Co-Implicating and Re-Shaping Clients’ Suggestions for Behavioural Change in Cognitive Behavioural Therapy Practice

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This article uses conversation analysis to examine Cognitive Behavioural Therapy (CBT) interactions with clients diagnosed with depression. The analysis explicates some routine conversational practices used by therapists in CBT to involve or co-implicate clients in the decision-making process regarding behavioural change. The article illustrates how the co-implication of clients in plans for behavioural change involves complex, therapist-guided sequences of interaction. Instances of co-implication are compared to those where therapists propose their own suggestions for change, resulting in different interactional consequences. The demonstration of therapists’ use of systematic turn structures to co-implicate clients in the therapeutic process offers an interactional specification of the therapeutic relationship of collaborative empiricism that is encouraged in CBT practice and also shows how this relationship unfolds in the moment-to-moment interaction of therapy.

Keywords: behaviour change; cognitive behavioural therapy; co-implication; conversation analysis; re-shaping

Introduction

The theory underlying Cognitive Behavioural Therapy (CBT) places great importance on the building of a collaborative relationship between clients and therapists. Emphasis is placed on the need for parties to work together to achieve therapy goals. Within the therapy session it is, therefore, important for the therapist to co-implicate the client in making decisions about how to achieve therapeutic goals. We take co-implication here to refer to moments in therapy interaction when therapists invite clients to participate actively in the institutional activity that is underway. Such co-implication is viewed as particularly important when therapists and clients are working to produce behavioural change. Government policies for the treatment of depression, such as the NICE guidelines in the United Kingdom, refer to this practice of co-implicating the client as “person-centred care” (National Institute for Health and Clinical Excellence 2009). Little is known, however, about how the co-implication of clients in CBT decision making is interactionally accomplished within the session. This article explicates some routine conversational practices used by therapists in CBT to involve clients in the decision-making process regarding behavioural change. Detailed analysis of these sequences of interaction demonstrate that co-implicating a client in this therapeutic process may be a much more complex practice.

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than CBT theory currently suggests, involving considerable guided negotiation towards behavioural goals. These instances are compared with those where therapists propose their own suggestions for change. The article will illustrate how therapists use routine conversational devices to co-implicate clients in plans for behavioural change while still actively guiding the suggestion-making process in a complex and highly negotiated sequence of interaction.

Background

Collaborative Empiricism in CBT Theory

Unlike other therapies, the therapeutic relationship in CBT is guided by a specific working alliance referred to as “collaborative empiricism” (Wright, Basco & Thase 2006). A relationship of collaborative empiricism involves therapists and clients working together to gather data to disconfirm core depressive beliefs or thoughts (Beck et al. 1979). Negative automatic thoughts are viewed as hypotheses that can be subjected to empirical verification through CBT interventions. Therapists are encouraged to engage clients in a highly collaborative process in which there is shared responsibility for setting goals and agendas, the giving and receiving of feedback, and putting CBT methods into action, both inside and outside the therapy session (Beck et al.; Neenan & Dryden 2000; Wright et al.). CBT theory encourages therapists and clients to work together to question the client’s cognitive distortions and unproductive behavioural patterns, with the aim of revealing opportunities for increased rationality, reduced symptoms of depression and improved personal effectiveness. Therapists are encouraged to achieve such a collaborative relationship by engaging clients with Socratic questioning and by using exercises that draw out clients’ own ideas and creativity (Wright et al.).

One aspect of CBT in which collaborative empiricism is considered particularly important is the technique of Behavioural Activation. According to CBT theory, Behavioural Activation involves engaging clients in a process of change that is designed to stimulate a sense of positive thought and hope or help them solve a problem (Blackburn & Davidson 1990). Therapists aim to help clients choose one or two actions that make a positive difference to how they feel and then assist them in coming up with a plan to carry out these actions. Therapists are encouraged to engage clients through the use of Socratic questioning and are advised not to suggest behavioural activation plans that might be too challenging (Wright et al. 2006). CBT theory suggests asking a series of inductive or open questions in a form that does not provide answers to which the client can respond but that requires the client’s direct input. For example, a therapist might ask: “What action could you take in the next couple of days that would begin to make a difference?” CBT theory provides therapists with suggestions to help them implement effective behavioural activation plans. Two of these suggestions for interaction are of particular importance to the analysis undertaken here:

- Preparing the client for behavioural activation: CBT theory suggests that therapists should lead up to behavioural activation with Socratic questioning to pave the way for change.
- Letting the client decide the actions to be implemented: Although therapists can guide clients towards actions that might be helpful, whenever possible, therapists are encouraged to ask clients to make the choice.
This article will analyse fragments from recorded CBT sequences, focusing on how “shared suggestion making” plays out interactionally between therapist and client within discussions concerning behavioural change. Before moving to the analysis, however, we will briefly review recent conversation analytic research in the domains of psychotherapeutic interaction and ‘co-implication’ in social interaction.

