

8. Language and Behaviour Patterns in a Therapeutic Interaction Sequence

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Abstract. The goal of this study is to describe an interaction sequence between a therapist and a patient. This sequence is extracted from a psychoanalytically oriented psychotherapeutic session that was filmed and transcribed. The selected sequence meets a specific criterion: to observe and analyze verbal and non-verbal dialogue in a series of patient-therapist exchanges that encourage the patient to change his thinking about the cause of his symptoms. We seek to specify the interactive conditions under which a form of insight is produced that we consider the key and driving factor in all psychotherapy. Two types of analysis were conducted: a hierarchical semantic analysis and an analysis of temporal behaviour patterns using the THEME program. The results show that therapeutic interventions first result in a deconstruction of the patient's initial point of view, followed by reinforcement of the patient's new point of view by means of confirmation. In this phase of reconstruction, the patient is led to reinterpret his symptoms along the lines encouraged by the therapist. The analysis of temporal patterns shows that (a) the deconstruction phase involves many non-verbal signs associated with challenges to the patient's statements, and (b) that certain themes in the patient's discourse are regularly associated, throughout the sequence, with gestures and hand movements that might constitute these themes' gestural signature. Therapeutic influence, far from being ineffable and based on therapists' impenetrable charisma, derives from concrete actions and an interactional approach that can be described and used in the psychotherapeutic training of university students.

Keywords: Psychotherapy; language; behaviour pattern; THEME.

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8.1 Introduction

Since the famous “cigarette scene,” which describes in great detail a short sequence from a psychological interview between a therapist and his patient [1], few similar studies have been conducted until the present time. Is this because the author demonstrated the limitations of this type of study by addressing the problem of the level of observation and analysis of short interactive sequences? Or is it because the psychological interview seemed so complex that any precise description risked being reductive and therefore not generalisable? We have nevertheless decided to apply the techniques of language and behavioural analysis to a brief sequence from a psychoanalytically oriented psychotherapeutic interview. There currently seems to be a wide range of psychotherapeutic situations and therapeutic theories and within the same approach, practice seems to depend more on the therapist’s personality than on any dogma or clinical manual [2]. In this landscape of undefined contours, we wanted to observe and describe how a therapist interacts with his patient. We believe that this interaction, which consists of encouraging a patient to change his viewpoint and discourse about a subject of direct concern to him, is the paradigm for all psychotherapy. We also think that psychotherapy is defined less by theory or the practice of this theory by patients and therapists than by the actions taken jointly by the therapist and patient. The common thread linking all psychotherapies may therefore reside in the similarity of concrete language and behavioural actions, even rituals, carried out in part or full by every psychotherapist. In our view, this perspective justifies the highly detailed analytical work that must be conducted to understand these various psychotherapeutic behaviours.

8.2 The therapeutic interaction

8.2.1 Evaluation of psychotherapies

Psychotherapeutic practices are observed in all contemporary cultures and they seem to have existed throughout history. They are consubstantial with human anxiety, cultural ritualisations and the existence of treatment practices. In today’s environment of hundreds of psychotherapeutic techniques, the evaluation of their efficacy is more important than ever. The many studies conducted over the past 50 years [2] show that overall psychotherapies have little efficacy but are rather effective. The concept of efficacy involves the achievement of a specific goal (for example, the disappearance of a particular symptom), while the concept of effectiveness involves the non-specific effects of the therapy on the patient (for example, improvement in the patient’s quality of life). In fact, overall studies or meta-analyses do not take into consideration the many different factors that occur during psychotherapy, which is a highly complex interactive situation. It has already been demonstrated [3] that therapeutic effectiveness is better explained by the relationship the professional establishes with his patient than by the application of a particular technique. These are non-specific factors inherent in any human relationship that allow us to explain the positive effects of any type of therapy. A number of factors characterizing this relationship have already been described [4], including the following: (i) an intense, emotional and trusting relationship with the helper, (ii) the use of a model or explanatory myth that allows the helper to understand the patient’s suffering, (iii) the addition of new information and concepts concerning the nature of the patient’s problems, their possible origin and possible alternative behaviours, (iv) an awakening of hope in the patient that he can be cured, based on his recognition of the therapist’s personal and professional qualities, (v) the patient’s experience of improvement, which strengthens his

self-confidence and the psychotherapeutic treatment, and (vi) development of the patient's ability to feel and identify his emotions. In a recent publication, Lecomte et al. [5] provide a remarkable summary of this issue. They show that the patient-therapist relationship and the therapist's contribution to the establishment of this relationship is the best criterion for distinguishing between effective and less effective psychotherapy. These results, which demonstrate the importance of the patient-therapist relationship in psychotherapy, lead to recommendations about the training of psychotherapists and the need to conduct research that focuses on the behavioural characteristics of this very special interaction. In fact, any psychotherapy can be described as a sort of conversation that includes specific constraints.

8.2.2 *A specific type of conversation*

This conversation can be seen as having an asymmetric structure and being fundamentally oriented toward a process of influence.

The conversation's asymmetric structure results from differences between the patient's and therapist's degree of verbosity and nature of discourse. The patient primarily talks about his life, while the therapist listens and occasionally interrupts to reflect back, reorganize and interpret the patient's statements. The therapist therefore responds to the information communicated by the patient in real time. Three components – referential (state of the world), modal (psychological state) and illocutionary (intention to act) – are simultaneously taken into account but the illocutionary component, which represents the speech acts carried out by the patient, is an essential factor in the therapist's analysis of the patient's discourse [6].

The therapist's act of listening is not comparable to a recording of data. Instead, it produces meaningful activity, bringing about the operations of selection, inference and comparison relative to the interview's objectives. The act of listening is similar to diagnostic activity [7] as it seeks to evaluate behavioural changes and patient reactions in response to the therapist's promptings. It is fundamentally a process involving self-reflective awareness [8]. Indeed, the therapist's evaluation of his own interventions and their effects cannot rely solely on the patient's immediate responses, as we shall see. Because listening is driven by objectives, it is guided by prior hypotheses that are either based or not based on a theoretical frame of reference. It is a cognitive behaviour that consists of obtaining clues, producing hypotheses, interpreting these clues and testing the hypotheses by obtaining yet more clues.

