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Struggling for Resonance: Mediopassive Interaction in a Long-Term Treatment of Severe Personality Disorder

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Although clinicians often report significant emotional challenges in psychotherapy for personality disorders, we still know relatively little about how these difficulties are enacted and reorganized in moment-to-moment patient–therapist interaction. We examine whether interactional resonance and mediopassive agency can help illuminate relational difficulties and change in a good-outcome long-term psychodynamic psychotherapy involving a patient with severe interpersonal pathology, chronic depressive symptoms, and somatic complaints. The patient met the diagnostic criteria for borderline and avoidant personality disorders, as well as depressive and somatic symptom disorders. For much of the treatment, the therapist described sessions as highly distressing. Over time, sessions were experienced as less distressing and more productive. We examined whether this shift could be accounted for by changes in how patient and therapist took up and developed each other's contributions in interaction. Following a preliminary screening of therapist reports, case notes, and session recordings, we selected 10 sessions for multimodal conversation analysis. Using exploratory conversation analysis, we specified analytic indicators for interactional resonance and then compared five high-distress sessions with five lower distress sessions. High-distress sessions showed lower interactional resonance, whereas lower distress sessions showed higher resonance. In lower distress sessions, patient and therapist more often engaged in mediopassive interactions—that is, they jointly participated in the stepwise construction of meaning across turns. Psychotherapy for severe interpersonal pathology may involve working with persistently low levels of interactional resonance that constrain spontaneous, collaborative meaning-making. The findings further suggest that a dyad's capacity for interactional resonance may increase over the course of long-term treatment.

Clinical Impact Statement

Question: How can we explain the emotional challenges that often arise in psychotherapy with patients with severe personality disorder? ***Findings:*** Sessions with subjectively high emotional distress lacked interactional resonance, while lower distress sessions showed higher interactional resonance as well as more mediopassive agency—collaborative meaning-making that is not fully predictable or controllable by either participant. ***Meaning:*** Very low interactional resonance may be linked to severe emotional difficulties in therapeutic relationships, but long-term therapy may foster increases in a dyad's capacity for resonance. ***Next Steps:*** Future research should explore how therapists can foster the development of interpersonal resonance in patients with severe personality disorder and how clinical training might better prepare clinicians to effectively recognize and work with noninterpretive mechanisms of change.

Keywords: resonance, mediopassive agency, personality disorders, conversation analysis, long-term psychotherapy

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In this study, we applied multimodal conversation analysis (CA) to video-recorded sessions of a good-outcome long-term psychotherapy (LTP) involving a patient with severe personality disorder (PD). Our aim was to examine whether interactional resonance (IR) and mediopassive agency (MPA) can help capture the implicit dynamics underlying emotional and interpersonal challenges in LTP for PDs. Such treatments are often clinically demanding because therapists must manage high interpersonal complexity while continually adapting over a long course of treatment. Available evidence suggests that both challenges are shaped, in part, by implicit attunement processes between therapist and patient. We introduce the concept of IR to capture the degree to which a therapeutic dialogue is characterized by emergent coconstruction through reciprocal uptake of expressive resources across turns. Put more concretely, IR concerns whether patient and therapist take up each other's words, pauses, formulations, and embodied cues in ways that allow a shared line of meaning to unfold over the course of the conversation. In interactions with higher IR, the exchange becomes an evolving relational process that is not fully predictable or controllable by either participant. We conceptualize the agency of both participants in resonant interactions as mediopassive, that is, as entailing both passivity and activity.

Emotional and Interpersonal Challenges in the Treatment of PDs

Improving the treatment quality of patients with PD is essential because (a) the burden of disease for these patients is comparable to that associated with severe somatic illness (Global Burden of Disease Study 2019 Mental Disorders Collaborators, 2022), (b) there is a high cost of illness for these individuals, and (c) in the case of borderline PD, there are increased somatic comorbidities and mortality (Jacobi et al., 2021). Although available treatments show good overall efficacy and effectiveness across different therapeutic orientations (Leichsenring et al., 2024), a significant proportion of patients with PD are still not sufficiently reached by current approaches. Woodbridge et al. (2022) found that 48.8% of patients with borderline PD did not respond to psychotherapy.

One promising way to improve treatment quality is to better understand the challenges that commonly arise during psychotherapy with patients with PD. Recent conceptual work argues that PDs may be best understood as interpersonal disorders because enduring difficulties in relating to self and others constitute their core (Wright et al., 2022). From this perspective, personality pathology is enacted and maintained in social interaction. Consistent with this view, clinicians often report significant emotional and interpersonal difficulties in working with these patients. These challenges occur across therapeutic modalities and have been linked to the high level of interpersonal dysfunction common among patients with PD (Wilson et al., 2017). Interpersonal dysfunction is associated with problems in the therapeutic relationship (Norcross & Lambert, 2019) and with an increased risk of negative therapist reactions (Wolf et al., 2017). Research suggests that therapists' capacity to manage their own countertransference becomes increasingly important for outcomes as patient interpersonal pathology increases (Heinonen & Nissen-Lie, 2019). Thus, for therapists treating severe PDs, navigating the emotional and interpersonal dynamics of sessions becomes both more critical and more challenging. At the same time, the interactional mechanisms and obstacles to change in these treatments remain largely unexplored.

The Need for Constant Adaptation in Long-Term Psychotherapies

The above therapist challenges in psychotherapy for severe PDs are amplified because these treatments are often long term. LTP is the treatment of choice for many patients with complex disorders (Leichsenring et al., 2013), and several guidelines for PDs include recommendations for longer treatment durations (e.g., Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften, 2024). For some patients with severe PD, meaningful change may require sufficient time to establish a therapeutic relationship and to modify entrenched patterns of relating; consequently, brief treatments may risk underdosing patients who need more sessions (Luyten et al., 2026). Compared with shorter treatments, however, LTPs pose additional challenges because manual guidance is less feasible when complexity and variability accumulate over time. Although manuals for LTPs can offer phase-based assistance, they are generally not prescriptive at the individual session level. Accordingly, LTPs demand greater flexibility: Therapists must continuously adapt and tailor their approach as the treatment unfolds (cf. Norcross & Lambert, 2019). Silberschatz (2017) found that therapists' ability to adapt to the individual process is associated with better outcomes. However, it remains unclear how such tailoring is accomplished in practice and which relational processes it depends on.

Microanalysis of Implicit Attunement and Noninterpretive Mechanisms

There is accumulating evidence that therapists' adaptation and the handling of emotional and interpersonal challenges are shaped in important ways by implicit, embodied processes. For example, spontaneous nonverbal synchrony between patients and therapists is positively associated with alliance quality (Gregorini et al., 2025), and experiences of responsiveness and attunement are positively associated with rupture repair and negatively associated with therapists' contribution to ruptures (Levy Chajmovic & Tishby, 2025). Taken together, these findings suggest that failures of attunement and low responsiveness within a dyad are linked to problems in the therapeutic relationship. If personality pathology is fundamentally interpersonal, then failures of implicit attunement may be among its most immediate interactional manifestations in therapy.

