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The process of problem (re)formulation in psychotherapy¹

Abstract One frequently heard critique of psychotherapy, particularly in feminist circles, is that it individualizes client's problems, i.e. they are shorn of their social significance and reduced to personal (psychological) shortcomings of the client herself. The present paper attempts to demonstrate what this phenomenon might look like at the level of the actual conversational interaction between the client and her therapist. It will become clear that the (re)formulation of the client's initial version of her troubles is by no means a spontaneous artefact of the therapeutic interview, but the result of considerable interactional 'work' on the part of the therapist. The process of problem (re)formulation consists of three analytically distinct stages, which are accomplished primarily by means of the everyday conversational device of 'formulations.' By using formulations in a special way, the therapist is able to transform the client's difficulties in her situation as full-time housewife and mother into a typical 'therapy problem'.

Introduction

In the present paper, it will be demonstrated how a client's initial version of her 'troubles' may be transformed in the course of a 45-minute therapy interview into a problem suitable for further psychotherapeutic work. This transformation is worthy of our attention in view of various commonly-held misconceptions concerning the nature of therapy problems and how they are arrived at, as well as in terms of the long-standing, predominantly feminist critique of the side-effects such transformations can have for women as clients.

To begin with, physicians and therapists often regard the issue of finding a suitable problem for therapy as a matter of diagnosis. This entails eliciting as much relevant information as possible from the patient's biography and assembling it into a factual body of

knowledge concerning what is the matter with the person seeking help. The professional is presumably able to perform this assembly work by means of his expertise, achieved after years of training and clinical practice. Whereas some practitioners may admit to being influenced by issues like expediency and personal preference (particularly when confronted with chronic complainers or those bothersomely vague, 'psycho-social' ills), few will deny the primacy of diagnosis in the therapeutic process (Wulff 1976) nor its essentially factual nature, requiring specialized skills for its accomplishment.

The client will be engaged in the business of 'troubles-telling' in the therapeutic encounter. In the process of recounting her current difficulties and her reasons for seeking the services of a professional helper, she will expect, with his aid, that the most salient reasons for her distress will emerge. Thus, she will also be oriented to the matter of diagnosis and possible transformations of her initial presentation of 'troubles' as a part of the therapy situation. Of course, first and foremost, she will be interested in relief from her suffering and will presumably take the point of view that what happens in the course of the therapy interview is being done with this aim in mind. Not only are clinicians and their clients oriented to diagnosis as part of therapy, but considerable literature is available concerning how a diagnosis of the client's difficulties might most effectively be reached in the course of the interview, as well as how the problem once found, might be suitably labelled (Zaro *et al* 1977). The literature deals consistently, however, with what therapists say *about* their patients' problems and about what they, as professionals, propose to do about them. Little attention has been paid to what therapists are, in actual fact, *doing*.² Taking a look at the therapeutic interaction in its natural setting could provide us with a few surprises. In other words, what clinicians think they are doing in therapy is not necessarily what the outside observer will see (or hear).

In view of the rather firmly-entrenched beliefs concerning how diagnosis is reached in clinical settings as well as lay notions that therapy is primarily for getting help, it might be worth our while to take a closer look at how the client's initial presentation of troubles, in all its contextual messiness, is organized and, ultimately, pared down to something treatable by means of psychotherapy. This entails treating the transformation, the process of problem (re)-formulation, as a topic in its own right, to be investigated when and where it occurs; namely, within actual therapy talk.

Aside from my wish as social scientist to gain a more comprehensive understanding of how members engage in various social activities (of which finding suitable problems for therapy is undoubtedly one), there is another reason for the present inquiry. In recent years, psychotherapy has borne the brunt of considerable critique, particularly from feminists (Chesler 1972; Smith and David 1975; Ehrenreich and English 1979; Greenspan 1983). One of the most frequently heard criticisms is that therapy *individualizes* women's problems. The client's difficulties are completely taken out of her social context and placed squarely in the realm of her personal shortcomings. In this way, problems which many women have in common and which are related to the oppressive exigencies of their living and working situations are shorn of all political significance. What is wrong, is wrong with the client. Smith (1975:7) describes this process in the following way:

Psychiatry instructs her to locate problems arising in her *relation* to her situation *inside* herself. Between what she knows most intimately as a matter of feeling and response and what is recognizable and sanctionable in terms of the ideology of her role, there is a gap. They do not correspond to one another. Psychiatry sanctions that disjunction. It places upon her the responsibility of learning how to live that disjunction as a permanent practice.

Feminist analyses have provided convincing arguments that individualization exists as a wide-scale form of social control and that psychotherapy is an institution eminently suited for its accomplishment. What is missing, however, is an investigation into *how* individualization occurs within the actual interaction occurring between the therapist and client. In other words, feminist critics have limited themselves to writing *about* women's oppression in therapy without examining how this oppression might be working within the therapy talk itself.

In the present paper, an attempt will be made to weave these two strands together. By taking a closer look at an actual instance of therapy talk, I shall demonstrate how the client's initial version of her 'troubles' may be transformed into a suitable problem for therapy. This process, which I have called problem (re)formulation, will be treated as a conversational activity and I shall be describing the kinds of interactional work required for it to be accomplished. The transformation of the client's version is by no means arbitrary, however. It is being done in a specific direction; namely, away from her concrete situation as housewife and mother. The problem which

ultimately emerges is a matter of her own personal, psychological shortcoming. By clarifying how this process of problem (re)formulation and individualization may occur, I hope to shed some light on a potentially oppressive aspect of psychotherapy.

Selecting data

As data for investigating the process of problem (re)formulation, a videotaped therapy session was selected from those available for teaching purposes at the Department of Clinical Psychology of the Vrije Universiteit in Amsterdam.³ The conversation was an initial therapy interview. The therapist, a member of the staff, engaged in psychotherapy alongside his teaching commitments. He was a highly respected trainer and therapist with many years of clinical experience. I chose this particular tape from all those available precisely *because* it so clearly demonstrated the process of problem (re)formulation in the direction of the individualization of the client's difficulties. In keeping with the notion of 'theoretical sampling' (Glaser and Strauss 1967: 45–78), I was looking for a particularly good example of the process in question in order to clarify it. When I selected the tape, however, I could only say that it *seemed* to be occurring.⁴ At that point, I was at a loss as to *how* it happened. It was only after transcribing the interview and subjecting it to a lengthy and painstaking analysis,⁵ that a pattern began to emerge. This pattern ultimately became an analytic description of one of the myriad processes occurring during the course of a therapy session; namely, how a problem is selected from all the difficulties initially presented by the client and transformed into a suitable problem for therapy.