During the interview, the psychotherapist constructs a meaningful structure, from which he develops interventions. These interventions convey to the patient an approximate reflection of the psychotherapist's listening techniques. They also help initiate the influence process that will allow the patient to reconsider the meaning he gives to his life and symptoms. This influence process triggers and drives the effects of change observed in patients' representations and behaviours [9]. The process is therefore comprised of factors that constitute the clinician's therapeutic function.

The quality of treatment is primarily based on the therapist's inferential behaviour. This behaviour does not rely on the concept of truth but on the notion of relevance. As a result [10], the efficacy and evolution of a therapeutic interview largely derive from the quality and validity of the therapist's clinical inferences and judgments. But what are the principles on which these therapeutic inferences are based? In other words, which principles distinguish these therapeutic inferences from conversational inferences? According to Labov and Fanshel [6], the therapist's listening behaviour mainly focuses on two phenomena that emerge from the patient's discourse: factual contradictions and emotional expression.

For example, in the case carefully analyzed by these authors, the patient, “Rhoda,” presents with anorexia and discusses family problems involving her mother and aunt. Her mother has left the home to live with her other daughter and Rhoda lives with her aunt (mother’s sister), who makes her do all the household chores, including cleaning, shopping, cooking and dishwashing, in addition to her homework. The patient believes her behaviour toward her mother and aunt is irreproachable. For example, she called her mother to ask for help, but states that her mother never offers to help her. She made the same request of her aunt, but she states that her aunt does not give her any concrete help. As for her weight loss, the patient claims that she eats normally, but her weight is actually far from normal. The therapist cannot resolve these contradictions, but he observes them and underscores the importance of the problem by focusing his attention on the patient’s verbal inconsistencies. According to Labov and Fanshel [6], this gives rise to the necessity to discover the patient’s psychological defenses and the emotional problems that underlie her repeated failure to assert what she believes are her rights.

Emotional expression is largely conveyed by intonation. The authors demonstrate (by analyzing verbalization wavelengths) that the paraverbal system of the patient’s discourse reflects an emotional semantics that is often taken into account by the therapist as he develops his understanding of the problem parallel with the patient’s own understanding.

This therapeutic function is therefore closely related to the therapist’s thought process, which leads the patient to recast his representational systems in a more efficient, and therefore more logical, manner. As a result, it can be demonstrated [11] that the therapist’s interventions tend to create new semantic links between the major themes of the patient’s discourse. The new verbal construction encouraged by the therapist is therefore essential to the effectiveness of treatment. This new verbal construction, however, cannot be dictated to the patient from the “outside”; the patient must develop his own new representations and conceptions. This change was described as a high point of therapy, during which the patient became more convinced of his beliefs. This heuristic process of an internal reshaping of beliefs is generally called “insight.” To our knowledge, there are no studies that attempt to describe the language and behavioural interaction underlying the mechanism of patient insight.

The therapist’s verbal and non-verbal interventions are technical tools whose objective is to modify the patient’s discourse and, correlatively, his way of thinking. Curiously, there is little clinical and scientific literature that seeks to observe and explain the nature and effect of these interventions, while most case narratives give considerable weight to “the therapist’s words, which have the power to cure.” The famous study by Birdwhistell [1] discusses the methodological problems inherent in this type of analysis. In particular, it raises the following question: “At what level of description should we conduct the analysis using the defined units? With slow-motion and stop-action techniques, a single moment in time can be captured, following the example of the “cigarette scene” [1].

In this chapter, our objective is to describe the moment in which the patient modifies his representation in response to the therapist’s encouraging attitude. We will describe all the language and behavioural processes involved in the development of interactive insight. To conduct this study, we selected an excerpt from a dialogue between a psychoanalyst and his patient – an excerpt that clearly includes a change in the patient’s point of view in response to therapeutic interventions.

8.3 Therapeutic interaction sequence

To describe and analyze a therapist-patient interaction leading to a process of therapeutic change, we chose a sequence comprised of nine turns at speaking from a set of videotaped

interviews. During this sequence, the patient, responding to the therapist's interventions, is encouraged to radically change his representation of reasons for taking heroin. The selected sequence satisfied several requirements. The sequence had to include a change in the patient's discourse (a statement made by the patient at the beginning of the sequence had to be modified by the same patient by the end of the sequence). This change had to clearly result from the effects of the therapist's interventions. The sequence had to be short so that the analysis could include the relevant verbal and non-verbal elements in the explanation for the observed change.

8.3.1 Analyzed data

The verbal data come from an interview between an experienced psychoanalyst specializing in the treatment of drug addicts and a patient who is a drug addict. The psychoanalytically oriented therapy is conducted face-to-face. The patient, age 30, has been addicted to heroin for several years and is undergoing withdrawal. The psychotherapy's goal is to support the patient during withdrawal and reduce the probability of a relapse. The interaction is excerpted from the third session.

8.3.1.1 Recording context and conditions

The sequence is recorded with the full agreement of the patient and therapist. Two video cameras (Figure 8.1) simultaneously filmed the patient and therapist in such a way that the final videotape shows a wide-angle frontal view of each person, including the tops of the legs. The sequence lasts one minute and 16 seconds.



Figure 8.1 Filmed sequence with two cameras

8.3.1.2 The actual sequence

(P1) Patient: I feel alive to some extent but at the same time, I feel like I've been dead for some time, you know? You see, I mean...

(T1) Clinician: Dead

(P2) Patient: Yeah, yeah, dead because I wasn't alive; it wasn't me who was alive. I was living through heroin. It wasn't me expressing myself, you know?

(T2) Clinician: You said "dead"; you didn't say "hibernating."

(P3) Patient: No, I can't say I was hibernating because somehow through heroin I was also searching for a kind of death.

(T3) Clinician: You think so?

(P4) Patient: Well, yeah, somehow I was...

(T4) Clinician: You thought that.

- (P5) Patient: Yeah, it was kind of like self-destruction; at the beginning it was...
- (T5) Clinician: You really think so?
- (P6) Patient: Oh yeah, to be honest, yeah, to be honest. And then at the beginning, heroin made me feel pretty good; it let me express myself in a certain way.
- (T6) Clinician: And then...
- (P7) Patient: And then it started to really bother me, you know?
- (T7) Clinician: Destruction if...
- (P8) Patient: Yeah, no – but then, then, I found that heroin led to my destruction. I couldn't stand it anymore; it made me feel bad; it really bothered me, you know, but unfortunately I needed it to exist.
- (T8) Clinician: To exist.
- (P9) Patient: Yeah, to exist but at the same time I was showing off.

