Abstract: This paper is an empirically-based theoretical contribution to the field of research that investigates the function of trust and re-enactment in psychotherapeutic interaction. We use an ecological, embodied approach that pays attention to how human interaction is constrained by multiple timescales (past, present and future). The analysis sheds light on how trust, here in terms of a therapeutic alliance, is enabled, performed and maintained in interaction through the work with embodied re-enactments of previous events. Specifically, we describe how this therapeutic work constitutes an emerging, situated opportunity for teaching/practising embodied emotion regulation in the form of a co-participated enactment of “taking a deep breath,” and we emphasise how embodied, co-participated re-enactment of past (dys)functional behaviours outside of therapy can be a resource for redirecting, teaching and reinforcing therapeutically relevant behaviours in the context of therapy presenting themselves as fruitful opportunities for facilitating incremental change. Further, psychotherapy serves as a useful case for demonstrating the relevance of such an embodied interaction approach far more generally.

Keywords: embodied interaction, embodied cognition, re-enactment, trust, psychotherapy

1 Introduction: Studying trust and re-enactments in psychotherapy

This paper uses psychotherapy as a case for demonstrating the practical and theoretical implications of investigating re-enactment from an ecological,
embodied interaction perspective. While we investigate the case of psychotherapy, we suggest that the case provides a perspicuous site for demonstrating the relevance of such an approach far more generally. In this introduction, we discuss why trust is crucial for interpersonal coordination and how it relates to the work with reenactments in psychotherapy, and finally how this focus enables cognitive changes for the patient. In the succeeding section (see Section 2), we elaborate on the theoretical background: the ecological, embodied interaction perspective.

Ardito and Rabellino (2011) and Linell (2009) — amongst others — have analysed how successful interaction is enabled by dialogical values such as caring and trust. In organisational settings, studies have emphasised how the interdependency of others is used to enact trustful coordination to be able to pursue a cognitive agenda (Giddens 1991; Linell and Marková 2013; Marková and Gillespie 2007; Marková et al. 2008; Rotter 1971, 1980; Pedersen 2015; Salgado 2014; Trasmundi and Linell 2017). As trust appears to be one central element in general successful interaction, we assume that this is also the case in psychotherapy, and that trust, therefore, is an expression of a good ‘therapeutic alliance,’ when goals and tasks are agreed upon too. A more radical proposal has been provided by Salgado (2014), who emphasises how trust has been described as a marker for change in psychotherapy. Therapeutic alliance relates to how the therapist engages with a patient. Further, there is a temporal aspect connected to the term that involves a focus on how the ‘bond’ between the two parties develops. Several psychologists have described how this bond develops in relation to an agreement on the tasks and goals of psychotherapy and yet others have emphasised how the bond emerges from a general experience of trust and empathy in therapy, that is identified in the rapport, willingness, supportiveness, positive attitude and congruence performed in the interaction (Cramer 2016). We ascribe to a standard definition, inspired by Hatcher and Barends (2006) that describes therapeutic alliance as “the degree to which the therapy dyad is engaged in collaborative, purposive work” (ibid.: 293). This definition synthesises the therapeutic alliance as a relationship that involves the three components: rapport or bond, agreement about goals and agreement about tasks in therapy. That the therapeutic alliance is one of the most studied non-specific, common factors in psychotherapy relates to the fact that human beings are the ultimate social species; as such, psychotherapy is a special case of a social soothing practise. However, the literature is scarce with regard to knowledge about how trust is practised. A remaining practical question thus is: How do therapists and patients embody trust and establish an alliance that enables cognitive work and possibilities for cognitive-emotional changes? In order to understand this phenomenon, we need investigations of how alliance and trust are brought about in real-life practises (Jensen and Pedersen 2016). Thus, in the analysis (see Section 4), we investigate such practises, by zooming in on how a
patient — through re-enactments — is willing and open to share, reflect on and adjust her perceptions of self and others as she engages in cooperative work with the therapist. Before we elaborate the theoretical background of our study, we provide a definition of re-enactment and argue why this concept needs to be studied from an ecological, embodied perspective.

While re-enactments traditionally have been explored from a linguistic perspective, an embodied, ecological (see Section 2) perspective necessarily studies the phenomenon as a whole-bodied, multi-scalar activity (Sidnell 2016; Streeck 2009). Thus, re-enactment — in this view — involves a rich embodied narrative of parts of past situations that are acted out in the here and now. The narrative often involves mimicking different characters’ actions as the speaker shifts between different roles in the re-enacted interaction, which we will also see in the example below. From the perspective of embodied interaction research, Streeck (2009) underlines the individual’s interactional capacities to perform different people’s stances in a multi-party interaction:

[…] re-enactments bear the seed of performance art, of stagecraft. A speaker can characterize another person by one or two mimetic strokes, delivering just as much as is needed to produce the characterization that the story, at this point, needs. Enactments can also be elaborated into pantomime and caricature. […] By projecting a hand-made gestalt onto a different domain of experience, enactments organize experience by enacting, exaggerating, embellishing and modulating patterns made from the same stuff from which their denotata are made. (Ibid.: 147)

Thus, during re-enactments, the speaker takes on different roles, i.e. he or she no longer only acts as him/herself but embodies a series of other speakers and characters relevant for playing out the scene. As described in the literature, gestural re-enactments or mimicking can in principle involve any relayed scene as performed by the speaker (Kendon 2004; Streeck 2009). However, for the purposes of the present paper, we use the term in a way that limits it to highlight the specific embodied re-enacted performances of a patient’s past or recurrent experiences, as well as enacted elaborations and explorations of such. As such re-enactments become efficient work material, and as the therapist co-participates in those interactions, she/he can affect the ecological life trajectory of the patient by initiating therapeutic interventions if the therapeutic alliance allows such involvements. In the analysis below, we show how this is done in a naturally occurring psychotherapeutic interaction through interactional and co-operative re-enactments of past behaviour that is made relevant and accessible for co-action in therapy.

