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# AN INTRODUCTION TO USING MICROANALYSIS TO OBSERVE CO-CONSTRUCTION IN PSYCHOTHERAPY

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*In psychotherapy,* co-construction *refers to the proposal that the therapist and the client(s), in their dialogue, collaboratively create what emerges in their session. We trace the development of co-construction from its origins in postmodernism and point out that, unfortunately, it has remained more theoretical than practical or observable. The primary thesis of this article is that the microanalysis of video-recorded therapy sessions can render observable the details of how psychotherapists contribute to co-construction in any therapy session. Moreover, there is basic research on the microanalysis of face-to-face dialogue that applies directly to the understanding of co-construction in therapeutic dialogues. We demonstrate these proposals with an overview of the recent and growing body of empirical research on microanalysis of psychotherapy sessions. A detailed example from a therapy session illustrates four key aspects of co-construction: grounding between therapist and client(s), therapist's* questions, *therapist's* formulations, *and therapist's* lexical choices.

When individuals and families come to therapy, they bring with them an account of their situation that usually includes a description of the problem(s), their ideas about what led to the present state of affairs, their expectations about what will happen in therapy, and their hopes for what will be different in the future. They meet a therapist with theories and knowledge about why problems exist and what is needed to solve, alleviate, or reduce them and, more generally, ideas about how to be helpful in making things better. The parties then enter into a dialogue in which the therapist is responsible for directing the communication for the benefit of the

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client and for bringing his or her theory and knowledge to bear on what the client brings to therapy.

Bavelas, McGee, Phillips, and Routledge (2000) proposed that the wide range of views about therapeutic communication can be divided into two paradigms. One common view assumes, more or less explicitly, that communication is simply transportation of knowledge, thoughts, and emotions from the mind of one individual to the mind of another. A more recent, contrasting view is that communication is a process of co-construction in which client and therapist collaboratively contribute in different ways to continually evolving versions of the client's history, situation, problems, and solutions. This article describes how a close, empirical examination of what therapists and clients actually do in their sessions can make co-construction observable and identify specific ways in which therapists' communicative acts contribute to the co-construction of what emerges in the session. Knowledge about *how* co-construction happens can provide practitioners (as well as trainers and supervisors) with practical insights into specific choices they could make deliberately in order to carry out their therapeutic goals.

## THERAPY AS CO-CONSTRUCTION: POSTMODERN CONTRIBUTIONS

In the 1950s and 1960s, an emerging postmodern movement began seriously calling into question the possibility of understanding essential truths about reality through positivist science and rational philosophy. The postmodern alternative suggested that what is true and real is context- and language-specific, that is, negotiated and arrived at through social interactions (Berger & Luckman, 1966; Garfinkel, 1967; Lyotard, 1984; Wittgenstein, 1958). These ideas have influenced many fields, including psychotherapy, where two streams of postmodern scholarship have contributed to new understandings. One of these came from developments in the philosophy of language, often traced to the work of Wittgenstein (1958), who argued that a proper understanding of how language functions is key to understanding how the meanings held by individuals and larger social groupings develop and change. Words do not gain their meaning simply because they give an accurate picture or representation of objective reality, analogous to a high-quality photograph. Instead, words acquire their meaning from the ways in which participants learn them and use them in different social contexts. Once these meanings have been created and shared, participants experience their words as meaningful, real, and correct whereas in Wittgenstein's view their meanings continue to be negotiable and flexible.

A second, related stream of scholarship, social constructionism, is a theoretical child of postmodernism. This theory, which cuts across sociology and psychology, maintains that individuals using language are in an ongoing process of negotiating meanings about what is true, important, and real in their lives and settings. Individual and institutional meanings are socially constructed in these interactions.

