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The Linguistics of Psychotherapy

Idiolect Competency and Understanding What the Client Means

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Almost all psychotherapy is conducted in language. In ordinary conversation, our words are organized to produce agreement that two people understand each other; confirming that the listener has understood what the speaker means is a separate task, and conversation does not routinely accomplish the goal of understanding the speaker's meaning. This paper argues that psychotherapy inherits the standard of agreement as sufficient but not necessarily understanding and we aim to make the difference explicit as it has implications for clinical effectiveness. Agreement can allow the clinician to proceed on his or her own understanding of the client's meaning without that having been confirmed or examined. Further, the client's meaning, when understood, provides fruitful information for mapping the client's psychological organization. Drawing on psycholinguistics, pragmatics, conversation analysis, and Vygotsky's work on thought and speech, it proposes **idiolect competency**: the clinician's ability to understand the client's distinctive use of language as the client means it. The competency includes recognizing signal words, exploring meaning until understanding is sufficient, recognizing withholding and premature agreement, and working these moments through within an explicit alliance. The paper sets out a standard for sufficient understanding, describes how a clinician builds a map of the client's idiolect across sessions, and argues that the same exploration helps the client describe his or her own experience more precisely, which has implications for client outcomes.

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THE POSITION OF THE CLINICAL EFFECTIVENESS INSTITUTE

It is the position of the Clinical Effectiveness Institute that **idiolect competency**, the clinician's understanding of the client's distinctive use of language, is a core clinical competency.

Nearly all psychotherapy is conducted in language. The client brings his or her experience into the therapy room predominately through words, and the clinician comes to know the client through those words. Each person uses language in his or her own way. Linguists call an individual's distinctive use of language an *idiolect*: the particular words a person reaches for, the meanings those words carry for him or her, and the habits by which he or she says, softens, or avoids saying what he or she means. A client's idiolect is shaped by family, culture, and personal history, and it is never fully transparent to anyone else.

Understanding a client's idiolect is a *dialogical process*. It is built through exchange between clinician and client. The clinician forms an understanding, checks it with the client, and revises it as the client clarifies, corrects, and elaborates. Each exchange changes what both people understand, and the client often comes to understand himself or herself more precisely along the way.

The clinician's task is to understand the client in order to help him or her. That understanding is reached through the client's language. The clinician must therefore understand the client's idiolect. A clinician who does not know what the client means by the words the client uses does not yet understand the client. And importantly, the clinician cannot know the client's meaning unless it is checked. This competency is measured by whether the clinician actually understands what the client means. Appearing to understand, and securing the client's agreement, fall short of that standard. Idiolect competency is foundational: it underlies assessment, formulation, the alliance, and every clinical decision that follows.

I. INTRODUCTION

A client says that a visit with her father "was fine." The therapist nods, and the session moves on. Both people leave believing they understood each other. The therapist understood that the visit went acceptably or well enough. The client may have meant that she got through it, or that nothing happened worth discussing, or that "fine" is the word her family has always used to close a difficult subject. Neither therapist nor client has any reason to notice the difference. The exchange looks complete, and in ordinary conversational terms, it is.

This paper is concerned with that kind of moment, and with how often it occurs in psychotherapy without anyone noticing. Ordinary conversation is organized to produce agreement that two people understand each other. It is not organized to confirm that the listener has understood what the speaker means. Research on everyday dialogue describes people working toward a shared belief that they have understood each other well enough for their present purposes, and then moving on (Clark & Brennan, 1991). In most of life, that standard serves us just fine. In psychotherapy, it can fail without either person knowing it has failed, because the therapist's understanding of the client is the foundation for everything the therapist does next: the questions asked, the formulation built, the direction treatment takes.

Every person speaks an idiolect, a personal version of the shared language. The same word can carry very different meanings for two clients, and different meanings for one client in different situations. The clinician speaks an idiolect too. When a clinician hears a client's word, he or she naturally hears it as it would sound in his or her own language (idiolect). Without deliberate effort, the clinician's idiolect takes the place of the client's, and the clinician has no way of noticing that it has.

Therapists misread their clients in measurable ways, and those misreadings have consequences. In one study, when therapists misjudged their clients' positive emotions, clients reported more symptoms the following week (Atzil-Slonim et al., 2019). Clients, for their part, often withhold, and they defer to their therapists in ways that make them unlikely to correct a misunderstanding (Hill et al., 1993; Rennie, 1994). A client who agrees with a therapist's summary may be agreeing because the summary is right, or because agreeing is easier than explaining why it is wrong. From the therapist's chair, the two can sound the same.

Understanding the client's idiolect is a distinct clinical competency, and it can be defined, observed, assessed, and taught. We call it *idiolect competency*: the clinician's ability to understand the client's words as the client means them. That means recognizing the words and phrases that signal a client's meaning is not yet understood ("it was fine," "I can't," "I guess so," "I don't know"). It means exploring those meanings until the clinician's understanding is sufficient. It means recognizing when a client may be withholding or agreeing too readily. And it means working those moments through within the therapeutic alliance. This competency serves the client directly. When a client is asked to say what he or she means, he or she has to make finer distinctions about his or her own experience, and those distinctions often change the experience itself.

