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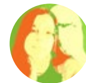

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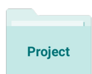

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Psychotherapy as a discursive genre: A dialogic approach

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Abstract

This study seeks to display therapeutic dialogue as a discursive genre. By using dialogic discourse analysis, the psychotherapeutic dialogue present in a set of excerpts from a time-limited psychotherapy is analyzed. This micro analytical methodology makes it possible to account for both the dialogal and the dialogic level of therapeutic conversation. The results show the linguistics markers employed by the participants and the voices in their speech. This enables us to illustrate how it is possible to perform a discursive analysis of therapeutic interaction. The value of approaching psychotherapy as a discursive genre and its methodological implications for research are discussed.

Keywords

Psychotherapy process, dialogic discourse analysis, microanalysis, qualitative research, psycholinguistics

The praxis of language is effected through (oral and written) utterances produced by interacting participants in any given domain of human activity. The contents, issue, style, and composition are inextricably linked to the utterance as a whole, and are determined by the specific domain in which a given communicative act takes place. According to Bakhtin (1982), each separate utterance is individual, but each participation sphere through language generates its own, relatively stable,

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types of utterance, which we shall designate as discursive genres. This author posits that the properties of utterances as communicative units within a given discourse acquire styles, shapes, and expressions that can be understood, or become meaningful within the genre of the discourse and also through their insertion in a given cultural framework.

Psychotherapy, as a cultural practice and as an instrument of social exchange (Willig, 2008), is a specific scenario with characteristics that follow certain rules and restrictions which result in a reduction of the uncertainty and entropy of individual and interpersonal mental functioning. Therapeutic discourse is not only characterized by a set of common expressions, but also by certain given positions or perspectives adopted by speakers in the discourse as a whole. The selection of linguistic resources in a discursive genre is defined by the commitment or intention adopted by a discursive subject or speaker within a given sphere of meanings (Bakhtin, 1986). This is determined by the roles participants play in the therapeutic dialogue, which are shaped by a culture and a wider set of social knowledge that supports the participants' actions and provides them with a relatively explicit relational framework (Avdi & Georgaca, 2009; Marková, 2003). In psychotherapy, as with all discursive genres, utterances may be directed to more than one addressee, but they are usually answered by the immediate interlocutor (Bakhtin, 1986). This increases the complexity of the dialogue, since a patient, by voicing an utterance, may pre-represent a response which is not necessarily related to that of the therapist, but one connected to another voice attributed to the therapist. This perspective states that an utterance is voiced by one of the positions of an individual and that the communicative function of this utterance is not only to say something to the listener, but also to say something to the position that the listener is using explicitly or implicitly in that moment. This multiplicity of positions which are possible to be voiced and, therefore, the multiplicity of positions that could be the addressees, constitutes the core aspect of Bakhtin's notion of polyphony (Bakhtin, 1982). Hence, Bakhtin (1982, 1986) sees in the dialogue the possibility to study the inner world of a person and, at the same time, study the way in which that inner world participates in an interpersonal relationship.

Dialogicity and voices in psychotherapy

Taking into account Bakhtin theory and his polyphonic metaphor, Hermans (1996, 2003, 2004) conceptualized the self as ''a dynamic multiplicity of relatively autonomous I positions in an imaginal landscape'' (Hermans, 1996, p. 33). Hence, this theory conceived these positions as associated with temporal and spatial dimensions. At the same time, this multiplicity of positions constitutes the identity of a person, and is not only in dialogue with another person, but also with other positions of his or her own inner world. Some of these positions could take the conscious control, temporally or permanently, and dominate the inner and external dialogues (Dimaggio & Stiles, 2007; Gonçalves & Guilfoyle, 2006). Sometimes, this excessive control impedes the dialogue and the consideration of his or her

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other voices. Hence, it could provoke rigidity in the way the person behaves and relates with the world. The psychotherapy could contribute to the modulation of and to the dialogue between the multiple voices and positions of the patient, activating the relationship between them, favoring those less conscious voices (or dissociated) to become more conscious and integrated for the patient, allowing the emergence of new voices that constitute a metaposition with novel meanings (Angus & McLeod, 2004; Bromberg, 1998; Dimaggio & Stiles, 2007; Hermans & Hermans-Jansen, 2004; Lehmann, 2013; Neimeyer & Buchanan-Arvay, 2004; Salvatore, Carcione, & Dimaggio, 2012; Salvatore & Gennaro, 2012; Stiles, 1999).

Thus conceived, psychotherapy becomes a process that takes place in the inter- and intra-mental domains. This makes it possible for each speaker to encounter himself or herself and, at the same time, the other. Both the therapist and the patient, in an endless circular process, facilitate this encounter with the other by finding their own self, a process which is multiple and dialogic in essence (Hermans, 1996, 2003, 2004). From this perspective, psychotherapy must be approached considering two levels or dimensions of the therapeutic dialogue. The first level, the inter-mental domain, is the ''real'' dialogue between the participants as a dialogal exchange (see Table 3), which shares elements of a conversational dyad, with the rules of a dialogue, as well as elements of the social participation structure or format of psychotherapy (Grossen & Salazar, 2006; Leiman, 2011). Some literature in psychotherapy research has deepened the understanding of conversational exchanges within the therapeutic dialogue (Peräkylä, 2004; Strong, Zeman, & Foskett, 2006). This dialogal level is approached in this study by means of selected conversational analysis tools that allow us to illustrate the ''real'' patient–therapist exchanges.

The second level, the intra-mental domain, consists in a dialogic exchange (see Table 3), and takes into account the dialogue that is established among multiple voices in the discourse of a single subject, which arise from the various positions he or she adopts during the therapeutic interactions (Grossen & Salazar, 2006; Leiman, 2011). This level is analyzed within the frame of a microanalysis system that intends to linguistically pinpoint the multivocity present in the discourse and its influence on the construction of shared meanings.

