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The language of psychotherapy

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THE LANGUAGE OF PSYCHOTHERAPY

by

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VITA

The author, Gaeanne S. Crowe, is the daughter of Gaetano J. Saccente and Lillian F. Kelly. She was born in Brooklyn, New York on February 4, 1958.

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CHAPTER I

INTRODUCTION

The process of psychotherapy is one in which persons engage in a special sort of dialogue and through this dialogue, the suffering of one person is alleviated. In order to understand this process, it seems necessary to examine the use of language in psychotherapeutic situations. Language is the medium through which the work of psychotherapy is accomplished, therefore, a detailed exploration of the language of psychotherapy may foster a greater understanding of it.

Psychotherapy as Discourse

Psychotherapy may be perceived as discourse (Foucault, 1972; Friedlander & Phillips, 1984; Lacan, 1968; Small & Manthei, 1986). What is created in session through dialogue is a discourse of the client's experience.

Generally, the client's task is self-description. The client uses available language in an attempt to articulate experience and emotions. This language reflects the client's self-perception and perceived relationship to the world (Rudestam, 1978). It may be regarded as the language of the self (Lacan, 1968). The therapist's task is to process this material and present the client with the result of this processing (Shawver, 1983). The therapist's presentation or intervention is usually carefully worded so that the client

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may benefit from it (Wachtel, 1980). The literature suggests
that these interventions are major factors in therapeutic
change.

The discourse resulting from psychotherapy is a blending
of two distinct languages: that of the client and that of
the therapist. Although the two languages share a common
base, their development and use may be quite different. As
the discourse progresses, it seems likely that the two
languages may become more similar. That is, the therapist's
language may modify to more closely resemble the client's
and, in turn, the client's language may change as well. The
literature suggests that the client may begin to use the
language of the therapist in order to make more sense of
experience (Frank, 1973; Strong & Claiborn, 1982).

It may be observed that discourse is frequently created
in an attempt to resolve difficulties in day to day living.
It seems that rendering inner turmoil into language is
consolatory in itself. Perhaps translating troubles into
language anchors them, renders them less threatening and
better understood (Frank, 1973). Indeed, the root of almost
all modern psychotherapies is psychoanalysis, the "talking
cure" (Forrester, 1980).

The "Talking Cure"

Freud's method of free association was the first
documented instance of a cure for psychological distress
through speech alone (Forrester, 1980). In his work with
hysterics, Freud found that if he allowed his patients to say
whatever came to mind, they would inevitably touch upon the

very source of their misery. Freud deduced that certain traumatic memories had been repressed. Through free association, a patient was able to put into words these memories. In so doing, the patient was able to free herself of symptoms caused by the repressed memory (Forrester, 1980).

Psychoanalytic method established the premise that talking is often at least partially curative or is a first step in the healing process (Forrester, 1980). A history of psychotherapy is beyond the scope of this paper, however, over time psychotherapy has become a ritual with all its attendent details.

Social Context

The importance of the ritual of psychotherapy lies in its impact on the language used within its boundaries. The specific psychotherapeutic discourse is circumscribed by the rules and regulations which govern it (Foucault, 1972).

First, there exists a set of socially sanctioned practitioners whose job it is to engage in dialogue with those who need psychological help. These practitioners are variously trained and this training impacts on their use of language. They may practice within an institution (a hospital or clinic), in which case, they are subject to the rules and purposes of that institution. Even in private practice, there are standards to be maintained, for example, ethical guidelines established by various associations to which the therapist may belong. The therapist's language is bounded by these circumstances and the result may be that the therapist functions not only as a helper of individuals but

as a guardian of society as well.

The client, too, is subject to a set of circumstances which impact on the way language is used by the client. Entering psychotherapy is, in a sense, an admission that all is not well. The client expects help, and, in turn, must be willing to attempt to explain the source of the trouble. A therapeutic relationship requires the client to speak, to put into language that which may be, literally, unspeakable. The client expects that therapy will be different from ordinary conversation. Hence, the client's language, as well as the therapist's, is subject to the boundaries of the psychotherapeutic discourse. The question which remains is how language is used in psychotherapy and what impact does this language use have on the client.

<center>Purpose</center>

The purpose of this study is to explore the complexity of language useage in psychotherapy through a review and synthesis of the relevant literature. An examination of therapist language will reveal the impact of training differences on the language used in therapy. Each school of therapy has its own theoretical language which is passed on to the therapist. The role of the therapist and view of the client are influenced by this language as well. These factors, in turn, effect what is said (and not said) in therapy sessions (Stiles, 1982).

Three aspects of therapist language seem unaffected by theoretical orientation. These are the use of empathy, explanation and interpretation. In highlighting these

similarities, it may be possible to establish a common language thread weaved through the various schools of therapy.

This study will investigate three theoretical models and examine differences and similarities between them. Further, this study will examine the many variables which effect client language as well as the universals in client language. Through this exploration, it may be possible to delineate ways in which therapists may better understand and help clients.

Finally, this thesis will examine social influence theory (Strong & Claiborn, 1982) as a metatheory of psychotherapy. This theory explains change in psychotherapy as the influence of the therapist on the client. This theory suggests that since it is through discourse that psychotherapy proceeds, it may be safe to assume that the therapist's language influences the language of the client. The intent in using the social influence model is to illustrate how the client may learn the language of the therapist and use this language to alleviate psychological distress.

Limitations of the Study

There are several topics related to the language of psychotherapy which will not be included in this study. First, it is difficult to tease language out of the context which is the therapeutic relationship. This relationship necessarily impacts on the language of the participants. However, language is the central focus of this work and not

the effects of the therapeutic relationship, which, in themselves, may produce change. Rather, the relationship may be viewed as a prerequisite for the discourse to develop. Therefore, it may be assumed that such a relationship exists (Havens, 1986). Changes which may be the result of the therapeutic relationship alone are not included in this paper.

An exploration of nonverbal communication will also not be included in this work. Gesture or body language give very important clues as to what is happening in the process of psychotherapy. However, the purpose of this paper is to examine the verbal aspects of psychotherapy.

A discussion of language development is beyond the scope of this paper, although it is a topic which is meaningfully related to language useage. Knowing how people learn and use language may be important in examining how language can change through psychotherapy.

An investigation of psychotic language will not be possible in this paper. Psychotic discourse may differ so radically from ordinary discourse that many of the universals of client language to be discussed here may not apply at all. Interpretation of psychotic language is especially hard (Mosak & Maniacci, 1989). In many cases, psychotic talk is not interpreted but is regarded as a symptom of a disease. In either case, it is a complex topic that deserves seperate treatment from the present work.

Language is necessarily a critical element in cross-cultural psychotherapy. Although relevant, this topic

is beyond the scope of this paper. The focus of this work will be on how the English language is used in psychotherapy.

Definitions of Terms

Psychotherapy: Refers to the dialogue between two people, one, the socially sanctioned therapist, the other, the distressed, non-psychotic individual. The words therapy and psychotherapy will be used interchangeably, as will the words therapist and psychotherapist.

Language: Will primarily signify vocal expression including words, phrases, sentences and combinations of sentences. In addition, language will be used to signify specific combinations of words, phrases sentences and combinations of sentences which are characteristic of a person, group or profession. Talk, speech and language will be used interchangeably.

Dialogue: Refers to the act of psychotherapy.

Discourse: Refers to the verbal product of psychotherapy. Both the content and function of language will be referred to in this paper.

Organization

The organization of this thesis is as follows: Chapter Two will be a discussion of therapist language. Two variables affecting therapist language will be presented. These are individual differences and training differences. Three schools of psychotherapy will be compared to highlight language differences in training. Similarities in language useage across theoretical orientations and methods of measuring therapist language will also be presented.

Chapter Three will focus on client language and the factors which impact on that language. Both differences and universals in client language will be discussed.

Chapter Four will outline the therapist-client interaction using a social influence model of psychotherapy (Strong & Claiborn, 1982). This will include a presentation of the model, its application across three theoretical orientations and the effect of therapist language on client experience. A case example will be presented to illustrate how language use changes in the social influence paradigm.

Chapter Five will be a summary of the thesis, conclusions and suggestions for future research in the area of the language of psychotherapy.

CHAPTER II

THERAPIST LANGUAGE

<u>Introduction</u>

A therapist is a socially sanctioned practitioner of psychotherapy. People who choose psychotherapy as their profession come from a variety of backgrounds. In general, however, psychotherapists are educated beyond four years of college (Frank, 1973). Factors which emerge as significant in terms of pre-training language useage among psychotherapists include attitudes toward verbal expression, especially emotional expression, experience with internal problem resolution and the ability to form relationships (Basch, 1988).

Psychotherapy is a discipline and, as such, may be considered a language system which is learned and deseminated through training (Foucault, 1972; Schafer,1976). However, there are many schools of psychotherapy, hence, a multiplicity of languages. Therapist's language will differ dependent upon the training they have received. The literature suggests that theoretical orientation, learned through training, effects the therapist's language: what is actually said in therapy (Stiles, 1982).

This chapter will first focus on individual differences in terms of therapist pre-training language. Next, an examination of training differences will be presented in

terms of their impact on therapist language. A discussion of content and function in language will follow. In the area of content, three theoretical orientations will be examined and the implications of their varied languages will be discussed. The function of language in psychotherapy will be explored through a discussion of explanation, empathy and interpretation in terms of their transtheoretical applications.

Individual Differences

As with most all behaviors, individual language useage is idiosyncratic to a certain extent. Factors which impact on a person's development and use of language are numerous and function in combination to produce each individual's "language" (Mitchell, 1988).

The first of these factors is innate predisposition. A person must possess the capacity to learn and use language. Environment plays a crucial role in the idiosyncratic ways that individuals use language. Family, friends and schooling all contribute to the ways a person thinks and subsequently translates these thoughts into speech (Mitchell, 1988; Rice, 1989).

Attitudes toward verbal expression vary widely. Some families place a great importance on communication, others less so. Rewards for verbal mastery, whether in the family, through friends or in school, will often contribute to the development of vocabulary and more precise communication (Mitchell, 1988; Rice, 1989).

The ability and willingness to verbally express emotion

may be particularly effected by early attitudes toward and rewards for this behavior (Basch, 1988; Headly, 1977; Mitchell, 1988). It seems likely that these abilities and attitudes are carried over into the therapeutic situation. A more thorough discussion of the preceding and additional factors which impact on language use will be presented in Chapter Three, Client Language.

Those who would become therapists may be more adept language users at the outset, for several reasons. First, verbal ability is often necessary for success in college and most therapists are, at least, college educated (Frank, 1973). Second, and more importantly, is the would-be therapist's experience with internal problem resolution. A common belief among the general population is that therapist's have more problems than their clients do. This unfortunate derision ignores the fact that, indeed, successful resolution of inner turmoil produces a therapist who can more readily understand client problems and help clients find ways to make sense of their experience (Cavanaugh, 1982). If many therapists have experienced personal difficulties and have resolved them, they are likely to have been able to translate emotions into language and have used language to soothe themselves (Kopp, 1972). Familiarity with this method seems a likely prerequisite to being able to help others through the verbal enterprise of psychotherapy (Frank, 1973).

A third and final notion which supports the idea that would-be therapists might possess more sophisticated language

skills is in the area of relationships. As was mentioned
earlier, a therapeutic relationship seems a necessary
prerequisite for the discourse of therapy to develop,
regardless of theoretical orientation (Frank, 1973; Strupp,
1989). The ability to establish a therapeutic relationship
hinges, in part, on the ability of the therapist to listen to
the client's language and use language effectively and in a
very specific way (Edelson, 1975; Strupp, 1989).

Therefore, through self-selection and education,
pre-training individual differences in therapist language use
are minimized. The most concrete differences in therapist
language develop through training and the adoption by the
therapist of a theoretical orientation.

