Microanalysis of Communication in Psychotherapy

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ABSTRACT

Microanalysis, which is the close examination of actual communication sequences, can be a useful way to understand how therapeutic communication works. This is a preliminary report on our research group's applications of microanalysis to communication in psychotherapy. We first describe the historical origins in the Natural History of an Interview Project of the 1950's and then the subsequent evolution of an alternative paradigm for psychotherapy, which has two key tenets: communication as co-constructive (vs. merely information transmission) and a more positive (vs. pathological) view of clients. Next, we use microanalysis to illustrate how communication in therapy, examined closely, cannot be nondirective. Finally, we describe the functions of three specific discursive tools available to therapists: *Questions* both embed the therapist's presuppositions and invite the client to co-construct a particular version of events. *Formulations* (such as paraphrasing or reflection) inevitably transform, to some degree, what the client has said. *Lexical choice*, or the decision to use particular words or phrases, can create new perspectives. Each of these tools is illustrated by contrasting their use in traditional and alternative therapeutic approaches. We propose that the effects of each of these tools are inevitable; the only choice is how to use them.

Introduction

The importance of communication in psychotherapy is obvious, whether one sees communication as the means of exchanging information and ideas or as a process whereby more helpful ideas are co-created. Yet, while there are many efforts to teach both therapists and clients how to communicate better, there is very little research to support these recommendations and even less analysis of basic communication processes in psychotherapy sessions. Our research group (a mix of communication researchers and psychotherapists) have begun to do such research. In this paper, we will describe and illustrate our approach to studying therapeutic communication by microanalysis, that is, by close examination of these conversations, moment by moment, utterance by utterance.

Background

The origin of interdisciplinary research on basic communication processes in psycho-therapy can be traced directly to the neo-Freudian analyst and respected therapist, Frieda Fromm-Reichmann. In 1955, Fromm-Reichmann initiated the Natural History of an Interview (NHI) project at the Center for Advanced Study in the Behavioral Sciences, near Stanford, because "she was interested in obtaining tangible evidence for her intuitive reactions to her psychiatric patients. She hoped that linguistics and anthropology would be able to provide such evidence, and that detailed study of psychiatric interviews would lead to concrete findings that could be relayed to her students" (Leeds-Hurwitz, 1989, p. 123).

Although this huge project was never fully published, it is available in microfilm (McQuown, 1971) and in several related, smaller works (cited in Leeds-Hurwitz, 1987, footnotes 6 and 7). Fortunately its history and pioneering achievements have been well summarized by Leeds-Hurwitz (1987, 1989). For example, it was "the first major study to use microanalysis as the primary method of analyzing social interaction" (1987, p. 2). This was possible because of another "first," which was the systematic use of filmed records that could be studied closely and repeatedly. It was also unusual in achieving an extended interdisciplinary collaboration (from 1955 until about 1971) of psychiatrists, anthropologists, and linguists[1], all focused on the detailed transcription and analysis of an actual, filmed interview. Their goal, however, was broader, because they sought generalizations from this particular analysis to the communication process itself.

The NHI project arose in the wider context of the post-war beginnings of the modern field of communication, including the development and application of information theory (Cherry, 1961; Miller, 1951; Shannon & Weaver, 1949) and cybernetics (Ashby, 1956). The interdisciplinary Macy Conferences (Schaffner, 1955-1960) on the application of cybernetics to the behavioural sciences had included some of the NHI participants (notably Gregory Bateson and Henry Brosnin) and helped to initiate a shift in emphasis from intrapsychic processes to social interaction as well as providing a model for interdisciplinary collaboration. Bateson had already begun to apply cybernetic principles in his research with John Weakland, Jay Haley, Don Jackson, and William Fry on communication in families with a schizophrenic patient (e.g., Bateson, Jackson, Haley, & Weakland, 1956).

By the 1960's, what became known as the Palo Alto Group (e.g., Jackson, 1968a, 1968b; Watzlawick & Weakland, 1977) was a combination of the Bateson Group researchers and those at Jackson's Mental Research Institute. Although the early work of the Palo Alto Group was best known for the study of family interaction and the development of family therapy, most of the main members had been directly or indirectly influenced by the NHI project. They had a strong interest both in therapy and therapeutic communication, culminating in the Brief Therapy Center (Watzlawick, Weakland, & Fisch, 1974), and also in developing a general theory of communication as social interaction (Watzlawick, Beavin, & Jackson, 1967[2]).

Two Contrasting Therapeutic Paradigms

Several other groups soon built on the early influence of the Palo Alto Group to develop their own unique therapeutic approaches, but always with a special interest in communication and language as central to psychotherapy: the original and subsequent Milan Schools (e.g., Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978; Boscolo, Cecchin, Hoffman, & Penn, 1987); Solution-focussed Therapy in Milwaukee (e.g., Berg & de Jong, 1998; de Shazer, 1982, 1985, 1994; de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, & Weiner-Davis, 1986); White and Epston's (1990) Narrative Therapy in Australia and New Zealand; and Jenkin's (1990) approach to violence, also in Australia.

