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THE LANGUAGE OF PSYCHOTHERAPY: A CONVERSATIONAL ANALYSIS OF DISAGREEMENT

City University of New York PH.D. 1981

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THE LANGUAGE OF PSYCHOTHERAPY:
A CONVERSATIONAL ANALYSIS OF DISAGREEMENT

by

SUSANNE BLEIBERG SEPERSON

A dissertation submitted to the Graduate Faculty in Sociology
in partial fulfillment of the requirements for
the degree of Doctor of Philosophy,
The City University of New York

1981

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SUSANNE BLEIBERG SEPERSON

1981

This manuscript has been read and accepted for the Graduate Faculty in Sociology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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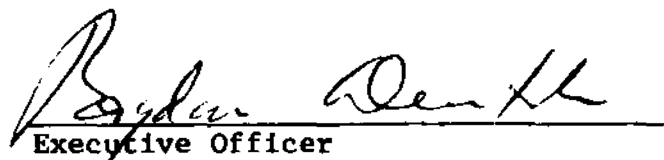
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To my mother, Annie Bleiberg
And in memory of my father,
David Bleiberg

ACKNOWLEDGEMENTS

In a sense this dissertation represents a "coming together" of the various experiences I had during my graduate school career. Therefore, it is with deep gratitude that I thank the following people for their impact:

The two people who have been most influential in my selection of this topic--conversation in psychotherapy--are Drs. Lindsey Churchill and Milton M. Berger. I thank Dr. Churchill, who as chairman of my dissertation committee, inspired me and guided me. My debt to him will be apparent to all who know his work. I thank Dr. Berger for making the data available for analysis and for his interest in all avenues which could bear on improved treatment for his patients.

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- Susanne Bleiberg Seperson
March 1981

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CHAPTER 1

INTRODUCTION TO THE TOPIC AND METHOD

Earl Babbie begins his introductory text, Sociology, with the statement "sociology is the study of the agreements that people make, organize, break and change. It's also the study of disagreements."[1] This puts the topic of my dissertation, disagreements, into the mainstream of sociological thinking. It is a study of disagreement in a more limited context, the psychotherapeutic setting and examines the above macro-sociological problem using micro-sociological data--language, the natural talk we produce in our everyday lives. The theoretical perspective used is an ethnomethodological one--asking the question, "how is a particular social activity done?" and the methodological technique is conversational analysis.

Harold Garfinkel developed the theory of ethnomethodology out of his 1945 work on jurors with Saul Mendlovitz and Fred Strodtbeck. He became interested in how the jurors were doing their work by listening to tapes of their conversations. He notes they wanted to be legal and not to be "common sensical" at the same time employing "common sensical" notions to make their decisions.[2] The main concepts of an ethnomethodological approach were presented in his seminal 1967 work,

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[1] Earl Babbie, Sociology, 2nd ed. (Belmont, CA: Wadsworth Publishing Co., 1980), p. 9.

[2] Harold Garfinkel, "The Origins of the Term 'Ethnomethodology'" in Ethnomethodology, ed. Roy Turner (Middlesex, England: Penguin Books, 1974), pp. 15-16.

Studies in Ethnomethodology,[3] wherein he emphasized how people make themselves accountable to others, using reflexive practices, indexical expressions, the etc. rule, glosses and the documentary method of interpretation. Garfinkel is interested in the grounds of people's practical accomplishments--how people construct reality and share it. Unfortunately, it is difficult to observe this directly and he undertook his now-famous disruption experiments--breaching the taken-for-granted world of reality--in order to make those rules observable. In a later conversation, he defined ethnomethodology as "an organizational study of a member's knowledge of his ordinary affairs, of his own organized enterprises, where the knowledge is treated by us as part of the same setting that it also makes orderable."[4] In short, it is the study of everyday practices.

Garfinkel developed his theoretical ideas and used data as illustration. Harvey Sacks, his protege, on the other hand, grounded his theory even more firmly in the data itself, creating the technique of conversational analysis. His technique, similar to the central method of linguistics, uses the reproduction or regeneration of social events as its methodological criterion.[5] Thus, if the elements and rules underlying the production of an event can be isolated and then used to produce or generate an instance of that events, we conclude

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[3]Harold Garfinkel, Studies in Ethnomethodology (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1967), Chapters 1-3.

[4]Garfinkel, "The Origins of the Term 'Ethnomethodology,'" p. 18.

[5]Lindsey Churchill, Questioning Strategies in Sociolinguistics (Rowley, MA: Newbury House Publishers, 1978), p. 2.

that such demonstration provides an understanding of the event in question.

One of Sacks' most important contributions has been in formulating the chaining rule. In a two-party conversation,

> . . . it runs: If one party asks a question, when the question is complete, the other party properly speaks, and properly offers an answer to the questions and says no more than that. . . . A person who has asked a question can talk again, has, . . . "a reserved right to talk again", after the one to whom he has addressed the question speaks. And, in using the reserved right he can ask a question. . . . It provides for the occurrence of an indefinitely long consersation in the form Q-A-Q-A-Q-A.[6]

The operation of turn-taking and the use of the chain rule has been studied further in his work with Jefferson and Schegloff.[7] The implication is that as competent members we intuitively use the chain rule successfully. An inability to do so would indicate a mental incompetency; that is the speaker-hearer may be to some degree stupid or crazy, unless he can convince the other he was only joking.

Sacks with Jefferson also developed the technique of transcribing audiotapes and a consistent notation system. This change in emphasis from Garfinkel's approach has resulted in a tension between the different orientations within the field of ethnomethodology.

This dissertation is an analysis of how disagreement gets accomplished in a psychotherapy[8] setting using an ethnomethodological

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[6]Harvey Sacks, "On the Analysability of Stories by Children," in Ethnomethodology, ed. Ray Turner (Middlesex, England: Penguin Books, 1974), p. 230.

[7]Harvey Sacks, Emmanuel Schegloff and Gail Jefferson, "A Simplest Systematics for the Organization of Turn-Taking for Conversation," Languages (1974):50.

[8]The kind of psychotherapy occurring in these sessions is psychodynamically-oriented and is based on a neo-Freudian model, specifically Karen Horney's formulation of psychodynamics.

theoretical point of view and conversational analysis as a methodological technique. It is a study of conversation occurring between two people, always a psychiatrist and various voluntary patients focusing on disagreeing activities. Disagreeing activities include those activities wherein one person basically takes a yes position and the other takes a no position. Disagreeing is intrinsic to the psychotherapy setting; as R. D. Laing notes: "Sanity or psychosis is tested by the degree of conjunction or disjunction between two persons where one is sane by common consent."[9] In this dissertation I study the background conditions of the doctor-patient relationship, including the use of threat and authority; analyze disagreement as a basic yes/no contradiction; examine the negotiation of disagreement through the use of category formation and negative reinterpretation; and the encouragement of change in a patient through the use of reality-confrontation.

I chose this topic for four reasons. (1) I have long been interested in the problem of how reality is socially created and shared; (2) I embedded this concern in the psychiatric setting because of an interest in the psychotherapy process and because I had access to audiotapes of psychotherapy sessions; and (3) since the bulk of the transcripts come from confrontational therapy sessions, I assumed that disagreeing activities would be easy to recognize and they would provide an abundance of material with which to work. (4) In addition,

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[9] R. D. Laing, The Divided Self (Middlesex, England: Penguin Books, 1965), p. 36.

with the exception of Turner's work[10] and my work with Churchill,[11] there has been little work done on rule use in psychotherapy.

The most important studies influencing my thinking on the problem posed here were done by Garfinkel, Sacks' work on story telling[12] and puns in joking behavior[13] and Churchill's work on questioning behavior.[14] Churchill analyzed how questions are asked by focusing on making requests, repairing procedural problems, denigrating the hearer or speaker and developing maxims for each of these activities. These will be referred to repeatedly throughout this dissertation. Other activities studied by ethnomethodologists utilizing rule use include walking,[15] passing in the female gender,[16] bidding at an auction,[17]

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[10]Roy Turner, "Some Formal Properties of Therapy Talk," in Studies in Social Interaction, ed. David Sudnow (New York: Free Press, 1972), pp. 367-96.

[11]Susanne Bleiberg and Lindsey Churchill, "Notes on Confrontation in Conversation," Journal of Psycholinguistic Research 4 (1975): 273-78.

[12]Sacks "On the Analysability of Stories by Children," pp. 216-32.

[13]Harvey Sacks, "On Some Puns with Some Intimations," in Sociolinguistics: Current Trends and Prospects, ed. Roger Shuy (Washington, DC: Georgetown University Press, 1973).

[14]Churchill, Questioning Strategies in Sociolinguistics.

[15]A. Lincoln Ryave and James H. Schenkein, "Notes on the Art of Walking," in Ethnomethodology, ed. Ray Turner (Middlesex, England: Penguin Books, 1974), pp. 265-74.

[16]Harold Garfinkel with Robert J. Stoller, "Passing and the Managed Achievement of Sex Status in an 'Intersexed' Person Part 1" in Harold Garfinkel, Studies in Ethnomethodology (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1967), pp. 116-85.

[17]Lindsey Churchill and Susan Gray, "Beyond Ethnography: A Conversational Analysis of Auctions," in Studies in Language Variation, ed. R. Fasold and R. Shuy (Washington, DC: Georgetown University Press, 1977), pp. 209-25.

talking on the telephone,[18] selling insurance,[19] ascribing insanity,[20] and more generally using rules in American society.[21]

Turner's work is an examination of beginnings in group therapy sessions. He analyzes the class of remarks: 1. Look, before we start; 2. Well, we might as well start, and 3. Well, I think what we had better do is start.[22] This is a very important article based on precepts developed by Garfinkel and particularly Sacks. Turner focuses on the routine everyday aspects of therapy talk; in other words, those features which therapy talk and normal conversational talk have in common. Therefore, he focuses on beginnings as a transition point to notice any change. He suggests that in some way the rules of everyday talk might be suspended during the course of therapy, but writes that that topic awaits further analysis.[23] This dissertation, by examining activities occurring within two-person therapy talk, then begins the kind of analysis Turner suggested. I focus on rules or more loosely held maxims of talk which are features of everyday conversation as well as maxims used in therapeutic conversations; the latter would otherwise

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[18]Emmanuel Schegloff and Harvey Sacks, "Opening up Closings," in Ethnomethodology, ed. Ray Turner (Middlesex, England: Penguin Books, 1974), pp. 233-64.

[19]Jim Schenkein, "Identity Negotiations in Conversation" (unpublished, no date).

[20]Jeff Coulter, Approaches to Insanity (New York: John Wiley and Sons, 1973).

[21]Jack D. Douglas, American Social Order (New York: Free Press, 1971).

[22]Turner, "Some Formal Properties of Therapy Talk," p. 367.

[23]Ibid., p. 396.

appear as impolite or rude. Therefore, I focus on disagreeing activities. Nevertheless, Turner's article is important in terms of suggesting this focus and beginning an analysis of therapy talk.

The other work dealing with the psychotherapy setting is my work with Churchill on confrontation.[24] We defined reality-confrontation as an activity where the confronter, in this case the therapist, brings the confronted, the patient, face to face with a fact that he cannot be permitted to avoid facing. The paradigm below was developed for an ideal confrontation.

PARADIGM OF IDEAL CONFRONTATION

STEP	ACTOR	ACTION
1	Confronted	Makes a general statement.
2	Confronted	Asks a close-choice (yes/no) question about a particular aspect of the general statement.
3	Confronted	Picks the answer that shows that the particular aspect under question is an exception to the general statement.
4	Confronted	Asks a second close-choice (yes/no) question about another particular aspect of the general statement.
5	Confronted	Picks the answer that shows that the particular aspect under question is another exception to the general statement.
6	Confronted	Asks a rhetorical question that contradicts the confronted's original general statement.

This work led me to examine reality-confrontation as part of a larger package of disagreeing activities. The activities I examine are

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[24] Bleiberg and Churchill, "Notes on Confrontation in Conversation," p. 276.

part of the implicit difference or disagreement between the therapist and patient. Harry Garner, a psychiatrist, states the implicit use of disagreement in psychotherapy as follows:

> That a confrontation approach to the patient has been characteristic of almost every type of psychotherapy endeavor is sometimes overlooked. Certainly, suggestion, persuasion, questioning, advice, reassurance, clarification and actions taken in a two party system of healer and to-be-healed is seen by the patient as confrontation. There is am implied--"look here, there is something wrong with how you perceive, think, or act and I will show you what's wrong and how to correct it."[25]

Sacks' notion of a correction invitation[26] is useful here. Churchill defined it as a question which requires "yes" or "no" as an answer with the addition of a correction to the direct answer which corrects an incorrect fact in the initial question.[27] Then the format following the chain rule would be Q, A--either yes or no plus the correction. Churchill posits the general maxim that says:

> Correct incorrect facts in another person' utterances. It is commonly used to teach children proper facts about their language as in [the following] hypothetical example:
>
> Child: Mommy, mommy. Two mouses just ran across the floor.
>
> Mother: No honey. Mice, not mouses.[28]

Continuing with Garner's point of view then, the entire act of psycho-

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[25] Harry H. Garner, "A Review of Confrontation in Psychotherapy from Hypnosis to the Problem-Solving Technique," in <u>Videotape Techniques in Psychiatric Training and Treatment</u>, ed. M. M. Berger (New York: Brown/Mazel, 1970), pp. 3-15, quoted from p. 6.

[26] Harvey Sacks, "The Search for Help" (unpublished doctoral dissertation, Department of Sociology, University of California at Berkeley, 1966), cited in Churchill, <u>Questioning Strategies in Sociolinguistics</u>, p. 62.

[27] Churchill, <u>Questioning Strategies in Sociolinguistics</u>, p. 41.

[28] Ibid., p. 49.

therapy can be viewed as a correction-invitation. A similar example from a psychotherapy session illustrates the proposition that psychotherapy as a whole may be viewed this way.

Example 1-1: Sherry

Pt.: I'm talking about the miracls of their staying and sticking and listening and talking with me, and being... because that's all out of this, I mean, you must know, that when that that was all. I'm if I said it millions of times, maybe millions, in four months, I spent all my waking hours repeating the same things over and over and over, to everybody and anybody who would listen. And I wasn't open to hearing them. And then I started hearing...

Dr.: That's not miraculous. That's an expression of human caring. Some people call it loving. Sometimes it is. Now. But we'll call it for the moment, caring.

This excerpt is further discussed in Chapter 5. The doctor corrects the patient's use of the word "miracle" just as the mother corrects the child. While, on the one hand, the conversation occurring between the doctor and patient is between two adults, on the other, it is between one competent member and one less than competent member. The mode of talk reflects their relationship.

It is the therapist's task to teach the patient a new system for living a more satisfying way of life. The voluntary patient comes because he is in pain and wants that pain removed, but he does not usually expect to give up his old security devices. But therapy is a disillusioning process; as old security devices are given up, the patient develops a new way of looking at the world and begins to deal with the new pains that inevitably arise in life in a healthier way; he can enjoy life more fully. The therapist moves the patient toward new ways of thinking, behaving and feeling, risking new options, showing him that life can be different better. In order to achieve these goals,

however, the therapist needs to work with a cooperative, introspective and non-resistant patient.[29]

In the course of therapy, the therapist utilizes and teaches the patient the following implicit rules of therapy:

1. You must want to get well.
2. Therefore you must cooperate with your doctor.
3. Be yourself.
4. Learn the rules and goals of therapy, e.g., learn about psychodynamics, psychoanalytic interpretations, verbal and nonverbal behavior, and the use of these rules, etc.
5. Present personal material for discussion.
6. End with such practical considerations as the time and place of the next meeting.

These rules are roughly hierarchical in character and are of different importance, yet they are all utilized during the course of psychotherapy sessions. It is in calling these rules into play while doing various therapeutic activities, some of which are under consideration here, that the work of therapy is accomplished. These rules are taken-for-granted by the therapist and ultimately shared by the patient.[30]

The disagreeing devices turn out to be central to the teaching of the hierarchy of rules. Some of these rules contradict each other

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[29]This description of therapy was developed in conversation with Dr. Milton M. Berger.

[30]See Parsons' discussion of rules in The Social System (New York: Free Press, 1951), Chapter 10; and Paul Watzlawick, Janet Helmick Beavin and Don D. Jackson, Pragmatics of Human Communication (New York: W. W. Norton and Co., 1967), p. 245. In this dissertation I focus on disagreeing activities. However, in therapy many activities are accomplished including agreement, support, praise, etc. For a list of activities involved in confrontational therapy, see Milton M. Berger, "Confrontation through Videotape," in his Videotape Techniques in Psychiatric Training and Treatment (New York: Brunner/Mazel, 1970), p. 31.

and the therapist utilizes them as necessary. For instance, while "be yourself" means to be yourself, if being yourself means being non-cooperative, then you can't completely "be yourself." Similarly, while the conversation occurring between a doctor and patient in a helping situation would normally be characterized as polite, rule #4 has many sub-rules which permit impolite talk as well. One of these sub-rules is, from the doctor's point of view, if you don't agree, at times I'll put you down. Nonetheless, in normal everyday conversation, put-downs are expected to be responded to. Churchill discussed this feature of conversation and formulated a denigration maxim: "Respond appropriately to any perceived denigration in question form made of you. Then give the turn back to the requester. In particular, you need not follow any of the earlier maxims [for responding to questions] that might apply."[31] He observes that denigration may be serious, in which case it is impolite, or joking in character. Since some of the rules of ordinary talk are suspended during psychotherapy session,[32] such as "be polite," the patient does not necessarily know when the various ground rules will be called into play or switched. This leaves him open to the double-bind, formulated by Bateson et al.,[33] which can be used therapeutically.[34] As the disagreeing activities discussed

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[31]Churchill, Questioning Strategies in Sociolinguistics, p. 126.

[32]See Turner, "Some Formal Properties of Therapy Talk," for a discussion of this topic.

[33]Gregory Bateson, Don D. Jackson, Jay Haley and John Weakland, "Toward a Theory of Schizophrenia," Behavioral Science 1 (October 1956): 251-64. This article is discussed in Chapter 2.

[34]Therapeutic double-binds are discussed in Watslavick et al., Pragmatics of Human Communication, pp. 240-53. This book is also discussed in Chapter 2.

in this dissertation are presented, the operation of these various rules will be displayed.

The activities I study as part of the larger category of disagreeing activities include: threatening, contradiction, category formation, negative reinterpretation and confrontation. The case will be made that they each stem from a basic yes/no disagreement position. The method used to do the analysis consists of transcribing conversation, collecting instances of the various activities under consideration (which I recognize as a member of the same culture as the therapist and patients producing the talks), and then through comparison with each other and with the surrounding conversation, proposing a set of rules for reproducing each isolable kind of disagreeing activity. Rules or maxims which are (more loosely held guidelines than rules) are proposed which are designed to reproduce each disagreeing type of activity. I have chosen this linguistic criterion as my central methodological principle, rather than the more usual "five per-cent level-of-significance" criterion, because the latter principle does not shed any light on how conversational activities get done.[35] I recognize that videotape would provide richer material to work with, but have used audiotaped material instead for the following reasons: (1) as yet no notation system has been fully developed to describe nonverbal communication (intonation and gesture); (2) where nonverbal communication is a central feature of the communication, I can infer it from the verbal content or it will be called attention to explicitly by the therapist who has a particular interest in nonverbal communication;

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[35]See Churchill, Questioning Strategies in Sociolinguistics, Chapters 1-3 and 9 for further discussion of the value of this method.

and (3) audiotaped material provides an already rich source to begin with, for a beginning analysis of the activity of disagreement.

I turn now to a description of the data collected for this dissertation and its goals. The audiotapes were made available through the generosity of a confrontation psychiatrist.[36] The tapes were selected using three criteria:

1. Clarity, so that transcribing them would be easier to do;
2. Loud, argumentative behavior, which I took as a layman's cue that disagreeing activities would be available to analyze; and
3. Session beginnings and/or endings clearly included on the tapes, since I intended to follow from Turner's analysis.

The patients knew they were being tape recorded and they could shut the machine off at any time. The sessions took place a number of years ago and all identifying information has been changed. The psychiatrist is a middle-aged white male who sees patients in his office. The patients have been described mostly as character neurotics or borderline personalities. The transcripts are based on eleven therapy sessions (45 minutes each) of four female and five male patients.[37] Background information on the patients selected is presented here so that the excerpts discussed throughout the dissertation may be more fully understood. The following demographic and psychiatric characterizations are based on the doctor's descriptions of his patients. The diagnoses are based on DSM-III, a diagnostic and statistical manual developed and periodically up-dated by the American Psychiatric

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[36] I wish to thank Dr. Milton M. Berger for making the data available and providing helpful discussion on various points.

[37] The dissertation includes examples from all but one of these patients.

Association.[38] As noted earlier, resistance is not conducive to a successful therapy. In listening for disagreement, in psychiatric terms, I also chose audiotapes of resistant patients.

The patients are herein called:

JILL--a 20-year-old, '60's "hippie" type of upper middle class background. She was a bright talented young woman who had dropped out of college. She had been hospitalized, and was fearful about going out. Her's is an initial interview.

DAN--a 17-year-old student of upper middle class background. He spent a brief time in therapy and had an oppositional personality disorder.

CARRIE--a 38-year-old middle class woman, working as a travel agent. She was a floundering, self-effacing character neurotic with immaturity, who had difficulty in maintaining relationships.

SHERRY--a mid 30's middle class woman who was unstable and volatile with a borderline personality. She had difficulty in holding a job and in sustaining a relationship with a man.

PHIL--a mid-40's, very successful businessman of the lower upper class, married, with four children. He was self-effacing with a character neurosis, but no major disorder.

BILL--a loner in his late 40's, who never married, from an old-monied Southern family; a borderline personality with obsessive-compulsive and paranoid features. He was distrustful and had difficulty in establishing relationships with others; he was in therapy for many years.

HAROLD--in his early 40's. A brilliant upper middle class professional

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[38] Diagnostic and Statistical Manual of Mental Disorders III (Washington, DC: The Task Force on Nomenclature and Statistics, American Psychiatric Association, 1980).

with a difficult marriage and three children. He experienced anxiety with somatization, and was a character neurotic. He was in therapy for a few years.

ELLEN--a 36-year-old woman married to John (see below) with one child, of an upper middle class background. She was an alcoholic, immature, with a character neurosis who left treatment prematurely. She ultimately left John for another man with whom she presumably had a more stable relationship.

JOHN--a 39-year-old upwardly mobile businessman. He was violent after episodic drinking bouts, and was seen only a few times as an adjunct to his wife's treatment. He was not interested in treatment for himself.

The goals of this dissertation are both practical and theoretical. The practical goal is to get a better understanding of disagreement and disagreeing activities and to show how disagreement is central to the psychotherapeutic relationship in terms of defining the illness, the therapeutic relationship and the treatment process. The theoretical goal is to add to the literature on how reality is created and shared; that is, to add to the developing corpus of knowledge about what rules people appear to follow when they carry out various activities. Therefore, I focus on the above practical problems, to show how those activities are produced and thus maintained by the participants.

In the following chapters, I review the relevant literature of various disciplines; discuss the background conditions of the therapist-patient talk, including power, threat and authority; discuss the structure of basic disagreement as yes versus no; discuss the negotiation of disagreement through the activities of category formation and negative re-interpretation which entails using the devices of examining category

packages, stretching, funnelling, analogy and psychoanalytic interpretation;[39] and analyze the encouragement of change through the activity of confrontation. In so doing, I hope the challenges described above will be met. I turn now to these topics.

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[39]Psychoanalytic interpretation as used here is based on a neo-Freudian model of psychodynamics.

CHAPTER 2

REVIEW OF THE TRADITIONAL LITERATURE

As noted earlier, this dissertation has a number of aims: most importantly to analyze disagreement in a psychotherapeutic setting from a sociolinguistic point of view, specifically using an ethnomethodological and conversational analysis perspective. The topic falls into the interstitial spaces between a few established disciplines. While it relies most heavily on the works cited in Chapter 1, especially Garfinkel, Sacks and Churchill, it also grows out of much established work. In this chapter I will review some of these works from the fields of sociology, psychiatry, communication, interviewing, logic and rhetoric which have a bearing on the problem posed. I do this in order to show why a conversational analysis is appropriate to the task and how the topic selected stems from these various disciplines.

2.1 The Sociological Literature

Substantively, some of the literature on the doctor-patient relationship, small group interaction, the sociology of mental illness, and the sociology of knowledge are relevant to my discussion. Theoretically, they are representative of structure-function theory and interactionist theory.[1] Parsons and Bales are representative of the

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[1]In philosophical terms the literature represents the positivist and phenomenomenological perspectives, respectively.

former theoretical view and Scheff and Goffman of the latter. While the works discussed below speak in some way _about_ the problems raised in this dissertation, none clearly point the way for further elucidation of the kinds of problems I am interested in--_how_ is the activity accomplished?

For instance, Talcott Parsons, a central figure in the structure-function school of sociology and whose work is seminal to the field of medical sociology, posits four aspects of the institutionalized expectation system relative to the sick role. The last two points are relevant to my discussion of the psychotherapeutic relationship. They are:

> One of the principal institutional features of the sick role [is] the expectation of a desire to get well . . . and the relationship is expected to be of mutual "trust," . . . that the physician is trying his best to help the patient and that conversely the patient is "cooperating" with him to the best of his ability.[2]

While these rules that the patient must want to get well and to work towards it, will be referred to repeatedly in the following chapters, Parsons does not show in detail how these rules really work.

Similarly, Robert F. Bales, using the same theoretical perspective, but a different methodological technique, does not show how the activities he recognized occurring in small groups, work either. That is, his system identifies, but does not describe. Bales developed the technique called Interaction Process Analysis[3] which identifies various kinds of disagreeing activities, including: Disagreeing, Showing Tension and Showing Antagonism. But there are two main problems

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[2]Talcott Parsons, _The Social System_ (New York: Free Press, 1951), p. 464.

[3]Robert F. Bales, _Interaction Process Analysis: A Method for the Study of Small Groups_ (Cambridge, MA: Addison Wesley, 1950).

with his system: (1) the latter two categories are crude in that they can be produced in many different ways, and (2) his categories are really recognitions and attributions made by the coder, rather than insolable activities. His system freezes interaction into frequencies of types of behavior. Such statistically-based hypothesis-testing falls into the mainstream of sociological technique but does not answer the main question posed here: how does disagreement get done?

An alternative sociological approach has been developed in the sociology of mental illness field by Thomas Scheff and Erving Goffman, labelling theorists. (Labelling theory falls within the interactionist perspective.) The labelling theorists perceive mental illness as (1) social rule breaking and (2) defining the rule breaker as mentally ill. Scheff writes: "psychiatric symptoms as withdrawal, hallucinations, continual muttering, posturing, etc., may be categorized as violations of certain social norms--those norms which are so taken for granted that they are not explicitly verbalized."[4] He has called these residual rules.

Erving Goffman notes that when psychiatrists define a person as mentally ill, they typically cite aspects of the patient's behavior that is "inappropriate in the situation." The psychiatrists follow that, however, with a study of the offender, rather than a study of the rules and social circles that are offended. Goffman proposes that we (sociologists, psychiatrists, social scientists) study the social rules instead, but has turned to etiquette books as one of the few sources of suggestions about the structure of public conduct in America. He

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[4]Thomas J. Sheff, Being Mentally Ill: A Sociological Theory (Chicago: Aldine Pub. Co., 1966), p. 38.

realizes, however, the limitation of etiquette guides in that they provide us with a catalogue of proprieties rather than an analysis of the system of norms underlying these proprieties.[5] Goffman concludes that a mental symptom is "a situational offense that the offender does not get away with; he is in a position neither to force others to accept the affront nor to convince them that other explanatory grounds ought to be accepted."[6] The ethnomethodologist, on the other hand, studies the behavior and speech directly, instead of making inferences indirectly from etiquette manuals. As we know from our own personal knowledge of the world, how one ought to behave and how we do varies greatly.

In a later work, Goffman incorporated some of the ideas of conversational analysis. In his study of "remedial work" for repairing minor rule-breaking,[7] he describes accounts and apologies as such strategies.

Thomas Scheff, also in a later work, adapts a sociology of knowledge perspective which suggests that people go through their lives constructing reality. (This too broadly falls within the interactionist perspective.) His analysis of power and responsibility as a negotiation

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[5]Erving Goffman, Behavior in Public Places (New York: Free Press, 1963), pp. 3-6.

[6]Ibid., p. 240. Within the sub-field of the sociology of mental illness, Walter Gove, a critic of labelling theory, makes a cogent point when he writes, "the societal reaction perspective does not explain why people initially commit deviant acts; it deals mainly with secondary processes" (p. 882). "Societal Reaction as an Explanation of Mental Illness: An Evaluation," American Sociological Review 35 (1970):873-74.

[7]Erving Goffman, Relations in Public (New York: Basic Books, 1972).

process is based on conversational materials--transcripts of an initial psychiatric interview and a fictional account of a defense for murder.[8] In this article Sheff provides material and analysis useful to a conversational analysis, although this is not his main concern. For instance, he writes, "The more direct the questions of the interrogator, and the more direct the answers he demands and receives, the more control he has over the resultant definition of the situation."[9] However, he does not explain how this occurs; nor does he use a reproduction criterion[10] to determine if his analysis is correct.

Despite the above sociological studies, there has been no systematic study of rule use within psychotherapy. It is the goal of this dissertation to, at least in part, correct this. Thus, I turn now to the field of psychiatry in order to examine the literature relevant to a discussion of disagreement in psychotherapy.

2.2 The Psychiatric Literature

The psychiatric literature has not fared much better than the sociological in the area of disagreement in psychotherapy. That is, the psychiatric literature is enormous, but it basically deals with theories about the dynamics of behavior, much of it ascribed to the

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[8] Thomas J. Scheff, "Negotiating Reality: Notes on Power in the Assessment of Responsibility," Social Problems 16 (1968):3-17. The psychiatric transcript is based on Merton Gill, Richard Newman and Frederick C. Redlich, The Initial Interview in Psychiatric Practice (New York: International Universities Press, 1954). This work serves as the basis of yet another work, The First Five Minutes by Robert F. Pittenger, Charles D. Hockett and John J. Danehy (Ithaca: Paul Martineau Publisher, 1960). Both of these will be discussed further on in this chapter.

[9] Scheff, "Negotiating Reality," p. 16.

