“You know it, how I feel, I mean you just did it”
The emergence of we-ness through re-enactment in psychotherapy
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Published in:
Cognitive Semiotics

DOI:
10.1515/cogsem-2019-2017

Publication date:
2019

Document version:
Final published version

Citation for published version (APA):

Go to publication entry in University of Southern Denmark's Research Portal

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You know it, how I feel, I mean you just did it:” The emergence of we-ness through re-enactment in psychotherapy

Abstract:
This article explores the nature and trajectory of a shared emotional experience in a psychotherapy interaction by combining insights from embodied cognition with the notion of intercorporeality along with the concept of re-enactment. The focus of the article is a detailed interactional analysis of the way the phenomenon of we-ness (or we experience) appears in a psychotherapy session. We-ness concerns the way two (or more) people share an experience by being aware and attentive to the way they participate together in the experience. It is argued that in social interaction, we-ness needs to be examined and understood as a profoundly temporal phenomenon that gradually evolves in the flow of interaction with different levels of intensity. It is built into and enabled by a skillful embodied coordination grounded in expressive movements and dependent on reciprocal patterns of action. Furthermore, it is suggested that the embodied enactment of we-experience may play a particular prominent role in psychotherapy. For the therapist, embodied communicative practices can work as an alternative resource to enhance the sensitive responsiveness in the interactive flow and thereby create an experience of being seen for the patient in a more direct manner than if only verbalized.

Keywords: intercorporeality, psychotherapy, re-enactment, social interaction, we-ness

DOI: 10.1515/cogsem-2019-2017

1 Introduction

It is generally accepted that face-to-face interaction is the basic arena for developing a sense of self and the accompanying social skills. It is in face-to-face situations that we learn how to distinguish between our own actions and those of others, thereby creating a more developed sense of who we are in-and-through dynamic patterns of action with our interlocutors. Another crucial dimension of face-to-face interaction is the possibility of developing shared understandings as well as a sense of acting, thinking, and feeling together. In fact, one can argue that the principal affordance of social interaction is the opportunity to share experiences and develop them together on the spot in the ongoing flow of conversation. In this article we view this phenomenon through the lens of what has recently been coined we-ness (Meyer et al. 2017) or we-experience (Zahavi 2015a, 2015b; León and Zahavi 2016). In the existing literature on shared experiences, the nature of we-experience is often defined as an experience in which two (or more) agents experience the same intentional object while also being aware and attentive to the fact that they have a feeling of participating together in the experience to the extent that their emotional experiences “are co-regulated and constitutively interdependent” (Zahavi 2015a: 90). A popular example is that of a couple enjoying a movie together, in which it makes sense to say that we saw the movie. Even though such a situation differs from face-to-face interaction, the intersubjective feeling of being closely together with a specific purpose points to common features. Thus, in this study, we ask if the close embodied coordination of social interaction can enable a sense of we-ness during interaction in a manner similar to that of experiencing a phenomenon together. If so, how is such a we-experience structured and achieved in the context of social interaction?

We investigate the notion of we-ness in social interaction using a theoretical perspective in embodied cognition (Chemero 2011; Shapiro 2011; Gibbs 2011; Gallagher 2017). Related to this concept of cognition are the phenomenological notions intercorporeality – originally derived from the works of Merleau-Ponty (1962) and recently redeveloped by different scholars within social interaction, communication, sociology, and anthropology (Meyer et al. 2017; Fuchs 2017; Andrén 2017; Cuffari and Streeck 2017) – and the closely related notion of...
We investigate we-ness in video data from psychotherapy. Sometimes, in psychotherapy as well as in mundane conversation, the most adequate way of understanding the topic at hand is not to respond directly to what has just been said, but instead to engage in a shift of perspective by re-enacting the scene or situation that has just been described to you. By shifting perspective in this way, the distinctions between speaker and hearer, sender and receiver, as well as the fundamental discrimination between your and my experience are for a brief while challenged to the degree of being dissolved. When you see your own experiences and reactions being re-played by your interlocutor, they are no longer just yours, they are also re-enacted or re-lived by the person just in front of you. This type of shift in perspective seems to play a more dominant role in psychotherapy (than in mundane everyday-interaction) since the sheer possibility of seeing your own actions being re-enacted by another involves a therapeutic potential for change, i.e. when your individual experience (typically that of the patient) is reflected in the actions of your interlocutor (the therapist), you are no longer alone with the experience. Thus, such a shift in perspective by your interlocutor allows for establishing a new perspective on your own actions and experiences making it possible to see them in a new light, which, in the case of therapy, may provide an essential step towards change for the patient. In this way, the complex inter-body coordination of the patient (viewed as an interpersonal system, enact a feeling of we-ness that may aid the patient in developing a new perspective on her reactions and experiences. In continuation of this, we argue (2) that the development of we-ness in social interaction needs to be investigated as a temporal phenomenon that evolves over time during the course of interaction involving different phases and levels of intensity. This temporal dimension of the experience of we-ness is unexplored in the literature so far since it has not yet been dealt with in any systematic fashion. In this study, however, we specifically tie the emergence of we-ness to the concept of re-enactment (Goffman 1979; Goodwin 2017; Philipsen et al. Forthcoming), thereby providing it with a more detailed trajectory (since re-enactments are concrete actions that unfold over time) and a material structure (since re-enactments are tied to embodied actions). Furthermore, we argue (3) that the expression of we-ness in social interaction needs to be studied as a multimodal phenomenon. It is grounded in an embodied activity that involves many modalities such as gesture, facial expression, posture, in-and-out breath, and gaze, as well as verbal actions. These modalities are deeply entangled from the start and cannot be disentangled without losing sight of the emergent character of we-ness as it comes about as a by-product of the totality of our actions. Finally, this study also entails (4) perspectives for developing a more precise and nuanced understanding of the embodied mechanisms at play in psychotherapy. The notions of we-ness or we-experience were not developed in relation to therapy but can nevertheless shed light on central aspects of what is at stake in the embodied interaction of therapy if these notions are operationalized to a larger degree.
2 Theoretical part