Getting started

In attempting to locate the transformation of the client's initial 'troubles', I discovered early on in the analysis that it was being accomplished primarily by means of one everyday conversational device: *formulations*. Formulating is the way conversational participants say-in-so-many-words-what-they-are-doing-or-talking-about (Heritage and Watson 1979:124). Formulating includes activities like explaining, characterizing, explicating, translating, summarizing, or furnishing gists of the talk-thus-far. The primary function of formulations is to exhibit understanding. It is one way members

have of indicating that they have been listening to one another and that their conversation has been an orderly phenomenon, making sense every step of the way.

Everyone uses formulations. Therapists, however, may use them in special ways. It is through this characteristic use of formulations, that the therapist in the present interview was able to transform the client's initial difficulties in her situation as full-time housewife and mother into a strictly personal problem: not being able to express her emotions openly and honestly in therapy.

Any description of this transformation will obviously require first taking a look at what the client herself had to say about her current distress. It is to this initial presentation of difficulties I shall now turn.

The client's version

The client's version of her difficulties may be found in the first ten minutes of the therapy interview. She engages in a long round of 'troubles-talk', whereby the therapist indicates by means of minimal responses (hmmm-ing, yeah-ing, etc.) that he is following what she says. For reasons of space, a complete transcript of the conversation has not been included. Instead, fragments have been selected from the transcript⁶ which serve as instances of each new topic presented by the client. Each fragment is part of an extended stretch of talk. My aim is to provide the reader with some examples of how the client presents her initial version of troubles. This can serve as a basis for viewing the subsequent (re)formulation these troubles undergo as the conversation progresses.

The client is a woman in her early twenties. She is married and noticeably pregnant. After indicating that her decision to call the therapist was not taken without serious deliberation, she begins as follows:

Extract 1

(T = Therapist, C = Client)

- 4 C: I've been feeling awfully upset the last two months
- 5 and I thought – well, I should go in and talk about
- 6 it sometime.
- 7 T: Mmhmm.
- 8 C: It kind of started since I finished my studies.

9 (Pause)

10 And that-, oh well, that does involve a number of changes-

11 T: Mmhmm

12 C: - that occupy my mind quite a lot and what's more I hadn't

13 expected it either - ahead of time.

The above works to initiate a troubles-telling. The client's preface (lines 4-6) marks the presence of a trouble. Since she is about to embark on an extended turn at talking, she will need to align the therapist as attentive listener and provide him with instructions for monitoring subsequent talk (Sacks 1972; Jefferson 1978; Ryave 1978). This orients the therapist to the fact that what follows will constitute her reason for being there. Since any story-telling in the context of psychotherapy will probably have to do with 'troubles', the therapist will be prepared to hear what follows as a potential trouble. Furthermore, information is offered concerning the nature of the troubles to follow: she is upset and that has something to do with various changes in her life. Thus, the therapist may listen to her talk for instances of changes which can then be made to account for her present distress.

Having elicited a minimal response from the therapist (line 7), the client may proceed with her 'trouble'. In the next ten minutes, she elaborates on the various changes in her life which have led to her feeling upset. These changes may be grouped into three, topically coherent areas. I shall deal with them separately using examples from the client's initial troubles-telling.⁷

1. Completion of studies and staying at home on full-time basis.

Extract 2

13 C: I think that the biggest change is that -

14 well, something is gone which was - completely for me.

15 I'm sitting it - uhh - I already have a two year old child -

16 and I was already sitting around at home pretty much the last

17 year, but then I still had my studies in the evening and

18 that was -

19 at least for me, something like, well, that's mine, that's

20 separate from -

21 T: Mmhmm

22 C: - husband and child and daily worries and things:

23 And that - yeah, well, that's not there any more. And

24 that does give me the feeling of kind of falling into a hole

25 or something.

26 T: Yeah

27 C: I have to – I have to figure out something else (sniffs).

The above example is the first instance of a difficult change: the shift in her situation from student-mother to full-time housewife and mother. What she finds problematic, is not having something of her own. She finds herself in a kind of vacuum. Although she feels she has to do something about her situation, she does not know – at this point – what.

2. *Relationship with husband.*

Extract 3

54 C: I'm at home, that's what I want,

55 (rapid) I definitely chose that and –

56 (pause)

57 but I'm finding it difficult after all.

58 The – it changes a lot of things,

59 T: Mmhmm

60 C: Like the relationship with my husband

61 (rapid) I'm finding as well.

62 T: Mmhmm

63 (pause)

64 C: Like – the responsibilities are getting to be different,

65 we used to – up until a little while ago – do an awful lot

66 together, worked together and – looked after our child together

67 and – yeah, now it's – resting on me an awful lot and –

68 T: Mmhmm

69 C: – I'm finding that

70 (pause)

71 I feel terribly responsible, I must say, and

72 T: (soft) Yeah.

73 C: I find that very difficult.

This second difficulty is presented as an unforeseen consequence of the first change. Now that's she's home on a full-time basis, her relationship with her husband has altered in a way that she neither expected nor is entirely pleased about. Her dissatisfaction is tied up with the (unequal) division of responsibility, together with the fact that they are moving into separate spheres. Her account of her problem is achieved by contrasting her present situation with some

former one where activities and responsibilities were shared (lines 64–67).

3. *Pregnancy and possible complications.*

Extract 4

- 177 C: Well, I can do less than I used to
178 (pause)
179 now that I'm expecting,
180 T: Mmhmm
181 C: I can get away less in the evenings –
182 T: Mmhmm
183 C: – and visit people.
184 I have to, I have to rest more and that sort of thing,
185 so you're more isolated that way
186 T: Yeah
187 C: And that –
188 T: Cooped-up feeling
189 C: Yes.

And, a bit later on:

Extract 5

- 201 C: I get the idea very easily that I fall short.
202 T: Mmhmm
203 C: And –
204 (pause)
205 well, that reminds me (laughs) of – what I was just saying –
206 T: Mmhmm
207 C: about – that things happen which are beyond –
208 T: Yeah.
209 C: – your – my last –
210 – my first child was born too early
211 T: Mmhmm
212 C: – because he wasn't getting enough to eat any more and that
–
213 well, that just happens to you, you know
214 T: Mmhmm
215 C: which – which I then very literally saw as –
216 I'm not giving him enough (sniffs)
217 the result of which was that he was born too early, so
218 the little thing had to stay in the hospital for weeks where
219 it wasn't at all like what I wanted –
220 where I also had the idea that it wasn't good, not good

211 T: Mmhmm

222 (pause)

223 C: And – and then a little afraid as well that – yeah, yeah,

224 couldn't I have prevented it –

255 T: – and taking it on –

266 C: yes

277 T: yourself –

288 C: yes

299 T: like – god, if I'd just –

230 C: Yeah.

231 T: Yes. Yes. And that's why, this time, let me –

232 C: Yeah.

233 T: – etcetera. Yes. Yes. Which would mean a lot of tension

234 for you.