Although in everyday life, the participants usually experience these meanings as real and firm, they are in fact tentative and changeable, constantly being created and reshaped through interpersonal conversation and broader social discourse (Berger & Luckman, 1966; Gergen, 2009). In the world of psychotherapy, as well as in counseling and social work, social constructionists use the term "co-construction of meaning" to emphasize that meanings are negotiated and built in a mutual process that happens in dialogue (Gergen, 2009; McNamee & Gergen, 1992). Each of the participants brings his or her current meanings to the dialogue and then, through their language interaction, they jointly create new and revised meanings. Social constructionists who write about psychotherapy suggest that change in therapy is the result of the co-construction of new meanings in the therapeutic dialogue (Franklin, 1998; Gergen, 2009). As Franklin (1998, p. 68) expressed it, "Working with language and the reconstruction of meanings is the main way of generating change in clients."

Several therapists have made connections between their work with clients and either social construction or Wittgenstein's view of language, or both. For example, Watzlawick (1976; Watzlawick, Beavin, & Jackson, 1967, Epilogue) identified points of convergence between Wittgenstein's insights and psychotherapy. Anderson and Goolishian (1988, 1992), Hoffman (1992), and Cecchin (1992) have reflected on the usefulness of viewing their therapeutic work through the lens of social constructionism. De Shazer (1994; de Shazer et al., 2007), who had already been applying his interest in language to the development of new therapeutic techniques, began to explore how Wittgenstein's understandings of language might capture the co-constructive nature of therapy. White and Epston (1990) drew on the ideas of postmodernist philosopher Michel Foucault to propose that the meanings expressed in the personal narratives of individual clients are heavily influenced by the power relations operating in their contexts (e.g., age, class, color, gender). These connections increasingly arouse curiosity about exactly *how* language contributes to co-construction in psychotherapy.

Although intriguing and influential, social constructionism has remained largely a broad theoretical outlook. As noted above, its contribution to psychotherapy has been to propose in general terms that therapeutic dialogue is a process of co-construction and that this process occurs in language interactions. For example, various psychotherapy theories have identified many products of co-construction, such as subjective meanings, understandings, realities of everyday life, knowledge, narrative realities that reflect power relations, the self, and several other broad categories of meaning (Anderson & Goolishian, 1992; Berger & Luckman, 1966; Gergen, 2009; Hoffman, 1992; White & Epston, 1990). Still, none of these concepts have definitions that are clear or specific enough to guide observation that would begin to develop an empirically based understanding of *how* co-construction happens within the context of psychotherapy and elsewhere. Co-construction must become more visible if it is to be accessible to the researcher and useful to the practitioner. It is necessary to find co-construction in the details of actual dialogues in therapy sessions, by

examining how specific language processes function in these interactions. This view echoes the appeal by Sluzki (1992, p. 221), who maintained that therapists and clients actively contribute to a developing story of clients' situations but added that "a new level of analysis must be introduced, focused on *micro-practices*, which allow one to specify and operationalize processes." Sluzki specifically included therapists' questions and comments as micro-practices in need of empirical study.

## RECENT RESEARCH ON DIALOGUE

Far from the practice of psychotherapy (and from the literature of Wittgenstein and social construction), psycholinguist H. H. Clark and his colleagues have been developing a new and radically different approach to language use, the *collaborative model* of communication in face-to-face dialogue (e.g., Clark, 1996). Traditional models have focused on the individual and therefore treat dialogue as alternating monologues in which the speaker delivers information while the listener is attentive but passive until they switch roles. As Reddy (1979) pointed out, this view reduces communication to a neutral conduit for each individual's thoughts and feelings. In contrast, Clark's collaborative model corresponds to what we have described as co-construction: The speaker and listener produce the information together, continuously coordinating and collaborating with each other to shape a mutually agreed-upon version to which both have contributed. Clark's collaborative model has led to lab experiments that support it as a better account of how dialogue works than the individual model (e.g., Clark, 1996). Although these experiments are basic rather than applied research, they provide an empirical foundation that supports the heretofore philosophical idea of co-construction and also suggests a new theoretical and methodological approach to co-construction in therapeutic dialogues (Bavelas, 2012). Our microanalysis research draws on and grows out of these developments.