The Boston Change Process Study Group (BCPSG, 2010) offers a process theory linking implicit relational processes—such as attunement—to therapeutic change. The BCPSG challenged many classical models of change by introducing the term *noninterpretive mechanisms of change*. They argue that the implicit therapeutic relationship may be as important as what is explicitly said. They trace these implicit processes to early parent–infant interactions and describe presymbolic, descriptively unconscious representations of early interactions as "implicit relational knowing" (BCPSG, 2010, p. 30). This implicit knowing is thought to continue shaping interactions later in life. From this perspective, therapeutic change occurs when new interactional experiences gradually reshape implicit relational knowing. Therapeutic progress is achieved, in part, through shifts in the implicit therapeutic relationship. Beebe and Lachmann (2002) also focused on patients' and therapists' "nonverbal systems of self- and interactive regulation" (p. 64). When these systems interact in-session, they claim, we can observe

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bodily resonance phenomena. Beebe and Lachmann suggested that mutual exchanges on "the level of rhythm matching, modulation of vocal contour, pausing, postural matching, and gaze regulation" (Beebe & Lachmann, 2002, p. 64) can result in emotional experiences as a vehicle for clinical change. Until now, however, psychotherapy research has rarely assessed such resonancelike phenomena as a coherent, multi-indicator construct.

IR

The concept of resonance "takes root in acoustics and the mechanics of oscillation; it refers to bodies and systems that are attuned to one another by their own vibrations and, above all, are currently connected with one another" (Fuchs, 2018, p. 166). The core idea is that resonant relationships emerge through circular interactions. Instead of a simple sender–receiver model, resonant bodies or systems mutually and continually affect one another. This makes cause and effect inseparable, creating a state of bodily interconnectedness. This idea has been repeatedly adapted to the human sciences. A prominent example is Rosa's (2019) sociological model of resonance. For Rosa, resonance describes a mode of human relationship with four core characteristics: (a) all parties are affected by the relational process, (b) they are capable of responding to the process, (c) resonant relationships have a transformative potential for those involved, and (d) resonance remains uncontrollable in that agents can neither control its occurrence nor predict the kind of transformation it brings.

Building on Beebe and Lachmann (2002) and the BCPSG (2010), we treat resonance as a candidate concept for describing clinically important noninterpretive processes in psychotherapy for PDs. Several authors have suggested resonance as a way of capturing problems and developments in patient–therapist attunement (e.g., Fuchs, 2018; Sell, 2022b). However, these prior uses have largely remained conceptual and metaphorical rather than specifying resonance as an empirically assessable interactional construct. To model how resonance can be interactionally realized in psychotherapeutic conversation, we draw on Rosa's (2019) conceptual work and on linguistic interaction research, where resonancelike phenomena have been described in fine-grained analyses of talk and embodied conduct. Goodwin (1999), for example, argued that the resonance of body movement and speech is central to coparticipation in interaction. Related work has examined such cross-speaker adaptation across contexts using terms such as resonance (Brône & Zima, 2014), alignment (Pickering & Garrod, 2021), and synchronization/entrainment (Scheidt et al., 2021). This literature suggests that resonance can be treated as an empirically observable conversational phenomenon.

In this study, we adapt Rosa's conceptual work as well as empirical findings and perspectives from conversational research for a psychotherapeutic framework. In line with the definition introduced above, we use the term *IR* to refer to the degree to which a therapeutic dialogue is characterized by emergent coconstruction through reciprocal uptake of expressive resources. In interactions with higher IR, the exchange becomes an evolving relational process across turns that is not fully predictable or controllable by either participant. IR is multimodally constituted and may become visible in semantic, prosodic, and embodied dimensions of interaction, and it can vary across moments, sequences, and phases within a therapeutic process. IR concerns primarily implicit, prereflective aspects of interaction rather than deliberate or strategic coordination. Even though some accounts of resonance in therapy carry the implication that resonance is inherently positive, IR is a descriptive concept, not an evaluative one: High levels of IR are not necessarily beneficial or detrimental; their clinical significance depends on the therapeutic context.

MPA

Once resonance is conceptualized as an interactional phenomenon in psychotherapy, the question of agency arises: How do patient and therapist participate in a process that is not fully predictable or controllable? Drawing on Han-Pile's (2017, 2020) phenomenological work on middle-voiced doings, we use the term *MPA* to refer to a mode of action in which a subject prereflectively experiences themselves as already part of an ongoing process and responds to that process. In psychotherapy, MPA describes the therapist's and patient's prereflective awareness of already being involved in an unfolding interactional process with the other, and their responsive participation in that process (Sell, 2022a). Importantly, MPA does not imply a deliberate choice or explicit intention. In our framework, the emergence of IR requires that therapist and patient participate in the dialogue in a mediopassive manner, allowing the interaction to develop beyond unilateral control. MPA is the mode of participation in the emergent interactional property of IR (Sell, 2022b).

MPA entails both passivity and activity. The subject finds themselves affected by a process that is already underway—something happens to them. At the same time, they respond to this process, whether through action, restraint, or waiting. Agency thus lies neither in directing the process nor in mere passivity but in responsive participation. Logically, responsiveness presupposes being affected; one must be moved before one can respond. Temporally, however, these aspects may not be experienced as separate phases. From the subject's perspective, being affected and responding may appear as one unified phenomenon, one action (Sell, 2025).

Research Question

In this study, we use the above conceptualizations of MPA and IR as a lens for examining psychotherapy with severe PD. Despite the above theoretical advances, we still lack empirical accounts of how severe interpersonal dysfunction in the treatment of PDs is enacted and potentially reorganized in moment-to-moment patient–therapist interaction. We examine whether IR and MPA can help account for systematic interactional differences between sessions characterized by subjectively high versus comparatively lower emotional distress in a treatment marked by severe interpersonal dysfunction. In our CA-informed analytic strategy, we first conducted exploratory multimodal CA across selected sessions; then used these observations to derive indicators of IR, with MPA serving as a sensitizing concept; and finally applied these indicators in a contrastive comparison of two sets of sessions.

Method

Data

The data consisted of video-recorded sessions from an LTP. The treatment was carried out at an outpatient clinic affiliated with a research university in southern Germany. Both patient and therapist provided informed consent for recording and analysis of the sessions and for publication of de-identified excerpts. This study was approved by the Ethics Committee of the International Psychoanalytic

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University Berlin. All audio- and video-based data processing was conducted locally on secure institutional devices to protect the confidentiality of the psychotherapy material. In accordance with American Psychological Association ethical guidelines for publishing clinical case material, all direct identifiers (e.g., names) were pseudonymized, and indirect identifying details were modified or omitted in the transcripts.

Case Selection

We aimed to identify a long-term treatment of severe PD with a good outcome that nonetheless involved marked interactional and emotional difficulties during the process. We first reviewed pretreatment and outcome data from a pool of treatments with Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders*-assessed PD diagnoses. We focused on cases with high interpersonal problems (IIP-$32_{Total} > 2.00$) and severe impairment in personality organization (IPO-$16_{Total} > 2.2$). We then held discussions with therapists at the outpatient clinic about potentially eligible cases meeting the above criteria. Among these cases, we selected one in which the therapist, in retrospective discussions informed by contemporaneous case notes, characterized the process as marked by particularly severe interactional and emotional difficulties that only gradually subsided over time.

