Psychotherapy is fundamentally about a special kind of communication between a therapist and one or more patients with the objective of producing desired changes in the patients. Although therapy is a verbal interaction, it differs from social conversations in its goals, roles, settings, topics, and focus.

I present a theoretical model of patient-therapist communications that includes patient verbalization, translation, transformation, theory, and therapist response as elements of a complex feedback process. This sequence of events influences the subsequent patient verbalizations in a continuing, behavioral, homeostatic system. Related studies provide empirical information on appropriate and inappropriate therapist responses to patient input. A number of suggestions are made about the nature of desirable and undesirable interventions. I also examine some of the questions of concern to psychotherapists about therapeutic dialogue and suggest some ways in which emotions are essential aspects of such a dialogue.

THE NATURE OF COMMUNICATION

In The Evolution of Communication, Hauser (1996) listed seven definitions of the word communication. All are similar; the simplest is that given
by Krebs, Davies, and Parr (1993): “communication is the process in which actors use specially designed signals or displays to modify the behavior of reactors” (p. 349). Linguists recognize that human language is different from nonhuman language. Pinker (1994), a psycholinguist, observed that nonhuman communication systems are based on one [or more] of three designs: a finite repertory of calls (one for predators, one for claims to territory, and so on), a continuous analog signal that registers the magnitude of some state (the livelier the dance of the bee, the richer the food source that it is telling its hive mates about), a series of random variations on a theme (a bird song repeated with a new twist each time).... (p. 334)

The human vocal tract provides a selective advantage over other configurations because (a) non-nasalization allows sounds to be more easily identified; (b) it produces sounds with distinct spectral peaks, resulting in fewer listening errors; and (c) it provides a greater rate of data transmission than other communication systems (Hauser, 1996).

At least two other important aspects of speech are relevant to psychotherapy. The content and the form of speech provide information about the emotional and motivational states of a speaker. Speech provides both digital and analog coding. Digital coding (the use of discrete words to convey information) is believed to be a late phylogenetic development. Analog coding refers to the graded signals varying in intensity, frequency, or tempo that convey information about emotional states. Humans use graded vocal signals just as lower animals do to convey emotional states.

The second aspect of speech relevant to psychotherapy is based on communicative displays, which are usually the result of more than one behavioral impulse in conflict (Hahn & Simmel, 1976; Wilson, 1975). Attack and retreat, affinity and sexuality, caregiving and exploration all interact to produce the graded facial, vocal, and postural signals that determine appropriate social interactions. Evidence from studies of animals, children born deaf and blind, and preliterate and isolated groups of humans demonstrates that facial expressions of rage, surprise, fear, and happiness are universal and probably have an innate basis. However, human beings have highly developed facial musculature, and a large number of facial expressions can be voluntarily created and given arbitrary meanings akin to those of a language. In ordinary interactions between humans, there is a subtle interplay between innate display signals that are characteristic of humans and those conventional expressions that people learn. Anthropologists have also suggested that language activities have been selected during evolution as a means of social manipulation in the context of subsistence activities (Parker, 1985). A similar view has been presented by Fridlund (1994), who has provided evidence that facial expressions function pri-
arily to manipulate the emotional states of other people. The overall conclusion is that communication reflects ideas, emotions, and conflicts.

However, neither emotions nor conflicts are immediately evident to a listener when exposed to a particular communication. A complex process of inference, based on knowledge, theory, and personal sensitivities, occurs in order to identify both emotions and conflicts. This is why the process of becoming a competent clinician is a long and complex one. The clinician "must attend to the antecedents and consequences of understated needs, unlabeled motivations, and metaphorical meanings of behavior in order to change them" (Vaillant, 1994, p. 151). The idiosyncratic use of language by patients is another complicating factor (A. A. Lazarus, 1997), as is the fact that communications often have meanings that are not necessarily understood by the patient (Szajnberg, 1992).

The complexity of the translation process from overt communication content to associated emotions, motivations, and conflicts means that interpretations are not only inexact, but, to a greater or lesser degree, incorrect as well (Karasu, 1992). From the point of view of psychodynamic thinking, interpretations, whether correct or not, have the role of regulating the patient's emotions. Interpretations ideally provide information about the patient's unconscious mental processes in relation to other people and may, in time, lead to a sense of competence in recognizing and controlling one's own affects (Spezzano, 1993).