Training Differences

There are hundreds of training programs available in the
United States for those who desire to become
psychotherapists. Within these institutions of training,
many theoretical orientations are represented. Often, a
training program is designed around a particular theory of
psychotherapy (Frank, 1973). Therefore, training programs
may be regarded as schools of psychotherapy, each school
representative of a particular theory. As training is often
a rigorous and all-consuming process, it is reasonable to
assume that the therapist who emerges from a chosen program
will have adopted the theoretical orientation most heavily
emphasized by that program. Indeed, training may be regarded
as an indoctrination (Frank, 1973).

One aspect of indoctrination is the necessity of

learning the language of the doctrine (Foucault, 1972; Schafer, 1976). Specialized language is a part of every field of endeavor and so it is with psychotherapy. Specialized language, while giving the possessor power over the subject, also tends to narrow the view of the subject (Hillman, 1975). In psychotherapy, the subject is the person. Specialized language is not only an attempt to develop a concept of the person theoretically, but also describes the role of the therapist, a view of the client and the way that therapy should proceed. The language of a school of psychotherapy reflects that school's particular understanding of the person or human condition (Havens, 1986).

The theoretical language of a school of psychotherapy is its descriptive language (Schafer, 1976). It provides an explanation of the concept of the person that the school espouses as well as a rationale for its claims. Each school also describes the role of the therapist. In terms of language, the therapist's role is circumscribed by the theoretical rationale of each particular school. Most importantly, the view of the client is reflected in the language of the school. For example: is the client a sum of behaviors? an id, ego and superego? struggling to actualize potential? The languages of the schools reflect these differences and effect the way psychotherapy is conducted (Stiles, 1982).

In any discussion of language, content and function differences must be deliniated. In psychotherapy, content

refers to the actual words being said; function refers to the purpose of the words. Hence, two aspects of the psychotherapeutic discourse emerge. The content of the therapist's speech will most likely be effected by theoretical orientation, however, the function of various words may be transtheoretical (Claiborn, 1982).

The next section of this chapter will be a discussion of the content of therapist language. Three theoretical orientations, psychoanalytic, cognitive-behavioral and client-centered, will be discussed in terms of theoretical language, the role of the therapist and the view of the client. The purpose of this section is to highlight the differences between the languages of each school of psychotherapy.

<p style="text-align: center;">Psychoanalysis</p>

Theoretical Language

The theoretical language of classical psychoanalysis is rich and complex. As with all theoretical languages, it provides an explanation of phenomena including the origins of psychological distress. Psychoanalytic theory also provides an explanation of the structure and development of the mind. Sigmund Freud, the creator of psychoanalysis, was a scientist and so the theoretical language he developed borrowed concepts from chemistry, biology and physics (Edelson, 1975). This language was never static. With new clinical observations, Freud modified his theory and those who followed him emphasized different aspects or changed the language to encompass further knowledge of the psyche (Arlow,

1984). It is beyond the scope of this paper to explore the
psychoanalytic language in its full complexity. The
following discussion will focus on classical psychoanalytic
theory from a Freudian perspective and the theoretical
language which forms the template for much psychoanalytic and
psychodynamic psychotherapy.

Through patient's talk, Freud was able to perceive
meaning behind the words, which led him to postulate the
concept of the unconcious (Forrester, 1980). The existence
of the unconcious implies a hidden self; moreover, it implies
that there is an aspect of the self which is beyond mastery
(Flegenheimer, 1989; Kohut, 1984). The unconcious, in the
early stages of Freud's thought, contained repressed
material, material too frightening or dangerous to remember
(Freud, 1905-9, 1916-17). Memories never went away,
especially those which were in some way traumatic or attached
to strong affect. Rather, these memories remained unconcious
but still exerted force, expressed in symptoms and dreams
(Freud, 1916-17). Freud's early work was characterized by
terms expressing the flow, storing and release of energy.
Free association allowed the repressed memory verbal
expression (deGramont, 1987). Psychic energy was released in
the cathartic experience and the patient became asymptomatic
(Forrester, 1980).

In order to explain how memories were repressed, Freud
developed the structural model. This model was a conflict
model, with the various sections struggling to maintain
equilibrium. Borrowing from Latin, the terms id, ego and

superego were created, naming the psychic apparatus (Freud, 1933).

The id represents primitive impulses, instinctual urges and repressed material. The superego functions unconciously as conscience. The ego (conciousness) balances external reality, id pressures and superego pressures. This intrapsychic conflict causes neurotic anxiety when id or superego impulses become too strong (Freud, 1933).

It is the job of the ego to take control of as much of the psychic energy as possible. That is, the ego, the rational aspect of the psyche, must attempt to make sense of behavior in terms of understanding the effect of the pressures of the unconcious material. Psychoanalysis is the method by which unconcious material may be brought to light and understood (Freud, 1933).

The psychic apparatus develops from infancy throughout the life span. During the first five years of life, the superego, based on parental introjects and ego ideals, forms. Id impulses are denied and unconcious material is protected by defense mechanisms. The ego forms and thereafter, the person struggles to maintain psychic equilibrium (Arlow, 1984).

The core factor of the psychoanalytic concept of the person is that behaviors (verbal and non-verbal) are predetermined and sometimes overdetermined by the original configuration of the psychic apparatus and by the constant conflict among the id, ego and superego. The client is unaware of these struggles and knows only that symptoms exist

for which there is no explanation. The role of the therapist, therefore, is to interpret the client's words and behaviors in terms of their reflection of the client's intrapsychic conflict (Arlow, 1984).

Role of the Therapist

In psychoanalytic or psychodynamic psychotherapy, the therapist's role is mainly that of interpreter (Stiles, 1982). The therapist is expected to find the meaning behind or within the client's words, rather than taking those articulations at face value. The unconcious may be revealed through speech and these revelations are often beyond the client's awareness (deGramont, 1987; Edelson, 1985; Flegenheimer, 1989). The therapist searches for patterns in the speech, carefully noting silences and evasions. The client's words form a fabric, the pattern of which reveals the client's inner world. The words may signify the underlying conflict causing the symptoms. The template of psychoanalytic theory is used to make sense of the client's story as it unfolds (Edelson, 1975).

In early sessions, the therapist's role as interpreter requires that the therapist allow the client to speak freely with minimal interruption (Flegenheimer, 1989). Free association makes it possible for the client to reveal information vital to the treatment. The client creates a symbolic representation of the client's inner world through this method (Edelson, 1975; Flegenheimer, 1989). When the therapist does make an intervention, it is usually to indicate that the therapist wishes the client to expound on

a particular point. Often, the discourse proceeds in such a
way that the client reveals important aspects of the client's
early life (Basch, 1980). This allows the therapist to begin
to assemble a pattern; to find connections between the
client's past life and present troubles (Edelson, 1975).
When the therapist has gathered enough information to
formulate an interpretation of the client's problem, the
process of working through the interpretation begins.
Interpretation is the necessary method because the unconcious
is rarely directly revealed (Freud, 1933).

Many times, interpretation begins after the
transference has developed. To simplify, the transference is
revealed as the client begins to respond to the therapist as
the client has responded in the past to significant others
(Freud, 1916-17). The transference gives the therapist an
immediate context for presenting the interpretation. Whether
or not the interpretation is accepted depends on many
factors. The therapist must speak carefully and present the
interpretation in such a way that it will be palatable to the
client (Wachtel, 1980). Interpretation provides the client
with grounds for the client's actions. That is, it helps the
client make sense of experience (deGramont, 1987; Edelson,
1975).

View of the Client

In psychoanalysis, symptoms are an expression of an
underlying disorder. Most often, the client is viewed as
suffering from unconcious patterns developed in the past and
relived again and again (Arlow, 1984; deGramont, 1987).

Although these patterns may have once been adaptive, they no longer are. The client is stuck in a repetition of the past which doesn't make sense in the present but continues to influence present behaviors (Edelson, 1975). One way a client may become asymptomatic is to understand or gain insight into these patterns. Insight may be gained by understanding and accepting the therapist's interpretation of the client's words. This allows the client to reassess life experiences in psychoanalytic terms (Edelson, 1975).

Psychoanalysis and psychodynamic therapies are particularly well suited for highly motivated and articulate clients. The therapist must also be very competent in the use of language as language is most important in these therapies (Flegenheimer, 1989).

<div align="center">Cognitive/Behavioral Therapy</div>

Theoretical Language

In simplest terms, cognitive/behavioral therapy is the application of learning theory to clinical problems. Hence, the theoretical language of cognitive/behavioral therapy is replete with terms which reflect its roots in experimental psychology (Wolpe, 1990).

B.F. Skinner developed his radical behaviorism based on operant conditioning (Cosgrove, 1982). Skinner postulated that all behavior could be accounted for by examining the consequences of the behavior. Behavior change could be accomplished by altering the consequences (Thorpe, 1990). The terms positive reinforcement, negative reinforcement and punishment were among those developed to describe the

techniques employed in behavior therapy to change behavior. The goal of behavior therapy is behavior change. In Skinner's conceptualization, the person, like a pigeon, can be taught any number of adaptive behaviors using operant conditioning (Thorpe, 1990). In addition, Skinner believed that the only legitimate subject of intervention is behavior because it is observable and results of intervention may be clearly observed and measured (Wilson, 1984).

Since its inception in the 1950's, behavior therapy has grown from Skinner's radical "black box" concept of the person to include variables which are not observable (Cosgrove, 1982). The neobehavioristic mediational stimulus-response model relies upon the precepts of classical avoidance conditioning. Although basically a stimulus-response model, it allows for a mediating variable, that is, something which is not observable or is a covert process. The techniques of systematic desensitisation and flooding for anxiety or phobia developed from this model (Wilson, 1984).

Social learning theory takes into account not only overt behavior but also environmental and cognitive processes. These factors may interact to produce psychological functioning. Cognitive mediational processes are emphasized: what a person thinks about or expects has an impact on behavior (Sherman & Skinner, 1988).

Cognitive restructuring is the featured procedure in cognitive/behavioral modification. Cognitive restructuring implies that a person's thoughts are the source of trouble

and if these thoughts can be changed or restructured then a person's troubles may be resolved (Dryden, 1990). Rational Emotive Therapy, developed by Albert Ellis in 1962, is based on the idea that irrational thoughts cause problems in living. Irrational thoughts are identified in therapy and the therapist attempts to replace them with rational thoughts so that the client may function better (Dryden, 1986).

There exist many variations of cognitive/behavioral therapy. However, some general principles guide the practice of almost all of these therapies. In contrast to the quasi-disease language used in psychoanalytic and psychodynamic therapies, cognitive/behavioral therapies do not recognize symptoms as having an underlying cause. Rather, the cause is a combination of variables, overt and covert, which can be manipulated. Problems in living are learned and may be unlearned through therapy. Current determinants are emphasized rather than historical determinants (Wolpe, 1990). According to cognitive/behavioral theory, the origins of problems need not be understood in order to resolve the problems. This present orientation is reflected in the language by the use of words such as how, what and when rather than why. These theories reject the concept of underlying unconcious conflict as a cause for mental distress (Thorpe, 1990). Cognitive/behavioral therapy reflects these theoretical notions in both the role of the therapist and view of the client.

Role of the Therapist

The cognitive/behavioral therapist is, in effect, a teacher. The primary mode of operation is explanation and teaching. The therapist emphasizes corrective learning experiences in a directive fashion (Dryden, 1990).

