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Linguistic manifestation of resistance in psychodynamic psychotherapy and its communicative treatment

Carolina Fenner

Abstract Resistance is a central concept in psychodynamic psychotherapy, though it is not an easily identifiable phenomenon, as it can manifest itself in many different ways. The challenge for therapists is therefore to recognize resistance and, if necessary, to address or work on it in order to achieve progress in therapy. To enable therapists to recognize resistance, it is helpful to know the possible linguistic and interactional characteristics of resistance phenomena. This raises the question of how (potential) resistance phenomena manifest themselves in psychotherapeutic interaction. The present dissertation – which consists of this framing paper and four articles – addresses this question by reviewing previous research and using conversation analysis (CA) to empirically examine interactional and linguistic phenomena that may manifest resistance in talk-in-interaction (verbosity, claims of not-knowing and silence). CA is a well-established method for analyzing psychotherapeutic interaction. However, beyond examining individual resistance phenomena, the dissertation also includes a longitudinal CA study to show how resistance can change on the interactional surface over the course of a therapeutic treatment.

The data, on which the four studies are based and which are reflected in this framing paper, consist of videotaped outpatient psychotherapy sessions in German from different patients and therapists. They were drawn from a large collection of videotaped data from a training institute for psychodynamic psychotherapy.

A key finding is that the investigated phenomena are rarely treated as resistance. Neither patients nor therapists make explicit attributions of resistance, but at most implicit ones. Moreover, the phenomena often have other functions, too, such as patients indexing difficulties with the ongoing task or topic.

The findings offered in this thesis have clear implications for conversation analysts, psychologists, and practicing psychotherapists alike, such as how to recognize resistance in psychotherapeutic interactions on the linguistic-interactional level. Additionally, it offers a detailed discussion of the concept of resistance.

Keywords resistance, psychodynamic psychotherapy, conversation analysis, verbosity, claims of not-knowing, silence, longitudinal analysis

Content

1. Introduction[1]

(Psychodynamic) Psychotherapy is also called "the talking cure" (Freud 1910, p. 13): The process of healing is contingent upon the successful establishment of a therapeutic alliance between the patient and the therapist, which is facilitated by the act of talking and the interaction between them. Thus, it is clear that the study of communication and interaction in psychotherapy is a central component of psychotherapy research. A well-established method for this is conversation analysis (CA), a qualitative research method, which has its origins in ethnomethodology. CA aims at identifying structures that underlie social interaction, "i.e. to describe the intertwined construction of practices, actions, activities, and the overall structure of interaction" (Stivers/Sidnell 2012, p. 2). "[C]onversation analytic studies elucidate the second-by-second, or utterance-by-utterance, unfolding of psychotherapeutic sessions, with the aim of explicating the actual interactional patterns and practices through which psychotherapy gets done" (Peräkylä et al. 2008, p. 7). While all phenomena occurring in psychotherapy are open to CA, it is of particular interest to examine established theories and concepts in the respective school of psychotherapy from an empirical per-

1 Framing paper of the cumulative dissertation for the award of the academic degree of Doctor of Philosophy from the University of Mannheim, 2025.

spective.[2] The following conversation-analytic study does precisely this by examining (potential) resistance phenomena in videotaped outpatient psychodynamic psychotherapy[3] sessions.

Resistance$_{psych}$[4] is a central concept in psychodynamic psychotherapy: It is "a counterforce in the patient, operating against the progress of the analysis, the analyst, and the analytic procedures and processes. […] The resistances oppose the effectiveness of the analytic procedures and defend the *status quo* of the patient" (Greenson 2016, p. 60). However, resistance$_{psych}$ is often not an easily identifiable phenomenon, as it can manifest itself in many different ways. The patient can, for example, stay silent, avoid topics, miss hours, or come too late to the session (ibid., pp. 60–69). The difficulty for the therapist is therefore to recognize resistance$_{psych}$ and, if necessary, to address or work on it in order to achieve progress in therapy.[5] To enable the therapist to recognize resistance$_{psych}$, it is necessary to know the possible characteristics of resistance$_{psych}$ phenomena. This raises the question of how (potential) resistance$_{psych}$ phenomena manifest themselves in psychotherapeutic interaction. The present dissertation addresses this question by reviewing previous research and empirically examining additional resistance$_{psych}$ phenomena, such as verbosity, claims of not-knowing, and silence. In line with recent trends in psychodynamics, resistance is understood as being produced interactively (Streeck 1995). As such, this thesis examines resistance$_{psych}$ from an interactional perspective. Rather than focusing solely on particular phenomena as expressed by patients, this dissertation adopts a more holistic, contextual perspective, as is usual in CA: It analyzes resistance within its sequential context, that is, the sequential pre-context, the phenomenon itself (including multimodal examination, if applicable) and the post-context as well as, for example, relevant interactional histories.

The dissertation is part of the interdisciplinary project *Linguistic Manifestations of Resistance in Psychodynamic Psychotherapy*, in which resistance phenomena in psychotherapy were examined from both a conversation-analytic and a psychological perspective. When identifying resistance phenomena at the beginning of the project, it quickly became apparent that both disciplines – CA and psychodynamics – have different understandings of the concept of resistance. I therefore selected three phenomena that are often understood to represent resistance$_{psych}$ from a psychodynamic perspective in order to describe and analyze them conversation-analytically.

This framing paper comprises the following five chapters: In chapter two, *Theoretical Background*, I will first describe psychotherapy as a form of institutional interaction in general and characterize psychodynamic psychotherapy more specifically. Second, I will provide an overview of some basic concepts in psychodynamic psychotherapy, including resistance$_{psych}$. Third, I will review CA research on psychotherapeutic interaction and outline what conversation analysts mean by the term 'resistance$_{CA}$'. Fourth, I will give an

2 For an overview of CA research on psychotherapeutic conversations, see Peräkylä et al. (2008).

3 Psychodynamic psychotherapy emerges from psychoanalytic psychotherapy (for an overview of different psychotherapy approaches, including psychoanalysis, see Corey 1991). It draws on the psychoanalytic framework but applies it to less intensive and/or short-term psychotherapy (Abrahams/Rohleder, 2021, p. 1). "Psychodynamic psychotherapy […] focuses primarily on unconscious aspects of our behaviour that lead to internal conflict, as well as how we experience, regulate and express our emotions in an interpersonal context, including in the therapeutic relationship" (ibid., p. 2). For an overview, see chapter 2.1.

4 In order to differentiate between the psychodynamic concept of resistance and a conversation analytic understanding of resistance, I will mark the former with the subscripted abbreviation *psych*, and the latter with the subscripted abbreviation *CA*. If I mean resistance in general, that is, in both disciplines, the term will be unmarked.

5 Messer (2002), among others, provides further background on resistance from a psychodynamic perspective.

overview of CA research on (potential) resistance phenomena in psychotherapy. Finally, I will review CA research on how therapists manage resistance in psychotherapy. Chapter three, *Method*, presents the methodological approach of the studies that make up this dissertation, including an overview of the project in which the research was conducted. In chapter four, *Data*, I will describe the data I used for my studies. Chapter five, *Research Questions*, outlines the research questions of the different studies. Chapter six, *Results*, reports the main results. However, I will not merely summarize the findings as presented in the aforementioned articles, but compare and relate them to each other. As part of chapter six, I will first focus on the different (potential) resistance phenomena that I analyzed (i.e., verbosity, claims of not-knowing and remaining silent). I will then illustrate how therapists manage these phenomena. Lastly, I will present the results of a longitudinal study I conducted to show how resistance can develop over the course of a therapy. In chapter seven, *Discussion*, I will discuss and evaluate the different studies and their results. In particular, I will discuss and critically reflect on the interdisciplinary design of the studies. I will also highlight implications for both researchers and practicing psychotherapists.

2. Theoretical Background

2.1 Psychotherapeutic Interaction

Psychotherapy aims at healing "disorders of the mind or personality by using psychological methods" (Oxford English Dictionary 2024) or in other words: restoring the psychological well-being of the patient (Fitzgerald 2013, p. 5). This is usually done by talking[6] – or even more precisely through communication as nonverbal and embodied behavior might also play a crucial role. Although it is a form of institutional interaction, psychotherapists and patients use some practices that are also common in ordinary interaction (Marciniak et al. 2016, pp. 1 f.; Peräkylä et al. 2008, p. 5). The content of these interactions, for instance, appears to be of a personal and confidential nature, akin to a dialogue between intimate acquaintances. In addition, psychotherapy does not adhere to the same continuous question-and-answer structure observed in other institutional settings (see, e. g., Clayman/Heritage 2002 for question-answer-sequences in news interviews). Instead, patients are more likely to provide extended narratives (Marciniak et al. 2016, pp. 1 f.). However, some interactional practices clearly differ from those employed in ordinary conversations or other institutional interactions: For example, complaint stories are usually not met with affiliative responses and/or second stories (see Madill/Widdicombe/Barkhame 2001). Furthermore, "[u]nlike everyday conversation, it [psychotherapy] has a pre-ordained, mutually agreed and specific purpose – that is, in general terms, to improve the client's mental health" (Voutilainen/Peräkylä 2014). Other significant differences between psychotherapeutic interaction and everyday interaction are, for example, certain implicit rules. Only recently, an article by Berger and Rae drew attention to the fact that in psychotherapy, "there is a preference for gaps and pauses while immediate responses are dispreferred" (Berger/Rae 2023, p. 1). This contrasts with what we know about everyday interactions, where a delay is normally a sign of an upcoming dispreferred response (Schegloff 2009, pp. 67 f.). However, in psychotherapeutic interaction, the therapist may treat a prompt response from the patient as dispreferred because it may suggest that the patient is not

6 Of course, there are some therapies, which use different modalities, such as dance therapy or art therapy. However, in this dissertation I will only focus on psychotherapeutic approaches that use talking as the main method.

actually reflecting on a therapeutic intervention (Berger/Rae 2023, p. 24). Instead, therapists usually expect patients to think and feel carefully about something before answering, as indicated by pauses, among other things (see Berger/Rae 2023).

More generally, interactional formats in psychotherapeutic interactions are characterized by an interactional asymmetry between the therapeutic actions and the actions from the patients, whereas ordinary conversation is characterized by more symmetrical participation (Mondada 1998, pp. 156 f.). For example, in psychotherapy patients normally do not self-select (except often at the beginning of a session, depending on the different schools). Instead, their turns are usually responses to therapeutic questions or formulations. Therapists' strategic use of continuers often enable patients to do extended turns (Fitzgerald 2013, pp. 30, 33 f.). Moreover, therapists are bound by a code of ethics and procedure that defines the standards of conduct expected of them in their professional practice. They should, for example, refrain from giving advice (Fitzgerald 2013, p. 34). Typical therapeutic interventions are, for instance, questions, formulations, interpretations, and challenges (see, among others, Voutilainen/Peräkylä 2014; Weiste/Peräkylä 2015).[7] A common basic sequence observed in psychotherapy consists of the following three steps: (1) initiation (e. g., question), (2) response (e. g., answer), (3) third-position action (e. g., acknowledgement or intervention) (Peräkylä 2019, p. 258).[8]

Furthermore, external factors of the setting also influence the interaction, such as the psychotherapeutic approach being used, the type of problem the patient suffers from and the overall number of psychotherapy sessions (Fitzgerald 2013, p. 30). The restricted time frame, which is typically 50 minutes (Abrahams/Rohleder 2021, p. 66; Thomä/Kächele 2006, p. 274), and the necessity of paying a fee or submitting an insurance claim to cover the cost also affect the nature of the conversation (Marciniak et al. 2016, pp. 1 f.). Other external factors include the training and procedural guidelines that a therapist must adhere to, as well as the theoretical framework within which their actions are situated (ibid., p. 1). Peräkylä/Vehviläinen (2003) conceptualize the different psychological theories and knowledge, a therapist has in mind during psychotherapy, as "professional stocks of interactional knowledge" and argue that these stocks concern the interaction between the therapist – 'the professional' – and the patient (see also Fitzgerald 2013, pp. 4 f.).

A further distinctive aspect of this form of institutional interaction is the common practice of concluding a treatment contract at the outset of a psychotherapeutic treatment. In this contract, therapists may, for example, delineate some fundamental tenets governing their collaborative work (Abrahams/Rohleder 2021, p. 61). As an illustration, the contract may specify the consequences of the patient's cancellation of the therapy (on multiple occasions) with minimal advance notice (ibid., p. 74). Additionally, contracts can also require patients to abstain from self-harming behavior or to seek care at an outpatient clinic if there is an emergency (ibid., pp. 106 f.).