2.1 Embodied cognition

The theoretical framework for this article can be subsumed under the notion of embodied cognition as it has been re-developed in recent years within cognitive science (Johnson 2007; Thomson 2007; Gibbs 2011; Chemero 2011; Shapiro 2011; Gallagher 2017) and neighbouring disciplines such as linguistics and interaction studies (Steffensen 2017; Trasmundi and Linell 2017; Jensen 2014; Jensen and Pedersen 2016; Goodwin 2017; Di Paolo et al. 2018).

The 1980s and 1990s saw the rise of the notion of embodiment as a response to the strong tradition in cognitive science to investigate and understand the workings of the mind as based on symbolic (disembodied) representational processes. As an alternative to this view, the notion of embodiment stressed that our cognitive capacities are fundamentally shaped by our bodily functions in the sense that the properties of the human body constrain the concepts we as humans acquire and entertain. Thus, the workings of the mind are part of the workings of the body from the very start. As such, psychological concepts as memory, perception, reasoning, language comprehension are never to be understood as purely mental and abstract categories separated from our bodies. Instead, they are all rooted in bodily experiences and various sensorimotor capacities. This strong focus on the role of the body meant a tremendous breakthrough in understanding the vital role of the body in virtually all aspects of our reasoning and behaviour, including language production (Lakoff and Johnson 1999; Talmy 2003), but it also came with a price. Thus, the seemingly logical assumption that since cognition is profoundly embodied and our bodies visibly have physical boundaries that separate us from the surrounding environment led to the implicit conclusion that cognition by definition must also be a bounded phenomenon tied to an individual body and reserved to processes in the head. In this way, early focus on embodied experience unwillingly came to refine and consolidate already established distinctions between individual/social, cognition/communication, thought/language, and so forth (Cuffari and Jensen 2014). To some extent, these distinctions came off as mutually exclusive in the sense that cognition was still conceived as an “inner phenomenon” in contrast to the social and more “external phenomena” of communication and social interaction (Cowley and Vallée-Tourangeau 2012).

The contemporary conception of embodied cognition, however, explicitly challenges these distinctions. Inspired by distributed, enactivist, and ecological tendencies in the field of cognitive science (Thomson 2007; Hutchins 2014; Gallagher 2017; Steffensen 2017; Di Paolo et al. 2018), it is now more widely accepted to claim that the phenomenon we call cognition emerges from processes that are distributed across brain, body, and environment. Thus, cognition is not skull-bound, i.e., it cannot solely be understood in terms of processes taking place in the head (or in the brain). In other words, it is insufficient to stress that cognition is part of the body – one must also recognize that the body is part of an environment. Thus, even though cognition is clearly dependent on neural activation in the brain, it cannot adequately be understood as an internal process.

The key to this reconceiving of mind is to stop treating percepts, concepts, propositions, and thoughts as quasi-objects (mental entities or abstract structures) and to see them instead as patterns of experiential interaction. They are aspects or dimensions or structures of the patterns of organism-environment coupling (or integrated interaction) that constitute experience. The only sense in which they are ‘inner’ is that my thoughts are mine (and not yours), but they are not mental objects locked up in the theatre of the mind, trying desperately to make contact with the outside world (Johnson 2007: 117).

Thus, embodied cognition is bound to action in the sense that cognition is more than an internal precondition for action. It is not only to be seen as an inner mental architecture that defines the route by which we are able to navigate in the world; rather, cognition is that navigation itself. In other words, cognition is understood as active sense-making of a living agent as it navigates and explores its world in movement, perception, and action. In this way, cognition is re-conceptualized as part of an organism-environment-interaction, in which the organism’s sense-making is always “co-authored” by the environment and by other organisms in it. These environmental dependencies are captured by the notion of structural coupling. In an organism-environment interaction, the coupled domains are reciprocally co-constituting; sensory inputs guide organism actions, and organism actions modulate the environment and thus modify the sensory returns. In this way, cognition is no longer understood in terms of an internal and universally structured schema, but rather as a coupling between bodies and their environment.

2.2 Intercorporeality and we-experience

A crucial part of this coupling between organism and environment is of course the close and complex coordination between living agents in a given situation. In social interaction, this inter-personal dimension of embodied
cognition is put centre stage. A useful way of understanding the role of the body, or rather inter-bodily dynamics, is captured in the phenomenological notion of intercorporeality (Merleau-Ponty 1962; Meyer et al. 2017). This notion was developed by the French phenomenologist Maurice Merleau-Ponty (originally coined intercorporeity) in an attempt to apprehend the extended embodied sociality of the human body: “We establish subjectivity while engaging in intersubjectivity. We experience ourselves through other’s perception of us. Thus, the boundary between self and Other is not hermetically closed, but deeply intertwined in intercorporeity” (Merleau-Ponty 1962: 106).

