

Final version to be published as: Sutherland, O., Peräkylä, A., & Elliott, R. (in press).
Conversation Analysis of the Two-Chair Self-Soothing Task in Emotion-Focused Therapy.
Psychotherapy Research. © Routledge. This is a post-print version of this article. This article
may not exactly replicate the final version published in the journal. It is not the version of
record.

Conversation Analysis of the Two-Chair Self-Soothing Task in Emotion-Focused Therapy

Olga Sutherland,
University of Guelph, Canada
Anssi Peräkylä
University of Helsinki
Robert Elliott
University of Strathclyde

Abstract

Despite an increasing recognition of the relevance and significance of self-compassion processes, little research has explored interventions that seek to enhance these in therapy. In this study, we used conversation analysis to examine the compassionate self-soothing task of emotion-focused therapy involving two-chair work, with seven clients. The analysis yielded a detailed description of interactional practices and processes involved in the accomplishment of self-soothing, drawing on Goffman's concept of the participation frame. In this article we show how therapists and clients collaborate to move from the ordinary frame of therapeutic conversation to a self-soothing frame and back again. Furthermore, we show that in this movement between the frames, they make use of a number interactional practices: therapists' instructions to clients, specific ways of sequencing actions in interaction, explanations and justification of the importance of the self-soothing task, pronouns as a way to distinguish among addressees (e.g., clients versus soothing agents), corrections of clients' talk, and response tokens (hm mm, yeah, good). These practices are used to help clients accomplish self-soothing in the form of self-praise, disclosing caring, and offering of helpful advice.

Keywords: self-compassion, self-soothing, self-kindness, conversation analysis, emotion-focused therapy, two-chair intervention

Running-head: TW-CHAIR SELF-SOOTHING TASK

Author Note. Olga Sutherland, Department of Family Relations and Applied Nutrition, University of Guelph, Canada; Anssi Peräkylä, Department of Social Research, University of Helsinki, Finland; Robert Elliott, School of Psychological Sciences & Health, University of Strathclyde, Scotland. Correspondence concerning this article should be addressed to Olga Sutherland, Department of Family Relations and Applied Nutrition, University of Guelph, Guelph, Ontario ON N1G 2W1. E-mail: osutherl@uoguelph.ca

Conversation Analysis of the Two-Chair Self-Soothing Task in Emotion-Focused Therapy

Emotion-focused therapy (EFT) is a process-experiential approach to therapy that incorporates assumptions and practices from Gestalt and other humanistic therapies (Elliott, Watson, Goldman & Greenberg, 2004; Greenberg, Rice & Elliott, 1993). EFT focuses on helping clients explore and modify emotional experiences (emotion schemes), involving constellations of perception, emotion, cognition, bodily experience, and behavior shaping the person's reactions (Elliott et al., 2004). EFT practitioners distinguish between primary and secondary emotions (Greenberg, 2002). Whereas primary emotions (e.g., hurt or fear) are unmediated "gut responses" to events in clients' lives, secondary emotions (anger, shame, anxiety) are responses to primary emotions. For example, EFT for social anxiety involves helping clients recognize and transform familiar secondary and maladaptive emotions (e.g., anxiety or chronic shame) into primary emotions (e.g., sadness at loss of connection or anger at unfair treatment by others). Through this process, alternate emotion schemes are developed involving a greater sense of connection to the self and others (e.g., pride, curiosity, self-compassion) (MacLeod, Elliott, & Rodgers, 2012).

To modify emotion schemas, various EFT tasks have been developed, including sets of empathy-based, relational, experiencing, reprocessing, and enactment tasks (Elliott et al., 2004). Enactment tasks (or enactments) represent the adaptation and elaboration of Gestalt therapy two-chair techniques. The therapeutic use of chairs (so-called "two chair work") was devised to help clients access and express previously unacknowledged emotions and aspects of self (Elliott et al., 2004; Greenberg, 2002). Although enactments are most commonly facilitated using chairs, other objects (finger puppets, hands) or imagination (*Imagine yourself as a five-year-old boy*) can also be used. Enactments in EFT are based on the two types of chair work (Elliott et al., 2004; Greenberg & Watson, 2005): two-chair dialogue for conflict splits or polarities within the client's self (referred to as "internal dialogue" in Gestalt therapy) and empty chair work for unfinished business or lingering negative feelings about a significant other (referred to as "external dialogue" in Gestalt therapy).

More recently, another enactment task involving the Gestalt external dialogue two-chair technique has been introduced called "compassionate self-soothing" (Elliott, 2012; Goldman & Fox, 2010; Goldman & Greenberg, 2010; 2013; Watson et al., 2012). Goldman and Fox (2010) reported an initial task analysis of self-soothing work in EFT using some of the segments to be analyzed here, defining the marker, as "inability to tolerate and regulate anguish" in the face of painful disregulated emotional states or powerful unmet existential needs (e.g., for love or validation). Although beyond the scope of this article, they also identified two key intermediate client processes, which they labeled as "protest" (in response to the proposed task) and "existential confrontation" (of the unmet need). Conceptually, self-soothing work is the antidote to self-criticism, but it works not by suppressing the self-critical process but by integrating the emotional pain that underlies the self-critical or unresolved experiences and then helping the client to access alternative self-supporting internal resources. The purpose of self-soothing is to help clients experience validation and transform their sense of self (e.g., from unworthy/unlovable to worthy/lovable). The first step in this task involves the therapist helping the client to connect with a sense of despair and anguish and the associated existential need.

Elliott (2013) has described four self-other combinations that can be used in self-soothing work. The exact nature of the self-other combination is negotiated with the client via process suggestions made by the therapist: (a) *Inner Child* ("Imagine yourself in the other chair as a

small/hurt/lonely/scared child and speak to them”); (b) *Universal or Known Child* (“Imagine some other scared/lonely/hurt child in the other chair and speak to them”); (c) *Close Friend* (“Imagine a very close friend of yours, so similar that they have had the same experiences as you and are feeling the exact same way as you”) (Paulo Quattrini, personal communication, November 2009); and (d) *Idealized parental figure* (“Imagine your parent [or other important other] in the other chair not as they were but as you needed them to be”). Once the appropriate self-other combination is identified, the self-soothing work occurs, with the client alternating, by changing chairs, between the soothing agent and the soothed self.

Self-soothing can be linked to the increasingly popular concept of self-compassion (see Barnard & Curry, 2011). According to Neff (2003), self-compassion is comprised of three interconnected aspects exhibited at times of failure and pain: (a) self-kindness (i.e., being understanding and kind toward self rather than being self-critical); (b) common humanity (i.e., seeing one’s shortcomings as part of the broader human condition rather than unique to self and isolating); and (c) mindfulness (i.e., holding one’s distress in mindful awareness rather than over-identifying with or avoiding it). Self-compassion has been found to promote well-being and protect against psychological distress (e.g., Neff, 2003; Neff, Hsieh, & Dejitterat, 2005; Neely, Schallert, Mohammed, Roberts, & Chen, 2009). Self-soothing seems to resemble most closely the self-kindness aspect of self-compassion and entails being touched by one’s own suffering and exhibiting understanding and empathy toward the self at times of distress; however, the common humanity and mindfulness aspects are implicit as well. They are implicit in that self-soothing implies an ability to mindfully face distress and recognize that distressing experiences are “normal” or common to other people and not a sign of personal abnormality.

