

Chair and Couch Discourse: A Study of Visual Copresence in Psychoanalysis

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In traditional psychoanalysis, patients recline on a couch in a way that prevents patients and analysts from seeing each other's faces. This has been argued to have significant effects, both positive and negative, on patients' treatment. The use of the couch creates an unusual communicative situation in which both parties are physically but not visually copresent. This study examines the content and form of discourse in 10 audiorecorded psychoanalytic treatments during which the same patient and analyst were (on different occasions) seated face-to-face and not, with the patient on the couch. Content was coded using Pennebaker and Francis's Linguistic Inquiry and Word Count program and Bucci's Computerized Referential Activity program. Disfluencies, silences, back channels ("uh-huh"), and other discourse features were also coded. The major finding is that analysts spoke significantly less when patients were on the couch. Despite some other differences in discourse form and content, what is most apparent is how strikingly similar couch and chair discourse were, contrary to what some psychoanalytic views would predict.

In psychoanalysis, patients traditionally recline on a couch while their analysts sit behind them, out of their sight. Patients reclining on the couch have restricted

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views of analysts, particularly of their facial expressions. Although the position of the analyst's chair can vary, a classic position has the analyst's chair directly behind the couch, severely limiting if not completely blocking the analyst's view of the patient's face. As such, the psychoanalytic situation involves a specific form of partial visual copresence (see Clark, 1996; Clark & Brennan, 1991; Whittaker, 2003) in which both analyst and patient share a view of the physical environment while lacking mutual access to each other.

In contemporary psychoanalytic treatments involving use of the couch, which is argued to have all sorts of therapeutic effects, the period of time on the couch (frequently years) is usually preceded by a shorter period when analyst and patient meet face-to-face, sharing full visual copresence. These different seating arrangements allow for an examination of how the two different kinds of visual copresence found in psychoanalysis affect discourse within pairs of interlocutors. Such an examination also offers the opportunity to contribute to debates about the effects of the couch in the psychoanalytic community.

In this study we examined differences in the content and form of discourse in 10 audiorecorded psychoanalytic treatments when the same patient and analyst were, on different occasions, seated face-to-face and not (i.e., the patient was on the couch). We first review psychoanalytic arguments about the effects of the couch, then we discuss what previous discourse research on visual copresence and mediated communication predicts should be the differences between chair and couch talk. As the data analyses show, there are fewer differences between chair and couch psychoanalytic discourse than various psychoanalytic views would predict.

PSYCHOANALYTIC DIALOGUE

Conversation in psychoanalysis takes a quite particular form, because the participants' goals and roles are quite particular. Regardless of an analyst's theoretical and technical leanings, a primary goal of psychoanalytic conversation is the careful exploration of patients' thoughts, feelings, and beliefs. To that end, both the analyst and the patient have particular roles to play. The patient's role in the treatment is to speak as freely as he or she can about all aspects of his or her experience and life history without regard to usual social constraints. The analyst's role is radically different. Although there are a variety of theoretical frameworks and technical prescriptions for the analyst's role, they all share a disciplined, focused attention on the patient's story and needs. Patients are expected to be relatively self-revelatory; analysts generally are expected to be significantly more restrained than patients. Also, the psychoanalytic situation privileges reflection and patience, tolerating intervals of silence more than the 1 s that has been proposed as tolerable in everyday conversation (Jefferson, 1989).

Obviously these distinct features of psychoanalytic discourse can be expected to affect the participants' communication; we know that interlocutors' goals, and their beliefs about each other's goals, affect basic conversational processes (see, e.g., Bateson, 1955/1972; Clark, 1996; Grice, 1975, 1987; Levinson, 1979, 1981; Russell & Schober, 1999; Wittgenstein, 1958, among many others). Psychoanalysis can be considered an example of an institutional setting with prescribed communicative modes and specific explicit aims (see Drew, 1999). Different institutional settings such as workplace meetings, media interviews, court appearances, police interrogations, and doctor's visits (e.g., Atkinson & Heritage, 1984; Clayman & Heritage, 2002; Drew & Heritage, 1992; Fisher & Todd, 1993; Levi & Walker, 1990; Peräkylä, 1995; Shuy, 1998) have been shown to affect details of language use in different ways (see Drew & Sorjonen, 1997). For example, police interrogators, unlike employment interviewers or journalists, avoid open-ended forms of questions; compared to other types of interviewers, they are also more likely to challenge individuals with tag questions such as "You were there, weren't you?" (Shuy, 1998), which can lead to terrible outcomes (Loftus, 2002, 2003; Loftus & Ketcham, 1991, 1994).

Despite the special character of psychoanalytic dialogue, the unique goals and roles in psychoanalysis are present in both chair and couch sessions. Our question is whether, above and beyond the institutional constraints common to chair and couch sessions, there is any evidence for effects of the nature of visual copresence on the discourse.

PSYCHOANALYTIC VIEWS ON USE OF THE COUCH

The use of the couch in psychoanalytic treatment was first advocated by the founder of psychoanalysis, Sigmund Freud. Before discussing theoretical considerations, he wrote: "The first is a personal motive, but one which others may share with me. I cannot put up with being stared at by other people for eight hours a day (or more)" (Freud, 1913, p. 126). From that time to the present, the couch has received much attention in the psychoanalytic literature.

A dominant view in the literature is that using the couch leads to expectable changes both in patients' mental functioning and in the observed psychoanalytic process. This view is hardly unanimous, as many analysts do not privilege the couch (e.g., Aruffo, 1995; Gill, 1994; Sabbadini, 1989; Wolf, 1995). However, for those who do, there are many (sometimes contradictory) theories about specific effects of use of the couch, some positive, others negative. The contradictions reflect the theoretical pluralism in contemporary psychoanalysis that has arisen from recent philosophical, scientific, and cultural movements (Aron, 1991; Cooper, 1987; Kantrowitz, 1993). This pluralism has resulted in a number of different schools of psychoanalytic thought.

One prominent idea is that the couch fosters what has been called an “internal mode of functioning” that is contrasted with a more “interpersonal mode” in face-to-face chair sessions (e.g., Freud, 1913; Goldberger, 1995; Greenson, 1965; Rapaport, 1958). The idea is that the couch restricts attention to external stimuli, including, importantly, visual access to the analyst. It therefore facilitates patients’ increased attention to their own thoughts, feelings, and fantasies and decreased attention to the interpersonal field. This effect generally is held to be positive by proponents of the use of the couch, who can be characterized as adhering to more traditional or “classical” psychoanalytic theories, such as Freudian and neo-Freudian perspectives. Psychoanalysts who oppose this view tend to emphasize the interactivity of psychoanalytic treatment, the mutual impact of patient and analyst on what is observed in the consulting room, regardless of the use of the couch (e.g., Aruffo, 1995; Gill, 1988, 1994; Kovar, 1994). In contrast to classical theories, this view is characteristic of theoretical orientations that fall under the category of “relational” psychoanalytic theories.