**Conversation Analysis of Psychotherapy Interactions**

Conversation Analysis (CA) has been used to study therapeutic and counselling interaction since Harvey Sacks first examined a group therapy session in the 1960s (see Sacks 1992). Since then, a number of studies have used CA to shed light on various therapeutic practices. The general analytic orientation is towards understanding how therapists and clients accomplish sequentially organized social actions by designing their utterances in particular ways (Peräkylä et al. 2008). The action focus, turn-by-turn analysis, and emphasis on participants’ orientation that characterize CA have been argued to make it ideally suited to empirical examination of the psychotherapeutic process (Madill, Widdicombe & Barkham 2001).

A range of therapy and counselling interactions has been studied to date, including psychoanalytic interactions (e.g., Peräkylä 2004, 2005; Peräkylä & Vehviläinen 2001; Vehviläinen 2001, 2003, 2008), psychodynamic-interpersonal psychotherapy (Madill et al. 2001), HIV counselling sessions (Kinnell & Maynard 1996; Peräkylä 1995; Silverman 1997), narrative and solution-focused therapy (MacMartin 2008), and CBT interactions (Antaki 2007; Antaki, Barnes & Leudar 2004, 2005a, 2005b). Within this work, various therapeutic practices have been the focus of detailed analysis. Much of the CA research on psychotherapy has focussed on therapists’ “formulations” of clients’ talk. These are practices whereby therapists propose a version of events that follows directly from a client’s own account but also includes some kind of transformation (e.g., Antaki 2008; Buttny 1996; Davis 1986; Madill et al. 2001). Therapist formulations have been identified as moving interaction in a therapeutically oriented direction by proposing versions of what clients say that are diagnostically relevant. Therapists can formulate a client’s contributions as either not therapeutically interesting at that point in the interaction or the client’s talk can be framed in terms of what is relevant to current or future therapy intervention (Antaki et al. 2004, 2005a). The analysis presented in this article will demonstrate how therapist formulations can also act as a way for therapists to co-implicate clients in decision making regarding therapeutic goals.

Other actions on the part of therapists have also been examined for how they are typically accomplished within therapy interactions. For example, therapists’ questions (e.g., Halonen 2008; Macmartin 2008; Silverman & Peräkylä 1990), therapists’ use of idiomatic expressions (Antaki 2007), and therapists’ self-disclosures (Antaki et al. 2005b) have all been studied. Some work on the nature of clients’ actions during therapy has also been carried out, including clients’ responses to therapists’ re-interpretations (e.g., Bercelli, Rossano & Viaro 2008; Peräkylä 2005, 2008), clients’ resistance to therapists’ (re-)formulations of prior talk (e.g., Antaki et al. 2004; Madill et al. 2001), clients’ disaffiliative responses to therapists’ optimistic questions (e.g., MacMartin 2008), and indications of clients’ unconscious resistance in psychoanalytic interactions (e.g., Vehviläinen 2008). However, no known studies have examined talk involving the behavioural techniques that are part of CBT treatment. Conversation analysis can explicate the routine ways in which Behavioural Activation techniques are performed in therapy, shedding light on how various therapist actions may result in different interactional consequences. In this article, we focus
in particular on the implications of therapists’ co-implication of clients into the Behavioural Activation process.

Co-Implication in Social Interaction

The action of co-implicating an interlocutor in social interaction has been the focus of several CA studies, in both mundane and institutional settings (e.g., Heritage & Sefi 1992; Hindmarsh & Pilnick 2002; Lepper & Mergenthaler 2007; Maynard 1989, 1991, 1992; Pilnick 2003; Vehviläinen 2003). For example, a recurring three-turn sequence in terms of which speakers could co-implicate an interlocutor, using what he labelled a “perspective-display series,” was identified by Maynard (1989, 1991, 1992) in doctor–patient interactions. In such sequences, doctors solicit the other party’s opinion before producing a report or assessment in a way that takes the other’s opinion into account. The perspective-display sequence can be schematized as follows:

1. A: an opinion query or perspective-display invitation
2. B: the reply or the recipient’s opinion
3. A: speaker A’s subsequent report

This three-part sequence can be seen in the following example involving a paediatrician and the mother of a child-patient (numbered arrows indicate the sequential turns):

(Maynard 1989, p. 93)

1 → Dr. E: What do you see as Donald’s difficulty?
2 → Mrs. C: Mainly his—the fact that he doesn’t understand everything, and also the fact that his speech is very hard to understand what he’s saying lots of time.
3 → Dr. E: Right . . . okay I you know I think we basically in some ways agree with you insofar as we think that Donald’s MAIN problem you know DOES involve you know language.