Cases were considered eligible if they demonstrated clinically significant improvement according to the criteria proposed by Jacobson and Truax (1991), with a reliable change index above ±1.96 indicating reliable change ($p < .05$). For the selected case, symptom severity and personality functioning were assessed at intake and termination with the Patient Health Questionnaire for depressive symptoms (PHQ-9) and somatic symptoms (PHQ-15; Spitzer et al., 1999), the Inventory of Interpersonal Problems–32 (IIP-32; Horowitz et al., 2000), and the Inventory of Personality Organization–16 (IPO-16; Zimmermann et al., 2015). Detailed cutoff derivations and clinical outcome data are provided in Supplemental Table S1. Pretreatment scores indicated substantial pathology across measures (PHQ-9 = 22, PHQ-15 = 21, IIP-32 = 2.70, IPO-16 = 2.92). By termination, all four measures had improved (PHQ-9 = 7, PHQ-15 = 14, IIP-32 = 1.56, IPO-16 = 2.06); depressive symptoms fell below the recovery cutoff, while somatic symptoms, interpersonal problems, and personality organization remained in the clinical range but showed substantial improvement.

Patient

The patient was a White woman whom we refer to as Sophie. Sophie was in her early 20s at the beginning of treatment. She presented to the initial consultation at the outpatient clinic with severe depressive symptoms, fluctuating somatic complaints, and persistent intense feelings of emptiness and hopelessness. She was unemployed, received basic income support, and lived in assisted living. She came to the clinic at the recommendation of her social worker.

In the initial interview, the patient described having been severely neglected since an early age. The mother worked full time, and the father was unemployed. Both parents suffered from severe alcohol dependence. The patient was an only child. She had tried to take her own life twice as a teenager and had left school at age 16 with bad grades. Various attempts at supported vocational programs were unsuccessful, and Sophie stated that she had no hope of ever finding a job that was remotely suitable for her. Until a year before this treatment, she had undergone LTP in cognitive behavioral therapy. She also had several short-term inpatient psychotherapy stays (3–8 weeks) during and after her prior cognitive behavioral therapy. She reported that some of these treatments had been somewhat helpful while they lasted, but she did not perceive any lasting changes.

Diagnoses included somatic symptom disorder, persistent depressive disorder, and major depressive disorder according to the Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, as well as borderline PD and avoidant PD according to the Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, Personality Disorders.

Therapist and Treatment Model

The nonmanualized psychodynamic LTP comprised 254 sessions over almost 4 years, scheduled twice weekly in the face-to-face setting. The therapist was a White man (48 years old at treatment start) with a doctoral degree in psychology and formal training in psychodynamic psychotherapy and psychoanalysis. He had several years of clinical experience in various settings. The treatment was conducted under regular supervision. The therapist described his clinical approach as informed by contemporary object relations theory, with an emphasis on relational psychoanalysis (Mitchell, 1988) and post-Bionian field theory (Ferro, 2009). He understood therapeutic change as emerging primarily from allowing unconscious aspects of the therapeutic relationship to unfold within the shared relational field, with interpretive interventions used to bring these processes into reflective awareness once they had been emotionally experienced. He also named structure-oriented psychodynamic approaches in the German-speaking tradition (Rudolf, 2020) as an influence for working with PDs. This entailed strengthening structural capacities through a supportive, relationship-oriented stance alongside interpretive interventions.

Treatment Process and Session Selection

The therapist reported experiencing significant emotional difficulties in his therapeutic engagement with Sophie over extended periods of the treatment, beginning shortly after the first sessions. This characterization is based on the therapist's contemporaneous session-by-session case notes and on retrospective discussions with the therapist conducted after treatment completion. In these discussions, we focused on reconstructing broad phases of the treatment, with particular attention to changes in the emotional and interactional quality of the sessions, the therapist's in-session experience, and the patient's level of engagement. For the first 3 years (~170 sessions), the therapist regularly experienced intense hopelessness and despair during the sessions. He described feelings of numbness and emptiness, occasional hostility, and great difficulty remaining focused. He frequently questioned his ability to do anything helpful for Sophie and, at times, even contemplated terminating treatment. After approximately 3 years of therapy, the therapist began reporting sessions that felt different, with Sophie at times confirming this impression during sessions. This shift was not abrupt but emerged gradually and was noted with increasing frequency. The therapist described experiencing sessions with Sophie as more lively, connected, and responsive. He felt more emotionally engaged with her, and he had the impression that Sophie was more

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actively involved in her therapy. Importantly, the therapist was unable to specify what had changed or to attribute these experiences to identifiable changes in either party. In the sessions and case notes available, Sophie likewise did not articulate a clear account of what had changed. Nevertheless, it was evident that something was different, and working together on Sophie's emotional problems had become significantly easier.

To explore the nature of this change, we first used the therapist's case notes and retrospective phase reconstruction to identify candidate sessions broadly representative of a more distressing and a comparatively less distressing phase of the treatment. We then reviewed all available recordings from these periods and selected two sets of five sessions on the basis of converging evidence from case notes and global markers of strain visible in the recordings. The final selection comprised five sessions from before the shift had been reported (Sessions 154, 163, 164, 165, and 166) and five sessions approximately 6 months later that were experienced as less distressing (Sessions 182, 185, 186, 197, and 199). For the purposes of contrastive sampling, "high distress" referred to sessions that were consistently characterized as particularly distressing and strained in the therapist's case notes, the retrospective discussions, and—where available—in in-session patient statements. "Lower distress" referred to sessions described as comparatively less distressing and more workable. These judgments were further corroborated by a qualitative review of the recordings for global markers of strain (e.g., prolonged silences, recurrent impasses, and sustained displays of tension). We selected sessions approximately 6 months apart to preserve sufficient common ground in themes and life context while still contrasting phases that differed in experienced distress and workability. No standardized session-level outcome or alliance measures were collected; the high versus lower distress distinction is a qualitative classification used for contrastive sampling.

Longitudinal Multimodal CA

To examine whether the reported shift in the treatment process was reflected in changes in tacit patient–therapist interaction, we used a CA-informed analytic strategy. CA is designed for the fine-grained study of naturally occurring interaction (Pfänder, 2026). It examines how participants organize talk, action, and embodied conduct sequentially and moment by moment (Couper-Kuhlen & Selting, 2018; Hepburn & Potter, 2021). In CA, analytic claims are grounded in observable features of recorded interaction and in the sequential organization of participants' turns rather than relying primarily on rater-based inferences. In psychotherapy research, such an approach makes it possible to study how clinically relevant interactional processes are enacted in real time (Peräkylä, 2019). Here, CA served as an exploratory method for identifying recurrent interactional patterns in the selected sessions and for developing analytic indicators of relatively higher versus lower IR. All CA analyses were conducted by the second author together with three additional researchers with experience in CA. Throughout the analytic process, all findings were reviewed within this team. When the team did not initially agree on the identification or characterization of a phenomenon, the relevant recordings and transcripts were reexamined and discussed until consensus was reached. The first author audited the resulting analyses.

The analysis proceeded in several steps. First, the 10 selected video-recorded sessions were reviewed repeatedly in their entirety. Audio tracks were initially transcribed using a locally run automated speech recognition pipeline (WhisperX, incorporating OpenAI Whisper and Pyannote.audio for speaker diarization) and then checked against the recordings and corrected manually. Video data and transcripts were managed and annotated in ELAN. Because IR was assumed to be multimodally constituted, the analysis also considered visible embodied conduct, including posture, gesture, gaze, and bodily orientation (Hayashi, 2013; Oloff, 2013).