Another view proposed by some psychoanalysts is that the couch induces a regressed mode of psychic organization (e.g., Grotstein, 1995; Lewin, 1954, 1955; Richards, 1985). The basic idea is that as the position on the couch resembles the sleep position, the couch induces preverbal and prelogical thought, allowing access to patients’ earlier, infantile experience. Other psychoanalysts disagree with an emphasis on the infantile during couch sessions (e.g., Gill, 1994; Lachmann & Lichtenberg, 1992; Mayes & Spence, 1994). For example, Lachmann and Lichtenberg suggested that regressive phenomena on the couch need not be seen as replicas of earlier childhood experience but rather as interactively constructed by patient and analyst to facilitate understanding and further exploration.

An example of a proposed negative effect is the idea that the couch induces a reduced sense of responsibility (Shapiro, 1989). This theory is based on the idea that the lack of visual contact on the couch leads to a diminished sense of personal connection. Though patients’ lack of visual access to analysts is believed to reduce patients’ shame, thereby helping them to speak more freely, it is also thought to have the undesired effect of reducing patients’ sense of ownership for their utterances.

DISCOURSE PERSPECTIVES ON USE OF THE CHAIR AND THE COUCH

The various psychoanalytic views of the couch, including those that do not privilege its use, are based on clinical observation informed by different, and often competing, psychoanalytic theories. There has been virtually no empirical investigation of whether couch use within the psychoanalytic situation actually results in observable differences. In contrast, the empirical discourse literature contains a number of comparisons of language use in face-to-face and non-face-to-face situa-

tions (see next section) but none with the precise characteristics of the psychoanalytic couch situation. This study is an attempt to connect the psychoanalytic literature on use of the couch and the discourse literature, as the latter provides an opportunity to make testable predictions about language use. Applying the methods used in such studies to examine language use in the psychoanalytic situation may help us to understand how the two different kinds of visual copresence found in psychoanalysis affect discourse in this particular setting.

Certain psychoanalytic theories about the couch suggest specific patterns of both conversational content and discourse features that could be observed in chair and couch sessions. For example, consider the idea that the couch facilitates an “internal mode of functioning” characterized by increased attention to one’s own thoughts, feelings, and fantasies and decreased attention to the interpersonal field. In light of this view, not only should the couch lead patients to talk more about themselves and their own thoughts and feelings, it might also lead to a lower rate of discourse features that suggest attention to one’s conversational partner, such as back channels (“uh-huh,” “mm-hm”), and a higher rate of discourse features that can suggest internal focus, such as silences. This is not to assume that back channels always reflect attentiveness or that silences are always straightforward indicators of a speaker’s internal focus; consider the distracted “uh-huh” of the bored interlocutor who wants to end a conversation, or the meaningful silence that can follow a rude question. Clearly both phenomena are complex, potentially multifunctional, and interpersonally constructed (see, e.g., Jefferson, 1989; Schegloff, 1982, among many others). Nonetheless, it is not unreasonable to propose that internal and interpersonal focus could be reflected not only in speech content but also in these discourse cues.

Or consider the idea that the couch facilitates regression characterized by preverbal and prelogical thought. This theory idea might predict not only that patients are more silent on the couch but also that they produce greater rates of discourse features that suggest difficulty speaking (Fromkin, 1973, 1980; Goldman-Eisler, 1958; Levelt, 1989), such as repairs (“I had a dream that I was—I mean, you were ...”), restarts (“I had—I had a dream ...”), and fillers such as “um” and “uh.” Of course, repairs, restarts, and fillers can reflect multiple functions, including speakers’ lack of confidence or uncertainty about what they are saying (Brennan & Williams, 1995; Smith & Clark, 1993), the novelty of the information they are presenting (Fox Tree & Clark, 1997), and the information’s complexity or conceptual difficulty (Barr, 2003; Bortfeld, Leon, Bloom, Schober, & Brennan, 2001). Nonetheless, the inarticulateness and difficulty of putting ideas into words that characterizes all these functions is consistent with the possibility that patients on the couch function on a more “preverbal” level.

A view of the couch as inducing a reduced sense of responsibility for one’s utterances also might suggest changes in language use. In addition to possible decreases in content that reflects the speaker’s agency, an increase in the rate of

hedges (“like,” “maybe,” “sort of”) may be expected, because hedges can indicate a diminished sense of ownership for what one is saying (Lakoff, 1977).

WHAT DO FACIAL CUES BRING TO PSYCHOANALYTIC INTERACTION?

A major difference between chair and couch interactions in psychoanalysis is that facial and other bodily cues, such as facial expressions, head nods, gazes, and gestures, are unavailable to either party when the patient is on the couch (except in cases where the analyst’s chair is positioned so as to make all or some of the patient’s reclining body visible¹). It seems obvious that this should have effects on the discourse, but what exactly should the effects be? The extensive and sometimes contradictory literature (see Whittaker, 2003, for a review) comparing face-to-face with non-face-to-face communication (e.g., video-mediated, telephone, or e-mail conversation) allows some guesses, but no previous study approximates both the physical setup and the interlocutors’ tasks in psychoanalysis.

For example, what Whittaker (2003) called the bandwidth hypothesis, which proposes that communication will be less efficient when any communicative cues are unavailable, does not directly apply to the psychoanalytic situation. Clearly, there is a bandwidth difference between chair and couch sessions; couch sessions lack visual cues. More communicative channels might be expected to lead to more opportunities to establish common ground: the mutual knowledge, beliefs, and assumptions that are continually updated in communication (Clark, 1996; Clark & Brennan, 1991; Clark & Marshall, 1981; Krauss & Fussell, 1991). However, the bandwidth hypothesis and the studies testing it are aimed at situations of relatively straightforward information exchange, largely about physical objects: finding locations on maps, describing objects, or jointly carrying out a physical task such as repairing a bicycle or building a pump. Thus, for instance, findings suggesting that bodily cues do not affect conversational efficiency much at all (e.g., Anderson et al., 2000; Chapanis, Ochsman, Parrish, & Weeks, 1972; Chapanis, Parrish, Ochsman, & Weeks, 1977) except when speakers are coordinating their physical actions (e.g., Bly, 1988; Kraut, Miller, & Siegel, 1996; Whittaker, Geelhoed, & Robinson, 1993), may not be particularly informative: In psychoanalysis, efficiency of communication is not the point. Also, because in psychoanalysis physical objects in the environment are generally not referred to or jointly manipulated, it is difficult to directly apply findings from studies using referential communica-

¹One might imagine that in such situations both analyst and patient might, for example, speak less than if both could not see each other at all; an analyst who can see a patient’s face might not ask for the patient’s immediate reaction to what the analyst said, and the patient, knowing the analyst can see his or her facial expressions, might not express his or her reaction verbally.

tion tasks (e.g., Boyle, Anderson, & Newlands, 1994; Clark & Wilkes-Gibbs, 1986; Fussell, Kraut, & Siegel, 2000; Garrod & Anderson, 1987; Krauss & Weinheimer, 1966; Lockridge & Brennan, 2002; Schober, 1993, 1995). As Whittaker pointed out, findings for one sort of task cannot be assumed to generalize to another.

