Resisting behavioural change: Proposal-resistance sequences in Cognitive Behavioural Therapy sessions for clients with depression

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Abstract

The thesis examines some of the standard ways in which therapists attempt to initiate behavioural change in clients attending Cognitive Behavioural Therapy (CBT) sessions for the treatment of depression, and highlights the interactional consequences that follow from such attempts.

CBT is one of the most widely used treatments for depression across the Western world. Previous research on the use of CBT for depression has largely involved outcome studies that measure the overall effectiveness of this form of treatment. These studies have not examined the specific aspects of CBT practice that allow therapists and clients to accomplish particular therapeutic goals. The analysis undertaken in this thesis was concerned with identifying the different ways by which therapists accomplished one specific CBT practice – that of behavioural activation.

Conversation analysis (CA) was used to analyse a corpus of 20 naturally-occurring CBT sessions involving clients diagnosed with depression. The sessions were recorded at the Centre for the Treatment of Depression and Anxiety (CTAD) in Adelaide, a university-affiliated teaching clinic that specializes in CBT treatment. Sessions were one-on-one with the therapist and client, and typically lasted one hour.

The analysis showed that when therapists approached the practice of behavioural activation by proposing their own suggestions for behavioural change - in what might be referred to as a non-collaborative manner - widespread client resistance ensued. That is, turns in which therapists proposed their own suggestions for change recurrently led to resistance from clients. This pattern
was noted, even though in each instance, therapists displayed subordinate epistemic authority within their turn design. In contrast, when therapists approached behavioural activation via questioning and the use of collaborative turn designs, such as gist formulations and collaborative completions, the sequence typically appeared to run off without a hitch.

The analysis also demonstrated patterns in the way that clients typically produced resistance to therapists’ proposals for behavioural change. Clients commonly drew, first, upon premonitory resistance resources (withholding a response or initiating repair), before producing one of four types of ‘resistive accounts’. It was shown that clients’ resistance turns were not only designed to reject therapists’ proposals but also to display resistance to more subtle implications carried within the proposals, and to display their epistemic authority over the matter at hand, relative to the therapist.

Finally, the analysis showed how therapists and clients managed clients’ resistance to therapists’ proposals for behavioural activation in the way that they exited the proposal-resistance sequence. By transitioning into a troubles-telling before therapists had properly responded to their resistance, clients’ resistance was left without immediate sequential consequentiality in the interaction.

These findings are discussed in relation to their implications for the field of conversation analysis and for CBT theory and practice.
Declaration

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

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Katherine Anne Simmons

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CHAPTER 1

Introduction

1.1 Overview

This thesis examines some standard ways in which therapists attempt to initiate behavioural change in clients with depression attending Cognitive Behavioural Therapy (CBT) sessions, and highlights the interactional consequences that follow from such attempts. CBT is one of the most widely used treatments for depression across the Western world. Previous research on the use of CBT for depression has largely involved outcome studies measuring the overall effectiveness of this form of treatment. These studies have not examined the specific aspects of CBT practice that allow therapists and clients to accomplish specific therapeutic goals. The analysis undertaken in this thesis concerns the different ways by which therapists accomplished one specific CBT practice that involves engaging clients in behavioural change – that of behavioural activation.

The aim is to explicate how this key practice is achieved interactionally within the CBT session. In particular, the thesis focuses on the consequences, for the interaction, when therapists attempt behavioural activation by proposing their own suggestions for behavioural change. When such proposals were introduced by therapists in ways that did not engage clients collaboratively, client resistance was observed, repeatedly, to be the consequence for the therapy interaction. The analysis thus demonstrates that the ways in which therapists construct their turns when performing behavioural activation techniques can have important interactional implications for the trajectory of therapy sessions.
Conversation analysis (CA) was used to analyse a corpus of 20 naturally-occurring CBT sessions involving clients diagnosed with depression. The sessions were recorded at the Centre for the Treatment of Anxiety and Depression (CTAD) in Adelaide, a university-affiliated teaching clinic that specializes in CBT treatment. The analysis examined, turn-by-turn in a sequential fashion, the ways in which therapists approached the practice of behavioural activation; the ways in which clients typically displayed resistance to some behavioural activation practices; and considered why clients may have displayed such widespread resistance at these particular points in the therapy interaction.

This introductory chapter will position the current analysis in relation to theory and research in CA and CBT. Previous contributions from conversation analytic research in the field of psychotherapy will be reviewed. In addition, an understanding of the theoretical underpinnings of behavioural activation techniques in CBT will provide a relevant background for examining how these practices are actually played out within the therapy interaction. Experimental outcome-based research examining CBT for depression will also be reviewed briefly in order to position the current analysis within the broader field of CBT research. Finally, the focus of the analysis undertaken in this thesis will be described in more detail, and the content of the remaining chapters will be outlined.

1.2 CA research with therapeutic data

CA studies of psychotherapy seek to understand how therapists and clients accomplish sequentially organized social actions by designing their utterances in particular ways (Peräkylä, Antaki, Vehviläinen, & Leudar, 2008). The action focus, turn-by-turn analysis, and emphasis on participants’ orientation make CA ideally suited to empirical examination of the nature of the psychotherapeutic process (Madill, Widdicombe, & Barkham, 2001). CA has been used to study therapeutic interaction since Sacks’ first study of a group therapy session (see Sacks, 1992). Much of this work has focussed
on psychoanalytic interactions, however, there are a handful of studies that have examined other types of therapy including psychodynamic-interpersonal psychotherapy (Madill et al., 2001), HIV counselling sessions (Kinnell & Maynard, 1996; Peräkylä, 1995; Silverman, 1997), and CBT interactions (Antaki, 2007; Antaki, Barnes, & Leudar, 2004, 2005a, 2005b). These studies all attempt to explicate the practices of therapy, that is, to demonstrate how therapists bring off their work. It is these studies that inform the analysis in this thesis. The following section provides a brief overview of some of these studies to illustrate the ways in which CA can contribute to psychotherapy research and practice.

1.2.1 Therapists’ ‘formulations’ and ‘interpretations’

Much CA work in psychotherapy has focussed on therapists’ ‘formulations’ of clients’ talk: the practice of the therapist proposing a version of events that follows directly from the client’s own account, but involves some kind of transformation (Antaki, 2008). Davis (1986) was the first to use CA to describe therapeutic formulations as an interactional activity. She described three stages in the process of problem formulation: (1) definition of the problem (therapist reshapes the gist of one aspect of the client’s telling in terms of a problem warranting therapeutic attention); (2) documentation of the problem (providing the client with evidence from her life which supports the therapist’s formulation); and (3) organization of the client’s consent (gaining acceptance from the client of this new formulation of her experiences). Buttny (1996) also subsequently found that therapeutic (re-)formulations commonly draw on aspects of clients’ accounts within an examination of two therapy consultations (one with a couple and the other with a family of five). He also found that these therapeutic formulations are often framed as tentative and left open for further revision from the client. The process of problem formulation within psychodynamic-interpersonal psychotherapy has been examined by Madill et al. (2001). They focused on the way in which a
therapist, following a telling from a client that focused on a complaint about her partner, used gist formulations and assessments to attempt to bring about topic shifts to focus on the client’s feelings.

It has also been shown that formulations can achieve other psychotherapeutic goals (Antaki et al., 2004, 2005a). In analysing a corpus of CBT sessions, Antaki et al. showed that formulations could be used by therapists to serve the management of the session, namely to propose diagnostically-relevant versions of what their clients say. In this way formulations act like traffic-management – they can formulate what the client has said as either not therapeutically interesting at that point in the interaction, or they can frame the client’s talk in terms of what is relevant to the current or future therapy interventions.

A domain similar to that of therapeutic formulations to which considerable analytic attention has also been paid involves practices of psychoanalytic interpretation. Vehviläinen (2003), for example, has found that psychoanalysts often build a case for an interpretation to be delivered in a stepwise manner, which she referred to as the ‘interpretation trajectory’. Three conversational devices were observed to contribute to the interpretative talk before the delivery of an interpretation. These devices included extensions on the client’s talk (including collaborative completions\(^1\)), formulations (a gist or upshot of the client’s talk), and confrontations (topicalizing some aspect of the client’s behaviour and making them accountable for it). In using these devices, therapists were able to produce their talk as being based on something that had already been said by the client.

Psychoanalytic interpretations that link different domains of the client’s experience have also been examined (Peräkylä, 2004). In a corpus of 27 audio-recorded psychoanalytic sessions, it was found that in the discussion leading up to these interpretations, analysts typically build up sequences that enabled them to re-explicate the client’s experience in ways that created a potential match between different domains of the client’s life, thus making potential links possible. Further, within the
interpretations themselves, analysts used the same words and descriptors as the clients for the domains of the client’s experience being linked. In this way, analysts can re-shape clients’ descriptions of their experiences thus allowing them to be linked to other domains of experience.

When trouble has been displayed in the therapist’s offering of a formulation or interpretation on the client’s telling, Buttny (2001) has described how humour may be used. Using a video-taped couple-therapy consultation, he showed how humour can work delicately to manage the task of providing a contrasting re-interpretation of clients’ relational circumstances.

### 1.2.2 Other actions by therapists

Other actions by therapists have also been examined. Therapists’ questions have been the focus of attention in previous CA research (e.g. Halonen, 2008; MacMartin, 2008). For example, ‘optimistic presupposition’ questions have been analysed in a corpus of narrative therapy and solution-focussed therapy sessions (MacMartin, 2008). These interrogative wh-questions carry presuppositions that affirm the client’s agency, competence, resilience and abilities (e.g., “what skills helped you to be able to do X?”). They accomplish the interactional goal of ascribing positive features to the client thereby enhancing the client’s agency. In a corpus of group therapy sessions with addicts, Halonen (2008) examined how therapists used variations in person reference within their questions to construct the experiences of participants as typical of addicts, and as something with which any addict could identify (e.g. through the use of indefinite person references).

Therapeutic objectives that can be achieved by therapists’ use of idiomatic expressions have also been considered in a corpus of official interviews between mental-health professionals and their clients (including marriage guidance counselling sessions, cognitive behaviour therapy sessions, and
psychiatric interviews) (Antaki, 2007). These sorts of expressions can function to close down a particular topic, or to normalize a client’s account.

It has also been shown how the conversational resource of repair, in particular that of lexical substitution, can be used by therapists to encourage clients to show more explicitly their emotional involvement in what they are talking about (Rae, 2008). This phenomenon is illustrated in the following examples:

[Extract 1] (Rae, 2008, p. 63)

Cl: It feels a little uncomfortable
Th: Or a lot uncomfortable.

[Extract 2] (Rae, 2008, p. 63)

Cl: It’s hard talking about this Michael
Th: Yeah I can see: that (. ) w- when you say har:d I think you mean painful

In both examples, the therapist provides an alternative or modified expression to that just used by the client (referred to by Rae as ‘lexical substitution’). In doing so, they redescribe the client’s affect in a more explicit way.

Another phenomenon, self-disclosure, has been examined in a corpus of psychotherapy sessions (including cognitive-behaviour therapy and humanistic therapy) and a corpus of mundane telephone calls. Antaki et al. (2005b) identified three major features of speakers’ talk that seemed to be significant in making it work as a self-disclosure. These features included that the design of the talk was a report of personal information, was significant (often produced with the use of extreme case
formulations), and was over and above the expectations of the moment. Within these data corpora, self-disclosure often appeared to be used in the sequential environment of reciprocation, that is, it was produced as a ‘second story’ that could be used to show the speaker’s understanding of the gist of the previous speaker’s story, and contribute a corresponding account.

1.2.3 Clients’ responsive actions

Less investigation has been carried out in relation to the actions of clients during the therapy session. There are, however, some recent contributions to this area. In particular, clients’ responses to therapists’ reinterpretations (statements that are grounded in the client’s previous talk but involve a reinterpretation of the client’s events) have been analysed in a corpus of audio-taped therapy sessions run in Italy by cognitive and relational-systemic therapists (Bercelli, Rossano, & Viaro, 2008). Clients typically responded in one of three ways: by using acknowledgement tokens, mere agreements, or extended agreements. In an extended agreement, clients agreed with the therapist’s reinterpretation but additionally accounted for their agreement by providing descriptions or tellings from their lives that corroborated the reinterpretation.

These extended agreements appear similar to the client ‘elaborations’ provided in response to therapist reinterpretations which were examined by Peräkylä (2005; Peräkylä, 2008) in a corpus of psychoanalytic interactions. Through an elaborative response, clients took up some aspect of the interpretation and continued a discussion on that aspect. In doing so, they conveyed agreement with the interpretation. However, clients’ elaborations also often involved discontinuity with the initial aim of the therapist’s interpretation. Rather than openly rejecting an interpretation, or showing their disagreement with it, clients elaborated on those parts of the interpretation with which they could agree. Clients’ discontinuous elaborations thus hid the fact that their response was
discontinuous with central aspects of the interpretation, and enabled them to maintain rapport with the analyst.

A few studies have also looked at client resistance to particular therapeutic practices. Madill, Widdicombe and Barkham (2001) identified several strategies in the way a single client undergoing psychodynamic interpersonal psychotherapy resisted the therapist’s problem formulations. These strategies included reasserting or revising the prior case, non-uptake of aspects of a prior turn, managing and rejecting topic shifts, and the withdrawal of cooperation. Similarly, the single client in Davis’ (1986) study of an initial therapy interview was noted to have displayed resistance to the therapist’s definition of her problem by pointing out instances from her life where it did not apply. It has also been found that therapists’ re-formulations can sometimes lead to a mismatch between the therapist’s and client’s understandings of how a ‘problem’ is to be handled (Antaki et al., 2004).

In an examination of one extended sequence of CBT therapy involving a client with schizophrenia, the therapist’s institutional objective of making a provisional list of problems conflicted with the client’s objective of fully explaining the problem she was currently expressing, and led to resistance from the client to problem formulations. In the first instance, the client did not provide any appreciation of the therapist’s formulation and instead projected more material from her telling, and in the second instance, the client competitively overlapped the therapist’s further elaboration with a version of her recurrent theme that was disaffiliative with the therapist’s prior turns.

Resistance in psychoanalysis has also been examined. Vehviläinen (2008) analysed actions that were taken by therapists as indications of clients’ unconscious resistance. Therapists often confronted these actions from clients and made the client accountable for their prior action. These confronting responses from therapists can, in turn, lead to defensive responses from clients resulting in an expanded argumentative sequence. Another recent study analysed clients’ disaffiliative responses to therapists’ optimistic questions (MacMartin, 2008). It was found that clients sometimes provided an
answer that downgraded the optimism of the question (e.g., by providing a response that oriented to limitations in the scope of the optimistic question), or involved a joking or sarcastic response (e.g., “well I’m an egotist...ha ha ha ha”). Clients also sometimes provided refocussing responses that resisted questions pursuing client self-descriptions by shifting the focus to non-optimistic aspects or re-assigning the optimistic aspects to other persons. For example:

[Client 2 Mar. 8/05 (37:10-37:30)] (MacMartin, 2008, p. 87)

Th: .Hg (.) hgh=what do you think it says about you that you’ve-you were able to:, (0.2) to:, ↑not ↑leave to stay there (0.5) to make the choice to stay: an’ kind of deal with (0.2) things that were going on.
(0.7)
Cl: Because I knew at the #end# my parents did #have# (.) #best intentions for me# in the [ir #hear]ts but.#

The therapist’s question enquired about the personal attributes of the client that enabled him to stay with his parents under difficult circumstances. The client’s response, however, is designed to answer a question about why he stayed with his parents. The client thus shifts the focus of the question within his response (MacMartin, 2008). Clients also sometimes provided non-answers to the questions including complaints about the question or questioner (e.g., “you ask that question a lot eh?”), or a refusal to affiliate with the presuppositions or agendas of the questions (e.g., providing an “I don’t know” response).

In the corpus of CBT sessions collected for this thesis, one particular way in which therapists attempted behavioural activation, through the production of ‘proposals’, recurrently led to overt displays of resistance from clients. I will examine in detail how and why clients may display overt resistance to such proposals, thus building on previous CA studies into client resistance.
This has been a brief overview of CA research conducted on psychotherapy data. The aim of this section has been to illustrate some of the therapeutic practices that have been examined using CA methodology. Other CA psychotherapy research will be discussed throughout the analytic chapters of the thesis as it becomes relevant to the analysis. From this overview, it can be seen that little CA research has analysed CBT data. Those studies that have examined CBT (Antaki, 2007; Antaki et al., 2004) have looked at the practice of formulations and therapists’ use of idiomatic expressions within the therapy session. No studies have examined the specific behavioural practices that are part of CBT treatment. This thesis is thus the first to use conversation analysis to examine aspects of the practice of behavioural activation within CBT. This study will add to previous work on client resistance by illustrating ways in which clients resist therapists’ attempts at behavioural activation, and speculate as to why they might do so.

Conversation analysis of these sequences can explicate how behavioural activation techniques are recurrently done, and the ways in which these actions from therapists produce interactional effects in the client. In describing the different styles used to enact behavioural activation in therapy interaction, and the different consequences of these styles for the interaction, the findings of this thesis can make important contributions to CBT research, theory and practice.

Before describing the focus of this thesis in more detail, in the next section, I will describe the theoretical underpinnings of behavioural activation techniques in CBT theory, in order to provide a relevant background for examining these practices in CBT interactions.
1.3 CBT theory

An examination of behavioural activation techniques in CBT requires consideration of the theoretical basis that informs the practice of this form of psychotherapy. CBT is a structured form of psychotherapy which, when applied to mood disorders, is designed to alleviate symptoms of depression and to help clients learn more effective ways of dealing with the difficulties that contribute to their suffering (Blackburn & Davidson, 1990). It is based on two central tenets: (1) people’s cognitions are considered to have a controlling influence on their emotions and behaviour; and (2) people’s actions are considered to affect their thought patterns and emotions strongly (Neenan & Dryden, 2000; Wright, Basco, & Thase, 2006). It is due to this second tenet that the initiation of behavioural change is considered important in CBT practice.

Aaron Beck’s original proposal, in the 1960s, for a cognitively oriented therapy targeted the reversal of dysfunctional cognitions and related behaviour (Beck, Rush, Shaw, & Emery, 1979; Neenan & Dryden, 2000; Wright et al., 2006). His cognitive behavioural model emphasized relationships among thoughts, emotions and behaviours in treatment interventions. In CBT, therapists encourage the development and application of adaptive conscious thought processes such as rational thinking and problem solving. They also try to help clients recognize and change pathological automatic thoughts and schemas. CBT emphasizes techniques designed to help clients detect and modify their inner thoughts, especially those that are associated with negative emotional symptoms, with the goal of bringing their cognitions into conscious awareness and control (Wright et al., 2006).

1.3.1 Automatic thoughts

For clients with depression, automatic thoughts are argued to centre on themes of hopelessness, low self-esteem and failure (Wright et al., 2006). There are thought to be three components to a depressed person’s thoughts, referred to as the ‘negative cognitive triad’ (Blackburn & Davidson,
These three components include: a negative view of self; a negative view of the world; and a negative view of the future. A negative view of the world might involve clients seeing their life-situation as generally unsatisfactory or frustrating. Problems are viewed as insurmountable and inescapable. A negative view of the future involves clients seeing their current problems as continuing indefinitely and perhaps even getting worse. They feel hopeless and helpless, and lack the ability to make changes to their situation.

1.3.2 Cognitive errors

Within CBT theory, it is proposed that these automatic thoughts involve significant ‘cognitive errors’ which can be modified with CBT interventions. Six main categories of cognitive errors are defined (Beck et al., 1979):

- Selective abstraction: clients draw a conclusion after looking at only a small portion of the available information.
- Arbitrary inference: clients draw a conclusion in the face of contradictory evidence or in the absence of evidence.
- Overgeneralization: clients draw a conclusion about one or more isolated incidents and then extend it illogically to cover broader areas of their lives.
- Magnification and minimization: the significance of an event or attribute is exaggerated or minimized.
- Personalization: clients relate external events to themselves when there is little or no basis for doing so.
- Absolutist thinking (or all-or-nothing thinking): clients place judgements about themselves, their experiences or others in one of two categories (e.g. good/bad, failure/success).
CBT therapists encourage clients to recognize these cognitive errors when they are making them.

In a similar way, clients can have adaptive and maladaptive schemas (or core beliefs) (Neenan & Dryden, 2000; Wright et al., 2006). An adaptive schema might be “I’m a survivor” or “people respect me”. A maladaptive schema, on the other hand, might include beliefs such as “I am a failure” or “nobody loves me”. CBT aims to identify and build up adaptive schemas whilst modifying or reducing the influence of maladaptive schemas.

1.3.3 Collaborative empiricism

CBT therapists, in a similar way to other psychotherapists, seek to establish a therapy environment in which there is warmth, positive regard, and empathy. However, unlike other therapies, the therapeutic relationship in CBT is also guided by a specific working alliance referred to as ‘collaborative empiricism’ (Neenan & Dryden, 2000; Wright et al., 2006). A relationship of ‘collaborative empiricism’ involves therapists engaging clients in a highly collaborative process in which there is a shared responsibility for setting goals and agendas, giving and receiving feedback, and putting CBT methods into action, both inside and outside the therapy session. CBT theory encourages therapists and clients to work together to question 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 a collaborative relationship by engaging clients with Socratic questions and using exercises that draw out the clients’ own ideas and creativity (Neenan & Dryden, 2000; Wright et al., 2006).
The analysis in the current thesis will demonstrate that maintaining a collaborative relationship with clients in the therapy session may not always be easy for therapists; however, it also shows that there are interactional benefits to doing so, and highlights the potentially detrimental interactional consequences when therapists do not approach CBT techniques in a collaborative manner.

In this section I have provided a broad overview of the theoretical underpinnings of CBT treatment for depression. The next section will be concerned with describing the CBT technique of behavioural activation which forms the analytic focus of this thesis.

1.4 Behavioural activation

The practice of CBT involves therapists’ use of a number of systematic techniques specified within CBT theory. Broadly, CBT techniques are divided into two types: cognitive restructuring techniques and behavioural techniques. Cognitive restructuring involves therapists working with clients to reveal and change maladaptive automatic thoughts (Wright et al., 2006). Therapists usually devote a large part of a session to techniques that work on a client’s maladaptive automatic thoughts. Initially, therapists and clients work on identifying problematic automatic thoughts. Once identified, the focus shifts to their modification. According to CBT theory, positive changes in behaviour are also likely to result in improved outlook or other desired cognitive modifications (Beck et al., 1979). The second major aspect of CBT treatment is thus concerned with helping clients make behavioural changes in their lives. It is thought that clients with depression commonly experience decreased capacity to enjoy activities and have difficulty completing tasks and solving problems. Behavioural CBT techniques are aimed at helping clients with these difficulties. Behavioural activation, the focal technique for analysis in this thesis, is one of the most common behavioural techniques used in CBT.
treatment for depression. In this section, I will describe behavioural activation according to specifications in CBT theory.

1.4.1 Behavioural activation within CBT theory

According to CBT theory, behavioural activation involves engaging clients in a process of change that will stimulate a sense of positive thought and hope, or help them solve a problem (Beck et al., 1979). The therapist helps the client choose one or two actions that make a positive difference to how they feel, and then assists them in coming up with a plan to carry out the activities. Therapists are encouraged to engage the client through the use of Socratic questioning. They are also advised to be careful not to suggest a behavioural activation plan that would be too challenging for the client. For example, the therapist might ask: “What ideas have you had about things you might do to change the situation?” or “Is there one more thing you could do in the next week that would help you begin to break out of the rut?” (Wright et al., 2006). According to CBT theory, therapists should strive to be attentive so as to be in a position to ask inductive questions without putting words into the client’s mouth. For example, the question “What action could you take in the next couple of days that would begin to make a difference?”, leaves the response open for the client to provide a suggestion for change. CBT theory provides therapists with several suggestions to help them implement effective behavioural activation plans (Wright et al., 2006). These include:

- Developing a collaborative relationship with the client before attempting behavioural activation. Without good collaboration between therapist and client, it is argued that behavioural activation may fail.
- Letting the client decide the actions to be implemented. Although therapists can guide clients to actions that might be helpful, whenever possible the therapist is encouraged to ask the client to make the choice.
• Judging the client’s readiness to change. It is suggested that therapists should try to
gauge the client’s motivation and openness to change before suggesting behavioural
activation. If the client does not appear interested in making changes, therapists are
encouraged to defer behavioural interventions.

Additionally, as a part of behavioural activation techniques, if clients are displaying deficits in
problem-solving skills, therapists can assist them to formulate a plan that helps organize their
thoughts, approach the problem in an objective fashion, and see the process through to completion
(Beck et al., 1979; Wright et al., 2006). According to CBT theory, the first stage of making this plan
may involve asking clients to record the number and magnitude of their problems (Wright et al.,
2006). This is supposed to allow them to separate their problems, so that they are not trying to deal
with several at once. Therapists can then ask clients to prioritize problems and choose one to target.
Next, therapists might ask clients to attempt to define the target problem clearly. In coming up with
a solution, therapists are again encouraged to ask clients Socratic questions which help them think
creatively about possible solutions. They might also use brainstorming techniques.

Therapists can sometimes make their own suggestions for behavioural change, but only after the
client has come up with a number of possibilities. It is suggested that therapists can then help clients
eliminate solutions from the list which might be unrealistic, are not likely to be useful, or are not
easily implemented at the present time. Clients can pick a solution which is most likely to succeed.
Coming to this decision might require going through the pros and cons of the various suggested
solutions. Therapists might also ask clients to select a day and time to implement their plan. They
might also role-play the proposed solution within the therapy session (Beck et al., 1979).

In summary, behavioural activation is the most common technique used to implement behavioural
interventions in CBT. Behavioural activation involves clients choosing one or two actions they are
able to do immediately, and that are likely to improve their mood. This technique can also be used to aid clients in problem-solving.

Behavioural techniques constitute only part of a single CBT session. As CA analyses focus on the sequential progression of interaction, moment-by-moment and turn-by-turn, it is important to examine where, in CBT sessions, behavioural techniques are generally implemented. In the next section, I will provide a brief overview of the structure of a CBT session with the aim of positioning behavioural activation techniques within the recommended structure of a typical CBT session.

1.4.2 Behavioural activation within the structure of a CBT session

Behavioural activation techniques are not drawn upon haphazardly, but are used at particular points within the CBT session. This structure is important for CA analyses of CBT that are interested in examining, utterance-by-utterance, the sequential unfolding of the therapy session. Although the analysis in this thesis focuses on one part of the CBT session, it is important for the reader to know where, in the session, behavioural activation techniques are routinely used. They are typically built up to within the session. Recognizing the activities leading up to these points in the interaction is important for coming to an understanding of why behavioural activation was deployed by the therapist at that point in the interaction, and what it was in response to. The therapeutic activities directly leading up to therapists’ use of behavioural activation techniques will be examined in the first two analytic chapters of this thesis. It should be noted, however, that it is outside the scope of the thesis to describe everything that has occurred in the lead-up to the use of behavioural activation techniques. I provide a brief overview of the overall structure of a CBT session here, and indicate where behavioural activation is typically positioned within it. CBT theory lays out the typical structure of a CBT session as follows (Blackburn & Davidson, 1990):
• A review of the client’s state. This may involve a general inquiry by the therapist or, more commonly, a review of the client’s score on a self-rated questionnaire (questionnaires used at CTAD include the Beck Depression Inventory (BDI); the Quick Inventory of Depressive Symptomatology (QIDS-SR); Kessler Psychological Distress Scale (K10+); the Mini neuropsychiatric interview version 5.0.0 (MINI); and the Depression Anxiety Stress Scales (DASS)).

• Set the agenda. At this point a discussion of the agenda for the current session takes place.

• Review of homework. Therapist and client discuss the outcomes, difficulties and conclusions from the client’s homework assignments over the previous week.

• The above activities may lead the client to embark on an extended telling, particularly if the client is troubled by something specific that has occurred during the previous week and they want to discuss it.

• Session targets. This stage takes up the main part of the session. It involves going through the focal techniques of the session. These techniques typically involve one or two cognitive or behavioural techniques, depending on where the client is at in their treatment trajectory. Behavioural activation techniques are drawn upon within this stage of the therapy session, if relevant to the session agenda.

• Set homework. The client is assigned a task relevant to the session’s targets to complete outside of the therapy session before their next appointment. Therapists generally explain the rationale of the task. The therapist and client may also discuss anticipated difficulties for the client in completing the task and, if necessary, rehearse the task.

• Session feedback. The therapist checks whether there was anything during the session that was upsetting, unclear, or unhelpful for the client. They also enquire how the client is feeling and invite the client to ask any other questions or comment about the session.
Although there is room for flexibility within a session, keeping to the structure of a session is considered important (Blackburn & Davidson, 1990). According to CBT theory, the session structure allows therapists and clients to deal effectively with problems within the time available, fosters a problem-solving attitude, ensures that the current important topics are covered, provides a convenient way of monitoring the client’s progress during therapy, and ensures adherence to the CBT model. Within the corpus of CBT sessions collected for this thesis, the session trajectory did (flexibly) follow these lines. When behavioural activation techniques were drawn upon by the therapist, they typically followed on from extended tellings by clients about troubles that had come up during the previous week. These tellings were initiated during the stages where therapists were reviewing the client’s week, reviewing homework, or immediately following the setting of the agenda.

In sum, this section has described behavioural activation in terms of how it is specified within CBT theory. I have also briefly described the typical structure of a CBT session, illustrating that behavioural activation techniques are generally deployed in the middle of the session as part of the session’s target activities. Before moving to further describe the focus of the present analysis on behavioural activation techniques, in the next section I will review some previous experimental research examining CBT treatment for depression. This review will provide a framework for understanding how the current analysis differs from the majority of research into CBT treatment for clients with depression.

1.5 Experimental CBT research

Mainstream research into CBT has typically involved outcome-based clinical studies that attempt to evaluate the effectiveness or efficacy of CBT treatment for depression. Of these mainstream studies,
those focusing on techniques of behavioural activation are also concerned with testing the overall effectiveness of these techniques. In this section, I will provide a brief review of some of the more mainstream research trajectories into CBT for depression in order to position the current research within the broader field of CBT research.

Outcome studies measuring the effectiveness of CBT for depression typically compare clients’ scores on the Beck Depression Inventory (BDI) before and after treatment (A. C. Butler, Chapman, Forman, & Beck, 2006). These studies have had mixed results. For example, a relatively recent review of meta-analyses and primary studies on BDI outcomes for CBT for depression concluded that the effectiveness of CBT has previously been overstated in the literature, and that its efficacy remains to be clarified (Parker, Roy, & Eyres, 2003). A more recent review of meta-analyses comparing BDI outcome studies by Butler, Chapman, Forman & Beck (2006), on the other hand, concluded that CBT is superior to other treatments for depression. Among these outcome-based studies, CBT treatment for depression has been compared to untreated controls, wait list, pharmacotherapy, behaviour therapy, and a heterogenous group of other psychotherapies (e.g. see DeRubeis et al., 2005; Dobson, 1989; Gaffan, Tsaousis, & Kemp-Wheeler, 1995; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Hollon & Beck, 1994; Leichsenring, 2001; Lynch, Laws, & McKenna, 2010; Parker et al., 2003; Shapiro et al., 1994; Thase et al., 1997).

There have also been a small number of experimental studies that have focussed on the effectiveness of behavioural activation (BA) techniques more specifically (Cuijpers, van Straten, & Warmerdam, 2007; Hopko, Lejuez, Ruggiero, & Eifert, 2003; Jacobson et al., 1996). For example, Jacobson et al. (1996) conducted a component analysis of CBT for depression, comparing CBT in its complete form with two component treatment conditions: a behavioural activation condition, and a condition focusing on the modification of automatic thoughts. It was found that behavioural activation alone was equal in efficacy to more complete versions of CBT. In other words, participants
with depression who received BA alone did as well on the outcome measures (BDI, Hamilton Rating Scale for Depression (HRSD), and the Longitudinal Interval Follow-up Evaluation II (LIFE)) as those who were additionally taught coping skills to counter depressive thinking. A review by Hopko et al. (2003) concluded that BA-only treatment may potentially be an economical and cost-effective means to treat clinical depression. However, they also concluded that more rigorous empirical testing was required in order to be conclusive about the potential efficacy of BA treatments for depression. A more recent meta-analysis reviewed 16 randomized effect studies of behavioural activation, that include 780 subjects (Cuijpers et al., 2007). In 10 studies, the effectiveness of behavioural activation was compared to CBT, and it was again concluded that both treatments were equally effective.

All of these studies were outcome-based, measuring the effectiveness of CBT or BA techniques for the treatment of depression. Those studies focusing on behavioural activation techniques examine BA as an independent therapeutic treatment, comparing it to general CBT treatment and cognitive techniques. None of these studies examined BA as one technique used within general CBT treatment. According to Streeck (2008), these types of studies overlook the reality-producing character of the communicative processes involved in CBT. In other words, they do not consider the actual interactional patterns and practices through which CBT gets done. Nor do they consider how particular CBT techniques are accomplished through the moment-by-moment unfolding of the therapy interaction, and the consequences these techniques have for the interaction.

Further, therapists can rarely draw conclusions from these effectiveness studies that would enable them to adjust better to their clients, develop more effective therapeutic strategies or to otherwise improve their practice (Streeck, 2008). Individual CBT techniques cannot be improved by the knowledge that CBT is (or is not), overall, an effective form of treatment for depression.
The focus of the current analysis is different from that of outcome studies. Rather than examining the effectiveness or efficacy of CBT treatment for depression, I will look in detail at how behavioural activation techniques are accomplished within CBT sessions, and at the interactional consequences of differing ways of approaching this technique. The analysis will show how turn design in sequences of behavioural activation in CBT contributes to variable consequences for the ensuing interaction. It will therefore be suggested that the way in which behavioural activation techniques are accomplished by therapists, through their turns-at-talk, can impact how clients respond to this technique within therapy sessions. This study thus provides a very different approach to examining behavioural activation than is found in previous outcome-based studies.

The next section describes the focus of the thesis in more detail, and provides an outline of the remaining chapters.

1.6 Focus of the thesis

This thesis focuses on the ways in which therapists in a corpus of CBT sessions attempted to initiate behavioural interventions for their clients. In particular, it examines the ways in which behavioural activation was achieved. Behavioural activation is typically introduced in CBT sessions after the agenda for the session has been set, and the client has already spent considerable time in-session telling the therapist about his or her specific troubles. As described above, behavioural activation involves therapists helping clients choose one or two actions they can put into practice outside the therapy session that will make a positive difference to how they feel. In doing this, CBT theory encourages therapists to use Socratic questioning, and advises that clients should be allowed to decide the actions to be implemented. In the corpus of recorded sessions, two ways in which therapists implemented this technique were identified. One involved the use of Socratic questioning,
where clients were asked to provide ideas for actions that could be implemented. The other involved therapists proposing their own ideas for actions to be implemented. These two ways in which therapists attempted behavioural activation were analysed in detail. In addition, clients’ responses to these activities were also analysed. In particular, it was noted that clients almost always resisted therapists’ proposals for behavioural change. The ways in which clients displayed this resistance were analysed, and the question of why they might resist at these points in the therapy interaction was addressed. Lastly, the ways in which therapists and clients moved away from these resisted attempts for behavioural activation and into some other activity were also analysed. The thesis is structured in terms of the Chapter outline described below.

1.6.1 Outline of Chapters

The thesis comprises eleven chapters. Following this Introduction, Chapters 2 and 3 are concerned with detailing the methodological approach of the thesis: Conversation Analysis (CA). In Chapter 2, the process of data collection will be described, as well as the use of CA for examining institutional interaction such as CBT sessions. In Chapter 3, I will review some of the major findings in CA which form the foundations for the analysis that follows.

Chapter 4 is the first analytic chapter of the thesis. The focus of this chapter is on one, less common, way in which therapists in this corpus attempted the practice of behavioural activation. This practice involved the use of Socratic questioning (which I have termed a ‘collaborative’ sequence), and it will be analysed through discussion of two case studies.

Chapter 5 focuses on therapists’ more common use of ‘proposals’ that suggest an idea for behavioural change. The lead-up to these proposals will first be described. I will then analyse, in detail, the three major ways in which therapists delivered these ‘proposals’. Subsequently, I will
analyse another practice drawn upon by therapists when delivering proposals that reflects the CBT practice of ‘modelling’.

In Chapter 6, I turn to clients’ responses to therapists’ proposals, in particular the ways in which they typically resist the proposals. Chapter 6 focuses on the ways in which clients display ‘premonitory’ responses to resistance. They do this in two main ways. The first involves withholding a response when acceptance or rejection of the proposal is due. The second involves initiating repair on the proposal. Over the course of this chapter I will show how these two resources can be used as premonitory resistance resources, subtly signalling to the therapist that more overt resistance may be forthcoming.

Chapter 7 will detail how clients in the corpus displayed overt resistance to therapists’ proposals for behavioural change. The four main ways in which clients displayed resistance will be described. Following this, in Chapters 8 and 9, I will analyse three other practices achieved through the clients’ resistance turns. I will show how the design of clients’ resistance turns allows them not only to reject the therapist’s proposal but also (1) to assert their epistemic rights over the matter at hand; (2) to avoid responsibility for the trouble under discussion; and (3) to avoid responsibility for their resistance toward the therapist.

Chapter 10 is the final analytic chapter. In this Chapter, I analyse two ways in which clients commonly exited proposal-resistance sequences and moved back into a troubles-telling. Clients achieved this exit in a stepwise manner, however they initiated the shift out of the sequence before the therapist had responded to their resistance. They were, therefore, able to manage their resistance to the therapist by moving on in the session without their resistance having long-term consequences for the interaction.
Finally, Chapter 11 involves a discussion of the findings and how they relate to previous literature in the fields of CA and CBT. In this chapter I will review the findings, discuss possible limitations of the study, and discuss possible implications and applications of this research for both CA and CBT.

1.6.2 Summary

CBT is one of the most common and well-recognised psychotherapies in the Western world. CBT emphasizes a strong link between cognitions and behaviour. The practice of this therapy, therefore, involves both identifying and modifying maladaptive cognitions, and making changes in behaviour in order to improve a client’s emotional state/experience. The majority of previous research into CBT for depression has involved outcome-based studies measuring the effectiveness or efficacy of CBT by comparing clients’ BDI scores before and after treatment. These studies do not attempt to examine specific treatment techniques used within CBT. Rather than examining outcomes, this thesis sets out to examine how one of the most common techniques used in CBT, behavioural activation, is interactionally accomplished in various ways within the CBT session, and considers the consequences that can follow from different ways of approaching this technique. In particular, analysis focusses on instances where therapists suggest their own behavioural changes, leading to widespread client resistance. The study uses conversation analysis as its methodological approach. Although CA has been used to analyse psychotherapeutic interaction in a number of previous studies, this study constitutes the first conversation analytic investigation of behavioural activation techniques in CBT. In describing how therapists recurrently initiate behavioural change within the therapy session, and the ways in which clients typically respond to these initiations for change, this thesis aims to make significant contributions to: (1) the field of conversation analysis; (2) previous CA research into psychotherapeutic interaction; and (3) CBT research and practice.
CHAPTER 2

Method: Conversation Analysis

2.1 Chapter overview

CBT is primarily accomplished through the exchange of talk between therapists and clients. The analytic method drawn on in this thesis, conversation analysis (CA), can thus be seen as appropriate to the research aim: to describe the procedures by which conversationalists in this setting produce their own interactional behaviour and understand that of others (following Heritage, 1984b). CA will be used here to describe how therapists and clients progressively design and produce their turns-at-talk in order to accomplish (or resist) behavioural activation techniques within the CBT session. This chapter provides an overview of the process of data collection for this study, and of CA as a method for studying ‘talk-in-interaction’. The term talk-in-interaction is used in CA, rather than that of ‘conversation’, so as to include not only mundane conversation, but also interactions within formal and institutional settings such as courtrooms, television and radio interviews, classroom settings, medical interactions, and psychotherapy interactions, among others (Schegloff, 1991).

2.2 Data collection

2.2.1 Data source

The data corpus for this study was collected at the Centre for the Treatment of Anxiety and Depression (CTAD) in Adelaide, South Australia. The Centre specializes in Cognitive Behavioural
Therapy. CTAD is a free clinic that is affiliated with the University of Adelaide. As well as providing clients with treatment by professional psychologists, the clinic also provides training and supervision to Masters of Clinical Psychology students from the University. Therapists working at CTAD thus have a wide range of experience and expertise. Clients are typically referred to CTAD for treatment by a General Practitioner or another healthcare service provider. During their initial visit to the Centre, clients are assessed according to the DSM IV criteria for mood disorders (American Psychiatric Association, 2000), and then referred for treatment for either depression or anxiety. All of the clients whose sessions were recorded for this study were being treated for depression. The depression group was chosen because treatment for depression is limited to the therapy room, whereas treatment for anxiety clients involves various excursions outside the Centre. The typical duration of treatment for clients who attend the Centre ranges from 8 to 12 weeks. Each weekly therapy session involves a one-on-one interaction between therapist and client, lasting for approximately 1 hour.

2.2.2 Recording the data

In the initial stage of this research, psychologists employed at CTAD were met by the researcher who described the nature of the project. They were also given information sheets (Appendix 1) and instruction sheets (Appendix 2) explaining the nature of the study. New student therapists were met by the researcher two weeks into their training at CTAD, and received the same information. If willing to participate, therapists and student trainees signed written consent forms (Appendix 3). They were then asked to invite their clients to participate in the study. Therapists were instructed about how to approach their clients and were provided with client information sheets (Appendix 4) and client consent forms (refer to Appendix 3).

Participation involved the audio recording of individual treatment sessions (recorded sessions did not include initial assessments). Whereas therapists and clients completed only one written consent
form for participation in the study, verbal consent was also obtained from clients at the beginning of each session that was recorded. Digital recording devices were provided for the therapists to use to record their sessions. The researcher had no direct contact with clients. Clients were asked at the end of each recorded session whether they remained willing to consent to the use of the recording for research purposes. If they declined, the therapist erased the recording immediately. Therapists also had the discretion to erase the recording if they did not wish it to be used in the study. The recording devices were stored in a locked filing cabinet in the front office of the clinic. Only the researcher and the therapists had access to this filing cabinet.

When recordings had been made, therapists contacted the researcher via email or phone. The researcher then attended the clinic to transfer files onto a laptop computer and subsequently erase the file(s) from the recorder. The relevant consent forms were also collected at this time.

A total of 20 CBT sessions were recorded, involving 9 therapists and 19 clients. Some participating therapists recorded multiple sessions with different clients. Only one client had two of her sessions recorded (these two sessions were with different therapists). These recordings were collected over a period of 12 months. The duration of the audio recordings for individual sessions ranged from 26 minutes to 75 minutes, with an average session time of approximately 56 minutes. The total duration of all sessions combined was approximately 1,006 minutes (16 hours, 46 mins). These audio recordings comprise the raw data for this thesis.

### 2.2.3 Transcription of the data

The raw data files from the digital recorders were transferred into wav and mp3 files using Sony Digital Voice Editor 3. The recordings were then transcribed by the researcher using two different software programs: Transana 2.12 and Audacity 1.2.6. The data were transcribed using the
Jeffersonian transcription system (Jefferson, 2004), customarily used in conversation analytic research (see Appendix 5 for details). However for the purposes of analysis, the transcripts were used in conjunction with the actual recordings, as transcripts can only ever be partial representations of the talk. All names of people mentioned in the recordings were changed to pseudonyms in order to ensure the anonymity of the participants. Transcribing the data with the Jeffersonian system allows the analysis of minimal turns, silences, in-breaths and out-breaths, intonation, non-lexical items (such as “uhm” or “ah”), laughter particles and overlapping talk that can all perform delicate interactional business (Schegloff, 1981).

The research was conducted in full compliance with, and approval of, the University of Adelaide Human Research Ethics Committee (HREC).

The raw data, in conjunction with the transcripts, were analysed using conversation analysis (CA). This method will be described in the remaining sections of this chapter.

2.3 Overview of conversation analysis

2.3.1 Theoretical underpinnings of CA

Conversation analysis focuses on, and provides conventions for, the analysis of talk as a vehicle for social action (Hutchby & Wooffitt, 2008). It places particular importance on understanding the sequentiality of social action (Peräkylä et al., 2008). CA is concerned with the ways that utterances are intrinsically related to the utterances that precede and follow them. In relation to the present analysis, 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 (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, 2007a). From CA studies, researchers can build a systematic view of recurrent practices in psychotherapy, or more specifically in this thesis, in CBT interactions.

There are three main aspects to CA which differentiate it from other analytic methodologies (Hutchby & Wooffitt, 2008):

- CA is based solely on recordings of naturally occurring talk-in-interaction.

- CA is primarily concerned with how the participants to the interaction understand or make sense of prior utterances, rather than being based on the assumptions of the analyst. Any next turn in a sequence displays its producer’s understanding of the prior turn, and if that understanding happens to be incorrect, that in itself can be displayed in the following turn in the sequence of talk.

- The production of utterances is viewed in CA as a practical social accomplishment. Rather than focussing on the structure of language, CA is concerned with the actions achieved through the specific design of turns-at-talk. CA attempts to describe how participants to interaction understand and respond to one another in their turns at talk, with a central focus on how sequences of action are generated.

In sum, CA’s enterprise is concerned with the detailed analysis of how talk-in-interaction is conducted as the instrument for social action and practice. When applied to CBT data, it provides a means by which therapists’ and clients’ utterances within the therapy session can be analysed for how particular social actions (such as questioning, telling, proposing, agreeing, resisting, or rejecting) are accomplished.
2.3.2 CA analyses

Conducting CA involves identifying patterns, building collections, examining individual instances, comparing instances across collections, and explaining the phenomena that parties rely upon for their interaction to make sense. In the current study, a collection of behavioural activation sequences were gathered for examination. Building this collection involved identifying sequences of interaction in which some sort of behavioural change was discussed between therapist and client. These sequences were identified with the aid of the CBT definitions of behavioural techniques that were discussed in Chapter 1. Once this collection had been built, individual instances were first analysed, before comparing these instances across the collection to identify patterns.

Findings from the study of mundane conversation constitute the benchmark against which other institutional types of interaction, including that of CBT, can be recognized and examined (Drew & Heritage, 1992). Key findings on the organization of mundane talk-in-interaction thus make up the foundations on which I am basing my analysis of CBT data. Findings concerning how participants in conversation build their turns, design their talk and organise sequences of action can be used to describe how particular tasks or actions are accomplished within CBT sessions. In particular, they can be used to examine how the task of behavioural activation is accomplished, and the consequences it can have for the character of the interaction as well as the outcome. In the next chapter I will review some of the foundational CA findings that have particular relevance to my analysis, however, in the remaining sections of this chapter I will first describe how CA can be used to shed light on the nature of institutional interactions such as CBT therapy sessions.
2.4 Conversation analysis of institutional interaction

Types of institutional interaction that have been studied include classroom settings, news interviews, medical visits, courtroom interactions, command-and-control work settings, and therapeutic interactions (Drew & Heritage, 1992). Institutional interaction shows many similarities to mundane interaction but can also show systematic variations and restrictions on activities and its design relative to mundane talk. In analysing the institutional nature of a stretch of talk, conversation analysts attempt to demonstrate that participants to the interaction construct their conduct in ways that display the distinctly institutional character of the talk (Drew & Heritage, 1992). This way of approaching institutional data sets CA aside from other sociological and psychological methodologies, where the analyst might look for aggregates and/or distributions of actions that set the interaction apart from mundane interaction.

Participants may orient to the institutional context in several ways. Firstly, institutional interaction usually involves an orientation by at least one participant to some goal, task or identity associated with the specific institution (Drew & Heritage, 1992). At the same time, however, the implementation of these institutional goals or tasks may be flexible within a given interaction, particularly in less formal institutional interactions such as medical, business or therapy interactions. For example, within a therapy interaction, at some points the talk may be quite formal in nature, whereas at other points the therapist and client may be heard to be speaking in a more mundane conversational manner. There may also be differences in how the lay and professional participants orient to the institutional goals and tasks. Organizational constraints and accountabilities may particularly shape the institutional participant’s conduct, whereas the lay participant may have only vague knowledge of these constraints. For example, in the therapy context, although the therapist may continually orient to the specific therapeutic goals of the session, the client may engage in more mundane, conversational story-telling.
Participants in institutional contexts also often orient to the special and particular constraints on what one or both participants will treat as allowable contributions to the business at hand (Drew & Heritage, 1992). In settings such as courtrooms, participants may shape their conduct in accordance with powerful, and sometimes legally enforceable, constraints on the interaction. However, in less formal settings such as CBT sessions, they may also orient to local and negotiable understandings about the ways that the institutional aspects of their activities may limit their conduct. For example, there may be times when therapists interrupt clients during a telling and do not allow them to continue, if they consider it irrelevant to the therapeutic goals. However, at other points in the interaction, therapists might allow clients to provide extended tellings about a particular problem.

Institutional interaction may be associated with institution-specific inferential frameworks. In some contexts professionals may be constrained to withhold certain expressions that would usually appear in mundane conversation such as surprise tokens or sympathy. In mundane talk the withholding of these actions may be heard by the recipient as disaffiliative, but in an institutional context, it may not.

Institutional talk may also differ in form to mundane interaction. For example, some institutional talk (particularly more formal types such as news interviews and courtroom interactions) may involve systematically different forms of turn-taking. In organizing their turn-taking in a way that is distinctive to mundane conversation, participants recurrently and persuasively display and realize the institutional nature of the interaction (Drew & Heritage, 1992). Variations in turn-taking can thus be analysed to provide a unique ‘fingerprint’ for each institutional form of interaction. In less formal institutional settings (including in therapy interactions) variations in turn-taking procedures may be negotiated and there may be considerable variation in how they are managed. In these settings, whilst the participants orient to the institutional nature of the talk in the ways described above,
turn-taking procedures may reflect conversational, or at least ‘quasi-conversational’ practices (Drew & Heritage, 1992). The boundaries between the forms of institutional talk and mundane conversation may be more permeable.

CBT, as a form of psychotherapy, can be characterised as a type of informal institutional interaction. The aim of CA in psychotherapy interactions is to examine and reconstruct the means and practices by which therapists and clients produce their therapeutic reality (Streeck, 2008). Therapists’ and clients’ utterances are examined primarily from the viewpoint of what is being done with them, that is, in terms of their nature as social actions. CA studies examine the moment-by-moment unfolding of the therapy session with the aim of explicating the actual interactional patterns and practices through which therapy gets done (Peräkylä et al., 2008). As described in Chapter 1, CA studies of psychotherapy can reveal micro-interactions within the therapy session, by identifying and examining subtle, communicative phenomena (Streeck, 2008). The study of these micro-interactions often reveals phenomenon that go un-noticed by therapists, but have important implications for the therapy interaction.

2.5 Summary

This chapter has introduced and described the methodological approach for the analysis of a corpus of CBT data: that of conversation analysis. It has described the process of data collection, the equipment used, and how the data were transcribed. The chapter has also described how CA can be used to create ‘fingerprints’ of institutional interactions, such as CBT sessions, and how it can also be used to identify and examine subtle interactional phenomena that accomplish important institutional goals. Using CA to examine institutional interaction involves the application of CA findings about the organization of talk from mundane interactions. It is these findings that form the
basis for analysing the CBT interactions in this thesis. In the next chapter, I will review some of these key findings that are particularly relevant to the forthcoming analysis.
CHAPTER 3

Foundational conversation analytic findings

3.1 Chapter overview

This chapter provides a brief overview of major CA findings that inform my analysis of the behavioural activation techniques drawn upon by therapists in the CBT corpus. The reason for describing these findings is to enhance readability of the analytic sections of the thesis by avoiding lengthy and distracting explanations within the body of the analysis. There are five major aspects of the organisation of talk-in-interaction that typically inform CA analyses, including the analysis presented in this thesis. These include the formation of recognisable actions (Schegloff, 1996a), the organisation of turn-taking (Sacks, Schegloff, & Jefferson, 1974), sequence organization (Schegloff, 2007a), repair (Schegloff, Jefferson, & Sacks, 1977), and word selection (Sacks & Schegloff, 1979; Schegloff, 1996b). Each of these areas of CA research will be described in turn.

3.2 Action formation

The central tenet of CA involves providing an empirically grounded account of the actions achieved through turns-at-talk. Behavioural activation techniques are achieved within the therapy session through the successive accomplishment of specific social actions in the therapist’s and clients’ talk (e.g., questioning and answering, proposing and accepting etc.). Determining what action is being done through a turn-at-talk involves looking at what action the co-participants in the interaction took to be getting done, as revealed by the way in which they respond to the turn in question (this practice is referred to as the next-turn proof procedure; Schegloff, 2007a). The immediately
subsequent talk, being responsive or appropriate to what has preceded it, ordinarily displays an understanding of what action the preceding talk was ‘doing’ (Schegloff, 1996c). For example, if a speaker responds to the question “would you like a biscuit?” with an acceptance (“yes, please”), it displays to the analyst that the speaker has understood the question as an offer. However, as Schegloff (1996a) has pointed out, it is not enough to show that some utterance was understood by its recipient to implement a particular action. A proper account of an action should also include an analysis of what it is about the observed talk that makes the enactment of it possibly an instance of the proposed action.

An account of a specific action requires not only a characterization of the form of the talk but also of its location within a larger sequence of conversation. A turn at talk, if isolated, may look as though it is doing one thing but, when examined within the context of the sequence in which it appears, could be seen to be doing something else.

In describing an action and how it gets done there are many contributing features. These include the timing and delivery of the talk, the location of the talk in the sequence, the participants’ stance toward the object of their talk, and the participants’ selection of linguistic resources. When attempting to describe the actions accomplished by participants, CA is concerned with considering all of these features of the talk on an individual case-by-case basis, with particular attention paid to the context of the turn-at-talk within the wider sequence of conversation.

The current analysis required the identification of the specific actions that therapists were accomplishing when attempting behavioural activation techniques (e.g., were the therapists asking a question of the client, were they proposing a behavioural change to the client, etc.). The analysis will show that the different types of actions used to achieve behavioural activation (e.g., via questions or proposals) can have very different consequences for the interaction. At the same time, the actions
being accomplished by clients in response to therapists also need to be identified (e.g., were the clients accepting, rejecting or resisting the therapist’s proposal).

It has also been demonstrated previously that speakers take their turns-at-talk in a systematic way. The next section will describe CA findings relating to the construction of speakers’ turns-at-talk.

3.3 Turn-taking

Previous findings regarding the construction of turns-at-talk are central to the analysis in this thesis. CBT practices are successfully accomplished because the therapist and client take turns at talking, and respond to each other’s turns in an organized fashion. In their pioneering paper on conversation analysis, Schegloff, Sacks & Jefferson (1974) set out several rules concerning how turns at talk are constructed. They labelled the units which construct a turn-at-talk ‘turn-constructional units’ (TCUs). TCUs are built and organized according to three main resources: grammar, intonation and action. In relation to grammar, TCUs are built as either lexical items, phrasal or clausal items, or in sentential units. TCUs are also grounded in intonational ‘packaging’ (Schegloff, 2007a) which refers to the phonetic realization of the talk. Lastly, and perhaps most importantly, all TCUs constitute a recognizable action in context. In the first instance, a speaker is entitled to one TCU within a turn at talk (Sacks et al., 1974). Unless particular work has been done by that speaker to gain another unit at talk, after the first TCU a transfer of speakership becomes relevant.

