Therapists' responses to young people's anger: a Conversation Analysis approach

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Abstract

Objective: The exploration of negative feelings is one of the core principles of psychoanalytic psychotherapy, yet anger experienced towards the therapist may lead to increased risk, ruptures in the therapeutic relationship and dropout. This study aimed to investigate the therapists' immediate responses to patients' anger in Short Term Psychoanalytic Psychotherapy (STPP) **Method:** This study used Conversation Analysis (CA) to analyse 10 patient-therapist conversations in extracts extrapolated from 4 different patient-therapist couples. The four treatments were audio-recorded as part of the STPP arm of the IMPACT study, a randomized controlled trial, investigating the efficacy of three types of therapy in the treatment of adolescent depression. **Results:** The CA analysis found six patterns of response that were produced following patients' expressed anger. Therapists responded in highly emotion-laden ways, they created space from addressing anger in the here-and-now interaction, they used their epistemic authority to support their point of view, they asked questions about patients' anger and they shifted their focus to moments of agreement. In one case, the therapist named the patient's annoyance and anger towards her. In all other three cases latent feelings of anger were named but evaded when those became explicit in the therapeutic interaction. **Conclusions:** Expressions of anger can be seen as moments of increased emotionality which temporarily affect the therapist's reflective stance and neutrality. Whilst anger indicates misalignment in the patients' and therapists' views and goals, strong emotional alignment on a non-verbal, procedural level seems to be at play. Pragmatic research in naturally-occurring data can inform psychoanalytic technique for STPP and bring awareness of factors likely to impact upon the therapeutic alliance.

Keywords: anger; negative emotion; STPP; psychotherapy; adolescence; depression

Chapter 1: Introduction

This doctoral thesis investigates therapists' responses to patients' anger in Short Term Psychoanalytic Psychotherapy (STPP) with adolescents diagnosed with depression. The sessions were audio-recorded for the purposes of the IMPACT trial (Improving Mood with Psychoanalytic and Cognitive Therapies) (Goodyer, I. M., Tsancheva, S., Byford, S. et al., 2011).

More specifically, this research project aimed to answer the question of how patients' anger affects the therapist and how therapists respond to it. Therefore, the aims of the project were to identify anger-expressions in the data and to analyse the conversational patterns that surround those, shedding light to how anger is co-constructed in therapeutic interactions.

I first became interested in the topic of patients' anger when I began working psychoanalytically with self-destructive and high-risk adolescent patients who struggled to express their negative feelings towards others. In psychoanalytic therapy, we hope to bring patients' anger into the therapeutic relationship and to survive it until some understanding of it can be possible. We try then to understand patients' anger as a communication of their psychic reality to the therapist, even when linked to patients' desperate attempts to alarm the therapist through risky behaviour.

Patients' anger nevertheless entails great risks for the continuation of the treatment and at such times one has to find the lay language to explain to the network what it is about a patient's anger that indicates that something is happening in treatment for which the patient has to be helped to stay, not leave.

However, even when treatment is completed with good outcomes, one wonders about the patient's experience of therapy. Therapists' experience of the therapeutic process is routinely

documented in their process notes and supervision discussions. But patients' accounts are missing from our endeavours to understand what patients are trying to communicate to us. One wonders whether anything could be done differently to help patients have a better experience of therapy. Do patients feel confident and trusting to access therapy again in the future? What is the patient's understanding of the therapeutic process and what do they feel they learn from their exchanges with the therapist?

Furthermore, anger poses ethical questions. Is it acceptable for a child-patient to feel angry and dissatisfied with their therapy as long as we see positive changes in their lives (which of course we can almost never be entirely sure they are merely the result of treatment)? And then again dissatisfaction and anger may not always be identical notions, this being explicated by the fact that some patients come willingly week after week to express their anger to us.

These questions sparked my interest in the study of patients' anger in the consulting room as an ambiguous phenomenon that could at the same time indicate both positive and negative developments.

A range of psychoanalytic theories contribute to the understanding of depression as aggression turned inwards in the form of self-reproach, self-criticism and even self-harm and suicidality (Bleichmar, 1996; Busch et al. 2004). Trowell and colleagues (2003) write that depressed patients present with an impoverished sense of self and often feel that they have little impact on those around them, therefore the appearance of realistic feelings of anger is a significant aspect of the recovery process. In addition, irritability is a known symptom of depression. In a study by Stapley, Midgley and Target (2016, p, 623), 25% of parents whose children participated in the IMPACT study reported that their children experienced extreme bouts of anger, and used abusive language and name-calling. It follows that working through feelings

of anger seems of paramount importance in the treatment of adolescents with depression, however the management of such feelings can be challenging, as angry feelings towards the therapist might cause ruptures in the therapeutic relationship.

A month before the submission of this thesis, O'Keeffe and colleagues (2020) published a paper on therapeutic ruptures in the therapy of adolescents diagnosed with depression. The study investigated the therapists' role in initiating or exacerbating ruptures, also finding that therapists of dissatisfied cases had increased likelihood of contributing to ruptures. Unresolved ruptures were associated with treatment dissatisfaction, dropout and poorer therapeutic alliance.

Patient dissatisfaction is a crucial factor affecting the continuation of treatment. Studies suggest that this may be easier for therapists to detect in "confrontation ruptures", where anger is openly expressed, compared to "withdrawal ruptures" where dissatisfaction or anger is shown indirectly through disengagement or silence (Safran & Muran, 2000). Whilst we assume that a degree of anger towards the therapist is inherent in every therapeutic rupture, the opposite may not be true, namely not all anger may lead to greater ruptures in therapy. Previous studies indeed suggest that ruptures that get resolved lead to stronger therapeutic alliances and positive treatment outcomes (Safran et al., 2011; Sommerfeld at al., 2008, Lansford, 1986). It is also a question whether an ability to express anger and dissatisfaction towards the therapist might indicate a robust therapeutic relationship. Paulson and colleagues (2001) have shown that it can be difficult for young people to articulate negative aspects about their therapists or treatments.

Psychoanalytically-informed treatments generally place the expression of negative emotions at the centre of clinical work. The gathering of negative emotions and their expression towards the therapist is the golden path towards exploring and integrating negative feelings and psychic

states which otherwise may become disproportionate and lead to psychopathology. Klein (1932) emphasised the importance of interpreting negative feelings transferred towards the therapist as a way of "tracing these effects back to the original situation" (p.21). Winnicott (1949) thought that in some cases the most important thing a therapist can do for a patient is to tolerate and survive their anger and destructiveness.

One may then hypothesise that identifying and repairing moments of rupture and giving attention to both expressed and unexpressed negative feelings towards the therapist is one of the predominant tasks of psychoanalytic work. Nevertheless, therapists have a significant and difficult role to play when it comes to the handling and management of negative emotions, and this involves their own unconscious reactions in the face of powerful emotion and patients' hostility. This handling seems to be crucial in maintaining a positive therapeutic alliance whilst making space for the exploration of angry feelings. How do therapists deal with anger and equally how does patients' anger -knowingly or unknowingly- affect therapists' stance and clinical choices?

The current study aims to explore this question by applying Conversational Analysis (CA) (Sacks, Schegloff & Jefferson, 1974) to conversation sequences of patients' anger and therapists' responses to it. CA was chosen as it would take a pragmatic view of what took place in the therapeutic conversations and would offer a fine-grain analysis of conversational actions that neither therapist not patient may have been conscious of.

Anger in this study is understood as feelings, emotional expressions and conversational actions produced by a perceived offence or mistreatment by the therapist. This includes both overt expressions of anger as well as indirect expressions or withdrawal where there is contextual evidence to support that patients experienced anger towards their therapist.

Over the years, anger has been studied from a psychobiological perspective as an innate, pre-organised and universal emotion (Damasio, 1999; Ekman, 1972; Levenson, Ekman & Friesen 1990), presenting with an increase in systolic and diastolic blood pressure, increase of heart rate, and sympathetic effects (Herrald &Tomaka, 2002). Observing anger has the potential to elicit either an anger state, or a 'complementary' fear state (Harrison et al., 2013 cited in Garfinkel et al., 2016), reflecting the dual response of fight or flight. By some, anger is a negative emotion enhancing avoidance behaviours (Marsh et al., 2005) and impacting on cognitive processes, for instance decision-making (Garfinkel et al., 2016). Others see anger as an "approach" emotion (Carver and Harmon-Jones, 2009) with motivating properties which facilitate behaviour. Other studies emphasise the specific contextual factors that anger emanates from, which differentiate anger from other negative emotions (Roseman, 1984; Kuppens et al., 2003). Sroufe (1982) offers a developmental theorisation of anger placing its formation at nine months, when the infant develops the cognitive ability to recognise the cause of his/her disappointment and when his/her actions feel intended.

In this study, anger is considered as a dynamic process of making sense of others' behaviours whilst also performing a function, for instance serving to intimidate or warn others, while also forming a basis for communication. Anger will be studied through non-verbal actions that make up an affective, discursive sequence, as well as through the lexical, rhetoric and prosodic qualities of participants' speech. As is common in therapeutic settings, anger may also feature in "emotives", namely first- and second-person speech acts describing a subjective experience (i.e. "I am angry") (Reddy, 2001).

The thesis will start with an examination of the empirical research literature on anger in psychoanalytic psychotherapy, followed by a review of the concept of anger in theoretical and clinical psychoanalytic texts (Chapter 2). Chapter 3 will present the methodological approach of the current study, including the operationalisation of anger, data selection and methods of

data analysis. The analysis of data is shown in Chapter 4, whilst Chapter 5 presents a summary of the main findings. Finally, a discussion of findings and general conclusions will follow in Chapters 6 and 7.

Chapter 2: Literature Review

This section offers a critical reading of the existing literature on anger in the psychoanalytic treatment of adolescents diagnosed with depression. While there are many studies on anger in general, the predominant focus of the literature review has been to identify studies on anger as part of the therapeutic process. This chapter starts by presenting the methods of conducting systematic searches of empirical studies, including some of the challenges in researching the literature on anger in psychotherapy. The review of the empirical literature highlights the links of patients' anger with dropout and strains on the therapeutic alliance, whilst some articles discuss therapists' contributions to the management of anger. The literature reflects that patients' anger can be associated with a fear of abandonment and seeking closeness with the therapist, whilst anger is also linked with patients feeling that the therapist has not respected their insight into their own experience. Finally, two studies highlight anger and disagreement as significant events in psychotherapy associated with improvement and change. Thereafter, the chapter discusses the psychoanalytic literature on anger. It highlights the need for more descriptive terms in the study of negative emotions in psychoanalysis and presents longstanding debates within the profession with regards to the way negative emotions are understood.

Empirical research on anger

Methodology

In order to identify empirical research papers documenting displays of anger in psychoanalytic psychotherapy, I undertook electronic searches in the bibliographic databases PsycINFO, PEP Archive and SocINDEX. PsycINFO is a comprehensive database in the field of psychology and related fields, covering research within a wide range of psychotherapeutic approaches. PEP

Archive is a source of peer-reviewed, scientific articles from the field of psychoanalysis. SocINDEX is a comprehensive database for sociology research and related fields.

My first step was to establish the core concepts relating to my research question. This was an arduous task because anger has been studied in a wide range of fields, whilst it appears in studies that do not necessarily have anger as their predominant focus. I therefore encountered vast numbers of diverse articles which were laborious to scan for relevance.

Conversely, anger expressed towards the therapist in treatment is a very specific area of research which usually features in studies of therapeutic alliance; yet it can also be an indicator of a patient being very involved in treatment and thus come under studies exploring the negative transference and the expression of negative emotions. These different meanings of anger required different search terms to ensure that all important results would be included.

A quick overview of some relevant research articles helped me identify alternative terms used in the literature. For example, the term "irritability" was used in clinical papers to describe patients' displays of frustration or anger, whilst in psychoanalytic articles anger was used as related to "aggression". Table 1 below shows the terms that were chosen for my comprehensive search.

Table 1

Anger	Psychoanalysis	Adolescence	Depression
Angry	Psychoanalytic Psychotherapy		
Aggression	Short Term Psychoanalytic Psychotherapy		
Irritability	Psychodynamic		
Dissatisfaction			
Complain			

Table 1 Terms for anger; Terms for treatment

Electronic Database Search 1

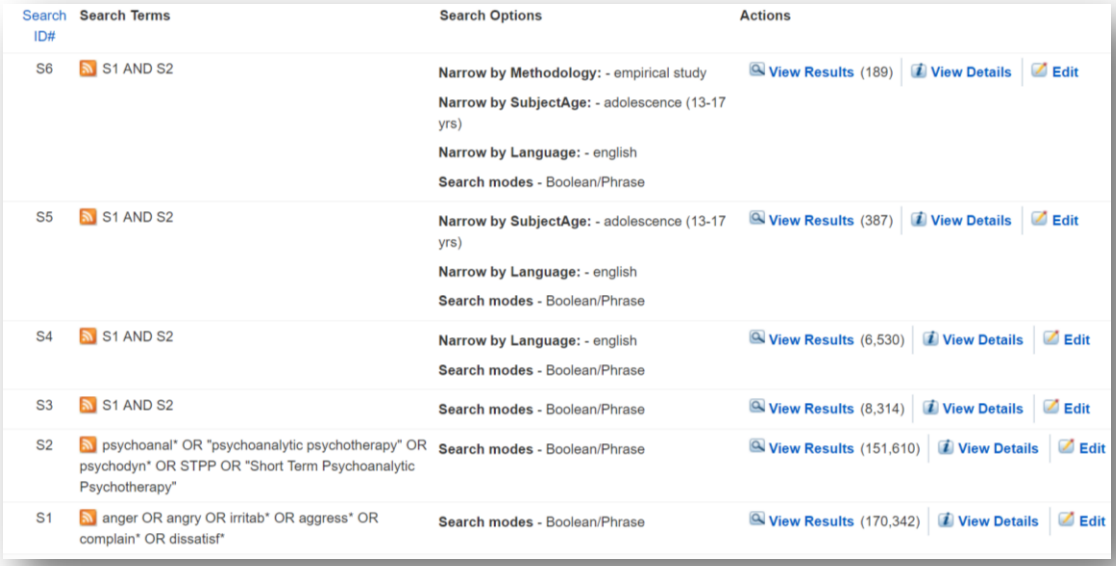
Using the terms above, I performed separate searches in all three search engines. In PsycINFO, I used the terms "anger", "angry", "aggression", "irritability", "complain" and "dissatisfaction"

combined with the Boolean Operator "OR" *(S1, Figure 1)*. This Boolean Operator ensured that any of these terms could feature in the search results of this strand. As Figure 1 shows below, the Truncation symbol '*' was used for the terms "irritability", "aggression", "dissatisfaction" and "complain" to ensure that derivatives of these words (i.e. irritable; aggressive) would be included, therefore maximising the number of relevant results. A similar process was followed for the second area of my research question (Figure 1). The two search strands were then combined using the Boolean Operator 'SEARCH WITH AND', to ensure that results combined terms from both S1 and S2 (*Figure 1*).

The results were consequently limited to Adolescents, using the "Age" limiter. I further limited relevant articles to "Empirical studies", "English language" and those having "Academic journals" as their source. The engine produced 165 results which were then scanned manually for relevance based on their titles and abstracts.

Of those, 4 were selected as relevant (O'Keeffe, 2019; Daldin, 1992; Stein et al. 1996; Topel & Lachman, 2007). No additional empirical research articles were produced by the other two search engines when searched in a comparable way.

Figure 1.



Search ID#	Search Terms	Search Options	Actions
S6	S1 AND S2	**Narrow by Methodology:** - empirical study **Narrow by SubjectAge:** - adolescence (13-17 yrs) **Narrow by Language:** - english **Search modes** - Boolean/Phrase	View Results (189) | View Details | Edit
S5	S1 AND S2	**Narrow by SubjectAge:** - adolescence (13-17 yrs) **Narrow by Language:** - english **Search modes** - Boolean/Phrase	View Results (387) | View Details | Edit
S4	S1 AND S2	**Narrow by Language:** - english **Search modes** - Boolean/Phrase	View Results (6,530) | View Details | Edit
S3	S1 AND S2	**Search modes** - Boolean/Phrase	View Results (8,314) | View Details | Edit
S2	psychoanal* OR "psychoanalytic psychotherapy" OR psychodyn* OR STPP OR "Short Term Psychoanalytic Psychotherapy"	**Search modes** - Boolean/Phrase	View Results (151,610) | View Details | Edit
S1	anger OR angry OR irritab* OR aggress* OR complain* OR dissatisf*	**Search modes** - Boolean/Phrase	View Results (170,342) | View Details | Edit

Figure 1. Anger, adolescence, and psychoanalytic treatment. Search in PsycINFO.

Electronic Database Search 2

An additional database search was conducted, this time exploring the links between anger, psychoanalytic psychotherapy and depression specifically. The same search terms were used as before. The term "therapeutic relationship" was added to the strand for psychoanalytic psychotherapy. This was decided on the basis that the term "therapeutic relationship" might yield more results relevant to psychotherapy processes which is the predominant scope of my research question. A third search strand was included for depression, as shown in Figure 2 below. The three strands were searched using the Boolean Operator 'SEARCH WITH AND' and the results were then limited to Empirical research methodology, English language, and Academic journals. The engine produced 249 results which decreased to 33 when limited to Adolescents. Due to the much smaller number of results when limited to adolescents, I decided to manually review all 249 papers for relevance. An additional reason was that I was also interested in trends in the adult literature that may not have been investigated in children and adolescents as yet. Of the 249 articles, 6 were found relevant to my study (Farber& Hall, 2002; Pollak et al., 1992; Mackay et al., 1998; McCarthy et al., 2017; Halfon et al. 2019).

Figure 2.