Other studies that at first seem relevant do not make sufficiently fine-grained distinctions about communication channels. For example, the findings that people interrupt each other less often and may pause less in audio-only conversation than in face-to-face conversation (Cook & Lalljee, 1972; Jaffe & Feldstein, 1970; Rutter & Stephenson, 1977; Williams, 1978) may or may not generalize to the psychoanalytic situation because they confound visual and physical copresence (Rutter, 1987; Rutter & Stephenson, 1979; Rutter, Stephenson, & Dewey, 1981). That is, unlike in the psychoanalytic setting, in these studies some of the audio-only interlocutors were in physically separate locations; others were separated by a physical barrier but in the same room, which is closer to the psychoanalytic setting but still a bit different.

Nonetheless, the previous discourse research does provide some hints about what is expectable in couch versus chair psychoanalytic discourse. First, across various conversational situations, people do not actually look at each other's faces all that much in conversation (Anderson, Bard, Sotillo, Doherty-Sneddon, & Newlands, 1997; Argyle, 1990; Whittaker, 2003); simultaneous gaze happens less than 5% of the time (Anderson et al., 1997), and looking at the other only happens from 3% to 7% of the time when there are other interesting things to look at (Argyle & Graham, 1977). These observations suggest that the impact of reduced access to facial cues may be slight, if there is any at all.

In terms of the role of gaze in conversation, numerous studies have examined its import in turn-taking, based largely on the theory that paralinguistic and nonverbal behaviors accompanying speech are important in allowing for the smooth transition from one speaker to another (e.g., Argyle, 1967; Duncan, 1973; Goodwin, 1981; Kendon, 1967). The results have been mixed. Some early studies found fewer interruptions and possibly fewer pauses in audio-only conversation than in face-to-face conversation (e.g., Cook & Lalljee, 1972; Jaffe & Feldstein, 1970; Rutter & Stephenson, 1977; Williams, 1978). In contrast, later mediated communication studies comparing audio-video, audio-only and face-to-face conversation (e.g., O'Conaill, Whittaker, & Wilbur, 1993; Sellen, 1992, 1995) found no differences between audio-video and audio-only conversations, though both differed from the face-to-face situation. Specifically, interlocutors had more trouble spontaneously changing turns and used more formal techniques for doing so in both audio-video and audio-only than in face-to-face situations. The predictions for the psychoanalytic situation from these studies are thus less than straightforward.

Second, there are studies that have aimed at disentangling physical copresence from full visual copresence (Kemp & Rutter, 1982; Rutter et al., 1981). Rutter et al.

examined 20-min conversations about sociopolitical issues (e.g., feminism, union management relations) in four conditions: (a) face-to-face (i.e., physical copresence and full visual copresence), (b) audio-only (i.e., no physical or visual copresence), (c) audio-video (i.e., full visual copresence with no physical copresence), and (d) physical barrier (i.e., physical copresence with no visual copresence). Although the conversational goals were different from those in psychoanalysis, the dialogues were more open-ended and less task-focused than in studies of information exchange. The finding was that there was little difference in the style of language use between the face-to-face condition and the physical barrier condition in which the interlocutors were physically but not visually copresent. This would suggest that there should be few differences between psychoanalytic dialogue in the chair and on the couch.

Third, studies that have focused more on the affective information provided by faces than on referring and information exchange may be particularly relevant to the psychoanalytic situation. Facial expressions allow speakers to monitor their partners for emotional reactions to what they say and to display a speaker's emotional stance to their own utterances (Whittaker, 2003). Lack of access to facial cues has been argued to lead to greater emotionality and "flaming" in e-mail (e.g., Sproull & Kiesler, 1986) but to reduced interpersonal focus in negotiation tasks (Morley & Stephenson, 1969, 1970; Stephenson, Ayling, & Rutter, 1976). As Whittaker summarized, the findings show that people are more likely to compromise when they converse face to face and less likely to reach consensus when they cannot see each other's faces, presumably because seeing each other's faces leads to greater focus on each other's emotional states. The idea is that there is a trade-off between attention paid to one's partner's emotions and focus on the task (which in negotiations can lead to less agreement). On the other hand, this may vary depending on the task; more intellectual judgment tasks do not seem to show the same trade-off (Hiltz, Johnson, & Turoff, 1986).

What does this predict about psychoanalytic dialogue on the couch and face to face? To the extent that psychoanalytic dialogue is like negotiation tasks studied in the laboratory, dialogue on the couch should be less interpersonally focused and more task focused, just as some psychoanalytic theorists propose. For example, in Stephenson et al. (1976), non-face-to-face negotiators referred to themselves less than face-to-face negotiators. The proposal is that non-face-to-face interactions are more formal and less spontaneous, which leads speakers to focus more on the task than on the people. Given that the task for the patient in psychoanalysis is to focus on the self, use of the couch should lead to greater self-focus; this should be reflected in greater use of first-person pronouns and fewer back channel signals of attention to the interlocutor. On the other hand, if psychoanalytic dialogue is more like laboratory judgment tasks, lack of access to visual cues should not make much of a difference in either the content or form of the discourse.

METHOD

Corpus

As the availability of audio-recorded psychoanalytic treatments is extremely limited, this corpus of 10 audio-recorded psychoanalytic treatments, which includes both chair and couch sessions, represents a unique research opportunity. The recordings were gathered from three sources of audio-recorded psychoanalyses: (a) the archive of Lester Luborsky, University of Pennsylvania Medical Center, Center for Psychotherapy Research; (b) the archive of Sherwood Waldron, Psychoanalytic Research Consortium; and (c) the archive of Hartvig Dahl, Downstate Medical Center, which includes the case of Mrs. C, a completed analysis that has been widely studied in the psychoanalytic community. The treatments used in this study were chosen on the basis of availability given the required constellation of events: It had to be clear, from recorded dialogue, (a) that the patient was initially seated and (b) precisely when the transition to the couch occurred. In all couch sessions, analysts and patients lacked full visual access to each other, but unfortunately it is unknown exactly what was in analysts' and patients' visual fields.