SOCIAL CONVERSATION VERSUS THERAPEUTIC COMMUNICATION: TWENTY DIFFERENCES

Psychotherapy is clearly a verbal interaction between someone who is a therapist and one or more people designated as patients or clients. This verbal interaction has some resemblance to typical social conversations, but there are, in fact, many important distinctions that one can draw. These distinctions, although sometimes a matter of degree, are usually fairly clear cut; they are described below.

1. **Goals (short term):** The purpose of social conversation is to socialize, to exchange ideas, and to have fun. The goal of therapeutic communication is typically to uncover the meanings of symptoms, to explore feelings, to change faulty cognitions, or to rehearse behavior changes.

2. **Emotions:** Social conversation usually focuses on emotions that are thought of as pleasant, such as attachment, curiosity, controlled competitiveness, and pleasure. In contrast, therapeutic communication is usually concerned with painful emotions such as depression, anxiety, resentment, revenge, shame, hate, and guilt.
3. **Roles**: Most social conversation is carried out in the context of two or more friends or associates talking together. Therapeutic communication usually implies different roles for each participant, for example, professional to client, expert to novice, parent to child, or teacher to student.

4. **Purpose** (*long term*): Social conversation is usually directed at maintaining a relationship that may continue indefinitely. Therapeutic communication tries to produce a desired change (e.g., decrease in symptoms or increase in self-esteem), so that the relationship can end.

5. **Power**: In a social conversation, there is no inherent assumption that one person has more power than the other (although this may sometimes be true). Both participants try to influence one another's ideas or behavior. In therapeutic communication, the therapist is generally seen as having a higher power than the client, and the aim is for the therapist to influence the client in a desired way, but not vice versa.

6. **Modeling**: Although people in social settings do sometimes try to hide some of their personality traits from others, there is no compelling reason for them to be anyone other than themselves. In contrast, therapists are trained to express, through their therapeutic communication, a model of themselves as accepting, concerned, and professional.

7. **Setting**: Social conversations are held anywhere. They are usually informal and open ended. Therapeutic communication is formal, structured, purposeful, and generally conducted only in the therapist's office.

8. **Structure**: Social conversation has no time limits and usually no financial arrangements are made, except in dating situations. Therapeutic communication always involves a limited time of contact and almost always involves a fee for service.

9. **Topics**: Social conversation may deal with any topic (e.g., work, family, gossip, politics, sports). Therapeutic communication primarily deals with personal life experiences.

10. **Intimacy**: Although social conversation may involve deep and moving contents, it is more likely to involve superficial communications. The aim of therapeutic communication is to create a deep intimate bond between therapist and patient so that the patient may feel willing to talk about highly personal material.

11. **Self-disclosure**: In social conversation, there is often relatively little self-disclosure except of a superficial kind (e.g., “I also
visited Alaska last year". When self-disclosure occurs, usually both parties contribute. In psychotherapy, self-disclosure is usually limited to the patient. Therapists are typically taught not to reveal much about themselves.

12. **Direction of interaction**: In social conversation, interactions are mostly bidirectional, with both parties contributing ideas and stories. Most therapists encourage the patient or client to do most of the talking, so that the content is usually initiated by the patients.

13. **Focus**: In social conversation, each person takes a turn being the focus of attention. Often, there is a certain amount of competition concerning to whom the most attention is directed. In psychotherapy, the focus of attention is almost exclusively on the patient and his or her life, emotions, and experiences.

14. **Amount of communication**: Although people vary greatly in their tendencies to talk a lot or a little, on the average the amount of contribution to the social conversation is roughly equal. In most types of therapies, the client talks considerably more than the therapist.

15. **Nature of reality**: Most social conversation is concerned with things that go on in the world outside of the client (e.g., sports, current news, family events). A good deal of therapeutic communication is concerned with the inner subjective world of the client.

16. **Revelation**: In social conversation, all participants generally feel free to reveal many aspects of their lives outside of the particular setting and conversation. In therapeutic communication, patients are expected to reveal aspects of their lives outside of the therapeutic setting, whereas therapists are not expected to describe their lifestyles.

17. **Values**: Each participant in a social conversation is free to express values, opinions, and attitudes about any and all topics. In contrast, therapists usually avoid expressing their personal values on issues brought out by the clients.

18. **Meaning**: For the most part, social conversation tends to deal with the surface aspects of events, what psychoanalysts would call the manifest content (however, this term is not intended to imply that the conversation is unimportant or uninteresting). In therapeutic communication, the therapist is often concerned with the hidden meanings of client communications.

