Mouton de Gruyter
Berlin • New York

COMMUNICATION & MEDICINE

When psychotherapists disclose personal information about themselves to clients*

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Abstract

Psychotherapists sometimes disclose personal information to their clients during therapeutic sessions. We report here our analysis of how these 'therapist self-disclosures' are done. In a sample of 15 sessions involving four therapists, we find that all therapists use them sparingly and some not at all. When they do, they 'match' something in the client's preceding turn. Vehicles for the match can range from comparatively simple agreements to more complicated 'second stories', which use analogies from the therapists' own current life. We find that these 'personal' disclosures are invariably rather ordinary but are made to bear visibly on the therapeutic business at hand, though not always in obvious ways. The ordinariness of therapist's self-disclosures underpins what seems to be one of their main actions—to 'normalize', for a number of disparate local interactional contingencies, the clients' experience. We discuss the practice of using one's own life experiences to bear on one's client's troubles, noting the recurrent features of extreme case formulations and explicit recipient design. We conclude with a brief discussion of the relation between our analyses and those which might be offered by members of the therapeutic community.

Keywords: conversation analysis; psychotherapy; self-disclosure; therapeutic practice; conversation practice.

1. Introduction

This article is about a vital aspect of psychotherapeutic practice—disclosing personal information. This is the clients' obligation and the bedrock of psychotherapy. Professional psychotherapeutic literature, however, recognizes that therapists also disclose personal information about themselves to their clients (Farber 2003). Research on self-disclosure in social psychology, based on work of Sidney Jourard, suggests that in everyday conversations disclosures of personal information tend to be reciprocated (e.g., Davis and Skinner 1974; Levesque et al. 2002). This finding, however, like most in social psychology, has acquired many qualifications over time and in any case cannot apply to systematically asymmetric interactions such as psychotherapy. Is revealing personal information by therapists a useful practice? Professional views on this vary. Freud's argument was that 'the doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him' (Freud 1958 [1912]). Why?—partly because disclosures present the psychoanalyst as a unique person in her own right and so interfere with 'transference', which involves the therapist symbolizing a significant 'other' to the client and is the psychoanalyst's important tool. Client-centered psychotherapists, working in Rogerian tradition, likewise avoid self-disclosures, but for a very different reason—they consider them therapeutically worthless since they turn attention in the session from the client. Other psychotherapies, however, consider therapist self-disclosure to be a useful practice, and even in psychoanalytic psychotherapy Freud's dictum lost some of its force (see, e.g., Geller 2003). Cognitive behavior therapists' policy is to use self-disclosure to normalize some problems (i.e., they are problems of living not requiring psychotherapy) or, alternatively, to model to the client how to deal with problems (e.g., Morrison et al. 2003 and personal communication). Feminist therapies (e.g., Raja 1998) and at least

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1612–1783/06/0003–0027
Online 1613–3625

DOI 10.1515/CAM.2006.004

some lesbian therapies (e.g., Pearlman 1996) encourage self-disclosure, arguing that it works to even up interactive asymmetries.

Therapist self-disclosure then is a dilemma for psychotherapy in general. It is discussed largely in terms of therapeutic principles at stake; for instance, between openness on the one hand and professionalism on the other (see, for example, Kahn 1997). The value attributed to self-disclosure depends on the school of therapy (compare, e.g., the articles in the special issue of the *Journal of Clinical Psychology*, Farber 2003). Whether self-disclosure is used or shunned, the common implicit theme seems to be that therapist self-disclosure may affect the therapeutic relationship on which the effects of psychotherapy depend. Self-disclosure may also have specific effects such as providing didactic examples and models.

These professional insights provide an ethnographic background essential in understanding psychotherapeutic practices but they do not reveal how psychotherapists actually do self-disclosure. It could be that therapists do this in any odd way, or maybe they follow relatively cohesive set of formats. As far as we know, there has not been one systematic inspection of therapists' self-disclosures as they happen in therapeutic talk. Conversation analysis (CA) can make evident practices of which therapists are not explicitly aware—they do not specify disclosure at the level of talk. Sometimes CA can correct professional accounts that do not correspond with what actually happens in talk, as Peräkylä and Vehviläinen (2003) pointed out. (See also the burgeoning CA literature on interviews and orally administered assessments, e.g., Maynard and Marlaire 1992; Houtkoop-Steenstra 2000; Antaki 1999.)

CA's main task is describing how people act through using the structures of conversational practices. Psychotherapy is talk but it is not just talk—therapeutic policies supervene on talk. Clients' and therapists' engagements are resourced by therapeutic policies, which are relatively specific to different schools of therapy and are inscribed in the practice of therapy through training, yet allowing therapists a room for maneuver. Such policies are both 'recognizable' in how the therapy is done and consequential for the talk. The problem for CA studies of psychotherapy is to show how therapists' orientation to such policies is introduced into the talk and becomes consequential, thus explaining how talk becomes a (specific kind of) therapeutic practice. One way this is accomplished is through formulating the therapeutic settings and the participants (Leudar et al. 2005; cf. Schegloff 1972, 1991). With respect to disclosure, this means that therapists may use it to manage locally their identity as well as psychotherapeutic settings.

There are, then, ample reasons to explore how self-disclosures are actually done in talk in psychotherapy. We shall ourselves take no position on whether such disclosures are a good or bad thing. Rather, our aim is to bring to focus their interactional features and visible consequences. This will add to ethnomethodological and conversation analyses' growing understanding of psychotherapeutic practices (for examples, see Turner 1972; Hutchby 2002; Madill et al. 2001; Peräkylä 2004; Vehviläinen 2003a, 2003b; Antaki et al. 2004, 2005a, 2005b). It will, we hope, also add to the understanding of institutional practices more generally, where service providers collaborate with clients to bring off the business they have in hand.

2. Data

We examined over twelve hours of recorded one-to-one psychotherapy sessions, involving four therapists (all female) and seven clients (two males, five females). These recordings comprised

- six cognitive behavior psychotherapy sessions offered on the British National Health system to clients with schizophrenia (three sessions by one therapist, and three sessions by another);
- three sessions of psychotherapy carried out by a humanistically oriented therapist in private practice;
- six sessions by a client-centered psychotherapist working in the Rogerian framework, providing brief therapy to clients with problems at work. Three of these are with one client, three with another.

All told, these 15 therapy sessions yielded 23 cases of therapist self-disclosure, 11 of which are used in detail in this article. The sources we looked into hardly hope to capture the range of psychotherapeutic practice and are a very partial sampling of therapy. We do not mean our findings to be taken as representative or exhaustive—the study is a first step.

How did we identify therapist self-disclosures? In everyday discourse, disclosure refers to making public something which one would have expected to keep private. The identification of self-disclosures in therapy talk is not always easy—in a sense, anything that therapists do 'says' something about them. What matters is what counts as a self-disclosure for therapists, and here we were guided by how the research literature defines therapist 'self-disclosure' (e.g., Jourard and Lasakow 1958). This came down to a commonsense member's intuition, which we characterize roughly as 'the voluntary provision of personal information qualitatively different from the kind of technical or professional personal information relevant to the interaction'. Of course, this kind of definition glosses a number of considerations about self-disclosure as a member's concern, but we leave such a discussion to another place (Antaki et al. 2004). Here we only need a robust idea of what to look for,

as raw material for subsequent analysis, in the same way as one might look for (say) 'news announcements' or 'story prefaces' prior to uncovering how they are designed to come across that way, and what they do in the interaction.