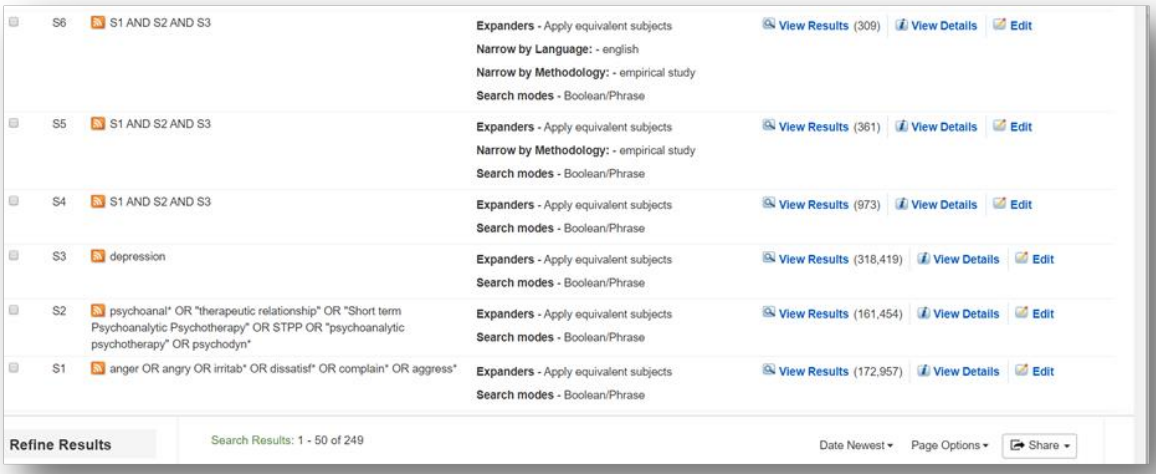


Figure 2. Anger, psychoanalytic treatment, and depression. Search in PsycINFO.

Third Search – Database and Snowball sampling method

Although relevant, very few of the results yielded by PsycINFO described the operation of anger in moment-by-moment processes in psychotherapy. To test whether there were other possible ways of identifying such results, I used PsycINFO again, this time searching for "anger" in relation to "conversation analysis". Two factors informed this choice. Firstly, data in the present study will be analysed using Conversation Analysis (CA), therefore it felt appropriate to look into previous studies on psychotherapy processes where CA has been used. Secondly, CA is the par excellence method for the study of interactions and conversations in vivo, therefore including the term in the search results could possibly identify studies using a similar methodological paradigm.

For the anger strand, the same terms were used as in the previous search. For conversation analysis the term was searched inside quotation marks so that the engine would search for it as a phrase and not as two individual words. The results were not limited to psychoanalytic psychotherapy this time, nor to adolescents as, when adding those parameters, the search did

not yield any results. From the 47 results of this search, 2 were relevant to process research in psychotherapy, and one specifically relevant to psychoanalytic psychotherapy, although these results had not emerged when searched using the terms "anger" and "psychoanalysis" or "psychotherapy". This is perhaps due to the way in which articles are labelled. Jalali and Wohlin (2012) document such incongruences in database searches and highlight the lower amount of "noise" (irrelevant results) when following a snowballing sampling procedure. From the two very relevant results, I followed a "forward snowball sampling process" (Webster and Watson, 2002). This means that I tracked articles as those were cited in text, when the content of the initial paper felt relevant to my research topic. From this third search 6 results emerged (Weiste, 2015; Voutilainen et al., 2011; Viklund et al., 2010; Della Rosa & Midgley, 2017; Selting, 2010; Retzinger, 1995).

Empirical findings on anger in psychotherapy

Does anger lead to dropout?

One area of the empirical research links patients' negative feelings to ruptures in the therapeutic relationship and discontinuation from treatment. In studying the reasons why adolescents drop out of treatment, as part of the IMPACT trial, O'Keeffe and colleagues (2019) stressed that there was no known study asking adolescents about their reasons for terminating therapy prematurely. In defining dropout, the most commonly accepted definition is that young people terminate therapy without their therapists' agreement. Such definitions of dropout do not take adolescents' experience of treatment into account, for instance positive or negative reasons for the termination of treatment.

In the IMPACT trial, a significant 37% of adolescents were classified as having dropped out of treatment. The authors (ibid.) found three meaningful categories of dropouts: "got-what-

they-needed", "dissatisfied" and "troubled". It is striking that in the STPP arm, most adolescents who dropped out were classified as "dissatisfied", whilst in the BPI and CBT arms most dropouts classified as "got-what-they-needed".

It is expected that adolescents who felt dissatisfied with their treatment and therapists are likely to have experienced some degree of frustration, resentment or anger. O'Keeffe and colleagues (2019) cite adolescents' post-treatment statements about their disappointment and anger towards the therapist. However, it is unclear whether these feelings were expressed in treatment and in what form. It would be interesting to know how therapists responded to such expressions and whether ruptures occurred in treatment. Given the higher number of dissatisfied dropouts in the STPP arm (12 out of 14), it is also a question whether there were factors intrinsic to STPP that caused the young people's dissatisfaction and their subsequent treatment termination. It is also striking that patients' and therapists' accounts of dropout reasons were sometimes contradictory. "Therapists appeared to be unaware of many of the adolescents' criticisms of therapy. Their narrative of the therapy therefore tended to be distinctly different from that of the adolescents" (ibid., p. 6). In addition, some adolescents reported that they had been unable to explicitly express their negative feelings to their therapists. Therefore, whilst this study offers insight into adolescents' accounts of dropout, further exploration could identify the specific processes around moments of anger and disappointment in the therapeutic relationship.

In line with O'Keeffe at al.'s (2019) findings, a study by Farber and Hall (2002) also concluded that angry feelings towards the therapist were amongst the themes less disclosed in therapy. These results came from interviews with 164 current psychotherapy clients receiving psychoanalytic psychotherapy (43.5%), CBT (13.6%), eclectic (16.3%), and "other" (7.5%). For the 17.7% the model was unknown. The average time patients were with their current therapist was 38.7 months, whilst participants ranged from 16-72 years old. An important

finding was that the therapeutic alliance and the time in therapy were strong predictors of how freely patients disclosed their thoughts and feelings. Given the fact that the participants of the study were already in therapy for nearly 39 months, the study alerts us to the clinical implications of patients' difficulty in disclosing negative feelings towards the therapist in shorter-term treatments.

Pollak et al (1992) related therapist and patient variables to dropout using data from adult psychoanalytic psychotherapy. Variables linked to dropout were compared against three periods in treatment; the first period covering sessions 1-3, the second period sessions 4-11, and the third period covering sessions 12-50 or more. Discontinuation patterns were studied in a sample of 339 patients and a subgroup of 73 patients was more closely studied. Whilst 35% of patients in the subgroup reported financial reasons for discontinuing, and another 16% reported to have seen improvement of their symptoms, therapists' views largely reflected that 34% of patients left treatment because of dissatisfaction with the therapy. Issues around negative transference were reported by therapists in 16% of the cases and issues around trust and safety in the therapy were reported by therapists for 34%. Discontinuation attributed to discomfort with the therapist and issues around trust were equally distributed across the three periods. Other intrapsychic dynamics were more typical of some periods; for example, fear of abandonment was linked to discontinuation in the third period while fear of intimacy and dependency were reported more in the second and third periods. These findings raise questions around the management of negative feelings in the therapy, whether those relate to the negative transference or other issues. Perhaps in line with some of the findings of O'Keeffe and colleagues (2019), this study highlighted a high percentage of patient dissatisfaction in dropouts from psychoanalytic treatment, although more specific patterns around dissatisfaction or negative feelings experienced towards the therapist remain unclear.

Anger in the therapeutic relationship

Another area of literature considers patients' anger and its impact on the therapeutic relationship. Halfon et al (2019) studied the trajectories in therapeutic alliance over the course of therapy in 89 children receiving psychoanalytic child psychotherapy. Children were diagnosed with a range of internalising, externalising and co-morbid difficulties. The study results indicate that the therapeutic alliance followed a U pattern with a decrease in the middle period of treatment and a subsequent increase as the treatment progressed. The rupture of the therapeutic alliance could, according to the authors, be explained by the fact that in the middle period of treatment patients' issues surface and are challenged. An important finding was that children presenting with externalising difficulties, namely aggressive and impulsive behaviour, showed poorer therapeutic alliance, which may be explained by the fact that such behaviours pose a challenge for relationship formation. The authors underline that future research needs to focus on the links between affect regulation in treatment and the strength of therapeutic alliance. Whilst this study does not offer descriptions of ruptures in the therapeutic relationship and how they were managed, it suggests that externalising behaviour can pose a great risk for the continuation of treatment.

Daldin (1992) studied 25 children (2-14 years old) who received psychoanalytic psychotherapy at the Anna Freud Centre and who had all physically assaulted their therapist in the course of treatment. The study examined index notes of all patients to systematically explore patterns in children's aggressive outbursts towards the therapist. As expected, all patients had felt increased anger, anxiety and guilt at the time of the attack. Two main categories of assault were identified. In the first group, children attacked the analyst out of fear of separation and abandonment and in seeking closeness with the object/analyst. Patients did not derive pleasure from attacking the analyst. On the contrary, they were relieved that the analyst had not abandoned them. In the second group, children were thought to re-enact sadomasochistic

patterns of relating to the object, namely they provoked the analyst out of a wish that they would receive pain or retaliation. This group enjoyed the pain inflicted upon the therapist and acted out a confused sense of intimacy. The article addresses the sensitive issue of how under-reported these difficulties can be in clinical and research work as therapists struggle to describe the raw reverberations of such work. The article establishes an understanding that past experiences are re-enacted within the therapeutic relationship and offers insight into therapists' understanding of aggression. However, it remains unclear what happens in the interaction between therapist and patient before and after such incidents and what are the aspects of the here-and-now relationship that trigger patients' negative responses. A limitation of this study is that patients' aggressive behaviour as well as the events documented in patients' records were based on therapists' recollection of events, therefore a more rounded perspective may have been compromised.

A study with an inpatient population by Stein et al. (1996) linked patients' behavioural, verbal and self-destructive enactments with therapists' planned vacations. Patients were engaged in multiple treatment modalities including psychoanalytic psychotherapy three times a week. Over a period of 29 weeks, 96 vacation separations were studied. Patients' behaviours were observed and recorded at 3 days before the therapist's break (anticipation period), at the actual time of separation (during the vacation) and at 3 days following the end of the separation (reunion period). These data were compared to baseline data on the patients' behavioural patterns. The study tested six aspects of patients' behaviour: Behavioural acting-up, verbal acting-up, agitation and anxiety, self-destructive action, self-destructive verbalization and somatic complaints. By behavioural acting-up, the researchers meant any violation of unit rules, refusal to comply with reasonable staff demands, antisocial behaviour or attempts to cause damage. Verbal acting-up was defined as yelling, swearing and making threats. Self-destructive action and verbalisation referred to actions or threats to self-harm respectively, and

somatic complaints referred to patients' complaints of physical distress or illness. The study concluded that acting-up behaviours noticeably increased at reunion. The researchers considered this as a manifestation similar to the mother-infant reunions of insecurely attached infants. Anger and behavioural acting-up was seen in this context as a replication of patients' early life experiences of traumatic separation and sense of abandonment. An interesting finding was that acting-up behaviours decreased lower than baseline during the anticipation period, a finding that was interpreted as patients' efforts to hold themselves together before the anticipated break or to deny the impact of their therapists' absence.

The researchers discuss several factors that compromised this study's internal validity, mostly with regards to the way behavioural acting-up was measured. The results were not compared with patients of different diagnostic groups and therefore it is difficult to establish whether patterns surrounding therapists' vacations can be generalised. In addition, the study did not explore patients' affective reactions which would imply that patients might have felt anger and resentment but not necessarily acted it out behaviourally or verbally.

Della Rosa and Midgley (2017) researched adolescents' responses to transference interpretations focusing on the end of treatment. More specifically, the authors used conversation analysis in STTP sessions in which therapists talked to their patients about the upcoming end of treatment and attempted to explore patients' feelings about it. They found two main patterns in patients' responses. On one hand, patients produced "dramatisation", namely catastrophic scenarios about what may happen to them in the future. Those catastrophic scenarios were expressed with heightened emotionality in patients' tone, with swear words and with references to suicidality, helplessness and hopelessness. A second group of patients responded by "down-playing" the impact of the end of treatment or the significance of their relationship to the therapist. They claimed that they had got much better and did not need the therapy anymore. These patients seemed to be getting into a "battle" whereby they produced

prolonged speeches in which they attempted to prove their point. Likewise, therapists often delivered long speeches to frame patients' responses as a resistance and to analyse the defences of the patients against the loss which comes with the ending. The authors interpret the dramatisation responses as involving anger (p. 287) as they see patients' hopeless scenarios as a way of attacking themselves and their future. It seems that anger here is linked with a worry around abandonment or preoccupation about the future.

Therapists' contributions in therapy with angry patients

Topel and Lachman (2007) tested the ways in which video-recorded sessions can facilitate therapeutic contact with angry and violent young people through the detailed examination of non-verbal aspects of the patient-therapist interaction. The researchers hypothesized that patients diagnosed with conduct disorders would use orienting behaviour (posture and position in space) for self-protective purposes at the beginning of therapy and that if the therapist connected with them on a non-verbal level this would facilitate the therapeutic process. Orienting behaviours ranged from a patient wanting to leave the room or averting their body, to an improved ability to establish full eye-contact or laugh with the therapist. Frame-by-frame analysis revealed non-verbal communications and responses that affected the therapeutic relationship in both facilitating and obstructing ways. For example, some patients' initial withdrawal caused the therapist to bend forward, a position that was perceived as intrusive, causing the patient to avert further. The video recordings also helped the therapist be aware of ways in which therapist and patient self-regulated and attuned to each other. Good outcomes were reported for all 8 children and adolescents (4-17 years old) who took part. Whilst the sample of this study is too small for the results to be generalised, the use of video recordings allowed for an in-depth examination of therapeutic processes, including therapist responses that can trigger patients' anger or withdrawal. One example of the latter was that when the therapist pointed out a patient's lack of engagement this caused further withdrawal.

This study offers insight into the non-transferential aspects of the therapeutic relationship, therapists' input and participation, as well as a frame-by-frame analysis of how these were perceived by patients. The article acknowledges that therapy with angry young people can evoke powerful emotions in the therapist and lead them to act in counter-productive ways. It has to be noted, that although this treatment model was labelled as a psychoanalytic treatment, transference was not mentioned as a therapeutic tool. It would be interesting to know whether anger was processed in the therapeutic relationship and how that was managed.

Anger- expression as a therapeutic process

A study by Mackay et al (1998) reports the significance of an anger event in the psychodynamic treatment of an adult female patient diagnosed with major depressive episode and generalised anxiety. This single case study was part of the Second Sheffield Psychotherapy project, a randomised comparison between psychodynamic and cognitive-behaviour therapy in the UK. The specific event was selected as "extremely helpful" by both therapist and client. Whilst the patient's anger referred to other people in the patient's life and not the therapist, this event was considered helpful in enabling the patient to feel and express anger and to reflect on the ways anger was linked to depressive emotional states. However, these emotions were not explored in the transference, raising the question again whether the management and processing of angry feelings becomes more problematic when those emotions are expressed towards the therapist. What seemed important in this study is that there was an agreement on the task of "staying with the angry feelings" which one could hypothesise strengthened the therapeutic alliance between patient and therapist.

McCarthy and colleagues (2017) researched significant events in time-limited psychoanalytic psychotherapy, namely events that strongly correlate with change and positive outcomes. Their analysis showed that both positive and negative emotions, particularly anger and sadness, characterised significant change events. The authors interpret this finding in line with previous

research finding that the arousal and expression of anger in therapy relate to therapeutic change (Van Velsor & Cox, 2001 as cited in McCarthy et al., 2017). Importantly, this study found that significant events in treatment were saturated not only with affective but also cognitive factors, namely indicators of insight into emotion and cognition.

The management of anger in therapeutic conversation

Previous studies on disagreement as a transforming process in psychotherapy are supported by Viklund and colleagues' (2010) study whereby clients identified important moments in treatment. Of the 16 events totally described, 12 contained moments of disagreement between therapist and client. This was an important primary finding as interactions of disagreement between therapist and client do not readily fit into the traditional therapeutic alliance theories. Clients' disagreements were not displayed in direct verbal content but instead through pauses, delayed responses or failures to take an assigned turn in the conversation, hesitations, restarts, an initial weak agreement followed by disagreement, or attempts at adding information that might change the therapist's point of view. The authors explain this by the fact that in institutional talks between professionals and clients, clients rarely openly disagree with professionals who are seen as experts.

The study identified three possible ways in which therapists handled disagreement: a. establishing a shared understanding, b. verbalizing different opinions and c. not responding to the clients' disagreement cues. Whilst focusing on structural aspects of disagreement in therapy, this study offers less insight into the emotional qualities of such events. As the authors themselves highlight (p. 162), just because disagreement patterns featured in those significant moments, this does not necessarily mean that this was the reason why clients found those moments significant, as their subjective emotional experience remains unclear.

Weiste (2015) analysed sequences of talk from 70 audio-recorded psychotherapy sessions (40 psychoanalytic and 30 cognitive psychotherapy) in which therapists disagree with clients' descriptions of their personal experience. The authors note that although disagreement has been found to be an essential aspect of psychotherapy, it can also risk the continuation of treatment. The study found two patterns of therapist disagreement: supportive disagreement and unsupportive disagreement. In supportive disagreement, the therapists aimed at finding congruence between their perspectives and those of the client, and showed respect for the clients' epistemic primacy, namely the clients' ability to know best about their emotional experience. They prompted clients to confirm therapists' formulations and to elaborate. In unsupportive disagreement, the therapists maintained their divergent perspectives and claimed privileged access to the client's domain of knowledge, therefore conveying disregard of the client's epistemic primacy. Anger and irritation towards the therapist featured in relation to this second pattern of disagreement. Clients expressed their irritation by hesitation, unilateral laughter particles, extreme-case formulations and knowledge disclaimers, i.e. "I don't know". The researchers also observed overlaps, attempts to take the floor in conversation, rises in pitch and volume and rhetorical questions as ways in which clients expressed their anger for being misunderstood.