19. **Theory**: Social conversation is generally unplanned, and topics may change and drift in random ways. In psychotherapy,
the therapist has a theory of therapy and of the human mind and uses such theory to guide the nature of the interactions.

20. **Sexuality**: Social conversation has a multitude of functions: It exchanges information, it enhances feelings of affiliation, it can attempt to manipulate the relationship between the people who are talking, and it can be a prelude to sexual or aggressive encounters. In therapeutic communication, the therapist is generally able to control his or her reactions to sexual or aggressive provocations.

Additional distinctions may be made between social conversation and therapeutic communication, but the list above is sufficient to demonstrate that significant differences exist between them.

**THE NATURE OF THERAPEUTIC DIALOGUE**

In an interesting book titled *Therapeutic Communication*, Wachtel (1993) observed that relatively little has been written on the words therapists use and when they should use them. The focus of his book is on distinguishing between comments that are helpful to patients in contrast to comments that tend to maintain the problems that brought the patient to treatment. He gave the following example: A therapist may tell a patient that he seems hostile or that he appears to be grouchy. The first comment tends to create resistance and anger at the therapist because of its negative connotation, whereas the second is more likely to be accepted by the patient as a realistic description of a current mood. In general, labels such as *hostile, passive, seductive, masochistic,* or *manipulative* tend to create feelings in patients that they have been criticized, resulting in further feelings of shame, anger, or anxiety, which are the very kinds of feelings that led them to enter therapy.

Most clinicians who have written about the issue of therapeutic communication have pointed out that therapist comments that create shame, embarrassment, guilt, blame, anger at the therapist, or a decrease in self-esteem are undesirable. Such comments are likely to produce resistance to further engagement rather than cooperation with the therapeutic process. Patients enter therapy with the feeling that they lack something in their relations to important people in their lives and that their personality or self is inadequate. If a therapist then directly or subtly implies that the patient is irresponsible, controlling, narcissistic, or regressed, the sense of inadequacy is increased rather than diminished. Above all, the therapist should not try to argue or preach to the patient in order to convince him or her that the labels and interpretations are accurate.

It has already been noted that insight is seldom a basis of successful
therapy. Benjamin (1993) stated that insight is not a goal of therapy, but only a stage. "Insight only tells the patient what needs to be changed" (p. 94); many therapeutic interactions need to take place before therapy can be considered to be successful. Clinicians know that narratives presented by patients are not complete and are not necessarily an objective recounting of events, so that a constant process of evaluation and interpretation takes place in the mind of the therapist. The process of therapy involves a kind of decoding of the bits and pieces of a complex, often disconnected narrative, in order to create a plausible (but not necessarily complete) understanding of an individual's life.

A PROPOSED MODEL OF PATIENT–THERAPIST COMMUNICATIONS

Anyone who has seen a written transcript of a psychotherapy session is usually surprised by the partial incoherence of segments of the transcript. Here is a brief illustration of this point. It represents part of the 95th session of an analytic treatment (P is the patient and A is the analyst) taken from *Therapeutic Discourse* (Maranhao, 1986).

A: No, I think you're afraid that, you know when we started to talk about this that you—what comes up is how angry you feel at [inaudible] . . .

P: Yes, at you?

A: Men. And you are frightened that you won't be liked. [. . .]

P: I never was. "When you get to college, dear, boys will like you," my mother said. I don't think she said "boys will like you"—that's what I, that's what I felt it really meant. But she said that you'll find boys that you like, that you have more in common with. You see, [inaudible] be based on common interest and good healthy things like that couldn't be based on [raises voice] fucking and sex [inaudible] to be something nice. It had to be a real relationship, not just sex. Shit. [. . .]

P: You know, I feel like I'm going to be released from this room and that I'm going to be raging, in a raging fury, and nobody will know why. [laugh] [inaudible] I just walk along, you know, nice and straight. If I get angry enough all at once, then would I get over it? Primal scream. I can't imagine, you know, feeling really, feeling like there isn't anything wrong with me. I was thinking about that the other day. What would it be like, you know to feel that you really just, you know, you were where you ought to be, and everything is just really full? (p. 43)

Every verbal interaction between two people has elements of ambiguity, incongruity, and vagueness in it. Despite this, conversations usually go on as if the participants are either unaware of the partial incoherences or are able to ignore them.
In psychotherapy, therapist interventions are part of a complex feedback system in which patient statements influence therapist reactions, which in turn influence subsequent patient comments. Because patient comments are often fragmented and partially incoherent, therapists generally fill in the blanks as best they can to create a reasonable narrative in their own minds. This idea is illustrated in Figure 9.1.