The article is structured in the following way: In the succeeding Section 2, we describe the implications of an ecological, embodied approach to the study of trust through embodied re-enactments. In Section 3, we argue that an ecological
perspective provides new methodological possibilities for investigating (1) the temporal complexity of re-enactments in psychotherapy by focussing on how multiple contexts are nested in local interaction and (2) re-enactments in embodied interaction more generally. Having described the methods and the data used in this study, we turn to the analysis (Section 4) and present an empirical video-recorded case of therapeutic alliance and trust through embodied re-enactments as they emerge in a naturalistic psychotherapy setting. Finally, in Section 5, we discuss the practical as well as methodological and theoretical implications of the study. First, we discuss how our findings may help therapists focus their attention on how whole-bodied embodiments function in therapy and can be used to direct and redirect attention towards therapeutically relevant places without violating the therapeutic alliance. Second, we discuss why it becomes vital to understand how interactional outcomes are enabled by multiple nested contexts. In turn, few existing analytical models to human interaction and cognition succeed in linking situational and trans-situational phenomena convincingly. Most methodological apparatus only unveil part of human interaction: for instance, the local timescale and context of social interaction. Indeed, there is a need to develop systematic embodied interaction approaches that adapt their methods in accord with these foundational theoretical assumptions about ecological interaction.

2 Theoretical background: An ecological perspective on embodied interaction

In this section we explain what an ecological, embodied perspective on human interaction entails and why it matters for the study of re-enactments. Further, we define the key concepts an ecological perspective on human interaction entails for empirical investigation. Specifically, we define the concepts ‘embodiment,’ ‘inter-bodily dynamics’ and ‘nested contexts,’ and we discuss how we apply them in the empirical section to better understand how the work with re-enactment involves the body, interpersonal coordination, lived experience and social normativity.

At a basic level, an ecological paradigm embraces a phenomenon in its wholeness — that means as part of a larger system than that which appears in real-time (Loiza et al. 2020; Pedersen 2015; Pedersen and Steffensen 2014; Steffensen and Pedersen 2014; Trasmundi 2020). We later refer to this trans-situational phenomenon in terms of ‘nested contexts,’ which means that multiple contexts are potentially relevant in local interaction. Moreover, any person is in direct relation with his/her environment, which means that the relation is not mediated by representations, and every action is viewed as a relational, structural coupling
between the person and his/her environment (Chemero 2009; Maturana 1978). An ecological perspective on therapeutic work thus involves that the patient is viewed as a person with a historicity that enables him to revoke the past in the present. It further treats the patient as a dialogical self (Linell 2009; Linell and Marková 2013), which means that its characteristics are a result of the way that the patient engages in various relationships over time. As such a person is in a constant process of becoming (Di Paulo et al. 2018) and a person’s unique individuality can be observed in his or her tendency of enacting a certain pattern of embodied behaviour in certain contexts (Bergson 1907). This ecological and multi-scalar perspective is important as a central methodological question that challenges interaction researchers in psychotherapy is how and where symptomatological change emerges and can be observed or measured in actual real-time behaviour. One methodological challenge relates to the fallacy of simple location (Whitehead 1925); the idea that we can point to a specific place in interaction where ‘the magic happens’ that fundamentally changes the patient’s pattern of behaviour including his or her thinking. An ecological perspective on therapeutic work hence considers the patient’s ability to impose small-scale changes over time and across contexts. Like learning to walk or talk, therapy is a temporal activity that works over time by engaging the patient in repeatable (dys)functional behaviours in order to affect the habitual and embodied historical and bio-social person that undergoes therapy (Trasmundi et al. 2020).

Successful psychotherapeutic interaction has been characterized by patients and therapists’ work on re-enactments (Cramer et al. 2016; Hilliard et al. 2000). That is, how the patient in therapy explores his or her own behaviour as he or she brings (critical) situations experienced outside therapy to life (Cramer et al. 2016). For instance, when a patient narrates what she experienced in a previous situation and that narration is explored later in a therapy session. We will argue that successful co-action with re-enactments in therapy can be viewed as materialised or performed therapeutic alliance. The way those re-enactments are played out and challenged in therapy reveals inter-bodily dynamics between the therapist and the patient that are linked to emotion, safety and trust in the dyad. That is the reason for our interest in therapeutic alliance and trust through the work with re-enactments. Inter-bodily dynamics is a common term in the literature of distributed language (Cowley 2011) and embodied cognition (Chemero 2009). Basically, dynamics refer to the mechanisms related to bodily movements (they can be social, neural, etc.) and they always entail some sort of change within a dyadic system (for instance, an utterance entails an action, gaze entails a reaction, etc. in the interpersonal system). Emotional dynamics are thus those that relate to emotional manifestations. With embodiment, we refer to the literature within the paradigm of radical embodied cognition (Chemero 2009; Goodwin 2017a; Loiza et al. 2020;
Stuart 2017; Trasmundi 2016). Here, the core idea is that the human mind is understood in relation to the human body and the context in which it is embedded. In our case, we thus analyse how inter-bodily dynamics (the system of therapist and patient coordination) enables the patient to embody different perspectives for instance as she/he learns from the re-enactment process.

Re-enactment is a powerful way of bringing life to lived experiences with the aim of manipulating one’s emotional-cognitive perceptions as they are played out. For the ecological embeddedness of such an excerpt of interaction, we visualise this idea in the following ‘nested context model’. This model is our visualisation of an ecological, multi-scalar perspective on human interaction as it emphasises that a person’s embodiments can be constrained not only by local interaction but also by the history of experiences that can be enacted in certain local circumstances. Thus, in our setting, we highlight how a patient’s (P) lived experiences serve as a constraint in local action just as a therapist’s (T) professional vision (Goodwin 1994) enables her or him to identify therapeutically relevant cues in real-time interaction. Further, the shared history of the therapist and the patient serve as a constraint for real-time co-action as well. We visualise this conceptual idea in the following model below, which is inspired by Linell (2009) and Streeck and Jordan’s (2009) notion of multiple nested contexts (see Figure 1).

