequences that the patient's partner's recent death has in the patient's life. Just prior to the extract, the patient expressed her worry that she might become 'stuck' in her grief and would not be able to return to normal living.

(4) 'To dance and to sing' (KA 18, 4:29)

1	PA:	[.hhh Tai että minusta tulee semmonen niinku [siitä
		'[.hhh Or that I will become like [that'
2	TH:	[((cough)) hmm
3		(.)
4	PA:	vanhasta #sukulaisestani# et minä sitten vaan
		'old #relative of mine# so I will just'
5		#kuljen e- ympäriinsä ja sanon että voi kun pääsis pois#.
		'#walk er- around then and say oh I wish I could get away from here#.'
6		(1.0)
7	PA:	Et eihän se ole (.) .hhh .hh (0.3) mikään tapa elääh.
		'I mean that is no (.) .hhh .hh (0.3) way to live.'
8		(0.4)
9	PA:	Et joko eletään tai ↓ei eletä.
		'You either live or you ↓don't live.'
10		(1.8)
11	TH:	.hhh Kyl mä luulen että siin on (0.5) öö aikamoiset
		'.hhh I do think that it has (0.5) uh considerable'
12		ulottuvuudet tuolla asialla että se .hhh kyl mä
		'dimensions that thing so that it .hhh I would indeed'
13		yhdistäisin sen taas siihen sinun (0.4) lapsuuden
		'connect it again to this (0.4) childhood'
14		tilanteisiin näihin (.) suur[iin suruihin.
		'situations of yours these (.) gre[at sorrows.'
15	PA:	[Nii:,
		'[Yeah:,'
16		(0.3)
17	TH:	Jolloin > sinul oli sellanen < tunne että et ne on vaan
		'When > you have the kind of < feeling that they must just'

18		(0.4) jätettävä heti °taakse°.
		‘(0.4) be left behind right °away°.’
19		(0.5)
20	PA:	Ni[i: (vaan<)
		‘Ye[:s (just<)’
21	TH:	[Ei saa jättäyty[ä sure°maan°.
		‘[One shouldn’t be drawn in[to grie°ving°.’
22	PA:	[Tanssimaan ja laulamaan.
		‘[To dance and to sing.’
23		(.)
24	TH:	Nii:,
		‘Yes:,’
25	PA:	Että muut olis ilosia (.) ja tyy#tyväisiä minuun#.
		‘So that others would be happy (.) and plea#sed with me#.’
26		(.)
27	TH:	Nii ja sinunkin ois helpompi ol°la°.
		‘Yes and you too would feel bet°ter°.’
28		(2.3)
29	TH:	Mut et siinä on sillon se ongelma että .hhh kuinka
		‘But there is the problem then that .hhh how’
30		paljon siitä surusta sitte jää kokonaan sure°matta°.
		‘much of that grief then goes completely un°grieved°.’
31	PA:	J:#oo# no: nytt tällä hetkellä nyt ei toistaseks (nää)
		‘#Y:es# well now at this moment so far one doesn’t (see)’
32		mitään .hhh KRÖHHHH (0.4) köh köh krhmm (0.4) mt .hhh
		‘any .hhh ((coughs)) (0.4) ((coughs)) (0.4) mt .hhh’
33		suurempaa vaaraa vielä että minä #pääsisin siitä irti#.
		‘great danger yet that I #would get rid of it#.’
34		(3.3)
35	PA:	Mu:#tta:# mutta minä (0.5) no: minä tasapainoilen että,
		‘But #but# I (0.5) well I balance so that,’
36		(1.0) kuljen (0.5) ja teen asioita ja. (0.8) .hhh
		‘(1.0) I go around (0.5) and do things and. (0.8) .hhh’
37		Kävin ostamassah amaryllissipuleita ja panen ne
		‘I went to buy some bulbs of amaryllis and will put them’
38		multaan.
		‘to the ground.’

Strong self-presentation. The patient first depicts the prospect of her becoming as miserable as her ‘old relative’ (lines 1, 4–5), and then expresses her disapproval of such a way of being (lines 7, 9). By contrasting herself with the relative, the patient, somewhat indirectly, presents herself as willing to live fully and fighting against getting stuck in her grief.

The therapist’s challenge. While the fighter self depicted by the patient implies a positive way forward in her life situation, the therapist puts it into a problematic

light. The therapist designs a description of the patient's childhood experiences in such a way that the resistance to grief is depicted as an externally given obligation (note the modalities of obligation in lines 17, 18 and prohibition in line 21); yet he also points out that rejection of grief served the patient's self-regulation ("and you too would feel better"; line 27). The therapist closes his intervention by challenging the adequacy of the patient's attitude: much of the grief "goes completely ungrieved" (line 30).