In the field of psychotherapy research there are several methods that seek to make the multivocity visible as well as the relationship between the voices and their unfolding along the psychotherapeutic process (Hermans, 2008). Among these methods are the sequential analysis developed by Leiman (1992, 1997, 2002, 2006), the personal position repertoire (PPR) developed by Hermans (2001; Kluger, Nir, & Kluger, 2008), and the microgenetic analysis developed by Valsiner (2001, 2002). Inspired on the same background of the aforementioned methods, Larraín and Medina (2007) developed the *dialogic discourse analysis* (DDA), which has been used before in the psychotherapy research field (see Martínez, 2011; Martínez, Tomicic, & Medina, 2012). DDA is based on Bakhtin's theory of enunciation and integrates the states of Ducrot (1986) and Kerbrat-Orecchioni (1993) with the purpose of having a tool for making subjectivity

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visible in the discourse. Specifically, DDA intends to shed light on the several voices present in the utterances, including the relationship among these voices and the ''real'' dialogue between the participants. In that sense, DDA also follows the tradition of the discourse analysis from authors such as Billig (2006), Fairclough (2005), and Shotter (1992), yet highlighting the linguistic aspects of the micro-discourse.

Hence, in this article we seek to show at a linguistic level of analysis that the therapeutic dialogue occurs in two simultaneous levels and that the particular way in which this takes place shapes it as a discursive praxis with its own limits and rules. We propose that this discursive structure could help facilitate change in one of the participants, especially when within the dialogue between them one participant interpellates the other over his actions in the interaction. That is to say, through an interpellation someone is demanded for an explanation about an action or expression (Merrian-Webster, 2001). When that occurs the interpellated person is convoked into a subjective position (Althusser, 1971). Thus when a patient asks the therapist for an explanation, the latter is being interpellated to adopt a determined subjective position. For Althusser (1971) interpellation is a cultural practice that contributes to the maintenance of a particular ideology. In this sense, an interpellation is part of a discourse genre and its manifestations are limited by the rules of the genre. In the case of psychotherapy, the interpellation is a discursive phenomenon, which allows to study how this discourse genre organizes the exchanges between its participants (dialogal level). In addition, it allows studying how these exchanges convoke different subjective positions or voices of these participants (dialogic level). From our point of view, these events are fundamental in psychotherapy insofar their discursive structure allows to make visible and to focus in the interactive behavior of its participants, both at inter- and intra-mental levels.

To illustrate and explore this proposal, our analysis was guided by the following questions:

What are the roles played by the therapist and the patient when they interpellate each other in the therapeutic dialogue?

What are the relationships among the internal voices present in each participant and what are the connections between them and the dialogal exchanges in psychotherapy during moments of mutual interpellation?

Method

The study is qualitative, specifically based on the DDA framework (Gonçalves & Salgado, 2001; Hermans, 2008; Leiman, 2012; Valsiner, 2002), and corresponds to a case study design.

Sample

The analysis was performed over selected excerpts taken from a corpus of 19 videotaped sessions of a time-limited psychoanalytical psychotherapy planning to 19 sessions that were done in a university center of mental health. The patient was a

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Table 1. Descriptions of the sample of excerpts.

Number of excerpt	Session	Stage of therapy	Content of the excerpt
1	1	First	The Therapist asks the patient about the description she does about herself.
2	1	First	The therapist asks the patient about the goals she has for therapy.
3	5	First	The therapist asks for explanations to the patient about the setback that she has shown in therapy.
4	9	Middle	The therapist asks the patient to become aware of her problem solving style.
5	10	Middle	The patient asks the therapist about how she can know what she needs for her life.
6	16	Final	The Patient and therapist interpellate each other about how they perceive each other

38-year old woman, while the therapist was a 40-year old man with clinical experience and formal psychoanalytic training. The patient came to psychotherapy due to depressive symptomatology after a divorce process. The therapeutic work focused on elaboration of post-separation mourning and other recent losses. Depressive symptomatology was not the main focus of psychotherapy and was treated with medication. The transcripts of therapy sessions were conducted by a specialized secretary, who followed the notation system attached (see Appendix 1). The excerpts were selected by the first author, who is a clinical psychologist and therapist. The three criteria were: first and main criterion, the excerpts should refer to explicit, mutual patient–therapist interpellations; second, they should represent each of the phases of psychotherapy (beginning, middle and end of the process); and third, they should be at least two exchanges long.

Following above criteria, six excerpts of therapeutic dialogue were chosen (see Table 3 and Appendix 2). They were divided into two extracts selected from the first session and one from the fifth (initial stage of the therapy); one extract from the ninth session and one from the tenth (middle stage of the therapy); finally, one extract from the sixteenth session (final stage of the therapy). In Table 1, the characteristics of each excerpt are presented. The symbols employed in the excerpts' transcription are based on various conversation analysis (CA) conventions (see Appendix 1).

Analysis procedure

Considering the dialogic nature of the therapeutic relationship, and to pursue the intention of revealing the voices that take part in its construction, discursive

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interaction mechanisms were evaluated using DDA (Larraín & Medina, 2007). The procedure that involved two levels (see Table 3):

(I) *Dialogal level*: The units of analysis were the dialogal exchanges in the therapeutic conversation, in which we employed selected CA procedures (Larraín & Medina, 2007). This analytic level allows to perform a detailed evaluation of the specific organization and the regularities of psychotherapeutic exchanges (Avdi & Georgaca, 2009). This analysis' objective is to identify the recurrent organizational properties of the interaction process (Forrester & Reason, 2006; Peräkylä, 2004). Specifically we used the following analytic categories:

1. *Turn organization*: rules which underpin how each speaker knows when to speak (Lepper & Riding, 2006).
2. *Sequence organization*: the ways in which consecutive utterances are linked (i.e. adjacent pairs) (Peräkylä, 2004).
3. *Turn size*: rules which establish how long a speaker may speak (Lepper & Riding, 2006).