8.3.1.3 *Descriptive analysis of the sequence*

In this sequence, the therapist reacts to a statement made by the patient that does not meet the therapeutic objectives. In fact, the main hypothesis underlying this type of therapy is the concept that the patient is treating himself with drugs (self-medication). Psychotherapy can thus focus on the mental suffering that the person is seeking to alleviate with chemical substances. As a result, the therapist cannot allow the patient to say that he is taking drugs to kill himself. At the same time, this representation of death-seeking corresponds to a social stereotype that is not compatible with the therapeutic experience, which consists of saying what one feels. For the therapist, the patient's impression of being dead provides a less satisfactory account of the experience (its role in the subject's background and desires) than the impression of hibernation. The therapist therefore suggests a second version (T2) of the modality associated with taking drugs. The consent of the patient (P3) is indicated by the term "also."

This passage helps us better understand how a patient concept that the therapist believes to be mistaken or incomplete can be changed by suitable therapeutic interventions. All such interventions are geared toward one objective: to modify the patient's version of seeking death through drugs and to make sure he understands that drugs are filling a certain need, allowing him to treat his mental suffering. Treatment involves moving from one semantic framework to another, throwing lifelines likely to be accepted by the patient. These mediations provide the patient with a rationale that is more likely to lead to a favorable outcome. In this excerpt, the therapist's interventions (T1), (T3), (T4) and (T5) first reflect an implicit challenge to the patient's "resistant" point of view, then a logical conclusion (T6) and (T7) that reinforces the patient's modified discourse.

This sequence demonstrates how therapeutic persuasion and influence can change patient representations by:

- a) encouraging patient discourse so that the therapist can gain an understanding of the patient's contradictions;
- b) confronting the patient with his contradictions;
- c) encouraging the patient to change his concepts in line with his own discursive logic.

8.3.2 *Analytical method*

First, we submitted the therapeutic interaction sequence to a hierarchical structural analysis to demonstrate the construction of the discourse during therapy. This analysis reveals the ways in which the interaction and discourse develop. We will show that the entire interaction is comprised of two complex components. One involves refinement and thematic explication while the other involves reinterpretation and thematic expansion.

Next, we will analyze the sequence using THEME software [12]. We will show how the behaviours of the therapist and patient are composed of meaningful patterns. We will focus on a joint analysis of verbal and non-verbal elements. With this analysis, we wish to demonstrate how the various components of the interaction work together. Verbal and non-verbal sign systems are not independent; an interlocutor uses both registers, verbal and non-verbal, to interpret the meaning of an utterance [13]. Moreover, we assume [14] that many different behavioural patterns will convey the intensity of the patient-therapist relationship.

8.3.2.1. Hierarchical semantic analysis

Analyzing the structural and functional organization of the conversation consists of studying the relationships among speech acts in order to understand the architecture of the resulting discourse. According to the Geneva theory [15], conversations are comprised of three components: the exchange [E], the intervention [I] and the speech act. Simple interventions are distinguished from complex interventions. A simple intervention means that one of the interlocutors speaks and therefore carries out a speech act [16]. A complex intervention includes speech acts, interventions and exchanges; as a result, conversations are analyzed on the basis of complex interventions [17]. An exchange is a linear series of at least two interventions uttered by two different interlocutors.

For example, figure 8.2, a formal diagram of a conversation excerpt, illustrates an initial model for structuring the various components. The diagram shows that during his first statement (P1), speaker P made an assertion, indicated as simple intervention I_{11} , after which speaker T, during his first statement (T1), made a request. T thus opens a first exchange (E_1), one of whose branches is the intervention containing the request and whose second branch is supposed to contain the response to this request. However, the expected response turns out to be complex because it is composed of several turns at speaking; in fact, the response itself generated a request, which waited for a response that also turned out to be complex, etc. One therefore observes that the more the conversation progresses according to this first structuring model, the further it strays from the initial question that awaited a response. The conversation thus progresses according to a retroactive or bottom-up structure. This structure is formally represented by a rightward expansion because, in order to diagram the structure, it is necessary to retrace the path of the conversation to the most dominant feature.

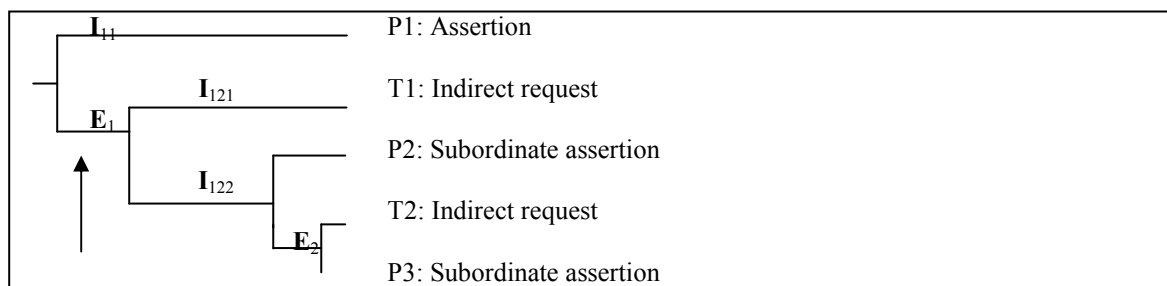


Figure 8.2 Retroactive and bottom-up structure

Figure 8.3 illustrates a second way of structuring the conversational components. On the one hand, exchange E_n makes way for intervention I_{n+1} , but on the other hand, the appropriation of exchange E_n takes place due to intervention I_{n+1} . In other words, the occurrence of component I_{n+1} in the conversation requires a reinterpretation of the previous component, E_n , because it is subordinate to I_{n+1} . The sequence (P8, T8, P9) progresses

according to a proactive or top-down hierarchical structure and this structure is formally represented by a leftward expansion.