### Microanalysis of Therapeutic Dialogues

Collaborative processes in dialogue are only visible through the close examination of the details of real dialogues. Since the mid-1980s, experimental lab research by Bavelas and colleagues has developed *microanalysis of face-to-face dialogue*, which is the rigorous, moment-by-moment examination of communication sequences in video-recorded dialogues. This method is also highly suitable for investigating the collaborative and co-constructive details of therapeutic dialogue (Bavelas, 2012). Microanalysis requires digitized video, ideally with both participants visible and audible at all times. The preferred tool for analysis is ELAN software (http://tla.mpi.nl/tools/tla-tools/elan; Wittenburg, Brugman, Russel, Klassman, & Sloetjes, 2006), which permits repeated and frame-by-frame viewing of any selected section, as well as annotation of these selections on the video itself.

Bavelas et al. (2000) described their early applications of microanalysis to psychotherapy, identifying at least three different ways in which therapists can contribute to and influence the therapeutic dialogue: *questions*, which bring the therapist's presuppositions into the dialogue; *formulations*, which include what therapists have called paraphrasing, summarizing, echoing, etc.; and *lexical choice*, which includes therapists' choice of positive or negative topical content. The present article reviews more recent microanalysis research on these three therapeutic tools and also adds the process of *grounding*. Our overview is an introduction and demonstration of how microanalysis is making the process of co-construction in therapeutic dialogue directly observable. The other articles in this special section present three of these new studies in full detail for the first time (Froerer & Jordan, 2013; Korman, Bavelas, & De Jong, 2013; Jordan, Froerer, & Bavelas, 2013).

## GROUNDING

In the collaborative theory of dialogue, the basic unit is *grounding*, a sequence of coordinated actions by which the participants establish and convey their mutual understanding (Clark, 1996, Ch. 8; Clark & Schaefer, 1987, 1989). We propose that grounding co-constructs common ground. In any natural dialogue, the participants constantly engage in this moment-by-moment process. That is, the grounding process is not just an occasional explicit summary or agreement; it is the rapid, overlapping sequences that are continuously going on in the background. Thus, with every grounding sequence, the participants in a dialogue are co-constructing (and aligning on) a shared version of whatever they are talking about, be it trivial or important.

In its simplest form, a grounding sequence consists of three steps involving both the person who is contributing information at that particular moment and the person being addressed:

1. The speaker *presents* some information.
2. The addressee *displays* that he or she understood it.
3. The speaker *confirms* the addressee's display of understanding.

### Example 1

One of PDJ's sessions at his college's counseling clinic began as follows:

1. Therapist: So is it okay if I call you Kathy?
2. Client: Mhm (while nodding).
3. Therapist: (Smiles) OK.

The therapist *presented* a polite request to call the client by her first name. She *displayed* understanding of his request by assenting, and he then *confirmed* her

understanding. They have grounded on his using her first name. Superficially, his smiling and saying "OK" might seem needless and redundant—after all, she had agreed, and his agreement was unnecessary. Seen as part of the grounding sequence, however, the third step functioned as a confirmation of their mutual understanding and completed this grounding sequence.

**Example 1 (Continued)**

Then the therapist spoke again:

4. Therapist: Please call me Peter. I'm real comfortable with that. (Smiles).
5. Client: (Nods) OK.
6. Therapist: (Looks up at her and smiles).

Again, the sequence consisted of his presenting new information, her displaying understanding, and his confirming her display (by looking at her and smiling) in the third step.

