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Interventive Interviewing: Part III. Intending to Ask Lineal, Circular, Strategic, or Reflexive Questions?*

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Every question asked by a therapist may be seen to embody some intent and to arise from certain assumptions. Many questions are intended to orient the therapist to the client's situation and experiences; others are asked primarily to provoke therapeutic change. Some questions are based on lineal assumptions about the phenomena being addressed; others are based on circular assumptions. The differences among these questions are not trivial. They tend to have dissimilar effects. This article explores these issues and offers a framework for distinguishing four major groups of questions. The framework may be used by therapists to guide their decision making about what kinds of questions to ask, and by researchers to study different interviewing styles.

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FROM THE PERSPECTIVE of an observer, the psychotherapies are essentially conversations. However, they are not ordinary conversations. Therapeutic conversations are organized by the desire to relieve mental pain and suffering and to produce healing. They occur between therapists and clients within the context of consensual agreement that the therapist will contribute intentionally toward a constructive change in the problematic experiences and behaviors of clients. Whereas other conversations may have therapeutic effects (for instance, personal discussions among family members, friends, work associates, acquaintances, and even strangers), these would not be considered "therapy" unless there were some agreement that one participant accepted responsibility for guiding the conversation to be therapeutic for the

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other. Thus, a therapist always assumes a special role in a conversation for healing. This role entails a commitment to be helpful with respect to the personal problems and interpersonal difficulties of the other.

The therapist's position in a therapeutic conversation not only implies special responsibilities, it also confers special privileges. One example of the latter is that a therapist can legitimately inquire about the clients' personal and private experiences. To do so can often expose the clients' vulnerabilities. Consequently, the potential for further trauma exists alongside that for healing. It is the manner in which such an inquiry is carried out that makes the difference. Some patterns of conversing are much more conducive to being therapeutic than others. One of the factors contributing to such variations is the nature of the questions asked.

During a conversation that is intended to be healing, the therapist usually contributes both statements and questions. These are quite different kinds of utterances. In general, statements *set forth* issues, positions, or views, whereas questions *call forth* issues, positions, or views. In other words, questions tend to call for answers and statements tend to provide them. At the same time, however, these characteristics are not exclusive; there is considerable overlap between questions and statements. For instance, questions can be posed in the form of statements. "You must have had some reason to come to see me"; "Most people come because something is troubling them very deeply." Alternatively, statements can be made in the form of questions: "Isn't it interesting that you came so late again?"; "Why didn't you leave earlier, when you knew the traffic would be so heavy?"[1] Despite this overlap, it seems reasonable to expect that the predominant linguistic form of a therapist's contributions will have an important effect on the nature and direction of the evolving conversation.

There seem to be some advantages for a therapist to ask mainly questions, especially in the early and middle parts of an interview. For instance, doing so tends to assure a client-centered conversation. The perceptions, experiences, reactions, concerns, goals, plans, and so on, of the client are repeatedly called forth and take center stage. If the therapist responds to the client's answers with further questions, the experiences and beliefs of the therapist remain in a supportive role as the conversation unfolds. Thus, when the balance is in favor of questions over statements, the "work" of the session naturally centers on the client, not on the therapist. Another advantage is that questions constitute a much stronger invitation for clients to become engaged in the conversation than do statements. The grammatical form of a sentence that poses a question arouses the social expectation for an answer. The cadence, tone, and ensuing pause in the therapist's speech add to the expectation for a response. When the therapist also conveys a clear commitment to listen, and to hear the clients' answers, the expectancy is strengthened even further. Thus, through questioning, clients are actively drawn into dialogue with the therapist. Indeed, even withdrawn and/or mute clients find it difficult to escape entering into a process of silent conversing when questions are addressed to them. A further advantage in therapists asking mainly questions, and refraining from making statements, is that

[1] One could claim that every statement raises certain questions and every question implies certain statements. This "reality" may be valid from the perspective of an observer performing an in-depth analysis of verbal transactions, but it is usually not experienced by those who actively participate in the conversation. Nevertheless, the complexities of what is being suggested or implied (in what is said or asked by the therapist) may be brought forth by the client upon deliberate reflection.

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clients are thereby stimulated to think through their problems on their own. This fosters client autonomy and allows a greater sense of personal achievement for family members when therapeutic change takes place, rather than inducing dependency on the "special knowledge" of the therapist.

There are, however, limiting conditions to a predominance of questions over statements. A therapist may, in effect, hide behind the perpetual questions and fail to enter into the relationship as a real person. This could constitute a major disadvantage by limiting the development of a therapeutic alliance. Clients usually need to experience the therapist as someone with coherence and integrity in order to extend their confidence and trust. For this, the therapist does have to make statements from time to time and take a position on certain issues (even if the position taken is deliberately not to take one, such as whether a couple should separate or remain together). Furthermore, the social expectancy for answers can be experienced as a demand and become an imposition. Certain questions can be extremely intrusive or threatening. A long series of questions may be experienced as an inquisition or as punishment. These possibilities highlight the need for therapists to monitor the conversation continually and switch to making statements when their questions become countertherapeutic. On the other hand, some of these difficulties may be dealt with by changing the kind of questions being asked.