The initial task of the therapist is to gather very specific information about the presenting problem. In contrast to the psychoanalytic method, the therapist questions the client and formulates a functional analysis of the problem in the first couple of sessions (Freeman, 1990). The client's self-reports are taken at face value; there is no search for hidden meaning. Client speech is not seen as an unfolding mystery but as a description of the actual life problem. The therapist seeks to operationalize the problem, that is, to make it specific enough to target for intervention (Thorpe, 1990). There is an emphasis, in cognitive/behavioral therapy, on the uniqueness of each individual. Interventions are based on empirical evidence and treatment techniques are applied in a way that suits an individual client's situation (Wolpe, 1990). Techniques are too numerous to explicate here. The directive, active therapist necessarily expects an active client. In contrast to psychoanalytic and psychodynamic therapies, the client is expected to do more than talk (Thorpe, 1990).

View of the Client

The client in cognitive/behavioral therapy is viewed as the agent of change (Wilson, 1984). A cognitive/behavioral therapist teaches and the client is expected to learn and

actively participate in the therapy. Often, a client sets goals, moniters progress, does homework and reports back to the therapist the result of these activities (Dryden, 1990). For example, a client might set a goal to be more assertive with her spouse. The therapist might suggest homework consisting of the client writing her thoughts during each situation that occurs between sessions when she felt she needed to be more assertive. At the next session, the client's observations may be discussed and used to formulate plans for behavior change.

The client, rather than being viewed as the victim of unconcious processes, is viewed as having the ability to solve problems when given the tools to do so. Much cognitive therapy revolves around changing the clients language in terms of internal self-talk or cognitions (Thorpe, 1990). Clients often present with one or more cognitive distortions. Examples include dichotomous thinking, overgeneralization, mind reading, catastrophizing and others (Freeman, 1990). The work of cognitive/behavioral therapists reflect this concern with the importance of the client's thoughts on the client's behavior. The idea is to change the maladaptive thoughts and behavior change will follow. The most important factor in cognitive/behavioral therapy is helping the client learn to solve problems in living more effectively (Freeman, 1990).

Client Centered Therapy

Theoretical Language

The process of client-centered therapy, as developed by

Carl Rogers in the 1940's (Rogers, 1980), relies on the basic tenets of humanistic psychology and the observation of what works in therapy (Meador & Rogers, 1984). The following is a brief overview of the theoretical underpinnings of client-centered therapy.

First is the idea of the self-actualizing tendency. This is an inherent tendency of the human being to strive and develop to their full potential. Experience is equivalent to all internal events which may become available to awareness. Feeling is an emotionally tinged experience which represents the unity of emotion and cognition. Behavior change comes from within the person; inner experiencing determines behavior rather than external control. Awareness is the symbolic representation of some portion of experience. The self-concept is the person's view of themselves (Meador & Rogers, 1984).

According to client-centered theory, incongruence between self and experience leads to tension and confusion; this is the discrepency between the self as perceived and the actual experience. For example, a client may perceive herself as a nice person but she is seething with anger which may lead to a state of incongruence or vulnerability. The threat that the discrepency may come into awareness causes anxiety (Meador & Rogers, 1984).

Psychological maladjustment, according to this view, consists of denying experience to awareness thus creating incongruence. Defense is used to maintain the structure of the self by denying experience in order to reduce this

incongruence. The meaning of experience may be distorted to make it consistent with the self-concept or it can be denied in order to preserve the self from threat (Meador & Rogers, 1984).

The concept of congruence is an important one in client-centered therapy. Congruence means that the individual revises their self-concept to include all experiences. Psychological adjustment is achieved when all experiences are assimilated into the self-concept (Meador & Rogers, 1984). Certain conditions are deemed necessary for congruence to be acheived. They are outlined in the next section.

Role of the Therapist

The primary task of the therapist in client-centered therapy is to create three necessary and sufficient conditions which promote client change (Rogers,1980).

The first condition is that the therapist be genuine and congruent. The therapist in client-centered therapy is a real person not merely a professional therapist. The therapist does not judge but is open to the experience of the relationship. The therapist is transparent, that is, the therapist uses immediate and personal experience in the therapy so that the client may "see through" the therapist. This genuineness guides the work and provides the client an anchor in reality (Rogers, 1980).

The second condition of therapy is unconditional positive regard meaning acceptance of all aspects of the client. The therapist does not approve or disapprove of any

client behavior or verbalization. In this climate it is assumed that the client may verbalize formerly unacceptable feelings knowing that the therapist will continue to accept the client (Rogers, 1980).

The third condition of client-centered therapy is empathic understanding. Empathy consists of the therapist's ability to focus on the client's phenomenologic world or accurately perceive the client's internal frame of reference. More than understanding what is said in the session, the therapist, through immersion in the client's world, must be able to anticipate or clarify that which the client is not yet aware. This process fosters the client's sense of being understood. Being understood and accepted is the key to client growth and change in client-centered therapy (Meador & Rogers, 1984).

<u>View</u> <u>of</u> <u>the</u> <u>Client</u>

The client in client-centered therapy is viewed as a person with the potential to change and grow. As the name suggests, client-centered therapy is focused on the client's potential and puts trust in the client's ability to change, given the appropriate conditions (Rogers, 1980).

Self-actualization is the primary motive of all human beings. It is an inherent potential toward fulfillment and it is a constructive tendency (Meador & Rogers, 1984). Each person possesses this tendency, however, it may become thwarted by the person's unfulfilled need for positive regard. The self-concept which each person develops is influenced by the person's caretakers who set up conditions

of worth which become part of the self-concept. These conditions may be in conflict with the self-actualizing tendency. Therefore, a person may experience selectively or distort or deny experience to satisfy the self-concept. This leads to incongruence between self and experience (Meador & Rogers, 1984).

Client-centered therapy works to correct incongruence by allowing the person to eliminate previous conditions of worth and trust in their own experience. The three conditions of therapy, genuineness, positive regard and empathy, set the stage for a client to become congruent and begin or continue to actualize potential.

The preceding sections illustrate three different approaches to psychotherapy and the way that theoretical language, the role of the therapist and the view of the client may influence the process of therapy and therefore the language used in therapy by the therapist. However disparate, most therapies share commonalities in language. The preceding section dealt with the content of therapeutic language. The following section will deal with the function of the therapist's language in therapy.

Transtheoretical Aspects of Language

The literature suggests that there are at least three major functional aspects of language that may be used across theories in the therapist-client interaction. These are explanation, interpretation and empathy.

A therapist may offer, early on in treatment, an explanation of what may be involved and how treatment may

proceed. This type of explanation may occur during the first session, either at the beginning or end of the session. The explanation may include the meeting place and time, how often and what may be done. For example, talking further to get a clearer understanding of the problem or perhaps homework to help the client clarify some aspect of the problem may serve to explain treatment procedures and expectations (Basch, 1980).

Later in the therapy, the therapist may offer a more complex explanation pertaining to the client's symptoms and perhaps diagnosis. For a client who is confused about why certain symptoms are occuring, an explanation may relieve some of that anxiety. For example, a client who suffers from tearfulness, insomnia, loss of interest in life and feelings of hopelessness may be relieved to learn that these are symptoms of depression, a treatable illness (Basch, 1988).

Throughout therapy, a therapist may explain to the client certain responses, for example, feeling worse before feeling better. When a client's condition begins to improve, a therapist may explain why this is occuring.

Interpretation is another functional aspect of language that may be used across theoretical orientations. Although the content of interpretations made by the therapist may vary due to different theoretical frameworks, the function of interpretation works across most theoretical orientations (Claiborn, 1982).

According to Levy (1963), interpretation may be defined as the therapist's presenting discrepant information to the

client. That is, a therapist may present the client with a re-working of client material which differs from the client's viewpoint of that material. The purpose of presenting the discrepant viewpoint is to prepare clients to change in the direction of the new information. Semantic discrepancy includes those interventions which reframe or label client material. Propositional interventions make new connections between events in the client's life which were not previously discerned. The discrepancy may be slight and still produce change. The discrepant information may consist of any number of theoretically influenced communications. It is asserted that regardless of theoretical framework, change will be promoted through this function. Interpretation may be understood as an alternative language system or viewpoint brought to bear on client issues with the purpose of inducing change (Claiborn, 1982).

Shawver (1983) presents another transtheoretical view of interpretation. The connotation of language used by the therapist may be important to the success of therapy. Connotation refers to the labels that are put on behavior, feelings and experiences. Transvaluation is an intervention that may be used by the therapist to change the connotation of the client material. Two basic dimensions of connotation are evaluation and action. Evaluation refers to how a client understands experience and action refers to the level of responsibility a client takes in the creation and resolution of problems. It is suggested that transvaluation assists the client in first accepting experiences and feelings and then

taking responsibility for controlling life experiences (Shawver, 1983).

Roberds-Baxter (1983) takes a similar approach, describing ways to confront client language which is self-limiting. It is suggested that speech which expresses helplessness and dependence may be replaced by speech which reflects responsibility and choice. Halleck (1982) emphasizes the importance of maximizing client capacities. Clients may be urged to use language which implies responsibility.

For interpretations to be useful, a client must be able to understand and accept them. Wachtel (1980) points out the importance of the wording of therapist's comments, especially in interpretation. Interpretations may function as rewards or punishments depending on how they are worded. Therefore, the therapist needs to be aware of the client's capacity to accept the therapist's interpretations without feeling threatened by them.

Suit and Paradise (1985) conducted research which explores the use of metaphor in therapy. Metaphor may be understood as a form of interpretation in the sense that it reframes some aspect of client experience and may offer a new meaning to previously unrelated events in the client's life. The researchers compared complex metaphors, narrative analogies, cliches and facilitative responses to measure how these would effect client perceptions of the therapist. The results suggest that the use of moderately complex metaphors in therapy may facilitate positive responses to therapists

and may therefore also facilitate client change through therapy (Suit & Paradise, 1985).

In addition to explanation and interpretation, another transtheoretical function of language is empathy. The literature suggests that a key element in the success of therapy is the establishment and maintenance of the therapeutic relationship. One aspect of that relationship may be understood as the perception by the client of an empathetic therapist (Small & Manthei, 1986). Empathy is, in part, expressed through language.

Havens (1978) defines empathic speech as that speech which puts the client's state of mind into words. Several types of empathic speech may be described. Empathic exclamations are those short phrases that indicate that the therapist shares and acknowledges the client's feeling state. These empathic responses can be as simple as a noise, for example, a noise of assent which is not a word but is readily understood by the client for what it is (Havens, 1978). There are many degrees of empathy as well as an active and passive empathy. Passive empathy may be described as a listening response. In active empathy, the therapist puts into language what the client seems to be feeling at that time (Havens, 1986). Empathy is validating for the client as it indicates that the therapist can also experience such states as the client describes.

Todres (1990) describes a training model for students of psychotherapy which relies on the concept of empathy across theoretical orientations. Although Todres (1990) uses the

theoretical language of the existential school of therapy to deliniate the model, the concepts proposed may be applied to almost any psychotherapy process. The model deals with the focus of the therapist's attention through the stages of therapy. The first modality is called Attentive Being-With which basically describes the therapist's focus on the assumptive world of the client. Attentive Being-With assists the client by demonstrating the therapist's acceptance and understanding. Three additional modalities are outlined. Focusing Being-With is when the therapist assists the client in recognizing themes which emerge from the client's material. Interactive Being-With occurs when therapist and client begin to pay attention to their shared world. The final modality outlined is Invitational Being-With. In this modality, the therapist is attending to possible directions and the client's healthy potential. Each modality includes a component of empathic responding (Todres, 1990).

In research designed to analyze differences in empathic responding, Wycoff, Davis, Hector and Meara (1982) found fairly consistent patterns of language in counselors labeled High Empathic Responders and Low Empathic Responders. The results suggest that empathic responding involves less therapist talk and fewer questions directed toward the client. In addition, empathic responding appears to include more state verb phrases than action verb phrases. The researchers conclude that language training may be beneficial to students of therapy so that they may develop language patterns that improve empathic responding (Wycoff, Davis,

Hector & Meara, 1982).