To give an extremely rough and pre-analytic idea of our sample, here—out of context, of course, cleaned up and stripped of notation—are two examples which, in their interactional context, we counted as disclosures by the therapist: *I'd love to know what gets put about me at the doctor's; I sometimes have off days*. A list like this, of course, tells us nothing about the occasion, the design, or the uptake of therapists' self-disclosure; we turn to an analysis of those aspects now. Our aim is to analyze how such 'self-disclosures' are delivered in the flow of therapy talk and to start working out, through analysis, what their effects are.

3. Analysis: Therapists' disclosures designed as 'experiential matching'

We start with some very general findings. First, as we expected, psychotherapists use self-disclosure sparingly. In fact, our client-centered therapist did not do so once in six sessions. Second, as we shall see, even these uncommon self-disclosures tend to be of ordinary matters—not obviously things one needs to keep secret. The final general finding is a negative one—almost none of the therapists' disclosures in our sample are designed as answers to clients' enquiries,[1] nor as part of a round of independent, non–recipient-designed personal confessionals. In other words, they seemed largely not to be designed to come across as standalone, 'textbook' disclosures (say, unilateral disclosures of the therapist's own sexuality). On the contrary, we found therapists' self-disclosures in the therapy sessions to occur overwhelmingly in positions where they come across explicitly as some kind of commentary on something that the client has just said (if we may gloss it so crudely for the moment) and in particular a commentary on a problem a client revealed. In effect, disclosure is hearably relevant to what the patient says.

The particular signal that the therapist's disclosure is set off by the client is that it is designed as some kind of topical *match* of what the client has just said, or of some aspect of it. There is some content in the therapist's turn that stakes a claim to be an echo, a 'me too', a 'second story', and so on, which has some family resemblance to something in the client's preceding turn or turns. Here are some examples (see the Appendix for the transcription conventions). In each case we have followed the extract with a presentation of the topical match as a distilled pair of turns (with the most obvious nucleus of the matches highlighted in bold), and without doing any further analysis for the moment:

(1) CBT CI&HD 020398 Doctors' records

```
12  C:  (I'd like to) see me own record
13      really, f'wha' they say
14      [°abou' me° (          )]
15  T:  [↑oh::: s:::::o would ↑I::]=
16  C   =°yeh°=
17  T   I'd ↑love to know what gets
18      [(put about me)   ] at the
19  C:  [(>nev' ge' it out<)]
20  T:  ↑doctor's
```

Stripped-down match:
Client: ***I'd like to** see my own record really for **what they say about me***
Therapist: *Oh so would I **I'd love to know what gets put about me** at the doctor's*

(2) CBT TI&JR040898 Independent living

```
 1    T:  I [would thih- ]
 2    C:    [jus' inde   ]pendent lab- ↑living
 3        is: stress:ful ↑y'know,
 4        (.7)
 5    C:  and
 6        (.3)
 7    C:  °yea [h::°
 8    T:       [yeah >I would agree with that<
 9        it is
10    C:  °yeah::°=
11    T:  =it is (.) .hh [   I mean I   ]
12    C:                 [(°it's been so°) ]
13 → T:  c'n absolutely=°er° appreciate
14        what you're saying there because
15        [I get fru s ]trated with
16    C:  [ °yeah::°  ]
17    T:  it .hh [and I thin]k I can- (.)
18    C:         [↑yea::h   ]
19    T:  totally, an' the sort of things
20        you say that you're frustrated,
21        .hh [about,] I c'n: (.)
22    C:      [ yeah ]
23        ve:ry well (.) imagine being very
24        frustrated with them [.hh y'know
```

Stripped-down match:
Client: ***Independent living is stressful***
Therapist: ***I get frustrated with it** totally, and the sort of things you say you're frustrated about, I can very well imagine being very frustrated with them*

(3) CBT CI&HD 020398 Solderer

```
1  C:  from there=on I go' shop work,
2      (          's) cut-price
3      sto:re, (.4) t'when I left school
4      this.
5  T:  uh↑huh
6      (2.7)
7  C:  an I (.) worked two weeks
8      as a sold'rer,
9      (1.5)
```

10 C: °hhh°=
11 → T: =that's about two
12 [weeks more than ↑I would]
13 C: [yeh ( )]
14 T: stand tu(h).
15 C: (ye(h)ehh)

Stripped-down match:
Client: *I worked **two weeks** as a solderer*
Therapist: *That's about **two weeks** more than I would stand*

In these examples the therapist is disclosing relatively ordinary experiences.[2] It is not, however, that therapists are doing something 'merely conversational' in matching trivial experiences (though that too would be of interest, of course). What we can observe here is that this sort of matching visible in the extracts above (and especially in their distilled form, as we have stripped them down) preserves some aspect of the prior by a number of means including lexical, for example pre- and/or post-framing, and grammatical, for example use of pro-term references. However, they also operate on the prior turn in a number of ways; for example, by upgrading a prior referent or by replacing words, and by changing the point of focalization (Genette 1980: 189–194), which change the interactional thrust of the prior. The clients' talk on 'A events' (Labov and Fanshel 1977), or their experiential informings, therefore become implementing actions for the therapists' 'A events'. This action-orientation calls to mind Heritage and Lindström's (1998) work on the interactions between health visitors and mothers. Heritage and Lindström found that mothers were very unlikely to disclose things about themselves (for reasons we need not go into here) but did find one deviant case where a mother did disclose; and in that case, the health visitor herself disclosed too. Heritage and Lindström call this an example of 'experiential matching', a term which resonates with what we see in our sample of therapists' disclosures. Here is an example from their data:

(4) Heritage and Lindström (1998: 417): (14) Episode #1 [3A2:27] lines renumbered
15 M: I mean I like he:r and
16 I think she's wonderful'n
17 (0.6) but I don't feel
18 "ohhh look at m[y ba:by"
19 HV: [No,
20 M: .h It doesn't really worry me
21 cause I know it'll come with
22 ti:me.=
23 HV: =It does [yes.
24 M: [But ehm-
25 HV: Yeah. .h Well when I first had
26 mi:ne I couldn't stand the
27 sight of him?
28 M: °Heh heh heh,

Stripped-down match:
Mother: *I don't feel 'ohhh **look at my ba:by**'*
Health Visitor: *when I first had **mi:ne** I couldn't stand the **sight** of him*

Heritage and Lindström's interests in that paper were in how the 'moral problem' of a mother disclosing that she does not feel much love for her child is introduced, depicted, and resolved, so their interest in the disclosure as such is comparatively tangential. But there is enough institutional similarity between the health visitor/troubled-mother pair and that of the therapist and client for us to use this reading of their work as a very helpful point of departure: the health visitor's subsequent disclosure (and, by extension here, the therapist's) matches something in the client's, and by doing so achieves some institutional objective (in their case, deal with the moral sensitivity of the mother's lack of affection for her baby; in ours, a set of therapy-related issues we shall see below).

