

CONVERSATIONAL EVIDENCE IN THERAPEUTIC DIALOGUE

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Family therapists' participation in therapeutic dialogue with clients is typically informed by evidence of how such dialogue is developing. In this article, we propose that conversational evidence, the kind that can be empirically analyzed using discourse analyses, be considered a contribution to widening psychotherapy's evidence base. After some preliminaries about what we mean by conversational evidence, we provide a genealogy of evaluative practice in psychotherapy, and examine qualitative evaluation methods for their theoretical compatibilities with social constructionist approaches to family therapy. We then move on to examine the notion of accomplishment in therapeutic dialogue given how such accomplishments can be evaluated using conversation analysis. We conclude by considering a number of research and pedagogical implications we associate with conversational evidence.

CONVERSATIONAL EVIDENCE?

In family therapy, conversation is usually seen as part of the therapeutic process and evidence is viewed as outcome. Process (conversation) affects outcome (evidence); both are intertwined and inseparable. Yet, one usually characterizes evidence in outcome research as being something far more measurable and tangible than the unquantifiable properties of conversation and discourse. In psychotherapy research, evidence of successful outcome is predominantly defined by test scores usually employed after and outside of the therapeutic conversation. Still, the nature of conversation is valued by therapists as facilitating outcomes by establishing and maintaining a therapeutic alliance (Bordin, 1994; Horvath & Symonds, 1991; Luborsky, 1994). In this article, we meld together two key process-outcome concepts, conversation and evidence, into "conversational evidence" for evaluating outcomes in psychotherapy. Larner (2004) recently pointed out that in family therapy, there are significant politics around what should constitute the evidence guiding practice. For us, conversational evidence *is* a tangible, empirical, and justifiable form of outcome evidence useful for examining therapeutic change. Accordingly, we present the case that family therapy outcome evaluation could involve conversational evidence as one form of evidence among other forms.

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BACKGROUND

We share a view with a number of social constructionist practitioners and researchers; that, to be helpful, therapeutic dialogue needs to elicit meaningful change clients prefer (Andersen, 1991; Bird, 2000; Ferrara, 1994; Gale, 1991). For dialogue to be meaningful speakers need a sense that they are understood, if not influential and mutual with each other. Such dialogue typically occurs in relationally responsive ways that speakers take for granted—that is, unless they feel misunderstood or at odds with each other. At such points speakers have conversational work to do. They turn to each other's responses for evidence that this work is creating shared understanding and perceived forward movement for them. In this sense, speakers are practical interpreters of each other, deriving what they say and do from what was said and done by their conversational partners as the dialogues they contribute to develop. Such dialogues typically occur without much need for conversational and interpretive work because history, cultural, and relational experiences have already created a common ground of understanding. But, through dialogue, speakers work out new understandings and ways of going forward together, and this is especially the case in rhetorical endeavors like family therapy.

Depicting therapy as a rhetorical endeavor may, for some readers, seem repugnant. Such a depiction places therapists in the same league as salespeople or politicians, but therapy has long been depicted this way by researchers and therapists (Frank, 1973; Maranhão, 1986; Roy-Chowdhury, 2003). Seen as a practice where an aim is to put language to effective use vis-à-vis clients' presenting concerns, however, we feel *rhetorical* can be an apt word to reflect therapists' mindful awareness and use of talk. We regard therapeutic dialogue as the means by which therapists and clients use language and other forms of communication to *accomplish* understanding and shared actions on client-preferred outcomes. Just as speakers would—as they talk—look for evidence from their conversational partners that they are being understood and working collaboratively, we see therapeutic dialogue offering an abundance of such evidence. How family therapists and clients accomplish these therapeutically relevant developments in the immediacies of their talking is part of what we will term “conversational evidence.”