In order to better describe therapist language and understand the influence of that language on the therapy process, it has been necessary for researchers to develop methodologies or classification systems to categorize and measure therapist language. The following section will highlight several of these methodologies.

Measuring Therapist Language

The establishment of the significance of language in psychotherapeutic process necessitates the development of systems to classify and measure that language. This may be accomplished in a variety of ways. This section will highlight some of the systems which were developed to measure language in psychotherapy.

Hill (1978) developed a Counselor Verbal Response Category system which incorporated components of systems that already existed but were not standardized in any way. The final system was developed through five revisions. Hill (1978) began by incorporating categories from existing systems into 25 counselor response categories, with written definitions and examples of each. Tapes and transcripts of practice therapy sessions were heard by qualified judges who categorized the counselor's language. During the first two trials, low interjudge agreement lead to refinement of the categories. Interjudge agreement reached 80-90% at the third trial. The system was revised twice more using counseling psychologists and graduate students who matched definitions with examples for each category. The final counselor

response system consisted of 17 categories each with a definition and examples to illustrate the category. Three judges then rated 3,866 counselor responses from 12 psychotherapy intake sessions. Judge agreement on the categories was analyzed and 14 categories remained: minimal encourager, approval-reassurance, information, direct guidance, closed question, open question, restatement, reflection, non-verbal referent, interpretation, confrontation, self-disclosure, silence and other (Hill, 1978).

Using this system, it is possible to learn, for example, how counselors of different orientations use language differently. Research might also show how different categories of language use shift within a session and through the course of therapy. The Counselor Verbal Response Category System might also be used in training to point out to trainees their primary language useage and how they might modify this to improve the quality of sessions (Hill, 1978). It seems, however, that in order to determine what actually occurs in sessions and the outcome of therapy based on a language analysis, a more complex system may be needed.

Hill and O'Grady (1985) used therapist intentions as a basis for psychotherapy research in a case study and with therapists of differing theoretical orientations. Intentions were defined as the therapist's reason for using a specific response mode or intervention in a session with a client. The importance of intentions emerges especially in training, where a trainee can think through and clarify what is being

done in sessions. One may also see how different therapists use the same response modes for different reasons (Hill & O'Grady, 1985). The study of therapist intentions may enable the researcher to understand therapist verbal behavior more accurately.

The intentions list which was developed by Hill and O'Grady (1985) was rationally derived, that is, the intentions may be used by therapists of varying theoretical orientations, based on general aims and goals common to most forms of therapy. The list of intentions includes the following: set limits, get information, support, focus, clarify, hope, cathart, cognitions, behaviors, self-control, feelings, insight, change, reinforce change, resistance, challenge, relationship and therapist needs (Hill & O'Grady, 1985). For each intention, a definition is given. Two studies using the system were conducted.

In the first, a case study approach was used to study whether intentions are systematically linked to therapist response modes and client response modes. The results suggested that therapist intentions varied over the course of therapy with decreases in the categories of set limits, get information and hope and increases in categories such as insight and change. In addition, the results suggest patterns of associations between therapist intentions and response modes (Hill & O'Grady, 1985).

Results of the second study reveal clusters of intentions within and across sessions. In the beginning of treatment, assessment intentions are used. The second

cluster is labeled therapeutic work and refers to those intentions which are designed to help the client reach understanding and take responsibility. Change is the third cluster associated with the therapist helping the client learn and maintain change. These clusters of intentions appear to be transtheoretical (Hill & O'Grady, 1985).

The study of intentions provides more complex information than a study of verbal response modes alone. Intentions refer to an internal process which cannot be directly observed. Verbal response modes refer to a grammatical structure and can be directly observed and measured (Hill & O'Grady, 1985).

Meara, Shannon and Pepinsky (1979) take a different approach to the measurement of language in therapy. In this and other studies, a computer assisted language analysis system (CALAS) is used to transform and analyze natural language into its structural properties and their relationships. The system provides units of measure such as clauses, phrases and verb types.

Meara, Shannon and Pepinsky (1979) used a film documenting three types of psychotherapy representing client-centered, gestalt and rational-emotive approaches to analyze the stylistic complexity of speech patterns of three therapists and a single client. Transcripts of the sessions were processed through CALAS which yeilded data used with four dependent measures of stylistic complexity: number of sentences, average sentence length, average block length and average clause depth. The results of this study suggest that

a number of significant relationships may exist between the natural language of counselors and clients and that language may effect the dynamics of therapy. The researchers found that the client's language modified in each different session according to which theoretical approach was being used. This result suggests that therapist speech may influence the speech of clients (Meara, Shannon & Pepinsky, 1979).

In a further study using the same film and similar methodology, Meara, Pepinsky, Shannon and Murray (1981) reinforced the findings of the previously cited study. Again, CALAS was used to process the speech from the film. This data was then analyzed on three dependent measures which were verb phrases. These were state verbs, process verbs and action verbs. In addition, three categories of verbs are described: experiential, benefactive and locative. The results suggest that the language of the therapists differed on the verb dimensions. The researchers found that although the client's language did not change semantically with each of the three treatment techniques, it did change stylistically which supports the notion that client language may change over a longer period of time in treatment. The researchers conclude that a more interactive approach to language research is indicated (Meara, Pepinsky, Shannon & Murray, 1981).

In a study of written language, Hurndon, Pepinsky and Meara (1979) used the Paragraph Completion Method to measure conceptual level of client responses and to ascertain the client's need for structure in therapy. It was assumed that

clients with a high conceptual level would need less structure. CALAS was used to analyze written responses to the Paragraph Completion. Both conceptual level and structural complexity of language were measured. The results suggest that the quantity of language is a key factor in conceptual level scores.· In less structured interviews, the client with a high conceptual level is expected to talk more. This sort of research may assist therapists in appropriate structuring of sessions based on the client's conceptual level (Hurndon, Pepinsky & Meara, 1979).

Wycoff, Davis, Hector and Meara (1982) conducted a study to measure counselor empathic responding, which was cited earlier. The independent measure consisted of counselor response as either empathic or nonempathic. Empathic responses were those which accurately reflected the client's feeling. Nonempathic were those which either denied the client's feeling, labeled the feeling inaccurately, expressed the client's thought, responded to content or moved into problem-solving. Tapes of sessions were rated for empathic responding. Stylistic complexity and semantic features of the language used by high empathic responders and low empathic responders was analyzed. The results suggest that high empathic responders talk less and ask fewer questions. This research might be useful in training to improve empathic responding (Wycoff, Davis, Hector & Meara, 1982).

Another approach to measuring language in psychotherapy is explicated in the work of Russell et. al. (1979, 1986, 1988). Russell and Stiles (1979) created categories for

classifying language in psychotherapy: content categories, concerned with denotative or connotative semantic content; intersubjective categories which deal with relationships between communicator and recipient; extralinguistic categories which include vocal noises, tonal qualities and temporal patterning of speech. In addition to these categories, two coding strategies are described. The classical strategy is concerned with the characteristics of the speech or text. The pragmatic strategy describes characteristics of the communicator (Russell & Stiles, 1979).

Russell and Stiles (1979) like Hill (1979), explore existing category systems in order to create a more cohesive way of measuring language in psychotherapy. Content categories, as described by Russell and Stiles (1979), may be used to investigate psychodynamic processes. Content refers to the semantic content of words or word groups. Manifest content refers to the denotative or connotative meaning. Latent content embraces symbolic or metaphorical meanings (Russell & Stiles, 1979).

In contrast, intersubjective categories describe relationships between the communicator and recipient without reference to semantic content. These categories are descriptive of interpersonal intentions. Intersubjective categories have been used to measure psychotherapeutic technique, relationships in therapy and therapy process (Russell & Stiles, 1979). A discussion of extralinguistic categories is not relevant to this paper.

Russell and Trull (1986) describe the differences

between frequency analysis and sequential analysis of language variables and conclude that sequential analysis is the more useful research overall. Frequency analysis consists of developing and defining categories, scoring predetermined units and then summing values or instances of category behavior. Sequential analysis, in contrast, takes into account the interactive qualities of psychotherapy and uses the transition between therapist and client speech as the unit of description (Russell & Trull, 1986). The researchers point out that language involves both speaker and listener and that to measure therapist or client language out of context ignores a vital aspect of psychotherapy (Russell & Trull, 1986).

In a review of process research, Russell and Trull (1986) found few language-oriented process studies which included reciprocal data. They suggest that in sequential studies, endpoints need to be considered as well as the development of interactional terminology. The researchers further suggest that single case studies be utilized to assess therapeutic language through sequential analysis (Russell & Trull, 1986).

Friedlander and Phillips (1984) conducted a sequential analysis based on a stochasic process analysis which is an analysis of temporal relationships according to the laws of probability. In this study, the authors developed the Discourse Activity Analysis to analyze the flow of the therapeutic discourse. In this process, the transition is the significant unit. The transition may be described as the

transaction between turns, turn being defined as the utterance of one speaker bound by the speech of the other speaker (Freidlander & Phillips, 1984).

In discussing the results of this analysis of psychotherapeutic interviews, the researchers conclude that early on, equal active efforts are made by both counselor and client to define the parameters of the problem and establish responsibility for the direction of the interaction. Topic shifts were noted as being attempts to assume control of the session. The researchers found, however, that passivity in interactions may be more powerful than topic shifts in maintaining control of the session. This is referred to as a passing turn and it discourages the speaker from shifting topics (Freidlander & Phillips, 1984).

Russell (1988) revised the original scheme for classifying verbal behavior (Russell & Stiles, 1979) in order to expand research possibilities in this area. Added are the speaker scope which refers to the number of successive speaking turns used to construct basic scoring units and descriptive statistics. These are added to the classical and pragmatic coding strategies along with the already developed content, intersubjective and extralinguistic categories. The author suggests that this new classification system operationally defines terminology and provides a systematic framework that can describe studies of verbal behavior in psychotherapy (Russell, 1988).

This chapter has dealt with therapist language which is at most only one half of the enterprise of psychotherapy.

The next chapter will consist of a survey of the extant literature dealing with client language.

CHAPTER III

CLIENT LANGUAGE

Client language is of profound importance in the psychotherapeutic process. The client's language in the psychotherapeutic discourse makes up the material from which therapeutic interventions emerge (Russell, 1989). For the purpose of this paper, two aspects of client language will be examined.

Client language may vary from client to client due to a number of factors. Differences in culture, gender, education, socio-economic status, right or left brain orientation and development may all impact on client language. The variance in client language may, however, be counterbalanced by the universals of client language. This aspect of client language refers to the needs and expectations of the client seeking psychotherapy as well as those language functions which are necessary to therapeutic discourse. Clients offer self-description which reveals the client's assumptive world or world-view. The language of emotion plays an important role in the healing process. A client's hopelessness, lack of insight, confusion and expectations of help are all revealed in psychotherapy. This universality of client language makes therapy possible with the infinite variety of both clients and therapists.

Differences in Client Language

Multicultural counseling has become an important part of the field in recent years. The realization that cultural differences effect expectations and outcomes of therapy is what has prompted researchers to explore the necessity of cultural sensitivity on the part of therapists. Therapists need to understand the cultural background of the client in order to develop goals and treatment procedures that will be effective in helping the client (Ibrahim, 1991). A person's world view is impacted by the environment in which it develops. The world view is then communicated through language during the psychotherapy session.

What may be healthy in one culture is not necessarily healthy in another. A therapist needs to understand the primary culture of the client in order to make sense of the client's distress. A client's beliefs and values are, in part, culturally derived, as are the beliefs and values of the therapist. A match of the two may be desirable and even beneficial (Erlich, 1983) but this is not always possible. Therefore, therapists must make every effort to familiarize themselves with the variety of cultural systems represented by their clients.