Another central characteristic of psychotherapeutic interaction is a fundamental epistemic asymmetry between the participants: "the talk mainly addresses the client's experience, which, as such, is unavailable to the therapist" (Weiste/Voutilainen/Peräylä 2016, p. 646). Since therapists have no direct access to the patients' (inner) experiences, they must gain sufficient insight to be able to work therapeutically (Fenner 2024a). Therefore, therapists and patients each have specific roles within psychotherapy: Patients, on the one hand, tell

7 This will be discussed in more detail in chapter 2.3.

8 However, especially at the beginning of a session, it is common for the patient to begin with a volunteered free association or narrative – rather than the therapist initiating such a sequence.

their story (Fitzgerald 2013, p. 6) by reporting their experiences, thoughts and feelings (Fenner 2024a). In addition, patients are expected "to enter into a therapeutic relationship and introspect and reflect on their thoughts, feelings, behaviours and social relationships" (Fitzgerald 2013, p. 8). Therapists, on the other hand, must listen empathically and reflectively without judging (ibid., p. 6). Furthermore, they need to point out underlying unconscious dynamics, as patients are (at least partially) unaware of inner processes and therefore rely on the therapists' expertise (Fenner 2024a; Fitzgerald 2013, pp. 35–40; Spranz-Fogasy/Kabatnik/Nikendei 2018, p. 112; Weiste/Voutilainen/Peräylä 2016, p. 646). This epistemic asymmetry ties in with the interactional asymmetry described earlier. Therapists, for instance, are in charge of the interaction following their interactional project (Pawelczyk 2011, p. 206). More generally, psychotherapy is "an asymmetric practice circling around the patient but steered and controlled by the professional therapist" (Worsøe/Jensen 2020, p. 282). Despite these asymmetries, both interlocutors – the therapist and the patient – work jointly on the patients' problems. Hence, psychotherapeutic interaction is an interactional accomplishment (Mondada 1998, p. 157).

Another important factor of psychotherapy is the relationship between the therapist and the patient – the so-called 'therapeutic alliance' (see chapter 2.2.1 for therapeutic alliance as a central concept in psychodynamic psychotherapy). Only if the patient trusts the therapist and feels safe, s/he will talk openly (see Pawelczyk 2011, p. 206).

The characteristics just described hold for psychotherapy in general. However, there are very different types of psychotherapy: "Each school of individual, group, or family therapy is characterized by specific theoretical ideas about mind, behaviour, and social relations, and about the ways in which these may change" (Peräkylä et al. 2008, p. 5). Since this dissertation deals with data from outpatient psychodynamic psychotherapies, I will describe this kind of psychotherapy in more detail in the following.

2.2 Psychodynamic Psychotherapy

In Germany, there is a lack of clarity regarding the terminology of psychotherapeutic treatment methods, as the term 'analytically based methods' is generally used as a generic term for analytical and analytically oriented, low-frequency psychotherapy[9] in relation to healthcare (e. g., with regard to guideline methods). In research, however, the 'Scientific Advisory Board for Psychotherapy'[10], for example, usually uses the term 'psychodynamic psychotherapy'. This term refers to various treatment methods that relate to psychoanalytic theory in terms of their disorder and change theory (Thomä/Kächele 2006, p. 38), but usually with less frequent or shorter therapies than usual in psychoanalysis (Abrahams/Rohleder 2021, p. 1). Hence, in this dissertation, psychodynamic psychotherapy refers to treatment methods that are based on psychoanalytic theory. The question thus arises as to what precisely constitutes psychodynamic psychotherapy. Abrahams/Rohleder (2021, pp. 2 f.) provide the following concise definition:

> Psychodynamic psychotherapy is distinguished from other models in that it focuses primarily on unconscious aspects of our behavior that lead to internal conflict, as well as how we experience, regulate and express our emotions in an interpersonal context, including in the therapeutic relationship […]. The focus includes identifying repeated patterns of behaving or relating to others that we adopt from childhood and then re-experienced in adulthood.

9 Also called depth-psychological psychotherapy.

10 In German *Wissenschaftlicher Beirat Psychotherapie*.

A fundamental premise of psychodynamic psychotherapy is that engaging with a client through verbal communication in a specific manner can facilitate the conscious awareness of unconscious conflicts, thereby prompting psychological transformations in the client (Fitzgerald 2013, p. 4).

Regarding the setting, in contrast to psychoanalysis, which is typically carried out up to five times per week with the patient in a supine position on a couch, psychodynamic psychotherapy usually takes place once, at the most twice, per week with the patient in a seated position (Gabbard/Crisp 2023, p. 41). Moreover, psychodynamic psychotherapy can be conducted over the long term or the short term,[11] depending on the needs of the patient.

2.2.1 Central Concepts in Psychodynamic Psychotherapy

Central concepts in psychodynamic psychotherapy are, among others, therapeutic alliance, (counter-)transference, principle of free association and resistance$_{psych}$. I will briefly introduce these concepts[12] below, with a separate chapter devoted to resistance$_{psych}$, as it is of central importance to this dissertation.

Therapeutic alliance is also referred to in the literature as working alliance, treatment alliance, and helping alliance. Sometimes, however, these terms are used more narrowly to describe certain aspects of the alliance (Horvath/Luborsky 1993, p. 561). Given the inconsistent application of these terms, I will use the term 'therapeutic alliance' in the following. In general, therapeutic alliance describes the relationship between the patient and the therapist. Hougaard (1994, p. 79) calls it an umbrella term that covers a broad set of therapeutic factors, such as mutual liking and task agreements. More specifically, it includes "three features: an agreement on goals, an assignment of task or a series of tasks, and the development of bonds" (Bordin 1979, p. 253). Numerous studies have shown that a stronger alliance is associated with a positive treatment outcome – both in psychodynamic psychotherapy and in other psychotherapeutic settings (Baier/Kline/Feeny 2020).

Another central concept in psychodynamic psychotherapy is transference. Abrahams/Rohleder (2021, p. 187) define transference as follows:

> 1. The process by which a patient transfers (or displaces) past experiences, expectations and feelings, both conscious and unconscious, on to figures and situations in their present-day life.
>
> 2. The way the patient relates to the therapist as though they were some former object in their life […]. This involves the activation of internalized object relationships that are externalized in relation to the therapist and in everyday relationship.

Transference is also an important aspect of achieving change in psychotherapy: Through the transference with the therapist, patients become aware of the problematic patterns that need to be changed (Abrahams/Rohleder 2021, p. 187). In contrast, countertransference describes the therapists' responses to the patients' transference, or, in other words, the

11 There is a variety of definitions regarding the exact duration of long-term and short-term psychodynamic therapies. According to one definition provided by Gabbard/Crisp (2023, p. 41), long-term psychodynamic psychotherapies last more than 24 sessions or longer than 6 months, whereas short-term psychodynamic psychotherapies entail up to 24 sessions or last less than 6 months.

12 In the limited scope of this paper, it is not possible to go into more detail and discuss further concepts. A good overview of these and other concepts is provided by Abrahams/Rohleder (2021), Gumz/Hörz-Sagstetter (eds.) (2018), and Thomä/Kächele (2006), among others.

patients' material,[13] including their feelings, thoughts and behavior in relation to the patients (Abrahams/Rohleder 2021, p. 196; Gumz/Storck 2018, p. 47). Therefore, therapists need to be self-reflective and aware of their emotional reactions to the patients (Abrahams/Rohleder 2021, p. 196). Countertransference feelings should help to recognize, understand, and change the patient's transference expectations through an alternative emotional experience with the therapist (Gumz/Storck 2018, p. 47). It is sometimes posited that transference is not explicitly worked on but only observed in analytically oriented, low-frequency psychotherapy (Jaeggi/Riegels 2008, p. 62). However, this view is controversial in the literature (see, e. g., Jaeggi/Riegels 2008, p. 74).

Finally, the principle of free association is another central concept of psychodynamic psychotherapy. It entails that patients are encouraged to verbalize their thoughts and feelings without any form of censorship or pre-established objective (Abrahams/Rohleder 2021, p. 169). In practice, patients typically commence their sessions by focusing on a specific topic. They are then encouraged to pursue their thoughts freely, typically by extending associations to earlier material. During this process of freely associating, thoughts, images, or memories that were previously outside their conscious awareness may emerge. However, free association may be a challenging process for patients, as it challenges the conventional norms of conversational conduct and can therefore feel unnatural or unfamiliar (ibid., p. 170).

2.2.2 Resistance in Psychodynamic Psychotherapy

Resistance$_{psych}$ in psychodynamic psychotherapy is very different from resistance in, for example, everyday interactions. The concept of resistance$_{psych}$ in psychodynamics dates back to Freud. He said, "whatever disrupts the continuation of the work is resistance" (Freud 1900, p. 521 [translated by the author]). Greenson (2016, pp. 59 f.) defined resistance$_{psych}$, inspired by Freud's definition, as

> [a]ll forces within the patient which oppose the procedures and processes of analysis, i.e., which hinder the patient's free association, which interfere with the patient's attempts to remember and to gain and assimilate insight, which operate against the patient's reasonable ego and his wish to change.

Acts of resistance$_{psych}$ can be interpreted as an attempt to maintain the status quo (Newman 2002, p. 174), even if it is dysfunctional and causes suffering, for example in the form of symptoms. This is undertaken unconsciously to circumvent the distressing emotions that may accompany a change, as well as feelings of being overwhelmed or distressed (Storck 2021, p. 30). Nevertheless, it would be erroneous to simply view resistance$_{psych}$ as a negative phenomenon. Rather, it has the potential to serve as a valuable source of knowledge (Messer 2002; Storck 2021, p. 33; see also Vehviläinen 2008, p. 120).

Freud distinguishes between three types of so-called 'ego resistance': displacement resistance, transference resistance and resistances emanating from the disease gain.[14] There are also two other types of resistance$_{psych}$, namely 'it resistance' (also known as unconscious resistance) and 'superego resistance', which is a kind of self-punishment and therefore prevents change. In principle, all of the patient's behaviors can be interpreted as resistance$_{psych}$. However, whether something counts as resistance$_{psych}$ depends on the degree of intensity

13 The term material is used in psychotherapy for everything that a patient 'offers' explicitly and implicitly, that is, verbal and embodied behavior, but also their clothing, etc. (see Thomä/Kächele 2006, p. 21).

14 For a more detailed description of the individual resistance$_{psych}$ types, see Storck (2021, p. 84).

of the behavior in question (Thomä/Kächele 2006, p. 120). There are obvious acts of resistance$_{psych}$ – such as arriving late for a session – and much more subtle ones, such as agreeing with the therapist without giving it much thought (Abrahams/Rohleder 2021, p. 146).

It is important to differentiate between resistance$_{psych}$ and defense, even though the two terms are often used interchangeably (Thomä/Kächele 2006, p. 124). Thomä/Kächele (ibid.) propose that resistance$_{psych}$ manifestations are observable, whereas defense processes can only be inferred, because they are not directly observable. It is also noteworthy that the concept of resistance$_{psych}$ is associated with the theory of treatment technique, whereas the concept of defense is linked to the structural model of the psychic apparatus (see van der Leeuw 1965).

It is the task of the therapist, particularly during the initial stages of establishing a therapeutic alliance, to identify and address the patient's resistance$_{psych}$, so that the patient becomes aware of his/her resistance(s)$_{psych}$ (Sandler et al. 2018, p. 118). Recognizing resistance$_{psych}$ can be challenging, especially in the case of subtle and complex forms of resistance$_{psych}$ (Greenson 2016, p. 113) and in view of the importance of free associations (described above). To avoid causing even more resistance$_{psych}$ in the patient, it is important to be aware of when and how to address it (Abrahams/Rohleder 2021, p. 147).

Over the past four decades, there has been a "corrective movement", as Schwartz (2012, p. 401) notes referring to Green (2000), towards a more interactional and relational concept of psychoanalysis. More contemporary theories re-conceptualized resistance$_{psych}$ as an interactive process (see, among others, Grabhorn et al. 2005, p. 471; Mitchell 1997; van Denburg/Kiesler 2002). As Schwartz (2012, p. 401) notes, this interactional perspective has always been deeply embedded in psychoanalysis; however, it has been inadequately conceptualized.