Of course, dialogue does not always flow so smoothly, and one function of the grounding process is to detect and correct potential misunderstandings. Therefore, a fuller description of the grounding process is necessary:

1. The speaker presents some information.
2. The addressee displays that he or she *understood it, did not understand it, or is not sure*.
3. The speaker confirms the addressee's display of understanding *as correct or, alternatively, indicates that it was ambiguous or not correct.*

An example of detecting and correcting a potential misunderstanding occurred at the beginning of the session excerpt presented in Table 1. HK, a solution-focused therapist, was visiting the U.S., where he was seeing a client who was going through a difficult divorce and starting a new life with her 19-month-old son. Following his initial presentation of information at #1 ("I will only be here today"), she made an ambiguous, slow upward nod (at #2), and he immediately requested another display (#3, "*OK*?"). Overlapping this request, she quickly added (at #4) a clarification of exactly what she had not understood, that is, what did "*here*" mean? Her accompanying downward gesture offered the possibility that "*here*" meant "in this room." Notice that, far from being a passive recipient, she had now directed the dialogue in the direction that would help them understand each other. In #5, he followed her direction and began to present fuller background information that would make it clear that "here" meant "at this agency."

Notice how closely the therapist and client collaborated on a mutual understanding of the background information he was presenting. For example, #7, #9, and #11 were all one sentence grammatically, but he presented it in three installments,

**TABLE 1. Transcript of the Beginning of a Therapy Session (Total Excerpt Time = 1 min, 48 sec)**

| | | |
|---|---|---|
| 1 | Th | "I think I need to tell you that I will only be—be here today." |
| 2 | Cl | (Slow upward nod) |
| 3 | Th | "OK?" |
| 4 | Cl | (Overlapping) "Be in here, you mean?" (pointing down at the space between them) |
| 5 | Th | "Eh, eh, I'm, I'm only visiting. I'm a psychiatrist from Sweden." |
| 6 | Cl | "Oh, OK." (nods quickly twice) |
| 7 | Th | "So, I'm, I'm a psychiatrist?" |
| 8 | Cl | (Nods) |
| 9 | Th | "And a brief therapist?" |
| 10 | Cl | (Nods several times) |
| 11 | Th | "Solution focused brief therapist." |

[Therapist goes on to explain that there will be a single session with him and that the agency will continue to be available. Then they establish first names, and the formal session begins:]

| | | |
|---|---|---|
| 12 | Th | "So, umm. Is it okay if we start like, uh." (pause) "What will have to happen, as a result of you (gestures toward her) coming here today—this afternoon, tomorrow, the day after tomorrow—for you to feel that it's been somewhat useful to, to be here?" |
| 13 | Cl | "Um." |
| 14 | Th | (Settles into listening posture; one hand holding chin; looking directly at her) |
| 15 | Cl | "I don't think I'm—" (laughs, then gestures toward him with a slight shrug) |
| 16 | Th | (Nods, then:) "It's a difficult question." (gestures, then returns to listening posture) |
| 17 | Cl | (Overlapping) "—am even looking that far ahead." (looks down) "Um." (long pause) |
| 18 | Th | (Returns to listening posture; does not speak up) |
| 19 | Cl | "Maybe just (pause) to sort together everything I'm—" |
| 20 | Th | (Overlapping: tilts head to right as if more interested, then poises pen to write) |
| 21 | Cl | "—feeling. I don't exactly know what that is yet." |
| 22 | Th | (Overlapping: looks up, then nods several times) |
| 23 | Cl | "I don't exactly know what's bothering me, like—I mean I—" |
| 24 | Th | (Overlapping: looks down and writes briefly) |
| 25 | Cl | "I'm in the process of going through a divorce, so—" |
| 26 | Th | (Overlapping: nodding) |
| 27 | Cl | "I'm sure that's (gestures out toward him) the majority of it." |
| 28 | Th | (Overlapping: looks up at her, then:) "Mm. Mm." (while nodding) |
| 29 | Cl | "I just recently haven't been able to sleep too well, 'n"— (pause) |
| 30 | Th | (Overlapping: looks down and writes; nods) |
| 31 | Cl | "So I thought maybe this might—(pause) help me sort out—whatever I need to—" (while speaking, gestures between herself and him) |
| 32 | Th | (Overlapping: looks up at her, then down to his notes. Nods and says:) "Right." |
| 33 | Cl | "to get my life (slight pause) back together." (smile and slight laugh) |
| 34 | T | (Looking at his notes) "Help you sort something out to get your life together." (Then nods and looks up; slight pause) |