We do not underestimate the diversity and healthy disagreement among these approaches, but we propose that, if one takes a broader historical view, these new approaches can be seen as offering an *alternative paradigm* (Kuhn, 1962; Wilder, 1978) in the field of psychotherapy because, whatever their particular differences, they share some fundamental assumptions, especially when compared to traditional approaches. What we will call the *traditional paradigm* for psychotherapy includes the most familiar approaches: psychoanalysis, client-centred counselling, behavioural therapy, psycho-educational and cognitive approaches (such as cognitive behavioural therapy), and some kinds of group or family therapy as well. The traditional and alternative therapeutic paradigms seem to us to differ on at least two fundamental assumptions that have guided our research; **see Table 1.** The first difference that we will discuss and apply here is about the role of communication in psychotherapy and the second, to be considered later in this article, is about the individuals who seek the therapy.

Table 1. Two Differences between the Traditional and Alternative Paradigms of Psychotherapy.

	TRADITIONAL PARADIGM[a]	ALTERNATIVE PARADIGM[b]
Communication in psychotherapy	• is done by individuals (alternating monologues)	> is collaborative and reciprocal (dialogue or conversation)
	• is a conduit for information transmission	> is inevitably co-constructive; shapes the information
	• involves global influence of therapist on client	> involves moment-by-moment (micro) influence
Clients in psychotherapy	• have pathologies that should be diagnosed and treated by the therapist	> have strengths and solutions that the therapist and client can discover and build on

[a] Therapies that make these assumptions include almost all that began before the 1950's and many that have developed since: psychoanalysis, client-centred counselling, behavioural therapies, psycho-educational and cognitive therapies, among others.

[b] Therapies that share these assumptions include Brief Therapy, Milan-style Therapy, Solution-focussed Therapy, Narrative Therapy, and Invitations to Responsibility, among others; see text for references.

The traditional paradigm applies a familiar model of communication to the therapeutic context: The problems are inside the individual's mind and the solutions are inside the therapist's mind, so communication consists of alternating monologues in which information is exchanged. The client describes his or her problem, history, or feelings, and the therapist provides diagnosis, insight, or instruction. In this information-transmission model, communication is implicitly seen as a conduit through which these reified ideas can be transmitted (Reddy, 1979; Phillips, 1998, 1999). Language is purely representational; it signifies thoughts, feelings, and truths that have an existence separate from language. While this model does provide for the influence of the therapist's communication on the client, the influence is seen as global (i.e., occurring either broadly over the course of therapy or only at special points, such as interpretations), rather than utterance by utterance.

In contrast, the alternative paradigm puts a primary emphasis on communication rather than on mental events (e.g., Anderson & Goolishian, 1988; de Shazer, 1994; Sluzki, 1992; Watzlawick, Beavin, & Jackson, 1967). Communication is not alternating monologues but a tightly interwoven dialogue; these conversations are always *collaborative* and reciprocally influential. As a result, they are also *co-constructive*: moment by moment, the therapist and client(s) co-create a version of the problem and its solutions. Because of its centrality, we must examine all therapeutic communication at a *micro* level, even down to the word or phrase. In this view, communication is the tool of therapy just as physical instruments are the tools of surgery, and it is incumbent on us to treat therapeutic communication equally carefully and precisely. We should emphasize that we make this assumption for all psychotherapies. That is, therapists in the alternative paradigm do not simply choose to use language to co-construct problems and solutions with their clients whereas traditional therapies can still choose to focus on the "real problem." In our view, all therapeutic communication is co-constructive; the only choice is whether to recognize this or not. There is a great deal of evidence accumulating that conversation is an intrinsically collaborative activity (e.g., Clark, 1996). If that is so, then mutual influence is inevitable, and therapists cannot be nondirective. They can and must choose *how* they will influence the conversation. These assumptions have taken our team out of the experimental lab or the daily practice of psychotherapy into microanalyses of the language of psychotherapy.

Observing in Detail

In 1967, Weakland wrote:

> "Probably the chief feature characterizing [this alternative] approach to communication ... and differentiating it from others, is our concern with the study and understanding of actual communication as it really exists in naturally occurring human systems, rather than involvement with some ideal ... of what communication *should be* ... .

Such a focus may seem simple and obvious, but it has until quite recently been denied, ignored, or bypassed to an amazing extent. The study of communication involved almost everything *except* observing, recording, examining, and describing real communication and interaction in detail." (p.1, italics original).

We are proposing that, by not attending closely to the effect of the therapist's communication on the client, the traditional paradigm runs the risk of seeing what "should be" rather than examining their communication and interaction in detail. Before illustrating this point with examples, we should be explicit about our preference for therapies in the alternative paradigm. However, our analyses are intended to focus, not on that choice, but on revealing the particulars of what may be happening in therapy at the micro-level. It is up to each therapist or researcher to judge the significance of what is revealed – or even to rebut our conclusions using the tools we offer here.

