Clients' and therapist's joint construction of the clients' problems.

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Then I proposed another construct, building further on the notion of complementarity. I did this by *describing/transforming* what they (the clients) defined as a *conflict* into a mechanism that served to *balance their relationship*. This description not only legitimized each of their personal styles; it also defined the reaction of each to the other's style as only natural . . . By means of these rather practical recommendations, I reinforced *my proposal of an alternative description of their predicament* [italics added]. (Sluzki, 1990, pp. 121–122)

These passages from a therapist's own account of his interventions capture a sense of the phenomena to be investigated in this study. The therapist offered an "alternative description" of the clients' problems, transforming what the clients defined as "conflict" into a "balance(d) relationship." A remarkable feature of therapeutic practice is that the therapist may not find the clients' tellings of their own relational troubles convincing and, instead, offers the clients an alternative version of their situation. Such alternative versions or reframings are, of course, central practices in therapy. What I want to do here is take what therapists

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commonly gloss as “reframings” as interactive achievements through talk between clients and therapist. Instead of privileging the voice of the therapist, the article focuses on: *How therapist and clients interactionally co-construct a version of the clients’ problems during an initial therapy consultation.*

**RATIONALE**

During initial interviews, clients need to say why they have come to therapy. Clients commonly tell problems, implicate blames, and offer accounts (Buttny, 1990; Buttny & Cohen, 1991; Buttny & Jensen, 1995). These speech activities may be accomplished by narratives of incidents (Wodak, 1981; Sarbin, 1986) or descriptions of recurring negative patterns in their relationship (Edwards, 1995). Such narratives and descriptions are not neutral reports, but instead involve members’ tellings of how to hear these events, and thereby, implicate responsibility and blame (Labov & Fanshel, 1977; Edwards & Potter, 1992; Buttny, 1993). To extend this line of research, a useful next step would be to look at what the therapist picks up on and interactionally makes relevant from the clients’ problem tellings and accounts. How does the talk move from clients’ problem tellings and accounts into the therapist’s version? Such conversational movement seems to be one of the most artful practices of therapy: the reframing, redefining, or reconfiguring of “the problem” (Gale, 1991; Anderson & Goolishian, 1992; Chenail & Fortugno, 1995).

In the course of the clients’ presenting their problems, the therapist (at least in my materials) remains far from a silent listener to these problem tellings. At various points the therapist stops the clients from going on at length detailing their troubles, complaints, and blamings. The therapist actively engages in how the client’s problems get told: what gets picked up on and made relevant for further discussion, and finally, what becomes the problems for therapy (Scheff, 1989).

Such therapeutic interaction has been characterized as the therapist “reformulating” the client’s problems in a way that is suitable for further work in therapy (Davis, 1986). Therapists, as members of a specialized speech community, do more than simply reproduce the clients’ terms, accountings, and assessments of the problems. The therapist reformulates the client’s problems into different terms—to a discourse consistent with
the therapist’s perspective. According to Davis (1986), the reformulation process involves three stages: the therapist’s defining the problem, documenting the problem, and pursuing consent from the client. To define the problem, the therapist needs to select an aspect of the client’s behavior from numerous possibilities presented in the troubles-telling relatively early on in the initial interview. This aspect of the problem is then reformulated into the therapist’s version of what is “really” the problem. Usually it is not enough for the therapist to present the therapeutic version of the problem one time to convince the client. The therapist’s formulation needs to be re-introduced as the problem throughout the session; indeed, Davis (1986, p. 65) observed that “more than half the session is devoted to persuading the client” of the problem as defined by the therapist. To accomplish this, the therapeutic version is documented by interpretations and instances from the client’s own tellings. The client’s consent is needed to proceed with the therapist’s reformulation of the problem. Although the therapist’s reformulation may be resisted, it seems more difficult for clients to disagree than agree with the therapist. In brief, the therapist displays expertise by “discovering” the problem quickly and then presenting this problem reformulation without disrupting the therapeutic interaction (Davis, 1986, p. 70).

To extend this line of research, but in a way that takes reformulations more centrally as talk-in-interaction—as a co-construction between clients and therapist—two research questions are examined:

(i) How does the therapist offer the clients an alternative version of their situation?

(ii) How does the therapist draw on the clients’ understanding or assessment of the therapist’s version as a resource for bringing the focus back to the therapeutic position?

DATA

Two therapy consultations are used as data for analysis. One session involves an unmarried couple and the other a family of five. The same therapist was involved in both cases. For the couple therapy consultation examined here, the therapist has independently written a commentary on his intervention strategies (Sluzki, 1990). The therapist, Carlos Sluzki,
identified his perspective as a combination of the interactional and constructivist views (Sluzki, 1990, p. 108). The therapist’s perspective, however, is not used because my approach involves a more fine-grained analysis of therapeutic–client reframings, whereas Sluzki’s project covered the entire videotaped consultation session. This study privileges neither the therapist’s nor the clients’ point of view, but takes therapeutic practices as mutual achievements—as interactionally co-constructed among clients and therapist.

TELLING CLIENTS ABOUT THEMSELVES

Therapy is commonly thought of as a form of institutional talk organized as an interview format: the therapist asking questions and the clients answering. However, some therapists ask few direct questions, but instead attempt to elicit information from the clients by “telling them something about themselves” (Bergmann, 1992). This therapeutic practice of “telling clients about themselves” works similarly to what Pomerantz (1980) called “fishing” in ordinary conversation—as a technique to prompt the recipients to volunteer information about themselves. Bergmann (1992) called this therapeutic practice “information-eliciting tellings.”