Generally, therapists look beyond conversation for evidence of change, yet clearly their conversational actions are guided by how clients respond to them in the back-and-forth of their dialogues. For example, it is not unusual for a therapist to start saying one thing and end up saying another—in the course of a single utterance to a client. That kind of “mid-course correction,” a conversational option as available to clients as it is to therapists, in our view owes much to evidence regarding the receipt of speakers' utterances *as* they talk. In another sphere, how people “change their minds” is often portrayed as a development quite apart from conversation. Evidence that clients change in such ways is frequently depicted as psychological despite being initiated and made evident *in* conversational interaction (Heritage, 1998).

While clearly a change in words in one conversation does not necessarily translate to changes beyond that conversation, therapists normally turn to what clients say and do in response to them for evidence that they are on the “right track” as they talk. We will examine the notion that the sayings and doings of therapeutic conversation are a source of evidence for therapeutic change. We take seriously the claims of conversation analysts (Heritage, 1984; ten Have, 1999) that conversation is a means by which people accomplish relational outcomes with each other. We also recognize that clinical acumen is in part informed by conversational evidence, as therapists initiate, evaluate, and respond to emergent developments in the immediacies of therapeutic conversation—as do clients. Our interest is in seeing conversational evidence taken seriously as a means of evaluating therapeutic outcomes. To this end, we will situate our interest in conversational evidence in the broader context of psychotherapy evaluation, in a social constructionist understanding of therapy, and in empirical demonstrations from family therapy.

THERAPY AND CONVERSATIONAL ACCOMPLISHMENTS

For us, therapy is a context where, to paraphrase Austin (1962), clients and therapists *do* and accomplish things with their words and other ways of communicating. In this respect, we are echoing the views of social constructionist theorists (e.g., McNamee & Gergen, 1992; Shotter, 1993) and practitioners (e.g., Anderson, 1997; Bird, 2000; Gale, 1991). Our interest in conversation and its evidential developments is like that of another important theorist, Harold Garfinkel (2002); we feel the heart of therapy occurs on “conversation’s shop floor.” Clients do things with what they regard as therapy’s significant developments beyond their dialogues with therapists. However, change begins in dialogues that take clients past the sameness or constraints of their present dialogues with self or others. We also join well-established hermeneutic (Gadamer, 1988), discursive (Billig, 1996; Edwards, 1997), and sociocultural thinkers (Vygotsky, 1978) in considering thought as an extension of dialogue. Thus, what does get spoken can be seen as a barometer of change, especially if one considers the birth of therapeutic change as primarily occurring in the dialogic interactions of clients and therapists.

At a mundane level we believe therapists are constantly guided by conversational evidence. Their choices of question, response, even posture, are part of their responsive ways of being with clients. These choices, however, are not simply guided by theoretical models of change (as if therapists could put textbooks on their eyes and ignore clients), but by what happens as therapists *use* their theories in interacting with clients. This view is quite in keeping with notions of reflective practice advanced by Donald Schön (1983) and fits nicely with a dichotomy of professionalism recently articulated by Robert Hopper. For Hopper (2005), there are “pre-strategy professionals” who develop and execute plans and work well from anticipatable developments (from which further pre-strategies can be deployed) in the course of professional activities. However, he described another group of professionals: “emergent-when professionals,” who improvise their interactions based on unanticipatable developments that arise in professional encounters. We see therapy as requiring lots of the latter kind of professionalism while each form of professionalism is significantly informed by conversational evidence.

From a process perspective (Rice & Greenberg, 1984), there are many important developments on the road to overall therapeutic success, whether in clients’ or therapists’ eyes. Seen this way, what gets constructed or deconstructed in therapy is marked by conversational actions which culminate in particular outcomes critical to next steps in therapy. So, for example, how rapport is accomplished, how goals are co-articulated in ways that suit clients and therapist, how problems are co-defined, how “homework” is worked up between client and therapist—many such activities get worked out in therapeutic dialogue. Our use of the “co-” prefix is no accident. We see relational accomplishments occurring in conversational work—in utterances used and responses given—evident to researchers as well as those engaged in the “work” itself.