(II) *Dialogic level*: At this level, we qualitatively analyzed the following aspects which we have defined and illustrated for better comprehension:

1. *Enunciators (voices/positions)*: points of view expressed in the utterance (enunciate), or an ideological position itself.[1] An utterance may contain more than a point of view, valuation, or position, which constitutes its polyphonic aspect (Larraín & Medina, 2007).
2. *Subject of the utterance (the one who's responsible of the utterance/the one who's in charge)*: it is understood as the protagonist of the narration, or the ideological center of reference from which it develops. It is the ideological foundation from which a subject enunciates (Larraín & Medina, 2007).
3. *Subject of the enunciation (the one who speaks)*: it is understood as the subjective aspect—not necessarily an objective one—whose impression on the utterance refers to the act of enunciation (Larraín & Medina, 2007).
4. *Modalizers and modalities (attitude and valuation)*: In this study, modalizers have been conceptualized as linguistic constructions, frequently adverbial in nature, which manifest the speaker's attitude and valuation, either implicit or explicit, with respect to what is uttered. They tend to appear towards the beginning or the end of the utterance to "color" or impregnate it with such attitude. From a dialogic point of view, modalizers acquire a functional social role, which allows them to regulate the dialogal and dialogic interaction (Larraín & Medina, 2007). Concurrently, modalities have been conceptualized as the relationship between the speaker and the utterances that express himself or herself—that is to say, the relationship between the propositional content and the speaker's point of view presented on them. Modalities can be marked using specific modal verbs and other linguistic elements. Álvarez (2001) classified them in: (a) Alethic, which refers to a "could be", i.e. situations that are probable or possible from the speaker's point of view; (b)

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Deontic, which refers to a "must be", i.e. situations that are obligatory, necessary or forbidden from the speaker's point of view; (c) Epistemic, which refers to "mental operations" such as to know, to believe, to think, etc.; (d) Volitional, which refers to a "will" or to a "want to be"; and (e) Appreciative or Axiologic, which refers to values or judgments expressed about persons, ideas, or objects.

In the next excerpt,[2] from a therapeutic dialogue we can see an example of discursive text with its dialogic elements in bold and with the aforementioned DDA elements, numbered in brackets after the utterance.

> T: .hhh Look ***I think that*** (2, 4c) when ***I was telling you*** (3) that ***I can tell you*** (3) how old I am and:: if I have children and if I am married or not (.) .hhh well actually look, ***I think that*** (2, 4c) what ***I hhh. am trying to explain*** (2) there is that um:: ***it is a type of question that has to do with a fact from reality*** (1) (.) right?, ***I mean, obviously, I mean*** (4) ***you um::have every right to wonder who I am, what I do, right, outside these four walls,*** (1) right? (.) then ***what I am telling you*** (3) is ***that I think*** (2, 4c) ***your question is valid*** (1).

The analysis procedure sought to integrate both levels after the individual evaluation of each (see Table 2). First, an analysis at the dialogal level of each interpellation was performed by two independent coders (the first and second authors, both with DDA training), followed by one at the dialogic level by the same procedure. Subsequently, these coders conducted an independent coding through intersubjective agreement. Second, a third researcher (third author, linguistics specialist) audited the analysis and complemented intersubjective agreement used by the two other raters. Finally the relationship between both levels in the exchanges of the two participants was analyzed.

Table 2. Summary of DDA procedure.

Descriptor	Dialogal	Dialogic
Level of analysis	Conversation	Discourse
Focus	"Real" dialogue/ inter-mental dialogue (between patient and therapist)	Inner/Intra mental dialogue (between voices and positions—positioning)
Analytic tools	Conversational: Turn organization (turn taking) Turn sequence organization Turn size	Linguistic: Enunciators (voices/positions) Subject of the utterance (the one who's responsible of the utterance / the one who's in charge) Subject of the enunciation (the one who speaks) Modalizers and modalities (attitude and valuation)

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Results

Results are organized around the questions that guided this study. To give an answer to each one of them we firstly show dialogal analysis results, followed by the results of the dialogic analysis. In turn, the results are supported and illustrated in a sample of three of the six extracts corresponding to the analyzed interpellations which are presented in Table 3.

Therapist and patient roles in the mutual interpellation

Dialogal level. In the excerpt, from the beginning of the psychotherapy compliance for the turn taking rules through the figure of the question–answer was observed. With respect to the excerpt from the second phase of the therapy, the turns do not follow the same question–answer logic. The turn taking dynamic is more diverse depending of the relational moment of the therapeutic dialogue, and for this reason it is more probable to find overlapping speakers' turns. Finally, in the third and last phase of the therapy, a more symmetrical turn exchange and an inverted length of turns was observed. This change towards a more symmetrical role in the interpellation manifests in the therapist's longer participation as compared to the patient. This suggests a transformation in the power dynamic of the relationship.

As it can be observed, in the excerpt corresponding to the initial session (see Table 3A) turn taking follows the logic of ''adjacent pairs'' of the question–answer type. Therefore, the transition from T1 to P1 follows the space given by the therapist for the patient's answer. The excerpt corresponding to the second stage of the therapy (see Table 3B) shows a different turn taking dynamic as compared to the extract of the first stage. There are fewer questions for giving the turn and, at times the participants are forced to raise the pitch of their voices to get the turn or to keep it. Finally, the excerpt of the last phase of the psychotherapy (see Table 3C) shows a diverse and harmonious turn taking dynamics, with sets of question–answer pairs; turn-giving being signaled by lowering the pitch or leaving a space of silence, or even interrupting the interlocutor in order to take the turn and finish an incomplete idea.

Dialogic level. Irrespective of the psychotherapy phase, in the analyzed excerpts, the frequent use of pronominals in atypical syntactic positions within utterance was a salient feature in the therapist's discourse. This procedure shows the hallmark of consciousness in the therapist's construction (who wants to highlight the subject of the utterance), for instance: *you/yours*. For example, in the excerpt from the first phase of the therapy (see Table 3A) during the therapist first turn (T1), it was interesting to observe the frequent use (six times—see Table 3A terms in bold) of the personal pronoun ''you'', in uncommon syntactic positions for a Spanish speaker from Santiago de Chile. This use of the second person is a polite way of addressing someone, respectfully or detachedly (for example: ''*. . .to know you to see if: (.) it's possible to help you: in this. . .*''; ''*. . .what do you think about. . .*''; ''*. . .the object you would like to:: work on*?''). In this interpellation, the therapist becomes in this way de-

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Table 3. Sample of excerpts of interpellations for illustration.