Second, we conducted an exploratory multimodal CA across the sessions without initially imposing IR or MPA as a coding scheme. Rather, we examined how interaction unfolded in high-distress versus lower distress sessions and which recurrent conversational and embodied phenomena appeared to differentiate these two sets of sessions. The analysis drew on established CA and interactional–linguistic concepts, including turn taking (Hayashi, 2005), collaborative utterance (CU) construction (Lerner, 2004), repetition across speakers (von Contzen et al., 2024), preference organization and affordances (Küttner & Ehmer, 2024), discontinuities in talk (Hoey, 2015), prosodic adaptation and temporal coordination (Szczepek Reed, 2000), pauses and overlap (Oloff, 2013), and other vocal and embodied resources relevant to the organization of psychotherapy interaction (Peräkylä, 2019). Passages that emerged in this exploratory analysis as relevant to these phenomena were then transcribed in greater detail using Gesprächsanalytisches Transkriptionssystem 2 (Selting et al., 2009), a fine-grained transcription system for spoken interaction that captures features such as pauses, overlap, intonation, and emphasis.

Third, based on the exploratory analysis, we repeatedly reviewed the identified conversational phenomena in random order while blinded to session number and therapy phase. Through an iterative comparative process, we developed specific indicators of IR. In this step, IR and MPA functioned as sensitizing concepts (Bowen, 2019), that is, as concepts used to select which of the previously identified conversational features could serve as indicators of IR and to specify how their lower versus higher resonance forms should be defined. Guided by the functional definitions above, we specified for each selected interactional feature a lower resonance form (IR−) and a higher resonance form (IR+) through which differences in IR could be identified in the material. These forms consisted of clearly identifiable conversational phenomena and, in many cases, of discrete, countable occurrences.

Fourth, we systematically reexamined the 10 sessions using the IR indicators, classifying the relevant interactional features into IR− versus IR+ forms. Where possible, these indicators were subsequently quantified for comparative analysis.

Quantification and Statistical Data Analysis

For each quantifiable feature, occurrences of its IR− and IR+ forms were counted across the high-distress sessions and the five lower distress sessions. These counts thus represent occurrences across sessions within each phase. To examine whether the distribution of IR− versus IR+ forms differed between the two sets of sessions, we conducted 2×2 χ^2 tests for each feature. Effect sizes are reported as φ. To reduce the risk of inflated Type I error across multiple tests, p values were adjusted using the Bonferroni–Holm procedure (family-wise error rate = .05). Analyses were performed using *R*.

Results

The comparative CA-informed analysis yielded nine indicators of IR summarized in Table 1. We present the indicators in an order reflecting the relative size of the interactional unit involved, from

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Table 1
Comparison of Indicators of Interactional Resonance in High-Distress and Lower Distress Sessions

Conversational feature	Low- versus high-resonance form	*n* (%) or qualitative assessment		χ^2	*p*	φ
		High-distress session	Lower distress session			
1. Turn design	Adjacency pairs (IR−)	57 (93.44%)	33 (55%)	23.46	.007	.44
	Multiturn units (IR+)	4 (6.56%)	27 (45%)			
2. Syntactic projects across speakers	Simple collaborative utterances AB(A) (IR−)	18 (81.82%)	9 (33.33%)	10.05	.008	.46
	Complex collaborative utterances ABA++ (IR+)	4 (18.18%)	18 (66.67%)			
3. Preference organization after requests for confirmation	Dispreferred next actions, continuer token only (IR−)	42 (66.67%)	37 (41.11%)	9.69	.01	.25
	Preferred next actions, (dis)confirmation token as projected by main speaker (IR+)	21 (33.33%)	53 (58.89%)			
4. Elaboration of thoughts subsequent to other-confirmation	Other-confirmation without further elaboration (IR−)	25 (51.02%)	24 (28.92%)	6.45	.013	.22
	Other-confirmation with further elaboration (IR+)	24 (48.98%)	59 (71.08%)			
5. Turn-initial conjunctions	"and" or "but" as bleached discourse markers (IR−)	27 (51.92%)	14 (19.44%)	14.39	.033	.34
	"and" or "but" as full connectors between biclausal sentences (IR+)	25 (48.08%)	58 (80.56%)			
6. Midturn repetition of $n = 4$ constructions	Syntactically identical, but semantically weak, chains (IR−)	21 (70%)	12 (40%)	5.46	.04	.30
	Semantically meaningful constructions or idioms (IR+)	9 (30%)	18 (60%)			
7. Long pauses after turn yielding (>5″)	Unproductive long pauses, followed by topic shift (IR−)	18 (50%)	11 (47.83%)	.03	.87	*ns*
	Productive long pauses, used for further formulation work (IR+)	18 (50%)	12 (52.17%)			
8. Prosodic adaptation	Degree of pitch and melody being synchronized	Mostly desynchronized	Often synchronized			
9. Body positions and movements	Degree of gestures being mirrored; spontaneous (as opposed to conventionalized) gestural movements	Rare gestural resonance, consecutive pre-fabricated movements	Freq. movement resonance, overlapping and spontaneous "ad hoc" movements			

Note. Counts (*n*) reflect occurrences aggregated across the five sessions per phase; *p* values were adjusted for multiple testing using the Bonferroni–Holm correction (family-wise error rate = .05, $m = 7$). IR = interactional resonance; IR+ = high-resonance form of the conversational feature; IR− = low-resonance form of the feature; AB(A) = collaboratively produced utterances spanning two to three turns (typically two); ABA++ = collaboratively produced utterances spanning ≥4 turns (often more); χ^2 tests compare the distribution of IR+ versus IR− between high- and lower distress phases (2×2 tables; $df = 1$ for all tests); *ns* = not significant.

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phenomena unfolding across several turns, to more local within-turn phenomena, to rapidly changing prosodic and embodied aspects of the interaction. For each conversational feature, we first distinguish its IR− and IR+ forms, then report their statistical or qualitative comparison, and finally illustrate both forms with extracts from the session material where helpful. While the nine features are presented as indicators of relatively lower versus higher IR, several of the higher IR forms also illustrate the mode of mediopassive participation through which such resonance becomes possible.

1. Turn Design

Turn design concerns how speaker changes are organized and whether they enable the participants to work jointly on an unfolding conversational task across several turns. Following our analysis, lower and higher resonance forms of turn design differ in whether the exchange remains within short two-part sequences or develops into a more extended multiturn unit. Accordingly, we operationalized the IR− form as adjacency pairs and the IR+ form as multiturn units. The distribution of adjacency pairs and multiturn units differed significantly between high-distress and lower distress sessions. Whereas high-distress sessions were dominated by adjacency pairs, lower distress sessions showed a substantial increase in multiturn units, resulting in a more even distribution of the two forms.

