AN INTERACTIONAL MODEL OF QUESTIONS AS THERAPEUTIC INTERVENTIONS[1]

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Increasingly, some psychotherapists use questions as interventions. We summarize a model by McGee that provides a theoretical basis and step-by-step analysis of how questions are co-constructive in therapeutic conversations. A question constrains the recipient to answer within a framework of presuppositions set by the question. In doing so, the answerer contributes to the perspective imposed by the question and accepts it as a shared perspective. If the question asks about the client's abilities and solutions, then the client can provide evidence of these from his or her life. If the question asks about problems and pathologies, then the client is likely to join in and provide evidence that co-constructs a different view of his or her life. The model described here is a tool for therapists to use for microanalysis of their own and others' questions to increase their awareness and creativity in the use of questions as interventions.

At first glance, questions seem to be simply seeking information, and it appears that, until recently, psychotherapy has viewed them solely from this perspective (Freedman & Combs, 1996). The use of questions with specific therapeutic purposes began as a little-noticed aspect of a group of therapies that include Brief Therapy (Watzlawick, Weakland, & Fisch, 1974), Problem-Solving Therapy (Haley, 1976), the Milan Approach (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980), Solution-Focused Therapy (de Shazer et al., 1986), and more recently, Narrative Therapy (Epston & White, 1992; White, 1991). One common feature of these approaches is that they employ questions more often than statements or assertions, in some cases almost exclusively.

The explicit possibility of seeing questions as more than information-gathering tools began, at least in the world of therapy, with the work of Selvini-Palazzoli, Boscolo, Cecchin, and Prata, also known as the Milan Associates (Selvini-Palazzoli et al., 1980). This group began to see the questions themselves as interventions in the sense that they introduced certain alternative possibilities, theories, and views of the world, simply in their posing (See also Adams, 1997.)

Our goal in this article is to support and extend the notion of questions as interventions by presenting a method for microanalyzing how they work in psychotherapy. Microanalysis is the close examination of actual communication sequences (e.g., question–answer sequences), with an emphasis on how these sequences function in the interaction (Bavelas, McGee, Phillips, & Routledge, 2000). Other examples of this approach, which is still relatively new, include Gale (1991), Gale and Newfield (1992), Buttney and Jensen (1995), Kogan and Gale (1997), and Strong and Paré (2004).

The data that we will present were selected from videotapes and transcripts available at the University of Victoria and the Vancouver Island Family Therapy training program. Virtually all of them were demonstration interviews for teaching purposes, conducted by highly respected trainers and therapists with many years of clinical experience. According to Glaser and Strauss (1967), this way of selecting the data is consistent with the technique of *theoretical sampling* (pp. 45–78). That is, by selecting teaching tapes and transcripts (rather than a random sample of everyday interviews), we can study questions that best exemplify the approach and technique of the various clinicians.

Consider the following apparently simple example of a question by Luigi Boscolo in an unpublished consultation interview in 1986 with a young man who had lived a tumultuous life[2]. In the following excerpt, the client was responding to Boscolo's initial question, "How do you see yourself now?"

Example 1: Luigi Boscolo

Client: I used to be promiscuous but I'm not any more.

Therapist: What made you decide to change, from being promiscuous to not being promiscuous?

Of the several possible questions that could have been asked, this one has several interesting features. Boscolo could have asked about the past history of promiscuity, its causes, and so on, ignoring or minimizing the positive change. Instead, he chose to focus his question on the client's change to not being promiscuous. Indeed, his wording was less elliptical than the client's in this regard: "But I'm not any more" became explicitly "not being promiscuous." Perhaps most importantly, he spoke of the change as the client's decision ("What made you decide?"), thereby offering the client credit for causing the change in his own life. Had he asked, "What stopped your promiscuity?", he would have offered the possibility that something or someone else caused the change, implicitly inviting him to provide details of himself as an agentless object.

Following McGee (1999), we call questions such as Boscolo's *constructive questions,* in two senses of the word. First, we propose that all questions are co-constructive. Boscolo's choice of language (e.g., "decide") discursively offered to construct the client as the agent of change in his life. Moreover, it invited him to join in this construction by providing answers that would document his agency. A question about external factors that caused the change would have invited a different co-construction, and a question about the past promiscuity that ignored the reported change would have initiated a conversation in which the positive change was irrelevant or even doubtful. Thus, all questions are constructive in this first sense. Second, some questions, such as Boscolo's, are also constructive in the ordinary sense of being positive or helpful, offering an affirmative view of the client's life and ability rather than a view of him as unable to direct his own life.