The balance between questions and statements, as utterances made by the therapist, tends to vary with different schools of therapy. For instance, the Milan systemic approach depends heavily on asking questions whereas the structural and strategic approaches depend on making statements as well. Among the variables that influence the balance between questions and statements in a particular session are the theoretical orientation and personal style of the therapist, the types of problems, beliefs, expectations, and interaction styles presented by clients, and the idiosyncratic pattern of interaction that evolves among them. As far as I am aware, the effects of this balance have not yet been systematically explored in marital and family therapy research, nor has the effect of deliberately altering the ratio of questions to statements during the course of the interview been examined.

Although this article focuses predominantly on questions and on the differences among them, it is not intended to imply that a therapist should only ask questions. When clients are simply unaware of basic information or do not have the knowledge resources to answer coherently, it is appropriate that therapists provide answers for them. In addition, provisional "if-then" statements that clarify mental process can contribute enormously to a family's awareness and understanding of relevant events. For example, if parents repeatedly demand disclosure from a child, they sometimes inadvertently teach the child to lie. The child may learn to invent any kind of answer that might satisfy the parents' demands for an immediate response. Furthermore, ironic and improbable statements by a therapist are sometimes the most effective means to awaken questions in the minds of clients and to enhance their capacity to make pertinent discoveries on their own.

THERAPIST INTENTIONS AND ASSUMPTIONS

Every question may be assumed to embody some intent. Whether consciously or not, the therapist has some purpose in asking. This intent or purpose arises from the conceptual posture of strategizing (see 4) that guides the therapist's moment-to-moment decision making during the conversation. The most common intention behind the questions asked by a therapist

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is to find out something about the clients or their situation. With the use of questions, the therapist invites clients to share their problems, experiences, histories, hopes, expectations, and so on. The immediate intent in the asking is to develop the *therapist's understanding*. The questions are designed to trigger responses from clients that will enable the therapist to become coupled linguistically with the clients, to draw relevant distinctions about their experiences, and to generate clinically useful explanations regarding their problems. The questions are chosen to support the therapist's activity in the conceptual postures of circularity and hypothesizing (see 4). Family members are expected to answer according to the understanding they already have. They are not usually expected to change as a result of these questions. In other words, during such questioning the primary locus for intended change is *the therapist*, not the client or family. The goal at those moments in the interview is for the therapist *to become oriented* to the problematic situation and the idiosyncratic experiences of the client and family members. As the therapist constructs impressions and images from the family's verbal and nonverbal responses, further questions are asked in order to fill in blanks, clarify ambiguities, and resolve inconsistencies that arise in the mind of the therapist. Thus, in the early parts of an interview the therapist asks predominantly *orienting questions*.[2]

However, during the course of assessing the clients' situation, occasions frequently arise in which therapeutic interventions seem particularly opportune. The therapist recognizes "a good moment" or "an opening" in the conversation to influence the family's perceptions or beliefs. In other words, the situation is conducive to an action on the part of the therapist that might enable family members to change their views, and consequently their behavior. The therapist could alter the pattern of asking questions and make some statements. If, however, the therapist decides to continue the inquiry, he or she can still take advantage of these opportunities by introducing therapeutic interventions in the form of questions. Indeed, for various reasons the therapist may prefer to use questions to influence the client, rather than resort to making statements. The therapist then formulates *influencing questions*, the kinds of questions that are liable to trigger therapeutic change. In this case, the primary locus for intended change is the *client or family*, not the therapist. This does not mean that the therapist is not open to further change in his or her understanding as a result of the client's answers to these questions. On the contrary, the therapist always remains open to change following an influencing question; otherwise the question becomes purely rhetorical. However, this change in the therapist is secondary with respect to the therapist's predominant intent in formulating that particular question.

Thus, one basic dimension for differentiating questions is a continuum regarding *the intended locus of change that lies behind the question*. At one extreme of the continuum is a predominantly *orienting intent*, for change in oneself, and at the other end is a predominantly *influencing intent*, for change in others. Orienting questions are designed to invite a response to alter the therapist's own perceptions and understanding whereas influencing ques-

[2] In an earlier publication (3), I referred to these questions as "descriptive" because they invited clients to describe their situation and experiences. However, the adjective "descriptive" could imply that family members provide objective accounts of events and experiences and, thus, it can be misleading. I now prefer "orienting" because it is more precise and coherent with a second-order cybernetic explanation of what takes place during an interview. The family's answers simply orient the therapist in his or her subsequent actions; the answers are not necessarily taken as statements about an objective "reality."

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tions are designed to trigger a response that might alter the family's perceptions and understanding. Any particular question may, of course, entail mixed intentions and fall anywhere along the continuum. This distinction between orienting questions and influencing questions constitutes an invitation for therapists to become more mindful of their intentions during the process of strategizing about what to ask.