Patient communications, even if ambiguously or unclearly presented, are somehow translated by the therapist into meaningful sentences in his or her own mind. Conceptually, the therapist then categorizes some of the ideas presented by the patient, first in simple descriptive terms, and then into more general theoretical categories related to such ideas as resistance, defense, or transference. These ideas are related in the mind of the therapist to broad theoretical issues related to diagnoses and goals of treatment. The therapist then considers what he or she should say in terms of the various categories of response that are potentially available. Should he or she interpret the patient’s remarks, or should he or she disclose something about himself or herself or make an empathic comment? When this decision is made (often rapidly and unconsciously), it is translated into meaningful sentences and revealed to the patient. This feedback then starts a new round of patient–therapist interactions.

These ideas may be illustrated in the following way. The patient may begin a session talking about feelings of helplessness or about feelings of discouragement concerning progress in therapy. The therapist may think, “the patient seems to be asking for help,” “the patient appears to be criticizing me,” or “the patient is talking about his mother and appears to be angry at her.” These descriptive categories are then transformed into theoretical categories, which may be of the form “the patient is showing resistance,” “the patient is handling his anxiety by displacement,” or “the patient is developing a transference attachment to me.” The theoretical descriptions of the patient’s communications are then related to another broad set of theoretical categories, which may include the diagnoses of the patient, the theoretical conceptions of the form of therapy preferred by the clinician, the goals of treatment, an estimate of the degree of vulnerability of the patient, and other concepts. On the basis of an interaction of the theoretical interpretation of what the patient said and a theoretical conception of what therapy is all about, the clinician then considers a number of possible responses that he or she might make. These responses include such possibilities as interpreting the patient’s resistance to change, challenging the patient, disclosing information about oneself, or exploring affects. When a decision is made among these various possibilities, the clinician’s theoretical response categories must be translated into a meaningful sentence, which is then spoken aloud. This is the clinician’s overt communication. It is evident, however, that the appearance of this communication implies the existence of a complex decision-making process.
with various feedback loops. An example of a feedback loop may be the countertransference reaction of the therapist, of which he or she may not be aware, that triggers defensive behaviors or resistances in the patient.

Knowledge of this circular, feedback process may sharpen a clinician's awareness of the role that therapy plays in the shaping of his or her responses to patient communications. This feedback model has also provided the theoretical basis for an empirical study of the various categories of response that clinicians use during the psychotherapeutic encounter.

In a study of the issues raised by this model of patient–therapist interactions, my colleagues and I reviewed a large number of psychotherapy transcripts representing different schools of therapy and different points of view (Plutchik, Conte, Wilde, & Karasu, 1994). The aim of the review was to identify the nature and basis of therapist interventions during psychotherapy. Previous reports had suggested categories such as questioning, advising, interpreting, and reflecting (Stiles, 1979) or categories such as getting information, support, focus, and clarification and providing hope (Hill & O'Grady, 1988). We believed that a review of a large number of transcripts would enable us to identify the implicit categories used by therapists when making interventions. We also hoped to identify, through a survey of experienced clinicians, what kinds of interventions would be considered appropriate and what kinds inappropriate.

To accomplish this latter aim, we identified 41 patient communication categories from the various transcripts. Examples of such communications are: (a) suicidal thoughts, (b) complaints about a lack of progress in therapy, (c) an intention to harm someone, (d) sexual thoughts toward the therapist, and (e) a desire to prolong the session. The 41 communications were then presented to a group of seven experienced clinicians who provided a list of possible responses that a therapist could reasonably make to each communication. This resulted in from 5 to 8 possible therapist responses for each item. Possible therapist responses include (a) asking for associations, (b) ignoring it, (c) pointing out the patient's sarcasm, and (d) looking for historical antecedents.

Patient remarks and possible therapist responses were then compiled in a survey form and were mailed to members of the clinical psychiatry faculty at the Albert Einstein College of Medicine; 141 responses were obtained.

The clinicians were given the list of patient communications and a list of 5–8 possible responses that one might make to each communication. They were asked to rate the extent to which they agreed or disagreed with each possible response to each patient communication. A 5-point scale was used, with responses ranging from strongly disagree to strongly agree. An additional analysis by a separate group of clinicians attempted to codify all the possible therapist responses into a small number of categories.