Because the first of these two meanings invokes social constructionism, we should clarify our position within this broad theoretical perspective. One point that the various approaches to social constructionism have in common is a recognition of the importance of discourse in constructing accounts of the social world around us. However, there are more extreme versions (e.g., Potter, 1996) and more moderate versions (e.g., Harré, 1983). We fall at the more moderate end, proposing simply that the presuppositions embedded in a question inevitably construct a version of events that could have been different. In particular we have the greatest affinity for models that focus on the dialogue itself and the process of meaning co-construction by both participants. We do not agree with extreme versions of social constructionism that propose there is no reality, or that any version is as plausible as any other, or that words can mean anything that anyone wants them to mean, or that any perspective is as "good" (useful) as any other perspective.

APPROACHES TO THERAPEUTIC QUESTIONS

Although a consideration of all possible therapeutic questions would seem to be a monumental task, several practitioners have made considerable efforts to describe and document questions. Some therapeutic research has examined the frequency of therapeutic questions (Baldwin, 1987; Long, Paradise, & Long,

1981; Neimeyer, 1988; Snyder, 1963; Stiles, 1987) and also has, in many cases, categorized therapeutic questions in various ways (de Shazer et al., 1986; Fleuridas, Nelson, & Rosenthal, 1986; Jenkins, 1990; Penn, 1982, 1985; Selvini-Palazzoli et al., 1980; Sluzki, 1992; Tomm, 1985, 1987, 1989; White, 1986). For instance, specific approaches have classified various questions with names like "circular," "triadic," "externalizing," "future-hypothetical," "ranking," "interventive," "experience of experience questions," and even "miracle questions." Through a consideration of the mechanisms by which particular kinds of questions might assist in the process of change, practitioners have suggested their questions are releasing information, inviting responsibility, (de)constructing dominant and impoverishing stories, or reframing experience (to name but a few). However, despite these general explanations, curiosity regarding the specific mechanisms by which therapeutic questions work would seem strikingly absent. That is, there has been little attention paid to how details such as the phrasing, choice of words, and implications of these questions can contribute to the transformation of personal difficulties.

Based on McGee (1999), we describe a different approach here. Instead of trying to categorize questions using a priori names according to each question's characteristics, we propose a functional analysis of questions as events in a social discourse. That is, we present an analysis of the process initiated by a therapeutic question, showing step-by-step how questions affect the answerer and subsequent discourse. In order to do so, we propose a detailed model of questions that allows us to understand how therapeutic questions work in psychotherapy. We also argue for a consideration of questions that includes the questioner and the answerer together as they interact in a sequence (i.e., an interactional view of questions). Finally, it will become clear that the questions that we are calling constructive questions in psychotherapy are, at one level, information-seeking questions: The therapist who asked "When did you decide to stop being promiscuous?" did not know when or why the client stopped being promiscuous; the client was the one who had this information and could provide it. However, at another level, the therapist may be introducing new information as well (e.g., that the client made a decision).

THEORETICAL PRINCIPLES

One of McGee's (1999) main contributions is his use of several principles from research on language and communication to the understanding and analysis of therapeutic questions. These principles are *adjacency pairs* (Goffman, 1981; Schegloff & Sacks, 1973), *presuppositions* (Dillon, 1990; Clark & Schober, 1992), *bridging inferences* (Clark & Schober, 1992), and *common ground* (Clark, Schreuder, & Buttrick, 1983). We will introduce and illustrate each of these necessary concepts using examples from training interviews. The first example will always be from an interview by Silverstein (1993), specifically, the second question in the following sequence

Example 2: Olga Silverstein

Therapist:	So. Do you want to tell me what the problem is?
Client:	Um. Well I was trying to pick, ahh—sharing. I um have been in training for the last 3 years to learn a therapy and I have a good friend who is a therapist also, and she wants to learn it now and I don't want her to (laugh). I don't want to share (laugh). [brief digression]
Therapist:	**Ah, How many children were there in your family?**
Client:	Thr. . . (laughter) Ah ha! (pointing at questioner). Three and I'm the middle.

Adjacency Pairs

Schegloff and Sacks (1973) and Goffman (1981) pointed out that question–answer sequences are one instance of an adjacency pair. Adjacency pairs are patterns of two successive utterances, spoken by different speakers, in which the second part of the adjacency pair is relevant and expectable; they are not independent of each other. Examples include greetings ("Hello"–"Hello"), a summons and answer ("Hey Jan"–"Yes?"), and a request and promise ("Please pass the salt"–"Okay"). In a question–answer adjacency

pair, the question evokes an answer, moreover, an answer that fits the question asked.