Drawing on linguistics, conversation research, and psychotherapy process research, this paper argues that the therapist's understanding of the client's language deserves the same deliberate attention the field gives to assessment, formulation, and the alliance.

II. IDIOLECT AND THE LINGUISTICS OF PSYCHOTHERAPY

An idiolect is a person's own version of the shared language. Two people can speak the same language and still mean different things by the same words, because each has learned those words in a different family, a different culture, and a different life. A client's idiolect has stable features, such as words he or she uses in the same way across months, and shifting features, such as words whose meaning changes when he or she is frightened, ashamed, or experiencing some other emotion. Both types of idiolect features have clinical implications.

This paper uses *the linguistics of psychotherapy* to name the body of knowledge the competency draws on, which has four main contributors.

Psycholinguistics studies how people produce and understand language in real time. Its research on dialogue shows that understanding between two people is built together, turn by turn, through evidence each offers the other (Clark, 1996; Clark & Brennan, 1991). It also shows the limit of that process: people stop building once they believe they understand each other well enough for their present purposes.

Pragmatics studies what speakers mean beyond the literal content of their words. When a client says "I guess so," the words express mild assent. What the client means may be agreement, reluctance, compliance, or polite disagreement.

Conversation analysis studies recorded talk in close detail, examining how each turn responds to the one before it (Sacks, Schegloff, & Jefferson, 1974). Applied to psychotherapy, it shows how therapists recast what clients say, and how those recastings can shift the client's account toward the therapist's understanding (Antaki, 2008; Weiste & Peräkylä, 2013).

Vygotsky's work on thought and speech distinguishes a word's *meaning*, its stable dictionary sense, from its *sense*, which is everything the word carries for a particular person in a particular moment (Vygotsky, 1934/1987). An idiolect is, in large part, a person's accumulated senses.

Throughout this paper, "the client's meaning" refers to what a word carries for this client, in this moment, given his or her history. The scope of the competency has three features. It applies across therapeutic approaches. The clinician remains free to use his or her own words, provided he or she understands the client's. And it belongs to ordinary practice with people whose language is intact.

III. HOW PEOPLE MAKE MEANING

Before asking how a clinician understands a client's meaning, we need an account of what meaning is. Four theoretical traditions supply one. They come from psychology, philosophy, and literary theory, and they tend to agree broadly.

Meaning is made, and it is made as story. Bruner argued that psychology went wrong when it began treating the mind as a processor of information. For Bruner, the mind's central activity is making meaning, and its primary instrument is narrative (Bruner, 1990). People understand their lives by telling how one thing led to another, and their culture supplies the forms those stories take. On this view, "it was fine" is a very short story. The clinician's task is to learn the longer story it stands for.

Meaning begins in the body, before words. Gendlin proposed that people carry an implicit, bodily sense of their situations, which he called the *felt sense* (Gendlin, 1962). The felt sense is always richer than any words for it. People find words by trying them against it. A word that fits produces a felt shift, a sense that something has moved. A word that does not fit leaves the felt sense unchanged and still waiting. Gendlin's theory gives a precise description of what may be happening when a client says "fine." The word may be a placeholder that has never been tested against what the client actually feels.

Words help make experience what it is. Vygotsky argued that thought is completed in the word (Vygotsky, 1934/1987). The constructionist theory of emotion extends this to feeling. On Barrett's account, an emotion is built as it happens, out of bodily sensation and the concepts a person brings to it, and language supplies many of those concepts (Barrett, Lindquist, & Gendron, 2007). A client who calls a feeling "mad" has not simply labeled something already finished. The word has helped give the feeling its shape. A different word might have shaped it differently.

Words arrive already used. Bakhtin, the Russian literary theorist, observed that no one speaks a word for the first time. Every word comes to a speaker carrying the voices of the people who used it before, and a speaker always speaks partly in borrowed voices (Wertsch, 1991). A client's "fine" may be her mother's word, or her family's, carrying a whole history of conversations that ended there.

Words both construct and limit. If words help shape experience, they also set its limits. A person can express only as much of his or her experience as his or her words allow. When those words are imprecise, or when no one takes the time to let them be elaborated, part of the experience goes unexpressed, and sometimes unknown, even to the person who lived it. "Fine" constructs a version of the visit, and it also

closes off everything the visit was that "fine" cannot convey. This is why elaboration matters. When a clinician invites a client to elaborate, the meaning is partly made in the asking, because the client finds new words. A careful clinician stays close enough to the client's experience that the meaning they arrive at together is as accurate as possible, and the client remains the authority on whether it fits.