235 C: Yes.

In the above example, the client refers to another change in her current situation – her pregnancy. Not only does it compound the 'troubles' already mentioned (her isolation, feeling over-responsible for the children, etc.), but it introduces new worries as well.

Taken together, this collection of 'troubles' might be viewed as the *client's initial version* of her present distress. They work as an account for why she is seeking the services of the therapist. If we examine these examples more closely, it becomes clear that they have several features in common.

To begin with, how the client feels remains firmly attached to the situation in which these feelings arose. In other words, she does not for some unknown reason feel as though she had 'fallen into a hole' (lines 24–25), but relates this to concrete events in her life – the completion of her studies and her staying at home with the children. In her presentation, her emotions, her behaviour, various life events, and her current distress are part and parcel of the context in which she lives.

In addition, the 'troubles' do not stand alone, but have a cumulative effect. They appear connected to one another. Thus, one trouble (for example, staying at home with the children) is compounded by another (her pregnancy and the possibility of complications). In this way, her pregnancy is even more distressful than it might have otherwise been. Finally, the changes – in her daily situation, her relationship with her husband, her pregnancy – are presented as not only difficult in and of themselves, but they are particularly so because the client had not expected them. She did

not know in advance that finishing her studies and deciding to stay home and have a baby would have such far-reaching consequences in her life. Nor did she think she would feel as she does now.

The client's troubles could be viewed as illustrations of what Smith (1975) calls 'problems of fit' (1975:5) between the actualities of her experience (feeling trapped at home, stifled by sole responsibility for children) and authorized ways of thinking about these experiences (motherhood brings happiness; middle-class women have freedom of choice in how they want to live).⁸

In the course of the next 35 minutes of therapy talk, the client's difficulties will undergo a transformation. During this process, they will be shaped up into a problem for further work in therapy. The problem which will ultimately emerge is that *she is not able to express her feelings openly and honestly*. In other words, her problem has become a matter of her personal (mis)management of her emotions, saying nothing of consequence about the situation in which these feelings arose in the first place.⁹

How this transformation and individualization of the client's initial version of 'troubles' could occur will be the subject of the next section.

The process of problem (re)formulation

Up until now, the therapy conversation has consisted primarily of the client's describing her present difficulties, whereby the therapist has been providing minimal responses. After 11¼ minutes of this kind of therapy talk, the therapist makes the following remark (directly following Extract 5):

Extract 6

- 236 T: You're kind of piling things up, I think – to
 237 to – go back to the beginning when – you started out with
 238 upset, a kind of *word* which I'm starting to see as not
 239 really fitting your situation.
 240 It's a – too flat word, I think,
 241 C: Mmhmm
 242 T: – to – to describe your experience.
 243 (pause)
 244 Is that right? Huh?
 245 C: Yeah.

This example is a formulation which appears, on the surface, to

be nothing more than a harmless observation on the part of the therapist concerning the client's manner of doing therapy talk. He is suggesting that she is talking in a way which probably belies her real feelings. In other words, she is putting up a façade.

This formulation serves to *introduce* this aspect of the client's behaviour as a new topic for conversation. Ultimately, it will become a full-fledged therapy problem, serious enough to warrant treatment to the exclusion (at least, temporarily) of all the other difficulties mentioned by the client at the beginning of the session. At this point, however, it is no more than a possibility.

What follows is a construction process, taking up the rest of the therapy hour. This process, once underway, falls into three stages:¹⁰ *definition of the problem, documentation of the problem, and organization of the client's consent*. Each stage will be dealt with briefly. It will, at the same time, be demonstrated how formulations provided by the therapist helped to move the process along to its successful completion: the client's agreement to work on this particular problem in future therapy session(s).

Definition of the problem

The therapist has introduced the client's way of talking about her feelings as a new topic for discussion. Once introduced, it becomes a red thread running through the therapy interview, finally emerging in the final minutes of the conversation in contract-form, i.e. 'what the client wants to work on next time.' Whereas the problem has been 'discovered' quite early on in the session, it is not enough to formulate it one time. Considerable interactional work is required before it can emerge as a suitable problem for therapy.

At this point, it makes sense to take a look at some 'candidate readings' (Heritage and Watson 1979: 136–137) of the problem. Taken singly, each formulation is simply an instance of the problem. When viewed as part of a larger set and by virtue of their placement within the conversation as a whole, however, they serve to construct a rather arbitrary behaviour into a full-fledged therapy problem. By examining several instances in more detail, we can get an idea of the kinds of construction work being done to accomplish this.

Extract 6

236 T: You're kind of piling things up, I think – to

237 to – go back to the beginning when – you started out with

238 upset, a kind of *word* which I'm starting to see as not
239 really fitting your situation.

240 It's a – too flat word, I think,

241 C: Mmhhh

242 T: – to – to describe your experience.

243 (pause)

244 Is that right? Huh?

245 C: Yeah.

Extract 7

389 T: And one thing which strikes me is that you –
390 all the things you've been telling about – like the,
391 the baby you're expecting, the changes in your work,
392 finishing your studies which gives you an empty space
393 in your life –
394 – the relationship with your husband – the children who
395 are slipping away from you, slowly, as they grow older –
396 something which you are finding (staccato) *very very hard*
397 that you really want to kind of hold on to all those things –
398 right?

399 that's *very striking*. That you just can't *let* things happen,
400 in a way. One way or another you have to –
401 control is a rotten word, but I can't find another one so
402 quickly –

403 (pause)

404 You seem to be having trouble *giving in*

405 (pause)

406 And you keep *thinking* about it, I guess,
407 and *worrying* and –

408 C: Uhh – yeah –

409 T: – *dreaming* and –

Extract 8

457 T: You get – uptight, telling it to someone,
458 telling it to me, and you're saying, I – I –
459 you – I – have the situation nicely under control, and
460 that's pretty uncomfortable –

461 C: Yeah

462 T: – somehow or other.

463 C: I know that, well, by this time, that I –

464 T: Yeah

465 C: can do that (laughs).

466 T: Mmm.

467 (long pause)

468 How do you want to *proceed* with this?

Extract 9

634 T: If you have the feeling that – that in a talk like this

635 there should really be –

636 well, a lot more *business* should be getting done, you know,

637 much more –

638 yeah, how should I say it –

639 (pause)

640 that those emotions – have to be there *exactly* as they are

641 and not so –

642 do you want to go through that one with me next – one more

643 time?