In this way, the notion of intercorporeality offers “a radical and coherent conception of the human body as being constituted by its corporeal relations and interactions with other human or animate bodies” (Meyer et al. 2017: xvi). Thus, intercorporeality involves a shift in perspective from seeing the body as an isolated unit with clearly defined boundary to seeing it as part of a meshwork co-present bodies. Within this line of thinking, the body is a pre-reflexive ground in the sense that the body is the condition of the possibility of experiencing “I” as well as “we.” In this way, the boundaries of our bodies are not a given but rather in continuous development and the result of our embodied engagements – to the extent that it even makes sense to say that the body is neither something I have nor possess, but rather “my body is something I do and I do not do it alone. I do not perform my body alone, but within an encompassing inter-kinaesthetic field” (Meyer et al. 2017: xv).

To sum up, there is a strong connection between the development of the notion of embodied cognition and the notion of intercorporeality. Both involve a strong aspiration to expand and develop the theoretical confinements inherent in the traditional concepts of ‘cognition’ and ‘body,’ that is, it is argued that cognition is not restricted to processes within the clearly defined boundary of the head of the single individual. Likewise, the surface of the skin is not seen as an absolute boundary or limit for the workings of the body. Thus, cognition and bodies can no longer be captured as clearly localized ‘processes’ or ‘entities’ – rather, they need to be understood as part of a larger and more dynamic configuration that involves many interrelated elements at the same time.

Within a similar line of thinking, we find the notion of we-experience, which addresses an experience that cannot properly be characterized as mine or yours, but rather the experience of being part of a ‘we.’ Thus, in continuation of the concepts described above, the notion of we-experience rests on the assumption that we develop an interpersonal self in which we not only experience ourselves in our interaction with others, but also experience the other’s perspective on ourselves as part of our own experience. To understand the particular nature of this experience, it can be helpful to contrast it with the related, yet distinct, phenomenon of emotional contagion. In emotional contagion, you – often as part of a group – catch an emotion and take it in as your own. The emotion that is transferred to you (for instance, a feeling of fear or panic in the case an immediate danger) becomes your own emotion on a first-person level. This also implies that you may not even be aware of the emotional state of others in your surroundings due to the intensity of the emotion. This stands in clear contrast with the sharing of an emotional experience that is at the heart of the phenomenon of we-experience, since sharing in this case involves a distinct awareness of your own experience and that of the other:

Sharing has nothing to do with fusion, nor with a merged unity. Sharing involves a plurality of subjects, but it also involves more than mere summation or aggregation. Even if two individuals by coincidence had the same kind of experience, this would not amount to a shared experience. Despite the similarity of the two experiences, they would not be integrated in the requisite manner. Contrast this with a situation where a couple is enjoying a movie together. Not only do they each perceive and enjoy the movie, but they also experience that the other is attending to and enjoying the movie, which is something that affects the structure and quality of their own enjoyment. In short, what the individuals feel when they do it together is not independent of the relation they have to each other. (Zahavi 2015a: 90)

Thus, the notion of we-experience does not assume a conflation or a complete merger between the experiences of different participants. On the contrary, in order to establish a sense of we-ness, both coordination and differentiation is required. This entails a reciprocal relation between A and B, that both A is aware of B and that B is aware of A. At the same time, A needs to be aware of her/himself as attended to or addressed by B, and vice versa. The precondition for this intricate process is a balance between your and my experience that neither assumes a merger nor a split between the different experiences, but rather seeks to preserve the tension as well as the shared characteristics. According to Walther (1922), it is an experience emerging from a vantage point in a feeling of us, “from the others in me, and from me in the others” (1922: 72 in León and Zahavi 2016: 228). Another way to describe this is to reflect on the relationship between subject and object. As humans we are both subject and object at the same time. Others are the object of our subjective experience and we are the object of another’s attention while also being the subject of an experience of other’s attention directed at us. In this way, to become a subject is also a way of becoming an object. As such, we see ourselves and learn to understand who we are through others – and, as part of this process, we also learn to understand others.
2.3 Re-enactment in social interaction

Before embarking on the analytical section, we will now briefly introduce the notion of re-enactment (Streeck 2009; Goodwin 2017; Trasmundi and Philipsen forthcoming; Philipsen et al. forthcoming). Compared to the notion of we-experience, re-enactment is a more grounded notion relying chiefly on empirical investigations of patterns of recorded (audio or video) stretches of social interaction. The term “re-enactment” addresses the way people engaged in social interaction convey or perform previous situations during the ongoing flow of conversation. The notion of re-enactment is closely related to and builds on reported speech, which has been investigated within both literary studies and linguistics (Bakhtin 1981; Semino and Short 2004; Prior et al. 2008), as well as footing studied within micro-sociology (Goffman 1979). In both cases, the focus is on how participants, in reporting a previous event, shift perspective and convey that they are “now speaking as someone else” (ibid.). This can be carried out in a number of different ways with varying strategies, most often involving the use of direct speech. According to Goffman, a speaker can adopt different positions as either animator, author, or principal. The animator is the one who delivers the utterance, the author is the one who originally composed the speech and who is responsible for it, and the principal is the one whose point of view is revealed in the utterance(s). According to Goffman, footing enables participants in an interaction to not only shift perspective and speak on behalf of someone else during the course of conversation, but also to express varying degrees of affinity and affiliation towards what is conveyed. As such, a speaker can express a high degree of affinity by acting as the author (typically marked by use of modality markers such as “I” or “we”) or, conversely, convey a lower degree of affinity by only being the animator of the speech without standing as the actor. In continuation of this, more recent studies have also investigated how people in producing multivoicedness or polyvocality not just report what has been said and done but, as part of this activity, also display their own attitudes and responses towards the previous reported actions (Couper-Kuhlen 1999; Semino and Short 2004; Prior et al. 2008).