Recent trends in the field include the conceptualizations of resistance found in intersubjective and relational psychoanalysis[15] as well as self psychology, and object relations theory[16], which I will outline briefly in the following: Resistance in intersubjective psychoanalysis (see Atwood/Stolorow 2014; Stolorow 2013) and relational psychoanalysis (see Mitchell 1997) is defined as "mutually constituted efforts by patient and analyst to create and maintain nonprogressive interactive dynamics" (Gerson 1996, p. 632). Consequently, the resolution of resistance is only possible by the joint work and achieved understanding of both the therapist and the patient (ibid.). In more general, resistance is based on a fear of the repetition of traumatization suffered in early relationships (Hagman/Weil 2018, p. 52). Such resistance is also called "intersubjective resistance" (Gerson 1996, p. 632; 2004, p. 65) in intersubjective psychoanalysis. In contrast, self psychology (see Kohut/Ornstein (eds.) 2011) conceptualizes resistance as a protection of the self: Resistance occurs when the patient fears that the relationship with the therapist could again be disappointing or hurtful – similar to previous relationships. Thus, resistance is the patient's attempt to protect him-/herself against repeating traumatic experiences (Rowe 1996, p. 69). Moreover, "resistances in self psychology are considered to be efforts at maintaining levels of organization which provide security to an enfeebled self" (ibid., p. 73). In object relations theory (see Greenberg/Mitchell 1983), resistance can be defined as an unconscious manifestation of the fear that early relationship experiences (so-called 'bad objects'), which were painful or dangerous, may be repeated in the therapeutic relationship (Celani 2010, pp. 48, 78). "[S]uch bad objects can only be safely released if the analyst has become

15 Both approaches are very similar and do not differ fundamentally in terms of the concept of resistance, so I will combine them here.

16 Object relations theory developed from the interpersonal theory.

established as a good object for the patient" (Buckley 1996, p. 52). Success, then, is a two-fold process: giving up the bad object and replacing it with the good object (Buckley 1996, p. 52).

To sum up, all these approaches emphasize the relationship and interaction between therapist and patient. However, the therapists in my data (see chapter four) tend to be taught the traditional view of resistance. Nevertheless, the results of my dissertation show, that they rarely use resistance-specific psychoanalytic techniques, such as interpreting the resistance or relating the subject at hand to the therapeutic situation. Moreover, the data selection process in the first part of the project (see chapter 3.1), which this dissertation is part of, was largely informed by the traditional perspective.

2.3 Conversation Analysis and Psychotherapy

The field of CA has engaged with the study of psychotherapeutic interactions particularly since the early 2000s. Over the past 15 years, a substantial body of literature has emerged on this topic. However, there are different approaches: While some studies focus on the (1) patients' actions, most of them consider the (2) therapists' actions. Some others specifically observe (3) the relationship between therapists and patients and (4) so-called 'transformative moments' or moments of change. A small number of studies also deals with (5) changes in the longitudinal course. The respective fields, which may overlap and do not represent distinct categories, will be discussed in more detail below. My aim is to provide a concise overview, but I make no claim to completeness.

1. For the patient's actions, a distinction is made between initiative (i.e., first position) and responsive (i.e., second or third position) actions. Initiative actions can take the form of questions (Yadlin et al. 2022). These can be of special interest, because they "may raise theoretical and technical challenges for clinicians" (ibid., p. 126) and are mostly neglected in the psychoanalytic literature (ibid.). Such questions can, for instance, target the psychotherapist's life or his feelings and thoughts. Taurogiński et al. (2023) describe another initiative action: the composition of patients' complaints in couple therapy and their delivery. Other initiative actions include, for example, distress displays (Muntigl et al. 2023). Patients' responsive actions have been examined more frequently than their initiative actions. Such responsive actions can be, for example, extended agreements (Bercelli/Rossano/Viaro 2008), elaborations (Peräkylä 2008), or silence (Berger/Rae 2023). Moreover, some studies focus on responses to a specific type of therapeutic action, for example, resistant responses to therapists' questions (MacMartin 2008; Yao/Ma 2017), defensive responses to topicalizations of prior action(s) (Vehviläinen 2008), and responses to therapeutic interpretations (Peräkylä 2005).
2. Therapeutic actions can also be distinguished based on their initiating (i.e., first position) or responsive (i.e., second or third position) nature. With regard to initiating actions, questions have been examined quite extensively so far (see, among others, Cantwell et al. 2022; Kabatnik et al. 2022; Lester et al. 2023; Muntigl/Horvath 2023; Spranz-Fogasy et al. 2020; Spranz-Fogasy et al. 2023). This is certainly owing to the fact that questions are a central resource in therapeutic conversations. Other initiative therapeutic actions like directives, for example, have received only limited analytic attention (Smoliak et al. 2022). To date, there has been a greater focus on examining responsive therapeutic

actions. Formulations (see, among others, Antaki/Barnes/Leudar 2005; Davis 1986; Scarvaglieri 2015; Weiste/Peräkylä 2013; Weiste/Voutilainen/Peräylä 2016; Wolff/Meier 1995), interpretations (see, among others, Stukenbrock/Deppermann/Scheidt 2021; Vehviläinen 2003; Voutilainen/Peräkylä/Ruusuvuori 2010b; Weiste/Voutilainen/Peräylä 2016), and showing empathy (see, among others, Muntigl 2023; Muntigl et al. 2014; Nissen Schriver et al. 2022; Voutilainen 2012; Henttonen et al. 2018; Wahlström 2023; Weiste/Peräkylä 2014; Wu 2019, 2022) are among the most widely discussed response types. Other responsive actions that have been studied include, for example, confirming critique (Voutilainen/Peräkylä/Ruusuvuori 2010a), shifting the focus to the patient's self (Guxholli/Voutilainen/Peräkylä 2022), delayed responses (Voutilainen/Koivisto 2022), minimal response tokens or even the lack of those (Wolff/Meier 1995), or repeating what the patient just said (Ong/Barnes/Buus 2024). One important study for this dissertation is Yao/Ma's (2017) investigation of how therapists manage patients' resistance to therapeutic questions through persistent asking. Yao/Ma (2017) address instances of resistance, which I examine in greater detail: remaining silent, making non-answer responses such as claims of not-knowing, and being over-talkative. There is also some overlap in our findings regarding the therapeutic management of these resistant reactions: In my data, too, therapists often respond with further questions (see chapter 6.2). Nevertheless, there is a paucity of research examining how therapists manage potential resistance phenomena and whether they treat the various phenomena as resistance.

3. The therapeutic relationship is also of special interest in the literature, as it is a crucial factor in the effectiveness of psychotherapy (Muntigl/Scarvaglieri 2023, p. 2). Muntigl/Scarvaglieri (2023) provide a review of interactional studies examining this relationship. Such studies focus on different aspects of this relationship, for example, (dis-)affiliation (see, among others, Muntigl 2022, 2023; Muntigl et al. 2014; Pawelczyk/Faccio 2022), (dis-)alignment (Guxholli/Voutilainen/Peräkylä 2022; Muntigl/Horvath 2014; Scarvaglieri 2020), empathy (see above and Alder et al. 2016), disaffiliation-repair-sequences that are rupture-repair-sequences (Cardoso/Pinot/Ribeiro 2020; Guxholli/Voutilainen/Peräkylä 2021; Muntigl et al. 2013), and implicit relationship comments (Alder 2020).

4. Of particular interest are also so-called transformative moments. Such moments of change are important because the "[p]sychotherapy process, in any psychotherapeutic approach, is about transformation of experience" (Peräkylä 2019, p. 265). Most research aims at identifying such moments and how transformation is achieved sequentially (see, among others, Herrera et al. 2023; Ma et al. 2022; Peräkylä 2019; Scheidt/Stukenbrock/Deppermann 2024). Pawelczyk/Graf (eds.) (2019) even published a special issue on understanding change in psychotherapy in which such transformative moments are discussed from different perspectives.

5. In psychotherapy, it is not only the occurrence of change that matters, but also the manner in which change occurs over the course of the therapeutic process. This is the subject of longitudinal studies (Bekkeli 2019; Bercelli/Rossaro/Viaro 2013; McVittie/Craig/Temple 2020; Peräkylä 2011; Voutilainen/Peräkylä/Ruusuvuori 2011; Voutilainen/Rossano/Peräkylä 2018; Rossano et al. 2018). However, such studies remain scarce, given the considerable time investment required for longitudinal studies, particularly for those involving long-term psychotherapies.

A more detailed and comprehensive overview of CA as an analytic tool for studying psychotherapeutic interaction can be found in Buchholz/Kächele (2013), Fitzgerald (2013), Madill (2015), Madill/Widdicombe/Barkhame (2001), Muntigl (2023); Peräkylä (2012), Peräkylä et al. (eds.) (2008), among others.

With the presented state of research in mind, this dissertation primarily focuses on the actions of the patients. However, in order to provide a comprehensive analysis, it is essential to consider the therapeutic actions that precede and follow these patients' actions as well.[17] The focus is on how possible forms of resistance are carried out and treated by both participants – the patient and the therapist. It is therefore necessary to take a closer look at previous CA studies on resistance and especially on resistance phenomena in psychotherapy.

2.4 Resistance in Conversation Analysis

CA has a different understanding of resistance$_{CA}$ than does psychodynamics. As explained above, psychodynamics typically conceptualize resistance$_{psych}$ as a counterforce in the patient. In contrast, according to CA, "resistance emerges as the alternative to cooperation and therefore [...] resistant actions are designed to deal with the sequential and moral accountabilities that arise from the specifics of the situation" (Humă/Joyce/Raymond 2023, p. 497). Hence, resistance$_{CA}$ is nothing *in* a person but something that becomes observable on the interactional surface. Humă/Joyce/Raymond (ibid., p. 499 [emphasis in original]), who provide a comprehensive literature review of resistance$_{CA}$ in talk-in-interaction, summarize it as follows: "resistance emerges as a form of action deployed in and as part of a *sequence* of actions".

Similar to resistance$_{psych}$ in psychodynamics, resistance$_{CA}$ can also take very different forms. This depends, among other things, on the specific entity to which the resistance$_{CA}$ is directed: an interlocutor's project, some prior action, or a specific aspect of a prior action (Humă/Joyce/Raymond 2023, p. 501). However, resistance$_{CA}$ always "entail[s] participants (temporarily) suspending their cooperation in the joint 'definition of the situation'" (ibid.; see also Goffman 1956, p. 51). Berger/Rae (2023) contradict this notion and argue that silence – which is associated with dispreferred responses in mundane talk-in-interaction – is often associated with preferred responses in psychotherapeutic interactions. Conversely, therapists often treat patients' prompt responses as inappropriate. In general, however, resistant$_{CA}$ actions can be associated with the concept of *disalignment* (see Steensig 2019; Stivers 2008), because disalignment is briefly defined as a lack of cooperation, a rejection of the activity or sequence in question, and a refusal to accept presuppositions that underpin it (Steensig 2019, pp. 1 f.). It bears reiterating that resistance$_{CA}$ is not merely a matter of *dispreference* or *disalignment*. To characterize an action as resistance$_{CA}$, it is essential to consider not only the action itself but also the manner in which the interlocutors receive it. For an action to be regarded as resistance$_{CA}$, the interlocutors must perceive it as such, whether explicitly or implicitly.

Humă/Joyce/Raymond (2023, pp. 505–512) distinguish between four kinds of resistant$_{CA}$ practices, depending on their sequential positioning and how they are realized.

1. Immediately after the completion of an initiating action, a response is required. If this does not occur, silence ensues. Humă/Joyce/Raymond (ibid., pp. 505 f.) call this "the simplest ways of resisting". In addition, in instances in which the recipients' affiliation is relevant, the lack of such affiliation can be seen as a

17 See for the *next-turn proof procedure*, among others, Sacks/Schegloff/Jefferson (1974, pp. 728 f.).

form of resistance$_{CA}$. Similar to silence, the lack of an embodied response can convey resistance$_{CA}$. Moreover, acknowledgement tokens can be used to accomplish resistance$_{CA}$, especially when they function as a continuer, although the preferred action would have been a completion of the sequence launched by the initiating action.

2. The turn-initial slot of a second pair part provides speakers with the opportunity to indicate their stance towards the first pair part and show, for example, resistance$_{CA}$. According to Heritage (2013b, p. 331), turn-initial objects have "'expectation canceling' functions" and can be used "to resist the constraints on second position speakers arising from first positioned turns". One turn-initial practice for doing resistance$_{CA}$ are well-prefaces, which may indicate that the answer will be expanded and will deviate from the expectations initially set forth by the initiating action. Similarly, the repetition of prefaces in responsive actions may be employed as a means of resisting$_{CA}$, for example, the agenda, presupposition, or implication of the initiating action (Humă/Joyce/Raymond 2023, pp. 507 f.).
3. Speakers also have the opportunity to resist$_{CA}$ while responding through elements later in the turn or the turn as a whole. Prosodic resources or laughter may, for instance, be interpolated in a turn to convey subtle resistance$_{CA}$. Resistance$_{CA}$ can also be displayed more explicitly through misaligning or dispreferred responses. Examples for the latter are rejections, refusals or disagreements (ibid., pp. 508–510). Humă/Joyce/Raymond (ibid., p. 510) argue, "that while resistance can be accomplished via any dispreferred responsive action, not all dispreferred responses are also resistant ones", because it depends on how the participants treat the dispreferred response.
4. Last but not least, speakers can resist$_{CA}$ without responding to the prior turn by making a response from another interlocutor relevant instead: "These actions do not only momentarily suspend the progressivity of the ongoing activity, but they can also temporarily or permanently divert the trajectory of the interaction" (ibid.). Such practices can be, for example, other-initiated repair, an action the prior action did not make conditionally relevant, or initiating a new and competing course of action (see Küttner 2020, p. 248 on 'sequential junctures').