Speakers cannot use “telementation” (Harris, 1981) to peer inside each other’s minds for proof that message sent equalled message received. Instead, they rely on lots of verbal and non-verbal evidence regarding how their utterance is received. They co-manage their talk (Goffman, 1967) as it develops from their participation—“on the fly” conversationally from their sense of how the conversation is proceeding. Here is where we invite an ethnomethodological turn (Garfinkel, 2002; Heritage, 1984) in considering what to make of the evidence. Ethnomethodologists are interested in how people do their sense-making and social influencing in ways they attend and respond to. It is hard to try to understand a conversation from outside of it. But, ethnomethodologists challenge us to understand social interactions based on the observable, often mundane, aspects (i.e., evidence) that guide speakers as they talk to each other.

A further scenario here might help. Adopting an ethnomethodologist’s stance you, witness a marriage proposal between two lovers. In observing or re-examining the conversation in which the proposal takes place, you note how one partner prepares the other for receipt of his

or her proposal, the kinds of things that get said, how either responds, and so on. You witness the delivery of the actual proposal—how it is made as one partner carefully calibrates her or his language in accordance with how she or he sees her or his delivery being received. Looking really closely, you may see the very things that guide the partners in the course of their interaction around this proposal: how a tone of voice by one influences that of the other, for example. Conversationally, there is much to go on to indicate how they are responding to each other and building something in their dialogue. Key to an ethnomethodologist's analyses of a circumstance like this is to make evident what it is the speakers attended to and built on as they talked.

While perhaps not as charged, therapeutic dialogue bears some similarities. Therapist and clients closely attend to each other's communications, responding in ways that are consequential *for them*. While one cannot get inside the heads of those talking, one can notice what they notice and respond to as they talk. It is in this sense that Harlene Anderson (1997) referred to therapists as "participant co-managers" of the therapeutic process. In the manner we described earlier as "emergent-when" professionalism, they turn to what emerges in therapeutic dialogue and deal with the momentary exigencies of conversational encounters they codevelop with clients.

RECONCEPTUALIZING EVIDENCE

Issues, Controversies, and Movements

There is increasing and convincing justification to employ ethnomethodological (i.e., conversational analytic) and social constructionist research approaches to psychotherapy evaluation. Such research ranges from guidebooks illustrating the use of discursive approaches (e.g., McLeod, 2001; Siegfried, 1995) to psychotherapy studies that use discursive methodologies (e.g., Avidi, 2005; Burck, Frosh, Strickland-Clark, & Morgan, 1998; Frosh, Burck, Strickland-Clark, & Morgan, 1996; Madill & Barkham, 1997). Given that therapists attend to conversational developments to inform their participation in therapy, it seems natural to examine the dialogical practices of clients and therapists for evidence of therapeutic change. Currently, however, there is a gap in the use of such methodologies in psychotherapy outcome research. While researchers such as Greenberg (1986) and others have helped shift attention to small "o" outcomes of the therapeutic process and the means by which these are attained, their analytic focus has largely been on "task" accomplishments where nonlinguistic behaviors or therapist/client ratings of dialogues where those accomplishments took place. We take seriously the claims of discursive researchers for whom conversation is the primary means by which relational outcomes are accomplished (e.g., Heritage, 1984; ten Have, 1999).

The case for applying ethnomethodological and other alternative approaches is overshadowed by the taken-for-granted and near exclusive use of experimental methods and psychometric assessment in evaluating therapy outcomes. Such measurement-based modes of assessment constitute a key component of the empirically supported treatment (EST) and evidence-based practice (EBP) movements. While use of randomized-controlled trials (RCTs) dominates EBP, such use limits evidence to the measurement of predefined constructs that define therapy outcomes. However, the American Psychological Association's (APA) recent adoption of EBP has encouraged additional and alternative methodologies to RCTs to be employed (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006). We will borrow from developments within APA and from medicine to present our case for conversational evidence.