A second major dimension for differentiating questions has to do with *varying assumptions about the nature of mental phenomena and the therapeutic process.* It seems reasonable to assume that a network of assumptions and presuppositions concerning the issues being asked about exists in the mind of the therapist as a foundation or rationale for the question. For the most part, these underlying assumptions or presuppositions tend to remain nonconscious during the conduct of an interview. They may, however, be brought into consciousness and deliberately be modified in one direction or another. In other words, these assumptions may be plotted along a continuum as well. At one extreme of this continuum might be predominantly *lineal or cause-and-effect assumptions,* and at the other, predominantly *circular or cybernetic assumptions.*

The distinction between "lineal" and "circular" was imported into family therapy from Bateson's pioneering work in exploring the nature of mind (1, 2). Since then, a rich network of ideas, concepts, and associations has evolved around this distinction. These ideas now permeate the family therapy literature. Lineal assumptions tend to be associated with reductionism, dormative principles, causal determinism, judgmental attitudes, and strategic approaches. Circular assumptions tend to be associated with holism, interactional principles, structure determinism, neutral attitudes, and systemic approaches. These associations do not necessarily imply identity or isomorphism within each cluster of concepts. Nor do they imply that lineal and circular assumptions are mutually exclusive. Because the distinction between lineal and circular may be regarded as complementary, and not just as either/or, these assumptions and their associations may overlap and enrich one another. Most therapists have internalized these concepts to varying degrees and probably operate with both sets of ideas, but in differing ways, with differing consistency, and at different times. Although these assumptions and presuppositions tend to exert their effects covertly and nonconsciously, they still have a significant effect on the nature of the questions asked. Hence, this second dimension adds considerable depth to an understanding of differences among the questions asked.

An intersection of these two basic dimensions (therapist intentionality and therapist assumptions) yields four quadrants, which may be used to distinguish four basic types of questions. This is indicated in the framework of Figure 1. The horizontal axis represents the degree to which the therapist's intentionality is oriented toward changing the self, or toward changing the other. The vertical axis represents the degree of lineality or circularity in the therapist's assumptions about the relevant mental process. If the therapist assumes that the events being explored occur predominantly in a lineal or cause-and-effect manner, the orienting questions will reflect this and may be considered "lineal questions." If the therapist assumes that the events being explored are circular, recurrent, or cybernetic, the orienting questions are labelled "circular questions." If the therapist assumes that it is possible to influence others directly through information input or instructive interaction, then the influencing questions may be regarded as "strategic questions." If the therapist assumes that influence only occurs indirectly, through a perturbation of preexisting circular processes in or among

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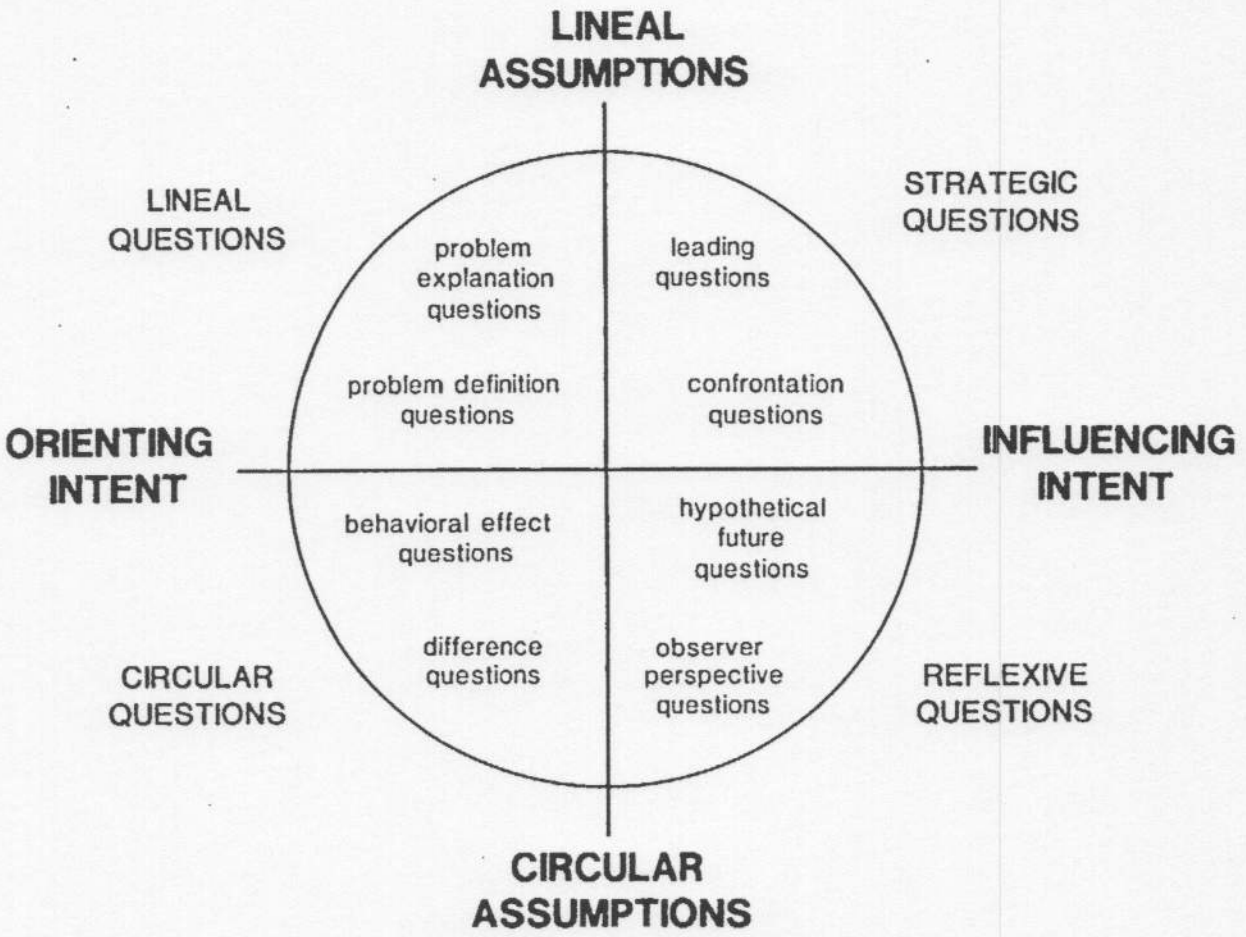

FIG. 1. A framework for distinguishing 4 major groups of questions.

family members, the influencing questions are considered "reflexive questions."