Note, of course, that when we say 'matching' (and, implicitly, when Heritage and Lindström do so), we are referring to the *form* of the therapist's turn—the achieved similarity, especially as it relates to the experiences of both parties—not to what it does. We use the term 'matching' in preference to something still more theory-laden like 'echoing' or 'reciprocating',[3] as we want to avoid anything that might prevent us from seeing, open-mindedly, just what it is that the self-disclosure is doing. We shall see examples of this below, but the thing to emphasize at this point is that the disclosures were visibly designed to be the opposite of 'stand-alone'; they were to be understood to do their work precisely in virtue of their juxtaposition with what the client was doing at the time.

What we shall do in the bulk of this article is, first, to offer an account of three different sequential environments for therapists' disclosures, and to say what they accomplish. We shall then look more closely at their internal design.

3.1. *Three sequential environments for therapists' disclosures*

In this first section, we will analyze three position-sensitive actions by which therapists match clients' experience: an agreement (or same evaluation; Pomerantz 1984a), a second story (Sacks 1992: see especially vol. 2, 222–268 on story-telling and story recipiency), and a candidate answer for one that is accountably absent (Pomerantz 1988). In each case we will try to bring out how by claiming and proving similarity of experience, the disclosure can do interactional work. Later, in the second part of the analysis section, we pick out two design features of disclosures for comment: their recipient design and their use of extreme case formulations (Pomerantz 1986).

3.2. *Matching with agreements*

We shall see later that disclosures can be designed to match a client's prior turn with quite complexly organized experiences of the therapist's own. But we shall start with what seems at first sight the simpler case, where the therapist responds with a (comparatively) 'straightforward' experiential match. Here the disclosure is occasioned by the client's expressed position on, or evaluation of, some topic, making relevant the therapist's response or second assessment. In our sample, if the therapist offered a disclosure on such an occasion, it was in the format of an agreement, often as a 'same evaluation' as in *oh so would I* (Extract [1]).

Let us consider that example in detail. On the face of it, we could gloss it thus: the therapist tells the client he can see her notes, he responds that he'd like to, and she discloses that she herself would love to see her own notes. But that gloss hides two significant things: just what the client is doing in his turn, and exactly what the therapist says in her disclosure, and how it bears on the implications of what the client had just said. We need go through the extract carefully, taking it as an illustration of the kind of work that such an apparently simple affiliative disclosure does.

(5) CBT CI&HD 020398 Doctors' records

1	T:	=so y'n- anything that I ↑write,
2		or anything that I write a↑bout
3		you, (.) *((rustle))*
4	C:	°right°
5	T:	quite happy ter: (.) ter let you
6		see °it at any° point,
7	C:	right
8	T:	if- y'can ↑read me ↑writin'.
9	C:	[(yu↑kan)]
10	T:	[↑that's]the ↑other thing
11		(.) °heh°
12	C:	(I'd like to) see me own record
13		really, f'wha' they say
14		[°abou' me° ( )]
15	T:	[↑oh::: s::::::o would ↑I::]=
16	C:	=°yeh°=
17	T:	I'd ↑love to know what gets
18		[(put about me)] at the
19	C:	[(>nev' ge' it out<)]
20	T:	↑doctor's
21	C:	all the ↑jargon they use an that.

Let us work up to the therapist's turn in line 15 onwards. At the start of the extract we see her begin announcing (presumably as part of some pro-forma script at the start of a session with a new client) that C may see her notes 'at any point'. She delivers this announcement going over and not ratifying C's minimal receipts as sufficient second pair parts to her invitation (if that is what it is). For C this may be a puzzle: his early understandings of the announcement have not been enough and the therapist still seems to hold him accountable for a reply.

C's response in line 12 is designed to solve the apparent problem with his previous receipts. This time, he designs it as a request that perhaps shows his understanding of what appears to be some kind of pre-offer by T: '(I'd like to) see me own record ↓really, f'wha' they say [°abou' me° ( )]'. The client's action at this point, then, can be heard as confirming the in-principle nature that he may ask to see his own records. Not now, but sometime. The therapist could have taken this as fully meeting the case: she would be willing to make her notes available, and he (eventually) requests that he would like to see them. She could have received his reply as confirming that he has understood her. But she recognizes it as an announcement rather than a request; she receives C's turn in overlap with the newsmark '↑oh:::' and with a 'same evaluation agreement' (Pomerantz 1984a), 's::::::o would ↑I::', the sound stretching causing it to be delivered in an exaggerated fashion. Indeed, an upgraded one: she'd '*love* to know'. What does this achieve?

It apparently puts the therapist 'on the same side' as the client. They both, it seems, have similar curiosity about what other people have written about them. But this is a marked shift away from what is on the table, namely what *she herself* is writing about this client. Her disclosure turns a possible source of conflict or embarrassment (that it is her own judgment and record-keeping that may be held accountable) into a generalized complaint about *other* people's record-keeping. T had perhaps been orienting to the delicacy of the client wanting to see his records *for what they say about me*. The *they* is ambiguous. 'They' might mean the records written by this therapist (*I'd like to see the records you're writing about me*). Or 'they' might be those who write the records, in which case the third-person reference may or may not include this therapist (*I'd like to see what people write about me*). Notice how the therapist treats this in her matching disclosure:

(6) (partial repeat of Extract [5])

17	T:	I'd ↑love to know what gets
18		[(put about me)] at the
19	C:	[(>nev' ge' it out<)]
20	T:	↑doctor's
21	C:	all the ↑jargon they use an that.
22	T:	°ri:: [ght.°
23	C:	[yeh.

What the therapist wants to know is *what gets put about me at the doctor's*. This specifies that what is of interest is 'records written by other people'—not, as C may have implied, what the therapist herself writes. That the curiosity be about *doctors'* records—the kind of medical doctor the therapist, as an ordinary person, might consult—is a hearable step away from

the institutionally relevant mental-health records that she herself writes. The client displays a reading of the problem with records that confirms this move: *all the jargon they use and that*. This promotes a reading of the problem with the records as (merely) their jargon; that is, their opaque language, not something more conventionally troubling like the severity of the illness they report, or the intimacy of the details they record. In sum, we can see the therapist successfully re-anchoring the client's prior turn, and the client offering a collaborative uptake. Her disclosure offers them both a routine, everyday appreciation of what it would mean to 'see records', deleting any ambiguity there might be as to what sort of understanding the client might have about it.[4] One might argue that this is an example of a 'retro-sequence' launched from the second position, invoking a 'source/outcome' relationship (Schegloff 1995).

3.3. *Matching with analogical 'second stories'*

In the same second-position environment, the therapist could go beyond a comparatively simple agreement of the kind we saw above, to offer a 'second story' (Sacks 1992: vol. 2, 222–268). That is, a narrative closely matching or treating as its source one aspect of the material in the client's immediately preceding turns.[5] Unlike the agreements we saw above, these disclosures recount some kind of complex episode, rather than merely relate an evaluation. In all the examples of second story in our sample, it was notable that the therapist went to some lengths to produce the story as an *analogy*. These analogies are narrative stories, certainly; the difference is that here, as is common with the use of analogies, there are very strong directions to the client to learn, from what the therapist is saying, how better to understand their own experiences.