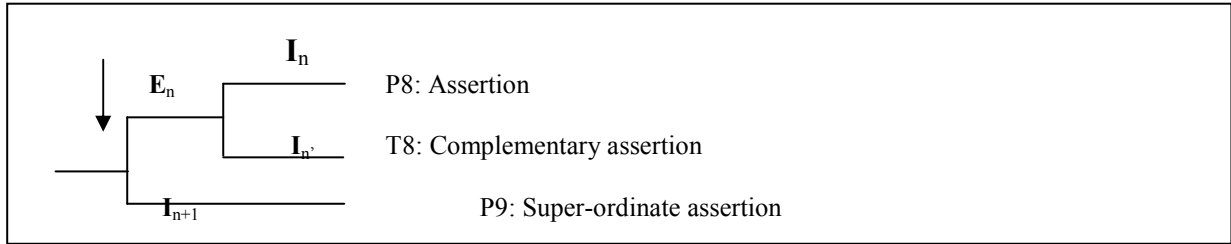


Figure 8.3 Proactive or top-down structure

This analysis illustrates interlocutors' subordinate or subordinating actions during a dialogue. It should be noted that the Geneva School [15] does not provide precise decision-making criteria for distinguishing a subordinating intervention from a subordinate intervention. According to other authors [17], analyzing the property of a speech act to which its successor is linked allows us to define the hierarchical structure of a conversation: *"negotiating the conditions of success for a request finds conversational expression in the appearance of a subordinate exchange"* ([17], p. 212).

8.3.2.2 Analysis of the temporal structure of THEME interactions

The temporal structure of interactions was analyzed using THEME software. It should be recalled that the basic principle underlying this software consists of revealing behavioural patterns in the patient-therapist dialogue as well as patterns in the behaviour of each individual. In the first stage, we selected frequent and obvious language and gestural behaviours that occurred during the sequence. To avoid the stumbling blocks of a microanalysis, such as the one conducted by Birdwhistell [1], we decided to select the most salient language and behavioural elements for encoding. This selection is based on the observable principles of communicative acts. From a language perspective, the selection includes speech actors, the major types of verbs used, key thematic references and different discourse markers. From a gestural perspective, the selection includes eye movements, direction of gaze, movements of the head, hands and fingers, and changes in posture. An encoding table was created for all encodings (Table 8.1).

ACT	B_E	SUJ	ATT	BUT	MOD	TEM	CON	YEU	REG	TET	EXP	MAI	DOI	POS
pa	b	p	cr	mo	o	av	ca	hau	dro	d	sou	ouv	tou	chg
th	e	t	di	vi	n	ap	ad	cli	gau	H	cri	fer	btt	
	:		ds	he	at	pd	op			g			cro	
	&		da	hi	pas	du								
	*				af									

Table 8.1 Encoding table. Legend: ACT: Actors (pa: patient; th: therapist); B-E: Beginning/End (b: beginning; e: end); SUJ: Subject uttered in the proposition (p: patient; t: therapist); ATT: Propositional attitude verb (cr: believe; di: say; ds: desire; da: bother;); MOD: Modalisation (o: yes; n: no; at: attenuation; pas: negation of phrase; af: affirmation); TEM: Modalisation of time (av: before; ap: after; pd: during; durant: for); CON: Connectives (ca: cause; ad: addition; op: opposition); YEU: Eyes (hau: up; cli: blinking); REG: Gaze (dro: right; gau: left); TET: Head (d: right; h: up; g: left); EXP: Expression (sou: smile; cri: tension); MAI: Hands (ouv: open; fer: closed); DOI: Fingers (tou: touching; btt: drumming; cro: crossed); POS: Posture (chg: change).

In the second stage, the beginning and end of the behaviours were encoded on a time scale of $1/25^{\text{th}}$ of a second (Table 8.2). One observes that at $72/25^{\text{ths}}$ of a second, the patient begins to raise his eyes, at $73/25^{\text{ths}}$ of a second, the therapist begins to blink his eyes, at $93/25^{\text{ths}}$ of a second, the therapist stops blinking his eyes, etc.

Time in $1/25^{\text{th}}$ of a second	Events
...	...
72	pa,b,hau
73	th,b,cli
93	th,e,cli
106	pa,e,hau
108	pa,b,cli
110	pa,e,cli
123	pa,b,hau
147	th,b,cli
147	pa,b,vi
148	pa,e,hau
152	pa,e,dro
152	pa,e,tou
154	pa,b,btt
155	pa,b,ouv
...	...

Table 8.2 Table of behavioural and time data

In the third stage, the THEME software analyzed the behavioural and time data. The search for interactive patterns reveals behaviours that tend to occur together in a significant manner. For this analysis, we chose the significance level of $p < .001$.

8.4 Results

The results of the analysis indicate an initial hierarchical structure that conveys the therapist's and patient's speech acts and a second structure comprised of behavioural patterns that illustrate the intense relationship between therapist and patient at this stage, during which the patient's representations are being reshaped.

8.4.1 Hierarchical analysis

Viewed from above, this sequence is an example of embedding, with an upper-level structure comprised of two complex components: a complex constituent α (P1...P6), which gives rise to a subordinating complex constituent β (T6 ... P9). This is illustrated in figure 8.4.

8.4.1.1 Analysis of the sequence's first constituent: α

α is mainly comprised (4 times out of 5) of the clinician's (T) simple interventions and the patient's (P) complex interventions; the two speakers thus construct a series of five successive exchanges. The exchanges succeed one another in a relationship of subordination, with the last exchange, E_5 , subordinated to the first, E_1 , which can be represented as an embedding of brackets: $\{E_1[E_2[E_3[E_4[E_5]]]]\}$.

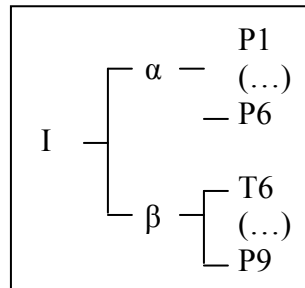


Figure 8.4 The sequence's two complex constituents

Figure 8.5 demonstrates that it is the clinician's implicit challenges [18] – during exchanges E_1, E_2, E_3, E_4, E_5 – that generate the opening of subordinate exchanges. The patient responds to the clinician's use of encouragers, which prevents a closing-off of the dialogue. These encouragers have the opposite effect of signs of agreement, which would have given rise to simple three-part exchanges [15]. As a result, the clinician keeps the dialogue going and due to T_1, T_2, T_3, T_4 and T_5 , the patient is encouraged to:

- to explain (develop) what he means by, “I feel like I've been dead,” arguing (elaborating) his point of view (enunciative justification)
- explain and reaffirm his initial assertion (illocutionary justification)
- support his utterance (“because” could, for example, be replaced by “since”)

In these three cases, the Geneva School [15] supports an argument-directive act structure in which the argument, of course, is subordinate. It therefore appears that complex constituent α generally shows a rightward expansion (or bottom-up or retroactive) that locally integrates proactive levels (top-down, leftward structural development).