Although self-compassion appears to be central in psychological well-being, little is known about therapeutic processes and intervention aimed at enhancing it (Barnard & Curry, 2011; Shahar et al., 2012). Compassionate mind training (CMT), self-compassionate imagery, mindfulness based stress reduction, and the self-soothing form of Gestalt inner dialogue/EFT two-chair work are the most commonly used interventions for enhancing self-compassion. Several studies have been conducted on the effectiveness of these interventions (e.g., Kelly, Zuroff, & Shapira, 2009; Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008; Neff, Kirkpatrick, & Rude, 2007; Shahar et al., 2012). Gilbert (2009) developed CMT to enhance self-compassion among self-critical individuals. This approach has been found to significantly reduce depression, shame, self-criticism, anxiety, and other symptoms following this training (Gilbert & Procter, 2006). Following the training, clients reported a significant improvement in their ability to self-soothe (Gilbert & Irons, 2004). Compassionate imagery, an aspect of CMT, entails clients visualizing a “nurturer” and being instructed to call upon this nurturer at times of distress and even to write letters to the self from the nurturer point of view (Gilbert & Irons, 2005; Gilbert & Procter, 2006).

Self-compassionate style of self-talk and imagery were found to decrease shame while self-talk resisting self-criticism reduced symptoms of depression and shame (Kelly et al., 2009). Lutz et al. (2008) similarly found compassion meditation and imagery to be helpful for enhancing long-term psychological and physical well-being of individuals. Finally, Adams and Leary (2007) demonstrated that a self-compassion intervention led to reductions in overeating following diet violations, increased positive affect, and decreased negative affect among college students who restricted their diet. Concerning the effectiveness of the two-chair technique, Shahar et al. (2012) showed that two-chair work for self-criticism led to significant increases in self-compassion as well as reductions in self-criticism, depression, and anxiety. A

single case study conducted by MacLeod et al. (2012) supported the effectiveness of EFT work for social anxiety, including the value of a strong, supportive therapeutic relationship and specific tasks including self-soothing. Finally, the use of the two-chair inner dialogue technique was shown to enhance self-compassion and psychological well-being (Neff et al., 2007).

This emerging evidence suggests the value of fostering self-soothing in clients. Still, there is little research that delineates *how* self-soothing can be promoted in the context of therapy. Existing studies focused on the effectiveness of self-compassion and self-soothing interventions, and little is known about therapy processes and dynamics involved in enhancing self-soothing. The purpose of the current study was to begin to describe qualitatively how the EFT self-soothing task was implemented conversationally. We approached self-soothing interactionally, viewing it as taking place in interaction between therapist and client (and as it turned out between different aspects of the client). Taking an interactional perspective on self-soothing has been supported by personality and social psychological work on adult attachment (e.g., Bretherton & Munholland, 2008; Mikulinger & Shaver, 2007). From this perspective, judgments of self-worth are interactionally derived and maintained. Repeated interactions with responsive, sensitive, and available caregivers create positive emotions and representations of self as worthy and lovable due to being valued and seen as competent by caregivers (Bowlby, 1969). Individuals who are able to receive attachment figures' support are able to engage in self-support, self-praise, and self-soothing later in life (Mikulinger & Shaver, 2007).

Most centrally, however, in our initial analyses we drew on a social interactionist approach to understanding the development and evolution of the self (e.g., Blumer, 1969; Goffman 1959, 1974; Mead 1934/1967). Client-participants in our study played more than one *role* as they engaged in self-soothing. That is, their participation did not involve a unified "role" of the self, but by a range of other roles. Therapists instructed clients to enact various roles, speaking from and to these imagined roles. At one moment the client was speaking (to the therapist) as *herself*; at another moment the client was asked to "become" *the daughter* and address the father who was imagined sitting in the opposite chair; and at yet another moment the client was asked to change chairs and speak as *the father* to the daughter (the other chair used to represent the daughter's perspective). Given the multitude of roles clients are asked to assume in the course of performing self-soothing, we became curious about how therapists and clients manage to introduce additional roles into therapeutic interaction, ensure that all parties are on the same page with respect to who is talking to whom, and repair misunderstandings or deviations from therapeutically relevant participation roles.

To better understand the therapeutic activity of self-soothing, we drew on Goffman's (1974, 1981) theoretical concept of participation frames. This model offers a unique, interactional perspective on the role-play activity central to the two-chair work of EFT, consistent with our methodological concern with the interactional accomplishment of the self-soothing task. According to Goffman, participation frames are largely concerned with how people label any given situation. For example, a playful fight or argument may involve actions and words that accompany a conflict but may be framed or understood by the participants as play. For Goffman, frames constantly shift and interact: One frame may replace the other or, alternatively, two frames may simultaneously define the same situation (e.g., the client talking to the therapist while, at the same time, talking to her father as his daughter). *Framing* refers to the overall view of an interaction (therapeutic interaction versus interaction between relatives), while *footing* is a stance speakers assume in relation to one another and their utterances. Changes in footing can influence tone, tasks, social roles, and interpersonal alignments

(Goffman, 1981). Examples of footing include a speaker shifting from speaking as him or herself to animating another person's talk (i.e., quoting them) or from being "serious" to "humorous." For Goffman (1981), changes in frames permeate social interaction and can be observed in the very details of talk—how it is designed and interpreted. For example, interactants may exploit the structure of language (e.g., second and third person pronouns) or make use of nonverbal aspects of language (e.g., eye gaze, gesture) to mark or index differential roles of speaker and addressee (Levinson, 1988). It is noteworthy that Goffman's analysis of participation roles is not limited to individuals who physically participate in an encounter. Absent parties may also be "brought" into a conversation. Our interest in the participants' use of the third (physically absent) party's voice or perspective fits well with Goffman's idea that "the conversational circle is not the relevant unit; the [broader] social situation is" (p. 88).

The questions guiding this study included: What conversational practices do clients and therapists use to accomplish effective self-soothing work? How are the alternative participant roles and frames constructed, dismantled and maintained? When clients have difficulties enacting the roles offered to them, how do therapists facilitate clients returning to or remaining in those roles? This study was based on the premise of the direct link existing between discursive and clinical practices. In other words, we saw participants' actions and responses as representing specific steps involved in the accomplishment of the self-soothing task.

Method

Conversation Analysis

Conversation analysis (CA), the methodology used in this study, is rooted in a sociological tradition of ethnomethodology (Garfinkel, 1967), which examines the everyday methods people use to produce social order and accomplish practical interactional tasks (e.g., making requests, raising delicate issues, ending conversations). CA allows examining audio or video recordings of naturally occurring social interaction, both everyday and more formal, such as therapy (ten Have, 2007; Heritage & Clayman, 2010). In studying recorded materials conversation analysts assume that interaction participants rely on shared communicative procedures for producing their own actions and interpreting actions of others. For example, therapy involves both distinct or "psychotherapy specific" interactional features (e.g., therapists offering interpretations of the clients' mind) and also practices found in other forms of human interaction (people taking turns at talking, or asking questions and giving answers) (Peräkylä, Antaki, Vehviläinen, & Leudar, 2008). It is these recurrent practices, both generic and distinct, that conversation analysts seek to identify through meticulous analysis of interaction.