The analogies tended to be narrated over a number of turns, so the extracts will be rather long. Here is the beginning of one such disclosure-as-analogy:

(7) CBT TI&JR 070798 Made me eat chocolate

```
 1    C:  y's ee I ↑can't stan::d it, (.)
 2        I <I just don't like> looking='im
 3        in the °e:ye°.=
 4    T:  =mm.
 5        (.5)
 6    T:  .pt      [↑↑I ah  ] I can- I (.) that
 7    C:           [(and eh)]
 8    T:  sounds quite ↑reasonable to me
 9    T:  given that you were made to do it
10 →      (.).hhh [if people] made me
11    C:          [yea::h.  ]
12 → T:  do anything against my will. .hh
13 →      [y'know, (.) I: (.) *I like
14    C:  [y eah
15 → T:  choc'late.* ((*'stage whisper'*))
16        (.4)
17 → T:  right, =I- I'm an [absolute
18    C:                   [°yh°
19 → T:  choc'late fan =.hh if you ↑made
20        me eat choc'late, (.2) 'n made me
21        and made me eat it, (.) [.h how
22    C:                          [°°y'°°
23    T:  might my s'=feelings about
24        something even about something
25        I [really like.
26    C:    [you ↑wouldn't ↑li:ke] it
27        [would you]
28    T:  [yeh. .hh  ]
29    C:  no
30    T:  and that's something I really
31        really ↑like °now°. ((*T continues with
          analogy*))
```

The material in lines 6–9 (*that sounds quite reasonable to me* . . .) is important, and we will come back to it later. Now, though, we want to concentrate on the self-disclosure (indicated by the arrows). A gloss will help. C has been complaining about disliking looking her father in the eye, and has suggested (in preceding talk not shown) that this is because she was made to do so when she was a child. The therapist assesses this as 'quite reasonable' and formulates the issue as being a matter of being made to do something. The therapist then applies the situation to herself (*if people made me do anything against my will* . . .) and discloses something analogous about herself—*y'know, I like chocolate*. She invites the client to consider how she (the therapist) would feel if she was nevertheless forced to eat chocolate.

We do not reproduce the whole sequence, but the therapist then goes on to invite the client to consider the consequence of the therapist being forced to eat something she did *not* like. She would end up hating that item even more. The therapist brings the analogy to a conclusion thus:

(8) CBT TI&JR 070798 Made me eat chocolate continued (missing out 23 lines of material)

```
54  T:  so [even  ] (.) I mean ↑that's
55  C:     [yea:h.]
56      just on a food basis which isn't
57  T:  (↑like feelin')=which isn't ↑half
58      as bad as feeling an↑comfortable
59      about °something°.
60  C:  yeah::.
```

The disclosure, then, introduces an analogy that picks out one aspect of the client's story—that she was made to do something she didn't like—and validates it by appeal to a general principle exemplified, albeit hypothetically, in a projection of what the therapist might experience. The point of the analogy must be to offer to the client a way of understanding the fact that she hates looking her father in the eye. It is, according to this analogy, just like the therapist ending up hating chocolate or some other food item.

At this point we want to return to the material in lines 6–9. Notice that the therapist, just before she delivered her disclosure, offered the following evaluation of the client's story:

(9) (Part of Extract [7] above)
6 T: .pt [↑↑I ah] I can- I (.) that
7 C: [(and eh)]
8 T: sounds quite ↑reasonable to me
9 given that you were made to do it
[....]

It is possibly significant that the therapist inserts this assessment—which normalizes the client's experience—before delivering her complex analogy. It brings to the fore a way of hearing what she has to say. The self-disclosure of the therapist's own liking for chocolate is set up as a vehicle for an analogy explicating just why the client's hatred of looking at her father is in fact quite reasonable.[6]

We can see another preface in this next example of a disclosure analogy. In this case, the disclosure is again arrowed, but notice the prefatory material in lines 14–17.

(10) JP&RONNIE 280200 Do it now
(The client has been talking about his tendency to impatience, and is now finishing off an account of how that impatience affects his project of converting houses for resale: when he sees a likely prospect he *wants to do it now*, line 14.)
1 C: =I m'n I can. [>I can look at a
2 T: [yes
3 C: house< and I can see how te sort
4 've turn it inta (1.0) nice living
5 units for ↑people, (.) °>y'nuh<°=
6 T: =°yes.°=
7 C: >°y'nuh that°- that're< people (.3)
8 um (.3) friendly. (.) if you like,
9 T: yes. (.) ↑yes indeed, (.) yes, yes,
10 (1.0)
11 T: °°mm°°
12 C: °°'t I,°°
13 (.5)
14 C: °but I wanna do it now.°
15 (.6)
16 C: eh heh HEH HUH huh hh=z
17 sort've [(risky)
18 T: [w'll I know the
19 feeling, (.) ↑ahh-hah[ghh (.)]
20 C: [( )]
21 → T: ↑yes I ↑do know that
22 → feeling very well, (.) yes. (.5)
23 ↑er-↑that- (th't / but) there are
24 times in your life when you're-
25 °y'know you think° you're ↑moving
26 forward. (.5)and you may not be
27 getting everything you want,=but
28 you=er laying >↑uhl-<= the.
29 → foundations (.) >↑cz ahm
30 → ↑ac'shly< doing the same
31 → my↑self really. (.5) I'm doing (>all
32 → this- s- stov-<) ↑studying and the
33 → ↑reading I'm doing. (.) .h it's a kind of
34 → latency pe:riod. °But it's all very
35 → ↑valuable,° (.5) I'm just building
36 → up=I'm not actually making ↑money
37 → but I'm [build]ing up my knowledge
38 C: [yes]
39 → T: ↓base::. (.) and I'm building up
40 → conn↑ections in the world
41 → I want to go into °an the writing
42 → I want to go into° (.) I'm
43 → ↑thoroughly enjoying doing ↑that,
44 → (.5)so I'm putting up with the fact
45 → that °I haven't got the money I would
46 → like to have° too=or the ↑house I
47 → °would like to have°.
48 (.3)
49 T: so ↑I- because I'm- (.3)↑in a way
50 they're similar sort of situation.
51 (.4)
52 T: and ↑I've rushed into things in the
53 past,°and lost a lot of money through
54 doing °°s'stupid thin-°° (.) I'm not
55 >g-↑ever going to< do ↑that again.
56 (1.0)
57 T: teaches you a lesson, °°doesn'it°°.

The client provides a 'jokey' expression of his state of mind—his impatience at the delays in getting going (line 14, '°but I wanna do it now.°'). The first opportunity to assess this (line 15) is not taken by the therapist, and the client goes on to offer a laughing expansion of, or commentary on, what he has just said ('eh heh HEH HUH huh hh=z sort've (risky)'). He abandons this when the therapist enters in overlap with a receipt ('w'll I know the feeling', lines 18 and 19), upgraded in lines 21 and 22 ('↑yes I ↑do know that feeling very well, (.) yes.') which, we might note in passing, is about as clear a manifestation of Heritage and Lindström's (1998) 'experiential matching' as it is possible to hear.

