



Gender-related Issues in Couple Therapists' Internal Voices and Interactional Practices

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The study demonstrates how motherhood gender-related discourse is intertwined with the ways in which the systemic techniques and systemic thinking are realised in the session. This research explores the consequences of gender-related discourse commonly co-constructed by participants in couple therapy and not recognised or challenged by the therapist. Video-recorded data from a couple therapy session containing unrecognised gender-related discourse were subjected to conversation analysis (CA). The interview (Interpersonal Process Recall) transcript was analysed according to the rules of dialogical analysis. Gender assumptions held unchallenged by a therapist can be manifested through: placing one spouse in the position of the person accountable for the gender-related choices, the therapist's mirroring of one participant's lexical choices only, sharing normative expectation of one person. Unrecognised gender discourse create difficulty in introducing circular thinking. The obstacles on the therapist's side can render power issues connected with gender invisible and thus unavailable for introduction into the therapeutic conversation.

Keywords: couple therapy, gender discourse, conversation analysis, dialogical analysis, circularity, process research

Key Points

- 1 The therapist's gender assumptions should be analysed in the course of therapeutic training.
- 2 Supervisors should pay attention to gender assumptions of all couple therapy participants.
- 3 The transcripts of the session can be used to recognise the conversational justification of gender power discourse.
- 4 Recognising the internal voices connected with gender assumptions can contribute to the introduction of circular thinking/questions and different perspectives into therapeutic dialogue.
- 5 Insufficient circular thinking, lack of a relational hypothesis, and a 'not-knowing' stance can contribute to conversational justification of the gender power discourse.

In this paper, we examine the way in which gender discourse emerges in couple therapeutic conversation and in the therapist's inner conversation. We present a case study of a therapeutic session in which a motherhood related topic deeply influenced the therapist's interactional practices and her way of experiencing the female client.

Circular causality, which is the key notion of the systemic approach, involves recursive, interactional patterns in the family or the couple. It denotes that behaviours

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of individuals are interconnected (Bateson, 1979; Cottone & Greenwell, 1992); this helps the participants to go beyond the blaming discourse. Circularity has also been associated with the therapist's neutrality toward his or her own beliefs and value systems (Selvini-Palazzoli, Boscolo, Cecchin & Prata, 1980; Tomm, 1984). Such a neutral stance on the part of the therapist facilitates the introduction of different *internal* hypothesising *voices* (Rober, 2002) and enhances the therapist's awareness of his or her own assumptions on which these voices are based (Brown, 2010). The feminist critique of circular causality, on the other hand, points out that these ideas encourage therapists to avoid stance-taking in situations of inequality (MacKinnon & Miller, 1987; Walters, Carter, Papp & Silverstein, 1988), which can lead to equal distribution of responsibility in situations of structural injustice (Kurri & Wahlstromm, 2005) and to reinforcement of socio-cultural inequalities in general (Knudson-Martin, 2013; Knudson-Martin & Huenengard, 2010).

The feminist critique of circular causality draws often from Foucauldian discourse analysis (see, e.g., Dallos & Draper, 2010; Knudson-Martin, 2013; Sutherland, LaMarre, Rice, Hardt & Jeffrey, 2016; Sutherland, LaMarre, Rice, Hardt & Le Couture, 2017a). Our understanding of gender and gender discourses is somewhat different. It is derived from ethnomethodology, conversation analysis and discursive psychology. Drawing upon (Stokoe, 2004; Stokoe & Smithson, 2001), we investigate gender as 'member's category', as something that can be invoked, or not invoked, in and through the details of the momentary social action. For us, then, gender discourse refers to all social practices – verbal or embodied – that in any given moment can invoke and make relevant assumptions about men and women. In couple therapy, it is not only important to recognise the existence of gender-related discourses, but also to acknowledge their complexity, as they are 'fluid, joint, variable, and context bound' (Sutherland, LaMarre & Rice, 2017b, p. 6).