644 C: Mmm – yeah.

645 T: Yeah? Good.

646 It's a bother, right? Having to work with an *agenda*, isn't it?

647 C: (laughs)

In each extract, a formulation is provided which, among other things, is marking significant gist (Heritage and Watson 1979: 150); namely, that the client presents her problems in a way which is incongruent with how she 'really' feels about them.

In Extract 6, the client's narrative of her troubles is closed down by the therapist's formulation. At the same time, a new topic – her way of doing therapy talk – is introduced. The implied gist is that this particular behaviour could be problematic (238–240). It is, of course, at this point unclear *how* the use of 'flat' (affective) language to describe experiences might be a source of difficulty for the client or, in fact, whether it is a problem for her at all. Here it is nothing more than a possible problem. In the second formulation (Extract 7), occurring some minutes further on in the conversation, the same behaviour – not being able to show how difficult things are for her or 'to let go', as the therapist puts it – are characterized as something 'very striking'. This evaluation, with heavy intonation, coming from an expert in the area of human problems, marks the behaviour as, at the very least, warranting further attention. Furthermore, it is demonstrated as having a deleterious effect on the client's life outside the therapy session. She is '*thinking* about it' and '*worrying* about it' all the time. By linking the façade-problem to the distress experienced by the client, the therapist may build a case that the latter is related to the former (Heritage and Watson 1979:152–153).

In other words, if she would 'just let go and tell it like it is,' she might not be worrying all the time.

In Extract 8, coming towards the end of the therapy conversation, it has become clear that the behaviour is problematic for the client in her dealings with the therapist as well. Her keeping a tight reign on her feelings is being made to account for her discomfort while talking to the therapist. This formulation is combined with a request to decide what she wants to do about the problem. The implication is, of course, that something should be done about it. Finally, the same problem, scarcely the worse for wear, emerges in contact-form in Extract 9: the client is agreeing to work on expressing her emotions honestly to the therapist in therapy. This (re)formulation of the problem as a positive course of action occurs at the end of the conversation and marks the completion of the process of problem (re)formulation.

By examining this collection of formulations, it becomes clear *that* the problem, starting as an observation about how the client talks about her feelings, is undergoing a transformation in the course of the therapy conversation. In order, however, to see how the process of problem (re)formulation works, we must fit these single formulations back into the conversation as a whole. We may now return to the beginning of the process of problem (re)formulation: (the *definition of the problem*,) and how formulations serve to accomplish it.

In order for a particular behaviour to be defined as a problem for therapy, two conditions must be met. I shall deal with each briefly. The first step entails, quite simply, *selecting* one aspect of the client's behaviour from all the possibilities available to the therapist by means of his monitoring the talk-thus-far. This is then presented as candidate reading of what they have been talking about, requiring that the client decide whether or not it adequately captures this talk (Heritage and Watson 1979: 139-149).

As previously mentioned, the therapist, in introducing a new topic for further therapy talk (Extract 6), has provided a formulation which differs from those occurring previously in the conversation. He no longer formulates *what the client has actually said* at some point in the talk-thus-far, but rather *how she has been saying it*. Thus, this formulation occurs at another level of abstraction. It remains, however, linked to the ongoing talk, demonstrating understanding, and will be heard by the client as such.

Once introduced, the problem of how the client talks about her

troubles may be maintained by means of formulations which repeatedly mark it as an 'important gist' (Heritage and Watson 1979:150). By re-attending and re-introducing the problem as topic throughout the ongoing conversation, it may ultimately achieve the status of 'first topic' or: what members are talking about, the 'point' of their talk.

It is not enough, however, to select an arbitrary behaviour and ensure that it becomes first topic in the conversation. After all, the conversation is occurring in a specific context, namely, psychotherapy. This will place certain constraints on possible topics; i.e. therapy talk is about problems. Thus, the second step will involve *establishing the behaviour as problematic*. This, once again, may be achieved by means of formulations.

In order to construct a particular behaviour into 'something problematic', the therapist may engage in 'meta-linguistic-listening' (Schwartz 1979:410). This special way of listening is reflected in the way he formulates the ongoing talk.

Most conversational participants formulate the content of their talk, i.e. *what* they are saying to one another. In other words, they take their talk at face-value. Not so with the therapists. Therapists not only listen to what the client is saying, but they may hear her talk as performing various other activities. For example, she may be *heard* as 'using emotionally flat language' or 'skipping from topic to topic' or 'skirting relevant issues'. This activity, once discovered, may then be given a label like 'odd', 'neurotic' or – depending on the theoretical arsenal available to particular therapist – 'avoidance behaviour'. Subsequently, what the client has said does not have to be paid attention to in its own right nor even believed.¹¹

In the present interview, the therapist formulates what the client herself has been saying, namely, that she is having a difficult time, feeling nervous (238–239; 390–395). He then indicates that the way she is talking about these matters would seem to belie her 'real' feelings (238–242; 397–405). She is putting up a 'façade' and the therapist 'hears' her doing it. This behaviour is evaluated by him as unusual. The implication is, of course, that it might well be worthy of further attention in therapy (238–240; 399). Thus, the behaviour is established as a potential therapy problem. Although the therapist himself has introduced it as a topic, it appears to be firmly embedded in what the client has been saying, part and parcel of the ongoing talk. The definition of the problem is, of course, only the beginning. At this point, however, two essential tasks have already been accomplished.

First, a potentially problematic behaviour has been selected which is separate from the client's situation. By isolating the way she talks about her problems from the context in which these problems arose in the first place, it may become a problem of interest in its own right. Consequently, it may be dealt with with as much legitimacy as it occurs in the therapeutic encounter in interaction with the therapist. The necessity for looking at outside sources as having something of consequence to say about the client's present distress has been effectively removed.¹²

Second, the therapist, having found an appropriate behaviour, may now devote his energies to establishing it as a problem warranting therapeutic treatment. This is no easy task. The client must be made to feel that her way of doing therapy talk is bothersome enough that she will be willing to drop – at least, temporarily – her other difficulties in order to deal with it. The therapist has, at this point, his hands free to embark on this arduous venture.

This brings us to the second stage of the process of problem (re)formulation.