Because specific questions may reflect differing degrees of lineality and circularity as well as varying intentionality, they could be plotted anywhere on the diagram. However, certain kinds of questions will tend to fall into a particular quadrant. For instance, the common kinds of problem definition questions and problem explanation questions tend to reflect a lineal inquiry. Difference questions and a series of behavioral effect questions suggest an exploration of a circular process. Leading questions and confrontation questions tend to be regulatory and strategic. Future oriented questions and observer perspective questions tend to be reflexive. Different kinds and sequences of questions may be expected to have very different effects in the evolving therapeutic conversation. For instance, the manner in which a specific historical event is reported by the client is influenced by the wording and tone of the therapist's question. A lineal question invites a lineal description whereas a circular question invites a circular description. A further sketch of these major groups of questions with a few examples of each will be provided before examining their differential effects more closely.

FOUR MAJOR TYPES OF QUESTIONS

Lineal Questions

These are asked to orient the therapist to the client's situation and are based on lineal assumptions about the nature of mental phenomena. The intent behind

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these questions is predominantly *investigative.* The therapist behaves much like an investigator or detective trying to unravel a complex mystery. The basic questions are "Who did what?, Where?, When?, and Why?" Most interviews begin with at least some lineal questions. This is often necessary in order to "join" the family members through their typically lineal views of their problematic situation. With this mode of inquiry, the therapist tends to adopt a reductionistic stance in trying to determine the specific cause of the problem. Efforts are made to tease things apart so that the origin of the problem eventually becomes clearly delineated.

For instance, a therapist may begin a session with a sequence of lineal orienting questions as follows: "What problems brought you in to see me today?" (It's mainly depression); "Who gets depressed?" (My husband); "What gets you so depressed?" (I don't know); "Are you having difficulty sleeping?" (No); "Have you lost or gained any weight?" (No); "Do you have any other symptoms?" (No); "Any illnesses lately?" (No); "Do you have a lot of morbid thoughts?" (No); "Are you down on yourself about something?" (No); "There must be something troubling you. What could it be?" (I really don't know); "Why do you think your husband gets depressed?" (I don't know either, he's just not motivated, he lies in bed all the time); "How long has he been so depressed?" (Three months, he has hardly been out of bed in three months); "Did something happen that started it all?" (I can't remember anything in particular); "Does anyone try to get him up?" (Not really); "Why not?" (Well, I get fed up after a while); "Do you find yourself getting frustrated at lot?" (Quite a bit); "How long have you been so frustrated with him?"; and so on.

The conceptual posture of lineal hypothesizing (see 4) contributes to the content issues and subject focus for generating these lineal questions. Included in this posture is the habit of thinking in dormative terms, that is, in maintaining the presupposition that certain characteristics, such as depression, are intrinsic to the person, rather than to the distinctions made about the person. Consequently, lineal questions about problems tend to convey a judgmental attitude, namely, that something in the individual is wrong and ought not be the way it is. This often evokes shame, guilt, and defensiveness in the client or family. Because people generally do not like to take blame onto themselves, these questions may stimulate family members to become more critical of one another as they provide answers.

Circular Questions

These are also asked to orient the therapist to the client's situation, but they are based on circular assumptions about the nature of mental phenomena. The intent behind these questions is predominantly *exploratory.* The therapist behaves more like an explorer, researcher, or scientist who is out to make a new discovery. The guiding presuppositions are interactional and systemic. It is assumed that everything is somehow connected to everything else. Questions are formulated to bring forth the "patterns that connect" persons, objects, actions, perceptions, ideas, feelings, events, beliefs, contexts, and so on, in recurrent or cybernetic circuits.

Thus, a more systemic therapist may begin the interview differently: "How is it that we find ourselves together today?" (I called because I am worried about my husband's depression); "Who else worries?" (The kids); "Who do you think worries the most?" (She does); "Who do you imagine worries the least?" (I guess I do); "What does she do when she worries?" (She complains a lot, mainly about money and bills); "What do you do when she shows you that she is worrying?" (I don't bother her, just keep to myself); "Who sees your wife's worrying the most?" (The kids, they talk

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about it a lot); "Do you kids agree?" (Yes); "What does your father usually do when you and your mother talk?" (He usually goes to bed); "And when your father goes to bed, what does your mother do?" (She just gets more worried); and so on. These questions seek to reveal recurrent circular patterns that connect perceptions and events. They tend to be more neutral and accepting. The responses they elicit from family members are also less liable to be judgmental.