In sequences where clients expressed anger, the disagreement was re-contextualised as a manifestation of the client-therapist relationship. For example, in one sequence taken from a psychoanalytic session, the patient tells the therapist that she feels reproached or criticised, namely identifying a problem in the therapeutic relationship. The therapist links this to the patient's past and her experiences of being reproached by others. It is a question whether patterns of unsupportive disagreement are more prevalent in psychoanalytic psychotherapies as the therapist's access to the patient's unconscious, namely to what the patient has no awareness of, is inherent in psychoanalytic practice. Could that be a reason for some

adolescents' increased dissatisfaction with psychoanalytic treatments as documented by O'Keeffe and colleagues (2019)?

What form does anger take in conversation?

The following two articles describe in detail the forms anger takes in conversation. The described forms will be used in the current study to operationalise anger (see methodology chapter).

Retzinger (1995) has reviewed the literature to provide a method for the identification of anger in texts and conversations. She sees anger as complementary to shame, highlighting that sometimes anger is a way to defend against shame. According to Retzinger (1995), anger is evident in verbal cues expressing irritation and annoyance or it is conveyed through verbal challenges, namely the attempts of one person to lower the status of the other person. These behaviours can be an enactment of hostility without naming the anger. They can take the form of interrupting; sarcasm; blame; questioning; presumptive attribution of thoughts or feelings to the other person; and threat. Temporal expansions, like "you always" or "you never", are common in displays of anger, whilst it is likely that the conversing parties refer to a third, irrelevant person in conversation, a mechanism also called "triangulation". Hiding behaviours can also co-exist with anger and those include: projection of a thought or feeling to another person; abstraction; verbal withdrawal; indifference; and the use of fillers, such as "I don't know", "you know" (Retzinger, 1995). Retzinger's contribution is important in that it stresses that often emotions are covert in conversations.

Selting (2010) studied displays of anger in the narration of complaint stories. Her study was based on the micro-analysis of naturally occurring conversational interactions. She found that participants used a range of verbal and non-verbal resources to express their anger and indignation, whilst they oriented to prove the rightness of their emotional experience.

Rhetorically, they presented the "offender" as acting unfair as opposed to the "self" presented as rational and justified. In terms of verbal cues, they deployed repetition; extreme-case formulations (Pomerantz, 1986), swear words and sounds that function as response cries (Goffman, 1978). They formed short and dense sentences and in terms of prosody they produced extra-strong accents, extra-high pitch peaks, lengthenings, stress shift, dense accentuation, tempo changes and changes of pitch register (Selting, 2010, p. 243). Participants also used visual and sound cues, such as facial expressions, slashing and slapping gestures, head nods and gaze direction. Another manifestation of anger was laughter of a "forced" quality, incongruent with the content of conversation. Selting found that this type of laughter, used both by storytellers and recipients, conveys sarcasm and irony, but on the other hand aims to modify and moderate the angry emotion. One may say that a limitation is that the paper studies re-constructions of the angry response in conversations and therefore it does not present us with anger in vivo. It would be interesting to know how co-participants would respond if the anger was current.

Psychoanalytic literature on anger

". . . confusion exists through our using the term aggression sometimes when we mean spontaneity."

Donald Winnicott (1950/ 1958, p. 217)

The word "anger" does not feature once (other than within the word "d-anger"!) in the psychoanalytic dictionary of Laplanche and Pontalis (1973). It appears three times in the "New dictionary of Kleinian Thought" (Spillius et. al., 2011), in relation to infantile sadistic phantasies and the need to project those outwards. The word appears fourteen times in "The

language of Winnicott" (Abraham, 1996), one of which is a dictionary entry defining anger as an aggressive response towards external frustration.

In psychoanalytic writings, anger is often understood as relating to "hate", "rage", "hostility", "violence", "destructiveness", and -in the therapy setting- "negative transference"[1]. These concepts, as well as anger, have been discussed as expressions of aggression, namely patients' hostile feelings and phantasies which are directed inwards towards the self or projected out towards external objects.

Aggression. An innate impulse or a defensive reaction?

Freud (1920) linked aggression to the death instinct as an innate drive aiming at self-destruction and programmed to return the organism to the inanimate state of things. Since then, theories of aggression have caused great controversy and debate amongst psychoanalytic schools, with some holding the view that aggression is an innate drive and others seeing aggression as a defensive reaction to an environmental failure. Melanie Klein believed in the existence of a destructive force operating from the beginning of life, which the young infant defends against through primitive mechanisms, such as projection and splitting. Klein (1952) stressed the importance of thoroughly interpreting the "negative transference" as a way of mitigating patients' aggressive feelings and enabling integration and coherence of the ego. Negative transference has been much debated over the years, but can be used as a broad term for all expressions or projections of negative feeling or destructive tendencies onto the therapist or the treatment. Such expressions can range from lightly expressed complaints to murderous or sadistic feelings. It is a debated theoretical question whether the negative transference operates as part of a destructive drive or whether negative feelings can often operate in the service of life. In that sense, anger towards the therapist could express the need to be understood and

[1] The list is not exhaustive.

therefore an effort to make a constructive link with one's object, whilst it could also express a controlling and omnipotent demand of a more sadistic or pathological nature.

Bion's (1962) work on containment derived from a similar idea that the infant projects hostile impulses outwards in the form of "beta elements". Beta elements threaten the infant's cognitive and psychic development, unless contained, metabolised and transformed by an attentive mother into meaningful and thinkable "alpha" elements. One may say that through his theory of containment and maternal reverie, Bion's ideas bridged between traditional Kleinian views on innate destructive drives and the role of the environment.

Some post-Kleinian analysts developed theories around pathological expressions of aggression, for example Rosenfeld's (1971) theory on pathological narcissism. Rosenfeld (1971) described patients whose internal and external circumstances have forced them to internalise harsh and destructive objects. In such presentations, there is a diffusion of instincts, and parts of the patient remain unintegrated, causing the individual to function under extremely omnipotent and (self-)destructive states of mind. In those cases, patients' anger and rage express a wish to dominate and to control rather that to object-relate.

In contrast, other psychoanalysts have seen aggression as a defence towards danger coming from without, as in the cases of ruptures of attunement (Stern, 1985), impingement (Winnicott, 1971) or threats to the psychological self (Fonagy et al., 1993). Such theories stress the significance of aggression as a propelling force in protecting the organism against a maladaptive or dangerous environment and they see expressions of aggression as a result of empathic failure (Kohut, 1972). These theoretical divergences not only pose important questions for psychoanalytic technique but also challenge our definitions around healthy and pathological aggression (Perelberg, 1999).

The centrality of aggressive feelings in psychoanalytic treatment

Despite these longstanding debates, aggressive feelings are central to the understanding of developmental processes in psychoanalytic work. Winnicott (1969) saw aggressiveness as a life force crucial for development and growth and emphasised the importance of the object surviving the infant's aggression in order for the infant to develop an idea that the object belongs to reality, not just in phantasy. Winnicott (1949) argued that the patient must experience that his hate can be tolerated and only then can an individual develop genuine love for their object. Likewise, he emphasised that the therapist should be open to and in touch with his own hate, evoked by the patient, in order to understand the patient's unconscious communications.

Kohut (1972) wrote about "narcissistic rage" deriving from narcissistic injury rooted in a sense of loss of control and shame which threatens the individual's sense of self. Kohut (ibid.) saw narcissistic rage as a "*spectrum of experiences that reaches from such trivial occurrences as a fleeting annoyance when someone fails to reciprocate our greeting […] to such ominous derangements as the furor of the catatonic and the grudges of the paranoiac*" (p. 379). Kohut writes that the therapeutic process itself is often perceived as a narcissistic blow for the patients who lack control of areas of their mind but reveal unconscious thoughts through slips of the tongue and other unconscious activity.

The links between rage and shame have been discussed earlier (Kuppens et al. 2003; Retzinger, 1995). Catty (2012) discusses rage within school settings as a defense against shame. Amongst others, Catty discusses self-harm as a communication of shame imprinted on the body and describes adolescence as a particular developmental stage when feelings of shame are activated.

The term ‘aggression’ has been used to cover a wide variety of behaviours and emotions, from self-assertion to destructiveness, and from anger and rage to belligerent behaviours. Each time it is a key question whether the patient’s anger, rage or hate are indications of a need not being met, of a denial of dependency or the workings of pathological defenses. Some psychoanalysts have emphasised the need for more descriptive terms, arguing that not every aggressive act is necessarily the derivative of an aggressive drive (Lussier 1971, in Perelberg 1999).

Some psychoanalytic classifications of negative emotions

Kernberg (1991) distinguished between the affects of rage, anger, irritation and hatred. With particular attention to anger, Kernberg saw anger as a developed cognitive system whereby the individual aims to eliminate an obstacle to a desired degree of satisfaction. In anger the object is not seen as “all bad” as in rage, neither there is a confused sense of love and despise as in hatred. One may say, that in Kernberg’s (ibid.) classification, anger is a more realistic emotion compared to rage and hatred.

Wiener (1998) offered a similar classification whereby rage is more primitive and unconscious whilst anger is usually conscious, ego-related, has a cognitive component and is partially controllable. Wiener writes about hatred that it is not always pathological, quoting Bollas (1987, p. 118 cited in Wiener, 1998) on “loving hate” the aim of which is not destructive, but rather an unconscious form of love in order to preserve a relationship.

Technical dilemmas in dealing with negative emotions in psychotherapy

Whilst Kohut (1972) emphasised an empathetic approach to rages and encouraged the unfolding of a narcissistic transference, Kernberg (1974) criticised Kohut for focusing less on the negative transference and patients’ wish to devalue and depreciate the therapist. Kernberg’s approach was to challenge such destructive tendencies head-on by interpreting the negative transference. Debating this, Nason (1985, para. 9) wrote, “the therapist […] may never be quite

sure if the rage he is seeing in the patient truly belongs with archaic perceptions of parental imagos or is perhaps justifiably aimed at the therapist's own aggressive confrontations".

Whilst there is a general agreement amongst analysts that negative as much as positive emotions should be equally explored in psychotherapy, technical difficulties have been documented around the management of patients' anger, especially when those are experienced towards the therapist. Adler and Buie (1973a, 1973b, 1979, 1982 cited in Nason 1985) describe rage as unavoidable in work with certain groups (i.e. borderline patients), yet enormously problematic for the therapy, as intensified feelings of hate increase the patient's feelings of aloneness and the consequent separation anxiety. Nason (1985) thinks that rage needs to be kept within tolerable limits, whilst primary attention must be paid to the patient's sense of aloneness and the state of the therapeutic relationship.

Another technical issue is that rage can be dangerous. Winnicott (1969) wrote that "when the analyst knows that the patient carries a revolver, then […] this work cannot be done" (p.92). Debatably, one may say that the degree to which a therapist tolerates anger and rage is subjective. Therefore, the factors that determine the processes of managing anger in treatment remain to be explored.

As the empirical research has shown, the risk of rupture in the therapeutic relationship poses another difficulty. In a meta-analytic review by Safran and colleagues (2011), two patterns of rupture response were observed in patients: withdrawal and confrontation. Strikingly, these two patterns led to different resolutions. In withdrawal, therapeutic conversations progressed from discontent to self-assertion and to a greater sense of agency which therapists validated. In confrontation, therapeutic conversations moved from feeling angry to feeling hurt and finally the wish to be taken care of. The authors did not offer a hypothesis about why these different patterns evolved and further exploration could help understand the mechanisms involved.

On the other hand, the literature reflects that ruptures, if overcome, are linked to good treatment outcomes and a decrease in dropout rates. Better treatment outcomes are achieved when therapist and patient deal directly with the rupture (Lansford, 1986 as cited in Safran, Muran & Eubanks-Carter, 2011). Sommerfeld, Orbach, Zim et. al. (2008) suggest that patients find treatment more helpful when their therapists are sensitive to subtle indications of rupture and encourage discussion around such issues. Their study found that, during ruptures, dysfunctional interpersonal schemas were active, meaning that these ruptures provided opportunities for patients and therapists to explore patients' wider relational patterns. These findings support the psychoanalytic emphasis on the interpretation of negative transference, namely that in moments of rupture negative emotions may be transferred onto the therapist, emotions albeit present in other relationships.

Conclusion

Both the empirical and the psychoanalytic literature reflect the many meanings of patients' anger. In some cases, anger expresses a wish to hurt and intimidate the therapist. In others, anger is a response to environmental failures and unmet needs, an act of seeking closeness and defending against anxiety and fear of abandonment. Anger has been linked to shame and low self-esteem, as a way to protect one's fragile sense of self, whilst studies focusing on therapeutic processes have detected anger as a response to the patient feeling that their epistemic rights have not been respected by the therapist. In that sense, anger can co-feature with disagreement, although the literature shows that not all disagreement leads to anger.

Empirical studies have highlighted the links of patients' anger with treatment dissatisfaction and dropout, whilst they highlight the strain patients' anger poses on the therapist and the difficulty of developing a positive therapeutic alliance. This is echoed in psychoanalytic texts that describe anger as a potentially dangerous phenomenon which can lead to increased risks for both therapist and patient. Despite anger being associated to therapeutic ruptures, only a

few studies have focused on therapists' contributions in therapy with angry patients, whilst even fewer have adopted a pragmatic design to look into what really happens in the therapeutic interaction which may be escaping the awareness of both patient and therapist. To our knowledge only one study focused on therapists' handling of anger emanating from disagreement (Weiste, 2015). The study highlighted that therapists recontextualised anger in the patients' past relationships whilst they did not focus on the processes through which anger arose in the present. Viklund et. al. (2010) study highlighted that, on some occasions, therapists avoided exploring disagreement with patients, although the study did not analyse therapists' responses to anger.

This literature review has not expanded on the links between anger and depression as I predominantly selected studies focusing on anger manifestations towards the therapist. Whilst there are known links between depression and anger or irritability as a symptom, fewer studies focused on anger manifestations in the therapeutic relationship or anger as part of the therapeutic process. Similarly, this chapter has not expanded on role of anger in typical development in adolescence. However, despite anger being a known aspect of adolescent development and of identity formation and individuation, no studies deriving from this literature review have focused on the exploration and management of anger towards the therapist in the treatment of adolescent patients, with the exception of one study focusing on non-verbal aspects of clinical work with adolescents (Topel and Lachman, 2007). This is striking as anger has a particular function and developmental significance in adolescence and in the task of achieving individuation. More importantly, studies have consistently shown the difficulty of young people to express complaints or negative feelings towards their therapists. Giving more attention to this overlooked area of research could help us overcome ruptures that would perhaps otherwise remain undetected and unresolved.

Finally, anger as a phenomenon has been associated not just with ruptures but notably to memorable and significant events in therapy and to therapeutic change. Therefore, focusing on anger as an emotion and its function in the therapy of adolescents is unique in hopefully highlighting not only the negative but possibly positive repercussions of it. Although affect and emotion are central issues in psychotherapy, few CA studies have explored the affective side of the therapeutic interaction (Voutilainen et al., 2010).

In summary, the literature review postulates anger as an ambiguous and multifaceted phenomenon in treatment, associated with either very positive outcomes or quite calamitous ones, as seen in the cases of rupture and treatment dropout. This learning has led me to the formulation of the current project, aiming to better understand the therapeutic processes surrounding anger in the treatment of adolescents.

Chapter 3: Methodology

Aims and Objectives

This study used CA to analyse therapists' responses to adolescent patients' anger in audio-recorded STPP sessions. More specifically, the study's objective was to identify patterns in therapeutic conversations surrounding patients' anger towards the therapist, namely how the patient's anger-expressions affected the therapist and how therapists responded to anger. The study aimed to describe how anger is co-constructed in interaction rather than to prove specific hypotheses to explain why therapists responded in certain ways to patients' anger.

Epistemological frame

A qualitative approach was deemed appropriate as the current study focuses on psychotherapeutic processes and qualitative aspects of therapeutic interaction. The study is following a social-constructivism paradigm which assumes that interactions are context-dependent. Anger too as an emotion is considered here a construct defined by the very context within which it appears. As Couper-Kuhlen (2009) highlights, affect is a "context-dependent interpretation based on lexical and prosodic cues in specifiable sequential locations" (p.118). The close observation of sequence becomes important as participants' responses to one another co-construct affect in their interaction.

Reflexivity

This study aims to start with a broad and open-minded view of the meaning and function of anger within the therapeutic relationship. It is important, however, to recognise that therapists in the recorded sessions are likely to understand patients' anger within a psychoanalytic conceptual framework.

With that in mind, my position in undertaking this study as a Trainee Child and Adolescent Psychotherapist needs to be acknowledged as I am inevitably influenced by psychoanalytic

theories of understanding clinical interactions. On undertaking this study, I have been aware of the possible inclination to identify with the therapist perspective. On the other hand, as personal analysis is a central part of the psychoanalytic training, I have been equally alerted to possible identifications with the patient perspective.

Lastly, I have been aware of cultural issues underpinning the study of anger. The audio-recordings used in this study have originated from treatments in the United Kingdom and in the English language. It is important therefore to acknowledge that expressions of anger may present differently in different cultures. Moreover, I as a researcher speak English as a second language and my cultural origins may have also affected my reading of this study's data, anger expressions being more outspoken and explicit in my culture. A continuous examining of my different positions in relation to the studied phenomena followed this entire research process. At the same time, the task of reflexivity and fruitful dialogues with my supervisors and colleagues enriched the understanding of anger by considering the multiple layers on which anger is constructed.

Setting

This study offers a secondary analysis of data originating from STPP sessions, audio-recorded for the purposes of the IMPACT trial. IMPACT was a national randomised controlled trial testing treatment efficacy for adolescent depression. Specifically, the IMPACT study compared the outcomes of Cognitive-Behavioural Therapy, Short-Term Psychoanalytic Psychotherapy (STPP) and Brief Psychosocial Intervention. The study was undertaken in the UK and was led by Professor Ian Goodyer of Cambridge University and funded by the National Institute of Health Research Health Technology Assessment programme (Goodyer et. al., 2011).