Confidentiality requirements limit the amount of information that can be revealed about the treatments included in this study, both to insure the anonymity of the individuals involved in treatment and the security of potential patients who might avoid treatment if anonymity is not guaranteed. What can be said is that, as a group, the treatments dated from the late 1960s through the present. The geographic locations in which they took place are deliberately concealed; however, each analysis was conducted in the United States. To further protect anonymity, analysts' identities and personal characteristics, such as their ages, ethnicities, professional qualifications (i.e., psychologist or psychiatrist), and affiliations (i.e., school of psychoanalytic training), must be concealed. However, all the analysts included in this study were men, and all spoke fluent English. For the same reason, no demographic information is available concerning the patients except that 8 of the 10 were women, and all spoke fluent English.

Confidentiality requirements also constrain our freedom to offer long excerpts from the transcripts. To ensure that potentially identifying material is not revealed, only short excerpts of language use involving less sensitive material can be quoted (although the full set was used in all analyses); due to their fragmentary nature, the excerpts permit only limited illustration of the discourse. Although the excerpts may appear rather banal, by and large psychoanalytic sessions lack the drama typically portrayed of them in the popular media. As psychoanalyst Glen Gabbard noted in a radio broadcast on the difference between movie depictions of analysis and reality, "If you actually put a video camera in my office or any other therapist's office, it would be so boring that people would demand their money back! Nothing exciting happens, generally, in a therapist's office" (Pesca, 2002).

Sampling

Psychoanalytic sessions typically last 45 or 50 min. For each of the 10 psychoanalytic treatments in this study, we took 10-min samples of talk from each of 10 sessions. These sessions included the “final chair session,” that is, the last session in which patients sat in a chair, face-to-face with their analysts, and the “first couch session,” in which patients lay on the couch without visual contact with their analysts (typically the next day after the last chair session). Additionally, the first 180 couch sessions in each analysis, approximately 1 year of treatment, were divided into quartiles of 45 sessions, chronologically. Two sessions were randomly chosen from each quartile to form a total of eight samples per pair from Quartiles 1, 2, 3, and 4. As such, 20 samples were included in the final chair versus first couch comparison, 100 samples were included in the final chair versus all couch comparison, and 80 samples were included in the trend analysis.

For each session, a segment 10 min in length, beginning 10 min after the start of a session was selected for use in this study. With one exception, the samples used were Minutes 10–20 of each session. In one treatment, the patient moved to the couch 23 min into Session 6; in this case, Minutes 10–20 were used as the patient’s final chair session and Minutes 33–43 were used to represent the first couch session.

The sample varied in the transition from chair to couch. Three dyads had lengthy face-to-face therapeutic contact prior to using the couch: One dyad had a prior, unrecorded, therapeutic treatment that was terminated before the patient returned to treatment with the same analyst for psychoanalysis; a second dyad spent more than a year in face-to-face psychoanalytic treatment, also unrecorded, before the patient moved to the couch; and in the third dyad, the patient’s final chair session was Session 249. In contrast, for two other dyads, the initial patient–analyst meeting was the only chair session. This may be less than optimal for comparability of the chair sessions because initial sessions are typically more focused on overt and directed information gathering than are other sessions. In the remaining four treatments included in this study, the final chair session was Session 2 for one dyad, Session 4 for two dyads, and Session 20 for one dyad.

Because of this unavoidable variability given the limited availability of audio-recorded psychoanalytic treatments that also include chair sessions, the final sample thus includes only one chair session (the final one) for each dyad. From a psychoanalytic perspective, the final chair session (and perhaps the first couch session) may be different from subsequent couch sessions, because much discussion would be expected to take place around the impending and actual move to the couch (W. Bucci, personal communication, May 5, 2000).

Overall, in 5 of the 10 cases included in this study, patients moved to the couch before 2 weeks of treatment, whereas the remaining 5 moved significantly later, ranging between a month and several years of treatment. The patterns of data are

the same for patients who moved to the couch early and later in treatment, and so this difference does not play a role in our discussion of the results.

Transcription

Each 10-min sample was digitized for archival storage. All potentially identifying information (e.g., proper names, places) was replaced with beep-tones. Transcripts included overlapping speech, silences with a minimum length of 3 s, disfluencies, fillers (e.g., “um”), and laughter. Information pertaining to intonation contours was not transcribed, nor were sighs or coughs.

Coding of Speech Content

We applied two computerized content analysis programs to the final chair and first couch sessions to examine whether use of the couch affects the content of psychoanalytic sessions, as some psychoanalytic theories suggest. These programs are Linguistic Inquiry and Word Count (LIWC) and Computerized Referential Activity (CRA).

LIWC. LIWC is a text analysis program that allows for the study of various content and structural dimensions of language use by counting words assigned to different categories (Pennebaker & Francis, 1996, 1999). It captures, on average, 80% of the speech people use. Each scale is composed of a dictionary of words that define it. For example, the Affective or Emotional Processes scale includes words such as “happy” and “hate.”

LIWC has been highly effective in demonstrating links between the content of speech and writing and other aspects of people’s lives, perhaps most famously in studies demonstrating that people end up with better physical health when they use more emotion and insight words in writing following traumatic or upsetting experiences (e.g., Pennebaker, 1993; Pennebaker & Francis, 1996; Pennebaker, Mayne, & Francis, 1997). Other studies focused on spoken language use (e.g., Berry, Pennebaker, Mueller, & Hiller, 1997; Liehr et al., 2002). For example, Berry et al. found that certain aspects of language use, such as negative and positive emotion words, present-tense verbs, and words concerning cognition, play an important role in social perception beyond that explained by more traditionally studied variables such as physical attractiveness.

The measure has some limitations. The power of each scale and subscale varies depending on the number of words that define it. Additionally, the measure is not context sensitive, which is a concern given the pervasiveness of polysemy in the English language and the metaphoric nature of language use on which the meanings of polysemous words may be based (Gibbs, 1994). Nonetheless, LIWC has shown the ability to detect relatively subtle differences in content, and thus is a rea-

sonable tool for beginning to examine speech in chair and couch psychoanalytic sessions.

Based on a review of the psychoanalytic literature, a number of LIWC categories may be relevant to an examination of chair and couch sessions. For example, potentially relevant to the view that the couch fosters an internal mode of functioning are categories pertaining to self- and other focus and to feelings. Specifically, patients on the couch should produce a greater percentage of first-person words, words about affective or emotional processes, words reflecting positive emotions, and words reflecting negative emotions; they also should produce fewer second-person words, third-person words, words about social processes, words about communication, and other references to people. The 20 LIWC categories shown in Table 1 were examined for content change for both patients and analysts.