**Figure 1**: Nested Contexts Model inspired by Linell (2009) and Streeck and Jordan’s (2009) notion of ‘multiple nested contexts.’
Trasmundi and Linell (2017) stress that even though we investigate one situation, that situation is saturated with multiple contexts. In a similar vein, Streeck (2010: 239) underlines how an activity is one of fluid, multi-scale, joint sustainment in multiple contexts simultaneously. The different circles that embrace the individuals in the context model above, each refers to different situation transcendent narratives and trajectories that make up the individual’s subjectivity (Di Paulo et al. 2018; Linell 2007, 2009). Linell (2009) as well as Streeck and Jordan (2009) emphasise how those situations are constantly re-contextualised and serve as constraints on embodied real-time interaction:

Interaction [...] is never ‘about’ one level of context [...] Rather, it is simultaneously ‘about’ all of the scales of embodied context the participants bring to bear during the interaction. Embodied action (including speech) always contributes to the sustaining of multiple nested contexts at once. (Ibid.: 454)

In the model above, the patient-therapist dyad is intertwined in multiple shared and individual interaction trajectories. Those are made relevant in various ways in therapy and they impact the patterns of behaviour in therapy. As such, the therapist’s job is to understand and aid in making explicit those global, habitual behaviours in real-time therapy in order to manipulate the embodied and skilled habitual ways of coordinating actions. One of several reoccurring activities in many different forms of therapy for achieving this is narrating, re-enacting and re-appraising past situations from the patient’s life. This task is a delicate and at times emotionally taxing activity that needs to be managed carefully in order to be successful.

In this paper, we use this model to frame the empirical investigation of how trust and safety is embodied in a therapist-patient dyad and how re-enactment of an emotionally distressful situation outside of therapy in this context becomes a fruitful opportunity and resource for cooperative therapeutic work. By hypothesis, such small-scale co-actions will eventually impact the patient’s habitual, embodied emotional-cognitive actions in and outside of therapy.

Rather than pursuing an accumulative approach (adding cognitive and linguistic analyses), the ecological, embodied interaction analytical approach outlined below pays attention to how people manage projects and achieve goals by integrating cognition with language (Love 2004). Such analysis involves investigations of how multiple timescales are enacted through embodied behaviour to understand the emotional-cognitive complexity of the patient’s life, pathologies and therapeutic progression (Di Paulo et al. 2018).
3 Methods, data and analytical procedures

The study presented in this paper relies on micro-analytic investigations of video-recorded data of a naturally occurring psychotherapeutic interaction between a MBT\(^1\) trained Danish therapist and a patient who is diagnosed with social anxiety disorder and obsessive-compulsive disorder (OCD). The study is based on video-recordings of 16 sessions of approximately 50 min of the dyad captured from three different angles — a front facing camera-angle of each participant as well as a global viewpoint capturing both. The case study further relies on ethnographic observation data and multimodal micro-analytic data. The analysis presented below presents a case of psychotherapeutic interaction from a patient’s ninth therapy session. The one example is divided into four data excerpts for pragmatic reasons, as each excerpt underlines specific embodied interactional resources for managing the patient’s interactional challenges. This example from the ninth session was selected for analysis as it demonstrates the mechanisms involved in — as well as the function of embodiment and co-action in a typical case of practicing therapy. As we deal with trust, shared sense-making, and embodied re-enactment in psychotherapy, we argue that there is a need to integrate a more linguistically-based approach with an embodied one, hence our main interest is to describe what people do as they talk, gesture and act in specific practices. Such an embodied approach integrates multiple disciplines that deal with human sense-making. The case was thus analysed using analytical procedures common to Multimodal Interaction Analysis (MMIA). MMIA involves taking an embodied perspective to interaction, taking into account the full array of gestures, head- and body movements, gaze and verbal utterances (Goodwin 2017a; Heath et al. 2010; Meyer et al. 2017; Norris 2004; Streeck 2009; Streeck et al. 2011). In particular, we rely on a Goodwinian approach to interaction analysis, i.e. we focus the analysis towards the cooperative actions that pivot on how participants use, reuse and transform each other’s embodied actions to generate new and joint meaningful actions (Goodwin 1994, 2000a, 2000b, 2003, 2007, 2013, 2017a, 2017b).

Altogether, the analysis exemplifies (1) the specific configurations of embodied and multimodal interactional mechanisms that comprise the cooperative therapeutic work of affective attunement, marking and re-directing the patient’s re-enactments and (2) how — when based on a trustful relationship — this activity enables opportunities for small-scale cognitive-emotional changes for the patient (change in perception, new understanding, different ways of responding etc.). An important point is addressed in relation to such investigation: We are

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\(^1\) Mentalization Based Therapy.
aware that the therapeutic alliance is not reducible to local negotiation and interaction pattern — alliance is also a historical and dialogical phenomenon (here we are embedded in the ninth session). While the alliance emerges as a result of previous interactions, it is not a fixed and stable phenomenon. Rather, it needs to be managed and renegotiated continuously. Hence, due to the nature of psychotherapy (the therapist works with the patient’s coping mechanisms and will often act to push the patient outside his/her comfort zone), the relationship between patient and therapist is delicate and changes between more or less functional states. The complex development of the therapeutic alliance has been described in empirical research, which emphasises the importance of nourishing the relationship throughout the whole course of therapy: “we would expect a development in the alliance to be characterized by a linear growth pattern over the course of the therapy […] however, according to the findings of numerous researchers, this is not the case” (Ardito and Rabellino 2011: 270). Thus, bearing in mind that relationship over time affect expectations and local interpretations, we argue, that we would be able to describe how the parties continually maintain and enable the emergence of the therapeutic alliance, in this case through the work with re-enactments.