The first example comes from a textbook chapter on clinical approaches (Pervin, 1970, 1980). The author was contrasting psychoanalytic with client-centred interviewing and chose to illustrate the latter with the Carl Rogers (1942) excerpt reproduced in full in Table 2 (See pages 52 & 53). The author's preferences for what "should be" were clear from his introduction to the excerpt he chose:

"The directed and guiding aspects of the psychoanalytic interview are in contrast with the more clearly phenomenological approach of other interviews. For example, in the *nondirective* or client-centered approach to interviewing associated with Rogers, the interviewer *asks few direct questions* and *avoids making interpretations which go far beyond the data*. The fragments of the previous [psychoanalytic] interview can be contrasted with the following fragments from an interview with a student who was having academic and personal difficulties ..." (Pervin, 1970, p. 104; 1980, pp. 422-423, italics added).

Before examining this excerpt in detail, we should hasten to point out that our analysis is not a criticism of Rogers himself. He was probably the first psychotherapist to tape-record therapy sessions, as early as the 1940's. This innovation helped lead to the living records that we now take for granted and which make the study of therapeutic discourse possible. Moreover, we are not criticizing Rogers for practicing Rogerian theory. Our point will be that the author who selected this particular excerpt (out of all those available) apparently saw, at that moment, what it should be and not what was observably happening.

Even a superficial examination of the excerpt in Table 2 reveals that the counselor does not avoid either direct questions or interpretations. He asks six direct questions (one in turn 5, two in turn 11, and one each in 15, 17, and 27). All of the counselor's remaining turns are interpretations. Both the questions and the interpretations direct the topic to the Rogerian theory of ideal versus real self (e.g., Rogers, 1959) and go well beyond the data or experience reported by the student. For example, note the discrepancy between the student's description of his ideal person (in turn 6) as someone who **"serves society by constructing, or by making things more convenient"** and the counselor's ostensible paraphrase (in turn 7) as **"someone who deals only in things, and not in emotions."**

Table 2. Excerpt from Rogers (1942), in Pervin (1970, pp.104-106; 1980, pp. 423-424).

C = Counselor
S = Student client

1.   C: You feel that you'd be a lot happier if you were just like the other fellows and not emotional.

2.   S: That's right. Of course, I'd like to be – not experience these fears. *(Pause)*. I'd like to be calm and clear-thinking in all situations.

3.   C: Instead of those things you find yourself to be somewhat emotional.

4.   S: I go haywire! *(Laugh, followed by pause.)*

5.   C: You've thought a lot about that. What is your ideal person?

6.   S: Uh, well, some scientist. That is what I consider an ideal person, preferably a physical scientist, in chemistry or physics or an engineer, one who – one who serves society by constructing, or by making things more convenient. I like everything modern.

7.   C: Someone who deals only in things, and not in emotions.

8.   S: That's right, something tangible.

9.   C: So you'd really like to solve this difficulty by being someone very different from yourself.

10. S: Yes. That's why I'm in engineering college. I have an opportunity to – well, just to experiment with myself and see actually what talents I do have in that direction. They're not so bad, but I lack some – some of the very fundamental things that a good engineer should have; that is, being calm, sticking right to it, and forgetting about things that have come up. A good engineer is not emotional, that's one of the worst things he could – No person who is emotional is a good engineer.

11. C: So that in some respects you've gone into engineering because you felt it would be awfully good discipline for you, is that right? Make you stop being emotional?

12. S: That's right.

13. C: It was that, perhaps, rather than being interested in engineering.

14. S: Well, it was mingled with a certain genuine interest. There was some, that's true. But it was largely due to that, exactly what I said, to a considerable extent.

15. C: You don't suppose that part of your trouble is that now you're wondering whether you want to be your real self. Could that be part of it?

16. S: Uh, what's that?

17. C: Well, I just wondered. You're trying so hard to be some other fellow, aren't you?

18. S: Yeah, because I'm not satisfied with myself.

19. C: You feel that the self you are isn't worth being.

20. S: Yeah, that's right, and unless you can change my mind about that, then I'll continue thinking along the same line.

21. C: *(Laughing.)* Why, that almost sounds as though you were wishing that somebody would change your mind about it.

22. S: *(Very soberly.)* Yeah. Because I don't know how I can solve it the other way.

23. C: In other words, you're finding it a pretty tough proposition to try to be a calm, unemotional engineer when really you're something quite different.

24. S: Right! Yeah, that is a very tough proposition. I find it impossible, and I hate the idea that it's impossible.

25. C: And you hate it partly because you feel there's nothing worth while about this real self of yours.

26. S: Yes.

27. C: What are some of the things your real self would like to do?

28. S: Oh, let's see. Well–uh, I told you I was interested in mathematics. That's one thing. Also, I was interested in anthropology. At the same time, I was interested in music and in–well, now, I used to like novels, but I don't care for them any more, but–I would like–I think I have a gift for writing, too, and I'm ashamed of those gifts.