Perspective-display sequences were observed by Maynard (1989) to be common in situations of “diagnostic news delivery” in GP consultations. Maynard (1992) argued that within a clinical environment, the perspective-display series operates to co-implicate the recipient’s perspective in the presentation of a diagnosis. By initiating such a sequence, the clinician can confirm the patient’s understanding and deliver news in a “publicly affirmative and nonconflicting manner” (Maynard 1991). Other work has examined how pharmacists co-implicate patients in the counselling process (Pilnick 2003). These practitioners sometimes took a stepwise approach to counselling, using questions that explicitly invited the opinion or judgement of child-patients’ mothers. In this way it was argued that a course of action was negotiated between the parties rather than being imposed by the professional.

Another stepwise approach, this time to advice-giving by health care visitors in the United Kingdom, was reported by Heritage and Sefi (1992) to co-implicate first-time mothers into the advice-giving process. Routinely, a “focussing inquiry” was issued by the health care nurses before they delivered their advice:

1. Healthcare Visitor (HV): initial inquiry
2. Mother (M): problem-indicative response
This routine practice allowed healthcare visitors to enter into advice-giving through a successive process that first established a problem and then topicalized measures for its solution through a focusing inquiry. Mothers were thus co-implicated into the advice-giving process. This allowed nurses to develop a course of advice in what Heritage and Sefi (1992) described as a “nonadversarial fashion.”

More recently, Pilnick (2008) has examined the interactional presentation of “choice” to pregnant women in relation to the process of nuchal translucency screening. She identified several interactional and sequential variations in how midwives presented the choice to conduct this test, and discussed the different impacts on mothers’ responses. The analysis highlighted how the test was sometimes presented as a presumed or recommended course of action to which the mothers should provide their assent. As Pilnick noted, a decision to assent is different from making a choice from a range of actions. So, although midwives believed that they were providing mothers with an open opportunity to engage actively in the decision-making process, the interactional presentation of the screening test served to undermine the recognition of that choice by pregnant women.

The present article builds on this body of interactional research by identifying the conversational resources that are recurrently drawn on by therapists to co-implicate clients in the accomplishment of Behavioural Activation within CBT therapy, and discusses the implications of such practices for the therapy session. Close analysis demonstrates that sequences in which therapists co-implicate clients involve considerable guided negotiation toward a plan for behavioural change.

**Data and Method**

Data presented in this article come from a corpus of 20 CBT sessions involving 9 therapists and 19 clients who were being treated for depression. The audio recordings were collected in a clinic in Adelaide, South Australia, that specializes in CBT treatment. The sessions involved one client and one therapist in each case and were generally about one hour long (average session time approximately 56 minutes). The total duration of all sessions combined was 1,006 minutes (16 hours, 46 minutes). Recordings were transcribed using the Jeffersonian transcription system (Jefferson 2004) and analysed using conversation analysis (see Drew & Heritage 1992 for a summary). Conversation analysis focuses on, and provides conventions for, the analysis of talk as a vehicle for social action (Hutchby & Wooffitt 2008). CA studies of psychotherapeutic interaction seek to understand how therapists and clients can perform sequentially organized social actions by designing their utterances in particular ways (Madill et al. 2001; Peräkylä et al. 2008). In other words, CA provides a means for examining how therapists and clients do what they do, and how each understands what the other is doing with their talk (Schegloff 2007).

The fragments analysed here all involve a discussion of behavioural change (otherwise known as Behavioural Activation in CBT). These fragments were taken from a corpus of 34 extended fragments where Behavioural Activation was discussed within therapy sessions. Detailed analysis of these fragments demonstrates the real-time, complex interactional work entailed in co-implicating (or not) clients in this process, and highlights the interactional consequences that follow.
Analysis

Co-Implicating Clients in Decision Making

The following fragments illustrate how therapists use information-soliciting questions to co-implicate the client in the process of formulating a goal for behavioural change. With these questions, clients are asked to provide the first suggestion for a possible change they could implement in their lives.

The first fragment follows an extended troubles-telling from the client concerning her feelings of being overwhelmed. She is dealing with problems involving her daughter, she is trying to prepare for Christmas, and she is not getting enough sleep. The fragment begins with the therapist’s formulation of the client’s trouble in lines 1–5. The therapist’s information-soliciting question comes at line 12 (marked with arrow). 5

(1) [CBT 019 beach 47:21]

1 T: SOUNDS LIKE (0.2) um when a lot of things come up (.) [u:m]
2 C: [Mm]
3 y’know for you: they kind’ve get priority over
4 C: Umhm
5 T: looking after yourself?
6 C: Mm.
7 (0.3)
8 C: Yeah.
9 (.)
10 C: I guess: (0.5) it’s: (.) yeah that does.
11 (0.4)
12 T: → Is there anything that you could do ta (0.3) help with that? Do
13 you think? Over the next couple of wee:ks?
14 (2.8)
15 C: >I dunno just < (. ) maybe (0.2) writing in my list a bit of time
16 out time.
17 T: ↑Okay.