In my data, the therapist tells the clients things about themselves, not solely to elicit information, but also to suggest, propose, or open up the clients to different ways of seeing their circumstances. As already mentioned, a remarkable feature of therapy is that the therapist may not find the clients’ accounts of their own relational troubles convincing; the therapist may propose an alternative reading of the clients’ situation. Given that clients come to the initial therapeutic interview with their troubles, accounts, and narratives, how does this shift occur from the clients’ problem-tellings to the therapist’s version? How the therapist interactionally initiates this sometimes delicate move of “telling the clients something about themselves” is the main focus of this first section.

Recipient Design

Practices of telling clients about themselves involve: (i) making ascriptions of the clients’ behavior, motives, or circumstances, and/or (ii) offering recommendations as to a future course of action. These speech
activities need to be performed with a certain delicacy, or "professional
cautiousness" (Drew & Heritage, 1992). The problem that therapists face
is how to present their version of the clients' situation when this departs
from the clients' own version.

In making ascriptions\(^3\) of the clients, the therapist may: (i) describe
the clients' past or present state-of-affairs, or (ii) talk about "possibilities"
or what may happen in "the future" (Perakyla, 1993). As regards (i),
therapists commonly qualify or mitigate their descriptions of the clients
in various ways, such as by expressing uncertainty, downgrading their
epistemological status, or drawing on publicly available facts (Perakyla
& Silverman, 1991a; Bergmann, 1992). For instance, in the following,
the therapist expresses tentativeness or uncertainty in making an ascription
through the use of the mitigator *maybe* in line 1, in describing the family's
circumstances.

(1) Family

Ther: Well maybe ( ) maybe what's happening is the kids are
jealous (.) and they are managing to eh managing to get in
between the two of them and occupy so much attention

Other techniques evident in transcript (2) are downgrading the epistemo-
logical status of the therapist's claims by identifying them as "my own fantasy" (line 1). Also, we see the therapist drawing on the publicly
available facts, "by the way you describe, (.) the situation" (line 6) and
"I already know you an half an hour" (line 7). The latter also serves to
downgrade the therapist's ascriptions.

(2) Couple

1 Ther: Do you know what my own fantasy is of all
2 ther:s if I may share=
3 Jenny: >Uh huh<
4 Ther: =it with you? hh is that (1.2) quite by the=
5 Jenny: >Uh huh<
6 Ther: =contrary (1.1) by the way you describe, (.) the situation
7 and b- if I already know you an half an hour UHM UHM
8 Clients: hhhhhhhhh
9 Ther: That (1.6) my fantasy is that you
10 express whatever (1.5) sensible- sensitive emotion . . .
By drawing on these down-grading techniques, the therapist can tell clients about themselves while simultaneously presenting these tellings as limited or open to revision.

The second way therapists form their ascriptions of clients is by discussing possibilities. Such “possibilities” may be articulated by the use of utterances with “irrealis verbs” (Gaik, 1992) of what might, could, may happen, for example, see lines 4 and 11–13 of (3) for the use of may.

(3) Couple

1 Ther: >Okay< ah there is certain risk (.) again that=
2 Jenny: >Uh huh<
3 Ther: =if you- you use big words: (.) and ah (3.4) you
4 may end up getting into this endless quest (.) and
5 there is another risk and it is that if you are the advocate-
6 advocate of therapy (.) and you want in to therapy
7 and you are the advocate of therapy uhm and
8 but mainly of finishing therapy and being able to go on you
9 are already caught in a (crueling) struggle with therapy (.)
10 the struggle of I want more and I am content or I want
11 less: (.) so it reproduces a bit what may be ah:=
12 Jenny: Uh huh
13 Ther: =ahm a stylistic issue in your:: (.) couple

Talk of future possibilities can also be formed by ascriptions of the clients using a conditional or hypothetical form (Perakyla, 1993), for instance: “if you- you use big words: . . . you may end up getting into this endless quest” (lines 3–4). Telling clients about themselves using a conditional syntax implicates that the clients can avoid these negative consequences by refraining from doing the behavior referenced in the antecedent clause. By ascribing “future possible worlds,” the therapist is able to raise delicate matters about the clients as well as to suggest alternative ways of seeing their problem, for example, as merely differences in style (line 13).

Therapeutic ascriptions of future possibilities are harder for clients to disconfirm than ascriptions about past or present states of affairs. Talk about possibilities is more difficult for clients to reject just because they are “possibilities” or speculations—contrary-to-fact conditionals. In the following, we see the therapist discussing a possible “risk” (lines 1–4) in their relationship and then attempting to support this by an ascription of
their relational history, that "individual therapy created some problems" (lines 7–9). Both Larry and Jenny move to disagree with this past ascription of their relationship (lines 16–22).

(4) Couple

1 Ther: Uhm: (2.2) .h the only risk is that you:: (. ) each one may end
2 Ther: up being an advocate of (. ) his or her own st- mode
3 (2.5)
4 Ther: Ah:: (0.6) and that may:: (3.6) >create some problems<
5 p: ah (.) indeed therapy create some problems, yeah?
6 Jenny: Um huh
7 Ther: And ah °so individual therapy:: ™if I understand correctly
8 individual therapy created some problems in the couple
9 that you are trying to solve (. ) ™and reasonably so by means
10 of ah of ah: ah:: (0.9) bringing Larry into (. ) ah: couple
11 therapy in which case ah both of you can tune up a bit
12 (0.8)
13 Jenny: Uh huh
14 Ther: Uhm
15 (1.3)
16 Larry: I don’t think that individual therapy created problems
17 be-tween us
18 Jenny: >It didn’t< Yeah, it didn’t create the problems but it
19 just made me more aware: (. ) of problems
20 (1.3)
21 Jenny: The problems were already there (. ) so they weren’t
22 crea- ted- they weren’t created by the individual therapy but
23 Ther: 
24 Ther: What kind of problems were there?