4 Analysis: Doing therapy — trust, re-enactments and possibilities for small-scale changes

The aim of the analytical section is to investigate and provide new insight into how the trustful bond (therapeutic alliance) is maintained and functions as the basis for potential cognitive changes for the patient — in this case, through the work of embodied re-enactments. These results naturally apply to general cases of human interaction where trust is key to caring relationships. Rather than favouring a specific approach, we zoom in on the function of working with re-enactments. The analysis falls in three parts. Together, it shows the interdependency between therapeutic alliance and therapeutic intervention through the work with re-enactments. First, we show how the trustful bond of the therapeutic alliance is maintained in the dyadic system, through embodied, supportive co-participatory work with re-enactment of a stressful situation the patient recently experienced outside of therapy. On the basis of the co-enacted trustful bond between the therapist and the patient we analyse how the therapist is able to challenge the patient’s cognitive work by skilled performance at therapeutically relevant places (see Section 4.1). Second, we discuss how possibilities for behavioural changes might be enabled by interlacing re-enacted previous experiences in local
embodiment, for instance by linking symbolic abstractions to bodily enacted reactions and how the therapist enables the patient to make that link and perceive her history from a new and more nuanced perspective (see Section 4.2). Finally, we investigate the benefits of re-enactment of emotional management for psychological development (see Section 4.3).

We enter the interaction just as the patient initiates such a re-enactment of a past situation she recently experienced in her own life. To get a sense of the overall situation, we provide an overview of the setting followed by a transcript of the case that we investigate (see Figure 2).

The patient and the therapist have just opened a new topic for conversation, which involves an investigation of the patient’s unpleasant feelings (an emotional topic which she generally finds difficult to talk about). Hence, the degree of trust among the two is crucial for how the interaction develops. In this example, the patient brings up a situation that involves her supervisor at her job. According to the patient, the supervisor has lectured and instructed the patient in work procedures in an unpleasant way, which the patient perceived as an act of dominance. In this first excerpt we show how the therapist, as the patient re-enacts the dialogue with her supervisor, provides an open, engaged and emotionally supporting environment, which scaffolds opportunities for trust emergence. Further, we point to how the patient, through whole-bodied re-enactment, employs resources to make salient and exhibit difficulties and emotional reactions. Such contrasting stances and emotional reactions, we argue, might be more evident in embodied performance than relying on verbalisation, i.e. on linguistic resources only, which is why re-enactment is an emotional-cognitive rich phenomenon. Embodiments, as argued above, reflect a person’s emotional stance and degree of affect in ways that is not possible to discern solely from a word-based analysis (Couper-Kuhlen and Selting 2009). Gestural and prosodic analysis is needed to account for the emotional dynamics inherent in interaction. Thus, following procedures from ecological, embodied interaction analysis (cf. Sections 2 and 3), we therefore zoom in on gestural and prosodic aspects inherent in the cognitive-emotional interaction between the therapist and the patient.

4.1 Embodied re-enactments: Therapeutic alliance, challenges and marking

Right before this excerpt, the patient revealed how an episode at work has left her agitated. Rather than just talking ‘about’ what happened, the therapist encourages the patient to go through this episode together with her to ‘relive’ what happened. In other words, she encourages her to re-enact the previous event in real-time.
Figure 2: Visual overview of the setting including transcription of the situation we analyse.

‘Bonnie’ (see l. 1) is an alias for a resident at the nursing home in which the patient works part time. 13.5s were left out (between l. 23 and 1. 24). In this part, the patient repeats a previous explanation about how she previously has carried out a task, which her supervisor has asked her to complete. This part is left out for reasons of space limitations and because it does not add any important information to the analytical focus in this article. In the actual recordings, the patient and therapist face each other, but we have — for pragmatic reasons — placed them next to each other in the galleries.
therapy. As we will learn, this task involves a re-enactment of the agitation and the bond between the patient and therapist needs to be strong enough to maintain such cognitive-emotional explorations. This excerpt thus pivots on how the therapist engages in the work with re-enactment (exploring what happened then) when she also performs a trustful, supportive behaviour (showing how she cares for the patient here-and-now).

The excerpt begins as the patient takes on the role of the supervisor, i.e. talking ‘as if’ she was her (l. 1–3 and l. 5–6) to re-enact the dominating attitude of the supervisor as she instructs the patient in the order of work procedures.

The patient re-enacts the role of the supervisor. Specifically, she divides the supervisor’s narrative into distinct demands following the same prosodic pattern: She initiates the demand in a monotone voice and ends with an intonational rise followed by “the::n” (l. 1, 1. 2 and 1. 5) which leads to the next demand. This pattern repeats three times: (- - - Bo↑nnie↓ [l. 1] - - - criticism↑ [l. 3] - - - que↑stions [l. 5]). Together, this vocal re-enactment underlines the repetitive, instructive character of the demands. Further, the patient’s direct and dominant gaze and facial expression and a series of abrupt pointing and sweeping hand gestures indicate the demonstrative instruction given by the supervisor (see Figure 3A-patient and 3B). During this reported speech, the therapist gazes intensely and focused on the patient’s face and nods slowly in a way that both follows the tempo of the patient’s speech and encourages her to continue (l. 4, see Figure 3A-therapist) when the patient hesitates.

In l. 8–9, the patient re-enacts a response to this reported demanding attitude of her supervisor. Her embodied response is salient in many ways: First, her facial expressions reveal surprise, insult and submission, as she raises her eyebrows, opens her eyes completely, and stares vacantly into space (see Figure 3C). Also, her body posture further underlines this emotional reaction as she leans back and lets her hands down and freezes for a short moment before she starts nodding for 1.7 s (l. 8) before finally uttering “°o[kay]” with a flat intonation and in a soft voice (l. 9, see Figure 3D-patient). Taken together, those actions clearly demarcate the two roles of the patient and her supervisor. The re-enactment of the perceived asymmetric distribution of authority as well as the patient’s distress or dissatisfaction become salient, not from the fact that she says so (for instance I felt that my supervisor overstepped my boundaries), but from the way she embodies how her supervisor’s instructions were performed from the point of view of the patient. As such, the patient’s re-enactment provides the therapist with a window into the patient’s emotional state and her logic of argumentation; in this case, that demanding such things is intimidating and agonising.

