The Undertow of Psychotherapy Sessions: A Conversation Analysis

Part A

Introduction

From a commercial perspective, there are a number of factors that dictate how successful a health service provider is, one of which is communication between the customer and healthcare personnel (Chichirez & Purcărea, 2018). From the standpoint of a health professional, communication also plays a crucial role in establishing therapeutic alliance, trust, and ultimately a unique interpersonal relationship between the patient and doctor. The patient-doctor relationship is undeniably the backbone of effective and efficient medical procedures, constituting as the main facilitator for nearly half of the successful therapies (Ahmad et al., 2013).

Addressing various health problems, health professionals with different specialities often adopt differing communication styles or approaches in a certain setting. Given its inherence, psychotherapy session, the setting upon which this study's analysis is based, is one of the scenarios representing the intricacies of patient-doctor communication. To date, psychotherapy has largely proven to be a promising treatment method in psychiatry (Lambert, 2013). However, there are also cases where psychotherapy proved ineffective, and these failures are partly attributed to "negative interpersonal processes" between the therapist and patient (Oasi & Werbart, 2020, p. 1).

Therefore, analysing patient-therapist communication is of great significance, as it enables both parties to gain an understanding of and develop awareness towards how and in what way the communication can be conducted in order to achieve the best therapy outcome possible.

Methods

The method of the current study is closely associated with the 'basic' conversation analysis (CA) approach that can be applied to a wide range of institutional talks (Heritage, 2005; Hoey & Kendrick, 2017) as well as CA of psychotherapy in particular (Peräkylä, 2019). The basic, inductive CA approach involves identifying and analysing mainly the function, meaning, and structural organization of conversational machineries such as adjacency pair, lexical choice, and repair (Heritage, 2005; Hoey & Kendrick, 2017). CA of psychotherapy, on the other hand, not only examines these types of machinery but also tries to yield findings that uncover therapeutic transformation that is manifested through basic CA machineries and occurs within psychotherapy sessions. Integrating both CA and CA of psychotherapy, the study thus has a double focus: one is identifying conversational machineries significant to the institutional setting of psychotherapy sessions, and the other is making implications of these machineries in terms of how they promote therapeutic effects.

The data consists of three transcripts of real-world psychotherapy sessions. Given the fact that observations and documentations of naturally occurring social interactions are preferred data for CA because "people's intuitions about how they should behave in interaction often conflict with their actual behavior" (Hoey & Kendrick, 2017, p. 4), naturalistic data like transcripts of real-world psychotherapy sessions is optimal for this study.

Analysis

CA puts a heavy emphasis on the sequence organisation of interaction in which an initial action from one participant is followed up by an action from another participant, and it is through this back-and-fourth action-taking process that the context of an interaction is continuously created, maintained, and renewed (Heritage, 1998; Schegloff, 2007). Adjacency pair is the fundamental trait of sequence organisation. In

CA of psychotherapy, adjacency pairs are embedded in a sequence organization system comprised of four components: prior action, target action, response, and third position (Peräkylä, 2019). In transcript 1, a prior action is taken by the client (Appendix 1.3, C15, lines 1-4), followed by a target action (Appendix 1.3, T15, lines 1-5), and then a response is given (Appendix 1.3 & 1.4, C16, lines 1-10), which invites an adjacency pair that is also considered third position from the therapist: "Yeah, I get the disappointment" (Appendix 1.4, T16, lines 1-3). All four actions are adjacency pairs that are conditionally relevant. However, the third position serving as the last adjacency pair demonstrates that the therapist acknowledges the emotional valence of the client's response while being neutral, which establishes therapeutic alliances between two parties and allows the therapist to detach and consider what actions to take next in accordance with therapeutic goal and professional standards (Peräkylä, 2019). Another example can be observed in transcript 1 where the therapist says "It sounds like a tough assignment" (Appendix 1.5, T28, line 1). Only this time the third position includes an evidential verb "sound", signalling an acknowledgement without necessarily implying emotional commitment from the therapist.