At this point, in lines 23–29, the therapist elaborates their shared position as a general principle—*there are times in your life when you think you're moving forward and you may not be getting everything you want, but you're laying the foundations*. The therapist then offers (lines 29 and following) an explicit second story: '>↑cz ahm↑ac'shly< doing the same my↑self really, (0.3) I'm doing (>all this- s- stov-<) ↑studying and the ↑reading ...'. Sacks (1992: vol. 2) noted that in telling second stories the narrator usually matches the story, and adopts the same character position as the 1st storyteller. He, however, also noted that sometimes in 2nd stories, narrators systematically vary the character position from which they speak (e.g., in accident stories the 1st narrator could be a bystander

but the 2nd-story narrator a victim). In the first format, the 2nd narrator matches and validates the 1st teller's experience; in the second format, however, the effect is more intricate—experiences of the 1st narrator can be complemented, developed, or even contrasted. This, it seems to us, is precisely what the therapist does in Extract (10). She presents what she says as matching the client's story, but then varies her narrative position and re-signifies the delayed gratification as not only the safe option but something that can be enjoyed.

The therapist's analogy is a way of dealing 'therapeutically' with the client's story. The client has expressed a self-awareness that he can be impatient in wanting to do something immediately before all the preparation is made; rather than offering advice that may be rejected, the therapist discloses that she herself is 'putting up with' preliminaries (studying and reading, building up her knowledge) before entering 'the world I want to go into' (lines 41 and 42). This disclosure picks out of the client's story the positive benefit of preparation; it emphasizes that (as the therapist herself is witness) it is a process that has to be 'put up with'. Indeed, it exemplifies the therapeutic axiom with which the therapist introduced the disclosure (lines 26–29): *you may not be getting everything you want but you (are) laying the foundations*. The therapist's observation here bears a family resemblance to what we saw the therapist doing in Extract (7). There the therapist claimed a general rule that one could end up hating something (as she herself might) if one were made to do it; here the therapist is claiming a general rule that one might have to (as she has had to) suffer a period of laborious preparation before enjoying the fruits of a project. Both generalizations serve to assuage, and normalize, the client's trouble. The tacit logic of normalization is that we all have such problems, they do not require psychotherapy, coping with them is a part of life. It is relevant that even though the therapist declares having a problem, it is not a problem which would position her as a potential psychotherapy client. Disclosure then normalizes the problem and in such a way that the therapeutic setting is maintained. Both presuppose that what the therapist reveals is mundane.

3.3.1. *A variant case.* The interest of the next case is in the dissociation between the therapeutic analogy and the therapist's self-disclosure that personalizes it. This shows that the two activities can be separated; to deliver an analogy, a therapist need not actually infuse it with her or his own experience. But, should the analogy seem not to engender an appropriate uptake, a self-disclosure can be a way of upgrading it to the point where it gets a receipt from the client.

Just before the extract starts, the client has been talking about the fact that he has been trying to relax more: something he finds difficult. He is *fighting against it all the time* (in material not shown). We join the extract at the point where the therapist offers an account for this objection (*it's new for you, it's not what you're used to, there's a new pattern*; lines 1–7).

(11) JP&Ronnie 280200 Fallow period

```
 1  T:  he [h heh heh °heh° .hh well
 2  C:     [(y'kner,)
 3  T:  because it's ↑new for you.
 4      (.8)
 5  T:  it's not- it's not what you're
 6      ↑used to.
 7      (1.5)
 8  C:  °w'l thas: true, ye[ah°
 9  T:                     [there's a new
10      pattern.
11      (1.0)
12  C:  °yeh:,°
13      (1.0)
14  T:  ut- thee- it w- so- (.3) ↑every time
15      we- (>we s't've-<) start- (.4)
16      acquiring new ↓skills. (.4) we ↑do
17      need time to assimilate those skills.
18      (1.2)
19  T:  and er: (.) it's ↑like (.9) ↑erm you
20      know=it's=like ↓fields where er-
21      (.) i- w- ((strangled)) ↓wheat is
22      growing or crops, >°right°<=they >
23      ↑have t've a<[7] fallow period ev'ry
24      now and then don't they
25      (.3)
26  C:  yes.
27  T:  for the la:nd to recover. (.) h and
28      then- >b- then they< can
29      produce an even b↑etter crop.
30      (.5)
31  T:  >w'll< =we all need our- (.) little
32      fallow periods too.
33      (1.4)
34  C:  °righ-°
35      (.4)
36  T:  I know ↑I do.
37      (.5)
38  C:  yeh
39  T:  >uz (Ih- ha-)[8]< very exciting day
40      at university. ↑ev'ry Tuesdee.
41      (.8)
42  T:  but the:n (.) I have a couple of
43      ↑quiet days at ↑home, and I
44      ↑nee:d those two days: (.) because
45      ev'ry- if every day was as
46      exciting as my univ↑er°s'y day
47      I g- .hh I get very t↑ired.
```

What interests us is the pause of 1.4 seconds in line 33. Before this the therapist has articulated her diagnosis 'there's a new pattern' as a rule: *every time we acquire new skills we need to assimilate them*, which she illustrates, in the same turn, as an analogy at a

general, nonpersonal level (*it's like fields where wheat is growing*). She offers a slot for a show of understanding at line 24, which the client provides after a brief pause of 0.3 of a second, then a turn-terminating pitch drop at the syntactically and pragmatically completing unit 'and then- >b- then they< can produce an even b↑etter crop.' (lines 28 and 29). Again there is a discernible pause, and this time the client makes no audible receipt. The therapist adds at lines 31 and 32 what may be heard as the 'punch-line' of the analogy *well we all need our little fallow periods too*. At this point there is a much longer pause, of 1.4 seconds. When the client's response comes at line 34 ('°righ-°'), it is a markedly half-hearted reception of the therapist's analogy. It is in this immediate context that we see the therapist launching her disclosure, with what could be a preface at line 36, between 39 and 42: *I know ↑I do. I have a very exciting day at University* etc.

The strong implication is that this disclosure, just here, is occasioned by the client's hearably dispreferred and 'unenthusiastic' (if we may gloss it as such) or 'noncommittal' receipt of the analogy the therapist had gone to some trouble to establish as a basis for interpreting his situation. Our case for reading it this way is confirmed in some degree if we play through the next few lines, where we see the client, again after a long pause, explicitly orients to the disclosure in a distinctly down-graded way:

(12) (follows on immediately from Extract [11])
48 (1.5)
49 C: (w' I c'n) relate to tha::t >inas
50 muchas ah< need my week↑ends
51 now

The client is prepared to acknowledge that he can 'relate to tha::t', but whatever 'that' is, he qualifies his acceptance of it with the formula *inasmuch as*. That is a very circumscribed acknowledgement of the pertinence of the therapist's disclosure, and retrospectively confirms that offer of a disclosure could have been occasioned by her reading of his previous receipts as 'reluctant'. The point we want to draw out from this example, is, as we said, that the analogy and the disclosure can be separated; but in pursuit of a response, the disclosure works to make the analogy more relevant to the client, and more effective as a means of normalization.