What follows for the clinician. Taken together, these theories say several things about a client's words. They are his or her construction of experience: a story, compressed. They may not yet fit the experience they name. They help shape that experience, and they limit what of the experience can be expressed. And they carry other people's meanings along with the client's own. Each point leads to the same conclusion: the clinician cannot know what a client's word means without finding out. Each also explains why finding out matters to the client. When the clinician asks what a word means, the client has the chance to test it against what he or she feels, and to find a word that fits better.

IV. WHY ORDINARY CONVERSATION IS NOT ENOUGH

The misunderstanding described in the introduction is a product of how conversation normally works. Understanding why requires a closer look at how two people come to believe they understand each other.

How people establish understanding in conversation

Clark and Brennan (1991) describe conversation as a joint activity in which speaker and listener work together to establish that what was said has been understood. They call this process *grounding*. A contribution to conversation has two parts. First, the speaker presents something. Then the listener gives evidence about whether he or she has understood it: an acknowledgment ("uh huh," "yeah," a nod), a relevant next turn (an answer that fits the question), or simply continued attention. When the evidence suggests trouble, the two repair it and move on.

Clark and Brennan's own example, drawn from recorded British conversation, shows a man asking a woman whether she and her husband have a car. She doesn't catch the end of the question and echoes "have a car?" back to him. He confirms, and she answers. The question counted as asked only once both had evidence that she understood it.

The feature of grounding that matters most for psychotherapy is its standard. According to Clark and Brennan, people aim to reach a mutual belief that the listener has understood what the speaker meant well enough for their current purposes. Three things follow. The target is a belief, held jointly, which is different from a verified fact about what the speaker meant. "Well enough" is set by the purposes of the exchange. And

people economize: speakers and listeners minimize their combined effort, accepting understandings that seem adequate and moving forward. In everyday life this economy is efficient. Most exchanges don't require more.

Why the standard fails in therapy

In psychotherapy, the economy of ordinary conversation works against the clinician. A client's "yeah, that's right" is exactly the kind of evidence that grounding treats as sufficient. It closes the exchange. Yet the client's agreement may reflect accurate understanding, or deference, or fatigue, or a wish to avoid explaining something painful. Grounding cannot distinguish among these, because it was never designed to. It certifies that both people believe they understand each other. Whether the therapist has understood what the client means is a separate question, and ordinary conversation provides no routine way to answer it.

Why the client's words carry more than they appear to

Vygotsky observed that in close relationships, people speak in abbreviated ways, leaving out what both already know (Vygotsky, 1934/1987). People waiting together for a tram need only say that it is coming. He drew on the scene in Tolstoy's *Anna Karenina* in which Levin and Kitty conduct a declaration of love using only the first letters of words; they succeed because each already knows what the other is thinking about. Vygotsky treated this as the successful case. Abbreviation works when the background is genuinely shared. When it is not shared, he noted, even fully expanded speech can fail to produce understanding.

A client early in therapy often speaks as if the background were shared when it is not. "It was fine," "you know," and "the thing with my mother" are abbreviations. They assume the listener already knows what the client means. The therapist does not yet know. Because grounding rewards acceptance, the therapist may proceed as though he or she does know. And Vygotsky's distinction between a word's meaning and its sense deepens the problem. The dictionary meaning of "fine" is clear. Its sense for a particular client may include a family habit of ending difficult conversations, a memory, or a way of managing feeling. That sense is what the client means, and it is invisible in the word itself.

The standard this paper proposes

This paper therefore proposes a standard for clinical understanding that is stricter than the standard of ordinary conversation. Clark's standard is mutual belief that the listener understood what the speaker meant, sufficient for current purposes. The clinical standard is that the clinician's understanding of what the client means is sufficient: the clinician has explored the client's words until he or she understands what they carry for this client. Agreement between the two people is evidence toward that standard but it is not sufficient on its own because it has yet to show that the clinician actually understands the client's meaning.

V. WHAT GOES WRONG IN THERAPY

Picture an ordinary session. The client says something compressed and the clinician fills the gap. The client agrees. Four forces shape that moment, and each one makes a misunderstanding easier to form and harder to see.

The clinician fills gaps from his or her own mind. A listener never receives meaning ready-made. He or she supplies it, and supplies it from his or her own sense of the words. When a client says "mad," the clinician hears his or her own "mad," shaped by his or her own history. The clinician's mood colors it too; research on therapists' judgments of their clients' feelings confirms that therapists' own emotions bend what they perceive (Atzil-Slonim et al., 2019). The clinician experiences the result as understanding, because from the inside an assumption feels the same as knowledge.

The client leaves things unsaid. Clients withhold for ordinary human reasons: shame, fear of judgment, and a sense that the therapist is the expert and shouldn't be corrected (Hill et al., 1993; Rennie, 1994). What is withheld leaves no trace in the conversation. The clinician can only notice its absence by noticing the places where the client's language thins out.