So although the therapist designs ascriptions of the clients with cautious- ness, sometimes they are challenged. This is the only instance in the two sessions, however, in which the clients mutually disagree with the therapist’s ascriptions. But even when the therapist gets an ascription wrong, he is able to use that marked correction as an interactional resource to engage the clients in further problem tellings.
Interactional Resources

In addition to the therapist telling clients about themselves by using these recipient design techniques of professional cautiousness, we also need to look at the related issue of the interactional resources the therapist may draw upon. Given that the therapist’s version differs in some way from that of the clients, how does the therapist respond to the clients’ version? One way is for the therapist to initially build on or confirm what the clients have said, and then move into the therapeutic formulation. However, we will see that it is not always possible for the therapist to find something to agree with in the clients’ versions, especially when the clients disagree among themselves. So we need to consider the alignment the therapist takes in relation to the clients’ prior positions.

A valuable lead in this regard is Maynard’s (1991a, 1991b, 1992) work in a language clinic concerning clinicians’ delivery of bad diagnostic news to the parents of developmentally disabled children. Instead of directly giving the diagnosis, the clinician may initially solicit the parents’ views on their child as a way to lead into the delivery of diagnostic news. Maynard called this latter approach a “perspective display series”: (1) clinician’s opinion query, (2) clients’ reply, and (3) clinician’s report and assessment (Maynard, 1991b, p. 167). If the parents’ views are “close” to the clinical findings, then the clinician can “confirm” some aspect of the parents’ version, “reformulate” it into a medical perspective, and give a further “technical elaboration” (Maynard, 1991a, pp. 468–469). However, if the parents’ views are “distant” from the diagnosis, then the clinician needs to work on “reducing the disparity” between the parents’ views and the clinical diagnosis. Here I want to apply Maynard’s observation of how the clinician (or therapist) confirms, or not, some aspect of the client’s views as a way to lead into the therapeutic telling.

In the following transcript, the therapist confirms Jenny’s self-ascription (lines 4, 7) while also making a recommendation.

(5) Couple

1 Jenny: ... and uhm (.) I don’t feel comfortable about it >at all<
2 (0.9)
3 Jenny: I just think it’s something ne: _w:
4 Ther: ^Yeah in addition to
5 that I
6 Jenny: >it’s something new<
Joint Construction of the Clients' Problems

7 Ther: I concur very much with you in the fact that precisely because
8 you have been exposed to several things in recent weeks. Uh huh
9 Jenny: =ah you should be: skeptical to start with and >you know< to
10 Ther: move slowly
11 Jenny: Uh huh
12 Ther: Very important to go very slowly

The therapist moves into his version by "adding to" and "concurring" with Jenny's version. Although the therapist's version, or recommendation, connects or aligns with Jenny's, it simultaneously attempts to redirect the implications of her statements, from Jenny being comfortable with therapy to the therapist's suggestion to "move slowly" in therapy. So here we see the therapeutic practice of confirming or agreeing in some sense with the client's version, but drawing a different upshot or implication from it.

Therapists may position themselves as "aligned" with clients while simultaneously moving to transform some of their views. This therapeutic practice is also evident in the following transcript though in a somewhat different way. The therapist confirms the client's version through positive assessments (a-arrows, lines 9, 11) of what she is doing. In addition, the therapist "draws inferences" from what the client is saying. Such inferences are displayed in the therapist's ascriptions (b-arrows, lines 18, 19, 21) of the client as a way to reframe the direction of the talk. The therapist picks up on an aspect of Jenny's accounts and makes relevant her participation in therapy as a sign of her commitment to her relationship.

(6) Couple

1 Jenny: Yeah I think- I mean in the past I've ah (0.9) been
2 a lot (0.5) less open with my feelings and I've repressed
3 a lot of my own feelings but I've been in therapy now for
4 awhile and a-h:
5 Ther: =For awhile?=
6 Jenny: =Yeah
7 Ther: How long?
8 Jenny: For about a year and a half
9 a→ Ther: That's sweet of you!=
10 Jenny: =Hhh h
11 a→ Ther: =No it's ( ) it's great you know what
12 you know what frequently happens with people in ther-
Transcript (6) begins with Jenny justifying her prior implicit criticism of Larry for being “closed.” The therapist’s queries make relevant her involvement in therapy, which the therapist favorably assesses (a-arrows). The therapist explains by contrasting the problematic of individual therapy—growing apart—to an ascription of Jenny’s motives of trying to involve Larry in therapy (b-arrows). This moves the talk away from Jenny’s initial justificatory accounts to a favorable portrayal of her motives for being in therapy vis-à-vis her relational partner, Larry. Also, by making ascriptions of Jenny’s motives as wanting to involve Larry in therapy as a sign of her love, the therapist can be seen—by a different analytic perspective—as “altercasting” (Malone, 1995), leading the clients toward a certain relational alignment consistent with the therapeutic portrait.

One of the most distinctive features of therapy is the character of the inferences the therapist draws from what clients say. The therapist at certain moments may be said to “hear beneath the surface” of clients’ talk. The therapist displays expertise through such practices as drawing inferences and telling clients something about themselves that seemingly goes beyond what they have revealed in talk. The ability to make explicit an implicit subtext perhaps most dramatically demonstrates the therapist’s professional competence.