Conversation analysts argue that each speaker's contribution to discourse is responsive to and contingent upon (immediately) preceding and anticipated contributions of others (Sacks, Schegloff, & Jefferson, 1974). Thus, the primary unit of analysis is sequences of actions, and the design of conversational turns within those sequences, rather than individual utterances. The most basic way for people to sequentially structure their interaction and achieve mutual understanding is to jointly rely on so-called "adjacency pairs" (Schegloff, 2007; Schegloff & Sacks, 1973), two-step sequences such as question-answer, greeting-greeting, accusation-defense, or offer-acceptance. When the first part of a pair is issued, it sets up a conversational expectation that the recipient will next produce the second part of the adjacency pair in his or her next turn, or else in some way account for its absence. When the second part is missing or inappropriate to the first part (e.g., question-greeting), conversations break down, do not go

smoothly or require repair. For example, if the second part is absent, the speaker will often pursue the recipient for a relevant response (Hutchby & Wooffitt, 2008). Overall, paired actions provide a resource for mutual understanding and serve as a way to organize or order talk (Schegloff & Sacks, 1973).

The CA transcription system developed by Jefferson (e.g., Sacks et al., 1974) allows capturing, as accurately as possible, the details of talk that most other transcription systems find irrelevant. The idea behind such detailed transcription is that micro-features of talk may have interactional meaning for the participants. A fall in intonation may be interpreted as a possible place to change speakers; an inhale may be used to signal that the addressee is about to assume the next turn in speaking; *uh* or *um*, at a place where their producer can be expected to be the next speaker, may indicate a delay in the production of a turn. CA researchers transcribe the micro-details of talk to show how the speakers themselves orient to and draw on these details in interpreting each other's communicative conduct.

Participants

A common practice in CA is to assemble a sample of segments of talk that exemplify a particular conversational activity, practice, or other feature. In this case, our interest in participation frames came out of working with a collection of eight recordings of therapy sessions containing the self-soothing task, selected by the third author, all but one taken from a larger project on the use of EFT for social anxiety (Elliott, 2013). The eight sessions (5 video-recorded and 3 audio-recorded) involved three therapists (1 female and 2 male) and seven clients (1 male and 6 female). All except one client were White, middle-class, and resided in the United Kingdom, with age ranging from 20 to 56. Consent forms were checked to ensure that clients had given explicit permission for this use of their recordings. The research clients were diagnosed using the Structured Clinical Interview for DSM-IV (SCID-IV; First, Spitzer, Gibbon, & Williams, 2007) and were offered up to 20 sessions of therapy as part of a larger study comparing EFT and person-centered therapy for social anxiety. Clients' level of social anxiety was moderate to severe, and the full range of clients with good, average, and poor outcomes were represented. The one non-social anxiety client was taken from a commercially-available video recording (American Psychological Association [APA], 2006). The analyses were carried out by the first and second authors and audited by the third author. All three have training and experience with CA; the first and second authors are active CA researchers. The first and third author practice as humanistic-experiential therapists and use EFT methods in their practice, including self-soothing.

Analysis

Self-soothing events were transcribed using conversation analytic transcription conventions (see Table 1), with the transcripts ranging in length from 233 to 555 lines (selected segments ranged from 6 to 20 minutes). All data were anonymized which involved masking of any identifying information. The first author made preliminary analyses of the data and selected segments that were to be scrutinized in data workshops (data sessions) between the first and second authors. Documented interpretations were then commented upon and revised by the third author. We began the analysis by examining one exemplar at a time, in chronological order. Upon identifying a specific communicative practice (e.g., directive, person pronoun), we examined it by using conventional CA analytic concepts: Turn-taking organization, overall structural organization, sequence organization, repair organization, turn

construction and design (for an overview see Hutchby & Wooffit, 2008; ten Have 2007; Sidnell, 2012). Through continuously identifying, analyzing, and comparing specific examples, we refined the list of structures and practices employed to accomplish the self-soothing task. We were particularly interested in deviant cases or times when routines broke down and the participants oriented to and directed their efforts at resolving these occurrences. Throughout the analysis, we attempted to identify how participants themselves produced and made sense of each other's actions in interaction (Sacks et al., 1974).

Results

Preliminary Analyses of Self-Soothing Activities

Our analyses revealed two aspects of the self-soothing task: (a) the self-soothing *structure* (i.e., the conversational actions and sequences involved in assembling a distinct, “self-soothing” interactional frame, which allows for a dialogue between the client and the soothing agent); and (b) the self-soothing *activity* (i.e., the actual soothing or comforting of the client by the soothing agent). Although our focus in this paper is on the self-soothing structure, we believe that it will be helpful for readers if we first specify the nature of the self-soothing activities used by the participants to “do soothing.” First, self-soothing was done by praising or crediting clients with positive attributes, abilities, or accomplishments, referred to in CA as *assessments*. Soothing agents offered positive assessments of clients in the form of three-part lists (Jefferson, 1990) that highlighted clients' positive actions and qualities (e.g., *You care, you love, you are so kind to animals; I think you're fun, nice, genuine*). *You're* structure and verbs with iterative aspect (e.g., care, love) allowed presenting clients as good and worthy individuals (Edwards, 1995). Second, soothing included expressions or disclosures of the soothing agent's displays of positive, caring feelings toward the client. These included offering sympathy by using the *I am sorry that you feel* construction and naming clients' needs and painful feelings (*I can see you need some support and are in a lot of pain*) (Beach & Dixon, 2001; Pudlinski, 2005). Finally, soothing agents also offered supportive, helpful advice in the form of positive or negative injunctions, for example, *Don't let yourself get worked up over it and get sick*, and *You need to the best you can and that's all anybody asks*.

Overall Trajectory

We will begin our presentation of the self-soothing structure with the overall trajectory of the interaction in and through which the client self-soothes. Accomplishing this involves the therapist and the client collaboratively establishing, maintaining, and eventually dismantling the self-soothing frame. After giving an overall view of this framework, we will offer a more detailed discussion of interactional practices used to distinguish and accomplish participation roles. The practices we discuss are summarized in Table 2.

For an overall trajectory of the establishment, maintenance, and dismantling of the self-soothing participation framework, consider Extracts 1-3. Hereafter, we will use the terms *self-soothing frame* (SF) and *ordinary frame* (OF) to refer to the “new” and “old” frames respectively. The SF involves interaction between the soothing and the soothed parties, while the OF denotes the original client-therapist interaction. In Extract 1, showing the *establishment* of the SF, the therapist and the client leave behind the OF where they address each other as a therapist and a client and establish self-soothing related participation roles.