At the beginning of the fragment, the therapist offers a gist formulation (Antaki 2008) of the client’s trouble (lines 1–5), which receives multiple acknowledgements from the client (“mm” line 2, “umhm” line 4, “mm” line 6, and “yeah” line 8). At line 10, the client looks as though she is about to expand on the formulation in some way (“I guess: (0.5) it’s:”), but she re-does her turn to form another confirmation (“yeah that does”). The therapist then, at line 12, asks the client a question which is framed as a yes/no interrogative but acts as a request for information (Schegloff 2007) about what the client could do to help her trouble (“Is there anything that you could do ta (0.3) help with that?”). With this informationsoliciting question, the therapist gives the client an opportunity to provide a suggestion for behavioural change and thus co-implicates her into the Behavioural Activation process. The interrogative does not contain a suggestion from the therapist for the client to accept or reject. It asks the client to provide a suggestion herself in the next turn.

Alternative responses made relevant by the therapist’s question include “yes + the provision of information,” a “no” response with accompanying account, or an “I don’t know” response. However, the therapist draws on several resources in her turn to set up a preference for a “yes + provision of information” response from the client. Using the “is
there” preface, the interrogative is grammatically structured with a positive polarity preference for a “yes” response (Raymond 2003). The therapist uses the conditional modal “could” (line 12) to downgrade her request to requiring only that the client think of some possible behaviours rather than actually committing to doing them. In addition, the therapist asks the client whether there is “anything” she could do, leaving the options for activities wide open. The term “anything” has been shown by Heritage et al. (2007) sometimes to be heard as a negative polarity item that produces “no” responses from recipients (e.g., in GP interactions, the question “is there anything else you would like to address in the visit today?” typically received a “no” response from patients). Here, the therapist appears to deal with the potentially problematic negative polarity in her question by incrementally adding the epistemic marker “do you think” immediately following the possible completion of her turn. The use of the epistemic modal “think” downgrades the therapist’s claim to knowledge on the matter and highlights that she is looking for the client to provide a suggestion in response, rather than providing a “no” or “I don’t know” response. Finally, the therapist also adds another increment that downgrades her question, expanding the time frame for possible activities to “over the next couple of weeks.” Thus, providing a “no” or “I don’t know” dispreferred response has been made difficult for the client. In this way, the therapist co-implicates the client in the suggestion-making process while still directing the trajectory of the sequence by restricting the client’s response options.

There is a gap (2.8 seconds, line 14) in the interaction here, following which the client begins her next turn with “I dunno.” She then moves to provide an option for behavioural change, thus orienting to the preference for the provision of information that was set up by the therapist’s interrogative. The therapist provides an “okay” (line 17), that accepts the client’s suggestion. In providing this acceptance response, the therapist re-asserts her involvement in the suggestion-making process. The therapist has provided the client the opportunity to suggest a behaviour, but this in turn allows her to accept the change and thus “have the last word” in the third position. This third-position turn again shows how the therapist co-implicates the client, while remaining the director of the sequence trajectory.

Some further examples can be seen below. In each case, the therapist asks an open, information-soliciting question that allows the client to provide his/her own possible suggestion for change (marked with an arrow). After the client provides a suggestion in response, the therapist provides an acknowledgement of the suggestion in the third-position.

(2) [CBT 019 beach 48:27]

1 T: → An’ what particular fun activity could you look forward to?
2 (0.6)
3 C: OH maybe jus’ watching a d-v-d maybe or jus’ goin’ out the
4 back [’n]
5 T: [O ]kay.

(3) [CBT 017 alcohol 13:30]

1 T: .hhh AND I SUPPOSE when we talk about your alcohol use as a bit
2 of a coping strategy,
3 C: hohh sorry.
4 T: N’t o that’s alright
5 (0.3)
6 T: hah hah [hah heh heh]
7 C: [( )] yep,
In each of these fragments, the therapist’s interrogatives have allowed clients to make their own suggestion for change. Although it is the therapist who initiates the action and thus restricts how the client can respond, the client is co-implicated in shaping the nature of the behavioural changes. In each case, in third position, the therapist produces an acknowledgment or acceptance response to the client’s suggestion, re-asserting her contribution to the suggestion-making process. In this way, the start of the behavioural change sequence is negotiated between the two parties to the interaction.
\textit{Therapists’ Re-Shaping of Clients’ Suggestions}

Looking further, in such “co-implication” sequences it becomes apparent that the suggestion-making process is a much more complex and therapist-guided interactional accomplishment. Therapists guide the suggestion-making activity much more actively than their first information-soliciting question may suggest. They routinely do this through turn constructions such as anticipatory completions, (re-)formulations and reported speech. For example, the fragment below is an extension of Fragment 2 above.