The concept of EBP, and the dominant framing of psychotherapy evaluation, is a relatively new development traceable through the 1990s. *Evidence-based medicine* (EBM), a term coined in 1988 by medical clinicians and epidemiologists (Donald, 2002), facilitated the rise of EBP in mental health (Tanenbaum, 2003). The rationale for EBM was to develop a structured framework for systematic clinical decision-making guided by evidence for best clinical practices.

Research evidence derived from statistical methods and reliability estimates help to answer such questions as “what is the chance that” some intervention will benefit people. Answers framed by such questions look past “how or why” questions about people’s efforts in moment-by-moment efforts to codevelop meanings and actions in therapy.

Emulating EBM, the Clinical Division (Division 12) of the APA produced a task force report on empirically validated treatments¹ in 1995. As with EBM’s Oxford-based Centre for Evidence-Based Medicine’s established evidence hierarchy (see Centre for Evidence-Based Medicine, 1998), the Clinical Division’s task force produced a similar hierarchy with RCTs as the “gold standard” (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). The difference between the two evidence-based standards was that the Clinical Division relied exclusively on experimentally produced evidence. Such standards include “well-established treatments” and “probably efficacious treatments” demonstrated to be superior to pill, psychological placebo, or another treatment and that required adherence to a treatment manual. This is in contrast to the Centre for Evidence-Based Medicine (1998); although it included RCTs as the gold standard, it additionally included other forms of evidence in its hierarchy (e.g., case-series studies and expert clinical opinion).

Concurrently, the EBP movement was gaining ground in psychology. With the rise of evidence-based practice journals in the 1990s,² in 1999, the United Kingdom’s Department of Health’s (DoH) *National Service Framework for Mental Health* (Department of Health, 1999, p. 6) created another evidence hierarchy listing five grades of evidence from at least one good systematic review and at least one randomized-controlled trial (highest grade) to expert opinion (lowest grade). As EBP became more of a public policy ideal (Tanenbaum, 2003), this clashed with Division 12’s restrictive focus on RCT methodology to obtain evidence. ESTs have been classified according to their efficacy in addressing different symptomatic presentations (i.e., principally *DSM*-based diagnoses of anxiety and depression). Most ESTs that were rated as well established or probably efficacious were from behavioral and cognitive-behavioral therapy. This is principally because their theoretical and methodological stances fit hand-in-glove with RCTs (i.e., experimental epistemologies: knowledge gained primarily through hypothesis testing and experimental manipulation). Between 60% to 90% of Division 12–approved ESTs are cognitive-behavioral interventions (Norcross, Beutler, & Levant, 2006).

However, EST framing generally has not fit well with theory and practice in most humanistic, family, and social constructionist approaches to psychotherapy.³ In 1997, Division 32 of the APA (the Division of Humanistic Psychology) produced a report critiquing Division 12’s ESTs as well as its own guidelines for the provision of humanistic psychosocial services (Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2001). This is not surprising given that these approaches are constructivist and eschew mechanistic uses of therapeutic administration. Instead, these approaches see therapy as an open-ended process and a nonlinear, meaning-making endeavor where goals often change as the therapy progresses, and with clients seen as the ultimate experts on their own experience. Thus, such approaches to therapy are ill suited to RCTs requiring the reliable adherence to therapy manuals. The dissemination of ESTs, RCTs, and cognitive-behavioral therapy has also influenced third-party payers’ perceptions: that what is best practice and fundable must involve such approaches (Greer & Rennie, 2006), which inevitably positions non-CBT therapies as less fundable and degrades the status of nonexperimental approaches and stakeholders in process-outcome research. Such critique has been mirrored in the criticism of ESTs for their constrictive implications for research (Bohart, 2005; Bryceland & Stam, 2005; Dumont & Fitzpatrick, 2005; Honos-Webb, 2005; Levitt, Neimeyer, & Williams, 2005; Mahrer, 2005). Such criticisms underscore the controversial nature of ESTs within psychology and created suggestions for alternative and additional research and therapeutic approaches (Beutler & Johannsen, 2006; Bohart, 2006; Duncan & Miller, 2006; Norcross & Lambert, 2006; Stricker, 2006; Wampold, 2006).