Referring to the context model above, the patient re-enacts a previous situation in real-time. However, it is not a simple or objective “reproduction” of a prior
Figure 3: Excerpt 1.

1 P: when we are done here with Bob the: :n eh
2 >then we will catch up afterwards< and the::n I
3 will give you some [constructive criticism↑] (.)
4 T: [*slow nod*]
5 P: and you can ask me some questions and then
6 (.). <then that is [how we will do] it<
7 T: [mmmm]
8 ps: *P nods, raised brow and wide eyes for 1.7 s*
9 P: °o[kay]°
10 ps: *T has raised brow, slight smile*
interaction. The patient produces exaggerated gestures and facial expressions and most likely overdoes the demanding and dominant features of the supervisor. As she caricatures the supervisor’s agency, the patient’s emotional understanding of what happened becomes crystal clear.

Until this point in the interaction, the therapist has been listening, allowing the patient to unfold the narrative as she experienced it, in other words, she has been providing good conditions for the emergence of trust (cf. Section 2). However, as the patient reaches a certain point in the interaction that involves her self-perception of her emotional reactions (surprise and intimidation l. 8–9), the roles of the therapist and patient change. This change affects the patient’s emotional state and the therapist needs to anticipate how her inter-reference might impact on the bond between them and, as such, the therapeutic alliance. This is elaborated in detail below.

We now zoom further in on how the therapist engages with the patient’s re-enactment and how that relates to the therapeutic alliance. After the patient has uttered “o[kay]” (l. 9) in low voice, she produces a wry smile as she maintains her wide-open eyes and raised brow facial expression (see Figure 4A-patient). The therapist simultaneously adopts a similar wry smile and raised brow expression while she maintains her intense gaze on the patient’s face (see Figure 4A-therapist). Thus, their facial expressions are aligned in simultaneous smiles, just until the patient bursts into laughter and makes a significant hand gesture (l. 11, see Figure 4B-patient). She moves her right arm down from the right side of the torso and up towards her chest with her hand in a fist in a semi-half circle (see Figure 4B-patient). At this exact moment, the therapist furrows her eyebrows and raises her chin (see Figure 4B-therapist). Her facial expression reveals confusion or surprise, but she does not yet verbalise this reaction. The therapist co-operates on the patient’s talk by laminating (Goodwin 2013) her laughter and gesture with a non-humorous and confused facial expression, rather than participating in the laughter with the patient, which is the preferred and most common response to laughter in general, social conversation (Jefferson 1979, 1984; Jefferson et al. 1987). In this way, the therapist ‘marks’ a change in her emotional understanding just as the patient performs the significant change in facial expression and body posture, but without verbally interrupting the patient. Marking means an action that directs attention to a certain relevant point in the interaction. The patient’s beat-like, low fist pump gesture serves multiple functions in the interaction. First, the gesture is synchronised with her laughter and, as she performs this action, she changes her overall body posture from the prior stiff upper-body to a more relaxed and animated bodily expression. Second, it marks the end of her re-enactment. She is now ‘back’ and awaits the therapist’s response. Third, it produces an attitude akin to a meta-comment on the re-enactment, stating the transformation from the
“insecurity then” to “something laughable now.” The therapist’s frowned brow during the patient’s gesture and laughter manifests the discrepancy in their performances, which were more synchronised in the beginning of the re-enactment. In a low voice and with a friendly and slight smile the therapist asks the patient “what happened just then?” (l. 13, see Figure 4C). There is an inherent ambiguity in this question that relates to the multiple contexts at stake: The here-and-now as well as the previous situation that the patient’s re-enactment has brought into their conversation. The deictic “just then” can be linked with both present and past tense, which in this case relates specifically to the re-enactment that was just performed as well as her laughing about it, or to the past situation that was recounted when the supervisor was actually there, and the patient responded to her instructions. The ambiguity is further reflected in the non-verbal interaction between the two parties. During the utterance “what happened just then?” (l. 13, see Figure 4C) the therapist makes an open hand gesture and moves it back and forth between two positions: (1) away from her personal space towards the patient and (2) back again towards her own chest. The back and forth-ness of the hand movement demonstrates a dynamic movement that symbolises the relation between aspects of the outer world with the inner world (what happened inside you as we experienced this activity out here). This question, the therapist’s focused gaze and the friendly facial expression all together denote a safe and trustful atmosphere alongside with the hand gesture that denotes a request for elaboration of a certain type that is recurrent in the therapy; namely a request for elaborating on the emotional underpinnings of a certain experience.

The patient immediately adapts to the request and performs a serious expression as she answers that she “became enormously [insecure]” (l. 14). Her answer refers to the previous situation she actually went through with her supervisor, verbally explicating the emotional expression she adopted during her re-enactment. The past tense I became refers back to that situation rather than the here-and-now interactional changes, the therapist observes. In this case, we observe how the therapist relies on expertise as a certain kind of embodied craftsmanship² (Streeck 2009) which allows her to pick up on the therapeutic relevant cues that enable cognitive-emotional work (co-elaboration of emotional reactions). Specifically, we observe this professional work performed in the way the therapist carefully coordinates and times her enquiry (bodily and verbally),

² Craftsmanship refers to the lived body (different from the pure biological body), which has developed a set of embodied skills that enhance specific task performances. That means that “every good craftsman conducts a dialogue between concrete practises and thinking; this dialogue evolves into sustaining habits, and these habits establish a rhythm between problem solving and problem finding” (Streeck 2009: 204)
Figure 4: Excerpt 2.
and finally how she acknowledges the patient’s responses but without taking the lead. Rather, she continuously lets the patient elaborate. She does so by shifting between attentive acceptance and whole-bodied questioning to bring specific elements that have significance for this therapeutic work to the fore. Based on this analysis, we thus claim that the establishment of the bond — as part of a functional alliance — is not just about mirroring (e.g. smiling and nodding per se), but about identifying crucial embodied (dys)functional dynamics and adjusting to them in subtle ways. In this case, we see how the therapist tilts her head slightly forward and uses facial expressions to mark exactly when she experiences important information given by patient. The therapeutic alliance is not a level-based phenomenon, where the trustful bond is primary, then agreement added and so on. The bond is continually being cultivated in interaction. However, once the bond is established, the therapist can interact more flexible and inaugurate different interaction styles in order to imbue therapeutic interventions. As such, the established trustful bond functions as the interpersonal substrate underlying therapeutic interaction, through which the patient’s emotional states and patterns are challenged. The alignment — in terms of aligned engagement — is significant or strong when the therapist acknowledges the patient’s behaviour as functional and good, whereas she objects to the narrative by enacting embodied discrepancy as a marker for stopping up and questioning.