As a speaker approaches the possible completion of a first TCU in a turn, transition to a next speaker becomes relevant (Schegloff, 2007a). Transition from one speaker to another usually occurs just after possible completion of the TCU-in-progress. This ‘space’ between the possible completion of one speaker’s TCU and the beginning of the next speaker’s TCU is called a ‘transition-relevance
place’ (TRP). In other words, it is a point where it is possibly relevant for the transition of talk to a new speaker.

The transfer of speakership is organized by the rules of speaker selection. A current speaker may select the next speaker within their turn (before the TRP) by referring to them by name, or connecting with them through gaze, for example. If this is the case, then it is that speaker who is obliged to take the next turn (i.e., an interactional constraint has been placed on that speaker to speak next). If the current speaker does not select the next speaker, then self-selection for the next turn may occur. In this case, the first person to speak usually gains the turn. Alternatively, the current speaker may also select to continue with an additional TCU. These rules for speaker selection occur at the possible completion of each TCU within a conversation.

This system of turn-taking and speaker transfer, with TCUs acting as units of conduct, composes the central organizing format for sequences of conversation (Schegloff, 2007a). The next section will briefly describe this organization of sequences.

3.4 Sequence organization

‘Sequence organization’ refers to the organization of courses of action enacted through turns-at-talk (or more specifically TCUs; Schegloff, 2007a). Sequences of talk are coherent and meaningful successions of actions, and are the vehicle through which activities get accomplished. In its minimal form, a sequence is constituted by an ‘adjacency pair’.
3.4.1 The minimal sequence: ‘Adjacency pairs’

An adjacency pair is a sequence of talk which involves two turns, one which initiates an action and another which responds to that action. The basic features characterizing an adjacency pair include:

- It is composed of two turns
- The turns are by different speakers
- The turns are placed one after another (i.e., adjacently placed)
- The turns are relatively ordered – they have a first pair part (FPP) and a second pair part (SPP). FPPs initiate some action whilst SPPs respond to the action of the prior turn.
- The turns are pair-related. That is, the FPP and SPP are of the same pair type. For example, question-answer, request-acceptance, etc (Schegloff, 2007a).

An adjacency pair can thus be represented diagrammatically as:

Speaker A: FPP
Speaker B: SPP

The movement from a FPP to a SPP in an adjacency pair sequence is how ‘progressivity’ (Schegloff, 2007a) occurs in conversation. Each TCU can be inspected by co-participants (and, later, by analysts) to see what action(s) may be being done through it. Similarly, series of turns can be inspected and tracked to see what courses of actions may be being progressively enacted through them (Schegloff, 2007a). By tracking the actions enacted, and the types of responses made relevant, by those actions, participants progress through the interaction toward whatever outcomes are being pursued or projected. Much of the analysis in this thesis focuses on actions that involve the structure of an adjacency pair. In particular, the following first and second pair parts:
Therapist: proposal for behavioural change ← FPP
Client: resistance to/rejection of proposal ← SPP

This adjacency pair can be seen in the following interactional example from the corpus:

(1) [CBT 007 cousin 43:05]

T: Um (0.3) might might you (0.3) say that to her? ← FPP proposal (2.4)
C: hhh oh we’re not talking at the moment. ← SPP resistance

The relationship of adjacency pairs operates both forwards and backwards. Each turn by a speaker demonstrates understanding of the just prior turn. However, a FPP also projects prospective relevance for the next turn in the sense that a FPP makes relevant a limited set of possible SPPs (e.g., a proposal makes relevant acceptance or rejection of/resistance to the proposal). A FPP thus sets constraints in place for the terms by which the next turn will be understood.

3.4.2 Preference organization

Most FPPs make relevant alternative types of SPPs, and these types are organized according to a preference organization. These alternative types of responses embody different alignments toward the project undertaken in the FPP (Schegloff, 2007a). Sequences are vehicles for the accomplishment of some activity. SPP responses which favour furthering or accomplishing that activity are known as ‘preferred’ SPPs. Responses that embody a problem in the realization of that activity are known as ‘dispreferred’ SPPs. For example, an offer generally invites an acceptance of the offer. Acceptance would thus be the preferred response, whereas rejection of the offer would be understood as the dispreferred response. This preference structure depends on the local context of the offer, however. An offer such as “Does anyone want the last biscuit?” may actually prefer a rejection if the speaker is
taken to be implying that she would like the biscuit herself. That is, it should be noted that this preference structure does not refer to a psychological preference. Rather, whether a response is ‘preferred’ or ‘dispreferred’ relates to the structural relationship of the sequence parts and the actions being pursued in the prior turn.

Preferred and dispreferred responses are typically characterized by different features. Preferred responses are generally delivered immediately and are short or unelaborated. Dispreferred responses, on the other hand, are often delayed in their production by silences and hedging or mitigating devices, and accompanied by an elaboration such as an account or disclaimer (Pomerantz, 1984). The different structural properties of preferred and dispreferred responses can be seen in the following two examples:

(1)  **Preferred response: JG 3:1 (Schegloff, 2007a, p. 30)**

1 Nel: Y’wanna drink?
2 Cla: Yeah.
3 Nel: Okay.

(2)  **Dispreferred response: Virginia, 11:16-19 (Schegloff, 2007a, p. 2)**

1 Mom: = hhh Whooh! It is so hot tonight. *Would somebody like some more ice tea. ((* = voice fades throughout TCU))
2 (0.8)
3 Wes: Uh(b)- (0.4) I(‘ll) take some more ice.

In the first example, an offer for a drink is met with a preferred “yeah” response (line 2). It is delivered immediately (without delay) and is unelaborated. In example (2), however, Wes rejects the offer for more ice tea (instead requesting merely more ice), thereby providing a dispreferred response. His response is delayed (there is a 0.8 second gap between the end of Mom’s turn, and the beginning of Wes’ turn). Wes also delays his response *within* his turn with hesitations and a further intra-turn pause (“Uh(b)- (0.4)”, line 4).
Differentiating between preferred and dispreferred responses is particularly relevant to the analysis of clients’ resistance to behavioural activation in the current thesis. Clients’ resistance turns can be characterized as dispreferred responses to therapists’ proposals for behavioural change, and the design of these dispreferred turns will be the focus of analysis in Chapters 6-9.

3.4.3 Sequence expansion

Many sequences involve an expansion on the adjacency pair unit. These expansions involve additional turns by the participants over and above the basic adjacency pair turns (Schegloff, 2007a). These expansions can occur at three places: before the FPP (pre-expansion); between the FPP and SPP (insert expansion); and after the SPP (post-expansion). These three positions can be represented diagrammatically as follows:

← Pre-expansion
Speaker A: FPP

← Insert expansion
Speaker B: SPP

← Post-expansion

Each of these forms of expansion can be substantial, leading to long stretches of talk built around a single base adjacency pair. Further, each form of expansion can be used to achieve different interactional goals for the participants. For example, pre-sequences (e.g., a pre-invitation such as “Are you free on the weekend?”) can be used by participants in order to avoid receiving dispreferred responses to the base FPP (e.g., a rejection of an invitation). Insert sequences can be used by recipients of base FPPs to initiate repair on the prior turn (other-initiated repair will be discussed in
the next section). Clients’ use of insert expansions (including other-initiated repair) in response to therapists’ behavioural activation attempts will be a focus of analysis in Chapter 6. Further, post-expansion sequences become relevant to the current analysis when I demonstrate, in Chapters 7-10, how clients’ accounts for their resistance to therapists’ proposals are expanded over several turns.

There are, of course, many variations and complexities in the organization of sequences over those described here. Other aspects of sequence organization will be described as they become relevant within the analysis. The next major CA concept I will turn to is that of conversation ‘repair’.

### 3.5 Repair

‘Repair’ in CA refers to practices aimed at dealing with ostensible trouble in speaking, hearing or understanding talk (Schegloff et al., 1977). The fragments under analysis in this thesis often include repairs by both therapists and clients, and these repairs often have important implications for the analysis under discussion. For this reason, in this section I will provide a brief discussion of each of the relevant types of repair, so that the body of the analysis is not routinely disrupted with descriptions of the mechanics of the repairs when they appear.

Repairs disrupt the smooth progressivity of the talk until the trouble has been dealt with. Repairs address all sorts of difficulties within talk and are not limited to the correction of ‘errors’ (Schegloff et al., 1977). It is not necessary for there to be an ‘error’ for repair to be used and, at the same time, error correction can be done without the use of repair procedures. Given that a repair may or may not involve an ‘error’, the problematic talk is referred to as a ‘trouble-source’ or the ‘repairable’.
Repair may be initiated by the speaker of the trouble-source (self-initiated repair) or the recipient (other-initiated repair). In the same way, the actual repair on the talk may get done by either the speaker (self-repair) or the recipient (other-repair). There are thus four major varieties of repair:

- **Self-initiated self repair** – repair is both initiated and carried out by the speaker of the trouble-source.

- **Self-initiated other repair** – the speaker of the trouble-source may attempt to get the recipient to repair the trouble, for example if the speaker is trying to search for a word.

- **Other-initiated self repair** - repair is initiated by the recipient, but carried out by the speaker of the trouble-source.

- **Other-initiated other repair** – the recipient of the trouble-source turn both initiates and carries out the repair (this repair is closest to what might be referred to as a ‘correction’) (Hutchby & Wooffitt, 2008).

There is a preference in conversation for self-repair over other-repair (Schegloff et al., 1977). Additionally, there are several differences in the way that self-initiated and other-initiated repair get done in interaction. I will turn first to self-initiated repair.

### 3.5.1 Self-initiated repair

Self-initiated repair involves a speaker initiating repair on their own talk. It is most common that the same speaker will also repair the talk (i.e., self-initiated self repair). ‘Repair initiations’ (RIs) signal to the recipient that what is to come may not be continuous with what has gone before. Common RIs include cut-offs, hesitations such as “uhm” or “uh”, sound stretches, or markers that what was said was wrong (e.g., “I mean…”). Self-initiated repair can come in a variety of forms including: insertions (speakers cut off their talk to insert an additional word or phrase); deletions (a word or phrase is
deleted from the talk); replacements (speakers cut off their talk and replace one word with another); reformulations (a word, phrase, or whole turn is reformulated); and word searches. Self-initiated repair is often pre- or post-framed, that is, the speaker may repeat the words that came immediately before and after the trouble-source when doing the repair. An example from the current data corpus is as follows:

(2)  [CBT 001 enlist Alison 33:51]

T: Well it might be um (1.4) might even be worth trying to enlist Alison.

This is an example of an insertion repair where the word “even” is inserted through a self-initiated self-repair. The repair solution (“even”) is pre-framed with “might” and post-framed with “be” – these words, which appear in the trouble-source, are repeated immediately before and after the repair solution. With this framing, it is easy for the recipient to register where the additional word is being inserted within the TCU. Importantly, the insertion repair achieves the action of further hedging the therapist’s forthcoming suggestion.

Self-repairs are usually initiated as close to the trouble-source as possible (either within the same turn or in the transition space between the completion of that turn and the next). However, there are other types of self-repairs where the repair is further distanced from the trouble-source. For example, ‘third turn repairs’ occur when there is the intervention of talk from another speaker between the end of the TCU containing the trouble-source and the repair initiation. With these, the repair is not in response to the intervening talk but does occur in a third turn position. For example:


1 Hannah: And he’s going to make his own paintings.
2 Bea: Mm hm,
3 Hannah: → And- or I mean his own frames.
Here, there is some intervening talk from Bea (“mm hm”, line 2) between the TCU containing the repairable (“paintings”, line 1), and the repair (“I mean his own frames”, line 3). Bea’s receipt claims understanding of the prior trouble source turn. However, at line 3, Hannah repairs the talk from her prior turn. This third turn repair is thus not responsive to or occasioned by the intervening turn by Bea at line 2.

Another type of repair includes ‘third position repairs’. These repairs occur when a speaker repairs a trouble-source from a prior turn of their own, but does so in response to the intervening talk by the other co-participant. In these cases, the recipient does not claim a problem with the prior turn. However, the recipient’s turn (turn 2) is treated by the speaker of the trouble-source as manifesting a problem with hearing or understanding. For example:


1 Annie: Which ones are closed, an which ones are open.
2 Zebrach: Most of ’em. This, this, // this, this ((pointing))
3 Annie: → I ‘on’t mean on the shelters, I mean on the roads.
4 Zebrach: Oh:

In this case, the turn at line 2 is treated by the trouble-source speaker (Annie) as manifesting a problem in understanding. Zebrach is pointing on a map to all of the shelters that are open and this signals to Annie that he has misunderstood her prior turn. She then repairs her talk at line 3, to clarify that she was asking about the roads, rather than shelters.

Third position repair becomes particularly relevant to the analysis of one example of premonitory-resistance examined in Chapter 6. I have described the mechanics of these types of repairs here so as not to distract the reader within the discussion of the repair in the analysis.
The above described repairs are the most common varieties and positions of self-initiated repair. I will now turn to other-initiated repair.

### 3.5.2 Other-initiated repair

Other-initiated repair (OIR) is initiated by the recipient of the problematic talk. OIRs locate problems of hearing or understanding as ‘obstacles’ to the production of their relevant next turn response. Most commonly, although the recipient initiates repair, it is the speaker of the trouble-source who repairs the talk (i.e., other-initiated self repair). Other-initiated repair occurs in one major position: in the turn immediately subsequent to the trouble-source turn (Schegloff et al., 1977). Attempts at other-initiated repair open up an insert sequence between the trouble-source turn and the recipient’s response to that turn. Diagrammatically, these sequences take the following form:

Speaker A:  FPP - trouble-source  
Speaker B:  repair initiation  
Speaker A:  repair  
Speaker B:  SPP response

Again, with OIR, the progressivity of the talk underway is disrupted until the trouble-source has been repaired. It is only then that the recipient of the talk provides their SPP response to the original FPP turn.

OIRs can take on several different forms. Some take the form of what Drew (1997) has termed ‘open-class’ repair initiators. These OIRs leave the nature of the problem with the prior turn completely open, for example: “huh?”, “what?”, or “pardon?”. Other types of OIR provide the
speaker of the trouble-source with more information about what the trouble-source might be. These include category-constrained repair initiators (e.g. “who?”, “where?”), partial repeats of the trouble-source, and candidate understandings or understanding checks of the trouble-source turn (e.g., “You mean + possible understanding”).

Other-initiated repair will be described in more detail in Chapter 6 where the analysis will demonstrate how clients use OIR as a ‘premonitory-resistance resource’ following therapists’ proposals for behavioural change. For now, I will leave the description of this phenomenon and move to another major contributor to the current analysis: the selection of particular words.

3.6 Word selection

Another major aspect of conversation involves the words speakers use to accomplish their action(s). The practice of ‘word selection’ in CA refers to how speakers come to use the words they do, and how that informs the hearing of the talk by recipients (Schegloff, 2007a). When describing a state of affairs or an object, there is a potentially inexhaustible range of words and combinations of words that could be used (Hutchby & Wooffitt, 2008). In analysing turns-at-talk, this then leads to the question “why that now?”. In addressing this fundamental question, conversation analysts examine how the words speakers select achieve important interactional goals for them, and how differing interactional consequences ensue for the subsequent interaction.

One particularly important aspect of word selection for the current analysis involves the use of membership categories. People are all members of an indefinite range of membership categories which are used for describing and referring (Schegloff, 2007b). These categories might include ‘female’, ‘Australian’, ‘British’, ‘client’, ‘catholic’, ‘football player’ and so on. Given that an individual
is a member of multiple categories at any one time, when a category is used in conversation to describe them it can be assumed to have been used for a specific reason. One reason relates to the fact that categories are inference-rich; that is, there are strong expectations and conventions associated with them (Hutchby & Wooffitt, 2008). These expectations can be referred to as ‘category-bound activities’ (Schegloff, 2007b). The use of a particular category thus provides a set of inferential resources by which recipients of talk can come to understand and interpret the behaviour of the persons being described. The selection of particular categories to achieve particular interactional goals is relevant to the analysis presented in Chapter 9, where it will be shown how clients draw upon particular categories in order to attenuate their responsibility for a trouble under discussion in CBT therapy.

3.7 Summary

In sum, there are five broad areas in which CA research has provided significant findings for understanding talk-in-interaction: action formation, turn-taking, sequence organization, repair, and word selection. Over the course of this chapter, I have provided a brief overview of key findings in each of these major areas that are relevant to the current analysis. These findings provide the foundations for the analysis of the CBT data undertaken in the current thesis. Other specific CA findings will be discussed throughout the analytic chapters of this thesis as they become relevant to the details of the analysis being described.

Although the majority of my analysis involves the application of previous CA findings to describe CBT data, I will also contribute to the field of CA by identifying some new, previously unexamined, phenomena. Although the description of these conversational devices will be limited here to the CBT corpus under investigation, as I will discuss in the final chapter of this thesis, they make some
valuable contributions to the field of conversation analysis and may also hold across other data sets (including mundane conversation). This is a matter for future empirical investigation, however.

Having introduced the background literature and methodological approach for this thesis, I will now move to the analysis of the data. The next seven chapters will involve analysis of behavioural activation sequences within this corpus of CBT sessions, in particular, sequences where therapists propose their own suggestions for behavioural change to clients. The first analytic chapter, Chapter 4, will focus on one, less frequent, way that therapists attempt behavioural activation within this corpus, through, what I have termed, the ‘collaborative sequence’.
CHAPTER 4

Collaboratively initiating behavioural change

4.1 Introduction

Within the corpus of recorded CBT sessions, and in accordance with the typical structure of a CBT session as described in Chapter 1, clients’ extended troubles-tellings were sometimes followed by a discussion of potential behavioural changes the client could make to their life outside the therapy session. These attempts at initiating behavioural change will be the focus of the next two analytic chapters. As mentioned in Chapter 1, behavioural change is a major aspect of CBT theory. Initiating behavioural change within a CBT session often involves the therapist and client making an ‘action plan’ detailing small steps the client can take toward beneficial behavioural change (Greenberger & Padesky, 1995). This aspect of CBT can prove problematic for therapists, however. Although therapists need to help clients make behavioural changes in their lives, therapists are not supposed to tell clients what to do. In the clinic where the data was collected, this feature of CBT theory is described to clients within the CTAD ‘Patient Information’ pamphlet as follows:

We focus on problems you are experiencing in your life now, helping you to define and prioritize them. We work in a collaborative way with you, as opposed to simply telling you what you should and shouldn’t be doing.

The difficulties for therapists in initiating behavioural change for the client can be seen within this corpus of CBT sessions. There are two different ways in which behavioural change is managed within
the sessions. In the less frequent pattern (two cases in the corpus), the sequence follows a trajectory in which the therapist asks information-soliciting questions that work to coax suggestions from the client regarding how he/she might change their behaviour. The therapist then works with the client’s ideas to build a collaborative agreement for behavioural change.

In these cases, the therapist typically works in a step-wise fashion and the sequence progresses smoothly. However, in the majority of cases, behavioural change is introduced by the therapist making a proposal that some particular action be taken by the client. Within these two different sequence types, the initial suggestions for behavioural change are thus produced by different parties. In the ‘collaborative’ sequence it is the client who first suggests possible changes following information-soliciting questions from the therapist. However, in the ‘proposal’ sequence it is the therapist who makes the suggestion for change. Within the corpus, proposals from the therapist are met, overwhelmingly, with resistance from clients. In fact, these proposal sequences are met with the most client resistance of all the different therapeutic tasks undertaken within the sessions. Within these proposal-resistance sequences, therapists and clients orient to some complex and delicate asymmetries in knowledge that exist between the therapist and client in talking about behavioural change. These proposal-resistance sequences will be the major focus of subsequent analytic chapters. Before moving to look at therapists’ proposal sequences, however, I will first turn, in the remainder of this chapter, to look at how the issue of behavioural change is played out interactionally within the less frequent, but nevertheless interesting, ‘collaborative’ sequence of behavioural change management.
4.2 The ‘collaborative’ behavioural activation sequence

In the sequence that I have termed the ‘collaborative’ sequence, the therapist and client display collaboration in the way they interact whilst working towards an agreement for behavioural change. In doing so, there is an orientation to the preference within Cognitive Behavioural Therapy theory for collaborative work between therapist and client. There are only two cases within the current corpus of this ‘collaborative’ sequence. Within these sequences, the therapist asks information-soliciting questions in a step-wise fashion, which request the client to provide suggestions for possible behavioural changes that can be incorporated into his/her life. The therapist then moves to make some suggestions to the client, but does so in a way that maintains a sense of collaboration of ideas. The therapists’ initial information-soliciting questions in these cases appear after extended troubles-telling on the part of the client, and following the client’s confirmation of the therapist’s formulation of this trouble.

Over the course of these two ‘collaborative’ sequences two main types of ‘collaborative’ turn structures can be seen to be used in negotiating behavioural change in a CBT context. A parallel can be drawn between these ‘collaborative’ sequences and the ‘perspective display series’ identified by Maynard (1989; Maynard, 1991, 1992). Maynard identified a three-turn sequence used in both mundane and institutional settings where a speaker solicits another party’s opinion before producing a report or assessment in a way that takes the other’s opinion into account (Maynard, 1989). The perspective-display sequence follows these lines:

(1) A: an opinion query or perspective-display invitation

(2) B: the reply or the recipient’s opinion

(3) A: speaker one’s subsequent report
Maynard (1992) argues that, within a clinical environment, the perspective-display series operates to co-implicate the recipient’s perspective in the presentation of diagnoses. The turns within the ‘collaborative’ sequences in the present corpus do not involve the same turn structure, sequence structure, or the same actions as in the perspective-display sequences. However, they do illustrate another way in which co-implicating both participants in an institutional interaction can actively be achieved. Within the two cases from the corpus, there are two main, three-turn, sequences drawn upon to achieve collaboration. These may be illustrated as follows:

1. (1) T: information-soliciting question  
   (2) C: information-giving – suggestion for behavioural change  
   (3) T: Sequence closing third (SCT) – acceptance of C’s suggestion

2. (1) T: gist formulation of client’s suggestion  
   (2) C: confirmation of gist formulation  
   (3) T: SCT – acceptance of C’s confirmation

In using these turn formats, therapists are able to hand control to clients to suggest possible behavioural changes they could make in order to help solve their trouble and, in doing so, a sense of collaboration is achieved in the process of incorporating behavioural change into the client’s life. By using information-soliciting questions, although it is the therapist who delivers the FPP and thus restricts the way in which the client can respond, the opportunity for making a suggestion is handed to the client. The therapists’ information-soliciting questions carry a strong preference for the provision of information as the client’s response. Clients orient to this preference by providing suggestions for behavioural change. Therapists sometimes then ask secondary “prompt” (Maynard, 1989) questions to coax out a more detailed suggestion from the client. Therapists also sometimes offer a gist formulation of a client’s suggestion. Typical of gist formulations (Antaki, 2008), the
therapists’ gist formulations here involve a summary of the client’s own words edited in some way. The therapists also add their own additional suggestions for the client’s behavioural change into their gist formulations. However, because the turn is constructed as being a formulation of the client’s own words, the therapists’ additional suggestions are difficult for the client to resist, and are accepted within the clients’ subsequent confirmation turn. Thus, within these sequences, even when the therapist offers suggestions to the client for behavioural change, the client is co-implicated, and behavioural activation is accomplished in an interactionally collaborative manner.

The two case studies in which ‘collaboration’ is achieved over these sequences will be analysed in detail on a turn-by-turn basis. The first fragment begins after an extended troubles-telling from the client about how she is feeling overwhelmed from having to deal with problems with her daughter, getting ready for Christmas and not getting enough sleep. The fragment begins with the therapist’s formulation of the client’s trouble in line 1. The therapist’s first information-soliciting question comes at line 12.

(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 fur you: they kind’ve get priority over
4  C: Uhm.  
5  T: looking afta 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 te:r (0.3) h:elp with that?
13 Do you think? Over the next couple of wee:ks?
14 (2.7)
15 C: >I dunno jus’< (. ) maybe (0.2) wri:ting in my list a bit of time
16 out time.
T: Okay.
C: [Like]
T: → [Do ] you have a diary?
C: tha- yeah- oh(h)h y(hea(h)h no I need to get a new one.
( .)
C: [YEA::H ]
(0.5)
T: → Uh- e- do you have u- ti:me ova the- this next week or so: that
you can schedule for yourself?
(0.6)
C: Yeah probably on the weekend when Jess’ NOT here=well she'll be
with her DAD.
T: ↑Okay.
C: An’ I can just have a break from all the hassles with her
friends and stuff.
T: [Yea:h ]
C: [It'll jus'] be nice to jus’ get away from all that. .hhhh AN’ I
CAN just (0.4) sl:EEP in in the morning if I wish.
T: [Yep.]
C: [GET ] UP when I wanno.
T: Umhm=
C: =An' there won't be any pressure to haveta go an' ((sniffs)) u:m
(0.6) do my shop:ping or do my wa:shing=cos I've got Monday
Tuesday [y'know] the next (0.2)
T: [Umhm ]
T: huh heh
C: next few weeks hhhh
T: → An’ what particular fu:n activity could you look forward to?
(0.6)
C: OH maybe jus; watching a d-v-d maybe or jus' goin' out the
back ['n]
T: [O ]kay.
(0.6)
C: No coz if I go out the back I look at the weeds.
T: Heh heh heh
(0.2)
C: Yeah maybe jus’ spend some time with Holly=or even just (0.2)
T: → go to the beach?=
C: =YEAH go down the beach [I reckon.] [Might even d]o that.
T: [Yeah ] [Yea::h. ]
59 T: That'd be (1.2)
60 C: Mm: (0.3) I reckon that would be nice jus’ go down just on the beach.
61 T: Okay.
62 C: Even just watch people walking by:
63 
64 C: CAN’T really take Holly down there.
65 
66 C: coz could you imagine it? Oh: my:: Go::d.
67 
68 T: [Oh co-]
69 C: [Scare ] all the boy dogs off.
70 
71 T: Yeah.
72 
73 C: Mm:
74 T: waves an' (0.2) [maybe] getting an ice cream [o:r something]
75 C: Mm: [Mm: ]
76 T: so just spending time (. ) w:ith yourself [an'] watching the
77 C: [Mm ]
78 T: wa:ves an' (0.2) [maybe] getting an ice cream [o:r something]
79 C: [Mm: ]
80 T: Yea:h.
81 C: Yeah.
82 (. )
83 T: Yeah.
84 
85 C: Y:eah that might be the way to go:

Over the course of this sequence, the therapist draws upon several different resources, including information-soliciting questions and gist formulations, to collaboratively achieve a commitment to a course of action from the client. Analysis of the sequence in a turn-by-turn fashion will show how this is achieved.

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 confirmations from the client (“mm” line2, “umhm” line
4, “mm” line 6, and “yeah” line 8). At line 10, the client looks as though she will expand on the formulation in some way (“I guess: (0.5) it’s:”), but re-does her turn to form another confirmation (“yeah that does”). In line 12 the therapist then asks the client a question which is framed as a yes/no interrogative but acts as a request for information (Schegloff, 2007a) about what the client could do to help her trouble. Thus, with this information-soliciting question, the therapist gives the client the opportunity to provide a suggestion for behavioural change. The alternative SPP responses made relevant by the therapist’s question involve ‘yes + the provision of information’, a “no” response, or an “I don’t know” response. The therapist draws upon several resources in her turn to set up a preference for a ‘yes + provision of information’ response from the client. Grammatically, the interrogative is structured with a positive polarity preference for a ‘yes’ response (i.e., it is framed to prefer an affirmative response).

Additionally, the therapist draws upon other resources to make it more difficult for the client to provide a dispreferred response. She asks the client whether there is “anything” she could do, leaving the options for activities wide open. However, the term “anything” has been shown by Heritage et al. (2007) to sometimes be heard as a negative polarity item and produce “no” responses from recipients. 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 completion of the initial TCU. 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 incremental TCU that downgrades her question, expanding the time frame for possible activities to being over the “next couple of weeks”. Thus, providing a “no” or “I don’t know” dispreferred response has been made particularly difficult for the client.
Whilst there is a gap in the interaction (whilst the client possibly thinks of her response) and the client then begins her turn with “I dunno”, she moves quickly to provide an option for behavioural change thus orienting to the preference for the provision of information set up by the therapist’s interrogative. The client only pauses mid-turn after holding maximum grammatical control with the addition of “just” after “I dunno”, signalling that she will continue with her turn. The client’s “I dunno” here, therefore, seems to act to downgrade her suggestion rather than acting as a dispreferred, blocking response to the question. The therapist then provides a sequence-closing third “okay”, which accepts the client’s suggestion. In providing this acceptance response, the therapist re-asserts herself as implicated in the suggestion-making process.

At lines 19 and 26 the therapist asks secondary yes/no interrogatives, which act as requests for further information from the client about the suggestion she has made. Again, in doing so, the therapist hands control to the client to expand on the suggestion. These secondary information-soliciting questions can be seen to act like a ‘prompt’ (Maynard, 1989, 1992) that works to draw more detailed information from the client. With this turn the therapist also attempts to shorten the timeframe for the enactment of the client’s proposed behaviour, shifting from “over the next couple weeks” in her previous question to “over this next week or so”. The therapist orients to the potentially delicate nature of this shift within her turn by hesitating, self-repairing on several occasions and adding the downgrader “or so:”. Her question still, however, carries a preference for a “yes + provision of information” response.

The client answers the question in a conforming format (Raymond, 2003) with the turn initial “yeah” before providing information about when she might have time for herself. The client even takes several post-expansion turns to elaborate on how nice it would be to have time to herself. The therapist then again asks an information-soliciting question (line 46), which the client responds to with the provision of further information. Thus far in the sequence then, the therapist’s
interrogatives have handed control to the client to make all of the suggestions, and have successfully managed to draw out more specific information from the client about what change she can make to her behaviour and when she might put this change in place. Thus, although it is the therapist who delivers the FPPs across the sequence and limits the client in how she can respond, the client remains in charge of shaping the nature of the behavioural change. In each case, in third position, the therapist produces an “okay” acceptance response to the client’s suggestion, re-asserting her contribution to the suggestion-making process. In this way, the therapist and client together produce a collaborative working-up of a proposed behavioural change.

The client’s answer to the therapist’s final question about what particular activity she could look forward to, which occurs over lines 48-55, is rather vague, however, and the therapist responds to this vagueness with some additional collaborative work. Instead of waiting for the client to finish her turn at line 55 the therapist comes in with an anticipatory completion (Lerner, 1996) of the client’s turn.

55 C: Yeah maybe jus’ spend some time with Holly=or even just (0.2)
56 T: → go to the beach.=
57 C: =YEAH go down the beach [I reckon.] [Might even do that.
58 T: [Yeah ] [Yea::h. ]
59 T: That'd be (1.2)
60 C: Mm: (0.3) I reckon that would be nice jus’ go down just on the
61 beach.
62 T: Okay.

The therapist enters at a point where it is projectable that the remaining component of the client’s TCU will be a suggestion of what activity she might do. The client has paused, intra-turn, providing the therapist an opportunity to enter (Lerner, 1996). Rather than beginning a new turn, the therapist designs her turn to be a continuation of the client’s current TCU (what Lerner (1989; Lerner, 1996, 2004) has termed an ‘anticipatory completion’ or a candidate completion’). Lerner (2004) has
demonstrated how anticipatory completions can achieve a heightened sense of affiliation between participants in interaction, and the resource seems to work in this way here. In fact, the therapist’s completion overtly achieves *collaboration* between the therapist and the client in coming up with suggestions for activities - the therapist and client are not just sharing ideas; they are sharing TCUs. 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 has 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 another TCU to her turn stating 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 being accepted anyway.

The therapist has thus made a suggestion for a course of action to the client, whilst at the same time allowing the suggestion to be ‘owned’ by the client. In using an anticipatory completion, the therapist has also been able to achieve affiliation with the client. Rather than making a suggestion, it is as though the therapist has ‘read the client’s mind’.

The client then takes several turns to expand on the idea of a trip to the beach. At line 75, 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.

75  T: →  SO so just spending *time* (.) with yourself [an'] *watching the*
76  C:                        [Mm ]
77  T:  wa:ves an' (0.2) [maybe] getting an *ice crea:m [o:r something]*
78  C:                  [Mm: ]                     [Mm: that's ] a
79          good idea just go down grab an ↑ice cream an’ jus’ sit on the
80          beach.
Gist formulations involve a turn where the therapist summarizes the client’s own words, or draws out a seemingly natural implication from them, while nevertheless editing them in some way (Antaki, 2008). Here, within the therapist’s formulation, additional 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, there exists an apparent cooperative link between the therapist’s version and that of the client. The therapist has made a suggestion about the activities in which the client should engage, but through the structuring of her turn, she does so in a way that sounds as though the suggestion has originated with the client. Although disconfirmation of the formulation is one relevant SPP 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 orient 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 then 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 collaborative manner in which the suggestion for behavioural change has been accomplished within the interaction, as both participants have now verbalised the suggested idea.

Over the course of this sequence, then, the therapist and client have produced a collaborative identifying of, and agreement on, a course of action 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. The therapist then moves to offer more specific suggestions to the
client, but does so in a way that maintains the client’s sense of ownership over the suggestions. 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. The sequence progresses undisturbed and the two interlocutors arrive at agreement without any signs of trouble, misalignment or resistance within the interaction.

I will look at one further example of a ‘collaborative’ sequence, below. This fragment begins after a troubles-telling from a client in which she speaks about ‘not being able to cope’ with being busy at work and then having to come home and take care of the house and her young daughter. Earlier in the session she has mentioned that she “should” be doing a lot of things but doesn’t have the motivation or desire to get them done.

(2)  [CBT 011 cooking 51:21]

1  T: →  I sp↑ose coz when you think about (..) should sta:teme:nts (0.9)
2                                    u::m (.) "I should be doing this:" (..) wha- what sort've (0.4)
3  what sort've feelings do you (come as-) (..) do you have? (0.3)
4  C:            Um I'm stressi:ng I'm panicki:ngk.
5                                    (0.4)
6  T:          Yea:h.
7                                    (.)
8  T:          It's it’s a PRESSure statement [I suppose.]
9  C:                                    [Pressure ] pressure yeah. I'm
10                      under pressure yeah.=
11  T:              =Yeah.
12  T: →  AND THEN (..) I suppose (0.2) if thːese are the ways you talk to
yourself it really maintains this whole pressure and stress for you to ma- to perform at a certain l;evel: (0.3) AN’ THEN if you don't perform at that certain level I wonder if these sorts of thoughts will come back through again=that this "I can't co:pe".

(0.4)

T: → Y'know by saying to yourself "I should have a perfectly clean house I should" .hh (0.3) you know keep all my ti- appointment times at work reGARDless of the situation an’ I should be there for my daughter and my husband" (0.7) y’know (.) if any of those things don't (1.1) you know (.)

C: work a hundred percent (.) that's when I (0.9) going d↓own.

(.)

C: [Yeah.]

T: [Yeah.]

(.)

C: [Definitely. ] [Yeah]

T: [(That being)] [Yep?]

(.)

C: Yep.

(.)

T: ↑Okay.

(0.3)

T: → SO THEN in thinking about that and tryin' to move away from these should <statements> (0.2) what do you think are some more helpful ways of (.) of (.) you know ta:ling to yourself?

(0.3)

T: Based on these adult way of ta- of [tau-]

C: [Yeah] (.) well (.) for EXample (1.2) we’re having friends over friend dinna: and I don't feel like to prepare dinner I I will jus' (0.5) need to say "no" (0.4) "I'm not going to prepare dinner I'm gonna buy takeaway".

(1.0)

T: Yep

(.)

T: → So thinking of alternatives? [I suppo]se [is is] somethink as

C: [yeah ] [yeah ]

T: well? [I’ll try] (.)

C: [yeah ]

C: yeah.=
66 T: =not pressure myself ta (.)to do (.) uh- m- to coo:k.
56 C: Yeah to cook if (. . .) if I'm tired or if I'm not in the mood to
do it.
57 T: Y↑ep.
59 C: But I don't think (. . .) like I don't mean lik(h)e e(h)very day
62 heh once in the like heh heh while heh heh heh
63 [heh heh heh .hhh]
64 T: [N↑o no that's good.] That's rea:llly good.

Again, in this example the therapist utilizes both information-soliciting questions and gist formulations to achieve a sense of collaboration with the client in the way that they move towards suggestions for behavioural change. In line 1, the therapist first asks the client an information-soliciting question about her feelings when she uses ‘should’ statements. After the client provides information in response (line 5), the therapist produces a sequence closing third which accepts the client’s response (“Yeah”, line 7). The therapist then offers a therapeutic formulation of the client’s trouble, which the client confirms with a partial repetition and an agreement token (“pressure pressure yeah. I’m under pressure yeah”, lines 10-11). The therapist produces another SCT and then expands on her formulation. This expanded form of the formulation receives strong agreement from the client including an anticipatory completion of the formulation at line 25, followed by the strong agreement token “definitely” at line 30.

After checking the client’s agreement with the formulation (line 31), the therapist then moves to ask another information-soliciting question about ways in which the client might better speak to herself (lines 37-39). As in Fragment (1) then, the therapist first asks for the client’s suggestions for behavioural change. In responding to this question the relevant SPP includes either providing information or giving a blocking response such as “I don’t know”. However, not only is the question formatted to prefer the provision of information, but a blocking response is made additionally difficult for the client within the content of the therapist’s turn. The therapist uses the phrase “some
more helpful ways” which suggests that there are multiple ways in which the change could be done and the client only needs to provide some ways. The therapist’s use of “some” here may also work to strongly elicit a response of a suggestion from the client, in the same way that previously has been found by Heritage et al. (2007) in doctor-patient interactions. Further, the client’s suggestions do not have to be the ‘most’ helpful ways, only ‘more’ helpful.

The therapist also downgrades her request for information: she frames it in terms of the client’s thoughts on the matter using the epistemic marker “do you think”. The epistemic marker produces the client as the knowledgeable person in comparison to the therapist. The sort of information being requested is thus downgraded, making it easier for the client to respond with the provision of some information. And, in lines 42-46, the client does provide a suggestion for behavioural change. Via a sequence-closing “yep” (line 48), the therapist accepts the client’s suggestions, and co-implicates herself in the suggestion-making process.

The therapist then takes a turn, at line 50, 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 the formulation is made difficult for the client. The therapist also voices the client in her formulation here (“I’ll try (.)...not to pressure myself ta (.) to do (.) uh- m- to coo:k”). The “I” and “myself” in the therapist’s turn here refers to the client, rather than the therapist herself. The voicing adds to 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 suggestion as being ‘owned’ by the client, and hence also building the suggestion collaboratively 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 + the elaboration] works to retain the client’s authority over the suggestion (Stivers, 2005). The therapist, however, provides a minimal “yep” to this response from the client, after a 0.5 second gap in the conversation. At this point some possible trouble becomes apparent in the interaction. The therapist’s “yep” appears to be taken by the client to indicate weak agreement with her suggestion; she moves to provide an account for the suggestion in lines 61-63 with extended laughter particles. There may also be an orientation by the client here to a moral obligation on her part to provide home-cooked meals in her category-membership role as wife/mother. The laughter particles and her expanded response may also orient to the delicacy associated with this moral issue.

The therapist, however, quickly enters with a positive assessment of the client’s suggestion to resolve this trouble. Again, we can see a sequence that negotiates behavioural change that has progressed reasonably smoothly, with no resistance displayed by the client. Resistance has, in fact, been made rather difficult for the client given the SPP responses that are available to her. The sequence also displays the production of ‘collaboration’ between the therapist and client in devising ideas for behavioural change.

### 4.3 Summary

To summarize, analysis of these two cases has demonstrated how therapists can use information-soliciting questions, gist formulations and other collaborative turn structures such as anticipatory completions, and voicing of the other, to produce a ‘collaborative’ negotiation towards behavioural change for the client. The therapists initially ask the client an information-soliciting question that
carries a strong preference for the provision of information as a response. In doing so, they pass the client the opportunity to provide a suggestion for behavioural change. The therapist may then ask secondary information-soliciting questions that work to ‘prompt’ the client to provide more detailed information about their suggestion.

The therapists can use gist formulations (Antaki, 2008) to summarize the client’s suggestion whilst still adding their own suggestions to the turn content. Gist formulations produce a cooperative link between the therapist’s version and that of the client, in the sense that the turn is framed as being a summary of what the client has already said. The clients respond to the gist formulations with a confirmation, but they also partially repeat the therapist’s prior turn. In repeating, clients convey a position of epistemic authority (Heritage & Raymond, 2005; Stivers, 2005) over the overall suggestion.

These sequences progress smoothly and in a stepwise fashion to a point where therapist and client agree on a suggestion for behavioural change. The therapist and client appear aligned and affiliated throughout the sequence, with minimal or no visible signs of resistance from the client. Thus, in using these turn designs, therapists appear to be interactionally accomplishing the institutional goal, set out in the client information sheets, of working “in a collaborative way” with clients.

As mentioned earlier, however, the majority of sequences that manage suggestions for behavioural change for the client do not follow this trajectory, but instead involve the therapist proposing some particular action for the client to undertake. It is to the analysis of these sequences that I will turn in the next chapter.
CHAPTER 5

Therapists’ proposals for behavioural change

5.1 Introduction

This chapter will analyse sequences where therapists make a proposal for behavioural change rather than deploying information-soliciting questions or other, more collaborative, turn structures. I will examine how therapists design their proposal turns, and consider the interactional implications of offering a proposal in this environment. As mentioned earlier, these proposals are typically resisted by the clients. The proposals take several different forms, which will be discussed in detail below but, in general, the minimal proposal sequence can be said to follow particular lines, as illustrated by the following fragment (therapist’s proposal marked with an arrow):

(1)  [CBT 017 volunteering 28:24]

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

Over lines 1-2, the therapist makes a proposal that the client undertake a new activity such as volunteering. The proposal is delivered in a tentative way and with questioning intonation. 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 the remaining analytic chapters, proposal sequences will be analysed in detail to illustrate some of the interactional
problems that arise. The ways in which therapists typically display attempts to manage these potential troubles will also be the focus of discussion.

The previous analysis of the ‘collaborative sequence’ for behavioural change illustrated how, through the use of information-soliciting questions and gist formulations, the client is put in the position of control over suggestions for behavioural change. In offering a proposal for behavioural change, however, the therapist takes control over suggesting what actions the client should take. The client, in second position, can then either accept or reject the therapist’s proposal. In the next section it will be shown how this action by therapists is potentially problematic, due to the complex and delicate asymmetries in knowledge expertise that exist between therapist and client within interactions around the client’s behavioural change.

5.1.1 The delicate activity of advice-giving

Proposals from therapists in this corpus can be broadly categorized within the activity of ‘advice-giving’. Advice-giving can be defined as any activity that involves an attempt by one participant to convey to another what they claim to be a beneficial course of action (Searle, 1969; Waring, 2007b). Advice-giving has previously been identified as a potentially problematic activity in both mundane and institutional interaction (Heritage & Sefi, 1992; Kinnell & Maynard, 1996; Vehviläinen, 2001; Waring, 2005, 2007a). The delicate and potentially problematic nature of advice-giving can arise from assumed or established asymmetries between the participants in respect to a given issue or topic. The activity of advice-giving generally constitutes the advice-giver as the knowledgeable, authoritative and competent party, and can carry the opposite assumptions of the advice receiver (Heritage & Sefi, 1992). Several CA studies have examined ways in which problems with advice-giving arise within various mundane and institutional interactions.
Problems with advice-giving in mundane interactions were studied by Jefferson and Lee (1992) who analysed the course of a troubles-telling between two friends over the telephone. They found that problems associated with the giving and receiving of advice in this context may be due to the shift in the speakers’ roles that occurs when advice is offered. The participant in the interaction who has thus far been the troubles-receiver shifts to being the advice-giver. At the same time, the troubles-teller in the interaction is shifted to being an advice-receiver. They propose that these shifts that occur on the proffering of advice may implicate the interaction as something entirely different from a troubles-telling - that of a service encounter (with its relevant categories of advice-seeker and advice-giver). Further, whilst in a troubles-telling the focal object is the ‘teller and his experiences’, in the service encounter the focal object is the ‘problem and its properties’. When advice is rejected, it may be an attempt by the troubles-teller to preserve the status of the interaction as a troubles telling, keeping its focus on the teller of the trouble, in contrast to the trouble itself.

However, problems with the activity of advice-giving have also been found in studies of interaction within environments that would be deemed ‘service encounters’. Heritage and Sefi (1992), for example, examined advice sequences in interactions between healthcare visitors and first time mothers. Although it is a service encounter, Heritage and Sefi (1992) noted that during these visits mothers saw their knowledge, competence and vigilance in baby care as being an object for evaluation. The volunteering of advice by the healthcare visitors could, therefore, carry assumptions about their authority and competence, relative to the mother’s, as the advice-receiver. Waring (2007a) has also found issues of competence to be salient within institutional advice-giving. In her study of graduate tutoring sessions, she found that the graduate students, despite their official ‘apprentice’ status in the interaction, mobilized a range of practices to assert their intellectual competence. Perhaps counter-intuitively, the asymmetrical nature of advice-giving can be particularly problematic in the environment of the therapy session, as will be seen over the next section.
5.1.2 The delicate nature of ‘advice-giving’ for therapists

Research into advice-giving within counselling interactions (e.g., Kinnell & Maynard, 1996; Vehviläinen, 2001) has noted that there is a similar dilemma for therapists and counsellors giving advice to that found in other environments (Vehviläinen, 2001). Therapy sessions can generally be viewed as a service encounter (Jefferson & Lee, 1992) where the therapist is primarily seen as the ‘expert’ whose role is to ‘solve a problem’ and someone who, therefore, is qualified to give advice. However, whilst they may carry the authority of a professional perspective, they do not have epistemic authority over, nor direct access to, the client’s perspectives and experiences. Only the client can be the expert on their own experience. Within the advice-giving sequences in this environment, there is thus a particularly complex and delicate asymmetry of knowledge expertise. This delicacy of advice-giving in the therapy environment is recognised in CBT theory. As mentioned above, although a major aspect of CBT involves effecting behavioural change in the client, CBT theory requires that therapists avoid giving advice in the form of telling the client what to do. Therapists in the current corpus of CBT sessions orient in several ways to the potentially problematic delicacies created by epistemic asymmetries between the therapist and client within the interaction.

Several recent CA studies have looked at how participants in interaction display and manage relative epistemic authority concerning the matters at hand (e.g. Clift, 2006; Heritage, 2002; Heritage & Raymond, 2005, 2010; Land & Kitzinger, 2007; Lerner & Kitzinger, 2007; Raymond & Heritage, 2006; Stivers, 2005). In discussing participants’ concerns with epistemic rights, Heritage and Raymond (2005) suggest that:

*The distribution of rights and responsibilities regarding what participants can accountably know, how they know it, whether they have rights to describe it,*

...
and in what terms, is directly implicated in organized practices of speaking

(p.16).

The majority of work into the management of epistemic status between speakers to interaction has been conducted in the environment of first and second position assessments. For the purpose of the current chapter, which focuses on the therapists’ first position proposals, I will focus the review of this literature on the findings related to first position assessments. Heritage and Raymond (2005) illustrate how speakers of both first and second assessments draw upon a number of resources to index within their talk their relative rights to perform the evaluation underway. Speakers of first assessments, who do not have epistemic authority over the evaluation relevant to their interlocutor, display their downgraded status through the use of tag questions (e.g., “they’re a lovely family now aren’t they?”) and evidential verbs (e.g., “this sounds so good”). Speakers in second position may assert their epistemic authority over an assessment through an array of practices which either invoke a pre-existing point of view (e.g., a confirmation + agreement, or an “oh” prefaced second assessment), or deploy interrogatives which translate their second turn into a new first-positioned assessment (e.g., “it is, isn’t it?”).

Raymond & Heritage (2006) continued this work on the management of epistemic authority in first and second assessments by showing how the resources used in managing epistemics can make relevant specific identities in particular courses of action. In particular, they showed how two callers maintained an ongoing collaboration that sustained one caller, Vera’s, epistemic privileges over issues with her grandchildren and thus validated her identity as a grandparent.

More recently, some research into epistemic authority and subordination has also been done in question-answer sequences. Heritage (2010), Heritage and Raymond (2010), and Raymond (2010) have established the notion of an epistemic gradient between speakers when engaged in the act of
questioning. A questioner invokes the claim that they lack certain information and can be thus referred to as being in a K- position. At the same time, the recipient of the question is projected as having access to certain knowledge that the questioner does not. They are in a K+ position. The act of questioning thus invokes a relative K-/K+ epistemic gradient between the questioner and answerer. For example:

\[ \begin{align*} & \text{K+} \\ \rightarrow \text{K-} \end{align*} \]

However, the design of a question can alter the steepness of the epistemic gradient. For example, the question “who did you talk to?” claims no knowledge concerning the matter being questioned and thereby makes relevant an ‘answer’ as the response. These questions express a large knowledge gap between questioner and answerer and a steep epistemic gradient. However, the declarative question “You talked to John?” asserts a possible answer to the question and thus makes relevant a ‘confirmation’ as a response. These questions embody a much flatter epistemic gradient between the speakers. Thus, within this previous work, several resources have been identified which are used by participants both to orient to, and display, their relative epistemic authorities within interaction.

In the collaborative sequence for behavioural change analysed in the previous chapter, the epistemic asymmetries between therapist and client are delicately managed. The therapist initially asks the client to provide the suggestions for behavioural change, and then incorporates their own suggestions into gist formulations of the client’s talk, thus orienting to their own subordinate authority in regard to the client’s life and experiences. Within the proposal sequences under discussion here, therapists’ proposals involve a suggestion that clients implement some specific action within their life outside of the therapy session. In offering a proposal for behavioural change, there is an implied claim by therapists that they have the professional therapeutic authority of
knowledge expertise over the situation under discussion. Therapists, however, can only ever have secondary access to knowledge about the client’s life and situation, based on what the client has shared within the therapy session. Clients will always have epistemic authority over both how the situation under discussion has played out in their life, and how their behaviour may affect their situation in the future. In offering proposals for behavioural change, therapists are thus in the position of having subordinate rights to knowledge expertise relative to the client.

In line with findings from previous work, therapists in the present corpus are seen to orient to asymmetries of knowledge and experience between themselves and clients when offering proposals for behavioural change. In sequences where therapists seem to offer, and are treated as offering, advice, the ‘advice-giving’ turns, on closer inspection, do not involve the imperative or directive nature that is generally reflective of advice-giving. That is to say, the proffered advice is typically ‘toned down’ or modulated in some way. Advice-giving can generally be understood to involve a prescriptive recommendation toward a course of action (Heritage & Sefi, 1992). Heritage and Sefi (1992) reported, for example, that health visitors delivered their advice explicitly and authoritatively, and in doing so projected their relative expertise as beyond doubt.

Therapists’ ‘advice-giving’ in the present corpus, however, is subtle, non-directive and, sometimes, only implied. This type of subtle advice-giving has been touched upon in previous advice-giving literature, particularly in the counselling arena. It has been noted, for example, that advice may be packaged as some other, more innocuous, activity. Kinnell and Maynard (1996) reported that counsellors delivering advice in a HIV clinic often characterized the advice as information that the clinic provided to ‘clients in general’. Alternatively, the target person of the advice can be constructed in a vague or ambiguous way. Peyrot (1987) examined instances where psychotherapists offered ‘oblique proposals’ to clients, using indefinite pronouns, or generic third-person references, instead of specifically referring to the client.
Rather than ‘give advice’ then, therapists appear, typically, to offer ‘proposals’ for future action in an attempt to make a suggestion for behavioural change. A proposal can be defined as the act of offering or suggesting something for acceptance. The term ‘proposal’ thus emphasizes the status of these turns from therapists as candidate suggestions to clients, which the clients can either accept or reject. For the purpose of this study, instead of labelling these actions by therapists as ‘advice’, I will, therefore, refer to them as ‘proposals’. The previous literature on advice-giving, particularly within counselling interactions, will be drawn upon, however, as the therapists’ proposals under consideration here can be categorized as subtle or indirect forms of giving advice.

Before moving on to discuss the ways that therapists delivered their proposals for behavioural change to clients, I will first, briefly, consider the lead-up to proposals in this corpus. The entry into advice has gained considerable attention in previous CA advice-giving literature, and is worthy of consideration here.

5.2 Step-wise entry into proposal sequences

In Chapter 4, it was shown how, in the ‘collaborative’ sequence, therapists’ formulations and questions work in a step-wise fashion toward a collaborative idea for behavioural change. Within these sequences, therapists also offer a formulation of the client’s trouble, to be confirmed or disconfirmed, before moving into any questioning. Much of the previous research into advice-giving in institutional settings has focussed on the entry into advice sequences. These studies have emphasized the importance of a step-wise entry into advice-giving in circumstances where the advice-giver initiated the advice sequence (Heritage & Sefi, 1992; Jefferson & Lee, 1992; Kinnell & Maynard, 1996; Vehviläinen, 2001). These studies have also suggested that if advice is delivered
prematurely it can lead to resistance. It is, therefore, worth looking at whether therapists’ proposal sequences in the current data corpus were entered in a step-wise fashion. I will first briefly review relevant findings from other institutional advice-giving settings that have informed my investigation of step-wise entry into advice-giving by therapists in CBT therapy sessions.

Heritage and Sefi (1992) identified five steps in terms of which a ‘problem-requiring advice’ was sometimes set up or constructed by the health visitors in their corpus. These involved:

1. HV: initial inquiry
3. HV: focussing inquiry into the problem
4. M: responsive detailing
5. HV: advice giving

Heritage and Sefi demonstrated how the step-wise procedure allowed health visitors to enter advice-giving through a successive process that first established a problem, and then topicalized measures for its solution through a focussing inquiry. The potential need for advice could, therefore, be jointly constructed by the co-participants. This allowed the HV to develop her course of advice without being heard as authoritative or hostile. The degree to which a need for advice was established prior to the initiation of advice varied within the corpus. The majority of advice-giving was initiated without an extended preparatory sequence. Heritage and Sefi suggested that the extent of the preparation could influence the subsequent reception of the advice. Considering this finding and the extent of the resistance to therapists’ proposals observed in this corpus, it is important to consider therapists’ sequential entry into the delivery of a proposal within the current data corpus.
Research on counselling interactions has also paid particular attention to the step-wise entry into advice. In their corpus of HIV counselling sessions, Kinnell & Maynard (1996) identified the use of the same full step-wise procedure identified in Heritage and Sefi’s (1992) study, as one way in which counsellors in their corpus initiated advice. They noted that this procedure ensured that the advice was tailored to the client’s specific problems and needs. Here, too, it was found that counsellors rarely employed this full procedure.

Stepwise entry into advice in educational counselling sessions has been examined by Vehviläinen (2001), who analysed counselling encounters in a Finnish adult education setting in which counsellors and students discussed students’ plans. Two variations of the stepwise entry into advice via questioning were identified. The first of these involved the advice being grounded in a question-answer sequence, often extended to a set of chained questions. The question was usually designed to elicit a particular kind of response from the student, and the advice was then grounded in this response. The basic structure of this sequence was presented as follows (Vehviläinen, 2001, p. 375):

1. CO: Question (topicalizing or eliciting student’s opinion)
2. ST: Response (confirming or displaying the elicited opinion)
3. CO: Advice (grounded in the view established in the prior turns)

When advice was offered in this way particular work was done to establish the personal relevance for the recipient. Counsellors’ questions were specific, often taking the form of yes/no interrogatives, and typically involved re-topicalizations that acted to incite the student to confirm a point (usually a personal choice, preference, or other such opinion) established in prior talk (Vehviläinen, 2001).
The second variation of stepwise entry into advice involved counsellors positioning the advice so as to evaluate and challenge students’ perspectives on an issue. This sort of entry into advice typically appeared in “planning sequences” in which plans were being made for the student’s future, and followed this structure (Vehviläinen, 2001, p. 379):

1. CO: Activation of a problem (eliciting ST’s ideas or plans regarding a particular task)
2. ST: Response (description of plans, ideas, intentions)
3. CO: Advice (commentary turn in which CO evaluates ST’s response)

Vehviläinen concluded that stepwise entry into advice allowed professionals to find possibilities for alignment in situations in which students and professionals’ perspectives may have a problematic relation. In particular, if students’ own ideas were the basis of the advice, opposing the advice was likely to be more difficult. However, resistance and argument from students was still common in this corpus.