Table 9.1 provides examples of clinicians' responses considered to be
highly inappropriate. They generally reflect the therapist's anxiety about what is going on, his or her anger at what is being said, or a lack of awareness of what to do in an ambiguous or critical situation. Table 9.2 provides examples of clinicians' responses considered to be highly appropriate interventions. They reflect a sense of honesty between therapist and patient (e.g., "I feel confused about what you are saying"), a desire to explore ideas and issues that arise, and a sense of tactful concern about the patient's feelings.

One interesting aspect of this study was the empirical list of 15 therapist interventions that was finally attained. This list was not concerned with grammatical categories such as "asks a question" or "makes a statement," but was solely concerned with broad content areas. These are shown in Table 9.3. They include categories of therapist behaviors such as gathering information, boosting morale, exploring affects, and searching for purposes. It is important to recognize that not every clinician does everything that is on the list. Different schools and personal styles encourage the use of certain types of interventions and not others. Cognitive-behavior therapists may emphasize educating the client and redirecting his or her
**TABLE 9.2**  
Examples of Clinicians’ Responses Considered to Be Highly Appropriate Interventions

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Therapist's response</th>
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</thead>
<tbody>
<tr>
<td>1. If your patient describes his or her problems .</td>
<td>Ask how long he or she has had them.</td>
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<tr>
<td>2. If you do not understand the meaning of a particular communication .</td>
<td>Express your confusion or lack of understanding.</td>
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<td>3. If your patient constantly complains . . .</td>
<td>Bring this to his or her attention.</td>
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<tr>
<td>4. If your patient expresses sexual feelings toward you . .</td>
<td>Explore further thoughts, fantasies, and dreams that the patient has about you.</td>
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<td>5. If your patient reports a dream . . .</td>
<td>Explore the affect in the dream.</td>
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<tr>
<td>6. If your patient is silent for what appears to be a long time . .</td>
<td>Comment on that fact.</td>
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<tr>
<td>8. If your patient reveals inconsistencies in his or her behavior in similar situations . .</td>
<td>Ask if the patient is aware of these inconsistencies.</td>
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<tr>
<td>9. If your patient focuses excessively on historical materials . .</td>
<td>Explore the possibility that this is a way of avoiding present issues.</td>
</tr>
<tr>
<td>10. If your patient appears to become overanxious while talking . .</td>
<td>Inquire about the patient’s feelings at that moment.</td>
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behavior. They may consider that self-disclosure by the therapist is reasonable and appropriate. Dynamic therapists tend to explore affects and the patient–therapist relationship and are inclined to interpret resistances, patterns, and purposes. They generally do not see the task of therapy as one of educating the patient, boosting morale, or redirecting the patient’s behavior. All therapists, however, regardless of school, gather information, define the therapeutic structure, and implicitly provide some kind of an educational model of human interactions.

**AN INAPPROPRIATE THERAPIST INTERVENTION: THE USE OF “WHY” QUESTIONS**

In ordinary social conversations, people frequently ask other people for the reasons behind their actions or experiences (e.g., “Why do you collect Chinese antiques?” “Why do you like romantic novels?” “Why do you date this man who criticizes your taste in clothes?”). Sometimes a
question is put in a negative form; for example, “Why don’t you go on vacation with me?” or “Why don’t you get married?”

Psychotherapists also use “why” questions. They sometimes ask patients why they came late to a session, why they are depressed, why they cannot enter an elevator, or why they are angry at the therapist.

“Why” questions can be divided into two general categories: (a) those that are concerned with scientific or technical issues and (b) those that are concerned with personal feelings and motivations. An example of the former type would be “Why did your car break down?” The answer might be given in terms of unpaved roads, heavy snow, or worn spark plugs. An example of the latter type would be “Why can’t you lose weight?” The answer might be given in terms of a lack of will power, poor habits of eating, or unconscious wishes to punish someone. The comments to follow are solely about the second type of why question.

If we think about it, we discover that why questions concerned with personal feelings and motivations tend to make most individuals to whom they are directed feel uncomfortable or defensive. People tend to become annoyed when asked such questions (e.g., “Why are you late?” “Why can’t you eat alone in a restaurant?” “Why are you afraid of insects?”). What is it about such questions that make people feel uncomfortable?