CRA. CRA is a computerized text analysis program used in psychoanalytic research (Bucci, 1997; Mergenthaler & Bucci, 1999). Building on Paivio's (1971, 1986) dual code theory, which proposes separate cognitive verbal and nonverbal processing subsystems, it measures what Bucci and colleagues (Bucci, 2000; Bucci & Kabasakalian-McKay, 1992; Bucci & Miller, 1993) call referential activity (RA). Referential activity is proposed to be the process through which nonverbal inner experience (i.e., images, ideas, emotions, sensations) is connected with

TABLE 1
Linguistic Inquiry and Word Count Categories

<i>Word Category</i>	<i>Examples</i>
First person	I, me
Second person	you, you'll
Third person	she, their
Social processes	talk, us
Communication	share, converse
Other references to people	our, we
Affective or emotional processes	happy, sad
Positive emotions	good, joy
Negative emotions	hate, worthless
Cognitive processes	know, ought
Insight	think, consider
Inhibition	block, constrain
Tentative	maybe, perhaps
Sensory and perceptual processes	see, touch
Physical states and functions	ache, breast
Sex and sexuality	lust, penis
Sleeping and dreaming	bed, dreams
Past tense verbs	were, had
Future tense verbs	will, shall

language and narrated in a precise, concrete and evocative way. A communication is rated according to four intercorrelated dimensions, leading to a single RA score for any given segment of dialogue or text: (a) specificity, or the amount of explicit detail; (b) concreteness, or the extent that descriptions include perceptual or sensory experience; (c) clarity, or intelligibility; and (d) imagery, or the extent to which experiences are described in a way that evokes corresponding experiences for a listener.

CRA computes RA automatically; as a word-based dictionary-based measure, it shares LIWC's lack of sensitivity to context. Rather than quantifying thematic content as LIWC does, CRA aims to infer underlying capacities for symbolization and verbalization from a speaker's manifest content and style. It does this via a dictionary of high and low RA word lists. High RA categories include determiners (e.g., "the," "a"), directional and spatial words (e.g., "on," "down") and specific actions in either the present or past tense (e.g., "gave," "come"). Low RA categories include nonspecific quantifiers (e.g., "any," "most"), nonspecific actions in the present tense (e.g., "make," "try"), and nonspecific objects (e.g., "thing," "someone"). Using CRA, Bucci (1997) found a changed discourse pattern over the course of a psychoanalytic treatment that may indicate how the treatment became disrupted; CRA identified the patient's difficulty connecting to emotional experience that was not present in earlier sessions.

As CRA appears to identify changes in narrative style, it offers a way to quantify discourse change across chair and couch sessions in psychoanalytic treatment. For example, a view of the couch as an important tool in psychoanalytic treatment, the goal of which is to increase self-understanding through increased attention to internal experience, suggests that a higher rate of narrative (i.e., high CRA) passages should be found in couch than in chair sessions.

Coding of Discourse Features

We selected 12 discourse features for coding (see Table 2). These features were chosen on the basis of an earlier pilot study (DiNardo, Schober, & Stuart, 1999), previous discourse research and a review of psychoanalytic theory concerning the use of the couch.

Based on earlier mediated-communication studies, back channels, fillers, disfluencies, tag questions, silences, and overlapping speech were included. As noted, some of these features also may be relevant to some psychoanalytic theories concerning the couch. Specifically, back channels, silences, and tag questions were selected due to their potential relevance as signals of an internal mode of functioning, and fillers and disfluencies were chosen based on the claim that the couch leads to a regressive mode of functioning. Similarly, hedges were included based on the proposal that the couch fosters a reduced sense of responsibility. A complete list of the hedges coded in this study is in the Appendix.

TABLE 2
Coded Discourse Features

<i>Discourse Feature</i>	<i>Example</i>
Back channels	
<i>absolutely, alright, exactly, fine, hmm, I know, I see, oh, okay, mm-hm, right, sure, uh-huh, yeah, yes</i>	T: It expresses your feelings. P: <u>Mm-hm</u> . T: and it also ties in with a lot of things.
Fillers	
<i>ah, eh, uh, um</i>	P: It just doesn't seem to <u>uh</u> make me comfortable.
Disfluencies	
Replacements	P: And I <u>was-</u> <u>we're</u> walking.
Repetitions	P: A street <u>that's-</u> <u>that's</u> parallel.
Restarts	P: So, we're walking down a <u>st-</u> <u>a street</u> .
Tag questions	
<i>hm? okay? remember (that)? right? follow? you know what I mean? right?</i>	P: So I called him, <u>right?</u> T: Mm-hm P: And he said ...
Overlapping speech	T: Well, of cour* <u>se not</u> * P: * <u>Yeah</u> *
Silences between clauses	T: But it's i- interesting that you feel that way P: I don't know how to explain it. [pause 00:15:312] He said ...
Silences within clauses	P: He said- [pause00:03:117] he said ...
Hedges	
<i>maybe, I guess, and things^a</i>	P: I <u>guess</u> it would be better to feel less angry
"You know"	P: It was late <u>you know</u> when we were leaving <u>you know</u> and ...
"I mean"	P: No really I <u>mean</u> I wasn't angry ...
"Like"	P: It was <u>like</u> very strange because in the dream ...
Laughter	P: I wonder [<u>laughter</u>] what that might mean ...

Note. Overlapping speech is contained within asterisks. T = therapist; P = patient.

^aSee Appendix for full list.

With respect to silences between clauses and silences within clauses, silences longer than 1 s are considered interpersonally meaningful (Jefferson, 1989), causing discomfort and leading speakers to produce some signal (e.g., fillers such as "um") to indicate that they will continue. In psychoanalytic conversation, however, with its conversational participants' nonsymmetrical roles and privileging of patience and reflection, silence may be better tolerated. As such, 1-s silences are likely far too brief to be considered long in the analytic setting and longer silences may be relevant, a view adopted in other psychoanalytic research (Gill & Hoffman, 1982). Therefore, for this study, silences lasting 3 s and longer were selected for coding.

"You know" and "I mean" were coded based on their potential to indicate interactive involvement. According to Schiffrin (1987), "you know" and "I mean" display speaker orientation and invite hearer attention to different degrees. Although

their relative emphases may differ, uses of both “you know” and “I mean” are directed to the interpersonal field.

“Like,” usually considered a hedge, and laughter were included based on pilot study results suggesting that these linguistic features might differ between chair and couch sessions.