Unlike ordinary conversations that typically do not have a set of clearly defined desired outcomes expected by two or more participants, psychotherapy sessions are goal-oriented towards transforming how a patient thinks, feels, and behaves, which in turn helps the patient overcome his or her social and emotional issues (Locher et al., 2019). Thus, psychotherapy sessions embody an overarching underpinning of CA, which is that it is not only the interaction that shapes the context per se but also the macro-social institutions that contribute to the shaping of context, in this case, the hospital or private clinic (Heritage, 1998). In transcript 1, after the greeting, the therapist immediately says "I'd be glad to know whatever concerns you," (Appendix 1.1, T2, line 3). This is an example of how macro-social institution shapes the context. It is seen in transcript 2 as well where the therapist (Dr. Balis) directs the conversation towards the main objective of the session by saying "What's going on in your life that leads you to seek therapy now?" (Appendix 2, lines 16-17). In transcript 3, the

utterance of the agenda opening statement shifted from the therapist to the patient/client (Appendix 3, C3, lines 1-10). These questions or statements are also part of "role preparation" in psychotherapy that sets the frame, facilitating efficiency in the initial phase of therapy (DeFife & Hilsenroth, 2011).

Notably, institutional settings not only shape the overall context of a conversation but also affect the lexical choice of participants (Drew & Heritage, 1992). In transcript 1, the client greets the therapist by his title and last name "Dr. Rogers" (Appendix 1.1, T1, line 1). It shows that the client acknowledges the therapist's profession and that her lexical choice is influenced by the institutional context in which they are communicating. On the contrary, the therapist asserts his title and addresses the client by her first name (Appendix 1.1, T1, lines 1-2). The same pattern is found in transcript 2 where the patient addresses the therapist by his title and last name "Dr. Balis" (Appendix 2, line 1) while the therapist addresses the patient by her first name (Appendix 2, line 2). Interestingly, in transcript 2, the patient uses the word "shrink" before immediately correcting herself by saying "I mean a therapist..." (Appendix 2, lines 5-6). Through both parties choosing certain lexical or descriptive terms, the therapy process becomes more or less formal, and as the formality of the therapy process varies, the trust, therapeutic alliance, and bond between a therapist and patient also undergo dramatic changes affecting the final outcome of therapy (Lee et al., 2022)

"A member may treat some part of the conversation as an occasion to describe that conversation, to explain it, or characterize it, or explicate, or translate, or summarize, or furnish the gist of it, or take note of its accordance with rules, or remark on its departure from rules" (Garfinkel & Sacks, 1970, p. 350). These actions are called formulation. Weiste and Peräkylä (2013) categorised formulation in psychotherapy into four types: highlighting, relocating, rephrasing, and exaggerating, all of which help therapists attain more detailed elaboration, confirm if their understanding of

preceding utterances is accurate, or elicit a change of perception among patients. These types of formulation are found within the transcript 1.

In transcript 1, following the client's speech (Appendix 1.2, C7, lines 1-3), the therapist rephrases the preceding talk into a question to confirm if he clearly understood what the client just said and to invite for elaboration (Appendix 1.2, T7, line 1). After the client confirms and elaborates (Appendix 1.2, C8, lines 1-6), the therapist again uses rephrasing to simply confirm intersubjectivity (Appendix 1.2, T8, lines 1-2). Ensuing next is the client's confirmation (Appendix 1.2, C9, line 1). Gaining clarification and elaboration, the therapist then relocates and highlights the client's concern about how her daughter thinks of her, which was brought up a moment ago (Appendix 1.2, C8, lines 1-6), by saying "And she may think you are worse than you are" (Appendix 1.2, T9, line 1). Right after the relocating and highlighting, the client corrects the therapist (Appendix 1.2, C10, line 1). This is an example of repair, indicating that the client does not find the therapist's interpretation accurate and tries to renew intersubjectivity. But more importantly, although the relocating and highlighting are inaccurate from the perspective of the client, they eventually narrow down the focus of the conversation to just one aspect of previous utterances made by the client, that is, concern about her image in her daughter's mind (Appendix 1.2, C8, lines 1-6), which ultimately leads to a significant shift of therapy to a central theme: the contradiction between the client's real-self and ideal-self (Appendix 1.2 & 1.3, T11, lines 1-2; C12, line 1; T12, lines 1-3; C13, lines 1-4; T13, lines 1-2). Helping the client to discover these two separate self-concepts and align one with the other is crucial in achieving successful psychotherapy (Rogers, 1959). Formulation, namely highlighting and relocating, aids the therapist in transcript 1 to achieve this goal, serving as the vehicle of therapeutic transformation.