Thus, a crucial aspect of re-enactment is the way that the reported action is embodied by participants in the here-and-now by use of gesture, facial expressions, posture, tone of voice, etc. As implied in the term re-enactment, “reporting” clearly involves more than just repeating the words from a previous speech event. It is also a way of re-doing or re-playing what took place and, in this way, involves a strong aspect of acting or performing the action, not just saying it. It is also exactly this aspect of re-enactment that points to the way that previous actions are revived in the here-and-now:

Re-enactments are not detached from the past, rather they embed and connect past actions to actions in the here and now, and allow for interactional co-participation, reformulations and interpretations of what happened. It is crucially important to reflect on, that the “window into the past” provided by re-enactments in interaction is a “tinted” one: in re-enacting the past, it is performed and staged with intention and purpose in ways that display the attitude of the re-enactor towards the re-enacted. (Philipsen et al. forthcoming)

In relation to the analytical intention of this study, we investigate a particular way of performing re-enactment – performed by the therapist but not chiefly carried out by the use of words. Instead, the re-enactments primarily rest on a number of embodied resources such as posture, facial expression, and in-and-out-breath. Thus, it is in fact not a case of speaking as someone else but instead of acting as someone else. This vivid bodily dimension makes the re-enactment a clear case of a tinted performance (as described in the quote) that has a specific purpose relevant for the therapeutic treatment in the sense that the re-enactment is neither directed at a previous situation nor another person, but instead concerns the patient’s reactions and behaviour in the present (therapeutic) situation. This intricate and powerful interpersonal element also involves the previously described notions of intercorporeality and we-ness as we will now account for in the analytical section.

3 Analysis

3.1 Method and data

The method used in the following analyses is Multimodal Interaction Analysis (MMIA) (Goodwin 2000). MMIA is devised to investigate social interaction as a whole-bodied activity embedded in a physical and social environment. At the heart of the method lies the assumption that verbal and bodily non-verbal dimensions of language are equally important dimensions of language use. This means that MMIA takes into account the full array of situated embodied actions, including gesture, gaze, facial expression, posture, and head movement in synchronization with verbal utterances. Likewise, MMIA makes it possible to investigate language use as an embodied activity connected to affect and emotion. Furthermore, a basic model of the transcription system
developed by the conversation analyst Jefferson (1975/2004) is employed in the extracts. It includes notations of basic prosodic features, such as pitch, volume, speed, intonation, and tone of voice (e.g., smiley or crying voice). Moreover, the textual transcriptions are combined with anonymized drawings, i.e., the physical traits of the persons depicted are altered in a way that make them unrecognizable while still maintaining their facial and bodily expressions.

The example is taken from a larger dataset of video recordings of therapeutic conversations between therapists and patients with personality disorders or anxiety in a Danish psychiatric clinic. Thus, the original transcription is in Danish but has been translated into English. The Danish original is available in the appendix. This specific session was chosen because the patient reported a significant drop of symptoms in the following session. This raised curiosity about how to understand this sudden symptom release. The dataset is part of a three-year research project supported by The Velux Foundation focusing on embodied and dialogical aspects of psychotherapy from an ecological perspective. The basis for the following analysis is a 5:07 minute long sequence of therapeutic interaction that involves stretches of close interpersonal coordination that, we will argue, lead to moments of shared experience.

### 3.2 Background for the analytical case

The example involves a 22-year-old female patient with two young children. She is diagnosed with borderline personality disorder and generalized anxiety disorder, as well as subdiagnostic symptoms of obsessive thoughts and panic attacks. The overall topic of this sequence concerns the patient’s conflicting emotions in relation to the hard work of raising two young children – and, in particular, the taboo of admitting that it is sometimes a relief to leave them at the day care in the morning and an exhausting experience to pick them up in the afternoon.

Overall, the patient is characterized by a general lack of trust in others, also called damaged epistemic trust (Fonagy and Allison 2014). She has only limited contact with her emotions as well as difficulties in verbally reflecting on her feelings in a psychologically adequate manner. Combined, this leads to suppressed emotions and hence an increased symptom pressure that is expressed in panic attacks, aggressive obsessive thoughts, and excessive worrying. The therapist has tried to address the problems in a conventional verbal manner with no significant results. Thus, a different strategy from a therapeutic point of view is to approach these problems in a primarily nonverbal embodied manner rather than only talking about them. This nonverbal approach results in sequences of shared experience with a clear benefit for the patient.

However, as we will lay out in detail below, this shared experience does not just appear out of nowhere as a sudden instance of perfect communication. Rather, we claim that in order to ground the notion of we-experience and gain a more precise insight into its characteristics, we need to investigate it in real life data, i.e., to examine the details of how it is developed and sustained in the flow of human interaction. Thus, based on the following analysis, we will argue that we-experience in real life social interaction is (1) embedded in a trajectory of multiple events; it is a gradual and temporal phenomenon that can only be properly analysed by incorporating an investigation of its different phases and different levels of intensity into the analysis. Furthermore, the enactment of we-experience is (2) built into and enabled by skilful embodied coordination between the participants; it is thus an embodied, or rather inter-bodily, phenomenon grounded in expressive movements with a strong affective potentiality. Finally, we suggest (3) that the embodied enactment of we-experience may play a more prominent role in psychotherapy than in mundane interaction. Psychopathology is often connected to a lack of psychological connection with painful experiences and affect (Allen 2013), and in this way embodied communicative resources such as gesture, facial expression, tone of voice, in and out breaths, etc. can work as alternative ways for the therapist to enhance the sensitive responsiveness in the interactive flow, thereby creating an experience of being seen for the patient in a more direct embodied manner.