(5) [CBT 019 beach 47:21]
\begin{enumerate}
\item T: \rightarrow An’ what particular f\textsuperscript{†}un activity could you look forward to?
\item (0.6)
\item C: OH maybe jus’ watching a d-v-d maybe or jus’ goin’ out the ba:\textsuperscript{ck} [‘n]
\item T: \rightarrow [O]kay.
\item (0.6)
\item C: No coz if I go out the back I look at the weeds.
\item T: Heh heh heh
\item (0.2)
\item C: Yes maybe jus’ spend some time with Holly=or even just (0.2)
\item T: \rightarrow go to the beach.=
\item (0.2)
\item C: =YEAH go down the beach [I reckon.] [Might even d]o that.
\item T: \rightarrow [Yeah ] [Ye:	extsuperscript{a}h. ]
\end{enumerate}

The client’s answer to the therapist’s information-soliciting question, which occurs over lines 3–4, is rather vague. The client produces three vague suggestions, including “maybe jus’ watching a d-v-d maybe,” “jus’ goin’ out the ba:\textsuperscript{ck},” or “maybe jus’” spending some time with her dog, Holly. All of these suggestions, at best, display a rather weak commitment to engage in an activity. The therapist responds to this vagueness with some additional work of negotiation. Instead of waiting for the client to finish her turn at line 10, the therapist comes in to complete the client’s turn.

The therapist enters at a point where it is projectable that the remaining component of the client’s turn will be a suggestion of an activity she might do. The client’s intra-turn pause provides the therapist an opportunity to enter (Lerner 1996). Rather than beginning a new turn, the therapist produces a continuation of the client’s current turn-construction-unit (TCU) (Sacks, Schegloff & Jefferson 1974). Lerner (2004) has demonstrated how these “anticipatory completions” can achieve a heightened sense of affiliation between participants in interaction, and the use of the form appears to work in this way here. Therapist and client are not just sharing ideas; rather, they are sharing turns. Although the therapist has suggested the idea of going to the beach, this has occurred as a completion of the client’s turn. Additionally, going to the beach is something that the client had said she enjoys doing 10 minutes earlier in the session.

The client responds with a loud “YEAH” confirming the therapist’s candidate completion. She then partially repeats the completion, re-instating her authority over the turn’s talk (Lerner 2004). The client then adds that she “might even do that.” The use of “even” here highlights that the therapist’s completion had not been exactly what the client had intended but that it is accepted anyway. The therapist has thus made a suggestion for a course of action to the client in a way that allows the suggestion to be negotiated. In using an anticipatory completion, the therapist has also been able to achieve strong affiliation.
with the client. Rather than making an independent suggestion, it is as though the therapist has “read the client’s mind.” And this time, it is the client who is able to produce the third-position acceptance of the idea, to re-instate her contribution to the suggestion.

One and a half minutes later, after the client has taken several turns to expand on the idea of a trip to the beach, there is one final act of participation from the therapist. Her turn is framed as a gist formulation (Antaki 2008) of the client’s idea, with the turn-initial upshot marker “so” followed by a summary of the client’s prior suggestion to spend time by herself.

(6) [CBT 019 beach 49:00]

1 T: → SO so just spending time (.) with yourself [an’ ] watching the
2 C: [Mm ]
3 T: waves an’ (0.2) [maybe] getting an ice crea:m [or something]
4 C: [Mm: ] [Mm: that’s ] a
5 good idea just go down grab an ice cream an’ jus’ sit on the beach.

Here, within the therapist’s gist formulation, suggestions of “watching the waves” and “getting an ice cream” are added. However, because the turn is framed as representing the gist of what the client has already said, a cooperative link appears to have been built between the therapist’s version and that of the client. The therapist has made a suggestion about activities in which the client should engage, but through the structuring of her turn she accomplishes this in a way that sounds as though the suggestion has originated with the client. Although disconfirmation of the formulation is one relevant response for the client, the turn projects a strong preference for confirmation. As Vehviläinen (2003) has noted, gist formulations are particularly persuasive because the talk is framed as being based on something that has already occurred in the client’s talk, so a disconfirmation of the therapist’s formulation would imply a disconfirmation of the client’s own talk.

The client orients to the dual action of the therapist’s formulation in her response. She first confirms the therapist’s formulation (“mm”), then accepts the new aspects of the formulation (“that’s a good idea”), and finally partially repeats the new suggestions (“just go down grab an ice cream an’ jus’ sit on the beach”). In repeating this part of the therapist’s turn, the client again conveys a position of epistemic authority (Heritage & Raymond 2005; Stivers 2005) over the suggestions, reinforcing that it is she who will decide what she will do. This repeat by the client also emphasizes the negotiated manner in which the suggestion for behavioural change has been accomplished within the interaction, as both participants have now verbalised the suggested idea. So, again, by designing her turn as a gist of what the client has already said, but adding new ideas as well, the therapist co-implicates the client while still guiding the trajectory of the Behavioural Activation sequence.