Conclusion

As seen in the analysis, basic CA machinery including adjacency pair, lexical choice, and repair can carry more than one conversational function in the context of psychotherapy, accomplishing intersubjectivity, allowing for reflexivity on both ends, and last but not least, facilitating therapeutic effect.

For one thing, adjacency pair within a sequence organisation system that is exclusive to CA of psychotherapy is termed differently than it is in CA studies in general and can establish therapeutic alliances between the therapist and client. Moreover, adjacency pair (third position) allows the therapist to acknowledge what the client says and prepare for the following actions.

Institutional setting influences the lexical choice and context of psychotherapy sessions, though both lexical choice and context are constantly evolving and being adjusted according to the dynamics of the psychotherapy session.

Importantly, formulation (highlighting, relocating, exaggerating, and rephrasing) plays an essential role in therapeutic transformation, more so than CA machineries that mainly aim to achieve intersubjectivity and allow for reflexivity.

Expanding on the fundamental roles that CA machineries play, this study, alongside the work by Peräkylä (2019), illustrates that using CA to analyse psychotherapy sessions equips both patients and therapists with an ability to decipher the underlying mechanisms of psychotherapy and therapeutic transformation transpiring moment-by-moment. Although it is rather easy for therapists to see what clinical progression has actually been made through examining the transcript after the session and evaluating the outcome, incorporating CA into the examination and evaluation process perhaps can allow them to broaden their view in the sense that the applicability of CA in various settings can potentially bring in new insights on how psychotherapy sessions should be conducted with regards to linguistically relevant practices and the manifestation of values, beliefs, and norms.

Part B

Critical discourse analysis (CDA) differs from CA in that it not only examines the sequence organization in which meaning and context of utterances co-construct the nature of an interaction but also the social, cultural, and political implication as well as power dynamics exhibited by utterances or conversation as a whole. Using CDA to analyse clinical interactions between doctors and patients other than psychotherapy sessions can be particularly salient. The data required will still be transcripts or other materials detailing the verbal communication.

Unlike psychotherapy, medical visits and clinical interaction aside from psychotherapy typically involve the use of medical jargon by the doctor, which, if not comprehended by the patient, can lead to a negative medical experience, less efficient treatment process, and non-ideal health outcome (Derevianchenko et al., 2018). When doctors refrain from speaking in a jargon-infused tone, patients largely perceive them "as more caring, empathetic, and approachable" (Allen et al., 2023, p. 1), but still, many doctors use medical terminologies for a number of reasons regardless of the patient's ability to comprehend (Allen et al., 2023). In certain cases, jargon-infused speech helps the doctor to advance their professional dominance, acting as means of speeding up the medical visit, reinforcing and perpetuating the experts-know-best position, and neglecting real-life concerns of patients, such as the inability to pay for the medical bill, lack of social support, family responsibilities hindering them from developing medical adherence, all of which can potentially threaten the professionalism and authority of doctors because they may simply not have answers to these concerns and may be given negative feedback from patients as the result (Maynard, 1991).

Such a phenomenon shows asymmetry of power and knowledge and epistemic asymmetry in the context of clinical discourse, which are the main foci of CDA. Thus, using CDA to analyse clinical interaction between doctors and patients may be of significance. Moreover, using CDA to analyse clinical interactions may yield findings that enable doctors to adjust or even revamp their linguistic practices so that a more friendly relationship can be established between the doctor and patient, thus a higher level of medical adherence and effectiveness of medical procedures.

Another analytic approach that can be used to study clinical interaction is multimodal discourse analysis (MDA), which takes into account the semiotic resources (image, gesture, environmental cues, etc.) of interaction along with the text, or in this case, verbal utterances (Ope-Davies & Shodipe, 2023). Clinical encounters sometimes involve patients who are cognitively or neurologically impaired that they cannot produce coherent and comprehensible utterances when talking to a doctor, forcing the doctor to make assessments and informed decisions based on non-verbal cues (Bellieni, 2022). Even if the patient is able to produce clearly understandable speech, it is essential for doctors to include other non-verbal cues in diagnosis and treatment because non-verbal cues like gestures, facial expression, and appearance of patients help doctors to grasp their affective state, which is especially meaningful in psychiatry (Bellieni, 2022; Foley & Gentile, 2010). Needless to say, the data required for using MDA to analyse clinical interaction will be videos, recordings, and pictures, the last of which can be seen in the study done by Llewellyn et al. (2022) where they analysed clinical interaction in the veterinary clinic.