Example 2, above ("How many children...?"), illustrates a question–answer pair in which the therapist posed a question and the client, as expected, provided an answer that addressed the question. There is a great deal of pressure to answer the therapist's question, and the client would ordinarily do so within a second or less. Therefore, the client is constrained to answer the question instead of, for example, ignoring it, continuing to speak on another topic, or even commenting on the question by asking for clarification (metacommunicating). For example, for the client to state "you're assuming this problem comes from my childhood" would be a digression and not an answer to the therapist's question (i.e., not the second part of the adjacency pair).

Presuppositions

A presupposition is what the question assumes (Clark & Schober, 1992; Dillon, 1990). In most cases of natural conversations, the presuppositions carried in questions are not overtly stated, that is, they are embedded in the question. Any answer to a question affirms the presupposition embedded in the question, even in those cases where the presupposition may not be true (whether false or indeterminate).

Consider the following classic legal example: "Have you stopped beating your wife?" There seems to be no way to answer this question without admitting a serious crime. The question presupposes that the addressee has beaten his wife, and it seeks only to determine whether the beatings have stopped or not. Further, the syntax of the question orients the person to supply an answer in the form of a yes or no response. To make matters worse, the immediate response of denial ("No" with respect to the presupposition) is the worse of the two available answer choices. The structure of adjacency pairs implicitly constrains the addressee to answer this question; the only way to avoid it would be to comment on it (which, strictly speaking, is not an answer).

In Example 2, above, contextual information is needed to understand the presupposition embedded in the therapist's second question ("How many children were there in your family?"). Both therapist and client in this example were psychotherapists and shared a considerable amount of common ground. A common assumption is that there is a relationship between birth order (e.g., being a middle child) and the way in which an adult will later relate to other adults. On the surface, Silverstein's question might seem unexpected and unrelated to the previous conversation. However, the client quickly understood its presupposition that somehow the place that the client had in her family as a child could have affected her present ability to share with others. Notice that the therapist did not explain or justify this presupposition in a preamble but simply embedded it in the question.

Presuppositions, Perspectives, and Bridging Inferences

According to Clark and Schober (1992), an important function of presuppositions is to communicate the perspective of the questioner. They pointed out that presuppositions also require the answerer to make logical connections or bridging inferences between successive turns. In Example 2, the question required the client to make a bridging inference between her description of a current problem about sharing information with a friend and the therapist's question about her birth order. In this case, we could actually see evidence of the client's doing so:

Therapist: Ah, how many children were there in your family?
Client: Thr. . . (laughs). Ah ha! (points at questioner). Three, and I'm in the middle.

Notice that she started to answer, automatically providing her part of the adjacency pair. Then she laughed and interjected an implicit metacommunicative comment ("Ah ha!") about noticing the presupposition in the question. Her subsequent full answer not only answered the explicit question ("Three") but the implicit one ("I'm in the middle"). In so doing, the client accepted a meaningful connection between her childhood and her current situation.

In describing ordinary discourse, Clark and Schober (1992) referred to the connections the addressee

must make as bridging inferences. McGee (1999) prefers to refer directly to the addressee's role in the process, which is one of making sense, as the listener must actively make sense of the speaker's utterance by creating the appropriate discursive context. In Heritage's (1984) words, "hearers must perform active contextualizing work in order to see what descriptions mean, and speakers rely on hearers performing such work in order that their utterances make definite sense" (pp. 147–148).

Creating Common Ground

What is important from a therapeutic perspective is that the answerer must infer and make sense of the therapist's likely intended meaning by forming a bridge that fits between the questioner's presupposition and something in their shared experience. Clark et al. (1983) referred to the accumulated mutual knowledge that interlocutors bring to their conversation as common ground. Common ground is the knowledge, belief, assumptions, terms, and so on, that the participants share before they enter the conversation, which they can therefore draw on in the conversation. The participants also establish new common ground in the course of a conversation, which Clark and Schober (1992) called the *principle of accumulation*. One way that new common ground emerges is through the acceptance of presuppositions embedded in the question. As we have shown so far, a question always contains presuppositions and the answerer often has to make bridging inferences in order to make sense of the question. That is, the answerer must locate something in their common ground that the presupposition(s) can be connected to, identifying the shared knowledge or belief on which the questioner is drawing. In default, it is usually easier for the answerer to accept the presupposition as common ground rather than to question or dispute it.