Extract 1 (Marcie, video, session 3, minute 29)

1 T: Come over he:re if you will ((touches the other chair))

2 C: °Oka:y° ((moves to the other chair))
 3 (2.0)
 4 T: And <ta:lk to you no::w> ((gestures to the now empty chair))
 5 C: ↑huh=
 6 T: =<abou::t (.) your situa:tio:n>
 7 (0.6)
 8 C: What would my dad say?
 9 T: Yeah (1.2) yeah because your ↑da::d is in your head right he's a
 10 pa:rt a you
 11 C: Yeah
 12 T: What does he say to you no::w, ((gestures towards the other
 13 chair))
 14 (3.4)
 15 C: I know he would, (.) hhhhh
 16 T: Be him
 17 C: He would< (.) eh (1.0) .hh tch (1.0) it's not fair to have, (.)
 18 for anybody to treat you that way ((gaze directed at the other
 19 chair))
 20 T: Ye:s

In the session from which Extract 1 is taken, self-soothing involves the client talking to herself as her father. (Marcie is the only client whose identity is not concealed, due to the video being available for training purposes; APA, 2006.) The new interactional frame is established with a series of instructions or directives (lines 1, 4, 12, 16) to the client to embody and enact the role of her father, which is what she eventually does from mid line 17 onwards. The shift from the OR to the SF is initiated in an embodied way: The therapist asks the client to move to another chair (line 1), which the client does in line 2. Thereafter the therapist advises the client to talk to herself (the now empty chair representing her), with the voice of her father. Once the role is established, the client is “on her own” when enacting or *maintaining* it, with minimal assistance from the therapist (see Extract 2 for the establishment and maintenance of the SF): Extract 2 (Marcie, video) (90 seconds after the end of Extract 1)

1 T: So what is he sa::ying so:, (0.4) take ca:re of yourse::lf?=
 2 ((gestures the other chair))
 3 C: =Oh he's always told me (.) [take] ca:re of yourse::lf
 4 T: [Yeah]
 5 C: .hhhh I I see a lot of (.) me::: (.) in you ((gaze directed at
 6 the other chair))
 7 T: Yeah
 8 C: .hhh
 9 (1.0)
 10 C: ↑A:::nd (.) >that's a< ha::rd way to live your li:fe,
 11 (0.4)
 12 T: .hh yea:h .hh
 13 C: And you don't wanna end up like me,
 14 (0.8)
 15 T: °But° so:: (0.8) you're saying try a:ll the possibilities but
 16 don't let yourself get so:::
 17 (0.4)
 18 C: Worked up over it a::nd (.) become sick ((gaze directed at the
 19 other chair))
 20 T: Yea::h yea::h

In extract above, the therapist's involvement is limited to two utterances (lines 1 & 15) and response tokens *yeah* in lines 4, 7, and 12. None of these actions involve a direct request for the client to maintain the SF. However, the client does that starting from the latter part of line 3. At first, her utterance seems to incorporate a hybrid of SF and OF. The client is orienting to SF by gazing towards the empty chair representing herself, whereby she embodies her father. However, she also maintains a sentence structure that can be heard to orient to the OF: She *cites* her father, thereby still speaking in the capacity of her ordinary self. As the client continues her talk in line 5, SF seems to be more unequivocally established, through gaze and the syntactical choices as well. It is, however, important to note that maintenance of a newly established interactional frame is not as straightforward as this extract suggests. As we shall demonstrate, frames shift constantly and interact in various ways (sometimes within the same conversational turn), until they are intentionally *dismantled* (Extract 3):

Extract 3 (Marcie, video) (60 seconds after the end of Extract 2)

1 T: .hhhhh hhhhhh so come back over here yeah I mean this is a voice
 2 insi::de of you:::, that's you::, and so o:n
 3 C: ((sniffs)) hhh
 4 T: No:w does that, (1.6) .hh what happens inside of you
 5 C: Hearing those thi:ngs?
 6 T: Yea:h
 7 C: I know them a:ll (f'alr(h)e(h)a-f) .hhh
 8 T: Yea::h yeah
 9 C: hhhhhh (.) but (.) it's alwa::ys (.) nice to ha:ve (.) someone
 10 that you tru::st (1.0) confirm ↑the::se, (.)
 11 [things must make you feel] like you're acting impulsively o::r=
 12 T: [Yea::h yea::h yea:::h]

The therapist initiates the change of frames by instructing the client to return to the OF (i.e., assume the client role) and assess or process what she has heard from her “father” (line 4).

The return to the OF also allows client and therapist to assess whether self-soothing has in fact been accomplished, which is not always the case (Extract 4):

Extract 4 (Nathalie, video):

1 T: And what e- >what do you< fee:l,
 2 (0.4)
 3 C: Mm n- quite negative feeli::ngs
 4 T: You've got quite negative feelings,
 5 C: Yea::h
 6 T: Oka:y (0.8) °right° so >so this isn't< a really compassionate
 7 pa:rt
 8 C: No:: hu:h
 9 T: No (.) right okay (1.2) °huh huh°
 10 ...
 11 T: Right lets try something e:lse (0.6) see how we're doing for
 12 ti:me (?) (.) oka:y so::, (.) let's see::: hhhh ((clears throat))
 13 (2.4)
 14 T: Can you imagi:ne a <sa::d lo:nely chi:ld> (0.4) there
 15 (0.4)
 16 C: Yeah

In this case, the return to the OF revealed a self-critical rather than a self-soothing process (line 3), leading the therapist to propose that the client re-enter the SF using an alternative self-other combination (line 14).

Directives and Accounts

As with any participation framework, the SF can only be maintained through moment-by-moment interaction between the speaker and the addressee. We will now describe practices used, at times concurrently, to introduce, index (i.e., identify), and transform frames. *Directives* were the primary strategy used to establish interactional frames, defined in CA as utterances used to get someone to do something (Goodwin, 1990). During the establishment and maintenance of the SF, directives were used to bring an imagined other (or aspect of self) into interaction and to facilitate dialogue between the client and this other, or between two parts of the client (e.g., soother and soothed). In the dissolution phase, directives enabled the client's return to the OF and an exploration of the client's experience of being soothed. Directives (e.g., *come, be, imagine, can you look at her*) featured most prominently in the establishment and maintenance phases. The dissolution phase typically began with a singular imperative (*change or come back over here*), followed by a *wh*-question (e.g., *what's that feel like?* or *what comes up inside?*) eliciting the description of the client's experience of being soothed.

Extract 5 (Heather, audio):

1 T: Can you come over here and do that the:n [okay]
 2 C: [↑Hm mm,]
 3 (0.4)
 4 T: And so be thi:s, (.) positive (0.4) coaching pa:rt tha:t's (.)
 5 helpful and [supportive] right (.) give her support
 6 C: [Hm mm::,]
 7 T: I'm kinda thinking of all the stre:ngths that you do ha::ve, and
 8 (.) all the good (.) feedba:ck people have given you:::, and
 9 C: Hm mm,
 10 T: .hh think about a:ll the strengths you do have
 11 [think] of what you're good a::t
 12 C: [Mm mm]
 13 T: [Tell her] some of the things she's good a::t
 14 C: [Yea::h]
 15 C: >Kind of< encouraging other peo:ple a::nd (.) getting them to (.)
 16 () [and (?)]
 17 T: [So you] (.) you are good at this
 18 C: Hm mm
 19 T: Right you ca::n
 20 (0.4)
 21 C: You're good at this you've [done] it [befo]::re (.) it's=
 22 T: [Good] [Good]

This extract shows a string of directives issued by the therapist aimed at establishing the SF (lines 1, 4, 5, 10, & 13). The client is initially instructed to change the chairs and “be” the soothing other, and “do that,” that is, reassure the vulnerable part of self. She is then directed to contemplate her own strengths and tell herself (the empty chair) what those things are. Although most directives were formulated as imperatives (do, be, tell) or requests (could you..., would you be willing to...), some directives indirectly instructed the client to repeat after the therapist without uttering *Repeat after me* (e.g., line 17). The client eventually

complies with the therapist's directives by telling herself (addressing the empty chair) about the things that she is good at (line 21). Importantly, directives are used not only to establish a new participant role, but also to delineate its parameters by specifying the "appropriate" kind of talk that the soothing person would produce (be this positive, coaching part..., lines 4-5).