The acknowledgments and agreements that are supposed to be the hallmark of a nondirective therapist are in fact all made by the client: 9 of the student's 14 turns include or consist of "yeah," "yes," or "that's right." In brief, this 28-turn excerpt consists entirely of question-answer or interpretation-agreement pairs, all initiated by the counselor. In our view, neither Rogerian therapy nor any other therapy can be nondirective; to interact is to influence, and the only choice is how.

In her highly original article, Davis (1986) analyzed an entire first therapy session, turn by turn, and showed how the therapist, over the course of the session, transformed the presenting problem into a problem that fit his theory. If one were to read the transcript Davis provided with a bias toward his particular therapeutic approach, the interview would seem an insightful discovery of the client's problem by the therapist . Examined more closely, however, the active influence of the therapist becomes clear. Davis showed how, in three stages, the therapist *reformulated* the client's social, situational problem into an intrapsychic, personality problem; *documented* the new problem using his interpretations of the client's own words; and *organized her consent* to treatment of the newly defined problem.

Research on Active Listening Techniques

Another way to question prescriptive models of how therapists should communicate is to focussed on the widely taught techniques of active listening. Norgaard (1990) and Armstrong (1998) both found that the considerable literature on these techniques contains virtually no evaluation studies demonstrating that they are effective with or preferred by clients. Norgaard (1990) showed that listeners preferred an audiotape of normal listening to one with active listening techniques. Armstrong (1998) followed up this finding by studying actual dialogues with real participants. The speakers were first-year university students who told a (true) story about a bad academic experience they had had. (Note that it was not appropriate to get into therapy problems with this population.) They told their stories twice, to two different listeners, in counterbalanced order. One listener was an upper-level student with no training, who just listened naturally. The other was also an upper-level student, but one who had been trained in active listening and who was currently practicing these techniques as a volunteer in a campus Peer Counseling program.

Armstrong created a wide-ranging set of comparison scales, including possible positive and negative reactions. The results were clear, with active listening garnering the preponderance of negative attributions. The narrators rated these techniques as significantly more *weird, unnatural, phoney,* and *unrealistic* than untrained listening. They also rated active listeners as more likely to *misunderstand* and more likely to *interrupt at odd times.* There were two positive results: the narrators rated active listeners as more *supportive,* apparently recognizing their good intentions, and as more likely to cause the speaker to *think differently* about the problem. One interpretation of these results is that the narrators appreciated the person but did not like the communication style.

Our laboratory research on natural listeners (Bavelas, Coates, & Johnson, 1995, 2000) has shown that an experimentally preoccupied listener could not listen normally and that his or her unnatural responses significantly affected the narrator's story, making it flatter

and less coherent. If we extrapolate from these results, it may be that active listeners (and perhaps other therapists) are similarly preoccupied with their techniques, which could produce apparently flat and disjointed narratives from their clients. We therefore have doubts about these purported communication skills, which continue to be widely taught as how communication "should be," without systematic observation of how they function in interaction.

Some Basic Tools of Therapeutic Discourse

The examples in the previous section suggest the utility of a close analysis and evaluation of therapeutic communication. What if, like the NHI team, we wish both to microanalyse actual therapeutic interviews and also to seek broader generalizations and understandings of communication through these analyses—then how do we begin? Our group started with several criteria. The first was to be selective rather than exhaustive. The NHI research went largely unfinished and unpublished because they sought to analyse virtually every aspect of several scenes of an interview. (The 1971 version is five volumes, three of them devoted to transcription alone; Leeds-Hurwitz, 1987.) Although this level of detail is a valuable introduction to how much regularity and pattern can be found through microanalysis, it also demonstrates that the careful selection of limited aspects or features might be a better research strategy. Another key criterion was that the analysis should be interactive; that is, it should be focussed on phenomena characteristic of dialogue rather than monologue. This would exclude, for example, the analysis of an individual's utterances as a way of understanding his or her mental processes (whether the client's or the therapist's). Instead, we wanted to examine utterances primarily in terms of their impact on and implications for the therapeutic interaction.

Our search for interactive phenomena that would occur in virtually all therapeutic conversations has led us to focus on three of the discursive tools available to therapists: They can respond to what the client says (called *formulation*), they can ask *questions*, and – in these or other kinds of utterances such as assertions or descriptions – they can choose how to phrase what they want to say (called *lexical choice*).