Circular questions tend to be characterized by a general curiosity about the possible connectedness of events that include the problem, rather than a specific need to know the precise origins of the problem. If the therapist has established a Batesonian cybernetic orientation toward mental process, and has developed skills in maintaining a conceptual posture of circular hypothesizing, these questions will come easily and freely. Two general types of circular questions, "difference questions" and "contextual questions," have been associated with Bateson's fundamental patterns of symmetry and complementarity. Several subtypes, including category-difference questions, temporal-difference questions, category-context questions, and behavioral-effect questions, have been described in an earlier paper (3).

Strategic Questions

These are asked in order to influence the client or family in a specific manner, and are based on lineal assumptions about the nature of the therapeutic process. The intent behind these questions is predominantly *corrective*. It is assumed that instructive interaction is possible. The therapist behaves like a teacher, instructor, or judge, telling family members how they erred and how they ought to behave (albeit indirectly in the form of questions). On the basis of hypotheses formulated about the family's dynamics, the therapist comes to the conclusion that something is "wrong," and through strategic questions tries to get the family to change, that is, to think or behave in ways that the therapist thinks is more "correct." The directiveness of the therapist may be covert, because the corrective statement is packaged in the form of a question, but it is still conveyed through the content, context, timing, and tone. Some families are offended by this mode of inquiry, but others find it quite compatible with their usual patterns of interaction.

Giving examples of influencing questions is more difficult because hypotheses about some of the mechanisms involved in the problematic situation are necessary for the formulation of the question. But, continuing on with the hypothetical family being interviewed above, the therapist might try to influence the couple by asking: "Why don't you talk to him about your worries instead of the kids?" (He just won't listen, and stays in bed); "Wouldn't you like to stop worrying rather than being so preoccupied by them?" (Sure, but what am I going to do about him?); "What would happen if for the next week at 8 a.m. every morning you suggested he take some responsibility?" (It's not worth the effort); "How come you're not willing to try harder to get him up?" (I'm tired and disappointed. He won't move and it just gets me more frustrated); "Can you see how your withdrawal gets your wife disappointed and frustrated?" (What do you mean?); "Can't you see how just going to bed instead of talking about what is bothering you is getting your family upset?" (Well, I...); "Is this habit of making excuses something new?" (I didn't know I had one); "When are you going to take charge of your life and start looking for a job?"; and so on.

It is quite apparent from these examples that by asking strategic questions the therapist is imposing his or her views of what

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"ought to be" upon the client or family. Sometimes a directive or confrontation by the therapist is needed to mobilize a stuck system, but too much directiveness in this mode of inquiry may risk a disruption in the therapeutic alliance.

Reflexive Questions

These are intended to influence the client or family in an indirect or general manner, and are based on circular assumptions about the nature of the process taking place in the therapeutic system. The intent behind these questions is predominantly *facilitative*. It is assumed that family members are autonomous individuals and cannot be instructed directly. Thus, the therapist behaves more like a guide or coach encouraging family members to mobilize their own problem-solving resources. One major presupposition behind these questions is that the therapeutic system is coevolutionary and what the therapist does is to trigger reflexive activity in the family's preexisting belief systems. The therapist endeavors to interact in a manner that opens space for the family to see new possibilities and to evolve more freely of their own accord.

Numerous examples of reflexive questions have already been provided in Part II (5) of this series of articles. However, to provide an indication of what they might be like in this scenario, the therapist could ask: "If you were to share with him how worried you were and how it was getting you down, what do you imagine he might think or do?" (I'm not sure); "Let's imagine there was something that he was resentful about, but didn't want to tell you for fear of hurting your feelings, how could you convince him that you were strong enough to take it?" (Well, I'd just have to tell him I guess); "If there was some unfinished business between the two of you, who would be most ready to apologize?" (She would never apologize!); "Would you be surprised if she did?" (Sure would!); "Suppose that it was impossible at this moment for her to recognize or to admit to any mistakes on her part, how long do you think it would take before you could forgive her for being unable to do so?" (Humm . . .); "If this depression suddenly disappeared, how would your lives be different?"; and so on.

These questions are reflexive in that they are formulated to trigger family members to reflect upon the implications of their current perceptions and actions and to consider new options. Even though reflexive questioning is also intended to influence a family in a therapeutic direction, it remains a more neutral mode of inquiry than strategic questioning because it is more respectful of the family's autonomy. Well-developed skills in maintaining a conceptual posture of neutrality contribute to the probability that an influencing question will be reflexive rather than strategic.

What is missing in all these examples is the emotional tone used in asking the questions. The differences between these groups would become even more apparent if the therapist's vocal cadence, tone, and accompanying nonverbal behaviors were present. What bears emphasis here is that the differentiation of these questions does not depend on their syntactic structure or their semantic content. It depends on the therapist's intentions and assumptions in the asking. Indeed, the exact same sequence of words could constitute a lineal, a circular, a reflexive, or a strategic question. For example, if a therapist asked a child "What does your mother do when your father comes home late, and dinner has already gone cold?" only to find out how the mother responds when provoked by the father, it would be a lineal orienting question. If it were asked as part of a planned *sequence* of behavioral effect questions (to be followed by something like "And what does your father do when your mother yells at him?") in order to explore

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the circular interaction between the parents, it would be a circular orienting question. If the original question were asked to trigger the parents to become observers of their own behavior and to mobilize their awareness to modify their own behavior, it would be a reflexive question. If it were asked because the therapist anticipated what the child probably would say, and wanted this information released at that moment to confront either the mother or the father on their intolerant or inconsiderate behaviors, it would be a strategic question. Thus, precisely the same words can mean and do very different things in the course of a single interview. It is usually the therapist's emotional posture in the asking that makes the difference in what the client hears in the question. These emotions are, in turn, associated with the therapist's intentions and assumptions.