Following self-soothing, the SF is dissolved and clients (as themselves) are directed to evaluate their experience of being soothed. In Extract 5, the beginning of the dissolution phase was marked with an imperative (*change*, line 9), followed in lines 13 and 15 by a query into the client's experience of hearing the other's message.

Extract 6 (Heather, audio)

1 C: You're goo::d and you ca:n accomplish this you're as good as the
 2 other person in this roo::m, (.) .hh just all have different
 3 stre:ngths, (0.4) and there'll be things that he:: isn't good a:t
 4 and >maybe he doesn't< recognise tha::t, (.) bu::t (0.4) you need
 5 to (0.4) just do the best you can ↑↑do and that's all (.)
 6 ↑<anybody> (.) asks
 7 T: Hm mm (.) hmm mm
 8 (0.4)
 9 T: ↑Change
 10 (1.8)
 11 T: ↓Giving you a work out today
 12 C: Ha ha ha ha huh .hh
 13 T: So what's that feel like to hear that
 14 C: ↑↑o::h thanks (.) >huh huh huh huh<
 15 T: Hm? It fee::[ls]
 16 C: [Re]assuring
 17 T: It feels good wh- where do you feel tha::t
 18 (0.4)
 19 C: Kind of just like a lighten::ss, (.) a::n-
 20 T: Cos you feel a lightness (.) oka:y

The client's locomotion from one chair to the other, in response to the therapist's direction to move, indexes a shift in interactional frames. The client is asked to switch roles (from being a soothing self to her ordinary role of the client) and in lines 13, 15 and 17, the therapist—now operating in OF—asks the client to produce an experiential assessment of hearing the soothing self reassure the other vulnerable self.

Two different ways of sequencing actions characterized the SF's dissolution and its establishment. During the dissolution, therapists' questions followed directives, as in the segment above (lines 9 & 13), whereas during its establishment questions typically preceded directives:

- T: Question/summary (in the OF)
- C: Answer/confirmation (in the OF)
- T: Directive (in the OF)
- C: Compliance (in the SF)

In establishing the SF, the client's experience is first explored or summarized in the client-therapist (OF) interaction. Elicited (using question-answer) or confirmed (using summary-confirmation) information becomes the basis of the subsequent directive-compliance sequence. Once clients verbalize the content of their mind (e.g., needs, perceptions, thoughts, emotions)

in relation to therapists (in the OF), they are directed to communicate these to themselves as soothing agents (in the SF). This sequencing of actions may be a way for therapists to position the client as the “expert” on his or her subjective experience and overcome the problem of limited access to clients’ inner mind (i.e., making claims about things that are not directly accessible to therapists) (Sacks, 1984). Once clients verbalize their experience in the OF, therapists can use this information in the SF. Extract 6 is an illustration of this practice:

Extract 7 (Natalie, video)

1 T: Can you imagine a <sa::d lo:nely chi:ld> (0.4) there ((points to
 2 the chair))
 3 (0.4)
 4 C: Yeah
 5 T: (?) (0.4) sa:d lonely:: (1.4) feels doesn't feel understoo::d
 6 (1.6) fee:ls (1.4) unworthy empty (1.4) boring
 7 C: Mm
 8 T: (Yeah)
 9 (1.6)
 10 T: Can you see her? Can you picture her the::re?
 11 C: ↑Yeah
 12 T: Yeah what can you say to her,
 13 (1.4)
 14 C: I'd a- I'd ask her what was wro::ng (0.4) [(?)]
 15 T: [Go] ahead ask her
 16 (0.4) yeah
 17 C: What's wro:ng are you okay
 18 T: Okay
 19 (1.0)
 20 C: Do you want someone to talk to:

While the therapist in lines 1, 5-6, 10 and 12 guides the client to imagine “sad lonely child” being there in the room, he is still maintaining the participation framework where the client responds to him as the client, in the OF. The therapist’s directive (line 15) builds upon the client’s answer to the question (line 14) in the OR and, at the same time, projects the establishment of the SF. The client’s question to the lonely child in line 17 complies with the therapist’s directive, and establishes the SF.

The directives were commonly accompanied by *accounts* justifying the proposed course of action (Goodwin, 1990). Such accounts provided a rationale for the relevance and importance of the self-soothing task.

Extract 8 (Natalie, video)

1 T: And support (0.4) and see that I need support and support me
 2 (0.4) ↑oka:y (0.4) so maybe try you ↑wanna work with ideal
 3 pare:nt?
 4 (0.4)
 5 C: Mm okay
 6 T: Is that oka:y? Yeah >this is this is a process< we call self
 7 soo:thing (0.4) okay you've had some of that (.) training and you
 8 had some experience of °that° .hh so be your ideal pa:re:nt (.)
 9 a::nd (0.4) give Natalie (1.8) what she needs °can you do it°?
 10 (1.8)
 11 C: Na- n- not really sure what to sa:y hu::h .hh

The therapist's description of self-soothing (lines 6-8) implies that it is a routine and relevant therapeutic task, justifying his immediately following directive to the client to engage in it.

Person Reference and Repair

We observed the participants marking and negotiating frames through discursive cues and markers (Goffman, 1981), most notably person references, such as pronouns (Schegloff, 2007, Stivers, 2007). When assuming the soothing agent role, the client is expected to speak *in first person* and to address the soothed self *in second person*. Extract 8 demonstrates the negotiation to achieve second person position (*you*, as opposed to *her*) for the soothed self. In line 1, the therapist asks the client to directly praise or compliment the soothed self.

Extract 9 (Heather, audio)

1 T: [Tell her] some of the things she's good a::t
 2 C: [Yea::h]
 3 C: >Kind of< encouraging other peo:ple a::nd (.) getting them to (.)
 4 have a ba::ll [and (?)]
 5 T: [So you] (.) you are good at this
 6 C: Hm mm
 7 T: Right you ca::n
 8 (0.4)
 9 C: You're good at this you've [done] it [befo]::re (.) it's=
 10 T: [Good] [Good]
 11 C: =all gone we::ll (.) it's just the last hurdle,
 12 T: °Hm mm°

The client at first (lines 3-4) manages to offer the description of herself without specifying *who* the description is addressed to. Using the present continuous verb tense (e.g., encouraging, getting them) the client utters compliments to an unspecified other rather than presenting them to the other part of self, as directed by the therapist (*tell her*) (line 1). The client's response thus conceals the participation framework. The therapist then (lines 5 & 7) reinserts the second person pronoun and, as such, re-establishes the SF dissolved by the client's lack of referential specificity (line 5). In response, the client displays her uptake of the SF by reusing *you* (line 9).

To safeguard clients' adherence to the SF, therapists relied on a *repair* and correction of clients' prior talk (e.g., Jefferson, 1974; Schegloff, Jefferson, & Sacks, 1977).