[10] See discussion in Chapter 1.

unconscious. Therefore, I exclude the whole body of literature which deals with the psychodynamic theories of Freud, Adler, Jung, Reich, Horney or Fromm-Reichman; although I do touch on the work of Sullivan, Saasz, Laing, and Garner, since their work bears more directly on a discussion of a conversational analysis of disagreement in psychotherapy. The literature I review here deals with the psychiatric interview, the definition of mental illness, psychiatric disease etiology, and the psychotherapeutic process. However, with the exception of the work of Harry H. Garner, not one psychiatrist to my knowledge has looked at confrontation or disagreement from a psychotherapeutic and <u>conversational</u> point of view (as used here).[11]

Harry Stack Sullivan, a neo-Freudian, defines the psychiatric interview as:

> A situation of primarily vocal communication in a two-group, more or less voluntarily integrated, on a progressively unfolding expert-client basis for the purpose of elucidating characteristic patterns of living of the subject person, the patient or client, which patterns he experiences as particularly troublesome or especially valuable, and in the revealing of which he expects to derive benefit.[12]

This definition is useful to a conversational analysis of psychotherapy since it points to the communication between the patient and therapist as the source for the relationship and material to be dealt with. Sullivan did not unfortunately move in the direction of a conversational analysis.

Thomas Szasz, another psychiatrist, also supplies an interesting definition of mental illness in that it is amenable to an analysis

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[11]See footnote 5 in Chapter 6.

[12]Harry Stack Sullivan, <u>The Psychiatric Interview</u> (New York: W. W. Norton, 1954), p. 4.

of mental illness as a form of disturbed communication. The treatment implication again points toward a conversational analysis of what goes on between a psychotherapist and patient. Szasz dispenses with the notion that mental illness is a disease type altogether; rather he defines it as problems in living.[13] Since a medical definition calls forth its own form of treatment, having a social relations problem calls forth another. Szasz sees one aspect of the psychiatrist's role as his being a theoretical scientist who is hired to make his expertise, special knowledge, available to others. This does not imply that the psychiatrist is an expert in his own living, merely that he is functioning at a mature level and has expertise in helping the patient solve his own problems. Szasz' definition of mental illness fits in nicely with Sullivan's definition of the psychiatric interview. Although Szasz continues with an explication of how nonverbal communication can be an indication of mental illness, he also does not move to conversational analysis as the next logical step for an analysis of the psychotherapeutic process.

R. D. Laing has written about the etiology of schizophrenia and the psychotherapeutic process.[14] He emphasizes interaction with others as the key to the "getting sick" and "getting well" processes. For instance, Laing describes the development of the schizoid process to the psychotic break as follows: the process continues until "the individual is beginning to be in a position to feel not only that his

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[13]Thomas Szasz, The Myth of Mental Illness (New York: Harper & Row, 1961).

[14]See, respectively, R. D. Laing, The Divided Self (England: Penguin Books, 1965) and R. D. Laing, The Politics of Experience (New York: Ballantine Books, 1967).

perceptions are false because he is continually looking at things through other people's eyes, but that they are playing him tricks because people are looking at the world through his eyes."[15] The individual becomes unreal and attempts to acquire realness, life, by touching it, copying it and even magically stealing it. Laing defines therapy as the efforts to reach the original "self" which is still a possibility and nurse it back to life.[16] In the sense that the therapeutic relationship should be on an I-Thou level as described by the philosopher Martin Buber,[17] Laing describes this as the patient's-therapist's experiencing of each other. Thus, what becomes important in the relationship is not only what the patient has experienced in the past, but also what the patient and therapist are experiencing in the here and now. "One hears now of therapists giving orders, laughing, crying, even getting up from that sacred chair."[18] In order for the therapist to understand the patient's experience, he must attempt to see it from the patient's point of view to the degree that this is possible, while of course at the same time maintaining his own identity. While Laing comes close to seeing that a conversational analysis is the next step, in that he quotes excerpts from family therapy sessions, and makes frequent use of this in his appendices,[19] the main thrust of his writing is theoretical and not empirical in nature.

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[15] Laing, The Divided Self, p. 144.

[16] In an excerpt from Bill, Ch. 6-25, p. 170, we see the point describing the process, the therapist explaining it and the process of re-education occurring.

[17] Martin Buber, The Way of Response (New York: Schocken Books, 1966).

[18] Laing, The Politics of Experience, p. 47.

[19] See R. D. Laing, A. Esterson, Sanity, Madness and the Family (London: Tavistock Publications, 1964), for an example.

The work of Harry H. Garner is an exception to the previous approaches. Garner, a psychiatrist, has looked at confrontation in psychotherapy from both a psychotherapeutic as well as a conversational point of view. He writes:

> The techniques of therapy applied in confrontation problem-solving psychotherapy include the presentation of a statement and a question. A problem which is crucial but only vaguely recognized or not recognized may be used as a therapeutic focus. It is then clearly stated: "Stop believing that you have nothing to look forward to. What do you think or feel about what I told you?"[20]

As will become apparent in the later discussion on confrontation, we have here the disagreement and twist necessary for confrontation to occur. In Garner's statement, there is the implied "I believe you have something to look forward to" which is the positive statement or disagreement with the patient's position, and the implied surprise or twist, "there is something for you to look forward to." Confrontation as a linguistic technique will be discussed in detail in Chapter 6. The fact that a psychiatrist has discussed it from a conversational point of view is unique in my reading of the literature.

I turn now to the area of communications and review the literature relevant to a sociolinguistic analysis of psychotherapy with attention to both verbal and nonverbal communication.

2.3 The Communications Literature

The communications literature relevant to psychotherapy is discussed in four parts: normal and abnormal communication, verbal and nonverbal communication, the process of communication in psychotherapy,

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[20] Harry H. Garner, "A Review of Confrontation in Psychotherapy from Hypnosis to the Problem-Solving Technique" in Videotape Techniques in Psychiatric Training and Treatment, ed. M. M. Berger, (New York: Bruner/Mazel, 1970), p. 14.

and the contribution of linguistics to psychotherapy. The communications literature is inter-disciplinary and much of it is based on audio- and video-tapes of actual psychotherapy discussion.

The relationship between psychiatry and communication is intimate. As Milton Berger, a leading confrontation psychiatrist, has noted: "improvement of the processes of communication with and to oneself and others is one of the goals of all psychotherapies, whether the therapist is consciously aware of this or not."[21]

2.3.1 Normal and Abnormal Communication

The communications theorists distinguish between "normal" and "pathological" communication as follows: in normal communication we take for granted the existence of at least two speaker-hearers, one of whom sends a message and then receives a suitable response from the other;[22] the message has a shared meaning in that it is understood and responded to. Jurgen Habermas, a sociologist,[23] notes "normal communication conforms to intersubjectively recognized rules; it is public.... In normal communication an intersubjectivity of mutual understanding, guaranteeing ego-identity, develops and is maintained in the relation between individuals who acknowledge one another." In contrast Jurgen

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[21]Milton M. Berger, "Some Implications of Nonverbal Communication in Psychotherapy, Medical Practice, Family Relations and Life in General," International Journal of Social Psychiatry, Congress Issue (1964):21.

[22]Jurgen Ruesch, Disturbed Communication (New York: W. W. Norton Co., 1957), p. 31.

[23]Jurgen Habermas, "On Systematically Distorted Communication," Inquiry 13 (1970):210.

Ruesch[24] notes that disturbed communication can be characterized as:

> Too much,
> Too little,
> Too early,
> Too late,
> At the wrong place,
> Is the disturbed message's fate.

2.3.2 Verbal and Nonverbal Communication

The communication process in psychotherapy consists of verbal communication of conscious and unconscious processes and non-verbal communication in the form of body language. Berger defines nonverbal communications as: "all those manifest and latent messages, other than verbal, which reach our selves and others about our selves and others and the time-space-continuum of the world we live in."[25] Ruesch and Szasz categorize verbal and nonverbal communication as follows: Ruesch distinguishes between (a) sign language, e.g., words, gestures, (b) action language, e.g., movements such as walking, drinking, and (c) object language, which comprises all intentional and non-intentional displays of material things such as art objects, the human body, clothes, etc., and Szasz distinguishes between "language," "sign" and "symbol,"[26]

The literature on body language is growing and some has even appeared on the best seller list. For instance, Fast's book, Body Language[27] is about messages we send nonverbally indicating our being

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[24] Ruesch, Disturbed Communication, p. 41.

[25] Berger, "Some Implications of Nonverbal Communication," p. 2.

[26] Thomas S. Szasz, The Myth of Mental Illness (New York: Hoeber-Harper Book, 1961), p. 116.

[27] Julius Fast, Body Language (New York: Pocket Books, 1974).

"open" or "closed" to other people. Scheflen[28] gives us a similar description of nonverbal body language indicating alliances and antagonism among family members in a therapy situation. Berger [29] writes about nonverbal communication describing how eyes and facial expressions can inform us of many different kinds of feelings in relation to oneself, such as anxiety, anger, jealousy, inner peace, depression, rigidity or emptiness, and questioning, killing, helplessness, independence, withdrawness, agreement or embarrassment in relation to others. He has also described the use of nonverbal communications as a therapeutic technique in group psychotherapy.

2.3.3 The Process of Communication

Reusch and Habermas discuss language problems as indicative of various mental illness disease types. Ruesch[30] notes that the psychiatric patient's problem "may reflect primarily a lack of mastery of nonverbal codifications, verbal codifications or deficient synchronization between the two methods of codification." The neurotic patient transmits his message over and over again the hope of being eventually understood.[31] Thus his attempt to control the situation by his use of language appears in the form of rigidity and compulsory repetition.

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[28]Albert E. Scheflen, "Communication and Regulation in Psychotherapy," Psychiatry 26 (1963):126-36.

[29]Milton M. Berger, "Nonverbal Communication in Group Psychotherapy," Group Psychotherapy and Group Function, ed. M. M. Berger and M. Rosenbaum (New York: Basic Books, 1963), p. 429.

[30]Jurgen Ruesch, "Nonverbal Language and Therapy," Psychiatry 18 (1955):326.

[31]J. Ruesch and Gregory Bateson, Communication: The Social Matrix of Psychiatry (New York: W. W. Norton, 1951), p. 89.

Habermas describes this process as follows: "Stereotyped behavior patterns recur in situations involving stimuli which cause emotionally loaded reactions. This inflexibility is symptomatic of the fact that the semantical content has lost its specific linguistic independence of the situational context."[32]

The psychotic patient, on the other hand, has difficulties not only with the communicational content, but also with the communication sender-receiver process. Ruesch notes that consequently he misinterprets messages (receives them incorrectly) and is unable to correct the information he already has. This leads him to continually build a more distorted model of himself in relation to the world.[33] Habermas views the psychotic patient as experiencing two types of deficiencies in communication and thought content: (1) "amorphous" speech disorders involve a fragmentation of structure which does not allow disintegrated single elements to be compiled into classes according to general criteria, and (2) "fragmented" speech disorders involve an amorphous structure which does not allow aggregates of superficially similar and vaguely compiled things to be analyzed.[34] For Habermas this becomes similar to having problems with the process of inductive and deductive reasoning.[35]

One of the most important theoretical works about communication and psychopathology is Bateson, Jackson, Haley and Weakland's theory of

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[32]Habermas, "On Systematically Distorted Communication," p. 207.

[33]Ruesch and Bateson, Communication, p. 88.

[34]Habermas, "On Systematically Distorted Communication," p. 213.

[35]See Chapter 5 on category formation for further discussion of this process.

communication in the development of schizophrenia.[36] They call this the double-bind theory as it involves continuously receiving simultaneous verbal and nonverbal messages which are contradictory. Because the victim cannot comment on the nature of the message itself, he opts out of this damaging communication system by turning to the world of metaphor and inappropriate behavior as a response. This theory suggests that schizophrenic behavior is a learned response which could then be unlearned in a healthy, communicational system, such as in therapy. The theory is based on Russell's Theory of Logical Types which states that "there is a discontinuity between a class and its members. The class cannot be a member of itself nor can one of the members be the class, since the term used for the class is of a <u>different level of abstraction</u>--a different Logical Type--from terms used for members."[37] The authors note that these are continuously breached in actual communication. While the theory itself remains an exciting one, there are problems with it. First, although the authors don't say so overtly, they do suggest the concept of a schizophrenogenic mother in particular or at least family pathology. Second, they have difficulty in showing how the theory operates in practice. There is a looseness of fit between the theory and family dynamics. R. D. Laing and others[38] have continued Bateson's work and have made a strong

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[36] Gregory Bateson et al., "Toward a Theory of Schizophrenia," <u>Behavioral Science</u> 1 (October 1956):251-264.

[37] Ibid., p. 251. For further discussion see Alfred North Whitehead and Bertrand Russell, <u>Principia Mathematica</u> (Cambridge: Cambridge University Press, 1910).

[38] Laing and Esterson, <u>Sanity, Madness and the Family</u>. The field of family therapy pioneered by Nathan Ackerman rests on the notion of the entire family as patient. See N. Ackerman, "Family

case for the above, however. And finally the authors don't explain why the victim can't respond to the double message, other than fear of loss of love, etc. That is, they resort to psychoanalytic theory to explain their communications theory. Nevertheless, it remains an important theory of schizophrenia, even if we ultimately find there are constitutional predispositions for acquiring it.

Watzlawick, Beavin and Jackson[39] wrote a text on communication and psychotherapy in which they draw broadly on a number of disciplines including psychotherapy, communication, mathematics, philosophy, systems theory and literature. They emphasize the concept of paradox which they define as a "contradiction that follows correct deduction from consistent premises"[40] which they use to explain mental illness, therapeutic process, and even the ultimate paradox of man's existence. They connect therefore Bateson's theory of the double-bind,[41] Russell's theory of logical types,[42] Godel's proof of formally undecidable propositions,[43]

Therapy," American Handbook of Psychiatry, ed. S. Arieti (New York: Basic Books, 1966), Vol. 3, Chapter 14.

[39]Paul Watzlawick, Janet Helwick Beavin and Don D. Jackson, Pragmatics of Human Communication (New York: W. W. Norton & Co., 1967).

[40]Ibid., p. 188.

[41]Bateson et al., "Toward a Theory of Schizophrenia"

[42]Whitehead and Russell, Principia Mathematica.

[43]Watzlawick, et al.,Pragmatics of Human Communication, p. 269. Kurt Godel, "Uber formal unentschiedbare Satzeder Principia Mathematica und verwandter Systeme I." in Monatschefte fur Mathematik und Physik 38(1931):173-98 (English translation, "On Formally Undecidable Propositions of Principia Mathematica and Related Systems I."), Edinburgh and London: Oliver and Boyd, 1962). Godel proves that any formal system is necessarily incomplete and that the consistency of such a system can only be proven by recourse to methods of proof that are more general than those the system itself can generate.

and Wittgenstein's philosophical formulation of proof theory.[44].
They also discuss the paradoxical injunction, "be spontaneous."[45]
The authors do not use examples from natural language nor review the literature on verbal and non-verbal communication, but they do provide a synthesis which is both interesting and historically important, since this work is one of the earliest to attempt an integration of so many different fields.

2.3.4 Linguistics and Psychotherapy

R. H. Wolcott[46] writes about language use in the psychotherapy of schizophrenics. In fact, for Wolcott, the disease itself is a problem of language. Schizophrenia is a private language that is based on a private meaning system of private objects which are inner, unknown, and unshared. Yet two types of inter-subjectivity are still possible: predictive joint-meaning and topical joint-meanings. It is the therapist's task to decipher the grammar and vocabulary of an unfamiliar language in order to help the patient find his true "self" and let it develop truly--not simply to create the behavior of a more "normal" person. The similarity in conception of the disease and therapy process to Laing[47] is obvious.

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[44]Watzlawick et al., Pragmatics of Human Communication, p. 270. Ludwig Wittgenstein, Tractatus Logico-Philosophicus (New York: Humanities Press, 1951). He "shows that we could only know something about the world in its totality if we could step outside it; but if this were possible, this would no longer be the *whole* world."

[45]Watzlawick et al., Pragmatics of Human Communication, p. 199.

[46]R. H. Walcott, "Schizophrenia as a Private Language," Journal of Health and Social Behavior 12 (1970):126.

[47]Laing, The Divided Self.

Spence, and Mazzanti and Bessell have used a linguistic approach to help to understand the therapeutic process, but again neither study employs conversational analysis from an ethnomethodologic perspective. Spence[48] describes the therapist's search for the patient's meaning of his statements as leading him to focus on the sign (the word itself in linguistic usage) rather than the significate (what the word conveys). For instance, in ordinary conversation when we hear a slip of the tongue, we fill in the right word verbally or mentally. We listen to what is being talked about (the significate). The therapist, on the other hand, focuses on the mistake and the word itself; the sign becomes the object of interest. Freud's use of the term, "free-floating" attitude, implies a similar phenomenon.

Mazzanti and Bessell[49] describe the therapeutic communication process as the utilization of a latent language by the patient. In this case, the patient will attribute his own feelings and behaviors to a third person in order to find out how someone else (usually the therapist) will react to it. In the non-therapeutic situation, in ordinary conversation between two persons, this might be called diplomacy or tact.

The close relationship between communication and the therapy process has been expressed by Laing, Scheflen, Lennard and Bernstein and Bateson as well. For Laing, Psychotherapy must be an obstinate attempt of two people to recover the wholeness of being human through

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[48] E. P. Spence, "The Processing of Information in Psychotherapy: Some Links with Psycholinguistics and Information Theory," Behavioral Science 13 (1968):349-361.

[49] V. Mazzanti and H. Bessell, "Communication Through the Latent Language," American Journal of Psychotherapy 10 (1956):250-260.

the relationship between them.[50] Scheflen[51] and Lennard and Bernstein[52] view the functions of communications in psychotherapy as (1) the transmittal of new information and (2) the reduction of ambiguity. Bateson[53] uses the term "deutero-learning" to describe the communication process in psychotherapy: that is, one learns not only what one is supposed to learn, but also something about the process of learning itself. Ideally, the new patterns of behavior learned in the therapeutic hour will then be utilized in the other 23 hours of the day as well.

Lastly I turn to two works which are linguistic in their orientation. The First Five Minutes[54] is unusual in its format in that the data and the linguistic analysis are presented on the top of the page and the psychological analysis is presented on the bottom. The pages are cut in half for easy access to each analysis. It is also unusual in that natural conversation is used which is taken from another study, The Initial Interview in Psychiatric Practice.[55] The work shows how linguists and psychiatrists can listen differently for different things and help each other. The authors are particularly mindful of nonverbal messages and boundary-markers for the change of topic. They also relate

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[50] Laing, The Politics of Experience, p. 53.

[51] Scheflen, "Communication and Regulation in Psychotherapy."

[52] H. Lennard and A. Bernstein, The Anatomy of Psychotherapy (New York: Columbia University Press, 1960).

[53] Gregory Bateson, "Social Planning and the Concept of 'Deutero-Learning'" in Science Philosophy and Religion, Second Symposium (New York: Harper and Bros.,1942), pp. 81-97, cited in Lennard and Bernstein, p. 27. Originally called "Social Planning and the Concept of 'Deutero-Learning' in Relation to the Democratic Way of Life."

[54] Pittenger et al., The First Five Minutes.

[55] Gill et al., The Initial Interview in Psychiatric Practice.

their work to Reusch and Bateson's work[56] on language and psychotherapy and suggest that a study of the interrelationships of these disciplines will have practical application for the training of future psychotherapists.

Using an even more linguistic approach, Labov and Fanshel[57] base their work on psychotherapy as conversation on the work of Bales[58] and on Sacks, Schegloff and Jefferson.[59] In their words, "the central innovation of [their] approach is the view that sequencing rules operate between abstract speech actions, and that they often are arranged in a complex hierarchy."[60] Labov's background as a linguist is quickly evident as he states that the concept of hierarchical organization as they use it is plainly derived from the linguistic analysis of phonology and grammar. Their work is important as a parallel development in the linguistic field.

Thus, although the literature on communication and psychotherapy is vast, again, little of it is of direct value to a conversational analysis of psychotherapy or disagreement. It is, I believe, of immense value as background to the problem and it is in this light that this review is presented. I turn now to the interviewing literature.

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[56] Ruesch and Bateson, _Communication_.

[57] William Labov and David Fanshel, _Therapeutic Discourse: Psychotherapy as Conversation_ (New York: Academic Press, 1977).

[58] Bales, _Interaction Process Analysis_.

[59] Harvey Sachs, Emanuel Schegloff and Gail Jefferson, "A Simplest Systematics for the Organization of Turn-Taking for Conversation," _Language_ 50 (1974):696-735.

[60] Labov and Fanshel, _Therapeutic Discourse_, p. 350.

2.4 The Interviewing Literature

The interviewing literature represents a cross-section of works written by sociologists, psychiatrists, psychologists, and social workers. Most of it deals with either statistical correlation on such variables as the background characteristics of the interviewers or interviewees, or "insight" papers where the authors intuitively "see" a lot of instances of questioning behavior. In most of these works it is the information learned during the course of an interview that is important, not the interaction per se. It is assumed that we all know how to ask questions. I will briefly look at the works of Gorden, and Merton and Kendall (sociologists), Gill, Newman and Redlich (psychiatrists), Sheatsley, and Kahn and Cannell (psychologists) and Kadushin, Schubert, and Benjamin (social workers).

Gorden, a sociologist, has written what is considered a basic text on interviewing,[61] yet provides us with few examples from a transcript of an interview. Interviewing is viewed as an information-gathering tool and he covers such topics as the ethics of interviewing, nonverbal communication, and leading questions. He tells us about interviews, but not how interviewing is actually done.

Merton and Kendall, renowned sociologists, developed the focused interview[62] in order to combine the best of the non-directive

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[61] Raymond L. Gorden, Interviewing: Strategy, Techniques and Tactics, rev. ed. (Homewood, IL: Dorsey Press, 1975).

[62] Robert K. Merton and Patricia L. Kendall, "The Focused Interview," American Journal of Sociology 51 (1946):541-47. Cited in John Madge, The Tools of Social Science (Garden City, NY: Doubleday Anchor Book, 1965), p. 180; or Robert K. Merton, M. Fiske and P. L. Kendall, The Focused Interview: A Manual of Problems and Procedures (New York: Free Press, 1956).

interview and survey questionnaire. As an interested, yet detached listener, the interviewer is supposed to ask non-directive questions focused on a specific topic in order to ascertain the interviewee's definition of the situation. The authors use the concepts of non-direction, specificity, range and depth, and personal context in order to describe a focused interview. Although this was written as an interview manual, and attention is paid to what kinds of questions to ask, there is only a little information on how to do questioning and that is done by way of example rather than the primary focus. Nevertheless, it is one of the earliest works (published in 1946) leaning toward this direction.

The Initial Interview in Psychiatric Practice,[63] by three psychiatrists, Gill, Newman and Redlich, is quite interesting. Published in 1954, it came with phonograph records. The major part of the book is devoted to transcripts of three interviews with commentary on the facing page. The authors advocate an initial interview which stresses the appraisal of the patient and the reinforcement of his desire to help, rather than a strictly diagnostic interview or the non-directive interview. They also encourage the use of "electrically recorded interviews for teaching and research."[64] Although it is exemplary of the "insight" kind of work, it remains unusual and innovative in its time. There is no systematic analysis, however, of the kinds of activities which occur during the questioning-answering process. It also served as the basis for Pittenger, Hockett, and

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[63] Gill et al., The Initial Interview in Psychiatric Practice.

[64] Ibid., p. 413.

Danehy's work, The First Five Minutes[65] and Scheff's article on negotiating reality.[66]

Sheatsley writes about "The Art of Interviewing" in the classic book, Research Methods in Social Relations.[67] Since the book is geared to survey research, I believe he stresses the "importance of asking each question exactly as it is worded."[68] The interview becomes an expensive tool for the survey-taker if he is only to recite pre-coded questions from a questionnaire, rather than probe and explain by asking open-ended questions. He stresses, "The first requisite for successful interviewing, therefore, is to create a friendly atmosphere and to put the respondent at his ease."[69] Sheatsley does discuss biasing factors introduced by the interviewer; that is, he notes, for instance, that the racial, religious, and sexual (my addition) background of the interviewer and interviewee can affect the results. Nonetheless, he is not concerned with the process of asking questions per se.

Kahn and Cannell,[70] also psychologists, based their orientation on Roger's non-directive, client-centered interview.[71] It is a

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[65]Pittenger et al., The First Five Minutes.

[66]Scheff, "Negotiating Reality."

[67]Paul b. Sheatsley, "The Art of Interviewing," in Research Methods in Social Relations, ed. Claire Selltiz et al., rev. ed. (New York: Holt, Rinehart & Winston, 1959), pp. 574-87.

[68]Ibid., p. 576.

[69]Ibid., p. 575.

[70]Robert L. Kahn and Charles F. Cannell, The Dynamics of Interviewing (New York: John Wiley & Sons, 1957).

[71]Carl R. Rogers, Counseling and Psychotherapy (Cambridge, MA: Houghton Hifflin Co., 1942).

very thorough work of the standard interviewing kind and includes many examples, some from natural conversation. It is somewhat unusual in that the last third of the book consists of transcripts of four interviews. But it is limited in its usefulness if we wish to learn how interviewing actually gets accomplished.

Kadushin and Schubert have both written about interviewing for social workers. Schubert's short work,[72] published by the Council on Social Work Education, is typical of this kind of literature. She writes <u>about</u> beginning and ending, using your time, the physical setting, topics to cover and reactions of the client and worker to the helping situation. Her conclusion, "the basic rules are simple, but as this presentation attests, they are not always easy to follow," I believe, presents the case for a conversational analysis of how an interview is accomplished. Kadushin[73] also writes about the phases of a helping interview--the introductory phase, developmental phase, development and termination.

In my review of this literature, I have come across only one work, Alfred Benjamin's <u>The Helping Interview</u>,[74] which is, in my opinion, asking the right questions. He begins to examine the activity of interviewing. He looks at bombardment, silence, mm-hm, restatement, clarification, interpretation, advice, moralizing, disbelief, contradiction, threat and punishment, among other activities. His many

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[72]Margaret Schubert, <u>Interviewing in Social Work Practice</u> (New York: Council on Social Work Education, 1971).

[73]Alfred Kadushin, <u>The Social Work Interview</u> (New York: Columbia University Press, 1972).

[74]Alfred Benjamin, <u>The Helping Interview</u>, 2nd ed. (Boston: Houghton Mifflin Co.,1974).

examples from natural conversation are from his own experience, since he is a rehabilitation counselor in Israel. He does the beginning of conversational analysis and writes "to me an interview is a conversation between two people."[75] He also discussed audiotape and videotape as a means of recording the interview, especially as a learning tool. This source, more so than any other of the interviewing works, was of direct help in my analysis of the transcripts.

Thus, while the interviewing literature is very broad as it comes from the diverse fields of sociology, psychiatry, psychology, and social work, only Benjamin's work is in the direction of conversational analysis. And even he writes in the preface to the second edition that the most serious criticism he has received is that the book is weak on theory and too strong on the "cookbook" side. Nevertheless, this "cookbook" style work is printed in many languages, which makes me believe that a conversational analysis of an interview is useful.

Lastly, I turn to a very different topic, logic, which has some bearing on my topic--a conversational analysis of disagreement.

2.5 Logic and Rhetoric

In this section I examine two works--one on logic and the other on argumentation, a kind of rhetoric. Argumentation in particular is relevant to the notion of convincing, that somehow the psychotherapist has to "change" the patient's mind. As will be apparent, they relate to a discussion of confrontation which is analyzed in Chapter 6.

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[75] Benjamin, The Helping Interview, p. xii

Black defines logic as the study of reasoning.[76] He discusses propositions and the use of Venn diagrams, which influenced my thinking about category formation (Chapter 5). He also discusses fallacies as errors in reasoning which are persuasive to the speaker or hearer in spite of their unsoundness, relevant to my discussion of confrontation (Chapter 6). Black's work led me directly to Schopenhauer's essay, "The Art of Controversy"[77] wherein the latter describes the essential nature of every dispute and strategems to win them.

For the ancient philosophers, such as Plato, Aristotle, Diogenes Laertius, Cicero and Quintilian, the terms logic and dialectic were synonymous.[78] For Schopenhauer dialectic is the art of getting the best of logic in a dispute. However, for him, the 38 strategems remain at the level of tricks. He writes: "It would be a very good thing if every trick could receive some short and obviously appropriate name, so that when a man uses this or that particular trick, he could at once be reproached for it."[79] Some of the strategems he described are apparent in the excerpts presented in Chapter 6 and posited by Churchill and me in the confrontation paradigm. They are available to all competent members. While Schopenhauer described the devices, he did not show how they are accomplished, in the same way that most of the interviewing literature is _about_, rather than an explanation _of_.

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[76] Max Black, _Critical Thinking_ (Englewood Cliffs, NJ: Prentice-Hall Inc., 1952), p. 3. See also his Chapters 7 and 12.

[77] Arthur Schopenhauer, _The Art of Controversy_, translated by T. Bailey Saunders (New York: Macmillan & Co., 1896).

[78] Ibid., pp. 1-4.

[79] Ibid., p. 12. He bemoans the loss of Theophrastus' writing on Rhetoric which may have already done so.

Nonetheless, taking Schopenhauer's point of view suggests that both trial lawyers and psychiatrists could benefit from the inclusion of argumentation in their education since both use interrogation in their practices.

To summarize Schopenhauer's position, he states there are two ways of refuting a thesis: we may show either that the proposition is not in accordance with the nature of things, or that it is inconsistent with other statements or admissions of our opponent. We may pursue either direct or indirect refutation. The direct refutation attacks the reason for the thesis; the indirect, its results. The direct refutation makes use of the diversion wherein the conclusion is false or the instance, which is an example to the contrary.[80] He concludes therefore:

> The only safe rule, therefore, is that which Aristotle mentions in the last chapter of his Topica: not to dispute with the first person you meet, but only with those of your acquaintance of whom you know that they possess sufficient intelligence and self-respect not to advance absurdities; to appeal to reason and not to authority, and to listen to reason and yield to it; and finally, to cherish truth, to be willing to accept reason even from an opponent, and to be just enough to bear being proved to be in the wrong, should truth lie with him. From this it follows that scarcely one man in a hundred is worth your disputing with him.[81]

To paraphrase, peace is better than truth.

This was written about 150 years ago,[82] yet these ways of doing argumentation are still employed today. It would seem then that a skilled logician might frustrate a less skilled psychiatrist. That is

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[80] Schopenhauer, The Art of Controversy, p. 13.

[81] Ibid., pp. 47-48. See Aristotle, Topica, Book viii, for his rules of argumentation.