The client agrees when agreeing is easier. A deferential "yes" is the most convincing evidence ordinary conversation offers, and the least reliable. Rupture researchers describe clients who withdraw by complying and appeasing, agreeing with the therapist while moving away from the therapeutic work (Eubanks, Muran, & Safran, 2018). The agreement closes the exchange and conceals the client's actual position.

The clinician's summary rewrites the client. When a clinician summarizes what a client said, the summary is always partly the clinician's construction. It selects some elements, drops others, and recasts the rest in the clinician's terms (Antaki, 2008). The client is then asked to accept a version of himself or herself written by someone else.

Put the four together and the sequence completes itself. The clinician supplies a meaning, offers it back in his or her own words, the client agrees, and both people leave believing they understood each other. Nothing in the exchange required anyone to establish what the client meant.

VI. THE GAP IN CURRENT TRAINING

Clinical training teaches listening through a familiar set of skills: restatement, paraphrase, reflection of feeling,

and summary (Hill, 2014). These skills share a single structure. The clinician offers his or her version of what the client said, and the client responds.

That structure is grounding, the conversational process described in Section IV. It produces mutual belief that the clinician has understood. When the clinician's version is right, the skill confirms it. When the clinician's version is wrong, the skill confirms it just as smoothly, because a deferential client will accept an inaccurate reflection as readily as an accurate one. The skill cannot tell the difference. It was built to produce the experience of being understood, which is valuable. It was never built to verify that understanding had occurred.

Open questions come closer, since they invite the client to speak in his or her own terms. Even so, training treats them as general tools for exploration. It does not teach clinicians to hear specific words and phrases as signals that a meaning is still unknown, to explore a single word until its meaning for this client is clear, or to treat agreement as insufficient evidence.

Alliance-focused training, built on the rupture research, teaches clinicians to recognize deferential compliance and repair it. It works at the level of the relationship under strain. The gap this paper addresses sits below that level, in the single word or phrase, where a meaning can be missed without any strain appearing at all.

VII. THE COMPETENCY DEFINED

Idiolect competency is the clinician's ability to understand the client's words as the client means them. It has four parts: recognizing the words and phrases that signal a meaning has not yet been understood; exploring those meanings until the clinician's understanding is sufficient; recognizing language that may indicate withholding or premature agreement; and working those moments through within the therapeutic alliance. The competency operates continuously. The clinician is always listening for the client's meaning, and specific words and phrases tell the clinician when that meaning needs to be explored.

Two levels of competency. The competency has two levels. The first is the practice of clarification: the clinician recognizes signal words and phrases, notices language that may indicate withholding or premature agreement, and responds by asking the client to describe what he or she means, without presupposing that the client's word was the right one. This level can be observed directly in the clinician's own conversational turns.

The second level is the achievement of sufficient understanding. Here the clinician stays with the exploration until the client's own elaboration supports the clinician's understanding, works through deference and

withholding within the alliance, and carries the client's meaning, rather than his or her own, into formulation and every later decision. A clinician can ask well without arriving at understanding. He or she may stop at the client's first answer, or hear the client's explanation and still proceed on his or her own meaning. A clinician can't understand what the client means without first asking about it. But asking about it doesn't mean the clinician ends up understanding it.

Part 1. Recognizing signal words and phrases

Certain words and phrases recur in therapy sessions and characteristically carry more than their ordinary meaning. Each should alert the clinician that the client's meaning is not yet known. The categories below are offered as a working framework, open to refinement through clinical observation. The Appendix lists individual words with their possible meanings.

- **Summary judgments:** "It was fine," "it was hard," "it was a lot," "it was weird." What is unknown: what actually happened, and what the judgment is measured against.
- **Statements of inability or obligation:** "I can't do that," "I have to," "I should," "there's no way." What is unknown: whether the client is unable, unwilling, not permitted, too frightened, or facing a cost that seems too high.
- **Hedged agreement:** "I guess so," "kind of," "maybe," "I suppose," a flat "yeah." What is unknown: whether the client agrees, partly agrees, is complying, or is disagreeing politely.
- **Statements of uncertainty:** "I'm not sure," "I'm just not sure," "I don't know." What is unknown: whether the client lacks the knowledge, hasn't yet formed the thought, is in conflict, or is reluctant to say.
- **Vague reference:** "it," "that," "the thing," "everything," "you know." What is unknown: the referent itself, which the client assumes the clinician already knows.
- **Feeling words, everyday and clinical:** "mad," "upset," "hurt," "anxious," "depressed," "triggered," "overwhelmed," "numb." What is unknown: what the feeling actually was for this client. "Mad" can mean irritated, enraged, hurt, betrayed, or frightened.
- **Intensifiers:** "really," "so," "totally," "honestly." What is unknown: what the emphasis is doing. "I'm really sure" can signal certainty, an effort to convince oneself, or doubt.
- **"Just":** a word that does several different jobs. It can minimize ("it's just a little thing"), hedge ("I'm just not sure"), exclude ("it's just me"), emphasize ("it was just awful"), or mark time and agency ("it just happened"). The clinician can't know which without asking.
- **Words of action and choice:** "decided," "figured," "tried," "handled." What is unknown: the process the word compresses: what happened, in what order, and how much choice it involved.