Therapists can move to present their version of the clients’ situation by explicitly confirming and adding to what the clients have already said (as in transcripts (5–6)). However, the clients’ positions may be distant from the therapist’s own such that the therapist may not find anything to confirm or build on from what the clients have said (also see Maynard, 1991b). Further, in sequential environments in which clients are disagreeing and disputing with each other, the therapist may tell the clients something
about themselves as a way to shift focus or topics. An instance of this is seen in (7). The clients disagree over whether Jenny overreacts to relational problems. The therapist responds, not by addressing the propositional content of the clients’ dispute, but by commenting on the dispute itself—as “an old discussion” (line 26).

(7) Couple (Buttny, 1990)

1        Larry:  ... and I think the balance between us is (0.5) is uh: about
2        right hhh hh
3    Ther:  Um huh
4        Jenny:  "Well: I don't know"
5        (0.6)
6        Ther:  Yeah:
7        Jenny:  I'm not so sure that I - I (.) overdo it though
8        (0.4)
9        >Because I talk to < other people: (.) ya know about problems
10       and they seem to have hhh similar reaction
11

12       ((skip nine lines))
13

20       Jenny:  So: (0.8) the way he views: (0.6) uhm my: (0.6) over-
21       reaction or the way somebody else would look at it
22       they might think that I'm even underreacting to
23       certain problems so it's again very subjective.
24       Ther:  Uh hhm
25       (0.5)
26       Ther:  Ah:: in addition to that this is an old discussion

In transcript (7) the therapist makes an ascription about the clients in the sequential environment of the couple’s dispute with each other. The therapist avoids entering into the dispute, but instead attempts to refocus the discussion. Notice how the therapist moves from Jenny’s version by immediately responding with an acknowledgment token, “Uh hhm” (line 24) and then “adding to” (line 26) what the clients are saying the ascription of their dispute as being “an old discussion.” This sequential movement of acknowledgment token (or minimal agreement) combined with an adding to what is being said allows the therapist to form the response as structurally “preferred” (Sacks, 1987), even though the im-
plication of the propositional content of this turn is to tacitly object to and shift the discussion.

Labeling a dispute “an old discussion” can be heard as to attempt to “transform” or “reframe” it—the implication being to cease the discussion because it is “old.” Further, this gloss, “old discussion,” implicates that it is not just something that has happened once, but is a recurring interactional pattern, what Edwards (1994, 1995) called a “script formulation.”

The following transcript offers another instance of clients openly disagreeing with each other, but here the therapist neither confirms nor acknowledges the clients’ views, but instead moves to tentatively propose a new way to portray the clients’ circumstances, from whether there will be “hollering,” to the issue of the children occupying too much of the parents’ attention.

(8) Family

1 Mother: I think we’ll just be a normal family I don’t know
2 ya know ( )
3 Father: Well no you’re you’re not going to
4 stop all the hollering ( ) somewheres along the line
5 you’re going to run into a problem where you are going
6 to lose your temper and you are going to ( ) holler
7 (1.3)
8 Father: Er- no one no one stops this completely I don’t think
9 Ther: Well maybe ( ) maybe what’s happening
10 is the kids are jealous ( ) and they are managing to eh
11 managing to get in between the two of them and occupy
12 so much attention and time that it takes uhm eh: a
13 vacation for the two of you to be able to talk in peace
14 ( ) without interference and without this noisy crowd

Notice how the therapist moves from the father’s concern about the mother’s “hollering” to the ascription of the children coming between the parents. Instead of explicitly responding to the father’s concern, the therapist (lines 9ff.) tentatively proposes another interpretation, “well maybe ( ) maybe what’s happening is . . .” In support of his ascription, the therapist draws on a prior discussion about hollering and alludes to the mother’s earlier narrative of a peaceful vacation the parents took without the children. The therapist thus preserves some of the events from the family’s earlier tellings, but reconfigures them into this present interpretation about the
clients. So here the practice of telling the clients about themselves gets achieved by the therapist drawing on various prior clients' descriptions or tellings and then using these materials to construct a different way to see their situation.

By way of summary, in this first section we have seen the therapist use various practices to move from the clients' accounts to the therapist's tellings. The therapist's ascriptions or recommendations are designed to display professional cautiousness: by forming utterances with qualifiers, by citing the therapist's circumscribed knowledge of the clients, and by discussing future possibilities. The therapist may also form problems with an if-then conditional syntax. The therapist draws on various interactional resources in doing tellings, such as by positioning himself as aligned or in agreement with the clients' accounts, but proceeding to draw a different upshot or implication from the clients' version. The therapist may add to what the clients have just said, but in so doing attempt to transform aspects of the clients' position or to comment on the clients' form of communication, for example, as "old discussion," to implicate that it should be transformed. In other cases, the therapist need not address the clients' assertions but instead offer alternative proposals.

These therapeutic practices do not guarantee that the clients will be convinced by the therapist's version. We need to examine the clients' responses to therapeutic tellings and how the therapist treats their responses.

CLIENTS' RESPONSES TO THERAPIST'S TELLINGS AS A RESOURCE FOR THERAPEUTIC PERSUASION

In telling clients about themselves, the therapist cannot simply decree the validity of the therapeutic telling of the clients' problems. Therapy, of course, involves the art of persuasion, of opening the clients up to a different way to see their situation. Clients are not passive recipients of therapy; they may resist the therapist's articulation or take it in a different way; they may withdraw, remain silent, or continue to maintain their own point of view. So the therapist needs to know the clients' alignment or positioning vis-à-vis the therapeutic reading of their situation.
Therapeutic Tellings Project Clients’ Responses

Client responses are sequentially implicated by the therapist’s ascriptions or recommendations. Telling others something about themselves—whether as an ascription or recommendation—makes relevant a response from the recipient either to accept it or to put the record straight (Bilmes, 1985). The therapist’s tellings open up a slot for the clients’ response to that telling. In other words, we have the adjacency pair formats:

(i) therapist’s ascription of other → clients’ confirm/disconfirm
(ii) therapist’s recommendation → clients’ accept/reject.