Stage of the therapy	Excerpts of interpellations
A. First stage and first session Excerpt 2 (1E2) (2.92 min)	1) T1: . . .hh the idea of this interview, ***right?*** is um:: a bit:: **(4 a)** to know **you** to see if: (.) it's possible **(4 a)** to help **you:** in this:: um: psychotherapy, ***right?*** the idea is to have it once a week until January more or less, ***no?*** mid January or the end of January (.) um:: what do **you** think about after talking in this conversation or what **you** have thought before would be the aim of this interview (.) what would **you** like (.) um:: > or of this therapy sorry < what would be the objective (.) the object **you** would like to:: work on? 2) P1: hh hhh the objectives I **(2)** would like to work on - - we – (6,0) .hh truth is ***I would like to***:: **I don't know (2)**, to have:: um:: find myself again, to be myself (.) **I don't know (2)** if I exist - - if that exists or ***I'm like*** that **(2)** (.) or or if there is another person I haven't taken out **(2)** (.) that that maybe:: (.) um:: disconnect myself a little:: **(2)** (.) from this:: disconnect myself **(2)**, say, from this problem that (.) that:: (3,0) that **I don't think (2)** is going to lead me to anything (.) that's it (.) having the ability to:: say **(3)** > yes, it happened to me **(2)** but it doesn't hurt <>it did happen to me **(2)** >, < but it doesn't hurt >, because ***I notice it hurts*** (.) I mean, every day I haven't been able to (.) to to:: make it not matter to me **(2)** (3,0) hh and the other thing that:: (.) ***I want*** not to < matter to me > **(2)** (.) to get the good from this, the good things, I mean **(3)**, trying not to go to the other extreme, trying to get the good from this (.) in this case which is the father (.) and who is a good person and who:: my children have to see it that way (.) because at some point I didn't speak well of him **(2)**, I did **(2)** it in front of them (.) um:: (4,0) and I wouldn't like **(2)** - - well I wouldn't like **(2)** to do it, in fact I still think **(3)** he didn't act well (.) and I didn't say **(3)** that in front of the children, I mean I didn't say:: **(3)** he did not act well, I said other **(3)** – I said other things **(3)** (.) then that didn't matter to me **(2)**, that he didn't act well with me **(2)** (.) trying to separate that, that only that.
B. second stage and tenth session Excerpt 1 (10E1) (1.85 min)	1) P1: hhh. How can I know ***what I want*** **(2)**, then? 2) T1: >well I think **(2)** that happens, ***right?***<, anger is an important signal that is telling you something, but since you don't want to:: face it, ***no?***, you don't know what you want (.) hhh. OR you want to get rid of it, >then I tell **(3)** you here let's review this anger and you tell me **(3)** < NO! that that's terrible (.) ↓why is it so terrible? you mean that something's happening to you (.) ***right?*** and maybe by following that anger we can discover what you want, and:: maybe **(4 a)** the anger will go away when you get what you want, or

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Table 3. Continued.

Stage of the therapy	Excerpts of interpellations
	when you know, say **(3),** that maybe **(4 a)** what you want maybe **(4 a)** doesn't exist, but but you have asked for it, you have looked for it 3) P2: (14,0) (the therapist coughs) um::: well, I'm thinking **(2)** of where to direct:::(.) 4) T2: then I gave you **(2)** a pointer again, ***right?*** (.) let's see that anger (3,0) but you're going to tell me **(3),** you don't tell me anything doctor (laughs) 5) P3: no no, no no, no, I'm thinking **(2)**, no 6) T: hm hm 7) P: what happens [is that] 8) T3: >[I SAID IT] **(3)** because you said **(3)** I don't know where to go< 9) P: that's right! 10) T: YOU KNOW WHERE TO GO **(2)**, following the anger, <u>the anger</u> the anger is telling you something, it's telling you that there is something that::: bothers you , ***right?*** and why does it bother you (6,0) we have another clue **(2)**, here you have been annoyed by certain things I haven't done, ***right?*** you would expect **(2)** more from me, ***right?*** 11) P4: so it did hurt you (laughs) (3,0) um:::: well [actual] 12) T4: [BUT] maybe **(4 a)** that's what scares you, ***right?*** feeling that this can be very aggressive, that:: that it may hurt me if you express your anger here, and maybe **(4 a)** with your husband and with others, and that may be **(4 a)** very destructive.

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Table 3. Continued.

Stage of the therapy	Excerpts of interpellations
C. Third stage and 16 [a] session Excerpt 1 (16E1) (2.83 min.)	1) P1: to dare? 2) T1: >to dare< ↓of course, then I believe **(2)** that at this point, to state as a criticism, ***right?*** > I understand **(2)** that you perceive it as a criticism < lets say, ***right?*** what I say **(3)** is that in some way you set a distance (.) you don't feel that you are equal to me or balanced when we are here both of us working together, ***you see?*** almost as if **(4 a)** I were a professor (.) so I believe **(2)** that this situation is for you (.) unconsciously, automatically, gives you a sense of safeness, you feel more relaxed ↑ ah! I am being told what I have to do, ah! I made a mistake, so now I will do it correctly >but at the same time< you pay the price of feeling that, actually (.) we are not working together **(2)**, that I am criticizing you, so, in the end, you are not really making use of the therapy, in the sense that we are both working together, and not as a criticism in this moment, but that you (.) don't feel deeply committed in this therapy (.) with me (.) to (.) for you to see your problems. 3) P2: (4,0) that may be so >but I **(2)** may look at you as if you were a professor< maybe it has been the way we treat each other (3,0) since you (,) since you >because that< that is. it sets something, **I don't know! (2)** perhaps ***I believe*** **(2)** in me :: **I don't know (2)** (.) I don't mean to generalize, but I think **(2)**it's the YOU [note: "Usted", respectful form of second person singular in Spanish] um:: this sets a distance:: of:: patient and professional, it gives me the impression, I mean, **I don't know** if it I or:: ***I have it*** very present.: **(2)** 4) T2: >Well, I think **(2)** there might be some things on my side <or::: or from here of the therapy that perhaps **(4 a)** give that impression I I can that be true, ***right?*** but I believe **(2)** that besides that, YOU have tendency to do it like that > because another person, even if one uses you [Usted, respectful form of the second person singular in Spanish] or another thing = 5) P: yes 6) T: = maybe **(4 a)** you could have interpreted it in another way, ***right?*** (.) so your tendency to feel criticized (.) I believe **(2)** it has something to do:: with you (.) that you:: criticize yourself, ***don't you?*** so put that:: on

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Table 3. Continued.