Shared knowledge. In his challenge starting in line 11, the therapist links the patient's concerns to her 'childhood situations' that involved 'great sorrows' (lines 13–14). By the demonstrative articles 'this' and 'these', he presents her childhood experiences as known in common. He points out that in her childhood, the patient felt that she was not allowed to grieve (lines 17–18, 21), thereby drawing on a shared interactional history. The therapist relocates current attitudes with respect to past experiences (Weiste & Peräkylä 2013): the problematic current attitude towards grief is seen as being rooted in her childhood.

Sensitivity. The therapist shows empathetic understanding for the patient. In lines 14, he refers to "these great sorrows" that the patient experienced in her childhood. In line 27, in elaborating further these childhood scenes, he displays understanding of the patient's motivation to get rid of the grief, as then "you too would feel better". In these descriptions of the patient's adverse experiences, he treats them as factual, not mitigating or relativizing them.

Core therapeutic project. Through the nineteen consecutive sessions of therapy that we have recordings of, grief is recurrently addressed. The therapist suggests that the patient is avoiding grief, and in different ways encourages her to face the loss that she is undergoing. The challenge in extract (4) contributes to this therapeutic project.

Patient's response. Her response to the therapist's challenge is first affiliative and then turns ambivalent. After the therapist has made the first linkage between the patient's current situation and her 'childhood sorrows', the patient produces a minimal agreement (*nii*; line 15; cf. Sorjonen 2001). After the therapist's interpretation regarding the patient's felt childhood obligation to leave behind grief (lines 17–18, 21), the patient produces an elaboration (cf. Peräkylä 2005) in agreement with the therapist. The elaboration is delivered in three parts ("yes just (…) to dance and to sing (…) so that others would be happy and pleased with me"; lines 20, 22, 25). Yet after the therapist has explicated his view regarding the problematic implications of rejecting grief (lines 27, 29–30), the patient contradicts ironically the therapist's assertion, pointing out that thus far, there's "not any (…) great danger" (lines 31–33) that she would get rid of the grief. Eventually she depicts a scene where she will be putting bulbs of amaryllis into

the soil (lines 37–38), which may be understood as implicit reference of processing death.

Even more than in extract (4), in extract (5) the self-claim and challenge are implicit, and the basic sequence 'self-presentation—challenge—response' is extended and embedded in other activities. The patient in this case is a man in his late twenties, who is making a career as a Lied singer. Through a narrative, he indirectly presents himself as an artistic 'snob' (line 3) that his family members criticize, but also admire.

(5) 'Snob' (T1_06)

1	PA:	ja sit mie oon vähä tällee
		'and then I've a little bit'
2		niinku .hh #ö# toisen serkun kautta kuulin että #yömh# he
		'like .hh #uh# heard through another cousin that #uhmh# *he*'
3		minuu ilmeisesti pietään siel £melko snobina£. he he
		'apparently I'm thought of as £quite a snob£. he he'
4	TH:	koska,
		'because,'
5	PA:	ko-ko- koska koska mie olen tällanen #ö# .h muuttanu
		'co-co- 'cos 'cos I'm this kind of #uh# .h moved'
6		Helsinkiin ja tällanen muusikko ja #eh eff eff# esiinnyn
		'to Helsinki and this kind of musician and #eh eff eff# I perform'
7		jossain #ö# (.) .hh missä lie Lied-konserteissa=#tää on vähä#
		'in some #uh# (.) .hh whatever Lied-concerts=#this is a little bit#'
8		tämmönen juttu.
		'this kind of thing.'
		((Thirteen lines omitted))
22	PA:	tän tota: (.) mun kummini äiti eli siis (.) °mt° äitin (.)
		'this um: (.) my godfather's mother so I mean (.) °mt° my mother's (.)'
23		vanhempi sisko .hh nii, (1.0) se < se taas
		'older sister .hh like, (1.0) she < she on the other hand'
24		niinku nykyään (.) aina jos me nähään (.) niin se ((pieni röyhtäys))
		'like nowadays (.) always if we see each other (.) she ((small burp))'
25		muistaa s(e)#e# kutsuu minuu
		'remembers sh(e) #e# calls me'
26		laulajaks. (.) mut se on ilmeisesti jonkinlainen kohteliaisuus.
		'a singer. (.) but apparently it's some kind of compliment.'
27		.hh koska sit se on myös kertonu kuinka se ite (.) niinkun (.)
		'.hh because then she has also told how she herself (.) like (.)'
28		nuorena (.) yritti käydä laulutunneilla mutta sitte
		'when she was young (.) tried to go to singing classes but then'
29		kuulemma kaks muuta sisarta nauro niille niin pahasti et
		'apparently her two other siblings laughed at her so badly that'
30		£se ei enää k(h)ehannu£ hhh he.
		'£she didn't d(h)are to anymore£ hhh he.'