Documentation of the problem

In order to establish the existence of the already-defined problematic behaviour as sufficiently troublesome to require treatment in psychotherapy, evidence must be gathered. The therapist will need to demonstrate how the client's tight grip on her emotions – her façade – plays a detrimental role in her dealings with other people in her life. As the contours are filled in, it will become clear how far-reaching the negative effects of this particular behaviour are. It seems, in fact, to touch nearly every other aspect of her life, presenting a serious obstacle to her general well-being.

Here again, formulations are particularly useful in marshalling evidence for the problem. Throughout the conversation, they serve to organize topic talk so that the problem, once introduced, may be maintained as first topic. In addition, and more importantly, they provide a way of linking various gists in an elegant and economic way. The client may then be confronted with a 'package deal', constrained to decide on both meanings simultaneously.¹³

Let me give an example of how this works:

Extract 10

299 C: Yeah, there's an awful lot happening there, too.

- 300 (long pause)
 301 That put the balance off again, too.
 302 T: Mmhmm
 303 C: I know that my husband –
 304 – really has an awful lot of problems as well and that
 305 he was small and weak –
 306 T: Mmhmm
 307 C: – which was a shock for him and for me too, a little,
 308 but I was also a little glad about it –
 309 T: Mmhmm
 310 C: – because I thought then we'd get a little –
 311 T: Mmhmm
 312 C: – closer –
 313 T: Yeah –
 314 C: – to each other at the same time.
 315 T: So he too had a way of doing things on the outside that
 316 didn't match what was happening inside. Yes.
 317 (pause)
 318 And that – changing that is really kind of nice for you –
 319 C: Oh, yes
 320 T: – because then –
 321 C: Yeah
 322 T: You're getting a little closer to one another as *two* people
 323 (pause)
 324 who – have their weaknesses –
 325 C: who are both weak
 342 T: Yeah.
 327 C: Yeah.

The therapist provides a formulation (315–325) of what the client has been saying about her husband and the changes in their relationship. The use of the word 'too' (315) implies, however, that the client has the *same* way of doing things as her husband; i.e. her outward presentation doesn't match what is happening 'inside.' Although this doesn't follow from what the client has been saying in the previous stretch of talk, it will be heard, by means of the economical tying device 'too,' as related to previous utterances in terms of topic. Thus, it becomes another instance of the client's problem – her façade – despite the fact that the subject of the formulation concerns another person entirely; namely her husband.

In a similar way, the therapist employs formulations to attach

what the client has said about her feelings to various other gists or implied gists (upshots). For example:

Extract 11

250 T: When you said, I don't ask for support easily, then I
251 just remembered the beginning when you said, I chose this
252 talk after long *deliberation*.

253 C: Yes

254 T: And – so it's true there –

255 C: Yeah

256 T: – as well –

257 C: Yeah

258 T: – that you don't go to a therapist –

259 C: Mmhmm

260 T: – so easily.

261 C: I always put that off, too.

262 T: Mmhmm

263 C: There have been times, of course, when I thought, well,
now –

264 now I really don't know any more

265 T: Mmhmm

266 C: but then I think, well, just this first, you know, first

267 vacation, or first graduation, then – that way there's

268 always something.

269 T: Yeah. Apparently you want to see yourself as someone
who's

270 strong and capable

271 C: Yeah

272 T: and you're finding it difficult to accept that it sometimes

273 just isn't that way.

274 C: Yeah.

275 T: Mmm.

276 Yeah. Anyway, probably – that –

277 if, as long as you go on acting like I'm getting along just

278 fine, or I'm coping pretty well, that people are going to

279 react –

280 C: Mmhmm

281 T: to that too with – oh well, O.K., huh? that – that –

282 (unclear) leaning on someone –

283 C: Yeah

284 T: Huh? or – or – she probably has her problems once in
awhile,

285 but A. is *really* a person who – who manages

286 C: Mmmmm

287 T: So you actually – stay locked up in your own system.

288 C: Yeah.

In the above example, the client explains how she tends to put off asking for help until she just can't avoid it. The therapist (re)formulates this stretch of talk (269–273) in a way that it becomes part of the 'problem', i.e. another instance where the way the client acts (strong and capable) does not coincide with how she *really* is. This is followed by another formulation (276–287) in the form of an upshot (implied gist) where the 'problem' is demonstrated as having far-reaching effects on her relationships with other people.

They won't be able to see how she feels and she will stay where she is (i.e. in distress). In this way, the problem, once established, may be linked with various events, thereby underlining how bothersome it must be for the client.¹⁴

The documentation stage is not limited to showing how the problem arises in various areas of the client's life. It will also be demonstrated that the problem 'rears its ugly head' in the therapy situation as well. In this way, empirical evidence for the problem is generated, giving it an additional credibility in the eyes of the client. Moreover, since the problem occurs within the therapy session as well as outside, the therapist may now legitimately treat it as a problem between the two of them. He is no longer constrained to refer to outside sources. This 'empirical evidence' for the problem was accomplished towards the middle of the conversation in the following way:

Extract 12

314 T: If I'm understanding you well, your basic feeling is, in
315 any case, a – a – kind of – yeah, well, how should I say it,
316 all kinds of things changing, all kinds of things shifting
317 which used to be pretty *stable*, but now –

318 (pause)

319 Yeah.

320 C: Yes (voice breaks)

321 T: And where you are really – yeah – *very* confused about or –
322 or – what you'd also like to straighten out –

323 C: Oh, yes –

324 T: because you –

325 C: Yes

326 T: want to talk –

327 C: if that would be possible –

328 T: here.

329 C: Yes. (emotional, clears throat).

In the above example, the therapist formulates what the client has been saying all along about her situation (314–317). He places special emphasis on her feelings by using heavy intonation and intensifiers; she is, for example, *very* confused. Drawing attention to someone's feelings will quite often elicit an emotional response. This is, in fact, a standard method employed by therapists to help clients express their feelings more freely. It works here as well; the client's voice breaks, she stammers and appears to be on the verge of tears. She confirms his candidate reading of the talk-thus-far. This indeed is what she has been saying all along.

The above formulation might be viewed as a particularly good example of empathetic listening. It is followed, however, by a formulation which merits some attention:

Extract 13

345 T: I do notice that you are finding this awfully *emotional* and –

346 (pause)

347 every time you take a sort of little decision like,

348 how should I continue –

349 C: Mmhmm

350 T: – with my emotions *here now* –

351 C: Yeah

352 T: And then the easy side of it is, I guess, that you are

353 telling it to me very *cooly* in a way

354 (pause)

355 a kind of – kind of intellectual puzzle –

356 C: Mmhmm

357 T: with – with lots of pieces and – whereby feelings –

358 tag along a little bit behind, don't they?