[82] Schopenhauer lived from 1788-1860; this essay was published posthumously in 1896.

precisely why the patient must be a voluntary one. By coming voluntarily, he admits his need for help. Rule #2, cooperate is of a higher order than rule #3, be yourself. Therefore, the therapist could call the cooperate rule into play, and if it didn't work, would consider the patient's behavior a block to the source of his troubles. The patient would also learn rule #4, the rules and goals of therapy, which include accepting the concepts of conscious and unconscious reasons for one's behavior. If rules #2 and 4 did not operate so as to sanction his behavior and improve his mental health, the therapist should after a trial period, suggest that the patient work with someone else, who could break through the patient's resistance.

* * *

To conclude this chapter then, I have reviewed literature from the fields of sociology, psychiatry, communications, interviewing, and logic and rhetoric in order to show their relationship to a conversational analysis of therapy. By reviewing the traditional literature, I believe I have strengthened the case for why a conversational analysis from an ethnomethodological perspective is necessary. I turn now to the data of this case study. I begin with a discussion of the background conditions prevailing in a psychotherapy setting and then do a conversational analysis of disagreeing activities.

CHAPTER 3

THE PSYCHOTHERAPEUTIC RELATIONSHIP: EVERYDAY TALK IN AN UNCOMMON SETTING

The purpose of this chapter is to provide a general introduction and description of the therapeutic relationship. I propose that the therapist and patient engage in normal everyday speech activities, but the power of their talk lies in the special features of the therapeutic relationship, namely, that the patient may be held accountable for everything he says and the patient does not know when the therapist will move him from an equal to unequal and subordinate role. In order to see how rules are used in therapy, two activities, threatening and displaying authority, are examined.[1] I begin this discussion with an overview of the goals of therapy, rules specific to the therapy situation, a description of the power and service aspects of the relationship and finally the setting, so that the operation of the above mentioned rules may be understood in its context. I then present examples from therapy to see how the everyday rules and rules of therapy are used.

The Goals of Therapy

As stated in Chapter 1, the purpose of therapy is to help the patient live a more satisfying life. Thus, the patient must give up some of the security devices he presently uses and his old way of

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[1] Although these activities were produced in the therapy sessions analyzed here, this does not imply that they must necessarily be produced in other sessions.

seeing the world and learn new ways of coping with life's stresses. These new healthier strategies for dealing with problems should result in less psychic pain for the patient and an increased enjoyment of life. However, how the work of therapy actually gets accomplished is unclear. I submit that the patient presents personal material upon which the doctor can comment, and it is through such routine talk that the work of therapy is done. Thus therapy may be viewed as a correctioning process.

Although there is a basic agreement among psychotherapists that personality change is one of the goals of therapy, there is no such agreement about how to achieve that end. The following quotes are descriptions, from psychotherapists, of how they believe they go about achieving their goals and doing the work of therapy.

Karen Horney writes:

> My main objective in therapy is, after having recognized the neurotic trends, to discover in detail the functions they serve and the consequences they have on the patient's personality and on his life. . . . If analysis . . . of the actual neurotic structure, helps the individual . . . , if he gains in inner strength . . . he no longer needs his safety devices, but can deal with the difficulties of life according to his judgment. . . . I hold that the aim of analysis is not to render life devoid of risks and conflicts, but to enable an individual eventually to solve his problems himself.[2]

Carl Rogers notes: "Intermingled with this process of insight . . . is a process of clarification of possible decisions, possible courses of action. . . . Then comes . . . the initiation of minute, but highly significant, positive actions."[3]

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[2]Karen Horney, New Ways in Psychoanalysis (New York: W. W. Norton & Co., 1939), pp. 281, 305.

[3]Carl R. Rogers, Counseling and Psychotherapy (Cambridge, MA: Houghton Mifflin Co., 1942), p. 41.

Milton Berger writes:

> It is the task of the therapist and patient together to free the patient's energies and capacity for risk-taking so that he can now choose to take action from amongst the expanded options available to him through therapy. . . . As there develops more of self to experience, more of what there is to experience develops; as there is more space and freedom to move about in, more space becomes available.[4]

Allen Wheelis writes:

> The most common illusion of patients and strangely, even of experienced therapists, is that insight produces change; and the most common disappointment of therapy is that it does not. Insight is instrumental to change, often an essential component of the process, but does not directly achieve it. The most comprehensive and penetrating interpretation -- true, relevant, well expressed, perfectly timed -- may lie inert in the patient's mind. . . . The therapist . . . should [say] 'What are you going to do about it?' . . . Some patients don't want to change and when a therapist takes up the task of changing such a one, he assumes a contest which the patient always wins.[5]

Nicholas Hobbs takes the position that

> insight may have nothing to do with behavior change at all. . . . You may have noted in the preceding arguments not only a strong disavowal of the efficacy of insight as a change agency, but also the strong emphasis on specific and concrete opportunities for learning new ways of responding, new ways of relating to other people, and new ways of perceiving oneself. . . . There is an implicit invitation to recast the analysis in terms of learning theory of a general reinforcement type.[6]

The essential vagueness of the therapists' descriptions is readily apparent. Thus I intend in this chapter and throughout the dissertation to describe in more detail some of the activities

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[4]Milton M. Berger, "The Relationship of Increasing Options to Choice--The Human Prerogative," submitted November 1, 1971 to American Journal of Psychoanalysis, p. 5.

[5]Allen Wheelis, "How People Change," Commentary (May 1969): 56-66.

[6]Nicholas Hobbs, "Sources of Gain in Psychotherapy," American Psychologist 17 (November 1962):741-47; also appearing in Social Work Processes, ed. by B. Compton and B. Galways (Homewood, IL: Dorsey Press, 1975).

therapists and patients engage in to achieve personality change, and hence, do correction. I conclude from the therapists' descriptions that the patient changes himself, but the therapist provides the encouragement to do so. This suggests that the patient enters therapy by taking one position, the "sick" one and the therapist presents an alternative position, the "healthy" one. This difference of position can be seen as a disagreement between them. Thus, disagreement is a central aspect of defining the illness and the treatment process. The former case was presented in Chapters 1 and 2 and the latter case is presented in Chapters 4-6.[7] In this chapter, I describe the relationship between the doctor and his patients and show through the activities of threatening and displaying authority that disagreement is central to their relationship as well. I turn now to the use of rules in therapy in order to show that the participants utilize everyday talk in an uncommon setting, that is, a setting with its own rules.

Rules of Therapy

The following implicit rules of therapy were presented in Chapter 1.

1. You must want to get well.
2. You must cooperate.
3. Be yourself.
4. Learn the rules and goals specific to therapy.
5. Present personal material.
6. Discuss the time and place of the next meeting.

As the activities produced in the treatment process are analyzed, the above hierarchy of rules will be referred to. In fact, it is in the

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[7]See Laing, Chapter 1, footnote 8 and Garner, Chapter 1, footnote 23. Also Chapter 2, section 2 for amplification. In Chapters 4 through 6, I present the case that the activities of contradiction, negative re-interpretation and confrontation are disagreeing activities.

accomplishment of the disagreeing activities that the rules are made visible and vice versa. That is, the therapist may call attention to these rules in the course of doing disagreement. The origins of rules one and two were discussed in Chapter 2.[8] While it could be argued that rule #4 encompasses all the others, rule #4 refers to learning the language of therapy and how to use that language, such as making interpretations, catching patterns in one's behavior, being introspective, etc. Rule #3 is substantially different and sufficiently central to the therapeutic process to be a separate rule. Rule #5 refers to the content of the talk that is presented. Rule #6 is specific and certainly of a different order than the others. Turner discussed this rule by distinguishing it as "business" separate from "therapy talk."[9] I include it here, yet list it separately, since it occurs in every therapy session, save the last one. The last two rules are really areas for discussion and not further developed in this dissertation. The others are referred to throughout the analysis of disagreeing activities.

Therapy as a whole may be characterized as consisting of everyday talk, but with the normal constraints of everyday conversation suspended.[10] Alternatively, it may be viewed as everyday talk with its own special rules. Rule #3 and especially rule #4 require that once a therapy session has begun, the patient may be held accountable

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[8] See T. Parsons' work discussed in Chapter 2, section 1.

[9] Roy Turner, "Some Formal Properties of Therapy Talk" in Studies in Social Interaction, ed. D. Dusnow (New York: Free Press, 1972), p. 396. See also Chapter 1.

[10] Ibid., pp. 393, 396.

for everything he says and his utterances are treated as data by the therapist. This requirement of therapy transforms the conversation into a series of correction-invitations.[11] It is not usual to have to potentially provide a reason for everything we say. In addition, the therapist listens carefully to the patient's utterances to search for patterns in accordance with his psychoanalytic theories. As a practical matter, the therapist listens for inconsistency and incongruity.[12]

The therapist has available to him rules 1-4 which he may use at any time in the course of the conversation. Thus, using Rule #4, he may not only question the grounds of the patient's statements at any time, but may also contradict, re-interpret, confront, etc. In short, in his position of therapist he may engage in disagreeing activities which would otherwise appear impolite or even rude in everyday talk. They are not viewed as impolite in the therapeutic context because the patient acknowledges the therapist's expertise and views his behavior as part of a therapeutic strategy. The importance of this perception on the part of the patient is considered in the discussion of the use of threat and authority.

In addition, the grounds of the therapist-patient relationship may also be shifted through the use of these rules. Thus, at one point the therapist and patient may be engaged in the work of therapy as equqls, and at another point the therapist may assume the role of

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[11] See Chapter 1, footnote 24 and the discussion of correction in therapy in Chapter 1.

[12] See Chapter 6 for my discussion of the importance of inconsistency and Chapter 4 for a discussion of incongruency.

expert and thus place the patient in a subordinate position. Hence they are no longer equals. The patient, however, does not know when this shift will occur. The fact that the grounds of their relationship may be shifted at any time is also used therapeutically and makes the conversation occurring in the therapy situation potentially different from ordinary conversation.

These rules, specific to the therapy situation, change the grounds and rules used in everyday talk. In the next section, I focus on the power and service aspects of their relationship and then describe the physical setting where the data I use was collected. I do this in order to understand the context in which the activities of threatening behavior and displaying authority will be discussed.

The Power Aspect of the Relationship

Power has been defined as the capacity of an individual or group to control or influence the behavior of others. Authority refers to legitimate power.[13] Power is a relational concept and usually refers to an unequal relationship. The therapist has power over the patient; he influences him. The therapy takes place in the therapist's office, his home territory, with the client coming for help. The patient views the therapist as an appropriate source to request help with his emotional problems. When the patient comes voluntarily, and acknowledges the therapist's expertise, the therapist has legitimate authority in the patient's eyes. This leads to accepting rules #1 and #2--you must want to get well and you must cooperate--and hence to accepting the hierarchy.

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[13] James W. Vander Zanden, Sociology, 4th ed. (New York: John Wiley & Son), p. 502.

Yet at the same time, the therapy relationship is one between two equals, two people affirming each other in a genuine relationship.[14] As Karen Horney states it, they are on "the road to reorientation through self-knowledge."[15] The psychotherapeutic relationship is different from the usual doctor-patient relationship where the patient is acted upon, given treatments or medications of some kind. Rather, it is characterized by the patient's active participation and collaboration in the treatment process.[16] Together they search for understanding that will lead to change and growth.

Thus the therapeutic relationship begins with an inherent contradiction: its participants are equals and unequals at the same time. The therapist utilizes this fact in the therapeutic relationship.

The Service Relationship

Implicit in the therapeutic relationship, whether verbalized or not, is the fact that this is a service relationship, with the patient in the role of customer who just be satisfied with the treatment he is receiving, and the therapist in the role of seller who must make it known to the prospective buyer that his treatment method is a good one

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[14] I use the term "genuine relationship" to imply an "I-Thou" dialogue. This latter description is employed in M. M. Berger, Videotape Techniques in Psychiatric Training and Treatment (New York: Brunner/Mazel Publishers, 1970), p. 93. See Martin Buber, The Way of Response (New York: Schocken Books, 1966), for further description.

[15] Karen Horney, Neurosis and Human Growth (New York: W. W. Norton & Co., 1950), p. 341.

[16] Jerome Frank, "The Dynamics of the Psychotherapeutic Relationship," in Mental Illness and Social Processes, ed. T. Scheff, (New York: Harper & Row, 1967), p. 184. This article originally appeared in Psychiatry 22 (February 1959):17-34.

and will be useful to him. The patient has the power to shop around or leave treatment.

According to Frank, the major determinant of the patient's faith in therapy and staying in treatment is the degree of his distress.[17] The therapist, however, at the same time attempts to develop the patient's confidence in him by showing his own faith in the capacities of the patient to change. This confidence in the patient and his treatment develops incentive in the patient to continue. The fact that the patient has been "accepted" for treatment illustrates the doctor's belief that he can be helped. It is now up to the patient to show that he wants to be helped.

While the therapist wants to choose "good" patients to work with ("good" meaning verbal, relatively young and open to change), he also does not want to appear too eager to increase the size of his practice. Being too eager would make him look money-hungry and diminish the sense of competence he is trying to display. He also wants patients with whom he can be successful for the satisfaction this gives him as a practitioner and to augment his reputation.

Since the basic commodity being sold is the therapist's time and really himself, he agrees to work with those whom he feels he can help. At the same time, by letting the client know that he is doing the choosing as well, it lets the client feel "fortunate" to have been chosen. It also decreases the obviously consumer aspects of the relationship.

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[17]Frank, "The Dynamics of the Psychotherapeutic Relationship," p. 176.

The Setting

Physically the psychotherapy setting has been described by Frank as follows:

> Psychotherapy has developed its own trappings, to symbolize healing; like other physicians, psychotherapists display diplomas prominently, but in place of the symbols of the stethoscope, the ophthalmoscope, and the reflex hammer, they must rely on the heavily laden bookcases, the couch, the easy chair, and usually a large photograph of the leader of their particular school looking benignly but impressively down on the proceedings.[18]

The setting for the sessions that I analyze include the couch, the easy chair and wall-to-wall books, but also other comfortable chairs for group therapy, videotape and audio equipment, track lighting, piles of cassettes, a desk, paintings, sculpture and a non-working fireplace. Perhaps the best description is given in the following conversation:

Example 3-1: Jill

1. Dr.: ... How do you feel about being with me? Do you have any reactions to being with me?
2. Pt.: (long pause) Well, I'm impressed by your surroundings.
3. Dr.: What are you impressed by?
4. Pt.: (extremely low voice) How everything is (laugh), how I feel, artistic paintings, sensitivity...
5. Dr.: Uh, huh.
6. Pt.: And I just feel like there's an imagination in your room,

To summarize the therapist-patient relationship thus far, I can characterize it as follows: The goal of therapy is to encourage the patient to adapt a new, healthier system for dealing with problems than he had used prior to entering therapy. Learning to see the world in this new way is the work of therapy. The therapy relationship is

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[18] Frank, "The Dynamics of the Psychotherapeutic Relationship," p. 172.

a service relationship in which the participants are both equals and unequals at the same time. In order to achieve the goals of therapy, the patient presents material to the therapist which the therapist evaluates, comments upon, and, in short, corrects. The rules of everyday conversation apply, but there are also rules specific to the therapeutic context which may suspend the everyday rules.

I turn now to two activities which occur in therapy, threat and the display of authority, in order to illustrate the following: (1) the therapist and patient use everyday speech activities to do the work of therapy, such as the correction-invitation, reason-invitation, invitation-to-balance and misfire; (2) therapy rests on disagreement; and (3) in the course of therapy, the patient learns the rules and goals specific to therapy.

Threatening

In the following excerpts we see threat in the doctor-patient relationship appear explicitly or implicitly. The extreme cases would be the patient threatening to leave treatment or the doctor threatening to withhold treatment. The use of threat is not something that readily comes to mind when thinking about the therapeutic relationship. Examples of threatening behavior are examined below. Before doing so, however, I wish to emphasize that the activities I analyze here do not necessarily appear in every therapeutic relationship, only that they have occurred here. Motivating unmotivated patients is most difficult. It appears that any available activity is employed in the hope that it may succeed. Since an unmotivated person is not considered a desirable

client, only a confident therapist would accept such a patient for treatment.

In example 3-2, we see the importance of rules #1 and #2, wanting to get well and working towards this goal, illustrated conversationally. It is so important that the doctor asserts his authority as an expert and also resorts to an activity as unlikely as threat in order to encourage the patient's cooperation. Jill is a 20-year-old woman who had recently been hospitalized.

Example 3-2: Jill

1. Pt.: Yeah, well that's why I don't think anyone could work with me.

2. Dr.: Well, if your attitude is I can't, then you're pretty sick and then my recommendation to your family would be to throw you out and put you in a hospital. That's what I would recommend.

3. Pt.: I won't, I won't go to a hospital.

4. Dr.: Whether they take you or not, I would tell them to throw you out, if you say I can't get out of bed. That's utter nonsense. The real answer is, I won't. Right?

5. Pt.: Yeah.

The patient must get out of bed in order to show she is working towards "getting well." It is the doctor, in this case the psychiatrist, who determines if the patient is adequately motivated. If she doesn't, he threatens her by saying he won't work with her and she should go back to the hospital. On the basis of his expertise (schooling and training), he asserts his authority and states he would recommend that to her parents. If her parents accept his authority, then that outcome would result. Thus, even threat may be used, if, in the therapist's judgment, it is in the patient's best interest.

In addition, in lines 4 and 5, he again demonstrates his expertise and therefore authority by showing the patient that he really knows what's wrong. As Frank states in another context,

> Whatever [the] specific nature [of the theory], all implicitly convey that the therapist knows what is wrong with the patient and that the special procedure is the treatment for it. . . . The underlying theory [also] supplies a frame of reference which helps the patient to make sense of behavior and feelings which had been mysterious and to learn that they are not unique, but represent important widely shared experiences.[19]

Two other examples of threatening behavior come from Benjamin,[20] an Israeli rehabilitation counselor. He resorts to the same threat that the psychiatrist had used earlier, the threat to withhold treatment. Benjamin does not provide background on his client, but it is apparent from the conversation in example 3-3 that this one is blind.

Example 3-3

Interviewee: You just don't know what it's like, walking with a cane or a guide dog. People stare and point at you like you were a freak or something. I'm going to use a guide--Mother is ready to it--or else I'll stay at home.

Interviewer: Well, if that is your attitude, we can't help you. But just remember that Mother won't be around forever and then--well, it's your problem.

Example 3-4

Interviewee: -----------

Interviewer: We've gone over and over this same point. You insist that you can't and that you have tried. I insist you can and that you haven't really tried. It's senseless to continue this way. You can come back to see me if and when you have something new to report.

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[19]Frank, "The Dynamics of the Psychotherapeutic Relationship," p. 173.

[20]Alfred Benjamin, The Helping Interview (Boston, MA: Houghton Mifflin Co., 1974; 2nd ed.), p. 149.

The service aspects of the relationship are clear. The therapist has something the client can use and the therapist threatens to withhold that. In excerpt 3-4, the interviewer himself clearly states the disagreement between them: "You say you can't and that you've tried. I insist you can and that you haven't tried." Apparently motivation is something that is brought out in the open for discussion when the patient is not sufficiently motivated. When that is the case, the therapist must add to his task of helping, that is, to help the patient want to be helped (rule #1). This is so important that any strategy is legitimate.

In the next excerpt the threat to withhold service is implied rather than direct. (This is the same patient as in Example 3-2.) Rule #1--you must want to get well--is utilized by the therapist as the expert. He decides if the patient is displaying enough evidence that she indeed wants to get well. If she does, he will work with her; if not, he won't. (This excerpt comes from a first consultation in order to decide if they will go ahead and work together.) In so doing the psychiatrist also uses activities found in everyday speech. In Example 3-5, we find the use of a correction-invitation [21] and the invitation-to-balance.[22] Churchill defined correction-invitation as a kind of yes/no question where more than a yes or no answer is requested; a correction to an incorrect fact in the question is invited.

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[21] Lindsey Churchill, Questioning Strategies in Sociolinguistics (Rowley, MA: Newbury House Publishers, Inc., 1978), p. 41. An example of a correction-invitation would be: Is X correct? The completion of it is: yes or no plus the correction.

[22] Ibid., p. 58. An example of an invitation to balance is: (1) Joe, you got $40,000 worth of goods there; (2) It is not; it is only about $20,000.

An invitation to balance is a question or statement with an exaggerated quantity which the hearer is invited to balance by providing another quantity that he thinks is not exaggerated. These activities are not specific to the therapy situation at all and may be present anywhere. They are also disagreeing kinds of activities, that is, activities in which one participant holds one position and the other participant holds a different one.

Example 3-5 - Jill

1. Dr.: ...I love to work in this field. I love to help people, be an agent of change for you, but if they don't really want to make it, at all

2. Pt.: Who doesn't want to make it?

3. Dr.: There are people who don't want to make it.

4. Pt.: No, they don't, they just don't think they can, they don't see any alternatives.

5. Dr.: People who are so resigned, that they won't move for themselves.

In line 1, the extreme "at all" may be heard as an invitation to balance. He is not saying that the patient is one of these, but rather is requesting evidence, even a little, that she is making some effort toward getting well (like getting out of bed in the morning). Developing a cooperative motivational alliance[23] is one of the first goals that the therapist has for himself and his patients. He uses the phrase "people who don't want to make it" in the hope that the patient would deny that she belongs to such a group. He would then have evidence that she wants to make it (get well--rule #1) and she would

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[23]The therapist uses the term "cooperative motivational system" further on in his conversation with the patient and stresses its importance. He refers to the fact that they must work together and be properly motivated to do the work of therapy.

therefore cooperate (rule #2) in the effort toward improved mental health. Instead, she balances his "at all" by saying in effect in lines 2 and 4: there are not people who don't want to get well; it's just that they don't think they can and that they don't see any alternatives. Although the threat to withhold services is implied, the speaker-hearers respond to what the other is saying "in essence." The understood implication is: if you don't want to get well, there's no point in my working with you. This patient, however, remains non-commital to her role in therapy throughout this session.

Benjamin offers the following three examples of the use of threat in therapeutic relationships. In the production of threatening behavior, he also utilizes a completion of reason invitation, which Churchill states consists of a yes or no response to a question with the addition of a reason for the disagreement.[24]

Benjamin does not include the reason-invitation in his examples, although they can be inferred from the replies. I have added such possible invitations to the transcripts to place the replies in context. In Example 3-8, the interviewee's line 1 seems to be an interjection which could come after a long piece of conversation. Therefore, I have not supplied a possible reason-invitation here.

Example 3-6

Interviewer: E.g., why did you come late today?

Interviewee: I couldn't help it; my bus came late again this morning.

Interviewer: If you come late once again, we shall have to ask you to leave our workshop. Maybe one bus came late, but I know there was one before that which you could easily have caught.

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[24] Churchill, <u>Questioning Strategies in Sociolinguistics</u>, p. 42.

Example 3-7

Interviewer: E.g., do you plan on continuing your education?

Interviewee: ...even though I've got the grades and the scholarship, I just don't want to go to college now.

Interviewer: If you keep this nonsense up, I am going to tell your parents to give you up as a lost cause. You're not going to college for me; and if you don't go, you'll see how far you can get!

Example 3-8

Interviewee: I don't feel as if we're getting anyplace.

Interviewer: No surprise to me! With your attitude it's no wonder we aren't getting anywhere. We'd better stop, but if you honestly believe that you will get far in this world with the way you have of looking at things, you're greatly mistaken. Unless you change--and fast--you're heading for plenty of trouble.

In Examples 3-6 and 3-8 the threats are overt: we shall have to ask you to leave the workshop; we'd better stop. In Example 3-7 the threat is indirect: I am going to tell your parents to give up up as a lost cause. A direct threat consists of the therapist acting directly on the patient or client. An indirect threat, as used here, means that the therapist must work through a third party in order to achieve his intended result. In either case, the threat is to discontinue treatment which could raise the question in the patient's mind that he really needs it. In the indirect threat the therapist utilizes his role as expert with the authority to influence the parents in a way not to the liking of the patient. We have seen this earlier in Example 3-2.

In the above three examples, we have the therapist completing the generalized reason invitation, that is, he disagrees and explains why he does so. If we look at the patients' statements, however, we can see that the therapist as the authority determines if the statements

made by the patients are reasonable. In the first two, the therapist does not deem "I couldn't help it" and "I just don't want to go to college now" as acceptable statements. In Example 3-8, he does not accept "I don't feel as if we're getting anyplace" (which is probably a realistic assessment of the events) and instead interprets the patient's statement as an occasion to remark about his negative attitude. All of the above are unacceptable reasons and the therapist in offering his alternative reason appeals to the patient's common sense as a "normal" member. He uses his position as the authority to determine what is right.

The generalized reason-invitation is closely related to the earlier discussion of the patient being accountable for everything he says. In these examples, we see its more general use: if you disagree, say so, and then give a reason for the disagreement. In the former case, the therapist can question the patient's statements and ask for a reason why he said it. Thus, the therapist may violate a usual practice in speaking because he is the therapist.

To summarize thus far, I have discussed the activity of threatening in a general way so as to illuminate the use of rules by the therapist and patient. They use both everyday rules and rules specific to therapy in the course of doing their work. The everyday activities used in the course of doing threatening, and threatening itself, are also disagreeing kinds of activities. Threatening behavior, as seen in these examples, is based on the position of authority which the therapist holds. When one person has what the other person wants, their relationship may be characterized as an unequal one.

I turn now to a discussion of authority. In these examples, the doctor-patient relationship is again between unequals; however, insofar as the work of therapy is accomplished, and authority is used to further that work, the doctor and patient are participating at a more equal or less unequal level than in the previous cases. I discuss the activity of displaying authority in a general way here to continue the objective outlined earlier, that is, to show that everyday speech activities are employed in the therapy context, which may be used to teach the rules specific to therapy as well and to show that the constraints of everyday conversation, such as being polite, may be suspended.

Authority

Here authority stems from expertise and must be displayed. In the next three excerpts we have the therapist displaying his authority and teaching or explaining to the patient the dynamics of what is occurring between them. The therapist is an expert at conversation. He uses speech activities, which are available to all members of a speech community, in a therapeutic way. In the last example, we have the patient taking the role of expert.

Dan is a high school student with an oppositional disorder of adolescence.[25]

Example 3-9: Dan

1. Pt.: I don't think that girl has a tender thought in her.

2. Dr.: (pause) So she's like you then. You'd like her to be more tender, you think (?)

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[25]As noted in Chapter 1, this diagnosis was made by his therapist and is based on the DSM III of the American Psychiatric Association.

3. Pt.: No. I wouldn't like her to be anything. I don't care enough for her.

4. Dr.: Yes you do. Dan, when you react this strongly with people, you're involved with them. You don't get this involved, u-uh react this way with people you're not involved with.

5. Pt.: Well, maybe it's only a personal, maybe it's only a personal feeling, but I'd like her to be more tender towards me.

6. Dr.: Maybe it's only a personal?

7. Pt.: Not apersonal, ay, ay, article personal feeling towards Cathy.

8. Dr.: Yeah.

9. Pt.: That she should be ender with me.

10. Dr.: Well, how about facing that, that that's what you'd like.

11. Pt.: But I don't want to, I don't want to admit that.

12. Dr.: How come? (righteously)

13. Pt.: 'Cause I don't want to talk about tenderness. (louder)

14. Dr.: You're in the wrong church in the wrong pew. Tenderness is one of the goals I have for people in this group, and in life, and for myself. My God, without tenderness, what the fuck are we?

In this excerpt we have two examples of Churchill's completion of reason invitations. In lines 2 and 3 the patient disagrees with the doctor and says, "No. I wouldn't like her to be anything," and then gives a reason: "[Because] I don't care enough for her." And immediately following in line 4 we have the doctor completing another reason invitation by disagreeing with the patient's "I don't care enough for her" or "no" position of line 3 and saying "yes" in line 4 and then stating why he disagrees: "[Because] when you react this strongly with people, you're involved with people."

Another everyday speech activity we see in this excerpt is the misfire. Churchill, following Austin's use, defines misfire this way: "When the utterance is a misfire, the procedure which we purport to invoke is disallowed or is botched; and our act (marrying, etc.) is void or without effect, etc."[26] Misfires must be attended to before the conversation on the topic can continue. Lines 5-8 are addressed to the clearing up of the misfire on the words "a personal." It is also a correction-invitation.

What is most interesting about this misfire is that the therapist uses it as an occasion to teach the patient some of the rules and goals of therapy. That is, the therapist moves to a higher order rule (from rule #5 to #4), from the content of the talk to the rules of therapy per se. Some of the rules of therapy include: tenderness as a goal, interpretation of dynamics between the patient and therapist, group members, member's family or associates, and the how of talking, i.e., verbal and nonverbal cues.[27] These will be seen in the various examples through the dissertation dealing with these rules. The misfire occurs around the patient's use of the words "a personal." He then continues in line 9 that what he'd like is for a female patient in group therapy to be more tender toward him. In lines 10 and 14 the therapist uses his turn to take the role of expert[28] and states,

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[26]Lindsey Churchill, Questioning Essays (unpublished: n.d.), Chapter 6, p 1. He quotes J. L. Austin, How To Do Things with Words, ed. by J. O. Urmson (New York: Oxford University Press [Galaxy], 1965), p. 16.

[27]See Chapter 4 for a discussion of the congruency maxim which addresses this question.

[28]Churchill pointed out that this is very much like Socrates who was treated as an authority even though he only asked questions.

"Well, how about facing that, that that's what you'd like"--directing the patient and in line 14 teaches him about therapy that tenderness is one of the goals he has for his patients and himself. When the therapist continues speaking colloquially (My God, without tenderness, what the fuck are we?), we see his alliance with the patient. That is, the therapist has shifted from an unequal power relationship as the authority, the teacher, to an equal relationship, indicating their mutuality in the work of therapy. Line 14 could also be heard as a rhetorical question. The therapist is a facile and clever talker and uses talk and the relationship between them to do therapy. This is part of his expertise.

In the next excerpt we again have the therapist using everyday speech practices, the correction-invitation, to explain the rules and goals of therapy, rule #4.

Example 3-10 - Jill

1. Dr.: ...What are your talents? What have you ever had as a talent? What have you ever had as a wish or want or goal in life? Let's start with talents first.

2. Pt.: When I was younger, I wanted to write.

3. Dr.: You wanted to write. Did you write?

4. Pt.: Just in school, and

5. Dr.: What's that, just in school? That's that just. Do you know how many times you've said just now? that I've spotted. At least 3, right?

6. Pt.: Mmhm.

7. Dr.: Try to remember that's a trend. That's a system. Just.

8. Pt.: I don't know what it means.

9. Dr.: That's a self-belittling and it's a belitting of whatever you're talking about, like just in school. Rather than, in school I wrote. I didn't since then because. Well, let's look at what the block was.