31 TH: ai: jaha?
‘oh: uhuh?’
32 PA: <tosin meijän äiti kie- kiistää tän ikinä tapahtuneen h:e m(h)ut,
‘<although my mom refu- denies this ever happened h:e b(h)ut,’
33 TH: hh [he
‘hh [he’
34 PA: [eihän se sitä muistais.
‘[she surely wouldn’t remember.’
35 TH: ei:
‘no:’
36 PA: todennäkösem[min. (.) [todennäkösemmin tuollaset
‘most like[ly. (.) [most likely those kind of things’
37 TH: [ei [ei.
‘[no [no.’
38 PA: muistaa [se<
‘are remembered [by<’
39 TH: [kohde muistaa.=sä tiedät tän n- n-
‘[the target remembers.=you know this n- n-’
40 PA: nii.=
‘yeah.=’
41 TH: =myöskin että ehkä nää sun (0.2) koulu (0.4) kiusaajat #öö# sä
‘=also that maybe these (0.2) school (0.4) bullies of yours #uh# you’
42 muistat paremmin sen ku he? [°tai°] [°mahollisesti° [°vaik]ka°,
‘remember it better than them? [°or°] [°possibly° [°even tho]ugh°,’
43 PA: [juu,] to[dennäkösesti [ja]
‘[sure,] most [likely [and]’
44 ja ensimmäiset #ö# mun konserteista (.) saamani kritiikit niin,
‘and the first #uh# critiques I got (.) for my concerts so,’
45 TH: mt ni[menomaan.
‘tch ex[actly.’
46 PA: [todennäkösesti mä muistan ne ja ne jotka on sanonu jotain
‘[most likely I remember those and those who have said something’
47 ei mui[sta mi[tään]
‘don’t reme[mber a [thing]’
48 TH: [.hh [krö]öh joo (.) joo.
‘[.hh [chr]uh yeah (.) yeah.’
49 (2.8)

Before the extract, the patient told about his godfather and other family members, who live in a small town (while the patient lives in a big city). At the beginning of the extract, he tells about having heard a hearsay that the family members consider him as a ‘snob’ (lines 1–3). Prompted by the therapist’s request for clarification (line 4), the patient elaborates the family members’ reasons for considering him in this way. After some further talk, the patients’ story takes a humoristic turn as he tells how his aunt was laughed at by her siblings, which made her stop taking singing lessons (lines 28–30). In lines 32–38 the participants collaboratively

evaluate the little story. The patient points out that his mother denies having laughed at her sister's singing lessons, and then expresses a doubt: the mother would not remember (line 34). The therapist agrees (line 35), whereafter the patient in line 36 starts a more general statement, apparently working towards an assertion about the better memory of the person who has been teased. In overlap with the patient's assertion, the therapist repeats twice (with 'no' tokens; line 37) his agreement to the patient's prior assumption about the mother not remembering the events. But before the patient completes his more generalized assertion about memory (lines 36–38), the therapist cuts in by saying "the target remembers" (line 39), thereby actively displaying his agreement with what the patient apparently was going to assert.

Strong self-presentation. The patient presents himself as someone whom the small-town family members consider as a 'snob' (line 3). While the patient is telling about the way in which others categorize him, he also conveys a self-claim: he is someone who others see as a snob. The self-ascription is here done from the perspective of a third person (a cousin told what the family members think about the patient), which gives credibility to the report. The categorization is followed by laughter (line 3), which may indicate an affective stance towards being seen as a snob. While this self-attribution seems to be ambivalent (involving both criticism and admiration from the side of the family; yet in both cases showing how the patient stands out from the others), in lines 22–26 the patient continues by telling about a particular family member (his mother's sister), who more unequivocally appreciates his artistic pursuits, because she wanted to be a singer in her youth, too.