In the psychoanalytic arm of the study, adolescents (11-17 years old at entry) with a diagnosis of moderate to severe unipolar major depressive disorder were offered 28 weekly sessions of

STPP. Clinicians were all full members of the Association of Child Psychotherapists or trainees in their final year. In addition, clinicians received specific training, read the STPP manual, attended an STPP training day and were confirmed as meeting specific criteria to become a STPP therapist.

Thirty-five STPP sessions were randomly chosen to be rated and analysed for the validation of the APQ-set (Calderon, Schneider, Target & Nick Midgley, 2017). The APQ items described events where we expected that anger would be present. For example, some items described that young people expressed negative feelings towards the therapist. Sessions rating high on such items were highly likely to direct us to sessions with explicit expressions of anger.

Therefore, the STPP sessions rated for the APQ-set were a subgroup of the IMPACT data from which I purposely selected sessions featuring anger-events between therapist and patient.

The APQ-set

The APQ is an instrument comprising a set of 100 items aiming to describe and classify psychotherapeutic processes in the treatment of adolescents. It aims to depict a wide range of events and processes in a form suitable for quantitative comparison and analysis, regardless of the theoretical background of each treatment.

For the validation of the APQ, 70 sessions were randomly chosen from both the CBT and the STPP arms of the IMPACT study. Of the 35 STPP sessions selected and rated, 17 were from the initial stages of treatment and 18 from the middle and final stages. The participants in the sample were 70% girls, reflecting the gender proportion in the IMPACT study overall.

To rate the sessions according to the APQ items, raters sorted the 100 items into 9 categories ranging from 1 (most uncharacteristic) to 9 (most characteristic) (Calderon et al. 2014). Raters could only place a specified number of items in each 1-9 category for each session. An item would be rated as very characteristic of a session if the theme or event described by the item

was true of the session overall. Raters were expected to ask themselves: Is this attitude, behaviour, or experience clearly present? To what extent is it present or absent?

Given how complex it was to identify anger in systematic and objective ways, the use of the APQ ratings offered validity as these sessions had previously been rated by the independent raters of the APQ validation study.

Design

A strength of using already existing data is that those were unbiased and independently collected by IMPACT researchers and researchers in the APQ-set validation study (see below). Most importantly, this data offers a unique opportunity to take a pragmatic view into what happened in the therapeutic relationship when patients expressed anger towards their therapists.

One of the most challenging tasks of my research design was to identify expressions of anger in a sample of 136 STPP cases and an even larger number of lengthy audio-recordings. A systematic way of overcoming this difficulty was to purposefully select from the STPP sessions specifically rated for the validation of the Adolescent Psychotherapy Q-set (Calderon et al, 2017).

My strategy was to

a. select APQ items relevant to patient anger directed to the therapist
b. identify sessions that were rated fairly characteristic of one of those items, namely having a score of 7 and above
c. listen to these sessions searching for anger and write summary of events in session
d. select and transcribe periods featuring anger
e. narrow data to specific turns where patients expressed anger and therapists' responses in the next turn

f. analyse data using Conversation Analysis

Sampling strategy and selection

Four doctorate students and our research supervisor worked together as a research group during the stage of data sampling. From the 100 items listed in the APQ, we selected five as relevant to anger towards the therapist. These items were

- Item 1 (*YP*[2] *expresses, verbally or non-verbally negative feelings towards therapist*);
- Item 10 (*YP displays feelings of irritability*);
- Item 14 (*YP does not feel understood by the therapist*);
- Item 20 (*YP is provocative, tests limits of therapy relationship*); and
- Item 36 (*Therapist openly reflects on 'mistakes', misunderstandings or misattunements that have taken place in the relationship with the YP*).

Scanning the APQ data, a table was created (*Appendix 1*) listing sessions that scored 7 (fairly characteristic or salient) or above on one of the selected items. A total of ten sessions were selected. Listening to these, I found that direct expressions of anger towards the therapist featured in just four of the sessions[3].

I closely listened to the audio-recordings and I wrote descriptions of the main themes unfolding in the session in periods of two minutes. The duration of all four sessions was an even number, therefore annotating the session in two-minute periods would result in units of equal duration. Moreover, by listening to the sessions, I felt that two minutes was a period long-enough for a theme to evolve, whilst contained-enough to ensure that the detail of events would not be

[2] Young Person

[3] In the other four sessions, young people had expressed anger about other significant people yet their interaction with the therapist did not feature anger, whilst in two sessions young people appeared withdrawn for the whole duration of the session with little evidence in the present session that their withdrawal was an indication of anger.

compromised. For each session, a table was created with summaries for all two-minute periods. An example of those is shown in *Appendix 2*. These descriptions provided context as to how therapeutic conversations evolved.

When anger was identified within a two-minute period, the period was selected for transcription. This process of selecting extracts seemed more systematic to selecting a period based on personal judgement, partly because it is inherently difficult to define when an emotion starts and ends[4], especially when it can be subtly present during the whole session.

Once the periods were transcribed, anger-expressions were more precisely located using anger-indicators that have previously been documented in the literature. As discussed in the literature review section, three CA studies have identified displays of anger in conversation (Retzinger, 1995; Selting, 2010; Weiste, 2015). Table 2 below gathers those in terms of content, form and prosodic and visual features. Without the use of these CA indicators, the location of these anger-expressions may be only vaguely identified.

Extracts extrapolated included one patient turn where patients expressed anger and the therapist's response in the next turn. Due to the nature of conversation, occasionally patients' anger and therapists' response were completed over two adjacency pairs (Drew, 2013) and then both pairs would be selected.

These extracts formed the dataset of this study and were analysed with CA. Overall, 10 extracts were selected from the four therapy sessions.

[4] This process of data selection had the limitation that an anger-expression could fall in-between two periods. Therefore, transcripts included 30 seconds before the beginning of the period and 1 minute after the end of the period. More time was allowed at the end of the period in case an anger-expression featured near the end of the period because the project focused on therapist responses following an anger-expression by patients.

Identifying anger

To summarise, patients' anger towards the therapist was identified based on the following criteria:

- Patients produced an antagonistic emotional expression as a response towards perceived offence or mistreatment by the therapist, or patients did not produce a response when a response was expected. Stivers and Robinson (2006) have shown that when a response is absent in conversation, that is typically treated as an indication of misalignment rather than of a non-answer response.
- Patients' turns were intuitively selected as expressing anger and were further verified by the anger-indicators listed in Table 2.
- The anger-expression was explicitly towards the therapist and not directed to another person in the patient's life.

Table 2

Content	***Linguistic forms***	***Prosodic and Visual features***
Interrupting	Swear words	Extra-strong accents
Blame	Temporal expansions ("you always..", "you never..")	Lengthenings
Sarcasm	Extreme-case formulations	Changes of pitch register
Questioning	Knowledge disclaimers ("I don't know", "you know")	Extra-high pitch peaks
Referring to a third, irrelevant person	Incongruent laughter	Dense accentuation
Threat	Repetition	Stress shift
Presenting the other as acting unfair- Presenting self as justified or rational	Sounds as response cries	Tempo changes
Hiding behaviours (verbal withdrawal, abstraction, indifference)		Slashing and slapping gestures
Presumptive attribution of thoughts or feelings to the other person		Gaze direction
		Head nods

Table 2 Indicators of anger in conversation

Characteristics of the dataset

The four therapy sessions were offered by female Child and Adolescent Psychotherapists.

There were two male and two female patients, a greater prevalence of males than in the IMPACT and APQ datasets, although conclusions cannot be drawn as to whether this comparison is meaningful. All young people were White British. One young person was 16 and three were 17 years old when treatment started.

The four sessions corresponded to session numbers 15, 19, 23, 26 of each participant's respective therapy, meaning one session belonged to the middle phase of treatment and three to the ending phase of treatment.

Three of the cases completed and one case dropped-out of treatment.

Data Analysis

CA takes a naturalistic perspective, aiming to describe naturally-occurring activities, without the intervention of researchers defining or imposing tasks. The analysis focuses on what people say and do rather than what they report saying and doing. CA has been used in a range of contexts, from naturally occurring everyday conversations to interactions in institutionalised settings, namely court hearings (Atkinson & Drew, 1979); primary care settings (Heath& Nicholls, 1986); and emergency call centres (Whalen & Zimmerman, 1987).

Psychotherapy is a specific form of institutional interaction where there is both an institutional setting (i.e. therapy room; clinic) and an institutional task (i.e. to treat). Therefore, interactions in STPP sessions are influenced by the institutional agendas set by psychoanalytic theory and practice. Peräkylä (2013) writes that unlike other interactions where language is used to display or understand the speaker's communicative intentions, in psychotherapy therapist and patient orient "to examine the patient's talk beyond its intended meaning" (p. 552). In psychoanalysis, "beyond the intended meaning" would mean the patient's repressed and unconscious thoughts and feelings, which the patient is not aware of. This may lead patients to resist therapists' interventions and cause mismatches between the "institutional talks" of therapist and patient (Vehvilainen 2008).

By focusing on the detail of structure, organisation, and sequential order of talk between young people and therapists in the study, my analysis aimed to understand how anger is co-constructed by patients' and therapists' interactional agendas.

The data analysis was closely examined by two other researchers (the doctoral supervisor and a research consultant with expertise in CA) to verify the findings.

Transcription

For the transcription of my data I used the CA transcription conventions first developed by Jefferson (2004), also explicated by Hepburn and Bolden (2013). Speakers' turns were annotated, the lines of the transcripts were numbered to facilitate referencing and the talk was presented as it was produced and not as it should have been produced. A list of the CA annotations used for the transcription of the data can be found in *Appendix 3*.

Ethical considerations

Ethical approval was granted as part of the ethics for the overall IMPACT study (Goodyer et al., 2011). Confidentiality of the material was ensured by several means: sessions were anonymized and all recordings were encrypted using TrueCrypt (http://www.truecrypt.org/).

Access to the IMPACT data by Tavistock & Portman doctoral students is covered by the ethical agreement between the trial and the National Research Ethics Service (NRES Committee East of England – Cambridge Central), in a substantial amendment submitted on 27 May 2011 and approved on 16 June 2011.

Specific permission for my study was granted by the IMPACT Principal Investigator at the Tavistock & Portman Trust, Dr Rob Senior. In addition, the study was approved by the Tavistock Research Ethics Committee (permission granted on 13th May 2019). Access was obtained only for the sessions selected for this study and no identifying details of the young

people were shared. Finally, I did not work clinically or in any other way in the service in which young people were seen.

Chapter 4: Data Analysis

As explained above, ten extracts were extrapolated from four different patient-therapist couples, from the middle and ending phases of STPP treatment. I shall now present my data analysis as a potential reading of the patient-therapist interactions, aiming to highlight conversational patterns between the two. Patients' anger-expressions are highlighted in the extracts in the text below, whilst an example of a transcript is shown in *Appendix 4*.

For the reader's convenience, I will introduce here a summary of CA designs identified in my dataset extracts around patients' anger expressions.

Table 3

Extreme case formulation (Pomerantz, 1986)	An exaggeration or emphasis to the maximum properties of an object with the aim to legitimise claims, persuade or complain.
Repair operation (Schegloff, 1987)	An attempt to manage trouble in conversation
Self-initiated repair (Lerner & Kitzinger, 2010)	An attempt to manage trouble in conversation where one pauses, displays unease or searches for a better word
Other-initiated repair (Schegloff, Jefferson, and Sacks 1977)	When the co-speaker initiates repair of trouble in conversation
Supportive disagreement (Weiste, 2015)	Disagreement by aiming at finding congruence with co-speakers perspective and showing respect for their epistemic primacy
Topical shift (Vehviläinen, 2008)	Shift in the focus of conversation
Statement of fact (Searle, 1969)	A declaration of something as true

Table 2 CA designs around anger-expression

Case A

The two extracts below have been taken from session 26, namely the very final phase of treatment of a female patient (17 years old) and a female therapist. The patient or young person (YP) starts the session apologising for having cancelled the previous one due to feeling unwell. Therapist (T) and patient progressively adopt divergent perspectives on the reasons why the session was missed. The therapist links the missed session to the patient's unconscious anger about the treatment ending, and formulates that the patient wishes to destroy and reject what has been achieved so far.

Extract 1, Minute 25

The patient has repeatedly claimed that she does not need the sessions anymore. In line 46, the patient produces an angry response by interrupting the therapist's talk and taking the conversational floor, whilst stating her disagreement with the therapist's point that she might like to have more sessions (line 47).

46	YP:	[Well but I just] I just
47		don't feel like I ne:ed it I just - (0.2) I just [d:on't]
48	T:	[↑IT'S not] - we are not talking
49		about needing it at the moment (.) we are talking about how you de:al with
50		something that was kind of ((offered)) - I think it's a beautiful example what
51		you said about .hhh your friend and ↓giving a present to somebody and
52		somebody kind of just .hhh not (notices) it's very frustrating (.) it's not it's not
53		good ↑ and perhaps you want me a bit like you would do with your fri:end to
54		put some kind of protest .hh and say well it's not quite right .hhh I've (.)
55		actually (.) really offered you sessions I sat here very willing to hear to listen
56		and to he:lp you .hhh

Case A, Extract 1

The word "*but*" expresses disagreement with the therapist's previous turn whilst the patient's frustration is emphasised both by a repetition of the phrase "*I just don't*" as well as by lenthenings of the words "*ne:ed*" and "*do:n't*". There is a *self-initiated repair operation* (Lerner & Kitzinger, 2010), namely an attempt to manage trouble in conversation, where the patient pauses, displaying unease about what she is about to say (line 47) or searching for better words.

Arguably, the patient has not felt heard; repetition and emphasis of her words are designed to reinstate her point. The word "*just*", repeated 3 times, conveys that the patient is not preoccupied with the reasons why she does not need the sessions, she "*just*" does not feel she needs them. The patient's turn appears to be confrontative, rejecting the possibility of more therapy and inviting the therapist to accept the fact that she does not need more sessions. One wonders, however, whether the patient's protest and the repetition of the phrase "*I just don't*" is designed here to invite the therapist to think with her about her experience or even convince her of why she may or may not need these final sessions or further sessions in the future.

Therapist's response, lines 48-56

The therapist's turn is highly affect-laden, with her response also conveying frustration. She interrupts the patient before the patient finishes and there is an upward shift in the pitch as well as an increase in the volume of her tone of voice (line 47). The therapist uses the words "*frustrating*" and "*not good*" to link the way she is made to feel with the way the patient has felt when previously rejected by a friend (lines 52, 53). The therapist's speech is long and continuous, and we can hear her heavier breathing, indicating a degree of alertness.

It is interesting that there is mirroring in the participants' affective responses. This is indicated both by the overlaps, lengthenings of words and increases in pitch in both speakers' turns, as well as by the fact that both speakers display unease by using *repair operations* (Schegloff, 1987), suggesting that both participants are aware of trouble in conversation.

The therapist attempts to deal with it by shifting the focus of conversation ("*we are not talking about*") and distancing from the here-and-now discussion of whether the patient should have more sessions. With this *topical shift* (Vehviläinen, 2008), the therapist changes topic and places the focus on the patient's prior action, in this case the fact that the patient has rejected the therapist's offer. The therapist produces a repair operation (line 50) which serves as an

increment; she adds an example to legitimise her previous point, namely that the patient rejects the therapist in the same way that the patient has felt rejected when her gift went unnoticed by her friend. The therapist then formulates that the patient needs her to protest in the same way that she would have liked to protest her friend's rejection. In line with Weiste's (2015) findings, the therapist here re-contextualises the patient's communication in the therapeutic relationship and links this to the patient's past experiences.

The therapist's turn appears to be persuasive and the emphasis on phrases "*beautiful example*" and "*not good*" are designed to establish a level of alliance with the patient. At the same time, the framing of rejection by the therapist as "*not good*" is one that holds the patient accountable for what is presented as not appropriate behaviour.

With the statement "*we are not talking about*", the therapist claims *epistemic authority* by stating that the therapeutic conversation is not about needing the sessions or not, but about how the patient deals with something that has been offered (line 47). The therapist here claims to know what the therapeutic conversation is or should be about. According to Vehviläinen (2008), these breaches to the patient's ownership of their experience are linked to the institutional orientations of psychoanalysis, namely the presumption that the therapist is trained to deal with the patient's unconscious. However, the therapist's epistemic authority seems to also be used here as an attempt to resolve trouble in conversation by claiming that one participant, in this case the therapist, is right. Interestingly, the therapist's turn starts with "*It's not-*" before she aborts it (Schegloff, 1987) with a *repair operation* and replaces it with "*we are not*". It seems that anger in this therapeutic conversation is linked to a shift from what participants feel, think or perceive, to a factual view of events, that which "is".

Extract 2, Minute 30

In minute 30 of the session, the therapist continues to pursue her perspective. The patient disagrees with the therapist that there is relevance between the two relationships, the one with the therapist and the one with her friend (extract 2, line 6). She does so by interrupting the therapist and twice using an *extreme-case formulation* (Pomerantz, 1986) to upgrade the emotion and emphasise her disagreement; the two scenarios do not relate "*at all*" (line 7 and 8). As before, the patient displays an angry response with the multiple repetition of the phrases "*I just don't think*" and "*I just don't see*", whilst the patient again hesitates in stating her strong disagreement. Her pitch also drops in lines 7 and 8, indicating that the patient might be attempting to regulate her emotional response. On the other hand, the word "*really*" is used by the patient to express her viewpoint as *a statement of fact* (Searle, 1969).