THE EFFECTS OF DIFFERENT QUESTIONS

Before discussing the differential effects of these kinds of questions, it is important to acknowledge the *discontinuity* between a therapist's intentions in asking certain questions and their actual effects on clients. Recognizing and accepting this cleavage between intent and effect reduces therapist frustration when therapy is not progressing well, and it opens space for the therapist to consider alternative courses of action. From the perspective of an observer of the therapeutic process (who is usually the therapist observing himself or herself at work), there are two points, one minor and one major, at which discontinuities occur. The first is between what the therapist intends to do and what the therapist actually does do. This gap can be steadily narrowed as therapists seek greater personal integration and develop better skills in implementing their intentions. The second is the discontinuity between what the therapist actually asks and how this is heard by family members. There is an absolute limitation here. The listening and responses of clients are always determined by their own biological autonomy. At the same time, however, the responses of family members are not arbitrary; they are triggered by and contingent to what the therapist says and does. There is much that a therapist can do to improve the contingencies between intent and effect by enhancing his or her linguistic coupling with clients through the conceptual posture of circularity (4). But, ultimately, the intentions of a therapist in asking specific questions *never guarantee* any specific effect on clients; nor could more highly refined precision in the wording and tone of the questions do so. What actually happens to the client or family always depends on the uniqueness of their own organization and structure at each moment. The importance of recognizing and accepting this cleavage between intent and effect, between therapist action and client responses, cannot be overemphasized. The actual effects are always unpredictable.

Nevertheless, a therapist can and does compute probabilities. For instance, it is *more likely* that clients will become interested in their own interaction patterns through a series of circular questions rather than lineal ones, or feel blamed more by strategic questions than by reflexive ones. Because the therapist cannot know in advance what the actual effects of any particular question will be, yet must make choices about what to ask before asking, these choices are made on the basis of *anticipated effects*. The therapist can envisage the probable, possible, improbable, and impossible effects of various questions. This process of anticipating is an important aspect of the conceptual posture of strategizing. The following generalizations about the more probable effects of different questions may be incorporated into a therapist's nonconscious habits of

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strategizing and may guide the process of deciding what questions to ask.

Lineal Questions

These tend to have a *conservative effect* on the client or family. Because family members usually think of their difficulties in lineal terms before coming to therapy, there is little "news of difference" for the family when the therapist invites them to articulate their prior views (of what happened, who was involved, and how) with lineal questions. Family members answer the questions but remain virtually unchanged.[3] However, one hazard of lineal questioning is that it may inadvertently embed the family even more deeply in lineal perceptions by implicitly validating preexisting beliefs. Unfortunately, this happens far more often than clinicians realize while they are conducting ordinary "assessment" interviews. The interviewer is seldom aware of the fact that further entrenchment of pathogenic perceptions and beliefs is taking place. This process is particularly liable to occur if, during the course of the inquiry, the therapist does not ask the kinds of questions (or make statements) that implicitly (or explicitly) challenge the family's prior beliefs. Another risk with lineal questioning is that the reductionistic thinking involved tends to activate judgmental attitudes. As the therapist brings forth "the cause" of a presenting problem or of an undesired situation, negative judgments are automatically directed toward it because the problem is unwanted. Thus, while lineal questions are necessary to develop a clear focus of the problem, and are helpful in establishing an initial engagement, it is useful for therapists to remain mindful of potential hazards as well.

Circular Questions

Circular questions, however, do have the potential of having *liberating effects* on the family. As the therapist asks questions to identify patterns for a circular or systemic understanding of the problematic situation, family members who are listening to the answers make their own connections as well. Thus, they may be able to become aware of the circularity in their own interaction patterns. With this increased awareness, they may be "liberated" from the limitations of their prior lineal views and subsequently be able to approach their difficulties from a fresh perspective. For instance, if through a series of behavioral effect questions a husband begins to see that it is not simply his wife's worrisome complaints that activates his depression but also that his depressiveness activates her complaining, he may be liberated to act differently rather than by just becoming despondent when she worries and complains. He has more space to recognize that some constructive initiative on his part may activate a different response from her. He is also likely to become more accepting and less judgmental of her "worrying response" to his depressive behavior. The main risk with circular questions is that as the therapist explores larger and larger areas of interaction, the inquiry may drift into domains that seem irrelevant to the immediate concerns and needs of the family. Another risk is that clinicians who are learning to use circular questions may use them in a rather stylized fashion. The questions then seem repetitive or trivial and, thus, can become irritating to the family. On the whole, however, circular questions

[3] Obviously, if the answer of the respondent includes information that other family members (who are listening) were not aware of previously, this could be important news and have significant effects. However, this may occur with all kinds of questions. It is a general effect of the method of *conjoint* interviewing in marital and family therapy, and not specifically an effect of the kind of question asked.

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are more liable than lineal ones to have inadvertent beneficial effects.