In this example, the therapist, having formulated what he *sees* (that she is very emotional), proceeds to indicate what he *hears* (metalinguistically, of course), namely, that she talks about her feelings as though they were an 'intellectual puzzle.' Taken at face-value, these readings appear to be contradictory, even mutually exclusive descriptions of what the client is doing at the moment. Thus, she is confronted with two versions of her behaviour: she is emotional *and* she is cool/intellectual. Both must be decided upon as possible readings of the ongoing conversation.

Faced with two contradictory readings, the client finds herself in an interactional double-bind. Conceivably, this could lead to various disruptions to the ongoing talk, such as confusion about which reading to verify or silence or whatever. Fortunately, there is a possibility for hearing these formulations in such a way that both parts may be simultaneously confirmable, thus freeing the client from the pitfalls such a double-bind would entail. A reading, i.e. that the client is noticeably *both* emotional and cool/intellectual would have to be based on two premisses.

First, the client may be very emotional *inside*, but she does not express herself in a way that does justice to this inner state. The presence of a façade, i.e. lack of correspondence between inner and outer states, is a possible explanation. Of course, this remains highly speculative as long as there is no one to discover the façade. In other words, as long as no one sees through the façade, it will be successful and, consequently, un-formulatable.

This is where the second premise comes in. The therapist indicates in his formulation that he 'sees' how emotional the client is. Similarly, he 'hears' the way she talks about her problems as cool and intellectual. His perceptions are demonstrated as contrasts. In this way, he demonstrates the façade by virtue of *his* unmasking it.

Aside from confirming his own position as empathetic listener, able to 'read between the lines', the therapist has also provided further documentation for the problem. An acceptance of this reading is a way for the client to handle the contradictions involved in these two formulations. Since she presumably feels the validity of one (that she is emotional), it will be a matter of accepting the second as part of what might best be described as a 'package deal.'

In this way, she has been made to experience the problem in a way no amount of linking it to various aspects of her daily life could have accomplished. The 'problem' has also become an integral part of how she functions in the therapy situation itself.

Of course, no matter how convincing the problem at this point nor how sound the proof, there can be no full-fledged problem for therapy until the client agrees to work on it.

This is where the final stage of problem (re)formulation comes in.

Organization of the client's consent

The matter of the client's façade has been defined as problematic and documented as having far-reaching negative consequences for

her, both outside and within the therapy setting. She is, however, by no means convinced that this is what she wants to work on in therapy. This is not really surprising since – as the reader will recall – she came to the therapist with quite a different list of troubles. None of these has, up until now, received more than cursory attention.

More than half of the therapy session is devoted to persuading the client that the façade-problem is what she needs to work on. This seeming unwillingness to cooperate in therapy has a name in psychological literature. It is called *resistance*. Regardless of what brand of psychotherapy we are talking about, this thorny problem is one of the obstacles the therapist will have to come to terms with one way or another.

Thus, the final stage of the process of problem (re)formulation concerns the client's resistance to having her problem defined in a particular way and how the therapist goes about overcoming it.

In terms of the actual conversational interaction, the client manifests 'resistance behaviour' in various ways. As previously mentioned (note 12), she is constrained to decide on each formulation offered by the therapist as candidate reading of the talk-thus-far. Whereas she may, theoretically, disconfirm formulations, this is not usually done. Because of the extra interactional work which disconfirmations entail, confirmations are massively preferred (Pomerantz 1975: 66–86). When the client does disconfirm a formulation, she will do it in a mitigated way. The most common method is to agree first and follow the agreement up with a counter-example, i.e. a narrative indicating that the therapist's formulation is, in fact, just the other way around. Thus, she counters his formulation in Extract 11 with the following:

Extract 14

289 C: That – goes for some cases.

290 T: Mmhmm

291 C: but I was just thinking about how it is between my husband
292 and me

293 T: Mmhmm

294 C: but there it was more the other way around, that I was the
295 weak one –

296 T: Mmhmm

297 C: And – and – the one with all the problems –

298 T: Mmhmm

299 C: I was always afraid –

290 (pause)

291 A – about how it was between us, I mean

292 T: Mmhmm

293 C: (rapid) whereas my husband was calmer, the – the harmonious

294 one, the – the – yeah – and that's still more or less true,

295 but that – not completely like it – like we always thought

296 it was.

297 T: Mmhmm

Here the client agrees that she sometimes puts up a façade (289), and proceeds to relate occasions where she is the one who is emotional, presents herself as the one needing help. By doing this, both her version and the therapist's remain standing and open confrontation is avoided.

Despite the therapist's expert use of formulations in organizing the client's consent to work on the problem as defined, a veritable tug-of-war has ensued. The therapist continually re-formulates the problem and the client, after supplying minimal agreement, describes various situations in which she is, in fact, quite open about her feelings. This could go on indefinitely, were the therapist not to resort to more drastic – conversationally speaking – means for overcoming her resistance. Towards the end of the session, the therapist makes two separate, but related requests:

Extract 8

457 T: You get – uptight, telling it to someone,

458 telling it to me, and you're saying, I – I –

459 you – I – have the situation nicely under control, and

460 that's pretty uncomfortable –

461 C: Yeah

462 T: – somehow or other.

463 C: I know that, well, by this time, that I –

464 T: Yeah

465 C: can do that (laughs).

466 T: Mmm.

467 (long pause)

468 How do you want to *proceed* with this?

And, a little later:

Extract 15

496 T: You haven't said this, but I think you do have trouble that

497 you –
 498 yeah, how would you like to have it –
 499 trouble with that – that extreme control and extreme acting
 500 out.
 501 C: How I would want it to be?

On the surface, these utterances (line 468; 498) can be heard as straightforward *requests for information*.¹⁵ Upon closer examination, however, much more appears to be going on here.