As we noted in Example 2, common ground was essential for the client to understand the therapist's question. The fact that both of them were psychotherapists made it easier, even "natural" to see the connection between family structure and a problem with sharing. The client did not dispute the presupposition embedded in the therapist's question and, in answering it, she made sense of the question by contributing to the co-construction of what might now be seen as a life-long history of trouble with sharing.

In many conversations, the bridging inference depends on obviously shared and readily available common ground, as in Example 2. However, McGee's (1999) approach to therapeutic questions focuses on those instances in which common ground is being deliberately created. That is, the questioner does not assume that the answerer shares his or her perspective or would even accept it. Instead, the perspective is, so to speak, smuggled in as an embedded presupposition, creating new common ground in a manner that permits the conversation to go on naturally between the two participants, without overt discussion. In Example 1, Boscolo's client may not at the outset have shared the notion that he "decided" to stop being promiscuous, but by providing evidence, he implicitly accepted this possibility as common ground.

THE MODEL

The theoretical constructs explicated above are the building blocks of McGee's (1999) model of how questions work in psychotherapy, but the model itself is a dynamic one and is based on the microanalysis of the communication between therapist and client (Bavelas et al., 2000). The model presented here can be likened to a slow-motion, frame-by-frame analysis of a sequence that is very rapid in real time. We will examine closely what happens from the moment a therapist asks a question, through the client's answer, and continuing a few turns further on. As before, we use one continuing example (Example 3) to illustrate all 10 functions; this excerpt is from Berg and De Jong (2002, pp. 15–16), shortly after the client has answered the miracle question. In some of the steps of the model when we thought it was important, we have also added other examples to further illustrate a particular point.

Example 3: Insoo Kim Berg

> *Therapist:* Rosie, I'm impressed. You have a pretty clear picture of how things will be different around your house when things are better. Are there times already, say in the last two

	weeks, which are like the miracle which you have been describing, even a little bit?

Client: Well, I'm not sure. Well, about four days ago it was better.

Therapist: Tell me about 4 days ago. What was different?

Client: Well, I went to bed about ten the night before and had a good night of sleep. I had food in the house, because I had gone to the store and to the food pantry on Saturday. I had even set the alarm for 6:30 and got up when it rang. I made breakfast and called the kids. The boys ate and got ready for school and left on time. [remembering] One even got some homework out of his backpack and did it—real quick—before he went to school.

Therapist: [impressed] Rosie, that sounds like a big part of the miracle right there. I'm amazed. How did all that happen?

Client: I'm not sure. I guess one thing was I had the food in the house and I got to bed on time.

Therapist: So, how did you make that happen?

Client: Ah, I decided not to see any clients that night and I read books to my kids for an hour.

Therapist: How did you manage that, reading to four kids? That seems like it would be really tough.

Client: No, that doesn't work—reading to four kids at the same time. I have my oldest boy read to one baby, because that's the only way I can get him to practice his reading; and I read to my other boy and baby.

Therapist: Rosie, that seems like a great idea—having him read to the baby. It helps you, and it helps him with his reading. How do you get him to do that?

Client: Oh, I let him stay up a half hour later than the others because he helps me. He really likes that.

And, a little later:

Therapist: I'd like you to put some things on a scale for me, on a scale from 0 to 10. First, on a scale from 0 through 10, where 0 equals the worst your problems have been and 10 means the problems we have been talking about are solved, where are you today on that scale?

Client: If you had asked me that question before we started today, I would have said about a 2. But now I think it's more like a 5.

Therapist: Great! Now let me ask you about how confident you are that you can have another day in the next week like the one four days ago—the one which was a lot like your miracle picture. On a scale of 0 to 10, where 0 equals no confidence and 10 means you have every confidence, how confident are you that you can make it happen again?

Client: Oh, about a 5.

1. Questions Require Answers

As soon as a question has been asked, the answerer is virtually required to participate, to contribute his or her part of the question–answer adjacency pair (Schegloff & Sacks, 1973). In each of the eight adjacency pairs initiated by the therapist in Example 3, the therapist posed a question to the client, and the client responded with relevant answers. Notice that, as one part of an adjacency pair, questions are effective at eliciting answers from the client and returning the turn to the therapist so that the next question can be posed. One feature of such exchanges is that each question–answer sequence tends to return the initiative to the therapist (as described in Step 9 of the model, below).