Although this basic adjacency pair structure does occur, sometimes the therapist’s ascription/recommendation is followed by a postpositioned query by the therapist that pursues the clients’ responses. The therapist not only tells clients something about themselves, but asks them if it makes sense. The therapist attempts to involve the clients in addressing the therapeutic position by forming it as provisional, tentative, or subject to their confirmation (as seen also in the earlier discussion of professional caution). Because the therapist’s view of the clients typically differs in significant ways from their own views, the therapist needs client responses to work on co-constructing the alternative account. The post-positioned queries work as a prompt to engage the clients with the therapist’s alternative.

For instance, in the following transcript, the therapist (lines 1–2) offers a differing version of the clients’ situation from each of their own versions (the clients’ accounts are not reproduced here). The therapist then pursues their assessment of this ascription (lines 5–6).

(9) Couple

1  Ther: And that is a factor that inhibits you (.) .hh but
2      that is my own fantasy educated guess let’s say
3  Jenny: >/uh huh<
4  Larry: ( )
5  Ther: Does it fit ( ) does it fit at all with your experience
6      of uh: ah:: ( )
7  Jenny: That’s partially true because I assimilate
8      his emotions with my emotions
Here I simply want to note the therapist's ascription and pursuit of the clients' assessment. This transcript is the most explicit or direct case of the therapist's pursuit of the clients' response to his interpretation. In the other instances of therapeutic tellings, the therapist uses postpositioned queries in the form of various particles, such as "yeah," "Uhm," "Hmm," and the like (see arrows in transcripts (10–11)). These serve to prompt the clients' responses to the therapeutic telling.

(10) Couple

1  Ther: There is one rule of thumb that you can apply for this
2    situation (1.9) uhm: and it is that eh if you want to meet
3    his needs: ? you have to listen? to whatever he expresses
4    emotion and do nothing about it, and on the contrary
5    ah and for you when you hear her expressing of emotions
6    you have to act (1.8) ah:: amplifying rather than damping
7    ((three lines omitted)) so you can experience his emotion
8    less and you can experience she is ah: overemotional
9
10  → Ther: Hmm
11  Jenny: "Uh huh"
12  Larry: She does complain that I minimize (1.5) problems

In transcript (10), after the therapist's ascription and recommendation, there is a two-second gap, at which point the therapist's query, "Hmm," gets an acknowledgment token from Jenny before Larry's assessment response.

In transcript (11), after the therapeutic ascription (lines 1–2), Jenny fills the brief gap (0.8 seconds) with "Uh huh," to which the therapist queries (line 5) whether Jenny agrees or is offering an acknowledgment token. Then after a noticeable silence, the therapist (line 7) proposes that Jenny critically evaluates his ascription and uses another postpositioned query (line 8). This ascription at line 7 indicates that Jenny's verbal response is called for and is noticeably absent.5

(11) Couple

1  Ther: ... so it reproduces a bit what may be ah: ahm
2    a stylistic issue in your:: (. ) couple
3    (0.8)
Jenny: Uh huh
Ther: Yeah?

(1.6)

Ther: You don’t like what I’m saying
yeah?

These postpositioned queries allow the therapist to both tell the clients something about themselves as well as to solicit their involvement and response. So the therapist’s turn can be seen as doing a telling and a questioning. Each of these utterance types projects a response, though the query seems to be more sequentially implicative for the clients.

Should the clients’ responses reject or display reluctance to accept the therapeutic version, the therapist will not simply leave it at that; instead, the therapist may use the clients’ responses as a resource to do more work in presenting the therapeutic version. Therapists may pursue their version of the problem even in the face of the clients’ resistance (Labov & Fanshel, 1977).

**Therapist’s Third Turn**

Given that the clients’ responses occur in the slot following the therapeutic telling, the therapist can take the clients’ utterances as displaying understanding or assessment of what the therapist has just said. As such, these client responses provide a valuable interactional resource in that the therapist can, in turn, move to correct, assess, or elaborate on the clients’ alignment with the therapeutic position. That is, the therapist can employ a “third turn” (Heritage, 1984) to interactionally connect the client’s positioning (as displayed in the second turn) to the therapist’s tellings. So instead of the earlier-mentioned two-part structure, this should be seen as a three-part sequence involving at least three turns:

(i) therapist’s ascription or recommendation;
(ii) client’s response or evaluation;
(iii) therapist’s evaluation of the client’s response.

What makes the third turn sequentially connected is that it is responsive to the client’s second-turn understanding/alignment and it makes relevant some aspect of the therapeutic telling in the first turn.
Transcripts (12) and (13) provide contrastive cases of the clients’ responses to the therapist’s recommendation and then the therapist’s third-turn evaluation. In (12), the therapist makes ascriptions and a recommendation to the clients (lines 1–17) that each needs to adjust to the other’s style more—Larry to “amplify” his affect toward Jenny and Jenny to tone hers down with Larry. Jenny responds by accepting this proposal and formulates her understanding of it (lines 18–21) and, in turn, receives a hedged confirmation from the therapist in the third turn (lines 22, 24).