We have been analysing each of these tools in terms of how they function to construct meaning in the therapeutic dialogue. One way to reveal this process is to contrast the kinds of meanings being constructed. To do so, we compared the meanings constructed in the two paradigms described above, specifically focussing on their contrasting views on pathology (cf. the second major point in Table 1). Traditional therapies begin with the notion that individuals come to psychotherapy because there is something wrong with them, usually an intrapsychic pathology (depression, ADHD, low self-esteem, poor communication skills, lack of coping skills or other behaviours, etc.), which Wade (2000) has called *the assumption of personal deficiency*. Brief Therapy quickly rejected the usefulness of pathology (Watzlawick, Weakland, Fisch, and Bodin, 1974) and assumed that "people know how to be well" (John Weakland, personal communication), which Wade (1997, 2000) has termed *the assumption of pre-existing ability*. In this view, the problems that individuals bring to therapy are, in principle, transient and often social or

external in cause and origin. Another way of describing the difference is to point out that traditional therapies are *essentialist*, emphasizing the reality of a reified individual pathology, whereas the alternative paradigm is more *constructionist*, emphasizing the social nature of diagnostic labels and particularly the role of language in constructing and re-constructing problems and solutions. In the following analyses, we will show how the therapist's use of basic communication tools can construct either pathological or non-pathological versions of clients and their lives.

Formulation and Reformulation

One of the most common and apparently neutral communicative techniques of the therapist is to summarize or paraphrase what the client has just said (e.g., turn 23 in Table 2). Because it seems simply to echo what the client has said, this tool is often seen as nondirective, that is, as not influencing the client's narrative. Phillips's (1998, 1999) micro-analysis has shown how influential and co-constructive these responses inevitably are.

Phillips (1998) drew on research conducted outside of psychotherapy on ordinary conversational practices. Garfinkel and Sacks (1970, p.350) identified the process of conversational *formulation*, by which one of the participants may describe, explain, characterize, explicate, translate, summarize, or furnish the gist of what the other person has just said. For example,

A: **Isn't it nice that there's such a crowd of you in the office?**

B: **You're asking us to leave, not telling us to leave, right?**

(Garfinkel & Sacks, 1970, p.350)

In his formulation, B is explicating both the meaning and the nuances of A's comment.

Heritage and Watson (1979) further developed the concept of formulation by pointing out that, even when they appear to be simple paraphrases, formulations serve three functions: They *preserve*, *delete*, and *transform* the original statement. If one person says **"I was in University from 1985 til 1996"** and the other says **"That's over 10 years!"**, her formulation has preserved some of the information given, deleted the actual beginning and ending years, and transformed the information from a precise span to an approximate, total amount of time. In her 1986 article, Davis introduced the possibility of *reformulation* in psychotherapy, by which the client's statements are selectively transformed into a version that fits the therapist's theoretical orientation.

In Table 2, we can see that the counsellor regularly responds to the student's statements with formulations. Some of these are explicitly labelled as formulations with discourse markers such as **"In other words"** (turn 23), **"That almost sounds as though ..."** (turn 21), or **"So ..."** (turns 9 and 11). Because of these markers, the counsellor's responses are officially just paraphrases, but the reader can easily see how, in each instance, they selectively preserve, delete, and transform what the student has said. It is important to emphasize, once again, that these changes are inevitable and cannot be avoided even by

, literal repetition. If the therapist repeats back some statements, the selection of these rather than other statements is noteworthy. (Only if the therapist constantly repeated all of the exact words and intonation of the client would there be no deletion or transformation; however, such responses would be quite bizarre. From a therapist, they might even be interpreted as ridicule, thus transforming the original statement dramatically.)

Phillips (1998, 1999) pointed out that the difference between formulation and reformulation is only a matter of degree and that any formulation must inevitably change the original statement. He also proposed that what have been called paraphrasing, reflecting, reframing, and so forth, are empirically indistinguishable from formulation. To demonstrate the functions of formulations, he compared how they were used in a traditional conflict resolution session versus an alternative, solution-focused conflict resolution session by Insoo Kim Berg. His data were role-played training tapes[3] (Brief Family Therapy Center, 1995; Rogers & Salem, 1987).

Phillips (1998) identified two different parameters of formulation; the first was *problem vs. solution* focus. A problem-focused formulation selects the problematic aspects of the original statement, whereas a solution-focused formulation would select the more positive aspects of the same statement. For example, the following sequence occurred at the beginning of the traditional mediation session between neighbours:

5. Mrs. M: **Well, I've been to the police and I asked them many times and called them out on this disturbance and uh, nothing seems to happen and uh, it just goes on just the way it was before, and, uh, last time I went down to the station and complained, about these intolerable situations, why, uh, they said, well, you can take it to court, and I said, uh, I don't have money for a lawyer. What can I do? You know. And, uh, the officer down there said well, there is a mediation process?**

6. Mediator: **Uh hum**

7. Mrs. M: **And we might be able to resolve this with your help, but I don't know**

8. Mediator: **Well**

9. Mrs. M: **I'm at a loss, I really am. I don't know what to do.**

10. Mediator: **Well, you mentioned disturbances and you've been to the police...**

At turn 10, the mediator explicitly formulated ("**you mentioned**") Mrs. M's turns 5, 7, and 9. Out of everything she said, he selected "**disturbances**" and "**the police**" – clearly a problem focus. A commonly used solution-focused formulation of Mrs. M's statements could have been, for example,

M: . **So you have been trying very hard to find a solution. What would have to happen here today so that, a few months from now, you would say, that was a good idea, going to see a mediator?**

Phillips's other parameter was whether the formulation was *open or closed.* Open formulations give the original speaker an opportunity to evaluate and comment on the

formulation. Both of the formulations given above are open because they invite Mrs. M's response or elaboration. A closed formulation would forestall comment – for example, by keeping the turn and continuing on with a new comment.