Overall the enactment of we-experience is nested within a longer trajectory of events leading up to and succeeding the brief occurrence of we-experience. Thus, to create an overview and demonstrate how the enactment of we-experience consists of different phases, the trajectory of the entire sequence is visualized in the model below highlighting the different phases and their relation to each other (see Figure 1). The sequence can be divided into 5 different phases, in which phase 1–2 concern the exploration of different emotions of the patient in relation to leaving her children at the day care, phase 3 circles around feelings of ambivalence and relief of the patient on a more general level, and phase 4 consists of the enactment of we-experience realized in relation to exploring the patient’s emotions on picking up the children. Finally, in phase 5, the experience is verbalized and reflected upon. However, it is important to note that even though only phase 4 is labelled as directly connected to enactment of we-experience, we-experience as an observable phenomenon in interaction exists in a continuum. Thus, we argue that the initial phases 1–3 enable the more fully developed emergence of we-experience in phase 4 in the sense that attempts at establishing a sense of we-ness can be traced to the
early phases. As such, it is present in varying degrees in other parts of the sequence as well, even though it only appears as fully developed in phase 4.

Figure 1: Visualizing interactional trajectory.

In the analysis below, we explain and give evidence for this progressive and continuous nature of we-experience. We show how it evolves in a back and forth manner that slowly leads up to a fully developed extended moment of we-experience. Furthermore, we investigate how this enactment of we-experience can be seen as an integral part of the therapeutic practise viewed as complex dialogical system. In this manner, we ask if the notion of we-experience can enhance our understanding of psychotherapy as a specific type of embodied social interaction.

3.3 Phase 1–2, exploring different emotions: “Feeling bad” and relief

The first phase lasts 23 seconds. The patient talks about the level of strain in relation to getting the children out of the house in the morning to go to the day care. The therapist focuses on the embodied aspects of these conflicting reactions in order to explore and validate their emotional basis:

Extract 1: Phase 1

1. P: I think it’s pretty tough to get going in the morning with two kids
2. (.) we live on the upper floor we need to get below using the stairs
3. and stuff and I think it’s pretty tough
4. T: yes
5. P: already there I start feeling bad (0.5)
6. T: at that point you feel bad
7. P: yes
8. T: bad in the same way
9. P: yeah:
10. T: is it the same here.h hhhh °°oh it’s tough°° [or is it something]
11. else
12. P: [no I think it can] be chest pressure or (0.5) yeah:
13. T: so it’s a different type of bad

Timecode: L. 1–13 (00:00–00:23)

From lines 8–13, the therapist and patient engage in an exploration of the negative emotions related to the work of getting the kids out of the building in the morning. The therapist not only acknowledges the emotions of the patient – she also attempts to get a sense of how it is to feel and experience these emotions in this concrete situation. Importantly, this exploration does not occur on a verbal level only (by asking questions and receiving an answer) since the therapist already attempts to re-enact the emotions of the patient on an embodied level. Thus, in line 10, the verbal question is accompanied by a distinct embodied and affective behaviour that seeks to explore and re-enact the perspective of the patient in relation to this specific emotion and the situation in which it occurs (see Figure 2). After asking “is it the same here” in line 10, the therapist performs a bodily action of placing both of her hands on each side of her body (designating the diaphragm or the lower belly) while also doing a distinct in-and-out breath. It is a clearly audible sigh that is followed by the direct speech of °°oh it’s tough°° uttered in a very low, almost whispering voice. The whispering nature of the utterance provides it with an affective emphatic quality that suggests that it is spoken from the perspective not of the therapist but of the patient. At least, it seems reasonable to assume that the combination of embodied verbal and non-verbal actions is directed towards the emotional state of the patient not only by describing it from the outside, but by re-enacting it from the perspective of the patient. As such, the therapist shifts egocentric perspective by speaking as someone else, in this case as the patient. As described in the theoretical section, re-enacting by use of direct or reported speech is a widespread and well-documented phenomenon. However,
re-enactment typically refers to reporting or re-living the speech and/or behaviour of someone not present in the current conversational situation. Here, the direct speech concerns the interlocutor and is in fact followed by an embodied performance approaching or enacting the perspective of the patient. In this perspective, the sigh performed by the therapist concerns an attempt at imagining how the patient must feel at an embodied level, i.e. the sigh is not incarnating the emotions of the therapist, but of the patient as imagined by the therapist.

**Figure 2:** Therapist and patient.

This initial phase of exploring the negative emotion of “feeling bad” is followed by a different, but closely connected, phase of exploring the more positive, but in this case also shameful, emotion of relief.

**Extract 2: Phase 2**

14. P: yes and it’s also like a bit like eh yeah when I have
then left
15. them then it’s like ahh:
16. T: mhm? hh what is this (.) that sigh
17. P: yeah it’s well that I’m just
18. T: hh hh
19. P: yeah can relax
20. T: yeah → (1.0)
21. P: yes and have my awful thoughts for myself (1.5)
22. T: hmm your awful thoughts
23. P: yes ugly thoughts I mean I hate them
24. T: "ugly thoughts" yeah (2.0) are they pleasant to have
by yourself
25. P: no
26. T: okay so why are you relieved [hh ]
there was a sigh of relief
27. P: it’s
28. that I can just relax that I don’t have any responsibility
right
29. there
30. T: Okay so not to have responsibility
31. P: yeah right there
32. T: that’s really nice
33. P: yes
34. T: you could lie on the couch [and] walk around and clean
up a bit
35. P: yeah and relax
36. T: and relax