(12) Couple

1 Ther. And my point is:: that eh (,) if you want to interact
2 more successfully and happily ah (1.0) you have to be
3 a little more like the other when you are with the other
4 when you are with yourself, hhhh but when you are with
5 her? unless you amplify a bit whatever she brings about
6 she feels that she’s throwing fire and getting ((vocal-
7 ization)) nothing and in turn when you are- when you are
8 opening up with whatever thing? what for you is an
9 intense emotion is for you ((vocalization to minimize))
10 so you: also:: ah::: eh the technique quote unquote of
11 ah getting his emotion should be really by means
12 of (2.1) just listening and not reacting= it’s easy to say
13 I’m an outsider I’m not involved in in an intense
14 relationship like the two of you are and therefore I can
15 say ( ) (1.3) uhm: but ah: (:) that’s uhm (:) would
16 be my view and an important way of doing something
17 for:: the other >and therefore for yourself heh<
18 Jenny: We can certainly try it? It’s sort of like role reversal
19 for a while=
20 Ther. =Ah:?
21 Jenny: [in a sense ( )
22 Ther. †If you want.
23 Jenny: Uh hum hhhhh
24 Ther. [If you want ah:

In transcript (13) (a continuation of (12)), Larry formulates his own understanding of the therapist’s recommendation (lines 25–28), in marked contrast to Jenny’s. Larry’s formulation here occasions a second third-turn
slot for the therapist, this time to assess, correct, and elaborate on Larry’s understanding (lines 30–37).

(13) Couple (continuation of transcript (12))

25 Larry:  ( ) those are the words but I think (.) that what
26   he’s really asking is that (.) .h we don’t interact with
27   each other because of fear for the- because of the
28   other we should be ourselves “more”
29   (1.9)
30 Ther:   Uhm (1.5) up to a point
31   but it happens that on the contrary what I’m saying is
32   you can do- as much of it as you want when you are
33   interacting with the other however unless you talk
34   a bit in the language of the other you: ah: you: get
35   into a: into a big misunderstanding and for you to talk
36   in the language of her means to receive her emotions (.)
37   ah: amplifying them a bit

In this second third-turn slot, the therapist, after a delayed initial qualified agreement (line 30), corrects Larry’s understanding by presenting the gist of what he had said in his prior recommendation and further explaining (lines 31–37). So the therapist makes relevant Larry’s misunderstanding in the course of evaluating Larry’s response to the therapeutic position. The therapist explains and elaborates on his prior recommendation that they adjust to and communicate more like their partner.

In both transcripts (12) and (13), the clients’ response includes a formulation of the therapist’s prior recommendation. These formulations open up a slot for an evaluation from the therapist (Heritage & Watson, 1979). But not all client responses include a formulation of the therapist’s first-part utterances. Still the client’s responses can be taken by the therapist as a display of understanding of the therapeutic point. For instance in the following, Jenny’s response (line 6) displays a misunderstanding of the therapist’s recommendation (lines 1–2, 4), as evidenced by the therapist’s overlapping correction (lines 7–8) and elaboration of the therapeutic view (lines 10–11).

(14) Couple

1 Ther:   Ah you should be:: skeptical to start with and >you
2 know< to move slowly
Therapeutic talk has the potential of being "mystifying" or "oblique" (Peyrot, 1987) to clients, so this third turn seems to be an especially important site, in that it allows the therapist not only to assess or correct, but also to explain, clarify, or elaborate *given the clients' uptake of the therapeutic position*. In the following case, the client seemingly misses the point (lines 16, 18–19) of the therapist's prior ascription (1–14), so the therapist uses the third turn (17, 20–24) to make explicit his earlier point and further explain.

(15) Family

1 Ther: Well maybe ( ) maybe what's happening is the  
2 kids are jealous (.) and they are managing to eh manag-  
3 ing to get in between the two of them and occupy so  
4 much attention and time that it takes uhm eh: a vacation  
5 for the two of you to be able to talk in peace ( )  
6 without interference and without this noisy crowd  
7 (2.5)  
8 Ther: Uhm (.) and if that's the case ( ) if that happens to  
9 be the case it seems then ah your own sense of responsi-  
10 bility and love as parents have ah ah: allowed for a situ-  
11 ation to happen that increases distance or a lack of a:  
12 connectedness between the two of you as a couple uhm  
13 and uhm in which case the kids ( ) would be helping  
14 contribute to ( ) as a couple  
15 (6.7)  
16 Mother: They all like attention (.) and a whole lot of it  
17 Ther: Yes but they are they are kids ( )  
18 Mother: [And they
vie with one another for that attention=

Ther: =It's about the two of you as a couple (.) as ah uhm::
(.) couple as a (unit) couple and that sometimes being
a mother and being a father occupies so much of one's attention
then ( ) the connection the two of you have
or may have or have had
(2.9)

Ther: And ah so:: if I was taking it from your own comment
of ah crying ah crying at the beginning of because of
the strain of the situation ( ) and then after a while crying
of the situation ( ) because that brings about seems
to bring about (.) ah:: the separation of the two of you

What the therapist proposes as the children coming between the parents and putting strain on their relationship (lines 1–14) the mother responds to with an ascription of her children wanting "attention" (lines 16, 18–19). The noticeable gap of nearly seven seconds (line 15) between the therapist's and mother's turn suggests something amiss. In the therapist’s third turn he comes back to his initial ascription that the problem is really about the parents as a couple and the children separating them.

As a way to explain his point, the therapist documents his interpretation as based on what the client herself had previously said, "I was taking it from your own comment of ah crying" (lines 26–27). So again the third-turn slot is used by the therapist to correct the client's understanding and, further, to clarify and elaborate on the prior therapeutic ascription. Of course, this third turn does not guarantee that the clients will be convinced, but it does provide an opportunity for the therapist to address the clients' take on the therapeutic version.