Gender discourses arise in couple therapy in manifold ways. Clients tend to perceive the therapist to be taking the side of one family member (Scheel & Conoley, 1998) or adopting a moral or judgmental stance (Stancombe & White, 2005). Furthermore, couple therapists tend to react and respond differently to men and women during sessions (Gehart & Lyle, 2001; Shields & McDaniel, 1992; Werner-Wilson & Price, 1997; Werner-Wilson, Zimmerman & Price, 1999). This gender bias can be intertwined with clients' expectations of stereotypical behaviours, for example, caring from a female therapist and directedness from a male therapist (Blow, Timm & Cox, 2008). Therefore it is important to investigate implementation of systemic ideas in the context of gender discourses both in conversational practices but also in participants' perceptions of the ongoing situation.

In order to understand the duality of circular thinking both in the therapist's mind and in the circular method of conducting the session, we need methods that can identify these internal and external realities. We used two methods. First, the dialogical approach, which focuses on the content of the therapist's mind – such as the origin of their ideas in the process of their formation of hypotheses (Rober, 2002; Rober, Seikkula & Latila, 2010; Rober, Van Easbeek & Elliott, 2006) Second, conversation analysis (CA), which is suitable for scrutinising the multidimensional and highly interactive talk in couple and family therapy (Muntigl & Horvath, 2016; Sutherland & Le Couture, 2007; Tseliou, 2013; Tseliou & Borsca, 2018). We acknowledge that our choice of methods is somewhat unconventional. Some social interaction scholars reject the possibility of considering cognition in any way

separately from interactional practice (e.g., Potter, 2006). However, as the process of hypothesising/circular questioning and identifying social discourses takes place simultaneously on two levels – in the therapeutic conversation, and in the therapist's mind – we also need two methods, one for cognition and the other for interaction. By examining cognition alongside interaction, we concur with the emergent conversation analysis voices that consider such a dual perspective fruitful (e.g., Enfield & Levinson, 2006). While CA often studies collections of relevant data (several encounters and/or segments of interaction), and seeks to identify *recurrent* interactional practices, our analysis focuses on a single case. Our legitimisation of the single-case approach is two-fold. First, CA in couple therapy is in its infancy, and research thus far has indeed been based on case studies (see Diorinou & Tseliou, 2014; Muntigl & Horvath, 2016). It is reasonable to believe that we have done the groundwork which can provide the foundations for future studies with larger quantities of data. Second, we use CA alongside another method (dialogical analysis), and the focus on the single case is motivated by the results of the latter method.

Dialogical analysis is rooted in Bakhtin's concept of self as a polyphony of inner voices (Bakhtin, 1981, 1984), which implies the dialogical nature of the self (Hermans, 2006). This type of analysis has been adopted in family therapy to analyse the authorship of the voices in the therapist's mind and also their positions in relation to each other (Rober, 2002; Rober et al., 2006, 2010).

We used conversation analysis (CA) as the other analytical method. In our study, one key facet of CA involves *accountability*. Inspired by Garfinkel's (1967) ethnomethodology, CA studies can explore the ways in which interaction participants treat some courses of action or states of affairs as routine and self-explanatory, while other actions or states of affairs require explicit explanations or grounds (Heritage, 1984). In issues related to gender, CA is compatible with the social practice centred idea of gender discourses presented above. It can elucidate the ways in which gender related categories are grounded at the micro-level of participants' exchanges (Stokoe & Smithson, 2001; Sutherland et al., 2016).

We employed conversational analysis to investigate the way in which gender-related assumptions are invoked in therapeutic conversation. We compare the conversational interaction with the therapist's inner conversation (Rober et al., 2010), which accompanies or is prompted by conversational exchange in the session. In the investigation of the inner conversation, the dialogical analysis made it possible to identify the presence of gender-related assumptions in the therapist's internal voices. We will showcase a situation in which the therapist indicates a lack of awareness of the cultural gender-related assumptions. In this case, our analysis shows how such assumptions are enacted in the actual conversation, and how they also are present in the therapist's mind.