Adjacency Pairs (IR−)

The IR− form of turn design is characterized by adjacency pairs in which one speaker initiates an action and the other responds in a way that closes the sequence. As a result, the exchange proceeds through short two-part units that are only loosely connected, and any further development requires a new initiative by one of the speakers. This pattern is illustrated here (Extract 1):

```
01 THE: i think there's a danger
02      that this success,
03      and i do think it is a success
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04      that you've started this now,
05      actually gets devalued.
06 PAT: hm
07 THE: well, that's only driving school,
08      you don't have all those many other things as well.
09 PAT: yes, yes,
10 THE: you'll surely manage the driving school.
11 PAT: that's right.
```

In the example, the therapist first formulates an assessment that the patient's recent success may be at risk of being devalued (Lines 1–5), to which the patient responds with "hm" (Line 6), thereby closing the sequence without further elaboration. The therapist then initiates a new thought, namely, that there are few other domains in which she can currently try out new possibilities (Lines 7–8), which is again followed by an affirmative but sequence-closing response ("yes, yes," Line 9). He then initiates yet another assessment, now expressing confidence that she will manage driving school (Line 10), which the patient again answers in a sequence-closing way ("that's right," Line 11). Thus, the exchange remains organized as a series of such separate adjacency pairs. Each next step requires a new initiative, here repeatedly by the therapist.t

Multiturn Units (IR+)

The IR+ form of turn design is characterized by multiturn units in which speaker changes are organized so that the participants can work jointly on the same conversational task across several turns. Rather than closing the sequence, each contribution creates a basis for further uptake and continuation. As a result, the exchange develops into a shared multiturn unit in which both participants contribute to the unfolding formulation of a thought. This is shown here (Extract 2):

```
01 PAT: i thought a little bit about where to stArt.
02 THE: is there a LOT on your MIND?
03 PAT: yeah, actually there's quite a LOT on my mind
        right now.
04      i've been thinking a LOT about the conversation
        from mONday.
05      i also saw ms surname on wEdnesday.
06 THE: what have you been thinking about?
07 PAT: i'm actually still kind of stuck on this Anger.
08      so i'm actually still trying, like to find out,
09      well, how should i put it,
10      whether that could be rIght.
11 THE: whether there's anything to it;
```

The patient begins by indicating uncertainty about where to start the session (Line 1). The therapist responds with a formulation ("is there a LOT on your MIND?"; Line 2), which the patient immediately confirms and takes up in expanded form ("there's quite a LOT on my mind right now," Line 3). She then continues by specifying what she has been thinking about (Line 4). The therapist's next turn ("what have you been thinking about?"; Line 6) again takes up and sustains this emerging line, thereby scaffolding the patient's further formulation work and enabling her to move toward a more specific affective articulation ("this Anger," Line 7). When the patient hesitates while trying to articulate the next step of her thought ("well, how should i put it," Line 9), the therapist joins in by completing the emerging sentence in Line 11. Here, both participants respond from within an emerging conversational task rather than merely contributing separate turns. This is consistent with and necessitates a mediopassive mode of participation by both participants.

2. Syntactic Projects Across Speakers

Syntactic projects across speakers concern cases in which patient and therapist collaboratively work on the completion or expansion of an emerging syntactic structure, such as a sentence. Research in interactional linguistics (Auer, 2005) has shown that speakers orient to the completion of syntactic projects not only as current speakers but also as recipients. Recipients can anticipate how an emergent utterance will continue and, at times, join in its production (Lerner, 2004). Lower and higher resonance forms of this feature differ in the complexity and temporal extension of such CUs. We operationalized the IR− form as *AB(A)*, that is, simple CUs spanning two to three turns, and the IR+ form as *ABA++*, that is, more complex CUs spanning four or more turns. The distribution of AB(A) and ABA++ CUs differed significantly between high-distress and lower distress sessions. Whereas high-distress sessions more often showed simple CUs, lower distress sessions showed more complex CUs.

Simple CUs: AB(A) (IR−)

In simpler CUs one speaker's syntactic project is taken up by the other and brought to a fitting completion but only across a short sequence of two to three turns. Such sequences clearly involve IR because the recipient anticipates and supports the speaker's ongoing formulation work. At the same time, the collaboration remains relatively limited in extent and complexity. Such a pattern is illustrated in the following extract (Extract 3):

```
01 PAT: yeah, i can understand that someone like you
02      or name or whoever
03      thinks i'm Angry, but i, i
04 THE: but you don't feel it, right?
05 PAT: I don't feel it
06      i couldn't really say now,
07      yeah, i'm Angry.
09 THE: hm_hm.
```

The patient begins to formulate a contrast between how others may perceive her and how she herself experiences her affective state ("but i, i," Line 3) but hesitates before bringing the syntactic project to completion. The therapist takes up this emerging structure and proposes a completion ("but you don't feel it, right?"; Line 4) while marking it as a candidate formulation by requesting confirmation. The patient then ratifies and repeats this formulation ("I don't feel it," Line 5) and elaborates it further (Lines 6–7). The resulting utterance is collaboratively produced, but it remains relatively simple and brief.

Complex CUs: ABA++ (IR+)

More complex CUs extend across four or more turns and involve repeated reciprocal uptake. Here, collaboration does not merely complete a projected utterance but sustains and progressively elaborates it over multiple turns. The emerging thought is repeatedly taken up, adjusted, and developed further. This pattern is well-illustrated in the following extract (Extract 4):

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```
01 THE: that's- ((silence of 1.3 seconds))
02      I think that's kinda esSENtial for you;
03      that you have the FEELing-
04      if it gets kinda WEIRD,
05      you can LEAVE;
06      or SOMEthing like that-
07 PAT: yeah yeah;
08 THE: yeah:;
09 (pause of 9.3 seconds)
10 PAT: and THAT I just,
11      (pause of 4.9 seconds)
12      probably kinda need like an imaginary STOP sign
        or something;
13      that then SAYS;
14 (pause of 1.4 seconds)
15 THE: YOU can stop at any time;
16 (pause of 1.0 seconds)
17 THE: it's gotta be something like THAT;
18 PAT: that's right. Yes, or if it says
19      no, you're not telling a lie right now
```

The therapist starts a tentative syntactic project concerning the patient's need to feel that she could leave if things became strange or overwhelming (Lines 1–6). This formulation is explicitly marked as provisional ("or SOMEthing like that-," Line 6), and both speakers briefly ratify it (Lines 7–8). After a longer silence, the patient reactivates the still-latent project by extending it in a new direction ("and THAT I just," Line 10), introducing the metaphor of an imaginary stop sign that could speak to her (Lines 12–13). When the patient pauses again after projecting the next element ("that then SAYS;" Line 13), the therapist takes this as an opportunity to propose a candidate completion ("YOU can stop at Any time;" Line 15) while again marking it as tentative in Line 17. The patient then partly confirms this proposal before adjusting it in her own words (Lines 18–19). This is a complex CU spanning more than three turns. Both speakers' agency is mediopassive: Each takes up and continues a process already underway rather than fully directing it alone.

3. Preference Organization After Requests for Confirmation

Preference organization concerns the extent to which a given action makes a particular kind of next action sequentially relevant. In psychodynamic therapy, one recurrent conversational task of the therapist is to check understanding or propose an interpretation of the patient's experience. Such actions typically make a direct response by the patient relevant, that is, a response that addresses the therapist's proposed understanding. Lower and higher resonance forms of this feature differ in whether these requests are indeed followed by such a preferred next action or by a less committal response. We operationalized the IR− form as dispreferred next actions, continuer token only and the IR+ form as preferred next actions, that is, confirmation or disconfirmation tokens. The distribution of these two forms differed significantly between high-distress and lower distress sessions. Whereas high-distress sessions more often showed continuers in response to requests for confirmation, lower distress sessions more often showed preferred next actions.

Dispreferred Next Actions: Continuer Token Only (IR−)

The IR− form is characterized by cases in which the therapist's request for confirmation does not lead to the projected preferred next action, that is, a direct confirmation or disconfirmation. Instead, the patient produces "continuers," that is, responses that encourage the therapist to continue speaking but without ratifying or rejecting any meaning. This is illustrated here (Extract 5):