3.4. *Self-disclosures as providing candidate answers*

We came across cases where the therapist offered a disclosure where there was an accountable *absence* of something. The previous talk had shown that the client had been deficient in providing an answer to a question, or in coming up with some other expected second-pair part. In such a case, the therapists' disclosure could be said to act as a solution to an inferred difficulty (Pomerantz 1984b)—it projects what the client could have said or *ought* to have said, in a species of model or candidate answer (Pomerantz 1988). In the example below, the therapist is asking the client to give reasons why people might smile at her (the previous material, not shown, shows that the client is worried about smiling back at people). Notice the absence of a response in lines 20–22.

(13) CBT TI&JR 23/04/98 Smile at people
1 T: >kay,< h↑ONE (.) one reason
2 you might smile at other people
3 is thehr pleased to see °you°.
4 (.2)
5 C: yeah:,
6 (.2)
7 T: yeah? other reasons.
8 (0.9)
9 C: er:: they've no:ticed me, an they
10 know me (3.9) ↑this ↑isn't jus:t
11 um (.4) this is just s:taff: really,
12 not:h um (.4) not people:
13 who are not staff.
14 (0.9)
15 T: okay,=
16 C: =ju [st s:taff] (.) yea°uh°
17 T: [just staff.]
18 (0.9)
19 T: yep- what el [s:e.
20 C: [°mm:°.
21 (.7)
22 C: em:
23 (2.4)
24 T: >.h= *akh- I* ((*strangled*))
25 DON'T KNOW ABOUT< you:
26 (fuh-)=(fuht) sometimes when- (.)
27 even w-when I see somebody
28 and recognise (uz) face (.) .hh
29 [h some]times I smi:le at them even
30 C: [yeah]
31 T: when I >(c)h:haven't< thought
32 who they a:re (.4)
((T continues with disclosure))

The client has given two reasons for why people might smile at her by the time we get to line 19, where the therapist asks *what else*. At that point there is a pause, the client offers *em:*, and there is a further pause of 2.4 seconds. Clearly what is wanted is another reason; equally clearly, the client is having trouble finding one. The therapist at this point discloses that she sometimes smiles at people even when she doesn't immediately recognize them.[9] This is a candidate answer that orients to a hearable absence (Pomerantz 1988; see also Houtkoop-Steenstra 2000) and offers a way to redress it.

Here is another example. The therapist is asking C what sort of training course he would like to go on, and so far has had no positive response:

(14) CBT UV&JR, 110698 World's worst cook

```
 1  T:  or (.2) .hh (.) have you ever
 2      *had a desire to >I don't know
 3      what people do< (.) cook or er*
 4      ((*smile voice*))
 5  C:  no c[ookin'
 6  T:      [PAIN:t or
 7  C:  No paint
 8      (0.6)
 9  T:  .hh I've always had a desire
10      to cook which is >why I say at-<
11      °I can't- I'm the° <world's
12      wor::st cook.> (Michael) I REALLY
13      am .hh but I've always had vis:ions
14      that one day I might just n(h)ip into
15      the k(h)itchen [and R(h)USTLE
16  C:                 [m
17  T:  something lovely up ↑.hh i(h)n fact if
18      it doesn't come from the freezer and go[10]
19      in the microwave I can't do it.
20  C:  °hh°
21      (0.6)
22  T:  .hhh: EH- ↑but we might like
23      to think about possibilities
24      [to get you on some sort of courses,
25  C:  [yeah
26  T:  (.) [you might be interested
27  C:      [yeah
28      yeah
29  T:  br↑ill↓iant (0.) .hh ↑well,
30      ↑LET'S have a l=look at what
31      we've done tod↓ay.
```

We join at the point where the therapist is making a suggestion in the form of a yes/no question: *have you ever had a desire to I don't know what people do, cook, or er paint*. The client's answers (*no cookin', no paint*) are institutionally unhelpful in the sense that they allow nothing to be entered in the record; in that sense, they are deficient. In line 8 there is a pause of 0.6 of a second after the client's second negative response, then the therapist launches her own disclosure: she's *always had a desire to cook*. The placement after an unsatisfactory response casts it as a way to answer the question. Although C provides no substantial take-up of even this candidate answer, the therapist nevertheless moves into closing this bit of business and starting the next (*brilliant well let's have a look at what we've done today* ...).

3.5. *Features common to the disclosures in our sample*

We have now seen three different sequential environments where therapists' disclosures are employed—what is spoken of as one phenomenon in the therapeutic literature: straightforward 'me too' agreements; more complex second stories elaborated as analogies; and candidate answers. We have said something about how each of these has different interactional consequences, for example they may offer a way of understanding what the client has just said (or guidance for what the client should have said). Let us now consider two internal design features recurring in the disclosures. One recurrent feature is the visible effort at designing the disclosure as pertinent to this recipient. The other, pointing in a rather contradictory direction, is the therapists' frequent use of hyperbole.

3.5.1. *Recipient design.* We observed two notable ways in which therapists took care to display that their disclosure was designed for this recipient, at this time, in this (sequential and therapeutic) environment. One was explicitly to call attention to the similarity or applicability of the disclosed experience to the client's circumstances (of course, the sequential placement of a second story will itself deliver a good deal of the implied relevance of this story to the first one; but the therapist could, and did, do more besides). The other was to recount the disclosure as a *current* experience, preserving the temporality of the client's own current problem or trouble. We describe these in turn.

a. *Calling attention to the applicability to the client.* We have already seen, in the extracts so far, explicit orientation to matching the therapist's position with the client's prior turn, in such phrases as *oh, so would I* (Extract [1]) or *I know that feeling, yes I do know that feeling very well* (Extract [10]); we have even seen straightforward direct naming address (*I'm the world's worst cook (Michael)*) (Extract [14]). Other features can also be brought in to make the match hearable. Consider the internal design of the self-disclosure in this example:

(15) JP&SARAH 010598. I have off days
(C has been recounting her efforts at controlling a class of children.)

```
 1  C:  =an it's- (.) thev bin- t- (.) a
 2      ↑tough bunch of [°kids°
 3  T:                  [°↑mhm,
 4      w'l ↑at's ↓nice°=s:so that's w-
 5      ↑grea:t °thing you've
 6      done [(then) is ]n'it°.
 7  C:       [yeah:°::° ]
 8  C:  °so° (.) that's erm-
 9  T:  >↑s'↑this ↑is certainly a<
10      matter,of er- (.3) acc↑epting that
11      sometimes you have this lah->n-
12      ↓ah have< (off) days
13      w'cl↑i:ents [an I (.) >feel'uvn<
14                  [mm
15      done very much [I- h
16  C:                 [ye:s
17  T:  [>n'and I'm n- an the thing
18  C:  [°m°
19      is that< ↑most of the
20  T:  time >(I'm doin very ↑well)=
```

21 most of the time ↑you
22 [do very well. <] (.)
23 C: [mm:: ye]h
24 T: [(er nah- that in itself is) a great
25 C: [m
26 T: achievement.