Method

Participants

The data were obtained from (i) the video recording of one couple's first consultation and (ii) an interview with the therapist conducted directly after the session. The data were part of a set of nine video-recorded consultations (all including interviews with the therapists) collected for a project on systemic phenomena in first consultations. This particular case was chosen for further analysis because the data obtained from the interview

contained: (1) a very explicit '*experiencing self*' voice from the therapist, who was able to share freely her emotional reaction to each partner; (2) clear references to the sexes of the participants and to male and female gender roles. The therapist in the case under study was a woman aged 63, a heterosexual, childless, Roman Catholic widow. She was trained as a systemic therapist and had a strong background in the Milan approach. She had been working as a family therapist for 25 years. The couple were a 50-year-old husband and 48-year-old wife with one daughter, aged 18. The couple therapy consultation was initiated by the wife who complained about not being respected enough by her husband. The consultation took place in the [Family Therapy Department, Medical College, Jagiellonian University, Kraków], and the project was approved by the bioethics committee of the [KBET/273/B2011].

Materials

Interpersonal process recall. The dialogical analysis was based on interview data collected according to the Interpersonal Process Recall (IPR) Protocol (Elliott, 1986; Elliott & Shapiro, 1988; Greenberg, Rice & Elliott, 1993), which involves reflecting in the present on the counselling/therapeutic session as it is being viewed during the IPR interview. The participant is asked to take on an observer role. Interviewees are requested to recall any thoughts, feelings, sensations or experiences that might have occurred at the time of the counselling session itself and the meanings that they placed on these experiences. The principles for framing IPR questions are: focusing on there-and-then experiences in session and internal processes that were unspoken at the time of the session itself. In framing IPR questions the following aspects are recommended: including phrasing in the past tense, de-emphasising content, and framing concise, succinct questions.

Dialogical analysis. The dialogical analysis tracks the possibility of inner conversation between the therapist's two positions of self (Bakhtin, 1981, 1984; Hermans, 2006). In order to analyse the internal voices of participants the transcripts of their utterances are prepared (see. Rober, 2005a, 2014). Within dialogical analysis that is applied to psychotherapy, the distinction between the therapist's *experiencing* and *professional self* is central (Rober, 2005a,b, 2014), yet still each of the selves can contain different voices. According to Rober, 'the experiencing self contains 'the observations of the therapist and the memories, images and fantasies that are activated by what the therapist observes. . . [This] implies a not-knowing receptivity toward the stories of the clients' (Rober, 2005a,b, p. 487, Rober, 2014). The therapist's *professional self* is much more connected with activity during the session, as it is focused on preparing responses and hypothesising (Rober, 2002); in this state of mind the therapist's role is largely as an observer (Rober, 2005a, 2014).

Conversation analysis. As a method, CA is used to study naturally occurring social interaction. Sidnell and Stivers (2013) mention the distinctive features of the CA approach as: assuming that language use is at a minute level of detail, detailed transcription of the data in order to facilitate the analysis of details of turns and sequences, which is connected with the assumption of fine-grained order in interaction. CA is considered as the most detailed and rigorous method available for describing social interaction processes in social and clinical settings (Heritage & Clayman,

2010). In therapeutic settings, CA seeks to uncover the specific practices through which the therapeutic work is done (Peräkylä, 2012).

Procedure

The therapist agreed to participate in the study as she was engaged in the project on systemic phenomena in the first consultations. The Interpersonal Process Recall interview was conducted right after the first therapy consultation. The therapist was asked to identify and comment on any moments in the video-recorded session that she found important or meaningful, or which caught her attention in any way. Both the interview and the session were recorded and transcribed. The transcript of the interview was subjected to dialogical analysis, and the appropriate fragment of the session transcript was analysed according to the rules of conversation analysis. The dialogical analysis of the interview transcript enabled us to identify nine instances of compromised circularity in the therapist's internal dialogue. In five of these instances we identified excerpts containing sex- and gender-related voices. From these five excerpts we chose one for in-depth analysis because this particular segment of the interview was very dense in terms of the therapist's references to gender issues in her inner conversation. The dialogical analysis was conducted by the first and the second authors of the paper, who are both scholars as well as systemic therapists and trainers. The corresponding part of the session transcript was subjected to conversation analysis, which was done by the first and third authors of the paper. The third author of the paper is of a different gender, from a different cultural background and has different professional experience (social sciences and psychoanalysis) from the first and second authors. Wherever interpretations of the data differed, the differences were solved by discussion between the analysts (the authors of the paper).