In line 9 the doctor as the expert provides her with an explanation of why he commented upon "just" and adds to his credence as the authority by explaining the dynamics of her behavior. There is an implied disagreement between them; he says it is not correct to say "just in school" and tells her to say "in school." As the authority, he has the "right," even the duty, to notice what might in everyday polite conversation be ignored. Thus we see therapy being in large part a correction of previous attitudes, feelings and behavior. This makes the therapist's role similiar to that of a teacher.

The next example is important because the therapist again displays his authority and because the therapist uses it to create a double-bind. The double-bind, as described by Jackson et al.,[29] is a sick device and poor communication. Here it is used therapeutically to produce health. Non-verbal cues are important as we see the therapist distinguish between what the patient is saying and how she is saying it. The assumption is that in a normal member's speech there is consonance between his verbal and non-verbal communications.[30] Carrie is in her late 30's, immature, with difficulty in maintaining relationships.

Example 3-11: Carrie

1. Dr.: You're capable of everything I just said. You do know that?

2. Pt.: Uh-huh.

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[29] Gregory Bateson, Don D. Jackson, Jay Haley and John Weakland, "Toward a Theory of Schizophrenia," Behavioral Science 1 (October 1956): 251-64. See Chapter 2 for a discussion of this article and also Paul Watzlawick, Janet Helmick Beavin and Don D. Jackson, Pragmatics of Human Communication (New York: W. W. Norton and Co., 1967), also discussed in this chapter.

[30] Again see Chapter 4 for a discussion of verbal and non-verbal communications.

3. Dr.: Huh?

4. Pt.: Yeah, yup.

5. Dr.: You're not just yessing me.

6. Pt.: No, no, no, I am.

7. Dr.: Say, "I believe it, God damn it,] overlap

8. Pt.: I do.]

9. Dr.: I can.

10. Pt.: I do. I can.

11. Dr.: Say it like you mean it.

12. Pt.: Uh. God damn it. I can. Yeah.

13. Dr.: You're still not saying it very powerfully.

14. Pt.: Well I can, but. I really can.

15. Dr.: Sure you really can?

16. Pt.: Yeah, I'm not that kind of person.

17. Dr.: Well, how about uh, risking becoming that kind of person.

18. Pt.: Yeah.

19. Dr.: Let me hear you say it.

20. Pt.: Hah (laughs)

21. Dr.: Like you mean it.

22. Pt.: I can be for me.

23. Dr.: That's a little better.

24. Pt.: (laughing)

25. Dr.: You still find it hard to say. I can be for me, God damn it. (pounding each word on the table) I will be for me.

26. Pt.: [Yeah.

27. Dr.: [Damn it. Huh? That means that some of where you automatically went along before you don't go along automatically.

28. Pt.: Yeah.

In line 1, the doctor states his belief in the patient that she can be helped by asking if she knows that she is capable of everything he just said, including ". . . the strength to say no to what needs to be said no to." She answers uh-huh, which is not an obvious yes, although she does mean yes. He answers "Huh?", meaning "What did you say? I'm not sure I hear you." This is a case of a challenging mis-fire. She clarifies uh-huh to mean yeah and yup. Since the patient tends to say yeah so frequently in her natural speech, the therapist says in line 6, "You're not just yessing me." This is the key to the double-bind and the assertion of his authority. The patient's answer in line 6 is interesting in itself. Her "No, no, no, I am" is ambig-uous. She seems emphatic in the three nos, but the "I am" could refer to "I am capable of everything you just said" or it could refer to "I am yessing you." Using her tone of voice as a clue, it sounded to me as though she is saying, "I'm not yessing you; I am capable." What is important is that I, as a listener, must use the same non-verbal cues of tone as the therapist to discern her meaning. The therapist uses ordinary everyday practices as all members do. As the therapist, however, it is even more important that he discern when she means yes and when she means no.

In line 7 the therapist puts the patient in a double bind by saying, "Say 'I believe it. God damn it, I can.'" If she says it, then she is yessing him, parrotting him; if she doesn't, then she's saying she doesn't believe she is capable of improving. As the expert, he determines when she has said it adequately, to his satisfaction. He uses his judgment and focuses on the non-verbal aspects of her statements to determine if she is just saying it or really means it.

The patient is cooperative and follows his commands of lines 11 and 19. The exchange in lines 22 and 23 illustrates her acceptance of the rules of therapy and his authority. In line 27 he supports his use of authority by providing some explanation and advice as to her behavior.

This excerpt also illustrates the hierarchy of rules referred to earlier. Rule #1 is you must want to get well. Rule #2 is you must cooperate with your doctor. In therapy, however, there is another all-important rule: rule #3--be yourself. After all, the therapeutic atmosphere is a permissive one in regard to expression of feeling.[31] The patient finds herself in a no-win situation. If saying, "I believe it, God damn it, I can" (line 12) and listening to the doctor will help her, then she must do it (rules #1 and #2). If she says it, however, she is yessing him and if she doesn't, then she doesn't want to get well. However, rules #1 and #2 take precedence over rule #3, be yourself. (This appears to be the case in the early phases of the therapeutic relationship.) Therefore, as a good patient, she says it. Theoretically, if she didn't cooperate, the doctor could choose to threaten her by saying it's useless or not fruitful for the two of them to work together and she should go and find someone else to work with, as was the case with another female patient. (That other patient, although threatened, did enter into therapy with this psychiatrist.) The psychiatrist's accepted authority in the situation gives him great control, as the above excerpt illustrates.

The next example (3-12) is interesting because the roles are reversed; the patient is the de facto authority as to what kind of

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[31] Carl R. Rogers, Counseling and Psychotherapy (Cambridge, MA: Houghton Mifflin Co., 1942), p. 88.

gymnastics are permissible during her pregnancy. She becomes the authority on that topic by telling her therapist what her obstetrician had told her. Ellen, in her mid-30's, has a difficult marriage, one daughter named Barbara, and is an alcoholic.

Example 3-12: Ellen

1. Pt.: My neck, it hurts like hell, but...

2. Dr.: And you did it in exercising?

3. Pt.: We went to somebody's house for dinner. It was really... It was very dumb. I guess. It didn't seem like it at the time. We were having a wonderful time. They were new people we had met through some mutual friends. And the gal had, they had children, and the people who were staying with us had children, and Barbara, and a lot of kids and dogs, and it was really, it was really nice. And uma, they had a gym. They had a... in their house. And the children were all doing their thing, and Barbara started asking how to do some things, and I was trying to teach her something, and she couldn't do it, and I showed her. And of course I showed her in the wrong clothes without warming up. It was a very simple thing that I'm perfectly able to do. Maybe, I should have though, and gee, I should you know, should not do this without working...

4. Dr.: What kind of an exercise?

5. Pt.: It's called, uh, it's called a fish. And it's like a backwards somersault. You just go back with your legs up over your head.

6. Dr.: And you did this thing?

7. Pt.: Yeah.

8. Dr.: While pregnant.

9. Pt.: I can do that, 'c you know. I can do it. That's been cleared. I can definitely do it in terms of being pregnant.

10. Dr.: He told you, you could do this sort of maneuver?

11. Pt.: Yeah.

12. Dr.: You can jump through the air and do a back somersault?

13. Pt.: No, not jump. He said not do anything aerial. I can't do anything.

14. Dr.: Well, what, then? What was

15. Pt.: It's on the floor. You're lying on the floor.

16. Dr.: You lie on the floor.

17. Pt.: And you just, you roll back, and your legs go over your head. But as you get your legs over your head, your legs go up in the air and then you kind of twist. And if you don't do it right, your head is underneath you, twisted. And uh I've done it maybe five hundred times. But I just, I think it was more not being dressed for it than it was not being warmed up. I just wasn't. I... the clothes were constricting it. And I knew it the second I got up, huh, that'd really done something... And I wondered about that, I wondered about having done that, I wondered...

18. Dr.: I don't know, it just seems to me, uh, again, uh, uh, I kind of sit here, not really knowing for sure, other than common sense, that if I were a GP or an obstetrician, and I had a patient who said she'd like to do some of these gymnastic exercises, I would think, unless, I don't know, I think offhand they'd be contraindicated.

19. Pt.: No, they're not. They're really hard. You do whatever you customarily do. You don't start taking gynmastics if you never did it before, if you're pregnant. You don't start any kind of vigorous

20. Dr.: But you don't do these gymnastics all the time.

21. Pt.: All the time. That's what I did at, at this spa. I taught a class there. I studied it for five years, and I do them, did them all the time. I hadn't done them in two months but I did (laugh) keep... this is about a month before, uh, since November, since the second week of November. I had discussed it with him and he said to, I could keep doing, whatever I was doing, except to give up the trapeze, give up anything off the floor. So that wasn't... That was never, I never had a thought about that, no. I danced until the end of my eighth month with Barbara, vigorously, every day. Taught, danced, about eight, nine hours a day, and never felt any kind of strain from it.

22. Dr.: It's all news to me. Let's get back to the traps. What options do <u>you</u> see to feel less trapped? What else are you trapped inside you with?

23. Pt.: I don't see any option. Honestly. But it's got to be there,

24. Dr.: But if they're not there you've got to create them. Hmm.

Line 18 is the key line where the doctor says, "I don't know, it just seems to me, uh, again, uh, uh, I I kind of sit here, not really knowing for sure, other than common sense, that if I were a GP or an obstetrician, and I had a patient who said she'd like to do some of these gymnastic exercises, I would think, unless, I don't know, I think offhand they'd be contraindicated." And in line 22 he says, "It's all news to me," so he is questioning and possibly willing to accept her explanations. But then he changes the topic back to where he is the expert and has the authority by saying, "Let's get back to the traps. What options, etc." As the expert, when he gets the floor back to speak, he has the right and from some theorietical points of view, the obligation, to direct the session, which he does.

Thus, in these excerpts where authority has been displayed, we see the therapist and patient using the rules of everyday conversation as well as the rules specific to therapy. Disagreement, in various forms, is often produced in the therapy sessions presented here and is an important feature of the therapeutic relationship.

To summarize then the discussion in this chapter, I presented a description of the therapeutic relationship, its goals and some background conditions affecting the relationship, i.e., the power and service aspects of the relationship. I proposed that the work of therapy gets accomplished using ordinary everyday speech activities where the patient presents personal material and the therapist evaluates it and comments upon it by disagreeing or making corrections. However, these

everyday activities are also subject to rules specific to the therapy situation. Thus, I presented a hierarchy of rules specifically related to therapy. The facts that the normal constraints of conversation could be suspended and that the grounds of the relationship between the therapist and patient could be shifted from equals to unequals and vice versa were also examined. I then focused on two disagreeing activities, threatening and displaying authority, in order to show both the everyday aspects and non-everyday aspects of the participants' talk. The purpose of the above descriptions was to provide a general introduction to the nature of therapy.

I turn now to the activity of disagreement which is discussed in a more systematic way in the next chapter. I do so in order to better understand the activity and to show how it is accomplished in the therapeutic context. It also provides a foundation for the more complex disagreeing activities analyzed later.

CHAPTER 4

DISAGREEMENT AS CONVERSATION: YES/NO

In the previous chapter I noted that correction is an essential part of the therapeutic relationship and treatment process and that correction can be viewed as disagreement--two people taking two different positions. Therefore, in this chapter I describe the elements necessary for the production of disagreement in its simplest form in order that we may better understand the more complex disagreeing activities of negative reinterpretation and confrontation which are discussed in later chapters. The analysis consists of a description of the verbal and nonverbal aspects of disagreement.

The initial question, how do we as normal members of the American speech community recognize when someone has disagreed with us or when we have disagreed with them? The appearance of the words "yes" and "no" signalled a marker for a potential disagreement site. Thus, I begin by using following member's working definition of disagreement: Disagreement exists when one person takes a "yes" position and the other a "no" position or vice versa.[1] Therefore, I examine the forms that the "yes" and "no" positions or lines 1 and 2, respectively, may take. I conclude that a yes/no disagreement as a two-liner takes the form either of an adjacency pair or as a contradiction, which is a more general term and both fall within the class of disagreements. I then

[1] In this analysis in order to facilitate understanding, the first speaker always takes a yes position and the second a no position. In the ensuing examples, the reverse is also found.

describe the non-verbal aspects of disagreement as it affects the production of contradiction. In so doing, two maxims are formulated: the disagreement maxim and congruency maxim. I turn now to the yes position.

The Yes Position

The yes position can take two forms which will be discussed in turn: first is the yes/no question which is in Sacks' and Schegloff's terms an adjacency pair, and second is the statement which serves either as an invitation to balance or as an occasion for the use of the disagreement maxim.

1. The yes/no question. Sacks and Schegloff define adjacency pairs "where the production of a first pair part requires that a next speaker produce (1) adjacently, (2) a second pair part, (3) of the pair type previously selected by a first speaker."[2] The yes/no question and its answer form the adjacency pair since the answer, the second part, appears adjacent to the question which posed the choice of "yes" or "no" answers explicitly or implicitly. Unless a misfire[3] follows the first pair part, the second pair part will appear adjacent to the first. Following Churchill, any specific proposal question as opposed to general proposal question and the appropriate response would qualify as an

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[2]Quoted from J. C. Heritage and D. R. Watson, "Formulations as Conversational Objects," in Everyday Languiage, ed. G. Psathas (New York: Irvington Publishers, a Division of John Wiley and Sons, 1979), p. 141. They cite H. Sacks and E. Schegloff on adjacency pairs: "Opening Up Closing," in Ethnomethodology, ed. Roy Turner (Middlesex, England: Penguin Books, 1974), pp. 238-39.

[3]Lindsey Churchill, Questioning Strategies in Sociolinguistics (Rowley, MA: Newbury House Publishers, 1978), p. 26. He uses the term as Austin does. See J. Austin, How To Do Things with Words (New York: Oxford University Press [Galaxy], 1965).

adjacency pair.[4] The example below taken from Dan, the angry young student, illustrates the use of the yes/no question leading to a disagreement. A specific proposal question or closed forced choice question is asked in line 1. Line 2 is a selection of one of the two implied choices, yes or no offered in line 1. Together they form the adjacency pair.

Example 4-1: Dan

1. Dr.: Do you have any feelings of tenderness, or concern, or compassion or empathy with this girl, Terry?

2. Pt.: Nah, deep down inside I I don't feel tender.

The implicit assumption is that Dan should have some of these feelings toward this girl. Churchill argued in his certainty series[5] that speakers have some belief in the correctness of the proposal when they ask specific proposal questions and the degree of belief is evident in the form it takes. For instance the question "Is your friend a policeman?" implies to the hearer that the speaker thinks that that is the case. I propose that this is true in general--the speaker has some kind of investment or belief in the correctness of the questions and statements he makes. Thus, I hear the doctor's question in line 1 of example 4-1 as a statement implying that Dan should have some of the above feelings toward Terry. Since Dan replied in the negative in line 2, there is an implicit difference of opinion between them and hence, a disagreement. Further on we shall consider how disagreement is influenced by tone of voice. In the above example, there is no strong rise in the tone of voice and therefore it is not a very strong disagreement.

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[4] Churchill, Questioning Strategies in Sociolinguistics, p. 45.

[5] Ibid., pp. 51-54.

2. The statement. The second site where a potential disagreement could occur was after a statement. In this analysis I discuss statements which can serve two purposes: (1) as an invitation to balance, and (2) as an occasion for the use of the disagreement maxim. "Strong" statements can appear as extreme statements which follows from Churchill's discussion of the "invitation-to-balance." He defines an invitation to balance as some quantity that the hearer may feel is exaggerated (either too high or too low) and thus will respond with a counter quantity in the direction opposite to the exaggeration.[6] I propose that the invitation to balance may be used more generally than a numeric quantity. Any statement using an "extreme" such as always, never, all, or none, in addition to a relatively extreme amount of something (in its context) calls for or almost demands a response. Thus the "strong" statements I analyze here are limited to only those available from these transcripts. Any other kinds await further analysis. For instance, the statement, "nobody in their right mind would spend $5000 on a dress" invites an agreement or disagreement with an explanation. Clearly the person who made this statement believes in the correctness of this fact: that is, $5000 is too much to spend on a dress (an invitation to balance the amount) and if he does he is not in his right mind (an invitation to balance a general statement). The following example, again from Dan, illustrates the strong statement which is an invitation to balance.

Example 4-2: Dan

1. Pt.: You think that I have to control my anger at all times.

2. Dr.: No, I don't. I'm trying to help you.

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[6] Churchill, Questioning Strategies in Sociolinguistics, p. 58.

Similarly the following statement also functions as an invitation to balance, with the amount not being specified. It can be heard as an invitation to balance "enough."

Example 4-3: Dan

1. Pt.: ...I don't care enough for her.

2. Dr.: Yes, you do. Dan, when you react this strongly with people, you're involved with them.

Such examples are common.

However, statements need not take the above form to provide occasions for doing contradiction and hence disagreement. Any statement a speaker makes is a potential site for a disagreement. For instance, a mild and relatively innocuous statement such as "the sky is blue," which does not demand or ask for a confirming or disconfirming response, could also be disagreed with. Consider the comment, "no it's not; it's gray." This led me to generalize Churchill's invitation maxim. The invitation maxim states: "If you are asked a specific proposal question and your answer is the confirming one, follow the chain maxim. If your answer is the disconfirming one, give the disconfirming answer, then give the correct answer, and then give the turn back to the questioner."[7] He developed this notion from Sacks' correction-invitation.[8] The generalization is: You need not be asked a specific proposal question (as in the yes/no question) in order to disagree. If you choose to disagree with the first speaker's remarks, say so and then provide an explanation for the disagreement and then give the turn back

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[7]Churchill, Questioning Strategies in Sociolinguistics, p. 46.

[8]Harvey Sacks, "The Search for Help" (unpublished doctoral dissertation, Department of Sociology, University of California at Berkeley, 1966).

to the first speaker. The disagreement maxim in brief is: any statement or specific proposal question offered is subject to being disagreed with. It is similar to Churchill's completion of reason invitation,[9] but is more general, since a reason need not be provided as the next two examples illustrate.

The next two examples can both be seen as responses to correction-invitations. However, in neither case is a reason for the correction offered. Churchill argued that corrections are or can be seen as a kind of reason response. The disagreement maxim is even more general. The first example is from Harold, a bright successful professional; the second, from Sherry, a volatile, unstable woman.

Example 4-4: Harold

1. Dr.: ...I experience it as a hijacking in which your wife consciously or unconsciously
2. Pt.: She didn't get into it.

Example 4-5: Sherry

1. Dr.: I appreciate that.
2. Pt.: No you don't.

Thus far, then, in our model of disagreement between two persons we know that it may occur as a response to a yes/no question with the second speaker taking a different position than the first; as a response to an extreme statement where it is heard as an invitation to balance; and at any time the second participant chooses to disagree with a statement the first person has made. Thus within the disagreement adjacency pair, the first line may take the form of a yes/no

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[9] Churchill, <u>Questioning Strategies in Sociolinguistics</u>, p. 42.

question and in a contraction, the first line may take the form of a statement. I turn now to the second or disagreeing line.

The No Position

The second line must consist of "no" or its equivalent and forms the basis of providing the non-preferred answer in an adjacency pair and for the contradiction of the first line. The "no" type response also conveys the strength of the disagreement. Disagreeing is an impolite activity; as Pomerantz has shown, agreeing activities (specifically confirmations) are massively preferred to disagreeing activities.[10]

The negative response falls into a continuum of responses from strong to weak or strong disagreement to weak disagreement to agreement. The disagreeing responses may be: no; no plus an explanation; an elided no; yes, but or the converse no, but; or an agreement, yes. We will consider the first four responses.

1. No. Disagreement in general and contradiction specifically is a rude, impolite activity. Therefore, if one is going to disagree, one normally provides a reason for that disagreement. In the following two examples from sessions with Dan and Jill, both in their late teens, we see this curt, even rude, reply. In both examples, the "no" is a response to a question or statement which is heard as the first pair part of adjacency pair.

Example 4-6: Dan

1. Dr.: ...Tell me. Do you have any of those feelings with your mother and father? that your father has done

[10] J. C. Heritage and D. R. Watson, "Formulations as Conversational Objects," in Everyday Language, ed. G. Psathas (New York: Irvington Publishers [Division of John Wiley and Sons], 1979), pp. 123-62, cited from p. 143.

anything like that with your mother? and with you?

2. Pt.: No.

Example 4-7: Jill

1. Dr.: ...I would, would you like to hear it playing back? You're on audiotape.

2. Pt.: No.

2. No plus explanation. A somewhat less rude negative reply consists of the no plus an explanation for that position. In terms of the continuum, the explanation serves to weaken the strength of the disagreement slightly. In these examples the no plus explanation is a response to a statement or question heard as a statement. Many examples of contradiction in the form of no with an explanation are available. Consider the following from Ellen and Dan. Ellen is pregnant and has problems with her marriage.

Example 4-8: Ellen

1. Dr.: ...I would think, unless, I don't know, I think offhand they'd be contra-indicated.

2. Pt.: No, they're not. You do what you customarily do.

In this excerpt they are discussing the kinds of gymnastics permissible during pregnancy. Ellen becomes the de facto expert by reporting what her obstetrician told her.

In another example she again explains her disagreeing position:

Example 4-9: Ellen

1. Dr.: Well, I guess we'd better get back to the whole issue of you being with you. What you talk about is that if I'm not doing something outside of me, being with me, then it's awful, because otherwise I'm with me, and we'd better find out what it means for you to be with you.

2. Pt.: That isn't it.

3. Dr.: What is it, what is it?

4. Pt.: That isn't it. I look forward to being with me, alone. I, I, I need, the silance and solitude when I'm earning money. When I'm not earning money, I can't do anything(?)

In the next example from Dan, contradiction with an explanation is used by the doctor to teach Dan about his behavior. In this way, rule #4, learning the rules and goals of therapy is also displayed. Dan's first line is also an invitation to balance "little" which the doctor responds to.

Example 4-10: Dan

1. Pt.: I don't want to run off on a little side thing like that.

2. Dr.: This is not a little side thing. Look how deeply involved you are in this, and then you discount what she says to you.

3. Elided No. In a typology of responses to questions, Churchill included ellipsis which he defined as "a response that skips over a piece of conversation understood by the hearer."[11] Thus the elided no response means that the "no" is omitted, but understood by the speaker-hearers and only the reason is offered. He offered the following example of elision: Jock and Roz are a young married couple.

Example 4-11: Jock and Roz

1. Jock: Yeah, I like the smell of that. It smells like burnt firecrackers. Doesn't it?

2. Roz: It smells like branded steer.[12]

In the above example, Jock makes his position known prior to the disagreement invitation in the form of the yes/no question. Roz chooses to disagree by eliding the "no" and providing a completion of reason

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[11]Churchill, Questioning Strategies in Sociolinguistics, p. 42.

[12]Ibid., p. 42. The example is from W. Soskin, ed., Verbal Interaction in a Young Married Couple (Lawrence: University of Kansas Publications, 1963), lines 23/5/98-99.

response; yet both understand that there is a difference of opinion between them and hence, a disagreement.

4. Yes, but or No, but. This response is interesting as a half-way or maybe response. It can do two things: buy time for the speaker or indicate both agreement and disagreement to different parts of line 1. Thus, "yes, but" and "no, but" indicate that the speaker will give a reason for his disagreement or agreement. Offering an explanation means that he will have the floor to clarify his response until he chooses to return it to the first speaker. In this sense it buys time. It also may mean through the explanation that he both agrees and disagrees to different parts of the first speaker's remarks. Assuming that the first speaker takes a yes position, a "yes, but" response from the second speaker indicates some agreement, but actual disagreement. To the first person's same remarks, a "no, but" response indicates disagreement, but with movement toward agreement. Churchill considers this class of remarks briefly as a way of disrupting a possible "3-liner" denigration and gives the following example:

Example 4-12: Roz and Jock

1. Roz: (Laughs) I can paddle pretty well now.
2. Jock: You sure can.
3. Roz: You haven't fallen in yet, have you?
4. Jock: No, but you almost swamped us.[13]

The following examples from Phil and Carrie illustrate the yes, but position as apparent agreement, but actual disagreement. Both patients were described as neurotic and self-effacing.

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[13]Churchill, Questioning Strategies in Sociolinguistics, p. 137, lines 236-239 quoted from above source.

Example 4-13: Phil

1. Dr.: And that's when I said you're a fucking horse's ass. I mean, how could you not be feeling that anger? It's like, my God. What do you do, that you? (can say) How could I feel that anger? It's like.

2. Pt.: Yeah, I know, I know. But I felt the anger, I experienced the anger.

3. Dr.: But you didn't express that anger.

Example 4-14: Carrie

1. Dr.: You're still not saying it very powerfully. (I can be for me)

2. Pt.: Well I can, but. I really can.

In Example 4-13, the doctor's "yes" in line 3 is elided, but understood. Thus, the doctor's line 3, "but..." is an even weaker agreement or disagreement than Phil's response in line 2 to the doctor's remarks.Carrie, in Example 4-14, also seems to be agreeing, but is in fact disagreeing with some part of the doctor's request in line 1. In fact, her statement of "yes, but" in line 2 supports his judgment of line 1--she has not said "I can be for me" very powerfully.

Thus, the negative or disagreeing response of line 2 can take various forms which can be viewed as constituting a continuum of responses. These range from a brusque, rude "no" to a more polite "no, but" with an explanation for the disagreement. The form of line 2 forms the basis for evaluating the strength of the contradiction, and hence, disagreement. Together with the form of line 1, the room for negotiation of differences is determined. To this point then I have examined the form that the disagreement adjacency pair may take. I turn now to the nonverbal aspects of the disagreement which also provides the hearer with the information about the strength of the activity.

Nonverbal Communication

The notion of a continuum is also useful to describe nonverbal communication. The three aspects considered here are tone, flow, and congruency. A loud tone of voice indicates a strong position and a soft voice a weaker one. Similarly, a clear tone of voice indicates a more strongly held position than a hesitating one.

The tone of voice indicating a strongly held position may be used in potential disagreeing activities in either line 1 or line 2. To indicate the disagreement, this nonverbal aspect is used in conjunction with the grammatical forms discussed earlier. Thus in the example below, a loud clear tone of voice is used in line 1 in the yes/no question and again in line 3 in a strong statement which is an invitation to balance. The patient appears angry. The therapist in this example does not engage in the disagreeing process, but instead uses rule #4, teaching the patient about her nonverbal communication. Sherry is a volatile, unstable woman in her mid-30's.

Example 4-15: Sherry

1. Pt.: I felt, okay. What are you doing. Will you stop that?

2. Dr.: Looking for the tape from the other day. See if I can find it, I can't find it. Go on.

3. Pt.: Certainly you can't find it. What are you looking for? You know you can't find anything.

4. Dr.: Let's take what just happened with the "Will you stop that." Is there another way that you could get me to stop it?

5. Pt.: I had a smile on my face when I said that.

6. Dr.: No, no. I know. I appreciate that.

7. Pt.: No you don't.

8. Dr.: I want to use it as an example.

Conversely a low, hesitant tone of voice weakens the disagreement. The following excerpt from Bill, who is distrustful, compulsive, and a loner, illustrates how hesitancy and a low tone of voice removes the strength of his remarks. It comes after the therapist has described the dynamics of his mental illness to him.

Example 4-16: Bill

1. Dr.: But do you increasingly recognize that there's a part of you now that can stand aside inside yourself and observe yourself doing this, some other part of yourself, maintaining this hairy dialogue whose aim is to have you do nothing but be hopeless?

2. Pt.: No, not at all, at that particular point, um, there's no clear thinking about it too much. I just find myself thinking those, thinking those thoughts, and then going on and, you know, ah...but that's, you know, that's ...I think another, well, I thought of course, you know the thinking, the thing to do would be to be conscious of myself thinking those things.

The third aspect to be considered which affects the strength of one's disagreement, is the degree of congruence between one's verbal and nonverbal statements. Thus, in Example 4-15, Sherry pointed to the smile on her face in line 5, as a way of weakening or denying her previous statements in line 3. Similarly, incongruence between one's verbal and nonverbal communications can be used to indicate joking behavior. That is, if a non-serious tone of voice is used in conjunction with a serious statement, it tells the hearer not to take the speaker's comments seriously. Or vice versa, if a silly statement is spoken in a serious way, this incongruence also signals not to be taken seriously. Thus, in instances of disagreement, these cases of incongruence weaken the strength of the disagreement.

Consider the following two cases which illustrate the above.

Example 4-17: Roz and Jock

28. Roz: You don't want me to look freakish, do you?

29. Jock: (laughs)

30. Roz: Do you?

31. Jock: Sure.

32. Roz: If you want me to look like a freak, that's all right. I'll be glad to oblige.[14].

Example 4-18

1. Interviewee: I couldn't just walk up to her and tell her I was sorry.

2. Interviewer: Oh, of course not, she might have eaten you.[15]

In Example 4-17, Roz's questions in lines 28 and 30 are yes/no questions, which indicate her preference that she expects negative replies. Jock's positive and non-preferred reply in line 31 is an example of this incongruence--a serious statement said in a joking manner. Line 2 in Example 4-18 is an instance of the opposite--a non-serious statement said seriously. Thus, in the three examples presented (4-15, -17, -18), we can see how incongruence weakens one's disagreement.

Another kind of incongruence between verbal and nonverbal communications is seen in the following example. The doctor's line 1, which is a statement, is said in a questioning tone of voice; that is, with an upward inflection, as if it were a question. This weakens his assertion.

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[14]Churchill, Questioning Strategies in Sociolinguistics, p. 136, line 6/21/28-31 from W. Soskin.

[15]Alfred Benjamin, The Helping Interview, 2nd ed. (Boston: Houghton Mifflin, 1974), p. 147.

Example 4-19: Jill

1. Dr.: You feel floaty.

2. Pt.: No.

Thus, a guideline for speaking generally may be: if you want to be believed, say it like you mean it. This fits in with the communications literature which suggests that there should be congruence between one's verbal and nonverbal communications.[16] As a maxim, it can be stated as: synchronize your verbal and nonverbal communications if you want to be taken seriously.

Therefore, on the dimension of strength of disagreement, nonverbal communication is an important indicator of how we want our statements to be heard. A loud clear tone of voice indicates a strong position; conversely, a soft, hesitant tone indicates the opposite and waters down the disagreement. In addition, incongruence between one's verbal statements and nonverbal statements weakens the potential disagreement. The incongruity may then be heard as a joke or if the remark takes the form of a statement, it may be heard as a question. Thus, a congruency maxim was formulated.