Stage of the therapy	Excerpts of interpellations
	me (.)> but when I tell **(3)** you that you are not using the therapy at its fullest < which I understand **(2)**, can be felt as a criticism, but you have a tendency::: to live it as a criticism > 7) P3: the truth of **(4 e)** (XXXX) **I don't know (2)** if I don't underst::: from the beginning **I did not understand (2)** how this thing was but (.) um::: 8) T3: I believe **(2)** you did understand, by the way, ***right?*** = 9) P: well::: yes::: 10) T: = > I mean **(2)**, because you have, ***haven't you?*** < 11) P4: yes (.) what happens **(4 b)** is that::: ***I HAVE tried*** **(2)** to do it but:: (.) I meant, it had been hard for me to understand because I:: (.) wanted to analyze first, I meant **(2)**, it's like ***I wanted*** **(2)** to foresee or:: or to do what it was the right thing, **I don't know (2)**, and that is what ***I have always done*** **(2)**, say **(3)**, as if:: I study the thing and say **(3)** I should **(2)** go this way, not that things turn up something li::: randomly, a bit:: or perhaps they do, because, because (.) ***I understand*** **(2)** that maybe because of that:: no **don't know**, no:: (.) I did not **(2)** use the therapy at its fullest **(1)** or I just **(2)** don't do it now **(1)** but it's just because I::, **I haven't known how (2)**, or **haven't figured out how (2)** to approach those things I do automatically

Note. (1) Enunciators. (2) Subject of the utterance. (3) Subject of the enunciation. (4) Modalizers and modalities: (a) Alethic, (b) Deontic, (c) Epistemic, (d) Volitional, (e) Appreciative or Axiologic. In bold and Italics are highlighted terms for other analytic porpoises.

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personalized, since he does not mark himself as the center of an ideological elaboration (subject of the utterance), but demands the patient to assume that role. When he plays the role of subject of the utterance, he does so in the first person plural, with expressions like: "*we have removed the cap*". Besides this, a second characteristic of the therapist discourse in the analyzed excerpts is the constant use of modalization procedures to relativize or to seek the patient's cooperation: *perhaps, maybe, a bit, as if*; and also the use of verbal forms that do not expressly indicate the subject, which in most cases are mental or existence constructions: *believe, feel, may, (something) is, suppose*, etc. In the same way, there is continuous presence of rhetorical questions with phatic value, to ensure the communicative contact, and with appellative value, in order to call the other person: *isn't it?; no?; ah?* (see Table 3A, T1; see Table 3B, T1, T2, T3, T4; and Table 3C, T1, T2, T3, terms in bold and italic). Overall, in the extracts analyzed is possible to observe a discursive construction in which the therapist does not commit with the utterances that configure his interpellations, but gives such responsibility to the patient. Here, the dialogical relationship in terms of power is managed by the therapist who gives that power to the patient.

The patient constructs her discourse by making use of explicit pronominals associated to mental verbs and mental adverbs of negation (*I don't know, I don't realize*—see Table 3, terms in bold); to emotional verbs and emotional adverbs of assertion (*I feel, I believe, I want, I try*—see Table 3, terms in bold and italic); and finally, summarizing or mixing these procedures in two enunciators about herself: *what she has not done and what she wants to do*, expressing two strong positions within herself: *I don't know v/s I want or should... but... I don't know*. In relation to role construction, the emergence of two opposite positions in the patient could be associated to the necessary presence of a conflict which can turn into the therapeutic work's object. In this case, the conflict emerges very clearly in front of the therapist interpellations that demand a stronger position regarding of her subjectivity.

Therapist and patient internal voices in the mutual interpellation

Therapist's subjectivity plays down during role exercising, insofar he makes use of verbal forms that do not specify neither the subject of the utterance nor the subject of the enunciation, or else when he does, he quickly relativizes his subjective position, using the enunciator corresponding to the patient's positions. That is to say, the therapist does not adopt an "author" position, nor he commits with the enunciators. However, this mutual interpellations exchange in which they negotiate the property of their utterances seems to allow the emergence in the patient of two opposite non-integrated voices: what she does not do and what she wants to do, and also the voices from the past and present. These two positions can be observed in the patient's turns P1 in Table 3A; turn P1 in Table 3B; and turns P2, P3 and P4 in Table 3C.

For example, in the excerpt from Table 3C, the therapist takes his turn (T2) assuming the position of the subject of the utterance ("*I believe...*") and relativizes his responsibility related to what the patient expresses using possibility constructions ("*...might... perhaps...*") and referring to the therapy as a neutral subject

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("... *from here of the therapy*"). He locates the patient as the subject of the utterance using the pronominal "you" on several occasions and even raising the intensity of his voice to highlight it. He ends his turn pointing at himself as the subject of the utterance ("... *I understand*...") that refers to the internal voices of the patient and, again, identifies the patient as the origin of those voices. The patient takes her turn (P3) and modalizes her answer ("... *the truth of*...") in order to justify her voices and diminish her responsibility. At a moment in which she doubts and seems to not know how to continue with her speech, the therapist intervenes marking himself as the subject of the utterance (T3) and vigorously referring to her in order to emphasize her responsibility ("... *I believe you did understand*...") and then he lets the patient proceed with her turn, with statements in the form of questions. The patient takes her turn (P4) and modalizes her answer ("... *what happens is*...") as a justification and explanation of something that has already happened. Immediately she sets herself as the subject of the utterance, which is expressed in past tense ("...*I meant*...") which would, in some way, explain her behavior. From that moment on, her speech comes from a nucleus of elaboration which oscillates between a past that justifies and explains ("... *I did not use the therapy at its fullest*...") and a present in which she accepts herself as the subject of the utterance and takes responsibility for her actions ("... *things I do*... *I do it now*...") and finally she ends with an utterance in present perfect, in which she is the subject who explains it all, by negating her capacities ("...*I haven't known how*...").