Up to now, conversation analysts have analyzed resistance$_{CA}$ across various forms of interaction, including a range of institutional contexts, such as news interviews (see Clayman 2013) and medical settings (see, among others, Gill/Pomerantz/Denvir 2010; Heritage/Sefi 1992; Koenig 2011).

2.5 Conversation Analysis on Resistance Phenomena in Psychotherapy

While some authors have already addressed the topic of resistance within the context of CA research on psychotherapy, there is no systematic investigation of (potential) resistance phenomena in psychotherapeutic interactions. Moreover, some studies use the term resistance without further conceptualization or classification and apply it indiscriminately to different psychotherapeutic settings. In the following, I will provide a brief overview of CA studies on resistance$_{CA}$ in psychotherapy. Since there are only very few studies with a specific focus on psychodynamic psychotherapy, I will extend the scope of this review to encom-

pass all types of psychotherapy (e. g., cognitive behavioral therapy, couples therapy, group therapy, etc.). It is important to note, however, that the concept of resistance$_{psych}$ as employed in psychodynamic approaches may not necessarily correspond to how other forms of therapy conceptualize resistance.

Resistance$_{CA}$ has been studied as a reaction to different therapeutic actions, for instance, formulations (see, e. g., Antaki 2008; Antaki/Barnes/Leudar 2004; Madill/Widdicombe/Barkhame 2001), interpretations (see, e. g., Bercelli/Rossano/Viaro 2008; Ekberg/LeCouteur 2015; Peräkylä 2005; Vehviläinen 2008), and questions (see, e. g., MacMartin 2008; Muntigl 2013; Muntigl/Choi 2010). In general, however, little attention has been paid to the special features of the actions that sequentially precede resistance$_{CA}$ phenomena.

In addition, researchers describe communicative practices of both active and passive resistance$_{CA}$. The latter consists, for example, in the absence of a response (see Yao/Ma 2017), minimal speech contributions (see Muntigl/Zabala 2008; Peräkylä 2005), topic avoidance, evasion of the therapeutic agenda or presupposition (see MacMartin 2008; Muntigl/Zabala 2008; Peräkylä 2005), unspecific or vague statements (see Muntigl/Zabala 2008; Schedl et al. 2018), and sarcastic comments (see MacMartin 2008). Active resistance$_{CA}$, by contrast, can manifest itself in the verbalization of ignorance (see Hutchby 2002; MacMartin 2008; Muntigl 2013; Muntigl/Zabala 2008) or not remembering (see Muntigl/Choi 2010).

Instead of focusing on one or several resistance$_{psych}$ phenomena, some authors examine the development of (non-)resistance$_{psych}$ over the course of a session. Avdi/Evans (2020), for instance, conducted such a case study and observed that the patient exhibits alternating resistance$_{psych}$ and temporary affective insight. During the later course of the session, the therapist made more active interpretations of resistance$_{psych}$ than at its beginning. In general, however, the therapist maintained an affiliative and empathic attitude in conjunction with more challenging therapeutic work.

Other authors are more critical towards the concept of resistance$_{psych}$. Keselman et al. (2018), for instance, analyze sessions from brief relational therapy (BRT), which is based on relational psychoanalytic concepts. In the examined excerpts, the therapist invites the patient to mentalize[18] about her situation or their therapeutic interaction, but the patient resists (partly). The authors show that the patient nevertheless mentalizes implicitly – even if she refuses to do so explicitly. Hence, they conclude that what looks like resistance on the surface is not necessarily resistance at all upon closer inspection. One limitation of this study is that the authors do not explicitly clarify which conceptualization of resistance – CA or psychodynamic – they are working with. However, such studies illustrate that resistance is not the same in both disciplines – CA and psychodynamics. This may pose difficulties for interdisciplinary work. I will go into this in more detail in the discussion (chapter 7.2 and 7.3).

18 "Mentalization encompasses a complex set of functions, competences, and behaviors that concern the capacity to reflect on and attend to one's own and other people's thoughts and feelings" (Keselman et al. 2018, p. 654). A distinction is often made between implicit and explicit mentalization. The former refers to "a procedural capacity to understand one's own and other people's affective states through body posture, facial mimicry, and gestures" (ibid.), whereas the latter comprises "the conscious and verbal capacity to attend to and reflect upon feelings and thoughts" (ibid.).

2.6 Conversation Analysis on Resistance Management in Psychotherapy

Patients' resistant actions open up a structural position in which the therapist must deal with the patient's reaction (see Peräkylä 2011 for third positions). Drawing on Vehviläinen's (2008) work, I will refer to the therapeutic handling of the patient's resistance as "resistance management". Vehviläinen (2008) analyzed fifty-six audiotaped psychoanalytic sessions involving three dyads and examined therapeutic strategies for focusing on the patient's actions in the here-and-now of the therapy session. She shows how therapists can address resistance – mostly without calling a patient's action 'resistant'. Therapists can address resistance implicitly, for instance, through reformulations of the patient's statements to reframe the patient's previous utterance in particular ways. However, therapists can also reformulate what they have already said to repair a misunderstanding and to clarify what they had initially meant, thereby indicating that the patient's response does not meet the requirements of the therapeutic action (see, e. g., MacMartin 2008, p. 92; Muntigl et al. 2013, p. 10; Yao/Ma 2017, pp. 228 f.). Other strategies therapists have been shown to use in order to address resistance implicitly are, for example, successive, partly reformulated or recycled[19] questioning (see, e. g., MacMartin 2008, p. 92; Yao/Ma 2017, pp. 227 f.), expansion initiations (see, e. g., Läpple et al. 2021, pp. 61–108), repair initiations (see, e. g., Läpple et al. 2021, pp. 109–133), topic changes (see, e. g., Läpple et al. 2021, pp. 134–151), therapeutic wait-and-see tactics (see, e. g., Muntigl/Zabala 2008, p. 198), and humor (see Jeffrey 2009). However, therapists might also use more confrontational strategies, such as overtly criticizing the patient's conduct through thematizations of resistance (see, e. g., Muntigl 2013; Muntigl/Zabala 2008; Vehviläinen 2008; Yao/Ma 2017). Studies have shown that such explicit strategies can have a negative impact on the further course of the conversation and the therapeutic alliance (see Muntigl 2013; Muntigl et al. 2013; Weiste 2015). Nonetheless, Vehviläinen (2008) recommends using confrontational strategies if other more implicit interventions remain unsuccessful, if patients do not show any willingness to cooperate, or if they consistently show systematic resistance.

3. Method

3.1 Interdisciplinary Project

This study is part of the interdisciplinary project *Linguistic Manifestations of Resistance in Psychodynamic Psychotherapy*, funded by the German Research Foundation (DFG; grant ID 445514280) and co-implemented by the Leibniz Institute for the German Language (IDS) and the Department of General Internal Medicine and Psychosomatics, Heidelberg. The project leaders are Prof. Dr. Arnulf Deppermann (IDS) and Dr. Inka Montan (Heidelberg University Hospital). The objective of the project was to identify and operationalize resistance phenomena in order to systematically assess resistance qualities (techniques) and resistance quantities (intensity). Additionally, the project aimed to investigate the relationships between resistance$_{psych}$ phenomena and the characteristics of the patient, the therapist, the therapeutic process, and the treatment outcome. Therefore, a psychologically and linguistically based typology of resistance$_{psych}$ phenomena had to be developed (Deppermann/Montan 2018, p. 5; Montan et al. subm.). The project went through three major phases, which I will delineate in the following.

19 Recycled questions incorporate material from patients' prior disaffiliative turns in such a way that acknowledge this resistant material in the reissued question (MacMartin 2008, p. 93).

1. In the initial phase of the project, four psychotherapists[20] identified instances of resistance$_{psych}$ within a subset of the data. Then, they passed these cases on to the conversation analysts. However, they only told the conversation analysts the time stamp in the video and not what constituted the resistance$_{psych}$. The conversation analysts could thus transcribe and analyze the corresponding video excerpts without being biased. They focused specifically on four key constituent stages: a) therapist actions that elicit resistance$_{CA}$, b) resistance$_{CA}$ manifestations, c) therapeutic modalities of intervention in the context of resistance$_{CA}$ management, and d) subsequent patient reactions to therapeutic interventions. Then, both disciplines compiled and discussed the results in joint data sessions (Deppermann/Montan 2018, p. 8). In our corpus (described in more detail in chapter 4), the four psychoanalysts identified 103 resistance$_{psych}$ sequences. 16 of these sequences could not be confirmed as instances of resistance$_{CA}$ from a conversation analytic perspective.
2. In light of the identified resistance phenomena, the research group devised a rating tool to systematically record both the qualitative and quantitative aspects of resistance (see Appendix, Figure 3). Qualitative aspects pertain to the linguistic and interactional manifestations of resistance, whereas quantitative aspects encompass the frequency and intensity of the respective act of resistance (Deppermann/Montan 2018, p. 8; Montan et al. subm.).
3. Subsequently, we conducted longitudinal analyses to examine the development of resistance. On the one hand, we performed conversation analytic case studies, on the other hand, the psychological project team evaluated the frequency and intensity of resistance phenomena throughout the course of psychotherapeutic treatment in relation to patient, therapist, and treatment characteristics (Deppermann/Montan 2018, p. 9).[21]

The studies collected in this dissertation were conducted at different stages of the project. The three articles on individual potential[22] resistance phenomena (verbosity, claims of not-knowing, silence) emerged from phase 1), which included a comprehensive conversation-analytic examination of the resistance phenomena observed in the data. It is important to note that the analyses and results of these studies have also been incorporated into the category system developed in phase 2). I wrote the fourth article in this thesis in phase 3) of the project. It consists of a case study that examines the development of resistance$_{CA}$ over the course of a therapeutic treatment.

3.2 Conversation Analysis

The project as a whole employs an interdisciplinary approach. However, in the context of my dissertation, I exclusively utilize conversation analysis (CA) as a research method. While CA represents a more general approach to the study of human social interaction, and is not based on or associated with any particular theory of psychotherapy, it has been

20 Some of the psychoanalysts had prior work experience, while others were still in training.

21 As the results of the quantitative studies are still pending, it is not yet possible to compare the qualitative results (presented below) with the quantitative results as part of this dissertation.

22 I intentionally refer to them as *possible* resistance phenomena, since the phenomena per se do not in and of themselves represent resistance. They only become interpretable as 'resistance' in relation to specific contexts.

proven as an effective method for investigating psychotherapeutic interactions qualitatively (Weiste/Peräkylä 2015, p. 4). In what follows, I will explicate this method in greater detail.

CA emerged as an independent field of research from the social sciences in the 1960s and 1970s. It is based on ethnomethodology[23] as developed by Harold Garfinkel. Harvey Sacks, Emanuel A. Schegloff, and Gail Jefferson are considered the founders of CA.[24] Sacks and Schegloff were students of Erving Goffman at the University of California (Heritage/Clayman 2010, p. 12). Goffman also studied social interaction and his studies were seminal for the development of CA (ibid., pp. 8 f.). Central to the development of CA was a reversal of the old social science perspective that individual actions are inherently disordered and that their patterns could only by approximated by statistics. Instead, Sacks and Schegloff insisted that social interaction is orderly at the individual level (ibd., p. 12). Initially only applied in the USA, CA spread geographically at the beginning of the 1970s (Bergmann 2012, p. 214). Despite its initially controversial status due to its rigorous empirical orientation and its strong focus on the structural level of interaction, CA has in the meantime developed into a common approach in linguistics, sociology, and communication studies (Stivers/Sidnell 2012, p. 1). CA has also found its way into other sciences, such as anthropology and psychology (ibid., p. 3).

The aim of CA is to investigate how people constitute their reality through talk-in-interaction and which implicit rules underlie successful communication. The objective of the research approach is therefore to identify mechanisms and principles that underlie social interaction (see, among others, Clift 2014; Heritage 1995). To put it in the words of Goodwin/Heritage (1990, p. 283), CA "seeks to describe the underlying social organization – conceived as an institutionalized substratum of interactional rules, procedures, and conventions – through which orderly and intelligible social interaction is made possible". From its very inception, CA has been used to study both mundane, everyday talk, as in so-called *ordinary conversations* (Heritage/Clayman 2010, p. 15), as well as talk in institutional settings (see, e. g., Sacks 1966).