The therapist's challenge. In lines 39–42, the therapist challenges the patient's self-presentation. Latched to his general statement about the target remembering, the therapist points out: "you know this (…) also that maybe these school bullies of yours (…) you remember it better than them" (lines 39, 41–42). Thereby, the therapist shifts the focus of talk away from the patient's family members' histories and their relation to arts. He draws an analogy to the patient's own painful history of having been bullied at school. In terms of construction of the patient's self, there is a shift from the successful artistic self of the present that the patient has portrayed, to his bullied self of the past. Yet, the therapist does the shift under the auspices of agreement with the patient's just prior talk. Thereby, the challenge of the patient's self-claim is not marked, but is rather embedded in a turn where the therapist agrees with and elaborates the patient's assessment of his own telling about the aunt and her sisters.

Sensitivity. It is noteworthy that the therapist designs his utterance that challenges the patient's self-presentation as a direct continuation to his display of agreement with the patient's prior assertions (see lines 35, 37, 39), thereby making this

potentially disaffiliative move in a strongly affiliative environment. He also mitigates his statement epistemically with 'maybe' (line 41) and 'possibly' (line 42).

Shared knowledge. When referring to the "school bullies of yours" in the challenge, the therapist uses the demonstrative article 'these', showing an orientation to the salience and psychological presence of the characters he is referring to (line 41). The preface "you know this" (line 39) formulates the expectation of shared knowledge. He also invokes the school-time events by the simple pronoun 'it' (line 42), thus presupposing shared knowledge about them.

Core therapeutic project. The topic shift that the challenge involves appears to come 'out of the blue', through the therapist's association prompted by the patient's story. It becomes understandable in the light of the patient's psychological problems: the experiences of having been bullied were a key part of the problems that brought him to therapy. It appears that the therapist is making use of the response space after the patient's story to redirect his attention to these problems. He seems to treat the patient's self-ascription as 'snob' or artist as less relevant at this moment, redirecting the talk to therapeutically more significant matters.

The patient's response. In lines 43–44, the patient agrees with the therapist's turn about the school bullies even before its completion. The short *juu* 'sure', followed by 'most likely', claims independent knowledge (Heritage 2012), according to which what the therapist has suggested is clear or self-evident for the patient. Through these utterances, the patient also seemingly ratifies the shift in the construction of self (from the current artistic self to the past bullied self); yet he does not treat it as emotionally significant or a surprising perspective. As he continues his turn (lines 43–44, 46–47), the patient elaborates, in agreement with the therapist, his proposal about remembering, by suggesting a parallel between the art critiques of his first concerts and having been bullied at school: in both, he has been the target of potentially frightening attention. Yet, the shift to the memory of the critiques also accomplishes another shift in self-presentation: the patient returns to the identity of an artist, leaving behind the identity of the bullied schoolboy that the therapist promoted. Through his agreements (lines 45 and 48), the therapist not only accepts the parallel that the patient suggested, but also ratifies his shift back to the artistic identity.

Conclusion

In this article, we investigated moments in psychotherapy where the therapists problematize the patients' presentations of themselves. In problematizing the patient's self-presentation, the therapists can convey that:

- the patient's self-conceptualization is too narrow or too rigid ('You are (also) something else than you claim to be'),
- the patient's self-conceptualization is inaccurate ('You are not what you claim to be'),
- the patient's self-conceptualization is an impediment to therapeutic change ('What you claim to be is a problem'),
- the patient's self-presentation is in need of being reflected upon, however without stating a problem or an alternative ('Look at what you are claiming to be').

As we have shown through our four examples, sometimes the patients' self-claims and the therapist's challenges are explicit and conveyed in a compact sequence of actions, whereas in other cases they are more implicit or indirect, and embedded in a more complex or extended sequence of actions.

Challenging a person's self-presentation is a highly sensitive matter. The self-presentation 'automatically exerts a moral demand upon the others' to treat the person as the kind of person they presented themselves as (Goffman 1959:13; Heritage 2011:160). According to Goffman, questioning a self-presentation is always possible in interaction but it is usually avoided. Psychotherapy, however, is one of the few interactional settings in which challenges to the (patient's) self are licensed and occur regularly. Challenges can elicit the patients' self-exploration and make them reflect on themselves. Therefore, challenges to the self are an integral part of the interactional work through which psychotherapy takes place and which is informed by the goal that 'the patient will find his or her own self, and will be able to exist and to feel real' (Winnicott 1971:5).