We may understand such questions better if we recognize the settings in which they typically occur. Parents feel free to ask their children why questions (“Why didn’t you call?”), whereas children rarely ask such questions of their parents. Teachers normally ask their students why questions (“Why didn’t you do your homework?”), whereas students rarely ask their teachers such questions. Supervisors feel free to ask their employees why questions (“Why were you late?”), but employees never ask such questions of their supervisors. Psychotherapists often ask their patients why questions about their feelings and motives (“Why didn’t you leave your abusive marriage?” or “Why do you look so upset when you talk about your father?”), whereas patients rarely ask their therapists to explain what they are doing or why they feel certain emotions.

What this suggests is that people who are in higher positions of power or authority usually ask why questions of those who are in lower positions. Implicitly, the asking of a why question of this type is an indirect expression of dominance. When one finds why questions typically being asked by one spouse to another or one friend to another, this is an indirect indication of who feels more dominant or powerful in the relationship. Similarly, dominance is being expressed when psychotherapists ask patients why they felt certain emotions or carried out certain acts.

There is another important aspect to why questions. Most people are so well-socialized and polite that their immediate thought when asked a personal why question is to begin a sentence with “Because.” Most people have a strong tendency to want to answer such questions, and this can
<table>
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<tr>
<th>Intervention category</th>
<th>Definition</th>
<th>Example</th>
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<tbody>
<tr>
<td>1. Educate</td>
<td>Provide specific information to the patient. For example, explain something about normal childhood development to a parent who is upset by a child's behavior.</td>
<td>“It is important for you to talk about your childhood because things that happened then can influence the way you feel now.”</td>
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<tr>
<td>2. Gather information</td>
<td>Ask the patient to provide present or past specific biographical information.</td>
<td>“Please tell me about your work history.” “Have you ever seriously contemplated suicide?”</td>
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<td>3. Define therapeutic structure</td>
<td>Indicate to the patient what is acceptable and unacceptable behavior in the therapy relationship.</td>
<td>“If you miss sessions you need to pay for them.” “I can't accept presents from you.”</td>
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<tr>
<td>4. Support self-control</td>
<td>Help the patient set limits on the expression of his or her emotions or thoughts.</td>
<td>“I'm sorry I'm late, but my car broke down.” “Yes, I am married and have three children.”</td>
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<tr>
<td>5. Make a self-disclosure</td>
<td>Reveal personal information about yourself (as therapist).</td>
<td>“You are doing very well.” “You showed a lot of courage under the circumstances.”</td>
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<tr>
<td>6. Boost morale</td>
<td>Say or do something designed to make the patient feel better.</td>
<td>“Can you tell me more about that?” “Hmm.”</td>
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<tr>
<td>7. Encourage elaboration/verbalization</td>
<td>Encourage the patient to generate more thoughts and feelings about a given topic.</td>
<td>“How did you feel about that?”</td>
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<td>8. Explore affects</td>
<td>Ask the patient to elaborate on his or her feelings and emotions.</td>
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<tr>
<td>9. Explore patient/therapist relationship</td>
<td>Relate the patient's behavior, thoughts, or feelings to you (as therapist).</td>
<td>&quot;You seem to be angry at me.&quot;</td>
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<tr>
<td>10. Interpret resistance</td>
<td>Make a connection between what the patient is doing, saying, thinking, or feeling at the moment and the fact that therapy is being impeded.</td>
<td>&quot;I notice that every time I go away on vacation you are late for the next session.&quot;</td>
</tr>
<tr>
<td>11. Interpret/search for pattern</td>
<td>Identify repetitive patterns in the patient's behaviors or identify common features underlying different behaviors or feelings.</td>
<td>&quot;You always seem to change the subject when I mention your father. I wonder if you are avoiding the topic?&quot;</td>
</tr>
<tr>
<td>12. Interpret/search for purpose</td>
<td>Try to determine what the patient's behavior is trying to accomplish.</td>
<td>&quot;You always seem to fall in love with married men.&quot;</td>
</tr>
<tr>
<td>13. Interpret/search for proximate cause</td>
<td>Try to identify a thought process that connects a recent event with some aspect of the patient's current behavior.</td>
<td>&quot;Do you think that if you act helpless people will take care of you or not abandon you?&quot;</td>
</tr>
<tr>
<td>14. Bring behavior to patient's attention/sharpen focus</td>
<td>Bring some aspects of the patient's current behavior or verbalizations to his or her attention.</td>
<td>&quot;Do you think that always being late will bring attention to you?&quot;</td>
</tr>
<tr>
<td>15. Redirect the patient</td>
<td>Propose that the patient think, feel, or behave differently.</td>
<td>&quot;You seem to be more nervous than usual since you got stuck in the elevator.&quot;</td>
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</table>