When it comes to actual analysis, CA poses two questions about any action: *why that now*? (Schegloff/Sacks 1973, p. 299) and *what is next*? (see Sacks/Schegloff/Jefferson 1974, pp. 728 f. for the *next-turn proof procedure*). To address these questions, CA examines the action in question in relation to the preceding action(s), as well as its projected impact on subsequent action(s) (Heritage/Clayman 2010, p. 14). This procedure relates to the following fundamental assumptions of CA: First of all, "turns at talk are context-shaped" (ibid.). This means that turns are typically oriented towards previous points in the conversation, predominantly the immediately preceding utterance(s). Moreover, "turns at talk are context-renewing" (ibid.), that is, speakers typically indicate the relevance of a specific subsequent action or series of actions to be undertaken by a subsequent speaker. Finally, "[b]y the production of next actions, speakers show an understanding of a prior action and do so at a multiplicity of levels" (Heritage/Clayman 2010, p. 15). Thus, sequentiality contributes to establishing intersubjectivity.

More generally, CA is a qualitative and inductive approach. The researcher should not have any expectations or precise ideas of possible results at the beginning, but should proceed in a material-oriented manner and always be open to new ideas. This understand-

23 For an overview of ethnomethodology, see, among others, Garfinkel (2023) and Heritage (2013a).

24 The correct name for the method is *ethnomethodological conversation analysis* (short: *EMCA*). Because it is commonly referred to as *conversation analysis* and because this is more readable, I will use the term *conversation analysis* (short: CA) here.

ing of empirical research requires that questions and hypotheses need to be developed from the empirical data (see, among others, Deppermann 2008, p. 11; Stivers/Sidnell 2012, p. 2). Of course, the results of previous research, both basic and applied research, are usually incorporated. Furthermore, every interaction is context-bound (as discussed previously), which is why individual elements should be considered in a situated way (Schegloff 1992, p. xviii).[25]

As conversations are fleeting events, they must be audiovisually recorded for analysis, with the sequence of events and details preserved, as they are of great importance for later analyses. Conversation analysts then transcribe the data to make them intersubjectively comprehensible and accessible to others, such as the reader of an article.[26] At the same time, the transcription is already part of the analysis, as the data is studied intensively and a selection of the elements to be transcribed is made (especially in multimodal CA, which will be explained below). No element of conduct in the conversation, such as a slip of the tongue, should be omitted from the written record, even if it initially seems unimportant.[27] This is due to the underlying principle of CA, which posits that each constituent element of the interaction is subject to analysis and that no element can a priori be regarded as non-significant or random. Consequently, an analysis in the sense of the hermeneutic circle should be indefinitely repeatable and intersubjectively comprehensible (Deppermann 2008, pp. 21 f., 301; Schegloff 1992, p. xxx).

Earlier CA studies typically relied on audio-only recordings of spoken interactions (Mondada 2018, pp. 85 f.). Since the beginning of the 21st century, however, the number of conversation-analytically oriented studies that use video recordings to investigate the coordination of the various resources used by the participants to organize the interaction has steadily increased, and multimodal CA has become an established and methodologically elaborated field of research (see Deppermann 2013). Today, audio recordings are only used for telephone calls and, in exceptional cases, for settings that do not allow video recordings at all (e. g., for data protection reasons) (Mondada 2012, p. 39). For most other settings, video recordings are preferred nowadays. Mondada (2018, p. 86) states that

> [w]hat is distinctive about CA's use of video is the careful and precise attention paid to temporally and sequentially organized details of actions that account for how coparticipants orient to each other's conduct and assemble it in meaningful ways, moment by moment.

Moreover, video recordings allow for the analysis of embodied actions, such as gaze, gesture, body postures, and manipulations of artifacts, alongside the analysis of talk and verbal actions. This is important, since the primary object of CA is not language, but rather (social) action[28] (Mondada 2018, p. 86; see also Sacks 1984).[29]

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25 An overview of the basic assumptions in CA, how to work conversation analytically and key topics in CA give, among others, Sidnell/Stivers (eds.) (2012) in *The Handbook of Conversation Analysis*, which is well-known among conversation analysts. Other well-established introductory publications are written, for example, by Goodwin and Heritage (1990) and ten Have (2011) in English as well as Deppermann (2008) for German-speaking students and researchers.

26 In anglophone countries, it is common to use the transcription system developed by Jefferson (2004). In contrast, GAT 2 (Selting et al. 2009) is generally the preferred system in German-speaking countries.

27 It should be noted that "transcription is at best an approximation to the recorded data" (Heritage 1995, p. 395) and never replaces the actual data.

28 For which, of course, language is an important resource (Mondada 2018, p. 86).

29 In the meantime, several transcription systems have been developed that can be used for multimodal transcription. However, the Mondada system (see Mondada 2018) is the best known and is predominantly used (in various languages).

The studies collected in my dissertation generally employ the methodology of CA as described. However, I had to make a few adjustments, which I would like to explain briefly: In contrast to traditional ethnomethodological CA, I did not record the data myself. Instead, the therapist holding the session, who set up a camera with an integrated microphone, recorded the data. As the data was recorded prior to the commencement of the project, it was not possible to provide instructions regarding the optimal positioning of the camera. Consequently, each therapist selected the position of the video camera independently, with each session filmed from a distinct angle. In some instances, both the patient and the therapist are fully visible from the side. In other instances, only one of the two individuals is visible, and in yet other cases, only specific body parts are caught on camera. Unfortunately, the use of a 360° camera (see vom Lehn 2021, p. 307) or separate microphones was not feasible, resulting in a lower quality of the recorded data. Nevertheless, the quality was sufficient to enable all analyses to be carried out effectively. However, when examining gaze behavior, the analysis occasionally had to rely on head movements to infer gaze direction. Furthermore, multimodal analyses were not possible if the individuals in question were not visible within the video frame. The advantage of initiating the project with the videos already recorded was the immediate availability of data.

Given the considerable amount of recorded data (see chapter 4), it would have been impractical to transcribe the entirety of the material. We therefore prepared conversation protocols that outline the agenda of each therapy session and only transcribed video excerpts that were selected for more comprehensive analysis.

With regard to the article on silence, I would like to briefly explain the following methodological considerations. I have defined silence as any absence of vocal sounds, including audible breathing, clearing of the throat, coughing, laughing, etc. as all these can also be forms of expressions. In addition, I considered a turn to be completed when it is syntactically complete, an intonation phrase is completed and/or the turn is passed by means of gaze behavior (see Fenner 2024b).

4. Data

The data for the four studies collected in this dissertation consist of videotaped outpatient psychotherapy sessions (each approximately 50 minutes long) involving 30 patients (19 females, 11 males) and 27 therapists (22 females, 5 males) who were still in training. They were drawn from a large collection of videotaped data from the *Heidelberg Institute for Psychotherapy* (HIP), a psychodynamic psychotherapy training institute at the Heidelberg University Hospital (see Schauenburg et al. 2019). Part of outpatient training therapies is the continuous videography of therapy sessions for quality assurance, supervision, and process research.

For the initial project phase, sessions 5, 15 and/or 30 of a patient were used to cover different points in time of the therapies. The sample of patients was taken from the available data using the following parameters and criteria: We included depressed patients who, at the time of starting the outpatient treatment, were diagnosed with a unipolar affective disorder (depressive episode, recurrent depressive disorder, persistent affective disorder in the sense of dysthymia), or mixed anxious-depressive symptoms (adjustment disorder, anxiety and depressive disorder (mixed)), or a depressive personality disorder as the main or secondary diagnosis in the gold standard diagnosis according to DSM-V, the SKID interview (see Wittchen/Zaudig/Fydrich 1997). We excluded patients with the following additional diagnoses: the presence of an eating disorder, a psychotic, schizoaffective, or delusional disorder, or current substance dependence, as well as premature discontinuation of therapy. Written

consent for using the data for psychotherapy research from patients and therapists was available and the Ethics Committee of the Medical Faculty of the University of Heidelberg approved the use of the data for this purpose (AZ: S-2020/2020).

Each of the four studies draws on a separate subsample, depending on the research question and the frequency of the respective phenomenon. As the videos had not been fully transcribed prior to the investigation, it was not possible to automatically search for the respective phenomena. Instead, I inspected the entire sample manually for instances of the respective phenomenon, which was, of course, considerably more time-consuming.[30]

5. Research Questions

The first study examined a phenomenon called verbosity, which struck both the psychologists and the conversation analysts in our project team as an interesting and understudied phenomenon. To date, there has been no consensus on a uniform usage or definition of the term 'verbosity'. Furthermore, the concept has been largely ignored in conversation analytical research. After an initial examination of the data, we roughly defined verbosity as the quality of being lengthy or rambling, particularly in the context of narratives that depart from the central topic of discussion or lack a clear internal narrative structure. It is characterized by the presence of irrelevant content, a lack of emotional engagement, and a narrow focus on the immediate surroundings (Fenner/Spranz-Fogasy/Montan 2022, p. 217). The aim of the study was to describe the phenomenon more precisely from a linguistic-interactional perspective, using three case studies. Hence, the research question was: 'What are the linguistic and interactional manifestations of verbosity as resistance in psychodynamic psychotherapy, and how is verbosity treated by therapists?' (Fenner/Spranz-Fogasy/Montan 2022).

In the second study, I analyzed claims of not-knowing as a response to therapeutic questions, which the psychologists in our project commonly characterized as resistance$_{psych}$. I focused on the German forms *ich weiß nicht* ('I don't know') and *(ich habe) keine Ahnung* ('(I have) no idea') as stand-alone responses since these might be the most striking forms used to disclaim knowledge. German *ich weiß nicht* (IWN) and English *I don't know* (IDK) have already been studied frequently in the literature, whereas German *keine Ahnung* (KA) and English *no idea* have not been examined at all in psychotherapeutic interaction. Since claims of not-knowing are often uttered together with embodied claims of not-knowing (e. g., shoulder shrugs), I used multimodal CA according to Mondada (2018). For building my collection, I searched the data for patient-generated, stand-alone (full response, or full TCU if an account follows) responsive claims of not-knowing (IWN and/or KA). I excluded instances from the collection in which these items were used as pre- or post-positioned elements to observably (re-)contextualize the patients' contribution as well as instances used in turn-medial positions, for example, to index approximation (see Helmer/Reineke/Deppermann 2016, p. 100) – even if they appeared within a non-preferred response. Furthermore, I excluded claims of not-knowing that were used to elaborate after conspicuously keeping silent or to close a topic before continuing with another topic. However, I included responses where patients gave accounts for their claims of not-knowing either before or after them. The final collection featured 71 instances in total. I examined them with regard to the following research questions: 'What are the functions of patients' claims of not-knowing after therapeutic questions, and how do therapists treat these claims?' (Fenner 2024a).

30 Many thanks to my student assistant Kim Laura Schröder who joined me in reviewing the data.

The third study investigated silences in a specific, previously unexamined sequential position: The patient finishes a multi-unit-turn and tries to allocate the turn to the therapist who does not take it but utters one or several continuer(s) instead. Since the patient remains silent, the therapist finally ends the silence by intervening. The research questions for this study were: "How do patients indicate they already finished their turn, and how do they try to allocate the turn? How do therapists show that they expect the patient to say more? How do therapists resolve silence?" (Fenner 2024b, p. 2). To analyze silence, the participants' embodiment has to be taken into account (Vatanen 2021, p. 326), so, again, I used multimodal CA. I built my collection by searching the data for silence with a duration of at least 3.0 seconds, because this is the minimum length that conversation analysts normally consider as silence in psychotherapy (see, e. g., Buchholz 2018, p. 97). I only considered silences in my collection, that occurred in the transition space, that is, after a transition relevance place (TRP) at the end of a patient's multi-unit turn (i.e., a narrative), and after a subsequent therapeutic verbal continuer. It was also crucial that the silence was ended by a turn from the therapist. I excluded cases in which therapists and patients ended the silence simultaneously, as well as 'silences' in which vocal sounds like breathing loudly, coughing, sighing, etc. occurred. Moreover, I excluded four cases in which therapists changed the topic after the silence to limit the collection to intra-topic silences. In total, the final collection comprised 21 instances (Fenner 2024b, Section 2: Materials and methods).

In the context of psychotherapy, it is of course also important to observe change in resistance over the course of an entire therapy. Therefore, I conducted a longitudinal study: I chose a recurring type of therapeutic intervention that can encompass different verbal practices and focused on both conversation partners equally – the therapeutic interventions as well as the patient's responses. Since longitudinal CA studies are time-consuming, I conducted a case study of a single psychotherapy. To develop a research question, I carried out the following steps: First, my student assistant and I watched all videos and prepared conversation protocols for all sessions. Second, I identified recurring topics. As part of this procedure, it became apparent that the therapist made recurring interventions with the same interventional goal while not always using the same practice. Third, I decided to build a collection with all recurring therapeutic interventions that have one particular interventional goal, which was of central relevance in this psychotherapy. Hence, the collection consisted of 19 instances in total (Fenner 2025, Section 2: Data and method). The research question was: "How do the therapeutic interventions and the patient's responses change over the course of therapy?" (Fenner 2025, p. 3).