Step-wise entry into advice in a family therapy session has also been analysed (Couture & Sutherland, 2006). The process involved the therapist first inviting the family had begun to consider possible middle ground between two conflicting positions. Only when the family began to show acceptance of this stage did the therapist move on to advice-giving. The researchers demonstrated how step-wise entry allowed the therapist to give advice that was built on common ground.

There is also evidence that therapists in the present corpus treat the offer of a proposal as a delicate action, and take care to use a step-wise entry into proposals for possible behavioural change on the part of the client. In the current corpus of therapy sessions, when a proposal is offered, it typically occurs after an extended troubles-telling by the client. In all instances, a definite ‘trouble’ has previously been established. Additionally, therapists mobilize a range of actions to topicalize the
trouble as being relevant to the current therapeutic interaction. This might include offering formulations of the client’s telling, questioning the client’s thoughts about their situation, or topicalizing certain aspects of the client’s telling that therapists thought were particularly relevant or problematic. Formulations and information-soliciting questions were the most common resources drawn upon. Therapists in this corpus, therefore, appeared to take care to enter a proposal sequence in a stepwise fashion. As considerable attention has already been paid to this phenomenon I will not describe these steps in detail, but one illustrative example is provided below.

(2) [CBT 002 dinner 26:35]

1  C: I'm really **cross** with my mother becuz um hh (0.2) it's her birthday this Satur[day?]
2  T: [Umhm ]
3  ((45 seconds of troubles-telling omitted where C explains that her mother does not want to go out for a birthday dinner organized by C because she considers it too expensive))
4  T: → So it's **difficult** for her to accept a gwi- a gift **graciously**.
5  C: Nevah. [She's] nev-=an’ this morning I- .hh I **lost** it.
6  T: [Umhm.]
7  ((1 minute, 22 seconds omitted))
8  T: → >Does it make you feel< very rejected (.) when you get kind’ve you offer a gift an’ it gets **slapped down**, 9  C: ABSO[lu:te]ly. I didn’t even...
10  T: [(   )]
11  ((2 minutes, 46 seconds omitted where C begins talking about trying to live in hope))
12  T: → W’ll t'I w’z jus- if we just< go back to the situation with your Mum for a minute.
13  C: m[m]
14  T: → [u]m (0.2) one of the things that it (.) was making me think of is that **really** (0.5) when you offer someone a gift (0.5) what you’re doing is **saying** (0.5) y’know I thought about you:.
15  (0.6)
16  T: → [I care-] I care about you. [I lo]ve you:.
17  C: [Y↑eh   ]
18  (0.2)
And when the person receives that gift graciously they say "thank you for your love I accept your love." (0.4)

In some ways it's as if they're saying "I don't want your love your love is stupid" (0.6) or it can feel like they're saying I don't want your love (0.2) I don't want your love your love (0.4)

[to] a person who'se giving a gift

I'm absolutely ~shatt'ed~. (0.8)

I feel like we're going to go out to dinner and I'll choke on my food.

It's always a struggle in our stupid family (0.2)

Nobody in our family knows how to say thank you.

Mmhm.

Everything's ANALYSED. It's just crazy. (0.5)

I just think life's too short for that crap but I just can't get it through to people. (0.9)
C: We're not gonna live forever.

T: Have you thought about talking to your Mum and saying, you know, okay mum obviously this idea of a seafood dinner is not pleasing you.

T: What is it that you'd actually like for your birthday?

C: Uh no: It's the way they've been brought up: Their mentality is we've got lots of food at home.

In line 1 the client begins a troubles-telling about having organized to take her mother out for her birthday. She relates how her mother subsequently told her that she did not want this because it was too expensive. Overall, the troubles-telling extends over 5 minutes. During this time, as can be seen at each of the marked arrows in the transcript, the therapist offers formulations of the client’s troubles and asks the client information-soliciting questions about her feelings on the matter. After the client’s telling has shifted slightly to another topic, the therapist brings the conversation back to the client’s mother (line 17) and then moves to offer a final, more detailed formulation of the trouble. The client responds with strong agreement to the therapist’s extended formulation (“yeh”, “yeah” line 25, “yeas” line 29, “absolutely” line 33, “yeah” line 41, “absolutely” line 42, and “yeah absolutely I mean” lines 44-45). The client then elaborates, providing further assessments on the situation.

Throughout the troubles-telling and the subsequent formulation sequence, therapist and client thus appear to be aligned. Further, the interaction has progressed in a step-wise fashion, with the therapist’s turns working to focus on the specific details of the client’s trouble, culminating in an agreement between therapist and client on the upshot of the client’s trouble. The client also demonstrates that she has come to the end of her telling by drawing upon essentialized and idiomatic expressions in her final turns to reinforce the upshot of her telling. She uses an
essentializing “just” in her assessment “it’s just crazy” at line 63. After no response from the therapist she moves to deliver two successive idiomatic expressions: “I just think life’s too short for that crap ‘n I just can’t get through to people” (lines 65-66) and “we’re not gonna live forever” (line 68). The closing nature of the client’s final turns before the therapist delivers a proposal suggests that, within these extended sequences, the interaction has reached a point where the client has finished her telling, and a proposed solution to the trouble could now relevantly be discussed. At this point, this could be done either by an information-soliciting question similar to the ones seen in the collaborative sequences analysed in the previous chapter, or by the therapist offering a proposal. Here, the therapist offers a proposal for behavioural change rather than asking for a suggestion from the client. This pattern is the case for all of the instances of therapists’ proposals across the corpus. In each case, at the point in the interaction where therapists offer a proposal, they might instead have asked an information-soliciting question to coax a suggestion from the client.

The therapists’ efforts to enter a proposal sequence in a step-wise fashion display an orientation to the delicate nature of offering a proposal in this environment. This activity also suggests that it is not the premature delivery of proposals for behavioural change that typically led to widespread resistance from clients in this corpus, as previous research had found to be the case in other contexts. I will, therefore, now move to consider how therapists routinely deliver their proposals to the clients, and consider the sequential implications of this delivery.

5.3 The delivery of therapists’ proposals

Having established that the proposal sequences under consideration were entered into in a stepwise fashion, this next section will examine therapists’ proposal turns. The therapists draw on several resources that overtly display their subordinate epistemic authority in relation to matters of
behavioural change within their proposal turns. These resources include the use of low modality operators and hedging devices, interrogative forms, vague impersonal references, and packaging their proposals as more innocuous activities such as information-giving. These resources will be discussed more fully in the subsequent sections. In doing so, I will build on the developing body of work into the negotiation of epistemic status by showing how speakers can display their downgraded epistemic authority within another first position environment – that of making a proposal. Three main types of proposal turns were identified in this corpus:

- hedged recommendations
- interrogatives
- information-giving (or what Heritage and Sefi (1992) have termed ‘factual generalizations’)

The resources used by therapists to display their subordinate epistemic rights to the clients’ situations will be discussed in the following sections for each type of proposal turn.

5.3.1 Hedged recommendations

Proposals expressed as hedged recommendations make up the majority of the proposal corpus, and are the type that most reflect the appearance of advice-giving. A recommendation can be defined as a suggestion for an advisable course of action. Although the imperative nature of a recommendation was implied, therapists’ recommendations were expressed tentatively with much optionality evident on behalf of the client. In other words, proposals were delivered in a way that displayed that acceptance was at the discretion of the client. In this corpus, therapists never framed their recommendations as “I recommend...” or “the recommendation is...” as has been seen in other advice-giving literature (e.g. Silverman, 1997). Rather, recommendations were typically framed in a
hedged way using a multitude of resources that included modal verbs, perturbations, and other delaying devices.

Modality was one of the major resources drawn on by therapists to hedge their recommendations. Modality can reflect the projected stance of participants towards claims of fact, authority or reality (He, 1993). It can also reflect a participant’s epistemic stance in relation to the matter at hand. The use of high modal operators (e.g., will, must, should, need) and adjuncts (e.g., exactly, definitely, certainly) constitute a stance of certainty, determinedness, and high obligation (He, 1993). Low modality operators (e.g., could, may, might) and adjuncts (probably, perhaps, maybe, I don’t know) on the other hand, can project a stance of uncertainty, tentativeness and low obligation (He, 1993). In using low modal terms the speaker thus constructs less truth value for their utterance as well as lower epistemic status in relation to their interlocutor. Therapists in this corpus exclusively use low modality words to deliver hedged recommendations (marked in bold in the examples below). In fact, therapists’ hedged recommendations often involve the use of multiple low modality operators or adjuncts.

In drawing on these resources within their recommendations, therapists display an attempt to manage the potentially problematic delicacies at play in offering a proposal to the client. The fragments below illustrate some instances:

(3)  [CBT 002 ombudsman 18:45]

1 T: → Might be worth maybe (0.2) tracking down the c- the helpline
2 of the ombudsman and jus’ ringing up and follow[ing up on]
3 C: [I’m gonna]
4 ring up the [lady] that wrote the letter=
In each of these examples, the use of minimizing terms, delaying devices and low modal terms all display an orientation, by the therapist, to the delicacy at play in offering a proposal.\(^5\)
Therapists’ use of low modality terms serves to project a tentative and qualified commitment to the proposal they are delivering. The multiple deployment of these terms within a single turn further emphasizes the tentativeness around proposing. For example, in Fragment (3), the therapist draws upon two low modal verbs within the first four words of her turn: “M↑ight be worth maybe”. This use reflects an orientation to the dilemmas therapists face in offering proposals. Low modal operators help create a sense of high optionality on behalf of the client, which displays an attempt to avoid ‘telling the client what to do’. Low modality also displays an attempt to respect the delicate asymmetries in knowledge and experience within the interaction. In using low modal operators therapists frame their proposals as both tentative and low obligation, displaying their lower epistemic status in respect to the client.

Essentializing devices are also common in therapists’ hedged recommendations, and can be seen to further downgrade the proposals. The use of ‘just’, for example, in three of the four above examples (“jus’ ringing up” in (3), “jus’ do a couple of walks::?” in (4), and “you could not just have a cup of t↑ea” in (5)) can be seen to be downgrading the potential inconvenience or difficulty of the proposed behavioural change. The use of ‘just’ here thus suggests an attempt by therapists to make their proposals appear as simple and straightforward as possible. The deployment of such devices suggests an orientation by the therapist to the potential trouble a proposal could cause to the interaction, and an attempt to manage that trouble. In making the proposal sound as simple as possible, acceptance of the proposal is, arguably, made easier.

A further resource deployed in these proposal turns is the use of delaying devices (Pomerantz, 1984; Schegloff, 2007a). Therapists’ turns are laced with intra-turn pauses, in-breaths, out-breaths as well as other hesitations. In Fragment (4), the therapist also deploys a turn initial delaying device “.tch” followed by an intra-turn pause before beginning to speak. Within her actual TCU, the proposal involves the client “going for a couple of walks”. This proposal is, however, left to the very end of the
turn which extends over three lines. All of the therapist’s talk that comes before acts to delay the
delivery of the proposal within the turn. Similarly in Fragment (6), after the turn initial “but” the
therapist delays her turn with “um (0.4) .tch (0.4) y’know (2.5)” before continuing her
recommendation TCU. All of these devices are characteristic of a dispreferred action, and can
suggest reluctance or discomfort (Schegloff, 2007a). Thus, again, therapists’ use of these devices
suggests an orientation to the potentially problematic nature of making proposals for the client’s
future action.

Combined, the use of the low modal operators, minimizers and delaying devices within therapists’
recommendations display their attempts to manage the complex and delicate asymmetries that
exist within the therapy environment. In making these turns more tentative with an emphasis on
high optionality, therapists display their subordinate epistemic authority over the client’s life and
experience, thus undercutting any epistemic authority that may have been inferred by their activity
of proposing an action to the client.

Clients, in turn, orient to their epistemic authority over the matters at hand. Clients’ resistance turns
will be discussed in detail in Chapters 7-9, but briefly for the current purposes, in each case it can be
seen that clients produce their account in a declarative manner, in contrast to the tentative style in
which therapists offer their proposals. Clients’ responsive turns show little evidence of hesitations or
perturbations. The contrast set up by this declarative manner also works to display an assertion by
the clients of their epistemic rights over the situation.

In summary, within therapists’ hedged recommendation proposals, low modal verbs and auxiliaries,
minimizing terms and delaying devices are typically employed which act to make the proposals
tentative and emphasize that acceptance is up to the client. In doing so, therapists orient to their
subordinate epistemic rights relative to the client in making a proposal for behavioural change.
Despite the tentative nature of these proposals, however, they still provide a suggestion that the client can accept or reject, rather than constituting a request that the client provide their own suggestions for behavioural change, as was seen in the description of ‘collaborative’ behavioural activation sequences.

5.3.2 Interrogatives

Another way in which therapists frame their proposals is through the use of interrogatives. Silverman (1997) noted, in his study of HIV counselling sessions, that questions can be highly implicative of, and heard as, a piece of advice. Forthcoming research by Butler et al. has also shown how interrogatives can be used to suggest or propose a future course of action within a corpus of calls to a children’s helpline (C. Butler, Potter, Danby, Emmison, & Hepburn, forthcoming). The interrogative package downgraded the potential prescriptiveness of the course of action the counsellors were proposing, and displayed their lack of knowledge about the contingencies of the child’s situation. The analysis in this section (as well as the analysis of clients’ responses to interrogative proposals in Section 8.3) will build on this prior research by showing how therapists’ proposals for behavioural change in this CBT corpus were sometimes designed as interrogatives, and the interactional accomplishments of designing the proposals in this way.

Interrogative proposals imply a proposal for a preferred future action whilst still suggesting high optionality on behalf of the client in accepting or rejecting the proposal. In other words, the discretionary nature of the proposal is indexed with the interrogative turn format. These interrogatives are very different in nature to those seen in the collaborative sequences. Rather than acting as information-soliciting questions that ask the client to provide a suggestion for behavioural
change, these interrogatives contain a suggestion from the therapist, within the turn, for the client to either accept or reject.

The therapists’ proposal interrogatives, in this corpus, are usually framed grammatically as yes/no interrogatives. Although all of the interrogatives are framed with an action-type preference for acceptance, some differ in their grammatical polarity. Some of the interrogative proposals are framed with a positive polarity preference for a “yes” response, whereas others are so heavily mitigated that they carry a negative polarity (Raymond, 2003). Those proposals which carry a grammatical preference for a “no” response, whilst still preferring acceptance, have what Schegloff (2007a) has termed ‘cross-cutting’ preferences (e.g., “does there happen to be any cake left at all?”).

Therapists deliver their interrogative proposals in a way that displays their significantly subordinate epistemic authority over the issue at hand. The proposals are designed in a way such that therapists claim to have no pre-existing access to the issue under question. The interrogatives are also considerably hedged, including low modal verbs (e.g., “maybe”), epistemic markers (e.g., “do you think”), and mitigating devices (e.g., “sort of”). All of the therapists’ interrogative proposals thus set up a steep epistemic gradient (Heritage & Raymond, 2010) between therapist and client over the matter under question. Examples of therapists’ interrogative proposals can be seen below.

(7)  [CBT 002 accommodation 4:42]

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>T: [Alright] so: (1.7) .hh g'iven that</td>
</tr>
<tr>
<td>2</td>
<td>he: hhh can't let you know until Christmas (0.6) an’ then even</td>
</tr>
<tr>
<td>3</td>
<td>if it's a yes: (0.2) there’ll still be a kinda bit’ve a gap</td>
</tr>
<tr>
<td>4</td>
<td>(0.2) [bet]ween (0.2) now and when you could possibly buy a</td>
</tr>
<tr>
<td>5</td>
<td>C: [Yes]</td>
</tr>
<tr>
<td>6</td>
<td>T: courtyard home [an’ get] into it.</td>
</tr>
<tr>
<td>7</td>
<td>C: [Yes. ]</td>
</tr>
<tr>
<td>8</td>
<td>C: Yes.</td>
</tr>
<tr>
<td>9</td>
<td>(0.2)</td>
</tr>
<tr>
<td>10</td>
<td>T: → Is it worth exploring some other al- accommodation options?</td>
</tr>
</tbody>
</table>
C: [Uh:]  
T: → [so ] that you're not livïng at home?  
C: We'll not really becuz (0.7) in the six weeks I'm off I don't get pai:d.  

8) [CBT 002 dinner 26:35]  
T: → Have you thought about talking to your Mum and s:aying (0.2)
y'know “okay mum obviously: (0.3) this idea of a seafood dinn;a
(0.3) is not pleasing you.”  

T: → “whïat is it that you'd actually like for your birthday?”  
C: UH NO: [IT’S] THE WAY THEY’VE BEEN BR;OUGHT ;U::P=THEIR
MENTALITY IS WE'VE GOT LOTS OF FOOD AT HO:ME.  

9) [CBT 001 walks 52:15]  
T: → Do you think you could talk with Pete about (0.4) the fact that
you are quite worried about Leah and y’think it's really
importan’ for her to have some one on one time with you.  
T: → and would he mind twice a week (0.6) just (0.7) you know (0.5)
keeping an ear out in the house.  
C: Yep  
T: So that Alison is gonna be (0.8)  
C: Yep see if ye- m (0.6) makes me wïorried what am I going to say
to Alison.  
C: you know cos she always feels:: (1.3) that (0.3) n- the- she's
always seen Leah (2.2) with the over extended (0.5) whatever’s
to get the attention. =[So sh]e's always gone (1.1)  
T: [Mmhm ]  
T: Yep.
In Fragment (7), the therapist first delivers an account for her proposal based upon the client’s preceding troubles telling. Pre-proposal accounts set up the delivery of a subsequent proposal by first stating the problem to be solved (Houtkoop-Steenstra, 1990; Waring, 2007b). The therapist’s pre-proposal account orients to the delicate nature of delivering the subsequent proposal. The therapist gets acceptance from the client of the candidate stated problem, which provides her with a go-ahead to deliver her proposal. Although the interrogative is grammatically structured for a “yes” response, in launching it with the phrase “is it worth” (line 10), the therapist downgrades her epistemic authority over the issue relative to the client.

Similarly, in both Fragments (8) and (9), the therapists’ interrogatives contain a preference for a positive polarity “yes” response, as well as acceptance of the proposal. However, the therapists’ use of the low modality phrases “have you thought about” and “do you think you could” on commencement of the interrogatives set up the proposals as candidate and tentative. In (8), the therapist includes the epistemic modal “thought” to downgrade the proposal. In (9), the combination of an epistemic modal (“think”) and a low modal auxiliary (“could”) downgrades the proposal from being not merely an objective possibility but being a subjective possibility on behalf of the client. Again, the use of these resources emphasises high optionality to the client in accepting the proposal, and displays an orientation by the therapist to her subordinate epistemic authority over the situation under discussion.

In the final example, below, the therapist’s interrogative is mitigated in such a way that the question carries cross-cutting preferences (Scheglof, 2007a). Whilst preferring acceptance, it is designed grammatically to prefer a “no” response.
The therapist initially delivers a proposal in the form of a ‘hedged recommendation’ in lines 1-3 which suggests that the client take her daughter to see a counsellor. After no response from the client at line 4, she reformulates her proposal as an interrogative which more specifically proposes that the client take her daughter to see a school counsellor. The grammatical design of the turn carries cross-cutting preferences (Schegloff, 2007a). The inclusion of the phrase “at all” (with high pitch intonation) reverses the polarity of the interrogative so that grammatically the question actually favours a “no” response (see Heritage, 2010). However, the proposal is framed to prefer acceptance, as it is that response which furthers the progress of the activity projected by the turn. So, whilst the action is designed for a “yes”, the grammatical format is designed for a “no” (Heritage, 2010). The format of the question thus displays the therapist’s downgraded epistemic status in relation to the proposal and respects the client’s right to reject the proposal.

As with hedged recommendations, therefore, interrogative-type proposals display a preference for the client to take up the proposed action. However, they are delivered in a hedged and tentative way, and emphasize high optionality on behalf of the client, displaying an orientation by therapists to their subordinate epistemic authority over the client’s life. They are delivered in such a way as to position the therapist as having little or no access or rights to knowledge over the situation, thus setting up a steep epistemic gradient between themselves and the client.
In each case, the clients, in their responsive turns, display their understanding of the therapists’ interrogatives as proposals by responding to both the interrogative form and providing a rejection of or resistance to the proposed course of action. The clients, in their responsive turns, also orient to concern over epistemic rights. They draw on several different resources in the design of their responses to the interrogatives that assert their epistemic rights. These client resources will be discussed in detail in Chapter 8.

5.3.3 Information-giving

The final, and perhaps most subtle, way in which therapists package their proposals for behavioural change is as information-giving. Hudson (1990) noted that a statement of knowledge, or the presentation of information within a particular environment can be interpreted as advice; when out of context it might not. In packaging the advice/proposal as the more innocuous activity of information-giving, the imperative nature of the advice/proposal is downplayed. This issue has been picked up by several analyses of institutional advice-giving (e.g., Heritage & Sefi, 1992; Kinnell & Maynard, 1996; Silverman, 1997). Heritage and Sefi (1992) noted that health visitors sometimes framed their advice as a ‘factual generalisation’, where the advice was packaged as a generalization of other mothers’ practices that amounted to a recommendation of that practice.

Along the same lines, it has been reported that HIV counsellors also sometimes packaged advice as information (Kinnell & Maynard, 1996). This involved counsellors characterizing advice as information that the clinic gave to clients in general. Kinnell and Maynard argued that advice-as-information can heighten the ambiguity between talk as advice specific to the client or as information that counsellors generally provide, therefore possibly avoiding displayed resistance from the client. This type of advice was sometimes used as a cautious way of initiating an advance toward
more personally relevant recommendations. Overall, Kinnell and Maynard (1996) found that there was a very strong tendency for counsellors to relay information to clients rather than to tailor advice to their individual needs and problems. This practice may be reflective of the institutional mandate of the clinic involved - counsellors were taught the importance of relaying information to the community through their clients.

Silverman (1997) also identified an ‘advice-as-information’ sequence in his corpus of HIV counselling sessions. This type of advice implied a general policy rather than being recipient-designed, personal advice for the client. In giving advice in this way, counsellors could be seen as reporters of general information, rather than as potentially intrusive advice-givers. Clients could then choose whether or not to hear the information as personally relevant.

In a similar way to that described in these previous studies, therapists in the present corpus sometimes deliver proposals by providing a piece of factual information for the client with an implication that the client takes up the action/service being described. Therapists’ factual generalizations target their proposed solution to the trouble as being a ‘general’ solution to that problem. In other words, any client who came to them with this trouble might receive this proposal for future action. Again, in designing their proposal turns in this way therapists display an orientation to the fact that they do not have epistemic authority over the client’s life, and cannot know whether the proposal might apply specifically to the client.

(11)  [CBT 001 time-out 26:39]
1  T: → I gu↑ess one of thee um (.)
2  C:  ((blows nose))
3       (0.6)
4  T: → one of the best (0.8) .tch (0.2) ways to:: (0.5) u- deal with a-
5            a problem like that when you've got a child who'se >really in
6            the mind set of well< (0.5) even baid [attention is better than]
C: [is structured ]
T: → no att[ention] (0.5) is to: start to put a: >a kind’ve a<
C: [ Umhm ]
T: → structure into place where (0.5) they get plenty of positive
attention.
(0.3)
T: Lots’ve (0.3) pats ‘n strokes an’ playing with an– an’ ti:me
with people who they care about (0.5) and when (0.3) the
negative attention behaviours come out (0.8) they just get
ignored.
((1 min, 27 secs omitted))
T: U:m (1.0) .h now I guess one of the (0.3) suh– so time out can
be used as an effective way of >managing that<. becuz ya just
saying yuh know “lºook” (.) n– thºis behaviour can’ºt go on >in
the< public space of the hºouse so: you need to go: to
[your time out arEA”]
C: [jus’ thow do not ] listen yu’ know they’ll hear it n’ they’ll
get punished for it the moment they’re not n– both of th’m no
teevee no computer for a week.
T: Mmmh.
(0.9)
C: BUT THEY’RE STILL (0.7) bickering and __fighting.

(12) [CBT 002 computer 10:26]
T: → Thez um (0.6) THERE ARE quºite a number o::f (0.3) ahh: computer
literacy skills for: sort’ve (0.5) people in your age group
.hhhh that are run by: libraries and local councils and stuff like
that.
((21 seconds omitted))
T: and some libraries will run (.) you know (0.3) ↑how to use a
computer for the first time sessions.
(0.6)
T: where they kind of give pe[ople jus’ a basic tu- ]
C: [I’m sure not at] our library
coz I went to __ library an’ .hh (0.2) they give you fifteen
minutes to __ get o:n.
(0.2)
C: it took me fifteen minutes ta work out how to turn the bloody
thing o::[n.
As can be seen in these examples, in this type of proposal the client’s ‘trouble’ is framed as a generalised trouble that is commonly experienced. In Fragment (11), the therapist frames the trouble as “a problem like that when you’ve got a child who...”. The reference to a “problem like that” generalizes the trouble as something that is commonly experienced by parents. The subsequent use of the inclusive “you” and impersonal “a child” further normalises the client’s trouble with her daughter’s behaviour. The proposal is thus set up as one that the therapist would give to any parent who had a child behaving in this way. From the outset of the turn the therapist also emphasizes the optionality of her proposal by referring to her proposal as “one” way to deal with the client’s trouble. Similarly in (12), the therapist invokes a relevant category of people as being the target of the proposal, rather than addressing it to the client directly (“people of your age group” in line 2). She also includes a vague and generalized reference to courses run by “libraries and local councils” (line 3). The proposal is thus delivered as one that the therapist would give to any client in her age group having trouble with computers. In providing an opportunity for the client to hear the proposal as generally relevant rather than specifically personally relevant, therapists display their subordinate epistemic authority over whether the proposal applies to the life of this particular client.

The design of these proposals allows the client to respond in a way that rejects the proposal on the basis that the information cannot or does not apply to them. And, in fact, in both of the above examples, the clients enter in interjacent overlap (Jefferson, 1986) with the therapist to provide an account of why the proposal cannot apply to them. The clients’ responsive turns are both clearly violative. They enter part way through the therapist’s TCU, and continue talking until the therapist drops out. Moreover, hesitations or perturbations are not evident in the clients’ turns. They are thus engaging in unmarked overlap competition (Jefferson, 1986) in order to get the turn. Such lengthy displays of violative overlap suggest an orientation by the client to their own epistemic authority over whether the proposal will or will not apply to them personally. In this sense, they are
accounting for their right to control the talk. They overtly establish that there is no point in the therapists continuing their proposal turn, before the client responds.

The clients’ turns provide explicit accounts as to why they cannot accept the proposal. Again, their accounts involve information about their life that the therapist could not have known. Thus, within the clients’ responsive turns, they again assert their epistemic authority over the issue at hand. In (11), the client draws upon the characteristics of her children in asserting that her children would not listen to a time-out request. In (12), the client draws upon knowledge of her library to state that the proposed computer courses are not offered there. These responses will be discussed in more detail in Chapters 7 and 8.

So, in packaging proposals as information-giving, therapists frame the client’s trouble as a generalised trouble, and the proposed behavioural change as a generalised solution that would be given to anyone in that circumstance. In framing proposals in this way, therapists provide clients with the opportunity to hear the proposal as generally relevant rather than necessarily specifically relevant, thus displaying their subordinate epistemic authority over the clients’ specific situation. The clients, in their responsive turns, reject the proposals on the basis that the proposal cannot apply to them specifically. In doing so, they assert their epistemic rights over the matter relative to the therapist.

5.3.4 Section summary

In this section I have demonstrated the ways in which therapists design their proposal turns in order to display their subordinate epistemic authority concerning the clients’ lives. Therapists draw upon resources such as delaying devices, minimization techniques, low modal operators, interrogative forms, and package their proposals as information-giving in ways that make them appear tentative.
and imply a degree of high optionality on behalf of the client in accepting the proposal. These resources were drawn upon within three main types of proposal turns:

- hedged recommendations
- interrogatives
- information-giving

Therapists’ hedged recommendations draw upon low modal verbs and auxiliaries, minimizing terms and delaying devices which make the proposals tentative and emphasize that acceptance of the proposal is up to the client. In using these resources within their recommendations, therapists display their subordinate epistemic rights relative to the client in making a proposal for behavioural change.

Interrogative proposals are delivered in a hedged and tentative way, and emphasize high optionality on behalf of the client. In some instances they are mitigated to the extent that they carry cross-cutting preferences (Schegloff, 2007a). They are delivered in such a way as to position the therapist as having little or no access or rights to knowledge over the situation, thus setting up a steep epistemic gradient between therapist and client. Again, the delivery of a proposal in this way allows therapists to display their subordinate epistemic authority over the client’s life.

In packaging proposals as information-giving, therapists frame the proposed behavioural change as a generalised solution that would be given to anyone in that circumstance. Therapists thus provide clients with the opportunity to hear the proposal as generally relevant rather than necessarily specifically relevant, thus displaying their downgraded epistemic authority over the clients’ specific situation, relative to the client.
This analysis has demonstrated how therapists in CBT can attempt to manage the delicate activity of making a proposal for behavioural change in an environment of epistemic asymmetry. These findings build on previous CA research into the negotiation of epistemics. The analysis shows some other ways in which speakers can index their subordinate epistemic rights from first position within a different sequential environment – that of delivering a proposal.

Although therapists display attempts to manage the delicate nature of making proposals for behavioural change, the design of these turns still places rather different constraints on how clients can respond in the next turn compared to the turns analysed in the ‘collaborative’ sequences. Before examining the responses by clients in more detail, in the next section I will look at one further way in which therapists commonly display an orientation to the delicacies associated with offering a proposal for behavioural change.

5.4 Hypothetical active voicing

There is one further, interesting resource that therapists utilize in delivering their proposals. Therapists often draw upon a resource that I have termed ‘hypothetical active voicing’. This resource is often deployed when therapists deliver a proposal as either a hedged recommendation, or an interrogative. Therapists adopt the speaking position of another in a similar way as has been identified when speakers use active voicing or direct reported speech (e.g. see Holt, 1996; Holt & Clift, 2007; Wooffitt, 1992). However, in the cases under examination here, therapists use active voicing to voice some hypothetical talk that the client should use in a future situation when undertaking the proposed behavioural change. In Goffman’s (1981) terms then, although the therapist is the physical animator of the talk within the proposal, the client can be seen as the
embedded animator and principal in the interaction – the one who will commit themselves to say (at some future point in time) the words being expressed.

It will be shown, over the following section, how hypothetical active voicing can manage possible resistance within a delicate epistemic environment. By actively voicing what they think the client should say, therapists can attempt to avoid resistance responses such as “I don’t know what to say” or “I wouldn’t know how to deal with that situation”, etc. Therapists spell out exactly what the client should do and clients are left with the responsibility of merely re-enacting a scenario. Before looking in more detail at the actions accomplished by this practice, I will first describe the common ways in which therapists achieved hypothetical active voicing.

5.4.1 The delivery of hypothetical active voicing

Therapists draw on various resources to overtly display ‘doing active voicing’. These resources include the use of future tense reporting verbs, intra-turn pauses, prosodic shifts and shifts in pronoun use. An example can be seen in the following fragment:

(13)  [CBT 001 enlist Alison 33:51]

1 T:  Well it might be um (1.2) might even be worth trying to enlist
2            Alison.
3 (0.4)
4 T:  into the (0.5) cause=of saying >you know< (0.3) “↑YOU (. ) you
5   know what it's like when your sister goes nuts: (0.2) I know
6   that you don't like fighting with her”, (0.6) you know “↑let's
7   (0.3) let’s see if we can make (0.6) this next week (0.7) a
8   really (0.8) happy time [no:w.”  ]
9 C:      [See I had] them both sittin' there and
10 I said “↑look” (0.5) “↑wha:atta you want”.
In the above example, typical of therapists’ proposal turns, low modality operators, essentializing devices and delaying devices are all evident within the therapist’s initial proposal turn at lines 1-2. The therapist even does the extra interactional work of an insertion repair to include the minimizing term “even” (line 1) that further downgrades the low modality verb “might” at the beginning of her proposal. After receiving no response from the client at line 3, the therapist builds an incremental turn (therapists’ incremental turns will be discussed in the next chapter) and moves into hypothetical active voicing to explain the proposal to the client. The therapist enacts the words that she is suggesting that the client says to her daughter. There are several ways in which the therapist achieves hearable hypothetical active voicing within her turn.

Firstly, in this instance, the therapist introduces her launch into active voicing with the reporting verb “saying” (line 4). Reporting verbs are common in the use of reported speech in conversation (Holt, 1996), however, the difference with the current phenomenon is that the reporting verbs have future rather than past tense. The therapist includes the generalising term “y’know” (to be discussed in Section 5.4.2 below), pauses and then launches into her active voicing. This intra-turn pause works to gain the client’s attention and signal that something different may be about to occur within the turn that is not necessarily continuous with what has gone before (similar to a repair initiation).

Secondly, the therapist uses marked changes in prosody to distinguish her hypothetical active voicing from the rest of her turn. Couper-Kuhlen (1999) has shown how participants can make sense of direct reported speech in part by relying on the prosodic details of the voicing. During the start of her turn at line 4, the therapist’s average pitch is 178 hertz. However, at the start of “you”, the first word in the therapist’s active voicing talk, the pitch rises to 200 hertz (marked by the upward arrow in the transcript). The therapist’s talk also increases in loudness at this point and the first word of the voicing “you” is stressed. The therapist also shifts her pronoun use to illustrate that she is doing active voicing talk. Because of the cues the therapist provides both prior to and at the beginning of
her hypothetical active voicing, the “you” referred to in line 4 can be understood as no longer referring to the client but to the client’s daughter. And later, the “I” referred to in line 5 can be understood to be referring to the client as principal of the hypothetical active voicing, rather than to the therapist as animator of the talk. In combination, these resources allow the client to distinguish this part of the therapist’s talk as hypothetical active voicing. Similar cues can be seen in the following examples.

(14) [CBT 002 dinner 26:35]

1 T: Have you thought about talking to your Mum and saying (0.2)
2 y’know “okay mum obviously: (0.3) this idea of a seafood dinner
3 (0.3) is not pleasing you.”
4 (1.0)
5 T: “what is it that you’d actually like for your birthday?”
6 (0.2)
7 C: UH NO: [IT’S] THE WAY THEY’VE BEEN BROUGHT UP=THEIR
8 T: [no ]
9 C: MENTALITY IS WE’VE GOT LOTS OF FOOD AT HOME.

(15) [CBT 010 activities 18:30]

1 T: That would be a good one.=I’m wondering if< you know even if
2 (0.2) regardless of (0.3) of (0.4) if we’re seeing you know if
3 you’re saying you’re not (0.3) seeing many people at the
4 moment=I wonder if we can: (0.7) um :tch you know (0.6)
5 organize so that it's not if you see someone you can do it but
6 maybe ringing they've got S-A like travel
7 C: Yeah?
8 T: places [here.] Maybe you can [just] ring them up and say “look”
9 C: [Yep. ] [Yep ]
10 T: you know ”>we used to drive around< to Hahndorf [whatever”]
11 C: [Yeah. ]
12 (0.8)
13 T: “I'm from Melburn.”
14 (0.2)
15 T: “What- what can you recommend?” Maybe they would [have sum]
16 C: [ Yeah. ]
17 T: ideas and maybe if you cud do them on the (. ) weekend, it would
be really good with the kids like you said.

C: Well yeah we talked this morning about um (0.9) taking the kids
to the Museum;

(16) [CBT 001 walks 52:15]

T: [I'm thinking] more sort've (0.9) for no purpose walks.

C: ↓for no purpose↑

T: [walks that are about (0.6) um (0.2) “I'm gonna take you out an' we're going to hang out together.”

(0.4)

T: “fur thirty five minutes or” (0.4) “however long you stay out
for”.=

C: =W'll see I wouldn't know what to do with the other child. Huh
[heh heh] see ya know uh- it's quite safe being home with

T: [Yeah ]

C: [but it's] not- they're my- my kids.

(17) [CBT 002 time-out 26:39]

T: U:m (1.0) .h now I guess one of the (0.3) suh- so time out can
be used as an effective way of >managing that<. becuza just
saying yuh know “look” (. ) n- this behaviour can’t go on >in
the< public space of the house so: you need to go: to
[your time out arEA”]

C: [jus’ thow do not ] listen yu’ know they’ll hear it n’ they’ll
get punished for it the moment they’re not n- both of th’m no

teevee no computer for a week.

In Fragments (14), (15) and (17) therapists use a future-tense reporting verb to introduce the
hypothetical active voicing (“saying” line 1, Fragment (14), “say” line 8, Fragment (15), and “saying”
line 3, Fragment (17)). In Fragment (16), there is no reporting verb used but the therapist pauses for
0.2 seconds before launching her hypothetical active voicing. In (14), the therapist additionally
pauses after the reporting verb, before beginning her active voicing. In each case at the beginning of
the hypothetical active voicing there is also a departure from the usual prosody of the therapist’s
talk, with a marked rise in pitch6.
Again, due to these hearable cues within the interaction, therapists’ subsequent shifts in pronoun use during their active voicing are distinguishable as involving different parties than would be expected in the therapist’s normal talk (see Holt (1996); and Couper-Kuhlen (1999) for how pronoun shifts are also used in direct reported speech). For example, in Fragment (14) the “you” referred to in line 5 can be distinguished as the client’s mother rather than the client. In Fragment (15) the “we” in line 10 can be heard as the client’s family rather than the therapist and client. Further, the “I” in line 13 can be heard to refer to the client rather than the therapist, and the “you” in line 15 can be heard as SA travel places as opposed to the client. In Fragment (16), the “I” in line 3 can be heard as referring to the client rather than the therapist and the “we” as the client and her daughter. Lastly, in Fragment (17) the “you” in line 4 is distinguishable as referring to the client’s daughter. In each case the combined use of reporting verbs, intra-turn pauses, prosodic shifts, and pronoun shifts allows therapists hearably to achieve hypothetical active voicing within their turns.

A more complex example of hypothetical active voicing will now be considered. In this instance, the therapist enacts a scenario involving the speech of three different figures: the client (via her thoughts), the client talking to a third person, and the client’s neighbour.

(18) [CBT 007 neighbour 17:59]

1 T: I G\textsc{uess} just (0.6) without going (0.2) into it so much that we
2 don’t continue with thi\textsc{s} (1.0) I would put it to you that you
3 might be on the look out (0.7) to (.). you might even make a
4 resolve to yourself (0.2) “\textsc{okay} (0.7) between now and next
5 appointment with Peter (1.0) I will make \textsc{sure} (0.6) to say no to
6 her once."
7 (1.4)
8 T: in that (.). she might say “\textsc{what’d ya do}ing<\textsc{today}>?” (.). an’
9 (0.7) you might say (0.4) “\textsc{oh I’ve got a very busy morning}.”
10 (0.3)
11 T: full stop.
12 (0.7)
T: “↑oh what are ya doing?” (2.0) “wh↓at I'm do↑ing” ↑you know
(0.2) “th↑at's my business.”
(0.9)
T: “Can you do this for me.” “no I don't have t↑ime today.”
(0.5)
T: ↑even if it's a f↑ib.
(0.7)
T: Just to practice. demonstrating to yourself that you're quite
capable.
(0.7)
T: of doing this.
(1.0)
C: Actually I did- >I can't remember what it was< but I did
actually fib.

I will look first at the hypothetical voicing of the scenario between the client and her neighbour that occurs at lines 8-16. The therapist uses the future tense reporting verb “say” in lines 8 and 9 when introducing hypothetical active voicing for both the client and the neighbour. However, from that point, he relies on changes in prosody and intra-turn pauses for the remainder of the enactment. The therapist’s use of prosody in this fragment is rather more complex than that in the previous examples, as he must animate two figures in the hypothetical scenario in a way that ensures they can be differentiated both from the therapist’s own voice and from each other (Couper-Kuhlen, 1999). The therapist shifts his pitch at the beginning of each stretch of talk by a different speaker. Initially, his pitch register is lowered when he launches the neighbour’s voice in line 8 “>wh↓at’d ya
doing< toda:y?”. The initial speech is also quickened in pace. When the therapist launches the client’s speech in line 9 (“↑oh I've got a very busy morning”), his talk has a marked rise in pitch. These pitch shifts occur each time the therapist shifts speaker for the remainder of the enactment. Lines 13-14 display particularly skilful prosodic enactment. The therapist’s pitch initially rises to deliver the neighbour’s question to the client (“↑oh what are ya doing?”). He then drops his pitch register to deliver the client’s speech (“wh↓at I'm do↑ing”). At this point the therapist resumes the position of the animator and principal of the interaction when he delivers his “you know” at line 13,
and he marks this by shifting his pitch again slightly upward. Lastly, to deliver the remainder of the client’s talk at line 14 (that’s my business”), he raises his pitch higher again. Similarly to the fragments considered previously, the therapist also uses pronoun shifts to display that he is ‘doing active voicing’. The shifts in prosody assist the comprehensibility of the therapist’s simultaneous shifts in pronouns within the interaction.

The therapist in (18) also uses hypothetical active voicing in lines 4-6 to voice a hypothetical version of the client’s thoughts. This phenomenon can also be seen in the following fragment.

(19) [CBT 002 anger homework 46:58]
1 T: An’ >but< the other bit of the homework is to- if there are
2 >situations that make you angry over the course of the week<
3 (0.5) after you’ve calmed down a bit (.) think “;okay” (0.5)
4 “what did I w↑ant in that situation that I wasn’t getting.”
5 (0.6)
6 T: And j↑ust like with the tap situation it m↑ight be a couple of
7 things.
8 (0.3)
9 T: So you might find that (.) “;okay I want to be treated (0.6) um
10 with respect.”
11 (0.3)
12 T: “;I wanna be talked to (0.3) in an appropriate tone of
13 voice.”
14 (0.5)
15 T: Um (0.5) “;I want not- (. ) I want people (0.2) not to burst into
16 my room in the middle of the night and wake me up.”
17 (0.5)
18 T: Whatever the (0.6) [situation is]
19 C: [The thing ] is (. ) we can want a lot of
20 things it doesn’t mean it’s going to happen.

In this example and in Fragment (18), similar resources can be seen to be drawn upon by therapists to convey the ‘voicing’ of the client’s hypothetical future thoughts. Therapists introduce the voicing
with a reporting verb: “make a resolve to yourself” in lines 3-4 of Fragment (18), and “think” in line 3 of Fragment (19). These introductions are produced with future tense to convey to the client that the subsequent talk is something they will be thinking to themselves in the future. Therapists then pause, intra-turn, before launching the active voicing. There are also prosodic shifts when the active voicing is launched. Both in Fragment (18) and in each case of voicing in Fragment (19), the therapists lower their pitch register when launching their voicing of the client’s thoughts. There are also shifts in pronoun use during the voicing of the hypothetical thoughts. In both fragments, therapists use the pronoun “I”, which can be heard as referring to the client. In Fragment (18), the therapist goes one step further to refer to himself in the third person during the hypothetical active voicing (between now and next appointment with Peter, lines 4-5). This type of hypothetical active voicing is fitting in a CBT context, where being aware of, and controlling, the client’s thoughts and cognitions is an important aspect of the therapeutic interaction.

From the above analysis it can be seen that therapists do considerable work to achieve hypothetical active voicing within their talk. This hypothetical active voicing can be used to produce both hypothetical interior monologues in the clients, and hypothetical interactions between the client and other third parties. Why do the therapists do this? What does it achieve in this context? These questions will be addressed in the next section.

5.4.2 Hypothetical active voicing as an interactional accomplishment

Within CBT theory, the practice that I have labelled ‘hypothetical active voicing’ can be seen as an instance of what is referred to as ‘modelling’ on the part of the therapists (Leahy, 2001). ‘Modelling’ involves breaking down proposed behaviour changes into a series of simple steps. The client is encouraged to rehearse and practise these steps outside the session. Modelling statements or behaviours is argued to enhance client compliance and behavioural maintenance. It is a practice that
is often used when clients have displayed non-compliance to behavioural change. In the above examples, such ‘modelling’ can be seen being played out interactionally. Proposals for behavioural change are broken down into a simple step for the client to take, essentially ‘say this’. Hypothetical active voicing, then, can be seen as a way in which therapists attempt to manage potential resistance from clients. When asked to change a behaviour, a client’s rejection might potentially involve an “I don’t know how” type of account. Hypothetical active voicing can act to pre-empt or fend off this type of resistance/rejection by providing the client with the exact words required to accomplish the activity being suggested to them.

Within the corpus, it appears that an attempt to pre-empt client resistance might be particularly salient for therapists at the point in the interaction where they draw upon hypothetical active voicing within their proposal turns. In each of the following examples the client had already displayed some resistance to behavioural change within the session. A closer look at the lead-up to Fragment (15) serves to illustrate how prior client resistance has sequential implications for the use of hypothetical active voicing within therapists’ proposals.

(20)  [CBT 010 activities 18:30]
1  T: Okay and the other the other thing we:rer- ((paper rustling))
2     sorry going back to the Melbourne (0.3) Adelaide thing  hh
3     (0.6) that- there was: (.) u::m: (1.0) asking people what
4     actitivities to do in Adelaide [and] seeing if you cud do some?
5  C:                      [oh ]
6  C: .tch well yeah.=I haven't really seen anyone becuz we've
7      been away.
8  T: Oh yep yep.=
9  C: =um (1.5) no:: yeah I haven't- (0.4) I haven't really (0.3) I
10     haven't seen anyone.
11     (.)
12  T: Yep.
13     (0.3)
14  C: at all.
T: Okay.= C: =apart from my girlfriend.  (1.7)
C: .hh but um (2.1) yeah.  (0.3)
T: Is that something you [still] (. ) fi[n[d would be valuable? ]
C: [no ] [YEA: H um I was th[inking]
um (0.8) yea:h.  (0.9)
C: I was thinking perhaps (1.8) we c’d spend our weekends like
(0.5) r’member we talked about jus’ going for dri:ves an’ (1.0)
stuff like that?
T: Ye[a:h.]  
C: [Yea ]h.  (0.2)
T: That would be a good one.=I’m >wondering if< you know even if
(0.2) regardless of (0.3) of (0.4) if we’re seeing you know if
you’re saying you’re not (0.3) seeing many people at the
moment=I wonder if we can: (0.7) u:m .tch you know (0.6)
organize so that it's not if you see someone you can do it but
maybe ringing they've got S-A like trave:l
C: Yeah?
T: places [here.] Maybe you can [just] ring them up and say “look”
C: [Yep. ] [Yep ]
T: you know “>we used to drive around< to Hahndorf [whatever”]
C: [Yeah. ]
T: “I'm from Melbu_.”
(0.2)
T: “What- what can you recommend?” Maybe they would [have sum]
C: [ Yeah. ]
T: ideas and maybe if you cud do them on the (.) weekend, it would
be really good with the kids like you said.
C: Well yeah we talked this morning about um (0.9) taking the kids
to the Museum;
could do with her family (husband and two children). This task is aimed towards a behavioural change for the client: instigating more enjoyable family time. However, when questioned in lines 1-4, the client tells the therapist that she has not been able to complete the task and gives an account for her failure. The therapist then asks the client whether this activity is one that she would still find valuable (line 21). The client provides a rather weak confirmation to this, an elongated “yeh”, followed by the start of an informing of her own thoughts on the matter “I was thinking”. She stops this TCU midway, however, to provide another elongated “yeh”. After a 0.9 second gap, the client recycles her “I was thinking” and provides her own, rather vague, suggestion for an activity: “going for drives an’ (1.0) stuff like that”. The therapist confirms and provides a positive assessment of the client’s suggestion but then moves to offer her own proposal. So, by the time the therapist comes to use hypothetical active voicing in her proposal (line 38), we can see that the client has already displayed resistance to the behavioural change under discussion locally within the sequence. A similar pattern can be seen in the sequential lead-up to Fragment (17), which is reproduced below as (21).

(21)  [CBT 001 time-out 26:39]
1   T: I remember you: asking me >a couple of weeks ago< if there's -
2     anywhere like ceetad for little kids an' I went an' (0.3) made a -
3     few enquiries.
4     (.)
5   C: Oh good.
6   T: [m basal]c’lly the only thing there is is the
7     [((clears throat))]
8   C: [right.]
9   T: <child and adolescent mental h;ealth service>?
10  (0.2)
11  C: [which ] is called ca:ms.
12  (0.5)
13  T: An’ that's a (0.3) publicly funded (.) body that's=*
14  C: =it’s in Port Adelaide isn't it?
15  T: Uh: they’ve got an office in Port Adel;aid [yep.    ]
16  C: [(maybe b-)]
think Alison was at **cams** when she waz (0.7) having uh problems.

(0.2)

C: she w’z go- getting bullied at scho:1.

T: ↑Okay.

(0.6)

C: So we went to cams for **that**. Uhm: (1.4) I don’t think they really got a lot out of it though.

((2 minutes, 12 seconds omitted))

T: Um hhh (0.4) yeah so (0.2) in terms of the- the (. ) I guess **publicly funded services available (0.8)** um (0.2) **there ’ s really only (0.3) **cams.

(0.5)

T: Um so (0.6) but >I think probably it would be worth following< up with that **again**:.

(.)

C: Yep.

((1 minute, 55 seconds omitted))

T: Um (1.0) .h now I guess one of the (0.3) suh- so **time out can be used as an effective way of >managing **that<. becz u just saying yuh know “°l↑ook° (.) n- th↑is behaviour can’t go on >in the< public space of the h↑ouse so: you need to go: to [your time out arEA”]

At lines 6-13 the therapist offers a proposal, packaged as information-giving, that the client take her youngest daughter to the Child and Adolescent Mental Health Service (CAMHS) for some psychological treatment. This proposal follows on from extended troubles telling by the client about the problem behaviours being displayed by her daughter. The proposal is rejected by the client in lines 16-24. Just over two minutes later, the therapist attempts to offer the proposal again (lines 26-31), and this time receives very minimal, weak agreement from the client (line 33). The therapist then shifts topic to changes the client might be able to make at home. Almost two minutes after the client’s weak agreement with the prior proposal, the therapist makes a new proposal that the client try using time-out (lines 35-39). At this point, after having already received some resistance from the client to the previous proposal, the therapist draws upon hypothetical active voicing within her
In lines 1-3, the therapist offers a proposal that the client take her daughter to see a school counsellor. The proposal is rejected by the client at line 7 and this rejection is subsequently accounted for in lines 7-13. Just under one and a half minutes later, the therapist offers another
proposal that the client try to enlist her older daughter, Alison, into the cause of helping deal with the younger daughter's bad behaviour (lines 17-24). This time, the therapist draws upon hypothetical active voicing in her proposal. Before the therapist begins her active voicing there is also another, more local, display of resistance from the client. At line 18, the therapist has come to possible completion of the proposal turn, and the client is due to respond to the proposal with acceptance or rejection. She does neither, however, leaving a 0.4 gap in the interaction (clients’ silences in response to proposals will be dealt with in more detail in Chapter 6). The therapist responds to the gap by adding an increment to her turn, transforming the gap with its negative interactional resonances into an intra-turn pause (Schegloff, 2001). It is within this incremental turn that the therapist then launches hypothetical active voicing within her proposal. In this instance then, hypothetical active voicing is used after the client has displayed resistance to a previous proposal within the wider sequence and has also displayed resistance more locally by withholding a response in the just prior turn.

It appears, then, that therapists may use hypothetical active voicing within their proposals at points in the interaction where clients have already displayed some resistance to possible behavioural changes. In using hypothetical active voicing, therapists provide clients with the resources necessary for successful completion of the suggested action, thereby simplifying the proposal and making it easier to accept.

However, in doing hypothetical active voicing in this environment, there are also potential problems at play for the therapist in that they are not the authority over the client’s experience and, according to CBT theory, they should avoid explicitly telling the client what to do. Therapists display an orientation to these delicacies within their hypothetical active voicing turns. The main way in which therapists do this is through the use of “you know”, which is common to many of these turns. Therapists usually insert this phrase just before launching into active voicing talk. For example, the
launch of the active voicing within Fragments (13), (14), (15), (17), and (18) (reproduced here as Fragments (23) – (27)) is prefaced with a “you know” phrase (marked in bold):

(23)  [CBT 001 enlist Alison 33:51]

1  T:  Well it might be um (1.2) might even be worth trying to enlist
2    Alison.
3  (0.4)
4  T:  into the (0.5) cause=of saying >you know< (0.3) “↑YOU (.) you
5   know what it's like when your sister goes nuts: (0.2) I know
6   that you don't like fighting with ↑her”, (0.6) you know “↑let's
7   (0.3) let’s see if we can make (0.6) this next   week (0.7) a
8   really (0.8) happy time [no:="""]
9  C:  [See I had] them both sittin’ there and
10   I said “↑look” (0.5) “↑whatta you want”.
11  (2.1)
12  C:  an’ y’know “not be annoyed an’ (1.3) play with my sista an’
13   have f↑un n’ y’know (0.2) fur her to stop annoying me”.
14  T:  Mmhm.
15  C:  “↑now whatta you want”.
16  (.)
17  C:  EXactly the same thing.
18  T:  Yep.
19  (0.3)
20  C:  “↑we(h)ll?”
21  (.)
22  T:  Yep.
23  (.)
24  C:  Y’know it's just (1.0) “↑well”
25  T:  heh
26  (0.8)
27  C:  huh hh
28  (0.8)
29  C:  I can't say anything more th’n “↑well”
30  T:  Mm.
31  C:  You know (.) it's (2.1) they jus’ don’ get it.
[CBT 002 dinner 26:35]
1 T: Have you thought about talking to your Mum and saying (0.2)
2 y'know "okay mum obviously: (0.3) this idea of a seafood dinner is not
3 pleasing you."
4 (1.0)
5 T: "what is it that you'd actually like for your birthday?"
6 (0.2)
7 C: UH NO: [IT'S] THE WAY THEY'VE BEEN BROUGHT UP=THEIR
8 T: [no ]
9 C: MENTALITY IS WE'VE GOT LOTS OF FOOD AT HOME.