```
01 THE: there are people who suddenly,
02      so to speak,
03      fall asleep=
04 PAT: yeah
05 THE: =or drift OFF so strOngly
06      that it
07      well,
08 PAT: yeah(.)
09 THE: i mean,
10      i haven't heard anything like that so far,
11      from you (.)((hold-ges+gaze@PAT))
12      and i mean,
13      you'll start taking driving lessons at some
        point, too.
14      so what i mean to say is,
15      if i had the impression
16      that from a psychotherapeutic point of view
17      there was fundamentally something against
18      you getting a drIver's license,
19      in a sense like we were [just] talking about
20 PAT:                          [mhm ]
21 THE: then i would already have told you that.
22      if I would think
23 PAT: yeah
24 THE: but how is that supposed to wOrk?
25 PAT: yeah,
26 THE: yeah.
```

The therapist repeatedly works toward securing the patient's understanding and assent. In Line 11, for example, a brief pause together with a holding gesture and gaze toward the patient makes a response relevant. However, the patient does not provide a preferred next action addressing the therapist's formulation. Thus, while the patient remains engaged as a listener, the therapist's requests for confirmation do not receive a committed answer that would guide the further course of the interaction.

Preferred Next Actions (IR+)

The IR+ form is characterized by cases in which the therapist's request for confirmation is followed by a response directly confirming, disconfirming, or modifying the therapist's proposed understanding. This is illustrated in the following (Extract 6):

```
01 PAT: i can feel the tears coming but they don't start to
        run
02 THE: there's a block. ((nodding+gaze@PAT))
03 PAT: that's right, that's right (.)
04 THE: and i think the block for grIef
05      is connected to the block for Anger.
        ((hold-ges+gaze@PAT))
06 PAT: hm_hm;
```

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As in the IR− example above, the therapist repeatedly offers formulations of the patient's experience and marks them as requests for confirmation through prosodic completion, gaze direction, nodding, and holding gestures (e.g., Lines 2, 5). Unlike above, however, the patient here responds with confirmation tokens such as "that's right," and "hm_hm" (Lines 3, 6). In this way, the patient's responses recurrently confirm the therapist's interpretive steps and thereby support the ongoing elaboration of a shared account.

4. Elaboration of Thoughts Subsequent to Other-Confirmation

This feature concerns what happens after a strong other-confirmation, that is, after a stand-alone confirmation token such as "that's right." Lower and higher resonance forms differ in whether the confirmation closes the sequence or opens up further elaboration. Accordingly, we operationalized the IR− form as other-confirmation without further elaboration and the IR+ form as other-confirmation with further elaboration. The distribution of these two forms differed significantly between high-distress and lower distress sessions. Whereas high-distress sessions did not show a difference between stand-alone other-confirmation with and without elaboration, lower distress sessions more often showed stand-alone other-confirmation followed by elaboration.

Other-Confirmation Without Further Elaboration (IR−)

The IR− form is characterized by cases in which a confirmation token ratifies the other speaker's formulation but does not itself open further development of the thought. The confirmation stands as a sequence-closing response, and any continuation of the topic must again be initiated by the other speaker. This is illustrated in the following (Extract 7):

```
01 PAT: that was like, as if i really,
02      as if i should have become an Actress.
03      as if i had a mAsk on then.
04 THE: as if those had been like two wOrlds then.
05 PAT: yeah.
06 THE: your old friends and this new grOup.
07 PAT: that's right, that's right.
08 THE: you had to keep that like completely sepArate.
```

The therapist offers a formulation of the patient's experience as divided between "two worlds" (Line 4), which he specifies further in Line 6. The patient then responds with a strong stand-alone confirmation token ("that's right, that's right," Line 7). This clearly ratifies the therapist's formulation but does not itself contribute further content or elaboration. Instead, the therapist again has to continue and develop the thought in Line 8.

Other-Confirmation With Further Elaboration (IR+)

In the IR+ form, by contrast, a strong stand-alone confirmation token is followed by further elaboration of the thought. In such cases, the confirming speaker not only ratifies the other's formulation but also takes it up as a basis for further development. IR is higher here because the confirmation becomes part of an ongoing collaborative process of meaning-making. This pattern is shown in the following (Extract 8):

```
01 PAT: and there I noticed
02      what i've already had so many times,
03      with this, yeah, understanding and expectAtions,
04      like, that the other people then don't understAnd
        it, like,
05      huh, but it's your bIrthday.
06 THE: as if you have to make a party rIght now for the
        others.
07 PAT: that's right, that's right.
08      so,
09      like,
10      one can't spend that (i.e., one's birthday) alOne
        at hOme by oneself.
11      well, actually I CAN.
```

The therapist formulates the interpersonal expectation the patient is describing—that a birthday requires making a party "for the others" (Line 6). The patient responds with a strong stand-alone confirmation token ("that's right, that's right," line 7), but unlike in the previous extract, she then continues by elaborating the thought in her own words (Lines 8–11). In doing so, she takes up the therapist's formulation and develops it further into a more explicit articulation of the underlying norm and her position toward it.

5. Turn-Initial Conjunctions

Turn-initial conjunctions concern cases in which a speaker begins a turn with a conjunction in order to relate the emerging contribution to the other's prior turn. Lower and higher resonance forms of this feature differ in whether these turn-initial tokens function as full conjunctions, establishing a strong semantic and syntactic link to the preceding turn, or as more weakly linked discourse markers with bleached semantics. We here focus on "and" and "but" because they are frequently used as discourse marker as well as full conjunctions in German. We operationalized the IR− form as turn-initial "and" or "but" used as discourse markers and the IR+ form as turn-initial "and" or "but" used as full conjunctions. The distribution of these two forms differed significantly between high-distress and lower distress sessions. Whereas high-distress sessions showed a relatively equal amount of both forms of turn-initial conjunctions, lower distress sessions more often showed them as semantically and syntactically connecting conjunctions. Because the contrast between the two forms was comparatively straightforward, we summarize the feature here without a full transcript illustration.

"and" or "but" as Bleached Discourse Markers (IR−)

These are uses of a turn-initial "and" or "but" that organizes the flow of talk only loosely, without strongly continuing or constraining the content of the preceding turn. The token still marks a connection to the prior talk and thereby creates the surface impression of a flowing conversation, but this connection is weak at the semantic level.

"and" or "but" as Full Connectors Between Biclausal Sentences (IR+)

The IR+ form is characterized by turn-initial "and" or "but" functioning as full conjunctions. The token links the new turn strongly to the preceding one, both syntactically and semantically,

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so that the emerging contribution is heard as a direct continuation, qualification, or restriction of the prior line of thought; this format contributes to a shared development of the issue under discussion.

6. Midturn Repetition of $n = 4$ Constructions

This feature concerns cases in which one speaker repeats, within a turn, a sequence of four words previously produced by the other speaker. Lower and higher resonance forms of this feature differ in whether such repeated $n = 4$ word strings constitute semantically meaningful constructions or idiomatic expressions or whether they form only grammatically parallel but semantically weak chains. We therefore operationalized the IR− form as syntactically identical but semantically weak chains and the IR+ form as semantically meaningful constructions or idioms. The distribution of these two forms differed significantly between high-distress and lower distress sessions. Whereas high-distress sessions more often showed semantically weak chains, lower distress sessions more often showed semantically meaningful constructions and idiomatic expressions.

Syntactically Identical but Semantically Weak Chains (IR−)

These are repetitions of four-word sequences that do not establish a clear form-function relation or add substantial semantic value to the jointly developing meaning. The repeated string still reflects some degree of IR because the lexical sequence is reproduced in the same order, but it does not form a clearly meaningful construction. Examples of this lower resonance form include repeated four-word strings: "I think I have," "yeah so I have," "that I think yeah," "I think that one," "yeah that one is," "yeah a little bit," "well I have, yeah," and "is in any case."

Semantically Meaningful Constructions or Idioms (IR+)

Repetitions of four-word sequences that constitute semantically meaningful constructions, including idiomatic expressions, do not merely reproduce a grammatical pattern but also carry a recognizable semantic function that supports the shared development of meaning across turns. This is illustrated in the following (Extract 11):