References

Ahmad, A. M. K., Al-Qarni, A. A., Alsharqi, O. Z., Qalai, D. A., & Kadi, N. (2013). The Impact of Marketing Mix Strategy on Hospitals Performance Measured by Patient Satisfaction: An Empirical Investigation on Jeddah Private Sector Hospital Senior Managers Perspective. *International Journal of Marketing Studies*, *5*(6). https://doi.org/10.5539/ijms.v5n6p210

Allen, K. A., Charpentier, V., Hendrickson, M. A., Kessler, M., Gotlieb, R., Marmet, J., Hause, E., Praska, C., Lunos, S., & Pitt, M. B. (2023). Jargon Be Gone – Patient Preference in Doctor Communication. *Journal of Patient Experience*, *10*, 237437352311589. https://doi.org/10.1177/23743735231158942

Bellieni, C. V. (2022). Verbal Communication with the Patient Is Not Enough: The Six Languages of the Sick. *Nursing Reports*, *12*(4), 726–732. https://doi.org/10.3390/nursrep12040072

DeFife, J. A., & Hilsenroth, M. J. (2011). Starting off on the right foot: Common factor elements in early psychotherapy process. *Journal of Psychotherapy Integration*, *21*(2), 172–191. https://doi.org/10.1037/a0023889

Derevianchenko, N., Lytovska, O., Diurba, D., & Leshchyna, I. (2018). IMPACT OF MEDICAL TERMINOLOGY ON PATIENTS' COMPREHENSION OF HEALTHCARE. *Georgian medical news*, (284), 159–163.

Drew, P., & Heritage, J. (1992). Analyzing Talk at Work: An Introduction. In P. Drew, & J. Heritage (Eds.), Talk at Work. Interaction in Institutional Settings (pp. 3-65). Cambridge: Cambridge University Press

Foley, G. N., & Gentile, J. P. (2010). Nonverbal communication in psychotherapy. *Psychiatry (Edgmont (Pa. : Township))*, *7*(6), 38–44.

Garfinkel, H., & Sacks, H. (1970). *On Formal Structures of Practical Actions* (pp. 349–351). Appleton-Century-Crofts.

Lambert, M. J. (2013). *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (6th ed., pp. 169–218). John Wiley & Sons.

Lee, J. H. N., Chui, H., Lee, T., Luk, S., Tao, D., & Lee, N. W. T. (2022). Formality in psychotherapy: How are therapists' and clients' use of discourse particles related to therapist empathy? *Frontiers in Psychiatry*, *13*. https://doi.org/10.3389/fpsyt.2022.1018170

Llewellyn, N., Hindmarsh, J., & Burrow, R. (2022). Coalitions of touch: Balancing restraint and haptic soothing in the veterinary clinic. *Sociology of Health & Illness*, *44*(4-5), 725–744. https://doi.org/10.1111/1467-9566.13458

Locher, C., Meier, S., & Gaab, J. (2019). Psychotherapy: A World of Meanings. *Frontiers in Psychology*, *10*(460). https://doi.org/10.3389/fpsyg.2019.00460

Maynard, D. W. (1991). Interaction and Asymmetry in Clinical Discourse. *American Journal of Sociology*, *97*(2), 448–495. http://www.jstor.org/stable/2781383

Oasi, O., & Werbart, A. (2020). Editorial: Unsuccessful Psychotherapies: When and How Do Treatments Fail? *Frontiers in Psychology*, *11*. https://doi.org/10.3389/fpsyg.2020.578997

Ope-Davies (Opeibi), T., & Shodipe, M. (2023). A multimodal discourse study of selected COVID-19 online public health campaign texts in Nigeria. *Discourse & Society*, *34*(1), 96–119. https://doi.org/10.1177/09579265221145098