[CBT 010 activities 18:30]
1 T: Maybe you can [just] ring them up and say "look"
2 C: [Yep ]
3 T: you know "we used to drive around< to Hahndorf [whatever"]
4 C: [Yeah. ]
5 (0.8)
6 T: "I'm from Melbun."
7 (0.2)
8 T: "What- what can you recommend?" Maybe they would [have sum]
9 C: [Yeah. ]
10 T: ideas and maybe if you cud do them on the (. ) weekend, it would
11 be really good with the kids like you said.
12 C: Well yeah we talked this morning about um (0.9) taking the kids
13 to the Museum;

[CBT 002 time-out 26:39]
1 T: Um (1.0) .h now I guess one of the (0.3) suh- so time out can
2 be used as an effective way of >managing that<. becuz ya just
3 saying yuh know "look" (.) n- thjis behaviour can't go on >in
4 the< public space of the h'ouse so: you need to go: to
5 [your time out area"]
6 C: [just' thow do not ] listen yu' know they'll hear it n' they'll
7 get punished for it the moment they're not n- both of th'm no
8 teevee no computer for a week.
In each of these instances, the “you know” phrase works to distance the therapist from the forthcoming talk. Its use implies that the talk to come will be a version of generalised talk that anyone would say in this circumstance. Its use, therefore, also implies that this is something that the client might choose to say in the relevant circumstance. In this way, the use of “you know” allows therapists to manage the delicate interactional task of the proposal. By using this phrase, the subsequent hypothetical active voicing appears less as if therapists are telling clients what to do, and more as if they are merely providing some commonsensical talk that anyone, including the clients, would say in this circumstance. In this way, “you know” works similarly to the proposals packaged as
information-giving, in that the talk is generalised to something that anyone would do. It also allows
the talk to be heard as a prompt for something the client already knows.

In making the hypothetical speech sound commonsensical and something the client would say in
that circumstance, therapists are able to manage the epistemic asymmetries between them. Doing
this, however, also opens up the turn to possible resistance on the grounds that there is a reason
why the client, specifically, could not enact the proposed scenario. The client is the authority on
their own experience and can resist such a generalised claim on these grounds. In Fragments (26)
and (27), the hypothetical active voicing is also downgraded. In (26), the therapist adds the
minimizer “just” before the reporting verb “saying” in line 2, which further emphasizes the simple
nature of the scenario the client is to enact. In (27), the therapist adds the low modal verb “might”
before the reporting verb “say” in lines 8 and 9 which works to downgrade the active voicing into a
suggested scenario rather than an actual, factual one.

If we look at clients’ responsive turns, it can be seen that, in each case, they resist the therapist’s
proposal scenario. The way in which they do this displays an orientation to their superior epistemic
authority over their previous experiences relative to the therapist. In Fragments (23), (25), (26), and
(27) clients respond with a telling about how they have already attempted to enact the scenario that
the therapist has proposed. In (23), the client even goes to the effort of using her own direct
reported speech (Holt, 1996) to display the factuality of her telling (this phenomenon will be
discussed further in Chapter 8). In (24), the client responds by asserting some particular
characteristic of her family’s “mentality” as to why she cannot enact the proposal, again drawing
upon an aspect of her experience that the therapist could not have known. In each case, in
responding in this way, clients assert their epistemic authority over the matter at hand. They are also
able to dismiss any implied claims within the proposal that they are not capable of coming up with
the proposed scenario themselves.
5.4.3 Section summary

In summary, it has been demonstrated how therapists draw upon the resource of hypothetical active voicing as one way in which to manage possible resistance to their proposals. Therapists set up the delivery of their talk to be heard as active voicing in four main ways: (1) use of future-tense reporting verbs; (2) pausing intra-turn, (3) marked shifts in prosody; and (4) shifts in pronoun use.

Hypothetical active voicing appears to be drawn upon when clients have already displayed some resistance to suggestions for behavioural change within the session. It works to simplify the proposal for the client, and thus acts as a way in which therapists can attempt pre-emptively to manage further possible resistance, and make the proposal easier to accept. However, when using this resource, therapists also orient to the problems of delivering a proposal in this way when they do not have epistemic authority in the interaction. Therapists display attempts to manage these delicacies by making use of the phrase “you know”, which generalises the subsequent voiced talk as being something that not only the therapist would say, but that anyone would say when faced with the particular circumstance under discussion. In doing this, however, therapists also allow clients the opportunity to resist the proposal on the grounds that it cannot apply to their particular circumstances. And clients do resist the proposals in this way. They either draw upon a telling of a previous occasion where they already attempted to do what the therapist is proposing, or they draw upon aspects of their own experience to explain why they could not attempt to enact the scenario the therapist is proposing.
5.5 Chapter summary

This chapter has examined the most common way in which the CBT task of behavioural activation is addressed by therapists within this corpus: by making proposals. Initiating behavioural change is an important aspect of CBT; however, it can create interactional problems for therapists due to some delicate epistemic asymmetries that exist within the therapy environment.

We saw over the course of the chapter that making a proposal for behavioural change is a much more problematic activity than the turn designs deployed in the ‘collaborative’ sequence. The lead-up to these proposal turns reflects a similar extended sequence as the lead-up to the collaborative sequence with there being an extended troubles telling from clients, formulations of the trouble from therapists with agreement from clients, as well as information-soliciting questions from therapists that result in further telling from clients. However, the proposal turns themselves can cause interactional problems within the sequence. Therapists are making proposals in an environment where they have subordinate epistemic authority relative to clients on the issue under discussion. Although therapists have professional authority, clients possess authority over their own experience. Within their proposal turns, therapists display an orientation to their subordinate epistemic authority. They do this by drawing on a range of resources that downgrade their epistemic status within the turn.

When therapists frame their proposals as hedged recommendations they use low modality operators, minimizing terms and delaying devices to generate a sense of tentativeness and high optionality on behalf of clients. Therapists’ interrogative proposals, whilst carrying a preference for acceptance, also contain low modal terms and delaying devices which, together with the interrogative form, also suggest high optionality on behalf of clients in accepting or rejecting the proposal. Lastly, proposals delivered as information-giving display and frame the proposal as a
generalised solution to the trouble that anyone, including clients, would do in the given situation. However, in doing so, therapists leave the proposal open to resistance on the basis that the information cannot or does not apply to the client.

Clients, in their responsive turns, also orient to their superior epistemic authority over the matters at hand. They do this by accounting for their resistance with a reason from their own personal experience as to why they cannot accept the proposal. Clients also assert their superior epistemic rights through the delivery of their turn. These responses by clients will be the focus of the analysis in Chapters 7-9.

There was one additional resource drawn upon by therapists within their proposal turns, which I have termed ‘hypothetical active voicing’. In using this resource, therapists actively enact a hypothetical version of talk in which they propose the behavioural change to clients. Therapists achieve hypothetical active voicing by using future-tense reporting verbs, intra-turn pauses, shifts in prosody, and shifts in pronoun use. Hypothetical active voicing is another way in which therapists display an attempt to manage the possibility for resistance to their proposals. Its use provides clients with the additional resources necessary to enact the therapist’s proposal, thus making the proposal as simple and straightforward as possible.

However, again, therapists display an orientation to the delicacies at play in doing this action. They do this most commonly by inserting a “you know” phrase before launching their hypothetical active voicing. In this context, “you know” phrases work to generalise the talk being voiced as something anyone might say in that circumstance. However, generalising the talk in this way also allows clients to resist the proposal on the grounds that enacting such a scenario could not work for their particular circumstance. In each case, clients do in fact respond in this way, either providing tellings of previous efforts to enact the proposed scenario, or drawing upon characteristics of third persons
whom the therapist does not know to account for why enacting the proposed scenario would not work.

From this analysis of therapists’ proposal turns I have identified some of the interactional problems that stem from making a proposal in an environment where there are delicate asymmetries between the participants. The consequence of these asymmetries is that clients are always able to resist proposals for behavioural change from therapists on the grounds that they have superior knowledge of their life and experiences which enable them to discount the proposal. This is in contrast to what transpires in ‘collaborative’ sequences, where resistance to suggestions for behavioural change is made rather difficult for clients. Features of clients’ resistance turns to therapists’ proposals will be the focus of the next four analytic chapters. I will show how clients display both premonitory and overt resistance to the proposals, commencing with clients’ deployment of premonitory resistance resources.
CHAPTER 6

‘Premonitory resistance resources’: Clients’ use of silence and other-initiated repair to foreshadow resistance to proposals

6.1 Introduction

As I showed in Chapter 5, within the CBT corpus under investigation, clients almost always overtly resist therapists’ proposals for behavioural change. Client resistance is, of course, considered detrimental to the success of CBT. Without acceptance of, and adherence to, the behavioural changes discussed within therapy sessions, CBT theory suggests that clients’ experiences of depression are unlikely to be overcome. Resistance can be achieved in multiple ways and, in this sense, can be difficult for the therapist to monitor. The following four chapters, focusing on forms of client resistance, will illustrate the subtle and overt ways in which clients can display resistance to behavioural change within CBT interactions, as well as considering the interactional consequences that routinely follow. This chapter examines some of the more subtle ways in which therapists and clients manage resistance within proposal sequences; in particular, the focus will be on clients’ use of what I have labeled ‘premonitory’ resistance resources.

6.1.1 Overview of ‘premonitory-resistance resources’

Within the corpus, clients sometimes display almost immediate overt resistance to therapists’ proposals, that is, within their next turn. Fragment 1 provides an example:
Across lines 1-2 the therapist offers a proposal that the client think of doing some volunteer work (the client has just told the therapist that she felt good when talking to a friend over the phone who needed her help with something). At line 3, the client enters quickly (without the usual beat of silence between the end of one turn and beginning of the next) to provide a weak agreement with the idea (“well yes”) followed by a rejection of the proposal. In this instance then, there is no delay in the client’s overt rejection of the therapist’s proposal. This type of resistance is rare in the data corpus, however. Although clients almost always display some sort of overt resistance to, or rejection of, therapists’ proposals, they typically delay this resistance over several turns.

In instances where clients’ overt resistance is delayed, more subtle, premonitory resistance resources are often apparent from the first transition relevant place of the proposal sequence. These resources do not display overt resistance then and there, but can foreshadow that resistance to the proposal is forthcoming. By passing up the opportunity to provide the relevant SPP response to the proposal (acceptance or rejection of the proposal), the client provides the therapist another opportunity to speak and thus allows them the opportunity to withdraw or modify the proposal in some way. Two main resources are recurrently drawn upon by the clients to foreshadow overt resistance:

1) Therapists’ proposals were commonly followed by considerable silences where acceptance or rejection of the proposal by the client was due (see also Heritage & Sefi, 1992; Kinnell & Maynard, 1996; Maynard, 1992; Silverman, 1997);
2) In a number of cases clients initiated an insert expansion (most commonly repair) following the proposal turn before overtly resisting.

These resources are ‘premonitory’ in the sense that they are downgraded versions of the adjacency pair response that is due (Jefferson, 1980). That is, at a point in the interaction where acceptance or rejection of a proposal is due, the client instead responds (or does not) using one of these resources. The resources themselves do not involve rejection of the proposal, nor do they resist the proposal outright. They do, however, mark the presence of trouble within the interaction. As Pomerantz (1984) has shown, preferred responses are usually delivered immediately, with little delay. The delaying of forthcoming acceptance or rejection of the proposal by the use of these resources suggests that a preferred response is unlikely and, in this sense, can be interpreted as premonitory to resistance.

It is not surprising that clients may attempt to delay the problematic activity of overtly resisting a therapist’s proposal. By resisting a proposal for behavioural change, the client could be seen as not complying with the overall goals of the therapy. As mentioned in Chapter 1, behavioural change is a major aspect of CBT, and clients who are complying with the goals of their therapy should be willing to change behaviours in order to overcome their depression. In all instances within the corpus, the premonitory resources did only work to delay overt resistance, however. Their use always culminated in a display of overt resistance to, or rejection of, the proposed solution.

In their study of advice-giving by home health visitors to first-time mothers, Heritage and Sefi (1992) identified one way in which mothers responded to advice by avoiding overt acceptance or rejection. The mothers frequently delivered unmarked acknowledgements (e.g., ‘mhm’, ‘yeah’, ‘that’s right’) in response to the health visitor’s advice. These receipts did not acknowledge the advice-giving as news, and did not constitute an undertaking to follow the advice in any way. By avoiding receipting
the advice as advice, Heritage and Sefi (1992) argued that such unmarked acknowledgements constituted a form of ‘passive resistance’ in the local context of interaction. The resources highlighted in the present corpus, however, rather than providing an unmarked response to a therapist’s proposal, work to delay a dispreferred response to the proposal. It is for this reason that I am referring to these resources as ‘premonitory resistance resources’, rather than forms of passive resistance.

In this chapter these premonitory resistance resources will be discussed in further detail. First, I will turn to consider the premonitory resource of withholding a response, as this was the resource most usually drawn on in the first instance by clients after therapists offered a proposal.

### 6.2 Withholding a response

Several CA studies into institutional advice-giving have found that silence at the point where acceptance or rejection of the advice was due can act as an indirect form of resistance (Heritage & Sefi, 1992; Kinnell & Maynard, 1996; Maynard, 1992; Silverman, 1997; Waring, 2005). Advice-givers can monitor the gap in interaction as foreshadowing rejection or resistance, and respond to the silence accordingly, perhaps by modifying their advice in some way. Within this corpus, at the end of therapists’ first TCU in which they make a proposal for behavioural change, clients often withhold a response. The lack of response from the client comes at a point where the relevant SPP to the therapist’s proposal was due (i.e., acceptance or rejection of the proposal). The client’s lack of response here is thus very noticeable, and disaffiliation is implicit in that absence. Silences in therapy are, however, reasonably common so the presence of silence, in itself, does not provide adequate evidence of possible disaffiliation. However, the way that therapists routinely respond to the silences does provide evidence for the client’s silence being treated as premonitory to resistance.
Silverman (1997) has demonstrated how counsellors in a HIV clinic attended to the dispreference-implicative nature of post-advice silence from the client by subsequently backing off from any strong urging of the advice upon the patient. Likewise, Heritage & Sefi (1992) found that healthcare visitors often revised their position after clients had withheld a response to their advice. In the present corpus, therapists typically respond to clients’ silences by building an increment to their proposal turn, in effect sequentially erasing the negative resonances of the gap from the interaction.

Building an ‘increment’ to one’s turn, in conversation analytical terms, involves a speaker bringing their TCU to possible completion and, following this, proceeding to add further talk which is fashioned, not as a new TCU, but as a continuation of the proceeding TCU (Schegloff, 2001). Increments can be seen to be a continuation of the prior TCU as they are formatted to be grammatically fitted to, or symbiotic with, the prior TCU. Sometimes increments may be added by a speaker post-possible-completion of their TCU, and following a gap in the interaction. Schegloff (2001) has shown how post-gap increments convert an inter-turn gap, with its negative interactional resonances, to an intra-turn pause that does not carry such resonances. In this way, increments act as an attempt to erase the ‘no response’ turn from the other speaker. In doing so, they thus appear to orient to the possibility of that ‘no response’ being relevant to disagreement with, or rejection of, the turn underway. The following fragment is a classic example of this practice:

[Stalled] (Schegloff, 2007, p.242)

1  Don:  .hh My ca:r is sta::lled.
2      (0.2)
3       ’n I'm up here in the Glen
4  Mar:   Oh:::
5      (0.4)
6  Don:  .hhh
7  Don:  A:nd.hh
8      (0.2)
9  Don:  I don' know if it's po:ssible, but .hhh/(0.2) see
10     I haveta open up the ba:nk.hh
According to Schegloff’s (2007a) analysis, Donny’s turns over lines 1-10 constitute a complaint sequence which verges on a request for help from Marcia. At each opportunity where Marcia could have intervened with an offer to help, she has failed to do so. Following Donny’s turn at lines 9-10, there is 0.2 second silence where again Marcia could respond with an offer. At the marked arrow, Donny builds an increment to his turn, grammatically fitted to his prior talk, and in doing so transforms the previous 0.2 second gap into an intra-turn pause within his now not-yet-completed TCU. The gap at line 11 can thus no longer be seen as a point at which Marcia has again failed to offer her help. When Marcia does respond at lines 13-15 she rejects any offer to help and provides an account as to why she cannot do so.

In the same way, by adding incremental turns to their proposals, therapists in this corpus reconfigure clients’ silences from an inter-turn gap with associated implications of possible rejection, to an intra-turn pause in what is now produced as their not-yet-complete proposal. The possible resistance displayed by the client through the withholding of a response is thus sequentially erased from the unfolding interaction. Therapists also often combined the addition of increments with post-expansion TCUs, expanding their proposal over several multi-unit turns, and providing the client with numerous opportunities to deliver a response. The following analysis of this practice will not only demonstrate the first way in which clients display premonitory resistance to therapists’ proposals for behavioural change, but will also build on Schegloff’s (2001) analysis of the use of post-gap incremental turns as resources for sequentially removing the negative interactional resonances of a gap in interaction.
The following fragments are illustrative of these practices. In each fragment, after the therapist completes the initial TCU of their proposal turn, there is a gap in the talk where the client was due to respond. These gaps are marked with an arrow. Following the silence, the therapist builds an increment to their proposal, converting the inter-turn gap into an intra-turn pause within the now expanded proposal turn. The therapists’ incremental turns are highlighted in bold.

(2)  [CBT 002 accommodation 4:42]

1 T:  [Alright]__so__ (1.7) .hh g↓iven that
2 he: hhh can't let you know until Christmas (0.6) an’ then even
3 if it's a yes: (0.2) there’ll still be a kinda bit’ve a ga:p
4 (0.2) [bet]ween (0.2) now and when you could possibly buy a
5 C:  [Yes]
6 T:  courtyard home [an’ get] into it.
7 C:  [Yes. ]
8 C:  Yes.
9 (0.2)
10 T:  Is it worth exploring some other al- accommodation options?
→ (0.4)
12 C:  [Uh:]
13 T:  [so ] that you're not liv↑ing at home?
14 (0.4)
15 C:  We'll not really becuz (0.7) in the six weeks I'm off I don't
16 get pai:d.

(3)  [CBT 001 enlist Alison 33:51]

1 T:  Well it might be um (1.2) might even be worth trying to enlist
2 _Alison._
→ (0.4)
4 T:  into the (0.5) cause=of saying >you know< (0.3) "↑YOU (.) you
5 know what it's like when your sister goes nuts: (0.2) I know
6 that you don't like fighting with h↑er", (0.6) you know "l↑et's
7 (0.3) let’s see if we can make (0.6) this next week (0.7) a
8 really (0.8) happy time [no:w.” ]
9 C:  [See I had] them both sittin’ there and
10 I said “l↓ook” (0.5) “wh↑atta you want”.

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In Fragments (2), (3), (4), and (5) therapists make a proposal to the client from line 1. After each therapist has come to possible completion of his/her turn, there is a gap in the conversation where the client does not take up a turn (at the marked arrows). This silence from the client comes at the point in the interaction where acceptance or rejection of the therapist’s proposal is due. A silence at this point can thus be interpreted as a sign of possible resistance from the client. In each instance, therapists respond to their clients’ silences by building increments to their turns, further expanding on their proposals (highlighted in bold). In doing so, they convert the prior gap, with its associated implications of resistance, into an intra-turn pause within the therapists’ now ongoing proposal turn. The possible resistance displayed by the client through the withholding of a response is thus sequentially erased from the interaction.
When the clients do finally respond to the proposals, in each case it comes in the form of resistance.

We can see from these examples that the clients’ withholding of a response at these points in the interaction can signal the possibility that more overt resistance may follow, and therapists, in fact, orient to these silences as working in this way. In this sense, the withholding of a response by clients is ‘premonitory’ to a misalignment between the two interlocutors.

A more extended example of this practice can be seen below. In this example, following silence from the client, the therapist either builds an increment to his proposal, or expands on his proposal in some way thus providing the client another opportunity to respond. The points at which the client is due to respond, and does not, are marked with an arrow.

(6) [CBT 007 neighbour 17:59]

1 T: I G↑UESS just (0.6) without going (0.2) into it so much that we don't continue with thi:s (1.0) I would put it to you that you might be on the look out (0.7) to (.) ↑you might even make a resolve to yourself (0.2) ↑"ok→↓okay (0.7) between now and next appointment with Peter (1.0) I will make sure (0.6) to say no to her once.”

2  → (1.4)

3 T: in that (.) she might say ↑”wh↓at'd ya doing< toda:y?” (.) an’ (0.7) you might say (0.4) ↑"oh I've got a very busy morning.”

4  → (0.3)

5 T: full stop.

6  → (0.7)

7 T: ↑"oh what are ya doing?” (2.0) “wh↓at I'm do↓ing” ↑you know (0.2) "th↑at's my business.”

8  → (0.9)

9 T: ↑"C↑an you do this for me.” "n↓o I don't have t↓ime today.”

10 → (0.5)

11 T: ↑even if it's a f↓ib.

12 → (0.7)

13 T: Just to practice. demonstrating to yourself that you’re quite capable.

14 → (0.7)
In this Fragment, the therapist comes to a possible completion point of his proposal at the end of line 6. At line 7, the client is thus due to deliver her response to the proposal. Instead, however, she does not respond at all. By not responding the client avoids the dispreferred response of resisting or rejecting the proposal and allows the therapist an opportunity to modify what has been said. After a 1.4 second gap, the therapist adds an increment to his proposal turn, converting the lengthy gap into an intra-turn pause. The dispreference implicative gap (belonging to the client) is thus ‘erased’ from the sequential unfolding of the interaction, and is transformed into an intra-turn pause in the therapist’s proposal turn. It is thus as if the therapist had not finished delivering his proposal at the prior turn. Within this incremental turn (lines 8-9), the therapist expands on his proposal by detailing a hypothetical situation (“in that she might say...an’ you might say...”). Here he uses ‘hypothetical active voicing’ (refer to Chapter 5) to describe the proposed situation, indicating explicitly how the client should respond to a troublesome neighbour.

However, at the end of this incremental TCU, the therapist is again in trouble, as the client continues to withhold a response to his elaborated proposal. This time, the therapist, rather than building an increment to his turn, expands on the proposal with a new TCU. Over this fragment, the therapist adds to his proposal (either incrementally or by a post-expansion) on five further occasions before the client finally takes a turn at talk, at line 25. Here she rejects the proposed idea by stating that she has already attempted it previously (clients’ overt resistance turns will be analysed in detail in Chapter 7). The therapist’s continued expansion of his proposal in this turn-by-turn way evidences an orientation to the dispreference-implicative nature of the client’s withholding of a response at obvious points of turn completion.
Analysis of these fragments has illustrated how silence from clients at points where they are due to respond to therapists’ proposals are treated by therapists as indicative of potential resistance to the proposal. The silences from clients can thus be seen as being ‘premonitory’ to a resistive response to the proposal. The way that therapists manage this potential resistance from clients is typically to build post-gap increments to their proposal turns. In doing so they are able to achieve a sequential ‘deletion’ of the gap in the interaction with its negative interactional resonances. Following therapists’ post-gap increments, clients are afforded another opportunity to respond. Analysis of these instances builds on the small amount of previous CA work into the interactional uses of post-gap increments. It supports Schegloff’s (2001) findings that post-gap increments display an orientation by speakers to the dispreference-implicative nature of a ‘no response’ gap in the interaction, and an attempt to ‘erase’ the negative interactional resonances of that gap.

Another resistance-premonitory resource commonly drawn on by clients in these interactions involved the initiation of an insert expansion following the therapist’s proposal. It is to a discussion of this resource that I now turn.

### 6.3 Insert expansions

As discussed in Chapter 3, insert expansions are positioned between the base parts of an adjancency pair, that is, after the base FPP and before the projected base SPP. Diagramatically, this can be represented as follows:
The insert expansion is initiated by the other speaker to that who has produced the FPP (i.e., Speaker B), and is produced instead of delivering a response to the FPP. The initiation of the insert sequence thus displaces or defers the base SPP (Schegloff, 2007a). Insert sequences are understood to be launched in order to address matters which need to be dealt with in order for the SPP response to be produced. They project the doing of the SPP response once the insert sequence is complete. One of the most salient features of insert sequences is that, by deferring a SPP response, they compromise the progressivity of the talk. In doing so, they can project the possibility of a dispreferred response (Schegloff, 2007a). Over the course of this section, I will illustrate how clients in this corpus sometimes use insert expansions to display premonitory resistance to therapists’ proposals. The most common way in which clients did this was by initiating a repair sequence following the therapist’s proposal, and it is to this resource that I will turn to first.

6.3.1 Other-initiated repair

Other-initiated repair (henceforth OIR) involves efforts to deal with troubles of the hearing, understanding or appropriateness of a prior turn which are launched by the recipients of the problematic talk (Drew, 1997; Schegloff, 2007a). OIRs are invariably initiated in the turn after the trouble-source turn and hence are often referred to as ‘next-turn repair initiators’ (NTRIs) (see also Chapter 3). Although the repair is initiated by the other-than-speaker, the repair itself is usually left for the speaker to deal with in their ensuing turn (Schegloff, 2000). When initiated after a FPP, the OIR constitutes the beginning of an insert sequence before the base second pair part is delivered.
repair initiations look backwards, obstensibly to clarify aspects of the prior talk, they are known as ‘post-first’ insert sequences (Schegloff, 2007a).

Four main types of OIR have been identified (Schegloff et al., 1977):

1) Open-class repair initiators (Drew, 1997). These repair initiators leave open what exactly the difficulty is that the speaker has with the prior turn. Examples of open-class repair initiators include: “Huh?”, “Sorry?”, “Pardon?” or “What?”.

2) Category-constrained initiators. These forms of OIR locate where in the prior turn the trouble source is located. These repair initiators usually include “wh-” questions. For example: “Of what?”, “Where?”.

3) A partial or full repeat of the trouble-source turn. This form of OIR also locates where the trouble source is in the prior turn, by repeating the repairable. For example:


1 Ken: Hey (.) the first time they stopped me from
2 selling cigarettes was this morning.
3 (1.0)
4 Louise: → From selling cigarettes.
5 Ken: Or buying cigarettes.

4) A candidate understanding of the trouble source turn. These repair initiators offer a candidate understanding of the prior turn and may or may not also include terms such as “You mean...” or “What...”.

These types of repair initiations are noted to have a natural ordering relative to their ‘strength’ or their capacity to locate the repairable in the prior turn (Schegloff et al., 1977). Open-class repair initiators are the ‘weakest’ type as they leave completely open what the repairable might be,
whereas candidate understandings are the ‘strongest’ repair initiator as they provide a possible understanding of the trouble source turn.

Of course, within conversation, a turn does not need to involve an error for it to be treated as a trouble-source. In addition to linguistic problems, repairables also include acceptability problems such as saying something untrue, inappropriate or irrelevant (Schegloff, 2007a). Rather than dealing with a trouble of hearing or understanding, other-initiated repair can, therefore, be used as a resource for pre-disagreements or to mask more delicate or serious interactional issues (Egbert, 2004).

6.3.2 Other-initiated repair as an operation for pre-disagreement

The notion that other-initiated repair could be used as a marker for forthcoming disagreement was first raised in a footnote in Schegloff, Jefferson & Sacks’ (1977) paper on repair. They noted that forms of other-initiated repair are “systematically related to ‘disagreement’, regularly being used and understood as ‘pre-disagreements’” (p.380). This operation of OIR was then elaborated by Pomerantz (1984) who discussed it as a resource used to delay dispreferred turns. For example:

[TG: 1] (Pomerantz, 1984, p.71)

1  Bee:       =W h y whhat'sa mattuh with y-Yih sou[nd HA:PPY,] hh
2  Ava:                          [ Nothing. ]
3  Ava: → u- I sound ha:p[py?]  
4  Bee:                        [Yee]uh.
5  (0.3)
6  Ava: No:,

Here, Ava initiates repair on Bee’s assessment via a partial repeat in line 3, providing an opportunity for Bee to modify her assessment. Bee, however, repairs her turn through a simple confirmation “yeeuh”. After a gap in the talk, Ava then goes on to disagree with Bee’s assessment in line 6.
In research on this operation of other-initiated repair, particular attention has been given to open-class repair initiations, which are usually identified as being used for problems with hearing. Drew (1997) identified two other particular environments in which open-class repair initiators are used:

1. where the repairable turn does not appear to connect referentially with its prior turn, and hence from the recipient’s perspective seems to be topically disjunct with what was being talked about; and
2. where the repairable turn is somehow inapposite or inappropriate as a response to the prior turn.

His findings highlight that a speaker may select an open repair form in such a way as to claim not to have heard (or understood) what the other said, in circumstances where the repairable trouble is manifestly not a problem of hearing but rather where the appropriateness of the prior turn is at issue.

More recently, in his book on sequence organization, Schegloff (2007a) again noted that other-initiated repair sequences often serve as vehicles for the expression of disagreement, or for introducing its relevance. By treating the speaker’s prior turn as potentially problematic, the recipient provides space in the next turn for the FPP speaker to make some adjustment to what was said and perhaps to make the content of their turn more ‘acceptable’ to the recipient. This may involve some form of back down or account being provided as a way to resolve the misalignment.

Additionally, Svennevig (2008) has identified a preference in conversation for the least serious construal of problems. That is, in the choice between different ways of addressing a problem in conversation, construing it as a hearing problem is preferred to construing it as an understanding
problem, which in turn is preferred to construing it as an acceptability problem. Providing a hearing repair initiator gives the receiver of the repair initiation the opportunity to pre-empt a problem of understanding or acceptability and deal with it in the repair. The speaker of the trouble source may then modify their utterance in some way, rather than just repeating their prior turn. For example, they may produce a revised version of the original utterance, or back down in some way from their original position, in anticipation of an objection from the recipient.

Although these studies have all noted that other-initiated repair can be used as a marker of dispreference, there has been very little systematic analysis of how this gets done. Additionally, the work that has been undertaken on this use of OIRs has focussed on the use of open-class repair initiators. In the present corpus, clients typically draw on stronger types of repair initiators such as candidate understandings or checks, which have received little attention in the previous literature. The following section will detail the common ways in which other-initiated repair was deployed by clients in the corpus as a premonitory resistance resource. The findings not only shed light on one way in which clients delayed their overt resistance to therapists’ proposals; they also contribute to the CA literature on ways in which other-initiated repair can be deployed as a marker of upcoming disagreement.

6.3.3 Other-initiated repair as a premonitory resistance resource

Other-initiated repair is a resource that was commonly deployed by clients following therapists’ proposals for behavioural change. In each case the OIR acts as a premonitory resistance device, highlighting to the therapist that there is some problem with the proposal. Following initial use of an OIR, clients respond with more overt resistance strategies. This is not to say that other-initiated repair after a proposal will always act as a premonitory resistance device, or that after an OIR
resistance must follow, however, in this corpus that is what OIRs following a proposal appeared to do.

There were several aspects of the client’s OIR sequences that suggest that the repair initiations are doing premonitory resistance.

1. Clients often withheld initiating repair at the first possible opportunity after the completion of the therapist’s proposal TCU. Previous research into other-initiated repair (Schegloff, 2007a) has suggested that repair is usually initiated at the first possible opportunity after the trouble source so that the sequence can progress with least disruption. The fact that the OIRs are delayed in the instances recorded here, suggests that the client’s trouble may not be one of hearing or understanding, but rather a trouble with the appropriateness of the proposal.

2. The OIRs used by clients are generally relatively ‘strong’ repair operations, such as candidate understandings or understanding checks. The repair initiators thus point out what it is in the proposal turn that the client has a problem with, and in doing so, (1) indicate that the trouble is not a problem of hearing; and (2) display considerable understanding of the proposal within their turn. Again, the use of these strong RIs makes the trouble more likely to be with the appropriateness of the proposal than with hearing or understanding it. Further, as Svennevig (2008) has shown that there is a preference to use the weaker forms of repair initiation first, the fact that clients initiate repair using strong repair operations suggests that they are more strongly displaying pre-resistance with their repair initiations.

3. The way that clients deliver their repair initiations often conveys a sceptical stance to the proposal. This was often related to the intonation of the repair initiation, but also sometimes by the way that the repair initiation was structured.
There are also aspects of therapists’ subsequent repair turns that orient to the possibility of the clients’ repair initiations acting as premonitory resistance resources. Therapists’ repair solutions are usually produced as confirmations followed by accounts for, or elaborations of, the proposal. Therapists do, however, orient to clients’ OIRs as dispreference-implicative. In some cases therapists’ responses to clients’ OIRs involve some form of back-down from the initial proposal; in other cases their repair turns are delivered in a dispreferred format, and in some cases they do both. When clients finally produce their base SPPs, they come in the form of more overt resistance to therapists’ proposals. The sequence, therefore, follows this format:

<table>
<thead>
<tr>
<th>Therapist:</th>
<th>Trouble source</th>
<th>Proposal for future action (across multiple turns)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client:</td>
<td>Repair initiation</td>
<td>Repair initiation</td>
</tr>
<tr>
<td>Therapist:</td>
<td>Repair</td>
<td>Confirmation + account/back down/explanation</td>
</tr>
<tr>
<td>Client:</td>
<td>Second pair part</td>
<td>Resistance to proposal</td>
</tr>
</tbody>
</table>

Below, I analyse, in detail, three examples of clients’ use of these premonitory resistance practices. The first fragment comes from a sequence that began approximately 9 ½ minutes into the therapy session. The interaction is focussed on the client’s belief that she makes more mistakes in her workplace (an accounting firm) than any other employee. The therapist delivers the focal proposal 35 ½ minutes into the session, after considerable troubles telling from the client, questions and formulations from the therapist, and one previous proposal from the therapist that the client should begin to be more aware of ruminating about her mistakes at work. In order to show the step-wise fashion in which the therapist led up to the delivery of the proposal, and to provide some context to the proposal-sequence, some of the therapist’s earlier questions are included at the beginning of the fragment. The target sequence begins at line 26.
1 T: Have you ever seen anyone?
2 (.)
3 T: make any mistakes?
4 (0.2)
5 T: other than you?
6 (0.3)
7 C: Uh:: .hh hhh I’ve got no i- oh I mean I'm sure that others do::
8 (0.2)
9 T: Umhm
10 C: But (0.5) y’know either they must pick em up themse:lves and it
doesn’t get to my bo:::ss (0.4) so: (. ) you know they correct it
themse:lves (1.0) u:::m nup.=Oh you know like in the time that
I've been working I I remember one other (0.3) I remember there
was an employee that made made a huge error.
11 ((17 seconds omitted))
12 T: .tch um (. ) an’ if you went to B↑ob for example and said you
13 know no one makes (. ) as many mistakes as I do=
14 C: =Which I h↑ave
15 (. )
16 C: ~QUITE A [LOT~.]
17 T: [What ] would he say?
18 C: He go- he says to me he sez oh e- he says nah don't be silly
19 C: [he sez] everyone makes mistakes.=That's what he [says] to me:
20 T: [Mm:: ] [Yeep]
21 ((8.79 minutes omitted))
22 T: But u:m (0.2) .tch (0.2) y’know (2.3) maybe d- ya do need
to ask other peeple.
23 (1.0)
24 T: an’ maybe that’s something that you could work on this
25 week.
26 (0.8)
27 C: → Wh↓a t whether they're making mista:kes?
28 T: ↑Well (. ) ↑yeah whether they make mistakes any
time=whether they ever feel like they're making a l↑ot’ve
29 mistakes.
30 (0.4)
31 T: .hh whether they ever compare themselves to other people
32 in the office.
33 (0.2)
AN’ HOW THEY COPE with making their mistakes=how do they right the mistakes once they know they happened.

Is there anyone in the office that you think you: would feel comfortable (. to talk to about that stuff?

I'd be- I'd be incredibly embarrassed.

The therapist delivers a proposal in lines 26-27 which is formulated as a hedged recommendation (refer to Chapter 5 for an analysis of these types of turns). As discussed in Chapter 5, hedged recommendations in this corpus have an implied imperative nature but consist of delaying devices (in this case “um”, “tch”, and several intra-turn pauses) and low modality operators (“maybe”)10. The therapist’s proposal is followed by a 1.0 second silence from the client at the point where either acceptance or rejection of the proposal is due. This silence is the first sign that acceptance is not likely to be forthcoming from the client. The therapist orients to this silence from the client as being possibly dispreference implicative by adding an increment to her turn, effectively transforming the inter-turn gap, with its negative interactional resonances, into an intra-turn pause. However, again, after completion of the incremental TCU, there is another 0.8 second silence from the client (line 31).

After that 0.8 second gap, the client still does not deliver the relevant SPP to the therapist’s proposal (acceptance/rejection of proposal), but instead initiates repair. This repair initiation can be seen to act as a premonitory resource for the client’s forthcoming resistance to the therapist’s proposal. That the repair initiation functions in this way is evidenced at several positions within the sequence thus far.

First, if the client’s trouble was that of mere hearing or understanding, previous research into OIRs would suggest that it would be more common for the client to have attempted to resolve this trouble sooner (i.e., at line 28 or 31) so that the sequence could progress with least disruption. The
fact that the clientwithholds initiating repair during this time suggests that the problem may not be
with understanding the proposal but, rather, is indicative of resistance.

Secondly, the repair initiation (marked by the arrow) comes in the form of “what + a candidate
understanding” (\textit{Wh↓at whether they're making mistakes}). The repair initiator is thus a ‘strong’
one: it displays that the client has heard the prior turn, and also displays a possible understanding of
the prior turn. From this repair initiator, it thus seems more likely then that the client’s trouble is not
a problem with understanding the proposal but with the appropriateness of the proposal. The turn
initial “what” before the candidate understanding also adds a skeptical hearing to the repair
initiation as it gives the sense that the client is challenging the candidate understanding of the
proposal that she is offering.

The content of the wider sequence can also provide evidence for the premonitory-resistance nature
of the OIR. The issue of the validity of the client’s thought that she makes more mistakes than other
employees in her workplace has been the focus of the interaction for the prior 25 minutes. As can be
seen by the questions asked by the therapist across lines 1-21, the possibility of asking other people
in the office about their mistakes has already been topicalized on several occasions. Given the
relevant content of this previous interaction, it should not be difficult for the client to understand
what it is that the therapist is proposing. The position of the proposal within the wider sequence,
therefore, provides further evidence that the client’s RI displays premonitory resistance rather than
highlighting a trouble in understanding the proposal.

Finally, the prosody of the client’s repair initiation also plays a role here. Selting (1996) has shown
how prosodically marked initiations of repair can achieve actions additional to initiating merely
repair, that produce different sequential implications for their recipients. In particular, Selting (1996)
illustrated how high global pitch\textsuperscript{11} and increased global loudness\textsuperscript{12} in a repair initiation can convey
astonishment or surprise\(^{13}\) (see also Wilkinson and Kitzinger (2006) for prosodic markers of doing surprise). The prosody of the client’s repair initiation here works in a similar way to convey skepticism toward the proposal. In this case, there is initially a lowering of pitch and emphasis placed on the client’s “wh↓at”, followed by a return to normal pitch and then later a rise to higher pitch, with elongation and emphasis on “mistakes”, with an extra high pitch peak at the elongated “a” sound\(^{14}\). Combined, these prosodic markers work to display a hearably skeptical stance to the client’s repair initiation.

Grammatically, the client’s repair initiation makes confirmation the preferred response within the therapist’s repair turn. However, with scepticism hearable within the client’s repair initiation, the turn arguably sets up a preference for a disconfirmation to come from the therapist, perhaps in conjunction with some modification of the proposal or a withdrawal of the current proposal. The therapist responds with a confirmation of the client’s candidate understanding and then further elaborates on the meaning of her proposal. However, her response contains the turn initial “well” and a pause before her “yeah”. This well-prefaced response may be doing two things. It may be alerting the client to monitor the therapist’s confirmation as a non-straightforward response (Schegloff & Lerner, 2009), as although she confirms the client’s question, she also moves to provide the client with additional examples of what the client might ask people in her workplace. Given the skepticism hearable in the client’s repair initiation, the therapist’s well-prefaced response may also orient to the possibly dispreferred nature of her confirmation response (Pomerantz, 1984; Schegloff & Lerner, 2009). By prefacing her repair turn with this ambiguous “well” followed by a pause, the therapist orients to the client’s repair initiation as being possibly dispreference-implicative, providing further evidence that the OIR is acting as a resource for foreshadowing resistance. The client’s repair initiation, then, accomplishes much more interactionally than just initiating repair. It allows the client to signal to the therapist that resistance to the proposal may be forthcoming, and allows the therapist the opportunity to modify her proposal in anticipation of resistance.
The premonitory resistance resources mobilized by the client do not, however, stop at the repair. The therapist runs into trouble again after completing her elaboration, with no response from the client forthcoming in line 36. At this point the client could have accepted the therapist’s repair with a sequence-closing third, or have delivered her delayed SPP to the proposal. However, she does neither. In response to the client’s silence, the therapist builds an increment to her turn that elaborates her proposal. These elaborations involve temporal references at the extreme end of the descriptive scale (e.g. “any time” in lines 33-34 and “ever” in lines 34 and 37). In therapeutic terms, such reference may be seen as orienting to the correction of “all-or-nothing” thinking (Wright et al., 2006); the aim being to encourage the client to search for exceptions to her irrational belief that she is the only one who makes mistakes at work. Interactionally, these temporal references act to downgrade the magnitude of the therapist’s proposal, making it appear a less distressing activity. This move is to no avail, however, as the client withholds response on two further occasions.

After silence from the client in line 42, the therapist launches a new FPP that re-does her proposal in the form of an interrogative. Schegloff (2007a) noted that FPP speakers may re-do their FPP in a different way in order to avoid some projected disagreement or problem with the FPP. The therapist’s re-doing of the proposal turn, here, displays her orientation to the client’s ongoing lack of uptake at lines 36, 39 and 42 as problematic. Arguably, here we have an attempt at re-working the proposal in order to avoid overt rejection. Within this turn, the therapist backs down on her initial proposal in several ways. She downgrades her recommendation that the client ask “other people” (line 27) to a formulation in which she asks whether there is “anyone” (line 43) the client could ask. The therapist also shifts from framing her proposal as something the client may “need to” (lines 26-27) do to framing it in terms of how the client thinks she “would feel” (lines 43-44) about doing what is proposed. Additionally, the new proposal is formatted as an interrogative whereas her initial FPP was delivered in the form of a recommendation. The interrogative form appears more tentative,
however, due to the constraints set out by a yes/no interrogative, it also prompts the client to respond with overt acceptance or rejection (Raymond, 2003). The reformulation of the proposal in both form (as an interrogative) and content (a back-down on the magnitude of the previous proposal) again provides evidence that the therapist is treating both the client’s silences and OIR as implicative of resistance. In this instance, after another, shorter silence (0.2 seconds, line 45), the client produces a SPP to the interrogative proposal, in the form of overt resistance.

Over this sequence the client has provided the therapist with seven opportunities to withdraw or modify her proposal before responding with any overt resistance. In addition to withholding responses, the client’s repair initiation acts as a premonitory resistance resource that highlights that there is some problem with the prior proposal turn. Despite the therapist orienting to the OIR as dispreference-implicative (displayed in the dispreferred format of her repair turn), in this case she responds to each of the client’s premonitory resistance resources by elaborating on her proposal, before finally backing down on her proposal in a reformulated interrogative form. It is this turn by the therapist that finally draws out overt resistance from the client.

A similar example from another session can be seen below. The following sequence begins after an extended troubles-telling from the client about a performance interview she had with the principal at the Special Education school where she works as a Teaching Aid. After the therapist and client have collaboratively formulated and agreed upon the issues that arose from the interview, the client gives a final summary of her trouble before the therapist launches a proposal to solve this trouble from line 1.

(8) [CBT 002 computer 10:26]

1 T: Th'z um (0.6) THERE ARE quˈite a number oːf (0.3) ahh:
2 computer literacy skills for: sortˈve (0.5) people in your age
group. libraries and local councils and stuff like that.

(0.5)

C: → Is there? ]

T: [> so it ] might< yeah

(0.6)

T: .tch um becuz you know it's a similar thing a lot've the older generation of people (0.4) don't have computers in their home (0.5) <and yet they want to:> find out about (0.4) the internet or typing letters or using email to contact. hhh (0.2) >children or grandchildren< that are interstate. hhhh um: and so the libraries actually run a little bank of computers.

( .)

T: and some libraries will run (. ) you know (0.3) how to use a computer for the first time sessions.

(0.6)

T: where they kind of give people jus’ a basic tu- 

C: [I’m sure not at] our library coz I went to our library an’ hh (0.2) they give you fifteen minutes to get on.

(0.2)

C: it took me fifteen minutes ta work out how to turn the bloody thing on.

(0.2)

T: [mmhm.

The therapist offers a proposal in the form of information-giving in lines 1-4. Although delivered as information, within the therapy environment the therapist’s turn carries the implication that this is a course of action she is proposing the client take. The relevant SPP to this information-giving is, therefore, not only a news receipt but also acceptance of the information as a proposed course of action. However, no response is immediately forthcoming from the client in line 5, suggesting the possibility of a dispreferred response (i.e., resistance to the proposal). After 0.5 seconds the client initiates repair. Although the repair initiation is not a clear example of one of the four main types listed by Schegloff, Jefferson & Sacks (1977), it uses the same machinery of other-initiated repair: the progressivity of the talk is deferred in favour of ostensibly questioning some aspect of the prior turn, and the client does not produce the relevant SPP to the proposal but instead initiates a first
turn of her own that ostensibly 'checks' the accuracy of the therapist’s proposal, asking the therapist to revisit her prior turn. As Drew (1997) has shown, speakers may initiate repair not apparently because they have not heard or understood what was said, but because the prior turn was in some fashion inappropriate. It appears that this is what the client does here.

There are also several aspects of the client’s turn that suggest it is not just attempting to initiate repair, but is also acting as a premonitory resource to resistance. Here, the repair initiation has been delayed which is customary for an upcoming dispreferred response. The repair initiation is also reasonably ‘strong’ as it indicates the precise aspect of the prior turn that is troublesome, thus displaying that the problem is not a lack of hearing and that the client has considerable understanding of the prior turn. Again, the prosody of the client’s repair initiation also conveys a sceptical stance toward the proposed information. This scepticism is reflected in the client’s delivery of her repair initiation using hearably lower pitch during “is”, followed by rising pitch and elongation of “the:re” (again with a pitch peak at the elongated “e” sound). The client’s OIR, therefore, again seems to be acting as a premonitory resistance resource here rather than as an attempt to solve a problem in hearing or understanding.

Also, in her repair turn, the therapist again orients to the client’s RI as being dispreference-implicative. One beat into the client’s turn, the therapist - possibly orienting to the gap in line 5 - has begun to elaborate on the proposal, but stops after slight overlap to deliver her repair. She initially delivers a minimal confirmation (‘yeah’) which is followed by a gap of 0.6 seconds where either speaker could have taken a turn. The fact that the client does not respond at this point is further retrospective evidence that her repair initiation was not delivered merely to sort out a problem of understanding with the previous proposal turn. A confirmatory “yeah” does not seem sufficient to have solved this type of trouble in the interaction. After the gap in talk, the therapist incrementally expands on her repair turn by offering a rather expansive account for the proposed idea (with the
turn initial “.tch um because”). The therapist also downgrades the information within her account from there being “quite a number of” courses offered by “libraries and local councils and stuff like that” to “the libraries” and “some libraries” offering courses. The therapist’s delivery of an account in conjunction with a downgrade on the proposal within her repair turn, suggests that she has heard the repair initiation and the gaps in talk in lines 5 and 8 as dispreference-implicative.

In lines 15 and 18 there are points where the client could have responded to the proposal but does not. The therapist responds to these silences as possible resistance by adding further increments to her proposal, thus transforming the gaps into intra-turn pauses. During the third incremental turn (line 19), the client enters in interjacent overlap with the therapist to reject the proposal. What is particularly noteworthy in this case is that the aspect of the proposal in terms of which the client frames her rejection (that her library does not run such courses), is the aspect of the proposal she initiated repair around in line 6 (whether there were computer literacy skills courses run by libraries and local councils). The repair initiation thus may foreshadow the content of subsequent resistance, and thus may give the therapist an opportunity to modify or expand on this aspect of the proposal before the client resists it overtly.

### 6.3.4 Ambiguous case

One last, somewhat more ambiguous, example of other-initiated repair following a therapist’s proposal will be discussed in detail. In this example, the repair initiator is in a slightly weaker form, is delivered without delay and conveys no hearable scepticism in its delivery. It will be shown, however, that it is possible in this case that the repair initiator signals a problem in understanding the therapist’s proposal rather than being used as a premonitory resistance resource. Unlike the two previous examples, the initial proposal for future action, here, is offered by the client. This sequence follows an extended sequence in which therapist and client have been thinking of ways in which the
client could be more ‘calm and collected’ in order to be a better mother for her two daughters. The client has stated that she feels guilty for being tired and lacking energy when the children get home from school. She then moves to make a mitigated suggestion of going for walks in line 1 (use of the progressive past tense, ‘maybe’ hedge, and questioning intonation).

(9)  [CBT 001 walks 52:15]

1   C:  I was thinking about maybe going for walks?

2   (0.2)

3   T:  Mhm

4   (0.4)

5   C:  again.

6   (0.7)

7   C:  specially with (0.2) my youngest.

8   ((18 seconds omitted))

9   T:  Maybe shouwee contract in for: (0.4) a couple of walks:

10  (0.6)

11  T:  this week as well.

12  (0.4)

13  C:  Yep.

14  (.)

15  T:  Shall I grab another contract [for you?]<

16  C:  [Sure. ]

17  T:  yep.=

18  C:  we walked to school (. yesterday morning.

19  (0.4)

20  T:  yep.

21  (0.8)

22  T:  [I’m thinking ]

23  C:  [and home from] school last night or somethin’ one of ‘em

24  (.)

25  C:  [( )]

26  T:  [I’m thinking] more sort’ve (0.9) for no purpose walks.

27  C:  → for no purpose;

28  T:  [walks that are about (0.6) um (0.2) “I’m gonna take you out an’ we’re going to hang out together.”

29  (0.4)

30  T:  “fur thirty five minutes or” (0.4) “however long you stay out for”.
In this fragment, the client’s repair initiation on the therapist’s proposal occurs at line 27. However, trouble within the interaction precedes this point, so the analysis of this example will begin at the client’s initial proposal (which begins the sequence) at line 1. After the client’s proposal, the therapist responds with a minimal “mmhm”. After a gap the client builds an increment to her turn, sequentially erasing any interactional implications of therapist’s prior turn (Lerner, 2004). After another gap, the client adds another increment to her turn and over the next 14 lines expands on her proposed idea, providing more details on why she thinks walks might be good for her daughter. The therapist offers a formulation of the client’s idea as being ‘really helpful’ (not shown here), and then at line 9 she reformulates the client’s proposal into a therapeutic format by suggesting they make a formal “contract” for the client to take walks. In reformulating the proposal as a formal therapeutic task, the therapist thus re-does the client’s proposal as a new proposal that the client needs to respond to. There is no immediate response from the client (line 10) and following this, the therapist adds an increment to her turn. At the next transition relevant place, line 12, there is again no immediate response from the client, although after 0.4 seconds she does deliver a minimal “yep”.

The responses from the client are interesting here. By withholding immediate response on two occasions and then delivering only a weak acceptance of the therapist’s proposal, the client displays some resistance to what was, initially, presented as her own candidate solution to the problem.

Over the next four lines there is some management talk about preparing the contract before the client offers a candidate version of already doing what the therapist has proposed. There is then a delay at line 19 before the therapist responds. It is at this point of silence from the therapist that a possible misalignment between the client’s and therapist’s proposals becomes relevant. After a
minimal response from the therapist (“yep”), a 0.8 second silence occurs where either party could have come in to talk, but did not. After this gap both therapist and client select to start speaking at the same time. The therapist begins “I’m thinking”, but drops out, while the client orients to the silence that has come before by adding an increment to her characterization of the walks that she already undertakes with her daughters. This characterization by the client of already doing what the therapist has proposed may indicate further resistance (see Chapter 7 for further analysis on ‘assertions of effort’ by clients as a form of resistance).

After a micro-pause at this point, the therapist then re-begins the turn that she had started at line 22. The therapist’s turn here acts as a third position repair to the misalignment that, now evidently, has stemmed from the therapist’s proposal at line 9. Whereas the therapist now makes it evident that she was suggesting the client go for a specific category of “no purpose walks”, the client was under the understanding that walking to and from various locations was being discussed (as displayed in her characterizations of ‘walks’ in lines 18 and 23). The client’s initial proposal was delivered in the past tense (“I was thinking”) whereas the therapist’s explanation of her proposal here is produced in the present (“I’m thinking”). At the same time, the therapist’s use of “more” in “I’m thinking more sort of (0.9) for no purpose walks” ensures that the client’s proposal is not completely rejected. The therapist’s version of the proposal is merely positioned as the more preferred version. The therapist thus delivers her proposal as the more current proposal being considered. With this explanation from the therapist, then, it becomes apparent that the client’s initial proposal and the therapist’s subsequent proposal are actually quite different in nature.

The misalignment is not fully repaired here, however. The therapist’s repair turn also acts as a trouble source for the subsequent talk about the proposal. The client initiates repair on the therapist’s turn, repeating the problematic formulation “for no purpose” (line 27). So, here we have a repair initiation from the client on an aspect of the therapist’s proposal similar to those analysed in
the previous examples. However, the RI here is different in nature to those in the previous fragments. Although the partial repeat is again a relatively strong repair initiator (it indicates to the therapist exactly which aspect of the turn is the source of trouble), it is in a slightly weaker form (a repeat rather than a candidate understanding or an understanding check). It is also delivered quite quickly after the trouble source turn and there are no strongly hearable prosodic markers indicating scepticism. The repair initiation, therefore, could either suggest a problem in understanding the therapist’s version of the proposal, or a problem with the appropriateness of this proposal. Given the misalignment between the therapist’s version of the proposal and the client’s version seen over the prior third position repair sequence, it seems likely in this case that the client’s RI is targeting a problem with understanding the therapist’s proposal. The therapist’s term ‘no purpose walks’ is a rather ambiguous description.

The therapist treats the OIR as the client having trouble with understanding her formulation and elaborates on her idea of ‘walks’ (lines 28-29). The therapist uses ‘hypothetical active voicing’ to make the proposal additionally comprehensible to the client. In this case, there is no obvious indication from the therapist that the RI has been understood as being premonitory to resistance. She does not deliver her repair in a dispreferred structure, nor does she backdown on the proposal in any way. At line 30, after the therapist’s explanation, there is no immediate response from the client, and the therapist orients to this silence as a dispreferred response by adding an increment to her explanation. On completion of the therapist’s incremental turn, the client rushes through to reject the therapist’s version of the proposed idea. Again, we can see in the client’s overt resistance turn (lines 32-33 and 35), that her reason for resistance reflects the very aspect of the therapist’s proposal to which her repair initiation was targeted (she cannot go for “for no purpose” walks because she cannot leave her other child at home).
In this instance, the client’s repair initiation is relatively immediate, and does not provide the marked cues of premonitory resistance that were evident in the repair initiations in the previous examples. This may be due to the previous misalignment that has already become apparent over the third position repair sequence. As there are two competing proposals from the therapist and client, the client’s RI may be an attempt to deal with a problem in understanding the therapist’s version of the proposal. It may also be indicative of premonitory resistance but delivered in a more ambiguous way. In either case, the repair initiation here again provides the therapist an opportunity to modify or retract her version of the proposal before the client overtly rejects the idea. The therapist uses her repair turn to explain her proposal in more detail, and does not, in this case, initially orient to the client’s RI as being dispreference-implicative. She appears to orient to the RI as being a problem with understanding. Again, this illustrates the ambiguity of the client’s repair initiation here compared to previous examples. The therapist’s elaboration does, however, draw out more overt resistance from the client, in this case targeting the aspect of the proposal to which she initiated repair.

Within the corpus, clients sometimes used other (non-repair) types of insert expansions as premonitory resistance resources. I will consider one example of these expansions in the next section.