4.2 Embodied re-enactments: Therapeutic alliance and therapeutic intervention

While the therapist acknowledges the patient’s verbal explication (l. 14), her very low “[œo] kay” with a rise in intonation also serves as an expression of surprise and thus as a continuer and a request for further interoceptive and emotional elaboration. The therapist thus challenges the patient as she wants more information. The therapist establishes the context where emotional experiences can be investigated and endures in the interaction. As such, she stays with the patient in the re-enacted situation to question further what happened, which will only be successful if the patient trusts the therapist’s proposal.

Apparently, the patient accepts the therapist’s questions and strategy, and she elaborates on her initial answer that she felt “enormously insecure” (l. 14) by performing a second re-enactment. This time she verbally explicates the parts of the supervisor’s request that she felt uneasy about. An embodied feeling of uncertainty saturates the re-enactment that is produced in a fast, stammering-like breathy voice “<then yh you’re just going to stand there and watch me do this?>” (l. 17, see Figure 5A,B). This feeling is performed as a reflection on how she now
understands the situation, and it is accompanied by a gesture: She raises her right index-finger in a stifled way as if to stop or object to the demands of the situation and she turns her face to the side (see Figure 5A). This re-enactment elaborates further on the emotional tension that relates to her supervisor’s expectations and the patient’s anxieties. The therapist dwells on the patient’s performed and verbally defined insecurity and asks for a further elaboration: “do you know what it was that made you insecure?” (l. 18, see Figure 5C). During this question, the therapist produces a recycling of the right-hand gesture going back and forth between a point further away from her and a point towards her chest. As McNeill and Levy (1993) convincingly showed, recycling gestures build cohesion between parts of talk: in this case cohesion between the previous question “what happened just then?” (l. 13) and the question posed here “do you know what it was that made you insecure?” (l. 18). In both cases, the therapist refers in similar ways to the dynamics between the patient’s inner emotional life and responses and outside events. Furthermore, the therapist builds on the patient’s prior understanding of being insecure however, she transforms the formulation. While the patient described her reactions as “I became enormously insecure,” the therapist reformulates it using a transitive formulation, that is, she asks what made the patient insecure. In this way, the therapist links both her own prior gesture and denotes the dynamics and relationship between the inner experiences and previous events. She further reuses and transforms the patient’s own expression and identification of her insecurity into a question that moves their shared activity from one focused on the identification of the emotion to the contextual embeddedness of it, giving opportunities for exploring what prompts such emotional reactions.

The patient initiates her response with a self-repair, that is, she stops during her verbal formulation and restarts with a new turn-design a few times: “it was- u::h kinda now I sh- now I suddenly have someone standing there looking over my shoulder (pointing, see Figures 5D,E) if I am doing it right” (l. 19–21) and “huh (.), arh↑ (.), <that I hope I am> .hh uhm.” (l. 23). Initially, the patient reused the therapist’s past tense formulation it was, referring to a reflective mode where she tries to recall what prompted the reaction. She then shifts to present tense and initiates another round of re-enactment that reevokes the past in the present, first: “now I suddenly have someone standing there looking over my shoulder.” And secondly, this comment prompts her to respond to whether she is doing things right: “huh (.), arh↑ (.), <that I hope I am> .hh uhm” (l. 23). During the first part of the re-enactment (l. 17, see Figure 5A), the patient makes two deictic gestures with her right hand in the space in front of her: a sustained point with her right index finger in the gestural space on her left side during “now I suddenly have someone standing there” (l. 19–20) and then she makes a small circle upwards and back down in a new point slightly behind during looking where she sustained a second
17 P: <thou yh thou are just going to stand and watch me do this>
18 T: do you know what it was that made you insecure?
19 P: yes it was—u::h kinda this now I sh- now I suddenly have someone standing there looking over my shoulder if I am doing it right
20 T: "yes"
21 P: huh (. ) arh (. ) <that I hope I am> .hh

Figure 5: Excerpt 3.
point during the utterance “over my [shoulder]” (l. 20, see Figure 5D). She then relaxes her finger slightly — though without retracting her hand. The final re-enactment functions in a slightly different way than the first re-enactment. In this last example, the patient combines the re-enactment of how she would explicate her answer to the pressure of the situation “huh (.) arh↑ (.) <that I hope I am> .hh uhm” (l. 23), which indicates an ego-centric perspective whereas the pointing reveals a novel allocentric perspective. As she depicts how she herself and the supervisor would be located in the gestural space in front of her, i.e. one person standing behind there and looking over one’s shoulders (see Figure 5D,E).

Compared to the first excerpt, we observe how the patient moves closer to a state where she is able to identify and reflect on the emotional reactions that emerge in a situation where insecurity saturates her bodily reactions. The verbalisations of her insecurity change from an overwhelmed and stunned expression and a delayed “‘o[kay]’” (l. 9); to a question which aims at narrowing down what specifically made the patient insecure in the initial request. And finally, the patient is able to explicate how it all makes her feel, namely afraid of failing, of not doing it right: “huh (.) arh↑ (.) <that I hope I am> .hh uhm” (l. 23). The diversity of the re-enactments is crucial. Each time the patient re-enacts part of the past event, she describes and explicates new aspects of her emotional state and overview. Further, this continuous re-exploring through multiple re-enactments is brought about in a combined effort of the therapist and patient. Hence, the therapist prompts the patient to go back and re-live or understand anew what was and is at stake. The therapist achieves this as she constantly uses the patient’s actions as indicators for further actions and for redirecting the patient’s narrative in purposeful ways by embodying empathy and caring (listening, aligning, understanding, questioning). The therapist functions as a gatekeeper who stops the patient and encourages her not to move on without dwelling on the bodily and emotional changes and reflect on them as they emerge. This function is important, as bodily states of stress often lead to a distancing behaviour, which in turn enable the patient to regain homeostasis in order to regulate the balance of the body states at a very short-term timescale (Fuchs 2018). Hence, the therapeutic challenge is to cope with stressful behaviours in order to manipulate and change the direct action-perception cycles that are enacted in such situations as they appear in contexts beyond the therapy.