5	T:	What did you [think]
6	YP:	[I just don't think] >I just don't think I just don't think< they're
7		similar scenarios at all ↓ I just don't see >I just don't see< (.) I just don't see
8		how they relate at all (.) ↓really
9		(3.0)
10	T:	(but) it relate in a very kind of simple way that it's you it's about you isn't it
11		that's what we are talking abo::ut we are talking about the side of you that we
12		said can be kind and give things but the >other <side of you that can be
13		me:an but mean in a particular ↑way I think (.) mean to me:: in terms of (0.2)
14		because the research is coming to an end and <there> is no ↑sessions for
15		you (0.7) and because of that you are saying like (.) you can knock everything
16		down that has been achieved befo:re (and) saying it's been nothing . (1.0) do
17		you ↑see that

Case A, Extract 2

The patient's sentence in lines 6-8 is structured as a negative declarative ("*I don't see how*") followed by a negatively tilted adverb "*really*" (Heritage, 2003). One may say however that the patient is indirectly questioning the therapist about how the two scenarios are linked.

Therapist's response, lines 10-17

The therapist responds with a silence of 3 seconds. She then provides an explanatory formulation that the way the two scenarios relate is through the patient. The focus here again is placed on the patient and emphasised by the repetition of the word "*you*". Whilst the therapist is formulating that the patient is becoming mean[5] to her because of the ending of treatment, her formulations are structured around the patient's mean-ness, rather than on the therapist leaving the patient or that the therapy is ending. Therefore, on one hand the therapist is attempting to re-use the patient's words and terms of reference and to form an alliance in thinking together about the patient's communications. On the other hand, the focus here is on the patient's actions, i.e. her mean-ness, rather than perhaps on the context in which those appear, for example the end of treatment and the meaning of that for the patient.

In line 10, the therapist is using the question tag "*isn't it*", a negative interrogative which is designed with a preference for a yes answer (Heritage, 2010). In other words, the therapist here is seeking agreement from the patient. Later, in lines 16-17, the therapist seeks agreement with a direct question, "*do you see that*?" These aspects make the therapist's long turn a persuasive one; the therapeutic conversation has moved away from the patient's experience and is focused more on the pursuit of a therapeutic agenda[6] introduced by the therapist. More specifically, the therapist characterises the patient as "*kind*" or "*mean*" to demonstrate the patient's various responses towards the therapist.

The phrases "*you can knock everything down*" and "*saying it's been nothing*" are extreme-case formulations that are used here to concretise the patient's mean-ness as a resistance to the ending. At the same time, one wonders whether these extreme-formulations indicate the

[5] "Mean" here is used in reference to the patient calling her friend "mean" earlier in the session.

[6] By "agenda" here we mean the system of values framing the institutional interaction between patient and therapist. For example, making the unconscious conscious is at the centre of therapeutic agenda of psychoanalytic treatments. In CA, these agendas are thought to express organised and institutionalised ways of communication and interaction between participants.

affective state of the therapist during this angry sequence, and the impact of the patient's anger onto the therapist. In other words, has the therapist got angry back?

Case B

In this case, in session 23, the therapist (female) has started by apologising for letting the young person (male, 17 years old) wait and has offered to extend the session accordingly, which the young person has rejected due to going to lunch with his mother. Therapist and patient observe that the patient rarely mentions his mother and the patient explains that this is because he has no complaints about her. Patient and therapist then talk about therapy as a space where the patient complains about the wrongdoings of people.

Extract 1, Minute 26

Whilst the patient has been accommodating and reassuring about the therapist's lateness, in the following extract the therapist is attempting a link between her lateness and the patient's feelings of complaint towards her when his expectations are not met.

In line 39, the patient disagrees with the therapist that he has any expectations in relation to the therapy. He states directly *"I don't have any"* and adds *"anymore"* to add emphasis, and to indicate that something has changed. Once he has stated this, the patient laughs in a way that conveys embarrassment. This laughter indicates an awareness of trouble in his previous talk and an attempt to perhaps regulate his affective response. The phrases "*I don't have any*" and "*anymore*" are *extreme-case formulations* which are also negatively tilted. For example, instead of saying "my expectations have been met", the patient here uses the negative declarative form. This indicates that there is an upgrade of negative emotion. One may say that anger is expressed in a rather concealed way here and is paired with laughter as a way of

lessening the intensity of the patient's anger. In line 43, the patient adds a second giggle and "*yeah*", encouraging the therapist to continue with her phrase.

37	T:	↑ We:ll (.) I was thinking what are (tra) these expectations of the therapy (.) in
38		a way
39	YP:	I don't have any (.) anymore .hhh ((giggles, conveys embarrassment or
40		awkwardness)) =
41	T:	= .hhh ((T returns the giggle/ also conveys awkwardness)) (.) this is what I (.)
42		=
43	YP:	= £ m . yeah . =
44	T:	what I I was (.) wondering about (.) you don't have any anymore =
45	YP:	=no .
46		(2.0)
47	T:	↓ d' you wanna tell me a bit more about that (?) ((T more staccato tone))

Case B, Extract 1

Therapist's response, lines 41-47

Strikingly, the therapist's immediate response (line 41) is to giggle in a similar way to that in which the young person has giggled before, therefore mirroring the affect in the room. She then adds, "*This is what I was wondering about*" and repeats what the young person has said with added emphasis on "*anymore"*. In this way, the therapist here communicates that she has registered what the young person has said and has noticed the importance of the word "anymore", namely the fact that the young person's expectations have changed. The therapist's use of the word "*wondering*" is one that invites further reflection, and her turn is inquisitive and conveys curiosity. At this point, the young person produces a brief negative response, "*no*", with which he maintains his earlier position that he has not got any expectations. The therapist responds with silence for 2 seconds. Her tone then drops and she enquires with a direct question this time, "*d' you wanna tell me a bit more about that*". Although there is a downward drop of the pitch and a low volume in the therapist's tone, her tone is of a more staccato, pointed manner. This seems to be by way of mirroring the patient's brief and distinct "no" which again indicates a direct impact of the patient's affective state on the therapist.

Extract 2, Minute 30[7]

In minute 30 (extract 2 below), the therapist is commenting that the patient finds it difficult to express his anger towards her. The patient is then responding with an "*other-initiated repair*" (Schegloff, 2007); he repeats the therapist's phrase "*the idea of being angry with*" (line 43) in order to mark it as problematic and to signal his non-alignment with the therapist. He corrects the therapist's formulation by bracketing "*for being late*"; in this way he disagrees with the therapist's generalisation of his actions and stresses that what he finds hard is being angry with her lateness. The patient emphasises this by pausing before the phrase "*for being late*" and by lengthening the word "*late*" (line 43).

40	T:	=it would be up for me to deal with (1.0) but the idea of getting angry with me
41		(0.2) ermm (.) it's hard (.) I think
42		(2.0)
43	YP:	the idea of me getting angry with you (.) for being late is hard £ because £ I
44		wasn't – but (0.2) yeah
45	T:	well no but you have al- that's .hh today- but we have also spoken about
46		other times when you may have [felt]

Case B, Extract 2

The patient's expressed disagreement and other-initiated repair is followed by a laughing tone when the patient states "*because I wasn't*" (lines 43, 44). The laughter here mitigates the strength of the patient's otherwise direct disagreement. The patient then produces a *self-initiated repair* on line 44; he stops himself and adds the phrase "*but (0.2) yeah*" which again functions as regulating the forcefulness of what he has said. This *self-initiated repair* as well as the patient's pause between the words "but" and "yeah" indicates that the patient is cautious of potential conflict in interaction caused by his disagreement and angered affect.

[7] The numbering of lines in this extract should not confuse the reader as extract 2.1 is from minute 30. This is 4 minutes later in the session than extract 1.

Therapist's response, lines 45-46

The therapist responds with the filler "*well*" followed by "*no*" both of which express disagreement. The therapist maintains her perspective here by initiating "but you have al-", however she interrupts her phrase with a *self-initiated repair*, adding "*that's today*". With this self-repair, the therapist increments, adding more evidence to her point. However, the repair here is also addressed at the patient; by adding "*that's today*" she corrects him that it is today he has struggled to express his anger in relation to her lateness. She implies in this way that at other times he may have felt anger for other reasons. Therefore, the therapist's phrase can be seen as an *other-initiated repair* in a string of repairs between patient and therapist. The repair sequence could take the following form:

YP: The idea of me getting angry with you - for being late - is hard

T: Well no - that's today - but we have also spoken

Whilst both therapist and patient maintain their divergent perspectives, there is symmetry in the way both participants structure their turns around the repair. Therefore, the therapist's response mirrors that of the patient, establishing a degree of sameness in parallel to their disagreement.

Following her repair and the increment "*that's today*", the therapist replaces her phrase "*you have al-*" with "*we have also spoken about…*". By doing so, the emphasis is located from the "you" to "we", serving perhaps the formation of an alliance between therapist and patient.

The therapist's style in line 45 is persuasive, attempting to convince the patient that he finds it hard to feel angry with her. This is a shift from the previous extract where the therapist maintained an inquisitive style.

It is interesting that with her formulation in line 45, the therapist also performs distancing from the patient's anger in the here-and-now whilst the therapeutic conversation around anger moves to "*other times*". For example, one wonders whether with his increment "*for being late*" the patient is inviting the therapist to enquire about his anger towards her, for example what makes him angry, if not her lateness. Instead, the conversation around the patient's anger is becoming theoretical here and distanced from the affect in the room and from specific examples of interaction between patient and therapist.

Extract 3, Minute 36

In minute 36, the therapist has pursued her formulation, this time in more general terms, that it is hard for the young person to believe that there could be space for his anger in the sessions. The patient responds with an upward shift of his pitch and a direct question "*but what you want me to be angry about*" (line 12). The word "*but*" at the beginning of his turn indicates disagreement and non-alignment with what the therapist has said. The patient's pitch drops half-way right before he articulates the word "*angry*", indicating that he is cautious of his anger. His question is accompanied by a giggle of embarrassment. Clayman (2013, p 645) writes that "there are question forms that are so aggressive that their status as 'requests for information' is in doubt." One may say, however, that the patient here may be communicating that he is not understanding the therapist's formulation or cannot see its relevance. Therefore, his question might be requesting that both therapist and patient think of the specific reasons that make him angry; the emphasis here being on "*<u>wh</u>at*". One may add that the patient's angry question places the therapist in the position of the one who wants or expects something. This is interesting in the context that the patient was made to wait for the therapist. Therefore, the question here positions the patient in a more powerful position.

12	YP:	£ ↑ but what you want me to be ↓ angry about .hh ((giggles))
13	T:	£ .hhh ((laughs)) £ I don't want you to feel angry about anything in particular I
14		am just trying to (.) explore what it is (.) that makes it so ha:rd (.) to give your
15		real (.) feelings (.) some spa::ce (?)
16		(3.0)
17		We kind talked about how in the pa:st you felt at times annoyed with me or
18		with the therapy (0.7) but it was – but that was something that we- that was
19		difficult to talk about when it actually happened

Case B, Extract 3

Therapist's response, lines 13-19

The therapist responds with a giggle too, again mirroring this aspect of the affective state of the young person. She states that she does not want the patient to feel angry "*about anything in particular*" (line 13), other than to explore what makes it hard for him to express his real feelings. The word "*explore*" (line 14) is stressed to mark the therapist's therapeutic agenda; she does not expect anything in particular, her intention or task is to explore. It seems that the patient-therapist interaction has become passionate following the patient's anger-expression, and one wonders whether the therapist states her institutional task as a way of reaffirming the boundaries of the setting. We also notice that the therapist takes distance from the particular reasons that would make the patient angry, whilst there is also a movement from the specific feeling of anger to the patient's "*real feelings*" in general. Distancing from the trouble-source conversation is also effected by the therapist using the third person, namely she uses "*what is it*" that "*makes it hard*". It appears that although the therapist attempts to take up the patient's anger towards her, when the patient's opposition becomes bolder, she -perhaps unknowingly- moves away from anger.

Both therapist and patient remain silent for 3 seconds. The therapist continues with an increment to her turn. This time she is using the pronoun "*we*" to refer to previous therapeutic conversations about times when the patient felt annoyed but struggled to express it. The

emphasis "*in the pa:st*" (line 17) can be seen here again as distancing in temporality where the therapist's formulation is not referring to the here-and-now but to a different moment in time.

In line 18, the therapist states "*but it was*", a phrase with which she pursues her previous point which has been the subject of disagreement. She pauses in hesitation and performs a self-initiated repair; she repeats her phrase although correcting it and replacing "*it was*" with "*that was something that we*", again affirming her therapeutic alliance with the patient. Finally, she returns to the use of the third person, "*that was difficult to talk about*". These conversational choices by the therapist indicate her awareness of trouble in conversation as well as her attempt to re-establish alignment.

Case C

The extracts that follow are from session 19 of a female therapist and a female patient (17 years old). The patient has arrived late and the whole session lasts for 22 minutes. At the beginning of this session, the patient has apologised for her lateness and has explained that she was late because she had to stay longer in school due to a teacher getting angry with the class.

Extract 1, Minute 3

Extract 1 is a longer extract due to the fact that the patient's anger is building up over two adjacency pairs. Therefore, we will look at lines 7 and 9 whereby the patient progressively disagrees with the therapist until the patient withdraws in what we see as an angry silence in line 12. We will also focus then on the therapist's response in lines 13-20.

In minute 6 of the session, in line 1, the therapist asks whether the patient thinks that others perceive her as deliberately "obtuse" which the patient agrees with. The therapist then enquires whether the patient thinks she is deliberately obtuse, the emphasis now being on the patient's obtuseness as a fact. The young person directly disagrees with the therapist by producing a lengthened "*no::*" followed by "*I don't thi-*" (line 7). The therapist interrupts before the patient

fully articulates her disagreement and takes the floor of conversation by asking a second question, "*not even with your brother and sister?*" The patient in line 9 disagrees again, "*that's been happening for years so*" whilst there is also a downward shift in her tone. Although the patient has not come to conclude her sentence, the therapist comes in, maintaining her divergent perspective and stating that the fact that it has been happening for years, does not mean that it cannot be true. It is at this point that the patient withdraws and remains silent for 2 seconds. Anger here takes the form of silence and withdrawal from further engaging with the therapist, indicating a rupture in the therapeutic relationship.

Whilst there is little other evidence in the audio-recording that the patient's silence expresses anger, the therapist's turn in line 13 seems to suggest that she also understands the patient's withdrawal as an angry response.

1	T:	D' you think that people do sometimes think you are being deliberately (.) ↑
2		obtu:se
3	YP:	Yeah ((soft low tone)) =
4	T:	= ye:ahhh ((soft tone)) . and d' you think just (.) > very very < occasionally (.)
5		you ↑ a::re (?) (.) maybe:
6		(1.0)
7	YP:	no:: I don't [thi-]
8	T:	[not] > ever ever < not even with your brother and sister (?)
9	YP:	↓ but that's (.) like (.) been happening for ye:ars so: ((very low tone by YP))
10	T:	£ w:ell: (.) just because it's been happening for years (.) it doesn't me::an (.)
11		there isn't a little bit of something to it maybe (?)
12		(2.0)
13	T:	hm (0.7) I am not- I am not criticising you:: £ I am just trying to maybe (0.5)
14		pluck up something that might (0.2) offer a bit of insight .hh ((laughs)) (0.2)
15		but maybe you a::re (.) naturally (.) just quiet and a bit (.) sort of (ye:m) - not
16		very forthcoming but actually:: (.) it could be a bit exaggerated when you don't
17		↓ want to speak . (0.2) £ yeah at least you agree: to that .hh ((laughs))
18		so that's kind of a habit that kind of can sometimes help you out of awkward
19		situations (0.2) ye::ah (0.7) mmm (0.7) but anyway (.) you- you are able to go
20		next year (.) and you don't have to do the maths (?)

Case C, Extract 1

Therapist's response, lines 13-20

The therapist produces "hm" and then pauses for 0.7 seconds both of which are delays, and indications of her hesitating in articulating her thoughts. The therapist continues with a self-initiated repair ("*I am not- I am not criticising you*") which also indicates hesitation and an awareness of trouble in the interaction. Her reassurance of the patient that she is not criticising her indicates her understanding that the patient has felt criticised. The therapist's awareness of the rupture in conversation is indicated by her smiley tone in line 13 which gives place to a more uncomfortable laughter in line 14. The therapist is becoming reassuring by stating that she is trying to "*pluck up something*" and to "*offer a bit of insight*", stating in this way her institutional task. The therapist also claims epistemic authority, namely that she has the expertise to offer insight into the patient's experience. The therapist's agenda seems to be in conflict here with what the patient has already expressed.

The therapist reformulates here that the patient may naturally not be very forthcoming but that this becomes exaggerated when she does not want to speak. One can say that the therapist is attempting a *supportive disagreement* here (Weiste, 2015); namely she has modified her argument to include the patient's perspective, before she continues with her interactional project which in this case is to show the patient that she (patient) becomes even less forthcoming when she does not want to speak. In this way, the therapist acknowledges that the patient does not want to speak to her, but the reasons for that are not being explored. The asymmetry between the patient's turns and therapist's turns is striking, with the patient's turns being significantly shorter.

In line 17, the therapist's "*yeah at least you agree with that*" indicates that the patient might have nodded in agreement although we cannot hear her responding verbally to the therapist.

The therapist's expression of relief suggests she is seeking the patient's agreement, whilst the words "*agree:*" and "*that*" are emphasised here.

In line 18, the therapist speaks of this withdrawal as a "*habit*" of the patient which has helped her out of awkward situations. The patient's behaviour is therefore characterised as a personal trait for which the patient is made accountable, rather than the behaviour being justified by the context. The therapist's emphasis on the word "want" (line 17) suggests that the patient intentionally resorts to such behaviour. One may say that the patient's withdrawal has been an example in the here-and-now of what the therapist has formulated about. Although this occurs in the session, the therapist does not explicitly uptake this within the therapist-patient relationship. As noticed elsewhere, one wonders if such designs indicate a tendency to distance oneself from anger and disagreement in the consulting room, whilst the emphasis remains on the patient's traits and behaviour. In line 19, another topical shift takes place with the therapist changing the subject to maths and the next academic year.