With the exception of silences between clauses, selected discourse features were coded separately for patient and analyst. Because they occur between complete clauses and can be broken by either interlocutor, silences between clauses were coded for dyads as a unit.

To establish interrater reliability, 20% of the transcript sample, randomly selected, was coded by a second coder for discourse features tracked in this study. The overall interrater reliability was high (Cohen's $\kappa = .94$); excluding tag questions, of which there were only two in this subsample, kappas for the individual discourse features ranged from .82 for back channels to .99 for instances of “like.”

The number of words spoken by each interlocutor and the number of conversational turns were counted per sample of talk. Rates of each discourse feature per 100 words were calculated. In addition, mean lengths of silences between and within clauses were computed.

RESULTS

What is immediately apparent is how strikingly similar the sampled chair and couch psychoanalytic dialogues were in both content and form. Comparing the final chair session with the first couch session, there were no differences in the percentages of words produced by either patient or analyst in 19 of 20 LIWC categories (see Tables 3 and 4), and no difference on the CRA (see Table 5). No differences were found in patients' word counts; analysts' back channels; rate, or length of patients' or analysts' silences within clauses; rate or length of dyads' silences between clauses; patients' or analysts' disfluencies, fillers, hedges, tag questions, “you know,” “I mean,” “like,” or laughter. Comparing the final chair session with all the couch sessions combined, there were no differences in analysts' back channels; rate or length of patients' or analysts' silences within clauses; length of dyads' silences between clauses; and patients' or analysts' disfluencies, fillers, hedges, tag questions, “you know,” “I mean,” “like,” or laughter.

However, this is not to say that there were no systematic differences. As Table 6 shows, analysts spoke over three times more in final chair sessions than in first couch sessions, $F(1, 9) = 15.60$, $p < .01$. Additionally, patients and analysts changed conversational turns four times more often in final chair sessions than in first couch sessions, $F(1, 9) = 18.05$, $p < .01$, and their speech overlapped four times more in final chair sessions than in first couch sessions, $F(1, 9) = 26.26$, $p <$

TABLE 3
 Content of Patients' Speech as Measured
 by Linguistic Inquiry and Word Count

	<i>Final Chair %</i>	<i>First Couch %</i>	<i>F(1, 9)</i>
First person	9.8	10.1	0.12
Second person	1.5	1.1	2.26
Third person	3.0	3.7	0.96
Social processes	8.2	9.3	1.46
Communication	1.7	2.1	1.85
Other references to people	5.1	5.5	0.28
Affective or emotional processes	3.2	3.2	0.00
Positive emotions	1.6	1.9	1.00
Negative emotions	1.5	1.2	1.18
Cognitive processes	8.7	9.2	1.10
Insight	2.9	3.3	2.66
Inhibition	0.2	0.4	2.27
Tentativeness	3.5	3.4	0.05
Sensory and perceptual processes	2.8	3.0	0.62
Physical states and functions	1.1	0.6	3.12
Sex and sexuality	0.2	0.1	0.27
Past tense verbs	4.6	4.9	0.34
Present tense verbs	11.6	12.0	0.67
Future tense verbs	0.9	0.7	0.89
Sleeping and dreaming	0.2	0.1	0.56

.01. Also, patients uttered three times more back channels in final chair sessions than in first couch sessions, $F(1, 9) = 7.75, p < .05$.

In terms of content, the only reliable difference found in this study was in analysts' speech. Specifically, analysts spoke in the future tense over four times more often in final chair sessions than in first couch sessions, $F(1, 9) = 9.18, p < .05$ (see Table 4). No other differences were statistically reliable. In fact, the (nonsignificant) differences did not reliably go in the directions one would predict based on psychoanalytic theories of the couch; patients' speech moved in the expected directions for only 8 of 20 LIWC categories and analysts' speech for 11 of 20 LIWC categories. For the proposal that patients on the couch are in an internal mode, only 3 of 9 relevant LIWC comparisons tended in the expected direction. For the proposal that patients are in a regressed mode on the couch, 2 of 3 LIWC comparisons moved in the expected direction, and for the proposal that patients have diminished responsibility for their speech on the couch, no LIWC comparison moved in the expected direction. Therefore, even the nonsignificant trends do not support the idea that speech content changes much from chair to couch.

As Table 7 shows, a comparison of all couch sessions with final chair sessions suggests that the first chair session was not unique. Analysts spoke more in final

TABLE 4
Content of Analysts' Speech as Measured
by Linguistic Inquiry and Word Count

	<i>Final Chair %</i>	<i>First Couch %</i>	<i>F(1, 9)</i>
First person	3.4	2.6	0.64
Second person	9.0	7.4	0.58
Third person	1.4	0.5	2.24
Social processes	14.4	14.3	0.00
Communication	2.6	1.9	0.74
Other references to people	11.1	8.7	1.35
Affective or emotional processes	4.4	1.9	3.81
Positive emotions	1.8	0.9	4.47
Negative emotions	2.5	1.0	2.10
Cognitive processes	10.8	15.3	1.24
Insight	3.4	6.1	1.43
Inhibition	0.7	1.4	1.09
Tentativeness	3.7	4.0	0.11
Sensory and perceptual processes	3.9	3.5	0.08
Physical states and functions	0.9	0.3	4.53
Sex and sexuality	0.3	0.2	0.03
Past tense verbs	2.5	3.0	0.17
Present tense verbs	12.7	11.3	0.45
Future tense verbs	1.4	0.4	9.18*
Sleeping and dreaming	0.2	0.0	2.12

* $p < .05$.

TABLE 5
Referential Activity as Measured by Computerized Referential Activity

	<i>Final Chair %</i>	<i>First Couch %</i>	<i>F(1, 9)</i>
Patients	15.5	15.8	0.01
Analysts	15.5	9.1	3.12

TABLE 6
Differences Between Final Chair and First Couch Sessions

	<i>Final Chair</i>	<i>First Couch</i>	<i>F(1, 9)</i>
Analysts' word counts ^a	284.8	93.0	15.60**
Conversational turns ^a	60.6	15.0	18.05**
Overlapping speech ^b	0.8	0.2	26.26**
Patients' back channels ^b	0.3	0.1	7.75*
Analysts' future tense verbs ^b	1.4	0.4	9.18*

^aNumber per 10-min segment. ^bRate per 100 words.