Phillips's detailed analysis showed that the traditional mediator and the solution-focused mediator differed dramatically in their use of problem- vs. solution-focussed formulations. The traditional mediator's formulations consistently focussed on problems rather than solutions, while the opposite was true for the Berg session. In addition, the traditional mediator systematically used more closed formulations with one disputant than the other, which gave them unequal opportunities to expand on or dispute his formulations. Although this mediator's goal was undoubtedly to be even-handed, this was not carried out at the micro-level and therefore not for the session as a whole.

How questions function in psychotherapy

It is striking that therapists in the alternative paradigm ask a lot of questions. The Milan Group were the first to recognize explicitly the usefulness of questioning in their therapy (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980; Freedman & Combs, 1996). There have been many efforts to classify these questions, but such taxonomies are necessarily static. They extract the question from its living context and cannot describe how it functions in that context. McGee (1999; see also www.talkworks.bc.ca) has developed a comprehensive functional analysis of questions that shows what they *do* and why they are often so useful. His starting point is that one of the main functions of questions is to introduce *embedded presuppositions*. That is, they can bring in new ideas without asserting them directly. Take, for example, de Shazer's (1985) familiar "miracle question":

> **"If there was a miracle one night while you were sleeping and the problem was gone when you woke up, how would you know? What would be the first thing you would notice?"**

This question embeds several presuppositions: that the problem might conceivably disappear and that, if it did, the client would notice specific, observable events in the world. More broadly, this question imposes a perspective that is both positive and future-oriented. In contrast, traditional therapies often ask questions that embed presuppositions about pathology and the importance of the past. Asking about the client's childhood presupposes that the childhood is relevant to the current problem. Asking about symptoms presupposes pathology.

Questions are, more subtly, a way in which the therapist introduces his or her theoretical perspective without overtly appearing to do so. Returning for the last time to the excerpt presented in Table 2, the counsellor asks (at turn 5) **"What is your ideal person?"** This question embeds the presuppositions that there is such a thing as one's ideal person and that the student is not his ideal person (or else the question would be, **"What kind of person are you?"**). The counsellor's question at turn 15 develops these presuppositions further: **"You don't suppose that part of your trouble is that now you're wondering whether you want to be your real self. Could that be part of it?"**

This question embeds the presupposition that there is (in addition to his ideal person) a real self. Together, the two questions form an indirect but clear statement of the Rogerian theory of discrepancy between ideal and real self (Rogers, 1959). These questions only make sense – and can only be answered – if the student accepts the theory and begins to talk in its terms, as indeed he does. There is a dramatic sequence between turns 15 to 21 in which we can see this process unfold: Notice that, at turn 16, the student does not understand the question (and its presupposition that he wants to be his real self rather than his ideal person). The counsellor rephrases the question, with his presuppositions much more explicit, and asks for agreement (in turns 17 and 19). Having agreed, the student (in turn 20) adopts these notions as his own way of thinking, which leads to an intricate exchange in which the student appears to be asking – even challenging – the counsellor to help him solve the discrepancy between his ideal and real selves. Only a close analysis of the actual talk reveals how the counsellor introduced this framework and recruited the student into it. This sequence illustrates the utility of McGee's close analysis of the role of questions in understanding a therapeutic dialogue.

Milan-style therapists ask *circular questions* (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980), such as the following question to the sister of an anorexic brother, asked in the presence of the entire family:

> **When your mother tries to get Marcello to eat and he refuses the food, what does your father do?**

This question embeds several presuppositions, all deliberately aimed at focussing on the relationships among family members (vs. an isolated focus on the patient): that the mother is the one who is likely to try to get Marcello to eat; that Marcello is likely to refuse; that, when this happens, the father is likely to do something worth asking about; and that the daughter is likely to observe all of this and that her observations would be of interest. Note that these presuppositions (and the new thoughts they may provoke) are available to everyone who hears them, not just the person to whom the question is directed.

White's (1989) "landscape" questions embed presuppositions about the individual's strengths and abilities, past and future. For example,

> **Of all the persons who have known you, who would have been the least surprised that you have been able to take this step in your life?**

This question presupposes that the client has taken a step worth discussing; that the step reflects his or her own ability (**"you have been able to"**); that many persons would notice and react to this step, some with surprise; that there is at least one person who would not be surprised; that therefore his or her ability to take such a step was evident to at least one person in the past.