Peräkylä, A. (2019). Conversation Analysis and Psychotherapy: Identifying Transformative Sequences. *Research on Language and Social Interaction*, *52*(3), 257–280. https://doi.org/10.1080/08351813.2019.1631044

Rogers, C. R. (1959). A Theory of Therapy, Personality, and Interpersonal Relationships: As Developed in the Client-Centered Framework. In S. Koch (Ed.), Psychology: A Study of a Science. Formulations of the Person and the Social Context (Vol. 3, pp. 184-256). New York: McGraw Hi

Schegloff, E. A. (2007). *Sequence Organization in Interaction*. https://doi.org/10.1017/cbo9780511791208

Chichirez, C. M., & Purcărea, V. L. (2018). Interpersonal communication in healthcare. *Journal of medicine and life*, *11*(2), 119–122.

Heritage, John. (1998). Conversation analysis and institutional talk: Analyzing distinctive turn-taking systems. 3-17.

Hoey, Elliott & Kendrick, Kobin. (2017). Conversation Analysis.

Weiste, E., & Peräkylä, A. (2013). A Comparative Conversation Analytic Study of Formulations in Psychoanalysis and Cognitive Psychotherapy. *Research on Language & Social Interaction*, *46*(4), 299–321. https://doi.org/10.1080/08351813.2013.839093

Appendix

Appendix 1 (Transcript 1)

Appendix 1.1 (Transcript 1)

T1	(Rogers stands as Gloria enters.) Good morning. (C: Hello, Dr. Rogers) I'm Dr. Rogers, you must be Gloria. (They shake hands and sit down.)
C2	Yes, I am.
T2	Won't you have a chair? Now then, we have half an hour together, and I really don't know what we will be able to make of it but uh I hope we can make something of it. I'd be glad to know whatever concerns you. (T: Sitting forward, C: Sitting back, legs crossed, right arm over the back of the chair)
C3	Well, right now I'm nervous (T: Mhm) but I feel more comfortable the way you are talking in a low voice and I don't feel like you'll be so harsh on me. But, ah ...
T3	I hear the tremor in your voice so I know you are... (C: Smiles)
C4	Uh, well, the main thing I um, want to talk to you about is uh, I'm just newly divorced and uh I had gone in therapy before and I felt comfortable when I left, and all of a sudden now the biggest change is adjusting to my single life. (T: Mhm, mhm) And uh one of the things that bothers me the most is especially men, and having men to the house and how it affects the children (T: Mhm, Mhm) and- Uh, the biggest thing I want - the thing that keeps coming to my mind I want to tell you about is that I have a daughter, nine, who at one time I felt had a lot of emotional problems. I wish I could stop shaking (T and C: laugh). And uh, I'm real conscious of things affecting her. I don't want her to get upset, I don't want to shock her. I want so bad to- for her to accept me. And we're real open with each other especially about sex. And the other day she saw a girl that was single but pregnant and she asked me all about "can girls get pregnant if they are single?" And the conversation was fine and I wasn't un- at ease at all with her until she asked me if I had ever made love to a man since I left her daddy and I lied to her. And ever since that, it keeps

Source: Shostrom, E. L. (1965). Three approaches to psychotherapy (Part I)[Film]. Orange, CA: Psychological Films. (Carl Rogers' Session Transcripts (wordpress.com))

Appendix 1.2 (Transcript 1)

coming up to my mind because I feel so guilty lying to her because I never lie and I want her to trust me. And I want- I almost want an answer from you. I want you to tell me if it would affect her wrong if I told her the truth, or what. (T:Mhm)

T4 And it's this concern about her and the fact that you really aren't - that this open relationship that has existed between you, now you feel it's kind of vanished?

C5 Yes. I feel like I have to be on guard about that (T: Mhm) because I remember when I was a little girl, when I first found out my mother and father made love, that was dirty and terrible, and I didn't- I didn't like her any more for awhile. And I don't want to lie to Pammy either and I don't know...

T5 I sure wish I could give you the answer as to what you should tell her. (Smiles.)

C6 I was afraid you were going to say that (Laughs).

T6 Because what you really want *is* an answer.

C7 I want to especially know if it would affect her if I was completely honest and open with her or if it would affect her because I lied. I feel like it is bound to make a strain because I lied to her. [Words lost]

T7 Mhm. You feel she'll suspect that, or she'll know something is not quite right?