*Note.* This excerpt is from "Bonding," an unpublished video. An audio version is available from Harry Korman (harry@sikt.nu).

with the client displaying understanding after each installment. He confirmed each display implicitly in the next installment, because each new presentation presupposed that she had understood the previous part of the sentence. Thus, what appear at first to be broken phrases with random nodding were actually functioning as a careful yet efficient way for speaker and addressee to ensure that they were back on track. This phase continued for another 20 seconds (not in Table 1), until they had co-constructed an agreed-upon version of what their relationship was going to be for this single session.

## HOW QUESTIONS FUNCTION IN DIALOGUE

Questions involve one person asking another about something that the questioner does not know and inviting the other to reply. For example, at #12 in Table 1, the therapist asked the client:

> What will have to happen, as a result of you coming here today—this afternoon, tomorrow, the day after tomorrow—for you to feel that it's been somewhat useful to, to be here?

Because the therapist cannot know what the client's goals are, this question is clearly a "not knowing" inquiry (Anderson & Goolishian, 1992).

For most of its history, psychotherapy has treated questions as though they were simple information-gathering tools (Freedman & Combs, 1996). However, at least since the 1970s, the authors of several therapeutic approaches have been calling attention to their usefulness as therapeutic devices (de Shazer et al., 1986; Epston & White, 1992; Haley, 1976; Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980; Watzlawick, Weakland, & Fisch, 1974). More recently still, McGee (1999; McGee, Del Vento, & Bavelas, 2005) proposed that therapeutic questions are co-constructive because they initiate a sequence in which the client provides responses that fit within the constraints of the therapist's approach. Healing and Bavelas's (2011) experiment suggests that asking different questions may lead to changes in subsequent behavior.

As outlined in McGee et al. (2005), the influence of a question begins with its *embedded presuppositions,* which are unstated assumptions that frame the question. For example, the question quoted above presupposed that (a) something could happen in the next few days as a result of this therapy session, and (b) this something could make the client feel that it had been useful to come; and (c) that the client is able to imagine what this something is; and (d) that the client is able to put this something into words that the therapist can understand.

In McGee's model, asking a question implicitly requires the client to provide an answer. In order to answer, though, the client has to make sense of the question with its presuppositions and then construct an answer that fits with it. In his microanalysis of a wide variety of therapy conversations, McGee pointed out that

even though the presuppositions of therapeutic questions constrain the direction in which clients can answer, clients rarely comment on, much less challenge the presuppositions. If the client does comment on or challenge a question and its presuppositions, the therapist can quickly backtrack and modify the question in a way more acceptable to the client but still consistent with the therapist's approach (McGee et al., 2005, p. 380). Ordinarily, however, clients work hard to answer the question and thereby involve themselves "in a process of meaning making" with their therapists (McGee et al., p. 377).

The dialogue in Table 1 illustrates how questions function in face-to-face dialogues. After the therapist had posed his question (at #12), the client had to search for an answer that fit the question and its presuppositions. At first (#13), the client hesitated and said only "Um." (In American English, speakers use *um* to signal a major delay in responding, whereas *uh* signals a shorter delay; Clark & Fox Tree, 2002.) In #14, the therapist responded to her "um" by settling into a listening posture (Kendon, 1970). At #15 the client started to answer with "I don't think I'm—" and then broke off with a shrug. At #16, the therapist responded to her delay in answering by formulating a reason ("It's a difficult question") and returned to his listening posture. In their exchanges from #17 through #33, the client constructed her answer, bit by bit, with the therapist participating in observable grounding sequences by displaying his understanding through non-interruptive nodding, other gestures, and an occasional minimal verbal response such as "Mm" and "Right." Finally, once the client had constructed her answer, the therapist offered a formulation of it at #34 ("Help you sort something out to get your life together"), which verbally displayed his understanding of her answer. Throughout this section (#13 to #33), the client's responses were consistent with McGee's model of how questions function in a face-to-face dialogue: She cooperated with the therapist's question by working hard to address the question and its presuppositions and by providing an answer consistent with the presuppositions without commenting on or challenging them. In so doing, she participated in co-constructing the beginning of a definition of how both she and the therapist would be able to tell whether or not the session they were having would be useful to her or not.