These questions also illustrate another aspect of McGee's (1999) larger theory, namely, that by searching for and providing answers to the therapist's questions, the client participates in co-constructing a shifted perspective of him- or herself, including relationships with others. This version (whether as deficient or as able) is likely to be all the more convincing because the client is providing the evidence from his or her own life.

Wade (1995, 1997, 2000) has emphasized the importance of particular questions in working with clients who have been abused and mistreated. Traditional therapists ask how the client was *affected by* the abuse, which embeds the presuppositions that the individual was a passive object and that he or she has had and may continue to display symptomatic effects (dissociation, depression, etc.). Wade proposes that if, instead, the therapist asks how the client *responded to* incidents of abuse, the question presupposes an active, agentic individual and focuses on the immediate situation of abuse rather than on presumed global after-effects. In response to such questions, dramatic, moving, and previously untold accounts emerge. Even though abusers always choose vulnerable individuals, their "victims" engage in imaginative and judicious resistance: Children being abused by a parent or sibling walk home from school more slowly, bring friends home, or become indispensable to another family so that they can spend most of their time away from home. Women being abused by their spouses become depressed, that is, refuse to be contented with mistreatment. Wade pointed out that the many ways in which they resist can only be revealed by asking questions that presuppose the possibility. These arts of resistance are hidden by traditional questions that presuppose a passive, affected victim.

In our view, because questions inevitably embed theoretically driven presuppositions, there are only two differences between questions in the traditional and alternative paradigms: Whether the embedded presuppositions pathologize or dignify the client and whether the therapist is embedding these presuppositions consciously or only inadvertently.

Lexical Choice

Whether in asking questions, formulating the client's statements, or using other conversational forms (e.g., assertions such as advice, interpretation, description, or information-giving), the therapist must choose his or her precise words from those available. *Lexical choice* (van Dijk, 1983) is a technical term for this aspect of discours, the systematic selection of wording or phrasing and its potential influence on the recipient[4]. For example, Danet (1980) analysed the systematic use of the terms "baby" or "fetus" in an abortion trial. The terms "pro-life" and "pro-choice" have also become familiar lexical choices in this debate. Routledge (1997a, 1997b) has been examining lexical choice in a particular therapeutic context, namely, the language that psychiatrists and many others use to discuss medication.

Two aspects of lexical choice are of particular interest to us: *Metaphors* construct reality in one way rather than another (see especially Lakoff & Johnson, 1980) and reflect systematic underlying versions of events. For example, to speak of employees as "team members" or as "human resources" are both metaphors, but they create very different versions of the employees and their relation to the employer. Second, the process of *re-lexicalization* (Fowler & Kress, 1979; Fairclough, 1992) refers to "generating new wordings which are set up as alternative to, and in opposition to, existing ones" (Fairclough, 1992, p. 194); "it promotes a new perspective for speakers, often in specialized areas" (Fowler & Kress, 1979, p. 210). In the following, we will first examine traditional lexical choices for the relationship between doctor, patient, and medication and then show how re-lexicalization and new metaphors can offer a different perspective.

Physicians often talk about medication using lexical choices that cast themselves as the agent and the patient as the object of treatment. For example, a common choice is **"I'm going to put you on this medication."** The very familiarity and superficial innocuousness of this phrase illustrates Fairclough's (1992, p.195) assertion that

"Some metaphors are so profoundly naturalized within a particular culture that people are not only quite unaware of them most of the time, but find it extremely difficult, even when their attention is drawn to them, to escape from them in their discourse, thinking, or action."

Examined more closely, this phrase, first, creates the physician ("**I**") as the sole agent of action with the patient ("**you**") as the object. The common metaphor **"put you on"** echoes the structure of the literal use of the phrase (e.g., "put the book on the shelf"; *Random House Unabridged Dictionary*, 2ⁿᵈ ed.) in which the object is not capable of independent movement or agency. ("To put" also has the meaning "to impose"; *Random House Unabridged Dictionary*, 2ⁿᵈ ed.) What else do we **"put** a person **on"**? A travel agent might put someone on a particular flight, or a parent might put a child on a plane, train, or bus. So, at most, the patient is a passive passenger, riding or being carried **"on"** the medication. In contrast, if one takes a more collaborative view and casts the physician as serving the patient, then saying **"I'm going to put you on this medication"** is analogous to – and as inappropriate as – a waiter saying **"I'm going to put you on this soup."** A somewhat less authoritarian choice is **"I'm going to give you this medication."** The metaphor **"give"** does imply that the indirect object (**"you"**) is at least capable of accepting, and it even implies an act of unsolicited kindness on the part of the giver. Still, the primary agency is with the physician (**"I"**), and the preface **"I'm going to"** brooks no choice by the recipient. Indeed, once the patient has been **"put on"** the medication, traditional medical parlance includes terms such as **"compliance"** ("the act of conforming, acquiescing, or yielding"; *Random House Unabridged Dictionary*, 2ⁿᵈ ed.) and **"noncompliance"** to describe the patient's subsequent decisions. These terms clearly stipulate that the patient's role is to acquiesce to the physician's decision, and they implicitly label any independent decision by the patient as either incompetent or disobedient. If the patient does not take the medication as directed, it is the patient who is wrong, not the physician or the medication.