To summarize this analysis of disagreement, we can see that it is a complex activity, even in its simplest form as yes/no. It is a rude, impolite activity which may be made less so through various strategies. Disagreement was analyzed as an adjacency pair and contradiction. The various forms of the negative reply were discussed and a disagreement maxim was formulated. Nonverbal communication was also examined as it affects the above forms. Thus a congruency maxim was formulated.

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[16] J. Ruesch, "Nonverbal Language and Therapy," Psychiatry 18 (1955):323-30.

These introductory remarks on disagreement serve as an introduction to even more complex disagreeing activities which are discussed in the next two chapters. Negative reinterpretation and confrontation are both kinds of disagreements with the first person taking a yes position and the second a no position. I turn now to these activities.

CHAPTER 5

NEGOTIATING DISAGREEMENT: CATEGORY FORMATION AND NEGATIVE REINTERPRETATION

The work of therapy gets done with the patient presenting personal material (rule #5) and the therapist teaching the patient about the rules and goals of therapy (rule #4). Rule #4 is extremely broad and includes learning about the techniques used within therapy, such as making interpretations, as well as the goals of therapy, e.g., living a more satisfying and productive life. That is, the therapist teaches a new system for living by pointing out the patient's old system and encouraging him to adopt a more healthful one which is slowly presented throughout the course of the therapy. It is up to the patient to incorporate these ideas as his own. This chapter deals with the patient presenting his material and the therapist commenting upon it. The comments are of the disagreeing type in that the message is always communicated to the patient, "The way you are living now is not as good as it could be. I will show you how it could be better." This system of the patient cognizing and the therapist evaluating is discussed in this chapter.

Theoretically, this chapter is based on Harvey Sack's notion of membership categorization devices[1] and Harold Garfinkel's documentary

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[1]Harvey Sacks, "On the Analysability of Stories by Children," in Ethnomethodology, ed. Roy Turner (Middlesex, England: Penguin Books, 1974), pp. 216-32.

method of interpretation.[2] Sacks defined "membership categorization device [or just "categorization device"] as any collection of membership categories, containing at least a category, which may be applied to some population containing at least a member, so as to provide, by the use of some rules of application, for the pairing of at least a population member and a categorization device member."[3] He developed his terms in an analysis of doing describing and recognizing a description, such as, "The baby cried. The mommy picked it up." In my discussion of category formation, the description need not refer back to a population member. In a sense, then, category formation, as I use it here, is a generalization of Sacks' notion.

The analysis of category formation consists of examining member's usage, how the notions that a member uses are constructed and the limits of the categories which he uses. Garfinkel refers to this examination of categories as the documentary method of interpretation which

> consists of treating an actual appearance as "the document of," as "pointing to," as "standing on behalf of" a presupposed underlying pattern. Not only is the underlying pattern derived from its individual documentary evidences, but the individual documentary evidences, in their turn, are interpreted on the basis of "what is known" about the underlying pattern. Each is used to elaborate the other.[4]

Category formation and the documentary method of interpretation are

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[2]Harold Garfinkel, Studies in Ethnomethodology (Englewood Cliffs, NJ: Prentice-hall, 1967), Ch. 3, "Common Sense Knowledge of Social Structures: The Documentary Method of Interpretation in Lay and Professional Fact Finding."

[3]Sacks, "On the Analysability of Stories by Children," pp. 218-19.

[4]Garfinkel, Studies in Ethnomethodology, p. 78.

member's devices; activities engaged in by members of a common culture. Garfinkel refers to common culture as "the socially sanctioned grounds of inference and action that people use in their everyday affairs and which they assume that others use in the same way."[5]

In studying the routine grounds of everyday activities, Garfinkel undertook his now-famous "disruption experiments." His students undertook to break the taken-for-granteds of everyday conversation, by asking "What do you mean?" after statements that they, as competent members, should have understood. Garfinkel notes that "the retrospective-prospective sense of a present occurrence, waiting for something later in order to see what was meant before, are sanctioned properties of common discourse."[7] However, in the therapy situation, the question "What do you mean?" is a legitimate question used to question the grounds of a category construction, without suffering the usual consequences for breaking the rules of everyday discourse.

In the excerpts I present, the therapist does not disrupt the conversation as Garfinkel's students did. Instead, he is a natural disrupter. In the therapeutic context, the therapist can question the grounds of a patient's categories by suggesting an alternate construction. By doing this in the context of making an interpretation, he displays his expertise and is in fact doing the work of therapy. The participants do not react as if the therapist has disrupted the conversation; they consider it for acceptance and incorporation into their self-system as a basis for changed behavior.

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[5]Garfinkel, Studies in Ethnomethodology, p. 76.

[6]Ibid., p. 42. [7]Ibid., p. 41.

The way that Garfinkel attempted specifically to show the grounds of people's statements was "to exaggerate the features of the documentary method of interpretation" and to catch the work of "fact production in flight."[8] He did this by setting up counseling sessions in which the subjects verbalized their thoughts after receiving random "yes" or "no" responses to questions they had asked of their pseudo-counselors. The subjects attempted to make sense of the advice given, even when it seemed not to. Garfinkel analyzed the exchanges and the subjects' thoughts about them. In this way he showed how we search for and determine patterns, and use the retrospective-prospective feature of conversations.[9] In both Garfinkel's counseling experiments and the therapy sessions I analyze, the patients often verbalize the grounds of their responses. However, in my sessions, the therapist can also question the patient's grounds or present alternative constructions through the activity of negative reinterpretation, which Garfinkel's experimenter-counselors were not permitted to do. Thus in the therapy situation the therapist examines the patient's category constructions and reinterprets them to show they are incorrect and why they are incorrect.

In the psychotherapy process the therapist teaches the patient new conceptualizations about the world he lives in, i.e., new construction for his category packages. Presumably, the patient sees the world differently than a "normal" member of the population and constructs his categories differently. The therapist seeks out the hidden pattern of

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[8]Garfinkel, Studies in Ethnomethodology, p. 79.

[9]Ibid., see Chapters 1-3.

which talk is the evidence. If the patient is schizophrenic, his constructions would be far afield from those taken-for-granted and shared by most normal members. If the patients are neurotic, not psychotic, then their constructions would be more in accord with the therapist's prescriptions. The therapist examines the grounds of the patient's categories and reinterprets what the patient is saying in a way that is considered healthier and that he believes will result in a more satisfying way of life for the patient, if the patient chooses to accept these re-definitions.

The therapist, perhaps unknowingly, uses a number of strategies to do category examination and negative reinterpretation. First, he makes use of the fact that categories consist of its constituent elements and he examines the contents of the patient's category packages. This is similar to Sacks' membership categorization devices and the concept of class; its constituent components being members of that class. I use the term "category package to connote a generalization of the idea of class. Thus, on a simple level, an examination of a noun such as "trees" would include members of that class of things, such as oaks, elms, pines, etc. However, in the case of therapy, the category packages being examined are far more complex; they are not limited to nouns and in fact include the patient's way of seeing or categorizing the world. Further on, an analysis of such patient's conceptualizations is presented. Here, not only are the constituent elements of category packages examined, but also the patient's attitude toward that category.

Second, the therapist not only corrects the constituent elements of the patient's category packages, but also re-classifies them by shifting them into larger or smaller packages. Thus, the former class

of trees can be grouped into evergreens and non-evergreens; short life-span and long life-span; hardwoods and softwoods, etc. Or the therapist can consider trees as one member of a class of living things which is, of course, a larger category. Thus, the therapist examines the patient's category formations at different levels of specificity and generalization.

As the patient presents material during the course of therapy, his view of the world becomes apparent. In so doing, the therapist has the opportunity to then correct the patient's category packages. The patient does not know when or how the therapist might choose to disagree with his constructions, or that his category packages even need to be re-constructed. I call this activity "negative reinterpretation" to connote the disagreeing aspect of the activity and the change which the therapist attempts to accomplish. The therapist disagrees with the patient's category construction and reinterprets it in a new, healthier way. In this chapter, I examine some of the ways this can be accomplished by focusing on shifting, which includes stretching, funnelling, making analogies, and psychoanalytic interpretations. Each of these techniques of doing negative reinterpretation can be viewed as part of a continuum from direct to indirect activities in relation to the category that is being reinterpreted. Thus, stretching is the least removed from the initial category package, funnelling into a new category is more removed; analogy which is a parallel construction is more removed from the initial category; and psychoanalytic interpretation is even more so. The last device can be seen as a special kind of analogy; that is, it is an analogy using its own language. Nonetheless, in terms of the continuum mentioned above, it is considered separately

since it is such an important part of the psychiatric literature. In all cases, category formation is involved. What is interesting about these devices is that in using them, the therapist can make a continuum out of contrast and thereby negotiate disagreement. Each of these devices of negative reinterpretation will be discussed in turn.

I turn now to specific excerpts in order to analyze the activities of category formation and negative reinterpretation and to see the kinds of hook-ups that are made to allow for these activities to occur.

Category Formation

The activity of forming categories implies that it has constituent elements. These elements together form a category or small package. The entire category can also be part of a larger class or package illustrated above. I argue for instance, that all the activities discussed herein are part of a larger category package, disagreeing activities. A category includes, however, not just its parts, but also thoughts, evaluations, judgments and attitudes about one's category constructions. The image of a snowball may be useful here. The center of the snowball is hard, but it gets soft and fuzzy towards its outer edges. Combined with more snow it loses its original form and becomes part of something larger. In reverse, the edges seem to dissolve and fall off, leaving the holder with only the hard core of a once large snowball. So too categories may be formed and enlarged or made precise and discrete. The heuristic device of a continuum will be used to show how category packages "hang together" and conversely may be stretched to the point where we have a whole new category. This activity of

constructing new categories will be considered under "negative reinterpretation." I turn now to a number of excerpts where the category package is examined by the doctor and patient. In these examples, the categories "schizophrenic," "feelings," "miracle" and "mental illness" are examined.

In the first excerpt the therapist examines the psychiatric label "schizophrenic." He states that the category "schizophrenic" consists of x, y, and z behaviors and in order for him to classify the patient as schizophrenic, she must meet these criteria. In the excerpt below, we see this process verbalized and he concludes she does not meet the test of his definition and therefore must not be schizophrenic. Jill had been so labeled during her previous hospitalization and she was aware of this. Sarah is the social worker who referred her. In line 5, the doctor makes an interpretation about her presentation thus far. In this example, we see the elements of a category presented.

Example 5: Jill

1. Dr.: I must tell you that although you look schizzy, from the way you put yourself together, you don't put yourself together, from my point of view, middle class background, New York,

2. Pt.: I don't, I haven't been middle class for years.

3. Dr.: What are you?

4. Pt.: Counter-culture. (mumble)

5. Dr.: Counter-culture. But you frankly, you don't talk...schizzy. You talk like a gal who's got a disturbed set of values, a stinking image and conception of yourself, a lot of confusion about your life, a lot of anger which is distorted from where you've been going. You may turn out, when I get reports, and I want you to know that I'm not biased by other people's reports. I read them, but what I go by is me. I'm the seismograph. Do you understand that? This I've learned a long time ago. So you

look like...a gal who I could cry with, I could cry with you. I could feel with you, but that alone won't help you. (small pause) That alone won't help you That would be like, let's say Sarah's patronizing. It won't be the same, if you felt it was sincere, when I say that

6. Pt.: I don't see what's schizophrenic about my appearance.

7. Dr.: I can't tell yah. You're not that much different than a lot of the younger people today. OK?

8. Pt.: They're all schizophrenic? (overlap)

9. Dr.: But from my point of view they all look loaded (?) and schizzy to me.

The therapist uses the patient's appearance as an indicator in the category "schizzy." However, since she doesn't talk schizzy, talk being another indicator, he concludes that this category cannot be used to refer to his patient. In line 6 Jill denies that her appearance is schizzy, which the therapist later agrees with in line 9, by saying she looks like other young people of her generation. The patient's line 8 marks the beginning of a confrontation which is not followed through. (Confrontation will be discussed in the next chapter.) The patient agrees that she and people who dress the way she does don't care about their appearance, but disagrees that she and they are schizzy. Further on in the transcript the doctor comes to agree by saying, "O.K., here's an area where we'll have difficulties where as a result of my not being on your generational level, I still have a problem."

In the next example, the therapist shows Carrie how her formation of the category "feelings" is incorrect and states that a normal member's package would include anger. The patient immediately accepts his corretion, and reconstitutes the package "feelings" to include "anger."

Example 5-2: Carrie

1. Pt.: It hasn't helped them. And one of the things I think that therapy teaches you to do or helps you to do is is to learn to express your feelings and also to learn to express your anger.

2. Dr.: Yes.

3. Pt.: [And one of these things

4. Dr.: [Well, that's interesting. You say your feelings, and also to learn to express your anger, as if your anger was not your feelings, separated feelings and anger. That must mean something for you.

5. Pt.: OK, no, anger is a part of feelings.

6. Dr.: It certainly is.

7. Pt.: Yeah.

In Example 5-3 the therapist discusses the formation of the category "miracle." He does so to show her the dynamics of her behavior. The disagreement over the use of the word "miracle" is used to illustrate how she creates categories which he implies is not how a "normal" member would. As the authority, his use and construction is the correct one. This category package is interesting because it is not only about the correct set of elements in the category, but also includes her attitude toward the category, miracle. Sherry is a volatile woman in her mid-30's who has difficulty with relationships. The miracle that she refers to in line 1 is the fact that she never lost a friend during the four months when, as she puts it, she was "off her bloody rocker, obsessed all over the place, pacing and repetitive," and the discovery that she takes her self-concept from other's attitudes towards her.

Example 5-3: Sherry

1. Dr.: Could you accept that it's not a miracle, but that it's you, not a miracle, that's responsible?.

2. Pt.: Me??? (incredulously)

3. Dr.: For finally being open to the data of reality?

4. Pt.: No, I'm talking about the miracle of their staying and sticking and listening and talking with me, and being... because that's all out of this, I mean, you must know, what when that that was all. I'm if I said something, I said it millions of times, maybe millions, in four months, I spent all my waking hours repeating the same things over and over and over, to everybody and anybody who would listen. And I wasn't open to hearing them. And then I started hearing...

5. Dr.: (overlap) That's not miraculous. That's an expression of human caring. Some people call it loving. Sometimes it is. Now, but we'll call it for the moment, caring.

The purpose of the therapist's first line is to get the patient to take responsibility for her improved mental health. She disagrees about two points: in line 2 her tone of voice expressed incredulity and in line 4 again by saying he ascribed to her that she thought her improvement was a miracle; in fact she was referring to her friends' behavior toward her in very difficult times. The doctor deftly displayed his expertise. Since he could not get her to agree and take responsibility for her improvement, he quickly shifted the agenda to correctly interpreting the other people's behavior toward her (line 5). As the authority he determines the correct reality--her friends' behavior toward her is an expression of caring. His original intention was to show her how her package "miracle" was incorrect, and how his, as a normal member, is correct.

In this last example the two speaker-hearers examine the category, "being sick," specifically being mentally ill. It also has to do with the patient's attitude toward a category.

1. Pt.: I said, I am ashamed, I feel the, whatever these host of feelings are, I let myself down, I am embarrassed,

I am ashamed, I am still surprised, the whole range of feelings, you're not ashamed of me, I'm ashamed of me. Therefore if anybody's gonna forgive me, it's myself that has to forgive me. Likewise,

2. Dr.: Forgive you for what?

3. Pt.: Being, getting sick.

4. Dr.: But there's an implication in there...

5. Pt.: I said...

6. Dr.: That being sick...

7. Pt.: [I am ashamed (overlap)

8. Dr.: [needs forgiveness.

9. Pt.: I said I am, not...I have not forgiven myself. I haven't made you accept that. I have not forgiven myself, I am still ashamed. That is my distorted perhaps sense of myself, but nonetheless, that are, those are my feelings. So it occurs to me that until I manage and work through these feelings for myself, you're saying, why, Sherry, that's all right. I, I forgive you. Everybody gets sick [once in a while.

10. Dr.: [I refuse to say, "Sherry, I forgive you," because there is nothing to be forgiven for. I will not play that game of allowing you to put in my mouth (laughs) that I forgive you. [I'm not joining your bag, that there's something to be ashamed of.

11. Pt.: [Will you let me tell you what I discovered, (loud) and you might just feel a sense that I found out something good for myself.

12. Dr.: I can hear that you did.

13. Pt.: But you keep interrupting so I can't tell you the bottom line. I know, that from your view I have nothing to forgive myself for, but to me I do...

In this excerpt Sherry and her psychiatrist disagree about a related aspect of the category "sickness." That is, they disagree not over the definition of the category, but over her attitude toward the category; they disagree if the category sickness needs to be forgiven. While she originally wanted his "forgiveness," she now recognizes it must come

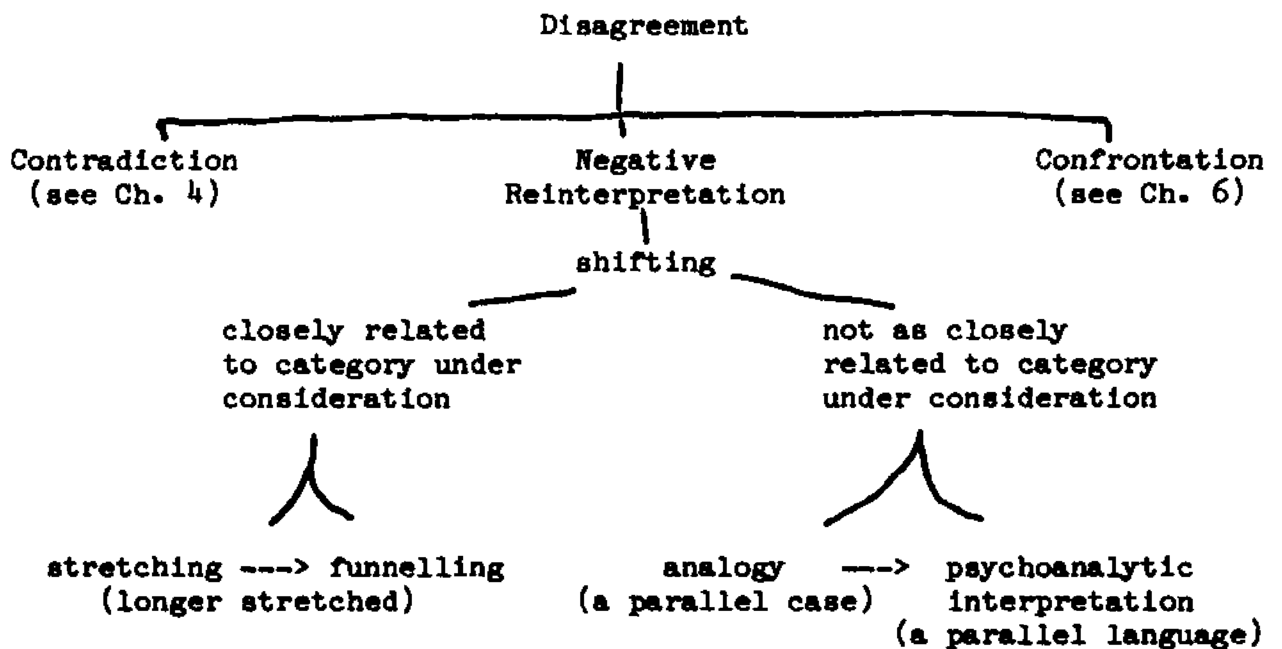
from herself. He denies that the activity needs forgiveness. In line 10 the doctor disagrees by saying, "I refuse to say 'I forgive you' because there is nothing to be forgiven for. I will not allow you to put words into my mouth." The patient responds in a loud and angry tone of voice, "Will you let me tell you what I discovered, and you might just feel a sense that I found out something good for myself." Their disagreement has to do with one of the elements in the category "sickness" and finally she states, "I know that from your view I have nothing to forgive myself for, but to me I do." Thus she includes foregiveness in her package, but he does not.

Negative Reinterpretation

The process of therapy is a process of re-education whereby one person's thinking process and category formation process becomes public and open for disagreement and discussion. As stated, I use the term "negative reinterpreting" since it is usually the therapist who is correcting, in a sense, disagreeing, with the patient's category formation and reinterpreting it in a new, healthier way.

These devices form their own continuum; each activity discussed is a broader step away from the original topic under consideration. Shifting as used here is a broad term, but is not equivalent to negative reinterpreting as a whole since it omits the disagreeing aspects of negative reinterpreting. Shifting includes stretching, funnelling, making analogies and psychoanalytic interpretation. While these may not be the only devices used, these are the ones I found in analyzing these transcripts. Stretching and funnelling are directly related to the category in question. The shift can be minor as in stretching or

involve funnelling into a whole new category; that is, moving from the specific to general or vice versa. Analogy is a much larger shift and involves creating its own category package which is parallel to the one under consideration. Psychoanalytic interpretation involves its own language and thus is an extreme kind of analogy and hence, shift. This language, which makes use of the conscious and unconscious as bases for behavior, is the foundation of psychoanalysis and well known to practicing therapists. Thus making psychoanalytic interpretations and attempting to get the patient to agree to them, is an attempt to teach the patient a new language and agree that it is a valid one. It is also an extreme shift from the category in question. However, as a device, it can be used to do positive reinterpretation as well as negative reinterpretation, although it is most frequently used in negative reinterpretation in psychotherapy. Analytically, negative re-interpretation can be viewed as follows:



The tree diagram above shows the relationship of negative reinterpretation to disagreement. It is one kind of disagreeing activity. In the remainder of this chapter I examine stretching and funnelling which are kinds of shifting that are closely related to the category under consideration and analogy and psychoanalytic interpretation which are more removed from the category under consideration. They are each ways of doing shifting, essential to the activity of negative reinterpretation and hence, disagreement.

Closely Related Shifts

The concept of category implies constituent elements and therefore a package. The two speaker-hearers can disagree about the elements that go into forming the package or the appropriate attitude toward a construction. Heuristically, it is conceivable that if enough new elements were included, we would have an entirely new category. A category must then have boundaries. It is possible then for the two participants to disagree not only about the elements which constitute a category or package, but to also dispute the boundaries of any category.

I again refer to the snowball image. It may be enlarged slightly or stretched; or, may be used in a materially different way, such as to make a snowman or igloo. Such substantial shifts I refer to as funnelling. The difference between stretching and funnelling is one of degree and therefore not easily distinguishable in the middle range. However I retain the distinction since a small overlap or stretch can easily be discerned as well as a qualitatively major one. The difference will be clearer upon examining the excerpts.

The therapist negotiates disagreement by verbally re-creating the patient's categories as parts of different or larger or smaller packages. Since the therapist disagrees with parts of the patient's constructions, I call this activity negative reinterpretation. The activity is available to both participants.

Stretching

I begin this analysis of negative reinterpretation with the notion of a continuum where the categories are reinterpreted by using stretching. Consider the following examples from Jill and Dan.

Example 5-5: Jill

1. Dr.: How come, you didn't call?

2. Pt.: 'Cause I didn't care anymore.

3. Dr.: You what?

4. Pt.: Because he [her father] was the one who wanted me to come. I didn't, particularly want to come.

5. Dr.: In other words, you're not here because you want to be.

6. Pt.: I don't really know.

In this example rule #1, you must want to get well, is examined. There is an implicit disagreement between the doctor and patient because from his point of view, she should be here because she wants to be. The patient's "I didn't particularly want to come" of line 4 is her amplification of "I didn't care anymore" of line 2. The doctor then reinterprets her amplication "I didn't want to come" into "I'm not here because I want to be here." While these statements are almost reverse sides of the same category, this stretch provides the doctor with an opportunity to ascertain if she is in his office for a consultation completely against her will or not. Since the patient does not reject

his reinterpretation directly in line 6, some agreement to his statement is implied. At least some part of her does not wish to be in his office. The doctor must discover through her statements if any part of her, i.e., the healthy part in her, recognizes the need for therapy and wants to be there.

The doctor makes other leaps on the continuum with the same patient.

Example 5-6: Jill

1. Dr.: Whether they take you or not, I would tell them to throw you out, if you say I can't get out of bed. That's utter nonsense. The real answer is I won't. Right?

2. Pt.: Yeah.

The doctor connects can't get out of bed with won't get out of bed and the patient accepts this connection.

The doctor continues with Jill below:

Example 5-7: Jill

1. Dr.: Now we're back to I can't. Now look, I can't accept I can't.

2. Pt.: So I won't. Well, I've tried.

3. Dr.: Say up till now I haven't been able to.

4. Pt.: All right. It's the same thing. Able is the same as can't.

5. Dr.: No, it's not. Uh, uh. I can not is a statement which implies a finality, a not trying, rather than, I haven't been able to make it up to now, but I'd like to. Would you like to?

6. Pt.: Yeah.

7. Dr.: That's a different statement. I like to help people who like to. (pause)

In example 5-7 the two participants disagree and the doctor shows the patient the links he is making conversationally. In line 4 the patient

attempts to connect two ends of a continuum within the category getting out of bed including the elements can't, tried, not able, won't. The doctor as the authority does not accept her category formation. In addition in this example, I infer that the doctor is checking out her degree of motivation to be there and whether the all important rule of wanting to get well is in operation. Its corollary that she must do everything she can in order to do so, suggests a docile patient who would respond to the doctor's request in line 3, "say up till now I haven't been able to," by repeating in line 4, "up till now I haven't been able to." Conceivably the doctor could then reply in line 5, "that's better." She would appear to be cooperating. Instead she rejects his request for demonstrating cooperation and offers her category package, which he rejects. He refuses to accept the stretch from not able to can't.

In another excerpt, the doctor confronts the patient and disagrees indirectly. He does not disagree with any part of the given remark, but with something else related to that remark. That is why this example is discussed here, although it will be presented again in the next chapter.

Example 5-8: Jill

1. Pt.: I don't--have much--faith--in therapy or anything any more.

2. Dr.: You don't have any faith in anything?

3. Pt.: No.

4. Dr.: You want to live? Or you want to die?

5. Pt.: I don't want to die; I'd be dead. (very low voice)

6. Dr.: OK, so there's obviously some evidence that you want to live. Is that right?

Here the therapist does not disagree with what the patient actually said. Rather he stretches it, exaggerates it, by substituting "any faith" for "much faith." In line 4, "any faith" is stretched to such a degree, beyond the ends of the continuum into a whole new continuum of "living" or "dying." This extreme shift may be considered a funnel. However, the patient does not comment upon any of the shifts which the doctor has made. The doctor has made Jill's remark in line 1 out to be "worse" than it really is and then he proceeds with the confrontation routine.

Larger Stretches--Funnel

In the next group of examples the "stretch" is much greater and therefore I use the word "funnel" to describe the largest stretches or shift from one category to another, substantively different or larger category.

In the next few examples from Dan we again see the doctor utilize more extreme stretching and the patient use an invitation to balance in the activity of negative reinterpreting.

Eample 5-9: Dan

1. Dr.: ...What is, what, Do you feel that you Alice is ready to leave therapy, right?

2. Pt.: Yeah, I think that she's about got out of it, what she's going to get out of it.

3. Dr.: So you're really saying that you don't have much hope for her to go further.

4. Pt.: All I can do is compare her to the a-average person in life. And I'm saying, we can't build supermen. She's going to have these angers and the rest of her life. She's not going to completely divest herself of them.

5. Dr.: Of what?

6. Pt.: Of her volity. [volatility?]

7. Dr.: The goal is not to divest herself of all anger. The goal is to be able to be free to be angry or tender or loving, when that's what's what's appropriate. Appropriateness is the goal.

In the first line the doctor seemingly asks a question by making a statement and slips in the word "you" instead of Alice. However the patient understands what the therapist said by responding that, yes, he thinks Alice, another patient, has gotten all she can out of (group) therapy. The therapist reinterprets this to "so you're really saying that you don't have much hope for her to go further." The therapist moved Dan's statement in line 2, an unmotivated description to a motivated "dig" in line 3. He has stretched the category "ready to leave" to be very broad, but the patient does not comment on this shift. Instead Dan continues by explaining what he means in line 4 and displays his implicit assumption that Alice should get rid of all of her anger. After the misfire in lines 6 and 7 which needed to be cleared up first, the therapist in line 7 displays his expertise by teaching the patient one of the goals of therapy: "appropriateness is the goal."

The next example of negative reinterpretation where the device of shifting is used again comes from Dan a little later on.

Example 5-10: Dan

1. Pt.: I just don't think you're gonna get too much further with a person like

2. Dr.: Well, maybe she'd be pleased to hear you say that she's gone about as far as she can go, and she ought to leave.

Again Dan does not disagree with the stretch that the therapist has made. However their negotiation about the amount of progress Alice has

made ends later on with the doctor saying, "...You may be right. But let's explore it in group....Everybody agrees and she agrees, then that takes care of it. And we might have quite a leave by the end of June." What is interesting is that the therapist has relinquished some of his authority by saying let the group be the arbiter of the degree of Alice's progress. Dan responds with a disappointed "oh."

Excerpt 5-11 from Dan illustrates the device of the funnel in shifting. Dan has stretched "getting any better" to "crazy." The therapist then stretches or funnels Dan's remark into a whole new category of arrogance.

Example 5-11: Dan

1. Dr.: So we have to find out her expectations in this? What she wants?

2. Pt.: Yeah. And I'm gonna tell her, if she thinks she's gonna get any better, she's crazy.

3. Dr.: Now that's arrogance. See how you shift upstairs. Instead of questionning it, and leaving it, you then shift upstairs. Like if you think you can get any better, you're crazy. That's condemning her! (loud) That's condemning her to whatever hell she's still living in.

In Example 5-11 the therapist does not disagree directly, but rather reinterprets the patient's remark as arrogance. The therapist then goes on to accuse the patient of shifting upstairs, but that is what the therapist has also done by funnelling Dan's description "crazy" into a new and different category, "arrogance." In using such a funnel, the therapist has pointed out what the patient is doing rather than disagreeing with him directly. In a sense, it is a kind of interpretation on the "how" rather than the "what" of the patient's behavior and is part of the therapist's task. Using negative reinterpretation

the therapist often moves from the concrete data presentation to a discussion of the method--how the patient is speaking or acting. This is a move from rule #5--present personal material to rule #4--learn about therapy, in this case metacommunications.

Excerpt 5-12 continues the discussion on Dan's arrogance. It is stretched even further, incorporating arrogance with other attributes. This last stretch is the doctor's categorization.

Example 5-12: Dan

1. Pt.: But they're only human, and they can only go so far.

2. Dr.: Yeah, but I, I. I've never seen any human being who's gone as far as he can go. I've never met one person who's gone all the way.