## FORMULATION AND ITS FUNCTIONS

Clark and Schaefer (1989, p. 267) proposed that, within grounding, the strongest evidence of understanding by the addressee is a "verbatim display of all or part of [the speaker's] presentation." Garfinkel and Sacks (1970) called such verbatim displays *formulations*, in which one participant describes, summarizes, explicates, or characterizes what another participant has said (p. 350). In Table 1, for example, #16 and #34 are formulations. In psychotherapy, formulations are called *echoing*, *mirroring, summarizing*, *paraphrasing*, *checking understanding*, *reflecting*, etc. Traditionally, these are seen as tools for clarifying, for showing understanding and

empathy, or for "joining" with the client(s) or family and are generally considered to be neutral, unbiased, and non-directive.

Watzlawick, Weakland, and Fisch (1974) began to describe some formulations as therapeutic tools that could be used to change the meaning that clients and families attributed to behaviors and consequently to change the behaviors as well. They called these *reframing*, *relabeling, normalizing,* etc. Davis (1986) and Phillips (1999) illustrated how formulations were consistent with the therapist's approach. We have proposed, even more radically, that *all formulations are influential choices rather than passive evidence of understanding* (Korman, Bavelas, & De Jong, 2013, in this special section). Heritage and Watson (1979) observed that formulations always transform what the speaker has said. We (Korman et al.) examined a wide range of therapeutic formulations, and expanded Heritage and Watson's analysis into the following distinct ways that formulations reshape what a client has said:

First, the therapist's formulation will almost always *omit* many of the exact words that the client has said. It would be very odd if a therapist repeated the client's every word. Second, the formulation will often *preserve exactly* some of the client's words. In Table 1, an examination of #13 through #34 illustrates how the particular combination of what is preserved and what is omitted can reflect the theoretical model of the therapist. The client was in the process of answering the question that the therapist had asked at #12. Here are her words (without the therapist's interjections), followed by the therapist's formulation at #34. (Words in *italics* were preserved exactly in the formulation.)

#13–33. CLIENT: Um. I haven't looked that far ahead. Um, I don't know, I guess, Maybe just to *sort together* everything, I'm, feeling. I don't exactly know what that is yet. I don't, I don't exactly know what's bothering me like. I mean I, I'm in the process of going through a divorce. So, I'm sure that's the majority of it. I just recently haven't been able to sleep too well and—. So I thought maybe this might *help me sort out* whatever I need to *get my life* back *together* (nervous laugh).

#34. THERAPIST: *Help you sort* something *out to get your life together*.

The formulation preserved the 11 italicized words of the client that indicated positive goals ("help me sort out" and "get my life . . . together") and omitted 88 of her 99 words, which were all either descriptions of problems (the divorce, not being able to sleep) or expressions of uncertainty ("I don't know," "I guess," etc.). The choices were typical for a SFBT therapist, focusing on what the client wanted to get out of therapy rather than focusing on her problems or uncertainty (e.g., de Shazer et al., 2007). One can with little effort imagine what therapists with other theoretical orientations would have chosen to omit and preserve—and thus to focus on. We propose that no "neutral" pattern of omitting and preserving is possible.