```
01 THE: is there a LOT on your MIND?
02 PAT: yeah, actually there's quite a LOT on my mind
        right now.
03      i've been thinking a LOT about the conversation
        from mONday.
```

The patient takes up the therapist's wording by repeating the four-word sequence *a LOT on my mind* with a change in pronoun (Lines 1–2). This is a semantically meaningful construction. By reproducing it, the patient adopts the therapist's formulation and integrates it into her own contribution. Other examples of this higher resonance pattern include repeated strings: "to beat yourself up," "set yourself a goal," "to get it together," "find themselves so terrible," "it's more like that," "that kind of feeling," and "to have a bad conscience."

7. Long Pauses After Turn Yielding (>5″)

This feature concerns long pauses following turn yielding and whether they become productive for the further joint development of meaning. Lower and higher resonance forms of this feature differ in whether such pauses are used by the recipient as a space for further formulation work or remain interactionally underused so that the sequence moves elsewhere. We operationalized the IR− form as unproductive long pauses, followed by a topic shift, and the IR+ form as productive long pauses, used for further formulation work. The distribution of these two forms did not differ significantly between high-distress and lower distress sessions. Given the absence of a significant phase difference, we summarize this feature here without fuller transcript illustration.

8. Prosodic Adaptation

Prosodic adaptation concerns the degree to which patient and therapist align in pitch and prosodic contour across adjacent turns. In the present material, lower and higher resonance forms of this feature differed in the degree to which speakers adapted to one another's pitch range and speech melody. Overall, lower distress sessions showed a higher degree of prosodic adaptation than high-distress sessions. This was evident both in the closer alignment of pitch and in the more similar shaping of prosodic contours across speaker turns. Such moment-to-moment adaptation of pitch and prosodic contour also suggests a mode of participation in which speakers respond from within the unfolding interaction (MPA) rather than merely producing locally self-contained turns.

9. Body Positions and Movement

Body positions and movements concern the degree to which patient and therapist show bodily alignment through posture, orientation, and gesture. In the present material, lower and higher resonance forms of this feature differed in the degree to which gestures and body positions were mirrored and in the extent to which spontaneous recurrent gestures emerged across speakers. Overall, lower distress sessions showed a higher degree of bodily resonance than high-distress sessions. This was evident, first, in a greater degree of similarity in body positions and orientation and, second, in more frequent mirroring of gestures. In addition, lower distress sessions showed more spontaneous recurrent gestures rather than only more conventionalized gesture forms. Because such bodily adaptations are likely to occur largely prereflectively, they are also consistent with a more mediopassive mode of participation in the lower distress sessions. Figure 1 illustrates how such resonance in body position and gesture can coincide with syntactic resonance in the lower distress sequence presented in Extract 4 above.

Conclusion of Conversation–Analytic Findings Across High- and Lower Distress Sessions

Across eight of the nine indicators, high-distress sessions were characterized by lower IR: Turn sequences more often remained short and sequence closing, CUs were less complex, requests for confirmation less often received preferred next actions, and elaborations of jointly emerging meanings were more limited. Lower distress sessions, by contrast, showed more sustained uptake across turns, more extended CU production, more frequent elaboration after other-confirmation, and qualitatively greater prosodic and embodied alignment. These findings suggest that lower distress sessions were characterized not only by higher IR but also by more

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Figure 1

Resonance in Gestures and Body Positions (Extract 4)



Note. THE = therapist; PAT = patient.

clearly observable MPA. Especially in the more extended collaborative sequences, patient and therapist appeared to respond from within an unfolding interactional process. In this sense, the CA findings suggest that reduced sessional distress coincided with a greater capacity to participate in the joint emergence of meaning.

Discussion

This study examined whether moment-to-moment interaction patterns can help explain the emotional and interpersonal difficulties that may characterize LTP with patients with severe personality pathology. By comparing an earlier and a later phase of a good-outcome treatment, we explored whether changes in how patient and therapist responded to and built on each other's contributions might illuminate a shift that neither therapist nor patient could clearly articulate. In the earlier phase, complex collaborative sequences were rare, reciprocal uptake was limited, and conversational initiatives often stalled before meaning could be jointly elaborated. Mediopassive participation was very limited. These interactional patterns coincided with the therapist's reported experience of hopelessness, emotional numbness, and disconnection. In the later phase, collaborative sequences were significantly more common, reciprocal uptake, and joint elaborations were increased, with agency more evenly distributed between therapist and patient. These microanalytic shifts coincided with reduced emotional strain and greater ease of collaborative work. These findings suggest that (a) IR is an empirically accessible construct in psychotherapy, (b) it is relevant for understanding emotional and interpersonal problems in LTP for severe PD, and (c) a therapeutic dyad's capacity for IR can change over the course of a successful treatment.

Conceptually, IR and MPA are closely related, but not identical: IR refers to an emergent property of the exchange, whereas MPA refers to the mode of participation through which such resonance can arise. Viewed through the lens of IR and MPA, the emotional and interpersonal difficulties in this case can be related to findings from attachment research. In the earlier sessions, the dyad's nonverbal interactional style resembled patterns observed in disorganized attachment, which Beebe and Lachmann (2014) linked to caregiver detachment from the child's emotional expressions. Empathic responsiveness was notably limited, potentially reflecting early attachment trauma in the patient. To clinically frame these problems, we turn to Greenson's (1967) tripartite model of the therapeutic relationship. Although all components of the therapeutic relationship likely play a role, we argue that the real relationship—the personal, reality-based aspect of the relationship that exists alongside transference and working alliance—was especially consequential in this case. The BCPSG (2010) defined the real relationship as "the intersubjective field constituted by the intersection of the patient's and the therapist's implicit relational knowing" (p. 33), and its quality has been found to predict therapeutic outcomes and in-session process (Gelso et al., 2018).

As our CA results show, the therapeutic dyad struggled with difficulties that manifested at the level of basic conversational organization. These IR problems cannot be fully accounted for by classical psychoanalytic processes (projections, transference). Rather, they reflect a difficulty in sustaining reciprocal, mutually responsive interaction. In this sense, Sophie's PD and the severe interpersonal dysfunction associated with it became visible in concrete, moment-to-moment exchanges with the therapist. Through recurrent breakdowns in turn design coconstruction, limited reciprocal uptake, and lack of joint elaboration, the dyad cocreated intense emotional strain within sessions. Our results thereby suggest that part of the reason the treatment felt so hard for so long was that interaction frequently failed to develop beyond minimal uptake. This is broadly consistent with Gelso and Kline's (2019) suggestion that problems with the real relationship can sometimes precede or be independent of the quality of the working alliance. Low-IR patterns may also become self-reinforcing: Limited uptake on one side makes it harder for the other to respond openly and collaboratively, which in turn helps stabilize the interactional pattern. Even when the two participants seemed to agree about what to do and why, a more fundamental constraint may have emerged at the level of interactional capacity: For long stretches, they could not jointly let meaning unfold spontaneously. At this stage, the patient appeared to lack an implicit expectation of emotional resonance in distress, and the therapist—despite training in relationally oriented psychodynamic approaches—found himself unable to spontaneously "feel with" the patient in session. This, in turn, likely fostered emptiness and doubt in the therapist and a pervasive sense of disconnection.