In lines 3–5 the therapist offers her assessment of C's situation and embarks at line 9 on what may have turned into advice (perhaps in the format of advice-as-information, described by Silverman 1997). This is however abandoned, and the restart is a disclosure of the therapist's own feelings of ineffectiveness: '>n-↓ah have< (off) days w'cl↑i:ents ↓an I (.) >feel'uvn< done very much'. The feature we would draw attention to (as indeed does the therapist herself, who announces 'the thing is ...') is the reciprocity between the therapist's and her client's situation: '↑most of the time >(I'm doin very ↑well)=most of the time ↑you do very well.' Pre- and post-framing the replacement of 'I'm doing' with 'you do' adds strongly to the message that the experiences and the circumstances are comparable (possibly recalling proverbs and other idioms, and perhaps even Thomas Harris's [1973] well-known therapy-culture phrase 'I'm okay, you're okay'). This use of pre-framing plus replacement is also visible in the following example.

(16) CBT CI&HD 020398 One grumpy woman
1 C: y[eh
2 T: [soun' like y'r pretty un↑happy=
3 C: =yeh
4 T: not sleepin' very well=
5 C: =noa
6 T: ↑e:::::r (.) so:: (.) you become
7 (one)bad tempered
8 gr [umpier person=
9 C: [yeh
10 C: =yeh=
11 T: =hardly surp↑rising then.=
12 C: =yeh
13 T: if you put ↑me in that
14 sit[uation,]
15 C: [huh ↑huh >huh]huhh ↓heh.<
16 T: you'd see one bad tempered
17 grumpy wom↑an °t hh°
18 C: yeh

We note without going into details that in this case, perhaps at the limit of what might count as self-disclosure, the therapist is matching her disclosure to a state of affairs that she herself formulates. It is she who says that the client *sounds like he's pretty unhappy, not sleeping very well*. What we want to use this extract for is merely to see that the therapist (in pre-framing *one bad tempered grumpier person* with *one bad tempered grumpy woman*) works to project an equivalence between her (admittedly hypothetical) situation and that of the client.

b. *The currency of the disclosure.* A second notable feature of the therapist's self-disclosures is that they are usually of rather ordinary things that the therapist currently or habitually does or feels, that is cast in the habitual present. To repeat the salient lines for an extract we have already seen, consider Extract (17) below.

(17) JP&Ronnie 280200 (part repeat of Extract [10])
29 T: >↑cz ahm
30 ↑ac'shly< doing the same
31 my↑self really. (.5) I'm doing (>all
32 this- s- stov-<) ↑studying and the
33 ↑reading I'm doing. (.) .h it's a kind of
34 latency pe:riod. °But it's all very
35 ↑valuable,° (.5) I'm just building
36 up=I'm not actually making ↑money
37 but I'm [build]ing up my knowledge
38 C: [yes]
39 T: ↓base::. (.) and I'm building up
40 conn↑ections in the world
41 I want to go into °an the writing
42 I want to go into° (.) I'm
43 ↑thoroughly enjoying doing ↑that,
44 (.5)so I'm putting up with the fact
45 that °I haven't got the money I would
46 like to have° too=or the ↑house I
47 °would like to have°.

We have already commented that the ordinariness of therapist self-disclosures function to normalize clients' problems that the disclosures matches while maintaining therapeutic situation, in which the client is the locus of therapeutic problems and the psychotherapist is the problem solver. The present-tense format aids the normalization—it is a part of living ordinary life. What is interesting is that when the therapist does *not* currently share a similar experience, what she or he can disclose is a hypothetical disposition to experience something like (or exactly like) the client's experience. We saw this in Extract (16), where the therapist went through a set of circumstances and discloses that 'if you put ↑me in that sit[uation] ((...)) you'd see one bad tempered grumpy wom↑an'.

3.5.2. *Extreme case formulations.* A common, but not universal, feature of our cases of self-disclosure is hyperbole, or the use of what Pomerantz (1986) calls *extreme case formulations* (ECFs). Examples in our sample include phrases such as 'I'm an *absolute* chocolate fan', 'I'm the *worst* cook in the world'.

Pomerantz observes that such extreme language is often offered in an environment where the description is at odds with some other state of affairs, and serves to justify the speaker's belief that the matter being described is significant and newsworthy. This may be less relevant here than a rather different aspect of ECFs identified by Edwards (2000): that they are designed to be understood as nonliteral, expressing not the facts of the matter, but rather the speaker's

attitude toward it. This sense of an ECF is well exemplified in our data. Consider Extract (18) below.

(18) CBT CI& HD 020398 Watch TV

```
 1  C:  can- (.) affect you (.) y- you (.)
 2      wun'ty watching something on
 3      the tee ↑vee as well (.5)
 4      somethin: violent or something.
 5      (.4)
 6  T:  ↑yeh I don't ↑like
 7      (to watch anything like that
 8  C:  [(          )
 9  C:  yeh [an (cem ca-) gets in
10  T:      [°(on telly)°
11  C:  your ↑brai:n an' [( )
12  T:                   [an'
13      I ↑can't- I can't bear it when
14      they're kissin [and s:loppin'
15  C:                 [°noh: no:h°[1]
16  T:  [all-=I have to switch=HAH [HOFF
17  C:  [°noh: noh:°               [°noh°
18  T:  THE Set: hee hh=
19  C:  =(that kind o' w- (.) i'- (.) th-' r- ah-
20      (.) [romantic ↓crap
21  T:      [°hehheh°
22  T:  hehhe [h (.) °'ts ↑awful isn'it°
23  C:        [()
24  C:  °ye:h°:: .hh [() >huh-huh<.=
25  T:               [.hh
```

The disclosure is markedly hyperbolic: the therapist doesn't '↑like [to watch anything like that', 'can't bear it when they're kissin and s:loppin', she 'has to' switch off the set, and it is 'awful'. Note the hearable nonliteralness of the disclosure. It is of course impossible for the therapist 'literally' not to be able to watch something (unless by physical impossibility, such as being unable to receive these images on her television set, but that is not the force of the claim). It must be, as Edwards (2000) remarks, that the extremity of the language is meant to communicate her attitude to such things. What comes across is the therapist's feeling that such images are embarrassing, in poor taste, 'cringe-making', and so on. These are all the feelings of an ordinary person, we should note, and not stereotypically those of a professional psychologist who can presumably take a cool look at even the most shocking material. Hence the disclosure works to affiliate with the client's own 'ordinary-person' reaction to television, and, thereby, normalize an otherwise potentially odd-sounding response. It could be of course that the use of extreme case formulations is a part of particular therapists' idiom—this has to be established in future studies.

4. Discussion

By looking at therapists' self-disclosures we wanted to add to a growing conversation analysis account of the working practices of psychotherapy—a tradition started by Harvey Sacks's inclusion, in his 1960s lectures, of analyses of recordings of group therapy of a set of American teenagers (indeed whether they were in therapy or 'in an automobile discussion' [1992: vol. 1, 144] is one of the points of departure for Sacks's analysis). Largely dormant since then, the tradition has been revitalized in the last decade by some intensive work on counseling (e.g., Peräkylä 1995; Silverman 1997) and now on psychotherapy (Hutchby 2002; Madill et al. 2001) and psychoanalysis (Peräkylä 2004; Vehviläinen 2003a, 2003b). By treating therapy as a form of interaction—institutional, to be sure, but nevertheless subject to the requirement that it be brought off in sequences of talk—CA is able to stand aside from the members' concerns in therapy (whether lay or professional) and throw its light on what they actually do.