8.4.1.2 Analysis of the second constituent of the sequence: β

The second complex constituent, β , depends on the first series of exchanges. It is initiated by the clinician in T_6 by the utterance of “then,” a consecutive connective [15]; the second complex constituent β is thus in a subordinating position to the first major constituent α .

In this second part, the interaction allows the semantic contrast of “bad drug (“destruction”) versus a good drug for self-treatment” to appear explicitly in P_8 . The connective, “but,” in P_8g invalidates and rejects the preceding utterances and gives way to a version in which the drug allowed the patient to treat his mental suffering. The strength of the reiteration (“to exist”) in T_8 leads to an intersubjective construction of this version. It is thus the process of influence (acceptance of the clinician's point of view) and the patient's reinterpretation of his initial discourse (death => to exist and to show off) that brings the exchange to an end. This is illustrated in figure 8.6.

An analysis of the sequence's hierarchical structure shows how the dialogue is conducted by the therapist, who indirectly encourages the patient to explain and justify his initial utterance by means of repetitions that implicitly challenge the patient's arguments. Afterwards, the patient is encouraged to reinterpret his reasons for taking drugs in line with the therapist's theory. The influence mechanism is apparent, but it also relies on non-verbal interactions.

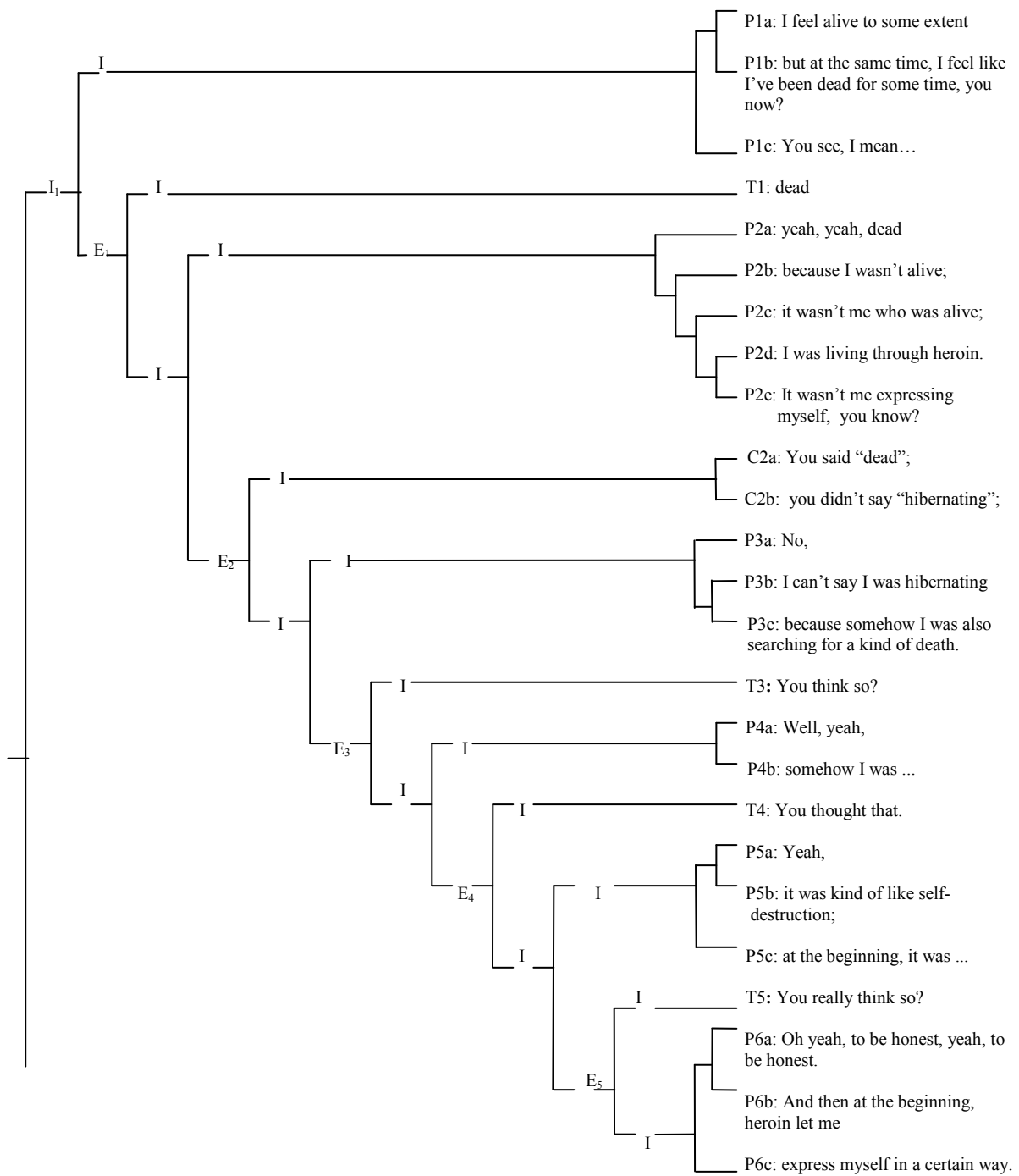


Figure 8.5 Complex constituent α

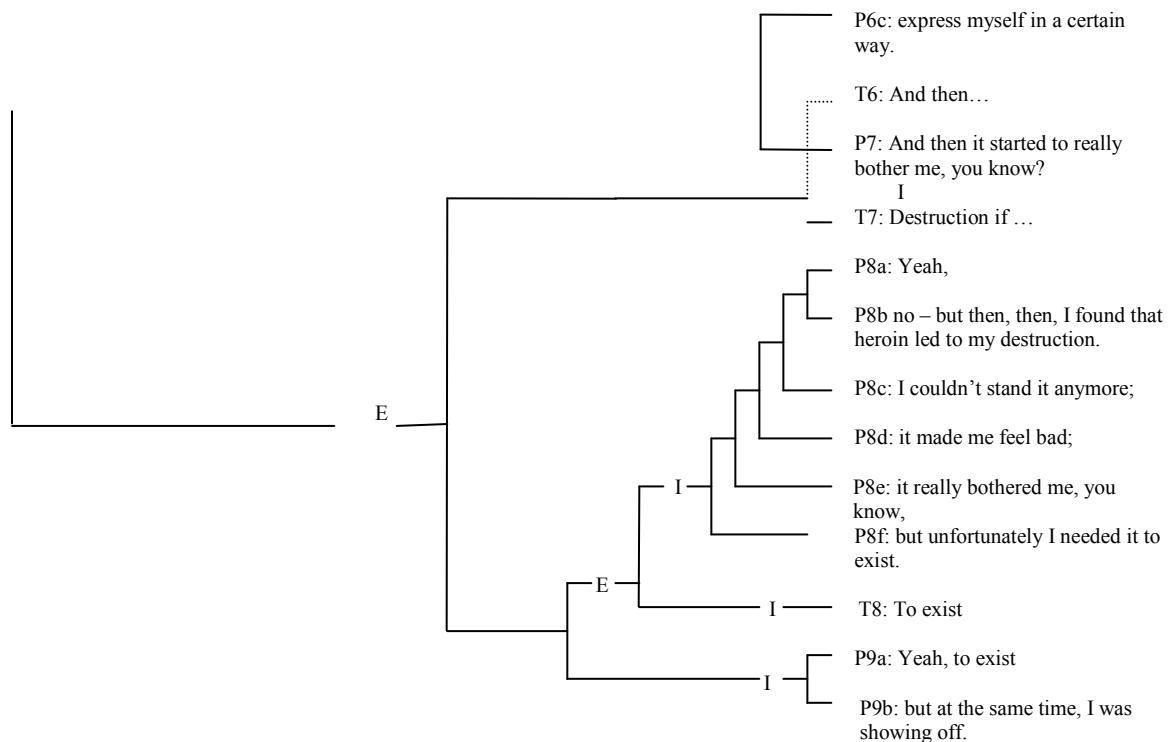


Figure 8.6 Complex constituent β

8.4.1.3. Overall analysis of the sequence

In part α (P1 to P6), the patient-therapist interaction is based on the therapist's indirect challenge to the patient's P1 assertion. In this first part, the therapist encourages the patient to develop a discourse that leads him to contradict his first P1 assertion. The therapist largely proceeds by indirectly challenging the patient's sincerity ("You think so?").

This stage is marked by a conflictual elaboration of the patient's discourse, which produces a deepening of this discourse.