Furthermore, because questions require answers, they are also useful for interrupting and redirecting dialogue that may be countertherapeutic. To examine this idea, we present a different example in which

Insoo Kim Berg is also the therapist, this time interviewing a couple seeking therapy for their marriage difficulties (Berg, 1995). Berg had begun the interview by asking the husband, Bill, about his work, which quickly led to Leslie's bitter complaints about the amount of time he spent away from home, leaving family duties to her. In the following excerpt, the therapist redirected the conversation with a question about the duration of their relationship.

Example 4: Insoo Kim Berg

Leslie:	Yes, I actually take responsibility for Bill's son by his first marriage, Bill, Jr.
Bill:	On occasion, on occasion.
Leslie:	It's more than one occasion.
Bill:	Not regularly.
Leslie:	When was the last time that you went to pick up Bill, Jr., and took him back home?
Therapist:	Ok, let me . . . let me come back to that, let me come back to that, I'm sure you have lots of issues. Sounds like you . . . **How long have you been together?**
Bill:	7 years.

It is worth noting that the couple broke off their argument for that moment to answer Berg's question on an entirely different topic.

2. The Answerer Must Make Sense of the Question

Because we ordinarily expect a question to be genuine and not trivial, meaningless, or false, the answerer must make sense of the question even if it does not at first appear relevant (Grice, 1975). He or she must contextualize the query, supplying bridging inferences and implicit common ground. In so doing, the answerer begins the process of co-construction initiated by the question. To make sense of the question, the answerer must take the perspective of the questioner. In the metaphor of perspective taking, the question requires the answerer to examine a new vista. It is as if the questioner points in a particular direction and the answerer must stop, look where the questioner is pointing, take in all the background of the scene, and then use this context to formulate a response. The answerer is thus involved in a process of meaning making, using both logic and imagination, in which the questioner's perspective both penetrates the answerer's discursive world and is enveloped by it.

In Example 3, when the therapist asked Rosie, "Tell me about 4 days ago. What was different?" (therapist's second question), the client must make sense of the therapist's question. That is, because many things could be classified as "different" 4 days ago, before the client could identify specific instances of any particular differences, the client first had to determine what kind of difference the therapist was seeking to know about.

Novel or unexpected questions often require considerable effort to understand. The next example came from an interview with a woman who described her spouse as having a "temper problem" and of being "controlling" and "critical all the time." The therapist asked the client to consider her plight from the perspective of partial solutions, rather than ongoing problems. In effect, the questions asked the client to consider what might be working, even if only partially. However, most people come to therapy because things are bad, rather than because things are not worse, so the question was initially confusing.

Example 5: Dan McGee

Therapist:	Why do you think things are not worse?
Client:	What?
Therapist:	Why do you think things haven't gotten even worse, say to the point of violence?
Client:	I don't know. They're pretty bad you know.
Therapist:	Um hum. But what do you think has prevented a total breakdown.
Client:	Well, I think down deep we really do care about each other.

In this example, it took several tries for the client to make sense of the question and to relate it to the presenting problem—especially because many therapeutic approaches would have focused on how bad the problem is and why it is so bad.

3. The Question Constrains and Orients the Answerer to a Particular Aspect of his or her Experience

The topic of the answer is fixed by the question. As de Shazer (1994, p. 97) has pointed out, on the one hand, questions open up possibilities for various types of answers, whereas on the other hand, they simultaneously constrain and limit possible answers (See also Rambo, Health, & Chenail, 1993.) From the very beginning of Example 3, the therapist's first question led Rosie to focus on "things . . . around the house." This question was not one that invited an exploration of her internal world as might be done in response to queries about feeling, thoughts, impulses, drives, and so on.

The therapist's second question constrained Rosie not only to talking about a difference, but about a particular kind of difference, namely, the difference that Rosie had just identified as "better" about 4 days ago. By questioning Rosie about the difference that was better, the therapist was able to evoke a particular kind of description, one of positive change. Finally, starting with her fourth utterance, the therapist's questions located Rosie as responsible for these positive changes, by repeatedly using the pronoun "you" followed by a verb (e.g., "How did you make that happen?" "How did you manage that, reading to four kids?" "How do you get him to do that?"). This phrasing further narrowed the focus of possible answers.

Let's look at a different example of how a question can constrain and orient the answerer to a particular aspect of his or her experience, even though the therapist seemed to be trying to avoid having such an influence. The following question (Wolpe, 1982) is a familiar way to start a session that has come about through a referral.