Conversation analysis takes it that talk in interaction accomplishes actions. With respect to studying psychotherapy, the perennial problem of choosing terms to describe these activities is particularly acute. As Peräkylä and Vehviläinen (2003) observe, therapy has an articulate set of terms for its own activities. How then to describe the actions of psychotherapists and their clients, and how to marry up their own members' descriptions with those of CA? Do therapists accomplish actions described 'publicly' (as questioning, answering, repairing, etc.) or in their own terms—as for instance 'countering transference', 'reflecting back', and so on? There is a debate to be had about whether actions that are specific to a therapeutic institution can be reduced to everyday communicative actions, so that, for instance, all therapeutic 'interpretations' would be realized in a particular conversational format. If one follows Elisabeth Anscombe (1959), one might say that such actions are conversational actions that are, however, understood in a different and inevitably progressively wider context (usually brought into the analysis through ethnography.) On that basis, to understand something as an interpretation or a disclosure, a conversational act has to be augmented by particulars made relevant by participants and seen as relevant by them. One of our significant findings is that while psychotherapists' self-disclosures share certain features in common (they match experiences avowed by clients, are rather ordinary but pertinent to the client, and are possibly hyperbolic), they are done using a variety of distinct conversational formats. This means that disclosure is not a cohesive conversational practice, and conversational properties of 'disclosures' are necessary but not sufficient to define them as disclosures. What then keeps them together in one category? Possibly just the fact that the therapist reveals something, however ordinary, about herself, *visibly in the service of therapy*. How, and with what consequences, was the subject of this paper.

We started from our preliminary observation that therapists' disclosures have an immediate resemblance to the kind of institutionally located disclosure found by Heritage and Lindström (1998) as part of their research on Health Visitors' interactions with mothers. As Heritage and Lindström found in the case of one of their health visitors, we found that our therapists designed their disclosures to match some element of the client's current talk. (We may say in parentheses that we did find some examples of therapist disclosures that made no such match, but, significantly, these occurred in the preamble to the therapeutic interaction itself, and we will not talk about them here.)

What does such matching do? Here we are comfortable only with explicating the formats that we found, and detailing their institutional interactional functions. Certainly disclosing in agreement and analogy suggests that the therapist is offering the clients a way of understanding their own experiences. We can go one step further and note that the disclosures normalized, or in some other way ameliorated, the client's expressed problematic experiences. Hating looking one's father in the eye became a normal outcome of being made to hate anything, even (as in the therapist's case), chocolate; wanting to look at one's records became (as it was for the therapist) wanting to look at any doctor's records; things going badly at work were (as they were for the therapist) a matter of having off-days; and so on.

But there are many ways of being concrete without making a personal disclosure. Indeed, we saw one example (Extract [11]) where the analogy (both fields and people needing *fallow periods*) was separate from the disclosure, and the analogy by itself received a markedly cool uptake by the client. That the therapist immediately went on to disclose how that analogy applied to her own case suggests strongly that the disclosure adds some kind of accelerant to what the therapist is doing. The accelerating ingredient must presumably be the appeal to personal, 'every-day' evidence, as opposed to more abstract and therapy-specific kinds of reasoning.

But we recognize that here we must hand back the turn to therapists for comment. It would be the work of a separate project to link the sorts of design and sequential placement features that were the theme of this analysis with the expressed, normative, institutional concerns of the therapeutic community. Conversation analysis is beginning to make its contribution to members' understandings of their institutional practices (for example, in medical consultations), and the work reported here might fruitfully be extended in that direction. For the moment, however, we shall have achieved our local purposes if, without going too far into speculation about their institutional objectives as they would be seen by members of the institution themselves, we have shed some light on therapists' self-disclosure as interactional phenomena.

Appendix: Transcription conventions

(.)	Just noticeable pause
(.3), (2.6)	Examples of timed pauses
word [word	
[word	The start of overlapping talk
.hh, hh	In-breath (note the preceding fullstop) and out-breath, respectively
wo(h)rd	(h) shows that the word has 'laughter' bubbling within it
wor-	A dash shows a sharp cut-off
wo:rd	Colons show that the speaker has stretched the preceding sound
(words)	A guess at what might have been said if unclear
( )	Very unclear talk
word=	
=word	No discernible pause between two sounds or turns at talk
word, WORD	Underlined sounds are louder, capitals louder still
°word°	Material between 'degree signs' is quiet
>word word<	Faster speech
<word word>	Slower speech
↑word	Upward arrow shows upward intonation
↓word	Downward arrows shows downward intonation
→	Analyst's signal of a significant line
((*sobbing*))	Attempt at representing something hard, or impossible, to write phonetically

Notes

* The research reported in this article was facilitated by ESRC grant number RES-000-22-0330.

1. We have just one example of a therapist being asked a question about her showering habits by the client, as part of a dialogue about the client's disinclination to bathe.
2. We do have examples of disclosure of more significant troubles, too (for example, detailed accounts of a failed business), but not such that would require psychotherapy.
3. 'Reciprocation' is a common description of self-disclosure in the psychological literature, but we avoid it precisely because of its causal implications.
4. What the therapist's turn does, might depend on how one hears a mumbled section of line 14 in the extract. What we have put as a blank between round brackets might be something like 'a dunno if that's possible to'. If it is, then it adds a sense that the client is making a positive bid actually to see these records. If the therapist hears it that way, then transforming what 'records' means also eliminates the motivation for his request.
5. Even though, as Sacks put it at the time, 'it is absolutely not the business of a psychiatrist, having had some experience reported to him, to say "my mother was just like that too"' (1992. vol. 1, 259). Nevertheless, Peyrot (1987) has already noted how self-disclosure in psychotherapy relies on elements of conversational organization, such as second stories, to display understanding of the prior.

6. That is not to say that the analogy, and the conclusion, must be accepted by the client. Consider again lines 54–59 and see how the interaction immediately continues. We join the talk when the therapist is drawing a conclusion about learning to dislike a food item (*that's just on a food basis*). She starts one formulation of what follows: 'which isn't (↑like - -)', but abandons that to restart 'which isn't ↑half as bad as feeling an↑comfortable about something'. Possibly the therapist has abandoned a more specific reference to the client's actual trouble of hating looking her father in the eye. The client restates her original complaint (not shown). This can be seen as putting aside, or 'sequentially deleting' (Schegloff 1987), all of the therapist's efforts at offering a reformulating analogy: in that sense, at least, the client's actions at this point might be called 'resistance' (see Antaki et al. 2004).
7. 'have to have'
8. 'coz if I have', but mangled
9. We notice, but do not analyze, that she prefaces her disclosure by a partly strangled, disfluent and mitigated introduction: >.h= *akh- I* ((*strangled*)) DON'T KNOW ABOUT< you:)
10. As well as the laughter particles in the words, there is 'suppressed laughter' at various times in this turn, but it isn't easy to specify its boundaries.
11. The overlap brackets in lines 7–15 above are approximate; the feel of the talk is that both speakers keep on with no gaps, throughout.

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