Strategic Questions

These tend to have a *constraining effect* on the family. The therapist tries to influence the client (in a lineal fashion) to think or do what the therapist considers more healthy or "correct." The questions are intended to constrain the probability of family members continuing along the same problematic path. A common side effect is for family members to feel guilty or ashamed for having taken the path they are on in the first place. The constraint may be of two forms: *not to do* something that the therapist thinks is "wrong" and is contributing to the problem or *to do only* what the therapist thinks is "right" and would be helpful. Both tend to confine the family's options to what the therapist thinks is best, whether it actually fits for them at that moment or not. Thus, these questions tend to be more manipulative and controlling. In the extreme, they can be like the questions a good lawyer might employ in cross-examining witnesses in a courtroom. The lawyer uses strategic questions to lead, seduce, intimidate, or coerce a witness into saying precisely what the lawyer wants the judge and jury to hear. Similarly, a therapist can "force" an individual into saying things that the therapist wants to hear, or wants other family members hear, even when the person really doesn't think or feel that way. Because of the potentially coercive nature of strategic questions, too many of them could have inadvertent, counter-therapeutic effects.

On the other hand, occasional strategic questions can sometimes be extremely constructive in the therapeutic process. These questions can be vigorously used to challenge problematic patterns of thought and behavior without having to resort to direct statements or commands. If the questions are carefully worded, clients often can be confronted with the limitations, constraints, or contradictions in their own systems of belief. Alternatively, strategic questions sometimes can be employed to lead the family quite directly to recognize and embrace an obvious solution.

Reflexive Questions

These questions are more liable to have a *generative effect* on the family. The therapist's influencing intent is moderated by respect for the autonomy of clients and, hence, the tone of these questions tends to be much softer. Family members experience themselves as being invited into entertaining new views instead of being pushed or pulled into them. The questions tend to *open space* for family members to entertain new perceptions, new perspectives, new directions, and new options. They also enable a reevaluation, without duress, of the problematic implications of the family's current perceptions and behaviors. As a consequence, family members tend to generate new connections and new solutions in their own manner and time. The most likely complication of reflexive questioning is that it could foster disorganizing uncertainty and confusion. Opening a multiplicity of new possibilities without providing adequate direction can easily become confusing. However, such confusion may not necessarily be problematic for the overall therapeutic process. Depending on the domain of the confusion, it may, in fact, be very therapeutic. For instance, when certain family members "know the Truth" or "have all the answers" in a manner that keeps them stuck in problematic patterns and blind to novel alternatives, the confusion can be quite liberating.

Finally, I would like to draw attention to the possible *effects on the therapist* of asking different kinds of questions. The therapist is influenced by the questions as well. His or her thinking is influenced not only by the assumptions and presuppositions aroused during the formulation of the

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questions, but also by responding to the clients' responses to the questions. Lineal questions tend to foster further lineal thinking in the therapist just as they do in the clients. Consequently, the therapist is also more liable to become *judgmental.* The effect of circular questions on the therapist is to enhance his or her neutrality and capacity to accept the client and family as they are. This *acceptance* itself has healing potential in the therapeutic system by countering the immobilizing effects of blame, which is so ubiquitous in symptomatic families. The effect of strategic questions on the therapist is that they tend to lead him or her toward an *oppositional* stance with the family. On the other hand, reflexive questions tend to guide the therapist toward becoming more *creative* in the questions asked. If one question "doesn't work" in opening space for the family to evolve more freely, the therapist searches for another one that is more likely to release the natural healing capacity of the clients.

Figure 2 summarizes the predominant intent and the more probable effects associated with each set of questions. Included in the diagram are the effects of the questions on the therapist as well as on the family. The parentheses are intended to indicate that the actual effects always remain unpredictable. Depending on the momentary structure of a family, a strate-