Following considerable debate and controversy over the narrow framing of ESTs, in 2005 the APA revisited the issue and published a presidential task force report on evidence-based practice in psychology (EBPP). This report suggested widening the notion of what should be evidence-based to include the “integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 273). It also endorsed multiple types of research evidence and acknowledges differences in research design, including qualitative research data as evidence. Still, APA holds experimental methods above all other approaches and qualitative methods such as clinical observation or experientially focused interviews are seen as less stringent than RCTs. Proposing an expansion of what constitutes outcome evidence (e.g., see Chwalisz, 2003) has generated debate on the merits and limitations of EPB (Feltham, 2005; Hage, 2003; Stricker, 2003; Wampold, 2003). Nevertheless, the EBPP report has opened space for additional and alternative evaluation methods in psychotherapy process and outcome. Here we intend to promote the *inclusive* use of qualitative and, more specifically, discursive analyses for psychotherapy outcome evaluations alongside current quantitative methods of analysis.

Evaluating Therapeutic Change in a Discursive Context: Positioning

The inclusion of qualitative approaches in EBP has enabled alternative means for evaluating psychotherapy, especially with the use of positioning theory in discursive analyses. By “positioning” we are referring to discursive practices in which one’s subjectivity is shown or performed in social interaction, in contrast to the formal, “static,” and transcendentalist concept of role (Davies & Harré, 1990). Each contributor, deliberately or implicitly, positions the other continuously through conversation while simultaneously positioning himself or herself (Harré & van Langenhove, 1991). Thus, shifts in client positions from problematic to counter-problematic positions in client-therapist dialogue, as evidenced in discourse, can be seen as indicators of “little outcomes” in therapy. Process research in family therapy has already used discursive positioning analyses, particularly the examination of changes in client positions (Avidi, 2005; Burck et al., 1998). An analysis of interactional positioning has also been useful in identifying markers for indicating early outcomes (Madill, Sermpezis, & Barkham, 2005). Assuming that clients and therapists co-construct meanings and understand their interactions via language (Goolishian & Anderson, 1987), it makes sense to identify shifts in meaning as evidence of therapeutic outcome as interactional changes in clients’ subjective positions in therapy. In Anderson and Goolishian’s (1988, p. 48) words: “Change is the evolution of new meaning through dialogue.” This is where empirically observable conversational accomplishments and new meaning can be considered as outcome evidence.

EVIDENCE OF OUTCOME THROUGH A DISCURSIVE LENS

Here, we present examples of such accomplishments in therapeutic dialogue where agreements in dialogue have been taken up as signs of outcome. These examples are taken from discursive analyses of how a family with an adolescent used talk to move beyond a conversational impasse (Couture, 2005, 2006). To evaluate macro-shifts in meaning, I (the third author) used Harré and van Langenhove’s (1999) notion of discursive positions. Discursive positions are locations (like conversational stances) from which people engage others as they converse, or differences in perspective from which people understand and act when conversing with one another. In this macro-analysis, I identified that conversational impasses arose from significant differences in these discursive positions of participants in therapy. As these differences were overcome in therapy, a forward-moving, more mutually satisfying, position was eventually constructed by the family and therapist.⁴ By analyzing how such discursive positions featured and were altered in the interview, evidence could be found for important macro-shifts in meaning.