A third change can occur when the therapist preserves what the client has said by paraphrasing or using synonyms, that is, by *preserving it in altered form.* In #34,

"Sort *together everything*" became "sort *something out.*" The alteration is consistent with her lack of specificity, but it also scaled down the task for the therapy and is again consistent with the therapist's theoretical position.

Finally, although a formulation is ostensibly merely a restatement of the client's contribution, it is noteworthy that therapists may also add elements that were not in what the client had said at all. Additions are more than paraphrases or synonyms; typically, they are interpretations that characterize or elaborate on what the client has been saying, expressed in words that reflect the therapist's approach. The formulation at #16 both preserves in altered form and adds to what she has presented. Describing something as being "difficult" captures her broken sentence, nervous laugh, and shrug, although in altered form. However, she had not said *what* was difficult, so his attributing the difficulty to his question (rather than to her emotional or cognitive state) is an addition that fits his SFBT approach. Korman et al. (2013) analyzed and found significant differences in the formulations of experts in three different therapeutic approaches: cognitive behavioral therapy, motivational interviewing, and SFBT.

## LEXICAL CHOICE

A therapist constantly chooses one way of saying something over other, alternative ways, including when formulating something the client said and when asking questions. By doing so, the therapist is exercising what discourse analysts call *lexical choice*: the systematic selection of wording or phrasing, with its potential influence on the recipient (van Dijk, 1983). That these selections are systematic rather than random is illustrated in our analysis of the question and formulations in Table 1, where the lexical choices of the therapist were consistent with his solution-focused approach. For example, the initial question at #12 in Table 1 was positive, specific, and future-oriented. Had the therapist, by contrast, been more focused on negative aspects of the client's descriptions, been more global in response, and more focused on the client's past, he or she might have asked: "Can you tell me about the problem that brought you here today?" Formulations, too, are a rich site for lexical choices, as the therapist preserves or alters some words, omits others, and even adds his or her own. The formulations in #16 and #34 illustrate the precision of these choices, as well as their consistency with the therapist's approach. Froerer and Jordan (2013, in this special section) microanalyzed the formulations of SFBT experts and showed that the content of their formulations was more likely to be positive than negative. Moreover, they preserved the client's language more often in their positive than in their negative formulations.

Lexical choices are broader than the therapist's questions or formulations. Jordan, Froerer, and Bavelas (2013) analyzed virtually everything the therapist and client said in published sessions by three SFBT experts and three cognitive behavioral therapy experts. There were significant differences in the overall amount of positive

and negative content that they contributed to the dialogue. Moreover, these choices significantly affected the clients' subsequent positive or negative content, as the client responded in kind.

Another exercise of systematic choice is the therapists' preference for using the client's lexical choices versus introducing their own technical language. Korman et al. (2013) found that the formulations of two solution focused experts were significantly more likely to preserve the client's exact words and to add fewer of their own terms than were those of two cognitive behavioral experts and one motivational interviewing expert. We propose that all of the above lexical choices, when woven into the dialogue through grounding, contribute to the ongoing co-construction occurring in the session.

## CONCLUSION

The principles and examples presented here show that the abstract notion of co-construction can be tied to specific, observable choices that therapists make at the micro-level. All therapists ask questions, offer their clients formulations, and make lexical choices in everything they say. They also inevitably participate in grounding, which jointly creates understandings or meanings with their clients. The microanalysis of therapeutic dialogue is a line of inquiry that uses scientific methods to investigate these choices and, thereby, to extend the examination of the co-construction of meaning in therapy from the theoretical to the empirically observable and verifiable. This article has been an overview of this line of inquiry; the remaining articles in this special section are the new microanalysis studies referred to here.

We hope that these concepts and methods will give practitioners, trainers, supervisors, and learners a new lens through which to examine their own therapeutic communication, including their questions, formulations, lexical choices, and use of grounding. This new lens can lead to enhanced skills through greater awareness of how their choices as therapists contribute to what is being co-constructed in their therapy sessions.

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