Results

Analysing the whole IPR transcript, we classified five therapist's voices (four experiential and the fifth professional) containing references to the sex and gender of the participants. Examples of each voice are given below:

- (1) voice of a woman interested in a man: *I have such an interest in him as a person inside me, I liked the fact that he is a carpenter, and . . .*
- (2) voice of a woman fantasising about contact with a man: *I thought that it is good to know that he is a carpenter, because as I would like a shelf or a wardrobe so I can sometime . . . go to him.*
- (3) voice perceiving the other woman–wife as having no interests: *I liked very much that he has different hobbies, but I don't like her as having any interests only sitting at home and nothing more, what is more these voices weren't balanced by the therapist's professional voices.*
- (4) voice disapproving of the wife's choices regarding motherhood (analysed in detail below).
- (5) voice of female anger (at the devaluation of a woman): *here is something that makes me mad, I'm angry (in relation to the husband), I have, not for the first time, an impression, as he said that she misheard herself (wife told in the course of the session that husband used offensive word toward daughter).*

- (6) voice of therapist's recognition of relational position (professional): *I felt somehow, that her feeling of being put down or also her feeling of being cheapened, that it could be also from this relation (marriage) and I have been considering more and more their relationship and it could be like her experience of being not acknowledged and being alone are interrelated to his attitude (toward her).*

We chose *a voice disapproving the wife's choices regarding motherhood* for further analysis as it was dense in terms of the therapist's references to gender issues in her inner conversation. Furthermore, the segment of the therapy interaction corresponding to this voice came in the initial part of the session, and this makes our analysis of this part of the session (see below) transparent for the reader, since no background knowledge of the course of the rest of the session is necessary in order to understand it.

The first part of the therapist's comment on the sequence contained an experiential voice which we named *a voice disapproving the wife's choices regarding motherhood*: *'I felt then that she is ... I need to say about her that she is so very weak, and I was astonished, negatively, that she wasn't able to have a second child, even though she wanted one – but maybe she didn't want to have a second child. The weakness inside her made her unable to decide to have a second pregnancy, and she had tears in her eyes and she was moved, somehow.'* This excerpt shows the therapist's 'experiential self' voice (see Rober, 2005a, 2014), which expresses astonishment and antipathy toward the wife, as well as an assumption that the woman's sense of the impossibility of having a second child was due to her 'weakness inside'. Importantly, however, the therapist partially managed to overcome her initial reaction during this segment while reflecting on her own emotional attitude toward the wife. Her voice became somewhat more 'professional' as she continued her commentary: *'but I wasn't moved by what she said; I didn't empathise with her. I had no sense of wanting to take care of her. What I had was rather a feeling of amazement that she had become so weak as to be unable to take the decision [to have a second pregnancy]. How to put it ...? There was something in her that I didn't like.* This fragment can be seen as a professional voice in as much as it indicates the therapist's awareness of her emotional attitude toward the wife. On the other hand, she expresses no relational, circular understanding of the wife's attitude, and no understanding of the participants' possible social discourses regarding gender roles.

In her further comments, the therapist says that despite her awareness of her personal feelings, her emotional attitude toward her remained unchanged: *I didn't like her for how she said that. I didn't have anything inside me that liked her, because she didn't take the decision to have a second pregnancy, because she seemed to me so miserable, so alone, that she didn't take the decision to have a second child. No, I had no empathy for her.* In this excerpt it is clear that the therapist was able to maintain a professional voice, as she could see the woman as miserable and alone. However, in her internal dialogue, she posed no curious questions (Cecchin, 1987), and did not formulate circular hypotheses for the anxiety and weakness expressed by the wife (Selvini-Palazzoli et al., 1980) or indicate any awareness of the possible social discourse on motherhood (see Sutherland et al., 2016).

The next step of our analysis focused on the part of the session on which the therapist was commenting. The section analysed starts in the seventh minute of the consultation. The sequence was initiated by the husband's volunteering of some

information about the family. In the segments below, an idiomatic English translation of the Polish original is given. CA notation is used (for transcription symbols, see Appendix).