6. Results

6.1 Resistance Phenomena

As part of the project *Linguistic Manifestations of Resistance in Psychodynamic Psychotherapy*, we aimed at developing "a rating measure able to systematically and reliably assess resistance qualities (techniques) and resistance quantity (intensity) in psychotherapy process research" (Montan et al. subm.). This resulted in the RESIST Rating Scale with the corresponding manual for researchers (see Montan et al. subm.). The scale encompasses 28 so-called resistance$_{psych}$ techniques. Each technique is described with a definition, at least one example (usually several), and, if necessary, one or more examples of differentiation. We grouped the 28 identified resistance$_{psych}$ techniques into four super-ordinate categories (see also Appendix, Figure 2 and 3): I. *challenging therapeutic and interactional setting*; II. *challenging therapeutic process*; III. *impeding (therapeutic) content work*; and IV. *avoid*

addressing therapist/therapy/therapeutic alliance directly. While the first three categories consist of phenomena that can be considered resistance from both a conversation analytic and a psychodynamic perspective, the last group comprises purely psychodynamic resistance$_{psych}$ techniques (so-called transference resistance, see Sandler et al. 2018, p. 103). The first group, *challenging therapeutic and interactional setting*, includes resistance techniques such as 'questioning time frame', 'questioning necessity of further treatment', 'being occupied with distracting/irritating actions in parallel in session' and 'remaining silent'. The second group, *challenging therapeutic process*, comprises techniques like 'refusing', 'talking endlessly' and 'interrupting therapist competitively'. *Impeding (therapeutic) content work* is the largest group and covers resistance techniques such as 'expressing not-knowing', 'contradicting', 'changing/shifting topic' and 'presenting oneself incongruently'. The last group, *avoid addressing therapist/therapy/therapeutic alliance directly*, includes the following three techniques: 'using generalizations/extreme formulations which necessarily include therapist/therapy', 'affectively loaded talking about other persons/things implicitly addressing therapist/therapy' and 'using statements which might indirectly address therapist/therapy by other means'.

Across this spectrum of potential resistance phenomena, I dealt with one phenomenon from each of the first three groups: remaining silent (I), talking endlessly, which includes being verbose (II), and expressing not-knowing (III). The studies shed light on different aspects of the investigated resistance phenomena and complement existing research on the respective topics.

In the case of verbosity, we first described and characterized the phenomenon as such based on three case studies, as there have been no CA studies on this phenomenon we could draw on. The following characteristics of verbosity emerged from our study: (a) a topic shift at the beginning of the respective narrative; (b) the subject of the narrative is about third parties who are not present and/or everyday events; (c) emotions are rarely (if not at all) addressed; (d) the narratives have a high level of detail; (e) verbatim reproductions of fragments of conversations (often in connection with features of gossip) (Fenner/Spranz-Fogasy/Montan 2022, p. 234). At least in our data, it is the combined interplay of these individual characteristics, rather than their individual appearance, that turns a narrative into a verbose narrative. From a conversation analytic point of view, however, this is not enough; it is also relevant to consider how the therapist treats the narrative – that is, whether s/he treats the narrative as verbose (see chapter 6.2).

In the case of the potential resistance phenomenon of not-knowing, I could build on previous work. Therefore, I could directly examine the possible interactional functions that such claims can fulfil as a response to a therapeutic question. The analysis yielded in four different functions: (a) refusing to answer, (b) indexing difficulties, (c) projecting continuation, and (d) disconfirming. Their specific functions can only be determined in the context rather than by reference to the structure of *ich weiß nicht* or *keine Ahnung* responses. Nevertheless, there are tendencies regarding their linguistic form. For example, patients use only a single claim of not-knowing to project continuation, but combine several claims of not-knowing to index difficulties (Fenner 2024a).

Silence (as a potential resistance phenomenon) has also been the subject of some empirical study, which is why I have analyzed it in a very specific sequential position that has not yet been explored sufficiently in psychotherapy research: When a patient has finished his/her story, both participants resist$_{CA}$ the turn allocation by their partner and remain silent instead. The study shows that both the therapist and the patient produce silence jointly. Patients allocate the turn to the therapists by using several interactional devices, such as

syntactic and prosodic means and gaze. With their embodied behavior, they indicate that they have nothing more to say – although they often stayed rather vague in their preceding narrative – or that they feel desperate and do not know what to do. With silence, they may refuse to provide a specification or to propose their own solution to a problem that they have previously discussed, despite the fact that therapists often appear to implicitly encourage them to do so (Fenner 2024b).

The three phenomena that I examined can be located on a continuum, ranging from an absence of potential variants to an infinite number of verbal expressions (see Figure 1). The phenomenon of silence presents the fewest possibilities for variable verbal expression. Patients have no verbal options for remaining silent – they can only vary the length of their silence as well as their embodied behavior during the silence. They may, for example, turn their head and look away or shrug their shoulders. The phenomenon of not-knowing has typical lexical forms of realization, but can be expressed variably overall: not only by different lexical expressions (*ich weiß nicht* and *keine Ahnung*) but also by, for example, varying word order (e. g., *weiß ich nicht*) or a combination of these different expressions (see Fenner 2024a). Moreover, claims of not-knowing can be accompanied by various embodied claims of not-knowing. Compared to silence, verbosity is located at the opposite end of the continuum: Verbosity does not have clear formal structures but can be expressed in a multitude of ways. It is defined by the manner in which a narrative is conveyed (with regard to the selection of vocabulary, its length, its content, and so forth), rather than through the utilization of particular lexical forms.

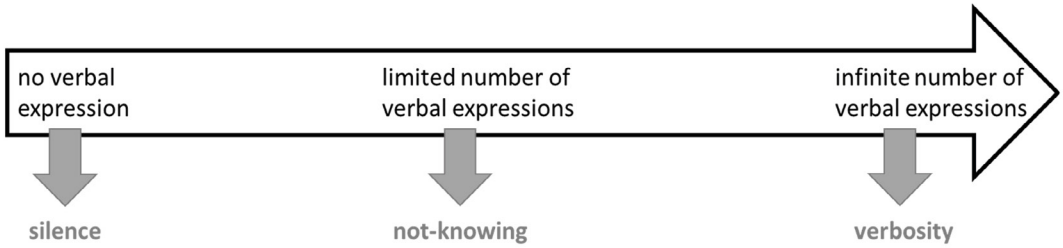

Figure 1: Continuum of possible verbal expressions for the examined phenomena

While silence and not-knowing can be quickly recognized by reference to formal structural criteria, verbosity requires a more contextual approach, since a verbose narrative usually extends over a much longer period of time and the therapist's management is also highly relevant to be able to characterize something as verbose. Nevertheless, the respective sequential position and at least the previous therapeutic turn must also be considered in the case of silence and not-knowing. Verbosity might occur at any time during a psychotherapy session. However, in my data, it never occurs at the very beginning of a session. Given that we identified a topic shift at the beginning of a verbose narrative as a co-constitutive feature of this potential resistance phenomenon, the therapist and the patient must have discussed another topic prior to this point in the session. In addition, we limited the investigation of verbosity to narratives told by the patient.

The specific kind of silence and the claims of not-knowing I examined occur in very specific sequential positions. I have only investigated silence, which occurs at the end of a multi-unit turn by the patient, whereupon the therapist utters a continuer and after which both parties remain silent. Of course, silence as a possible phenomenon of resistance may also occur in other sequential positions (e. g., after a therapeutic question). However, the focus here was on silences that may have their origin in divergent turn-taking orientations. Fur-

thermore, it is noteworthy that patients sometimes project an upcoming silence by using multiple turn-closings before they definitely end their turn and try to hand it over to the therapist.

With regard to claims of not-knowing as a potential resistance phenomenon, I only analyzed them as a response to therapeutic questions because this is probably one of the most resistant sequential positions. Of course, not-knowing is also frequently expressed at other points in conversation, but then often functions as a prospective or retrospective epistemic or pragmatic marker (see Helmer/Reineke/Deppermann 2016), rather than as a form of resistance.

Although the investigation of verbosity did not focus on working out its functions[31] but on its (linguistic and interactional) characteristics, it is nevertheless apparent that resistant verbosity functions to avoid dealing with another (difficult) topic or feelings. Further research is required to determine if verbosity can also fulfil other (non-resistant) functions. In the case of claims of not-knowing and silence, the aim of the studies was, among others, to identify particular interactional functions. As previously mentioned, claims of not-knowing can be used to refuse answering a question, to index difficulties, to project continuation and to disconfirm. This functional variability shows that the phenomenon does not always embody resistance$_{CA}$, but can be used in a variety of ways (Fenner 2024a). The same applies to silence, which patients can use to indicate that there is nothing more to say or that they feel desperate and do not know what to do. Moreover, it may embody a refusal, for example, to provide a specification or to propose a solution. With regard to turn-taking, silence can also work to allocate the turn to another participant – in the case of psychotherapy, to the therapist (Fenner 2024b). In any case, (potential) resistance phenomena must always be examined in context and with regard to how the other participant(s) treat them: Do they treat them as full-blown resistance, as weaker forms of disalignment, or maybe even as totally unproblematic? If therapists do not treat something as resistance, then the corresponding phenomenon can at best be described as resistance on the part of the patient. However, in this case, it is the researcher who attributes resistance to the patient, not the therapist him-/herself. As previously outlined, this does not align with a conversation analytic perspective. In such instances, it is crucial to consider how the respective conversational partner treats the action in question. If he/she clearly does not regard something as resistance, then the corresponding action cannot be described as resistance$_{CA}$. It is therefore important to consider how the therapists in our data treat the examined phenomena.

6.2 Resistance Management

In a follow-up study on verbosity, my colleagues and I looked specifically at how therapists deal with verbosity. In several case studies, we demonstrated that verbosity is by no means a purely patient-related phenomenon, but the patient can produce it interactively together with the therapist. This is usually the result of the therapist's asking questions. As a result, the narrative becomes more and more extended and the resistance$_{psych}$ – from a psychodynamic perspective – persists. The resistance$_{psych}$ can only be grasped on the lexical level of the narrative, as little or no emotion is the subject of the narrative, which inhibits the therapeutic process from a psychoanalytic point of view. However, on the interactional level, the resistance is not visible in such cases, as both conversation partners are oriented

31 An action can have several functions. Depending on the context, one or more of these functions can serve as a resistance.

towards each other and advance the narrative together. Conversely, therapists can also try to resolve this form of resistance by asking specific questions that guide the patient away from the talk about third parties or external experiences and re-direct him/her to talking about him-/herself and his/her emotions (Fenner et al. 2022). Other potential interventions by the therapist are (relocating) formulations or attempts at refocusing a previous topic (Fenner/Spranz-Fogasy/Montan 2022). From a conversation analytic perspective, such practices make visible that the therapist is pursuing a different agenda than the patient – and thus ascribes resistant$_{CA}$ behavior to the patient. However, in most cases in our collection, the patients stay verbose and thus resistant (Fenner et al. 2022).

The study on not-knowing also includes an investigation of the therapists' resistance management. When patients refuse to answer therapeutic questions by claiming not-knowing, therapists use different kinds of interventions. However, they usually treat such claims of not-knowing as disaligning actions. When patients use claims of not-knowing to index difficulties, therapists mostly respond with candidate answers, which they often formulate as questions. In the case of claims of not-knowing to project continuation, therapists mainly react with a continuer, thereby indicating their expectation that the patient will continue. When patients use claims of not-knowing to disconfirm, therapists usually give an account for their prior statement, thus insisting on its accuracy and importance (Fenner 2024a).

When patients use silence to allocate the turn to the therapist, therapists usually end the silence using one of four different kinds of interventions: (a) They can ask a question, whereby they make an answer from the patient conditionally relevant. (b) They can give an interpretation, thus opening up a new perspective to the patient. (c) They can use challenges to provide new input and make a response relevant. (d) They can apply formulations to focus on and deepen a specific aspect (Fenner 2024b).

When considering how therapists deal with the potential resistance phenomena of not-knowing and silence, it is apparent that they often do not treat these phenomena as resistance$_{CA}$. Instead, they often treat the phenomena as a sign that the patients need help or simply wait for the patients to continue. It is striking that the therapists in our data never address the potential resistance$_{psych}$ directly. The most explicit orientation towards resistance observable in the data consists of therapists questioningly repeating a claim of not-knowing that the patient offered as a response to a therapeutic question. In the vast majority of cases, therapist's orientations to patient's resistance are more implicit. One possible explanation for this is that the data represent psychotherapy sessions conducted by psychotherapists in training. Since addressing resistance to the patient as an interpretation or as a simple observation always represents a confrontation that brings with it a certain challenge or strain on the therapeutic relationship, it is possible that the trainee psychotherapists are particularly cautious here (Fenner et al. 2022, p. 22).