Extract 10 (Marcie, video)

1 T: Yea::h (0.8) tell hi::m (0.4) tell him about the difficulty
 2 you're having no::w maybe::
 3 (1.4)
 4 C: He would know al↑ready,
 5 T: [Ahu:::h]
 6 C: [He would] know,
 7 T: You would know [already] ((points towards the empty chair))
 8 C: [He would] kno- (.) you [would] know Da::d
 9 ((gaze directed at the empty chair))
 10 T: [Yea:::h]

The client observably struggles to remain in the daughter's role, which is evident in her continuing to refer to her father in the third person (*he*). Though the client is instructed to speak *to* the father (line 1), she continues to interact with the therapist *about* the father (lines 4, 6, 8)

misaligning from the role of the daughter allocated to her. She accounts for her non-compliance by claiming the father's foreknowledge of her situation, implying that it is not necessary to inform the father of something he already knows (lines 4, 6). The therapist corrects or repairs the client's talk (line 8) by inserting the second person pronoun in place of the third person pronoun, while leaving intact all other elements of the client's utterance. Repair, combined with non-linguistic means (pointing gesture), work to elicit the client's direct engagement with the father. The client's self-initiated self-repair in line 8 ('He would kno- (.) you would know Dad') shows her uptake of the SF and her compliance with an earlier direction to 'tell.'

Response Tokens: The Therapist's Presence

In the analysis presented thus far, we have examined the practices of the therapists through which they set up, maintain, and eventually dismantle the specific participation framework that makes possible the soothing dialogue between the different "agents" in the client's life. However, the therapists regularly do something more. They do not only serve as facilitators and bystanders of the soothing dialogue, but they have a more active participation role in it, as illustrated in a number of previously discussed extracts.

Extract 10 (segment)

T: You would know [already] ((points towards the empty chair))
 C: [He would] kno- (.) you [would] know Da::d
 ((gaze directed at the empty chair))
 T: → [Yea::::h]

Extract 7 (segment)

T: [Go] ahead ask her
 (0.4) yeah
 C: What's wro:ng are you okay
 T: → Okay
 (1.0)
 C: Do you want someone to talk to:

Extract 9 (segment)

C: You're good at this you've [done] it [befo]::re (.) it's=
 T: → [Good] [Good]
 C: =all gone we::ll (.) it's just the last hurdle,
 T: → °Hm mm°

Extract 10 involves the client, as herself, speaking to the soothing agent, her father. In Extract 7, the client, as herself, talks to the "child" part of her self. Extract 9 illustrates a dialogue between the soothing (positive and supportive) self and the experiencing self. In spite of the fact that these dialogues take place between agents other than therapists, therapists take an active role in them. The therapist acknowledges the client's question to the child (Extract 7); encourages the client-acting-as-soothing-other in praising the client (Extract 9); and agrees with what the client tells her father (Extract 1). We might compare the therapist's role to that of a drama or athletics coach, so their role is more active than that of an audience. It does have a "policing" role in the sense of helping the client maintain the SF, but more importantly it seems to be about guiding and encouraging. The therapist's response tokens (*hm mm*, *yeah*, *good*) indicate that the client is on the right track and encourage the client to continue.

Discussion

In carrying out this study, we were struck by how painful and difficult the work of self-soothing was, as clients faced a range of painful emotions, including despair, isolation, abandonment, self-consciousness, shame, and unworthiness. As a result, clients struggled to access and stay with the painful feelings, to find an appropriate self-other combination to carry out the task, to enter into an unfamiliar and highly unusual communication process, and to stay with the process to the point of resolution. In particular, we described how the participants established, dissolved, and continuously distinguished between the two frames using a range of communicative practices, including directives, accounts, person reference, repair, and response tokens. We also commented on the therapist's role or presence in the dialogues between client/vulnerable aspect and self-soothing agent. The study has illustrated the delicate process by which therapists facilitated self-soothing as an experiential activity, consistent with an EFT process-experiential orientation (Elliott et al., 2004). Clients were asked to *perform* care-giving and care-receiving, through changes in frames, rather than *discuss* these activities.

Implications for Practice

The activities we have delineated only make sense and are coherent within a larger context of a strong, secure therapeutic relationship in which the therapist consistently interacts with the client in a nonjudgmental, genuine and compassionate manner; guides the process only as much as is needed to keep it moving forward and does not direct the content; and acts sensitively to help the client access and support the emotions and needs underlying deeply self-critical or unresolved painful experiences. When working with self-critical processes, the compassionate self-soothing task counters self-criticism not by shut downing it down or reprimanding it but by empathizing with it, integrating it, and moving past it. Within this context, this study offers therapists a specific account about how to respond to clients at specific junctures in self-soothing dialogues and how to structure and accomplish the self-soothing task. Our analyses point to a set of flexible guidelines or suggestions for facilitating compassionate self-soothing (translated into EFT terms here):

1. Therapists can help clients engage in a variety of self-soothing activities, not just self-praising (naming specific positive attributes or activities), but also offering supportive helpful advice and simply disclosing caring to themselves.
2. To do this, therapists have a wide range of different responses that they can use, described in EFT terms as process suggestions, exploratory questions, feeding the client lines to try out, and offering information about how to enact the two roles.
3. Often, one form of client self-soothing action or type of therapist response does not help the self-soothing work move forward, in which case the therapist can immediately, flexibly, and responsively offer a different kind of response.
4. In order to help the client enter the self-soothing frame, the following four-turn sequences (made up of linked two-turn sequences) are particularly useful: Question-answer (OF) or summary-confirmation (OF), followed by directive (OF)-compliance (SF).
5. In order to help the client maintain the self-soothing frame, the therapist can systematically use person reference (*you* rather than *he/she*) to as a marker of whether the client is in the SF, initiate conversational repair if the client is in the OF, and offer response tokens (*yes, good*) if the client is in the SF.
6. When the therapist senses that there has been enough self-soothing work for it to have

an impact on the client, they can help the client exit the SF and return to the OF by using a process suggestion followed by an exploratory question, to see if self-soothing has in fact occurred and to re-start the task if it has not or if more is needed.

The results highlight not only how participation frames could be used, but also when to introduce alternative frames. Once clients have been identified as distressed or in need of support, and the identity of a soothing agent has been determined, therapists may wish to initiate a shift from the OF to the SF, directing clients to sooth themselves. Later, a shift back to the OF, either temporary or permanent, may be warranted when the self appears to have been “sufficiently” soothed, as evident in clients’ relatively prolonged, unassisted enactment of soothing. Clients can then be asked to assess their experience of being soothed.

Therapists are continuously faced with the reality of having to make immediate decisions about *how* to proceed sensitively and responsively in their interactions with clients. The use of CA, exemplified in this study, can address this gap by: (a) describing in detail how interventions are implemented (issued and responded to sequentially); (b) examining which actions of therapists lead to what effects in clients in particular contexts; and (c) identifying more recurrent practices of intervention delivery and receipt, as well as deviant or atypical examples (Peräkylä et al., 2008). This analysis offers a deeper understanding of how self-soothing can be accomplished *discursively*, that is, in the client-therapist interaction using language. A sequential micro-analysis of therapy talk provides concreteness and explicitness concerning therapists’ responses and their immediate effects in specific contexts (Elliott, 2010). Therapists can use these analyses to expand their awareness of their (and clients’) immediate responses and within-session activities, and can consider their relevance to overall treatment goals (Elliott et al., 2004). Although there is no guarantee that a specific practice (a directive to self-soothe) will yield a desired therapeutic outcome (client engaging in self-soothing and feeling soothed), it is possible to anticipate that certain kinds of responses would lead to certain kinds of interactional outcomes. Through the exposure to nuanced and contextual description of EFT interventions coupled with their immediate outcomes (i.e., clients’ responses and the subsequent progression of talk), practitioners can expand their repertoire of skills and become more mindful of the immediate effects of their actions on clients and the overall process and progress of therapy.