* $p < .05$. ** $p < .01$.

chair sessions than in couch sessions overall, $F(1, 9) = 5.87, p < .05$. Dyads' number of conversational turns and rate of overlapping speech also were higher in final chair sessions than in all couch sessions, $F(1, 9) = 15.93, p < .01$ and $F(1, 9) = 11.31, p < .01$, respectively. Similarly, patients' use of back channels was higher in final chair sessions than in couch sessions overall, $F(1, 9) = 7.75, p < .05$. Two additional differences emerged that were not found between final chair and first couch sessions. Patients spoke more in final chair sessions than in couch sessions overall, $F(1, 9) = 7.06, p < .05$. Also, consistent with patients' and analysts' reduced rates of speech across all couch sessions, dyads were silent between clauses four times more frequently in couch sessions overall than in final chair sessions, $F(1, 9) = 12.15, p < .01$.

Discourse features also were examined across the course of couch sessions. As in comparing chair and couch sessions, few differences were found. However, examination of patients' and analysts' word counts over the couch sessions included in this study (see Table 8) shows that analysts spoke marginally more over time (across the four quartiles), quadratic trend $F(1, 9) = 4.55, p < .07$. In contrast, patients spoke marginally less over time (across the four quartiles), quadratic trend $F(1, 9) = 3.97, p < .08$. To look at this another way, Figure 1 shows analysts' and patients' proportion of speech in all sessions included in this study. As shown, patients' and analysts' speech rates were most disparate during the first couch and first quartile sessions. Analysts' proportion dropped suddenly from final chair to

TABLE 7
Differences Between Final chair and All Couch Sessions

	<i>Final Chair</i>	<i>All Couch</i>	<i>F(1, 9)</i>
Analysts' word counts ^a	284.8	156.0	5.87*
Conversational turns ^a	60.6	22.7	15.93**
Overlapping speech ^b	0.8	0.3	11.31**
Patients' back channels ^b	0.3	0.1	7.75*
Patients' word counts ^a	1,307.2	1,127.4	7.06*
Silences between clauses ^b	0.4	1.2	12.15**

^aNumber per 10-min segment. ^bRate per 100 words.

* $p < .05$. ** $p < .01$.

TABLE 8
Mean Word Counts Across the Couch Sessions

	<i>First Couch</i>	<i>Quartile</i>			
		<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>
Analysts	93.0	98.5	163.2	215.5	178.3
Patients	1,304.5	1,244.8	1,022.5	1,088.1	1,065.8

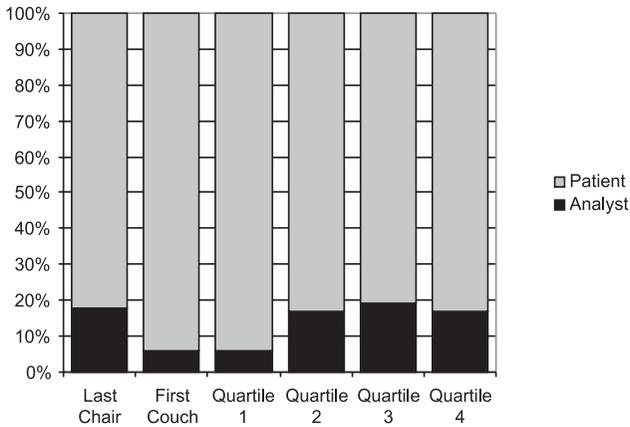


FIGURE 1 Proportion of words spoken by analyst and patient.

first couch sessions and stayed low in the first quartile sessions, whereas patients' proportions increased (although their actual words counts did not differ). Beginning with Quartile 2, the difference between analysts' and patients' rates of speech decreased. In Quartiles 2, 3, and 4, analysts' and patients' respective verbal production resembled that found in final chair sessions.

DISCUSSION

The content and form of the discourse following patients' transitions to the couch largely resembled the content and form of the discourse in face-to-face sessions. Over a year of treatment (180 sessions) on the couch, there were also few systematic changes in discourse features. These results are hard to reconcile with views that propose that the use of the couch radically changes patients' speech; instead, they are more consistent with findings in other domains of conversation that access to one's partner's facial cues often does not substantially affect task performance.

Nonetheless, the use of the couch had some clear effects on how analysts and patients talked. Most strikingly, analysts suddenly spoke dramatically less in the first couch sessions than they had in the final chair sessions, whereas patients continued to talk about as much as they had before. This change in analysts' behavior probably accounts for the other observed changes in language use between final chair and first couch sessions. That is, the fact that pairs exchanged 75% fewer conversational turns and produced 66% less overlapping speech follows directly from the analysts' speaking 67% less, thus providing fewer opportunities for changing conversational turns and for overlapping speech. Similarly, the fact that patients

produced 74% fewer back channels makes sense because there was simply less of analysts' speech for patients to acknowledge verbally with back channels.

The only difference in speech content found between final chair and first couch sessions (i.e., analysts' reduced use of the future tense in the first couch sessions), turns out to be unremarkable on closer inspection. At some point during most of the final chair sessions, analysts and patients discussed the possibility of the patient's moving to the couch in the next session, using the future tense as they did so. The evidence thus looks quite overwhelmingly as if use of the couch does not lead to any immediate change in the content of what is discussed, at least as measured by LIWC and CRA.

Of course, there is always the possibility that what LIWC and CRA measure, as well as the discourse features we coded, somehow fail to capture what is truly distinctive about psychoanalytic dialogue. One bit of anecdotal evidence argues against this possibility. A senior practicing clinical psychologist who learned of these results was convinced that the coding was inadequate and proposed that he could distinguish chair sessions from couch sessions by reading the transcripts. We presented him with 10 unidentified transcripts, 5 chair and 5 couch, chosen based on their lacking explicit mention of the dyads' seating arrangement, used in this study, and he could not accurately tell them apart. To his surprise, our colleague could not distinguish chair from couch sessions and had to admit that the transcripts simply show little evidence for major differences between them.

One might also argue that the fact that we have found little difference in psychoanalytic discourse in the chair and on the couch is a null result and thus hard to interpret. Perhaps there are other differences that we have failed to uncover. Although there is no way to fully reject this possibility, the fact that some substantial differences were observed (in analysts' speech rates when patients are on the couch, in particular) argues against the idea that the study lacked statistical power to detect differences. Consistent with this is the fact that the direction of (nonsignificant) changes was not reliably in the direction predicted based on psychoanalytic theories. Note also that the measures of content and form used in this study have been regularly shown to detect even subtle differences in other domains and even in psychoanalytic dialogue (cf. Bucci, 1997).

The Couch Stance

Why did analysts suddenly speak so much less when the patient moved to the couch? It seems unlikely to have resulted merely from the sudden change in visual copresence, because patients' speech production did not decrease accordingly. Instead, we suspect that analysts assumed a "couch stance": speaking less, being less immediately responsive, and tolerating more silence. Such a stance violates everyday norms of conversational cooperation and responsiveness (see, e.g., Grice, 1975;

Schwarz, 1996); in more typical contexts, it would be quite unusual to have (or be) a conversational partner who does not immediately reply and who does not say much.