Over the course of this sequence, therapist and client have negotiated an accepted version of behavioural change for the client. The therapist begins with information-soliciting questions that prompt suggestions from the client about the type of action she may take to solve her trouble. In using this interrogative form, the therapist co-implicates the client in the suggestion-making process. The therapist then moves to offer more specific suggestions to the client, but does so in a way that allows the client to remain part of the negotiation. She first offers an anticipatory completion of the client’s turn, which the client can either accept or reject. She then offers a gist formulation (Antaki 2008) of the suggestion that is framed as a summary of the client’s own words despite containing additional suggestions within the turn content. Again, in using a gist formulation, the client is given the opportunity either to confirm or disconfirm in the next turn. Both the anticipatory completion
and the gist formulation are turn structures that offer only candidate suggestions to the client. In this way, it is the client who is able to have the ‘last word’ on whether to accept or reject the therapist’s participation in the sequence. In other words, although the therapist has guided the sequence of suggestions for behavioural change, this has been done in such a way that the suggestions can still be attributed to the client. The sequence progresses undisrupted and the two interlocutors arrive at agreement without major signs of trouble, misalignment or resistance within the interaction. Although the client’s agreement may appear passive in comparison to the guiding strategies used by the therapist across the sequence, an agreement has still been reached, and the therapy session is able to progress.

We will look at one further example of how therapists actively re-shape clients’ suggestions for behavioural change below. This fragment is an extension of Fragment 4. In the just prior sequence of talk, the therapist has been discussing the need to implement a behavioural change to shift some negative thoughts of the client concerning that she “should” be doing things she doesn’t necessarily want to do. It is suggested that the negative thoughts (or “should statements”) might be shifted by some changes in the client’s behaviour.

(7) [CBT 011 cooking 52:24]

1  T: SO THEN in thinking about that and tryin’ to move away from
2    these should <:statements:>(0.2) what do you think are some more
3  helpful ways of (.)(.) you know talk:ing to yourself?
4          (0.3)
5  T: Based on these adult way of [tau-]
6  C: [Yeah] (.). well (.). for EXample
7     (1.2) we’re having friends over for dinner: and I don’t feel
8  like to prepare dinner I will jus’ (0.5) need to say “no”
9     (0.4) “I’m not going to prepare dinner I’m gonna buy takeaway”.
10 (1.0)
11 T: Y↑ep
12 (.)
13 T: → So thinking of alternatives? [I suppo]se [is is ] somethink as
14 C: [yeah ] [yeah ]
15 T: well? [I’ll try] (.).
16 C: [yeah ]
17 C: yeah.=
18 T: =not pressure myself ta (.). to do (.). uh- m- to coo:k.
19 C: Yeah to cook if (.). if I’m tired or if I’m not in the mood to
20 do it.

The therapist takes a turn, at line 13, formatted as a gist formulation of the client’s suggestion (again with the turn-initial upshot marker “so”). At this point, she reformulates the suggestion slightly (“thinking of alternatives”). Again, as the turn is structured as a gist formulation of the client’s prior talk, rejecting or disconfirming it is made difficult for the client. As seen in Fragment 5, the therapist’s use of a gist formulation here co-implicates the client (by using a formulation of her prior talk), while also directing the trajectory of the sequence (by subtly reformulating the suggestion).

An additional resource is also drawn on in the therapist’s formulation to co-implicate the client in the Behavioural Activation discussion here. The therapist voices the client
in her formulation: “I’ll try (.) . . . not pressure myself ta (.) to do (.) uh- m- to coo:k.” The “I” and “myself” in the therapist’s turn here refer to the client, rather than to the therapist herself. This voicing bolsters the sense that the therapist’s formulation is based on the client’s own talk. So, the therapist is able to provide a reformulated suggestion for behavioural change while maintaining the client’s involvement in the suggestion, and hence jointly negotiating the suggestion with the client. The client responds with a confirmation of the therapist’s formulation, also partially repeating her earlier suggestion and elaborating it slightly (“Yeah to cook if (.) if I’m tired or if I’m not in the mood to do it”). The [partial repeat of the formulation + elaboration] works to retain the client’s authority over the suggestion (Stivers 2005). Again, the suggestions for behavioural change can still be attributed to the client, despite the therapist having re-shaped the client’s original suggestion that occurred within her own talk. In this way, the client can still take responsibility for the behavioural changes and has the opportunity to feel the accompanying empowerment over, and confidence in, her recovery.

In these instances, we have illustrated how clients are co-implicated into the process of suggesting possible behavioural changes in order to help solve their trouble, while therapists still actively engage in guiding the process toward an end goal. In this way, the suggestion-making process is gradually developed as a complex joint production by both participants. In the next section, these instances will be compared with those where therapists make their own suggestions for change to clients.