The patient’s hesitation reveals the emotional pressure she undergoes, but her willingness to explore, reveals a functional alliance where the anxiety is kept at bay and becomes the object of professional manipulation. In the final excerpt, we show the overall result of functional and dialogical co-action.
4.3 Reaping the benefits of a functional therapeutic alliance and embodied re-enactment

The final excerpt emphasises how the therapist’s co-participation in the re-enactment impacts the bond and the interpersonal relationship between them, which again enables the patient to trust what they are doing and calmly reflect on what she has experienced.

The therapeutic work involves not only identification of the experienced emotions enacted in dysfunctional relations, but also a conscious knowledge about how reactions to such emotions are managed. Therefore, the therapist soon asks the patient how she dealt with the experienced self-doubt and insecurity, which invites yet another re-enactment to be co-explored.

The patient explains what she did to calm herself down as she just revealed she felt enormously insecure. Specifically, she combines a linguistic explanation and a whole-bodied performance of how she took a deep in breath. The patient tilts her head slightly back and raises her upper-body as she sucks in air through tight lips and also utters: “.hhhhhh thhen I took a” (l. 24, see Figure 6A-patient) and then continues to utter during multiple out-breaths “[hh ni:ce] hh [deep] bh [reath and he then]” (l. 24–25, see Figure 6B-patient). With a slight delay, the therapist participates in this action by performing an even more exaggerated in- and out-breath (see Figure 6B-therapist). As the patient and the therapist do the out-breath together, the tension previously observed in the patient disappears and she smiles (see Figure 6C-patient). The therapist, however, extends the breathing and overdoes it: As she breaths in, she raises her eyebrows and inclines her head backwards in a much more significant way than the patient (l. 26, Figure 6C-therapist). As she breathes out, she visibly relaxes her head, cheeks and lips and her face brightens compassionately (see Figure 6D). At one point, the patient’s utterances in this case are descriptive: “.hshshshh thhen I took a [hh ni:ce] hh [deep] bh[reath and he then]” (l. 24–1. 25), however, the utterances are also richly embodied, which provides the patient with a bodily experience, that is, a richer history of using a functional breathing technique. Taking a deep breath is a common soothing technique for emotion regulation and the therapist’s co-participation in the breathing marks it as a recognisable and generalisable action, which at the same time constitutes a rich intercorporeal link between the two. Their inter-bodily dynamics reveal co-action and, altogether, the embodiments emphasise this activity as an important one as well as one that is sanctioned by the therapist. As the therapist overdoes the breathing, she extends the temporal duration of it, and thus highlights the activity by bringing it to the forefront of their joint activity.
24 P: .hhhhhh thhen I took a [hh nifce] (.h hh [deep] br[heath
25 and he then]
26 T: [.hhhhh ] [hhh ] [hprp
27 P: I just got started
28 ps *T smiles*

Figure 6: Excerpt 4.
The result of this small therapeutic interaction is a stabilisation of the patient’s interaction trajectory: The patient lowers her shoulders, smiles, gazes at the therapist, and appears to be relaxed and calm despite the stressful event that they just went through together. The therapist’s timed actions provide the patient with apt possibilities for understanding what just happened, as she can visually perceive the therapist’s behaviour. What is crucial in this example, thus, is the acknowledgement and sanctioning behaviour the therapist embodies, which provides the patient with good possibilities for changing her emotional stance. Initially, the patient was hesitant and forceful, and in the end, she smiles and behaves in a contented and relaxed manner. Re-enacting the stressful situation thus manifests the patient’s management of the emotional tension as successful, not just in words but in action (taking a deep breath and releasing tension). The hypothesis we generate from this analysis is that re-enactments (as embodied repetition) is particularly valuable to manifest cognitive behaviour and to work with self-perception. If this work enables the patient to perceive her own actions differently, it can be viewed as a small-scale cognitive change that might lead to changes in behaviour in future situations. We therefore argue that there is a need for testing the hypothesis that re-enactment is linked with successful outcomes for the patient on a larger sample and across different kinds of re-enactments.

5 Conclusion and discussion

As mentioned in the introduction, the aim of this article is twofold: On the one hand, it is an empirical contribution to the branch of psychotherapy research that is concerned with understanding how the trust is enabled, performed and maintained in interaction through the work with embodied re-enactments; and finally, how this all might relate to positive outcomes for the patient. On the other hand, by turning to the domain of embodied co-action, the article challenges traditional approaches to human interaction. In this conclusion, we thus (a) synthesise the analytical findings which might have an impact on psychotherapy practice, (b) examine those findings in the broader context of human interaction and (c) discuss the theoretical/methodological implications of an ecological, embodied approach for the field of pragmatics and its neighbouring disciplines, such as qualitative cognitive sciences.

In terms of analytical results, the first part of the analysis demonstrated how the on-going embodied work of building a trusting relationship and an engaged and attentive atmosphere, was managed in interaction through encouraging whole-bodied behaviour. This situation served as a safe context for the patient to re-enact and explore — in a fully embodied and expressive way — emotions of fear
and insecurity contextually grounded in her memories of a situation outside of therapy. Further, by operating on and re-using the patient’s full-bodied emotional expressions, the therapist marks which of the patient’s actions that are of crucial relevance in this context. As such she works to transform the re-enactments into something that falls within the scope of the patient’s cognitive resources. Finally, in the last analytical section, we showed how the therapist co-participated in the patient’s reported use and re-enactment of the emotion regulation technique of ‘taking a deep breath.’ The therapist seized the opportunity for engaging in contextually relevant reinforcing and teaching of this embodied practise by adapting to the actions of the patient in a whole-bodied manner.