3. Pt.: Right. But you are not capable of making these people...

4. Dr.: Go all the way?

5. Pt.: Leading (?) them.

6. Dr.: No-o I can't, I I can't make myself go all the way yet. How can I do it for anybody else? But I can help people find a road to keep going for themselves. And a pattern and a process. That's what's my, that's how I see myself. I can't go all the way.

7. Pt.: Yeah, well, I just think that she's gone about as far as she can go.

8. Dr.: You tell her, but I say, instead of you're this, and you're crazy if you think you can go any further, that's fucking arrogance.

9. Pt.: he, he (laughs)

10. Dr.: And belittling and cynical. Don't you see it--it's demeaning, it's, it's, it's not so

11. Pt.: It expresses very strongly my feeling that people are human.

12. Dr.: Yeah, but I believe they're are human too, and they can go as far as...

This excerpt begins with the patient's invitation to balance in line 1 --so far, along one end of the continuum. The therapist responds to it in line 2--as far. The continuum is along the line of how far can people go in therapy and they are attempting to negotiate the distance. In line 4 the doctor asks if it is permissible to stretch "so far" to "all the way." Perhaps the patient nodded, but the therapist responds as if that is Dan's position, even though in line 1, Dan stated people can only go "so far." In line 6, the therapist uses this exchange to teach the patient about therapy, its goals and his role in it. Dan repeats his contention on the distance in line 7 and here the therapist responds by reinterpreting his position (she's gone about as far as she can in therapy) to mean that Dan is saying Alice is crazy if she thinks she can go any further. The therapist then defines Dan's behavior as arrogance. He has raised Dan's comment into the new larger package consisting of arrogant, belittling, cynical and demeaning. Dan doesn't disagree with this reinterpretation and the two continue disagreeing until the end of the session. At the very end of their session, they agree to continue disagreeing as seen below:

Example 5-13: Dan

1. Dr.: So. You listen to whatever statistics and people you want. Believe what you want. And that's what I do. But I keep going on. I keep trying.

2. Pt.: Listen, uh do I have the appointment next week?

3. Dr.: Yeah.

The session ends as do all others, with the exception of a last session, with arrangements made for the following one--very practical considerations. It ends with the therapist again explaining his own goals in therapy.

In another part of Dan's therapy session, the therapist also uses a funnel by pointing out a specific instance from the patient's general statement. Here the therapist again moves from the presentation of material to a correction, part of the teaching that he does.

Example 5-14: Dan

1. Pt.: ...You know why I was revolted, 'cause there I'm just sitting there and I'm, I don't relate to the whole damn thing. I felt like saying - bunk, I felt like saying

2. Dr.: Why didn't you say it? You're very much related to the whole thing. You're very angry about lots of things that are going on. That's related.

In this example of disagreement the therapist disagrees by reinterpreting Dan's statement. Dan's "I don't relate to the whole damn thing" is an invitation to balance, at the extreme end of the continuum. The doctor disagrees that he doesn't relate by pointing out an exception to his statement, he relates by feeling angry. The doctor has funnelled Dan's statement upward into the larger category--relating which includes feeling angry. The therapist has broadened the category package proposed by Dan. Being angry is classified as one way of relating to what's going on in the group. This way of disagreeing corrects Dan's extreme stand to--I relate to some of it; I get angry.

As noted earlier, we are always subject to being disagreed with. However, we do not know what direction this disagreement will take. Thus using funnelling into a larger category does not tell us what connection the person who refutes will make.

In this next excerpt we again see the negotiation of disagreement with the use of categories, stretching and funneling. The therapist connects some ideas which on the face of it have no connecting link. However the second speaker-hearer does not object to the

connections and the therapist uses these links to make interpretations and display his expertise.

Example 5-15: Dan

1. Dr.: Now that's the important thing. What's your need to
2. Pt.: I want to believe it.
3. Dr.: What is your need to believe this?
4. Pt.: I want to believe ['cause then I can be angry with you.
5. Dr.: [because then you can be angry with me. You know, if you weren't so angry with me, and you liked me, you'd have to feel tender. That would be awful, wouldn't it.
6. Pt.: Yeah.
7. Dr.: You'd have to trust me and feel tender.
8. Pt.: I couldn't do it.
9. Dr.: I wasn't a bastard. I wasn't just a bastard.
10. Pt.: Well
11. Dr.: It's hard.
12. Pt.: You're right.
13. Dr.: Then I might turn on you. Then I'd be a bastard.
14. Pt.: Yeah.
15. Dr.: It's disillusioning.
16. Pt.: Yeah.
17. Dr.: It's pretty crucial, whether you can take that chance.
18. Pt.: Well, I can't take it really, obviously I can't. I have
19. Dr.: Well, you did though. There are many tender moments that come through between you and me. Or they, don't you know? They must sneak out. Despite yourself. I have many tender feelings with you. And you are tender with me at times. It's usually begrudgingly, but not always. It's like it's hard for you. And it isn't always that way. Isn't that where we are?

20. Pt.: I don't know. I'll have to hear myself on tape.

21. Dr.: All right. I'll try to pick out some spots where you come through, tenderly, you just did a moment ago

22. Pt.: Well, maybe, but

This excerpt begins with the therapist asking for a reason for the patient's need to believe that the co-therapist, the psychiatrist's wife, gets dragged down against her will to group therapy sessions. The patient provides the answer in line 4--so that he can be angry with the therapist. In line 5 we have the first aspect relevant to this chapter--the formation of categories and stretching. Implicit in this discussion is a dichotomy of "soft" and "hard" as polar ends of a continuum. While the items are not interchangeable, the therapist treats them as if they were and the patient makes no objection to these switches. So for instance, anger, tough, distrustful forms one package and passive, tender, trust forms another. The therapist thus stretches and reinterprets: "If you weren't <u>so angry</u>" (on a scaled continuum) to "and you liked me," then (he stretches again) "you'd have to feel tender." The invitation to balance "so angry" is not taken up by the patient. Feeling tender however is what the patient said previously he didn't want to do and the therapist had already said tenderness is one of the goals he strives for in himself and his patients. An implied disagreement exists between them. The therapist classifies and attempts to connect two categories "you'd have to trust me and feel tender" which on the face of it are not connected. Such a reinterpretation is important because the therapist as the expert and authority made connections which were not questioned by the patient. Dan would be questioning the therapist's expertise had he done so. However, if

Dan had made such leaps the therapist could always interject and ask, "How can you do that?" The patient under rule #3, be yourself, could have done so as well, but chose not to. Therefore the therapist's reinterpretation is tacitly accepted.

Lines 7-14 also deal with categories and shifting; this time, however, the therapist uses a funnel to make a category package. He connects "trust me" with "feel tender" and then puts it into the larger category of "wasn't a bastard or just a bastard." Trust and tender, as stated above, were already implicitly connected by the therapist. He has now funnelled this package to include the opposite of bastard or only a bastard. The therapist is trying to ultimately broaden the patient's horizons of acceptable emotional responses and to show him that the responses can range from one end of a continuum, "a nice guy," to the other, "a bastard." The therapist makes these leaps which Dan tacitly accepts by not disagreeing or noticing them. In line 13 the therapist makes an interpretation on the dynamics of their relationship (rule #4) which the patient agrees with: "If I wasn't just a bastard in your mind and you trusted me, I might turn on you and I'd be a bastard," confirming Dan's fears.

In the last part of this excerpt (lines 17-22) the therapist attempts to get agreement between them. Line 18 is a refutation of line 17 with the therapist saying it's pretty crucial whether Dan can take a chance and trust and feel tender towards him. There is an implication that he ought to. The patient replies in line 18 that he can't and the therapist contradicts him in line 19 saying he did. The patient's line 18 makes it seem from his point of view that this is a technical failure on his part. It is the therapist's task to get him

to accept the position that he is disagreeing. The therapist implies he should take these chances. He then denies Dan's "technical incapacity" by saying that perhaps unknowingly, he already did. The therapist tried to get agreement that tender feelings sneak out sometimes without the patient being aware of it. This time Dan neither agrees nor disagrees, but holds up the process by saying, "I don't know" and asking for evidence, which the therapist promises to find for a playback for him. Dan's equivocation ends the negotiation process. His line 22 is an apparent agreement, but actual disagreement.

Shifts Removed from the Original Category

In this section analogy and psychoanalytic interpretation will be considered. They are shifts which are more removed from the original category under consideration than stretching or funnelling. As such they are termed indirect. Nonetheless, they are both devices used in doing reinterpretation, and are therefore examined here. Of the two, psychoanalytic interpretation is even further removed from the original category. Thus, of the four activities under consideration here, the continuum moves from stretching to funnelling to analogy to psychoanalytic interpretation. Therefore, they are discussed in this order.

Analogy

Making an analogy is a technique used to compare two topics that are different on the surface, but are similar in some ways. The analogy consists of category packages itself. Logically, it is a form of inference in which it is reasoned that if two (or more) things agree with one another in one or more respects, they will (probably) agree in yet other respects. One speaker gets the other to agree with the

analogous example in order to point out the inconsistency in the first speaker's presentation. Using an analogy to disagree is an indirect form of disagreement since the topic itself is not disagreed with directly. Thus it is less direct an activity than examining the original category itself or stretching or funnelling from that category. It is more direct, however, than making a psychoanalytic interpretation. Analogy is a special kind of shifting.

In excerpt 5-16 we again see the use of the funnel and Dan's use of an analogy.

Example 5-16: Dan

1. Pt.: ...You'e a master, you're a master of making the most of a situation. You'd be a great preacher. You can, you can draw moral lessons from anything that happens. You know that?

2. Dr.: Hm. Really?

3. Pt.: Yeah, a you can, you can construe things, you can make it, sound you know even credible, you, even plausible. You could even, you can make, you can make the sky turn black. If you said, the sky is black, hu, ha (laugh) people would believe you.

4. Dr.: How could I do that? (he sounds pleased to me) How do I do it? What do I do?

5. Pt.: You talk very well. Let's put it that way. You talk very well, and you talk spontaneously and it sounds very sincere. That's why, you know, you have this a-remarkable a rapport with the group. That's why they respect you. Otherwise you wouldn't get to first first base with this group, or with anyone for that matter. Because you have, have a tone of sincerity in your voice.

6. Dr.: Are you implying that it isn't sincere, now?

7. Pt.: No.

8. Dr.: Phony.

9. Pt.: No. No. A lot of the time it is sincere, but a I, sometimes I just don't see how the hell you turned that around. You know, it's like

10. Dr.: That's, so I do try to see the other side of things. Huh?

11. Pt.: Ha, ha, aha. (big laugh) You see, there you go again.

12. Dr.: Well, then

13. Pt.: I didn't say that, but you said, you turned it

14. Dr.: You said I turned them around. I said I tried to see the other side.

15. Pt.: Heh, heh, heh. (small laugh) Yeah.1.

In this excerpt Dan makes two analogies. The first is in line 1 where he compares the therapist with a preacher. They both draw moral lessons from anything that happens. The second analogy occurs in line 3 where Dan compares the therapist implicitly with a magician. They both can make the sky turn black. This is said laughingly, and he amends his statement and hence his category to--people would believe the therapist if he said the sky is black. However, in line 4 the therapist sounds pleased to me that so much power has been attributed to him and asks Dan how could he do that. The doctor's question is a difficult one to answer, and Dan does so in a general way, saying, "You talk very well." In fact, the therapist accomplishes his "magic" by being an accomplished speaker, using the devices discussed herein. In line 5, Dan shifts "you talk well" to "it sounds sincere." The therapist questions this aspect of Dan's category and asks if it only sounds sincere and is not in fact sincere. The important line is line 9 where Dan responds--"no a lot of times it is sincere" (implying that sometimes it isn't) and explaining, "I just don't see how the hell you turned that around." The doctor then reinterprets "turning that around" to "seeing the other side of things." This is verified in

lines 11-14 and the patient laughs because the doctor has given him an example of exactly what he was talking about.

The next example is a confrontation. However it is presented here since within the confrontation, an analogy is used. In this case the analogy is a comparable situation in a parallel case. The disagreement is indirect and subtle. The example comes from the Talmud.

Example 5-17

The Emperor said to Rabban Gamaliel: "Your God is thief, for did He not cause Adam to fall asleep and then steal one of his ribs?"

At this the Rabbi's daughter interrupted and cried to the Emperor to send for the police.

"What has happened?" asked the Emperor.

"A thief entered my house last night," she replied, "and took away a silver pitcher; but left a gold one in its place."

The Emperor said: "Would that such a thief would come to me every night."

Whereupon the daughter of Gamaliel replied: "Why then do you decry your God? Did he not steal a rib from Adam only to enrich him with a wife?"

The daughter could simply disagree and say that "real" theft is not involved when the person replaces the "stolen" object with something more valuable. That would express the nature of her disagreement, clearly an indirect one. This also gives us an idea of her definition of the category of "theft" which becomes apparent through the analogy of God and Adam's rib. Clearly she starts out from "left field" inducing the Emperor to agree with her interpretation in a parallel case that he doesn't recognize as parallel. Thus, when the listener detects that he has a disagreement with something the speaker says, that disagreement may be quite far in a direct logical sense from what the speaker said. The listener disagrees with a more general category

in which the specific statement fits. The daughter does not attempt to disagree with the emperor's claim that her God was a thief (though she certainly would disagree with that). Rather she disagrees with the general claim that theft is always involved when something is stolen. Thus, an analogy was used in the process of doing negative reinterpreting. Analogy is thus a special kind of shift.

The next example of reinterpretation from Carrie focuses on the category--giving in to him sexually. From her point of view this is feminine behavior; from the therapist's, it is a kind of prostitution. The therapist uses the analogy from a book he asked her to read to her behavior. It is in his use of the analogy that he makes an interpretation. The disagreement is implicit in their conversation as they each present their own point of view. Throughout Carrie says, "yeah, yeah," as a speech habit; at the end of the excerpt where she seems to agree with the therapist's interpretation she agrees by saying, "uh huh, right."

Example 5-18 - Carrie

1. Dr.: ...So your answer was at yourself and at him, pushed down, and it comes out now in your tears. Do you understand that?

2. Pt.: Yeah?

3. Dr.: Do you?

4. Pt.: No.

5. Dr.: [You don't understand that.

6. Pt.: [Yeah, but I had good sex with him. I mean, my sexual fantasies with him were, I mean, fabulous (snort). I mean, here I'd found somebody to take care of me and he would, I mean, I had great sex with him (snort) at times, you know...

7. Dr.: At times.

8. Pt.: Yeah but then there, I still have trouble accepting it. I have to think about it.

9. Dr.: You have trouble accepting what?

10. Pt.: The fact that my acquiescing, my giving to him sexually...

11. Dr.: When you didn't want to

12. Pt.: Yeah. Uh, uh, I somehow always that that was feminine.

13. Dr.: That's if you love a man and you're not feeling sexual and

14. Pt.: Yeah.

15. Dr.: Your love is of such a nature that in loving him you give your body to him and yourself to him and

16. Pt.: Yeah.

17. Dr.: You join him sexually even though you don't feel it, but you

18. Pt.: Yeah.

19. Dr.: Do it lovingly.

20. Pt.: Yah.

21. Dr.: That's not prostituting yourself. When you give it to the man

22. Pt.: Because I'm afraid of losing him

23. Dr.: In anger, or for fear of not getting the money, or being abandoned financially, which is what prostitution is, isn't it? To do it for money? Whether it's pure money or security in the form of the rent or something else.

24. Pt.: Yeah

25. Dr.: It's a form of selling your soul. I'm not trying to call you a whore in that sense, that it'll make you feel worse. Do you understand? But nevertheless when we sell ourselves for money we call it whoring. I'm not ashamed to look at myself at times when I feel that I may be selling my myself for money.

26. Pt.: Yeah, yeah.

27. Dr.: I say, "Gee, is that what I'm doing here in this situation?" I'm kissin' ass,

28. Pt.: Yeah.

29. Dr.: Or do something because the goal here is either power or glory or money or something. Is it really what I want? How far will I sell my soul, my integrity?

30. Pt.: To get that, yeah.

31. Dr.: To do it? That's why I wanted you to read that book, The Wild Ass of Skin, which had to do with selling oneself. Do you remember?

32. Pt.: Yeah, yeah.

33. Dr.: For a wish and a want, and losing one's self in the process.

34. Pt.: Yeah, because it, but then you don't even know what you want after a while. (snort) Yeah, I see that.

35. Dr.: Particularly if when when you want, it comes to you without a struggle, you just wish it and it comes, huh? Magical.

36. Pt.: Yeah.

37. Dr.: When you struggle for something you may get clearer about what you want.

38. Pt.: Uh huh, right.

The first six lines have to do with her understanding of the explanation he gave of the dynamics of her tears in line 1. She says she has difficulty accepting the idea that giving into her boyfriend sexually was not acceptable behavior. She states that she thought that that was feminine. He corrects her by adding "when you didn't want to" (lines 10-11). He agrees with her, but specifies "only if your love is of such a nature that you do it lovingly, then it's not prostituting yourself." He expands the conditions under which her assumption is true, and she comes to realize, through the two analogies about himself and the book he recommended, that she is doing it because she is afraid

of losing her boyfriend (line 22). He classifies certain behavior as whoring (line 23) and she accepts his redefinition (line 36). So in this excerpt the therapist has used analogy to re-create a category for the patient and thereby make an interpretation, displaying his expertise. In addition, by using his own behavior as an example of analogous behavior, it mitigates the strength of his analogy. After all, he has compared her sexual behavior to a kind of whoring. Using himself and the behavior of the main character in the book he recommended, shows Carrie that she is not the only one who has acted in this way. The patient seemed to accept the reinterpretation of the category and thereby her behavior.

In this last example of the use of analogy, the patient introduces an idea (becoming a slave) as analogous to her behavior, and the therapist presents another analogy (Russians use soap) to show her that her analogy and therefore behavior are incorrect. The patient also moves from rule #5, presenting material, to rule #4, learning the goals and rules of therapy. She shows that she knows at least one of the rules of therapy by using it appropriately. The exchange ends in line 10 with the therapist being silent and then he changes the topic.

Example 5-19: Jill

1. Pt.: But I feel in pleasing them, I become a slave. I don't see any alternatives.

2. Dr.: Yeah, but you see,

3. Pt.: yu

4. Dr.: But if I told you that I believe that because the Russians use soap, if I use soap, I'm a slave to the Russian system, would you say I was a nut or I was sane?

5. Pt.: I admit that it's ridiculous.

6. Dr.: Of course it is. (a lot of overlap)

7. Pt.: I'm not arguing that.

8. Dr.: O.K.

9. Pt.: I'm just telling you how I feel.

10. Dr.: umhm. (long pause) Do you want to close that? (He refers to the door. Another door slams in the background, other noises) Now look, why don't I..., you can ask me any questions you want about me. I don't know much about you yet...

The doctor uses an analogy to show Jill how she connects her ideas in crazy, i.e., non-logical ways. However, Jill points out quite correctly that she is not arguing that that is acceptable behavior, rather that that is how she feels. She moves to a "higher" level by not discussing the issues, but by discussing the "process" of what she is doing: the how instead of the what; she has moved from rule #5 to rule #4. The doctor accepts this in his "OK" (line 8). The patient's line 9, her reference to her feelings, substantiates her correctness in this discussion. She is smart enough to know that in a psychiatrist's office one's emotional state is the appropriate topic for discussion and also part of the be yourself rule (rule #3).

This example is also interesting because we can also see in line 5 the double bind for the patient and the operation of the cooperate rule, rule #2. The doctor offers her a choice, "would you say I was a nut or sane, if I said if I use soap, I'm a slave to the Russian system because they do." However, if she chooses sane, then as members of the American culture, we would know that she is insane, because that is obviously not so. If she chooses a nut, she must acknowledge, by analogy, that her own behavior is nutty. Presumably the doctor does this to encourage the patient to see how foolishly she is behaving. He

is truly trying to talk her out of it. Instead she says, "I admit that it's ridiculous." The use of the word "it" is vague and could refer to her behavior, her thoughts, her analogy to slave, or his analogy to the Russian system, or to all of these. This permits them to continue talking as if there was a shared understanding as to what is meant and a sharing of possible alternative forms of action. In addition, the doctor's "of course it is" in line 6 is said in a loud tone of voice. On a verbal level it appears he is agreeing with her. On the nonverbal level, he acts as if there were disagreement between them and inherently in the situation there is. She is saying, this is what I'm doing, and he is saying, that's foolish; let's learn how to change it.

Thus, in these examples we can see where the use of analogy is available to both patient and therapist. The analogy has elements of a "package" in its own context. It is a kind of stretching of the category and resulting shift into a whole new, yet comparable, category. The therapist uses analogy to reinterpret the patient's categories and thereby influence and change the patient's attitude and behavior.

Psychoanalytic Interpretation

I turn now to the last device discussed in the activity of negative reinterpretation and that is psychoanalytic interpretation. The psychoanalytic interpretation is the most indirect of the strategies as it is the most removed from the original category under consideration. The psychoanalytic interpretation is based on a language of its own. Developed by Freud, it makes use of conscious and unconscious motives, the concepts of the id, ego, and superego, Oedipal and Electra Complexes, transference and counter-transference, among other

concepts. The psychoanalytic interpretation need not be made using these terms. Their use would depend on the patient's familiarity and even more so, on the therapist's intellectual orientation. This therapist's orientation is based on a neo-Freudian theory of psychodynamics, specifically that of Karen Horney. Therefore his psychoanalytic interpretations are not necessarily in the language of Freudian analysis. The psychoanalytic interpretation is similar to an analogy to the patient's behavior, but is based on a different idiom. The therapist uses such interpretations to get the patient to accept the different interpretation of his present behavior as appropriate and thereby want to change towards a more satisfying way of life. It also displays the therapist's expertise. If the patient accepts the therapist's interpretation, then presumably he would view his behavior differently, and therefore, want to change. That is, he would choose to reconstruct his category packages. It is up to the patient to accept or reject the psychoanalytic interpretation.

Psychoanalytic interpretation is another way of doing negative reinterpreting. Let us consider the following examples:

Example 5-20: Carrie

1. Pt.: Well, you know. I always went. I always went. I always um (crying) totally tossed out a guy out of my life because wouldn't give me security, because he wouldn't fulfill or because he wasn't my type, or had had to fulfill all those things.

2. Dr.: He wouldn't perfectly fill the bill, right?

3. Pt.: Right, because he...

4. Dr.: And that's some bill of particulars. Right? (Pt. nods head?) Now let's get that bill of particulars. A, he would have financial security, right?

5. Pt.: Not necessarily.

6. Dr.: And he would take care of you.

7. Pt.: No, not necessarily.

8. Dr.: No, what then?

9. Pt.: Peter wasn't financially secure.

10. Dr.: What is the bill of particulars?

11. Pt.: (crying) That somehow I would be sure he'd be around all the time. I mean, when I met Peter, my husband, he was making very little money and he was an alcoholic, but I just felt that he was emotionally...

12. Dr.: Dependent.

13. Pt.: Dependent on me, and that he loved me.

14. Dr.: That would be your security blanket. You would find a dependent man.

15. Pt.: I know it doesn't work.

16. Dr.: You would be supported by finding a man you could support. Right? Now I just want you to hear it as I say it out loud. Is that right?

17. Pt.: Um hum.

18. Dr.: You would create a nice neurotic interaction with a weak man.

This excerpt is about the qualities Carrie desires in a man. She begins in line 1 with the category of "desirable man" and lists related ideas, i.e., give me security, wouldn't fulfill, wasn't my type, fulfill all those things. In line 2 the therapist summarizes this using an extreme--perfectly fill the bill, suggesting that perhaps she is being too rigid. In line 4 the therapist guesses at to what that bill of particulars is and he guesses incorrectly. It is as though based on his experience, he can make an educated guess at to what the bill of particulars of this "type" of person might be or perhaps he thinks he has heard them and is stretching her description of line 1. Thus he

checks this out twice (lines 4 and 6) stretching "security" to "financial security" and "fulfill" to "he would take care of you." This is the therapist's category construction for "desirable man." However, he checks this out to find out that these are not her package in line 10. After he hears her description in line 11, he hears of another "type" and so based on experience, he offers another interpretation in line 14: "That would be your security blanket. You would find a dependent man." When that interpretation is not rejected in line 15, he takes it as an agreement and offers a full-blown interpretation that makes clever use of the word "support": "You would be supported by finding a man you could support." Carrie agrees with this and in line 18 this same interpretation is reworded in psychiatric language: "You would create a nice neurotic interaction with a weak man." Thus using a check-out procedure in lines 4, 6, and 8 he proceeds to question the category package presented by the patient in line 1. It ends with a psychoanalytic interpretation which results in the patient questioning her category. In making such an interpretation, the therapist displays his expertise and by questioning her package, illustrates his disagreement with that construction. He has negatively interpreted that category both psychologically and linguistically. The therapist's play on the word "support" displays his facility with language.

In the next example, from Dan, the category "perfect human being" is discussed. Both the patient and therapist use extremes, at the ends of the continuum, which makes their statements subject to the funnel process, that is, a re-interpretation into a wholly new category. Instead, the therapist chooses to move from the content of the talk (rule #5) to making a psychoanalytic interpretation (rule

rule #4). In so doing, he demonstrates disagreement with the patient's category formation.

Example 5-21: Dan

1. Dr.: ...In other words, if it's true, that I'm seeing her with old eyes, I'd like to get over that. I don't want to keep seeing her with old eyes.

2. Pt.: Yeah, but the girl has been coming here for three years, don't you, and she's and she's obviously making progress, from what she talks about,

3. Dr.: Yeah,

4. Pt.: I mean she's not going to be a perfect human being. In fact, she's better off than the average schmuck on the street. But you're not satisfied. You, you refuse to see that she's healthy. I, I re, r, I, really think that you're afr, you're not afraid. For some reason, it, it isn't conducive for this group for one person to get healthy and leave it.

5. Dr.: Where did you get that idea? Where'd you get that idea?

6. Pt.: Just fr, from what you're saying. Wh, wh, when you have to criticize what she says all the time.

7. Dr.: And you see it only as criticism.

8. Pt.: You know, in other words, what it all boils down to, is that I could never do anything, perfectly the right to satisfy you. Whatever I would do would come under criticism. Either I would be too angry (Dr. tamping pipe), if I wouldn't be too angry, I would be too soft,

9. Dr.: Isn't it fascinating that the very things that you're criticizing me about today, are the things that you do here?

In line 4 Dan talks about a girl not being the perfect human being and then states, it isn't conducive for this group for one person to get healthy and leave it. Although perfect human being is an extreme and open to questioning, the doctor ignores this statement and focuses on leaving the group by making a completion of reason invitation, with where did you get that idea? (line 5). The patient gives his reason,

"when you criticize what she says all the time." Dan uses the extreme "all the time." The doctor could have responded with, "I don't criticize what she says all the time, only some of the time," focusing on the amount of criticism. Instead the doctor answers "and you see it only as criticism." Only is also an extreme, implying from the doctor's point of view that praise and other activities are accomplished as well. However, the patient sticking with extremes, returns to the perfect human being idea. He states, "whatever I would do would come under criticism. Either I would be too angry; if I wouldn't be too angry, I would be too soft." The doctor responds in line 9 by making a psychoanalytic interpretation: "Isn't it fascinating that the very things that you're criticizing me about today, are the things that you do here." He is saying, you're projecting. By making this interpretation, the therapist stops the process of discussing the material (rule #5) and instead demonstrates his psychoanalytic expertise. He also thereby questions the patient's category construction and leaves open the possibility or implies that the patient's category should be revised. By making the psychoanalytic interpretation, the therapist also teaches the patient the rules of therapy (rule #4). The therapist can make this leap from rule 5 to 4 whenever he thinks it is appropriate or does not wish to respond to the subject matter being discussed. In this example we can see that Dan has caught on to the fact that presenting acceptable category formations would be an indicator of psychological health. The therapist, however, moves to a higher level of discussion and does not debate the finer elements within the category, a psychologically healthy person.

I turn now to this last excerpt to illustrate that reinterpretation can be positive as well.

Example 5-22: Ellen

1. Pt.: I, I...That has validity, I think, except that I feel very enriched as person when I'm working. I find a lot of things to do, by my, not find, they're things I want to do, by myself. When I'm not working I don't want to do them.

2. Dr.: What, what things?

3. Pt.: I don't want to do any of those same things.

4. Dr.: Well, you're saying that for you fi money and a job are equate with being significant and independent and good feeling, and then feeling good you do have more of an interest in other things at that point. Is that what you're saying?

5. Pt.: Yeah. (whew)

The therapist demonstrated his expertise by making an interpretation in line 4 on the dynamics of the patient's behavior. The patient accepted his interpretation. Her "whew" is an exclamation of her amazement, possibly that the doctor reinterpreted her feelings and made her aware of them in a way that she wasn't aware of previously. The whew seems to be, "gee, is that what I said? That's good." In this case the therapist made an interpretation that showed that he agreed with the patient's observation. His reformulation in line 4 is a low level psychiatric interpretation. Although he does not use the psychoanalytic language, it is a psychoanalytically-based reformulation of behavior based on the concept of ego-strength.

Making psychoanalytic interpretations is another way of potentially doing linguistic reinterpretations. Psychoanalytic interpretations are based on a language of the unconscious which mirrors conscious behavior and thoughts. As such it is a special kind of analogy to the

presentations the patients make, using rule #5 of therapy. This stretched out analogy is an indirect way of commenting upon the patient's category formulations. By connecting the links that the patient has offered, the therapist displays expertise and suggests the dynamics of what is "really" happening. This suggests to the patient that the patient's interpretations of events might not be right and he is offered an alternative one by the therapist. The patient is free to accept or reject it. In offering an alternative definition, we and the patients can see implicitly that there is a disagreement existing between the two speaker-hearers. Analyzing the devices, however, gives us no clue if the patient has incorporated the therapist's position to any degree.

Summary

In this chapter I have tried to show how psychotherapy is a process of re-education by discussing how the patient displays how he forms categories and how the therapist can then disagree with that category formation. The therapist then engages in negative reinterpretation to show the patient an alternative category construction which he is free to accept or reject. That is, the patient cognizes (rule #5) and the therapist evaluates (rule #4). Category formation and its analysis is always involved in doing negative reinterpretation. The therapist has a number of devices available to him to do reinterpretation including: category examination, shifting via stretching, the funnel process, analogy and psychoanalytic interpretation. Of these activities, the first two are more direct and the last two are indirect. Thus, these activities form a continuum from direct to indirect dis-

agreeing activities. They are all disagreeing activities in that they propose a change from the patient's original presentation of a category package.