create problems for them. One problem is that we do not always know the reason we do things. If a mother says to a child "Why did you knock over my favorite lamp while playing in the living room?" what can the child say? If the child says it was an accident, this does not really answer the mother's question. The child might have a number of other thoughts about it. For example, the child might think, "Because I'm clumsy," or "Because I'm stupid," or "Because I'm mad at you for making me go to bed early." None of these responses, even if true, are acceptable either to the mother or the child. More likely, the child is simply unaware of any plausible reason for the action.

This point is also true for patients in psychotherapy. They often do not know the reasons for the behaviors they engage in or the emotions they have with which they are dissatisfied. They have only the vaguest ideas about why they keep checking to see that the gas is off, why they lose their tempers easily, why they sometimes have suicidal thoughts, or why they feel love (or hate) toward the therapist. Even when a patient can cite what seems like a plausible reason for a feeling or behavior, therapists recognize that all actions are multidetermined and many previous experiences and emotions enter into a single current feeling or behavior. Recognizing one or two components of an event does not mean that the event is fully understood.

Both adults and children feel defensive and uncomfortable when asked why questions. For the most part such questions are put-downs and the implied response is a negative one. Asking an adult "Why didn't you get that promotion?" leads to the feeling "Because I'm not competent." "Why is your room always so sloppy?" implies the response "Because I'm a slob." Thus, why questions often seem to press people to supply an internal stable attribute (or trait) to account for implicitly undesirable actions.

In summary, why questions imply a hierarchical dominance relation between the questioner and the one being questioned, and they have no truly adequate answers. The one being questioned may have to lie to get around them gracefully. It is also likely that the person asking the question is not really interested in the answer but rather in the implied right to ask the question; often there is an implied insult. Because of normal social expectations, most people who are asked why questions try to answer them in some way. However, because motives are not often clear, this may lead to exaggerations or lies.

Sometimes therapists may ask why questions partly because they wish to discover the exaggerations or lies that patients use when faced with an ambiguous or embarrassing situation. However, to assume that a patient's answer to a why question is complete and accurate would be naive. If the ideas that have been presented are correct, does this mean that the therapist should never ask the patient why he or she feels or does things?

As mentioned above, why questions may sometimes provide the ther-
apist with insights into the ways that the patient handles ambiguous or confusing problems. They may reveal something about the patient's personality traits related to hierarchical issues and issues of dominance and submission. They may indirectly reveal something about how the patient handles problems of power and control and what emotions are generated by feelings of embarrassment or defensiveness. These may all be useful insights, but if why questions are used too frequently, they generate anger and distrust in the patient. The question then arises: What alternatives do therapists have in the ways that they interact with patients in the therapeutic dialogue?

**APPROPRIATE INTERVENTIONS**

Table 9.3 lists 15 types of therapist interventions. Eight of the 15 imply efforts to get the patient to explore, elaborate, identify, generate, and connect ideas and experiences in his or her life. The process of exploration is the alternative to simple why questions. Therapists often ask exploratory questions such as

- Could you talk more about the feelings you have when you think about your father?
- What emotions do you have when you go into an elevator?
- What is it that I said that made you feel uncomfortable?
- What do you feel like doing right now?

In fact, many of the tactics listed in chapter 7 concerned with uncovering emotions may also be used.

In his book *Therapeutic Communication*, Wachtel (1993) described a number of desirable ways of interacting with patients. In general, the goal of the therapist's statements or comments should be to avoid arguing with the patient, criticizing the patient, or blaming the patient. Many therapists believe that answering the patient's questions, giving advice, or indulging the patient's fantasies (e.g., accepting gifts from the patient) is not good practice. Wachtel, like most therapists, considered the emotion of anxiety, with the self-protection, self-deception, and avoidances it generates, as the key issues to be dealt with in psychotherapy.