Routledge proposes alternative, more collaborative language, often in the form of questions rather than assertions and using re-lexicalization to introduce new metaphors. For example, **"Would you be interested in seeing if this medication could be helpful for you?"** or **"Would you consider employing this medication?"** These questions embed several presuppositions: that it is not certain this medication could be helpful for this patient in particular; that it is entirely the patient's choice whether even to consider the possibility of taking it; that the physician is in the background, a consultant to the patient, who can choose to employ the medication or not. Another phrasing makes their reciprocal roles even clearer: **"I'm an expert on this medication's record, but you are the only expert on how well it suits you."** One metaphor that makes this point is to ask the patient how well his (the physician's) shoes fit him. It is obvious that only the wearer

can answer that question and, by analogy, that the physician can suggest medications but only the patient can judge how well they work for him or her.

The prescriber can also change the standard metaphors (**"put you on"**, **"give"**) to ones that support the patient's autonomy by *personifying* the medication, making it a metaphorically explicit party in the interaction but one that the patient is the judge of. These personifications might include: **"I'd like to tell you a bit about this medication's reputation"** or **"Would a medication like this help you with this crisis or keep you from seeing the problem clearly?"**

Personification also creates an alternative to the traditional language of **"side effects"**, which implicitly blames the patient in phrasings such as **"He developed side effects"** or **"does not tolerate"** or **"She is not responding well to ..."** An alternative construction, using personification, would blame the medication:

"This medication has a habit of ..."

"One of its tricks is to ..."

"It has a bad reputation for ..."

Personification can be useful for describing medications and possible side effects more fully:

> **Topiramate is a medication that began life as an antiepileptic but is now interested in mood stabilizing. The problem is that it bites about 25% of the people it meets. But the other 3/4 really stick with it because it helps.**

Or for asking about drug interactions: **"How are your medications getting along with each other?"** as compared to **"Are you having any problems with your medications?"** which implicitly blames the patient for the medication's limitations. Personification can also be used in extended metaphors:

> **"There are few well behaved medications, but the situation is like this: Your sink stops working and it becomes important to fix it. You call a plumber, but he smokes on the job. The second one looks at your daughter the wrong way. The third tracks mud in on his shoes. Now you are out of plumbers, there are no others in town. What do you do?"**

The lexical choices the physician makes will inevitably define the triangle of relationships between prescriber, patient, and medication. Who has agency or authority in this situation, and who gets the credit or blame? As we have seen, the tools of re-lexicalization and the introduction of new metaphors can create a more positive role for the patient.

Summary

We have been drawing on our various backgrounds as discourse analysts, communication researchers, and therapists to examine therapeutic communication more closely while connecting these details to some larger issues in the field. Microanalysis of therapeutic discourse can be a fruitful way to understand the process of psychotherapy. By "observing, recording, examining, and describing real communication and interaction in detail" (Weakland, 1967, p. 1), it is possible to gain new insights into what transpires

in the consulting room. Besides its intrinsic interest, microanalysis can begin to identify the specific tools available to therapists (here, questions, formulations, and lexical choice) so that they can be used more precisely and developed even further. We have emphasized that the use of these tools is inevitable and should therefore be made explicit. The therapist cannot avoid influence at the micro-level in therapy. The only choice is whether the relationships constructed through his or her influence are deliberate and respectful or are unexamined and may therefore be inadvertently disrespectful.

Footnotes

[1] The original psychiatrists were Fromm-Reichmann and Henry W. Brosnin, the linguists were Charles F. Hockett and Norman A. McQuown, and the anthropologists were Alfred L. Kroeber and David M. Schneider. They were soon joined by linguist Ray L. Birdwhistell and anthropologist Gregory Bateson, whose interview with "Doris" became the object of their microanalysis (Leeds-Hurwitz, 1987, pp. 4-8).

[2] Also published in the U.S.A. under Watzlawick, Beavin Bavelas, and Jackson.

[3] When we have not been able to obtain records of actual therapy sessions, we have chosen role-played training tapes, on the grounds that the producers of the tapes are presenting their best case. That is, training tapes represent how the particular therapeutic approach "should be" done; we can then examine how these recommendations are carried out.

[4] Other terms for this or similar phenomena include "lexical variation – differences in wording" (Trew, 1979, p. 131), "lexical style" (van Dijk, 1993, p. 264), and "lexicalization" or "relexicalization" (Fairclough, 1992).

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Acknowledgements

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