Connections between participants' internal voices and dialogal exchanges during interpellation

In the interpellations corresponding to the beginning of the therapy (see Table 3A), the patient tries to show herself from different perspectives, two of which are highlighted: one of them corresponds to the questions "regarding the person" made by the therapist, to which she responds from a negative enunciator, emphasizing her "weak" traits or characteristics of hers that she dislikes. The other aspect corresponds to a more positive voice—that of her social roles as worker or mother.

In the middle phase of the therapy (see Table 3B), the turns do not follow the question–answer sequence, and more turn overlapping is observed. At the same time, from the dialogical point of view we see in the patient the presence of past and present voices that are not merged and confuse her over/regarding her identity.

Towards the end of the therapy (see Table 3C), in the interpellations analyzed, the therapist has lost the initial place of being the one who questions the other. In turn, even though she is finishing the therapy, the patient still cannot reassure herself as the subject of the utterance, not having a clear point of view that reflects the integration of her internal voices. She continues, much like she did at the beginning of the therapy, relativizing negatives aspects of herself.

Irrespective of the phase of the therapy, the therapist shows difficulties in committing with his point of view as subject of the utterance, and uses ventriloquism to make the patient talk through his own voice and in thus avoid the intromission of supposedly

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interfering voices of his interlocutor. For example, in the excerpt presented in Table 3B, the therapist begins his first turn (T1), taking the patient's question (P1) as addressed to himself as the subject of the utterance ("...*that I think that*..."), but this quickly becomes a dialogue within the dialogue, with a now typical ventriloquism mechanism that uses two subjects of enunciation, himself and the patient ("...*then I tell you here let's review this anger and you tell me, no!*..."). As before, he asks and answers himself, and uses cooperation modalizers as supporting elements ("*no?*"; "*right?*"). This ventriloquist-mode dialogue is used by the therapist to support an interpretation about what he thinks the patient should do; yet, the repeated use of a modalizer that relativizes the utterances ("*maybe*", four times in a few utterances) makes his intervention lose some of the strength the ventri-dialogue had conferred to it. As a result, we can observe a subject of the utterance whose enunciators are ambivalent regarding both rigurosity and strength. He abandons his position as the subject of the utterance to employ a more rhetoric strategy (ventri-dialogue), but when that works, he becomes weaker with the use of modalizers that relativize his enunciators.

Conclusions

In this study, the DDA made it possible to recognize, in the concrete communicative event referred to as interpellation, the discursive markers, or materializations of the patient's internal voices and the voices of the therapeutic dialogue. It also enabled us to recognize these voices, their interaction, psychological tension, and crystallization in the discursive chain (Bakhtin, 1986). In this sense, the interpellation in this study has been understood as a kind of therapeutic interaction that highlights the tensions between the participants and the power distribution in this interaction. The interpellation has also been understood as a discursive context that allows the observation of how these tensions are resolved both in the organization of exchanges in the interaction (dialogal level) and in the emergence of inner dialogues that come into play in the patient–therapist interaction (dialogic level). Taken together, these two dimensions of the interpellation allow to observe the way in which certain rules of the discursive genre of psychotherapy are tensioned in the therapeutic interaction and, in turn, to analyze the way in which these rules are restored.

DDA allowed us to analyze the way by which the utterances in an interpellation are intertwined into a dialogic weaving in which participants' subjective positions show their different aspects, nuances, and their possibilities of being transformed. However, we observed that these positions or voices do not unfold in the same way for both participants since they are immersed in different roles, which are determined and regulated by the discursive genre in which they are situated and the power dynamic modeled by the broader social and cultural context where the notions of patient and therapist are established. As seen in the results' analyses exposed, these rules organize the conversational exchange between therapist and patient, for example, by restricting their roles in adjacent pairs of question and answer. In the case of the specific excerpts analyzed, this conversational structure marks very clearly a turn taking pattern at the beginning of a psychotherapeutic relationship, which seem to

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get more flexible and even messier as the therapeutic process progresses. During therapy, it seems the participants—in this case, more evidently the patient—are gradually freed from the restrictions imposed by this discursive genre at the dialogal level. In turn, at a dialogic level, the therapist seems to be even further restricted by genre rules. This therapist uses various linguistic and rhetorical strategies (e.g. ventriloquism) to plays down his subjectivity, which appears to lend support for the unfolding of patient's subjectivity. Therefore, the use of these rhetorical strategies, which are not part of the discursive genre of psychotherapy, enabling the restoration of the rules of the genre, stressing the subjectivity of the patient. Some of these strategies may be specific to a more classical psychoanalytic practice, in which it is considered that the analyst can take a neutral position as an observer who has access to aspects of the patient's mind that this does not know. From this privileged place the therapist enables himself to say what the patient should do.

In the whole set of interpellations analyzed, two conflicting positions or voices in the patient subjectivity are clearly identified from the start, these are brought into play in the dialogue, and constitute the object of therapeutic work. In this way, and under the prism of psychotherapy's discursive genre structuration, it seems that both levels, dialogal and dialogic are associated in such a manner so that the first creates the conditions of possibility for the latter. Hence, for example, in the analyzed case, restrictions imposed over therapist and patient roles by the adjacent pair of question and answer, respectively, would generate the necessary conditions required so that the patient's subjectivity is the one to be unfolded and turned into the therapeutic conversation's focus.