A related set of unusual conversational behaviors has been shown to affect performance in important ways in another institutional setting: standardized survey interviewing. In strictly standardized interviews, interviewers are trained to avoid providing substantive answers to respondents' clarification questions (e.g., Fowler & Mangione, 1990), saying "whatever it means to you" or otherwise leaving the interpretation of a survey question up to respondents. Such interviewer unresponsiveness can lead to demonstrably odd interactions (e.g., Houtkoop-Steenstra, 2000; Schober & Conrad, 2002; Suchman & Jordan, 1990) and to respondents' misinterpreting what survey designers meant by questions (Conrad & Schober, 2000; Schober & Conrad, 1997).

The question, then, is why Gricean violations do not seem to have a greater effect on the content and form of psychoanalytic discourse on the couch. The proposal in the survey world has been that even though respondents know that they are engaged in an unusual institutional setting with its own norms, they still interpret interviewers' behavior through the lens of their more day-to-day interpretations (Schober & Conrad, 2002), for example interpreting an "mm-hm" as evidence that they have provided a sufficient answer. It may be that the Gricean violations in psychoanalytic dialogue are so much more extreme than those in survey interviews that analysts and patients are constantly reminded that ordinary norms do not apply. To speculate further, it may be the unusual physical setting of the couch that supports the discourse oddities of the couch stance. The couch may provide a continuous external reminder that the participants are in an unusual discourse mode; the fact that the patient and analyst do not see each other's faces may reduce the pressure to resolve the discomfort that the analyst's silence can cause.

The fact that analysts' speech rate crept up over the time on the couch suggests that the couch stance is not maintained with complete strictness and that more everyday norms of interaction are resilient. However, with analysts continuing to speak less overall than ordinary conversationalists and patients speaking less over the course of couch sessions, the discourse patterns in the psychoanalytic situation remain unique.

Implications

We propose that, to the extent that they are available to researchers, psychoanalytic dialogues provide a rich resource for examining other kinds of questions of interest to discourse researchers. As part of a general theory of how institutional practices affect discourse (Drew, 2002), comparisons of discourse patterns in psychoanalysis and other forms of psychotherapy would be important. One could examine how patients become socialized to the psychoanalytic setting over time, in the tradition of seeing language use as a socializing practice (e.g., Blum-Kulka, 1997). One

could examine how discourse features reflect and create power differentials in psychoanalysis, along the lines of O'Barr's (1984) demonstration that speakers can exert power through use of silences that enable them to hold the floor; one could compare such power moves in psychoanalysis to those in other medical settings (e.g., Treichler, Frankel, Kramarae, Zoppi, & Beekman, 1984).

How do these results inform arguments for and against the use of the couch in psychoanalysis? They undermine views that assume that it is the use of the couch itself that makes a difference, positive or negative. For example, if patients really experience a reduced sense of responsibility during couch sessions, then surely there should have been differences in agency as expressed linguistically (and captured by LIWC) or in the rates of hedging. At first glance, the fact that patients produced fewer conversational turns and less overlapping speech in couch sessions appears consistent with the idea that the couch encourages an internal mode. However, there is just as much evidence that both patients and analysts continue to be attentive to the interpersonal field on the couch, producing discourse markers directed to the other and accommodating to each other in how much they say. Similarly, at first glance one might interpret the fact that there is much more silence when patients are on the couch as consistent with the view that patients have regressed to a preverbal state. However, it is difficult to assign authorship of the silences, when actually it is the analysts who are speaking much less.

Instead, it may be that when psychoanalysts have made proposals about the effects of the use of the couch, they are really making proposals about the set of discourse practices that make up a couch stance. It is possible that this set of discourse practices constitutes part of what has been called an "analytic attitude" (Schafer, 1983), as compared to any specific technique.

Our findings have nothing to say about the therapeutic value of the use of the couch in general, of the "couch stance" that analysts seem to take, or of the increase in silences found in couch sessions; the long-term value of analysts' interventions and behaviors is far beyond what the study examines. Other methods found in psychotherapy process research can begin to address such issues. Using the example of silences, Levitt's (2001) coding system, for instance, offered a way to explore this question by viewing silences not as homogeneous events but as distinct types. In this system, by examining the context in which the silences occurred, including utilizing recall interviews with patients, silences are assigned to categories, some considered productive and others obstructive.

Finally, the findings do not suggest that the unusual partial visual copresence that patients and analysts have when using the couch might not have effects in other sorts of conversations where participants have different kinds of roles and goals. Partial visual copresence should indeed have effects when facial cues are essential to the task at hand. In fact, not seeing each other's faces may prove discombobulating for patients and analysts in ways that are useful for the analytic enterprise. It just does not seem to change what is said very much.

ACKNOWLEDGMENTS

This study was funded in part by National Science Foundation Grants SBR-9730140 and ISS-0081550 and by the Albert J. Marrow Dissertation Fellowship. It was conducted as a doctoral dissertation presented to the Department of Psychology at the New School for Social Research, Graduate Faculty. We thank Wilma Bucci, Hartvig Dahl, Robin Gay, Lester Luborsky, David Shapiro, and Sherwood Waldron, Jr., as well as the anonymous patients and analysts who participated in the creation of the psychoanalytic archives without whom this research would not have been possible.

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APPENDIX

Coded Hedges

a (little) bit
 a little
 about
 almost
 along the lines
 appear(s)
 and all (else/that/this/these things)
 (and) all that/this business/stuff
 and everything (like that)
 and so forth
 and so on
 (and) this and that
 and things
 around
 (not) as
 assuming/assume
 as though
 basically

(I) believe
 (not) exactly
 fairly
 (I) guess
 I (would) imagine
 in a (certain/some) way
 in a/tha/the/one sense
 in part/partly/partially
 in some way(s)/respect(s)
 kinda/kind of/some kind
 may
 maybe
 might
 more or less
 most (of)/mostly
 (not) much
 (not) exactly
 or/and anything (like that/or other)
 or/and something(like that/or other)
 or so
 or what (have you)
 part of
 (not) particularly
 perhaps
 possibly/(it's) possible
 practically
 presumably/I presume
 pretty
 probably
 (not/nothing) quite
 seem(ed/s)
 slightly
 not so
 somehow (or other)
 something like
 something or other
 somewhat
 (some) sorta/sort of/of some/one sort
 (kind of) stuff (like that)
 suppose/supposedly
 I suspect

(not) that this
things like that/this
(I) think/(I) don't think
(s/he) thinks/(s/he) doesn't think
to a certain/some extent
to some degree
(not) too
type (of)
(or/and) whatever
(not) very(much/badly/well/good)

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