Example 6: Joseph Wolpe

> *Therapist:* Dr. N has written to me about you, but I want to approach your case as though I knew nothing about it at all. **Of what are you complaining?**
>
> *Client:* I'm afraid of sharp objects, especially knives. It's been very bad in the past month. (p. 63)

Notice, first, that the question constrained the client to talk about herself as a case who is complaining. Second, the question was quite broad; for example, it is likely that the client had a number of different complaints, perhaps related to taxes, the quality of magazines in the waiting room, and so on. However, framing the question with a reference to Dr. N seemed to orient the client to make sense of the question in relation to conversations she has probably had with Dr. N and, therefore, to specific symptoms.

4. In Order to Answer the Question, the Answerer Must Do Considerable On-The-Spot Review Work

Once the answerer has made sense of the question and oriented to the questioner's perspective, there is still more work required. In the process of answering a question, the answerer must review his or her personal experience and knowledge and also may need to draw conclusions or formulate opinions on the spot. This involvement is not trivial; rather, it demands the answerer's attention and concentration in order to provide the requested specifics—the details that infuse the narrative with meaning and render it relevant to and connected with his or her life experience.

To answer the first question about what was different, Rosie had to conduct an on-the-spot review of specific recent experiences that would provide the required details:

> *Client:* I went to bed about ten. . . . I had food in the house. . . . I set the alarm. . . . I made breakfast. . . . The boys ate . . . got ready for school . . . one even got some homework out of his backpack and did it real quick.

In her follow-up question, the therapist referred to the aforementioned details, suggesting "That sounds

like a big part of the miracle," then asking "How did all that happen?" This "how" question encouraged and required Rosie to further review her own decisions and actions that made this "miracle" happen.

In the next excerpt (Strupp, 1986), the therapist asked the client about things he might have done to worsen his relationship with his wife, who later divorced him. The question required a search for details of a different kind of narrative.

Example 7: Hans Strupp

Therapist:	**Were you aware of any of the things you might have done to aggravate the situation or create in part the problem that arose? Somehow or another she was disappointed in you. Might there been other things that somehow made it worse?**
Client:	She complained several times that I was not attentive enough to her. [Goes on to explain in more detail.]
Therapist:	You said earlier that you were strongly in love with her, there was a strong attraction between you.
Client:	Initially yes, when we dated and like I said the first 2 years of marriage.
Therapist:	**So you felt basically that she was somehow disappointed or dissatisfied, displeased in one way or another.**
Client:	Yes . . .
Therapist:	**Were you asking yourself questions as to what you might have been contributing to this or continuing to contribute to this?**
Client:	At that time I first started noticing my own negative thoughts towards my wife and telling myself it was her fault.
Therapist:	**The negative thoughts were what?**
Client:	She's just a bitch, she screwed up.
Therapist:	**You are getting angry at her.**
Client:	Yes . . .

In telling the story elicited by these questions, the client reviewed his personal experience in the marriage and located negative descriptions of his wife and himself. Encouraged to continue with this story, the discourse of his experience appeared to become fixed or even extreme. ("She's just a bitch, she screwed up.") By asking for information within this negative perspective, the therapist led the client to provide evidence that could both document and expand the problem.

5. In Formulating an Answer, the Answerer Does Not Ordinarily Comment on the Embedded Presuppositions

We have endeavored to show that a question has considerable power to embed presuppositions that create common ground and impose the questioner's perspective, and yet this power ordinarily operates entirely implicitly. If the answerer were to evaluate each idea or concept presupposed to exist as common ground, conversation would slow to a crawl. Thus, it is unnecessary, impractical, or even uncooperative to comment explicitly on embedded presuppositions. Furthermore, there is an important difference between stating a presupposition directly (e.g., that the client was responsible for the problems in his marriage) and asking questions in such a way so as to have him "discover" that he did so. The former is open to challenge and debate, whereas the latter leaves little or no opportunity to object.

In our continuing example, the therapist's last scaling question had at least three basic presuppositions on which Rosie did not comment. The first was that there existed a possible scenario in which her problems could be solved. This free-of-problems scenario would have a value of 10 on a scale where the opposite ("worst your problems have been") would receive a value of zero. Note, however, that the therapist did not mention a situation in which problems could get even worse on this scale (i.e., a minus value). A second presupposition embedded in the scale question was that all of Rosie's problems could be integrated into

one single value, useful for measuring Rosie's current state. And, a third embedded presupposition was that the client could place herself on such a scale. In answering, Rosie did not comment on any of these presuppositions; instead, she smoothly accommodated her answer to fit them, saying simply, "Oh, about a 5."