At this point, the conversation has reached a stale-mate. The client's façade has been established as problematic. She does not feel 'comfortable' keeping her emotions under control. Moreover, having such a tight reign over her feelings can also lead to sudden emotional outbursts. Whereas the client admits to this behaviour, she is not convinced that it is serious enough to be worked on in therapy. Time is running out, however. The above requests fulfill two important functions:

1. They serve as *indirect requests for action*.¹⁶ The client is being asked to demonstrate whether or not she is willing to work on the problem. In other words, it is a mitigated way of saying: let's get down to business. What are you planning to do here anyway? Assuming the client hears the request as such, she may respond in one of the following ways: by accomplishing the act requested (agreeing to work on her façade in the next therapy session), by refusing ('I'm not going to work on this.'), or by putting off deciding. The client avoids the interactional pitfalls inherent in a direct refusal and opts for the last possibility. She puts off acting by providing counter-examples of behaviour where she is, in fact, quite open about her feelings (as in Extract 14) or where she demonstrates how this behaviour, although bothersome, also has its advantages. This is illustrated by the following:

Extract 16

512 C: Yeah, that uncontrolled part, I don't think that's *so* terrible
 –
 513 it's just that *afterwards* I have a lot of trouble with the fact
 514 that I *was* so uncontrolled
 515 T: Yeah
 516 C: That I – (pause)
 517 although at the moment when I let myself go, I can feel very
 518 relieved.
 519 T: Mmm

520 C: That's something which I've been able to do a bit more lately, too.

521 T: Mmm

In this way, the client allows the conversation to proceed as usual while, indirectly, questioning the necessity for working on the problem as it has been defined by the therapist.

2. In addition to requesting indirectly that the client take an action, the therapist's utterances serve as a *challenge*. When a request for action is based on 'needs, abilities, obligations or rights which have been valid for some time,' then it will be heard as a challenge to the other person's competence in her particular role (Labov and Fanshel 1977:94). This possibility emerges based on the context in which the conversation occurs (psychotherapy) and the assumptions participants will share concerning their respective duties. One such assumption is that clients are expected to be cooperative and open-hearted in therapy (Labov and Fanshel 1977:54). Provided that this knowledge is shared by the client and therapist, the therapist's utterance may be heard as a criticism of the way she has been fulfilling her duties as client, i.e. doing therapy talk. Repeating the request some minutes later serves to underline the criticism even more forcefully. Presuming that the client is aware that she should be cooperative and open-hearted in therapy and that she has been engaged in therapy for the past 45 minutes, this works as a challenge to her competence in her role as client. Thus, her options at this point have become more sharply outlined. She can no longer gracefully put off deciding about the problem and will be constrained to either agree to work on it or to put up a good defense for why she is (still) unwilling to work on it.

It is not surprising that, having reached the final five minutes of the therapy session, that the balance of the negotiations tips in favour of the therapist.

Extract 17

579 T: We have to stop because the time's up.

580 I want to ask you if you're *satisfied* with the way you've
581 been telling this to me.

582 C: No.

583 (long pause)

584 I've been holding things back.

585 T: Mhmm

586 (long pause)

- 587 C: And I've been really doing my best not to let you see too
much
488 how uptight I am, although I –
489 T: Mmm.
490 C: really feel that way.
491 T: Mmhmm
492 And that makes you dissatisfied *really*? You find it a little
493 bit *dishonest* of yourself.
494 C: Mmhmm
495 T: Yeah.

The time is up. The client can no longer put off the therapist's request without causing considerable disruption to the conversation. She reconfirms his formulation of her problem (lines 492–495) and agrees to work on her 'façade' in the next therapy session (see Extract 9). This brings the process of problem (re)formulation to a close.

Conclusion

The aim of the present inquiry was to provide an analytic description of one of the processes occurring in the course of a therapy interview; i.e. the transformation of a client's initial version of her troubles in her situation as full-time housewife and mother into a problem suitable for psychotherapy. The process of selecting and working-up the problem was demonstrated as an interactional activity, accomplished primarily by means of the routine conversational practice of formulating. By virtue of his ability to listen 'meta-linguistically,' the therapist could chose a behaviour which was already once-removed from the client's situation. This behaviour, at first merely a possible problem, underwent a transformation. It was documented as having far-reaching and decidedly negative consequences for the client in her daily life as well as within the therapy session itself. Whereas she could be rather quickly convinced of the validity of this problem, she remained sceptical about whether it was something she actually needed to work on in therapy – to the detriment of her other troubles, as mentioned at the beginning of the therapy hour. Organizing her consent became the task to be accomplished in the latter part of the interview. Despite her attempts to resist the therapist's definition of her problem (by pointing out instances where it did not apply or where it was not

particularly serious), she did ultimately agree to work on it next time around. Thus, the problem which emerged at the end of the therapy session was that she did not talk openly and honestly about her feelings. Her current situation as well as her feelings within that situation were no longer the issue. The problem had become a matter of how she engaged in the business of therapy talk.¹⁷

In closing, a few words are in order concerning the relevance of the present analysis for some of the issues mentioned at the beginning of this paper.

By taking a look at the actual therapy conversation, the process of finding a therapy problem (or diagnosis) emerges as an interactional activity, subject as much to the local, organizational constraints imposed by the therapy situation as to any scientific notions the therapist might have about the client's psychological malfunctioning. The problem becomes viewable as a construction, requiring considerable work on the part of the therapist. His main activity, in fact, resides in persuading the client to accept the problem, as defined by him. By making this construction process the focus of the analysis, the matter of diagnosis may be seen in another light. It appears to involve more than a matching up of certain kinds of clients to pre-existing psychiatric labels on the basis of some professional or scientific criteria. On the contrary, this therapist's expertise seems to lie in finding a problem quickly and in getting his definition across as efficiently as possible without disrupting the ongoing therapeutic interaction. Thus, a rather different picture emerges than what one commonly finds in handbooks for practitioners. Hopefully, it is a picture which will de-mystify therapy by giving us a better idea of what is actually being done (or not being done) there.

In addition to providing insight into how therapy works at the level of conversational interaction, the analysis is of interest for the development of (feminist) theory about how oppression works in specific situations, for example, psychotherapy. The depolitization of women's problems has been cited by many writers as an artefact of the institution of psychotherapy, in particular, when the therapist is a man. Little attention, however, has been paid to what this depolitization might look like at the level of the actual therapy conversation between the therapist and his client. This is, of course, a rather general criticism of macro-theories about various social problems; they fail to link global statements about the 'way things are' with actual instances occurring in everyday life (Knorr-Cetina and Cicourel 1981).

The present inquiry was an attempt to do just that. By demonstrating how a woman's difficulties in relation to the realities of her situation (her pregnancy, her position as full-time housewife and mother, the inequalities in her relationship with her husband) could be transformed into her own personal problem (not being able to talk openly and honestly about her feelings), a connection was made between the more general discussions around individualization of women's problems in psychotherapy and what such practices might look like in real life.