We may conclude that since we speak inexactly, anything we say is subject to being disagreed with, unless we object when it occurs. Thus, whenever any of the devices discussed in this chapter are utilized, the second speaker has attempted to change in some way the first speaker's remarks. As in confrontation, which is discussed in the next chapter, more general remarks are open to reinterpretation by focusing on specifics and specific remarks are subject to being included in larger categories. We are then always offering disagreement invitations; and whenever we make an "extreme" statement, we are offering an invitation to balance. In all of these cases, the first speaker has been disagreed with by the second and the disagreement maxim has been utilized.

CHAPTER 6

ENCOURAGING CHANGE: CONFRONTATION

Confrontation is an activity used to promote psychic change. As discussed earlier, this is one of the goals of psychotherapy. However, while the therapist provides the encouragement to change, it is the patient who changes himself. In this chapter, I examine the activity of confrontation, which is seen as a strong encouragement to achieve psychic change. However, successful confrontation as used here means only that the activity has been completed. We do not know if psychic change has been achieved. I leave this determination to the psychotherapists and patients themselves. While a few therapists have written about the activity, until my work with Churchill[1] it has not been analyzed in terms of its production in any detailed way. We defined it as an activity where the confronter, in this case the therapist, brings the confronted, the patient, face to face with a fact that he cannot be permitted to avoid facing. By doing so, he is disagreeing with the patient's initial assertion.

Confrontation, as an activity, has been accomplished using audiotapes and videotapes as well as verbal exhortations. Here I concentrate on the activity as a speech event. Paredes and Cornelison have written about confrontation as follows:

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[1]Susanne Bleiberg and Lindsey Churchill, "Notes on Confrontation on Conversation," Journal of Psycholinguistic Research 4 (1975): 273-78.

> . . . self-confrontation in the presence of and with the assistance of a trained therapist may help patients to better understand the self-deceiving and self-defeating mechanisms they have been using to deny or conceal their conflicts and low self-esteem. Following such understanding they may be motivated to work toward finding ways of handling or solving their conflicts.[2]

Berger writes:

> I must state unequivocally my belief that confrontation alone is not enough to bring about the kind of characterological change and growth which is the usual goal of psychoanalytically-oriented psychotherapy. Almost any confrontation can be accepted and assimilated to some degree if a patient is prepared for the work of psychotherapy, is in a state of positive transference to his therapist or group and there is enough mutuality, caring, regard, trust and intimacy present.[3]

Evaline Schulman discussed confrontation as an expressive skill of communication in the helping interview: "The essential purpose of confrontation is to produce suitable circumstances that encourage an individual to look at and hopefully to find ways to change his behavior."[4] Garner, as noted earlier, is the only psychiatrist who discussed confrontation as the accomplishment of an activity, writing:

> The techniques of therapy applied in confrontation problem-solving psychotherapy include the presentation of a statement and a question. . . . An alternative is to express the end results of a continued maladaptive activity in so exaggerated an expression that the person would wish to discontinue such behavior. . . . It is as if the therapist's repetitious question acts as a continuous

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[2]A. Paredes and F. S. Cornelison, "Development of an Audio-visual Technique in the Rehabilitation of Alcoholics," unpublished manuscript based in part on paper presented at the 19th clinical meeting of the A.M.A. in Philadelphia, November 1965, cited in M. M. Berger, "Confrontation through Videotape" in _Videotape Techniques in Psychiatric Training and Treatment_, ed. M. Berger (New York: Brunner/Mazel, 1970), p. 28.

[3]Berger, "Confrontation through Videotape," p. 34.

[4]Evaline D. Schulman, _Intervention in Human Services_ (St. Louis: C. V. Mosby, 1974), p. 156.

pressure to force the acceptance of a need to explore and solve a problem.[5]

However, none of these writers has analyzed the activity in a detailed way. Churchill and I began such an analysis formulating the following paradigm[6] of confrontation:

Paradigm of Ideal Reality-confrontation

Step	Actor	Behavior
1	Confronted	Makes a general statement.
2	Confronter	Asks a closed-choice (yes/no) question about a particular aspect of the general statement.
3	Confronted	Picks the answer that shows that the particular aspect under question is an exception to the general statement.
4	Confronter	Asks a second closed-choice (yes/no) question about another particular aspect of the general statement.
5	Confronted	Picks the answer that shows that the particular aspect under question is another exception to the general statement.
6	Confronter	Asks rhetorical question that contradicts the confronted's original general statement.

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[5]Harry H. Garner, "A Review of Confrontation in Psychotherapy from Hypnonsis to the Problem-Solving Technique," in <u>Videotape Techniques in Psychiatric Training and Treatment</u>, ed. M. Berger (New York: Brunner/Mazel, 1970), p. 14. Another work came to my attention after this dissertation was completed; therefore it is not discussed above. It is <u>Confrontation in Psychotherapy</u>, ed. G. Adler and P. Myerson (U.S.: Science House, 1973). However, all the articles are psychoanalytically oriented and have no direct bearing on the analysis presented here. Only "Confrontation in Short-Term, Anxiety-Provoking Psychotherapy" by Peter E. Sifneos (pp. 371-82) even includes an excerpt from a psychotherapy session as an illustration. My conversational analysis and Sifneos' psychoanalytically based conclusion support each other.

[6]Bleiberg and Churchill, "Notes on Confrontation on Conversation," p. 276.

However, as I continued this analysis, it became clear that there are many variations of this paradigm which we, as competent members, still recognize as confrontations or confrontation-like activities. Thus, I conclude that the activity does not rest on following the structure presented in the paradigm, but rather rests on its essential features. Thus, Schulman's examples of 2-liners and even one example of a one-liner (which are discussed below) are still recognizable as confrontations. Similarly, Churchill's analysis of "three liners" which are denigrations[7] have confrontation-like features which result in our being able to recognize when we have been "put down." Since his three-line denigration is actually based on an initial assertion or action (really the first of four-lines) I conclude that it is essential to analyze the features or elements of the confrontation activity, rather than the form per se. In addition, since no strict form is followed automatically, it lends additional credence to Garfinkel's assertion that we are not norm followers, but rather norm-users.[8] The confrontation model is used creatively, since we are thinking, creative beings, and not robots. Thus, I turn to an analysis of essential features of confrontation by analyzing the various forms of (1) completed confrontation, (2) confrontation variations, and finally (3) incomplete confrontations. In examining the non-completed confrontations, I notice its similarity to another activity, already discussed, interpretation.

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[7]Lindsey Churchill, Questioning Strategies in Sociolinguistics (Rowley, MA: Newbury House Publishers, 1978), p. 119.

[8]See Garfinkel's discussion of the et cetera clause in Harold Garfinkel, Studies in Ethnomethodology (Englewood Cliffs: Prentice-Hall, 1967), especially p. 735.

Completed Confrontations

The development of the six-line paradigm was based in part on the following two examples and numerous variations:

Example 6-1: Jill

1. Pt.: I don't want them [my parents] to have anything to do with my life, except (pause) security (?).
2. Dr.: You live at home?
3. Pt.: Yes.
4. Dr.: They pay your bills?
5. Pt.: Yeah.
6. Dr.: How could they not have anything to do with your life?

Example 6-2: Jill

1. Pt.: I don't- have much--faith--in therapy or anything any more.
2. Dr.: You don't have any faith in anything?
3. Pt.: No.
4. Dr.: You want to live? Or you want to die?
5. Pt.: I don't want to die, I'd be dead (very low voice).
6. Dr.: OK, so there's obviously some evidence that you want to live. Is that right?

They were analyzed by Churchill and me[9] as follows:

The confronter facilitates the activity by his tone of voice and rapid-fire nature of his questions. If we look at the examples, we see that the questions demand yes/no answers, not carefully thought-out answers. In reality-confrontation the question-answer sequence leaves no room for a middle ground, a gray area.

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[9]Examples 6-1, 6-2 and the analysis are from Bleiberg and Churchill, "Notes on Confrontation in Conversation."

The tacit consent of the confronted to this activity is evident when we look at her responses to the direct yes/no questions. The patient agrees to supply the alternative answer that will support the confronter's later "punch line." For instance, she answers "yes," she lives at home, and "yes" her parents pay her bills, in Example 6-1. Thus, she accepts the confronter's "invitation" to continue their joint production of reality-confrontation. Similarly in Example 6-2 Jill provides the preferred answers to the doctor's yes/no questions. In addition, as discussed in the previous chapter, the patient does not object to the "stretches" the doctor has made and thereby participates in the joint production of the activity.

The confrontation or "punch line" comes after the "funnel-like" yes/no question-answer sequences and refers back to something spoken about in the immediate previous past. (By "funnel-like" we mean that so long as the patient answers in the prescribed way, i.e., using the alternatives that support the therapist's position, it will be increasingly difficult for her to avoid facing the logical conclusion of the therapist's punch line.) Her options are progressively closed in this funnel-like process, and then too quickly she is confronted with the punch line. The conclusion is self-evident and short of appearing stupid, there is no alternative way of reading the conclusion.

Thus in each case the therapist has contradicted the patient's initial statement; in the former, her parents do have something to do with her life, and in the latter, she does have faith in something, since she doesn't want to die.

Yet Schulman presented the following examples in her description of confrontation which are only "two-liners." In analyzing these

examples, it became apparent to me that it is the elements, which will be discussed shortly, and not form that lead us to recognize the production of an activity.

Example 6-3: Tom

1. Tom: If only my wife wouldn't make so many demands on me, I wouldn't drink.

2. Mr. O: Ten years you've been drinking, Tom. You've been married for five. How come you drank before you were married?

Example 6-4: Wilma

1. Wilma: My mother was just like that. I know I'm like her. She and my father would argue about such petty things as how high or how low the window shade should be. Then she would get more and more upset...throw up... my father would shut up. I'm just like her.

2. Dr. N: Are you saying that you can't be different just because of your mother?

Example 6-5: Ted

1. Ted: You're a jerk. You don't understand anything.

2. Mr. R.: Aren't you foolish talking to a jerk who doesn't understand?[10]

The problem of form became secondary since it is possible to re-create these excerpts in the form of the six-liner. They are condensed forms of the activity which illustrate that confrontation is based on disagreement. In each case, line 1 is a statement and line 2 is another statement which disputes the original statement. Similarly, line 6 in the paradigm disputes the contention made in line 1. In each case here the middle part of the yes/no question/answer sequence, is elided. This condensed form has less force than the full version since the confronted has not participated in his own "destruction" so to

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[10] Schulman, Intervention in Human Services, p. 159.

speak. The punch line is based on inconsistency and is a surprise; the confronted did not know that this activity was going to occur. This supports the disagreeing maxim: disagreement can occur at any time. In both Tom's and Wilma's examples, however, it presupposes prior knowledge of the patient by the doctor (e.g., when the drinking began and how many years he had been married in Tom's case, and knowledge of Wilma's relationship as well).

In the following hypothetical recreations of examples 6-3 and 6-4, the premises on which the conclusion is based are publicly admitted. In Tom's case, the change is minor. The doctor's lines 2 and 4, "How long have you been drinking?" and "How long have you been married?", are then rhetorical questions,[11] since the answer is already known to both participants. In Wilma's case, there is an implied disagreement over whether she can be different from her mother: she thinks she can't, he thinks she can. In the hypothetical recreation below, the confrontation is based on, "I'm just like my mother."

Example 6-6: Hypothetical re-creation of Tom excerpt

1. Tom: If only my wife wouldn't make so many demands on me, I wouldn't drink.

2. Dr.: How long have you been drinking Tom?

3. Tom: 10 years.

4. Dr.: How long are you married?

5. Tom: 5 years.

6. Dr.: Then how can you say you're drinking because your wife puts so many demands on you?

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[11] See Churchill, Questioning Strategies in Sociolinguistics, p. 135, for further discussion of the rhetorical question.

Example 6-7: Hypothetical re-creation of Wilma excerpt

1. Wilma: My mother was just like that. I know I'm like her. She and my father would argue about such petty things as how high or how low the window shade should be.

2. Dr. N: Have you ever argued with your [father, husband, whoever] about how high or low the shade should be?

3. Wilma: No.

4. Dr. N: Did you ever throw up after an argument?

5. Wilma: No.

6. Dr. N: Then how can you say you're just like your mother?

In Example 6-4 the doctor confronted Wilma on whose responsibility it is that she is the way she is, not on what she specifically said in line 1. In Example 6-7, on the other hand, the doctor confronts Wilma about whether she really is the way her mother is. Thus, if Wilma had hypothetically responded in line 3 (of example 6-7), "I've never argued about the height of the shade, but I have argued about some other equally ridiculous thing with my husband," the doctor can still follow up, "But did you throw up after the argument?" If the patient says no, then he can still confront her with his punch line, "Then how can you say you're just like your mother?" Of course, she could reply, "But I cried after the argument." However, the doctor could say, "OK, you cried, maybe it's something that you could learn not to do, but you didn't throw up--so you're not just like your mother." However, in the example the doctor shifts and says, "Are you saying that you can't be different just because of your mother?" That starts the patient thinking about her responsibility for her behavior. The shift is a good one therapeutically, and, from the example, one that the patient doesn't disagree with.

Before continuing with the analysis of form, it is important to clarify the "yes, but" and "no, but" issue. As noted in Chapter 4, "yes, but" is a qualified agreement which means in essence "no." "No, but" is a qualified disagreement, which means in essence "yes." These are weak agreements and disagreements, respectively. In addition, the "but" or explanation which follows qualifying the initial "yes" or "no" is a completion of reason invitation. The speaker who adds the reason or qualifier thus holds the floor for a longer time and is in control of the situation, determining when he shall return the floor to questioner. This delay in the confrontation sequence has the force of blunting the contradiction the confronter wishes to make. As Churchill notes in discussing this issue in terms of his "3-liner" denigration, it can also be used to beat the confronter to the punch line. However, the punch line works "only if no objections to it remain on the floor."[12] Thus, the "but" strategy can be used during the activity of confrontation to do two different things: control the floor and give the punch line. In both cases, however, they serve to derail the confrontation sequence. This, as a strategy, will be discussed in the last section of this chapter.

I turn now to Schulman's third example which is a two-liner which varies slightly from her other two examples. Example 6-5 is compounded by name calling. In addition, Mr. R. responds to the name-calling by placing Ted in a double-bind. The problem for Ted is he either must accept that he is a fool (for talking to a jerk) or that Mr. R. is not a jerk in which case Ted must admit that he was wrong.

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[12] Churchill, <u>Questioning Strategies in Sociolinguistics</u>, pp. 137-8.

This punch line has particular force in that the inconsistency does not follow from the initial premise, but from the name-calling. For example, this confrontation could be based on the second half of Ted's statement, "You don't understand anything." The following hypothetical re-creation then results in an inconsistency in the punchline, following from the initial premise that Mr. R. doesn't understand anything.

Example 6-8: Hypothetical re-creation of Ted excerpt

1. Ted: You're a jerk. You don't understand anything.
2. Mr. R: Who did you come running to when you have a problem at the school?
3. Ted: You.
4. Mr. R: Who had to talk to the judge when you were in trouble?
5. Ted: You.
6. Mr. R: Then you couldn't possibly mean it when you said I didn't understand anything and called me a jerk.

Schulman provides another example of confrontation which is even more condensed, the one-liner:

Example 6-9

1. Client: -----------
2. Counselor: You say you're perfectly satisfied with your sexual relationships with your present husband. How, then, do you explain what you said after your recent "fling" with your former husband?[13]

In this example, the disagreement is implicit. The therapist responds to something his client said previously, and then not necessarily directly. In this case, the punch line and implicit disagreement alone result in the accomplishment of the activity of confrontation. But

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[13]Schulman, Intervention in Human Services, p. 157.

even this extremely condensed version of the activity can be recreated as follows:

Example 6-10: Hypothetical re-creation of example 6-9

1. Client: I'm perfectly satisfied with my sexual relationships with my present husband.
2. Counselor: Didn't you have a fling with your former husband recently?
3. Client: Yes.
4. Counselor: Didn't you say that you went to him because he alone satisfied you as no one else can?
5. Client: Yes.
6. Counselor: Then how can you say you're perfectly satisfied with your present husband?

This very short confrontation again points to the fact that recognition of the activity of confrontation results not in its overall form but its elements, which we know includes an initial disagreement and punch line.

I now turn to Churchill's "three-liner" before focusing on the necessary elements of confrontation and how the activity is actually accomplished.

Churchill's discussion of the three-line form of denigration follows from our analysis of reality-confrontation. In terms of the six-line paradigm presented earlier, he concentrates on lines 4-6. Churchill notes line 4 (his line 1) is used "to disagree with some prior utterance or action by H that he feels is silly or stupid or obtuse."[14] Hence the three lines are an indirect response to a prior first line. Churchill writes that his first line of the potential

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[14] Churchill, _Questioning Strategies in Sociolinguistics_, p. 132.

three-liner rests on loaded questions, either a rhetorical question, an ability question, or an attitude question, although these do not exhaust the possibilities.[15] He also discusses the non-required answer as potentially denigrating to H and the self-denigrating question.[16]

Thus, I have presented some of the forms confrontation may take. Given their variety, even at this point (others are considered in the next segment), how is it that we are still able to recognize a confrontation when we hear one? As competent members we hear the necessary elements constituting a confrontation and recognize when it has occurred. I turn now to these elements and the reasons for the effectiveness of this particular kind of disagreement.

Confrontation is a disagreeing activity; the punch line contradicts the first person's first line. It is also a denigration; completing a confrontation results in the first speaker having been subject to a "put down." Thus the essential elements are:

1. a general proposition or idea on the floor which can be refuted
2. a punch line which refutes the above; hence, a disagreement
3. the unforeseen aspect of the punch line: the twist
4. a punch line in the form of a rhetorical question.

The fact that the checkout procedure is done through questioning means that the confronter will keep getting the floor back after the confronted answers. It is this feature of asking questions that gives the

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[15]Churchill, <u>Questioning Strategies in Sociolinguistics</u>, p. 135.

[16]Ibid., p. 136.

confronter the immediate next "slot" in the conversation for his punch line.[17] Also, rhetorical questions have an air of inescapable logic to them which makes it difficult to argue against their implication. The unforeseen aspect of the punch line and the fact that it takes the form of a rhetorical question makes the confrontation different from a simple contradiction. Contradiction is a direct response; the punch line in confrontation is arrived at indirectly.

There are four basic reasons for the power and effectiveness of the confrontation activity:

First, is its relationship to logic. The punch line is logically unexpected, and the first speaker-hearer cannot be sure in what direction the second is heading. This is the case since the punchline is a conclusion arrived at inductively, rather than deductively. If it were a deductive conclusion, the premises and logical steps would be readily apparent and the confrontation would not be a surprise to the first speaker. Instead, the punch line is arrived at inductively; the conclusion follows from an initial statement and instance, and the first speaker is unaware of what direction the second is heading. The former does not know what kind of category packages the latter will construct and use against him, since the package in its totality is not presented; hence, the punchline appears as a surprise and even shock.[18]

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[17] See L. Churchill, "Answering Questions," in Perspectives on the Social Order, rev. ed., ed. H. Ross (New York: McGraw-Hill, 1973).

[18] See Clarence Schrag's discussion of induction and deduction, in his article "Elements of Theoretical Analysis in Sociology," in L. Gross, Sociological Theory: Inquiries and Paradigms (New York: Harper & Row, 1967), pp. 220-253.

Second, the confrontation activity is a violation of the rules of talk.[19] We speak inexactly and assume others will understand what we are saying, in essence, even if only by waiting for later statements to clarify earlier ones. Thus by springing the punch line, the basic trust between speakers is gone. This alone is a surprise, even shock, to the confronted. That is, the confronted makes a general statement rather than a particular statement in line 1. The confronter shows the statement is false by pointing out one or more facts that contradict it. He relies on the principle that general assertions of fact cannot be absolutely true because they overlook exceptional cases that the asserter would exclude if he were talking more carefully.

Third, is based on the denigrating aspects of the activity. Here there are five aspects to consider. (1) The confronted participated in his own "destruction" so to speak, by providing the preferred answers to the yes/no questions in the checkout process. (2) By cooperating, it shows that he has little "saavy"; by not realizing where the confronter was going, "his own action denigrates himself as stupid or slow-witted."[20] (3) The punch line is used to disagree with the first speaker's statement. The disagreement alone is a denigration as it puts the first speaker's statement into a category of incorrect remarks; hence, the first speaker is sanctioned for being wrong. (4) By being inconsistent, the first speaker leaves himself

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[19]See Harold Garfinkel, Studies in Ethnomethodology (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1967), pp. 3, 41, 77, for a discussion of how we make ourselves understandable to others, in particular a discussion of the et cetera property and the retrospective-prospective properties of talk.

[20]Churchill, Questioning Strategies in Sociolinguistics, p. 139.

open to being sanctioned for his behavior, as it violates a fundamental assumption in conversation: people are expected to be consistent in their remarks. The inconsistency pointed out in the activity appears to sanction the confronted for violating this assumption. Thus, it is not only that the confronter disagrees with the confronted, his disagreement had added force in that it operates as a sanction for improper behavior as well. (5) If it is the therapist confronting the patient, the additional authority of his position adds strength to the sanction.

Fourth, is the power of the rhetorical question. It is difficult to refute since it seems to be correct.[21] As a conclusion or punchline, the confronted must show where it is faulty. This could be accomplished by noticing any "stretching" that may have been used, or showing any faulty logic on the part of the confronter; specifically where the conclusion might not follow from the premise or a faulty initial premise. In short, the confronted would have to refute the punchline by violating the rules of talk himself. In addition, since the rhetorical question implies that the confronter knows for a fact that the confronted's statement is not true, it makes the confronted appear to have lied, or be mentally incompetent, i.e., stupid or crazy. In any case, such indirect name-calling is seen as such a personal attack and demands a strong response, that it usually receives one. Not responding, either by silence or by an unrelated or inappropriate statement, would support the appropriateness of the denigrating label

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[21]See Arthur Schopenhauer's The Art of Controversy (New York: Macmillan & Co., 1896) for an excellent discussion of argumentation strategies.

which the rhetorical question implied. For these reasons, confrontation is persuasive as a disagreeing activity.

Other than refuting the conclusion, once it has been reached, there are only three ways of stopping the confrontation process. It is certainly in the potential confronted's own interest to do this, if he wants to avoid being confronted. He should stop the confrontation process before the conclusion has been reached, rather than refuting the conclusion afterwards, since he would not have participated in the joint production, and he would show that he knows in which direction the confronter is heading. He could do this by not responding as requested to the yes/no questions if they are asked. That is, the first speaker-hearer could answer (1) "yes, but" or "no, but" as discussed earlier, or respond with (2) a "misfire" which would have to be cleared up before the routine could continue. Such a "maybe" response would effectively sidetrack and stop the confrontation process. Or, (3) the respondent could also refuse to answer the question. This would leave him open to being charged as mentally incompetent unless it is a response to the loaded question which damns the respondent no matter which way he responds as in the question, "Are you still beating your wife?"[22]

Thus, confrontation is a rude, impolite activity, not often found in natural conversation. It is a disagreement which is also persuasive. It was used on occasion in these psychotherapy sessions, since as a motivational device it often works. However, as noted earlier, successful confrontation as used here means only that the

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[22]Churchill, Questioning Strategies in Sociolinguistics, p. 136.

punchline was reached. No assumption is made if the confronted "truly accepts" the confronter's point of view or not, or if, as Allen Wheelis noted, the conclusion lies "inert in the patient's mind"[23] for any length of time, or is incorporated into the patient behavior or attitude as his own or not. As will be seen shortly, confrontation as an activity is available to any speaker-hearers. I turn now to a discussion of variations in completed confrontation routines.

Confrontation Variations

The confrontation variations discussed in this segment include only those where the four necessary elements are present, but are different in some respect. These elements are: (1) the general statement under consideration, (2) the disagreement in the form of a punchline, (3) the unforeseen aspect of the punchline, and (4) a punchline in the form of a rhetorical question. As we shall see shortly, the essential elements of a confrontation can be reduced to a contradiction heard as a rhetorical question.

Consider the following kinds of variations: In excerpt 6-16 from Ellen, the yes/no question has been replaced with a "why" question. Churchill has discussed this kind of question briefly,[24] so I only mention it here as a variation. Ellen had been talking in great detail about her relationship with her husband which caused her to feel great anguish.

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[23]Allen Wheelis, "How People Change," Commentary (May 1969):59.

[24]Churchill, Questioning Strategies in Sociolinguistics, p. 138.

Example 6-11: Ellen

1. Pt.: And I don't know. It's all too, it's all too confusing for me. It's all to deep for me. It's all too confusing for me. I don't know. There seem to be so many things going on on so many different levels, that I don't know if there's ever a way out.

2. Dr.: You did something just now. After saying all that you said you know, you than said, "I don't know." How come you then said "I don't know" after you said all that you said?

As Churchill notes, a "why" question is only partly loaded. If the respondent can answer to the questioner's satisfaction, then he will have escaped the potential denigration. However, in this excerpt, the why question is also in a sense a rhetorical one. The doctor's question, "How come you then said 'I don't know' after you said all that you said?", implies that she (a) should not have said what she did, and (b) she should not have needed to say that kind of a thing either. These aspects of the therapist's question are denigrating in themselves. The implication of the confrontation is that she should focus on her need to feel that way. This is what he is confronting her about -- bringing her need from a sub-conscious to a conscious level.

The next three excerpts of confrontation are also undertaken to raise the level of conscious awareness of one's behavior. The next excerpt from Jill is about the therapist trying to make the patient more aware that she is not living her life fully.

Example 6-12: Jill

1. Pt.: I want to be alive. But I <u>can't</u>. I mean

2. Dr.: You want to be alive where? You want to be alive like an animal in a cage?

3. Pt.: No.

4. Dr.: Who's fed?

5. Pt.: No. I mean, I, would, I...

6. Dr.: You think that'll do you

7. Pt.: Of course I'd like to be alive like anybody else, and healthy, and creative and productive and

8. Dr.: Yeah, but what?

9. Pt.: But I can't do it. I've tried all my life.

10. Dr.: Now we're back to "I can't." Now look, I won't accept "I can't."

11. Pt.: So I won't. Well, I've tried.

The variations in example 6-12 include (1) the compound nature of the general statement in line 1; (2) the confronted beat the confronter to his punch line in line 7; (3) the rhetorical question takes the form of a "why" question in line 8; and (4) another confrontation routine could have occurred starting in line 10, but a comparatively direct disagreement is offered instead. These variations are discussed in turn.

1. Problems arise from the patient's initial statement, "I want to be alive. But I <u>can't</u>." The problem is which aspect will be confronted. The two different definitions of reality involved: "I want to be alive/I don't want to be alive" and "I can/I can't." At the beginning the therapist deals with the patient's use of the word "alive." He offers one definition of "alive" as "alive like an animal in a cage," which the patient does not accept. The funnel grows narrower as the therapist refines even further, "Who's fed?" Again the patient chooses not to accept this definition of reality. The general statement that is being repudiated is that she doesn't want to be alive in the full sense of the word or she wouldn't be living a life as though she were an animal in a cage.

2. She acccepts his interpretation of reality and recognizes her position by her outcry, "Of course I would like to be alive like anybody else and be healthy and creative and productive." Since she has beaten him to the punch line (by cutting off his line 6, assuming he was going to make one), we can see that the punch line can be given by the confronted as well as the confronter.

3. The therapist then offers his own form of a punch line in line 8, asking a "why" question. The assumption is that there really is a difference of opinion on the issue at the subconscious level, i.e., that the therapist believes that the patient doesn't really want to be alive in the full sense. This is similar to the issue in the previous example.

4. At this point the conversation turns to the second part of the patient's initial compound statement. Beginning in line 10 the therapist might have begun another classical reality-confrontation, in the following way:

Example 6-13 (hypothetical)

9. Pt.: But I can't do it. I've tried all my life.

10. Dr.: Did you ever write a short story?

11. Pt.: Yes.

12. Dr.: Did you ever hold a job?

13. Pt.: Yes.

14. Dr.: Then how can you say you can't do it?

However, the therapist shortcircuits this process by expressing his own position directly in Line 10 of example 6-12: "Now we're back to 'I can't.' I won't accept 'I can't.'" That is, rather than posing a rhetorical question, he states his position directly. Nevertheless,

Example 12 is included here as a successful reality-confrontation on the grounds that it has been completed. There is a contradiction present heard as a rhetorical question on the basis of lines 1 and 8.

The next example, again from Jill, includes two variations. Line 1, the initial statement, and line 6, the disagreement statement or punch line, are variations from the model presented earlier. Consider the following:

Example 6-14: Jill

1. Pt.:

2. Dr.: Your behavior and your functioning says, "I'm a little girl. Take care of me. Enter my life, take over, and maintain it. Keep me as a little girl." And you're bitching, "I don't want to have anything to do with them. I don't respect them. I want to be independent." You sound like that's, that's, crazy. Would you agree with that's crazy?

3. Pt.: (pause) Yeah. Well, I know I'm crazy. (chuckle)

4. Dr.: Or would you rather be, um, intellectual, and we'll say that's ambivalent? How would that be?

5. Pt.: No, I don't like that. That's not me (?). (chuckle)

6. Dr.: Hah, isn't that nice? An intellectual? That'll get you, you know where that'll get you? Don't you? I'm telling you that's downright crazy.

Line 1 of the disagreement is clearly a variation here. This is the case since the therapist begins as if he is confronting the patient's immediately preceding statement, "I am not crazy." However, she never made any statement like that at that point. (That is the reason why the patient's initial line is left blank.) The therapist, then, is trying to confront her not with any specific statement of hers, but rather with a conclusion that he infers from her remarks throughout the conversation, that she really doesn't believe that she's crazy, even

though she has exhibited crazy behavior in the past. The general statement which is disagreed with, then need not be said specifically, but can be inferred by the confronter from the confronted's other remarks. Element two is also a variation in that the punch line in line 6, "You know where that'll get you, don't you?," makes it sound as though there is a disagreement between them, even though in line 3 the patient had already agreed with the therapist that she is crazy. Nevertheless, this example is included here on the grounds that the therapist is talking to the patient's subconscious level as much as to her conscious level of awareness.

Example 6-15 is the last of the "variations" that deals with an appeal to the subconscious as well as conscious level of awareness. it is quite far from the initial paradigm presented or earlier examples. Nonetheless there is a disagreement with a punchline. However, it is not clearly in the form of a rhetorical question. Rather it is a statement with an implied rhetorical question, "How could you be doing this?" coming after the doctor's statement in line 14. The disagreement is also about the patient's action which is inferred in line 1, rather than about something that she had said. Finally in line 21, the patient, in effect, "steals" the real punchline by supplying the correct answer (she knows the nasal spray is addictive) to the therapist's inferred punch line above. It is also, however, a more direct response as an elision plus a reason to the therapist's yes/no question of line 20.