C8 I feel that in time she will distrust me, yes (T: Mhm, mhm). And also I thought well, gee, what about when she gets a little older and she finds herself in touchy situations. She probably wouldn't want to admit it to me because she thinks I'm so good and so sweet. (Points to herself.) And yet I'm afraid she could think I'm really a- a devil. And I want so bad for her to accept me. And I don't know how much a nine-year-old can take.

T8 And really both alternatives concern you. That she may think you're too good or better than you really are.

C9 Yes.

T9 And she may think you are worse than you are.

C10 Not worse than I am. (Smiles) I don't know if she can accept me the *way* I am. I think I paint a picture that I'm all sweet and motherly. And -- I'm a little ashamed of my shady side too. (T:Mhm, mhm)

T10 I see. It really cuts a little deeper. If she really knew you, would she, could she accept you?

C11 This is what I don't know. Yeah. I don't want her to turn away from me. (T: That

Source: Shostrom, E. L. (1965). Three approaches to psychotherapy (Part I)[Film]. Orange, CA: Psychological Films. (Carl Rogers' Session Transcripts (wordpress.com))

Appendix 1.3 (Transcript 1)

relationship-) And I don't even know how I feel about it because there are times when I feel so guilty like when I have a man over, I even try to make a special set-up so that if I were ever alone with him, the children would never catch me in that sort of thing. Because I'm real leery about it (T: Mhm). And yet I also know that I have these desires.

T11 And so it's quite clear it isn't only her problem or the relationship with her, it's in you as well.

C12 And my guilt. Yeah. Yeah. (T: Oh) I feel guilty so often. (Moistens lips.)

T12 "What- What can I accept myself as doing?" And uh (C: Yes, Yes) you realize that you set up sort of subterfuges, so as to make sure that you're not caught or something, you realize that you are acting from guilt, is that it?

C13 Yes (T: Mhm, mhm) and I don't like the ... I would like to feel comfortable with whatever I do. If I choose not to tell Pammy the truth, to feel comfortable that she can handle it, (T: Mhm, Mhm, Mhm) and I don't. I want to be honest, and yet I feel there are some areas that *I* don't even accept (T: Mhm, Mhm) .

T13 And if you can't accept them in yourself, how could you possibly be comfortable in telling them to her?

C14 Right.

T14 Mhm. Mhm. And yet, as you say, you do have these desires and you do have your feelings, but- but you don't feel good about them.

C15 Right. (T: Nods and smiles.) (Pause) And I, I, I have a feeling that you are just going to sit there and let me stew in it (laughs) and I- I want more. I want you to help me get rid of my guilt feeling. If I can get rid of my guilt feeling about lying or going to bed with a single man, any of that, just so I can feel more comfortable.

T15 Mhm. And I guess I'd like to say, "No, I don't want to let you stew in your feelings," but on the other hand, I, I also feel that this is the kind of very private thing that I couldn't possibly answer *for* you. But I sure as anything will try to help you work toward your own answer. I don't know whether that makes any sense to you, but I mean it.

C16 Well, I appreciate you saying that. (Takes her arm off back of chair, now uses both hands to gesture.) You sound like you mean it. But I don't know where to go. (T: Mhm, Mhm, Mhm) I don't begin to know where to go. I thought that I had pretty well worked over most of my guilt, and now that this is coming up I'm disappointed in myself. (T: Mhm, Mhm) I really am. I want- I like it when I feel that no matter what I do, even if it's against my own morals or my upbringing, that I can still feel good about me. And now I don't. Like uh, there's a girl at work who sort of mothers

Source: Shostrom, E. L. (1965). Three approaches to psychotherapy (Part I)[Film]. Orange, CA: Psychological Films. (Carl Rogers' Session Transcripts (wordpress.com))

Appendix 1.4 (Transcript 1)

me and she just- she- I think she thinks I'm all sweet, and I sure don't want to show my more ornery devilish side with her. I want to be sweet and it's so hard for me to - this all seems so new again (T: Mhm) and it's so disappointing.

T16 Yeah, I get the disappointment - that here, a lot of these things you'd thought you'd worked through, and now the guilts and the feeling that only a part of you is acceptable to anybody else.