Arguably, for Goffman, the self is 'entirely' in the presentation: there is no other, more authentic ego hiding behind the presentation and its social recognition. This conceptualization is different from psychotherapeutic theories of the self. Winnicott's (1965) distinction between false and true self is a case in point. The true self involves experience that is closely connected to physical, motion-related, and erotic aspects of the individual. The true self needs to be protected by the false self that is anchored in social conventions. Yet, the false self can entirely hide the true self, so that the individual, as well as the others, understands the false self as the whole person. In psychotherapy, the true self can be rediscovered.

Our theory and methods do not allow assessing any of the proposed versions of the self as indexes of a false or a true self. We investigated the technique of challenging, without committing ourselves to the metatheory of true self, which might be motivating the challenges.

The working alliance of psychotherapy (Greenson 1967:203–15) requires that therapist and patient disclose and discuss the patient's psychological processes and motives sincerely, even if this means disregarding considerations and taboos of social etiquette. However, even in this 'amoral' context, challenging the other's self-presentation still is a sensitive action. This is reflected by the design of the therapists' challenges: Therapists mostly mitigate their challenging statements (Stukenbrock, Deppermann, & Scheidt 2021), and they almost always take care to root the challenge in shared knowledge arising from the shared interactional

history (Deppermann & Pekarek Doehler 2021), thus making it accountable. In particular, they refer back to the shared interactional history of the therapeutic process. Admittedly, epistemic sources of the challenge might lie as well in the psychotherapist's clinical theory. Yet, in our data, the therapists never account for the challenges by directly appealing to theoretical assumptions. Instead, they always draw on the patient's prior talk and/or shared biographical knowledge.

Challenges to the self in most cases respond to a strong self-presentation of the patient. The self-presentation often involves a more or less pronounced assessment of the self, which can be either positive or self-deprecatory. These are kinds of actions that in other contexts would make affiliation relevant (however, in a complex way in the case of self-deprecation, see Pomerantz 1978). While therapists often first affiliate with the patient's account or at least show empathy before delivering an interpretation (Vehviläinen 2003; Voutilainen et al. 2010b; Stukenbrock et al. 2021), in this article we have analyzed sequences in which therapists do not produce the projected affiliative response, but rather a straightforward challenge. It seems that, in particular, strong self-related statements seem to provoke challenges, probably because such self-presentations are seen by therapists as symptoms of conflicts or as inherently problematic by virtue of their tendency to reify an unchangeable self.

Rather than simply stating a competing aspect of the patient's self, the therapists' challenges are tailored to the patient's prior accounts and lines of interpretation. The therapeutic challenges treat patient's accounts, which often refer to single actions, events, or situated thoughts and feelings, in terms of enduring, general facets of the patient's conceptions of their self (i.e. personal tendencies to act, motives, habits, conflicts, etc.)—and in response make facets of the patient's self a topic of discussion and exploration. Challenges to the self in this way are a primary instance of the general tendency of therapeutic action to constantly put the spotlight on the patient's habitual feelings, thoughts, relational patterns—and self-conceptualizations, taking situated report and events as a point of departure. Although therapists' challenges often respond to pronounced self-presentation, they sometimes also follow patients' descriptions and narratives, which to an outsider (and often to the patient as well) do not seem to have a definite self-presentational value, but which are interpreted by the therapist as indexing more general self-conceptualizations of the patient in need of being problematized.

In our data, patients' responses to therapists' challenges are very diverse. They include, for example, agreement, taking up some of the challenge while ignoring other (often more fundamental) aspects of it, pro-forma agreement and resuming the patient's prior storyline, irony, justification of their self-related claims, and straightforward rejection of the challenge. Therefore, when considering only immediate responses, the therapeutic effectiveness of challenges seems dubious. We can understand patients' tendency to disaffiliate with the challenges in different yet overlapping ways. On one hand, challenges can be at odds with deeply entrenched ways that patients conceive of themselves. Thus, their response can indicate that

they are not (yet) ready to adopt the new perspective to themselves. However, the resistance can also be more locally anchored. The challenge questions the just prior presentation of self. Yielding to the challenge would amount to an inconsistency of self-presentation—which is something that we generally avoid (Goffman 1959). Local inconsistency of self-presentation may be as problematic as the acceptance of new understandings of what one 'really' is.

Since challenges to the self address core issues of the therapy, we can expect that, in spite of the lack of immediate acceptance, they may nevertheless unfold some impact in later sequences and sessions, for example, by therapists pursuing them further, or by patients who reinvoke the challenge by their own initiative and use them for more in-depth self-exploration. Thus, a next step in the study of challenges to the self in psychotherapy would be analyzing them within a broader interactional histories' perspective. In this way, we may understand better if and how they are taken up and become consequential for the further course of the therapeutic process.

Note

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