Therapists’ Proposals for Behavioural Change

The ‘co-implication and re-shaping’ sequences can be compared with other sequences in the corpus where therapists proposed behavioural changes to clients without ever soliciting clients’ suggestions or opinions. Such sequences have been found to lead to widespread resistance from clients (Ekberg & LeCouteur forthcoming). For example, Fragment 8 comes from a sequence where the client has been talking about feeling good after teaching a class where the students seemed keen for her help. This telling leads to a discussion about possible behavioural change that could occur for the client to get that feeling more often. However, instead of the therapist asking the client for suggestions about what she might be able to do, she offers her own proposal (therapist’s proposal turn marked with an arrow):

(8) [CBT 017 volunteering 28:24]

1  T: → .hh that’s interesting as w↑ell um I don’t know if you’ve
2  C: thought about volunteer work or:: (0.9) anything like that?= (ˌfʌŋk.tɪŋ)
3  T: =Well yes but at the moment my I- (.) physklee
4  C: Umhm
5  T: I can’t do more than I’m doing as far as my work is concerned.

In this fragment, the therapist, across lines 1 and 2, makes a proposal for behavioural change, that is, that the client undertakes a new activity such as volunteering. Although the proposal is delivered in a tentative way (“um I don’t know if you’ve thought about”) and with questioning intonation, it is the therapist’s own suggestion, and the client is not co-implicated in the suggestion-making process. By making her own suggestion, the therapist is positioned as the person with the best knowledge of what action the client should undertake (volunteering work or anything like it), and the client is not provided with much
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opportunity to make her own suggestions for change. In second position, the client can merely either accept or reject/resist the proposed suggestion. Here the client responds with resistance across lines 3 and 5. In particular, she provides an account based on her own experience for why she cannot take up the proposed action. In doing so, she asserts her epistemic authority (Heritage & Raymond 2005) over what she can and cannot do.

Another example of the type of therapist proposal for behavioural change that was common in the corpus can be seen in Fragment 9.

(9) [CBT 002 dinner 26:35]
1 T: → H↑ave you thought about talking to your Mum and s:aying (0.2)
2 y’know “↑okay mum obviously: (0.3) this idea of a seafood dinn↑a
3 (0.3) is not ↑leasing you.”
4 (1.0)
5 T: → “wh↑at is it that you’d actually like for your birthday?”
6 (0.2)
7 C: UH NO: [IT’S] THE WAY THEY’VE BEEN BR↑ought ↑U::P=THEIR
8 T: [ no ]
9 C: MENTALITY IS WE’VE GOT LOTS OF FOOD AT HO↑ME.

Again, the therapist proposes her own suggestion for behavioural change (lines 1–5) without attempting to co-implicate the client in the process of identifying possibilities. The proposal is, again, delivered tentatively, in this case as an interrogative. The therapist uses the low modality phrase “have you thought about” on commencement of the interrogative and, in doing so, sets up the proposal as candidate and tentative. However, despite the tentative delivery, the therapist is still making her own suggestion for behavioural change and is thus positioning herself as “knowing best” about what the client should do. Further, the use of the past tense, “thought,” emphasises that the therapist has already thought of the solution and is merely checking whether the client has also thought of it (a similar use of “thought” can be seen in Fragment 8 and can be compared with the present tense “do you think” seen in Fragment 1). In response to this proposal, the client is only provided the opportunity to accept or reject the proposal passively. The client resists the therapist’s proposal (lines 7–9), again providing an account from her own experience as to why she could not commit to the proposed change.

These examples demonstrate how therapists’ proposals for behavioural change set up a very different next-turn for the client than the information-soliciting questions seen in Fragments 1–4. Whereas the information-soliciting questions allow clients to make a suggestion for change, clients can only passively accept or reject therapists’ suggestions (and clients overwhelmingly resisted such proposals in this corpus). In the above ‘co-implication and re-shaping’ sequences, even though therapists guided the negotiation towards a behavioural plan, the suggestions could still be attributed to the clients. Such sequences appeared to progress in a much smoother manner than the sequences in which therapists suggested their own changes from the outset, thus removing the client from the suggestion-making process altogether.

Conclusion

Analysis of these fragments has demonstrated how therapists can use information-soliciting questions to provide clients with an opportunity to make a suggestion for behavioural change in the achievement of a joint negotiation towards an agreement for change. Such
questions thus positioned the client as the knowledgeable party in the interaction; as the one who would know how to change their own behaviour. However, further analysis demonstrated that therapists guided the negotiation in a more active way than their first question might suggest. They commonly used gist formulations and other collaborative turn structures, such as anticipatory completions and active voicing, actively to engage in, and guide, the behavioural activation process. In this way, the suggestion-making process became a complex negotiation between both parties: clients were invited to participate in the suggestion-making process, while the therapist directed the trajectory of the sequence in a therapeutically relevant way.