We suggest that the eventual therapeutic change in Sophie's treatment may also be understood with regard to the real relationship. At the level of conversational microinteractions, therapist and patient gradually began to participate in a more mediopassive way that allowed sequences to unfold more collaboratively. In other words, both experienced themselves as already engaged in a relational process and responded to it in an open-ended way. This change did not appear to be reducible primarily by rupture repair or transference interpretation alone, although the present material does not allow us to exclude the possibility that less readily identifiable interpretive processes also contributed to this shift. At the same time,

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the present material suggests that noninterpretive mechanisms may have played an important role. The therapist had to bear with the patient through a long period of emotional disconnection. This persevering presence may have allowed new relational experiences to emerge slowly. Rather than sudden qualitative shifts ("moments of meeting"), the change observed here appears to take the form of a gradual increase in IR (cf. BCPSG, 2010, p. 53).

Viewed through the lenses of attachment theory and the real relationship, our microanalytic findings converge on a shared process: the emergence of an implicit capacity for sustained coconstruction of meaning within the therapeutic dyad. In the high-distress phase, interaction repeatedly stalled at the level of minimal responsiveness, low IR. Initiatives did not develop into collaboratively elaborated sequences, and resonant exchanges remained brief and fragile. From an attachment perspective, this may reflect the patient's ingrained expectations of non-responsiveness; clinically, it manifested as an emotional strain in the felt relationship. In the lower distress phase, by contrast, the interaction did not become exceptionally resonant. Rather, the dyad reached a common level of reciprocal responsiveness at which sequences could be sustained and elaborated across turns. Over the course of treatment, the change thus appears to involve crossing a threshold at which sustained uptake of expressive resources becomes reliably possible.

Crucially, the relation between IR and therapeutic progress is unlikely to be straightforward. Research on early caregiver–infant interaction suggests that moderate rather than maximal synchrony predicts secure attachment (Beebe & Lachmann, 2002). Similarly, Gregorini et al.'s (2025) meta-analysis indicates that some degree of nonverbal synchrony is associated with better process, but more is not necessarily better. This is also consistent with process models of alliance rupture and repair (Muran & Eubanks, 2020), which emphasize that psychotherapy necessarily includes moments of challenge or rupture that may involve temporary reductions in resonance. Accordingly, we do not equate therapeutic success with continuous or maximal IR. Rather, the present case suggests that chronically low IR—below a functional threshold for coconstruction—may be particularly associated with sustained emotional strain in the therapeutic relationship.

Methodologically, our approach speaks to a broader question of how implicit process dimensions can be modeled. In this regard, our attempt to render implicit process dimensions tractable connects to other efforts to operationalize clinically meaningful change in verbal material. Notably, Bucci's (2013) work on the referential process within multiple code theory also provides linguistic measures (e.g., referential activity) that capture shifts in how experience is symbolized in psychotherapy. While our approach differs in focusing on the sequential, dyadic organization of participation across turns rather than on speaker-level lexical markers, both frameworks share the assumption that change involves systematic shifts in implicit communicative processes. Future research could examine how these levels relate—for example, whether increases in referential activity co-occur with increases in IR.

On the level of intervention and therapeutic stance, we see parallels between our findings and some clinical approaches proposed for challenging groups of patients. For example, in their psychodynamic manual for work with psychosis, Lempa et al. (2016) distinguished between a therapeutic mode focused on jointly experiencing a lived interpersonal connection and a mode focused on understanding these connections, that is, interpreting them. In our case, the earlier sessions were characterized by markedly reduced IR and limited coconstruction of meaning, despite ongoing interpretive efforts. Our CA findings suggest that interpretations alone did not shift the interactional pattern. Instead, change coincided with a gradual transformation in how therapist and patient participated in the interaction itself. If this interpretation is correct, therapists may not be able to produce IR directly, but they may be able to foster conditions under which it becomes more likely to emerge by tolerating uncertainty, sustaining responsiveness, and continuing to invite collaborative elaboration. This supports the idea that treatment of severe personality pathology may sometimes require an initial phase of living, rather than primarily interpreting, the relationship with the patient. In the case studied here, this involved the therapist bearing a prolonged absence of resonance while continuing to invite forms of interaction in which collaborative elaboration could eventually take hold.

Limitations

Several limitations of this study should be acknowledged. First, this investigation was exploratory and based on a single case. Both the identification of treatment phases and the interpretation of interactional change relied, in part, on retrospective reports and case-specific contextual knowledge. As a result, the generalizability of the observed interactional patterns remains to be established. It is unclear to what extent the trajectory described here also reflects specific features of this particular dyad, the treatment method, or the phase of treatment examined. Future research is needed to examine whether comparable patterns of IR can be observed in other therapeutic dyads, across different treatment modalities, and in cases with less favorable outcomes. Further, although we propose IR and MPA as useful conceptual lenses for describing the microprocesses observed, the phenomena identified here may also be captured, in part, by established process constructs—such as therapist responsiveness (Levy Chajmovic & Tishby, 2025), rupture–repair dynamics (Muran & Eubanks, 2020), or now moments (BCPSG, 2010). Further theoretical and empirical work is required to clarify how IR relates to, extends, or differs from these constructs. Finally, while this study takes steps toward specifying observable indicators of IR, the construct remains in need of further refinement. It is not yet clear how the different resonance indicators relate to one another conceptually, whether some are more central than others, or which components might be necessary versus optional for higher IR to emerge. Moreover, no session-level outcome or alliance measures were collected, limiting the possibility of directly relating fluctuations in IR to independent markers of process or change.

Clinical and Research Implications

Our case study illustrates how a lack of emergent IR can be both a manifestation and a perpetuator of emotional and interpersonal difficulties in LTP for severe PD. Over time, the dyad was able to transform this relative absence of resonance into a more workable pattern of interaction. In the later sessions, we observed longer resonant sequences, greater reciprocal uptake, and a more fluid MPA in therapist and patient—microanalytic shifts that coincided with reduced emotional strain and greater ease in collaborative work. We therefore propose that IR and MPA may be core ingredients in

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successfully working with severe interpersonal pathology. Such processes may enable the dyad to spontaneously cocreate meaning as a session unfolds. Importantly, this kind of relational reorganization may require considerable treatment duration. If change depends not primarily on isolated interventions but on a gradual increase in the dyad's capacity for sustained coconstruction, shorter treatments may not provide sufficient time for such a process to emerge.

Although this study examined a psychodynamic LTP, the implicit interactional processes described here are not inherently specific to this therapeutic orientation. Any psychotherapy that conceptualizes the therapeutic relationship as an agent and a medium of change necessarily involves attention to implicit moment-to-moment coordination. Accordingly, the perspective developed here shows conceptual affinities with relational strands within cognitive–behavioral traditions, such as functional analytic psychotherapy (Tsai et al., 2014), which conceptualizes change as emerging through in-session interpersonal contingencies and mutual regulation. We therefore conceptualize IR as a potentially trans-theoretical process dimension, even though different therapeutic models may conceptualize and work with such phenomena in distinct ways. Future research is needed to clarify how IR manifests across therapeutic modalities and how therapists can be supported in recognizing and fostering it in clinical practice.

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