6.3 Resistance over the Course of a Therapy

When looking at resistance in psychotherapy, its development over the course of a therapy is of particular interest, for example, when it comes to operationalizing the success of a psychotherapeutic treatment. Hence, I conducted a longitudinal case study in which I focused on the patient's responses to a recurring thematic intervention[32] of central relevance that can encompass different verbal practices.

32 With this intervention, the therapist attempts to convey to the patient that she cannot know what other people think or feel unless she asks them.

It is striking that, in the first half of the therapy, the patient does not respond in the preferred way when the therapist intervenes in the context of talking about people with whom the patient has highly problematic relationships. Towards the end of the treatment, the patient shows herself to be less resistant, though his/her resistance is not completely dissolved. It is particularly interesting that not only the patient's reactions change, but also the therapist's interventions (Fenner 2025) – which may of course also trigger a change in the patient's reactions. Even if the study only relates to one thematic intervention, it can be considered exemplary for this particular therapy. The following points serve to substantiate this argument: First, the focal intervention is very frequent in this therapy and targets the patients' relationships with several people (and not just one person). Second, the therapeutic intervention "represents a typical therapeutic strategy: The therapist tries to make the patient aware of a vicious cycle and – together with the patient – to work out how to break it" (ibid., p. 23). Third, other recurring therapeutic interventions exhibit a similar trajectory over the course of the therapy.

What this case study show is that resistance does not always develop as desired. Rather, resistance emerges in and through the interaction of both participants in the conversation and can also (partially) dissolve in it. Resistance is therefore highly individual and context-specific and must be analyzed accordingly. It is particularly important to adopt a longitudinal perspective, since both participants build their interaction on previous knowledge and their shared interactional history. Moreover, changes tend to occur in the form of small, incremental developments rather than as sudden major leaps. They are evident, but rather gradual (Fenner 2025).

7. Discussion

7.1 Conversation Analysis

The objective of this study was to examine linguistic and discursive phenomena that psychoanalytic theory frequently categorizes as forms of resistance$_{psych}$ from a conversation analytic perspective.

In the longitudinal study, I focused on both interlocutors – the therapist and the patient – whereas previous studies typically focused on one or the other. By demonstrating that changes are observable in the linguistic and interactional behavior of both parties, my study expands on prior longitudinal CA research and highlights that longitudinal analysis should consider the conduct of all the participants in an interactional setting. Furthermore, the studies on not-knowing and silence included embodied behavior, which so far has often been neglected in analyses of potential resistance phenomena in psychotherapy. The study on verbosity is the first to deal with this phenomenon in detail and lays the groundwork for further research on this topic. Likewise, the study on not-knowing is one of the first CA studies to deal with the German expression *keine Ahnung* in an institutional setting such as psychotherapy. Hence, this dissertation expands the existing CA literature on psychotherapeutic interaction and shows the importance of including multimodal as well as longitudinal analyses.

Moreover, the dissertation links the conversation analytic concept of resistance$_{CA}$ with the psychodynamic concept of resistance$_{psych}$. It explores some similarities and differences of the concepts, while also acknowledging challenges of applying one concept to the other. The latter is due to the different epistemological approaches: While in CA, we can only refer to something as resistance$_{CA}$ if this becomes visible on the interactional surface, psy-

choanalysts work with psychological inferences and with their intuition based on theoretical knowledge/theories as well as their experience. How CA can capture cognition is a very broad field that cannot be considered here as a side topic, but is rather a research on its own (see, e. g., Deppermann 2018). Accessing the interior of the human psyche, including thoughts and emotions, is generally difficult. Psychologists often attempt to overcome this difficulty through the use of questionnaires. CA offers an additional entry point. It is evident that CA can encompass not all aspects. For instance, unarticulated thoughts and feelings cannot be captured. However, as evidenced by the studies conducted, we can effectively capture the linguistic and interactional aspects that are visible on the surface.

Furthermore, in psychodynamics, there is a distinction between 'defense' and 'resistance$_{psych}$'. In CA, in contrast, there is no such distinction between the intrapsychic and the interactional levels. At the interactional level, however, we can make an even finer distinction between the concepts of disalignment, dispreference and resistance, as will be shown below (see chapter 7.2). This finer distinction might also be helpful for psychodynamic theory as well as practitioners. More generally, by focusing on institutional interactions and offering relevant insights for practitioners (see chapter 7.4), CA as a qualitative research method becomes more widely recognized, is better positioned for future research proposals, and may meaningfully inform or even advance psychotherapeutic practice.

7.2 The Concept of 'Resistance'

While research in psychology is predominantly quantitative (Haig 2013, p. 9), this dissertation offers a much-needed qualitative perspective on the phenomenon of resistance$_{psych.}$ However, as previously outlined, the two disciplines, psychodynamics and CA, have disparate conceptualizations of resistance. Therefore, I would first like to discuss the two disciplines separately.

The concept of resistance$_{psych}$ is particularly challenging to comprehend because it can be interpreted in a multitude of ways, rendering it both a complex and elusive notion. Thus, for psychologists, the studies collected in this dissertation might be a good starting point to reflect on the concept of resistance$_{psych}$ and its (so far insufficient) operationalization (Montan et al., subm.). While those of a more conservative inclination within the psychodynamic community tend to view resistance$_{psych}$ as a unilateral phenomenon on the part of the patient, more recent theoretical perspectives conceptualize resistance$_{psych}$ as an interactional phenomenon. The present dissertation contributes to this ongoing discourse in the field of psychodynamics by offering empirical insights that can bridge the gap between these different theoretical orientations. More specifically, it supports more recent psychodynamic trends by presenting empirical findings on resistance$_{psych}$ as an interactional phenomenon. Thus, resistance$_{psych}$ occurs between the therapist and the patient and also changes over the course of a therapy interactionally – that is, by the interplay of the communicative behavior of both, the therapist and the patient. Moreover, the studies offer insights that may spark a fundamental theoretical discussion of the therapist's role in the production of resistance$_{psych}$ and the psychotherapeutic process as a whole (see Avdi 2008, p. 69). Hence, I claim that the term "intersubjective resistance" (Gerson 1996, p. 632; 2004, p. 65) in intersubjective psychoanalysis illustrates the interactional dimension of resistance$_{psych}$ more appropriate than only the term 'resistance'. However, this dissertation cannot contribute to the origins and motivational backgrounds of resistance$_{psych}$, which are explained differently in the various approaches, such as in intersubjective psychoanalysis and object relation theory.

In the context of this dissertation, I exclusively made reference to prior actions and/or the interactional history of the parties involved in the interaction. As already mentioned, CA's concept of resistance$_{CA}$ is more closely aligned with the tenets of contemporary psychodynamic theory, which defines resistance$_{CA}$ as an interactional phenomenon. However, in the existing CA literature, there is often no clear distinction between resistance$_{CA}$, disalignment and dispreference. This dissertation claims that it is not appropriate to treat these concepts on an equal footing. Therefore, it has sought to flesh out the distinction more fully. Resistance$_{CA}$ is more uncooperative than disalignment. Furthermore, the former is also more dependent on how the interlocutor deals with it. Dispreference, in contrast, is used to refer to two different concepts: an action and the design of an action.[33] When dispreference is used to refer to an action, then this action "does not structurally align or cooperate with a prior conversation turn's initiated course of action/project/activity" (Pillet-Shore 2023a). However, when dispreference refers to the design of an action, then this includes both sequence-initiating and sequence-responding actions. A dispreferred design can be characterized by delays, speech dysfluencies, uncertainty or hesitation markers, etc. (ibid.). Hence, when referring to dispreference as an action, this is similar to disalignment, which is concerned with structural-level uncooperation (Stivers 2022, p. 22). The difference, however, is that (dis-)alignment represents the analytically grosser phenomenon of (not) supporting an ongoing activity, while (dis-)preference is a more granular phenomenon (Pillet-Shore 2023b). Resistance$_{CA}$, in turn, is stronger than disalignment and describes not only a lack of support, but also an attempt to oppose the ongoing activity. When referring to dispreference as the design of an action, this is not related to alignment or resistance$_{CA}$, which, as previously stated, may manifest in various forms and lacks having a specific design. Furthermore, as already explained in the theory section, design-based preference patterns may look different in psychotherapeutic interactions than in other institutional settings and mundane, everyday talk (e. g., delayed responses may not be oriented to as dispreferred in psychotherapeutic interaction). Hence, the concepts just explained are very complex, highly context-dependent and are applicable only within the specific parameters of the given setting. More specifically, in psychotherapeutic interaction, we cannot equate cooperativeness, progressivity and affiliation, as it is the case in other settings (see, e. g., Steensig 2019; Stivers 2008, 2022, p. 22). In psychotherapy, the interaction goal frequently necessitates a search activity, for example, as patients are confronted with aversive things that are initially perceived as problematic and therefore require a significant investment of time. In such cases, delays are often desired, and a rapid response is regarded as inadequate (Berger/Rae 2023). Moreover, narrow sequential-structural expectations – defined as the progression from one point to another as quickly as possible – are generally not applicable and frequently contradict the principles of progressivity and expectations that prevail in other settings (see, e. g., Amar et al. 2002 for classroom interactions; Hofstetter/Robles 2023 for multi-party board game interaction; Stivers/Robinson 2006 for mundane multi-party interactions). Thus, the concepts dispreference, disalignment and resistance are not transferable to psychotherapeutic interaction without any adjustments.

In my dissertation, I show if and how different (designs of) actions are treated as (dis-)preferred, (dis-)aligned or even as resistant$_{CA}$ in psychotherapeutic interaction. However, it is essential to conduct more research to determine in more general how these concepts can be applied in psychotherapy. An overall result is that the three phenomena that were examined in this dissertation (verbosity, claims of not-knowing, silence) often cannot be described as resistance$_{CA}$ from a CA perspective. Rather, the participants usually treat them

33 To illustrate, an action can be conceived as a request for confirmation. In this regard, the action design can be understood in terms of its realization; for example, as a verb-first question.

as 'dispreferred' or 'disaligned'. It also regularly happens that none of the interlocutors indicates that there may be a problem within the conversation. In such cases, against the background of psychoanalytic theory, one could at most speak of *shared resistance* (see Fenner 2024b). If both the patient and the therapist display resistance, neither party will attribute resistance to the other. However, both will interact in a way that is consistent, that is, aligning with the views of the other, leading to shared resistance. It is extremely rare for patients to attribute resistance to themselves. The assumption is that, on the one hand, it is difficult to recognize whether one is showing resistance oneself (without the necessary distance that the therapist has) and, on the other hand, that it is even more difficult to admit it. Moreover, it almost never occurs in the data that the therapists explicitly address or refer to resistance. As mentioned above, this may be because the data are video recordings from training therapies. Nonetheless, this finding is surprising, as the underlying data base was very large, and the author examined more videos in total than have been used in the four articles. There are various possible explanations for why the therapists do not generally address resistance explicitly: It could be that therapists use the concept of resistance$_{psych}$ to a lesser extent than it is discussed in theoretical literature. Alternatively, they might worry about confronting the patient too directly, which could potentially jeopardize the efficacy of the therapy or the therapeutic alliance. Another possibility is that therapists themselves struggle to grasp the concept of resistance$_{psych}$, because, according to psychoanalytic theory, all kinds of behaviors can represent resistance$_{psych}$ (Greenson 2016, p. 60). However, since this theoretical assumption is too vague to be practically applicable in a targeted manner by therapists, a more concrete theoretical concept is required: one that can serve as an operational framework for practitioners. CA, with its strictly empirical focus on what happens on the linguistic-interactional surface, can contribute to the development of such a concept of resistance.

In CA, the central question is 'why that now?' (see chapter 3.2). In light of the potential resistance phenomena under investigation, it is not possible to determine with certainty the reasons behind a patient's use of the phenomenon in question. However, I would like to make a few assumptions in the following that result from studying the data.

In general, it should be noted that verbosity formally fulfills something that is required in therapy, namely that patients talk. In the case of verbosity, however, this disclosure is often excessive in scope or lacks the desired focus, as set forth by the therapist. At the beginning of a psychodynamic psychotherapy, therapists usually explain the principle of free association (chapter 2.1). As this is often unfamiliar to patients, they may feel encouraged to talk a lot. This may result in verbosity, especially at the beginning of the therapeutic treatment. It is similarly conceivable that therapists request patients to provide a detailed account of a particular matter. Some patients may overgeneralize this and apply it to all kinds of topics, including impersonal matters and/or the experiences of others. To validate these assumptions, longitudinal studies are required. In general, patients cover up or overplay something with verbosity that is probably difficult for them to discuss. Dwelling on perceivable ordinary or banal topics may serve them to maintain a sense of security and to ward off fears.