Whether the therapist initiates an elaboration or correction in the third-turn slot is contingent on what happens in the clients' second-turn responses to the initial ascription. In the following, we see the therapist making an ascription about future possibilities of Jenny not wanting "to change too much" (lines 3, 5, 10–14), with which Larry immediately concurs (line 15). A discussion and disagreement between Jenny and Larry then unfold over the length of time Jenny wants to be in therapy (lines 27–46). The therapist intercedes by bringing the discussion back to his initial ascription over the length of time in therapy (47, 49–57). So although the therapist's intervention here is not literally a third turn, because the clients take nine turns after his initial ascription, nonetheless
it serves the similar functions of bringing the discussion back to the therapeutic view in light of the clients’ positioning, and of further elaborating and explaining.

(16) Couple

1  Ther:  Do you follow me
2  Jenny: =Yeah=
3  Ther:  =The ri::sk=
4
5  Jenny: >°Um huh°<
6
7  Ther:  =of any change (. ) is (. ) that you may leave therapy
8
9  Jenny: Um huh
10  Ther:  And if therapy in itself is a ritual (4.7) uhm: (. )
11
then it doesn’t make sense for you (. ) to do: to
12 change too much? in the direction >whatever direction
13 it may be because you would have to leave therapy
14 and therapy itself is a very important ritual< (. )
15 a token of appreciation for each other and of love
16  Larry:  That assessment is one that I- I mean (. ) the real
17 purpose of therapy is to get out of therapy (. ) as
18 soon as possible

.  

.  

((skip six lines))

.  

24  it’s a paradox but that’s one of the problems with
25 therapy is that you’re drawn in and held in to the
26 ritual not (. ) to the goals- not attaining the goals
27  Jenny: But- but only until you can do it on your own I mean
28 it’s almost like you- you acquire the awareness
29  in therapy (. ) so you are able to handle your own
30 problems (. ) you know it’s almost like you- you learn
31 something in therapy and then you take it home and
32 you work on it=
33  Larry:  =I know what the teaching is=
34  Jenny:  =Yeah but I’m just saying it’s- it’s so that you can:
35  do it yourself (afterward)s
36  Larry:  ^But of course
37 Jenny: ( ) OBVIOUSly
38 I mean then then once you can do it yourself
39 why do you need therapy anymore?
40 Larry: Well that’s the point why do some people stay in
41 therapy for ten years? (.) why do some people
42 Jenny: Well to that extent
43 then ( . ) it’s really dangerous
44 Larry: Why do some people leave after a year? I think
45 it’s the therapist that ah is good or bad based on
46 whether they can get you out the door
47 Ther: >Okay< ah there is certain risk ( . ) again that if=
48 Jenny: >Uh huh<
49 Ther: =you- you use big word: s: ( . ) and ah (3.4)
50 you may end up getting into this endless quest ( . )
51 and there is another risk and it is that if you are
52 the advocate- advocate of therapy ( . ) and you want
53 in to therapy and you are the advocate of therapy uhm
54 and but mainly of finishing therapy and being able to
55 go on you are already caught in a (crueling) struggle
56 with therapy ( . ) the struggle of I want more and I am
57 content or I want less

Notice that the therapist’s intervention is a marked reference to his initial ascription by the repeated use of the same word “risk” (line 47, cf. line 3), which is emphasized by the micropause immediately afterward. Also, the therapist calls attention to its being repeated by adding the indexical term “again” (line 47).

The therapist intervenes in the sequential environment of the couple’s dispute about the length of Jenny’s involvement in therapy. To initially gloss the therapist’s moves here, he first addresses Jenny about the risk of lengthy therapy (lines 47, 49–50). The therapist then attempts to shift the discussion from the level of individual blames and accounts to framing the issue as “the couple” as an interpersonal system. To achieve this the therapist formulates the gist of both Jenny’s position (“you want in to therapy,” lines 52–53) and Larry’s position (“finishing therapy and being able to go on,” lines 54–55) and then draws the upshot of this opposition as a “struggle with therapy” (lines 55–57). By drawing on the gist of the
clients’ respective positions, the therapist can connect the clients’ own accounts to the therapist’s version.

CONCLUSION

Therapy has been characterized as involving both the discourses of medicine and of morality (Bergmann, 1992). We may add to this characterization the art of rhetoric—for in and through words the therapist attempts to persuade clients of different ways to see their problems. Seeing therapy as rhetorical has, of course, already been discussed (McNamee & Gergen, 1992). What is less understood—and to what this analysis attempts to contribute—is how the rhetoric of therapeutic reframings gets interactionally achieved through the practices of telling clients about themselves and third-turn evaluations.

Therapeutic reframings may be seen as a consequence of the therapist’s conversational control (Scheff, 1968). “Conversational control” is a gloss on various practices that get played out in context. Conversational control may be empirically displayed through various interactional asymmetries between clients and therapist: For instance, the therapist initiates, whereas clients are responsive; the therapist asks questions, whereas clients give answers (Melinger, 1993); the therapist controls the opening and closing of topics (Perakyla & Silverman, 1991b); clients tell their own problems, whereas the therapist tells the clients of their problems; the therapist “orchestrates” (Aronsson & Cederborg, 1994) the direction and focus of the talk by requesting, disattending (Jones & Beach, 1995), cutting the clients short, and repeating or elaborating on the therapeutic position. The therapist’s third-turn evaluation slot can bring the discussion back to the therapeutic proposal. Conversational control gets achieved through the therapist’s professional competencies and expertise and the clients’ interest and deference toward these (Perakyla & Silverman, 1991b).