Picture 1, extract 1 (7.09)

01 H: hhh Yes. (2.0) Tsk. And so that's it, HHhhh
02 T: Mhh
03 H: >↓What else? <
04 (0.4)
05 H: >So we only have the one child <
06 (2.2) ((T nods))
07 H: Financially we're quite comfortable,
08 (0.2) ((T nods))
09 H: no problems.
10 (1.2)
11 T: Regarding Klara hh (.) did you only want to have the >one
12 ↑child?< or [>were<
13 H: [No: ((continues))

In line 1 the husband's utterance is lexically constructed as closing a segment of talk: by saying *that's it*, he ostensibly suggests that he has now completed his presentation of the family. However, the flat intonation at the end of his utterance (Clayman, 2013) and the maintenance of eye contact with the therapist (Rossano, 2013) imply an intention to say more. The utterance is followed by a deep sigh, possibly indicative of something problematic. The therapist aligns herself as a recipient of the husband's further talk by her token *Mhh* (line 2). In his continuation in line 3, the husband poses the rhetorical question *What else?*, whereupon he volunteers additional information about the couple: '*So we only have the one child*' (line 4), emphasising the word *child*. By volunteering that the child is the only one, the husband treats that fact as noteworthy, as something that might have been otherwise but is not. Again, his utterance is incomplete in terms of its intonation (now marked by an abrupt ending). The therapist nods in response to his statement (line 6), whereupon he, in lines 7 and 9, goes on to say that the couple's financial situation is comfortable and without problems. By volunteering these two pieces of information (*only the one child*, and *financially comfortable*) one after another, the husband creates a connection between them: conveying that only having one child *might* have been due to financial problems, but

that this is actually not the case. Thereby, he is also implying that there is another reason for their having only one child.

After a pause (line 10) the therapist directs a question to both spouses (indicating both as its addressees by using the second person plural form), asking whether it was their wish to have only one child. By asking about their choice or preference, the therapist treats the fact that they have only one child as accountable (Garfinkel, 1967), something for which there must be a reason – thereby adopting the perspective brought in by the husband. The therapist's alignment to the husband's perspective is strengthened by her choice of words. Her question in lines 11-12 reflects his utterance in line 5: in both, the key phrase is *have the one child*. The therapist's lexical choice thus incorporates the perspective brought in by the husband, in which only one child is a noteworthy and potentially problematic state of affairs. In response to the therapist's question (lines 11-12), the husband, speaking in overlap with the therapist, responds as shown in Extract 2 below.

Having first refuted the suggestion that they might have wanted to 'have only the one child' with his *no* (line 13), the husband then gives the reason for this state of affairs: emphasising the word *wife* (line 13), he suggests that she *couldn't bring herself to* have another pregnancy. At the beginning of his utterance the husband gestures with his hand at his wife, and when uttering the words *couldn't bring herself* he glances at her. The 'reason' is thereby both verbally and non-verbally attributed to the wife, and her account is made relevant. She in her turn starts speaking in overlap with her husband's utterance (line 14) and unpacks further what he might have meant: she was afraid that she could not have coped with a second pregnancy. In her answer she emphasises the word *afraid*, and after this the therapist nods, thereby non-verbally acknowledging her explanation. An affectively neutral vocal acknowledgement, *ahem*, follows in lines 16, overlapping with the wife's continuation of her account.

Picture 2, extract 2 (continuation of extract 1)

- 13 H: [No: my wife couldn't bring herself some[how, not
hand/h: (w)--
gaze/h: (w)-----
- 14 W: [I mean, (.) I
- 15 was so ↑terribly (.) afraid that th[at >something like
nod/t: x-----x
- 16 T: [ahem
- 17 that< I wouldn't have been able to ↓cope with that again.
- 18 T: A second time, yes?
- 19 W: ↑Yes, (0.2) °yes° ((nodding))

To sum up the analysis thus far: from line 5 the participants concordantly establish their orientation to the lack of a second pregnancy as something accountable, requiring explanation. The husband first volunteers the information that the

couple's child is their only one, and juxtaposes this with an assertion about their financial situation. He thereby implicitly suggests that there is something other than lack of money to explain the fact that they do not have a second child. In her query, the therapist then adopts the perspective brought in by the husband regarding the accountability of this fact; in their answers, the spouses collaboratively attribute this reason to the wife and her fear, and the therapist acknowledges this reason – thereby also upholding the accountability of the fact that they do not have a second child. At the end of this sequence the therapist asks the wife a clarifying question (line 18) about the impossibility of having a second pregnancy, suggesting indirectly that the first pregnancy had been difficult, which the wife confirms verbally and nonverbally (l.19). This perspective is then further explored by the therapist, as seen in Extract 3 below.