By claiming not-knowing, patients may make it easy for themselves to respond to a therapeutic question that may be difficult for them. In the case of resistance, they may try to avoid a difficult topic altogether. Silence, which may appear to be the antithesis of verbosity on the linguistic-interactional surface, can also be employed as a strategy to avoid engaging with challenging topics. Compared to verbosity, however, long silences in psychotherapeutic interactions are less common and can be perceived as uncomfortable or difficult to endure. Thus, a long silence may suggest that a patient is attempting to disengage from the discourse and to prompt the therapist to initiate further discussion. It is also conceivable

that patients remain silent due to their preoccupation with external stimuli (e. g., watching something outside of the window) or a sense of detachment from the therapeutic process.

The employment of any phenomenon in the context of resistance inevitably results in the dissolution of the patient's collaborative engagement with the therapist on the matter at hand. Regardless of how far apart the phenomena are on the linguistic-interactional surface – all of them can be used to refuse to do something.

It is crucial to highlight that the findings of this dissertation have shown very clearly that resistance$_{CA}$ is often not apparent on the linguistic-communicative surface. An important observation in this context is, for example, the following by Fenner et al. (2022, pp. 22 f. [translated by the author]): If "there is no 'resolution' [for example by addressing the resistance retroactively], the resistance often remains a psychoanalytic perception. On a linguistic-interactional level, it is hardly or even not at all recognizable when patient and therapist create a narrative together, each reacts in a preferred way and no 'problem' indicating resistance becomes visible on the linguistic-interactional surface."

7.3 Implications for Practitioners

The four studies collected in this dissertation provide valuable results for psychotherapeutic practice. First, the studies increase awareness of the characteristics of specific communicative (verbal and multimodal) phenomena in psychotherapy. Thereby, they further our understanding of interactional processes that underlie psychodynamic psychotherapy (see Avdi 2008, p. 81). Since the data involve a large number of different patients and therapists, we could rule out a person-related bias. The comparability of the data was further enhanced by virtue of the fact that all patients had been diagnosed with depression (among other diseases). However, it must be acknowledged that we could only examine interactional phenomena that frequently occurred in this particular group of patients. It may well be that patients with other diagnoses show other resistance phenomena (more frequently).

Second, the studies draw attention to the fact that phenomena that psychodynamic literature often classifies as resistance$_{psych}$ can also have other functions. Moreover, the articles comprising this dissertation name and explain these functions. This can increase psychotherapists' awareness that an interactional phenomenon can have different meanings depending on the context.

Third, the studies also address the subsequent therapeutic interventions. This can provide therapists with insight into how other practitioners address the same phenomena, thereby enhancing the breadth of their own methodologies. Furthermore, they "can become aware of the effects of their interventions" (Avdi 2008, p. 82). The more therapists reflect on their own interventions, the more they will develop a more ethical practice. Additionally, the descriptions of these interventions may serve as a valuable resource for training and continuing professional development (see ibid., pp. 69, 82).

Fourth, the articles demonstrate an interplay between resistance phenomena and therapeutic reactions to them. While a relocating formulation or a refocusing of a previous topic may prove effective in addressing verbosity as resistance, a reformulation of the previous question or an account for the same question may offer a more fruitful approach in instances of not-knowing, depending on the context. In situations where silence is employed as a form of resistance, a question can serve as a valuable tool. The articles offer also insights into potential therapeutic strategies in contexts where the aforementioned phenomena do not constitute resistance: In instances where patients claim not-knowing, a continuer may be a viable option, whereas in the case of silence, an interpretation may be

beneficial, always contingent upon the context. These insights might help to make psychotherapy even more effective in the future.

Fifth, the longitudinal study shows how changes in resistant behavior become visible and that it is not just a one-sided change on the part of the patient, but always an interplay between the two – patient and therapist. It is particularly important that psychotherapists are fully aware of this so that they may perceive, initiate and react to changes precisely.

I would like to echo Voutilainen/Peräkylä (2014) in this regard, who very aptly summarize CA's contribution to practicing psychotherapists:

> Practitioners of course have theories about resistance and practical ways of handling it, but where CA can make a distinctive contribution is in showing the actual details of how resistance is offered by the client and dealt with by the therapist, at the level of the internal design of turns and at the level of their sequential organization.

Beyond resistance, CA can refine the attentional skills of psychoanalysts more generally and increase their sensitivity to understanding material in sessions (see Forrester/Reason 2006, p. 40). As such, this dissertation provides points of reference for a methodology of supervision and further education/training for psychotherapists. For example, the presented results can be discussed with practitioners on the basis of the transcripts. Alternatively, practitioners can initially consider how to address a specific phenomenon in psychotherapy and then use the transcripts to ascertain how the participants in the data actually addressed it. In this manner, situated therapeutic practices can be subjected to reflection.

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Appendix

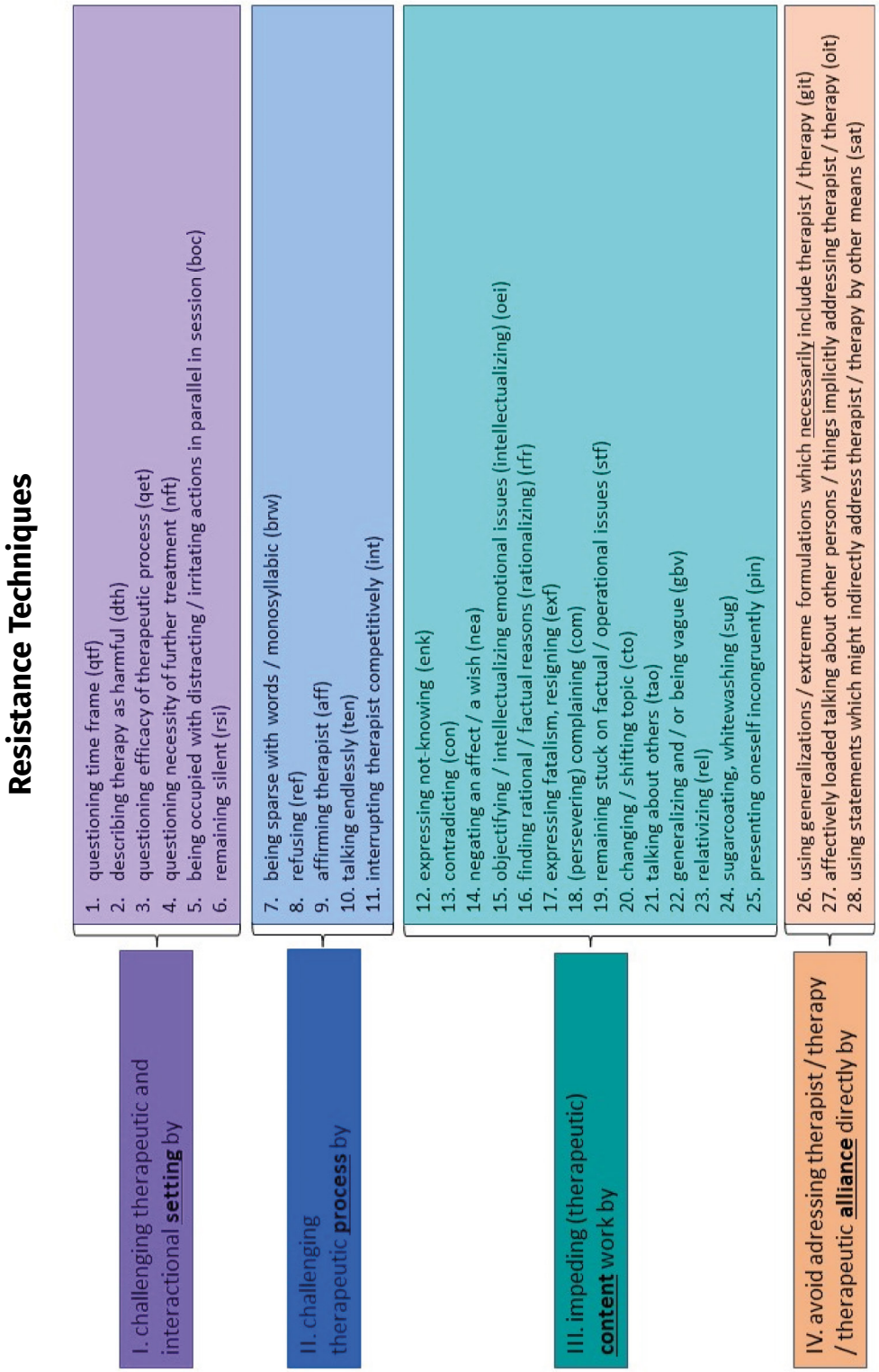

Figure 2: 28 resistance techniques in the RESIST Rating Scale

Resist Rating Scale

Session-ID: _____ **Rater-ID:_____**

time	00:00 - 04:59	05:00 - 09:59	10:00 - 14:59	15:00 - 19:59	20:00 - 24:59	25:00 - 29:59	30:00 - 34:59	35:00 - 39:59	40:00 - 44:59	45:00 - 49:59	50:00 - 54:59	55:00 - 59:59	60:00 - 64:59
I. challenging therapeutic & interactional setting													
(1) questioning time frame (qtf)													
(2) describing therapy as harmful (dth)													
(3) questioning efficacy of therapeutic process (qet)													
(4) questioning necessity of further treatment (nft)													
(5) being occupied with striking/ irritating actions in parallel in session (boc)													
(6) remaining silent (rsi)													
II. challenging therapeutic process													
(7) being rare with words (brw)													
(8) refusing (ref)													
(9) affirming therapist (aff)													
(10) talking endlessly (ten)													
(11) interrupting therapist competitively (int)													
III. impeding (therapeutic) content work													
(12) expressing not-knowing (enk)													
(13) contradicting (con)													
(14) negating an affect/a wish (nea)													
(15) objectifying/intellectualizing emotional issues (intellectualizing) (oei)													
(16) launching rational/factual reasons (rationalizing) (rfr)													
(17) expressing fatalism/resigning (exf)													
(18) (persevering) complaining (com)													
(19) remaining stuck with factual/ operational issues (stf)													
(20) changing/shifting topic (cto)													
(21) talking about others (tao)													
(22) generalizing and/or being vague (gbv)													

time	00:00 - 04:59	05:00 - 09:59	10:00 - 14:59	15:00 - 19:59	20:00 - 24:59	25:00 - 29:59	30:00 - 34:59	35:00 - 39:59	40:00 - 44:59	45:00 - 49:59	50:00 - 54:59	55:00 - 59:59	60:00 - 64:59
(23) relativizing (rel)													
(24) prettifying, whitewashing, sugarcoating (pws)													
(25) presenting oneself incongruently (pin)													
IV. avoid addressing therapist/therapy/therapeutic alliance directly													
(26) using generalizations/extreme formulations which necessarily include therapist/therapy (git)													
(27) affectively loaded talking about other persons/things implicitly addressing therapist/therapy (oit)													
(28) using statements/depictions which might indirectly address therapist/therapy (sat)													

Session-ID: _____ **Rater-ID:**_____

	Did you perceive resistance?		If you perceived resistance: What was the level of resistance?					
time-sequence	no	yes	very low	low	rather low	rather high	high	very high
00:00 – 04:59	☐	☐	1	2	3	4	5	6
05:00 – 09:59	☐	☐	1	2	3	4	5	6
10:00 – 14:59	☐	☐	1	2	3	4	5	6
15:00 – 19:59	☐	☐	1	2	3	4	5	6
20:00 – 24:59	☐	☐	1	2	3	4	5	6
25:00 – 29:59	☐	☐	1	2	3	4	5	6
30:00 – 34:59	☐	☐	1	2	3	4	5	6
35:00 – 39:59	☐	☐	1	2	3	4	5	6
40:00 – 44:59	☐	☐	1	2	3	4	5	6

	Did you perceive resistance?		If you perceived resistance: What was the level of resistance?					
45:00 – 49:59	☐	☐	1	2	3	4	5	6
50:00 – 54:59	☐	☐	1	2	3	4	5	6
55:00 – 59:59	☐	☐	1	2	3	4	5	6
60:00 – 64:59	☐	☐	1	2	3	4	5	6
whole session	☐	☐	1	2	3	4	5	6

Comments / Questions

Figure 3: RESIST Rating Scale

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Contact Information

Carolina Fenner
Leibniz-Institut für Deutsche Sprache
R 5, 6–10
68161 Mannheim
E-Mail: fenner@ids-mannheim.de

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