In the second part, β , the exchange initiated by the intervention (T6) – "And then" – creates a collaboration aiming to draw conclusions from the new assertions uttered in the first part, α .

This phase is marked by a collaborative elaboration of the patient's discourse, which produces an expansion of this discourse.

8.4.2. Analysis of behavioural patterns

For this analysis, we are first going to consider the patterns that characterize the patient-therapist exchanges, then the patterns that appear in the patient's discourse. It should be recalled that the exchange includes a conflictual phase and a collaborative phase. The beginning of the collaborative phase (T6) is indicated in the figures illustrating these patterns.

8.4.2.1. Analysis of interactive patient-therapist patterns

The first pattern characterizes the linkage between the patient's discourse and the therapist's interventions. The "you think so" interventions follow the patient's attenuations, such as "to some extent, somehow, to be honest, in a certain way," after which the patient agrees by saying "yeah" (Figure 8.7). It is as if the therapist were stepping into the breach created by the doubt expressed by the patient. This type of pattern only occurs in the first part of the sequence (before the change in the patient's point of view, supported by statements T6, T7 and T8).

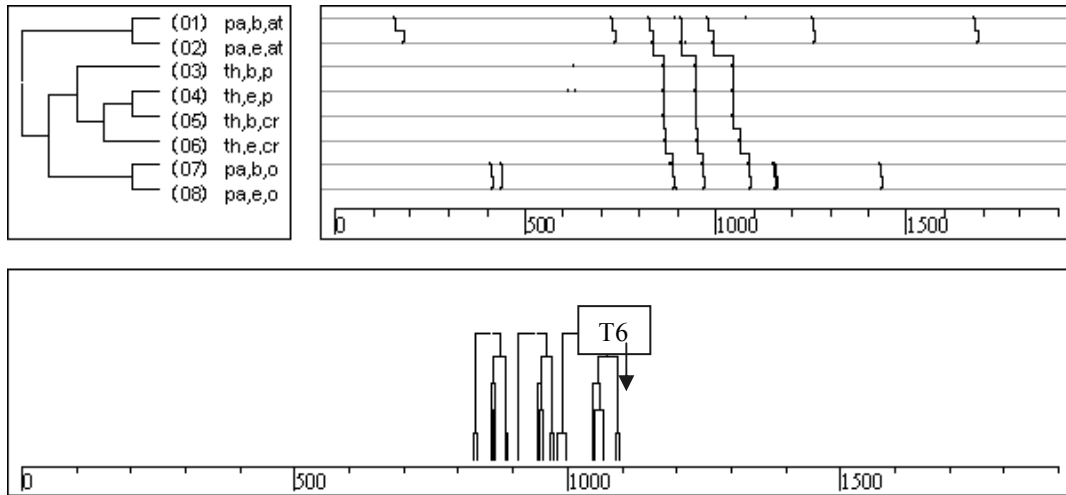


Figure 8.7 Patient's attenuations, therapist's interventions and patient's confirmations

In the following pattern, the patient's attenuations and expressions of doubt are linked with non-verbal signs communicated by the therapist's eye-blinking (Figure 8.8).

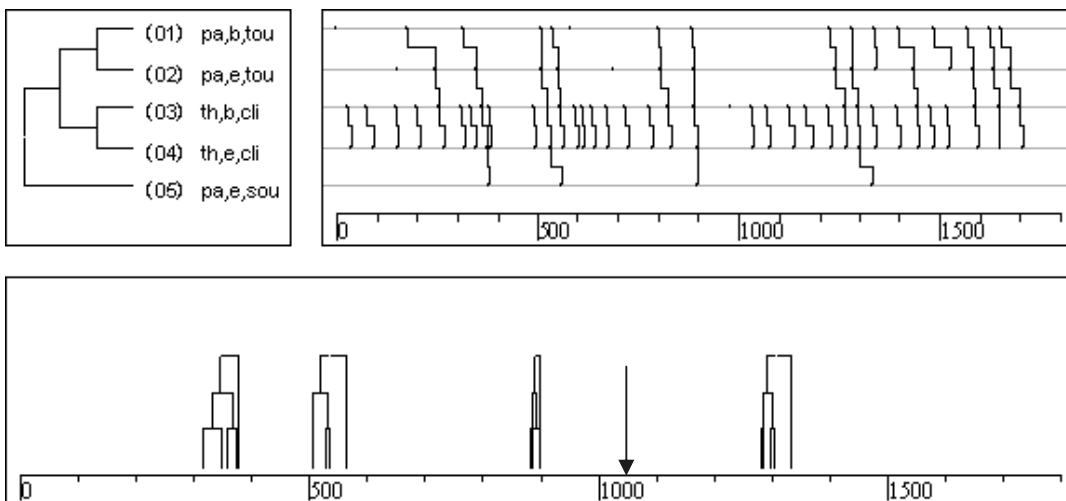


Figure 8.8 The therapist's eye-blinking is associated with the patient's smiles and touching hands

The therapist's eye-blinking is frequently associated with the patient's touching hands, then with his smiles. Through his facial expressions, the therapist expresses a connection with the content of the discourse, which is accompanied by certain patient gestures. The intensity of the relationship is conveyed by meaningful behavioural patterns.