Ibrahim (1991) advocates the use of a Scale to Assess World Views (SAWV) as a first step in the interview process. This instrument helps clarify the sociopolitical histories of the groups the client identifies with, language(s) spoken, impact of gender from an ethnic/cultural and majority culture perspective, neighborhoods the client grew up in, religion(s)

the client subscribes to and the family/life cycle history. This approach assists the therapist in understanding the client's cultural identity, assumptions and belief systems. The therapist may then choose appropriate interventions based, in part, on these factors.

Clients of differing cultural backgrounds may be expected to express themselves differently as well as understand themselves differently. Client and therapist must share a common language in order for psychotherapy to take place (Flegenheimer, 1989). Therefore, the primary language of the client is of obvious importance.

Ethnocentricity may be part of the regulating function of therapy (see Chapter I). Multicultural therapy is an attempt to alter that function so that clients may become healthy within the parameters of their own culture in so far as that is possible.

Gender differences in client language may be considered a kind of cultural difference also. Sex-role stereotypes may play a damaging role in a person's development and these factors need to be taken into account. Rigidly masculine or feminine role expectations may repress aspects of a person that need expression thereby creating psychological ill health (Sharpe & Heppner, 1991).

In terms of language behavior in psychotherapy, gender differences may become apparent in the choices clients make regarding therapist gender (Erlich, 1983) and in the depth and type of discourse clients engage in (Snell, Hampton & McManus, 1992). The literature suggests that more women than

men seek counseling and that, due to sex-role socialization, women are perceived as more relationship oriented and men are perceived as emotionally unexpressive and less able to engage in a therapy process (Snell, Hampton & McManus, 1992). Snell, Hampton and McManus (1992) used the Relationship Disclosure Scale (RDS) to measure how willing students would be to discuss 25 relationship topics with male and female counselors. The results suggest that women are more willing than men to discuss feelings, social-emotional topics and topics rated high on intimacy (Snell, Hampton & McManus, 1992).

Socio-economic differences between clients may effect client language use in therapy. The positive correlation between poverty and mental health problems has been well documented (Belle, 1990). Poverty may produce its own problems which may interact with a client's individual capacity to endure and cope. Clients in poverty endure persistant stress and are often dependent on the public welfare system for survival. This consistent high level of stress may negatively alter a person's ability to cope and may contribute to depression, anxiety and low self-esteem (Belle, 1990). The concept of a heirarchy of needs may be useful in deliniating this particular point. A client who has the basic needs met (food, clothing, shelter etc.) may be more inclined to seek therapy regarding their growth and potential. A client who has never had the basic needs met will present with quite different issues that will require a different therapeutic approach (Maslow, 1954).

Along with socio-economic status, a client's level of education may effect a client's language in therapy (Frank, 1973). The uneducated client may have language deficits, being unable to express certain ideas or have difficulty articulating the problem. On the other hand, highly educated clients may have difficulty because of intellectualization of problems, being unable to express feelings. Frank (1973) describes the ideal psychotherapy client as being young, attractive, verbal, intelligent and successful. The client's education level needs to be taken into account because of how it may effect what the client can articulate in therapy (Schwalbe, 1983).

Another factor that may produce differences in client language is right/left brain orientation. The right hemisphere of the brain has been associated with intuition, imagery and emotion. The left hemisphere has been associated with analytical thinking, abstractions and language (Banmen, 1983). Individuals may be classified as tending toward one or the other hemisphere in processing information. This may be a factor in therapy in that clients with differing tendencies may express themselves and respond to interventions differently according to which hemisphere the client tends to use more (Banmen, 1983). In addition, clients may use language from visual, auditory or kinesthetic modalities depending, in part, on hemispherocity. Matching modalities with a client is one way in which a therapist may help a client feel understood (Cormier & Cormier, 1985).

Finally, client language may vary due to developmental

or individual differences. Language is used to develop self-concept in both receiving messages and in self-expression (Caraway, 1986). Information about a client's self-concept is important in the therapeutic process and clues may be gleaned from the client's use of language. Children, adolescents and adults have varying ways of using language to express themselves. A developmentally disabled client will use language differently and a therapist needs to recognize idiosyncratic uses of language of this and other populations. Client language will vary depending on the client population.

In the area of client language, research is not abundant. Variables effecting client language are often discerned through the therapeutic process. An exhaustive survey of these variables is beyond the scope of this paper.

Differences in client language may be understood as the content of client language much like the theoretical language of the therapist. In both, training and environment effect the content of language used in therapy. The next section will deal with the functions of client language. These functions transcend client language differences and are common to most psychotherapy clients.

Universal Elements in Client Language

The psychotherapy process begins with the client's story (Basch, 1980). The story consists of the clients descriptions of themselves and their world. The story or narrative may begin with a description of the problem that brought the client to therapy. With direction from the

therapist, the client might go on to give a brief history wherein the client describes who they are. Facts are less important than the way the story is told in this beginning assessment. This is the client's own version of reality from which the therapist may gather information about the way the client exists in the world (Dean, 1989).

The client's language use may reveal the level of self esteem or self-efficacy the client possesses. Competent use of language effects the client's world and successful use of language may increase self-esteem (Schwalbe, 1983). Therapists need to pay attention not only to semantics in client communication but also to syntax, or the way the client structures communication (Garfield, 1986). These factors may assist the therapist in designing appropriate interventions from which the client can benefit.

Self-perception may be revealed in the client's use of language. Rudestam (1978) points out several ways clients reveal important information about themselves through language. Words like "should" and "ought" may indicate that a client leads a rigid existence and suffers from guilt. The word "can't" may indicate that the client feels limited in ability or opportunity. Clients may use apologies, indicating perhaps the need to protect themselves from rebuke. Using the word "it" in place of "I" or "you" may indicate avoidance of responsibility. The use of semantic paradoxes such as "awfully nice" are a cue that the client has conflicted feelings about an event (Rudestam, 1978). These and other words and phrases may reveal much about a

client's self-perception. Clients may use self-limiting language (Roberds-Baxter, 1983) and this itself can become a target of intervention.

A cognitive-semantic method of analyzing client language was developed by Sherman and Skinner (1988). The authors used cognitive theory to explain distorted cognitive processes through language cues. Clients seem to share the same ways of distorting experience cognitively and linguistically.

Deletion is the process by which parts of experience are left out. Words like "should" and "must" indicate deletion in that the client insists that an event occur one way only, thus limiting alternatives. Generalization may be inferred when a client uses words like "everybody", "nobody", "all" and "always". The authors describe lost performatives as those statements used by clients in which they express absolutes based on their own experiential model. Words that indicate lost performatives include "right", "wrong", "good" and "bad" (Sherman & Skinner, 1988).

Sherman and Skinner (1988) used 95 clinical session transcripts to analyze the frequency of cognitive distortions revealed in client language. They found dysfunction in 97% of the 95 cases. They also found that dysfunctional process is decreased from earlier to later stages of treatment (Sherman & Skinner, 1988).

A client's assumptive world, also referred to as the world-view or frame of reference may be revealed through the language the client uses in therapy. An assumptive world may

be described as the filter through which the client creates
meaning from life events. In therapy, the assumptive world
is revealed through client disclosure (Stiles, 1982).

Certain patterns in a client's life may be understood by
understanding the client's world-view. Issues of
helplessness and dependency, choice and responsibility emerge
as important aspects in the development of treatment
interventions (Halleck, 1982; Roberds-Baxter, 1983).

Emotion plays a large part in psychotherapy treatment.
It may be revealed nonverbally as through tears or laughter
and verbally, through language. Mitchell (1988) points out
that there is a language of emotion which needs to be
developed in order that clients may have more satisfying
interpersonal relationships and a higher level of
self-esteem. The inability to express feelings may lead to
distress and the seeking of psychotherapy. Mitchell (1988)
advocates teaching clients the language of feelings as a
therapeutic intervention.

Clients use what may be referred to as feeling words.
These words vary in intensity and may express feelings of
happiness, sadness, fear, uncertainty, anger,
strength/potency and weakness/inadequecy (Cormier & Cormier,
1985). The client's use of feeling words provides important
information about the client's emotional state. Many
therapists encourage clients to translate emotions into
language. This may help the client clarify what is being
felt and may give the client some control over those
emotions. If the client seems to be blocking emotion,

feeling vocabulary can assist in releasing emotion in the client (Cormier & Cormier, 1985).

Individuals seeking psychotherapy may be regarded as demoralized (Frank, 1973). They may express feelings of anxiety and confusion. Often, they experience a sense of hopelessness which may be alleviated through psychotherapy. Clients may lack insight into their problems and have probably utilized all other means available for solving them before seeking therapy. Clients come to psychotherapy expecting help and it is part of the therapist's function to instill hope and assure the client that help is available (Frank, 1973).

In the next chapter, client-therapist interaction will be examined in terms of a social influence theory of psychotherapy. Social influence theory is a transtheoretical model that may be applied to the client-therapist interaction in order to further clarify the therapy process.

CHAPTER IV

THERAPIST-CLIENT INTERACTION

For the purpose of this paper, client language and
therapist language have been treated seperately. However,
the psychotherapy process necessarily involves two or more
people. In this chapter, the therapist-client interaction
will be examined using a transtheoretical model of
psychotherapy developed by Strong and Claiborn (1982).

The social influence model of psychotherapy (Strong &
Claiborn, 1982) is based on the idea that the therapist's
role in psychotherapy is one of interpersonal influence on
the client (Frank, 1973). According to this
conceptualization, part of what a therapist does is shape the
language of the client or condition the client to respond in
what the therapist considers a more healthy manner (Frank,
1973). Strong and Claiborn (1982) identify several
principles which emerge from the work of Frank (1973): a
client needs to believe in the possibility of change through
psychotherapy and the therapist needs to believe also and
encourage the client's belief. Treatment must enable the
client to change and maintain change. The course of
treatment needs to have a ritualized aspect with known phases
and expected events. The therapist needs to have ways to
overcome client resistence and encourage the client to
present symptomatic material so that symptoms may be

eliminated (Strong & Claiborn, 1982). These principles may
be applied in any number of psychotherapies and also apply to
other healing practices.

The social influence model of psychotherapy may be
described in three distinct phases (Strong & Claiborn, 1982).
In the first phase, it is assumed that the client's and
therapist's languages may be quite different. In order to
establish rapport, therapists need to modify their language
to more closely match the language of the client. This may
promote the client's feeling of being understood (Small &
Manthei, 1986). In this initial phase of therapy, listening
responses allow the therapist to gather information which may
be utilized later in the process. The therapist may already
be influencing the client in this phase through subtle
indications of interest in certain parts of the client's
story (Dean, 1989; Meara, Shannon & Pepinsky, 1979).

After matching the client's language to establish
rapport, the therapist and client may enter the second phase
of therapy. In this phase, the therapist begins to present
discrepant information, mostly in the form of interpretation.
Strong and Claiborn, 1982) state that discrepancy or
incongruence needs to be paced in order that the client's
language may slowly modify in the direction of the
therapist's language. Meara, Pepinsky, Shannon and Murray
(1981) point out that the client and counselor tend to work
together to reduce discrepancy in the sense of moving from
the actual to the desired state.

In the final phase of therapy, it is assumed that

congruence is reached. That is, the client has changed in the direction of the counselor's influence to the point where both are comfortable that adequate change has been acheived and the relationship can be terminated (Strong & Claiborn, 1982).

Cormier and Cormier (1985) reconceptualize the social influence model to include four stages of counseling and the purpose of the therapist's influence efforts in each stage. In the first stage, rapport and relationship are established by communicating credibility to the client, creating a favorable impression, structuring the session to reduce client anxiety and learn client expectations and encouraging client openness by inspiring trust. In the second stage, assessment and goal setting, the therapist helps the client obtain better understanding of self, challenges the client's language errors and encourages self-disclosure. In this stage, the therapist might also use self-disclosure to convey perceived similarity to the client. In the third stage, interventions may become more active and may include interpretations. In the final stage, the client's progress is assessed and termination may take place (Cormier & Cormier, 1985).