We saw in Fragments 8 and 9 how therapists sometimes proposed their own suggestions for change without co-implicating the client in the suggestion-making process. By proposing their own suggestions for change, therapists implied that they knew what was best for the client. Clients, in response, were positioned either to accept or reject the proposal. These proposals were subsequently resisted by clients in ways that asserted the clients’ epistemic authority (Heritage & Raymond 2005) over the situation, and this resistance was typical across the data corpus. This resistance can be compared with the ‘co-implication and re-shaping’ sequences which typically progressed smoothly, and in a stepwise fashion, to a point where therapist and client agreed on a suggestion for behavioural change. Therapist and client appear aligned and affiliated throughout these sequences, with little or no signs of resistance that can be heard from the client.

These findings support the premise proposed by Pilnick (2008) that, for clients in institutional settings, specifically health care settings, deciding to agree on a proposal for action is not recognised as the same and not responded to in the same way as choosing their own action. The different ways in which therapists interactionally structure their involvement in the behavioural activation process can have significant consequences for the trajectory of the therapy session.

These findings add to the established CA literature on turn designs that can be used to co-implicate clients in institutional activities. For example, similar to Maynard’s (1989, 1991, 1992) perspective-display series, the current analysis demonstrates that asking clients to provide their own suggestions for behavioural change, through information-soliciting questions, works to co-implicate them in the therapeutic process. The analysis of these sequences also extends previous research by showing how clients can be co-implicated in a complex negotiation across extended sequences of interaction. The process of inviting the client to commit to behavioural change occurred over a long and complex, negotiated, sequence of interaction. A turn-by-turn analysis of these sequences is ideally suited to demonstrating the joint and gradual negotiation of this therapeutic goal, and the complex relationship between the participants in coming to an agreement for change.

The findings also have implications for CBT research and practice. The way in which therapists attempt to co-implicate clients in these interactions reflects the therapeutic relationship encouraged in CBT referred to as “collaborative empiricism” (Wright et al. 2006). Therapists are encouraged to collaborate with clients in the therapeutic process, in particular by using Socratic questioning to draw out clients’ own ideas and allow them to have direct input (Beck et al. 1979; Neenan & Dryden 2000; Wright et al. 2006). However, there has been no previous evidence of how this practice might be accomplished within the CBT interaction. The analysis presented here illustrates the benefits that conversation analysis can bring to examination of the therapeutic process. The findings suggest that this CBT notion is perhaps more interactionally complex than is often described in the theoretical CBT literature. Although it appears straightforward, it is apparent from the CBT corpus that it can be a complex task, as therapists face the dilemma of needing actively to guide
the trajectory of the therapeutic interaction, as well as offering clients the opportunity to be co-implicated in the suggestion-making process. When working with clients in a theoretically “collaborative” manner, therapists may risk losing sight of the therapeutic goals of the session. The analysis demonstrates, however, that therapists can use specific turn structures to co-implicate clients, while remaining the director of the sequence-in-progression. They can, in this way, continue to work towards the accomplishment of the therapeutic goal (in these cases, an agreement for behavioural change). Whereas using “Socratic questioning” is part of the current CBT professional stock of interactional knowledge (Peräkylä & Vehviläinen 2003), CBT theory arguably provides less guidance for therapists about how behavioural activation might progress beyond Socratic questioning of the client, particularly if the suggestions provided by the client are vague or not in line with overall therapy goals. The analysis presented here has shown some of the implicit strategies used by CBT therapists, in practice, to negotiate behavioural change beyond the step of Socratic questioning in order to guide clients into alignment with the overall therapy goals.

Further research into interactional accomplishment of CBT activities is required, in particular into how these activities might be jointly produced by therapist and client. Future research may also look to examine video-recorded data to examine the potential coordination of gaze and gesture within negotiated sequences of behavioural change, and other CBT techniques.

Notes

1. Socratic question involves asking clients questions which: (1) the client has the knowledge to answer; (2) draw the client’s attention to information which is relevant to the current discussion; and (3) shift the focus of the discussion from the concrete to the abstract so that clients can apply the new information to re-evaluate a previous conclusion or construct a new idea (Padesky 1993).
2. A nuchal translucency scan is a prenatal ultrasound scan to help identify higher risks of chromosomal defects, including Down’s syndrome.
3. All participants provided informed written consent, and the study was approved by the University of Adelaide ethics committee. All names are anonymized in the transcripts.
4. According to CBT theory, Behavioural Activation involves engaging clients in a process of change that is designed to stimulate a sense of positive thought and hope, or help them solve a problem (Blackburn & Davidson 1990). Therapists aim to help clients choose one or two actions that will make a positive difference to how they feel, and then assist them in coming up with a plan to carry out these actions (Wright et al. 2006).
5. In each of the below fragments, T = therapist and C = client.

References


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