8.4.2.2 Analysis of behavioural patterns in the patient's discourse

The patient's language and gestural behaviours also show special characteristics. Because the sequence revolves around two themes – death and life – we observe that any mention of these two themes is associated with a gesture specific to each one.

In figure 8.9, we observe that the patient discusses death in a complex behavioural pattern. Before bringing up the subject of death, he does not look at the therapist and his head is turned toward the right; after bringing up the subject, he turns his head back toward the right. During his mention of death, he opens his hands, and then crosses his fingers.

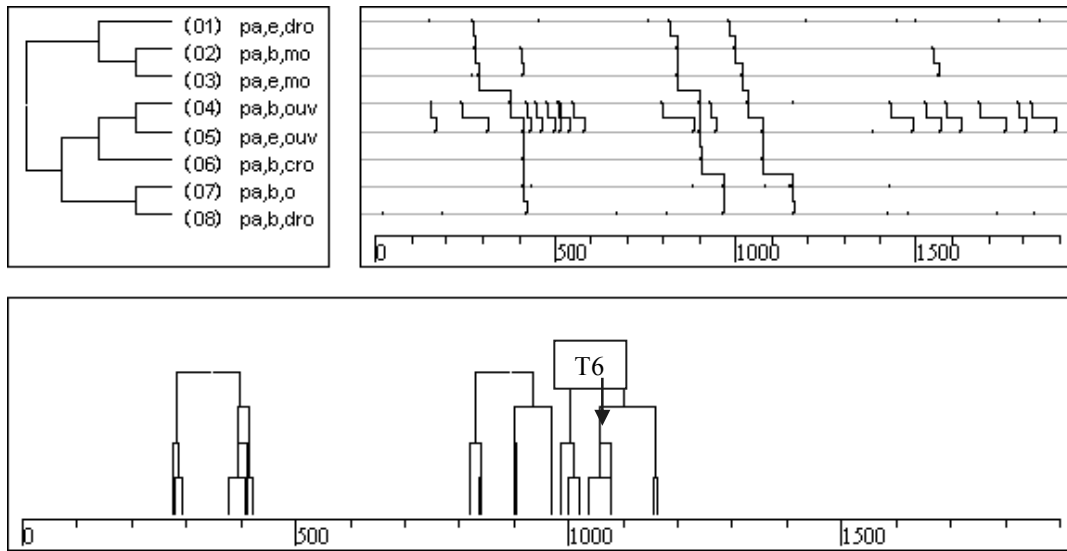


Figure 8.9 The patient stops looking to the right, talks about death, opens his hands, crosses his fingers, says “yeah” and then again looks to the right

In figure 8.10, the patient touches his fingers when he talks about life and does so throughout his discourse. This pattern is very apparent throughout the sequence.

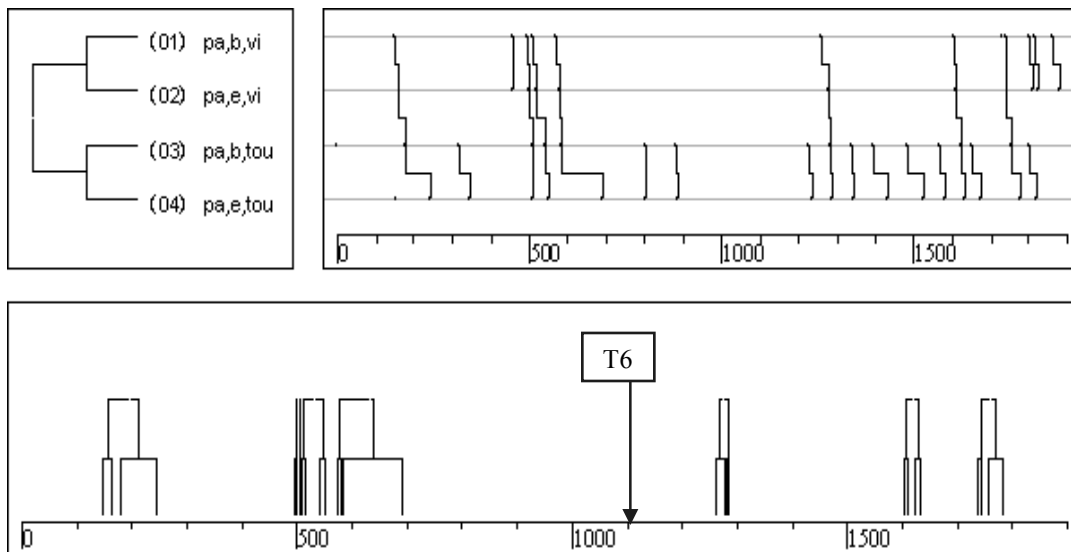


Figure 8.10 The patient talks about life and touches his fingers

In figure 8.11, the patient's discussion of heroin is followed by the same behaviour of touching his fingers as when he talks about life. This observation tends to confirm the implicit analysis of the therapist, who believes the patient takes heroin to live and not to die. In both cases, the patient makes similar movements with his fingers.