A variety of language may be used to describe the process of psychotherapy from an interpersonal influence perspective. The more important aspect of this view is that, being a metatheory of psychotherapy, it allows analysis of a number of theoretically oriented processes. In this next section, the model will be applied across three theoretical

orientations to illustrate this point.

Application of the Model

The social influence model is transtheoretical. This implies that in any given psychotherapy, the process is the same. By studying the patterns of discourse of three psychotherapies of differing theoretical orientations, it may be possible to discern the distinct phases explicated in the social influence model. Phase one will be referred to as matching, phase two as discrepency and phase three as congruence.

In psychoanalysis, free association begins the process. The client speaks and the therapist is mostly silent (Flegenheimer, 1989). This may be construed as matching in that the therapist says nothing to discourage the client's production of material. Any direction given by the therapist in this beginning phase is most likely neutral. This neutrality may provide clients the psychological space in which to express themselves. As the therapy proceeds, the therapist may learn enough to begin offering interpretations of the client's material (Weich, 1983). Interpretations may be regarded as the discrepent information in the second phase of the model (Claiborn, 1982). The emphasis in psychoanalysis is on interpretation. Congruence in psychoanalysis may be considered acheived when the client accepts the therapist's interpretations and integrates this information in a way that may produce a positive change in the client's life (Edelson, 1975).

Cognitive-behavioral therapy requires, in its first

stages, gathering of specific information to be used in
formulating therapeutic goals (Freeman, 1990). It may be
assumed that the therapist matches client language in that,
in order for information to be gathered, the client must
understand what the therapist requires. Discrepency begins
as the therapist points out behaviors and thoughts which may
be damaging to the client and of which the client is not
aware (Freeman, 1990). In this phase, the client is expected
to integrate the therapist's direction in an active way
(Dryden, 1990). Congruence occurs when the client is able to
behave, think and speak in the manner prescribed by the
therapist. In cognitive-behavioral therapy, the emphasis is
on the congruence phase of the social influence model.

Client-centered therapy emphasizes the matching phase of
the model. The three conditions of therapy, genuineness,
unconditional positive regard and empathic understanding
(Rogers, 1980) all work to provide an atmosphere that
suggests that client and therapist are more similar than
different. Reflection is a common intervention in the
client-centered approach. Essentially, it is the therapist's
reflecting the feeling part of the client's verbalization
often using some of the same words as the client (Cormier &
Cormier, 1985). At some point in the therapy, the
client-centered therapist has become so familiar with the
client that the client's internal frame of reference is
accurately perceived by the therapist. At this stage, the
therapist may be able to anticipate the client and the
therapist's comments may reflect a greater awareness of the

client's world view than the client has been able to become aware of (Meador & Rogers, 1984). In the language of client-centered therapy, congruence occurs when previously established conditions of worth are eliminated and the client is able to integrate all aspects of self and experience self-actualization (Meador & Rogers, 1984). In the language of social influence, congruence may occur when the client becomes more like the therapist in terms of self-actualization.

Stiles (1982) suggests that different therapies may produce different kinds of healthy people. This notion supports the idea of a metatheory such as the social influence theory. With emphasis on different phases of the model it may be expected that clients benefit in different ways from differing therapeutic experiences.

In the next section, the effect of therapist language on client experience will be explored. In addition, the social influence model will be further explicated.

<div align="center">Effects of Therapist Language</div>

Empathy

The first stage in psychotherapy according to a social influence model is joining the client or matching client language to establish rapport (Strong & Claiborn, 1982). Both listening and the therapist's use of empathic language may accomplish this task.

Cormier and Cormier (1985) explicate four listening responses which may communicate empathy to a client and which may be attempts on the therapist's part to match client

language. Clarification is a question intended to encourage the client to elaborate, to check accuracy and clarify confusing or vague messages. Clarification involves a rephrasing of the client's words. Paraphrase is a therapist's response to the content of the client's message which involves rephrasing that message. Reflection is a therapist's response that is most closely associated with the concept of empathy in psychotherapy. Reflection occurs when the therapist is able to grasp the affective and perhaps unstated part of the client's message. A reflection encourages the client to recognize feelings and become more aware of them. An accurate reflection by a therapist helps the client feel understood. In addition, an accurate reflection helps the client develop trust in the therapist as the therapist may seem to be able to see beyond the words to what is happening on an affective level. This can be a powerful intervention in the beginning stage of therapy. Summarization is a listening response in which the therapist ties together two or more client messages using paraphrase or reflection (Cormier & Cormier, 1985).

Havens (1986) presents a somewhat different conceptualization of empathic responses. Imitative statements are those beginning approaches by the therapist to enter the client's world. The objective of imitative statements is to comfort the client. This may be done through bland statements which do not challenge or confront. Havens (1986) warns that empathic statements may have the effect of forcing clients to feel what the therapist thinks

they should feel if used indiscriminantly in the first stages of therapy. Creating a safe atmosphere allows the client to continue and become more involved in the therapeutic discourse.

Simple empathic statements are those which are directed to the client's state of mind. Haven's (1986) describes these short emotional utterances which acknowledge the client's state and allow the client to feel that the therapist can share that state. For example, the description of a frightening experience might elicit "How awful!" from a therapist quite automatically (Havens, 1986).

Havens (1986) goes on to suggest complex empathic statements which may serve as bridges in certain therapeutic situations. For example, "No one understands." speaks to feelings of abandonment or being misunderstood. This sort of empathic statement encourages the client to perhaps talk about who might understand or who does not (Havens, 1986).

Extensions are those empathic statements that the therapist may use to explore the client's world in terms of entering the client's experience. For example, a therapist may add "...for a long time." to the client statement "It has been difficult.". The therapist has, in this example, extended the client's statement to gain a better understanding of the client's world (Havens, 1986).

Mosak and Maniacci (1989) apply the concept of matching client language to work with schizophrenic clients. The researchers suggest that the first task is to join clients in their world and gradually move toward a shared world. In

order to join the schizophrenic client, a therapist needs to learn the client's language rules by listening attentively for long periods of time. A therapist needs to realize that the client is trying to communicate and the therapist is obliged to understand rather than expect the client to be clear in communicating (Mosak & Maniacci, 1989).

It may be assumed that if a therapist and client are matched for certain variables before therapy begins that the therapy process may proceed more smoothly. Some of these variables may include gender, age, race or primary language (Erlich, 1983). Empathy may be easier to establish if therapist and client are similar in some ways or already matched. However, it may also happen that both therapist and client may, because of perceived similarities, develop a sense of knowing the other which is false. This may certainly result in truncated therapy (Erlich, 1983).

How dissimilar or similar client and therapist are at the beginning of therapy does not change the essential task of the therapist to establish rapport by listening and matching client language. As the client feels more understood, the therapy may progress to the stage when the therapist begins to present new language or discrepancy in the form of interpretation, while maintaining the empathic stance.

Interpretation

Interpretation is the heart of the therapy process. During this phase, the therapist deciphers client messages and adds to them in a way which promotes client change.

Interpretation may be the most difficult part of therapy, requiring therapist tenacity and client readiness to absorb and use new ways of thinking and speaking (Strong & Claiborn, 1982).

Client messages may contain manifest and latent content, as do dreams in psychoanalytic therapy. The manifest content may be the surface meaning of the words the client uses to describe experience. The latent content may include the way the words are spoken and the implicit meaning of the choice of words used. The therapist needs to hear beyond the surface to what may be the significant but somewhat masked client message. These messages may be the material which is interpreted (Cormier & Cormier, 1985).

Labeling client experience is perhaps the simplest form of interpretation (Claiborn, 1982; Frank, 1973). Frank (1973) points out that a therapist's labeling client experience conveys the message that the therapist is familiar with what the client is saying thus enabling the client to continue in the same direction. It may also reduce tension in the client and increase the client's trust in the therapist. In addition, labeling client experience may increase the client's sense of control: what had been perhaps a chaos of thoughts and feelings may now be seen as something controllable and understandable (Frank, 1973).

Claiborn (1982) differentiates between the semantic and propositional aspects of interpretation, both of which are ways of labeling client experience. An example of semantic interpretation might be when a therapist relabels a vague

feeling word such as "upset" with the more specific words "hurt" and "angry" (Claiborn, 1982). In doing so, the therapist may uncover for clients an aspect of their experience of which they were unaware. Accepting the angry part of a client may increase the client's feeling of the therapist's acceptance.

A propositional interpretation may include explicating various intentions of a client's behavior that the client may not be aware of. For example, a client who cries during an argument with her spouse may be expressing her hurt feelings but the crying may also be manipulative if the outcome results in the spouse apologizing. A therapist may make this interpretation with the intention of helping the client understand the effect her behavior has on others (Claiborn, 1982).

Another aspect of the labeling process may be referred to as reframing or restructuring. A therapist first identifies the implicit meaning of the client's message and then presents a somewhat different way of viewing the material, emphasizing positive factors and in a language that matches that of the client (Cormier & Cormier, 1985; Watchtel, 1980). The reframing is intended to allow the client to perceive another way of describing the problem that may be more useful.

Bandler and Grinder (1982) have utilized the idea of reframing to formulate Neurolinguistic Programming (NLP), a form of therapy which relies solely on the changing of language as the way to conduct therapy and produce change. A

full explanation of NLP is beyond the scope of this paper.
However, NLP reframing techniques may be applicable to other
therapies as well. NLP proposes that a therapist attaches
new meaning to the client's experience so that the client
perhaps does not need to change the situation but sees the
experience in a new light. For example, a man may become
quite agitated coming home to find his spouse has cleaned his
desk top. He may view his spouse as obsessively clean and
meddlesome. An NLP therapist might reframe the man's
response by leading him to recognize that he would be
devastated if his spouse left him and that her cleaning the
desk top means that she is there and caring about him
(Bandler & Grinder, 1982).

Another aspect of reframing may be observed in the
practice of Rational-Emotive Therapy (RET) which uses a
specific set of language variables to assist clients in
changing their responses (Dryden, 1986). For example, an RET
therapist might consider a client's statement as absolutist;
something "must" happen in order for the client to feel well.
An RET therapist may say that while the thing that happens
might increase the client's feeling of wellness, if it does
not happen, the client might still be quite well regardless.
Much of RET is based on the reframing or restructuring of
client thought and speech patterns to produce therapeutic
change.

Reframing may also be conceptualized as the use of
connotative language in psychotherapy. The discrepant
information a therapist presents during interpretation may be

connotative in nature. Shawver (1983) points out the influence labels have on experience. For example, a steak may be referred to as a piece of dead animal which may change a person's experience while eating it. In this way, perhaps, clients learn to label themselves in negative ways. Shawver (1983) refers to therapists' attempts to change the connotation of client language as transvaluation. For example, clients commonly refer to themselves as failures for a variety of reasons. A client may say that she is a failure as a worker because she is having difficulty in her job as a nurse's aid in a nursing home. A therapist may offer a transvaluative alternative: the client is not well suited to this type of work because of sensitivity to the deaths of the patients who she cares for. Hence, "failure" may be changed to "sensitive" by the therapist. The client may then be able to view herself differently which may lead to increased self-esteem and other positive therapeutic gains.

The labeling process, occurring during the middle stages of therapy, may promote client insight by increasing the possibilities in a client's life. Clients may begin to recognize how their thought and speech patterns have contributed to their feelings of helplessness in the face of problems (Roberds-Baxter, 1983). Therapist language in interpretation may empower clients to view themselves as responsible and capable of change. These changes may become apparent through changes in the ways clients talk about themselves in therapy.