6.3.5 Pre-second insert expansions as a premonitory resistance resource

Whilst post-first insert sequences, such as the OIR sequences analysed above, look backward to address problems in the prior talk, pre-second insert expansions look forward, obstensibly to establish the pre-requisite resources necessary to implement the pending SPP response (Schegloff, 2007a). For example:
Here, the customer, at line 1, asks for a bottle of Mich (an alcoholic beverage). Rather than providing a base SPP response to the request, the service provider instead initiates an insert sequence with the question “are you twenty one?”. This question does not retrospectively address a clarification on the customer’s prior turn, but is directed at establishing the conditions on which to grant the request - if the customer is not twenty one years old (in America, where the data was collected), then he/she cannot legally be sold the alcoholic drink. And, in fact, as the customer responds to the question with a “no” response, the service provider declines the request at line 4. It is the customer’s answer at line 3 that provides the service provider with the necessary resources to produce his/her SPP response to the initial request.

Using the following extract as an example, I will argue that pre-second insert expansions can be used as premonitory-resistance resources in a similar way to initiations of repair. As can be seen in the above example with the customer, the initiation of an insert expansion can subsequently lead to a dispreferred SPP response. In the case of the current data, insert expansions initiated by clients following therapists’ proposals can lead to subsequent resistance to the proposal for behavioural change. In the same way as the initiations of repair analysed above, in the following example, the client draws on several resources in their insert expansion that suggest its use as premonitory to resistance.

Before the beginning of this fragment, the client has been telling the therapist about some problematic behaviour being displayed by her youngest daughter, Leah. Across lines 1-13 the
The therapist moves to offer a proposal to the client that she take her daughter for some psychological counselling at the Child and Adolescent Mental Health Service. The reference to “ceetad” (CTAD), at line 2, refers to the clinic where the data was collected.

(10)  [CBT 001 CAMHS 21:37]

T: I remember you asking me a couple of weeks ago if there's anywhere like ceetad for little kids an' I went an' (0.3) made a few enquiries.
C: Oh good.
T: Um basically the only thing there is is the child and adolescent mental health service?
C: [(clears throat)]
T: Which is called CAMHS.
C: [(right.)]
T: An' that's (0.3) publicly funded.
C: It's in Port Adelaide isn't it?
T: Uh, they've got an office in Port Adelaide [yep.]
C: [(maybe b-)] I think Alison was at CAMHS when she was (0.7) having uh problems.
C: She w'z go- getting bullied at scho:el.
T: Okay.
C: So we went to CAMS for that. Uhm: (1.4) I don't think they really got a lot out of it though.

The fragment begins after a troubles-telling from the client concerning the behaviour of her youngest daughter, Leah. The client has detailed the problematic behaviour and has implied that she does not know how to deal with it. The therapist sets up the delivery of information in lines 1-3. The client responds with a news receipt (Heritage, 1984a) which acts as a go-ahead response for the therapist to continue with her proposal. In lines 6-8 the therapist then offers a proposed solution in
the form of information-giving about where she can take her daughter for some psychological treatment (the Child and Adolescent Mental Health Service). As in Fragment (8), although the turn is packaged as information-giving, within the context of the counselling session, there is an implied sense of prescription about this information. By providing the information as a candidate solution to the problem under discussion, the therapist can be seen as offering a preferred course of action for the client. Because of this implication, the relevant SPP to the therapist’s turn is not only a receipt of the information but also acceptance or rejection of the information as a proposed course of action.

At line 9, after the initial delivery of information, there is no immediate forthcoming response from the client. As in the above fragments, the fact that the client withholds responding at the first point at which acknowledgement of the proposal is due (receipt + acceptance/rejection of the proposed information) suggests that acceptance of the proposal may be unlikely. After 0.2 seconds the client does respond with a confirmatory “right”, rather than a news receipt such as “oh right” (Heritage, 1984). This response is what Heritage and Sefi (1992) have termed an unmarked acknowledgement. Heritage and Sefi (1992) argue that unmarked acknowledgements in response to advice-giving act as ‘passive resistance’, as they do not treat the information as news. Likewise, Kinnell & Maynard (1996) have argued that such unmarked acknowledgements function to avoid overt acceptance of the information-as-advice. The client’s “right” appears to be working in a similar way here.

At the same time as the client produces the unmarked acknowledgement, however, the therapist responds to the prior gap (at line 9) by adding an increment to her previous turn, converting the gap in the talk to an intra-turn pause, and providing further information about the service (line 11). By adding the increment the therapist has cancelled out the sequential relevance of the client’s response in line 10, and makes another response from the client due. This time, however, the client does not respond at all (line 12). Neither a receipt nor an acceptance of this new piece of information is provided by the client here. At line 13, the therapist again responds to the client’s
silence with an increment, providing both further information about the organization and another opportunity for the client to respond.

At the next possible transition relevant place the client initiates an insert expansion (line 14). The therapist comes to a possible completion point after “publicly funded (.) body” and, one beat later, the client produces a new FPP. The FPP of the insert expansion is delivered at a position in the sequence where the client would be expected to deliver a SPP response to the proposed solution for her trouble, and it thus disrupts the smooth progressivity of the talk. In a similar way to the OIR sequences analysed above, this insert expansion has come late – the client has already had two prior opportunities to initiate an expansion to question the conditions of the proposal (lines 9 and 12). The client’s prior delays in addition to her previous confirming response, “right”, has suggested thus far in the sequence that she has all of the information necessary to produce a SPP response to the proposal. Instead, however, she delays a response further by initiating an insert expansion with a follow-up question. The FPP of the insert expansion at line 14 comes in the form of a tag question that checks the referent CAHMS (“it’s in Port Adelaide isn’t it?”). The structure of this question suggests it embodies possible resistance. The use of a negative interrogative “isn’t it?” strongly invites agreement (Heritage, 2002; Heritage & Raymond, 2005), and thereby suggests that the client is invoking an established position of knowing CAMHS. By seeking confirmation on the location of the service, the client displays that the therapist’s proposal is not ‘news’ to her, thereby making it redundant and not a proposal to be acted on. This question thus foreshadows resistance to the proposal in the client’s forthcoming SPP response.

The therapist’s response in line 15 comes in the form of a confirmation, but it is formatted as a dispreferred response. It begins with a dispreference-implicative delaying device “uh” (Pomerantz, 1984). Further, the client’s previous tag question has set up a yes/no response to which the therapist answers in a non-conforming format (Raymond, 2003), leaving the confirmatory “yep” until the very
end of the turn. Raymond (2003) has demonstrated that yes/no interrogatives prefer a “yes” or “no” response that comes at the beginning of the turn. Non-conforming responses are designed to avoid the constraints that are set in motion by the grammatical form of the interrogative. They achieve this either by not delivering a “yes/no” response at all or by delaying it within the turn. By delaying her “yep” response until the end of her turn, the therapist thus delivers the response in a non-conforming format. Raymond (2003) has also argued that non-conforming responses are dispreferred, and treat the prior turn as problematic in some way. By structuring her answer in a dispreferred format, the therapist displays an orientation to the possibility that the client’s insert expansion is indicative of possible resistance. At the first possible completion point of the therapist’s answer turn, the client launches a rejection of CAMHS as a possible solution to her problem (lines 16-20; 23-24).

Within this sequence both silence and a pre-second insert expansion act as premonitory resistance resources before overt rejection of the proposal is provided by the client. Here, the client uses these resources to delay any overt rejection on four occasions, allowing the therapist the opportunity to modify the proposal in some way. The therapist responds to the client’s silences by either adding an increment to her previous turn, or by expanding on her proposal, in each case orienting to the missing acceptance or rejection response from the client. In response to the insert expansion, the therapist frames her answer in a dispreferred format, suggesting an orientation to the client’s turn as being premonitory to resistance.

Analysis of the fragments in this section demonstrate that both (post-first) other-initiated repair sequences and pre-second insert expansions can be used to display premonitory resistance. Both types of expansions delay the projected SPP response to the therapist’s proposal and thus disrupt the progressivity of the talk. Together with the way they are structured and the intonation of their
production, these turns from clients foreshadow that resistance may be forthcoming in their projected response to the therapist’s proposal.

6.4 Chapter summary

This chapter has attempted to demonstrate, using several examples, how premonitory resistance resources are often drawn on by clients in response to therapists’ proposals before overt resistance was displayed. One way in which clients did this was by withholding a response altogether, resulting in an (often lengthy) gap in the interaction. Therapists responded to the dispreference-implicative nature of the client’s silences by adding increments to their proposal turns, converting the gap in talk, with its negative interactional resonances, to an intra-turn pause, without them.

A second way in which clients displayed premonitory resistance was by initiating repair on the therapist’s proposal turn. Several common aspects of clients’ repair initiators suggested they were being used as premonitory resistance resources. First, clients often withheld a response at the first possible opportunity after the trouble source. Previous CA work into OIR would suggest that if hearing or understanding had been the trouble, clients would have initiated repair sooner so that the sequence could progress with least disruption. Second, clients usually chose repair initiators that displayed a strong sense of what the trouble source was in the prior turn (e.g., candidate understandings or understanding checks). The repair initiators generally illustrated that it was not a problem in hearing that the client experienced, and clients also displayed considerable understanding of the proposal within the turn. It, therefore, appeared more likely that the trouble was a problem with the appropriateness of the proposal. The clients’ deployment of strong repair operations as their first attempt at initiating repair is contrary to the preference in conversation, identified by Svennevig (2008), for the least serious construal of problems in first repair initiations.
Drawing upon such strong repair operations in the first instance can thus be seen as quite an overt display of premonitory resistance, as the clients did additional work so as not to risk their repair initiations being heard merely as troubles of hearing.

Finally, the way in which clients delivered their repair initiators conveyed a sceptical stance to the proposal. This was often done through the intonation of the repair initiator. Scepticism was displayed prosodically by an initial lowering in pitch on the first word of the RI, followed by a rise to normal pitch rate and then a high increase in pitch and elongation of the last word of the repair initiation, with a pitch peak on the elongated vowel.

In initiating repair, the clients delayed the progression of the interaction and provided therapists with an opportunity to modify or withdraw their proposal. Therapists responded to clients’ repair initiations with a confirmation of clients’ understanding, and additionally either elaborated on or accounted for the proposal providing further explanation of what the proposal entailed. These elaborations were often met with silence from the client and therapists responded to this silence by incrementally expanding on their proposals. Therapists, in their repair turns, oriented to the dispreference-implicative nature of the clients’ OIRs by framing them in a dispreferred format, and often also downgrading their proposals in some way, or providing an account for them.

A final way in which clients displayed premonitory resistance was via a pre-second insert expansion. Rather than initiating repair on a troubling aspect of the prior turn, the client produced a FPP that posted a follow-up question, before producing a SPP response to the proposal. These insert expansions also disrupted the progression of the talk, and together with the structure of the turn (e.g., as a negative interrogative), foreshadowed that resistance may be forthcoming from the client.
Clients’ deployment of these premonitory resistance resources illustrates an attempt at managing resistance within an environment where resistance is particularly problematic. By drawing on these resources clients are able to make resistance relevant to the interaction, and allow therapists an opportunity to modify their proposals in some way, while avoiding having to display overt resistance. Patterns in the way clients initiate repair in these instances make a contribution to the CA literature on other-initiated repair. Little attention has been paid to the use of ‘strong’ repair initiators. The examples from this corpus demonstrate one way in which ‘strong’ repair initiators can be drawn upon, in conjunction with sceptical prosody, to display a resistive stance. It can be speculated that the way in which these repair initiators are used to display premonitory resistance may hold across other data sources both in mundane and institutional talk. That hypothesis, however, will need further empirical analysis. The analysis also builds on the CA literature of pre-second insert expansions, demonstrating that these sequences may also be used to display premonitory resistance.

The examples show that although overt resistance was often delayed several turns after therapists initially delivered their proposals, premonitory resistance can be tracked from the completion point of the first proposal TCU, and several resources were skilfully used by clients to delay overt resistance. As can be seen in each of these examples, however, overt resistance did come. This was the case across the corpus. The next chapter will look in detail at clients’ overt resistance turns, including how they were launched, the accounts provided by clients for their resistance, and the interactional accomplishments achieved through these accounts.
CHAPTER 7

‘Resistive accounts’: Clients’ overt resistance to therapists’ proposals for behavioural change

7.1 Introduction

As seen in the previous two analytic chapters, in all but one case, clients in this corpus displayed some sort of overt resistance to therapists’ proposals for behavioural change. In Chapter 6, I showed that sometimes clients delayed their overt resistance for several turns. In these instances, resistance to the therapists’ proposals was typically foreshadowed by the use of what I have labelled ‘premonitory-resistance resources’. However, the use of premonitory resistance resources is never sufficient within this corpus to result in therapists backing down on their proposals and, in each case, clients end up producing more overt resistance in subsequent turns.

Clients’ overt resistance turns will be the focus of analysis in the following three analytic chapters. We will see over the course of these chapters how clients draw upon what I have termed ‘resistive accounts’. These accounts involve a regular pattern: clients resist therapists’ proposals by providing a specific reason from their personal experience, which would be unknown to the therapist, as to why they cannot accept. Clients’ resistive accounts achieve two other interactional goals. First, the accounts display an assertion by clients of their superior epistemic authority over the matter at hand. Secondly, the accounts are produced in a way that allows clients to manage the delicate activity of resisting the therapist by moving all responsibility for the trouble, and by implication for their resistance, away from themselves. The current chapter will focus on the content of clients’
resistive accounts. The next two chapters, Chapters 8 and 9, will focus on an analysis of the two interactional goals accomplished within clients’ resistive accounts. Before I present an analysis, however, I will briefly summarise the meaning of resistance as understood within CBT theory. I will also summarise previous CA research on resistance, in particular, that dealing with resistance to advice-giving.

7.1.1 ‘Resistance’ in CBT

Resistance to change on the part of the client is a major limiting factor to the success of CBT treatment for depression. Cognitive behavioural resistance has been defined as “anything in the patient’s behaviour, thinking, affective response, and interpersonal style that interferes with the ability of that patient to utilize the treatment and to acquire the ability to handle problems outside of therapy and after therapy has been terminated” (Leahy, 2001, p. 11). In accordance with this definition, research into CBT has outlined several possible causes or dimensions of resistance to change within therapy (Leahy, 2001). These include:

- Validation - clients may first need validation of their feelings and perspective before they can change them;
- Self-consistency – clients may feel they have committed a great deal of time and effort to their current life/relationships and therefore be reluctant to make changes;
- Personal schemas – clients may have a negative pattern of viewing themselves which supports and promotes their current behaviours;
- Moral resistance – clients may feel that they do not deserve things to be another way, or they may feel they have an obligation to another/others to keep things the way they are;
- Victim – clients may feel that they have a right to their complaints and it is not they who should be obligated to change;
- Risk – clients may feel that change is too risky;
- Self-handicapping strategy – clients may use their problem to justify failures or troubles in other parts of their life.

Although these proposed dimensions of resistance are important in CBT theory, they do not provide therapists with any information concerning how and when clients typically display such resistance, within the therapy interaction. The aim of the next two chapters is to explore just these matters: to demonstrate how clients display resistance to behavioural change, in real-time, within the therapy interaction. These chapters will also attempt to explain why clients overwhelmingly display resistance when therapists make proposals for behavioural change. Rather than defining resistance using the CBT definition set out above, resistance will be analysed using the conversation analytic framework of turn-taking, in particular adjacency pairs and their preference structure.

7.1.2 ‘Resistance’ in CA research

As detailed in Chapter 3, the minimal sequence within conversation consists of an adjacency pair (Schegloff, 2007a). An adjacency pair is made up of two turns by different speakers which are adjacently placed (i.e., one after the other). These two turns are made up of a first pair part (FPP) and a second pair part (SPP). A FPP makes relevant a limited set of possible SPPs, which are organized by a preference structure. The alternative types of response made relevant by a FPP embody different alignments to the project underway. The response which favours furthering the action underway is known as the preferred SPP. The alternative response which embodies a problem in the realization of the action underway is known as the dispreferred SPP. When therapists make a proposal for behavioural change, the two alternative types of response made relevant to clients involve acceptance of the proposal (preferred) and rejection of, or resistance to, the proposal (dispreferred). The preference structure of these two alternative SPP turns is not related to any form
of psychological preference, but relates to the preference structure set up by the preceding turn. All therapist proposals in this corpus are designed in a way that prefers an ‘acceptance’ response. It is ‘acceptance’ that will further the therapist’s attempts at behavioural activation. The adjacency pair sequence under investigation here can thus be represented schematically as follows:

Therapist: FPP Proposal
Client: SPP Acceptance of proposal (preferred)

or Rejection of/resistance to proposal (dispreferred)

In the following analysis I have defined resistance as any dispreferred response to the proposal (not accepting the proposal when acceptance is the preferred response), whether it be outright rejection or a more subtle form. So when clients produce some kind of dispreferred response to therapists’ proposals, they are displaying resistance, then and there, for both the therapist and subsequently any analyst to see. Analysing the turns in this way can demonstrate how resistance, as a dispreferred action, can be managed delicately by both parties within the interaction in the ways in which the resistance turns, and subsequent turns, are designed. Analysing resistance in this way thus enables the analyst to explore in detail the complex nature of resistance and the consequences it has for the interaction as it unfolds.

7.1.3 CA research into resisting advice

As described in Chapter 5, therapists’ proposals in this corpus can be defined under the broad category of advice-giving. Resistance to advice has been explored by only a handful of CA researchers. Of these studies, even fewer have explored the ways in which more overt forms of resistance get done. This gap in the research is mainly due to the fact that overt forms of resistance have been found to be rather rare in other corpora (e.g., Heritage & Sefi, 1992; Kinnell & Maynard,
Much more work has been done on ‘passive’ (Heritage & Sefi, 1992) forms of resistance. For example, Heritage and Sefi (1992) identified one way in which new mothers receiving advice from home-visiting nurses overwhelmingly responded to advice. Typically, they produced an ‘unmarked acknowledgement’ such as “mmhm”, “yeh” or “that’s right” which achieved what Heritage and Sefi termed ‘passive resistance’. The resistance was passive in the sense that such forms of response (1) do not acknowledge the advice-giving as ‘news’ to the recipient; and (2) do not constitute an undertaking to follow the advice. Similarly, in Kinnell and Maynard’s (1996) analysis of advice-giving in an HIV clinic, the most frequent way in which clients responded to advice was observed to involve unmarked acknowledgements or silences at transition-relevant places. Silverman (1997) also found that clients in his corpus of HIV counselling sessions tended to respond to counsellors’ advice with unmarked acknowledgements and silences rather than with overt rejection.

There has been some exploration of overt forms of resistance to advice. Heritage and Sefi (1992) found that one less frequent way in which mothers in their corpus responded to advice was to provide some assertion of their knowledge or competence. These assertions resisted the advice through a claim that its content was already known and/or had been acted upon by the mother. Overt advice-resisting practices have also been discussed by Waring (2005) who analysed the resistance practices of one student within her corpus of academic counselling sessions. When the student resisted advice on general academic issues she would often cite difficulties concerning the resources available to her. When resisting advice on specific content matters related to her essay, the student drew upon one of three practices: (1) she asserted her own agenda for writing an essay that was unrelated to the advice; (2) she invoked the authority of her professor; and (3) she provided what Waring labelled an ‘irrational, autocratic response’ to the advice such as “they’re there because they’re there”. When the student resisted advice relating to the mechanics of her
writing, she displayed an attempt to minimize the import of the advice by shifting the topic to more
general academic writing issues.

In each of these practices of overt advice resisting, an account is offered that expresses the student’s
difficulty in implementing the advice. Accounts for doing a dispreferred action very often invoke an
‘inability to comply’, which carries a ‘no fault’ quality (Heritage, 1984b). Such accounts display an
attempt to manage the potential problems created by the dispreferred action underway. Within the
CBT corpus under analysis here, clients display overt resistance by providing accounts of why they
cannot take up the therapists’ proposals. I refer to these accounts as ‘resistive accounts’. Clients’
accounts all draw, in some way, upon an aspect of their experience (that the therapist could not
know) that allows them to assert their inability to accept the proposals. The next section will
describe the four major types of accounts that were drawn upon by clients to resist therapists’
proposals. Two subsequent chapters will look in more detail at some of the practices used by clients
within their resistive accounts to achieve other interactional goals. These additional interactional
achievements of clients’ accounts include displays of epistemic authority over the matter at hand,
relative to the therapist, and removal of responsibility for the trouble from the client.

7.2 Varieties of resistive accounts

As mentioned above, in responding to the therapists’ proposals, clients typically provide ‘resistive
accounts’. The types of accounts drawn upon by the clients in their responsive turns resist the
therapists’ proposals by providing reasons from clients’ own experience as to why they cannot
accept the proposal. In this way, the accounts correspond with what Heritage (1984b) has termed
‘inability to comply’ formulations. Within the content and the design of these resistive accounts,
clients are able to achieve several interactional goals. This first section will briefly describe the
different types of accounts identified in the corpus. This section is, therefore, of a more broad descriptive nature. Later sections will look more closely at the turn design of these resistive accounts, and the interactional accomplishments that are achieved through them.

Within this corpus of interaction in CBT, clients typically draw upon one of four types of accounts to assert their inability to accept therapists’ proposals:

- An appeal to a restricting contingency within the client’s life;
- An appeal to a third party;
- An appeal to a physical state;
- An assertion of a previous effort to do what the therapist is proposing.

Each of these types of accounts involves the client drawing upon knowledge from their personal experience that the therapist did not know as their reason for rejecting the proposal. In each form of account, clients also frame the trouble under discussion as being something that is out of their control, and unsolvable by a change in their own behaviour. In the sections below, each of the four types of resistive accounts will be described in turn with some interactional examples.

### 7.2.1 Appeals to restrictive contingencies within the client’s life

Clients, in their resistive accounts, often appeal to a specific restrictive contingency in their life that renders them unable to accept the therapist’s proposal. The aspect of clients’ lives that is invoked is something that is external to them and is thus out of their control. Below are two examples of how clients typically form this type of resistive account. Prior to Fragment (1) there has been a troubles-telling from the client about her visit to a financial planner who is investigating whether she can buy her own home and thus move out of her parents’ house. The client has told the therapist that the
financial planner will not be reporting back to her until closer to Christmas, which is still six weeks away. The fragment follows on from the therapist having delivered a gist formulation (Antaki, 2008) of the client’s trouble, which the client has confirmed. The client’s resistive account is marked with an arrow.

(1) [CBT 002 accommodation 4:42]

1 T:   [Alright] so: (1.7) hhh given that
2 he: hhh can't let you know until Christmas (0.6) an’ then even
3 if it's a yes: (0.2) there’ll still be a kinda bit’ve a gap
4 (0.2) [bet]ween (0.2) now and when you could possibly buy
5 C:  [Yes]
6 T: a courtyard home [an’ get] into it.
7 C:  [Yes. ]
8 C:  Yes.
9
10 T: Is it worth exploring some other al- accommodation options?
11 (0.4)
12 C: [Uh:]
13 T: [so ] that you're not liv↓ing at home?
14 (0.4)
15 C: → We’ll not really becuz (0.7) in the six weeks I'm off I don't
16 get pai↓d.
17 (0.2)
18 T: Oka:y.

In Fragment (1), the therapist’s proposal (across lines 1-13) is structured as a yes/no interrogative, with a pre-proposal account (refer to Chapter 5 for a detailed description of these types of turns). The therapist completes her incremental turn at line 13, and there is a gap of 0.4 seconds where the client does not respond. When the client takes her turn she begins with “well” which may be indicative of either a forthcoming complex response or a dispreferred response to the interrogative proposal (Schegloff & Lerner, 2009). In this instance, the “well” preface appears to be a marker of the upcoming dispreferred response given the silences from the client at lines 11 and 14, and the “Uh” preface of the client’s abandoned turn at line 12. The client responds to the interrogative with
a softened ‘no’ response: “not really”. The client’s subsequent account for not accepting the proposal involves a specific reason from her own life as to why she is unable to accept the proposal: “in the six weeks I’m off I don’t get paid”. This account draws on an aspect of the client’s life that the therapist could not have known, and is something that the client has no control over. The reason provided for the resistance is also a factor that is essential for the proposal to be able to be acted out – the client cannot find new accommodation out of her parents’ home without money. This factor is presented as a restrictive contingency within the client’s life that prevents her from accepting the proposal, independently of her own wishes.

In Fragment (2) the client has been telling the therapist about her performance interview at work (a special needs school) in which she was told that she needed better computer skills. No-one at her workplace, however, is willing either to teach her computer skills or pay for her to take a course. Again, the fragment follows on from the therapist having delivered a gist formulation (Antaki, 2008) of the client’s trouble, which the client has confirmed.

(2) [CBT 002 computer 10:26]

1 T: Thez um (0.6) THERE ARE qu\Auml;ite a number oh :f (0.3) ahh: computer
2 literacy skills for: sort’ve (0.5) people in your age group
3 .hhhh that are run by: li\Phries and local councils and stuff like
4 that.
5 ((21 seconds omitted))
6 T: and some libraries will run (. ) you know (0.3) :how to use a
7 computer for the first time sessions.
8 (0.6)
9 T: where they kind of give pe\[ople jus’ a basic tu-   ]
10 C: → [I’m sure not at] our library
11 coz I went to our library an’ .hh (0.2) they give you fifteen
12 minutes to get o:n.
13 (0.2)
14 C: → It took me fifteen minutes ta work out how to turn the bloody
15 thing o:|[n.
16 T: [mm\Phm.
A similar pattern can be seen here as seen in Fragment (1). The therapist delivers a proposal as information-giving in lines 1-4. As we saw in Chapter 5, this type of proposal involves the therapist providing some piece of factual information for the client with an implication that the client takes up the action/service being described. The therapists’ information-giving proposals target their proposed solution to the trouble as being a ‘general’ solution to that problem. In other words, any client who came to them with this trouble may receive this proposal for future action.

In line 10 the client enters in interjacent overlap (Jefferson, 1986) with the therapist’s ongoing account for her proposal, and provides a rejection of the proposal “I’m sure not at our library”. The client rejects the proposal on the basis that the information provided by the therapist does not apply to her specifically, that is, there are no computing courses offered at her particular library. In other words, there is a concrete restrictive contingency within the client’s life that inhibits her from accepting the proposal. It is notable, here, that the client does not use the term “my” library, but rather “our” library. This phenomenon of clients shifting to refer to a collective within their resistance turns is common within the corpus and will be addressed further in Chapter 9. At line 11, the client then moves into an evidentiary account in which she details a specific instance of visiting her library where the computer access supplied by the library was inadequate. This account draws on a specific circumstance from the client’s experience, which allows the client to display an inability to accept the therapist’s proposal.

Another way in which clients produce their resistive accounts is by appealing to some third party whom the client knows but the therapist does not. These types of accounts will be the focus of the next section.
7.2.2 Appeals to a third party

When drawing on this type of account clients appeal to a third party to explain why they cannot accept the therapist’s proposal. This was the most common type of account drawn upon by the clients. These resistive accounts occurred when clients’ troubles-tellings involved problems with a third party, and therapists’ subsequent proposals involved a suggestion for solving or managing the trouble between the client and this third party. The third parties invoked were people whom the client knows very well, usually family members or friends, and whom the therapist would not know. The accounts suggest that the client is not resisting the overall therapeutic goal of behavioural change, but has an inability to comply with the therapist’s proposal due to a characteristic of the third party invoked.

Fragment (3) illustrates this practice. The fragment comes late in the session. The focus of the talk for most of the session has been around the problematic behaviour of the client’s youngest daughter, Leah. The therapist has already offered several proposals for managing Leah’s behaviour, which have all been resisted by the client. One of these proposals has involved getting the client to ask her eldest daughter, Alison, to help her in the task of managing the younger daughter’s behaviour. The therapist attempts this proposal again from line 1 of this fragment. The “her” in line 2 refers to the client’s eldest daughter, Alison. The client’s resistive account is marked with an arrow.

(3)  [CBT 001 walks 52:15]
1   T:   Well I mean (0.2) uh:: (.) like I suggested >earlier< can you
2   enlist [her] as (0.2) being on your team for this.=y’know like
3   (0.6) you know like “you n’ me Alison (0.2) we’re kind of a bit
4   bigger:” (0.6) y’know “Leah’s little (0.6) she needs a bit of
5   extra attention right no:w”.  
6   (0.7)
7   T:   You know (0.2) “can we >concentrate really hard on< tryin’ to
8   help her”.  

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Across lines 1-5 the therapist offers a proposal to the client in the form of an interrogative, supported by ‘hypothetical active voicing’ of the proposed scenario. The client initially responds with weak acceptance to the proposal (note that this is the second time the therapist has attempted to propose this solution to the client). The therapist does not accept the client’s weak response, however, and adds an increment to her turn, in essence sequentially deleting the client’s “maybe” response from the interaction (see Lerner, 1989). The client, therefore, must respond to the proposal again. She does so, entering in interjacent overlap with the therapist, at line 12. This time the client’s response involves a rejection of the proposal supported by a resistive account. The client asserts new information about her daughter that the therapist could not have known. The client’s reason for resistance is framed as an inability to accept the proposal based on the way that her daughter would respond to such a request. The client’s resistance is thus not due to any lack of personal desire to accept the proposal but to the behaviour of a third party.

Two further examples of appeals to a third party can be seen below. Fragment (4) comes from the same session as Fragment (3) but occurs earlier in the session. The focus of the talk at this point is the same, however - the problematic behaviour being displayed by the client’s youngest daughter. Fragment (5) is from a different session, and follows a troubles-telling from the client about how her neighbour makes too many demands on her and is always requesting her help at inconvenient times.
(4)  [CBT 001 school counsellor 31:52]

1 T: Okay so:: um (1.2) from what you've told me about Leah (1.2) u::m (1.7) it sounds like (0.9) she might benefit from (0.5) some kind of (1.2) >opportunity to talk with a counsellor.<
2 T: Umm (0.3) is there a school counsellor ↑at ↑all? (0.5)
3 C: → .hhhh ↑there ↑i::s but they don't- I- hhh hu:m: (1.7) ↓I think that's just a little bit too close to ho:me.
4 T: Okay.
5 C: for her.
6 T: Yep.
7 C: → Ah I don't think she'd be comfortable.
8 T: Mmhm.

(5)  [CBT 007 neighbour 17:59]

1 T: So (0.7) I want you on the look out to just say this “no” she probly won't take much notice but y↑ou'll feel better.
2 T: about yourself.
3 (0.4)
4 T: “I'm not at your beck and call all the time Angela”.
5 (1.3)
6 T: “And (0.2) it's very annoying that you seem to think (1.0) that I'm just supposed ta (1.5) be your servant kind of”.
7 (22 seconds omitted)
8 T: Keep it simple. Don't get into a justification. In fact don't say very much at ↑all.
9 (0.5)
10 T: The more you talk (0.9) the more frustrated you're gonna get.
11 C: It’s ju- she
12 T: She sort of gets you talking.
13 (0.4)
14 T: Don't say anything.
15 (0.6)
16 T: Just say (0.4) no.
17 (2.4)
In Fragment (4), after a 0.5 second gap (line 6), the client responds to the therapist’s interrogative proposal with a non-conforming confirmation (Raymond, 2003) followed by a rejection that involves a resistive account. This account involves announcing new information about her daughter to which the therapist has less access: that is, that a school counsellor would be “too close to home” (line 8) for her daughter. The client goes to the effort of adding the post-other-talk increment, “for her”, to emphasize that she is talking about her daughter, specifically. The reason for the client’s resistance is thus framed as being due to her daughter’s stance towards school counsellors and not the client’s own wishes or desires. The client is unable to accept the proposal because her daughter would not agree to see a school counsellor even if the client wanted her to do so. Further detail regarding the management of epistemic authority in the client’s responses here will be discussed in Chapter 8.

In Fragment (5), at line 23 (after an initial attempt to respond at line 16), the client launches a resistive account. In her first turn she uses the prospective indexical (Goodwin, 1996) “that” which works to buy her another turn at talk to explain what the other “bad thing” is that her neighbour does. Further, the continuous, iterative tense used by the client (“thing she has of doing”) formulates the neighbour’s behaviour as generally the case, rather than specific to one circumstance (Edwards & Fasulo, 2006). The neighbour is thus formulated as someone who generally does ‘bad things’. After 0.4 seconds, the client continues her account to explain that when she tries to talk to
her neighbour she is teased about stuttering. Again, the client draws upon knowledge of her previous experiences with the neighbour in order to resist the therapist’s proposal. Further, the account is framed in such a way that the reason for the client’s resistance is entirely attributed to the neighbour, specifically to her routine response when attempts are made to reason with her. Again, we can see how the client frames her trouble as being unsolvable by any change in her own behaviour.

A less common form of account drawn upon by clients involved an appeal to a physical state. These types of resistive accounts will be discussed next.

7.2.3 Appeals to a physical state

In appealing to some physical state as the reason for their resistance, clients provide descriptions of experiences that are internal to them. However, they are framed as states that are caused by external factors and are thus out of the client’s control. These accounts occurred less frequently in the corpus than other types of accounts, so I will limit analysis to one example, Fragment (6), here. This fragment comes from a wider sequence in which the therapist has given the client a list of possible behavioural changes to consider as ways of breaking her habit of coming home from work and drinking alcohol throughout the evening. Within this sequence, the client has stated that she has thought about going for a walk along a beach walking-trail. After further discussions, the therapist picks up on this idea 13 minutes later, and proposes that the client go for walks when she gets home from work.

(6) [CBT 017 walking after work 36:09]

1 T: .hh alright so:: coming out of this I spoze thez (. ) **two** (0.4)
2 areas (0.7) where s- (0.2) there would be good to have some
3 kind of intervention where you .hh (0.6) >gunna< ( . ) go=in a
The therapist’s proposal over lines 13-18 is packaged as a hedged recommendation with questioning intonation. The client enters in pre-terminal overlap (Jefferson, 1986) to the therapist’s incremental turn at line 22 to deliver an overt rejection of the proposal “I won’t”. After a brief gap, the client then provides an account for her resistance which appeals to the physical state of being “too tired”. The therapist does not respond to the client’s resistive account at line 23, and the client takes
another turn in which she upgrades her account. Within this turn the client first addresses the therapist directly using her first name and then adds the epistemic marker “honestly” which prompts a receipt from the therapist. The use of “honestly” here does some specific interactional work for the client.

Unlike the previously discussed types of resistive accounts which all draw upon circumstances external to the client, this account draws upon the client’s subjective state. Because of this, the client could be seen as merely providing an ‘excuse’ not to take up the proposal. By using an honesty phrase here, however, the client is able to show not only that her account is a factual one, but also that her motivation in reporting it is sincere (Edwards & Fasulo, 2006). It thus makes her account more difficult for the therapist to challenge. In challenging the account, the therapist would be challenging the client’s integrity and would thus appear more confrontational.

The client moves to upgrade her account to being “literally exhausted” (line 26), and then upgrades it again in her assessment “I feel sick I’m so tired” (lines 26-28). The client’s tiredness is then attributed to having “worked all day”, something that the client cannot change. After another 0.4 second gap where the therapist does not respond, the client upgrades her account again, this time generalising the knowledge of this physical state by using “you know” and the generalised “you” (line 30). The state of tiredness being described by the client is thus formulated as a state that anyone would feel after having worked all day. The account is also upgraded from feeling “sick” in the prior turn (line 26) to the physical feeling of when “your eyes are burning” (line 30). With each of these upgrades, the client thus works to describe tiredness, not as some emotional state that she could overcome, but as a physical state that she does not have control over, and that is caused by her working commitments which also cannot be changed.
There is one final resistive response type that clients draw upon in this corpus. This type of account involves clients asserting a previous attempt at doing what the therapist is proposing.

### 7.2.4 Assertions of previous effort

Clients sometimes provide an evidentiary account of a previous instance where they had attempted to do what the therapist is proposing, particularly when appealing to a third party to account for their resistance. In these instances, clients respond to therapists’ proposals by making an assertion that they have either already thought of the proposed action themselves, or that they have already attempted to do what is being proposed, thus making the proposal redundant. Again, in making such a claim, clients draw upon knowledge of the situation that the therapist did not and could not know. Also, the proposal is not being rejected because clients think it is a bad suggestion, or because they do not want to accept the proposal, but rather because they have already thought of, and attempted, the same thing. Within the corpus, at times clients’ assertions of previous effort take the form of rather vague and generalised claims; in other instances, clients detail a specific instance where they have attempted the proposed solution.

Fragment (7), below, is an example of a vague assertion of effort. In this instance, the client makes an assertion of already having thought of the proposed idea herself. The fragment comes after a troubles-telling by the client about a visit to her cousin’s house where her family spent the afternoon teasing her. The teasing began because, due to some OCD behaviours (including an aversion to germs), the client refused to use her cousin’s rubbish bin. The client had gone to make cups of tea for the family, and had left used tea bags on the sink rather than putting them in the bin.

(7)  [CBT 007 OCD 11:38]

1. T: You could have some sort of way of just not confronting situations I spose there.
In lines 1-2 the therapist proposes that the client avoid situations where she is likely to be uncomfortable. After a 1.3 second silence from the client, the therapist adds an increment to his turn, and then adds an additional TCU that provides the client with the example of not having a cup of tea. The client responds to this second turn with a minimal acknowledgment “Mm”, which Heritage and Sefi (1992) have identified as a form of ‘passive resistance’ in the context of advice-giving. After a 0.7 second gap, the client takes another turn, at the marked arrow, asserting already to have thought of what the therapist proposed. The client’s assertion is vague, involving no details of the nature of her thoughts. She merely states that she has “thought of that already”. The client refers to the action described in the therapist’s proposal with the vague indexical “that”. This indexical is all-encompassing; in other words, it refers to the therapist’s whole proposal. The use of “that” thus suggests that the client had already thought of the entire scenario being proposed by the therapist, and rejects it as an option for behavioural change. Further examples of vague assertions of effort by clients can be seen in the fragments below.

(8) [CBT 017 list 17:55]
1 T: Well I've actually um got a list a whole list of things here (.)
2 .tch .hhh (0.2) u:m so it doesn't have to be I suppose sitting
3 there having (. a different food or dr;ink.
4 (0.2)
5 T: .hh (. there might be some other things?
6 (0.3)
7 T: that you could do?
8 (0.3)
T: .hh um I mean there's a lot of really **Active** things here (0.2) but there's also some (.). hh (.). quite (0.3) um some quite 
(0.2) as well. (.)
T: that you could do at home?
(0.2)
T: So .hhh (.). maybe just have a quick look.
(.)
T: I mean there's all kinds of **stuff**
(0.6)
T: but maybe just see if there's anything that (0.3)
C: Mm.
T: that might take yur fancy.
((3 mins, 4 secs omitted while C reads list))
C: → Yeah I guess there's ce- there's a couple of things (0.3) there's some things in there that I already do::
(.)
T: Um:hm.

In this fragment, at line 25, there is an assertion by the client of having already attempted the action(s) being proposed by the therapist. The assertion is rather vague in nature – the client provides no details of how their previous efforts played out, nor of the type of situation in which they had attempted them. However, the vague assertion accomplishes a rejection of the therapist’s proposal as an option for behavioural change. At lines 25-26, the client merely asserts that there are “some things in there that I already do::” (upgraded from “a couple of things” via a replacement repair). A similar pattern can be seen in Fragment (9) below.

(9) [CBT 007 neighbour 17:59]

T: I GUESS just (0.6) without going (0.2) into it so much that we don't continue with this (1.0) I would put it to you that you might be on the look out (0.7) to (.). you might even make a resolve to yourself (0.2) “okay (0.7) between now and ___
appointment with Peter (1.0) I will make sure (0.6) to say no to her once.”

T: in that (.) she might say “what’d ya doing< today?” (.) an’
(0.7) you might say (0.4) “oh I’ve got a very busy morning.”
(0.3)

T: full stop.
(0.7)

T: “oh what are ya doing?” (2.0) “what I’m doing” you know
(0.2) “that’s my business.”
(0.9)

T: “can you do this for me.” “no I don’t have time today.”
(0.5)

T: even if it's a fib.
(0.7)

T: Just to practice. demonstrating to yourself that you’re quite capable.
(0.7)

T: of doing this.
(1.0)

C: → Actually I did- >I can't remember what it was< but I did actually fib.
(1.6)

C: "Um"
(0.8)

T: Fibbing is (0.4) not the greatest option but in the (0.2) in the interest of getting to a point where you can have a good respectful relationship with her may be: (1.3) it's certainly acceptable along the way.=what- what was your example.
(0.8)

C: → Oh I can't remember but I did fib.
(0.3)

T: Yeah okay.

In Fragment (9), the client asserts that she “did actually fib” in the past. This assertion is overtly oppositional to the therapist’s proposal marked by the turn-initial (and repeated) production of “actually” (see Clift, 2001). In this instance, the vagueness of the client’s assertion is emphasized further through the parenthetical insertion of “I can’t remember what it was” (line 25). When the
therapist then attempts to coax more details from the client about her fib, the client again responds by saying that she “can’t remember” (line 35). In both of the above instances, by asserting that they have previously attempted to solve the trouble through a change in their behaviour, but that the trouble persists, the clients also imply that a solution to the trouble is out of their control.

In other instances, however, clients make assertions of previous effort by describing a specific instance in detail to account for their resistance to therapists’ proposals. Fragment (10) is an example of this practice. The client’s trouble talk in this session has focussed on the bad behaviour being displayed by her youngest daughter. The therapist has proposed several possible solutions to the client throughout the session, all of which have been resisted. Within this fragment, the client not only makes an assertion of effort but also appeals to a third party to account for her resistance.

(10) [CBT 001 enlist Alison 33:51]

```
1 T: Well it might be um (1.2) might even be worth trying to enlist
   2 Alison.
   (0.4)
4 T: into the (0.5) cause=of saying >you know< (0.3) “↑YOU (.) you
   5 know what it’s like when your sister goes nuts: (0.2) I know
   6 that you don’t like fighting with her”, (0.6) you know “↑let’s
   7 (0.3) let’s see if we can make (0.6) this next week (0.7) a
   8 really (0.8) happy time [no:w.” ]
   9 C: [See I had] them both sittin’ there and
10 I said “↑look” (0.5) “wh↑atta you want”.
11 (2.1)
12 C: an’ y’know “not be anno:yed an’ (1.3) play with my sista an’
13 have fun n’ y’know (0.2) fur her to stop annoy ing me”.
14 T: Mmmh.
15 C: “now whatta you want”.
16 (.)
17 C: EXactly the same thing.
18 T: Yep.
19 (0.3)
20 C: “↑W↑e(h)ll?”
```
Across lines 1-8 the therapist offers a proposal in the form of a ‘hedged recommendation’ (see Chapter 5). The proposal involves the client asking her older daughter whether she might help her by not fighting with her sister because it causes the sister to get wound up and engage in more bad behaviours. Within the therapist’s incremental turn at lines 4-8, hypothetical active voicing is invoked (refer to Chapter 5 for a detailed explanation of this phenomenon) which works to simplify the proposal by providing the client with the necessary resources for her to enact what the therapist is suggesting. The client enters in pre-terminal overlap (Jefferson, 1986) at line 9 and launches straight into a detailed account of a previous effort to talk to her daughters about their fighting (beginning with the dispreference-implicative appositional “see”).

Again, the client draws upon knowledge of the situation that the therapist could not have known. Interestingly, the client uses direct reported speech (Holt, 1996) in her account, and this will be discussed in detail in Chapter 8. In describing a previous attempt that came to no avail, the client also shows that a change in her behaviour will not solve the trouble with her daughters. Preventing the trouble is framed as being out of the client’s control. The client’s lack of control in the matter is overtly displayed in her final turn “I can’t say anything more than well”. The client has thus, again, produced a resistive account in such a way that she cannot be held responsible for either her resistance, or for the trouble itself. The trouble is framed as being solely due to the behaviour of her two daughters, which she cannot change, despite previous attempts.
7.3 Chapter summary

To summarize, there are four major types of resistive accounts that clients draw upon to reject or resist therapists’ proposals for behavioural change. These include:

- An appeal to a restricting contingency within the client’s life;
- An appeal to a third party;
- An appeal to a physical state;
- An assertion of a previous effort to do what the therapist is proposing.

The first type of resistive account drawn upon by clients involves an appeal to a restrictive contingency in their life that renders them unable to accept the therapist’s proposal. The aspect of the client’s life which is invoked is something that is out of the client’s control. The second type of resistive account involves clients appealing to a disposition of a third party to explain why they cannot accept the therapist’s proposal. On a few occasions, clients also appeal to a physical reason for their resistance. In these accounts, clients work to essentialize their physical state (using upgraded and generalised assessments) and construct it as being out of their control. Clients also work to produce their motivation for providing such an account as being sincere and truthful. The final way in which clients produce resistive accounts in this corpus is to assert a previous attempt of having done what the therapist is proposing. In these accounts, clients are either extremely vague about their previous attempt or provide very specific details of the prior occasion. Whether vague or detailed in their accounting, clients’ resistance is produced as being due to the redundancy of the proposal rather than to a lack of desire to accept it.
In each of these accounts, clients draw upon knowledge from their previous experience and their knowledge of the current troubling situation to produce reasons for their resistance. Clients are able to draw upon this knowledge because they have direct access to it. Therapists, however, do not. In drawing upon such knowledge to frame their accounts, clients thus claim authority over the situation under discussion. In looking at the ways in which clients design their turns when producing their resistive accounts, we can also see that clients draw upon several different resources to display, subtly, their epistemic authority over the situation. In other words, whilst the content of their accounts claims epistemic authority by overtly stating new knowledge that the therapist could not have known, there are also subtle aspects in the design of the clients’ turns that also display their epistemic authority. Clients’ displays of epistemic authority within their turn design will be analysed over the course of the next chapter.
CHAPTER 8

Clients’ assertions of epistemic authority in their resistive responses to proposals

8.1 Introduction

It was demonstrated earlier, in Chapter 5, that considerable epistemic asymmetry exists between therapist and client in regard to the negotiation of behavioural change. Although therapists may be considered the ‘experts’ and carry the authority of professional perspective, they do not have direct access to, or epistemic authority over, the client’s perspectives and experiences. Only the client can be the expert in regard to their own experience. In making a proposal, therapists have to make certain assumptions about a client’s situation, as they do not have direct access to all of the details of the client’s troubles. These assumptions, in many cases, could be incorrect or may not apply specifically to a particular client. As seen in Chapter 5, therapists attend to this epistemic asymmetry in multiple ways within their proposal turns. They deliver their proposals as hedged recommendations, interrogatives, or information-giving. Within each of these turn formats they draw upon a range of resources such as low modality terms (“might”, “maybe”, “could”, “do you think”), delaying devices, and minimizing terms to display their subordinate epistemic status over the matter, relative to the client. The following section will illustrate how clients also display their epistemic authority over the matter at hand, relative to the therapist, in the design of their resistance turns.
Clients’ assertions of epistemic authority are in part achieved through the content of their accounts. As seen in the previous chapter, such accounts all involve an appeal to aspects of their life and experience to which the therapist has less access. The accounts thus draw upon the clients’ expert knowledge of the situation, relative to the therapist. However, clients also display their epistemic authority in the way that they design their accounting turns. Clients draw upon several resources to accomplish this interactionally. These include:

- The use of generalised declarative tense and high modality verbs or adjuncts
- The design of their responses to interrogative proposals
- The use of direct reported speech

Before analysing clients’ use of each of these resources to display their epistemic authority, I will first review recent CA research into the negotiation of a speaker’s epistemic status relative to their co-participant. This literature was reviewed in Chapter 5, but a brief overview will be provided here to set the scene for this new analysis.

There are several recent CA studies that have analysed the ways in which participants in interaction manage and attend to their rights and responsibilities related to knowledge and information (e.g., Heritage, 2002; Heritage & Raymond, 2005; Land & Kitzinger, 2007; Lerner & Kitzinger, 2007; Raymond & Heritage, 2006; Stivers, 2005). The rights and responsibilities regarding what participants know, and whether they have rights to describe it, are directly implicated in organized practices of speaking (Heritage & Raymond, 2005).

The majority of work on the management of epistemic status between speakers in interaction has been conducted in the environment of first position and second position assessments. Heritage and Raymond (2005) illustrated how speakers of both first and second assessments drew upon a number
of resources to index their relative rights to perform the evaluation underway. Speakers of first assessments who do not have epistemic authority over the evaluation relative to their interlocutor typically display their downgraded status through the use of tag questions (e.g., “they’re a lovely family now aren’t they?”) and evidential verbs (e.g., “this sounds so good”). Speakers in second position may assert their epistemic authority over an assessment through an array of practices which either invoke a pre-existing point of view (e.g., a confirmation + agreement, or an “oh” prefaced second assessment) or alternately, they may deploy interrogatives which translate their second turn into a new first positioned assessment (e.g., “it is isn’t it”). Stivers (2005) extended this work by showing how partial and full repeats in second position can also work to assert the second speaker as having primary rights to the claim and having epistemic authority over the matter.

Raymond and Heritage (2006) continued this work on the management of epistemic authority in first and second assessments by showing how the resources used can make relevant specific identities in particular courses of action. Specifically, they showed how two callers maintained an ongoing collaboration that sustained one of the caller’s - Vera’s - epistemic privileges over issues with her grandchildren, and thus validated her identity as a grandparent.

Clift (2006) has also demonstrated how direct reported speech can be used in second assessments to provide an evidential display of having reached the assessment independently of the first, thus indexing the speaker’s epistemic rights over the assessment. Lerner and Kitzinger (2007) added to this body of work by showing how extraction repair (a same-turn replacement repair used to extract the speaker from a collectivity; i.e., a collective reference term is replaced with an individual self-reference term) can be used by speakers to narrow their epistemic authority from that of a relational collective of which they are a member to just themselves. These repairs were usually found in instances where the speaker was making an extreme case assessment. For example:
Most recently, some research into epistemic authority and subordination has also been done in question-answer sequences. Heritage (2010), Heritage and Raymond (2010), and Raymond (2010) have established the notion of an epistemic gradient between speakers when engaged in the act of questioning. Questioners invoke the claim that they lack certain information and can thus be referred to as being in a ‘K-’ position. At the same time, the recipient of a question is projected as having access to certain knowledge that the questioner does not. They are in a ‘K+’ position. The act of questioning thus invokes a relative K-/K+ epistemic gradient between the questioner and answerer. For example:

![Epistemic Gradient Diagram]

However, the design of a question can alter the steepness of the epistemic gradient. For example, the question, “who did you talk to?”, claims little knowledge concerning the matter being questioned and thereby makes relevant an ‘answer’ as the response. These questions express a large knowledge gap between questioner and answerer, and a steep epistemic gradient. However, the declarative question, “You talked to John?”, asserts a possible answer to the question and thus makes relevant a ‘confirmation’ as a response. These questions embody a much flatter epistemic gradient between the speakers. Whilst these types of questions position the recipient as having
epistemic rights over the matter at hand, they also constrict the way that the recipient can respond. Heritage and Raymond (2010) have found that recipients can further assert their epistemic rights by responding to these questions in a non-conforming way, in particular, by using repetitional responses in contrast to a yes/no response (“I talked to John”). Repetitional responses work in this way by ‘confirming’ rather than ‘affirming’ the proposition raised by the questioner.

The following analysis builds on this developing body of work by showing how clients display their epistemic authority over the matter at hand, relative to the therapist, in their second position resistance turns. Clients draw upon some of the resources already identified in the assessment literature, as well as others. The first resource I will examine involves clients’ use of high modal verbs and adjuncts, and generalised declarative tense, within their resistance turns.

### 8.2 Modality & generalised declarative tense

Modality is one way in which speakers can display their status in relation to an utterance. As was demonstrated in Chapter 5, therapists often use multiple low modal verbs and adjuncts to display their subordinate epistemic status in relation to clients in situations in which they are proposing a solution. In contrast, clients, in their resistive accounts, draw upon high modal verbs and adjuncts as well the use of generalised declarative tense, to produce their turns in a declarative manner. In doing so, they display their epistemic authority, relative to the therapist, over the situation under discussion.

He (1993) noted that verbs and adjuncts with a high modality value construct an utterance as having enhanced truth value. They also construct the speaker as having a higher status, in the claim, than the co-participant. High modal verbs include forms such as “must”, “will”, and “should” whereas
high modal adjuncts include constructions like, “I’m sure”, “certainly”, “definitely” and “always” (He, 1993). In addition, the absence of modal verbs or adjuncts but the presence of generalised declarative tense (e.g., “I do that”) can also project an utterance as truthful and verifiable, and the speaker as having a higher epistemic status relative their co-participant (He, 1993).

In the fragments below, I will show how clients’ resistive accounts typically either include high modal verbs or display an absence of modality together with use of generalised declarative tense. In their sequential position as the SPP response to therapists’ proposals with their downgraded epistemic status, clients’ use of modality works to display their higher epistemic status within resistance turns.

Fragment (1) is an example of clients’ use of a high modal adjunct within a resistance turn. Prior to the start of the fragment, the client has been providing a troubles-telling about a performance interview at her work in which she was informed of the need to improve her computing skills. However, her employer (a special education school) is not willing to provide her with resources to learn better computing skills, and the client claims not to have the money to pay for such training herself.

(1)  [CBT 002 computer 10:26]

1 T:  Thez um (0.6) THERE ARE quːte a number oːf (0.3) ahh: computer literacy skills for: sort’ve (0.5) people in your age group .hhhh that are run by: libraries and local councils and stuff like that.  
(21 seconds omitted))

6 T:  and some libraries will run (..) you know (0.3) ↑how to use a computer for the first time sessions.  

9 T:  where they kind of give pe[ople jus’ a basic tu- ]

10 C: →        [I’m sure not at] our library coz I went to our library an’ .hh (0.2) they give you fifteen minutes to get oːn.

13 (0.2)
The therapist’s proposal here is packaged as information-giving. The therapist frames the client’s trouble as a generalised trouble, and the proposed behavioural change involves a generalised solution that the therapist might give to anyone in that circumstance (lines 1-4). In framing the proposal in this way, the therapist provides the client with the opportunity to hear the proposal as generally relevant rather than as necessarily specifically relevant, thus displaying the therapist’s subordinate epistemic authority over the client’s specific situation. In contrast, in launching her rejection of the proposal, at line 10, the client uses the high modality adjunct “I’m sure” at the beginning of the turn. By beginning her turn in this way, the client displays to the therapist that she is certain of the factuality of her ensuing account. The use of “I’m sure” also displays an assertion of the client’s epistemic authority over the issue. It is only the client, and not the therapist, who can ‘be sure’ about whether her library, specifically, offers computing skills courses. As analysed in Chapter 7, the client then goes on to provide an account that draws on an aspect of the client’s life that the therapist could not have known, and is something that the client has no control over (from line 11).

Another example of clients’ use of high modality verbs and adjuncts within resistive accounts can be seen in Fragment (2) below. In the transcript, the modals are marked in bold.

(2) [CBT 001 walks 52:15]

1 T: Do you think you could talk with Pete about (0.4) the fact that
2 you are quite worried about Leah and you think it's really
3 important for her to have some one on one time with you.
4 (0.4)
5 T: and would he mind twice a week (0.6) just (0.7) you know (0.5)
6 keeping an ear out in the house.
7 (0.2)
8 C: Yep
9 T: So that Alison is gonna be
10 C: Yep see if ye-m makes me worried what am I going to say
to Alison.
12 C: you know cos she always feels that n- the- she's
always seen Leah with the over extended whatever's
to get the attention. [=So she's always gone]
16 T: [Mmhm ]
17 T: Yep.
19 C: sa- sat back an' ya know every time I've spoken to her
about it y'know .hhh >like I've< made her aware m
I can see that ya sittin back becuz your sister needs a
little more attention [and ] stuff like that.
23 T: [Mmhm]
24 C: and that's: y'know jea::h you know does matta
[kind of] thing.=It's okay.
26 T: [Mmhm ]
28 C: [I un]derstand.
29 T: [Mmhm]
30 C: So it would be nice for her tuh I Always seem to leave
her out becuz: the youngest one is: (0.4)
33 T: Okay.
34 C: Yuh know.