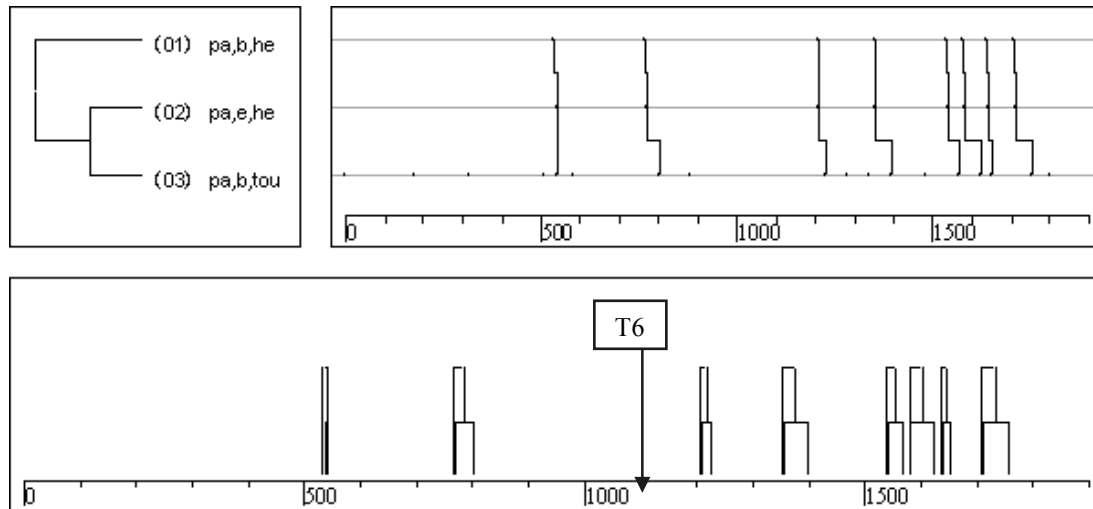


Figure 8.11 The patient talks about heroin and touches his fingers

8.5 Discussion

The goal of this study is to demonstrate the hidden behavioural factors that occurred during a psychotherapeutic exchange. The sequence we selected shows a series of therapeutic interventions that lead the patient to change his discourse. This is a complex interaction that involves verbal exchanges and non-verbal behaviours. Using a hierarchical semantic analysis, we demonstrated that this sequence is comprised of two distinct parts structured around a reversal of the speakers' positions in the dialogue and a modified discourse on the part of the patient.

In the first part of the dialogue, the psychotherapist challenges the patient's initial version, according to which he took heroine because he wanted to die. Two reasons can be proffered to explain the therapist's position: first, the patient's initial version is not compatible with the therapist's psychoanalytical theory and second, the therapist doubts the patient's sincerity. The first part of the sequence consists of the therapist questioning the patient's sincerity by indirectly challenging it. The therapist's successive challenges are gradually integrated into the patient's discourse. The patient uses attenuators that diminish the truth value of his first version. The hierarchical analysis shows that the therapist's challenges construct a retroactive hierarchical structure with the patient in which all the patient's utterances are subordinated to the therapist's utterances. The patient responds to the challenges of the therapist, who initiates the exchanges. Using THEME software, we demonstrated that in this part of the dialogue the therapist structures his speech around the patient's attenuators, as if to base his challenges on the patient's own doubts. We had already demonstrated this type of pattern, which is typical of psychological interviews. In general, interviewers have a tendency to select the attenuated parts of the interviewee's discourse for their use of encouragers and paraphrases [19]. But we also showed that the therapist demonstrates a specific response – eye-blinking – to the patient's body language.

In the second part, the therapist's statements agree with the patient's discourse. The therapist thus reinforces the second version of the patient's discourse, according to which he took heroine to live, to take care of himself, to get better. This part is characterized by a proactive structure in which the therapist's statements are subordinated to the patient's statements. The therapist radically changes his dialogic position in this second part. The dialogue is initiated by the patient and the therapist finds himself in the position of confirming the patient's utterances. The patient initiates the discourse; in psychoanalytic terms, he is the "subject."

The behavioural analysis conducted with THEME software also allows us to understand hidden patterns that characterize the patient's discourse and body language. In particular, the patient's discussion of death is accompanied by a specific head movement. The patient talks about death after turning his head to the right and then again turning his head to the right. The patient gives the impression of seeking this idea elsewhere, far from the therapist's gaze, and then turns elsewhere again, far from the therapist's gaze once more. This thought seems to be located outside the therapeutic session, as if it were not included in the discourse jointly constructed with the therapist. When the patient talks about life, however, he tends to touch his fingers and does so throughout the sequence. This same gesture of touching his fingers accompanies his discussion of heroine. Heroine and life therefore seem to be associated with the same gestural behaviour. The therapist's eye-blinking accompanies, confirms or reinforces this pattern of "life – heroine – hand touching." This observation could account for the accuracy of the therapist's inferences and their basis in the patient's statements and gestures. It is because the therapist pays such close attention to the patient's speech and body language that he can lead the patient to modify his own point of view regarding the causes of his addictive behaviours.

8.6 Conclusions

Psychotherapy is a complex interactive situation based on the asymmetry of the speakers and the therapist's search for specific goals. While research on the efficacy of psychotherapy uses clinical studies to address various psychotherapeutic situations as if they were "soul medicine," few studies examine the properties of the "active ingredients." What are the interactive factors that explain the phenomena of change and influence that are sometimes observed? The research we conducted attempts to answer the following question: How do we encourage individuals to modify the representational system they have constructed of themselves and their lives? The techniques used are never described in psychotherapy manuals; instead, they illustrate the therapist's specific qualities [5]. The therapist's work involves analyzing the patient's discourse and inducing change in patient representations. But this goal can only be achieved if an intense relationship is established between the patient and therapist. The behavioural factors that we demonstrated confirm the existence of this relationship, which mobilizes all the attention and interest of the two individuals.

The microanalysis we conducted on a short sequence of verbal interaction in a therapeutic setting helps us refine our understanding of the therapeutic influence mechanism. This influence comes about through intense communications that concentrates the attention of the two partners. In this relational context, which is sometimes called the "therapeutic alliance," the therapist strives to expand the patient's discourse through explication (retroactive structure) and interpretation (proactive structure). The result of this patient-therapist effort is the joint construction of a discourse that can lead to a better understanding of the patient's life, emotions and experiences. This effort is guided by the therapist, his gestures, facial expressions and verbal interventions. This type of so-called

“non-directive” therapy tends to exert all the more influence because it is indirect and the patient perceives it as relatively unintrusive.

This type of study also aims to provide analytical and diagnostic tools for the training of psychotherapists. Unfortunately, new therapists largely receive such training through on-the-job experience. The teaching of therapeutic techniques is a considerable challenge for the future of this type of treatment and for technique-related advances in a field in which human suffering still remains insufficiently alleviated by psychotherapeutic treatment.

8.7 References

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