Congruence

In the final stages of therapy, congruence between therapist and client may be reached. That is, the client may have internalized, to some extent, messages conveyed by the therapist and has been able to change through these rethinkings of the self and the world. The therapist may reinforce the client's use of the new language by sharing with the client as more of an equal in the relationship (Strong & Claiborn, 1982).

The client's acquisition of the therapist's language may serve more than one function. At first, the client's anxiety may be alleviated by the therapist's labeling of experience (Frank, 1973). As the language is tried out in therapy, it may become part of the client's thought process or cognition. For example, a client may remind herself during an unfortunate incident at work that she is not a "failure". Cognitive-behavioral therapy is based on the concept that therapeutic change comes about through changing the way a client thinks. The language used in therapy may begin the process of cognitive change. The language may also prevent the client from discouragement outside the therapy session by providing an alternative way to attach meaning to experience (Schwalbe, 1983).

A Case Example

The following case example, taken from this author's clinical work, illustrates how a client's language may change through psychotherapy.

Jean (a pseudonym) is a 30 year old divorced mother of

two sons. She has been a Public Aid recipient for a number
of years. Her issues in therapy centered around low
self-esteem, trust and relationships. Jean had been in
therapy before and during that time had overcome panic
attacks with agoraphobia. She continued to suffer from
dysthymia.

The following material is taken from clinical progress
notes from 46 sessions conducted over a period of one year
and four months. Each comment presented is a direct quote
from Jean, sometimes followed by an indication of what or who
she is referring to. Following some of the quotes are
descriptions of counselor interventions in that session.

Session 1

I don't know how to show love and it hurts me.

How can I learn to trust?

I was her robot. (mother)

Session 2

If someone touches me, it is a violation.

Session 3

What is a real lifestyle?

It couldn't be real. (relationship)

Session 4

At the last session, I got a lot of hurt out.

In my fantasy world, I can meet the kind of man I want

but in the real world, it doesn't seem possible.

Why am I attracted to losers or they are attracted to

me?

What if I don't get married? Am I supposed to not have

sex for the rest of my life?

I don't think people want me to be happy. They want me
to be a mother but not a woman.

I still feel shame about my body.

Session 5

I am never alone but I am always lonely.

I am still trying to please my mother. She always had
to be in control.

Session 6

I even sometimes don't trust you.

I never let anybody see my vulnerability. The only
place I cry is here.

(Counselor creates a metaphor: Jean has built a
fortress to protect herself.)

Session 7

I want to be away from my mother but I'm afraid that
without her to tell me what to do, I wouldn't be able
to cope.

How do you separate?

My image of myself is of a person who is ugly on the
inside.

I'm a person with low self-esteem.

I don't want guys to see what I'm really like.

I am controlled by guilt. Only negative messages get
in.

(Counselor creates a metaphor: Treat negative comments
like pitches in baseball. Hit each one out of the
park.)

Sessions 1-7 represent the matching phase of the treatment. During these sessions, the counselor focused on creating conditions which would foster trust through empathic responding. While remaining empathetic, the counselor now begins to interpret client messages and offer discrepant information.

Session 8

What's the use.

Everything hits me like a blow. Sometimes I leave here feeling good and then something happens and it hits me like a blow.

I'm feeling sorry for myself.

(Counselor offers a transvaluative alternative: feeling sorry for oneself is a form of compassion.)

(Jean hugs counselor at the end of the session.)

Session 9

I got all my pain out during the session.

I'm going to take my time and not get into a fantasy world.   (relationship)

That baseball image really helped the criticisms from getting in.

I'm crying a lot less.

The only people I really trust are (names three people).

It was a disease. (hitting children)

I don't like talking about the past but I need to.

I get discouraged.

I made up a little song to say to myself when I walk:

I feel good, I look good.

Session 10

My life is getting more and more wonderful.

I had the best time. I was like a totally different person.

I can get along without my mother.

I had a kind of panic attack in Kentucky. It makes me feel like a failure because I've been doing so well. I hate to admit it to you.

I have fears that something is terribly wrong.

(Counselor offers an explanation of secondary gains from symptoms.)

Session 11

Mother is coming home from vacation. I feel like I'm going back to prison.

She is going to make me feel so guilty.

I'm afraid to reject her because I don't want to hurt her.

(Counselor confronts Jean: she allows mother to induce guilt. Counselor offers an explanation of mother's behavior and suggests Jean take a more active role in the relationship.)

Session 12

I forgive my mother everyday but I'm becoming numb to some of what she says.

There is always a need for a mother's love.

I feel like my mother is breathing down my back.

I never laughed at my mother because I'm afraid. When

I stand up to her, the little child in me comes out.

I'm reading some self-help books.

Session 13

Mother has me on a 1500 calorie a day diet. She is
cooking all my meals. This is one thing I will let her
control me in, she is leaving me alone with everything
else. She still irritates me but I'm letting it go.
Maybe if she controls the diet we won't struggle so
much.

I feel like my mother is a person not just my mother.

It's OK to have a need for my mother.

Session 14

I am sick and it's her fault. I want to punish her.

It makes me feel ugly and it hurts but I can't forgive
her.

I'm so disappointed that I'll never get what I want and
need from my mother.

Session 16

If my mother can't deal with my independence, it's her
problem.

I smacked him very hard. It feels like another person
inside me. I felt like I was hitting myself. (son)

I am ashamed.

I am a terrible person.

(Counselor offers that Jean may have done a terrible
thing but it does not make her a terrible person.)

Session 17

I'm not where I want to be.

Session 18

I'm seeing him because I know mother would disapprove.

It's my secret.

Session 19

I feel like a whipped puppy.

I don't want to go to school. I would be happier in my

safe place.

You say things I already know but I have to hear you

say them.

Session 20

I'm surprised I'm doing so well. (school)

I'm excited and scared.

Session 21

I ran him off. (a man)

I fall into her traps every time. (mother)

Sometimes in counseling I feel like I sound like a

child.

Session 22

Is it alright to be mad at somebody?

I'm overcoming my fear of heights.

Session 24

I'm losing interest in school.

I let myself get dragged down.

My biggest fear is losing control in anger.

(Counselor offers explanation of negative thoughts

leading to negative feelings.)

Session 26

I fell in love.

I haven't been able to love until now but if it hurts

so much I don't want it.

I have an automatic shut-off on hurt by saying I don't

care.

I'm afraid of getting depressed again.

(Counselor offers that these feelings are probably

  temporary.

Session 27

He's macho and unemotional.

I felt like I was playing therapist.

I took my anger out on my tests. As I was controlling

it, I heard your voice.

These sessions, 8-20, represent the phase of therapy when the

therapist presents discrepant information. The fact that the

client hears the therapist's voice internally indicates the

beginning of the congruence phase.

Session 28

I've learned to control my temper.

Session 29a

I feel very insecure and dependent on him.

Session 30

When I look to the future with him, I would be putting

up with abuse and that's not for me.

I'm waiting for the world to crash in on me.

Session 31

We have communication problems. I didn't know how my

language affected him. Like I have trouble with "I"

statements.

It will be weird away from mommy.

Session 34

Nobody can push me around.

I have unconditional love for her. (friend)

What keeps me going is knowing that the feelings I'm

having now are temporary. I'm feeling sad.

Session 35

I never realized how much work a relatiomnship takes.

I find my mother's opinions irritating. (religion)

Session 36

My mother was right about him. Why did I put myself

through this?

I'm weak.

Session 37

He didn't want the responsibility of being mature.

When I'm stronger, I want to be hypnotized to relive my

past experiences.

Session 38

Thanks for letting me talk. This is the only place I

get listened to.

I have my own life to live. If he's not in it, fine,

if he is in it, fine also.

I've got control of things.

No man will ever make me not be myself again.

My personal life is my own business, not my mother's.

It is a wonderful feeling being in control of my own

life.

I've been let out of a cage.

Session 40

I've played counselor with him. He is like my patient.

I need to be there for him. It's like my mother, she

needs me to be the patient.

Session 41

The man I fell in love with isn't that man.

I sacrificed my own self-esteem to boost his.

I'll just have to go on.

Session 42

I thought I would never get to this point.

I'm not grieving anymore. The problems in the

relationship were not me.

Mother is upset about my independence but she'll have

to get used to it.

Session 43

Sometimes people treat me badly because they know they

can get away with it. I'm sick of it.

When I talk about things in counseling, they sometimes

seem funny afterwards.

Session 44

I told her off. (mother)

Session 45

He has made a complete turnaround. He wants a

committment. He talks more and expresses his emotions.

I can't believe I'm actually getting what I want.

Session 46

I'm more content than ever.

Over the course of treatment, Jean learned how to use

her inner resources to help her overcome her feelings of low self-esteem. She was able to seperate from her mother by forming mature attachments to other adults.

Jean used her therapist's language to help herself; first by hearing her therapist's voice and then by internalizing the therapist's style. She became so adept at this that she felt she could "play therapist" with her boyfriend.

Throughout the course of treatment, Jean gained a greater understanding of herself and was able to, for the most part, discontinue the all or nothing thinking which characterized her early statements in therapy.

With this client, the therapist maintained an empathic stance throughout the treatment. The therapist used metaphor and cognitive techniques which were matched to Jean's conceptual level and her knowledge and previous use of self-talk. The therapist also explained concepts such as object relations and family systems. Information about the therapy process was offered when appropriate.

It remains difficult to separate language variables from changes which occur in response to the therapeutic relationship.

CHAPTER V

SUMMARY: CONCLUSIONS AND DIRECTIONS FOR FUTURE RESEARCH

In studying and analyzing the extant literature regarding language use in psychotherapy, several conclusions may be drawn.

The literature suggests that psychotherapy is a process which remains somewhat elusive in terms of why and how it effects change in clients (Marmar, 1990). There seem to be two areas which function to produce change; the therapeutic relationship and specific interventions driven by theoretical considerations (Jones, Cumming & Horowitz, 1988).

Therapist language is impacted by training and some of this language is passed on to the client during the psychotherapeutic exchange. Therapist neutrality, in this sense, probably cannot exist. Therapists need to recognize how their theoretical framework and personal attributes may effect the work they do. Therapy may be considered an influencing process and as such, therapists need to constantly be aware of their position of power in the process. The therapist is considered an expert and what the therapist says may be quite influential (Dean, 1989).

In terms of language, it is not possible to conclude that the client's changing throughout treatment is a result of the therapist's use of language. It is apparent that client language may change as a result of participation in

therapy. It remains uncertain what relationship exists between behavior, thought and language and how these variables interact to produce change in a therapy process.

Factors that may impact clients during therapy seem impossibly numerous. First, there is the person of the therapist. If the therapist is the tool of psychotherapy, then it may be assumed that in greater or lesser ways, each therapist is different. Idiosyncratic ways that language may be used by therapists varies widely. Although the literature suggests similarities regarding the function of therapist language, the content may differ along any number of lines. Combining these facts with the person of the client results in a great number of variables. Although clients may have similar reasons for seeking psychotherapy, each one is unique, with their own set of predispositions and their own ways of using language.

Formation of the therapeutic relationship seems to be based on therapist activities which enhance the client's feelings of being understood while at the same time, providing the client confidence in the expertise of the therapist (Frank, 1973). Perhaps, as Kopp (1972) suggests, the important factor is that the therapist and client are two human beings struggling to make sense of their lives and the world around them. The therapist may offer comfort just by being there for the client and listening to the client's story; a bit of stability in a chaotic world.

Several researchers mention attempts to develop a common language to describe the therapy process. A common language

may make it possible to describe events transtheoretically and also provide clients with explanations free of psychotherapeutic jargon (Andrews, 1989).