We argue that situations, as those investigated in this article, function as a stepping stone towards identifying the global emotional trajectories that inhibit the patient from achieving the tasks she wants in general. Hence, such small-scale emotional re-enactments are crucial for development as they give the therapist just enough material to work with the patient and to challenge her in a safe situation where the basis for such work is the operation of a functional therapeutic alliance. Here, we observe the work of this alliance through co-acceptance, co-exploration and various modes of inter-bodily dynamics (for instance mirroring and marking) during re-enactment. While it is clear that the therapist adopts a calm, soft and very attentive attitude during most of the patient’s talk, the micro-actions reveal a much more complex picture of their coordinated inter-bodily activities. When the therapist uses her professional therapeutic range of embodied facial and gestural practises, she marks, highlights and exaggerates, thus actively co-participating in the construction of the patient’s sense-making activities. This practise points to an embodiment that extends further than taking a passive, receptive and trustful stance, revealing possible crucial effects of such collaborative actions. By promoting this viewpoint, we do not mean to imply that building a safe atmosphere through positive, caring and engaging embodied attitudes are not central to maintaining a fruitful therapeutic alliance. The argument that we advance is that this is not maintained by simple nor stable actions of providing a “positive facial expression” or “trustful body-language” by the therapist, and thus, cannot be reduced to a list of “correct actions,” i.e. smiling or speaking softly. Rather, what we have shown is that embodied activities in therapy further involve meaningful operations by the therapist on the patient’s talk, emotion expressions and bodily performances in ways that change and transform them, serving therapeutically relevant purposes such as exploring the causality of patient behaviours and reinforcing emotion regulation body-techniques.

The therapeutic alliance is thus not stable and fixed. As it is intertwined with interaction, it develops with changes in interaction. We see an example of this as soon as the therapist challenges the patient’s self-perception and reaction.
The challenge entails a change in the patient’s agency; she becomes nervous and her utterances incoherent. From a therapeutic point of view, the therapist balances between letting the patient have control and pushing her outside her comfort zone. If she does not do this, the danger is that the patient’s re-enactment becomes a self-fulfilling prophecy, which means that she brings to life a traumatic situation without feeling able to do anything different from what she initially did in the past event. The re-enactment, then, would only strengthen her self-perception and the dysfunctional feelings of being intimidated without being able to put her foot down. Building on recent studies (Trasmundi et al. 2020), we argue that the therapeutic alliance is maintained as the therapist pushes the patient into this state of emotional distress, however, aligning with her and over-exaggerating small-scale actions that can be viewed as a step in the right direction (for instance, by taking a deep breath). As such, she moves in and out of zones of curiosity, surprise and relief, giving the patient an impression of how threads are always gathered in the end in their safe therapeutic setting.

Summing up, the analysis demonstrates how this therapeutic work constitutes an emerging situated opportunity for teaching/practicing embodied emotion regulation in the form of a co-participated enaction of “taking a deep breath.” Specifically, we emphasised how an embodied, co-participated re-enactment of past (dys)functional behaviours outside of therapy can be a resource for redirecting, teaching and reinforcing therapeutically relevant behaviours in the context of therapy presenting themselves as fruitful opportunities for facilitating incremental change. The aim, therefore, is that the empirical findings presented here may serve as a showcase for how therapeutic alliance is enabled, performed and maintained in interaction though the work with embodied re-enactments. The goal is that it thus helps therapists focus their attention on how whole-bodied embodiments function in therapy and how they can be used to direct and re-direct attention towards therapeutically relevant places in the interaction without violating the therapeutic alliance.

The findings are also relevant beyond the psychotherapeutic setting. While therapeutic alliance is a term linked with this kind of practise, it is based on a basic principle for successful human interaction in general, namely trust. The analysis provides an insight into how trust is maintained by embodying a caring attitude. Further, embodied re-enactment occurs in many kinds of human interactions (Sidnell 2016). One crucial function of re-enactment in psychotherapy is the opportunity for exploring and re-living suppressed emotions and creatively playing with one’s own perception of a past event. This action-based exploration of

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3 See Trasmundi et al. (2020) for an example where the therapist discusses the often-experienced dilemma of pushing the patient too much or too little to make therapeutic progression.
previous situations is important as memory is a whole-bodied phenomenon that goes beyond linguistic understanding/communication. This conclusion applies to all situations where emotional states are important: Remembering and understanding a previous event — a fight or a discussion, for instance — is best accomplished by re-enacting the event rather than just recalling the words being articulated. The ability to select and exaggerate certain interactional features is powerful, as we have seen, however, such action also easily becomes an exceptionally subjective re-enactment of an event.

The article applied an ecological, embodied approach to the study of human interaction, and the theoretical underpinnings of such an approach must be met by analytical procedures that account for interaction as an ecological, multi-scalar phenomenon. Theoretically, this article proposed to work with an ecological-embodied-based perspective that allows for investigations of multi-scalar social and interactional systems. At a methodological level, it showed how one is able to account for trans-situational dynamics through investigations of how people adapt, re-enact, move and coordinate (cf. the context-model in Section 2). Obviously, studying human behaviour from an ecological perspective requires interdisciplinary methods and theories. Multiple challenges follow as one opens up for the ecology of human interaction. This insight connects to the scientific interest concerning which methodological innovations can be derived from an ecological perspective. In a recent chapter that reviews qualitative methods in cognitive psychology, Ormerod and Ball (2017: 587) argue that there is a need for future methodological developments and that: “it is qualitative approaches that are rising to the fore in relation to the analyses of real-world, embodied cognition in the context of complex task-performance.” We hope, with this article, that we have taken a step in the direction of qualifying an ecological, embodied approach to human interaction.

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