C17 Yes.

Appendix 1.5 (Transcript 1)

T27 What you'd like to do is to feel more accepting toward yourself when you do things that you feel are wrong. Is that right?

C28 Right. And I feel like, I feel like...

T28 (Smiling) It sounds like a tough assignment.

C29 Yeah, I feel like you are going to say, "Now why do you think they're wrong?" and uh, I have mixed feelings there too. (T: Mhm) Through therapy I will say, "Now look, I know this is natural. Women feel it - sure, we don't talk about it lots socially but all women feel it and it's very natural." I have had sex for the last 11 years and I'm- of course going to want it, but I still think it is wrong unless you're really, truly in love with a man, and my body doesn't seem to agree. And so I don't know how to accept it.

Source: Shostrom, E. L. (1965). Three approaches to psychotherapy (Part I)[Film]. Orange, CA: Psychological Films. (Carl Rogers' Session Transcripts (wordpress.com))

Appendix 2 (Transcript 2)

Ms. Lough: Um, hi. You're Doctor Balis, right?

Dr. Balis: Yes. Hello, Sharon. You're a little early.

Ms. Lough: Oh, sorry. I can come back...

Dr. Balis: No, no, that's fine. Come in, sit down.

Ms. Lough: I'm a little nervous. I haven't seen a shrink...I mean a therapist in a long time.

Dr. Balis: It's perfectly natural to be a little nervous your first session. When did you last see a therapist?

Ms. Lough: I hope you're not offended by me calling you a shrink.

Dr. Balis: No, that's fine. I've been called worse. When were you last in therapy?

Ms. Lough: About a year ago. I've been in and out of therapy most of my adult life, since I was about 19 or 20. That's almost a whole decade.

Dr. Balis: What's going on in your life that leads you to seek therapy now?

Ms. Lough: Well, work, for one. I hate it. I'm overwhelmed. And I'm having problems at home. Everything sucks, basically. Everything's going to hell in a bucket.

Dr. Balis: Hmm. Let's start with work. You say you're overwhelmed?

Ms. Lough: Yeah. I'm a one of the secretaries for SII. There are three secretaries assigned to this group of software engineers I work for. We have a major project deadline coming up, the paperwork never seems to end, and they always want constant revisions. I've been working really long days--12, 14, 16 hours, sometimes. I feel like a zombie, one of the walking dead. I'm always exhausted; it's like I'm barely alive.

Dr. Balis: It must be a drain to work such long hours.

Ms. Lough: Yeah. Well, it's not like I have much of a social life anyway. One of the secretaries in my group is a dud, a real pain in the ass. I get stuck picking up after her all the time.

Dr. Balis: Hmm.

Source: The Company Therapist

(http://www.thetherapist.com/Lough_Session_110797.html)

Appendix 3 (Transcript 3)

T1: I'm always nervous. I seem to get nervous that the tape is something that I've got control of, you know, like its going to be my tape and I think I'm nervous about speaking into it because usually if it is someone else's then I'm less conscious of it or something you know.
C1: Is this yours or is it . . .
T2: No its not mine. I mean I'm not going to . . . its going to be theirs. So hopefully I'm not going to be as nervous as I would have had it been (brief laugh). We could put it where we couldn't see it.
C2: I don't mind
T3: Yeah, O.K. You don't mind.
C3: Um, I kinda of wanted to start with a part of the dream that I had last night. Um, it's been grating at me. Every once in a while I have a dream that I feel was significant and that . . . that sticks with me and I . . . and I know that I need to know what it meant. This one part of the dream had a lot of complexities. It really was odd and what it was was this car which belongs to a man that I have been dating. I was like looking for it in the dream. And I couldn't find it. And so I thought well he wasn't around. And then all of a sudden I saw it. It was like in the brush, you know. It was definitely in sight. But it was as if it was parked so that it wouldn't be in sight. And, you know, I can see the tree limb hanging down and I'm real intrigued by it. I . . . It definitely reminds of . . . the fact that this car doesn't have head lights right now.
T4: You mean like they are gone. There are holes in there?

Source: The Association for the Development of the Person-Centered Approach

(https://adpca.org/article/1_3/transcript-of-therapy-session-by-douglas-bower/)