Picture 3, extract 3 (continuation of extract 2)

- 20 T: Was your first pregnancy difficult?
- 21 W: Yes, and on top of that (0.4) I kind of felt hh (0.8) kind of @alone@ in that pregnancy.
- 22 T: Mm hm hm ((nodding))
- 23 (1.2)
- 24 T: What do you mean by ↑alone (0.2) Frania?

In line 20 the therapist asks the spouses to confirm explicitly what has just been conveyed implicitly: whether the first pregnancy was '*difficult*'. The question seeks to unpack further the reasons for what the wife has just reported: her fear of (line 15), and inability to cope with (line 17), a second pregnancy. In line 21 the wife confirms the therapist's inference, emphasising the word '*yes*'. She also elaborates further on the difficulty, now emphasising the word '*lonely*' softly and tearfully. By mentioning her loneliness during the pregnancy, the wife is implicating her husband (as not there for her). In so doing she is also redirecting the attribution of responsibility: the husband, who in line 13 said that his wife could not have brought herself to a (second) pregnancy, is now rendered potentially responsible for her predicament during her first pregnancy. The therapist, with acknowledgement tokens and nods (line 22), acknowledges the wife's disclosure of her loneliness, and then in line 24 invites her to elaborate further on her experience of loneliness. In the wife's answer to this question (not shown in the data presented here) she points out both her husband's dedication to his work and their suboptimum living arrangements. Later in the session the therapist asked further questions about these living arrangements (at the husband's parents' home) without confronting the husband on his wife's loneliness during her pregnancy or exploring her experience from a relational perspective.

In the sequence we have now analysed, the issue of 'having only the one child' was collaboratively established as problematic. While this perspective was initially introduced by the husband, both the therapist and the wife accepted it: the therapist by treating the fact that there was no second pregnancy as an accountable issue, and the wife by

explaining her decision with reference to her problematic circumstances. Subsequently the wife indirectly indicated her husband as responsible for her loneliness and consequently for the fact that there was no second pregnancy. In this section all the participants tried to find an explanation for the 'problematic' fact that there was no second pregnancy, but nobody (including the therapist) was able to challenge this discourse.

Discussion

The therapist's internal dialogue and the therapeutic conversation were consistent in a significant way. The therapist did not challenge the gender-based motherhood-related assumption that one spouse – the man – had conveyed and she had shared, either in her internal dialogue or in the conversational process during the session. The second layer of correspondence occurred between the therapist's expression of empathy toward the wife's loneliness and the investigation of the reasons for this loneliness in the therapeutic dialogue. This aspect of the talk can be seen as an unrealised potential introduction to circular thinking in respect of the wife's decision not to try for a second pregnancy in relation to her feeling of lack of care from her husband, though this kind of circularity could serve to reinforce socio-cultural inequalities, which echoes the feminist critique (see Knudson-Martin, 2013; Knudson-Martin & Huenengard, 2010) as it still places the accountability for not having a second child with the wife (although it 'excuses' her). It indicates that gender assumptions should be recognised in therapists' inner conversations and discussed during the session (Dickerson, 2013; Knudson-Martin, 2013).

In methodological terms our study demonstrates the benefits of combining cognition- and interaction-focused methods. In addition to the interaction itself we also explored the therapist's attitudes, which might have contributed to the way she conducted the session. This does not mean that we consider her attitudes to have been the cause of the interaction that emerged between her and the family; rather, we see that the organisation of cognition and the organisation of interaction are interrelated (cf. Enfield & Levinson, 2006).