- **Absolutes:** "always," "never," "nothing," "everyone." What is unknown: the actual scope of the claim, and what the absolute accomplishes for the client.
- **Minimizers:** "it's not a big deal," "whatever." What is unknown: what is being made smaller, and why.
- **Relationship labels:** "we're close," "he's supportive," "it's toxic." What is unknown: what the relationship is actually like in practice.
- **"I feel like…":** often introduces a belief or judgment ("I feel like he doesn't care"). What is unknown: whether the client is reporting a feeling or a conclusion.
- **Closers:** "it's complicated," "it is what it is." What is unknown: what is being closed off, and why.

Part 2. Exploring the client's meaning

When a signal word or phrase appears, the clinician explores what the client means. The defining feature of this exploration is that the clinician asks the client to supply the meaning, rather than offering the clinician's version for the client to accept. The difference is visible in the form of the clinician's response. "So it felt like he abandoned you?" can be answered with "yes," and a deferential client will often answer that way. "When you say it was fine, can you describe what you mean?" can only be answered with the client's own account.

The clinician's question should not presuppose that the client's word was the right word. "What was fine about it?" accepts "fine" and asks the client to justify it. "When you say it was fine, can you describe what you mean?" leaves the word open, and lets the client say what the experience actually was. The clinician is free to use his or her own words throughout. What matters is that the meaning comes from the client. Exploration continues until the clinician's understanding is sufficient; Section VIII sets out the standard for sufficiency, within a single session and across many.

Part 3. Recognizing possible withholding and premature agreement

Withholding is largely invisible, because what is withheld is absent from what is said. The competency cannot detect withholding directly. Rather, certain features of the client's language may signal it, and the clinician should treat those features as reasons to explore. Drawing on the rupture research described in Section V, these include agreement that arrives quickly or is followed by a qualifier ("yes… kind of"); minimal responses to questions that invite elaboration; a shift of topic soon after a sensitive subject is raised; abstract or general language where concrete description would be expected; agreement that fits poorly with what the client said earlier; and a difference between what the client says and how he or she appears to feel while saying it. A client may not be withholding or agreeing prematurely, but each is a signal that the client's position is not yet known.

Part 4. Working it through within the alliance

When the clinician suspects premature agreement or withholding, exploring meaning alone may not be enough. A deferential client may continue to defer. The fourth part of the competency places this moment within the therapeutic alliance.

In an explicit alliance as the Clinical Effectiveness Institute uses the term, the client has agreed that part of his or her role is to be as honest and clear as possible and to work with the clinician toward shared understanding. That agreement changes what the clinician's exploration means to the client. Without it, a question about what the client meant can feel like a test to pass, and agreement can feel like the safe answer. With it, correcting the clinician becomes part of the therapeutic work the two have agreed to do together. The clinician can draw on that agreement directly: inviting correction openly, making disagreement safe to express, and treating the client's corrections as contributions to the therapeutic work. Here, we are treating the alliance as the condition under which the competency can function fully.

VIII. ASSESSING THE CLIENT'S IDIOLECT

Idiolect competency asks more than the clarification of single words in single moments. Over time, a clinician can come to know a client's idiolect the way he or she comes to know the client's history: deliberately, cumulatively, and with the client's help.

Sufficiency within a session. Understanding of a single word is sufficient when the clinician can state what the word carries for this client, and the client's own elaboration supports that statement. The evidence is the client's: the client has described concrete instances in his or her own terms; the client has corrected or refined the clinician's understanding, or has had a clear opportunity to do so; the client confirms the understanding without hedging, and adds detail; and the understanding holds when new material arrives.

The client as the authority on fit. Because the meaning is partly constructed in the exchange, accuracy cannot mean matching a meaning that existed, complete, before anyone asked. It means something more practical: that the understanding the clinician and client arrive at fits what the client knows of his or her own experience. In Gendlin's terms, the client's felt sense recognizes it as right (Gendlin, 1962). The clinician's skill lies in staying close enough to the client's experience that the client can make that judgment, and in noticing when the client is agreeing for some other reason.

Sufficiency across sessions: the idiolect map. Over many sessions, the clinician builds a working map of

the client's idiolect. The map has six parts:

- **Established meanings:** key words whose meaning for this client has been explored and confirmed ("fine" means "I got through it").
- **Habitual hedges and minimizers:** the words the client uses to soften, protect, or retreat ("just" appears whenever something matters).
- **Agency language:** how the client describes his or her own part in events, whether things "happen" or the client "decided."
- **Borrowed voices:** words the client carries from someone else ("my mother would call it selfish"). The clinician learns both what the word means to the client and whose word it is.
- **State-dependent shifts:** words whose meaning changes when the client is distressed, frightened, or ashamed.
- **Words still unknown:** words the clinician has noticed and not yet understood. This part of the map is always present, because an idiolect is never fully known.