6. An Embedded Presupposition Is Malleable and Can Be Corrected

Because they are not explicitly stated, presuppositions can usually avoid direct attack. If the answerer should challenge the question's embedded presupposition, the questioner can change it in the guise of clarification ("What I meant was. . ."). In example 3, Rosie only challenged minor presuppositions in the therapist's questions, for example:

Therapist: How did you manage that, reading to four kids? That seems like it would be really tough.

Client: No, that doesn't work—reading to four kids at the same time. I have my oldest boy read to one baby, because that's the only way I can get him to practice his reading; and I read to my other boy and baby.

Therapist: Rosie, that seems like a great idea—having him read to the baby. It helps you, and it helps him with his reading. How do you get him to do that?

Notice how easy it was for the therapist to correct her presupposition and incorporate the new one into her line of questioning as a "great idea."

Sometimes, however, a client will challenge a more central presupposition, as happened in a videotape of an unpublished interview conducted by de Shazer in about 1990 with a client who had a long-term drinking problem. de Shazer had asked her some earlier scaling questions (e.g., about money) and was now focusing on the drinking.

Example 8: Steve de Shazer

Therapist: Well let's go, another one then. "Ten" stands for you want to stop drinking or, yeah okay yeah, stop drinking. And um and you want that very badly, as badly as you can want that [Client: Mhm], and "zero" is "well, you know, if I drink I drink, if I don't I don't."

Client: Well, see, I look at that differently [Therapist: Right], 'cause I can't just say "if I drink I drink, if I don't I don't" 'cause sooner or later my . . .

Therapist: Right, that what I said. That's what zero means. Right?

Client: Okay, because I can't say that the way I can say about money though. [Therapist: Right] I can't put them in the same category 'cause [Therapist: Right] sooner or later my health is gonna step in and stop me somewhere. [Therapist: Right] So I got to think about my health: Do I wanna get to the point where I have cirrhosis of the liver and it might be too late to stop? Or do I wanna stop now? That's different.

Therapist: Right.

The therapist's question contained some of the same presuppositions as the scaling question that the therapist had asked Rosie, in this case, that the client could place her motivation to stop drinking on the scale de Shazer offered. The client directly challenged this presupposition ("I look at that differently") and expressed a different perspective, namely, that the sole issue was when she wanted to stop. The therapist quickly agreed and seamlessly moved over to the client's perspective.

7. Once the Answerer Has Responded, the Very Act of Answering the Question Implicitly Accepts the Embedded Presuppositions as Common Ground

Returning to Example 3, after Rosie's responses, both she and the therapist had accepted the success of

the bedtime story as having been engineered by Rosie; this was now common ground. It would no longer be appropriate for the client to characterize herself as an incapable parent, given the exceptions to the problem she has described and elaborated; these particular questions and answers appear to have co-constructed a new view.

8. The Answer Is Owned By the Client, Not the Therapist

Because the client must provide information that the therapist does not have, he or she discovers and presents information consistent with the embedded presuppositions. So whether the client discovers, on one hand, abilities and positive qualities or, on the other hand, disabilities and pathology, he or she has been intimately involved in co-constructing this new common ground.

In our first example, the particular facts upon which Rosie was basing her conclusion were, for the most part, known only to her. In other words, she generated the data herself, she collated the data herself, she subjected the data to her own methods of analysis, and she reported the results herself. It would be difficult indeed for her to say that the conclusions were spurious or merely the therapist's opinion.

Similarly, in Example 6, the client's answers documented his contributions to the problems in his marriage and his "negative thoughts" about his wife. In response to the therapist's questions, he provided unique details that co-constructed a decline into blame and anger.

9. When the Question Has Been Answered, the Initiative Returns to the Questioner, That Is, to the Therapist

So far, we have shown that a great deal happens within a single question–answer adjacency pair. For the last two steps, we will look briefly at what follows. Coulthard (1992) pointed out that, in many contexts, questions initiate an alternating three-part pattern of: (1) question, (2) answer, (3) follow-up. That is, after the client has answered, the therapist has the follow-up slot, with the opportunity both to comment on the answer (e.g., to reformulate it) and to initiate another question. This was especially clear in the interview with Rosie, in which the therapist constantly used the follow-up slot to move from locating a bit of the miracle, to getting the full details, to gradually leading Rosie to take responsibility for her own achievement. The therapist was able to persist on the same topic because each answer gave her back the turn, with the opportunity to comment on Rosie's answer and then pose a new question. The therapist can be like a tennis player holding the serve and in control of the ball, maintaining the initiative as the turn repeatedly returns to him or her.