Whereas these interactional asymmetries may work to provide some conversational control for the interview, at the same time we see the therapist’s efforts to involve the clients in considering and addressing the therapeutic position. The work of the therapist is contingent on the clients’ narratives, responses, and positionings. As we have seen, therapeutic
tellings may draw on aspects of the clients’ accounts; also these tellings are
designed as tentative, limited, and open to further revision from the clients.
Indeed, not only does the therapist tell clients about themselves, he also
queries their responses to these tellings. The therapist wants to engage the
clients in interactionally co-constructing the problem and solutions (Ed-
wards, 1995).

One obvious way to involve clients is to ask them their views of the
problems as a prelude to offering the therapeutic version. This resonates
with Maynard’s (1991a, 1991b, 1992) analysis of the perspective display
series (discussed earlier). However, a major a priori difference between
the interaction in the language clinic that Maynard studied and the present
therapy context comes from the epistemological character of the “diag-
nosis.” In therapy (such as the kind studied here), unlike the language
clinic, there are no independent tests that can be performed to ascertain
the problem. Therapists have no recourse to some medical technology or
tests on which to base their diagnosis. Indeed this therapist, Sluzki (1990),
did not use the medical-laden term diagnosis.

In the one case (transcript (10)) in which the client, Jenny, withholdsa response to the therapist’s version and prompt, the therapist, instead of
continuing, pursues a response by an ascription of disagreement and a
further prompt. Such pursuit of a client response contrasts with Heath’s
(1992) observation of medical interviews: When patients withhold re-
sponses to the physician’s diagnosis, the physician does not pursue a
response from the patient. This contrast may reflect the distinction between
doing therapy and doing medical examinations. So the therapist needs to
be much more of a rhetor to convince the clients of the therapeutic version.

In my data, the perspective display series is not empirically found. What
is found is other interactional dynamics described by Maynard: the therapist
looking to confirm some aspect of the client’s accounts, moving to
formulate them in a way consistent with the therapeutic version, and further
elaborating on the therapeutic perspective. Both the clinician and therapist
need to involve the clients, but in therapy, the problem and solutions are
discursively formed through the clients’ and therapist’s talk. As we have
seen, following the clients’ problem-tellings the therapist may attempt to
reframe by: (i) giving a minimal agreement and moving on to add a differing
account, (ii) making relevant an aspect of something the client said but
drawing different implications from it, or (iii) using what the client has said
as a conversational resource to formulate the therapeutic interpretation. One
technique was for the therapist to position himself as aligned with the clients
through the preferred responses of confirming while simultaneously attempting to transform some aspects of the clients’ version of the problem. Of course, the therapist may not find anything to align or agree with in the clients’ accounts, particularly in the sequential environment of their disputes.

In telling clients about themselves the therapist not only means to “prompt” the clients to respond (Bergmann, 1992), but also to convince the clients of this alternative version. Clients’ responses provide a valuable resource in that the therapist can take these responses as a display of understanding and assess the clients’ alignment in relation to the proffered reframing. In other words, the therapist can use a third turn (if need be) to explain, correct, or elaborate on the therapeutic version. The third part of this sequence, the therapist’s evaluation, captures Davis’s (1986) observation of the repetition the therapist employs in presenting the therapist’s version. But crucially, such repetition is recipient designed to the clients’ understandings and positionings as displayed in their second-part responses.

This third-turn slot of an expert evaluating the answer of a client is also found in the classroom setting (McHoul, 1978). Here we have the familiar sequence of the teacher’s question giving rise to a student’s answer followed by the teacher’s evaluation. Indeed, the teacher’s third-turn assessment, challenge, or further questioning is what characterizes the interaction as pedagogical (Heritage, 1984). Although there are obvious differences between the classroom and therapy contexts, to a certain extent the therapist’s third turn serves a similar educational function: The therapist may correct, defend, explain, or elaborate on the therapeutic view. Part of persuading the clients is to open them up—to educate them—as to the plausibility or reasonableness of the therapeutic alternative.

In some sense, once clients present their problem to the therapist it is no longer theirs. Problems are not simply the clients’ subjective sentiments or inner cognitions, but become an object for examination through talk (Coulter, 1979). Problems can be scrutinized, questioned, and even challenged, in short, they are open to public criteria as to how they are to be described and ultimately evaluated. Clients are not the final authority for their own avowals or affect; clients who profess irrational fears or unwarranted alignments can be challenged or overruled by others for holding these positions. So therapeutic reframings of the clients’ problems can be seen as the therapist offering a new language game for discussing the clients’ situation. Similar to how Wittgenstein (1953) handled metaphysical problems in philosophy, some relational problems can be seen as problems of language: Change the language game that is played and
how the problem is described, and the problem becomes, not solved, but dissolved.

NOTES

1 The term therapy is used here throughout, rather than psychotherapy, psychiatry, and the like, because that is the activity term employed by the therapist.

2 By way of contrast, other therapeutic perspectives, such as the Milan school, rely exclusively on questioning (see Perakyla, 1995, for a conversation analytic approach to the Milan school therapy).

3 I use the term ascriptions here rather than the more common attributions to avoid the latter’s association with attribution theory. See Antaki (1994) for a discourse-based critique of attribution theory.

4 The therapist’s referencing the discussion itself, rather than continuing “within” the discussion, is what Bateson (1972) called “metacommunication”—a moving to a so-called metalevel to comment on the discussion itself. Making the discussion itself relevant implicates an activity both clients partake in, and thereby, can be heard as an attempt to shift the talk away from the clients’ prior individual blames and accounts.

5 Unfortunately the videotape does not capture Jenny’s bodily response at this point; her nonverbal displays plus the marked silence may be what the therapist is responding to here.

6 There are different kinds of therapy, some of which use such tests or exams; for instance, see Mehan (1990) on the psychiatric outtake interview.

REFERENCES