Extract 2.1, Minute 7

As the session continues, the therapist enquires about horse riding, an activity that she previously suggested to the patient. The patient has explained that her mother was not happy with her going to that part of town but that nevertheless she has phoned to ask for more information and is expecting the professionals there to return her call. The patient has shared with the therapist that she has not received a phone-call so far. In minute 7 of the session, (line 10, extract 2.1 below) we see another example of the patient withdrawing in silence following the therapist's previous turn whereby the therapist has formulated that it is a shame not to contact the person on the basis of very little information. There is a silence of 6 seconds in which the patient does not correct the therapist's inaccurate understanding. Again,

disagreement seems to be expressed in an implicit way and by means of a rupture in the communication between patient and therapist.

5	T:	↑A-ha ↓ well . I have no idea what it would be: I am only saying that (.) I saw
6		that in X but I don't know anything about (0.7) you know (.) what (.) you (.)
7		could be asked to do: or indeed ↑ about the organisation (?) > but it seems a
8		shame < (0.5) to eerm not (.) contact the person just on the basis of (0.2) vss
9		- very little information (?)
10		(6.0)
11	T:	But you did phone he:r and she said she'd phone you ba:ck
12	YP:	yeah

Case C, Extract 2.1

Therapist's response, line 11

The therapist responds by making two consecutive corrections to her previous statement; she firstly states that the young person "*did*" call the horse riding professional and secondly that now it is "*she*" (the professional) that is expected to call back. The patient's anger has therefore led the therapist to alter her understanding of the events. The therapist's conversational actions indicate her awareness of the misunderstanding and an attempt to put things right. The word "*ba:ck*" is also lengthened to perhaps emphasise that the patient's actions (phoning) have not been reciprocated. We can see that following the young person's silence, there is a transferring of responsibility from the young person to the horse riding professional. Indeed, the therapist's turn starts with "but" indicating a disagreement with her own previous formulation, which is not voiced by the young person but by the therapist herself, in the form of a self-initiated repair. In other words, the patient's silence makes the therapist realise that she has misunderstood the patient and the therapist voices this for the patient.

Case D

The following extracts are from session 15 of a female therapist and a male patient (16 years old). The patient starts the session discussing his provocative school essay in which he criticised a taught piece of poetry. The essay annoyed his teacher and resulted in a detention. The therapist's formulations have focused on how difficult it can be to struggle with poetry.

Extract 1, Minute 15

In line 30 of extract 1 below, the patient produces an angry response to the therapist's earlier formulation. There is an increase in his pitch and a stress of the words "*ca::re*", "*se::nse*" and "*wo::rds*". The lengthening of these words conveys the young person's annoyance, perhaps despair. His disagreement with the therapist seems to be that it is not difficult to struggle with poetry, it is just that he does not care about it or cannot see the relevance to his experience. The patient tries to convince the therapist that poetry does not make sense and does not matter to him (lines 31-33). The patient stresses consonants at the beginnings of words, expressing an upgrade of affect ("*slightly*", "*small*" and "*story*"). This goes together with hesitation in his speech and words getting stuck ("*ma- ma:ke s s- slightly makes*") in lines 31-32 and later "*th- of th-*" in line 37. It is striking that there is a one-way, factual presentation of the issue in the patient's angry speech as indicated by the phrase "*is basically it*" (line 34).

30	YP:	↑ I don't ca::re about poetry (.) it's just doesn't make se::nse (0.2) I just look at
31		it and it is just like (0.2) it's a lot of wo::rds that someone's put together to ma-
32		ma:ke s s – slightly make sense and >they basically use small lines so that it
33		goes down the page like that instead of across the page about that big
34		instead< (0.2) ↓ is basically it (0.5) you might as well write a story
35		(8.0)
36	YP:	↓it's just pisses me off eel then they always ((been/get)) to detail (.) like ↓ (.)
37		one time I just said (.) he was like oh the rhythm of th- of th- of this indicates
38		(.) like (.) the ra:in (.) and I was like well ↑maybe is not (.) maybe the rhythm
39		just happens to .hh sound a bit like rain ((but)) and then again when have you
40		ever heard rain >that< sounds like someone chanting a poem in a particular
41		rhythm (1.0) ((makes muffled angry sounds))
42	T:	and I wonder ↑ what it is that you do: to you::r (0.2) thinking (?)

Case D, Extract 1

There is a long silence of 8 seconds in which the therapist does not intervene. The young person continues then with an *emotive* (Reddy, 2001), "It's just pisses me off" (line 36) with which he declares his anger and elaborates on his disagreement with his teacher. The stress on the word "*not*" is used here to communicate the patient's disagreement.

Although the disagreement here seems to be directed at the English teacher and poetry, the patient seems to also be expressing anger towards the therapist who has not explicitly sided with his perspective. In line 39, the patient addresses a direct question to the therapist, "*have you ever heard rain that sounds like someone chanting a poem*". This is a polar question which invites a yes or no answer and therefore is provoking debate. One may add that this is a rhetorical question that does not aim to request information but rather to affirm the speaker's view. In addition, the patient here places himself in a powerful, knowledgeable position in relation to the therapist, asserting that he already knows the answer.

Therapist's response, line 42

The therapist in line 42 responds with a much shorter turn. Her turn begins with "*and*", a conjunction indicating that with her turn she is adding to the young person's thoughts. She then prefaces an enquiry, "*I wonder*" with which she warns him of the question that will follow,

"*what is it that you do to your thinking*". By prefacing her question, the therapist addresses the question to the room rather than directly at the young person. One can say that in this way further polarisation of the debate is avoided.

The therapist's question encourages further exploration although one may say that her formulation here is focused on the patient's actions ("*that you do*"). The therapist does not uptake the patient's angry feelings towards her.

The therapist's focus is on the young person's actions making him accountable for those. The patient's anger is framed here as doing something, presumably of negative consequence, to his thinking. At the same time, the therapist's use of "*to you::r thinking*" suggests a preoccupation with the patient's best interest, namely that his anger is counter-productive not for others but the patient's own thinking.

Extract 2.1, Minute 21

Later in the session, the therapist comments on the patient's attacking feelings and the perception perhaps in the patient that others, specifically his teacher, need to be strong enough to withstand his attacks. The young person angrily disagrees asking a prolonged "*wh:y*", albeit in a whispering, muffled tone (line 26, extract 2.1 below). He follows this with an elaboration in line 27 that his essay was not a personal attack on his teacher (emphasis on "*<u>hi</u>m*") and he mumbles angrily. The patient's "*wh:y*" can be seen as expressing exasperation for not feeling understood by the therapist. In lines 28-29, he explains that his essay meant to convey that he is "annoyed with the subject", "sick of it" and that the subject is a massive waste of time. These phrases are again *emotives* with which he expresses his anger both towards the subject and teacher but also the therapist who has misunderstood the meaning of his actions. The patient here seems to emphasise that he needs the therapist to understand not his attacks but how annoying and pointless the subject is. In line 30, the patient's tone of voice increases when he

articulates "*I AM*". The phrase is repeated twice to emphasise his feelings as real facts, whilst he also emphasises that he does not "*think*" the subject is a waste of time, the subject "*is*" a waste of time. The patient stresses that this is not his experience of the subject, the subject really is the way he describes it. In line 33, the patient overlaps the therapist and takes the conversational floor to further support his point. He legitimises this by repeating that the subject is a waste of time according to many other people in his year (lines 33-34).

26	YP:	wh:y ((almost whispering tone))
27		>it's not a personal attack on him< ((YP mumbles))
28		basically it's me saying I am annoyed with this subject and I am sick of it and
29		it's a massive waste of time ((low, soft tone))
30		>coz I AM annoyed with the subject I AM sick of it< and I-m I don't think it is a
31		massive waste of time (.) it is a massive waste of time
32	T:	but I don't know [when we]
33	YP:	[well according to] everyone in my English set it is (.)
34		according to many other people in my year it is
35	T:	when we spoke about it last time we were really thinking more about what it
36		feels like not to understand something ((T uses very mellow voice))

Case D, Extract 2.1

Therapist's response, lines 35-36

The therapist responds with a soft, mellow tone of voice, although she maintains her divergent point indicated by the emphasis on the word "*but*" (line 32). She then uses the filler "*I don't know*", a knowledge disclaimer with which she pursues her disagreement. The therapist is referring back to "*last time*" (line 35), distancing the conversation from the present time to a past moment. The therapist here is referring to a time when there was alignment between the viewpoints of therapist and patient, "*we were really thinking*". In addition, the therapist returns the conversation back to what "*it feels like*" (line 36) not to understand something. Her formulation focuses on the young person not understanding poetry which makes him angry and attacking.

Extract 2.2, Minute 22

In minute 22 of the session, the patient seems angry with the therapist's formulation that he does not understand poetry. He states that his mother is of the view that he does not like these subjects because he is not good at them (Extract 2.2 below, lines 46-47). The patient is here opposing his mother's argument as an obvious one whilst his aggravation is communicated by the use of swear words ("*shit*", "*stupid*", "*crap*"), an increase in his volume "*NO SHI::T*" (line 49), as well as sound stretches ("obviously", "stupid"). The use of extreme-case formulation ("*that's the same with everyone*") and the repetition of the word "everyone" in line 53 expresses that the young person has perhaps felt too sensitive and possibly criticised by the therapist's formulation that poetry is a struggle for him.

46	YP:	well my mum said to me ↑ oh I feel you are doing crap with these subjects
47		because you don't like these subjects coz you are not very good at them ((YP
48		mimicries his mum's voice in a derogatory tone))
49		(.) and I was just like ↑↑oh NO SHI::T mum (0.2) obviously if- subjects you are
50		good at (.) you enjoy
51	T:	mm because it- you fee:l a sense of achievement
52	YP:	yeah and that's the same with everyone ↓it's not just me (.) and my stupid (.)
53		<second grade> everyone ((unclear)) ever- if someone's good at maths they
54		enjoy maths (.) if someone's crap at English literature they don't like English
55		literature but no one likes English literature anyway ↓↓ so it doesn't really
56		matter ((under his breath))
57	T:	you are quite annoyed with me ((T uses soft tome conveying empathy))

Case D, Extract 2.2

Therapist's response in line 57

The therapist responds by naming and acknowledging the young person's anger as a communication towards her. With her emphasising the word "*annoyed*" (line 57), she is bringing attention to the affective state of the patient, but also to what is happening in the therapeutic relationship. Her formulation focuses on the young person's feelings however she acknowledges that the young person is annoyed with something she did in the here-and-now

interaction. The therapist maintains a tone that conveys empathy and encourages discussion of the patient's feelings of anger.

The main patterns arising from the above analysis will be presented in Chapter 5.

Chapter 5: Findings

This section aims to offer a summary of the findings of the CA analysis presented in the previous chapter.

Young people expressed anger towards their therapists for different reasons, however almost always anger featured together with an expression of disagreement with the therapist's previous turn in the conversation. In two of the cases, patients' anger related to a feeling of not being listened by the therapist (Case A and C), in one case anger was expressed in relation to feeling disappointment with the therapist (Case B), whilst in one case the patient felt angry at the therapist addressing his difficulties with a school subject and his aggression towards others. Patients expressed anger in various forms, from withdrawing to actively disagreeing, using swear words and manifesting aggravated affect. From a CA point of view, we found that in this dataset, anger-expressions featured in two additional forms less discussed in previous studies in relation to anger: a. the use of repair-operations, namely hesitations and (self-)corrections in speakers' speech and b. the use of statements of fact, namely patients conveying their views and experiences in a factual way as if they were objective truths.

Patients' anger affected not only the therapists' formulations, but also their affective responses in interaction. Through anger-expressions, patients performed different functions in conversation: they provoked the therapist to convince them of the usefulness of further sessions, showed their disappointment, requested clarification of therapists' formulations, and communicated that the therapist had misunderstood them, eliciting the therapist's curiosity and care. Whilst therapists ordinarily held a powerful position in the sense of epistemic authority, expressing anger was a way in which patients often claimed a position of power. Interestingly, therapists' responses were constructed accordingly as persuasive, reassuring, explanatory or inquisitive in style. The therapists' responses were therefore seen as co-constructed in the

context of the conversational actions of both participants and in the dynamics of the patient-therapist interaction at any one time.

In terms of therapists' formulations, therapists understood anger as an intra-subjective state, belonging to the patient's internal world and past experiences. Anger was largely seen as an internal response, an entrenched habit or trait. Strikingly, in most cases, anger was treated as a destructive urge synonymous to an act of rejecting and putting the therapist down, or causing negative consequences for the young people themselves. Therapists commented on patients' angry feelings for reasons to do with the end of treatment or therapists' lateness, but they did not take up anger when there was a rupture or when young people indicated that they may have felt angry for other reasons, such as not being listened to. Overall, interpretations on anger were delivered with emphasis on patients' actions ("*knocking everything down*", Case A; "*when you don't want to speak*", Case C; "*what is it that you do to your thinking*", Case D), rather than on the context or reasons from which anger emanated.

In addition, therapists only occasionally discussed their own role and contribution to patients' anger, whilst only one example was found where the therapist directly named that the patient was annoyed with her (Case D, Extract 2.2, line 57).

The CA analysis identified six patterns of therapist-response across the four cases.

Therapists' affective state and mirroring of patients' emotion

What emerged most strikingly from the analysis of data was a shift in the affective state of the therapist following an expression of anger by the patient. Therapists' turns were emotion-laden and very often mirrored the young person's emotional expression. For instance, in Case B, when the young person produces a giggle following his strong opposition to the therapist, the therapist returns a giggle of similar quality before she reflects on what the young person has said (Case B, Extract 1, line 41). At another point, the therapist's tone becomes more pointed

and staccato to match the patient's previous pointed "*no*" answer (Case B, Extract 1, line 47). Changes in therapists' affective states were also indicated by the use of repair operations, namely pauses, hesitations and attempts to put things right. Such pauses and hesitations in therapists' turns mirrored similar hesitation in the young people's earlier anger expression, indicating that both participants were aware of trouble or misalignment in conversation. These patterns of mirroring between patient and therapist were sometimes so attuned that one could see the rhythm of the patient-therapist exchange in the transcript.

In many examples, a full expression of emotion was more pronounced in the therapists' turns than in the patients', while patients appeared more self-controlled or inhibited. In such cases, therapists seemed to be affected by and speak according to the patients' underlying anger. For example, in Case A (A, Extract 1, line 47) the therapist responds by raising her tone of voice, whilst her pitch increases. Her frustration feels palpable with her breathing becoming heavier and faster. In another case, the therapist presents with intensified emotion and active attempts to engage the young person who has become quiet and withdrawn (C, Extract 1, line 13). The presence of powerful emotions in therapists was also evident in them describing the patients' actions in an exaggerated way, using extreme-case formulations (A, Extract 2, line 15). It appears that the young people's disagreement and anger sometimes caused an even stronger emotional reaction in the therapist and in some cases perhaps actual anger.

Avoiding anger in the here-and-now: topical and temporary shifts

In response to young people's anger, therapists often moved away from the here-and-now interaction. Therapists either changed the topic of conversation (a topical shift) or shifted conversations to a different point in time (a temporal shift). For example, in one case, when the patient argues that she does not need the sessions, the therapist directly changes the focus of

the conversation to a new idea introduced by her ("*we are not talking about needing it at the moment…*", Case A, Extract 1, line 48).

A similar distancing pattern takes place in case C. The patient here has withdrawn following the therapist's turn. Although the therapist formulates that the patient can become intentionally withdrawn when she does not want to speak to someone, the therapist does not uptake this as happening in the actual interaction between the two of them. One may say that the therapist's comment is a general one, whilst she does not indicate to the patient that what she is talking about is happening right in that moment. Next, the therapist effects a second topical shift, changing to the less conflicting subject of maths (C, Extract 1, lines 16-20).

In a temporal shift, the therapist in Case B switches to "*other times*" in therapy when she talks about the patient finding it hard to express his angry feelings to her. Although the patient here implies that it is not the therapist's lateness that he feels angry about, the therapist does not explore what he thinks he might have felt angry about. Instead, she refers to "*other times when he may have felt [angry]*" (B, Extract 2, line 13). The conversation about the patient's angry feelings towards the therapist becomes theoretical and removed. When the patient's anger becomes bolder in the room with the patient asking "*but what you want me to be angry about*" (B, Extract 3, line 12), the therapist formulates that it is hard for the young person to give space to his real feelings. This is an example of distancing from the specific emotion of anger to the more general category of feelings, whilst later in line 17, the therapist makes a temporal shift when referring to "*the past*" as a time when the young person had felt annoyed with her or with the therapy. She does not comment on him having just become frustrated with her. In case D, we encounter a similar pattern when the therapist responds to the young person's anger by mentioning "*last time we were really thinking about …*" (Case D, Extract 2.1, line 35).

Epistemic authority and a "factual" view of events

In response to patients' anger, therapists often spoke from a position of knowledge, whilst their turns tended to be long, explanatory or persuasive in style. In case A, when the patient states that she cannot see the connection in what the therapist is talking about, the therapist provides an explanatory answer and then asks "isn't it?". This question positions the patient to agree with the therapist's view as correct (Case A, Extract 2, line 10). Later in the same extract, the therapist asks "*do you see that*" at the end of a long turn, seeking the young person's agreement with her formulation (Case A, Extract 2, line 16-17). A similar pattern occurs in case C when the therapist states with an uncomfortable giggle, "*yeah at least you agree to that*" (Case C, Extract 1, line 17).

It seemed that such designs in conversations constructed a situation where participants positioned themselves as "right". In those moments, therapeutic conversations shifted from exploring the participants' different perspectives or experiences, to the assertion of one, factual "truth". Therapists used their epistemic authority to support their viewpoints in the face of patients' anger and disagreement.