Again, within the therapist’s proposal across lines 1-9, displays of her subordinate epistemic authority over the situation at hand can be seen. The proposal is framed as an interrogative and further downgraded with an epistemic marker (“do you think”), the use of low modal verbs (“could”), and downgrading devices (“quite”, “just”).

The client’s resistive account (across lines 10-35) draws upon knowledge of her daughter to reject the proposal. The account notably lacks any weakening evidentials (e.g., “hear”, “seem”, “according to”) in describing the daughter’s feelings and behaviour (the client’s use of “seem” in line 31 is to
describe her own behaviour, rather than her daughter’s, and thus does not work as weakening evidential). Additionally, the client draws upon several high modality adjuncts to show that her account is not just based on knowledge of one particular occasion, but is based on her knowledge of how things *always* are. When describing her daughter’s feelings toward her sibling, the client uses the adjunct “always” several times across lines 13-15. Then, in her expansion at line 19, the client uses the adjunct “every” to describe occasions when she has tried to talk to her daughter about her younger sister. Again at line 31, the client states that she “always” seems to leave her older daughter out. In producing her account as a factual and generalised description of what happens in her household, the client displays her access to direct knowledge of what everyday life is like in her house, and how her daughter generally reacts to conversations such as the one the therapist is proposing. In designing her turn in this way, the client thus displays her epistemic authority over her family life, relative to the therapist. It is her greater access to this knowledge that allows the client to resist the therapist’s proposal in the way that she does.

Fragment (3) is an example of a client using generalized, declarative tense in her resistive account to display epistemic authority over the matter at hand.

(3)  [CBT 017 walking after work 36:09]

1  T:  .hh alright so:: coming out of this I spoze thez (.).
2        two (0.4)  (0.7) where s- (0.2) there would be good to have some
3  kind of intervention where you .hh (0.6) >gunna< (.).
4  go=in a
diff’rent direction to you usually do and that’s ah when you
5  come home from w::ork? (0.9)
6  and when you’ve had a few drinks:. (0.5)
7  T:  so there’s those two points there.
8  (0.6)
9  T:  where (0.2) um (0.3) currently (0.2) you’re going in a certain
direction (0.2) and it’s (0.2) lea;ding you to feel depress:ed.
11  C:  Uhmhm.
12  (0.2)
T: .hhhh um: an’ so: (0.3) the first thing (. uh that’s come up (0.2) is the wa:iking?
(0.6)
T: .tch (0.3) and I don’t know if this week you wanted to actually .hhh have a tri::al a bit of an experiment (0.2) .hh and maybe (0.2) jus’ do a couple of walks::?
(0.2)
T: after: (0.2) ya finish your day?=after you’ve wor:ked or (0.9)
before [dinna? ]
C: →   [I won’t] (.) I’m too ti::red.
(0.2)
C: → Becky honestly [it’s the] (0.7) ya know by the time I've worked
T: [Umhm ]
C: all da:y I'm (0.5) lit’rally ex:hausted [I feel] sick I feel so
T: [Umhm ]
C: ti::red.

Over lines 16-18 the therapist proposes that the client go for walks after work rather than sitting down and having a glass of wine (the client is having problems with alcohol consumption). The proposal is delivered in a tentative way qualified by low modal verbs (“maybe”), downgraded with essentializers (“just”) and epistemic markers (“I don’t know”), and delivered with questioning intonation. In contrast, the client’s response at line 22 is delivered with generalized and declarative tense: “I won’t. I’m too tired”. The client produces her reason for resisting as being due to something which is generally the case – she won’t go for walks because she is too tired. In producing her resistance in a declarative manner the client projects certainty over her account. In doing so, she also displays her greater epistemic status over the matter. The client’s epistemic status is made particularly apparent by the declarative manner of her response in contrast to the tentative nature of the therapist’s prior proposal turn. A generalised tense is also used in the client’s turns across lines 24-28: “by the time I’ve worked all da:y I’m (0.5) lit’rally ex:hausted I feel sick I feel so ti::red”.

Again, this generalised declarative tense frames the client’s exhaustion as being certain and generally the case rather than referring to a specific context or time.
In looking at the three examples above, it has been shown how clients’ use of high modal verbs and adjuncts, or their use of generalised tense, can work to display their epistemic authority over the matter at hand, relative to the therapist. Another way in which clients display their epistemic authority within the design of their responsive turns involves the way that they respond to therapists’ interrogative proposals and I will now turn to a discussion of this resource.

8.3 Responses to interrogatives

As mentioned above, Heritage and Raymond (2010) have identified that yes/no interrogatives position the recipient as having epistemic rights with respect to a certain knowledge domain, however these interrogatives also restrict the exercise of those rights - the recipient should answer the question in a specific way, that is, with either a ‘yes’ or ‘no’. Yes/no interrogatives thus exert pressure on the recipient to affirm or deny the state of affairs under question.

There are, however, certain ways in which recipients can resist the restrictions of yes/no interrogatives and thus display their higher epistemic authority within the design of their responsive turn. Raymond (2003) demonstrated that yes/no interrogatives are responded to with either ‘yes’ or ‘no’ as the first item of the response in instances where the speaker is taken to be purely in agreement with the question. He labelled these responses ‘type conforming’ responses. These responses accept the terms of the question unconditionally, exert no agency with respect to those terms, and thus acquiesce to them (Heritage & Raymond, 2010).

On the other hand, responses that delay or leave out a yes/no response (i.e., non-conforming responses) can achieve very different interactional goals. These responses can assert the respondent’s epistemic entitlement in regard to the matter at hand. They do so by ‘confirming’
rather than ‘affirming’ the proposition raised by the questioner (Heritage & Raymond, 2005, 2010). These responses resist the constraint exerted by the question in several ways. First, they modify the terms of the question by confirming rather than affirming the propositional content of the question (e.g. by providing a repetitional response which confirms the question, rather than providing an affirmative “yes” response). Secondly, they exert agency with respect to those terms, thus asserting more rights over the matter. Lastly, they are associated with sequence expansion, in comparison with yes/no responses which are usually sequence-closing (usually maximally followed by a sequence-closing third).

In this corpus, therapists deliver their interrogative proposals in a way that displays their significantly subordinate epistemic authority over the issue at hand. The proposals are typically designed to indicate that therapists claim to have no pre-existing access to the issue under question. Their interrogatives are also considerably hedged, typically via the use of low modal verbs (e.g., “maybe”), epistemic markers (e.g., “do you think”), and mitigating devices (e.g., “sort of”). Their proposals sometimes even carry ‘cross-cutting preferences’ (Schegloff, 2007a) where the interrogative is so mitigated that it is grammatically designed to prefer a “no” response, even though the action of the turn prefers a “yes”, accepting response (e.g., “is there any chance you could do that at all?”). Therapists’ interrogative proposals thus set up a steep epistemic gradient between themselves and clients over the matters under discussion.

Despite therapists’ display of their subordinate epistemic rights within proposal turns, clients typically draw upon several resources to assert their epistemic authority within their responsive turns. They can do this in three main ways. First, they can produce a non-conforming “yes” response before subsequently resisting the proposal. These non-conforming responses depart from the constraints of the interrogative turn and assert the client’s agency over these terms. Secondly, clients can produce non-conforming sentential responses which negate therapists’ proposals
altogether. By launching straight into a fully sentential resistive response, clients depart completely from the terms of the question. By resisting these terms, clients display an assertion of their epistemic rights in relation to the issue under discussion. Lastly, clients can respond to interrogative proposals with a type-conforming dispreferred response. With these responses clients assert their epistemic authority over the issue by displaying their right to reject the proposal. Over the course of this section, I will analyse each of these resources, turning first to clients’ use of non-conforming “yes” responses followed by resistance.

8.3.1 Non-conforming “yes” responses

Clients in this corpus sometimes provided non-conforming “yes” responses to therapists’ interrogative proposals before providing their resistive accounts. In doing so, they display an assertion of their epistemic authority over the situation, relative to the therapist. This finding provides an extension to Heritage and Raymond’s (2010) findings on interrogatives, as it shows that non-conforming “yes” responses can be used to assert epistemic authority in another sequential environment – that of resistive responses to proposals.

Fragment (4) is an example of this practice. Prior to this fragment there has been a troubles-telling by the client about the problematic behaviour being displayed by her youngest daughter. The therapist has offered two proposals to solve this trouble previously, both of which have been resisted by the client. The therapist’s interrogative proposal is marked with P→ and the clients’ non-conforming response to the proposal are marked with an arrow.

(4) [CBT 001 school counsellor 31:52]

1 T: Okay so:: um (1.2) from what you've told me about Leah (1.2)
2 u::m (1.7) it sounds like (0.9) she might benefit from (0.5)
3 some kind of (1.2) >opportunity to talk with a counsellor.<
4 (1.0)
The therapist delivers a proposal in the form of a ‘hedged recommendation’ in lines 1-3 that the client take her daughter to see a counsellor (refer to Chapter 5 for details on the turn design of hedged recommendations). After no response from the client at line 4, she reformulates her proposal as an interrogative which more specifically proposes that the client take her daughter to see a school counsellor. The therapist’s interrogative proposal at line 5 invites a type-conforming “yes” or “no” response (Raymond, 2003). The grammatical design of the turn together with the therapist’s increase in pitch when producing “↑ at ↑ all” creates cross-cutting preferences (Schegloff, 2007a). The inclusion of the negative polarity item “at all” reverses the polarity of the interrogative so that, grammatically, the question favours a “no” response (see Heritage, 2010). Pragmatically, however, the proposal prefers acceptance. So, whilst the action is designed for a “yes”, the grammatical format is designed for a “no” (Heritage, 2010). The format of the question thus displays the therapist’s downgraded epistemic status in relation to the proposal and respects the client’s right to reject the proposal. However, as an interrogative, the therapist’s turn still carries constraints on the client for how she can respond. The client’s subsequent response, however, shows how she resists the constraints exerted by the interrogative form.

After a gap of 0.5 seconds, the client responds to the therapist’s yes/no interrogative, in line 7, with a non-conforming confirmation (Raymond, 2003). The client’s response, “There ::s”, confirms the therapist’s question without providing the grammatically preferred response (Heritage & Raymond, 2005). So, despite the client aligning with the therapist’s question at the beginning of her turn, she goes out of her way to subordinate the action of delivering a “yes” response, before proceeding to
resist the uptake of the proposal. The turn-initial repeat resists the constraint exerted by the question by modifying the terms by which the client can respond. The client thus asserts agency over these terms and her right to authority over this issue. The client’s response of [confirmation + resistive account] reflects the [agree + disagree] format for a dispreferred response to an assessment (Heritage, 2010; Pomerantz, 1984).

The client’s subsequent resistive account involves announcing new information about her daughter that the therapist could not have known: that is, that a school counsellor would be “too close to home” (line 8) for her daughter. In doing this, the client asserts greater authority over knowing her daughter, than the therapist. In fact, the client asserts that she has the right to speak on behalf of her daughter. The client’s display of epistemic authority over the matter is emphasised by the post-other-talk increment (Schegloff, 2001) added in line 10 (“for her”), in which the client ensures that therapist knows she is talking specifically about her daughter, rather than making a general claim about school counsellors. Framing her talk in this way thus makes the client’s reason for resisting the proposal more difficult for the therapist to dispute. The therapist is not in a position where she can assert greater rights over the issue, and so can hardly challenge the client’s resistance. That this is the case is evidenced by the therapist’s turns at lines 9 and 11 where she merely produces minimal acceptances of the client’s account (“Okay” and “Yep”).

8.3.2 Non-conforming sentential responses

The above example demonstrated that clients can use non-conforming response designs to achieve a [confirmation + resistance] format similar to the [agreement + disagreement] response types sometimes used in second assessments (Pomerantz, 1984). Clients in this corpus also use non-conforming, sentential response designs to negate therapists’ proposals. These responses completely overturn the terms of the question. In fact, in these instances, the interrogative aspect of
the proposal is not responded to at all. This practice can be seen in the following fragment that comes from a session in which the client has been telling the therapist about the problematic behaviour of her youngest child. Following this telling, the therapist has proposed that the client take her daughter to the Child and Adolescent Mental Health Service (CAMHS) but this was resisted by the client. At lines 1-2, the therapist attempts to propose this action for a second time. In this fragment, and each of the fragments in this section, the therapists’ proposal is marked with P→ and the clients’ non-conforming responses to the proposal are marked with an arrow.

(5) [CBT 001 enlist Alison 33:51]

In lines 1-2, the therapist proposes that the client investigate taking her daughter to CAMHS. Within her proposal, the therapist displays her subordinate epistemic authority by framing the proposal as an interrogative, including an epistemic marker “do you think” and a hedging of the request, “sort of”. However, the proposal is still produced with positive polarity – to prefer a “yes” response and an acceptance of the proposal. After a 0.5 second gap, the therapist adds an increment to her turn at the same time as the client launches her response to the proposal. Rather than initially responding
with a conforming “yes” or “no” response, the client launches straight into a fully sentential resistive response (with a turn initial “well”). The client thus does not respond to the grammatical constraint of the interrogative. In fact, she does not respond to the interrogative nature of the therapist’s proposal in any way. The client does not state whether she will or will not investigate getting CAMHS help for her daughter. Instead she responds to the second action – that of accepting or rejecting the proposal. In responding in this way the client thus departs from the terms of the interrogative. In doing so, the client claims more epistemic rights over the situation at hand than the therapist’s interrogative conceded. We can see a similar pattern in the following two fragments.

(6)  [CBT 002 dinner 26:35]

1 T: Do you think there would be a (1) something that (1) she could accept (0.2) as a gift (0.2)
2 T: As a (0.4) thoughtful indication of your love (0.9)
3 T: Um (0.7) in the world at all?
4 T: Is there anything that she could accept?
5 C: Absolutely not.
6 T: Mm.
7 T: P→ What about something that (0.3) didn’t cost any money.
8 C: → I do stuff for them.
9 T: Um

(7)  [CBT 007 cousin 43:05]

1 T: What’s her intention toward you? do you think she wants (0.2) to upset you?
2 T: Is that her intention?
3 (.)
4 (.)
5 (.
T: Your cousin?
(0.6)
C: No she's um oh I spose she's thinking she's doing the right thing.
(1.3)
T: [Like give it]
C: [Okay and all] you've said is you don't have to do that which is a little bit vague.
(0.4)
T: if I can *jus be bold.*
(0.4)
T: cos she may well think oh that's nice of Sarah to say that I don't have to do it but I'm happy to help out.
(0.8)
T: I mean you haven't actually said "I'd be much more comfortable if you don't talk about or refer to the o-c-d."
(0.6)
T: Is that right?
(1.3)
C: Probly yes.
(0.5)
T: P- Um might might you say that to her?
(2.4)
C: hhh oh we're not talking at the moment.

In each case the therapist offers a proposal in the form of an interrogative with positive polarity – each turn is designed to prefer a ‘yes’ response and an acceptance of the proposal. The clients, at the arrowed turns, respond to the proposals by launching a fully sentential response which resists the proposed action (“I do stuff for them” in (16) and “oh we're not talking at the moment” in (17)). In each case, the client does not respond to the grammatical constraint of the interrogative: they do not provide any sort of “no” response. Neither do they provide any sort of repetitive response to the interrogative, as found by Heritage and Raymond (2010). Instead, the clients only respond to the second action within the therapists’ proposals turns - they resist/reject the proposal. By launching straight into a fully sentential resistive response, the clients depart completely from the terms of the
question. By resisting these terms clients display an assertion of their epistemic rights in relation to the issue under discussion. In responding in this way, they create a steeper epistemic gradient between the therapist’s interrogative proposal and their response to it.

8.3.3 Conforming dispreferred responses

In some other instances, clients also provide conforming dispreferred responses to the therapists’ proposals. In doing so, they provide an overt rejection of the proposal, which is not mitigated or delayed, as is usually found with dispreferred responses. These responses also act to assert the client’s epistemic rights in the matter at hand. By responding with an immediate type-conforming but dispreferred response, clients assert their right to reject the proposal.

The next fragment is an example of a client responding to an interrogative proposal with a rejection produced in a conforming format. Prior to this fragment the client has been talking about her meeting with a career guidance officer who gave her a psychological test to see what types of jobs she might suit. The client was not happy with the results of the test as she did not think the suggested occupation-type, administration work, ‘fitted’ her. The therapist now moves to propose that idea to the client as well from line 1.

(8) [CBT 002 employment 14:55]

1  T: [I mean] would you be interested doing an
2                     administration job a couple of days a week?
3  C: No.
4  (0.2)
5  C: [but either ]
6  T: [like answ’ring] tele[phones typing letters ]
7  C:                   [Oh I can answer tele]phones and
8                   filing an’
9  T:  Y↑ep
10 C: Yeah but is- eh- uh yeah .hhh but anything full o::n .hhh coz
The therapist’s interrogative proposal in lines 1-2 is produced to prefer a “yes” response from the client and an acceptance of the proposal. It is, however, downgraded by the inclusion of the low modal verb “would” which, in conjunction with the interrogative turn structure, shows an orientation by the therapist to her own subordinate epistemic authority over the matter of the client’s employment. Without leaving any gap in the interaction, the client produces a rejection of the proposal (the dispreferred action) in a conforming format – a flat “no” response. Within that turn she does not attempt to delay her dispreferred response in any way, nor does she attempt to provide an account for her rejection. In producing her rejection in this way, the client displays an assertion of her right to reject the proposal given that she has epistemic rights over the matter at hand.

At line 6 the therapist adds an increment to her proposal turn at the same time the client begins to provide (but drops out) what is possibly an alternative suggestion. The therapist’s increment works sequentially to delete the client’s prior “no” response (Lerner, 1989). The client must, therefore, respond to the incremental interrogative for a second time. This time the client shifts to provide a confirmation of the therapist’s question before resisting the proposal again. Rather than producing a “yes” response, however, she enters in interjacent overlap (Jefferson, 1986) at line 7 with an “oh” prefaced sentential response.

With this second response the client achieves an assertion of epistemic authority in two ways. The “oh” preface displays that the client already holds a position on whether she can answer telephones and do filing tasks (Heritage, 2002; Heritage & Raymond, 2005). She thus conveys her superior knowledge in regards to her employment skills. Secondly, in responding with a sentential response,
rather than a “yes” response, the client confirms that she can do those tasks rather than agreeing with the therapist that she can (Heritage & Raymond, 2010). The client uses a turn-initial repeat to resist the constraint exerted by the question on how she can respond. The client thus asserts agency over these terms and her right to authority over this issue. Subsequent to this confirmation (“Oh I can answer telephones and filing”, lines 7-8) the client moves to resist the proposal for a second time. This second response from the client thus reflects the [confirmation + resistance] response type seen in Fragment (4). The [confirmation + resistance] response is marked with the turn-medial production of both “but” and “really”, which highlight the oppositional nature of the second part of client’s TCU to the first. The use of “really” here also works to bolster the client’s account as factual.

Over the course of this fragment, then, the client first asserts her authority by displaying her right to reject the proposal through a type-conforming dispreferred response. In having to respond a second time, the client shifts to a [confirmation + resistance] type response. She draws upon an “oh” prefaced turn-initial repeat, rather than a type-conforming “yes” response, in order to confirm the therapist’s question rather than agree with it. In doing so, she asserts her rights to authority over the issue before subsequently resisting the proposal for the second time with a more extended resistive account.

We have seen that in responding to therapists’ proposals which are formed as interrogatives, clients can assert their epistemic authority in three major ways. They can produce a nonconforming [confirmation + resistance] response; a full sentential response that negates the therapist’s proposal, or a conforming dispreferred response. There is one final way in which clients in this corpus commonly asserted their epistemic rights within their resistance turns. This last resource involves the use of direct reported speech (Holt, 1996) and will be the focus of the next section.
8.4 Reported speech

Clift (2006) has demonstrated how, in the environment of second assessments, reported speech can be used by participants to display epistemic authority with regard to co-participants. By reporting a past event, the speaker displays their own prior engagement with what has just been raised, and thus lays claim to primary rights to do the assessing. The use of reported speech can act as a powerful evidential display of having reached that assessment first. The analysis below will show how clients also use reported speech in this way when displaying resistance to therapists’ proposals. This analysis extends Clift’s (2006) findings by showing that reported speech can also be used to display epistemic authority within a proposal-resistance type sequence.

Fragment (9) is an example of this practice. Prior to the start of this fragment, the client’s trouble talk has focussed on the bad behaviour being displayed by her youngest daughter, Leah. The therapist has proposed several possible solutions to the client throughout the session so far, all of which have been resisted. The therapist’s proposal at lines 1-8 involves the client asking her elder daughter, Alison, to help her in the cause of keeping Leah’s behaviour under control. As seen above, the client’s resistance to the proposal, from line 9, involves an assertion of effort and also an appeal to a third party to account for her resistance.

(9)  [CBT 001 enlist Alison 33:51]

1 T:  Well it _might_ be um (1.4) might even be worth trying to enlist
2 Alison.
3 (0.7)
4 T:  into the (0.5) cause=of saying >you know< (0.3) “†YOU †(.) you
5 know what it's like when your sister goes nuts: (0.2) I know
6 that you don't like fighting with _her_”, (0.6) you know “†let's
7 (0.3) let's see if we can make (0.6) this next week (0.7) a
8 really (0.8) happy time [no:w.”  ]
9 C:    [See I had] them both sittin' there and
10 I said “†look” (0.5) “wha†tta you want”.  

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Across lines 1-8 (with no response from the client at line 3) the therapist makes a proposal to the client in the form of a hedged recommendation. The therapist uses low modality operators (“might”, “worth”), essentializing devices (“even”) and delaying devices (intra-turn pauses, “um”) within her proposal turn in order to index her subordinate epistemic authority relative to the client over the situation under discussion. The therapist goes to the extra interactional work of an insertion repair to insert the minimizing term “even” (line 1) that further downgrades the low modality verb “might” at the beginning of her proposal. After no response from the client at line 3, the therapist builds an incremental turn and moves into hypothetical active voicing to explain the proposal further to the client. The therapist enacts the words that she is suggesting the client say to her daughter, however, she includes the phrase “you know” before doing so, which works to distance the therapist from the forthcoming talk. The use of “you know” implies that the talk to come will be a version of generalised talk that anyone might say in this circumstance. Its use, therefore, also implies that this
is something that the client might also choose to say in the relevant circumstance. In this way, the use of “you know” allows the therapist to manage the delicate interactional task of the proposal underway. By using this phrase, the subsequent hypothetical active voicing appears less like the therapist telling the client what to do, and more as if she is merely providing some commonsensical talk that anyone, including the client, would say in this circumstance.

At line 9, in pre-terminal overlap (Jefferson, 1986), the client launches straight into a resistive account of a previous instance where she had attempted to speak with both her eldest and younger daughter about their fighting. Within her account, subsequent to the therapist’s use of hypothetical active voicing, the client uses direct reported speech (Holt, 1996). The client, over multiple turns, enacts an entire scenario for the therapist, including voicing not only her own speech but also the speech of both of her daughters. The client thus provides the therapist with an evidential display of having already attempted the proposed solution in the past. By displaying her prior attempt in this way, the client lays claim to primary rights to knowledge of the situation with her daughters. In doing so, she not only resists the therapist’s proposed course of action, but also resists the implication that she had not previously thought of enlisting her eldest daughter to try and prevent fights.

It is interesting that in responding to the therapist’s proposal that contains hypothetical active voicing, the client herself uses reported speech to resist it. The client’s use of reported speech highlights, within the interaction, the hypothetical nature of the therapist’s enacted scenario. By reporting an actual encounter with her daughters, the client is able to show that she is the only one with direct access to the situation under discussion and that she has authoritative knowledge of how her daughters behave.
A similar example is reproduced below. Again, in this instance, the therapist’s proposal involves the use of hypothetical active voicing and the client’s subsequent resistive account involves the use of direct reported speech. This fragment comes from the same session as the one above, approximately 7 minutes earlier. The topic of conversation is the same – the client’s trouble with her youngest daughter, Leah.

(10) [CBT 001 time-out 26:39]

1. T: One of the best (0.8) .tch (0.2) ways to: (0.5) u- deal with a-
   a problem like that when you've got a child whose >really in the
   mind set of well< (0.5) even ha:ld [attention is better than]
2. C: [ is structured ]
3. T: no att[ention] (0.5) is to: start to put a: >a kind’v e a<
4. C:  
5. T: stru ct[ure] into place where (0.5) they get plenty of positive
   attention.
6. (0.3)
7. T: Lots’ve (0.3) pats ‘n strokes an’ playing with an- an’ ti:me
   with people who they care about (0.5) and when (0.3) the
   negative attention behaviours come out (0.8) they just get
   ignored.
7. ((1 min, 27 secs omitted))
8. T: U:m (1.0) .h now I guess one of the (0.3) suh- so time out can
   be used as an effective way of >managing that<. becuz ya just
   saying yuh know “l’ook’ (. ) n- th’is behaviour can’t go on >in
   the< public space of the h’ouse so: you need to go: to
   [your time out arEA”]
9. C: [jus’ thow do not ] listen yu’ know they’ll hear it n’ they'll
   get punished for it the moment they're not n- both of th’m no
10. teevee no computer for a week.
11. T: Mmhm.
12. (0.9)
13. C: BUT THEY’RE STILL (0.7) bickering and fighting.
15. C: An’ “you got it yet?” “Do you need to lose something else”.

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In this fragment the therapist’s proposal is packaged as generalised information-giving. The client’s trouble with her daughter is framed as a generalised trouble that is commonly experienced by parents: “a problem like that when you’ve got a child who...”. The use of the inclusive “you” and impersonal “a child” normalises the client’s trouble with her daughter’s behaviour. The proposal is thus set up as one which the therapist would give to any parent who had a child behaving in this way. From the outset of the turn the therapist also emphasizes the optionality of her proposal by referring to it as “one” way to deal with the client’s trouble. In framing the proposal in this way, the therapist provides the client with the opportunity to hear the proposal as generally relevant rather than necessarily specifically relevant, thus displaying her subordinate epistemic authority over the client’s specific situation. At lines 17-19, the therapist also draws upon hypothetical active voicing to enact the type of speech the client might say to her daughter when using time-out, thus providing the client with all the necessary resources to enact the proposed solution. The hypothetical active voicing is also preceded by “you know”, another generalising device.

At line 20, the client enters in interjacent overlap (Jefferson, 1986) with the therapist to launch a resistive account which details previous instances where she has attempted to use time-out with her daughters. Within her turns across lines 20-31, the client draws upon generalised present tense to produce her account of how her daughters always react to time-out, rather than in just one specific instance. At line 27, the client then uses direct reported speech to voice her own speech to her daughters within that type of situation. The client’s use of reported speech here is a way in which
she can display her prior attempts to use time-out with her daughters. Its use also displays the client’s primary access to knowledge over (1) whether the client has used time-out in the past; and (2) how her daughters respond to time-out. Her use of reported speech thus displays an assertion of her epistemic authority over the situation relative to the therapist.

Again, the client’s use of reported speech reflects an orientation to the therapist’s prior use of hypothetical active voicing in the proposal. The client voices her own speech to her daughters when using time-out. Similarly, the therapist had voiced a hypothetical version of the client’s speech when using time-out. So, in using direct reported speech in her account, the client can highlight that the voiced speech within the therapist’s proposal is only hypothetical whereas the client has direct access to her actual speech in one of these situations.

One final example will be considered below. In this instance, the therapist does not use hypothetical active voicing within her directly prior proposal. She has, however, used hypothetical voicing in a previous proposal on the same issue earlier in the extended sequence. The focus of the client’s prior troubles-telling in this instance has been on how her mother is refusing a birthday gift idea of being taken out to dinner because it will be too expensive for the family. The proposal to which the client responds with reported speech comes at line 32.

(11) [CBT 002 dinner 26:35]

1 T: Have 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 (0.3) is not pleasing you.”
3 (1.0)
4 T: “wh↑at is it that you'd actually li
5 (0.2)
6 C: UH NO: [IT’S] THE WAY THEY’VE BEEN BR↓OUGHT ↑U::THEIR
7 T: [no ]
8 C: MENTALITY IS WE'VE GOT LOTS OF FOOD AT HO:ME.
9 T: Um↑hm.
11 ((3 mins, 28 secs omitted))
12 T: So do you think that (0.7) on saturday night you'll be taking her out?
13 C: [On ]
14 C: We'll be taking her on Sunday night.
15 T: [On Sunday night. So when it gets to Sunday night and she's going out for dinner,]
16 C: Mm.
17 (0.4)
18 T: Do you think she'll actually enjoy it then or will she be so wrapped up in how much it costs that she won't be able to enjoy it.
19 (1.1)
20 C: I think- I don't think she'll enjoy it.
21 T: Okay.
22 C: She loves seafood but [>I don't<] I think every mouthful's gonna be how much is this mouthful costing me.
23 (0.2)
24 T: Okay well (.)
25 C: Heh heh >I don't know how to de(h)al with it< heh
26 T: Maybe you shouldn't take 'er out for dinner;
27 (0.4)
28 C: Well she actually said just cancel it. An' I said "no:" (.)
29 C: I said "no I'm not cancelling it. I went to a lot've trouble to o:rganise it."

Both of the therapist’s proposals at lines 1-5 and then at line 32, involve the suggestion that the client withdraw her offer to take her mother out to dinner for her birthday. The therapist’s first proposal (lines 1-5) is framed as an interrogative and uses the low modality and epistemically downgraded phrase “have you thought about” on commencement. Within the proposal the therapist thus draws upon several resources to display her subordinate rights to knowledge of the situation relative to the client. The therapist also employs hypothetical active voicing to provide the client with the resources necessary to enact the proposal. In lines 7-9, the client rejects the therapist’s proposal (supported by a resistive account which is subsequently expanded).
Over 3 minutes later, after continued talk about the client’s mother’s birthday dinner, the therapist attempts to make the proposal to the client again. This time the proposal is only qualified with the turn initial modal “maybe” (line 32). Now the client resists the proposal by launching an account of a previous conversation with her mother where her mother asked her to cancel the dinner. The client’s turn preface “Well she actually” suggests that what is to follow will be in opposition with the therapist’s proposal (see Clift (2001) on “well actually” prefaces). The client uses direct reported speech to voice her own, and her mother’s, speech during that conversation. In voicing this prior conversation with her mother, the client (1) provides evidence for her account; and (2) displays her primary access, and thus epistemic rights, to the situation under discussion.

Again then, in using direct reported speech in her resistive account, the client is able to highlight that she can reproduce an actual conversation between herself and her mother whereas the therapist has only been able to produce a hypothetical version of such a conversation. The contrast built between the therapist’s hypothetical active voicing in the proposal and the client’s direct reported speech in her response thus highlights the client’s epistemic authority over the matter, relative to the therapist.

In this section, it has been shown how direct reported speech is another resource that clients can draw upon within their resistive accounts to display their epistemic authority over the matter at hand relative to therapists. This resource is often drawn upon when therapists have used hypothetical active voicing in their proposals for behavioural change.
8.5 Chapter summary

Clients draw upon several resources to display, in their second position resistance turns, their epistemic authority over the issue at hand relative to therapists. The three major resources used by clients to accomplish this include:

- The use of generalised declarative tense and high modality verbs or adjuncts
- The design of their responses to interrogative proposals
- The use of direct reported speech

The use of high modal verbs and adjuncts, and generalised declarative tense is one way in which clients in this corpus commonly display their epistemic authority over the matter at hand relative to therapists. In using these terms within their resistive accounts, clients displayed their greater access to knowledge of the situation under discussion. The declarative manner of clients’ responses in comparison to the tentative and downgraded manner in which therapists delivered their proposals creates a steep epistemic gradient (Heritage & Raymond, 2010) between therapist and client over the matter in question.

Clients also display assertions of epistemic authority in the way that they respond to interrogative proposals. Clients typically respond to interrogative proposals in one of three ways. First, they can produce a [confirmation + resistance] response. With these responses, clients deliver a turn-initial repeat rather than a “yes” response. They then move to resist the proposal. Secondly, clients can produce sentential responses which negate the therapist’s proposal altogether. With these responses clients do not respond to the interrogative aspect of the proposal in any way, but instead respond to the second action of the proposal – that of inducing acceptance or rejection. With both types of responses (turn-initial repeats and full sentential responses), clients depart from the terms
of the question. By resisting these terms clients display an assertion of their epistemic rights in relation to the issue under discussion. The final way in which clients respond to the interrogative proposals involves a type-conforming dispreferred response. These responses are delivered by the clients without the usual delays and mitigation typical of dispreferred responses. These responses display the clients’ right to reject the proposal, and thus their epistemic authority over the matter under question. Again, with these interrogative proposals, and the clients’ responses to them, a steep epistemic gradient is set up between therapist and client in relation to the situation under discussion.

The use of direct reported speech within resistance turns is the final way in which clients typically display their epistemic authority over the matter at hand. Direct reported speech provides evidence for clients’ accounts whilst also highlighting clients’ primary access to knowledge of the situation. In using reported speech clients show that they have already independently experienced what the therapist is proposing. Clients’ epistemic authority relative to therapists is highlighted even further by the contrast that is built by clients’ use of reported speech when therapists have used hypothetical active voicing in their proposals. In these instances, the use of reported speech emphasizes that whereas therapists must rely on producing hypothetical conversations for the client to have with others, clients are able to re-enact actual conversations from their prior experience in order to resist the proposed solution.

In each case, therapists display their subordinate epistemic rights within their proposal turns. They do this through the use of low modal terms, essentializing devices, interrogative forms and packaging the proposals as information-giving. Clients, in turn, draw upon the above-mentioned resources to assert their epistemic authority over the issue under discussion. With each proposal and response, then, a steep epistemic gradient (Heritage & Raymond, 2010) is set up between therapist and client. The therapist claims little or no knowledge concerning the client’s troubling
situation and the client claims to have greater, if not direct, access to this knowledge. Thus, resistance is made (1) rather easy for clients to achieve; and (2) rather difficult for therapists to challenge. By displaying their epistemic authority within their resistive turns, clients position themselves as having ultimate rights to resist therapists’ proposals. Clients are assigned these rights despite the fact that resistance in CBT is viewed as being detrimental to the success of the treatment. Herein lies a dilemma for therapists in making these types of proposals to clients.

There is one other interactional accomplishment achieved by the design of clients’ resistive accounts. This feature involves the way clients attribute responsibility for their trouble, and their resistance, onto others thus avoiding being held responsible themselves. There are several ways in which clients achieve this, and one of these will be the focus of analysis in the next chapter.
CHAPTER 9

*Aggregation as a resource for attributing responsibility*

9.1 Introduction

This chapter focuses on a resource used by clients in resisting therapists’ proposals, which works to diminish their responsibility for the trouble under discussion. A potential problem with therapists’ proposals for behavioural change is that they carry implications that (1) responsibility for the trouble under discussion lies, at least in part, with the client; and (2) the client’s current behaviour has been deficient in any attempts to solve their trouble. It was shown in Chapter 7 that, through their resistive accounts, clients frame their trouble as something which is out of their control. In framing the trouble as being unsolvable by a change in their own behaviour, clients display resistance to these implications. Through their resistive accounts, clients are thus able to diminish their own responsibility for the trouble.

Although clients achieve this interactional project, in part, through the content of the accounts they produce, there are additional practices that they draw upon that work to attribute responsibility for their trouble elsewhere, and thus attenuate clients’ personal responsibility. One such practice is the focus of the current chapter. This practice involves clients’ appeals to third parties within their resistive accounts. In their responsive turns to proposals, clients refer to themselves with the individual self-referent “I”, but often shift the other focal referent of their talk (a non-present third party) from being an individual to being a member of a collective/category of people. These shifts in reference by clients can be referred to as ‘aggregation shifts’.
The practice of aggregation has been examined by Lerner and Kitzinger (2007), who analysed instances of ‘aggregation repair’. These aggregation repairs all involved a same-turn replacement repair used to aggregate the speaker into a collectivity, that is, an individual self-reference term is replaced with a collective reference term. For example:

[CTS03] (from Lerner & Kitzinger, 2007: 534)

Sta: I wa- we were waiting for them for a:ges at the Met stop as well

Lerner and Kitzinger (2007) describe the interactional practices achieved by aggregation repairs. When a speaker aggregates to a collectivity, the repair works to shift responsible authority from the individual to the collectivity. This often occurs in the environment of a delicate action such as a request or negative judgement. Through aggregation repair, responsibility for making the request/judgement is broadened, for instance, to include a couple (‘relational aggregation’) or a whole organization (‘organizational aggregation’), thus reducing individual responsibility.

The analysis in this section builds on the work of Lerner and Kitzinger (2007) by showing how clients in the CBT corpus aggregate an individual third-party reference into a collective reference. In this corpus, aggregation is not usually done through a repair of the talk (as seen in Lerner & Kitzinger, 2007) but rather by an unmarked shift in person reference. In other words, following a span of talk where an individual referent has been used, clients shift (without using repair to do so) to a collective reference. The analysis thus builds on previous research in two ways: (1) it shows how third-person references can be aggregated into collectivities; and (2) it shows how speakers make shifts in person reference from an individual to a collectivity without the use of repair. The analysis also demonstrates how clients use this practice to achieve the important interactional goal of diminishing their own responsibility for the trouble under discussion. In the next section I present
some examples of ‘aggregation shifts’. I will then move to a more detailed analysis of these examples, showing how ‘aggregation shifts’ can achieve particular interactional goals.

9.2 ‘Aggregation shifts’

Clients’ aggregation shifts involve a shift from an individual third-party reference (e.g., “she”, “her”, “mum”) to a collective third-party reference (e.g., “they”, “them”). In each case the collective reference includes the individual third party previously mentioned. The shifts occur after an extended troubles-telling from the client which has focussed on a trouble with a particular individual third party. Following these tellings, not surprisingly, therapists’ proposals are targeted at this individual third party. However, clients, in their responsive turns to the proposals, shift the individual referent to a collective. In one case, Fragment (1) below, this occurs using an aggregation repair (Lerner & Kitzinger, 2007). However, in all other cases, the aggregation occurred via unmarked shifts in person reference. I will first look at the aggregation repair, before turning to consider aggregation shifts.

(1)  [CBT 001 school counsellor 31:52]

1  T:  Okay so::: um (1.2) from what you've told me about Leah (1.2) u:::m (1.7) it sounds like (0.9) she might benefit from (0.5) some kind of (1.2) >opportunity to talk with a counsellor.< (1.0)
2  T:  Umm (0.3) is there a school counsellor ↑at ↑all? (0.5)
3  C:  .hmmm ↑there ↑i:::s but they don't- I- hhh hu:::m: (1.7) ↑I think that's just a little bit too close to ho:me.
4  T:  Okay.
5  C:  for her.
6  T:  Yep.
7  (0.4)
8  C:  Ah I don't think she'd be comfortable.
In her proposal across lines 1-5, the therapist first uses the locally initial reference “Leah” to refer to the client’s daughter (Schegloff, 1996b), followed by the locally subsequent reference “she” (line 2). The client, in her response to the proposal, initially refers to Leah via the locally subsequent individual references “her” (line 10) and “she” (line 13). Following this, at line 19, in an aggregation repair (Lerner & Kitzinger, 2007) the client aggregates these individual third-person references to the collective references, “them both” and a collective “you” (including both daughters). The shift comes at a point where the client could have kept the reference to Leah, as it is Leah who is still the focus of the interaction. And yet, the client broadens the reference by aggregating her youngest daughter into the collective. In this one case, the shift is an obvious repair. It is initiated by a disruption in the smooth progressivity in the talk (the 0.4 second pause at line 18), it is prefaced with “well”, and the repair solutions are both pre- and post-framed: “them both” is pre-framed with “let” and post-framed with “know”, whilst “you” is pre-framed with “know” and post-framed with “could”. The interactional accomplishments of this aggregation repair will be discussed in the next section. For now, I will move on to examine the alternative (non-repair) ‘aggregation shifts’ that occur in examples from this corpus.

As mentioned above, the more common way for clients to aggregate in this corpus was to produce unmarked shifts in person reference. The following Fragments (2), (3), and (4) are examples of this practice.
(2) [CBT 002 dinner 26:35]
1 T: Have you thought about talking to your Mum and saying (0.2) y’know “okay mum obviously: (0.3) this idea of a seafood dinner (0.3) is not pleasing you.”
2 (1.0)
3 T: “what is it that you’d actually like for your birthday?”
4 (0.2)
5 C: UH NO: [IT’S] THE WAY THEY’VE BEEN BROUGHT UP= THEIR MENTALITY IS WE’VE GOT LOTS OF FOOD AT HOME.
6 (0.8)
7 T: [no ]
8 C: MENTALITY IS WE’VE GOT LOTS OF FOOD AT HOME.
9 T: Umhm.

(3) [CBT 002 dinner #2 26:35]
1 T: Do you think there would be: hhh (1.0) something that (1.0) she could accept (0.2) as a as a (0.4) gift?
2 (0.2)
3 T: As a (0.4) thoughtful indication of your love?
4 (0.9)
5 T: Um (0.7) in the world at all?
6 (0.7)
7 T: Is there anything that she could accept?
8 (.)
9 C: Absolutely not.
10 (0.8)
11 T: Mm.
12 (0.8)
13 T: What about something that (0.3) didn't cost any< money.
14 (3.3)
15 C: I do stuff for them.
16 T: Mmmhm.

(4) [CBT 001 time-out 26:39]
1 T: One of the best (0.8) tch (0.2) ways to: (0.5) u- deal with a- a problem like that when you've got a child whose >really in the mind set of well< (0.5) even bad [attention is better than] [ is structured ]
2 C: [ Umhm ]
3 T: no att[ention] (0.5) is to: start to put a: >a kind’ve a<
4 C: [ Umhm ]

In each case, the therapist uses an individual third-party reference within his/her proposal. In Fragment (2), she refers to “your Mum” (lines 1 and 2), and the singular “you” (line 3). In Fragment (3), the therapist uses the locally subsequent individual referent “she” in lines 1 and 8 to refer to the client’s mother. Similarly in Fragment (4), the therapist’s proposal is directed at an individual, displayed through the reference, at line 2, to “a child” rather than “children”: “One of the best (0.8) ways to deal with a problem like that when you’ve got a child whose mind set of well even bad attention is better than no attention...”. The therapist’s subsequent references over the course of this proposal involve a singular use of “they”, often used in conversational English as a gender unspecific individual reference.

The clients’ responsive turns, however, all shift to use a collective third-party reference. In (2), the client uses the locally subsequent collective referent “they” and “their” in her responsive turn. In (3), the collective reference “them” is used by the client (line 16). Lastly, in (4), the client uses the collective references “they” (lines 15-16) and “both of them” (line 16). The client draws upon the collective reference “they” several times in her initial responsive turn and even cuts off the trajectory of her turn to include the formulation “both of th’em” which further emphasizes the collective reference now being used. These shifts are not exposed with any type of repair. The progressivity of the sequence is not suspended in any way; the client merely shifts referent within
her responsive turn to the proposal. Thus, clients’ aggregation shifts are realized with an unmarked shift in the use of person referents.

In summary, the above examples show the ways in which clients use the practice of aggregation in their responsive turns to therapists’ proposals. Clients can do this in two ways: (1) via an aggregation self-repair (as seen in Lerner & Kitzinger, 2007); and (2) via an ‘aggregation shift’. These aggregation shifts involve an unmarked shift in person reference from an individual third-party referent to a collective third-party referent. Why do clients make these shifts? I will show, in the next section, that clients can achieve several important interactional goals by making such shifts in the sequential environment of their responsive turns to proposals.

9.3 Interactional achievements of ‘aggregation shifts’

Aggregation shifts by clients achieve an important interactional goal, similar to that found in Lerner and Kitzinger’s (2007) aggregation repairs. With these shifts, clients broaden responsible authority for the trouble under discussion to a collective of people and thereby diminish their own responsibility.

In aggregating the third party into a collective, clients are able to invoke a particular category of people and, along with it, category-specific attributes. Invoking these categories allows clients to frame their trouble as being due to an attribute of the category of people invoked. The characteristic shared by these third parties is framed as being something which the client themselves cannot do anything about. In fact, within their accounts, clients provide evidence of instances in the past in which they have attempted to change the behaviour of the third party, but could not. By deflecting responsibility for the trouble to a characteristic of non-present third parties, clients are able to
diminish their own responsibility for the trouble. Further, framing the trouble in this way renders the client unable to accept therapists’ proposals. They are thus also able pre-emptively to avoid the possibility of being held responsible for their resistance. This practice is another way in which clients delicately manage their displayed resistance. In this section I will present a more detailed analysis of extended versions of the above Fragments (1)- (4) to demonstrate how clients’ aggregation shifts work to achieve these interactional goals.

Fragment (5) below is an extended version of the above Fragment (1). The proposal in this fragment follows a troubles-telling from the client about some problematic behaviour the client’s youngest daughter has been displaying. The therapist has already offered two proposals for managing the daughter’s behaviour, including visiting the Child and Adolescent Mental Health Service (CAMHS), and using time-out when at home. The client resisted both of these previous proposals. As seen above, in this case, the client aggregates using an aggregation repair (Lerner & Kitzinger, 2007). The aggregation comes at the client’s turn at lines 17-20.

(5)  [CBT 001 school counsellor 31:52]

1 T:  Okay so: um (1.2) from what you've told me about Leah (1.2)
2 u::m (1.7) it sounds like (0.9) she might benefit from (0.5)
3 some kind of (1.2) >opportunity to talk with a counsellor.<
4 (1.0)
5 T:  Umm (0.3) is there a school counsellor ↑at ↑all?  
6 (0.5)
7 C:  .hmmm ↑there ↑i::s but they don't- I- hhh hu:m: (1.7) ↑I think
8 that's just a little bit too close to ho:me.
9 T:  Okay.
10 C:  for her.
11 T:  Yep.
12 (0.4)
13 C:  Ah I don't think she'd be comfortable.
14 (0.2)
15 T:  Mmmh.
C: Um: (1.0) I mean I’ve always let her know that she can say absolutely (0.4) well the last (0.5) time we went to cams I jus’ let them both know you could say absolutely anything (0.7) about anyone.

T: Mmhm

C: ‘n even me:. T: Mmhm.

C: And that’s okay you can say anything you feel. T: Mmhm

C:  But they still didn't really (0.3) open up an' (0.5) T: Were you in the room with them the [whole time?]

C: [I was in ] the room. T: [°Okay°

C: [But that's what they wanted.]

The therapist delivers a proposal in the form of a ‘hedged recommendation’ in lines 1-3 (refer to Chapter 5 for details on the turn design of hedged recommendations). After no response from the client at line 4, she reformulates her proposal as an interrogative. The proposal involves the client taking her daughter to see a school counsellor. After another 0.5 second gap, the client launches a resistive response to the proposal. The client’s account for her resistance involves informing the therapist of new information about her daughter that the therapist could not have known, that is, that a school counsellor would be “too close to home” (line 8) for her daughter. On completion of her incremental turn, the client’s account is receipted by the therapist with a minimal “yep” (line 11). The client then expands on her account at line 13, and is again receipted by the therapist (“mmhm” line 15).

Despite now having achieved rejection of the proposal (across lines 7-13), the client’s accounting does not end here. Although the client has superior access to knowledge of Leah relative to the therapist, she still does not have direct access to Leah’s feelings about talking to a school counsellor
(which is why she uses a personal-perspectival preface (Edwards & Fasulo, 2006) to her resistive explanation involving her daughter’s feelings: ‘I don’t think she’d be comfortable’). Given that she has rejected the therapist’s proposal without the offer of even asking Leah, she is now in a position where she might provide some evidence for her resistive claim.

In her turn at lines 17-20, the client makes two shifts in her resistive account.

17 C: Um: (1.0) I mean I’ve always let her know that she can say
18 absolutely (0.4) well the last (0.5) time we went to cams I jus’
19 let them both know you could say absolutely anything (0.7) about
20 anyone.

First, she shifts to provide evidence that she has encouraged Leah to speak her mind to a ‘counsellor’ type person in the past. She begins her TCU with “I mean I’ve always let her know that she can say absolutely” but then re-starts her turn (at line 18) to provide an actual instance of when and where she had ‘let Leah know’ that she can speak her mind (the last time they went to CAMHS). In doing this re-start, the client is able to display that the specific instance that is to follow is an example of what she ‘always’ does. The client also switches from generalised present tense (“she can say”) to past conditional tense (“you could say”) which also works to produce the client’s account of a particular instance from the past as an example of what generally happens. In providing evidence of her encouragement of Leah to speak her mind, the client is able to avoid any implied claim that she has not put in any effort to help Leah overcome her difficulties around speaking to a counsellor. The client is presented as generally being a supportive and open-minded parent to both of her children.

Secondly, as seen above, the client uses an aggregation repair to shift from talking about the target third person of the proposal, her youngest daughter Leah, to invoking both of her daughters. She continues to use a collective reference in her subsequent turns with the collective “you” at line 25.
(“And that’s okay you can say anything you feel”), and the use of “they” at line 28 (“but they still didn’t really (0.3) open up”) and line 32 (“but that’s what they wanted.”). The therapist even joins the client in using the collective third-person reference “them” in her question at line 29, marking the occurrence of the shift within the interaction.

In making this shift from individual to collective reference, Leah is shifted from being positioned as an individual to being positioned as a member of a category: ‘the client’s children’. This category is not explicitly named by the client but is indexed through the formulation “them both” (Wilkinson & Kitzinger, 2003). The client attributes a common characteristic to the members of this category: a reluctance to speak up in a counselling situation. Indexing this category, together with using generalised present tense, produces the children’s reluctance to speak in counselling environments as a character-implicative repeated pattern of behaviour. The client’s statement that Leah would be uncomfortable talking to a school counsellor is thus not framed as merely a ‘feeling’ the client has about Leah, but as based on her knowledge of a common characteristic of both of her daughters. The client has also shifted Leah into a category in which she herself is not included. The aggregation repair, therefore, allows the client to attribute responsibility for the trouble to an attribute shared by a category of people of which the client is not a member. Responsibility for the trouble is placed on a shared, underlying characteristic of her daughters: that they do not feel comfortable speaking their minds. It is unrelated to the client’s own wishes, desires or behaviour. In fact, the client has made it clear with her evidential account that their ongoing trouble with speaking their minds is not due to any lack of attempt on her part to encourage them. In attributing blame to a character-implicative behaviour of her daughters, the client displays an orientation, and resistance to, the implication in the proposal that she is in any way responsible for the trouble with Leah.

In addition, if responsibility for the trouble has been relegated to a shared attribute of the client’s two daughters, and there is nothing the client can do to change their behaviour, then the client is
rendered unable to accept the therapist’s proposal to send Leah to the school counsellor. Her resistance to the proposal is thus not due to any lack of desire or motivation on her part to accept, rather she is *unable* to accept. The aggregation shift thus also works pre-emptively to manage the client’s resistance to the therapist in an environment where resistance can have extended interactional consequences.

The client’s account has also become even more difficult for the therapist to challenge. The therapist can hardly challenge such an ingrained characteristic shared by the client’s children. Further, as the client has displayed an attempt to change her daughters’ behaviour by encouraging them to speak out, the therapist cannot question the client’s willingness to help her daughter via counselling.

So, through her aggregation repair, the client has been able to (1) index a category with category-bound attributes; (2) place responsibility for the trouble under discussion onto those shared category-bound attributes, thereby diminishing her own responsibility for the trouble; and (3) pre-emptively avoid the possibility of being held responsible for her resistance toward the therapist.

I will now look at the interactional accomplishment of the aggregation shift from Fragment (2) above (reproduced here as Fragment (6)). This fragment follows a troubles-telling from the client about how her mother is refusing a birthday gift idea of being taken out to dinner because it will be too expensive for the family. The proposal from the therapist comes at line 1. The therapist’s and client’s person references are marked in bold.

(6)  [CBT 002 dinner 26:35]
1 T:   Have you thought about talking to your Mum and saying (0.2)
2      y’know “okay mum obviously: (0.3) this idea of a seafood dinner (0.3) is not pleasing you.”
3 (1.0)
4  5 T:     “what is it that you’d actually like for your birthday?”
Across lines 1-5 the therapist makes a proposal to the client in the form of an interrogative (refer to Chapter 5 for details on these interrogative proposals). The proposal involves a possible way in which the client could manage a trouble she is having with a third party, her mother. After a brief gap in the interaction at line 6, the client provides an overt, and loud, rejection of the proposal (“UH NO:”). The client then accounts for her rejection by drawing upon knowledge of a third party whom she knows well, but whom the therapist does not.

The client does not, however, invoke her mother as the reason for her rejection, but, as seen above, she aggregates the individual third-person reference to a collective. Rather than aggregating the person reference through a self-repair as above, or by initiating a correction of the therapist’s turn, the client in this case merely shifts the referent. The therapist, within her proposal turn, has referred to an individual: the client’s “mum”. In her response, however, the client makes reference to “the way they've been brought up and their mentality”. This shift in reference indexes a category without explicitly naming it (Wilkinson & Kitzinger, 2003). The category can be determined from the content of the client’s turn to refer to both of her parents, as the client lives at home with her mother and father. Through this aggregation shift, the client is able to attribute her mother’s reluctance to go out for a meal to a generational difference. Her mother and father would have been brought up separately (within different families) and yet in approximately the same era. In the client’s indexing of the category “they” (both parents), her mother’s reluctance to go to dinner is treated as being a result of how people of her generation more generally were brought up, rather than being due to a personal character flaw.
In shifting the person reference from the individual referent (her mother) to a collective (her mother and father as people raised in a particular way), the client is able to achieve several interactional outcomes. She is able to frame the trouble as being out of her control, and thus remove herself from any responsibility for the trouble. Instead, the trouble is attributed to the attributes of people in her mother’s generation. Further, the aggregation shift allows the client to manage her resistance to the therapist. She is not resisting the therapist’s proposal because of a lack of desire on her part, or even because of a particular character flaw of her mother. Rather, she is resisting the therapist because there is in fact nothing that she can do about the trouble she is facing – her mother’s troublesome behaviour is due to being part of a generation that was brought up in a certain way. An implication which thus flows from this is that the therapist also cannot attempt to challenge the client’s resistance. The client’s vague description of her parents’ “mentality” is also something that the therapist can hardly dispute (and indeed she does not, responding instead with a minimal receipt of the client’s account at line 10 – “um↑hm”).

Thus, again, we can see that through the aggregation shift within the client’s resistive account in this fragment, she has been able to: (1) index a particular category of people; (2) attribute responsibility for her trouble to category-bound attributes of those people thus diminishing her own responsibility for the trouble; and (3) pre-emptively remove the possibility of her being held responsible for resisting the therapist by rendering herself unable to accept the proposal.

The final fragment under consideration is a more extended version of Fragment (4) first considered in the previous section. This fragment appears around five minutes before the above Fragment (5) within the same session. When this fragment appears the client has completed her troubles-telling about her youngest daughter, and the therapist has already proposed that the client take her daughter to the Child and Adolescent Mental Health Service (CAMHS), which was resisted by the client. Again, the client’s shifts in person reference are marked in bold.
In terms of things that you could do at home it sounds like you've really put your finger on it when you've said look she's just decided that any attention is better than no attention.