| Table 1 <i>Transcription Notation</i> | |
|--|---|
| Symbol | Indicates |
| (.) | A pause which is noticeable but too short to measure |
| (.5) | A pause timed in tenths of a second |
| = | There is no discernible pause between the end of a speaker's utterance and the start of the next utterance. |
| : | One or more colons indicate an extension of the preceding vowel sound. |
| Under | Underlining indicates words uttered with added emphasis. |
| CAPITAL | Words in capitals are uttered louder than surrounding talk. |
| (.hhh) | Exhalation of breath; number of <i>h</i> 's indicates length |
| (hhh) | Inhalation of breath; number of <i>h</i> 's indicates length |
| () | Indicates a back-channel comment or sound from previous speaker that does not interrupt the present turn |
| [| Overlap of talk |
| (()) | Double parentheses indicate clarifying information, e.g., ((laughter)) |
| ? | Indicates rising inflection |
| ! | Indicates animated tone |
| . | Indicates a stopping fall in tone |
| ** | Talk between * * is quieter than surrounding talk. |
| > < | Talk between > < is spoken more quickly than surrounding talk. |
| { } | Nonverbals; choreographic elements |
| <i>Source:</i> Kogan (1998, p. 232). | |

However, a more fine-grained, ethnomethodological analysis (conversation analysis) also showed specific conversational evidence of positive change in how the family talked.⁵ Below I present two exemplars illustrating the family at an impasse and one that demonstrates the accomplishment of forward movement. Using these exemplars I then first show how discursive analyses provide conversational evidence that family members mutually accomplished this forward movement and then briefly demonstrate one way I noticed these changes were achieved.

The family who participated in this study included a father (Bob), mother (Sandra), and son (Joe), and a therapist (Dr. Karl Tomm).⁶ The session analyzed was the first one after Joe, the 14-year-old son, was released from the hospital after concerns about his recent self-harming ("cutting") behaviors. Before leaving the hospital, Joe had agreed to a contract that listed things that he could have done to keep himself safe. The family began the session firmly entrenched at an impasse. In our view, the two exemplars below offer strong baseline evidence of this impasse in contrast to positive changes shown in how the son and father relate in later exemplars.

EXEMPLAR 1

- 67⁷ B: . . . and um (3) myself (1) and I can't speak
68 for everybody else but I want to make sure (.) . . .
69 J: {Joe picks up pop bottle}
70 B: I mean I understand that the way it was is not the way it is going

71 to be in the future it is going to be totally different it has to be. (3)
 72 And I don't know how Joe feels about that but um (.8)
 73 JOE and I over the last couple of days (.6) {Looks at Joe} we had
 74 a chance to talk one on one huh (.8)
 75 J: {Joe leans back and looks away from Bob}*uhuh* (1)
 76 B: just him and me (.5)

For the majority of the initial dialogue, Joe and Bob labored as they did not often directly communicate. When they did, the interaction played out in ways similar to the example below.

EXEMPLAR 2

395 B: Which ones are your biggest concerns Joe? (2.3) {looking down not at Joe}
 396 J: * > don' know < * {looking down}
 397 (5.6)
 398 B: {Looks up to the ceiling and pierces lips} See part of wha[t]

Later in the session, Bob and Joe began to communicate in ways that showed they were speaking from a more forward-moving and common position (a positive outcome evident in the transcript), codeveloping *what* they said and *how* they said it.

EXEMPLAR 3

534 B: = a::nd and it was (.) I think (.) ::I think **we both** kind of came up
 535 out of there (.3) and > Joe you can (.) speak for yourself < **but** (.)
 536 what **I** came out of it was that (.1) ummm > **we** need to do things
 537 a little bit different < (.5) **we** need to **start** (.1) > do things a little bit
 538 different < and I asked you one **question** remember (.) what I asked? (.5)
 539 J: No {Looking down, playing with bottle, sarcastic tone} (.9)
 540 B: You don't remember (.3) it had to do with the fact I said (.9) umm (.8)
 541 wouldn't it be neat (.5) o::r did you like the fact that we just sat and
 542 talked (.4) just talked about stuff (.) and you said you did (1.9)
 543 And I asked you if you would like to do more in the future what'd
 544 you say? (1.1)
 545 J: Sure {Solidly spoken} (2.2)
 546 B: And that is something that (.3) maybe I haven't done very much in
 547 the past? (.) >for what ever reason < (.5) but **just** (.5) shoot the fat (.2)
 548 talk.