Wachtel provided a number of clinical examples of both good and bad therapeutic communications. For instance, a woman in group therapy had been silent for a long time. The therapist finally said "I think you're silent because you're trying to hide a lot of anger." Such a comment was experienced as a criticism calling for more defensive behavior. The therapist was really not sure of the reason for the silence because, after all, reality is inherently ambiguous; it could have reflected fear as much as anger, a sense of embarrassment or shame, or more likely some combination of these...
emotions. A better intervention might have been, “I wonder if you are silent because of all the emotions that are churning around inside of you.” A good interpretation tries to convey the message that it is all right to look at one's conflicts if one wishes to and that it is not dangerous for the patient. It also reflects a sense of empathy with the emotions of the patient and a sense that the therapist knows how it feels and will not criticize, rebuke, or blame the patient for her emotions and conflicts.

Good therapist interventions should avoid implicit or direct criticisms of the patient or an implication that the patient is childlike or immature. They should avoid static images that suggest that a person has a fixed personality style that is not likely to change. Rather than say something like “You seem to be a shy person,” a better alternative comment might be “I notice you talk more easily at some times than at other times.” The aim of the intervention is to help the patient feel that the therapeutic conversation is like a mutual exploration of considerable interest to both parties, rather than an interrogation designed to drag information out of a reluctant witness. “The therapist must help the patient grasp the truth about his life, but the nature of that truth is continually changing” (Wachtel, 1993, p. 157).

Wachtel suggested the following approaches to take when making an intervention:

- Avoid diagnostic terms (e.g., words like narcissistic or borderline).
- Avoid telling the patient what he or she “really” means.
- Describe behavior as temporary or transitional.
- Assume that the patient already knows what you are about to tell him or her (e.g., “As I know you’re aware . . . ”).
- Clarify for the patient who owns the problem.
- Let the comment point toward implied action (e.g., “It sounds like what you might like to do or say is . . . ”).

Most experienced therapists probably use many of these ideas. The key is for the therapist to avoid an adversarial relationship with the patient and not to use power in too obvious a way. The patient should feel that there is nothing more important to the therapist than the attention devoted to the patient during the therapeutic encounter.

CORRECT TREATMENT INTERVENTIONS

Benjamin (1997) identified five categories of correct treatment interventions: those that (a) increase collaboration between the patient and therapist, (b) enable the patient to recognize past and present patterns of behavior and how they may be related, (c) inhibit the expression of un-
desirable behaviors, (d) decrease the patient’s need to maintain anxiety, and (e) facilitate the patient’s learning of more adaptive behavior. “If a therapist action does not meet one of these five conditions, it is probably an error” (p. 88).

Benjamin offered a number of suggestions on how to implement correct treatment interventions. With regard to developing a collaborative relationship, she suggested that one way to create a bond is to team up with the patient against “it,” the “it” being undesirable aspects of the patient’s past behavior and current fears. With regard to learning to recognize one’s own maladaptive patterns of behavior, it is important to recognize that insight is not enough. There are at least two reasons for this. One is that insight only reveals what one has been doing that is harmful to the self (e.g., “You keep picking abusive boyfriends because that is what you learned from your father about how men should treat women. You keep hoping that if you can be good enough . . . then at last you will be loved;” p. 94). Patients must go beyond insight by developing the desire to change and the strength to begin to modify their own behavior.

The second reason that insight is not enough is that insights often change in the course of therapy. A first insight might be that one’s mother was neglectful because she was selfishly preoccupied with her own needs. A second insight might reveal that mother was ignored by her own parents, leading to a desperate search for approval. If insights produce emotional reactions, these may serve as a barometer of the significance of the insights. If little or no emotional reaction occurs, this may reveal to the therapist that the insight is not particularly meaningful to the patient. The expression of emotions may thus act as an indicator of the importance to the patient of revealed material.

CONCLUSION

Social conversation differs considerably from therapeutic communication in terms of goals, emotions, purpose, topics, focus, setting, and roles. Therapeutic communications may be appropriate or inappropriate. Inappropriate ones are those that imply blame or criticism of the patient or deficiencies in his or her personality or family and increase the patient’s level of anxiety. Appropriate interventions are largely concerned with tactful exploration of the patient’s life, with a focus on emotional reactions to present and past life events.

Most patients enter into therapy because they have emotional problems. These problems may first be clothed as problems in relationships, problems with substances, or problems with work. However, underlying
these problems are problems with emotions. The therapist must recognize the importance of the emotions for the therapeutic process and have the knowledge and skills necessary to uncover emotions and to recognize their significance to the individual. Therapeutic communication should reduce anxiety and anger and generate hopefulness and trust, emotions that stay with patients long after the details of the encounter have been forgotten.