Judging by feminist alternatives to traditional therapy (Smith and David 1975; Greenspan 1983), a client's 'problems of fit' do not have to be reduced to something wrong with her. The social and political dimension of these difficulties could have been maintained as part and parcel of her current distress. This is, of course, not what happened in the present therapy session. Nevertheless, if we assume that individualization is not a necessary or spontaneous occurrence, an artefact of psychotherapy, then it makes sense to take a closer look at what therapists and clients are actually doing in therapy. Knowing the kinds of conversational techniques which one uses and how they provide the possibility to manipulate the conversation in a particular direction, can open up the road to doing therapy in a different way.

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Notes

- 1 An earlier version of this paper appeared in Dutch in *Psychologie en Maatschappij* 22 (March 1983), pp. 59-79.
- 2 Labov and Fanshel (1977) are a notable exception. Theirs is one of the first attempts to study therapy as conversation.
- 3 The present inquiry was conducted in the context of the doktoraal-programme for Clinical Psychology at the Vrije Universiteit.
- 4 Obviously, my partisan stance as feminist permitted me to 'see' the process in question. I was already oriented to viewing women's distress as having something of consequence to say about the reality they live in - a reality organized around the subordination of women as a group. For this reason, it was not remarkable that I should take note of the present transformation of a woman's problems as housewife and mother into a strictly personal (psychological) matter of mismanagement of her emotions. I considered this removal of

the 'problem' from the situation in which it arose as problematic. Whereas I saw something problematic in the present interview, for my less critical colleagues and fellow students it could be viewed as a perfectly satisfactory example of how therapy should be done. It would be in accordance with the ethnomethodological tradition (Garfinkel 1967), from which I borrow my general research orientation, to explicate how I – as researcher and feminist – came to 'see' the phenomenon in the first place. Whereas this would make an interesting topic in its own right, I have limited myself in the present inquiry to a description of what I saw happening. Thus, it was a modest attempt to 'cut out' the process as it occurred in the therapy interview and to show, in a step by step way, how it took place. The question of how it is possible to view such a process as potentially problematic (for clients, women, therapists, etc.) remains a subject for further research.

- 5 In the present inquiry, qualitative research methods were used for analyzing a transcript of a taped therapy conversation. For an overview of these methods, see Schwartz and Jacobs (1979). I made particular use of Heritage and Watson's (1979) analysis of the general conversational features of formulations as well as Labov and Fanshel's (1977) analysis of therapeutic discourse.
- 6 A few words are in order concerning the transcript. Examples have been selected and numbered as they occur in the transcript (which contains 554 lines in the Dutch original). Reference to the numbering can give the reader a general idea where the segment occurs within the entire 45-minute conversation. For reasons of space, it was not feasible to provide the transcript in its entirety, although it is available in Davis (1984). The original conversation was in Dutch. The translations in the present paper are my own, undertaken from my fortunate position of English native speaker and long-time resident of The Netherlands.
- 7 The client does her trouble-telling in a series-of-stories format (Ryave 1978), which are linked by means of a summarizing statement 'another distressful change'. The organization of this protracted troubles-telling into three main areas is not the client's method of organization. It does, however, match certain formulations of the therapist (see Extract 7, for example).
- 8 It would go beyond the scope of the present paper to develop this view of the client's present distress in any detail. The reader is referred to the vast body of feminist literature on the subject of women's problems for how they might be seen (Smith 1975; Greenspan 1983). It is, in fact, only one possible reading of what the client has been talking about. At this point, it is meant to serve as an alternative, another possibility for the reading which was introduced by the therapist and eventually became the therapy problem which the client would be working on in further session(s). That I find the above reading a 'better' one, has to do with my political and personal beliefs more than having an edge on the Truth as such (Stanley and Wise 1983).
- 9 For a comprehensive treatment of the philosophical underpinnings of the practice of separating emotional and behavioural states from the contexts in which they occur, see Scheman (1983). Her point is that much of psychological thought is based on an erroneous 'individualist assumption' that emotions can be treated as individual rather than social entities. This practice has more to do with the ideology of liberal capitalism than any scientific or empirical requirements.

- 10 The stages are not temporal entities as much as necessary steps in the process of problem (re)formulation. Once delineated, they provide a structural framework within which the individualization of the client's problems may be located.
- 11 See Schwartz (1979) for a more comprehensive discussion of this activity. He treats it as a more general procedure which members may employ in conversations to demonstrate mistaken thinking on the part of one of them.
- 12 It is quite common for therapists to assume that clients will behave with them much as they do with their family and friends. This is the stuff transference, the *sine qua non* of psychodynamic as well as awareness psychotherapies, is made of. Whereas I do not wish to dispute the existence of the phenomenon of transference in therapeutic interaction, its use as theoretical concept may serve as legitimation for endless talking about the 'relationship' between the therapist and client.
- 13 Formulations belong to the category of utterances referred to as adjacency pairs. The first part – the formulation – constrains the next speaker to decide upon it as candidate reading of some aspect of the talk-thus-far. The second part, then, is a decision, either confirming or disconfirming the formulation offered (Heritage and Watson 1979:139–149).
- 14 This practice should not be confused with the feminist practice of helping the client see her problems in terms of the actualities of her situation (Smith 1975:155–163). In this example, the problem has already been constituted as an abstraction and the events of the client's life are being used, retroactively, to back it up. The selection of events is subordinate to their utility as evidence for the problem, being, at this point is the conversation, uninteresting in their own right.
- 15 This is an example of a discourse rule as derived from Labov and Fanshel's (1977) analysis of therapeutic discourse. Such rules formalize procedures used by members for producing and understanding utterances. The rules expand the actual transcript of the interaction in the sense that they make explicit the interactional work being accomplished. Rules make uses of the web of rights, obligations and privileges which are part of any specific social setting. Knowledge of these is shared by participants and determines how they will identify and understand speech acts. The rule for producing and understanding a request for information is: 'If A addresses to B an imperative requesting information I, and B does *not* believe that A believes that a. A has I had b. B does not have I, then A is heard as making a valid request for information (p. 89.)'
- 16 'If A makes to B a Request for Information or an assertion to B about
 - a. the existential status of an action X to be performed by B
 - b. the consequences of performing an action X
 - c. the time T₁ that an action X might be performed by B
 - d. any of the preconditions for a valid request for X (need for the action; need for the request; ability; willingness; obligation)
 and all other preconditions are in effect, then A is heard as making a valid request of B for action X' (Labov and Fanshel 1977: 82–83.)
- 17 It is not my contention that the client's way of talking about her problems, her façade, was not a source of difficulty for her. It may very well have been, even before she embarked on psychotherapy. The point is, however, that there is no way of knowing for sure. The only thing we can say with any degree of certainty is that it *became* a problem for her in the course of this therapy interview.

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