Conversational Evidence of Forward Movement

At the beginning of the session the parents were talking from a discursive position of *certainty* with respect to adherence to the contract. Joe, on the other hand, did not appear to be as certain about adhering to the contract; he spoke from a position of *doubt*. While the parents demanded unconditional certainty that their son would ensure his safety, Joe defended his doubts, saying he would *try* his best to accomplish what was expected of him, showing his hesitancy to adhere to the contract. Such opposing positions (doubt and certainty) exemplify a family stuck at an impasse—based on their use of incompatible ways of talking and understanding. This initial impasse was evident in what the father and son initially said. The father's certainty

In this turn, he assumed Joe had joined him in a new position as indicated by his continued use of the word “we.” Joe did not contest Bob’s use of “we”;¹⁰ moreover, the language chosen led to a more engaged father-son dialogue, as discussed in the next section.

Bob’s uncontested use of “we” suggests that he and Joe were coming closer to agreeing on a shared discursive position. This exchange showed evidence of outcome in the actual talk of the session; in therapy family members may offer such evidence to each other (and the therapist) in working out new, shared, forward-moving positions. Joe’s responses changed throughout the transcribed dialogue (e.g., from early disagreements or weak agreements to solid uptakes). For example, in Exemplar 1 Joe responded to Bob’s statements of certainty by leaning away from his dad, crossing his arms, fiddling with objects, looking down or away, moving from his dad’s touch, or biting his nails as in the following exemplar.

73 B: JOE and I over the last couple of days (.6) {Looks at Joe} we had
74 a chance to talk one on one huh (.8)
75 J: {Joe leans back and looks away from Bob}*uhuh* (1)
76 B: just him and me (.5)

Although in line 75 Joe’s words conveyed he agreed with his dad (“uhuh”), the way he offered those words and the accompanying nonverbal behavior communicated likely disagreement. This acknowledgment token (Jefferson, 1984) “uhuh” acts as a “continuer” (Bangerter & Clark, 2003; Goodwin, 1986; Schegloff, 1982) and stands in contrast to “Yeah,” which communicates a higher degree of engagement or readiness to extend a turn in talk. Toward the end of the transcript in Exemplar 3 (seen below), Joe’s response showed an *increased commitment*.

543 B: And I asked you if you would like to do more in the future what’d
544 you say? (1.1)
545 J: Sure (2.2)

At first glance, “Sure” could be understood as another ambivalent response. However, given the tentativeness and ambivalence of his previous responses to Bob, Joe’s “Sure” communicates a more solid uptake. Further evidence of shared commitment to a common ground came in how Bob showed he understood Joe’s utterance as sincere (Bob paused, leaned back, and almost smiled in contemplating his son’s previous utterance). In addition, when Tomm asked a similar question a bit further in the session, “Are you willing to give it a try (spending time together talking and doing things) and see what happens see how it goes?” Joe upgraded his commitment as he looked up at the therapist and said, “Sure.” With this very rare instance of eye contact, Joe built on his previous response to Bob and further acknowledged his commitment to the small two-way steps they were co-constructing in their dialogue.¹¹

Accomplishing Change: Performative Advice Giving

As shown earlier in Exemplar 2, Bob and Joe initially struggled in their interactions.

395 B: Which ones are your biggest concerns Joe? (2.3) {looking down not at Joe}
396 J: * > don’ know < * {looking down}
397 (5.6)
398 B: {Looks up to the ceiling and pierces lips} See part of wha[t]

In the final exemplars, Bob and Joe demonstrated progress relative to their previous conversational attempts. Concurrent with progress in their dialogue, Bob adopted conversational practices previously used by Tomm (e.g., tentative packaging of his talk, attention to ambivalent

responses) to engage Joe. Tomm's ways of engaging Joe throughout the session were where he "performed advice" or "modeled" how Bob might take small steps in talking with Joe.