Conversation analysis can help us to explore the ways in which actual interactions in institutional settings realise, or fail to realise, concepts and prescriptions expressed in clinical and professional theories (Peräkylä & Vehviläinen, 2003). In this study we reveal some points where the actual clinical interaction deviated from the relevant clinical theories. Our case study not only confirmed the idea that gender is a specific discursive construct (Stokoe, 2004) but also demonstrated how the therapist, who contributed to the creation of such a discursive construct, was unable to escape from it, either in her own mind or in the actual conversation.

Limitations

Finally we want to point out the limitations of the study, which include the fact that we interviewed the therapist directly after the conversation using IPR, which may have been an obstacle to her recall of thoughts from particular parts of the session, as she was still under the influence of the whole session while commenting on the selected extracts of the dialogue. It is also impossible to establish the direction of mutual influences between the therapist's internal dialogue and the therapeutic conversation. The fact that only a single case was examined is also a limitation.

Clinical Conclusions

The case under analysis shows that gender-related assumptions not recognised and not challenged by the therapist create difficulty in circular thinking. We would like to point out that the therapist should be particularly mindful when he or she identifies intensive negative or positive feelings toward one spouse as they can contain sex and gender-related assumptions. These kinds of sex and gender-related assumptions identified in the therapist's inner conversation – regarding having a second child – as obvious can inhibit the introduction of circular questions connected with possible differences between the spouses' positions on the decision to have a second child (see Diorinou & Tseliou, 2014). We can pose the hypothetical question of what would have happened if the therapist, instead of asking 'Regarding Klara [...] *did you only want to have the one child, or were*' (line 11), had directed a circular question at the husband, for example, 'I understand that you would have liked a second child. Do you think your wife also wished that you had had more children?' We assume that, a detailed CA-informed investigation of the therapy recording in the supervision process can contribute to recognition of sex and gender assumptions that are reflected in the therapeutic dialogue. And, as a consequence, it can stimulate looking for different perspectives while formulating therapist's questions and comments.

These breaches of established systemic practice such as multipartiality and relational comments, but also the possibility of deconstruction of the dominant cultural discourse (see Dallos & Draper, 2010) became manifest as the therapist was (i) mirroring only one participant's lexical choices (see CA analysis: picture 1, 'one child only' phrase), (ii) sharing the normative expectation of one of the participants (CA analysis: picture 1, line 11, picture 2, line 20, (iii) placing one spouse in the position of the person accountable for gender-related choices (dialogical analysis: the wife's sense of the impossibility of having a second child was due to her 'weakness inside'). Through these observations, our study confirmed the constructionist idea that the therapist is at constant risk of replicating gender-related oppressive experience (Dickerson, 2013), as gender is 'something that one does' (Stokoe, 2004), such as the particular interactive behaviours (listed above) negotiated by the participants, which validated the categorisation of women and men (see Schegloff, 1992). The research outcomes prompt the suggestion to introduce detailed analysis of therapists' and participants' interactional practices into therapeutic training and supervision, as cultural discourses are considered difficult to recognise and ultimately impossible to confront (Dickerson, 2013).

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Appendix : Transcription Symbols (see Hepburn & Bolden, 2012).

Symbol	Meaning
T/C/W/ H:	Speaker identification: therapist (T), client (C), wife (W), husband (H)
[]	Overlapping talk
(.)	A pause of less than 0.2 seconds
(0.0)	Pause: silence measured in seconds and tenths of a second
word	Talk lower volume than the surrounding talk
WORD	Talk louder volume than the surrounding talk
.hh	An in breath
hh	An out breath
£word£	Spoken in a smiley voice
@word@	Spoken in an animated voice
#word#	Spoken in a creaky voice
wo(h)rd	Laugh particle inserted within a word
w <u>o</u> rd	Accented sound
w <u>o</u> -	Abrupt cut-off of preceding sound
wo:rd	Lengthening of a sound
>word<	Talk faster than the surrounding talk
↑↓	Rise or fall in pitch
?	Final rise intonation
,	Final level intonation
.	Final falling intonation
gaze/h	Husband's gaze direction, timing synchronised with the utterance shown in line above
hand/h	Husband's hand pointing towards a co-participant, timing synchronised with the utterance shown in line above
nod/t	Therapist's nod, timing synchronized with the utterance shown in line above