Such as was observed in the extracts analyzed, the practice of psychotherapy can be conceived as a recursive dialogue network. On one hand, we can see the therapist–patient dialogues and the dialogic interactions of their internal voices; and on the other hand, the dialogues between their voices and the voices of their surroundings or culture.

The possibility of studying psychotherapy as a discursive genre places language as an essential nucleus and a fundamental tool for therapeutic work, since through language it is possible to indirectly approach thought, emotional, and affective processes of patients. In this regard, Leiman (2011) states that psychotherapy works at the border between the interpersonal and the intrapsychic, and if psychotherapy is understood as a discursive practice, we observe that the utterances are shaped by social and psychic forces, and are related to the intrapsychic processes of the patient. In the interaction with the patient, the therapist would simultaneously have a dialogue with the voices of the speaker and his or her inner voices, which include ideological positions coming from his particular psychotherapy theory. Thus, the therapist would be in continuous dialogue with his or her own cultural framework and this dialogue would feed and structure the specific way in which he or she exercises his or her therapeutic role as a discursive practice. This is sustained by Avdi and Georgaca (2009), who argue that psychotherapeutic discourses constitute systems of meaning that have been built by psychotherapy as institution and which are then maintained through practice. These discourses function as reference points by means of which therapists organize their intervention.

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In this way, psychotherapy is conceived as a privileged space for the explicitation or recognition of those dialogic interactions, and therefore this approach can be a powerful instrument with concrete applications to therapeutic praxis, since it may allow the therapist to show the patient her or his own internal tensions and conflicts. Moreover, the approach to understanding psychotherapy as a discursive practice allows us to identify the regulations performed by the therapist and patient in the proposed two levels of therapeutic dialogue—dialogal and dialogic—which are immersed in a broader cultural context. Through the case exposed in this article, we have illustrated a possible way to observe the changes that take place during the course of the therapy regarding the roles of the therapist and the patient. Additionally, the method exposed allows us to witness how both levels show adjustments that occur according to the variety of subjects covered in the psychotherapy. These regulations result from the changes experienced by each subjectivity as well as from the evolution undergone by the therapeutic interaction. However, the analyzed case corresponds to a therapist from a specific psychotherapeutic model (psychoanalysis) and with a patient with a particular symptomatology (depression). Both features could constrain the way by which they follow the rules of the discursive genre associated with that particular model or with that specific mental state. In the future, it will be interesting to analyze other cases with therapists from different psychotherapeutic models to see which discursive rules are common among them and which rules could account for specificity of each model as well. Also, analyze therapies with different types of patients in terms of symptomatology and sex, whose characteristics could propose different kinds of interactions. That is to say different dynamics of power associated with social representations concerning psychopathological states, different therapeutic approach, different gender relations, etc. that will determine the ideological and value positions involved in the organization of such interactions. Finally, we believe that this kind of microanalysis is a very useful tool for researchers who seek to pursue the study of therapeutic interaction by focusing on the language present in the discourse of its participants, which establishes them as subjects of dialogue and interaction. Authors as Leiman (2011), Salvatore, Gennaro, and Valsiner (2012) have stated that this kind of psychotherapy research is relevant, not only because its contribution to comprehend the changes processes in the patients, but also its contribution to the development of basic knowledge about psychological transformations in persons by means the language and its meanings.

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Notes

1. The theoretical background, based on Bakhtin, Voloshinov, and Vigotsky, considers that language and discourse always entail an ideological position, because they are part of a broader social and cultural background (see Bakhtin, 1986; Vigotsky, 1962; Voloshinov,

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1973). Therefore, an enunciator from the DDA point of view, always involves taking a position in the social and cultural scenario in which a given conversation is performed.
2. See Appendix 1 for transcript notation.

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Appendix 1

Transcription symbols

Symbol	Meaning
T	Therapist
P	Patient
[	Starting point of an overlapping
]	End of an overlapping
(2.0)	Silence measured in seconds
(.)	Silence shorter than 2 seconds long
word	Emphasis
WORD	Word uttered with a higher pitch
:::	Lengthening of the sound of the last syllable
.hhh	Inhalation
hhh	Exhalation
↑ ↓	Pitch increase or decrease
word	Word uttered laughingly
(XXXX)	Inaudible word
(gestures)	Comment on non-verbal elements
((coughs))	Non-discursive noises
> PHRASE <	Phrase uttered faster than usual
< PHRASE >	Phrase uttered more slowly than usual

Based on Gumperz & Berenz (1990).

Appendix 2

A. First stage and first session

Excerpt 2 (1E2) (2.92 min). 1) T1: hh la idea de esta entrevista ¿cierto? es e:: un poco:: conocerla a usted para ver si: (.) es posible ayudarla: en esta:: e: psicoterapia ¿cierto? en que la idea es que sea una vez por semana hasta más o menos Enero ¿no? mediados o o finales de enero (.) e:: ¿qué piensa usted después de hablar en esta conversación o lo qué ha pensado antes sería el objetivo de esta entrevista (.) qué le gustaría a usted (.) e:: > o de esta terapia perdón < cuál sería el objetivo (.) los objetivos qué a usted le gustaría como:: trabajar?

2) P1: hh hhh los objetivos que me gustaría trab - - nos – (6,0) .hh la verdad de las cosas que me gustaría:: no sé tener:: e:: reencontrarme, ser yo (.) yo no sé si existiré - - si existirá eso o soy yo así (.) o o existe otra persona que yo no he sacado (.) eso eso a lo mejor que:: (.) e:: desvincularme un poco:: (.) de este:: desconectarme, digamos,

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de este problemática que (.) que:: (3,0) que creo que no sé no me va a conducir a nada (.) eso (.) tener la capacidad de:: decir > sí me sucedió pero no me duele < >sí me sucedió >, < pero no me duele >, porque noto que me duele (.) o sea cada día no he sido capaz (.) de de:: de que no me importe (3,0) .hh y que lo otro que:: (.) deseo que no me < importe > (.) rescatar lo bueno de esto, lo bueno, o sea, no tratar de irme pal otro extremo, tratar de rescatar lo bueno (.) en este caso que el es papá (.) y que es una buena persona y que:: mis hijos tienen que verlo así (.) porque en algún minuto yo no hablé bien de él, lo hice delante de ellos (.) e:: (4,0) y no quisie-- bueno no quisiera hacerlo, de hecho todavía lo pienso que no fue derecho (.) y no dije eso delante de los hijos, o sea no dije:: no fue derecho, dije otra – dije otras cosas (.) entonces que eso no me importara, que no haya sido derecho conmigo (.) tratar de separar eso, eso sólo eso.