Well I think that's what it is [coz] it started out you know

whenever we've come back from our friend's place she'd act like this child.

One of the best ways to deal with a problem like that when you've got a child whose mind set of well even [attention is better than]

no attention is to start to put a kind've structure into place where they get plenty of positive attention.

Lots of pats 'n strokes and playing with an' time with people who they care about and when the negative attention behaviours come out they just get ignored.

Um I guess one of the suh- so time out can be used as an effective way of managing that. becuz ya just saying yuh know "look (. . . n- this behaviour can't go on in the public space of the house so: you need to go: to your time out area"

[just' thow do not ] listen yu' know they'll hear it n' they'll get punished for it the moment they're not n- both of th'm no teevee no computer for a week.

Mmhm

BUT THEY'RE STILL bickering and fighting.
the therapist at line 27 to reject the proposal. The client begins her turn with the acute minimizer “just” which functions to narrow the reason for her rejection purely to the forthcoming account. The client then produces an evidentiary account of generalised previous occasions in which she attempted time-out but it did not work. She uses a generalising and iterative present tense (Edwards, 2006) across her turn that suggests that her children’s response to time-out is a character-implicative, repeated pattern of behaviour. She states that her children “do not listen”, “they’ll hear it”, and “they’ll get punished for it” (lines 27-28) suggesting that this is the way her children always respond to time-out.

As in the other fragments, the client aggregates the individual referenced in the therapist’s proposal, Leah, to a collective. As we saw above, in the same way as in Fragment (6), the client here simply shifts the referent in her responsive turn without use of a repair. The sequence thus far has been targeted solely at the client’s youngest daughter, as she is the one presenting problems for the client. Likewise, the therapist refers to Leah using individual references in her proposal. However, in her response to the proposal, the client invokes both of her daughters in the resistive account, stating that “they’ll hear it n’ they’ll get punished for it the moment they’re not n- both of th’m no teevee no computer for a week”. Leah is shifted from being referred to as an individual to being referred to as a member within the category ‘the client’s children’. By aggregating the referent of the proposal to this collective, the client is able to suggest that not only does time-out not work for her youngest (problematic) daughter, but that it doesn’t work for either of her daughters. The combination of the client indexing this category, and using generalised present tense, produces the fact that time-out does not work with her daughters as attributable to an underlying characteristic shared by both of her daughters.

Again, this shift from an individual to a collective reference form works to allow the client to diminish her responsibility for the trouble under discussion. The client’s trouble is framed as due to a
shared characteristic of her children - they do not listen to time-out requests, despite the client’s attempts to get them to do so. With this account, the client is thus able to counter the implication that her own behaviour is deficient in dealing with the troubles. In attributing responsibility to a collective, the client is also able to reduce the likelihood of her account being heard as a ‘blaming’, as attributing responsibility to Leah as an individual might be heard as doing.

The client’s aggregation shift also enables her to manage her resistance to the therapist. The client conveys that she is not resisting because she is uninterested in trying what the therapist is proposing; by contrast, she asserts that she has already tried the exact behavioural management tool. It is, instead, because of the way that both of her daughters respond to time-out that she cannot accept the therapist’s proposal. The therapist responds to the client’s account with minimal acknowledgements ("mmhm” at lines 30 and 33), suggesting potential difficulty in challenging the client’s account.

This example is another illustration of how clients shift to a collective, non-present third-party and, in doing so, index a category with category-bound attributes. Responsibility for the trouble is attributed to this category, diminishing clients’ responsibility. Further, the shift allows clients pre-emptively to manage the delicate nature of their resistance by rendering themselves unable to accept the proposal due to the third party invoked.

**9.4 Chapter summary**

In summary, in instances where therapists’ proposals are aimed at resolving a trouble that clients are reporting with a third party, clients’ resistive accounts often invoke not only the individual third party, but that third party within a collective, as the reason for rejecting the proposal. In one case,
the client shifts with an aggregation repair (Lerner & Kitzinger, 2007) from speaking about her youngest daughter, Leah, to speaking about her two daughters as a collective. In the other fragments analysed, clients made an unmarked shift in person reference from an individual third party to a collective. In these instances the shifts do not involve a repair, as they do not suspend the progressivity of the talk in any way.

Analysis of these fragments has thus illustrated how the clients in this corpus achieved aggregated shifts in person reference without the use of repair. It has also provided evidence for the practice of aggregation occurring outside the domain of self-reference, and also in the domain of non-present third-party references. This analysis thus builds on the work of Lerner and Kitzinger (2007) by showing that the practice of aggregation can be used more broadly in conversation, and in several different ways.

The analysis also lends support to prior findings on the interactional accomplishment of aggregation. In a similar way to the instances of aggregation repair in Lerner and Kitzinger’s (2007) paper, instances of aggregation shifts presented here also do the work of achieving a shift in responsible authority. In Lerner and Kitzinger’s (2007) corpus of relational aggregation repairs, the aggregation was employed to shift responsible authority for a delicate request from the speaker, alone, to a relational collectivity.

Through their aggregation shifts, clients in this corpus index a category with category-bound attributes. These aggregation shifts thus allow clients to attribute responsibility for trouble onto the attributes of the collective invoked. Their use thus diminishes clients’ own responsibility for the trouble. In using this practice, clients display an orientation to the implication in therapists’ proposals that they are responsible for the trouble under discussion, and display significant attempts to resist this implication while simultaneously rejecting the proposed action.
The use of these types of accounts also allows clients to manage the delicate activity of resistance. Clients’ reasons for resisting are not due to a lack of want or desire on their part, nor are they due to the flaws of a single third party. Instead, clients’ resistance is packaged as due to a shared characteristic of a category of people; something that they can hardly change. In passing responsibility for their resistance to these non-present third parties, the clients display an attempt to diminish their responsibility for resisting therapists’ suggestions for behavioural change. They thus also avoid any possible implications that they are being non-compliant with the overall goals of their CBT therapy.

Overall, the previous three analytic chapters have demonstrated that, in drawing upon particular types of ‘resistive accounts’, clients are able to achieve four distinct interactional goals:

- a rejection of therapists’ proposed action;
- an assertion of their epistemic authority over the circumstances of their life, relative to therapists;
- resistance to any implication that the trouble under discussion is caused by a deficiency in their own behaviour;
- management of the dispreferred activity of resisting therapists, as their resistance is presented as due to an inability to accept the proposal rather than as a want or desire to reject it.

There is one further way in which clients’ resistance to therapists’ proposals is managed within these interactions. This technique involves the way that clients transition out of their resistance and into some other type of talk. These transitions out of the proposal-resistance sequence constitute the focus of the next, and final, analytic chapter.
CHAPTER 10

*Getting out: The stepwise exit from proposal-resistance sequences as a resource for managing resistance*

### 10.1 Introduction

In this last analytic chapter, I will demonstrate how clients and therapists work in a step-wise fashion to exit proposal sequences and enter back into troubles-telling. This exit is accomplished without the clients’ resistance being responded to in any direct way. The way in which the exit from proposal-resistance sequences occurs enables both participants to manage the potential interactional consequences of the clients’ resistance. Both parties can move on from the resistance without it having major immediate implications for the interaction.

It has been noted in previous CA research that some types of sequences can be rather difficult to exit from (Jefferson, 1984; Sacks, 1992). These sequences include those that involve an embarrassing or controversial topic, or a troubles-telling. Previous research has found that one way in which participants can exit from these types of sequences is by gradually disengaging from it over a span of talk - what Sacks (1992) and Jefferson (1984) have referred to as a ‘stepwise transition’. The proposal-resistance sequences under consideration here also appear to be a type of sequence in which the participants deploy a stepwise exit. In this corpus, when the participants exit from the proposal sequence, they enter into one of two sequences. One of these involves a stepwise transition into a new troubles-telling. The other involves a stepwise transition back into the client’s original troubles-telling before the proposal sequence had been initiated. With both of these
transitions the participants are able to achieve an important interactional goal. By shifting from accounting for their resistance into troubles-telling, clients place a greater interactional constraint on the therapist to respond to the telling, rather than to the resistance. And indeed this is what the therapists do. The participants are then able to move away from the resistance without it having immediate interactional consequences in the ensuing sequence. Over the next two sections I will analyse these two types of transitions out of resistance in turn. In order to track the stepwise fashion in which the participants exit from the proposal sequences, the fragments presented in this section are necessarily lengthy.

10.2 Stepwise transition into another troubles-telling

The way in which therapist and client move from proposal-resistance sequences into a new troubles-telling is similar in nature to the stepwise transition reported by Jefferson (1984) in movement from talk about a trouble to inappropriately next-positioned matters. Jefferson (1984) showed how participants in mundane interaction transition out of a troubles-telling across five main steps:

1 → the troubles-teller sums up the heart of the trouble.
2 → the troubles-teller turns to matters that, although on-topic with, and part of, the trouble, are ancillary matters.
3 → the troubles-recipient produces talk that topically stabilizes the ancillary matters.
4 → the troubles-recipient produces a pivotal utterance which has independent topical potential.
5 → thereafter, matters that may specifically constitute the target of a series of moves are arrived at (Jefferson, 1984, pp. 202-204).
In the present corpus, the transition out of the proposal sequence and into a new troubles-telling follows six major steps:

1 → the client resists the therapist’s proposal, providing a resistive account over multiple turns.

2 → at a point where the client’s resistive account could be complete and the therapist has the opportunity to respond to the client’s resistance, the client shifts into a telling about an ancillary matter (the pivot turn).

3 → the therapist passes up the opportunity to take a turn at the first possible completion point of the client’s new telling by responding only with a continuer or minimal acknowledgement.

4 → the client expands on the new telling.

5 → the therapist topicalizes the new troubles-telling via an information-soliciting question which prompts further talk from the client on the new topic. The new ancillary troubles-telling is topically stabilized at this point.

6 → the client responds to the therapist and, in doing so, furthers the new troubles-telling.

Participants have now exited from the previous proposal sequence and are now into a new troubles-telling sequence on a new topic.

In achieving this shift into a new troubles-telling, an important interactional project is achieved. When clients make the shift from an account for their resistance into a new telling (at Step 2), it places a greater interactional constraint on the therapist to respond to the telling, rather than to their resistive account. In other words, the shift into a telling makes relevant a response to the telling in the therapist’s next turn, over a response to the resistance. Indeed, therapists in their next turns provide a minimal acknowledgement or a continuer that allows the client to expand further on the new telling. At this point it becomes more difficult for the therapist to steer the conversation back to the client’s resistive turns. Typically, the new telling continues and the client’s resistance is never responded to by the therapist in any way. This stepwise transition into a new troubles-telling
is thus another way in which the delicate nature of the client’s resistance is managed. Both participants are able to move on without the resistance having prolonged sequential consequentiality for the interaction. This may be important for the client, as signs of resistance can be viewed as non-compliance with therapy goals, which can have dramatic consequences for the trajectory of the remainder of the therapy sessions. It may also be beneficial for the therapist to move on from the resistance if it was the case that discussing the issue further could be detrimental to achieving the current therapeutic goals.

Each of these transitional steps into a new troubles-telling will be analysed over two extended fragments to illustrate how participants move out of proposal sequences and into a new troubles-telling. The first fragment, below, begins in the midst of a discussion about the client’s depression scores across the previous week. The therapist is reviewing the activities the client was engaged in when her depression scores were either high, or had dropped significantly. The “it” in lines 1-2 refers to the client’s self-rated score on a depression questionnaire she had completed for homework over the previous week. Within the fragment, the therapist’s proposal is marked with P→ and each of the six transition steps are marked with a number and an arrow.

(1)  [CBT 017 volunteering 27:23]

1 T:  And it stays up=>the only thing I noticed here as well< is that
2 it went down to ten >from sixty to ten< .hhh when you phoned a
3  friend.
4 (1.6)
5 C:  Oh oh what day was that.
6 (0.2)
7 T:  That was I think Friday?
8 (0.2)
9 C:  Oh::: yes I was talking to Kate
10 T:  Mm:
11 C:  Yes that was intresting because she needed my help.
12 (.)
13 T:  O:h okay.
C: Um and u- with a problem that she's got
T: Um[hm ]
C: [tha]t (0.2) u- I had some information (0.2) tha- that (0.4) she needed 'n .hh um (0.9) and it that makes me feel good when I can do things for other people
T: Umhm
C: You know [a-]
T: [O ]kay (0.5)
T: P- .hh that's interesting as well um I don't know if you've thought about volunteer work or:: (0.9) anything like that?= C: 1= Well yes but at the moment my like (. ) physically
T: Umhm
C: I can't do more than I'm doing as far as my work is concerned. (0.6)
C: I- (0.4) last week and this week (0.6) mondays are my only days off.
T: Umhm
C: I'm not working all day every day but I'm working part of every day.
T: Umhm
C: Tuesday Wednesday Thursday Friday (0.5)
T: Umhm
C: And I find that quite exhausting.=I mean apart from age
T: Umhm
C: it's I- (0.7) had trouble in lifting my energy levels since the chemo.=One of the nurses told me (0.6) when I was in there that it was like (0.5) being involved in a huge motor vehicle accident.
T: Umhm.
C: Um and being smashed to bits except it happened on the inside rather than the outside.
T: Umhm.
C: ((coughs))
T: [O]kay.
T: Alright.
C: S[o]
54  C: If it happen- if I got sick a lot you::nger: (0.5) I probably
55    would've recovered more compl[etely.]
56  T:  [Right.]
57  C:  Mm.
58  T:  Okay.
59  C:  An’ I asked my haemotologist when (0.5) I'd be able to do all
60    the things that I used before?
61 (0.6)
62  C:  And he said “wh(h)y wud you want to°
63 (0.6)
64  C:  You work too ha:rd they're long hours an’ (0.3) [you know]
65  T:  [Umhm    ]
66 (0.3)
67  C:  And so (0.2) as you can see oh (0.2) oh no the bruising’s gone
68    now (0.3) tch they took some blood from me jus’ (0.4) [here.]
69  T:  5→           [Okay ]
70 and how often do you go and see them?
71  C:  6→ Jus’ once a year n[ow.]
72  T:  [On ]ce a year?
73  C:  M[m:  ]
74  T:  [↑An’] you’ve been recently have you?
75  C:  Yeah >couple of days ago<.

Analysis of this fragment will follow the six steps that transition the participants from the proposal
sequence into a new troubles-telling sequence.

1 → the client resists the therapist’s proposal, providing a resistive account over multiple turns.

At lines 23-24 the therapist proposes that the client might like to think about doing some volunteer
work. The client rejects this proposal and accounts for her rejection by stating that she is physically
incapable of doing any more activities (“Well yes but at the moment my like (. ) physically...I can’t do
more than I’m doing as far as my work is concerned” lines 25 and 27). This account is expanded over
lines 29-37. Across these accounting turns the therapist passes up the opportunity to respond in any
way other than providing continuer utterances (“umhm”).
at a point where the client’s resistive account could be complete and the therapist has the opportunity to respond to the client’s resistance, the client shifts into a telling about an ancillary matter (the pivot turn)

At lines 39-42 the client continues her expanded account for not being able to take up volunteering work:

\[\begin{align*}
39 & \text{C: I- (0.7) had trouble in lifting my energy levels since the} \\
40 & \text{chemo. = One of the nurses told me (0.6) when I was in there that it was like (0.5) being involved in a huge (0.4)} \\
41 & \text{motor vehicle accident.}
\end{align*}\]

Within this turn she introduces a new reason for her rejection: she has trouble lifting her energy levels since undergoing chemotherapy. This is the first mention of chemotherapy within the client’s account about being physically incapable of taking on more activities. At completion of this TCU the client’s account could be heard as being complete. It is, therefore, a point where the therapist might, in her next turn, respond to the client’s resistance in some way. However, at the possible completion point of her TCU, at line 40, the client produces a rush-through into a new TCU. Within this next TCU the client topicalizes the ancillary matter of chemotherapy mentioned in her prior turn by launching a telling about a previous experience during chemotherapy. This turn from the client represents, in Jefferson’s terms, the ‘pivot’ where an ancillary matter to the proposal sequence is topicalized.

The client’s rushed entrance to topicalize her chemotherapy performs an important interactional goal. In topicalizing a new telling before the therapist has a chance to respond to the prior turn, the client changes the relevant next SPP response. Following the client’s turn, the relevant SPP response has now become a response to the telling (e.g., a go-ahead response for the client to continue the
telling, or acknowledgement or assessment of the telling). Schegloff (1996c) has noted that within an interaction speakers are able to draw upon resources to render a unit of their talk ineffective or, in other words, to deprive it of any sequential consequentiality. One way they can do this is to follow the unit of talk directly with further talk which will supersede the relevance of what preceded, before the recipient has the opportunity to provide a response. Here, the client follows her resistance turns with a topicalization of an ancillary telling before the therapist has had a chance to respond properly to the client’s prior turn (which was part of her account for her resistance). In doing so, a response to the new telling supersedes the relevance of a response to the client’s resistance.

3 → the therapist passes up the opportunity to take a turn at the first possible completion point of the client’s new telling by responding only with a continuer or minimal acknowledgement.

At line 43, the therapist produces a continuer (“umhm”). In doing so, she passes up the opportunity to take a turn at talk other than acknowledging the client’s telling-in-progress. Doing so allows the client to continue the new telling about chemotherapy.

4→ the client expands on the new telling.

Across lines 44-68, the client expands on this telling about her chemotherapy, with the therapist providing continuers and acknowledgements which prompt the client to continue.

5 → the therapist further topicalizes the new telling by asking an information-soliciting question which prompts further talk from the client on the new topic.
At lines 69-70, the therapist then takes a turn which constitutes more than just a continuer or an acknowledgement. She asks the client an information-soliciting question which further topicalizes the talk about chemotherapy (“Okay and how often do you go and see them?”). The question prompts the client to provide more information about the chemo, and the new topic is thus stabilized.

6 → the client responds to therapist by providing further information.

The client responds to the therapist, providing further information about the regularity of her visits to the hospital. Two further adjacency pair question-answer sequences follow, which further stabilize the topic of chemotherapy as the new focus of the interaction. The sequence has now completely shifted from a proposal sequence about volunteering, to a new troubles-telling about the client’s experience with chemotherapy. The client’s resistive account is never responded to, and the client’s resistance is thus left unattended in the immediately ensuing interaction.

A similar transition can be seen in the extended fragment below. It begins at line 1 with the therapist’s topicalization of a visit to a financial advisor that the client was supposed to have made during the previous fortnight. From line 7 the client begins her telling about the visit. Again, the therapist’s proposal is marked with P→ and each of the steps in the transition is marked with a number.

(2) [CBT 002 accommodation 1:40]

1 T: Um SO (. ) there was one really big thing you were doing (0.5)
2 while I was (. )
3 C: Ye[ah.]
4 T: [or ] just after I saw you last time, [how ] did [that] go?
5 C: [Yeah.]
6 (0.2)
C: Uhm (0.2) WELL hhh h it KInd’ve woz (0.5) positive.

T: Um\hm

C: Uhm (0.5) I went to see a financial advi:sor to see how I could get some money [so I] c’n (. ) BUY a courtyard home.

T: [Yep.]

T: Yep.

C: .hhh Uhm hh he's till working on it it's like a difficult case for him.

T: [Sure.]

C: [U:hm ] .tch but he did give me some positives.

T: Okay.

C: Uhm he: he did say he was going to work really hard on it.

T: [Yep. ]

C: [heh heh] .hh

T: An’ so an’ you fe:lt

C: Yeah I felt like he really meant [i::t.]

T: [Yep. ]

T: P→ [Alright] so: (1.7) .hh g↑iven that he: hhh can't let you know until Christmas (0.6) an' then even if it's a yes: (0.2) there’ll still be a kinda bit’ve a gap (0.2) [bet]ween (0.2) now and when you could possibly buy

C: [Yes] a courtyard home [an’ get] into it.

T: [Yes. ]

C: Yes.

(0.2)

T: Is it worth exploring some other al- accommodation options?

(0.4)

C: [Uh:]

T: [So ] that you're not liv\ing at home?

(0.4)

C: l→ We:ll not really becuz (0.7) in the six weeks I'm off I don't get pai:d.

(0.2)

T: Oka:y.

C: It's no- it's not like I have any money com[ing in.]

T: [Okay. ]

(0.2)

C: SO >i- i-< it's not an option.⇒I've already [told] MUM

T: [Yep ]
C: I've already told my Mum not my Dad.

C: I went to my Mum it's no— I've told her exactly the truth what the guy said .huh and she just shook her head an' said oh well there's nothing much we can do about that. SHE'S NOT happy:

T: Mmhm

C: NEITHER am I: but

T: Mmhm

(.

C: this's how it is.

T: So what's she not happy about? The fact that you'll be there for the next six weeks with no money or:

C: Just the fact that I'll be there [hh heh]

T: [Okay.]

C: AHH: it's not hh it's not that my mother doesn't want me there<. m- my mother's really great:

T: Mmhm

C: it's just that she has to put up with all the stuff that my father dishes out becaus I'm there.

T: Right. [Okay]

C: [SO ] she reckons she can hang in there just a little bit longer (like it's not [my active]) so

T: [Okay]

C: Yeah [so °yeah°.]

T: [Okay]

T: UM: SO: so until you start work again in January_

C: UM when I had an interview uhm (0.3) u- u- e- e- the ad-

T: 3- [Um-hm ]

C: all the rest of that um=

T: 5- =How did that go?
Again, analysis of this fragment will follow each of the six steps that make up the transition from the proposal sequence into the new troubles-telling.

1 → client resists therapist’s proposal, providing a resistive account over multiple turns.

Between lines 25-37 the therapist proposes that the client should explore some alternative accommodation options so that she is not living at home where she is experiencing problems with her parents. At line 39, the client launches a rejection of this proposal and subsequently accounts for her rejection (see Section 7.2.1 for a more extended analysis of the client’s resistance). The client’s account for her rejection remains the focus of the conversation until line 80.

2 → at a point where the client’s resistive account could be complete and the therapist has the opportunity to respond to the client’s resistance, the client shifts into a telling about an ancillary matter (the pivot turn).

The client’s account for her resistance comes to possible completion is at line 61 (with the idiomatic expression “this’s how it is”). At this point, the floor is handed over to the therapist to respond in some way. The therapist responds by requesting an elaboration of the client’s account, and the client then continues from lines 66-79. At line 79, it appears as though the client has finished accounting for her resistance for the second time (with the closing nature of the line “yeah so yeah”).
At line 82, the therapist takes a turn: “UM: SO: (1.9) yu- so until you start work again in January”. The projection of where this turn is going is slightly ambiguous. The turn could project towards a check on the most recent part of the client’s account (that the mother thinks she can hang in there a bit longer despite not really being happy about her daughter staying). The turn could also involve a challenging response to the client’s resistance. Alternatively, the turn could project towards a new proposal being offered. Before a possible completion point of the therapist’s turn (it is not grammatically, pragmatically or intonationally complete), the client enters to take another turn at talk. Within this turn, the client selects an ancillary matter from the therapist’s prior turn (starting work) and topicalizes that matter in her turn. Within the therapist’s turn, the client’s work schedule is a relevant, but ancillary, matter to the discussion surrounding the client’s accommodation situation. In the client’s subsequent turn she topicalizes this ancillary matter of her work by announcing that she has just had a performance interview at work. Here we have the client’s pivot turn where a new topic is launched which is ancillary to the prior proposal sequence.

The client’s violative entrance here to topicalize her performance interview again performs an important interactional goal. The client changes the relevance of the next SPP response required from the therapist by topicalizing the new telling before the therapist has properly responded to her just prior account for her resistance. Thus far, both participants have failed to respond directly to the client’s resistance. A response to the client’s new telling has now become more relevant as a SPP response for the therapist in the next turn, rather than any sort of response to the client’s resistance. The client has thus minimized further opportunities for the therapist to respond to the resistance.

3 → therapist passes up opportunity to take a turn at the first possible completion point of the client’s new telling by responding only with a continuer or minimal acknowledgement.
The shift in the type of SPP response now made relevant for the therapist is reflected in her next turn. At the first possible point of completion of the client’s ‘pivot’ turn, the therapist produces a continuers “umhm” (line 86). Although this point does not actually end up constituting the end of the client’s turn, if the client’s turn had been complete, it shows that the therapist was willing to pass up her turn and allow the client to continue a telling on the ancillary matter of having a performance interview at work.

4 → client expands on the new telling.

Across lines 85 and 87, the client continues her turn of informing the therapist about her performance interview.

5 → therapist topicalizes the new troubles-telling via an information-soliciting question which prompts further talk from the client on the new topic.

At line 88, the therapist then asks the client an information-soliciting question which further topicalizes the client’s performance interview (“How did that go?”). The question asks the client to produce a telling about the interview. At this point the new troubles-telling is thus stabilized.

6 → client responds to the therapist and in doing so furthers the new troubles-telling.

The client responds to the therapist’s question at line 89 by launching a telling about her performance interview. At this point the participants have exited from the previous proposal–resistance sequence (which was focussed on accommodation options for the client) and are now well and truly into a new troubles-telling sequence on a new topic. The participants have shifted away from discussions around the client’s resistance to the proposal without the resistance having
immediate consequences for the interaction. This shift may be beneficial for both participants. For the client, it means that their resistance to the proposal has not been challenged at this point in the sequence. For the therapist, it may be beneficial for the interaction to move away from resistive talk and into a more productive sequence of interaction.

10.2.1 Section summary

In summary, analysis of these two extended sequences has illustrated how therapists and clients commonly transitioned out of a proposal sequence and into new troubles-telling sequences. The stepwise transition follows six key steps:

1 → client resists therapist’s proposal, providing a resistive account over multiple turns.

2 → at a point where the client’s resistive account could be complete and the therapist has the opportunity to respond to the client’s resistance, client shifts into a telling about an ancillary matter (the pivot turn)

3 → therapist passes up opportunity to take a turn at the first possible completion point of the client’s new telling by responding only with a continuer or minimal acknowledgement.

4 → client expands on the new telling.

5 → therapist topicalizes the new troubles-telling via an information-soliciting question which prompts further talk from the client on the new topic. The ancillary troubles-telling is thus topically stabilized.

6 → client responds to therapist and in doing so furthers the new troubles-telling. Participants have now exited from the previous proposal sequence and are now into a new troubles-telling sequence on a new topic.
The way in which the participants move out of the proposal sequence and into a new troubles-telling achieves an important interactional goal. Proposal-resistance sequences, like the troubles-telling sequences analysed by Jefferson (1984), are difficult sequences for the participants to exit. On completion of their resistive accounts, clients face the possibility that they will have their resistance challenged, questioned or at least discussed by the therapist. Therapists face the challenge of getting the client back on track for addressing the therapeutic goals of the session, whilst at the same time encouraging them into a more productive ‘frame-of-mind’. In making a stepwise shift into a new troubles-telling by topicalizing an ancillary matter within the prior turns, clients are able pre-emptively to avoid having their resistance responded to. The shift from accounting to troubles-telling places a constraint on the therapist to respond to the telling, rather than responding to the client’s resistance in some way. This constraint, and the therapist’s compliance with it, allows the client to continue with the new telling, and the participants are able to move further away from the proposal-resistance sequence. The clients’ resistance to a proposal for behavioural change is thus left without it having an immediate sequential consequentiality for the interaction.

There was one further way in which the therapists and clients sometimes exited proposal-resistance sequences. Again, the participants followed a stepwise transition out of the proposal sequence, but in these cases the client transitioned back into talk about the same trouble. I will now turn to an analysis of these sequences.

### 10.3 Stepwise transition back to prior troubles-telling

This final section will address one other way in which clients successfully exit proposal sequences after having resisted therapists’ proposals. Rather than transitioning into a new troubles-telling sequence as we saw above, clients sometimes shift back into their prior troubles-telling. To do this
clients draw upon ‘tying’ techniques (Sacks, 1992) which produce the talk as topically disjunct from their immediately prior accounting turns. Talk is, instead, tied to their earlier troubles-telling turns before the proposal sequence was initiated. In doing this, they accomplish some sense of continuity in their telling across the intervening proposal-resistance sequence. By producing their talk as a continuation of their telling in this way, clients are able to initiate a shift out of the proposal-resistance sequence and, again, place a constraint on the therapist to respond to the continued telling in the sequentially relevant next position, rather than the resistance. With the sequence shifted back to the troubles-telling, it would take considerable work from a therapist to respond to, or challenge, the client’s resistance. Thus, tying the talk back to the prior telling before the client’s resistance is responded to, is another way in which the delicate nature of the client’s resistance can be managed successfully, and the participants can move on from an instance of resistance within the interaction.

It has been shown that speakers use tying techniques to link their current turn to the prior turn and to further prior turns within the conversation. For example, whereas participants generally first refer to a person with a locally initial person reference, such as a name or a description (e.g., “my friend”), for the remainder of the conversation they usually use a locally subsequent reference term such as “she” or “he” (Schegloff, 1996b). In doing so, the speaker is tying their turn to the prior turn with the assumption that the co-participant will be able to understand the reference to “she” or “he”. Pronouns or pro-verbs are also prototypical tying terms (e.g., “do”, “it”, “this”, “that”) (Sacks, 1992). Conjunctions (e.g., “and”, “but”) can also be used at the beginning of a turn to tie that turn to the prior turn, as can appositional terms (e.g., “now”, “then”, “so”). These are just some examples of the many tying rules at play within conversation. With the use of tying techniques, conversations are able to progress more efficiently. These techniques can also achieve other interactional goals for the speaker; one example will be examined in detail here.
In the phenomenon under discussion, clients use tying techniques to tie their talk to turns within their prior troubles-telling that occurred before the therapist offered a proposal. These ‘tying’ techniques include:

- drawing upon locally subsequent person references for people who have been referenced within their troubles-telling, despite others having been mentioned using the same subsequent referent form in the intervening proposal sequence;
- producing a disjunct turn from the just prior turns, but using a conjunctive in turn initial position (such as “and”);
- designing the talk in the same manner as has been used in the troubles-telling but not in the intervening proposal-resistance sequence; and
- partially repeating aspects of prior troubles-telling turns.

In drawing upon these resources to make the shift back into troubles-telling, clients achieve a sense of continuity in their troubles-telling across the intervening proposal-resistance sequence. They are also able to accomplish the additional interactional goal of managing their resistance to the therapist’s proposal by shifting back into the telling before the therapist has had the opportunity to respond to the just prior resistive account turn.

I will analyse this phenomenon over the next two extended sequences. The analysis aims both to (1) illustrate another way in which resistance is managed by participants within the proposal-resistance sequences under consideration; and (2) contribute to CA literature on the interactional uses of tying techniques in conversation. I will demonstrate how the transition from the proposal sequence back into the prior troubles-telling sequence occurs over six steps. These steps include:

1 → client resists therapist’s proposal, providing a resistive account over multiple turns.
at a point where client’s resistive account could be complete and therapist has the
opportunity to respond to the client’s resistance, the client produces a transition utterance
which shifts the talk back into the prior troubles-telling.

therapist passes up the opportunity to take a turn at the first possible completion point of
the client’s new telling by responding only with a continuer or minimal acknowledgement.

clients’ subsequent turns expand on troubles-telling and deploy further tying techniques
to link their talk to prior troubles-telling sequence.

therapist topicalizes further troubles-telling by asking an information-soliciting question,
or attempts to re-formulate the client’s trouble, allowing the client the opportunity to
provide further telling.

client responds to therapist and continues troubles-telling.

These steps, and the resources drawn upon by clients in their tying utterances, will be analysed in
the following extended fragment. The fragment begins at the point where the client initiates a
troubles-telling about her youngest daughter, Leah, and the problematic behaviour she has recently
been displaying. The turns representing each of the above six steps are marked with a number and
arrow.

(3)  [CBT 001 CAMHS 21:37]

1 C: [Also] um if we’ve got time I wouldn't mind >sort’ve< (.)
2 talking about my little (0.4) my little one.
3 (0.2)
4 T: Um↑hm.
5 (0.2)
6 C: She's u:m (1.3) just all ↑over the place and I'm gettin’ really
7 quite worried about her=she's um (1.2) STARTED OUT (0.2) SEEING
8 (0.9) ((paper rustling)) not good behaviour from her friends
9 an’ such ((paper rustling)) with which (. ) one of my best
10 friend's (0.2) daughters has got (2.9) ((paper rustling))
11 Asperger's.
T: Leah's the youngest isn't she?
C: [Leah] that's right. And um (0.7) while seeing me (. ) deal with >what I deal with and how I deal with it<.
T: Yep.
C: Completely off the rails kind've thing.=She's sort of learnt to do that and I think she's got herself into the rut where (0.8) to get attention she's doing (0.5) things like this.
T: Umhm
C: And at the moment she doesn't know how to get out of it.
T: Uhm.
C: And she's just if you spoke to her and frantic an' just thumps an' jus'
T: "Yep. Okay."
T: P→ I remember you asking me a couple of weeks ago if there's anywhere like cettad for little kids an' I went an' made a few enquiries.
C: Oh good.
T: Basic form's the only thing there is is is the <child and adolescent mental health service>?
C: [right.]
T: [which] is called ca:ms.
T: An' that's a publicly funded (. ) body that's in Port Adelaide isn't it?
T: Uh: they've got an office in Port Adelaide [yep.]
C: I-'
think Alison was at *cams* when she waz (0.7) having uh
problems.

(0.2)
C: she w’z go- getting bullied at schoo:l.
T: œOkay.
(0.6)
C: So we went to cams for *that*. Uhm: (1.4) I don't think they
really got a lot out of it *though*.
(0.9)
C: I don't know if that was because I was there or if it was
because they just weren't comforatable or: (0.2) they didn't
think (0.3) something was gonna come out of it, I [don't kno::w]
[ Yep. ]
C: 2→ but (0.6) <*I need* to do something> with her, she- .hhh (1.7)
well it's it’s making me sort’ve (0.2) pull my socks up and get
the stop light and stop and think.
T: 3→ Yep.
(.)
C: 4→ U:m (0.6) it started out (0.3) for her benefit. [But ] I know
[Umhm]
C: it's also benefiting me [cos ] I'm doing it as well
[Yep.]
C: [kind of] thing.
T: [Yep ]
(1.5)
C: But she's just absolutely fra:ntic an' (0.3) she hates herself
an (0.9) she thinks she's fat and ugly: an' jus’ worthless an'
(.) an' I know all the attention that she does (1.8) well the
things that she does (0.9) gets not good attention?
T: Uhm
(0.2)
C: An’ that she's *learnt* that well it's just attention?
T: Mmh. [Mmh.]
C: [And ] just keep going with it.—>And [I think] she's got
[yeah ]
C: herself in the rut where she can't< .hhh (1.0) she's been
labelled.
(0.2)
T: Yelp.
C: [this thing and she can't get out of that.
T: Yeah.
The analysis of this fragment will be structured according to the six steps across which the participants move out of the proposal sequence and back into a previous troubles-telling sequence. Analysis will begin at the client’s responsive turn to the therapist’s proposal at line 52. However, analysis of Steps 2 and 4 will require moving backwards to consider turns within the prior troubles-telling sequence.

1 → client resists the therapist’s proposal, providing a resistive account over multiple turns.

Across lines 37-49, the therapist proposes that the client takes her daughter, Leah, to a public psychological counselling service (CAMHS). At line 52 the client launches a resistive account (see Chapter 7) to the therapist’s proposal. The client expands over lines 55-63 to describe a previous occasion on which she took her daughters to CAMHS (see Chapter 9 for an analysis of the aggregation shift that occurs here), and explains that they did not “get a lot out of it” (lines 59-60). Within her resistive account the client first mentions that it was her eldest daughter, Alison, who was taken to CAMHS (line 53), but later includes both of her daughters (via the referent “they” at line 59).

2 → at a point where the client’s resistive account could be complete and the therapist has the opportunity to respond to the client’s resistance, the client produces a transition utterance which shifts the talk back into the prior troubles-telling.
In the above section it was shown how, in transitioning from a proposal sequence to a new troubles-telling, clients produce a ‘pivot’ turn where they shift talk to some ancillary matter. Clients also produce a ‘pivot’ turn in the sequences under consideration in the current section. However, here, rather than pivoting to a new sequence, clients use this turn to shift to the previous troubles-telling sequence. They draw upon several tying techniques to achieve this move. In this fragment, the shift is initiated in the client’s turn at lines 62-68.

62  C: I don't know if that was because I was th↑ere or if it was
63   because they just weren't comf↓ortable or: (0.2) they didn't
64   think (0.3) something was gonna come out of it, I [don't kno::w]
65  T:  [  Yep.      ]
66  C: 2→ but (0.6) <I need to do something> with her, she- .hhh (1.7)
67   well it's it's making me sort've (0.2) pull my socks up and get
68   the stop light and stop and think.

At line 66, the client is in the middle of what becomes a compound TCU (though it is not projected as a compound TCU from the start). So far in the turn she has produced an account as to why she thinks her daughters did not get much out of CAMHS when they were last there (“I don't know if that was because I was th↑ere or if it was because they just weren't comf↓ortable or: (0.2) they didn't think (0.3) something was gonna come out of it, I don't kno::w”). At a point of possible completion after “I don’t know”, she elongates the final word “kno::w” with flat intonation and then produces a “but” before pausing at a point of maximum grammatical control. After this 0.6 second pause, when the client continues her TCU, she makes a shift from accounting for her resistance into troubles-telling. Whilst the “but” has linked this second part of her TCU to the first, there are several aspects of the second part of the client’s turn which make it disjunct from the just prior accounting turns and, instead, tied to her prior troubles-telling turns.
The client uses the locally-subsequent reference form “her” (Schegloff, 1996b) within her turn at line 66. The person referred to in the client’s turn here is her youngest (and currently problematic) daughter, Leah. For this locally subsequent reference term to be used here, there should be a prior locally initial reference to Leah somewhere in the client’s previous turns. However, in tracking the client’s prior talk, it can be seen that her previous reference to “she” was at lines 53 and 56, and there it referred to the client’s eldest daughter Alison (subsequent to the initial reference to “Alison” at line 53). Sequentially then, any locally subsequent person references involving “she” or “her” should, normatively, relate to Alison. A reference back to Leah within the sequence at this point should thus involve a locally initial person reference (Schegloff, 1996b). So, the client has used a locally subsequent reference form in a locally initial position.

Tracking back further, whereas the therapist’s proposal targets Leah as an individual (who has also been the focus of the prior troubles-telling), she only makes a generalised reference to CAMHS being a service for “little kids” (line 38). Going back further in the sequence then, the last reference to “her” and “she” in reference to Leah can be seen to have been within the client’s final troubles-telling turn at lines 31-33. It seems then, that in using this locally subsequent reference form for Leah within her turn at line 66, the client is tying her turn back to a reference she made to Leah in lines 31-33, before the proposal sequence had been initiated by the therapist. By use of a locally-subsequent reference form, the client is able to bring off a sense of continuity in her troubles-telling across the intervening proposal-resistance sequence. The client marks her shift away from accounting for resistance and back into the prior action of telling.

Within the same turn, the client also uses the pro-noun “it’s” (repeated twice at line 67), which refers to ‘Leah’s bad behaviour’ (“But (0.6) <i need> to do something> with her, she- .hhh (1.7) well it’s it’s making me sort’ve (0.2) pull my socks up and get the stop light and stop and think.”) first described in the client’s troubles-telling at lines 31-33. However, in the client’s just prior accounting
turns where she has accounted for her rejection of the proposal to visit CAMHS, “it” has referred to
the therapy treatment the daughters previously received at CAMHS (lines 60 and 64). So, again, the
client has drawn upon a locally subsequent pro-term in a locally initial position. That she does this
provides further evidence that her talk here is being tied back to where her troubles-telling left off,
before the therapist launched the proposal sequence. The use of the locally subsequent reference
forms brings off ‘continuity’ in the client’s troubles-telling across the intervening proposal sequence.

In making this shift into troubles-telling with the second part of her compound TCU (“but (0.6) <I
need to do something> with her, she- .hhh (1.7) well it’s it’s making me sort’ve (0.2) pull my socks up
and get the stop light and stop and think.”), the client is able to achieve an important interactional
project. The shift comes at a point where the client’s resistive account appears to be complete. She
has informed the therapist that her daughters did not gain anything from visiting CAHMS in the past,
and has given a possible account as to why that was the case. So, had the client come to completion
after “I don’t know”, the next position in the sequence would be open for the therapist to respond
to, and perhaps challenge, the client’s resistive account.

By shifting her talk from doing accounting to troubles-telling midway through her turn, the client is
able to remove this opportunity for the therapist to respond to her resistance account. As noted in
the above section, Schegloff (1996c) has identified that speakers can attempt to deprive a unit of
their talk of sequential consequentiality, or in other words, bury that part of their talk so that it
becomes ineffective for the progression of the sequence. One way they can do this is to follow their
talk directly with further talk that supersedes the relevance of what preceded it. This is what occurs
with the client’s turn here. By shifting into troubles-telling midway through her turn, the client does
not provide the therapist with any opportunity to respond to the just prior resistive account. The
client’s shift makes it more relevant for the therapist to respond in her next turn with either a
continuer or a receipt of the telling so far. The turn places a constraint on how the therapist can respond at this point, and this is demonstrated in the therapist’s turn.

3 → therapist passes up opportunity to take a turn at the first possible completion point of the client’s new telling by responding only with a continuer or minimal acknowledgement.

At line 69, the therapist responds with an agreement-implicative acknowledgement token (a minimal “yep” response) (Heritage & Sefi, 1992), a relevant SPP to the telling the client has just provided. There is no gap in the interaction, which could signify confusion, before the therapist responds. It appears, then, that the therapist is also able to tie the client’s “she” and “it” references back to those referred to in the client’s troubles telling, 12 turns earlier. In responding with an agreement-implicative acknowledgement token of the client’s turn, the therapist offers the floor back to the client to expand further.

4 → clients’ subsequent turns expand on troubles-telling and deploy further tying techniques back to prior troubles-telling sequence.

The client subsequently expands on her current line of telling. Within the client’s post-expansion at lines 78-81, evidence that she is tying her talk back to her previous troubles-telling can again be seen. In doing so, she produces a sense of continuity in the telling across the intervening proposal sequence. The client’s turns here involve partial repetition of her previous turns within the troubles-telling. According to Sacks (1992), partial repetition is another way in which a speaker can show that their talk is tied back to some previous talk. Partial repetition of a phrase can help the recipient locate where in the prior talk the current turn has been previously produced. The client’s turn at lines 78-81 involves a partial repetition of her earlier troubles-telling turn at lines 31-33. Within the turn at 78-81 the client builds a list of four descriptive behaviours that her daughter displays: “But
she's just absolutely frantic an’ (0.3) she hates herself an (0.9) she thinks she's fat and ugly: an’ jus’ worthless” (repeated word in bold).

A similar list has appeared in the client’s talk before. In fact, the client’s final turn in her troubles-telling at lines 31-33 before the therapist produces a proposal, also involves a list of behaviours displayed by her daughter: “U:m: (1.2) an’ she’s (2.2) jus’ (1.7) she’s like me just ah::: if you spoke to her and frantic an’ jus’ (0.5) tantrums an’”. The client’s second list begins in the same way as the first (she’s just), similarly involves intra-turn pauses before the next item of the list is delivered, ends with a hanging “an’” despite another list item not being produced, and perhaps most interestingly, involves repetition of the item “frantic”. With the use of partial repetition, the client signals the prior utterance to which her current talk is being tied. Again then, within this turn, the client draws upon tying techniques to link her current talk to the prior troubles-telling and hence accomplishes continuity in the telling across the intervening proposal-resistance sequence.

A similar thing can be seen in the client’s turn at lines 86-89, which is also incrementally expanded at line 92 (bold emphasis added):

86 C: [And] just keep going with it.=>And [I think] she's got
87 T: [yeah ]
88 C: herself in the rut where she can't< .hhh (1.0) she's been
89 labelled.
90 (0.2)
92 C: this thing and she can't get out of that.

This turn boasts several similarities to the client’s previous turn at lines 19-22, and expanded in lines 26-27 (these turns are the client’s second and third last turns of the troubles-telling sequence).
Again, the client uses partial repetition to tie her talk back to turns within the troubles-telling sequence. Across her turn at lines 86-89 and 92, the client partially repeats the sentiment that her daughter has “got herself into a rut”, and that “she doesn’t know how to get out of it”. With this turn the client seems to tie the talk back one step further in the troubles-telling sequence, than she had done with her previous turn at lines 78-81. So, rather than initially tying her talk right back to her turn at line 19, the client first ties her talk back to the last turn of the troubles telling sequence and then proceeds, with her subsequent turns, to tie her talk to the previous two troubles-telling turns before that.

The partial repetition of the client’s earlier turns shows that, at this point in the interaction, she is not adding any new information to her telling. Her turns, instead, appear to be consumed with the work of tying the interaction back to where her troubles-telling had been left when the proposal sequence was initiated. She thus produces the talk as a continuation of the prior telling.

The therapist topicalizes further troubles-telling by asking an information-soliciting question, or attempts to re-formulate the client’s trouble, allowing the client the opportunity to provide further telling.
At line 97, the therapist takes a turn at talk that constitutes something other than a continuer. This turn, rather than drawing the conversation back to the resisted proposal, is made up of an information-soliciting question which topicalizes the renewed troubles-telling (“Is she finding that at school as well?”). This question allows the client the opportunity, in her next turn, to continue the progression of her troubles-telling about her daughter’s behaviour.

6 → client responds to therapist and continues troubles-telling.

The client responds to the therapist’s question at lines 99-100, providing more information about her daughter’s experience at school (“A:H:: n- (0.8) she- she does have trouble (0.4) u:m she's a very quite person?”). The therapist responds to the client’s answer with a continuer, passing up a further turn at talk. The client is handed back the floor and continues the telling about her daughter. The two interlocutors are now well removed from the CAMHS proposal sequence. More importantly, they are also well removed from the client’s resistance to the proposal.

So, across these turns, both participants mutually move on from the client’s resistance without it being topicalized further in the sequentially relevant next position after the client’s account. This transition is thus another way in which the client’s resistance to the therapist can be successfully managed within the interaction. By virtue of the client’s shifting of the talk back to the prior troubles-telling, the participants can move on from the resistance and progress the therapy session along a different line, while still focusing on the same trouble. For the client, the outcome appears to be beneficial - it enables her to manage her resistance delicately within an environment where signs of resistance can have negative consequences for therapy trajectory. For the therapist, it allows another opportunity to respond to the client’s troubles-telling in a possibly more appropriate way. However, if part of the therapist’s goal in the session is to question, or try to manage, resistance
from the client, it would take much more effort on the therapist’s behalf to steer the conversation back to the client’s resistive account.

I will analyse this pattern of transitional steps over one further extended sequence. It begins at the point in the interaction where the client topicalizes a performance interview she recently had at her work – a special education school where the client works as a teaching aid.

(4)  [CBT 002 computer 6:16]

1 C: .hh UM when I had an interview uhm (0.3) u- e- e- the ad- hhhh .hh I had an interview about my performance [at work] an’

2 T:                                  [Um↑hm ]

3 C: all the rest of ___ um=

4 T: =How did _ that go?

5 C: Oh: that w’z pretty stressful actually.=I found it quite stressful becuz .hhhh uh I’m not computer lit’rate?

6 T: Mmhm.

7 C: An’ they require me to learn?=I said “w↑ell that’s fi:ne I’m quite willing to lea:rn”.  

8 T: Umhm

9 (0.3)

10 C: “I need someone ta sit down one to one and ___ show me:”

11 T:                                  [Umhm.]

12 (.)

13 C: I don’t have a comput:er.=I’m not gonna go out and buy one coz (0.2) I expl:ained that I jus’ don’t have the money.

14 T: Umhm=

15 C: to do any of _ that:t.

16 T: Umhm

17 (0.5)

18 C: If they want me to learn a patri- particular progra:m uh:m .tch (0.2) y↑eah I’m willing to stay back an’ [in my] own ti:me.

19 T:                                  [Um↑hm]

20 T: Um↑hm.

21 (0.2)

22 C: Their biggest problem is tryin’ ta teach me.

23 T: Umhm.

24 269
(4 minutes omitted of further troubles—telling about the performance interview. The therapist then offers a gist formulation of C’s problem which C confirms)

T: P→ Thez um (0.6) THERE ARE quːite a number oːf (0.3) ahh: computer literacy skills for: sort’ve (0.5) people in your age group. hhhh that are run by: liːries and local councils and stuff like that.

C: ↑Is th[ːeːre? ]

T: [>so it ] might< yeah

C: ↓Is th[ːeːre? ]

T: .tch um becuːz you know it’s a similar thːing=a lot’ve the older generation of peːople (0.4) don’t have computers in their hːoːme (0.5) <and yet they want to:> find out about (0.4) the internet or typing letters or using email to contact .hhh (0.2) >children or grandchildren< that are interstate . hhhh um: and so the lǐbries actually run a little bank of compuːters.

T: and some libraries will run (.) you know (0.3) ↑how to use a computer for the first time sessions.

C: 1→       [I’m sure not at] our library coz I went to our library an’ .hh (0.2) they give you fifteen minutes to get oːn.

T:      [mmːhm.]

C:  I- somebody was using it an I couldn- (0.4) an I jus’ sat there like a gawk thinkin’ ↑I need somebody to help me:: heh [heh hih] .hhh

T:  [Y↑ep. ]

T:  Well (.)

C: 2→ AND I ACTually think that the teaːcher (0.2) an’ I understand where she’s coming from ↓she’s the deputy headmistress [she]

T:  [Yep]

C:  said um (.) .tch (0.4) oh she NAMED a girl and I said “that giːrl is twenty one years old”.

(0.5)
C: "I AM (.) nearly fifty six".

T: Mmhm.

C: I wasn't even brought up with a calculator.

T: Mmhm.

C: So an' she just looked at me an' she s'd "that's a really poor excuse".

T: Mmhm.

C: An' I looked at her and said "I don't think so: I've never needed a computa in my life".

T: Mmhm.

C: hh And a twenty one year old's got a quicka brain than my brain hh and that's what they're brought up with that's the environment.

T: Mmhm.=

C: =And she said "oh well" then I said "well if she's so good why doesn't she teach me?"

(0.6)

T: [Mmhm ]

C: [I'm I']m quite willing to learn it's jus' the hardest part is finding somebody to actually stay back.

T: Yep.

C: Yeah. Nobody's gonna do that.

T: Okay.

T: SO: u[:m]

C: [ I just left it with her.

T: THAT sounds like it might have been tapping a little bit into you::r (0.2) remember we talked two weeks ago about your< (.).

recognising that when you felt like something was a bit unfair (0.2) you were jumping straight in and going "THAT'S UNFAIR." (0.5)

T: And not le- not letting people >kind’ve< finish what they were saying?

(0.4)

T: So that sounds like that might have been another example [of ]

C: 6- [OH:]
Again, analysis of this fragment will follow the six steps participants take to exit the proposal sequence and re-enter the previous troubles-telling sequence. The steps begin at the client’s responsive turn to the therapist’s proposal at line 51.

1 → client resists therapist’s proposal, providing a resistive account over multiple turns.

The therapist’s proposal, over lines 32-50, comes in the form of information-giving about computing skills courses run by local libraries. The information is delivered as generalised information via categorical references (people) that might apply to anyone who found themselves in the circumstance of the client. Within the therapy environment, this turn from the therapist carries an implication that the client should take up the service being described, as a way of initiating behavioural change that will help solve her trouble. At line 51, the client enters in interjacent overlap (Jefferson, 1986) with the therapist to reject the proposal on the basis that the proposal cannot apply to her as these types of courses are not run at her library (refer to Chapter 7 for an analysis of the way that she accomplishes this rejection). Over multiple turns across lines 52-61, the client then provides an account for her rejection by reporting on a previous experience she has had trying to use the computers at her local library.

2 → at a point where the client’s resistive account could be complete and the therapist has the opportunity to respond to the client’s resistance, the client produces a transition utterance which shifts the talk back into the prior troubles-telling.
At lines 64-65 and 67-68, the client produces a pivotal utterance which is topically disjunct from her prior accounting turns, and is instead tied to a turn in her troubles-telling prior to the proposal sequence:

```
63  T:  Well (.)
64  C:  AND I ACTually think that the teacher (0.2) an’ I understand
65          where she's coming from ;she’s the deputy headmistress [she]
66  T:            [Yep]
67  C:  said um (.) .tch (0.4) oh she NAMED a girl and I said “that
68       gi:rl is twenty one years old”.
```

At the point in the interaction where the client has come to a possible completion of the account for her resistance, and it seems possible that the therapist was about to comment on the client’s resistance (by beginning a turn with “well” - a potential indicator of doing a dispreferred action), the client violates the therapist’s turn and enters loudly with a conjunctive “AND” at the beginning of her turn. In beginning her turn with “and” the client shows that she is building on some prior turn. However, the client follows with “actually” (line 64), which can serve to show that what is coming differs from or contrasts with a prior turn (Heath, 1992). It later becomes apparent that whilst the client is tying her turn to a prior turn, it is not her just prior turn. The client moves to say something that she “thinks” about “the teacher”. The previous proposal sequence has been targeted at computer courses that are offered at local public libraries. The client’s reference to “the teacher” here obviously does not refer to anyone at her library. Rather, the client has reverted to speaking about the teacher/deputy headmistress who conducted her performance interview. The client’s talk is thus topically disjunct from the previous talk about inadequate computer resources at her library. However, her turn began with a conjunction that links the turn to a prior turn (“and”). It becomes obvious through the client’s reference to “the teacher” that she is in fact linking her turn to a prior turn in her troubles-telling, rather than any of her just prior accounting turns. Further to this,
although this is the first reference to “the teacher” as an individual (previous references have referred to “they” at her work), the reference to “the teacher” is not unpacked any further by the client (i.e., she does not say, “the teacher who conducted my performance interview”). Further, “the” teacher is used, rather than “a” teacher, which also serves to suggest that this is a recognitional reference term. By referring to “the teacher” the client implies that the therapist can track back through the prior sequence and understand where the client is picking up her talk.

The other resource that the client uses to tie her current turn to her previous troubles-telling turns is to revert back into using direct reported speech (Holt, 1996). The client has used reported speech throughout her telling of the performance interview to communicate both what she said and what the interviewer said. Here, the client again begins to use reported speech to relay part of the interview: “and I said “that girl is twenty one years old” (lines 67-68). The client’s turn here is thus structured as if it were continuing directly from where the prior troubles-telling turn had left off. The topically disjunct nature of the turn, the reference to “the teacher”, and the reversion to using reported speech all bring off a sense of ‘continuity’ in the client’s telling despite the intervening proposal-resistance sequence.

By entering in violation of the therapist’s turn (at line 63), and at that point making the shift back into her troubles-telling, the client deprives the therapist of the opportunity to respond to her resistive account. The client’s topically disjunct troubles-telling turn makes the relevant next to be a continuer or an acknowledgement of the telling. A response to this turn now supersedes the previous relevance to respond to the client’s resistance.

3 → therapist passes up the opportunity to take a turn at the first possible completion point of client’s new telling by responding only with a continuer or minimal acknowledgement.
At the first possible point of completion after the client’s topically disjunctive turn, the therapist does not take a turn at talk (line 69). The client then takes the opportunity to expand on her telling. At the completion of this second turn, the therapist provides a continuer “mmhm” – a relevant response to a turn in a telling (line 71). With the continuer, the therapist passes up an opportunity to speak and offers the client the opportunity to expand on the telling, and thus move further away from the proposal sequence.