The map is never finished, and it is never the clinician's alone. Entries are confirmed, revised, and sometimes discarded as the client corrects them. Sufficiency across sessions means the map has been tested against the client's own account often enough to be relied on, and that the clinician holds it open to revision.

The map and the formulation. A formulation is an account of the client in the clinician's understanding. The idiolect map keeps that account tied to the client's own meanings. Before a formulation rests on a word the client used, the clinician should be able to find that word in the established part of the map. If it sits in the unknown part, the formulation is resting on the clinician's meaning, and the clinician should know it.

Assessing the competency. The idiolect map also gives a way to assess the clinician. The first level of the competency, asking well, is visible in session transcripts. The second level, arriving at understanding, is visible in the quality of the map: how many entries the client has confirmed, whether the clinician's formulation draws on established meanings or unknown ones, and whether the map changes as the client corrects it.

IX. WHAT THE PROCESS DOES FOR THE CLIENT

Return to the client whose visit with her father "was fine." The clinician asks, "When you say it was fine, can you describe what you mean?" She pauses. Then she says that her father talked about himself for an hour and never asked about her, and that she left feeling the way she felt at twelve.

Something has happened that goes beyond the clinician's understanding. The client now knows something she didn't know a minute earlier.

The theories in Section III explain why. In Gendlin's terms, "fine" was a placeholder that had never been tested against her felt sense. Asked to describe what she meant, she had to test it. The word failed, and a truer description took its place. That replacement is what Gendlin called a felt shift: the experience moved because the words finally fit it. In Vygotsky's terms, her thought about the visit was completed in the act of saying it. In Barrett's terms, naming the feeling more precisely gave it a more precise shape. "Fine" became something specific enough to work with.

The listener is part of this. A thought finds its words more fully when someone is waiting to understand it, and less fully when no one is (Bavelas, Coates, & Johnson, 2000). The clinician's question does more than gather information. It creates the conditions in which the client can say what he or she has not yet said, even to himself or herself. Psychotherapy research calls this movement from surface report toward felt meaning *experiencing* (Klein, Mathieu-Coughlan, Gendlin, & Kiesler, 1969), and the depth of a client's experiencing in session predicts how much he or she improves (Pascual-Leone & Yeryomenko, 2017)

So the same question does two things at once. It brings the clinician to an accurate understanding of the client, and it brings the client to a more precise understanding of herself.

X. HOW TO KNOW THE COMPETENCY IS HAPPENING

A competency that cannot be observed cannot be taught or assessed. This one can be observed, because it lives in what the clinician and client actually say. A session recording or transcript contains the evidence.

What a transcript shows

The clearest test is simple: find each signal word or phrase in the session, and look at what happened next. When the competency is present, the clinician's next turn invites the client to describe what he or she means, without assuming the word fits: "When you say it was fine, can you describe what you mean?" The client answers with something concrete, and sometimes corrects or replaces his or her own word along the way. When it is absent, the signal phrase passes without notice, or the clinician supplies a meaning and the client agrees. "It was fine." "Sounds like it went okay." "Yeah." The exchange closes, and the clinician now holds an understanding the client never supplied.

Four further markers can be observed from a session transcript or recording. The first is the form of the

clinician's checks: whether a check asks the client to supply the meaning or offers the clinician's version for agreement. A session dominated by agreement-seeking checks ("So you felt rejected?") may sound attentive while producing little of the client's own meaning. The second is what happens after a hedge: when the client says "kind of," "I guess," or "sort of," the clinician either follows it up or moves on. The third is where the formulation came from: for each element of the clinician's working understanding, the record shows whether it rests on the client's own elaboration or on the clinician's inference. The clinician's words may appear in it; the substance should trace back to something the client said. The fourth is whether understanding is revised: when later material conflicts with an earlier understanding, the clinician either reopens the question or proceeds as before.

Asking the client

The two levels of the competency call for different evidence. The first is visible in the clinician's turns: which signal words he or she follows up, and how he or she asks. The second is visible in the client's turns: whether the client elaborates, corrects, and confirms, and whether the client's own account of what was understood matches the clinician's.

The client is therefore a second source of evidence. At the end of a session, a client can be asked to say in his or her own words what the two of them came to understand. That account can be compared with the clinician's. Where the two diverge, the divergence locates a meaning that was grounded without being understood.

Building on existing methods

These methods are new in application, though not in kind. Rupture research already trains observers to code withdrawal markers such as minimal responses and deferential agreement, and to do so reliably (Eubanks, Lubitz, Muran, & Safran, 2019). Conversation analysis already examines, turn by turn, how therapists respond to what clients say. The competency proposed here can be rated with the same tools, turned to a new question: did the clinician come to understand what this client meant?