10. As Conversations Move Rapidly Ahead, It Becomes Increasingly Difficult To Return To Earlier Embedded Presuppositions

In example 3, a transformation occurred in Rosie's narrative. Hypothetical possibilities based on an imaginary miracle scenario became actual competencies displayed by Rosie on a recent occasion. The assumption of a miracle, as well as Rosie's recent experience of "a big part of the miracle" could hardly be challenged now, even though these were never explicitly discussed. Furthermore, these assumptions were now common ground, shared between the therapist and Rosie, which allowed the therapist to ask Rose (in her last question) about the possibility of having another "miracle day" in the next week. Similarly, after the key question in the Silverstein interview (Example 2), they proceeded with a discussion of the interviewee's childhood experiences with sharing, and Strupp and his client (Example 7) continued to discuss his individual weaknesses and their possible causes.

CONCLUSION

The purpose of this article has been to outline a model of questions that microanalyzes how they operate within the therapeutic context. This model can be an analytic tool for therapists, to help them

make visible the impact that questions can have on the therapeutic conversation. To understand the process initiated by a therapeutic question, it is necessary to focus on both questioner and answerer at the level of microanalysis. We have proposed that microanalysis can help to identify possible discrepancies between theories of what happens and what we can observe when therapists and clients do therapy. More broadly, we are proposing an empirical approach to social construction in which the process of construction is examined in the details of the interaction.

It is important to point out that our purpose here has been to analyze processes and not outcomes. That is, we were interested in uncovering the subtleties involved in the action of asking and answering questions, and we make no assertion regarding the efficacy of the therapeutic approaches used as examples. Further, we did not discuss the theory or the specific therapeutic technique behind any of the particular approaches described here, rather we limited our work to an analysis of the talk. Finally, the present examples were limited to written discourse. We did not include either the prosodic aspects of discourse (e.g., intonation, stress) or the equally important informative visual features such as facial displays, gaze, or gestures.

Several directions for future research are possible. McGee (1999) has used the model to compare various therapeutic approaches by examining the differences in their questions. He distinguished between "alternative" and "traditional" paradigms in psychotherapy according to use of questions by each therapeutic approach and offered several examples of each paradigm, which can be valuable for therapists interested in critically reviewing their own work while learning to do microanalysis. We hope that the model proposed here can further assist practitioners in doing research on their own practices (i.e., evaluating their own questions and those of others). Furthermore, it is possible to test the effect of specific questions in experiments outside of psychotherapy. For example, Healing (2004) conducted an experimental test of Jenkins's (1990) use of questions designed to invite offenders to take responsibility for their actions. Using an innocuous task, she tested whether varying the wording of questions could affect both perceptions of responsibility for one's actions and future task performance. Questions that presupposed personal responsibility (versus external causes) were significantly more likely to lead the addressees to describe themselves as the agent or cause, an effect that was still present when tested a week later. In addition, their task performance was significantly better than those who answered questions about external causes.

Finally, we want to emphasize that in the context of psychotherapy all questions are constructive because they offer a perspective that the client is very likely to join in with and contribute to. Asking about success can create conversational space for an account filled with positive and helpful details, while asking about failings will probably to lead a very different perspective of the same life. Therefore, it is important to understand that asking a question is not a benign act, particularly within the therapeutic context. The Nobel physicist Isaac Isador Rabi said, "There are questions which illuminate, and there are those that destroy. [We should] ask the first kind." Therapists who have cultivated an appreciation of the efficacy of questions understand that to question is to wield a powerful linguistic blade. It is necessary to ensure that the blade is used to reveal strength and beauty rather than to carve away these same qualities. By understanding in detail how questions function interactionally over the course of a therapeutic conversation, we can sculpt questions of Rabi's first kind, questions that better assist our clients to identify options for enhancing their abilities and qualities, ones that McGee (1999) called doubly constructive questions. Questions recruit both imagination and logic within a powerful combination of human creativity and reason. The elegantly finessed constructive question provides the person seeking therapy with the opportunity to enter into a unique and prophetic moment. It is our privilege and responsibility to craft our questions with much care.

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NOTES

[1] This article is a shortened and modified version of the original work by McGee (1999).

[2] We have changed some irrelevant identifying features of unpublished examples to ensure clients' confidentiality.