**Timecode: L. 14–37 (00:23–01:17)**
In the first phase, the therapist and the patient together went deeper into the exhausting and negative feelings of struggling with your kids in the morning. In this second phase, they address and explore the different positive but conflicting and somewhat forbidden feelings of relief and letting go of any responsibility in relation to leaving your children at the day care. From a we-experience perspective, it is the first part of this sequence that is of particular interest and thus the analysis will focus on this part exclusively. Again, the focus is on the mutual attempt by both the patient and therapist at getting in touch with the feelings that arise in relation to the situation in the morning. In line 15, the patient finishes her utterance not by the use of words but by articulating a distinct outbreath “it’s like ahh::.” The therapist immediately picks up on this in line 16, again not on a word level, but in using sounds and out breaths as a way of responding. Firstly, by acknowledging and affirming the patient’s outbreath in producing a minimal response with a distinct rising intonation, “mhm↑.” Secondly, the therapist transforms the patient’s outbreath as a way of clarifying its exact meaning in this context: “hh what is this () that sigh” (See Figure 3). Thirdly, in lines 18–19, the therapist completes the patient’s turn by delivering the last part of it; again, not by offering a specific phrasing (as when someone in a conversation is searching for the right word), but by offering a more complete and distinct version of the initial sigh, this time with an in-and-out breath: “that I’m just / T: hh hh.” Thus, this repeated and structured use of in-and-out breaths plays an important part in the mutually coordinated exploration of how it is for the patient to experience these feelings in this situation. It is the patient that is the source and primary narrator of this emotional experience, but it is to a very large degree the therapist that breathes life into and re-enacts this experience for the patient, thereby providing it with another dimension. The complexity and conflicting nature of the experience is clearly difficult for the patient to articulate in words, and as such it is difficult both to gain access to it on an emotional level and to reflect upon (and perhaps challenge) it on a more conscious level. Thus, from a therapeutic perspective, it is important that the patient now acknowledges the shameful feeling of relief associated with leaving the children in day care. It is acceptable and more bearable for her now because the acceptance was enacted on a nonverbal level.³ In relation to the overall ambition of the analysis of investigating the continuous emergence of we-experience in real life interaction data, we can on a preliminary basis note that the initial building blocks to such an experience are already set in this part of the sequence.

### 3.4 Phase 4, enacting we-experience

As stated in the beginning of the analytical section, the total sequence is 5:07 minutes long and divided into 5 different phases on an analytical level. However, when we focus strictly on the emergence of we-experience, phase 3 is of less analytical interest. Different topics are discussed here, all of them related to the conflicting emotions of feeling relief and guilt when leaving the kids at the day care, but these phases do not entail a further embodied exploration into the emotional dimensions of this. But in phase 4, 3:45 minutes into the overall sequence, something new happens that also connects and points back to phases 1 and 2. This time the topic is the patient’s feelings when she picks up her children from the day care at three o’clock in the afternoon.
Extract 3: Phase 4

83. T: but how are you really when it’s close to three o’clock
84. P: so yeah .h hhh [.hhh t yes.hh]
85. T: [hhb PHH:: hh]: hh:: hhh phh
86. P: yeah like that yes heh
87. exactly like this
88. T: (0.5) .hhh PHH:: you really need to take a deep breath right
89. P: yes hh: heh heh that’s right that is exactly how I feel

In phases 1 and 2, we saw how the therapist and patient on an embodied level and in collaboration approached a common understanding of how the patient felt when (1) she had to get her children out of the house in the morning and (2) when she left them in the day care. This phase, in turn, concerns the logically last part of the narrative, namely (3) picking up the children again from the day care and the feelings that arise in connection to this. The topic is initiated by the therapist as a specific question in line 83. It is interesting to the notice the type of answer or response she receives from the patient. Normally, a direct verbal question, as the one posed by the therapist, anticipates and requires a verbal answer for a conversation to proceed. In this instance, however, the patient does not produce a fully developed verbal answer. She does initiate the beginning of what looks like an utterance, “so yeah,” but then stops and instead she makes a slightly prolonged in-and-out breath “.h hhh.” This bodily action is immediately mirrored or repeated by the therapist in line 85 in which she, partly in overlap with the patients turn, makes two prolonged and enlarged in-and-out breaths. These are also accompanied by an intensified and heightened series of facial expressions in which she, in an overtly enhanced fashion, breathes in and out (see Figure 4). These actions, we argue, need to be seen in relation to the actions of the therapist in extract 1 in which she briefly took on or re-enacted the perspective of the patient. Also, in this example, it is perfectly clear for both participants that the enlarged in-and-out breaths mark a shift in egocentric perspective and as such are performed from the perspective of the patient, not the therapist. This is evident since they receive a clear and positive verbal confirmation from the patient in lines 86–87, “yeah like that yes heh exactly like this,” followed by laughter and smile showing that the shift in perspective is effortlessly and immediately understood (see Figure 5). But what does this re-enacted shift in perspective amount to in relation to enabling a we-experience?

Figure 4: Therapist breathing out and in.
First of all, it is apparent that the enlarged nature and repeated use of these bodily actions are ways for the therapist to highlight a particular structure (the sighs) in the ongoing flow of interaction. In this sense, it can be seen as a professional skill, a type of “body technique” marking particular bodily actions. Thus, instead of talking to the patient about how she feels, the therapist, in and through her bodily actions, shows the patient how she feels. The therapist shows a version of the patient to the patient through her embodied actions. As such, these bodily actions provide a model of the patient in situ that has a more profound impact than if only verbalized. Secondly, the therapist re-enacts a specific situation (about to pick up the children at the day care) by acting out the specific anticipated embodied emotional response to this situation. In this way, the situation and the emotions connected to it in some sense come back to life right in front of the patient, incarnated in the actions of the therapist. Furthermore, as described in the theoretical section, the performed re-enactment by the therapist is a tinted version of the patient’s experience. The in-and-out breaths are enlarged and performed with an embodied intensity with an almost theatrical nature. This intensified element can be seen as having at least two purposes. (1) The embodied actions are a way for the therapist to gain access to the experience and related feeling that the patient has expressed to her. It is crucial that the therapist is doing the same bodily actions – breathing heavily in-and-out – and thereby re-enacting the experience and feeling on an embodied level (rather than just describing it in words). (2) The enlarged nature of the performance also has a clear intention and purpose – that is, to facilitate an animated and vivid image to the patient in which she can see and recognize herself. Thus, the therapist must transcend her own point of view in order to have an authentic and truthful understanding of the patient on an embodied level.