Implications for Theory and Research

This study is an example of how therapy theory can be linked to therapy discourse (Peräkylä & Vehviläinen, 2003). The underlying premise is that therapy is primarily talk-based, and that it is *through* the micro-practices of communication that psychological distress is communicated and change is accomplished. It can be argued that conversation itself constitutes a valid and valuable source of evidence of change (Sutherland, Sametband, Gaete Silva, Couture, & Strong, 2012). Accordingly, it may be beneficial to continue exploring connections between discourse and theory: Identify and examine interactional phenomena (participation frames) and practices (directives, person reference, repair) associated with therapists’ theories of change (self-soothing as a therapeutic antidote to self-criticism). At the same time, discursive analyses of therapy may be a way to further inform and support clinical theory.

Other qualitative approaches to the study of therapy (e.g., task analysis, sequential analysis), while generally outlining a task’s phases and steps, commonly lack the means for delineating the micro-details of talk involved in the accomplishment of specific phases and steps. CA helps not only identify specific phases in a therapeutic task (e.g., establishment,

maintenance, and dissolution of the SF), but also explicates in detail actions and sequences of actions involved in the accomplishment of each phase. It also assists in exploring variations actions and, as such, offers a context-sensitive account of the self-soothing task, arguably capturing the variability and unpredictability of real-life clinical practice.

Discursive and critical perspectives on human subjectivity, informing this analysis, contrast with more conventional understandings of self-compassion (e.g., Chang, 2007; Gilbert, 2007) as taking place “within” individuals. Discursively-oriented scholars envision human experience as socially, culturally, and historically contingent. In particular, discursive psychologists (e.g., Edwards, 1999; Potter, 1996) have conceptualized clients’ emotions as *emotion discourse*, highlighting their rhetorical functions (e.g., how people use descriptions of emotions to advance certain versions of events and identities and undermine other versions).

Future research might focus on how self-soothing is accomplished over the course of therapy. This analysis was limited to sessions featuring the two-chair self-soothing task and excluded other parts of these sessions or other sessions involving same client-therapist dyads, including extensive instances of the obverse of self-soothing: Self-criticism. In the course of analyses described here we noted many similarities between self-soothing and self-criticism dialogues, and hope to take up the analysis of the latter in future research. While both self-soothing and self-criticism are clearly not the same task, and have very different goals, both are examples of enactments in EFT (Elliott et al., 2004). It may prove useful to be able to delineate a broader *enactment frame* encompassing both activities as instances of the frame.

Furthermore, tracking interactions over the course of therapy may help answer the following questions: How and when is it best to introduce the self-soothing task? How do the therapists effectively sequence therapeutic initiatives within sessions? How do therapists enhance client engagement in and collaboration with specific initiatives? How do therapists particularize interventions and accomplish the task collaboratively without encountering negative relational consequences? Subsequent studies can also examine “conversational evidence” of the effectiveness of EFT interventions (Strong, Bush, & Couture, 2006), leading to improved understanding of the change process. Finally, we focused on the self-soothing structure and only marginally commented on the self-soothing activity. It may also be useful to examine more psychotherapy data to generate a more thorough and detailed description of conversational practices involved in self-soothing, for example the intermediate “protest” and “existential confrontation” phases of the task found by Fox and Goldman (2010).

In this article we have offered a detailed description and explication of specific practices and processes involved in enhancing self-soothing in the context of EFT two-chair work. We highlighted recurrent patterns in client-therapist interactions within and across sessions involved in the accomplishment of self-soothing. To generate an interactive account of self-soothing we examined the evolving, interweaving discursive contributions of both therapy participants, seeing them as reflexive—shaped by and shaping of—the contributions of each party in a conversation (Heritage, 1984). The analytic unit was the sequence of actions in interaction or chaining of speaking turns. As such, we approached the study of self-soothing as a set of ongoing, non-linear, and dynamic processes, consistent with the EFT perspective of dialectical constructivism (Elliott et al., 2004; Rice & Greenberg, 1984).

References

- Adams, C. E., & Leary, M. R. (2007). Promoting self-compassionate attitudes toward eating among restrictive and guilty eaters. *Journal of Social and Clinical Psychology, 26*, 1120-1144. doi:10.1521/jscp.2007.26.10.1120
- American Psychological Association (L. S. Greenberg) (2006). Emotion-focused therapy over time [DVD]. Available from <http://www.apa.videos/>
- Barnard, L., & Curry, J. (2011). Self-compassion: Conceptualizations, correlates, and interventions. *Review of General Psychology, 15*, 289-303. doi:10.1037/a0025754
- Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. New Jersey: Prentice-Hall.
- Bowlby, J. (1969). *Attachment and loss* (Vol. 1). New York: Basic Books.
- Bretherton, I., & Munholland, K. A. (1999). Internal working models revisited. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 89–111). New York: Guilford.
- Chang, E. C. (Ed.). (2007). *Self-criticism and self-enhancement: Theory, research, and clinical implications*. Washington, DC: American Psychological Association.
- Edwards, D. (1995). Two to tango: Script formulations, dispositions and rhetorical asymmetry in relationship trouble talk. *Research on Language and Social Interaction, 28*, 319-350. doi:10.1207/s15327973rlsi2804_1
- Edwards, D. (1999). Emotion discourse. *Culture and Psychology, 5*, 271-291. doi:10.1177/1354067X9953001
- Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy Research, 20*, 123-135. doi: 10.1080/10503300903470743
- Elliott, R. (2012). Emotion-focused therapy. In P. Sanders (Ed.), *The tribes of the person-centred nation* (pp. 103-130). Ross-on-Wye: PCCS.
- Elliott, R. (2013). *Compassionate self-soothing for stuck/dysregulated anguish*. Unpublished Powerpoint slides, Counselling Unit, University of Strathclyde.
- Elliott, R. (2013). Person-Centered-Experiential Psychotherapy for Anxiety Difficulties: Theory, Research and Practice. *Person-Centered and Experiential Psychotherapies, 12*, 14-30. DOI:10.1080/14779757.2013.767750
- Elliott, R., Watson, J., Goldman, R., & Greenberg, L. (2004). *Learning emotion focused therapy*. Washington, DC: American Psychological Association.
- Garfinkel, H. (1967). *Studies in ethnomethodology*. Englewood Cliffs, NJ: Prentice-Hall.
- Gilbert, P. (2007). *Psychotherapy and counselling for depression* (3rd. ed.). London: Sage.
- Gilbert, P. (2009). *The compassionate mind: A new approach to life's challenges*. London: Constable & Robinson.
- Gilbert, P., & Irons, C. (2004). A pilot exploration of the use of compassionate images in a group of self-critical people. *Memory, 12*, 507–516. doi:10.1080/09658210444
- Gilbert, P., & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research, and use in psychotherapy* (pp. 263–325). London: Routledge.
- Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study. *Clinical Psychology and Psychotherapy, 13*, 353–379. doi:10.1002/cpp.507
- Goffman, E. (1959). *The presentation of self in everyday life*. New York: Doubleday.