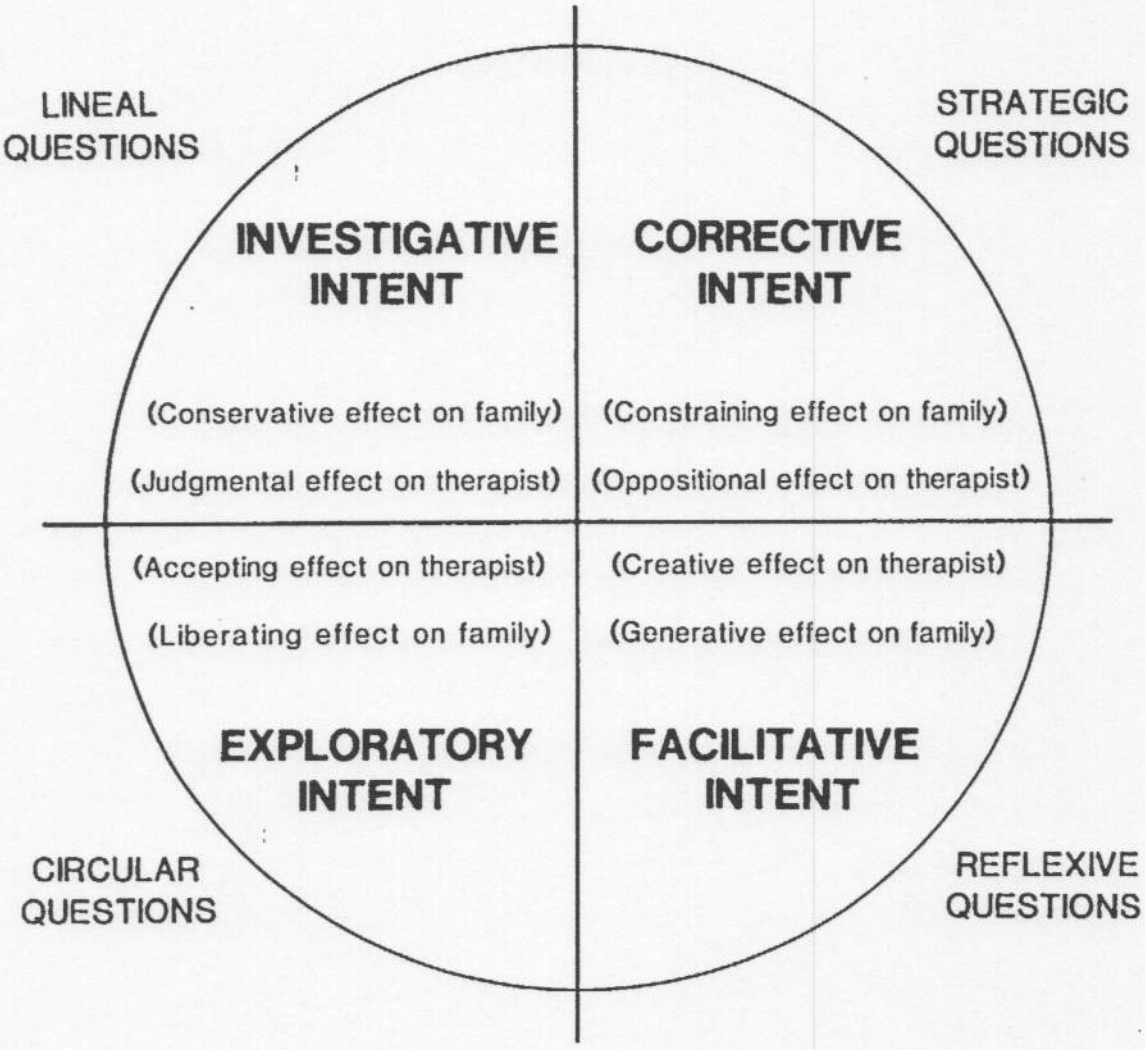

FIG. 2. Predominant intent and probable effects of differing questions.

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gic question *could have* a generative effect instead of a constraining one. A lineal question could have a liberating effect, and a reflexive question could have a constraining one, and so on. All that one can say is that it is *more likely* that family members will experience respect, novelty, and spontaneous transformation as a result of circular questioning and reflexive questioning, and judgment, cross-examination, and coercion as a result of lineal and strategic questioning. If family members begin to feel judged or manipulated, the session often becomes tense or "frozen." This could become a cue to the therapist to change the kind of questions to those that are more neutral and accepting (or temporarily to abandon the process of questioning altogether). Alternatively, if family members have become too comfortable and complacent in the therapy process, perhaps a few well-placed strategic questions could stimulate them to consider new directions. What is being proposed here is that the use of these distinctions could enable therapists to choose those kinds of questions that are more liable to guide the interview to actually become a conversation for healing.

CONCLUDING COMMENTS

The impossibility of predicting actual effects points to the importance of the therapist's ongoing activity of monitoring the immediate reactions of family members and revising hypotheses as the session unfolds. However, the actual effects of a question often cannot be observed; the reactions of family members are altogether too difficult to "read." Sometimes the effects may not even materialize at the time of the interview. The pertinent realization may dawn on family members only after the session, perhaps the next day, or even later. There are some questions that linger in the minds of clients for weeks, months, and occasionally years, and continue to have an effect. To a large extent, a therapist always has to "work in the dark" and never knows the final outcome of specific questions. This leaves even more responsibility on the therapist's intentionality in making decisions about what to ask. In other words, therapists need to take responsibility for the questions being asked without ever knowing what their full effects might be. At the same time, however, much can be done in personal professional development to increase the probability that a therapist's spontaneous behavior in an interview is more liable to be therapeutic than nontherapeutic or countertherapeutic. One has to bear in mind that, to a significant degree, the question "prefigures" the response in that it structures the domain of an "appropriate" answer. That is, a question presupposes a particular answer, or at least an answer in a particular domain. To ask a particular question, then, is to invite a particular answer. The kinds of questions a therapist chooses to ask depends on what kinds of answers the therapist would like to have heard. Whether or not the client accepts the therapist's invitation to provide an answer in the "appropriate" domain is quite another matter, but to select the question is to restrain the range of "legitimate" responses. This selectiveness gives the therapist an enormous amount of influence in setting and maintaining a direction for the conversation.

The distinctions in this article reflect the results of some qualitative research I have been engaged in for the past several years. If an empirical researcher wanted to explore these issues further and, for instance, establish whether a particular question was lineal, circular, strategic or reflexive, he or she would have the problem of identifying the intentions and assumptions of the therapist in asking it. The most direct route for this would be to ask the therapist to try to articulate his or her thoughts while formulating questions. This could perhaps be achieved during a review

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of a videotape immediately after the session. An outside observer could also evaluate each question in its context. Subsequently, these ratings could be compared for degrees of fit and set alongside descriptions of the moment-to-moment experiences of clients who also reviewed the tape. Further studies along these lines may contribute a great deal to a deeper understanding of the process of interventive interviewing.

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