As such, we suggest that the embodied re-enactment of the therapist enables the patient, for a moment, to see herself as a ‘you’ from a second person perspective. Likewise, the therapist engages in an experience emating from her interpretation of the patient’s experience and feelings. Together, these intersubjective actions create a particular experience of ‘we-ness’ – albeit not in the sense that patient and therapist have the same undifferentiated experience or feeling (as would be the case with emotional contagion), but they still share an experience of how exhausting it sometimes feels to pick up your kids from kindergarten (the therapist also has small children). Again, they share it not in the sense of feeling exactly the same, but in the sense of enacting emotional experiences that are “co-regulated and constitutively interdependent” (Zahavi 2015: 90). Furthermore, if we see these actions through the lens of intercorporeality with a vantage point in co-present bodies, the enlarged nature of the therapist’s repeated sighs makes it clear that they, in some sense, do not belong to her exclusively. Rather, they are enacted as a way of giving life and expression to the previous experience of the patient and the experience that the therapist has with the patient in this moment. In this way, the sighs emerge not from the therapist as an isolated unit, nor from the patient as a bounded entity, but from a ‘we.’ These bodily actions point both ways, so to speak, towards the therapist and the patient alike. It is the patient that is the source and experiential basis of this emotional experience – but it is the therapist that breathes life into, shapes, and re-enacts this experience, thereby providing it with another dimension.

3.5 Phase 5, verbalizing and reflecting upon we-experience

Looking at the entire 5:07 minutes sequence as a whole, the short duration of the enactment of we-experience in phase 4 is noticeable and worth considering – as are the bodily dynamics connected to it. It lasts only 21 seconds before it develops into a more conscious and reflective phase of talking about the experience they jointly re-enacted. However, as described in the previous parts of the analysis, the enactment of we-experience did not occur out of the blue. Going through the entire sequence, it is evident that it is gradually enabled through a trajectory of sighs and embodied intersubjective actions beginning in phase 1 and 2, receding in phase 3, culminating in phase 4, and finally verbalized and reflected upon in phase 5. Thus, as a final point in the empirical
investigation of this gradual nature of we-experience in social interaction, we shall now take a look at phase 5 following after the enactment of we-experience.

Extract 4: Phase 5

90. T: what are you laughing at
91. P: it’s just (0.5) you know I can tell exactly how (. ) you know it how
92. I feel I mean you just did it
93. T: ( .) it was you who did it first right
94. P: yes
95. T: and that tells me that phh: so when they just have left in the mor-
96. or you have left them in the day care (. ) you had to take them down
97. the stairs and get them into their snow suits phh: one of them can’t
98. be bothered the other one is tired and doesn’t want to take on his
99. jacket (. ) no they are still too small for that so maybe it’s not that
100. but it is still there is one thing and another and in a car seat and
101. P: yes
102. T: yes hh and then there came a sigh when they were in day care hh::
103. that was like something that is nice
104. P: yes
105. T: it was a completely different one when time is getting close to
106. three o’ clock
107. P: yes
108. T: when it was a HHH PHHHH now we have to do it again
109. P: yes(1.5)
110. T: yes

In the first part of this phase from lines 90–92, the patient confirms on a verbal level the intersubjective validity of the embodied actions (the sighs in phase 4) of the therapist. Indeed, in lines 91–92, the patient describes clearly how the therapist managed to enact (an image of) her own the emotional embodied experience: “you know it how I feel I mean you just did it.” The patient’s choice of words is interesting here. According to the patient, the therapist knows how she feels since she just did it. Thus, the emotional experience of the patient, tied to the concrete situation of having to pick up her kids from the day care in the afternoon, was not just described or analysed. It was re-enacted and brought back to life and through a series of embodied actions by the therapist. For a short moment, the therapist did it—that is, she acted as the patient from an imagined first-person perspective. This seems to have had a much more profound effect on the patient (on a second person-perspective) than any type of verbal analysis or description could have offered. In fact, the vividness of these embodied actions has made such an impact that the therapist in line 93 stresses that, in fact, it was the patient who made the initial sighs: “it was you who did it first right.” Still, it is noteworthy that the enlarged and augmented nature of the sighs of the therapist apparently have made them more real than the patient’s own much more slender sighs. She has to be reminded that they did in fact originate from her, which, in relation to the topic of this article, further testifies to the central point that they shared the enacted experience: it originated from a ‘we’ that momentarily came to characterize the interaction.

Subsequently, in the following lines the episode is retold and reflected upon. In lines 102–108, it is again to some degree re-enacted by the therapist. This time, however, the in-and-out breaths are utilized as a way of summing up and concluding on the experience rather than re-living it again. The sighs are more clearly placed within a verbal narrative of how different the patient feels depending on if she has just left the kids in the day care or, conversely, when she is picking them up again. These two scenarios are depicted here as two different types of sighs, one expressing relief, the other exhaustion and perhaps some level of anxiety. In this way, the sighs are reused to establish and confirm a shared understanding of the situation.