XI. HOW THIS COMPETENCY DIFFERS FROM RELATED CONCEPTS

A client says, "I'm really mad at her." Here is how four established skills would handle that sentence, and what each would miss.

Reflective listening would offer the clinician's version: "You're furious with her." The client would likely say yes. Now the clinician believes the client is furious. "Mad" might have meant hurt, or betrayed, or frightened,

and "really" might have been the client bracing to be dismissed. Reflection produces agreement. It has no way to tell whether the agreement is accurate.

Empathic accuracy would measure afterward how close the clinician's guess came to what the client actually felt (Ickes, 1997). It tells us whether the clinician got it right. It says nothing about how to get it right. The idiolect competency is how we know: the clinician asks, "When you say you're really mad, can you describe what you mean?", and keeps exploring until the client's own answer supports the clinician's understanding.

Mentalizing, the capacity to understand behavior in terms of mental states (Fonagy & Allison, 2014), would ask why the client is mad and what the anger is doing for her. Those are valuable questions. Both rest on a prior one: what does "mad" mean for this client? The competency answers that question first, so that mentalizing works on accurate material.

Rupture repair would come into play if the client withdrew, went quiet, or began agreeing too easily (Eubanks, Muran, & Safran, 2018). The competency draws directly on that research. But "I'm really mad" may never become a rupture. The client may simply be misunderstood, politely, for weeks. The competency operates at the level of the single phrase, long before the alliance shows strain.

XII. LIMITS AND WHAT WOULD TEST IT

Any account of understanding another person has to admit where understanding runs out. Five limits apply here.

A signal word may mean just what it says. Sometimes "it was fine" means the visit was fine. The competency doesn't treat every signal word as concealment. It treats each one as a meaning the clinician doesn't yet know. Exploring may confirm the ordinary meaning, and that confirmation is itself understanding.

Sufficient understanding is a judgment. Vygotsky held that the sense of a word is never complete, since it reaches into everything the person knows and has lived. No clinician will ever possess a client's full meaning. The standard proposed here is sufficiency, and sufficiency is a clinical judgment made on evidence. It can be wrong, and it can be revised.

The clinician's question shapes the answer. No question is neutral. When a clinician asks what a client means, the client's answer is formed partly in response to that clinician, in that moment, in that relationship. The meaning the clinician reaches is always partly a joint construction. The competency reduces the clinician's influence by asking for the client's meaning instead of supplying one, and by treating the client as the

authority on whether the understanding fits. It cannot remove that influence entirely, and the clinician should hold his or her understanding with that in mind.

Exploration depends on the alliance. For a strongly deferential client, a question about meaning can become one more test to pass, answered with whatever seems wanted. That is why the fourth part of the competency places this work within an explicit alliance. Without that agreement, the competency is weakened.

Signals vary with culture and language. Which words carry hidden meaning, and how directly people say what they mean, differs across cultures, communities, and families. The categories in Section VII and the Appendix are a starting framework. They are not a universal list, and clinicians will need to learn the signal words of the people they work with.

What would test it. The competency makes claims that can be examined: that clinicians can be trained in it; that trained clinicians will show different patterns in their sessions, in how they respond to signal words and in the form of their checks; that their understanding will match their clients' own accounts more closely; and that their clients will show greater depth and precision in describing their experience. A study comparing trained and untrained clinicians on these measures, and following their clients' progress, would test the paper's central argument.

XIII. CONCLUSION

A client says her visit was fine. In most conversations, that would be the end of it, and it should be. Ordinary conversation is built to move on once two people believe they understand each other.

Psychotherapy is not ordinary conversation. Everything a clinician does rests on what he or she understands the client to mean. Yet the habits of everyday talk, together with the skills clinicians are trained in, allow a clinician to proceed on an understanding the client never supplied. And the client often won't say so.

This paper has proposed a competency to address that gap. Idiolect competency is the clinician's ability to understand the client's words as the client means them: hearing the words and phrases that signal a meaning is still unknown, exploring those meanings until understanding is sufficient, recognizing language that may conceal withholding or premature agreement, working those moments through within an explicit alliance, and building over time a map of the client's idiolect that the client has helped to confirm.

The competency serves the client as well as the clinician. When a clinician asks what a word means, the client has to find out. In finding out, he or she often discovers something new: a truer word, a sharper feeling, a

thought completed for the first time.

The clinician's understanding of the client's language is the ground on which every other clinical skill stands. It deserves to be taught as a skill in its own right.

APPENDIX: SIGNAL WORDS AND THEIR POSSIBLE MEANINGS

Each word below can carry more than its ordinary meaning. The possible meanings listed are illustrations. The client's meaning is found by asking, and how to ask is left to the clinician's judgment. Two kinds of words call for different aims. For words whose meaning is unclear ("fine," "mad," "just"), the clinician seeks to understand how this client is using the word. For words that stand for something the client did ("decided," "figured," "tried," "handled"), the word compresses a process, and the clinician seeks the client's account of that process: what happened, in what order, and how much choice it involved.