Therapists also claimed to know something about the patient's unconscious which the patient could not know about. For example, when the therapist in Case A formulated that the young person stopped attending sessions because therapy was soon ending, she claimed to know about the patient's unconscious wish to "*knock everything down*". At other times, therapists used epistemic authority to characterise a patient's reaction as an intrinsic trait, as this is demonstrated in case C where the therapist understands the patient's withdrawal as a habit she has developed to get out of awkward situations.

Therapists' exploratory stance

Young people's anger led therapists to ask questions about the young people's point of view and to explore and reflect on the young people's experience. In case B, when the patient states that he has no expectations of therapy anymore, the therapist responds with "*this is what I was wondering about*" (Case B, Extract 1, line 41/44), expressing curiosity into what the young person has said. She repeats what the patient has said with an inquisitive tone, emphasising the word "*anymore*", questioning what has changed in terms of the young person's expectations. When the patient affirms this with a "no" without providing more information, she asks a direct question, "*d' you wanna tell me a bit more about that*" (B, Extract 1, line 47). Here, the therapist demonstrates interest in the patient's statement and expresses to him that she wishes to understand him further. One may add that the patient's anger places him in a powerful position in relation to the therapist and places the therapist in the position of one who has asked a question and is waiting for a response.

Similarly, the patient in case D produces a long turn in which he expresses his anger in relation to poetry, his teachers, as well as towards the therapist who has not sided with his point of view. The therapist responds with a question "*and I wonder what is it that you do to your thinking*" (D, Extract 1, line 42). With her question, the therapist encourages more reflection on the consequences of the patient's anger for his thinking.

One may say that when therapists asked questions about young people's anger, they relinquished their epistemic authority and did not assert their view of what the patient was expressing but aimed for a shared understanding of the patient's emotional state. In other cases, the use of questions seemed to function as a way to re-engage young people when they became withdrawn or too angry. This is exemplified in case C when the therapist attempts to re-engage the patient who is not responding to her comments by asking "*and you don't have to do the*

maths" (C, Extract 1, line 20). The question here summarises what the therapist already knows and the therapist seems to be using it in an attempt to get a response from the young person.

Emphasis on moments of agreement

In the face of angry feelings, therapists often emphasised a positive working relationship or moments of alliance in the therapy. Across the four cases, therapists used and emphasised the pronoun "we" to remind patients of moments when patient and therapist had reached shared understandings. Therapists often corrected their phrases to include the pronoun "we" as shown in Case A where the therapist changes her phrase from "*it's not*" to "*we are not*" (A, Extract 1, line 48).

Therapists amended their understanding of the patient when that caused the patient's aggravation or withdrawal. For instance, the therapist in case C stated "*but you did phone her and she said she'd phone you back*" (C, Extract, 2.1, line 11). Similarly, when the patient withdrew in silence, the therapist offered reassurance by stating that she was not criticising her (C, Extract 1, line 13). Later in the sequence, the therapist performed a supportive disagreement (Weiste, 2015) bridging her and the patient's divergent perspectives (Case C, Extract 1, lines 15-17). Therapists thus responded to anger by reminding patients of moments in treatment when there had been an alignment between the therapist and patient perspectives.

Naming anger towards the therapist in the here and now

There was one example of the therapist naming the young person's anger towards her (Case D, Extract 2.2, line 57). The therapist here did not contextualise the patient's angry feeling as an internal response transferred to the therapist and originating from past experiences. She named the emotion as arising in the present and in the context of the relationship between them. The therapist's naming action acknowledged the patient's experience of anger whilst one may say that such a formulation addressed the patient's dissatisfaction with the therapist and made space

for that to be discussed as belonging to the relationship rather than to the patient. The lexical choice “annoyed” is perhaps a meaningful one as a passive verb that acknowledges the presence of another person who has acted or done something to annoy.

With these themes in mind, I shall turn now to discussing my findings in relation to the literature on anger.

Chapter 6: Discussion

The aim of this research project has been to identify patterns in therapeutic conversations surrounding patients' anger towards the therapist, and to describe how anger affected the therapist and how therapists responded to patients' anger. This chapter will offer a discussion of my findings in relation to the existing literature, whilst evaluating the implications of these findings both for clinical practice and for future research.

Before discussing the results derived from the extracts selected, I wish to reflect on the rather restricted expressions of anger in this dataset. As shown in the methodology chapter, the therapy sessions selected for this study through the use of the APQ-rating system scored 7 and 8, and never 9 on the items describing negative feelings like anger. One could interpret that these items did not characterise sessions to such a degree as to be given the score 9, indicating that anger was either of mild or moderate degree or that it was short-lived in the sessions. In our data, anger did not feature in extreme ways, for example resulting in the discontinuation of a session, and overall expressions of anger felt of moderate intensity. As shown in the data analysis, young people expressed a lot of hesitation in their attempts to express anger, and similarly therapists hesitated when responding to angry patients. This observation is in line with studies documenting the difficulty of patients to disclose negative feelings towards their therapists (O'Keeffe, 2020, 2019; Viklund et al., 2010; Farber & Hall, 2002; Paulson et al., 2001). Farber and Hall (2002) have also reported long periods before patients develop the confidence to express their anger to their therapist. In this study, all the identified moments of anger were from the middle or final stages of treatment. Whilst anger may be seen as triggered by the upcoming ending, another interpretation could be that patients expressed anger only once a therapeutic relationship was long-established. These initial observations are particularly striking when taking into consideration the high level of irritability that these patients presented with (Stapley, Midgley & Target, 2016). It is a question why such irritability did not become

manifest with the same strength in sessions and within the therapeutic relationship. Was anger contained and well-managed or did anger remain latent and unexpressed?

One wonders whether the experience of participating in a research trial and sessions being audio-recorded were factors that limited both young people's freedom to express negative emotions and therapists' responses. Therapists' responses to anger may have also been affected by implicit pressures to prevent research attrition and to achieve good outcomes for STPP. The fact that the study figured in therapists' minds was evident in at least one case in our dataset where the therapist referred to the trial as the reason for ending treatment. Finally, Safran and Muran (2000) mention some professionals' critique of manualised treatments and manuals "artificially constraining the clinical practice of therapists" (p. 3).

The use of CA in this study offered an opportunity to study both the patient and therapist contributions in the way anger featured and functioned within the patient-therapist exchanges in STPP. To summarise the findings of this study, patients expressed anger when they did not feel understood or listened to by their therapists, when therapists pursued their therapeutic agenda despite patients' disagreement, when they had felt disappointed for expectations not met, and when they felt sensitive to their therapists' interpretations. By expressing anger, patients claimed power and control, asked for clarification, and elicited the therapists' curiosity and active interest. We have seen that therapists produced their conversational turns accordingly by attempting to convince patients of the usefulness of their interventions, providing explanations or asking questions. Specifically, the CA analysis identified six significant types of response that therapists produced following patients' anger-expressions. Therapists a. showed increased affect, b. used avoiding and distancing strategies (possibly unconsciously), c. employed their epistemic authority to support the points they were making, d. attempted to re-establish a positive therapeutic alliance, e. explored patients' anger by asking questions, and f. named the patient's anger.

Strikingly, anger appeared to evoke powerful emotions in therapists, leading them to take a more active stance. At the same time, even though therapists attempted to explore patients' anger in their interpretations, when anger became lived in the consulting room therapists sought some distance from it, as seen in their conversational actions. One wonders whether anger expressions, even when of moderate intensity, evoked a sense of danger and often affected the therapists' neutral stance. This is in line with the literature on emotional contagion, stating that anger in interaction evokes a similar angry response or a complementary fear-state (Harrison *et al*., 2013 cited in Garfinkel *et al.* 2016).

The literature has highlighted the problematic nature of anger in the therapeutic relationship and the negative consequences it can have in terms of ruptures and increase in risk (Winnicott, 1969; Epstein, 1984; Nason, 1985). Did the STPP model render the exploration of anger an even riskier task? In contrast to open-ended psychoanalytic treatments, it is a question how able therapists felt to deepen, explore and at the same time contain anger in the face of an impending treatment ending. In that regard, distancing could be seen as a much-needed and even attuned approach in preventing negative emotions from becoming too intensified. Meltzer (1976) discussed the importance of modulating the "temperature" and "distance" of psychoanalytic interventions and he wrote, "*we can also modify the distance by not addressing the part [of the patient] concerned in our formulation at all, but rather talking about that part to another or by ruminating aloud in the presence of the patient leaving it to his choice to listen or ignore*" (p. 378) (emphasis mine). By placing emphasis on moments of alignment and agreement, therapists seemed to appeal to a part of the patient that had perceived the therapist as helpful. This indicates therapists' alertness to episodes of increased emotionality that could risk the continuation of treatment.

On the other hand, therapists' distancing responses to young people's anger could be seen as a shutting down of the dialogue on the young people's expressed needs, whilst in such moments,

therapists often did not appear to monitor the state of the therapeutic relationship in the here-and-now, including patients' reasons for being angry with them. This is perhaps a surprising finding as the taking up of negative emotions, referred to as the negative transference, is a core aspect of psychoanalytic technique and is emphasised in the STPP treatment manual. The literature has highlighted that patients' anger is associated with seeking closeness (Daldin, 1992), anxiety at separation and fear of abandonment (Pollak, 1992; Stein, 1996), as well as with patients' epistemic primacy being breached. Additionally, in the IMPACT study, patients had been randomised to one of the three treatments and therefore they might have had additional reasons for feeling dissatisfied or out-of-control in terms of their therapy; for instance, possible resentment for what had possibly not been achieved in treatment, dissatisfaction with the format of sessions or preference for a different therapeutic modality. Such factors were not highlighted in the therapeutic conversations selected in this dataset, whilst therapists often laid emphasis on patients' angry actions, and less so on the underlying reasons causing patients frustration or anxiety. It is a question whether therapists avoided anger when they felt surprised by it or when their understanding of it was different to that of the patient.

Although the STPP manual states that the appearance of realistic feelings of anger is an important step in the recovery process (Catty, 2016, p. 11), in this dataset therapists interpreted patients' anger mostly as an attacking or potentially destructive tendency. Whilst we cannot know of therapists' countertransference feelings that perhaps led to those interpretations, nor what had transpired earlier in treatment, it was striking that anger was not interpreted as a claim for change, a sign of improving health, a way of communicating one's needs or developing potency and independence. This is intriguing if we also consider that the predominant task of adolescence is to achieve individuation, which is often mediated by denigration and anger towards adult figures. One then wonders what was the total situation (Joseph, 1985) enacted in

moments of anger and what we can learn about the function of anger from both the therapists' and patients' reactions in those specific moments. It was felt in the analysis of this data that when therapists predominantly linked patients' anger to their past experiences, this took away from the opportunity to explore with them what was evident in the dynamics of the here-and-now interaction as "total transference" (Jackson, 1998).

It is possible to interpret anger from a psychanalytic point of view as being linked to an increased sense of guilt and anxiety which by extension interferes with the development of agency and a robust sense of self. The interpretation of anger might therefore be seen as crucial in the therapy. Two of the therapists in the dataset of this study seemed to be making some preliminary attempts to make such an interpretation. For example, in Case B the therapist comments on the patient being worried of expressing his anger to her out of fear that she would not be able to deal with it. Similarly, the therapist in Case D comments that the patient's teacher may have felt attacked by the patient's provocative essay. However, it is a question how comprehensible such interpretations were for young people. Did patients understand their usefulness and purpose, or did they feel criticised and blamed, experiencing the therapist as taking a moral position? In this study, we encountered moments when patients seemed confused. For instance, the patient in Case D asked "why" and protested further towards the therapist that his essay was not a personal attack on his teacher. Could it be possible that interpretations focusing on young people's aggression if offered prematurely may discourage the expression of anger rather than help unravel it further? This raises questions about what we can learn about addressing anger in time-limited work and what the prerequisites are in a therapeutic relationship before anger can be safely expressed and explored in the here-and-now without the risk of unrepairable ruptures or impasses. Rosenfeld (1987, p. 152) warns that therapists can become "too entrenched in a negative counter-transference" and often interpret in ways that patients can find humiliating, belittling and infantalising. He writes (ibid, p. 269)

in relation to a clinical example of impasse that "it was extremely important for the analyst to change the picture *she* had of the patient in *her* own mind", emphasising that psychoanalysis is an interaction between two people.

It follows that the therapist may be both a transference object and a new object in the service of development and change. Indeed, in this study, following the patients' expression of anger, therapists rectified their understanding of the patient, became more inquisitive, softened their tone of voice and lexical choices, and acknowledged the patient's divergent perspective alongside their own. Whilst one could argue that this indicates the degree of patients' control of their therapists, another perspective could be that patients' anger brought up change in the therapists' approach, indicating an ability in patients to elicit care, to make their needs known and attended to. Did the expression of anger also indicate the existence of faith in young people that they could be understood? It was an interesting finding that despite the episodes of anger and disagreement shown in this study, three out of four cases analysed here completed their treatment.

Anger-expressions in this study brought up the issue of power, in particular anger expressed around who holds the power to know about patients' experience in treatment, and anger as an attempt to assert control and power when one feels small, fragile or not understanding something. In writing about the differences between grievance and complaint, Weintrobe (2004) discusses the issue of lively, healthy entitlement seen in complaints as opposed to entitlement to an omnipotent position of power seen in grievance. Healthy entitlement pertains to being loved and respected, to have freedom of thought, to have one's differences respected and to have ownership of one's body. She writes that power as a key aspect of relationships has little presence in psychoanalytic writing, although it is implicit in many psychoanalysts' thinking (ibid, p. 92). Whilst Viklund et. al (2010) already showed that patients treat therapists as experts, which increases their difficulty in expressing complaints, the issue of power and

entitlement is perhaps even more critical in the treatment of child and adolescent patients where there is an inherent age and seniority difference between patient and therapist. Is there scope then for complaints to be seen not just as an expression of the transference but as a need of the patient to understand how their treatment works or what the general goals are in treatment? Mackay and colleagues (1998) emphasised the importance of task agreement when working with patients' anger. In addition, Safran and Muran (2000, p. 108) are interested in the use of metacommunication to work through ruptures or complaints, namely the stepping outside of the relational cycle that is enacted and treating it as a focus of collaborative exploration.

Whilst interpretation is a central component of psychoanalytic technique, many psychoanalysts have acknowledged that therapeutic process and change lies in the affective interactions between patients and therapists, and in the learning that occurs from an intersubjective experience of emotions. This dates back to the theory of the container-contained whereby Bion (1962) saw projective identification not just as an evacuation of unwanted intrapsychic material but a communication of such internal states to another object. More contemporary theorists have supported the view that therapeutic change occurs as a result of mutual recognition and regulation of affect (Tronick et al., 1998) which modifies the patients' implicit relational knowing (Stern et al, 1998), namely patients' expectations in relating with others.

The CA analysis in this study showed that therapists participated passionately in debates, became fixated on their divergent views as facts as much as patients did, and used their epistemic authority in a persuasive way. In other words, therapists seemed to have embodied the patients' angry feelings and mirrored the patients' emotional state and expression in striking ways. Whilst traditionally we would understand such enactments as a failure of the therapist to contain and reflect on the patient's unconscious communications, one wonders whether this degree of emotional connectedness, which seems to happen unconsciously, is a key element of the therapeutic process. One wonders whether anything can be learnt from the here-and-now

experience without a degree of enactment by both participants. In fact, patients' anger led therapists to actively participate, to expose their vulnerable parts and to become the voice of anger in the room. What do patients learn when they seek to witness these states in their therapists? In writing about therapists' "failures" and patients' corresponding anger, Winnicott (1969/1989) states, "*These failures produce anger, and this has value because the anger brings the past into the present. At the time of the initial failure (or relative failure) the baby's ego-organisation was not organised sufficiently for so complex a matter as anger about a specific matter*" (p. 257). Winnicott (1968/ 1987) also writes elsewhere:

"*The baby does not know about the communication except from the effects of failure of reliability. This is where the difference comes in between mechanical perfection and human love. Human beings fail and fail: and in the course of ordinary care a mother is all the time mending her failures. These relative failures with immediate remedy undoubtedly add up eventually to a communication, so that the baby comes to know about success. […] As analysts we know about this because we are all the time failing, and we expect and get anger. If we survive we get used. It is the innumerable failures followed by the sort of care that mends that build up into a communication of love, of the fact that there is a human being there who cares. Where failure is not mended within the requisite time, seconds, minutes, hours, then we use the term deprivation.*" (p. 98)

Symington (2007) proposes an understanding of psychotherapeutic process as a particular use and application of communication involving two people and he argues that the predominant request of a patient is to be understood by another. Tronick (1998) compared the therapeutic relationship to the mother-infant interaction stating that both participants are active members of an affective dyadic state in a process of mutual regulation and "*each participant must "come to know" the current state of the other if the regulation is to succeed*" (p. 294). Such states of intersubjectivity have been called by Stern (2004) a "mutual penetration of minds" (p. 74),

namely the ability to experience what the other is experiencing. From this perspective, the psychoanalytic process creates a particular condition where patients come to know their mind through that of another. Peräkylä (2008) calls such states a "communion of minds" (p. 115) in contradistinction to "divergence of minds" when therapist and patient are not aligned. What was interesting in this study's findings was that in moments of anger and disagreement, despite the misalignment on an explicit level of verbal communication or interpretation, on a procedural and non-verbal level therapist and patient were indeed in a state of communion, as explicated by their mirroring of one another, the synchrony in their turns and the pitch of their tone of voice.

These contributions emphasise emotion as belonging to the relationship rather than one participant and invite for a more open discussion on how these affective states are co-constructed. Whilst therapists' clinical notes and interviews with therapists shed light to therapists' subjective experience and their clinical choices based on counter-transference, the contribution of analysis of naturally-occurring data is offering us a language to describe step-by-step and in detail how such processes are being realised. One may argue that some of these processes do not come to either the therapist's or patient's awareness and therefore without the contribution of pragmatic research methodologies a great amount of learning is missed (see Creaser, 2015).