4 Conclusion

In this last concluding part, we will point to the potential of working with a more conscious focus on re-enactment and shared experience in therapy. Then, we will elaborate further on the discussion of the perspectives and challenges in applying the concept of shared experiences to studies of social interaction.

It is important to stress that the experience of we-ness investigated in this study emerges from the embodied level of interaction from a trajectory of embodied re-enactments – this aspect entails an important therapeutic
potential. Thus, the way that therapist prolongs and enlarges the sigh also marks a prolonged exposure of an emotion that is difficult and hard to accept for the patient (the guilt and shame of admitting that it is difficult to raise two small children). Working with these embodied aspects of ‘hard to reach’ patients – such as eye contact, accurate turn-taking, tone of voice, and attuned in-and-out breaths – plays an essential role in making the patients feel understood and thereby restoring their capacity to learn from experience. As such, the example illustrates a general point about intervening with exposure on an embodied non-verbal level. The complexity and conflicting nature of the experience is clearly difficult for the patient to articulate in words. As such, it is difficult both to gain access to it on an emotional level and to reflect upon (and perhaps challenge) it on a more conscious level. Thus, it is likely that this shared experience can help to lay the groundwork for a slight emotional and cognitive change for the patient. In seeing herself from the outside, the patient may be able to see, accept, and understand her own actions better.

This therapeutic perspective is closely connected to the theoretical (and empirical) question of working with shared experiences in social interaction. As mentioned in the introduction, an experience emanating from a ‘we’ will usually require a shared attention towards an intentional object external to the people having the experience (such as in watching a movie together). Clearly, this condition is fundamentally different in the example analysed in this article. Here, the shared intentional object is part of the interaction itself – or, rather, the experiential basis of their attention derives from the actions and dynamics of the interaction. This means that the ‘we’ in this situation is harder to disentangle from the object of their intention. Still, one of the essential features and affordances of face-to-face interaction in the here-and-now is the possibility of bringing back and re-enacting past situations and exploring them together in situ. As such, this re-enacted scenario obtains a status similar to that of intentional object external to the participants. This does not amount to claiming that the shared experience is identical with, for instance, the experience of watching a movie together. As shown in the analysis, it differs in many ways, chiefly because it is the result of a shared accomplishment built into the structure of the interaction. As such, it is dependent on the active ‘doings’ of both participants in order to be sustained and developed. This also makes the shared experience a fundamentally temporal phenomenon in a manner different from other types of shared experiences. As documented in the analysis, the achievement of shared experience in phase 4 was enabled by actions and developments in the previous phases. As such, it is mandatory in working with social interaction to investigate what came before and what follows an instance of shared experience.

Unlike (watching) a movie, the re-enactment is performed by the participants themselves. Still, due to the dialogical nature of interaction, in which the re-enactment is performed, it is possible for the participants to switch roles between “actor” and “spectator,” thereby partaking in a shared multi-dimensional experience. This also means that the re-enactment only makes sense in light of the fundamental co-presence of the situation – not just in the banal sense of them being in the same room situated in front of each other, but also in the more profound sense of “the other as participating, with me, in that experience” (Hobson and Hobson 2014: 188). Thus, the re-enactment becomes a meaningful act in virtue of both participants being engaged in it – the therapist re-enacting the experience and behaviour of the patient while being aware of the patient as experiencing this re-enactment, and the patient participating in the re-enactment by giving feedback and thereby supporting the act. They co-construct the experience, albeit not in the sense that they have the same experience, but rather that they explore and develop a joint perspective on a particular emotional experience. Thereby, the experience is no longer one that exclusively belongs to the patient (or the therapist) but rather it, for a brief while, concerns a ‘we.’

**Funding**

This work was supported by the Velux Foundation (Grant no. 10384). We thank all employees, patients, and psychotherapists at the outpatient clinic for anxiety and personality disorders at Brønderslev Psychiatric Hospital, Denmark. Without their time and expertise, this research would not have been possible.

**Notes**

1 This new wave in cognitive science has been coined using different terms, such as distributed, or embodied, enacted, embedded, and extended (in short “4E cognition”) (Menary 2010). As such, the way we use “embodied” in this article is meant as an umbrella term to some extent encompassing all of the different E’s. This also implies that we, for reasons of space, do not go into discussions on the subtle internal differences between these new approaches. Instead, we focus on the commonalities that, seen together, set them apart from a more standard in-the-head view on cognition. For discussions on these and related issues, see Steffensen (2009), Chemero (2011: ch. 2), and Gallagher (2017: ch. 2).
2. This is not to say that the enactment of we-experience is planned or rehearsed in any way. Rather, it develops as a part of the ongoing interaction in a more or less spontaneous fashion as most interactional phenomena in real life situations do. Still, as mentioned above, it is likely that the therapeutic interaction, with its focus on building an intersubjective understanding of sensitive topics, may entertain a likely scenario for the occurrence of we-experience.

3. In terms of the therapeutic dimension, it is worth noticing that as soon as the therapist points to the sigh on a verbal level, the patient turns her focus to her “awful thoughts.” Thus, the relief sigh marks a moment of possible realization about the cause and function of the symptoms expressed by the aggressive obsessive thoughts (which the patient names “awful thoughts” or “ugly thought” in this sequence). The therapist focuses her interventions on exploration and acceptance of the positive emotions associated with having a break from the responsibility of two small children.

4. The reason behind the question relates to the fact that earlier in the session, the patient stated that her obsessive thoughts increase around three o’clock on weekdays.

References


**Bionotes**

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