B. Second stage and tenth session

Excerpt 1 (10E1) (1.85 min). *P1: hhh. ¿Y cómo saber lo que quiero, entonces?*

T1: >bueno es que yo creo que eso pasa ¿no?<, la rabia es una señal importante que le está diciendo algo, pero como usted no quiere:: enfrentarla ¿no?, no sabe lo que quiere (.) hhh. O quiere sacársela de encima, >entonces yo le digo acá revisemos la rabia y usted me dice< ¡NO! que que eso es terrible (.) ↓¿porqué tan terrible? quiere decir que hay algo que le está pasando (.) ¿cierto? y a lo mejor siguiendo esa rabia podemos descubrir lo que usted quiere, y:: a lo mejor la rabia se le va a quitar cuando usted consiga lo que quiera, o cuando usted sepa, digamos, que a lo mejor lo que usted quiere a lo mejor no existe, pero pero lo ha pedido, lo ha buscado

P2: (14,0) (el terapeuta tose) e::: bueno, estoy pensando para donde dirijo:::(.)

T2: entonces de nuevo le di una guía ¿no? (.) veamos esa rabia (3,0) pero usted me va a decir, usted no me dice nada doctor (ríe)

P3: no no, no no, no si estoy pensando, no

T: hm hm

P:lo que pasa [es que]

T3:>[LO DIJE] porque usted me dijo no sé para dónde ir<

P: si poh!

T: SABE ADÓNDE IR, seguir la rabia, la rabia la rabia algo le está diciendo, le está diciendo que hay algo que a usted::: le molesta ¿no? y por qué le molesta (6,0) tenemos otro indicio, aquí usted se ha molestado de ciertas cosas que yo no he hecho, ¿no? usted esperaría más de mi, ¿cierto?

P4: que le dolió (ríe) (3,0) e:::: bueno en [reali]

T4: [PERO] a lo mejor ese es el susto ¿no? de sentir de que puede ser muy agresivo, que:: que me duela mucho si usted expresa su rabia acá, y a lo mejor con su marido y con los demás, y puede ser muy destructivo eso.

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C. Third stage and 16ª session

Excerpt 1 (16E1) (2.83 min). P1: ¿atreverme?

T1: >atreverse< ↓cla::ro entonces yo creo que aquí usted al poner como crítica ¿cierto? >o sea yo entiendo que usted lo percibe como crítica< digamos ¿no?, lo que yo digo de alguna forma usted pone distancia (.) no se siente igual a mí o má::s en equilibrio conmigo aquí los dos trabajando juntos ¿entiende? casi como si yo fuera un profesor (.) entonces yo creo que eso a usted (.) inconscientemente, automáticamente, le da seguridad, se siente más tranquila ↑ ¡ah! me están diciendo lo que tengo que hacer, ¡ah! lo hice mal entonces ahora lo hago bien, >pero al mismo tiempo<, sufre el costo de sentir que en verdad (.) no estamos trabajando juntos, que yo la estoy criticando, entonces, a fin de cuentas, no le saca el provecho a la terapia, en el sentido de los dos trabajando juntos, y no como una crítica ahora sino como que usted (.) no se siente comprometida a concho, en esta terapia (.) conmigo (.) para (.) que usted ver sus problemas

P2: (4,0) puede que sea, >pero puede que también haya sido el que yo lo mire como profesor< e:: ha sido el trato a lo mejor (3,0) el usted (.) el usted >porque eso< eso ya::: e:: pone un no sé poh! yo creo a lo mejor en mí:: yo no sé (.) no quiero generalizar, pero yo creo ese USTED eee pone una distancia:: de:: profesional paciente, me da la impresión, o sea no sé si será o:: yo lo tengo muy marcado así

T2: >bueno yo creo que pueden haber algunas cosas mías< o::: o de aquí de de la terapia que pueden dar esa impresión yo yo puede ser cierto eso ¿cierto? pero yo creo que además, USTED tiene una tendencia a hacerlo así, >porque otra persona por mucho que uno diga usted u otra [co]sa =

P: [sí]

T: = a lo mejor podría haberlo tomado de otra forma ¿no? (.) entonces, la tendencia a sentirse criticada suya (.) yo creo que tiene que ver un poco:: con usted (.) que usted:: se critica ¿cierto? entonces lo pone:: en mí (.) >pero cuando yo le digo usted no le saca el jugo a la terapia< que yo entiendo se puede sentir como una crítica, pero usted tiene una tendencia::: <a vivirlo como una crítica >

P3: es que la verdad de (XXXX) yo no sé si no enten::: desde el principio no entendía esta cosa como era pero (.) e:::

T3: yo creo que sí entendió, a propósito ¿ah? =

P: bueno::: si::

T: = > o sea porque lo ha hecho ¿ah? <

P4: si (.) lo que pasa es que::: YA si he tratado de hacerlo pero:: (.) quise decir que me había costado entender porque yo:: (.) quise analizar primero, o sea a ver, como que me quise anticipar, o:: o hacer lo que era correcto, no sé, y eso es lo que siempre hago en realidad que, como que:: estudio la cosa y digo por este camino debiera ir, no que las cosas me resulten así co::: al azar un poco:: o a lo mejor sí, por por (.) entiendo que a lo mejor yo por eso:: no sé poh no:: (.) no le saqué el jugo a la terapia o no le saco el jugo pero es porque simplemente no::, no he sabido cómo hacerlo o no he sabido como enganchar esas cosas que hago en forma automática::

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