Word	Possible meanings
AGREEMENT AND HEDGING	
yeah	agree; heard you; move on; complying; tired
sure	agree; polite; indifferent; lost
right	agree; following; lost but nodding
guess	yes; partly; unsure; going along; no
maybe	possibly; no, softly; afraid to commit
kinda	partly; close but different; uncomfortable admitting
probably	likely; hoped; avoiding certainty
whatever	don't care; care too much; given up; angry
AGENCY AND CHOICE	
decided	weighed options; acted on impulse; gave in; was told
figured	reasoned it out; assumed; guessed; gave up deciding
chose	free choice; least-bad option; felt forced
tried	made real effort; made a gesture; failed; avoided
let	permitted; didn't stop it; couldn't stop it
wanted	desired; was expected to; wished

Word	Possible meanings
ended up	drifted; avoided choosing; things happened to me
realized	understood; concluded; was told; suspected
handled	resolved; endured; suppressed; avoided
snapped	lost control; finally spoke up; overreacted
made (me)	forced; pressured; influenced; I allowed it
ABILITY AND OBLIGATION	
can't	unable; unwilling; not allowed; afraid; too costly
should	believe it's right; expected; self-criticism; old rule
have to	required; guilt; habit; fear; duty
supposed	told to; what's normal; disagree but comply
need	require; want strongly; feel pressured
SUMMARY JUDGMENTS	
fine	acceptable; nothing to say; got through it; painful; family closer
okay	acceptable; tolerable; not great; don't ask
good	pleasant; relieved; no conflict; what you want to hear
hard	effortful; painful; confusing; held back; old pain
weird	unfamiliar; wrong but unnamed; uncomfortable; outsider
normal	typical; acceptable; familiar; never compared; don't pathologize
crazy	chaotic; intense; frightening; self-judgment
FEELING WORDS	
mad	irritated; enraged; hurt; betrayed; afraid; humiliated
upset	sad; angry; anxious; ashamed; mixed
hurt	sad; rejected; insulted; abandoned
stressed	busy; anxious; overwhelmed; afraid of failing
bad	sad; guilty; unwell; vaguely wrong
off	unwell; uneasy; numb; something's wrong
anxious	nervous; dread; agitated; worried; panicked

Word	Possible meanings
depressed	sad; empty; tired; hopeless; grieving
triggered	reminded; flooded; angry; bothered
overwhelmed	too busy; too much feeling; can't think
numb	calm; shut down; detached; protected
INTENSIFIERS AND QUALIFIERS	
just	minimizing; hedging; only me; emphasis; suddenly
really	emphasis; convincing myself; convincing you; doubt
honestly	sincere; expecting disbelief; what follows matters
actually	correcting; surprised; expecting disbelief
literally	exact; emphasis; habit
only	merely; minimizing; alone
still	continuing; stuck; unresolved
MINIMIZERS	
nothing	truly nothing; ashamed; afraid of reaction
little	small; minimized; afraid it's too much
stupid	embarrassed; expecting judgment; testing you
anyway	moving on; avoiding; done feeling it
ABSOLUTES	
always	literally; often; when it mattered; feels that way
never	literally; rarely; not when needed
everyone	literal; exaggeration; one important person
nobody	literal; lonely; one person failed me
VAGUE REFERENCE	
it	something specific; unnamed; too painful to name
that	specific event; assumed known; avoided
thing	unnamed event; feeling; something shameful
stuff	untold story; many things; kept distant
everything	several things; one thing coloring all

Word	Possible meanings
RELATIONSHIP WORDS	
close	talk often; dependent; enmeshed; wish we were
supportive	listens; helps; doesn't object; defending him
toxic	hostile; controlling; painful; borrowed word
together	partnered; united; enmeshed; on paper only
SELF-LABELS	
lazy	tired; avoidant; depressed; someone's judgment
mess	overwhelmed; ashamed; chaotic; self-criticism
sensitive	perceptive; easily hurt; told I overreact
selfish	took care of myself; guilty; someone's judgment
PROGRESS WORDS	
better	than last week; than my worst; what you want to hear
worse	actual decline; more aware; discouraged
same	no change; stuck; can't tell
CONNECTORS	
but	second half matters; both true; softening
because	real cause; justification; blame
so	conclusion; giving up; changing subject
TIME AND FREQUENCY	
sometimes	rarely; often; whenever it matters
lately	days; months; since a specific event
usually	most times; the pattern that hurts

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RELATED CEI TRAINING

Building an Explicit Therapeutic Alliance: Beyond Rapport Toward Real Clinical Agreement develops the alliance this paper treats as the condition for idiolect competency: an agreement in which the client works to be honest and clear and the clinician invites correction. *Clinical Formulation: The Missing Link Between Understanding and Intervention* addresses the formulation that the idiolect map is meant to keep tied to the client's own meanings. Neither training takes up the full competency described here. Details and current dates at sarahozolshore.com.

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