- Goffman, E. (1974). *Frame analysis: An essay on the organization of experience*. London: Harper and Row.
- Goffman, E. (1981). *Forms of talk*. Philadelphia: University of Pennsylvania Press.
- Goldman, R., & Fox, A. (2010, May). *A task-analysis of self-soothing in emotion-focused therapy*. Paper presented at the 26th Annual Meeting of the Society for the Exploration of Psychotherapy Integration, Florence, Italy.
- Goldman, R., & Greenberg, L. S. (2010). Self-soothing and other-soothing in emotion-focused couples therapy. In A. S. Gurman (Ed.), *Clinical casebook of couples therapy* (pp. 255-280). New York: Guilford.
- Goldman, R., & Greenberg, L. S. (2013). Working with identity and self-soothing in emotion-focused therapy for couples. *Family Process, 52*, 62-82. doi:10.1111/famp.12021
- Goodwin, M. H. (1990). *He-said-she-said: Talk as social organization among black children*. Bloomington: Indiana University Press.
- Greenberg, L. S. (2002). *Emotion-focused therapy: Coaching clients to work through feelings*. Washington, DC: American Psychological Association.
- Greenberg, L. S., Rice, L., & Elliott, R. (1993). *Facilitating emotional change: The moment-by-moment process*. New York: Guilford.
- Greenberg, L. S., & Watson, J. (2005). *Emotional-focused therapy for depression*. Washington, DC: American Psychological Association.
- Have, P. ten (2007). *Doing conversation analysis: A practical guide* (2nd ed.). London: Sage.
- Heritage, J. (1984). *Garfinkel and ethnomethodology*. Cambridge: Polity.
- Heritage, J. & Clayman, S. (2010) *Talk in action: Interactions, identities, and institutions*. Oxford: Wiley-Blackwell.
- Hutchby, I., & Wooffitt, R. (2008). *Conversation analysis* (2nd ed.). Cambridge: Polity.
- Jefferson, G. (1974). Error correction as an interactional resource. *Language in Society, 3*, 181-199. doi: <http://dx.doi.org/10.1017/S0047404500004334>
- Jefferson, G. (1990). List-construction as a task and a resource. In G. Psathas (Ed.), *Interaction competence* (pp. 63-92). Washington, DC: University Press of America.
- Kelly, A. C., Zuroff, D. C., & Shapira, L. B. (2009). Soothing oneself and resisting self-attacks: The treatment of two intrapersonal deficits in depression vulnerability. *Cognitive Therapy and Research, 33*, 301-313. doi:10.1007/s10608-008-9202-1
- Lutz, A., Brefczynski-Lewis, J., Johnstone, T., & Davidson, R. J. (2008) Regulation of the neural circuitry of emotion by compassion meditation: Effects of meditative expertise. *PLoS ONE, 3*(3). e1897. doi: 10.1371/journal.pone.0001897
- MacLeod, R., Elliott, R., & Rodgers, B. (2012). Process-experiential/emotion-focused therapy for social anxiety: A hermeneutic single-case efficacy design study. *Psychotherapy Research, 22*, 67-81. doi:10.1080/10503307.2011.626805
- Mead, G. H. (1934). *Mind, self, and society: From the standpoint of a social behaviorist* (C. W. Morris, Ed.). Chicago: University of Chicago Press (Original work published 1934)
- Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change*. New York: Guilford.
- Neely, M. E., Schallert, D. L., Mohammed, S. S., Roberts, R. M., & Chen, Y. (2009). Self-kindness when facing stress: The role of self-compassion, goal regulation, and support in college students well-being. *Motivation and Emotion, 33*, 88-97. doi:10.1007/s11031-008-9119-8
- Neff, K. D. (2003). Development and validation of a scale to measure self-compassion. *Self*

- and Identity*, 2, 223-250. doi: 10.1080/15298860309027
- Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). Self-compassion and adaptive psychological functioning. *Journal of Research in Personality*, 41, 139-154. doi:10.1016/j.jrp.2006.03.004
- Neff, K. D., Hseih, Y., & Dejitthirat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. *Self and Identity*, 4, 263-287. doi:10.1080/13576500444000317
- Peräkylä, A., Antaki, C., Vehviläinen, S., & Leudar, I. (2008). *Conversation analysis and psychotherapy*. Cambridge: Cambridge University Press.
- Peräkylä, A., & Vehviläinen, S. (2003). Conversation analysis and the professional stocks of interactional knowledge. *Discourse & Society* 14, 727-750. doi:10.1177/09579265030146003
- Potter, J. (1996). *Representing reality*. London: Sage.
- Pudlinski, C. (2005). Doing empathy and sympathy: Caring responses to troubles tellings on a peer support line. *Discourse Studies*, 7, 267-288. doi: 10.1177/1461445605052177
- Rice, L. N., & Greenberg, L. S. (Eds.). (1984). *Patterns of change: Intensive analysis of psychotherapy process*. New York: Guilford.
- Sacks, H. (1984). On doing being ordinary. In J. M. Atkinson & J. C. Heritage (Eds.), *Structures of social action* (pp. 413-429). Cambridge: Cambridge University Press.
- Sacks, H., Schegloff, E. A., & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking in conversation. *Language*, 50, 696-735. Retrieved from <http://www.liso.ucsb.edu/Jefferson/>
- Schegloff, E. A. (2007). *Sequence organization in interaction: A primer in conversation analysis*. Cambridge: Cambridge University Press.
- Schegloff, E. A., Jefferson, G., & Sacks, H. (1977). The preference for self-correction in the organization of repair in conversation. *Language*, 53, 361-382. Retrieved from <http://www.liso.ucsb.edu/Jefferson/>
- Schegloff, E. A., & Sacks, H. (1973). Opening up closings. *Semiotica*, 4, 289-327. Retrieved from www.stanford.edu/~eckert/PDF/schegloffOpeningUpClosings.pdf
- Sidnell, J. (2012) Basic conversation analytical methods. In J. Sidnell & T. Stivers (Eds.), *The handbook of conversation analysis* (pp. 77-100). Oxford: Wiley-Blackwell.
- Shahar B., Carlin, E. R., Engle, D. E., Hegde, J., Szepsenwol, O., & Arkowitz, H. (2012). A pilot investigation of emotion-focused two-chair dialogue intervention for self-criticism. *Clinical Psychology & Psychotherapy*, 19, 496-507. doi:10.1002/cpp.762
- Stivers, T. (2007). Alternative recognitional in person reference. In N. J. Enfield & T. Stivers (Eds.), *Person reference in interaction: Linguistic, cultural, and social perspectives* (pp. 73-96). Cambridge: Cambridge University Press.
- Strong, T., Busch, R., & Couture, S. (2008). Conversational evidence in therapeutic dialogue. *Journal of Marital and Family Therapy*, 34, 388-405. doi:10.1111/j.1752-0606.2008.00079.x