Implication for clinical practice and research

I am hoping that this project has made a double contribution, both to clinical and research practices. Clinical practice can only be enriched by an external perspective, a "third" through which an honest reflection on the therapeutic relationship is possible. Through the examination of exact and rigorous data, this study has attempted to describe the therapists' conscious and unconscious responses to young people's anger and has raised questions about the function of

anger in the context of the therapeutic relationship. In so doing, this study has emphasised the difficulty of making judgements and by extension interpretations when sometimes so little is known about the nature of emotion. Anger in particular poses additional pressures for psychoanalytic psychotherapists who are aware of the importance of integrating negative feelings; yet their powerful repercussions make the clinical exploration of those a risky ground that can so easily lead patients to experience dissatisfaction, dropout or rupture of the therapeutic relationship. Knowing how much patients struggle to express dissatisfaction to their therapists, I am hoping that this study as well as further studies can clarify the various functions of anger in the consulting room, possibly inform technique and help therapists be aware of factors that often affect the therapeutic alliance. Whilst the STPP treatment manual refers to the management of aggression in different stages of treatment, more space needs to be given to understanding when negative emotions are indicators of change and when they express a resistance to recovery. In addition, perhaps research methodologies using naturally-occurring data can be incorporated in core parts of the clinical training to offer triangulation and to highlight the subjective and intersubjective aspects of clinical work.

From a research point of view, this project is adding to those studies that have offered a window to a particular type of conversation occurring within a psychoanalytic model of treatment. The contribution of a psychoanalytic perspective may hopefully create new terrains of inquiry and enrich the repertoire of phenomena that CA studies. Peräkylä (2008) discusses the importance of CA engaging with "professional stocks of interactional knowledge" (p. 100), namely notions describing professional interactions. The understanding of the specific professional processes not only offers a better understanding of the context in which conversations occur but enriches the range of meanings CA researchers attribute to conversational patterns. Descriptive methodologies such as CA can only be complemented by interpretative perspectives such is the psychoanalytic approach and vice versa. Last but not least, institutional settings such as the

one of psychoanalytic psychotherapy offer a great opportunity for the systematic study of affect and emotion in action, not only in terms of its organisation and display but also its impact on organisational tasks.

Limitations

This study examined extracts from four psychotherapy sessions in which four different clinicians and young people participated. This is a very small sample and therefore the results of the study cannot be generalised to the wider population. However, the small sample and the design of this study offered the unique advantage of a detailed exploration of anger in these specific therapeutic conversations. The use of naturally-occurring data was an opportunity to study therapeutic exchanges as those happened and not as they were reported.

Conversational patterns were studied in four different therapist-patient dyads, with the benefits of acquiring a varied view on therapists' responses, while the study analysed therapists' immediate responses to anger, namely responses in the moment and within one therapist conversational turn. Therefore, our dataset was inevitably compromised as to the broader understanding of the meaning of anger for each particular patient-therapist dyad, to the way conversations around anger developed over time or the different ways anger may have been addressed at earlier or later stages in treatment.

The study undertook no comparisons between different patients of the same therapists to explore whether therapists are prone to similar responses or whether their responses differ according to the young people they work with. We also did not systematically analyse which specific anger-expressions may evoke specific types of responses in therapists. For example, it is likely that therapists respond differently to a withdrawing patient compared to a patient whose anger is explicitly manifest. Thus, a limitation of this study is that we know very little about the underlying reasons for therapists' responses, and we have a limited understanding as

to whether their responses were spontaneous and even partly unconscious, or whether they were informed by what happened in earlier stages in treatment.

It is important to consider that these sessions derived from STPP treatment where the timeframe of the work is specific and set from the start, as opposed to open-ended psychoanalytic treatments. Expressions of anger and therapists' responses might differ in longer-term or open-ended work where the ending is not in view from the onset of treatment. Therefore, the findings of this study can be meaningful for other psychoanalytic treatments only with caution.

This study relied on audio-data therefore a range of bodily movements and gestures was inevitably missed, leaving us with a partial picture of what happened in the consulting room. This is important if we consider that emotion is expressed not only verbally but also as an embodied experience. It is possible that therapists understood and interpreted the young people's communications based on their observation and experience of physically being with them in the consulting room. The researcher's point of view would have inevitably missed such non-verbal expressions due to the fact that we mostly had access to the verbal exchanges of the therapeutic interaction. Moreover, it is a question whether the fact that sessions were being audio-recorded affected the participants' freedom and therefore somewhat compromised the value of the recordings as naturally-occurring data.

Finally, culture and language both need to be taken into consideration. This study's data represent sessions that took place in the United Kingdom and in the English language and culture. The way anger was expressed and managed in sessions here may not represent emotional stances and expressions of anger in other cultures or languages. In addition, I was aware of my personal cultural background which inevitably was part of the specific cultural and psychosocial context in which anger was understood in this study.

Further research

Whilst it was beyond the scope of this study to look into the details of the attendance patterns or the treatment outcomes of the selected patients, it would be of clinical interest for future research to understand whether young people who more openly expressed anger to their therapists showed better treatment outcomes compared to those who continued to present as withdrawn or those that dropped out of treatment prematurely.

This study has focused on the detail of conversation patterns immediately after anger has been expressed. Different study designs and different methodologies could shed light on participants' experience of anger, the broader meaning anger has in different treatments, or how conversations around anger evolve over time. In addition, whilst this study offered a range of examples from different patient-therapist dyads, a single-case study design would have enabled one to follow shifts within the therapeutic relationship of the same therapist-patient dyad. Finally, future studies using CA and naturally-occurring data may benefit from including therapist or patient interviews to triangulate the CA findings.

Conclusion

This was a qualitative study of secondary data which used the CA methodology to identify therapists' immediate responses to adolescent patients' anger in STPP. The study identified six significant types of response most of which figured in all four cases studied. The therapists responded in highly emotion-laden ways, they took distance from addressing anger in the here-and-now interaction, they used their epistemic authority to support their point of view, they asked questions around patients' anger and gave attention to moments of agreement. In one case, a therapist named the patient's annoyance and anger towards her, whilst in three cases latent feelings of anger were named but evaded when those became explicit in the therapeutic interaction.

Although this study looked into psychoanalytic clinical work where the up-taking and addressing of negative emotion towards the therapist holds a central place, this study's findings indicated that expressions of anger can be seen as brief moments of intensified emotion which affect the therapist's reflective stance and neutrality. Whilst in moments of anger patient and therapist are misaligned in terms of their views and opinions, the CA findings indicated that emotional alignment on a non-verbal, procedural level seems to be at play.

The study has highlighted the clinical implications of the handling of negative emotions in STPP and offered insight into how pragmatic research methodologies can inform the work of psychoanalytic psychotherapists. From a CA perspective, the study has analysed the co-construction of the emotion of anger within therapeutic conversations, as well as its immediate impact on the institutional tasks of psychoanalytic treatment.

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Appendix

Appendix 1- Sampling process

APQ Items	**1** YP expresses, verbally or non-verbally negative feelings towards therapist	**10** YP displays feelings of irritability	**14** YP does not feel understood by the therapist	**20** YP is provocative, tests limits of therapy relationship	**36** Therapist openly reflects on 'mistakes', misunderstandings or misattunements that have taken place in the relationship with the YP
109	7	8	4	5	7
104		7	4	4	
136		7	3	1	
156		7	3	4	
171		7	6	5	
125	6	4	7	7	
158	6	7	8	7	
172	6	1	6	6	
243	6	6	7	6	
112		6	6	4	7
116		6	6	4	
122		6	2	4	
252		6	2	3	
260		6	4	4	
315		6	1	2	
176		1	4	6	6
177		2	6	6	7
311		3	1	3	6

Appendix 1. Session ratings for the selected APQ items

Appendix 2- Session Summaries in two-minute intervals

Case A- Session 26
Duration 40:16
Female therapist
Female patient

Time intervals	Summary of what happens	Researcher's comments/ reflective thoughts
2 min	Therapist (T) gives code of session. Leaves room to pick up YP. Patient apologises for not having come last week due to not feeling well. T asks what happened. T states that YP's mother had left a message to cancel. Patient shares that she was too embarrassed to call herself.	
4 min	T curious about attendance pattern and links recent missed sessions to the ending of treatment. YP thinks her attendance was better before only because she went to school. YP says that the problems she used to have don't exist anymore, "so what's the point?" YP says she just makes herself happy, not others. T links attendance drop (since Session 20) to end of treatment. Patient offers that "there is nothing to talk about".	YP disagrees twice with view of the therapist YP presents reason for dropout the fact that 1. things have improved 2. there is nothing to talk about T persists with her view that YP has stopped coming after the end of treatment was announced
6 min	YP expresses tiredness. T addresses tiredness as linked to the ending. T links the ending to the patient leaving session early or not turning up. T comments on her holiday and having 3 more sessions in September. YP says she doesn't think she needs to come back. YP does not feel she has	

	problems anymore. T shares view that there are things to talk about.	
8 min	YP responds "yeah..I guess". Then expresses doubt about what T has said. YP expresses disagreement that there are problems. YP states that all her problems were linked to school. T states that it sounds "strange" that all problems have disappeared. T says it is strange that YP cannot remember. T says it is strange that YP may have pushed things away	T sounds irritated. Tone goes up when T says "it is strange" T repeats the word "strange" three times in relation to the YP's actions, thoughts
10 min	YP disagrees. She says she has such little problems. There is silence. T states that YP finds it hard to come to see her. YP states "no offense to you" but there is no point. T refers to past when sessions were helpful. T links again to the ending of treatment. T asks YP of she agrees with her that it is hard that therapy ends. YP agrees minimally. There seems to be a misunderstanding. YP says she would have liked to be in a different type of therapy. YP expresses that this type of therapy never helps. T makes a point about length of treatment. T states that other therapies on the project are shorter.	YP and T seem to misunderstand each other. T is rooted to believe that end of treatment is the main reason for YP's dissatisfaction. YP shifts to say that this therapy has not helped. T maintains a view that time is what the patient is preoccupied with.
12 min	YP shares that if she was in the 5th or 6th session she would have quit. T states that YP did not quit back then. T comments that YP is regressing to a state where it is hard to	The YP's statements have shifted from "there are no more problems" to "this therapy has not helped".

	acknowledge/ receive help. YP states disagreement “no, no” and adds that she cannot see how the current therapy helps. T talks about process of how therapy helps. YP states “yeah..I guess” and goes quiet. YP adds that she doesn’t know what to say.	T focuses on process of how therapy works rather than outcomes.
14 min	T wonders if YP is cross. T reflects on patterns in the therapy.	
16 min	T invites the YP to review the need for more sessions. YP says she doesn’t need more. T questions why. YP maintains that she does not feel down anymore, she just feels tired. YP disagrees that she is depressed. T talks about the fact that it is going to be difficult to give her anything.	T and YP seem to occupy polarised views.
18 min	YP says there is something to talk about but she doesn’t know how. T makes transference interpretation that T becomes a person in YP’s mind that she does not know how to open up to. YP begins to tell a story involving another girl who the YP has given a present to. T interrupts to say that she has heard about this before- does the patient remember?	
20 min	YP says that the girl ignored her although YP had caught her looking at her. YP says she felt “pissed off”. YP uses words expressing anger like “annoying”, “rude”.	

	T acknowledges that the girl's behaviour made YP angry. T wonders about rejection.	
22 min	YP says the girl's behaviour was "rude"/ "mean". T makes link between the girl being rude and the YP feeling that she "can't be bothered" or "feeling pissed off".	YP feels the need to repeat those a of something has not been heard enough
24 min	T makes a link between the girl's anger and the YP's anger towards therapist. YP cannot see the correlation.	Transference interpretation It seems that the point is not clear to YP
26 min	T comments that YP knocks everything down (what the T has given to the YP so far). YP retreats to "there's not much to talk about". T talks about YP's anger and feeling that she's been given nothing.	
28 min	T comments that YP is "knocking things off". YP states that there is genuinely not much anymore to talk about. YP responds to T's comment "I guess, she is mean though"	YP is trying to say perhaps that the girl "is mean though" as if to say that there is a difference between the girl and herself.
30 min	T asks "can you see that?" YP responds "not really". Silence. YP returns to talk about how rude the girl was. YP asks the question "Why would you do that?" Silence T comments that YP wants her to be angry with her. YP responds "not really". Tone goes up.	YP expresses disagreement explicitly. YP asks questions- could that be to involve the T and make her understand something that has not been understood? Silence indicates rupture ?
32 min	YP says that these are not similar scenarios! YP expresses disagreement.	T maintains the view that YP needs to reject due to ending

	YP says she can't see how the therapy helps, "I don't really…" T overlaps. T wonders why it is hard for YP to ask for more. YP expresses disagreement "I don't really think so", "there isn't anything to talk about". T talks about YP needing to reject.	There don't seem to be other points of understanding what is happening YP has stopped talking about incident with girl and has returned to "there's nothing to talk about" which indicates anger (as previously the patient was in fact talking about something preoccupying) YP's anger is not understood as relating to what is happening in the session Or this being the last session before holiday and therefore YP reassuring herself she can manage
34 min	YP says "no offense to you", "I am not depressed anymore" T responds by saying "you don't sound that you are fine" Patient yawns. YP talks about the girl having been mean before.	Does YP feel that the T is mean to her like R is ? Therapist-centred interpretation is not used in this session
36 min	Tone of voice in YP rises. T makes comment that it's a fight about who's going to be more mean (between YP and girl). YP disagrees with T "it's not a competition" YP adds, "Why would you treat somebody like that?" YP states "I don't think that's right!" YP sounds angry. T asks why the YP thinks the girl has behaved like that. YP states "because she is a bitch" "stupid" YP sighs out. T acknowledges that this has left YP in a difficult situation.	YP occupies the scene here. YP's tone increases. Rhetorical questions are direct ways of communicating anger to therapist?
38 min	YP says friends sided with her views. YP states "there's no point". YP	

	explains that the girl has knowingly treated her badly. “It shows the kind of person she is”	
40 min	T invites YP to think again in September about the future of therapy and what has happened between them in treatment YP surprised that it is the end of the session YP agrees to come in September and asks for text to be sent	

Appendix 3- CA transcription annotations

a. square brackets for overlapping talk	**[ ]**
b. equal signs for latching, namely the absence of any discernible silence between two turns	=
c. a period in parentheses for a micropause of less than two-tenths of a second	**(.)**
d. to indicate the respective durations of silence	**(0.2), (0.5), (0.7)**
e. a period to indicate falling intonation	**.**
f. a question mark to indicate strongly rising intonation	**?**
g. underlining to show stress or emphasis	**(i.e Wh<u>at</u>?)**
h. capital letters for especially loud talk	**WHAT**
i. arrows to indicate shifts in pitch	**↑ upward pitch** **↓ downward pitch**
j. a colon for sound stretching	**:**
k. less-than symbols for compressed/ rushed speech	> <
l. more-than symbols for slower speech	< >
m. the pound symbol for smiley voice	**£**
n. tremulous voice, signalling upset	**~**
o. double parentheses for transcriptionist's descriptions	**(( ))**

p. single parenthesis for transcriptionist's comments on unclear speech	**( )**

Appendix 4- Transcripts

Case A - Extract 2- Min 30-32

T: Perhaps you want me to be annoyed with you:: as well (.) ((you said)) last week you asked your mum to call that you can also get ((ba:d))

YP: ↑Not really:: I don't think you'd be anno:yed just ↓ (0.5) don't kno:w

(3.0)

T: What did you [think]

YP: [I just don't think] >I just don't think I just don't think< they're similar scenarios at all ↓ I just don't see >I just don't see< (.) I just don't see how they relate at all (.) ↓really

(3.0)

T: (but) it relate in a very kind of simple way that it's you it's about you isn't it that's what we are talking abo::ut we are talking about the side of you that we said can be kind and give things but the >other <side of you that can be me:an but mean in a particular ↑way I think (.) mean to me:: in terms of (0.2) because the research is coming to an end and <there> is no ↑sessions for you (0.7) and because of that you are saying like (.) you can knock everything down that has been achieved befo:re (and) saying it's been nothing . (1.0) do you ↑see that

(2.0)

YP: ↓Yeah I guess but I just don't see how (0.7) ↑ how it's helped I just (0.2) don't see it really: I just #don't ↓(0.7) [I just don't really? ((quieter, tone sounds sad))

T: [I WONDER] WHy whether it's so much more difficult for you to say that you do need more sessions because I I really think you do:: (0.2) I think this was a short intervention for you I think you have .hhh (0.7) things to talk abo::ut and to explo::re ((softer tone)) and I think you need more ti:me (0.5) but it is very difficult for you to kind of acknowledge that in which case then we would kind of think a little bit about that about how to ↑do that how to finish this as I said then ((begin)) and then do [something else]

YP: [no no I don't] no I don't really think so I don't think there's anything to talk [about]

T: [mm] ((showing understanding))

(5.0)

T: But you are kind of ↑conti::nuing as if (.) I I haven't haven't quite understood something about .hhh this kind of being able to reject ↓being able to be ↓in charge or reject somebody is err very impo:rtant ((somehow/sometimes))

(2.0)

YP: [(erhm)]

T: [‘CAUSE] being in the receiving end is not nice ((softer empathetic tone))

YP: [unclear]

T: [a bit like] with Maria

(2.0)

YP: I mea- I mean (.) no offense to you but I just think that someone could use the I just think that someone could be sat in here and could be using the time more [wisely]

T: [mm]

YP: (.) so .

T: why can’t it be you:: =

YP: =↑ coz I don’t ne:ed it I just (.) nothing to talk about (.) so (0.2) ↓ I am not depressed anymore so .

(20.0)

T: D’ you think I agree with that (?)

YP: Well probably

(1.0)

T: You think I agr<u>ee</u> that you are not depressed (?) and you are fine ↓ ((fades off) =

YP: .hh Yeah (well) I do ↑ I don’t know to be honesт