Research in the area of language and psychotherapy is part of process research in general. It seems that oversimplification of the psychotherapy process may provide only a small part of the information available (Marmar, 1990). Marmar (1990) suggests that multiple levels and dimensions of the treatment process be identified and measured. Marmar (1990) also suggests that significant change events from different studies be combined in an effort to develop a transtheoretical language to describe the process.

Other research directions might include refinements in sequential analysis of therapist and client language (Russell & Trull, 1986). This might provide information useful in determining which interventions effect client change.

Multicultural research may yield information to assist therapists in altering their language to more closely match that of the client. This may ease the development of rapport in early sessions.

Reasearch which identifies therapist responses and interventions may be useful in training. Other aspects of language study may also be useful as part of training programs. For example, assisting trainees in listening for connotative language and using methods to alter negative connotations (Shawver, 1984). Empathic language may be taught using research which measures this aspect of language

(Wycoff, Davis, Hector & Meara, 1982).

Although language is the medium through which psychotherapy is conducted, it is but a fraction of all that occurs during psychotherapeutic treatment. The complexity of the enterprise necessitates complexity in research to further understand the process of psychotherapy.

References

Andrews, J.D. (1989). Integrative languages in therapeutic practice and training: Promises and pitfalls. _Journal of Integrative and Eclectic Psychotherapy, 8(4),_ 291-302.

Arlow, J.A. (1984). Psychoanalysis. In R.J. Corsini & Contributors, _Current Psychotherapies_ (3rd ed.). Itasca, IL: F.E. Peacock, Inc.

Bandler, R. & Grinder, J. (1982). _Reframing: Neuro-linguistic programming and the transformation of meaning._ Utah: Real People Press.

Banmen, J. (1983). Cerebral laterality and its implications for psychotherapy. _International Journal for the Advancement of Counseling, 6(2), 99-113._

Basch, M.F. (1980). _Doing psychotherapy._ New York: Basic Books, Inc.

Basch, M.F. (1988). _Understanding psychotherapy: The science behind the art._ New York: Basic Books, Inc.

Belle, D. (1990). Poverty and women's mental health. _American Psychologist, 45(3),_ 385-389.

Caraway, S.S. (1986). Language: The window into a child's self-concept. _Journal of Instructional Psychology, 13(4),_ 177-181.

Cavanagh, M.E. (1982). The counseling experience: A theoretical and practical approach. Monterey, CA: Brooks/Cole.

Claiborn, C.D. (1982). Interpretation and change in counseling. Journal of Counseling Psychology, 29(5), 439-453.

Cormier, W.H. & Cormier, S.L. (1985). Interviewing strategies for helpers. Monterey, CA: Brooks/Cole.

Cosgrove, M.P. (1982). B.F. Skinner's behaviorism: An analysis. Grand Rapids, MI: The Zondervan Corporation.

Dean, R.G. (1989). Ways of knowing in clinical practice. Clinical Social Work Journal, 17(2), 116-127.

DeGramont, P. (1987). Language and the self. Contemporary Psychoanalysis, 23(1), 77-121.

Dryden, W. (1986). Language and meaning in RET. Journal of Rational-Emotive Therapy, 4(2), 131-142.

Dryden, W. (1990). Rational-emotive counselling in action. London: Sage Publications, Inc.

Edelson, M. (1975). Language and interpretation in psychoanalysis. Chicago: University of Chicago Press.

Erlich, I.S. (1983). Speaking the same language. Journal of American College Health, 31(4), 174-176.

Flegenheimer, F.A. (1989). Languages and psychoanalysis: The polyglot patient and the polyglot analyst. International Review of Psychoanalysis, 16(3), 377-383.

Forrester, J. (1980). Language and the origins of psychoanalysis. New York: Columbia University Press.

Foucault, M. (1972). The archaeology of knowledge and the discourse on language. New York: Pantheon Books.

Frank, J.D. (1973). Persuasion and healing: A comparative study of psychotherapy. Baltimore: The John Hopkins University Press.

Freeman, A.M. (1990). Clinical applications of cognitive therapy. New York: Plenum Press.

Freud, S. (1905). Dora: An analysis of a case of hysteria. Philip Rieff, Ed., (1963). New York: Macmillan Publishing Co.

Freud, S. (1916). Introductory lectures on psychoanalysis. The Standard Edition, James Strachey, Ed. New York: W.W. Norton & Company.

Freud, S. (1933). New introductory lectures on psychoanalysis. The Standard Edition, James Strachey, Ed. New York: W.W. Norton & Company.

Friedlander, M.L. & Phillips, S.D. (1984). Stochastic process analysis of interactive discourse in early counseling interviews. Journal of Counseling Psychology, 31(2), 139-148.

Garfield, D.A. (1986). The use of primary process in therapy: I. Concrete thinking and the perception of syntax. Psychotherapy, 23(1), 75-80.

Halleck, S.L. (1982). The concept of responsibility in psychotherapy. American Journal of Psychotherapy, 36(3), 292-303.

Havens, L. (1978). Explorations in the uses of language in psychotherapy: Simple empathic statements. Psychiatry, 41, 336-345.

Havens, L. (1986). Making contact: Uses of language in psychotherapy. Cambridge, MA: Harvard University Press.

Headley, L. (1977). Adults and their parents in family therapy: A new direction in treatment. New York: Plenum Press.

Hill, C.E. (1978). Development of a counselor verbal response category system. Journal of Counseling Psychology, 25(5), 461-468.

Hill, C.E. & O'Grady, K.E. (1985). List of therapist intentions illustrated in a case study and with therapists of varying theoretical orientations. Journal of Counseling Psychology, 32(1), 3-22.

Hillman, J. (1975). Re-visioning psychology. New York: Harper Colophon Books.

Hurndon, C.J., Pepinsky, H.B. & Meara, N.M. (1979). Conceptual level and structural complexity in language. Journal of Counseling Psychology, 26(3), 190-197.

Ibrahim, F.A. (1991). Contribution of cultural worldview to generic counseling and development. Journal of Counseling and Development, 70(1), 13-19.

Jones, E.E., Cumming, J.D. & Horowitz, M.J. (1988). Another look at the non-specific hypothesis of therapeutic effectiveness. Journal of Consulting and Clinical Psychology, 56(1), 48-55.

Kohut, H. (1984). How does analysis cure?. Chicago: University of Chicago Press.

Kopp, S.B. (1972). If you meet the buddah on the road, kill him!: The pilgrimage of psychotherapy patients. Ben Lomond, CA: Science and Behavior Books.

Lacan, J. (1968). The language of the self: The function of language in psychotherapy. Baltimore, MD: The John Hopkins Press.

Levy, L.H. (1963). Psychological interpretation. New York: Holt, Rinehart and Winston, Inc.

Marmar, C.R. (1990). Psychotherapy process research: Progress, dilemmas and future directions. Journal of Consulting and Clinical Psychology, 58(3), 265-272.

Maslow, A.H. (1954). Motivation and personality. New York: Harper & Row.

Meador, B.D. & Rogers, C.R. (1984). Person-centered therapy. In R.J. Corsini and Contributors, Current Psychotherapies. Itasca, IL: F.E. Peacock, Inc.

Meara, N.M., Pepinsky, H.B., Shannon, J.W. & Murray, W.A. (1981). Semantic communication and expectations for counseling across three theoretical orientations. Journal of Counseling Psychology, 28(2), 110-118.

Meara, N.M., Shannon, J.W. & Pepinsky, H.B. (1979). Comparison of the stylistic complexity of the language of counselor and client across three theoretical orientations. Journal of Counseling Psychology, 26(3), 181-189.

Mitchell, C.E. (1988). Teaching to speak in feelings as a second language. _Family Therapy, 15(1),_ 75-81.

Mosak, H.H. & Maniacci, M.P. (1989). An approach to understanding "schizophrenese". _Individual Psychology, 45(4),_ 465-472.

Rice, M.L. (1989). Children's language acquisition. _Journal of Counseling Psychology, 44(2),_ 149-156.

Roberds-Baxter, S. (1983). May your force be with you. _Personnel & Guidance Journal, 62(2),_ 88-90.

Rogers, C.R. (1980). _A way of being._ Boston: Houghton Mifflin Co.

Rudestam, K.E. (1978). Semantics and psychotherapy. _Psychotherapy: Theory, Research & Practice, 15(2),_ 190-192.

Russell, R.L. (1988). A new classification scheme for studies of verbal behavior in psychotherapy. _Psychotherapy, 25(1),_ 51-58.

Russell, R.L. (1989). Language and psychotherapy. _Clinical Psychology Review, 9(4),_ 505-519.

Russell, R.L. & Stiles, W.B. (1979). Categories for classifying language in psychotherapy. _Psychological Bulletin, 86(2),_ 404-419.

Russell, R.L. & Trull, T.J. (1986). Sequential analyses of language variables in psychotherapy process research. _Journal of Consulting and Clinical Psychology, 54(1),_ 16-21.

Schafer, R. (1976). _A new language for psychoanalysis._ New Haven: Yale University Press.

Schwalbe, M.L. (1983). Language and the self: An expanded view from a symbolic interactionist perspective. Symbolic Interaction, 6(2), 291-306.

Sharpe,, M.J. & Heppner, P.P. (1991). Gender role, gender role conflicts and psychological well-being in men. Journal of Counseling Psychology, 38(3), 323-330.

Shawver, L. (1983). Harnessing the power of interpretive language. Psychotherapy: Theory, Research & Practice, 20(1), 3-11.

Sherman, E. & Skinner, K.W. (1988). Client language and clinical process: A cognitive-semantic analysis. Clinical Social Work Journal, 16(4), 391-405.

Small, J.J. & Manthei, R.J. (1986). The language of therapy. Psychotherapy, 23(3), 395-404.

Snell, W.E., Hampton, B.R. & McManus, P. (1992). The impact of counselor and participant gender on willingness to discuss relational topics: Development of the relationship disclosure scale. Journal of Counseling and Development, 70(3), 409-416.

Stiles, W.B. (1982). Psychotherapeutic process: Is there a common core? In Abt and Stuart (Eds.), The Newer Therapies: A Source Book. New York: Van Nostrand Reinhold Co.

Strong, S.R. & Claiborn, C.D. (1982). Change through interaction: Social psychological processes of counseling and psychotherapy. New York: John Wiley & Sons, Inc.

Strupp, H. (1989). Psychotherapy: Can the practitioner
     learn from the researcher? <u>American Psychologist</u>,
     <u>44(4)</u>, 717-724.

Suit, J.L. & Paradise, L.V. (1985). Effects of metaphors
     and cognitive complexity on perceived counselor
     characteristics. <u>Journal of Counseling Psychology</u>,
     <u>32(1)</u>, 23-28.

Thorpe, G.L. (1990). <u>Behavior therapy: Concepts,
     procedures and applications</u>. Needham Heights, MA:
     Allyn & Bacon.

Todres, L.A. (1990). The rhythm of psychotherapeutic
     attention: A training model. <u>Journal of
     Phenomenological Psychology</u>, <u>21(1)</u>, 32-45.

Wachtel, P.L. (1980). What should we say to our patients?:
     On the wording of therapist's comments. <u>Psychotherapy:
     Theory, Research & Practice</u>, <u>17(2)</u>, 183-188.

Weich, M.J. (1986). Clinical aspects of language. <u>Journal
     of the American Psychoanalytic Association</u>, <u>34(3)</u>,
     687-698.

Wilson, G.T. (1984). Behavior therapy. In R.J. Corsini and
     Contributors, <u>Current Psychotherapies</u>. Itasca, IL:
     F.E. Peacock, Inc.

Wolpe, J. (1990). <u>The practice of behavior therapy</u>. New
     York: Pergamon Press.

Wycoff, J.P., Davis, K.L., Hector, M.A. & Meara, N.M.
     (1982). A language analysis of empathic responding to
     client anger. <u>Journal of Counseling Psychology</u>, <u>29(5)</u>,
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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

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