4 → client’s subsequent turns expand on troubles-telling and deploy further tying techniques to prior troubles-telling sequence.

From line 72, the client expands on her telling about the interview. Within these post-expansion turns, we see the client draw upon a similar practice to that of the client in Fragment (3), in that she begins to use partial repetition of some of her previous turns within the troubles-telling. By partially repeating phrases from her previous troubles-telling, the client marks where, in the prior talk, her current turns are being tied to. The partial repetition also allows the client to bring off continuity in her telling across the intervening proposal-resistance sequence. At lines 91-92, the client states:

91 C:  \[I'm I']m quite willing to lea:rn it's jus' the hardest part is finding somebody to actually stay back. \]
92 T:  Yep.

This turn involves a partial repeat of the client’s prior turns at lines 9-10 and 27-28:

9  C:  An’ they require me to learn?\textasciitilde I said "w\textasciitilde ell that's fi:ne I'm quite willing to lea:rn".
10 T:  Umhm
11  (0.3)
12  C:  “I need someone ta sit down one to one and sh\textasciitilde ow m[e:"
13  T:  [Umhm.
14  ((12 lines omitted))
With this partial repeat, the client ties her talk back to the final turns of her troubles-telling which had focussed on her limitations with computers. In tying these later turns back to this part of her troubles-telling, the client not only ties her talk back to a point before the proposal sequence was initiated, but back to where her telling about computer skills, specifically, left off. Again, this allows the client to bring off continuity in her telling about her work’s refusal to help her gain better computing skills, despite the intervening proposal and resistance.

5 → therapist topicalizes further troubles-telling by asking an information-soliciting question, or attempting to re-formulate client’s trouble, allowing the client the opportunity to provide further telling.

At lines 99 and 101-109, the therapist offers a new gist formulation (Antaki, 2008) of the client’s trouble, prefaced by “so”. The gist formulation is based on the client’s prior talk but adds a therapeutic focus. In doing this, the therapist maintains the focus on the client’s troubles-telling about the interview, rather than attempting to shift the conversation back to the resisted proposal of finding computing courses at the local library. This turn from the therapist allows the client, in the next turn, to confirm or disconfirm the new gist formulation of her trouble, and provides the opportunity for further telling to be provided.

6 → client responds to therapist and continues troubles-telling.

In the next turn, the client provides a weak confirmation of the therapist’s gist formulation “OH: I probably was” (lines 110-111). In prefacing her response with “oh”, the client asserts her stronger rights to make the assessment (Heritage, 2002; Heritage & Raymond, 2005). The client expands on
this turn to provide an account for this weak confirmation, which involves her providing more information about the interview. The therapist, at this point reverts back to responding with continuers (“umhm” line 117), and the client is able to expand on the troubles-telling even further. At this point then, the conversation is well and truly back into the troubles-telling sequence, and far from the proposal sequence about computing courses offered at libraries. The client’s resistance has not been responded to, and the client has achieved a sense of continuity in her troubles-telling across the intervening proposal-resistance sequence. The client’s resistance is successfully managed by both participants so as not to have any sequential consequentiality for the immediately ensuing interaction.

10.3.1 Section summary

In this section, through an analysis of two extended sequences, I have demonstrated how clients make a shift from accounting for their resistance to continuing their prior troubles-telling. In making this shift, clients use tying techniques to mark their current turn as tied to their prior troubles-telling turns, rather than to their just-prior accounting turn. In doing so, they accomplish a sense of continuity in their troubles-telling across the intervening proposal-resistance sequence.

The shift from client resistance back into the prior troubles-telling occurs over six main steps:

1 → client resists therapist’s proposal, providing a resistive account over multiple turns.

2 → at a point where the client’s resistive account could be complete and the therapist has the opportunity to respond to the client’s resistance, the client produces a transition utterance which shifts the talk back into the prior troubles-telling.

3 → therapist passes up the opportunity to take a turn at the first possible completion point of client’s new telling by responding only with a continuier or minimal acknowledgement.
client’s subsequent turns expand on troubles-telling and deploy further tying techniques to link their talk to prior troubles-telling sequence.

therapist topicalizes further troubles-telling by asking an information-soliciting question, or attempting to re-formulate the client’s trouble, allowing the client the opportunity to provide further telling.

Client responds to therapist and continues troubles-telling.

This transition achieves an important interactional project. The transition places a constraint on the therapist to respond to the telling, rather than responding to the client’s resistance. The client resists the therapist without the resistance having an immediate sequential consequentiality within the interaction. It would now require more effort from the therapist to veer the conversation back to the client’s resistive account, and, beneficially, it allows the therapist another opportunity to respond to the client’s troubles-telling in a possibly more appropriate way.

10.4 Chapter summary

Proposal-resistance sequences can be difficult to exit for the participants involved. In this corpus, participants attempt to exit the sequence by gradually disengaging, otherwise known as a stepwise exit (Jefferson, 1984; Sacks, 1992). There were two different sequences that clients commonly entered after exiting a proposal-resistance sequence. Sometimes, clients transitioned into a new troubles-telling with a different topical focus to the one before. In other cases, clients transitioned back into a continuation of their prior troubles-telling. Each of these transitions occur over six major steps.
In each case the stepwise transitions out of the proposal sequence involve a ‘pivot’ turn at Step 2 (Jefferson, 1984). In instances where clients transition to a new troubles-telling, the ‘pivot’ turn involves the client topicalizing an ancillary matter from the prior turn to begin the new troubles-telling. Within this turn, clients select a topic that contains an ancillary aspect of the prior turn, but has its own topic potential, and launch a telling on that topic. In instances where clients shift back into their prior troubles-telling, the ‘pivot’ turn is structured to be disjunct from the prior accounting turns, and includes the use of techniques that tie the turn to one of the clients’ turns in their prior telling.

In both cases, therapists in their next turn respond to the telling as this action has superseded the relevance of responding to the clients’ resistance. They usually respond with either a continuer or a minimal acknowledgement of the telling turn (e.g., “mmhm”, “umhm”, “yep”). In doing this, therapists pass clients an opportunity to continue their telling and move further away from the proposal-resistance sequence. In subsequent turns, therapists produce a turn that topicalizes either the ancillary matter in instances of a new telling, or the continued telling in instances of clients continuing their prior telling. Again, this move from therapists allows clients to continue with their telling.

In both types of stepwise transitions out of the proposal-resistance sequence, an important interactional goal is achieved. The clients’ resistance does not get responded to in the sequentially relevant next position after their account. The shift from accounting to troubles-telling places a constraint on therapists to respond to the telling, rather than responding to clients’ resistance in some way. Clients’ resistance is thus managed by removing the possibility of prolonged consequences in the interaction. It becomes much more difficult for therapists to bring the conversation back to the clients’ resistance for discussion. There are rare instances in the corpus where therapists do attempt to do this, and re-issue the same proposal. However, these secondary
proposals are usually also resisted by clients. Moving away from the proposal-resistance sequence in this way may be beneficial to both participants. It enables clients to manage their resistance delicately within an environment where signs of resistance can have negative consequences for therapy trajectory. For therapists, it allows another opportunity to respond to clients’ troubles-telling in a possibly more appropriate way.

In summary, this Chapter has shown how clients gradually disengage themselves from the proposal-resistance sequences into a telling sequence. Clients exit the sequence in a way which allows the participants to progress in the interaction without their resistance having impacted too negatively on the interaction. The implications of these findings, as well as the findings in the six prior analytical chapters, for both therapists of CBT and for CA research, will be discussed in the next, and final, ‘Discussion’ chapter.
CHAPTER 11

Discussion

11.1 Introduction

In this last chapter, I will review the analytical findings from this thesis. The contributions these findings make to the field of conversation analysis (CA) and to Cognitive Behavioural Therapy (CBT) research will also be discussed, and limitations of the study will be addressed. Finally, I will discuss some potential practical implications of this study for CBT teaching and practice. Before doing so, however, I will provide a brief overview of the major findings from each of the analytic chapters.

11.2 Summary of research findings

The first analytic chapter, Chapter 4, examined one, less frequent, way in which the CBT task of behavioural activation was accomplished by therapists within the corpus. The sequences examined were instances where behavioural activation was addressed through a ‘collaborative sequence’ where therapists asked the client to provide a suggestion for behavioural change by posing a number of successive information-soliciting questions. Therapists’ questions were formulated in a way that strongly promoted the provision of information as the preferred response from the client, and clients did respond in this way. When therapists did put forward their own suggestions for behavioural change, they did so in a way that still allowed the ideas to be ‘owned’ by the client. This latter practice was largely achieved by embedding the new suggestions within a gist formulation of the client’s prior talk. In one case, the therapist also made a suggestion for behavioural change via
an anticipatory completion of the client’s turn. Again, making a suggestion in this way achieved a display of collaboration, as it was within the client’s TCU that the suggestion was made. These successive questions and formulations reflected the CBT theoretical practice of ‘Socratic questioning’ when approaching behavioural activation. It engaged the client, and included them in discussions about the potential actions to be implemented.

More frequently, in instances where therapists attempted behavioural activation in this corpus of CBT interaction, they proposed their own suggestion for clients’ behavioural change. Therapists’ proposals were the focus of the analysis in Chapter 5. The lead-up to these proposal turns reflected a similar extended sequence as did the lead-up to the collaborative sequences: an extended troubles telling from the client, formulations of the trouble from the therapist with agreement from the client, as well as information-soliciting questions from the therapist that resulted in further telling from the client. However, the proposal turns themselves caused interactional problems within the sequence. Therapists were making proposals in an environment in which they had subordinate epistemic authority relative to the client on the issue under discussion. Although the therapist is the professional authority, it is the client who has authoritative knowledge of their own experience. Within their proposal turns, therapists displayed an orientation to their subordinate epistemic authority. They did this by drawing on a range of resources that downgraded their epistemic status within the turn, and made the proposals appear tentative and imply a high degree of optionality on the part of the client with respect to accepting the proposal. These resources were drawn upon within three main types of proposal turns:

- hedged recommendations
- interrogatives
- information-giving
Therapists’ hedged recommendations drew upon low modal verbs and auxiliaries, minimizing terms and delaying devices, which made the proposals tentative, and emphasized that acceptance of the proposal was at the discretion of the client. For example: “Might be worth maybe (0.2) tracking down the help line of the ombudsman and just ring[ing up on]”. In using these resources within their recommendations, therapists displayed their subordinate epistemic rights relative to the client in making a proposal for behavioural change.

Therapists’ interrogative proposals were also delivered in a hedged and tentative way, and emphasized high optionality on behalf of the client (e.g., “Is it worth exploring some other accommodation options?”). In some instances they were mitigated to the extent that they carried cross-cutting preferences (Schegloff, 2007a). They were delivered in such a way as to position the therapist as having no access or rights to knowledge over the situation, thus setting up a steep epistemic gradient between therapist and client. Again, the delivery of a proposal in this way displayed the therapist’s subordinate epistemic authority over the client’s life.

In packaging the proposal as information-giving, therapists framed the proposed behavioural change as a generalised solution that could apply to anyone in that circumstance. For example: “There are quite a number of computer literacy skills for: sort’ve people in your age group. That are run by: libraries and local councils and stuff like that”. Therapists thus provided clients with the opportunity to hear the proposal as generally relevant rather than necessarily specifically relevant, thus displaying their downgraded epistemic authority over the clients’ specific situation, relative to the client.

One final practice commonly deployed in therapists’ proposal turns, I have termed ‘hypothetical active voicing’. Therapists achieved hypothetical active voicing within their talk by using future tense reporting verbs, intra-turn pauses, shifts in prosody, and shifts in pronoun use. This practice was
commonly deployed after clients had already displayed resistance to the therapist’s attempts at behavioural change. Its use provided clients with additional help in regard to how they might enact the therapist’s proposal, thus making the proposal appear simple and straightforward. It was thus another way in which therapists displayed an attempt to manage the possibility of resistance to their proposals. Therapists downgraded their ‘hypothetical active voicing’ proposals by inserting a “you know” phrase before launching their hypothetical active voicing. In this context, “you know” phrases worked to generalise the talk being voiced as something anyone might say in that circumstance. Thus, although drawing on this practice involved the therapist essentially telling the client what they should say, by inserting “you know” the proposal was framed as being something that anyone would say in that circumstance, including the client.

In summary, Chapter 5 provided a description of some of the interactional problems associated with making a proposal in an environment where there are complex and delicate asymmetries between the participants. It also described how therapists typically orient to these problems. The consequence of these asymmetries was that the client was always able to resist therapists’ proposals for behavioural change on the grounds that they (the client) had superior knowledge of their own life and experiences. These proposal sequences were in contrast to ‘collaborative’ sequences of behavioural activation, analysed in Chapter 4, where resistance to suggestions for behavioural change was shown to be more difficult for clients to achieve.

In Chapter 6, I moved to an examination of clients’ responses to therapists’ proposals. The focus of this chapter was on how clients drew upon ‘premonitory resistance’ resources that foreshadowed resistance to the therapist’s proposal. One way in which this foreshadowing occurred involved clients withholding a response to a therapist’s proposal at the point at which acceptance or rejection of the proposal was normatively due, marked by an (often lengthy) gap in the interaction. Therapists typically responded to the dispreference-implicative nature of clients’ silences by adding increments
to their proposal turns, effectively converting the gap in talk, with its negative interactional resonances, into an intra-turn pause.

A second way in which clients recurrently displayed premonitory resistance was by initiating repair on the therapist’s proposal turn (e.g., “Wh↓at whether they’re making mista:kes¿”). Several common aspects of the clients’ repair initiators suggested they were being used as premonitory resistance resources. First, clients often withheld a response at the first possible opportunity after the trouble source. Previous CA work into other-initiated repair suggests that if hearing or understanding had been the trouble experienced by clients, they would have initiated repair sooner so that the sequence could progress with least disruption.

Furthermore, clients typically chose repair initiators that displayed a strong sense of the nature of the trouble source in the prior turn (e.g., candidate understandings or understanding checks). These repair initiators generally illustrated that it was not a problem in hearing that clients had experienced, and also displayed considerable understanding of the proposal within the turn. It, therefore, appeared more likely that the trouble was a problem concerning the appropriateness of the proposal.

Finally, the way in which clients delivered their repair initiators conveyed a sceptical stance in relation to the proposal. This was often done through the intonation of the repair initiator. Scepticism was displayed prosodically by an initial lowering in pitch on the first word of the RI, followed by a rise to normal pitch rate and then a high increase in pitch and elongation of the last word of the repair initiation, with a pitch peak on the elongated vowel. Scepticism was also sometimes conveyed in the way the repair initiator was structured (e.g., as a negative interrogative).
In initiating repair, clients delayed the progression of the interaction and provided therapists with an opportunity to modify or withdraw their proposal. Therapists, in their repair turns, oriented to the dispreference-implicative nature of the clients’ OI repairs by framing them in a dispreferred format and also often downgrading their proposal in some way, or providing an account for the proposal.

A third way in which clients displayed premonitory resistance was via a pre-second insert expansion. Rather than initiating repair on a troubling aspect of the prior turn, clients produced a FPP that posts a follow-up question, before producing a SPP response to the proposal. These insert expansions also disrupted the progression of the talk, and together with the structure of the turn (e.g., as a negative interrogative), foreshadowed that resistance may be forthcoming from the client.

Clients’ deployment of these premonitory resistance resources displayed an attempt at managing resistance within an environment in which resistance is particularly problematic. By drawing on these resources, clients were able to make resistance relevant to the interaction, and allow therapists the opportunity to modify their proposal in some way, while avoiding having to display overt resistance in the first instance.

I moved on to analyse clients’ displays of overt resistance to therapists’ proposals for behavioural change in Chapter 7. Clients resisted therapists’ proposals using one of four ‘resistive accounts’. These were:

- an appeal to a restricting contingency within clients’ lives;
- an appeal to a collective third party;
- an appeal to a physical state;
- an assertion of a previous effort to do what the therapist was proposing.
Each of these accounts involved clients drawing upon direct knowledge of their own lives that therapists could not have known. The first type of account, an appeal to a restrictive contingency in clients’ lives, involved clients highlighting some external factor that rendered them unable to accept the therapist’s proposal. For example: “We'll not really becuz (0.7) in the six weeks I’m off I don’t get pai:ed”.

The second type of resistive account involved clients appealing to a third party as the reason why they could not accept therapists’ proposals (e.g., “I know that would be >difficult for ‘er<. I can see the look on her face ‘n the arms folded ‘n her eyes rolling back already.”). This was the most common form of resistive account in the corpus.

The third type of resistive account identified in the corpus involved an appeal by clients to a physical state within themselves (e.g., “I won’t (. ) I’m too ti::red.”). When drawing on this type of account, clients framed the physical state as something that was severe and caused by factors out of their control. They also produced their account as both factual and ‘sincere’.

The final type of resistive account drawn upon by clients involved an assertion that they had already attempted the actions or activities being proposed by the therapist. These accounts were sometimes produced as vague and minimal assertions (e.g., “I thought of that already.”). In other instances, however, they were produced as extensive and detailed accounts of a previous instance in which clients had attempted to do what the therapist was proposing, to no avail.

The focus of Chapter 8 involved clients’ assertions of epistemic authority. Within each of type of resistive account, there were several aspects of turn design that displayed an assertion of clients’ epistemic authority over the situation under discussion. These included:
• The use of generalised declarative tense and high modality verbs or adjuncts

• The design of their responses to interrogative proposals

• The use of direct reported speech

In using generalised declarative tense and/or high modal verbs and adjuncts, clients produced their resistive accounts as declaratives. In framing them in this way, they displayed their higher epistemic status in relation to the matter, relative to the therapist. For example: “I’m sure not at our library coz I went to our library an’ hh (0.2) they give you fifteen minutes to get on”. The declarative design of their turns was particularly noticeable given the tentative and hedged manner in which therapists had designed their proposal turns.

In responding to interrogative proposals, clients displayed their epistemic authority with several different response designs. The first involved using a non-conforming repetitional confirmation of the therapist’s question (instead of a type-conforming “yes” response) before moving on to resist the proposal. For example, “.hhhh th↑ere ↑i::s but they don’t- l- hhh hu:m: (1.7) ↓I think that’s just a little bit too close to ho:me”. This [confirmation + resistance] design departs from the constraints set by the interrogative design of the proposal and thus displayed an assertion, by clients, of their agency and epistemic rights in relation to the therapist’s question.

The second response type worked in a similar way. Clients sometimes produced non-conforming sentential responses which negated therapists’ proposals. These responses departed completely from the constraints of the interrogative design by not responding to that aspect of the turn at all (e.g., “well she needs somethink”). Finally, in other instances, clients responded with type-conforming dispreferred responses that were delivered with little or no delay, and did not involve any mitigating devices typical of a dispreferred response (e.g., a straight “no” response). These
responses displayed an assertion by clients of their right to reject the proposal, and thus also displayed their epistemic authority over the issue at hand.

Clients also used direct-reported speech in their resistive accounts. This resource was commonly drawn on when therapists had used hypothetical active-voicing within their proposal turns. In using reported speech clients provided evidence for their accounts, whilst also highlighting their primary access to knowledge of the situation. Further, in instances where therapists used hypothetical active-voicing in their proposals, a contrast was built between the hypothetical nature of therapists’ proposals and the reality of the client’s reporting within their resistive account.

A final interactional accomplishment of clients’ resistive accounts involved attenuation of clients’ individual responsibility for the trouble under discussion by attributing responsibility, instead, to a third party. This practice was the focus of Chapter 9. Clients achieved attenuation of responsibility via ‘aggregation shifts’. These shifts involved clients shifting the focal referent of the talk (a non-present third party) from an individual to a member of a collective/category of people. The aggregation shifts allowed clients to attribute responsibility for the trouble to the characteristics of the collective of people invoked. In drawing on this practice, clients thus displayed resistance to any implication that their own behaviour might have been deficient and in some way contributing to the trouble under discussion.

The use of aggregation shifts also allowed clients to manage the delicate activity of resistance. Clients’ reasons for resisting were presented as not being due to a lack of want or desire on their part, nor were they due to the flaws of a single third party. Instead clients’ resistance was packaged as being due to a shared characteristic of a category of people; something that they could hardly be expected to change. In passing responsibility for their resistance to non-present third parties, clients themselves were able to avoid responsibility for resisting therapists’ suggestions for behavioural
change. They thus also avoided the implication that they were being non-compliant with the overall goals of the CBT therapy.

In sum, a detailed examination, over Chapters 7-9, of the way clients designed their resistive responses to therapists’ proposals, shows that they were able to achieve four distinct actions:

- a rejection of therapists’ proposed actions;
- an assertion of their epistemic authority over the circumstances of their life, relative to therapists;
- resistance to any implication that the trouble under discussion was caused by a deficiency in their own behaviour;
- management of the dispreferred activity of resisting therapists, as their resistance was due to an inability to accept the proposal rather than a want or desire to reject it.

The final analytic chapter of this thesis, Chapter 10, examined the way that clients commonly exited from proposal-resistance sequences: by gradually disengaging, otherwise known as a stepwise exit (Jefferson, 1984; Sacks, 1992). There were two different sequences that clients commonly entered into after exiting the proposal-resistance sequence. Sometimes they transitioned into a new troubles-telling with a different topical focus to the one before. In other cases, clients transitioned back into a continuation of their prior troubles-telling. Clients’ transition into a new troubles-telling sequence followed these six key steps:

1 → client resisted therapist’s proposal, providing a resistive account over multiple turns.

2 → at a point where client’s resistive account could be complete and therapist had the opportunity to respond to the resistance, client shifted into a telling about an ancillary matter (the pivot turn).
3 → therapist passed up the opportunity to take a turn at the first possible completion point of client’s new telling by responding only with a continuer or minimal acknowledgement.

4 → client expanded on the new telling.

5 → therapist topicalized the new troubles-telling via an information-soliciting question that prompted further talk from client on the new topic. The ancillary troubles-telling was thus topically stabilized.

6 → client responded to therapist and in doing so, furthered the new troubles-telling. Participants had now exited from the previous proposal sequence and were into a new troubles-telling sequence on a new topic.

In a similar way, clients’ shifts from resistance back into their prior troubles-telling occurred over the following six main steps:

1 → client resisted therapist’s proposal, providing a resistive account over multiple turns.

2 → at a point where client’s resistive account could be complete and therapist had the opportunity to respond to the resistance, client produced a transition utterance which shifted the talk back into the prior troubles-telling.

3 → therapist passed up the opportunity to take a turn at the first possible completion point of client’s new telling by responding only with a continuer or minimal acknowledgement.

4 → client’s subsequent turns expanded on the troubles-telling and deployed further tying techniques to link their talk to prior troubles-telling sequence.

5 → therapist topicalized further troubles-telling by asking an information-soliciting question, or attempting to re-formulate client’s trouble, allowing the client the opportunity to provide further telling.

6 → client responded to therapist and continued troubles-telling.
In each case, the stepwise transitions out of the proposal sequence involved a ‘pivot’ turn at Step 2 (Jefferson, 1984). In instances where clients transitioned to a new troubles-telling, the ‘pivot’ turn involved them topicalizing an ancillary matter from the prior turn to begin the new troubles-telling. Within this turn, clients selected a topic that was an ancillary aspect of the prior turn but had its own topic potential, and launched a telling on that topic. In instances where clients shifted back into their prior troubles-telling, the ‘pivot’ turn was structured to be disjunct from the prior accounting turns, and included the use of tying techniques which tied the turn back to one of the turns in their prior telling.

In both cases, therapists responded to the telling in their next turn, as this action had superseded the relevance of responding to clients’ resistance. They usually responded with either a continuer or a minimal acknowledgement of the telling turn (e.g., “mmhm”, “yep”). In doing so, therapists passed clients an opportunity to continue their telling and move further away from the proposal-resistance sequence. In subsequent turns, therapists produced a turn which topicalized either the ancillary matter in instances of a new telling, or the continued telling in instances of clients continuing their prior telling. Again, this move from therapists allowed clients to continue with their telling.

In both types of stepwise transitions out of the proposal-resistance sequence, therapists and clients were able to achieve an important interactional goal. The likelihood of therapists challenging clients’ resistance in the sequentially-relevant next position after their account was minimized. The shift from accounting to troubles-telling placed a greater interactional constraint on therapists to respond to the telling, rather than responding to clients’ resistance in some way. Clients’ resistance was thus managed, as there was less risk that their resistance would have prolonged consequences for the interaction. In effect, it became much more difficult for therapists to bring the conversation back to clients’ resistance for discussion. There were rare instances in the corpus where a therapist did
attempt to do this and re-issue the same proposal, however any such secondary proposals were also resisted by clients.

In sum, the analysis presented in this thesis has shown, over the course of seven analytic chapters, how CBT therapists in the corpus attempted to accomplish the key practice of behavioural activation, and the interactional consequences of this practice in terms of clients’ typical responses. In particular, the analysis has shown that when therapists approached the practice of behavioural activation by proposing their own suggestions for behavioural change - in what might be referred to as a non-collaborative manner - widespread client resistance ensued. This pattern was noted, even though in each instance, therapists displayed subordinate epistemic authority within their turn design. In contrast, when therapists approached behavioural activation via questioning and the use of collaborative turn designs, such as gist formulations and collaborative completions, the sequence typically appeared to run off without a hitch.

The analysis also demonstrated patterns in the way that clients typically designed resistance to therapists’ proposals for behavioural change. Clients commonly drew first upon premonitory resistance resources (withholding a response or initiating repair), before producing one of four types of ‘resistive accounts’. It was shown that clients’ resistance turns were not only designed to reject therapists’ proposals but also to display resistance to more subtle implications carried within the proposals, and to display the their epistemic authority over the matter at hand, relative to the therapist.

Finally, the analysis showed how therapists and clients managed clients’ resistance to therapists’ proposals for behavioural activation in the way that they exited the proposal-resistance sequence. By transitioning into a troubles-telling before therapists had properly responded to their resistance, clients’ resistance was left without immediate sequential consequentiality in the interaction.
These findings contribute to CA research in several ways. I will consider these implications in the next section.

### 11.3 Contributions to the field of Conversation Analysis

In this section I will describe both the general and specific contributions this study makes to CA research. First, the analysis presented here contributes to the limited CA research into the nature of CBT interactions. As described in Chapter 1, only three previous CA studies have analysed CBT data (Antaki, 2007; Antaki et al., 2004, 2005a) and, of those, only one (a case study) focussed solely on CBT data. This study is also the first CA research to examine the practice of behavioural activation, a key technique in the CBT therapist’s armoury. In describing the interactive production of this CBT technique, and the local consequences that different styles of approaching it can have, the current project contributes to development of a systematic ‘fingerprint’ (Drew & Heritage, 1992) of CBT interactions. The study also adds to the CA literature on client resistance in therapy. Previous studies have analysed the way clients can resist therapists’ formulations and questions, however, no other studies have examined client resistance to therapists’ proposals for behavioural change. This study highlights other actions that clients can accomplish through their resistance turns, namely asserting epistemic authority and attributing responsibility. The current research thus contributes to the CA psychotherapy literature in multiple ways.

There also some other, more specific, contributions to CA from this research project. These include contributions to the following areas of research inquiry: active voicing, other-initiated repair, negotiation of epistemics, and the practice of aggregation. I will consider each of these contributions in turn.
In this thesis, I have described a practice that I have termed ‘hypothetical active voicing’. In using ‘hypothetical active voicing’, therapists adopt the speaking position of another in a similar way as has been identified when speakers use direct reported speech (e.g., see Holt, 1996; Holt & Clift, 2007; Wooffitt, 1992). However, in the pattern identified here, therapists used active voicing to present some hypothetical talk that the client should use in a future situation when undertaking the proposed behavioural change. I analysed the common resources that therapists drew upon to achieve ‘hypothetical active voicing’, as well as the broader interactional accomplishments of this practice (see Chapter 5 and Section 11.2 above). Analysis of the practice of hypothetical active voicing adds to the CA literature into the reporting, or voicing, of another speaker’s speech.

A second contribution to CA research is within the area of other-initiated repair. The description of patterns in the way clients initiated repair following therapists’ proposals makes a contribution to the CA literature on other-initiated repair in two ways. Little attention has been paid to the use of ‘strong’ repair initiators in previous CA research. The examples in this corpus demonstrate how ‘strong’ repair initiators, such as candidate understandings and understanding checks, can be drawn upon in the first repair position. Clients’ deployment of strong repair operations as their first attempt at initiating repair is contrary to the preference in conversation identified by Svennevig (2008), for the least serious construal of problems in first repair initiations. Clients’ deployment of these types of RIs in first position in the sequences under consideration here appears to achieve an important interactional goal. Drawing upon such strong repair operations in the first instance can be seen to work as a display of premonitory resistance. Arguably, clients did the additional work of using a strong repair so as not to risk their repair initiations being heard merely as troubles of hearing or understanding.
This point leads to a second contribution that the present analysis makes to CA research into other-initiated repair – how OIR can be used to achieve the interactional goal of displaying a subtle resistive stance. Although previous CA studies have noted that other-initiated repair can be used as a pre-disagreement, there has been very little systematic analysis of how this gets done. Additionally, the work that has been undertaken on this use of OIRs has focussed on the use of open-class repair initiators (e.g., “huh?”, “pardon?”). Analysis of the clients’ use of OIR in this corpus provided a systematic demonstration of how strong repair operators could be used to accomplish a display of a pre-resistive stance. Clients achieved this stance by initially withholding repair at the first possible point, then deploying RIs that displayed having heard and understood (at least partially) the prior turn, and they also typically delivered the repair initiation with sceptical intonation or turn design. It can be speculated that the way in which these repair initiators are used to display premonitory resistance may hold across other data sources both in mundane and institutional talk. This suggestion is in need of further empirical analysis. The analysis of a client’s use of a pre-second insert expansion in response to a therapist’s proposal, also demonstrated how these types of sequences also delay the progressivity of the talk, and may also be used to display premonitory resistance. This finding adds to CA literature on the types of interactional goals that can be achieved by pre-second insert expansions.

The current analysis also builds on the developing body of CA work into the negotiation of epistemics in interaction. It shows how epistemic authority is oriented to within a new sequential environment – that of proposal-resistance sequences. The analysis showed how therapists displayed their downgraded epistemic status within another first-position environment – that of making a proposal. It was demonstrated that therapists displayed their subordinate epistemic status by drawing upon the following resources within their proposal turns: low modality operators and hedging devices, interrogative forms, vague impersonal references, and by packaging their proposals as more innocuous activities such as information-giving. Analysis also illustrated some new ways in
which epistemic authority can be asserted in second-position responses, including through the use of high modal verbs and adjuncts, primary generalised tense, full sentential responses that negate interrogatives, type-conforming dispreferred responses to interrogatives, and the use of direct reported speech.

Finally, the analysis of clients’ ‘aggregation shifts’ also makes a contribution to the limited CA research into aggregation practices, building on previous work by Lerner and Kitzinger (2007). The analysis illustrated: (1) how aggregated shifts in person reference can be achieved without the use of repair; and (2) how the practice of aggregation can occur in the domain of non-present third party references. The analysis also lends support to prior findings on the interactional accomplishments of aggregation. In a similar way to the instances of aggregation repair in Lerner and Kitzinger’s (2007) paper, the instances of aggregation shifts analysed in this study also do the work of achieving a shift in responsible authority.

This research has thus contributed to basic CA findings, to institutional CA findings, and more particularly, to CA findings in relation to psychotherapeutic interactions.

11.4 Contributions to CBT research

I outlined in Chapter 1 how the majority of previous research into CBT for depression has been based on outcome studies measuring overall effectiveness. CBT is, however, a thoroughly interactive endeavour - everything that happens within the therapy session is an event interactively and collaboratively created by the therapist and client. Conversation analysis can help to reconstruct the means and practices by which therapist and client co-create the events within the therapy session. This study makes a contribution to CBT research by analysing in detail how one key practice used
within a CBT session, proposing suggestions for behavioural change (‘behavioural activation’ in CBT theory), can lead to localised client resistance. In describing different styles of participation by therapists in behavioural activation, this analysis has shown how features of clients’ and therapists’ therapeutic talk-in-interaction can be more or less helpful to the interaction.

Findings from this thesis suggest that the way that behavioural activation techniques are interactionally accomplished can have important implications for the therapy session. Although I would not suggest that proposing a change to a client would always lead to resistance, it does appear that proposals for behavioural change can often lead to client resistance. This resistance appears to be related to the issue that therapists are proposing behavioural change in an environment of epistemic asymmetry. They can never be the authority over the client’s life experiences. The findings suggest that a more collaborative approach via questioning (Socratic questioning, to use the CBT terminology) may not lead to such pervasive resistance. These findings thus support the CBT theory literature, which encourages the building of therapeutic relationships guided by ‘collaborative empiricism’ where therapists engage clients in a highly collaborative process in which there is a shared responsibility for setting goals and agendas, giving and receiving feedback, and putting CBT methods into action both inside and outside the therapy session (Wright et al., 2006). CBT theory suggests that behavioural activation, in particular, should be addressed with Socratic questioning and, whenever possible, that therapists should ask clients to make a choice about the types of changes they might implement in their lives. The findings from this thesis lend support to these aspects of CBT theory. They also extend these ideas by providing evidence that alternative ways of addressing behavioural activation can have detrimental consequences for the therapy goals.

More specifically, the findings also provide support for following the institutional goal that the Centre for the Treatment of Anxiety and Depression (CTAD) promote on their ‘Patient Information’
pamphlets: “We work in a collaborative way with you, as opposed to simply telling you what you should and shouldn’t be doing”. Again, it appears that approaching behavioural activation tasks in an interactionally collaborative manner (as seen in Chapter 4), leads to a smoother progression of the CBT interaction.

Demonstrated patterns in the way clients resist therapists’ proposals for behavioural change also contribute to the field of CBT research. These findings show that when clients resist, they are not only concerned with rejecting the proposed change, but also with resisting other implications that are carried within these types of proposals. The present analysis has shown that clients display resistance to the implication that therapists have authority over their life experiences, and also to the implication that they may, themselves, be responsible for the trouble(s) they are presenting in the therapy session. These findings suggest that therapists might benefit from orienting to the subtle implications carried within proposals for behavioural change, as clients appear to be sensitive to such issues in the way that they frame their sequential turns.

The findings concerning clients’ resistance to the implication that they carry some responsibility for the troubles they are describing may also contribute to theoretical understandings of clients with depression in CBT. CBT theory suggests that clients with depression have a tendency to make attributions to life events that are biased in an internal direction (Wright et al., 2006). In other words, clients with depression are suggested, commonly, to take excessive blame for negative events. Although it is beyond the scope of this thesis to comment extensively on CBT theory, the findings based on close study of clients’ talk-in-interaction suggest that clients often appear to resist subtle therapeutic implications that they carry some responsibility for changing their own behaviour in relation to their troubles. As seen in Chapters 7 and 9, when engaged in the action of resisting a proposal for behavioural change, clients recurrently produced the trouble under discussion as being the responsibility of others, not themselves. This finding suggests that clients with depression may
attribute responsibility in different ways depending on the social action being worked up at any point in the interaction. Clients’ displayed attributions of responsibility for events within therapy interactions are thus something that appears to need further detailed examination in future studies.

The findings from this thesis also have implications for CBT practice and training. The application of the research findings to CBT practice, and their broader implications, will be described in the next section.

### 11.5 Practical implications for CBT training and practice

Providing practitioners, whether they are professionals or students, with the opportunity to listen to their actual interactions with clients, gain feedback and reflect on performance has been found to be very valuable (Kitzinger, forthcoming). For example, Kitzinger has found that presenting feedback from her CA research to call-takers at a birth crisis helpline has provided alternative ways for call-takers to handle interactional troubles more effectively.

According to Kitzinger (forthcoming), one of the most significant ways in which CA research can inform training is via collaborative group workshops for practitioners. Within these workshops, pre-analysed data fragments can be used to shed light on methods of practice. In the case of the present research, proposal-resistance sequences, as well as collaborative behavioural activation sequences, could be used to make practical recommendations regarding the ways in which therapists approach the key practice of behavioural activation. Data recordings can be played to therapists/students and paused at particular points in the interaction. Therapists/students can then be asked to discuss in pairs or small groups what they might say next if they were a participant in the interaction. For example, a data fragment can be paused at the point where a client has just finished their troubles-
telling, and the therapist is due to respond. Participants would then discuss how they might respond to the client at that point.

Participants’ responses can later be discussed as a whole class/group and feedback provided on the various response alternatives. Finally, these responses can be compared with how the therapist in the recording actually responded, and the consequences of this for the interaction can be addressed. For example, if the therapist in the recording responded with a proposal for behavioural change on the part of the client, this can be discussed in regard to the alternatives available to them, and how the proposal was responded to by the client. It is, of course, how the client responded to the therapist that is most important in discussing the interactional consequences of the therapist’s prior turn. Having an extended recording of an actual interaction allows the participating therapists/trainees to see the extended consequences of a therapist’s turn at talk for the interaction. Further data extracts can then be played and paused for discussion. Finally, participants may be given transcripts of the data they have listened to, for their future reference. This type of workshop provides more realistic exercises than those using fabricated role-play scenarios, as has been the custom in therapy training. Such teaching exercises could also be formatted into software training manuals for more widespread use.

11.6 Limitations of the current study

Within any research project, it is important to note possible limitations to the research findings. There are two main limitations to the research carried out for this thesis. The first relates to the size of the data corpus, and the second concerns the fact that video data were not collected.
A corpus of 20 CBT sessions made up the data for this thesis. Although the 20 sessions constituted ample data to analyse within the time-frame of a PhD, a larger collection of ‘therapist proposals’ would have allowed me to provide further evidence for my analytic claims. Given the delicate nature of therapeutic interactions, some therapists at CTAD were unwilling to record their sessions. However, as mentioned in Chapter 2, the total duration of all sessions used as data for this thesis was approximately 1,006 minutes (16 hours, 46 mins), which amounted to a substantial corpus of therapeutic talk.

The second limitation relates to the fact that audio recordings were collected for this research. Although it is the case that much of the therapeutic interaction is accomplished through conversational practices, therapy interaction is also mediated by nonverbal signs such as body gestures, postures, and gaze. For the purposes of the present research, however, I was only granted permission to undertake audio recordings of CBT sessions at CTAD. The investigation of the contribution of nonverbal communications awaits further analysis. Given the difficulties I experienced in attempting to persuade therapists to agree to make audio recordings of their sessions, collecting video data seemed an impossible feat given the time limit necessary for this project. However, in future research, the collection of video data, wherever possible, would be an important adjunct to analysis of audio records of interaction.

11.7 Conclusion

This thesis set out to analyse how a specific, theoretically important, CBT practice was accomplished within a corpus of CBT sessions involving clients diagnosed with depression. The practice that was the focus for analysis was behavioural activation. When approached by therapists in a collaborative manner with information-soliciting questions that asked clients for suggestions for change,
behavioural activation sequences were observed to progress smoothly, with little or no disruption. However, when therapists made their own proposals for clients’ behavioural change, they were regularly faced with resistance. This resistance appeared to be related to an imbalance in epistemic authority over the matter under discussion. Clients oriented to issues that therapists could not know about their life experiences and, in this sense, proposing behavioural change became a difficult, delicate activity.

Clients’ resistance also seemed to be related to the implication carried in some forms of therapists’ proposals that the clients themselves carried some responsibility for the trouble under discussion. Clients systematically oriented to these issues within their resistance turns. Such turns were not only concerned with rejecting therapists’ proposals, but also with asserting clients’ authority over their own experiences, and with resisting the implication that they were in any way responsible for the trouble. Clients also structured their turns in ways that managed their resistance to therapists’ proposals without it having immediate interactional consequences. Because of this, it is possible that clients’ localised resistance to these proposals often goes un-noticed, or is regarded as unimportant, by therapists in later debriefing sessions.

Despite being based on a relatively small corpus of sessions, and being restricted to audio data, this research has contributed to expanding knowledge in the field of CA research, as well as in relation to CBT theory and practice. This thesis constitutes the first CA study to examine the practice of behavioural activation and, in doing so, makes a significant contribution to the development of a systematic ‘fingerprint’ of naturally-occurring CBT interactions. The thesis also contributes to some more specific CA findings in regard to the following areas of talk-in-interaction: active voicing, other-initiated repair, negotiating epistemics, and the practice of aggregation.
In regards to CBT theory, the thesis lends support to the notion that behavioural activation techniques are best approached in a collaborative manner through the use of information-soliciting questions that coax suggestions for change from the client. The research also contributes to this aspect of CBT theory by providing evidence that an alternative approach, involving therapists proposing changes to clients, can have detrimental consequences for the therapy goal. The findings regarding the way clients typically resisted proposals for behavioural change also make two important contributions to CBT theory. They suggest that clients systematically orient to issues surrounding the negotiation of epistemics within the therapy environment. They also suggest that clients orient to implications by therapists that they carry some responsibility for the troubles they have been discussing. This finding may have extended implications for the theoretical view that clients with depression typically make internal attributions of responsibility for negative events. This is an issue that requires further empirical investigation.

The research findings can be applied to CBT training and practice involving both professional and student therapists. One way that this can be done, and which has been found to be successful in other institutional environments (Kitzinger, forthcoming), is through collaborative group workshops where therapists are given the opportunity to listen to, discuss, and receive feedback on, extracts of actual CBT interaction.

There is, of course, room for further CA research into CBT interactions. This project has focussed on one key CBT technique that is consistently used within therapy sessions. Future research could profitably focus on therapists’ and clients’ joint production of activities such as agenda setting, cognitive restructuring, negotiation of homework tasks, and troubles-tellings, among other aspects of the CBT session. There are also other aspects of the practice of behavioural activation that require further analysis that were beyond the scope of the current project. CBT therapy sessions are complex, jointly-produced interactions between clients and therapists.
This thesis has examined the interactional production of a key CBT technique, behavioural activation. The analysis has demonstrated that the way in which this technique is accomplished can have variable consequences for the CBT interaction. In particular, when therapists propose their own suggestions for behavioural change it typically leads to resistance from clients in the immediately ensuing interaction. These findings constitute new and important contributions to the field of conversation analysis and to CBT research and practice.
NOTES

1 A ‘collaborative completion’ involves a turn-at-talk by one speaker which, rather than constituting a new turn, is designed to be a continuation of the prior speaker’s current turn-constructional unit (TCU) (Lerner, 1996, 2004). These sorts of turns will be described more fully in the analysis of Chapter 4.

2 Particularly those formulations that propose a diagnostically-relevant version of the client’s telling.

3 Beck and colleagues have suggested that there are three primary levels of cognitive processing (Wright et al., 2006). According to CBT theory, the highest level of cognition is consciousness, which is defined as a state of awareness in which decisions can be made on a rational basis. The two other levels of information processing involve automatic thoughts and schemas. Automatic thoughts are considered to be cognitions that stream rapidly through our minds and are just below the surface of the fully conscious mind (Wright et al., 2006). They tend to be spontaneous, specific and discrete, have a consistent theme and precede emotional arousal (Clark & Beck, 1999). Schemas are thought to be core beliefs that act as enduring internal templates for processing new information in a meaningful way thereby determining how phenomena are perceived and conceptualized (Clark & Beck, 1999). People with depression are thought to show negative biases at all three levels of thinking (Blackburn & Davidson, 1990).

4 Whilst the BDI is the most common outcome measure used in these studies, other questionnaires and self-report measures have also been used in these outcome studies (see Butler et. al., 2006).

5 In Fragment (4), the turn-medial use of “actually” also appears to show an orientation by the therapist of the delicate nature of delivering the proposal. Its use sets up the proposal as possibly contrastive to what the client may be thinking or planning.

6 The therapists’ rise in pitch was measured using the Praat software program. In Fragment (14), the therapist’s pitch rises from 200 hertz to 214 hertz during the active voicing talk. In Fragment (15), the therapist’s pitch rises from 174 hertz to 218 hertz. In Fragment (16) the pitch rises from 150 hertz to 209 hertz. Finally, in Fragment (17) the pitch rises from 155 hertz to 183 hertz.

7 The consecutive pitch shifts of the therapist’s active voicing across Fragment (18) are: (1) from 88 hertz to 84 hertz (“wh↓at’d ya doing< today?”, line 8), (2) from 77 hertz to 94 hertz (“↑oh I’ve got a very busy morning”, line 9), (3) from 88 hertz to 100 hertz (“↑oh what are ya doing?”, line 13), (4) from 100 hertz to 90 hertz (“wh↓at I’m do↑ing”, line 13), and (5) from 95 hertz to 220 hertz (“th↑at’s my business”, line 14).
In Fragment (18), the therapist shifts from 98 hertz to 92 hertz at the beginning of the hypothetical active voicing of the client’s thoughts (“↓okay (0.7) between now and next appointment with Peter (1.0) I will make sure (0.6) to say no to her once.”, lines 4-6). In Fragment (19) the therapist’s pitch shifts are consecutively as follows: (1) from 187 hertz to 118 hertz (“↓okay”, line 3), (2) from 174 hertz to 166 hertz (“↓okay I want to be treated (0.6) um with respect.”, lines 9-10), (3) from 174 hertz to 169 hertz (“↓I wanna be talked to (0.3) in an appropriate tone of voice.”, lines 12-13), (4) from 170 hertz to 162 hertz (“↓I want not- (.) I want people (0.2) not to burst into my room in the middle of the night and wake me up.”, lines 15-16).

It is interesting to note, here, that therapists in this corpus never orient to their professional authority when discussing behavioural activation tasks.

It appears, however, that the therapist could have initially been going to deliver the proposal as an interrogative. The cut-off on “d-” in line 27 appears to be heading for “do”. The possible existence of “do” as an auxiliary verb before the subject here suggests that the therapist may have been heading toward delivering a question such as “maybe do you need to ask other people?”. However, the therapist self repairs in line 27 to reformulate the proposal as a hedged recommendation and re-does “do” after the subject.

High global pitch involves both high pitch register and rising pitch direction for a stretch of talk (Selting, 1996).

Increased global loudness involves increased loudness in comparison to surrounding units (ibid).

High global pitch or loudness may also be combined with a locally marked accent with an extra high pitch peak or locally increased loudness to convey ‘astonishment’ (ibid).

Using the Praat phonetics software program, the client’s mean pitch across the sound “what” drops to 154 Hertz (line 32). It then rises back up to the client’s more average range of 157 Hertz. At the end of the turn, across the word “mistakes”, the mean pitch then rises to 168 Hertz with a pitch peak at the elongated “a” sound of 184 Hertz.

In order to evidence this claim, Drew (1997) uses the clear example of adults initiating repair on childrens’ utterances that do not accord with expected standards of politeness. For example:

[Drew, 1997, p. 95] (Drew, 1997, p. 95)

Child: Put on th’ li::ght (0.9)
Mother: Pa:rdoni:n (.).
Child: Put on the light please (.).
Mother ( ) better
The mean pitch level during the client’s “is” is 183 Hertz (line 6), rising to 247 Hertz during “there” with a pitch peak of 256 Hertz at the elongated “e” sound.

It is interesting to note that a more subtle version on this pattern occurs at line 46. The client rushes through at the end of her TCU to begin a new TCU which provides a telling about how she has already spoken to her mother about staying at home. It is still on topic, but does involve a subtle shift away from accommodation options into a discussion about her living with her parents. This shift could constitute a more subtle version of the shifts discussed within step 2 of the transitions away from proposals. Step 3 occurs at line 49 with a minimal “yep” from the therapist. Step 4 occurs at line 50 with the client continuing the telling. The therapist topicalizes the new telling with a question at line 63 (step 5), and the client responds to the question and continues the telling at line 66 (step 6). I am labelling this a more subtle version of the pattern because the new topic is not completely ancillary to the proposal. It would be more achievable for the therapist to bring the conversation back to accommodation options at this stage, as she may be attempting to do with her uncompleted turn at line 82.


Appendix 1: Therapist information sheet

INFORMATION SHEET
(THERAPISTS)

This research is being conducted as part of a PhD project within the School of Psychology at The University of Adelaide. The study aims to explicate how various practices are accomplished within CBT interactions between therapists and clients diagnosed with depression, focusing particularly on the nature and consequences of any troubles that may arise.

The research project aims to explore material from recorded therapy interactions. The process involves recording and transcribing some CTAD therapy sessions for detailed analysis. The researcher will not be involved in the counselling process in any way, and records of sessions are only kept if both counsellor and client consent. If you wish to stop the recording at any time, or withdraw your consent to record, you may do so. Any recording that has already taken place will then be deleted.

The following ethical safeguards will be strictly applied:

- All participants would give their informed consent to participation in recordings;
- Any person participating in conversations recorded for the research project would remain completely anonymous;
- If played to an audience, all voices will be distorted so that they cannot be identified;
- Any names or personal information stated during sessions will be omitted or a pseudonym will be used in the transcripts and any published output;
- All tapes will be transcribed only by the responsible investigator;
- The data will be kept in a password protected electronic database and identified by a number that in no way corresponds to the names of participants or any other potentially identifiable information.

If you have any questions or require any further information about the study please do not hesitate to contact:

Katie Simmons (primary investigator)
- Email: katherine.simmons@adelaide.edu.au
- Phone: 0403 784 921

Assoc. Prof. Amanda LeCouteur (supervisor)
- Email: amanda.lecouteur@psychology.adelaide.edu.au
- Phone: 8303 5557

For any questions concerning ethics, please contact the convenor of the Subcommittee for Human Research in the School of Psychology, Assoc. Prof. Paul Delfabbro:
- Email: paul.delfabbro@psychology.adelaide.edu.au
- Phone: 8303 5744
Appendix 2: Therapist instruction sheet

INSTRUCTIONS SHEET
(CTAD THERAPISTS)

Whether you decide to mention the possibility of involvement in the research project to any particular client is entirely up to you. If you do wish to mention it, your participation will just involve these 3 short steps.

1. Explaining the project to clients:

You will have been given an information sheet to give to your clients which explains the project. This info sheet should cover all the necessary details required. You may, however, want to introduce the project to the client with a short ethics script such as this:

“Before we start, I would like to let you know that we have a research project currently being conducted at the clinic, which aims to examine CBT practices and to help counsellors continue to develop their skills. The research involves recording some counselling sessions at the clinic. This information sheet explains the project. Can I ask if you would like to read the information sheet and decide whether you would agree to your sessions being recorded? I can assure you that you that if you do, you will still remain completely anonymous. If you do not want to be involved, however, then I will not record the sessions…”

Once the client has read the information sheet, and if they would like to consent to participate, they need to sign a standard consent form. This requires them to print their name at the top, and then sign and date the bottom of the form.

2. Recording:

If the client has signed a consent form, and you are happy for that session to be recorded, you can then start recording the session. The ‘record’ button on the digital recorder is the top button and is marked with a red circle. Press this button once to start recording. You can pause the recording by pressing the ‘record’ button a second time. To stop recording, press the ‘stop’ button next to the record button.

3. Consent check:

At the end of the session you should check with the client again whether they are happy to have the recording included in the project. If they decide they would like to withdraw their consent, the recording can be deleted. The ‘erase’ button is to the left of the screen on the recording device. Press the ‘erase’ button for more than 1 second. The recording number and ‘ERASE’ will flash on the screen. Check that it is the correct number, and then press ‘erase’ again to delete the recording, or the ‘stop’ button to cancel.
Appendix 3: Consent form

THE UNIVERSITY OF ADELAIDE HUMAN RESEARCH ETHICS COMMITTEE

STANDARD CONSENT FORM
FOR PEOPLE WHO ARE SUBJECTS IN A RESEARCH PROJECT

1. I ................................................................. (please print name)
   consent to take part in the research project entitled:
   .................................................................................................................................

2. I acknowledge that I have read the attached Information Sheet entitled:
   .................................................................................................................................

3. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker.
   My consent is given freely.

4. Although I understand that the purpose of this research project is to improve the quality of medical care, it
   has also been explained that my involvement may not be of any benefit to me.

5. I have been given the opportunity to have a member of my family or a friend present while the project was
   explained to me.

6. I have been informed that, while information gained during the study may be published, I will not be
   identified and my personal results will not be divulged.

7. I understand that I am free to withdraw from the project at any time and that this will not affect medical
   advice or the management of my health, now or in the future.

8. I am aware that I should retain a copy of this Consent Form, when completed, and the attached
   Information Sheet.

   .................................................................................................................................
   (signature)    (date)

WITNESS

I have described to ................................................................. (name of subject)
the nature of the procedures to be carried out. In my opinion she/he understood the explanation.

Status in Project: ........................................................................................................

Name: .......................................................................................................................

   .................................................................................................................................
   (signature)    (date)
PARTICIPANT INFORMATION SHEET

This research is being conducted as part of a PhD project within the School of Psychology at The University of Adelaide.

What is the study about?
The study aims to examine therapist and client interactions in CBT therapy sessions.

What will participation involve?
The process involves agreeing to have some of your therapy sessions tape-recorded for later analysis by the researchers. If you are willing to do this all you need to do is to sign the attached consent form. No other action is required. The researchers will not be involved in your counselling process in any way. They are interested in analysing the audio recordings to examine specific CBT practices as they unfold in a therapy session.

Can I be identified from the recordings?
No. The recordings will be treated as strictly confidential. You will remain anonymous. All tapes will be listened to and transcribed only by the responsible investigators. If recordings are played to an audience then all voices will be distorted by a computer programme, so that the listeners cannot identify any participants. Any names or personal information mentioned during sessions will be omitted or changed from the transcripts and any published output.

Do I have to participate in the study?
No. The study is completely voluntary, and participation will not affect the standard or type of counselling that you receive at CTAD.

Can I change my mind if I decide not to participate?
Yes. If you wish to stop the recording at any time, or withdraw your consent to record, you may do so. Any recording that has already taken place will then be deleted.

Is the study being undertaken with permission?
Yes. The study has been examined and approved by The University of Adelaide Human Ethics Committee.

Who can I contact if I want any more information about the study?
If you have any questions or require any further information about the study please do not hesitate to contact:

Katie Simmons (primary investigator):
katherine.simmons@adelaide.edu.au
Ph: 0403 784 921

Assoc. Prof. Amanda LeCouteur (supervisor)
amanda.lecouteur@psychology.adelaide.edu.au
Ph. 8303 5557

Assoc. Prof. Paul Delfabbro (convenor of the Subcommittee for Human Research in the School of Psychology):
paul.delfabbro@psychology.adelaide.edu.au
Ph. 8303 5744
Appendix 5: Jeffersonian transcription system

This list represents the most widely-used transcription symbols in my thesis. For a more comprehensive list, see Jefferson (2004).

(.) Micro-pause – less than a tenth of a second

(0.2), (2.6) Examples of timed pauses

↑word Onset of noticeable pitch rise

↓word Onset of noticeable pitch fall

A: word [word Square brackets aligned across adjacent lines denote the start of overlapping talk.

B: [word

. Falling vocal pitch

? Rising vocal pitch

.hhh In-breath

hhh Out-breath

wo(h)rd Within-speech aspirations

wor- A sharp cut-off

wo:rd Colons show that the speaker has stretched the preceding sound

(words) A guess at what might have been said if unclear

( ) Unclear talk

A: word= The equals sign shows that there is no discernible pause between two speakers’ turns

B: =word

word Vocal emphasis

WORD Talk pronounced loudly in comparison with surrounding talk

“word” Talk between “degree signs” is quieter than surrounding talk

>word word< Talk between inward arrows is delivered faster than surrounding talk

<word word> Talk between outward arrows is delivered slower than surrounding talk

→ Analyst’s signal of a significant line

((sniff)) Transcriber’s effort at representing something difficult, or impossible, to write phonetically