Example 6-15: Ellen

1. Pt.: (sniffs something)

2. Dr.: Can I ask you what were you just sniffing?

3. Pt.: Neosynephrine.

4. Dr.: Do you know what's in that?

5. Pt.: No. I mean...

6. Dr.: Just something you bought on the counter?

7. Pt.: Yes.

8. Dr.: Did you ask your doctor if you could use it?

9. Pt.: I've always used it. No. Why do you say that?

10. Dr.: Well, it's something like in the direction of the adrenalin family, epenephrine.

11. Pt.: Is it really?

12. Dr.: It affects your circulation.

13. Pt.: ...phenylepenephrine, hydrochloric...

14. Dr.: And you who are pregnant and are so concerned about taking substances into your body that can affect your biology...

15. Pt.: I never even thought about this, really.

16. Dr.: This is a vaso-constrictive...

17. Pt.: I never thought of it as a drug. You know, I never...

18. Dr.: Adrenalin is something that relates to people's periods, and contractions of the smooth muscle...

19. Pt.: Really?

20. Dr.: ...and little things like that, so I would wonder about your use of that. I would check it with him, would you? I had a vague feeling it was that, neosynephrine. I'd better tell you the second story about neosynephrine. It gives you relief for a while, doesn't it?

21. Pt.: I know it's addictive, I know it. I'm so hooked, it's terrible.

In this excerpt, the potential for the punchline comes often and early. However, the doctor does not offer one, possibly because there is no statement on the floor to be disagreed with. Instead the doctor

poses four quick questions to her which require brief answers (one fill-in and three yes/no questions in lines 2, 4, 6, and 8). Thus, in line 9 the patient takes control of the conversation posing her own question, "Why do you say that?" The doctor's questions are in response to the patient's action: she has taken out a nasal spray possibly and used it. The punchline finally appears in line 14. The rhetorical questions inferred is "Why are you using neosynephrine since you are concerned with your health since you are pregnant?" The disagreement is also implied: the therapist doesn't think she should be using it; she obviously does, since she is using it. Thus, this is a major variation from the elements proposed as necessary for the successful completion of a confrontation; the disagreement is implied and the rhetorical question aspect of the punch line must be inferred. However, it is included since, as in the last two examples, the therapist has moved her from possibly subliminal awareness to direct awareness. This confrontation is then a mild one. That it has been successful is evident, however, since in line 21 the patient "steals" the punchline --she really does know that the drug she was using is addictive.

This next example from Jill is another variation of the confrontation routine. The essential elements are present in lines 1 and 10. There are two variations: the first is minor. That is, rather than a check-out procedure in the form of yes/no question/answer sets, they speak almost simultaneously. There are three such check-out sequences. In addition, in the process, the doctor stretches each category presented. He shifts "appear strong" to "tough" and adds "fuck you, tough." She accepts "tough," but rejects "fuck you." The second variation is more important, that is, the punch line appears in

line 10 in the form of a statement, "and yet, at the same time, you function on such a dependent level." The unspoken, rhetorical question following that statement would be, "How come you do that?" This inferred punch line would then be analyzed in the class of "why" questions already discussed.

Example 6-16: Jill

1. Pt.: I felt, I have always felt that if I ever showed somebody how much I needed them, that they'd reject me and that the only way I can receive love is by, is by playing the role of not needing it, and of being kind of admired.

2. Dr.: mmhm.

3. Pt.: And, and ap, appearing strong. You know, this is how I was always

4. Dr.: Tough

5. Pt.: brought up

6. Dr.: Fuck you, tough.

7. Pt.: to act.

8. Dr.: Tough.

9. Pt.: This is how both my parents wanted me to be. Not fuck you, but tough, and independent. And, uh, anyway I always had to put on this attitude of not needing anything, emotionally from either of them.

10. Dr.: And yet, at the same time, you function on such a dependent level.

11. Pt.: I know.

The therapist thus points out the inconsistency of her behavior, which she accepts. This is permissible precisely because this is a therapy situation. For a friend to do so would appear impolite. In terms of the process, he encouraged her to state her position openly and directly and then without her being aware of it, he changed his position (he had been agreeing with her all along) and then presented the

punchline. While it is possible for her to disagree with his punch line and say, "I do not, I'm very independent. I've traveled all over the world, myself," she doesn't. Hypothetically, she could disagree and provide a reason for disagreeing. As stated earlier, however, it is difficult for her to disagree, not only because the punchline is coming from "left field," but also because he is the acknowledged expert. By making a professional observation, she would then have to question his expertise, something she is unlikely to do.

The last two examples presented in this segment are variations in quite different ways. Example 6-17, taken from the Talmud, is a confrontation within a three-person conversation and Example 6-19 can be heard as a joke. Example 6-17 was presented in the previous chapter because it also contains an analogy. It is re-written in conversational form and presented here for its confrontation features.

Example 6-17

1. Emperor (to Rabban Gamaliel): Your God is a thief, for did He not cause Adam to fall asleep and then steal one of his ribs?

2. Rabban Gamaliel's daughter: Call the police!

3. Emperor: What has happened?

4. Daughter: A thief entered my house last night, and took away a silver pitcher; but left a gold one in its place.

5. Emperor: Would that such a thief would come to me every night.

6. Daughter: Why then do you decry our God? Did he not steal a rib from Adam only to enrich him with a wife?

What this example shows us is that confrontation as an emerging event can be placed anywhere. The fact that three people are involved in the conversation is extraneous to the activity. It essentially occurs between the daughter and the Emperor, who is being confronted.

Certainly the fact that the daughter is the third person enables her to speak line 2, "Call the police!" which does not follow directly from the Emperor's line 1. Had the Rabbi tried that, the Emperor could have asked in line 3, "What are you talking about? We're talking about God; why are you calling the police all of a sudden?" However, the essential elements of the confrontation are present, including a general statement which is presented in line 1 and a punchline presented in line 6. The punchline is "unexpected" and in the form of a rhetorical question. The form of this confrontation follows the paradigm presented earlier. It is the presentation of a general statement, movement to a specific statement (which turns out to be an analogy), and then back to the general statement in the form of a rhetorical question. As described in Chapter 5, the disagreement is about what real theft is. The confronted, the Emperor, doesn't know where the "specific" is going to be connected with a "general." Hence, he is led down the primrose path, and, in a sense, duped. He has participated in his own "destruction." The use of the analogy makes this confrontation example a variation of the form also.

The excerpt below is a hypothetical re-creation of this piece of conversation which lays out the grounds for the disagreement between the confronter and confronted in a two-person conversation.

Example 6-18

1. Emperor: Your God is a thief, for did He not cause Adam to fall asleep and then steal one of his ribs?

2. Daughter: If a thief takes a silver pitcher, but leaves a gold one, has he stolen anything?

3. Emperor: No.

4. Daughter: If God takes a rib but leaves a woman, has he stolen anything?

5. Emperor: No.

6. Daughter: Then why do you call our God a thief?

Implicit in this discussion is the agreement to the statements that gold is more valuable than silver and a woman is more valuable than a rib.

Finally, I come to the last of the variations in example 6-19 which has the character of a joke. It was offered by Paul Lazarsfeld in the way of a comment on the use of the word "success" in confrontation. As will be very evident, success only refers to reaching the conclusion and not that the confronted was convinced, although this also occurs. He points out that "a clever patient could probably always turn the skit around. I recall the story about the patient who believes he is dead. The doctor asks him whether he knows that dead people cannot bleed; upon agreement, the doctor pricks his finger and the patient bleeds. He reaches the conclusion that, after all, dead people can bleed."[26] I have re-written this in conversational form as follows:

Example 6-19

1. Pt.: I'm not alive, I'm dead.

2. Dr.: Do you know that dead people can't bleed?

3. Pt.: Yes, I know that.

4. Dr.: (pricks patient's finger and patient bleeds)

5. Pt.: So dead people bleed after all.

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[26]Personal letter from Paul Lazarsfeld to Susanne Bleiberg dated April 4, 1973.

This example contains the essential elements of a confrontation including the general statement in line 1 and the punch line in line 4. What makes this a variation is the fact that the punch line is a demonstration rather than in the form of a spoken rhetorical question; instead, it is implied. The joking character comes from the patient's response to being confronted; he draws a false conclusion from a faulty premise. In addition, this example varies in that only one yes/no question is asked, which suggests the direction from which the punchline will come. Nevertheless, I imagine actually having his finger pricked and really bleeding would still come as a surprise.

Thus, to conclude the description of variations of confrontations, the necessary elements of a confrontation need to be present in order for the confronted to recognize that the activity has been accomplished. It is the punch line which makes the disagreement overt. However, either the general statement or the punchline in the form of a rhetorical question need not be stated directly, but can be implied. The examples presented thus far employ finding an exception, shifting, making inferences and using the confronted's own logic against him. The examples suggest that a confrontation can potentially be located after any statement, since it is a disagreement. The disagreement maxim states anything we say is subject to being disagreed with. What makes these disagreements different are their persuasive character that encouraged the confronted to change his original position. I turn now to confrontation "failures." These are confrontations which could have been completed, but were not.

Incomplete Confrontations

This last section considers those excerpts which might have completed confrontations, but did not. From the examples below we will find that most often the punchline is not presented; hence, there is no confrontation and no overt disagreement between the two speaker-hearers. In addition, the punchline on occasion is replaced by an explanation of psychodynamics, i.e., an interpretation is offered. Thus, if the punch line is not offered, the conversation may become a different activity. The therapist uses rule #4, explaining the rules and goals of therapy to the patient instead. Finally, if the yes/no question/answer format is not accepted by the patient (confronted), e.g., an equivocal "maybe" is given instead, the reality-confrontation is again subverted. Confrontation can be subverted, then, temporarily or permanently if any of the basic elements for its production are not there. I turn now to these kinds of examples.

In the examples presented below the punch line is not present in the proper form of a rhetorical question and therefore the activity of confrontation was not completed.

Example 6-20: Jill

1. Dr.: I can't tell yah [what's schizophrenic about your appearance]. You're not that much different than a lot of the younger people today. OK?

2. Pt.: They're all schizophrenic?

3. Dr.: But from my point of view, they all look, a lot of them look schizzy to me.

4. Pt.: Oh see that's where I feel that I can't relate to you.

5. Dr.: You can't relate.

6. Pt.: Because it's a whole different world.

7. Dr.: A whole different general (?)

8. Pt.: And I don't see it as schizophrenic. It's just a different set of esthetics and a different set of values.

This example is interesting because the patient attempts to confront the therapist. She disagrees with his assertion that her appearance is schizophrenic. However, the confrontation is not successful because the patient aborted her own beginning confrontation by not coming back in line 4 with either another closed choice question or with the punchline. For example, a second closed-choice question might be, "How about Mark Spitz, the swimmer? He's only 22. Is he schizophrenic?" Instead she says, "Now see that's where I feel that I can't relate to you." She has introduced a new subject, her ability to relate. And at this point the therapist ceases to cooperate in being the confronted; he becomes non-directive. Or she could have posed a rhetorical question as her punchline, as follows: "How can you say people are schizophrenic just because of the way they dress?" However, later on the therapist admits that they will have a problem. He says, "OK, here's an area where we'll have difficulties, where as a result of my not being on your generational level, I still have a problem."

The next example, also from Jill, also lacks a punchline and is therefore not completed.

Example 6-21: Jill

1. Pt.: Well, all I can gather is that there were just never any standards set for me.

2. Dr.: By whom?

3. Pt.: By my parents.

4. Dr.: You just grew. They didn't ask anything of you? They were completely permissive.

5. Pt.: Completely. I mean, they asked things from me, uh, you see I can't explain it, easily (?).

6. Dr.: Don't explain it. Tell me. Do not explain to me. I'm not a judge. You don't have to justify, just tell me. And I'll try to be of help.

7. Pt.: I was brought up feeling that I was, well, first of all, basically along, with nobody to rely on.

While this excerpt had the potential for a confrontation, the therapist does not speak in a confrontational way. This is probably due to the fact that the therapist has spent most of the session trying to motivate her and be cooperative, and just when it appears that she is being cooperative, he wouldn't want to undo it possibly by such "harsh" treatment. There is the possibility that the therapist might begin a confrontation sequence in line 4 since he asks two yes/no questions, "They didn't ask anything of you? They were completely permissive." (The second line is heard as a question.) The patient, however, does not cooperate; that is, rather than a simple yes/no answer, she attempts to amplify her statement. It is possible that she has learned from her experience in the prior conversation where such brief answers might lead. She subverts this potential occurrence by amplifying her remark.

It is possible that line 4 might have led to a confrontation; we see this in the following hypothetical re-creation:

Example 6-22: Jill (hypothetical)

1. Dr.: Your parents were completely permissive.

2. Pt.: Yes.

3. Dr.: You could come and go as you pleased?

4. Pt.: Not exactly. I had to be home at certain times.

5. Dr.: You could do whatever you wanted?

6. Pt.: No.

7. Dr.: Then how could you say they were completely permissive?

In addition, in line 6 of Example 6-21, the therapist does not offer a punchline. Instead, he says, "Don't explain it. Tell me. Do not explain to me. I'm not a judge. You don't have to justify, just tell me. And I'll try to be of help." Thus here he uses this opportunity to teach her the rules of therapy, how she should behave. And so in line 7, she begins, "I was brought up feeling that I was, well, first of all basically alone, with nobody to really rely on." This is really a victory for the therapist, as we see here the beginning of her cooperation from which a therapeutic alliance may be developed. In order for him to help her, she must begin by presenting personal material (rule #5), which she does. This is an indication that she is cooperating (rule #2) and hence wants to get well (rule #1).

Similarly, if the therapist does not follow the closed-choice questions with a punchline, there cannot be a successful completion of the activity. We see this in Example 6-23.

Example 6-23: Jill

1. Pt.: Then I got very sick.

2. Dr.: While you were away?

3. Pt.: Yes.

4. Dr.: What'd you get? Hepatitis? Or something?

5. Pt.: No. Amoebic dysentary.

6. Dr.: From needles or from other things?

The therapist's last line is not a punch line based on the immediate past question-answer sequence. For example, if he had said in line 6, "Why are you lying to me? I know for a fact that you've never had

amoebic dysentary either here or away," we would have had a confrontation sequence based on the "why" question. In fact, the therapist is trying to gain information in this sequence. He does not disagree with the patient's initial statement, and therefore an essential element is missing from the reality-confrontation paradigm.

From line 1 of example 6-23, we see that virtually any general statement can trigger a reality-confrontation production. It may seem unpromising to start with "Then I got very sick." But consider the following hypothetical example:

Example 6-24: Jill (hypothetical)

1. Pt.: Then I got sick.
2. Dr.: Were you ever nauseous or achey?
3. Pt.: No.
4. Dr.: Did you have an elevated temperature?
5. Pt.: No.
6. Dr.: Then how can you tell me you were sick?

In the next example, instead of having a punch line in line 8, there is an explanation of the dynamics of the patient's past behavior. That is, the patient starts out in line 1 with a statement of his behavior. The therapist asks three yes/no questions (lines, 2, 4, and 6) which are slightly longer than anticipated and are spoken in a gentle tone of voice. If they are not answered in the yes/no format it becomes harder to come back to the initial statement, since the second speaker would then control the floor. However, here the patient gives the expected brief and correct answers for a potential confrontation. But instead, the doctor offers an interpretation where the punchline would come. The therapist utilizes rule #4 in the hierarchy of rules

of therapy. That is, the doctor can make an interpretation at any time. Of course, the doctor could have offered the punch line and confronted the patient; however, he chose not to and worked toward the same end, helping the patient become more aware, by offering an explanation. The key difference between the two is that in this example the interpretation is offered without any disagreement or hostility apparent in the question-answer process of the check-out procedure before the punch line. Therefore, while the form of a confrontation is followed, the disagreement and punch line in the form of a rhetorical question are not there for its accomplishment.

Example 6-25: Bill

1. Pt.: (coughs) I guess I get into wanting some, well, like I said, when a paranoia starts, paranoia started, when I felt very isolated after coming out of the hospital and ta I wanted to talk to somebody, so here they are talking, talking to me.

2. Dr.: Is that how it sounds to you like it began?

3. Pt.: Yeah.

4. Dr.: Being isolated, so you created a world within which you had a dialogue, huh?

5. Pt.: Yeah.

6. Dr.: Even though the world was a world giving you a rough time?

7. Pt.: Right. Yeah. That's the way it,

8. Dr.: That's fascinating, you know, what you're saying (?). Like kids who are isolated, live in imagination, and have imaginary playmates. Huh?

9. Pt.: Um-hm.

10. Dr.: You've heard about that. Did you do that as a kid?

11. Pt.: Yeah. We used to make up stories about deers. Y'know. After seeing Bambi. Heh. (laugh)

12. Dr.: What kind of stories?

13. Pt.: I think there were a number of deers and, I pretended one time I was one of them. I feel like I kind of made an ass of myself during the whole, because I remember when I was much too old I imitated a deer, ...

Finally, the last example of a non-completed confrontation is based on supplying a non-preferred answer during the yes/no question/answer check-out phase of the confrontation routine. By offering other responses, the continuity of the confrontation sequence may be destroyed, and the activity is at least temporarily foreclosed.

Consider the following example:

Example 6-26: Jill

1. Pt.: I just want to be naturally attractive.

2. Dr.: You just want to be naturally attractive. Tell me, were you born naturally attractive? Are you physically so constituted that you're naturally attractive?

3. Pt.: Yeah, I have been at times. When I feel good.

4. Dr.: What do you do about feeling good and being naturally attractive? Do you take care of yourself?

5. Pt.: No.

6. Dr.: Well how do people take care of themselves who, whose natural attractiveness shows through?

7. Pt.: They, it just happens.

8. Dr.: It just happens. You know you used that phrase a couple of times already, "just." I "just want to," the "just," "just," you mean like (click) from the sky?

Here, the patient aborts a beginning confrontation in line 3 by saying "sometimes," rather than the "no" which would move toward the classic example. Hence, the therapist has to give up confronting "I just want to be naturally attractive," and finally confronts the general statement, "Natural attractiveness just happens" that is implied by the patient's answer in line 3. In addition, instead of a punch line in

line 8 as a contradiction to line 1, we have an observation instead. The therapist comments on her use of the word "just" and its implications.

To summarize, then, reality confrontation requires at its minimum: (1) a disagreement implied or explicit between the two speaker-hearers, (2) a punch line arrived at in a non-direct way, (3) in the form of a rhetorical question which points out a basic inconsistency. We see this in the following paradigm:

Paradigm of Ideal Confrontation (revised)

Step	Actor	Behavior
1	Confronted	Makes general statement or one is inferred by the next speaker.
2	Confronter	Asks or implies a rhetorical question which contradicts the first speaker's statement.

This model does not imply that the intermediate steps cannot occur. The greater the number of intermediate steps, the greater the possibility of "turn-offs" or derailments, and the chances of not reaching the punchline.

The activity of confrontation rests on its relationship to logic and reason. Its power is based on its ability to sanction inconsistency--an undesireable trait; its violation of the rules of everyday talk; and its denigrating aspects. The rhetorical nature of the punch line also serves to heighten its effectiveness since it is difficult to respond to and implies that the confronter knows for a fact that the confronted's statement is not true. This makes the confronted appear to have been lying or be stupid or incompetent. Each case of such indirect name-calling demands a response since it

is seen as a personal attack. Thus, confrontation as an exhortation to change is usually responded to and the work of therapy begins to be accomplished.

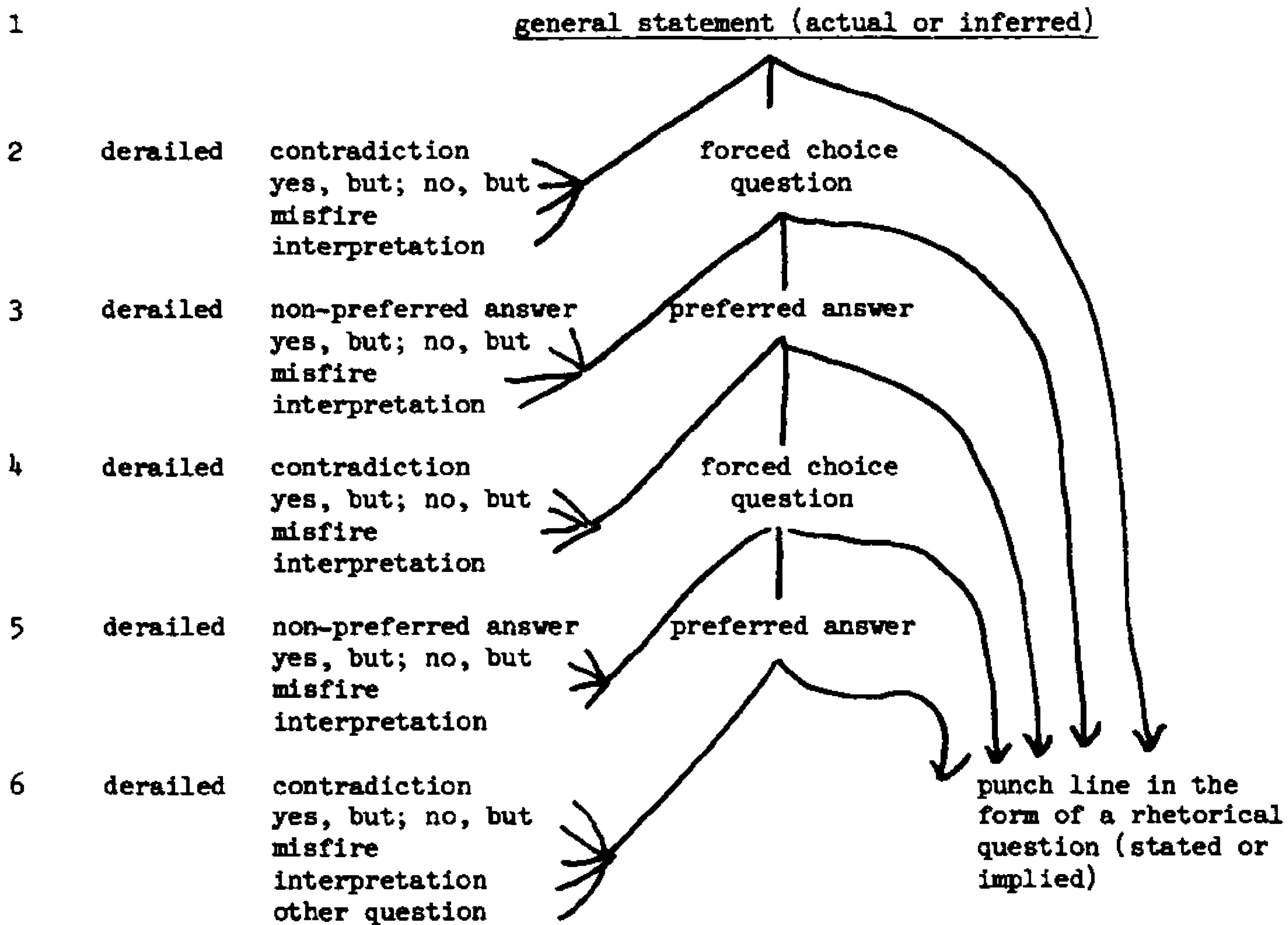
On the following page is a "tree-diagram" in grammatical form of how confrontation may be accomplished.

Confrontation may be accomplished in its classic form by using a funnel process which includes two, but not many more, short yes/no or closed-choice questions or "invitations" which the respondent must take. The check-out procedure does not have to be included, however. What is important is that the confronter gets to his punch line by stretching a category in the confronted's initial statement, shifting from a special case to a general proposition, and then basing his conclusion on this general statement or vice versa, presenting a specific instance which negates the general rule. Thus, category formation and negative reinterpreting are essential to developing the punch line. The disagreement in the form of the rhetorical question may be strong or mild and stated or implied. Successful confrontation as used here means only that the punch line is reached, not that the confronted necessarily changed his or her mind. Confrontation failures, then, mean that the punch line has not been reached. If the disagreement is not there, or the punch line is not presented, or the routine is sidetracked or stopped, the routine will be subverted.

Without these two essential elements (the disagreement and punch lines) we may end up as witness to another activity. There is some probability that it will be an interpretation of psychodynamics or the rules of therapy, moves that are always available to the therapist. Confrontation is based on an appeal to one's intelligence and

Grammatical Model of Confrontation

Step



common-sense understanding of what is logical and what is real. Thus, even someone behaving in a truly "crazy" fashion has some relation to reality. Confrontation appeals to that connection, however tenuous, and attempts to build on it. Thus, confrontation is a kind of dis-agreement which is a denigration, and, at the same time, an exhortation to change.

I turn now to the last chapter of this dissertation for a summary, conclusion, and implication of this research.

CHAPTER 7

SUMMARY AND CONCLUSION

As stated in the first chapter, this dissertation had two goals: one practical and the other theoretical. The first is to get a better understanding of disagreement and disagreeing activities in general and and to understand these activities within the psychotherapeutic context specifically. The second is to add to the literature on how reality is created and shared. In order to achieve the theoretical goal, a practical problem was pursued.

Thus, the following topics were discussed:

In Chapter 1, I introduced the topic of this dissertation: a conversational analysis of disagreement. I attempted to show why pursuing the practical problem of how disagreement gets accomplished in the therapeutic setting can add to our theoretical knowledge about how reality is created and shared. Therefore, I reviewed the relevant ethnomethodological literature and conversational analysis literature and presented an overview of the methods of this study.

In Chapter 2, I reviewed the traditional literature in the fields of sociology, psychiatry, communication, interviewing, logic and rhetoric. I undertook such a review in order to show that the question posed in this dissertation--how is disagreement accomplished--and the thesis--disagreement is central to the psychotherapeutic treatment process--had not been answered previously using traditional techniques

and thus a conversational analysis is appropriate to the task. I also showed how the topic stems from various disciplines.

In Chapter 3, I provided a general description of the nature of the therapeutic relationship as a correctioning process. I suggest that the therapist and patient engage in normal everyday speech activities, but the power of their talk lies in the special features of the relationship, namely, that the patient may be held accountable for everything he says and he does not know when the therapist will move him from his equal to his unequal and subordinate role. Threatening behavior and the display of authority were examined in order to see how the therapist and patient use the rules of therapy.

In Chapter 4, I defined disagreement as one person taking a yes position and the other a no position and analyzed disagreement as an adjacency pair and contradiction. In discussing the verbal and non-verbal forms of doing disagreement, a disagreement maxim and congruency maxim were formulated. The former states, "Any statement or specific proposal question offered is subject to being disagreed with," and the latter states, "Synchronize your verbal and non-verbal communications if you want to be taken seriously."

In Chapter 5, I described strategies of negotiating disagreement. I presented data which showed that as patients present data and hence the formulations of their category packages, the therapist can then disagree with that formulation by using negative reinterpretation to show the patient an alternate category construction. In so doing, the therapist employs category examination and shifting via stretching, the funnel process, analogy and psychoanalytic interpretation. The patient is free to accept or reject the therapist's reformulations.

In Chapter 6, I analyzed the activity of confrontation in order to show how it is used to encourage change. I analyzed the elements necessary for its production and why it is often used successfully. I presented a grammatical tree diagram for its production and conclude that it is a contradiction heard as a rhetorical question. Confrontation works as a kind of denigration and at the same time an exhortation to change.

Finally, in this chapter, besides providing the above review of the dissertation, I pose two questions:

1. Have the theoretical and practical goals posed in Chapter 1 been achieved? and
2. Where do we go from here?

The questions are interrelated.

The questions are interrelated because where we go from here depends on how far we have come. I conclude that to some degree we do have a better idea of how disagreement and disagreeing activities get done generally and in the psychotherapeutic context specifically. My application of conversational analysis has provided a more detailed description of the activity disagreement. The literature talks only vaguely about this topic, even by practitioners of the activity. In this dissertation, I showed how disagreement is an essential activity in the psychotherapeutic relationship and treatment process. That is, I actually examined how disagreement is done and proposed several ways in which it is done, specifically contradiction, negative reinterpretation and reality-confrontation. It is this application of conversational analysis to the problem of disagreement that is the original contribution of this thesis. The theoretical goal is more difficult

to accomplish. I have elucidated some of the rules by which the activity of psychotherapy is guided. In addition, the analysis of confrontation is the deepest and hence furthers the theoretical goal more so than any other disagreeing activities examined. Theoretically this may be viewed as a contribution to the understanding of the constructed nature of everyday events. This suggests to me a number of alternative courses as to "where we go from here."

1. The analysis of each of these disagreeing activities can be taken to a new level of analysis. Hence, only the outer layers of the onion have been peeled and further analysis of these activities is possible.

2. Other disagreeing activities within the psychotherapeutic context may be analyzed. The activities of browbeating and control readily come to mind.

3. Disagreeing activities may be studied in other contexts such as in courts, labor negotiations, welfare centers, schools, etc.

4. Other kinds of activities may be studied in the therapeutic context such as giving support, advice, praising, rewarding, etc. In short, positive or agreeing activities may be studied as well as negative or disagreeing ones. Therapy endings may also be studied.

Following each of these courses of action would result in a better understanding of how an activity gets accomplished and hence have practical results. In the context of therapy, as long as therapists are interested in the motivational structure of their patients, they have no recourse to discover these structures, but through everyday activities. Thus this analysis and further work of this kind should aid the therapist in his central task, the improvement of the

mental health of the patient. Pursuing the above courses of action would also have theoretical results since such studies would add to our knowledge about what rules people appear to follow when they carry out various activities. In this way, our theoretical goal--to have a better understanding of the social construction of reality--will eventually be realized.

I conclude then that disagreement is a socially constructed and shared production. As such, the participants have the option to maintain it, modify it or change it altogether and we would be witness to another kind of activity. The implication is that Garfinkel is correct; we are norm users rather than norm followers. This suggests that (1) for a better understanding of social interaction and the institutions in which we participate, we ought to study from the member's or actor's perspective the production of his activities and hence his use of rules, and (2) all of the activities currently engaged in by sociologists ought to be analyzed insofar as we are part of and produce the activities which we currently believe we are analyzing. Therefore, how we achieve the production of the activities we engage in should be a main concern for the field of sociology. This dissertation, insofar as it is successful, is an attempt to move in this direction. Since the social construction of reality is an on-going process, our work, as members and analysts, always lies in the moment and before us.

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