Pomerantz (2003) discussed modeling as a form of "invisible teaching" in preceptor-intern interactions in medical training. By looking closely at the micro-details of the talk, we noticed actual positive outcomes that may have resulted in part from Tomm's "invisible teaching."¹² In the exemplar above, Bob demonstrated what he previously did when faced with an ambivalent response; he abandoned direct dialogue in frustration. However, by the end of the transcript (Exemplar 3), Bob was responding differently.

- 538 B: ... and I asked you one question remember (.) what I asked? (.5)
539 J: No {Looking down, playing with bottle, sarcastic tone} (.9)
540 B: You don't remember (.3) it had to do with the fact I said (.9) umm (.8)
541 wouldn't it be neat (.5) o:r did you like the fact that we just sat and
542 talked (.4) just talked about stuff (.) and you said you did (1.9)
543 And I asked you if you would like to do more in the future what'd
544 you say? (1.1) ...

The above exemplar shows Bob engaging Joe differently, especially in the more tentative and responsive ways he talks with him. Joe's response in line 539 ("No") could be understood as another "avoidance strategy"; his "No" was communicated such that he might have an answer to Bob's question, but was not prepared to share it. Instead of abandoning the talk, when faced with such ambivalence (e.g., "don't know" in the previous exemplar), Bob adopted a practice that Tomm used when faced with ambivalent responses from Joe: treating Joe's response as *legitimate* or at least selectively responding to a part of Joe's response that extended their dialogue (I. Hutchby, personal communication, April 1, 2004; O'Hanlon & Wilk, 1987). Bob and Joe performed new, more acceptable ways of talking that could work to *anchor* change in how they would extend their conversations to come (Couture, 2005).

Bob also used another strategy that Tomm repeatedly demonstrated; he reformulated his question in line 540. In this conversational "repair,"¹³ Bob carefully repackaged¹⁴ his question (lines 543 and 544) to bridge his talk with his son's. This careful construction of his question was evident in the pauses and verbal tokens¹⁵ "(.9) umm (.8)" in line 540 and his self-correction of the content of the question in line 541 ("wouldn't it be neat (.5) o:r did you like . . ."). In addition, instead of just answering for Joe, he invited Joe to join him in line 544 ("what'd you say?"). As when Tomm had used these practices, Bob used them successfully to engage Joe (line 545 below).

- 545 J: Sure {Solidly spoken} (2.2)
546 B: And that is something that (.3) maybe I haven't done very much in
547 the past? (.) >for what ever reason < (.5) but just (.5) shoot the fat (.2)
548 talk.

In line 545, Joe offered a rare instance of clearly accepting his dad's invitation to extend dialogue. Increasingly, Bob and Joe come to speak from a discursive position more acceptable to them, one which shows both a shared understanding (in what gets said) and a shared way of talking (in how they "perform" their talking). In this case, Joe responded to his dad with a solid voice, showing evidence of his willingness to try out the small steps that Bob was suggesting. Bob then, again, selectively listened to Joe's potentially ambivalent¹⁶ "Sure," "utilizing" (O'Hanlon & Wilk, 1987) Joe's "small step" ("Sure"), showing that he accepted and extended Joe's assent, thereby assisting them both in moving forward in small increments. Finally, Bob later adopted a more cautious approach to inviting Joe into dialogue reminiscent of Tomm's

verbal packaging to engage Joe earlier. Contrast Bob's previously insistent style of questioning from Exemplar 2 with the turn in later talk (Exemplar 3, following).

- 395 B: Which ones are your biggest concerns Joe? (2.3) {looking down not at Joe}
396 J: * > don' know < * {looking down}
- 534 B: = a::nd and it was (.) I think (.) ::I think we both kind of came up
535 out of there (.3) and > Joe you can (.) speak for yourself < but (.)
536 what I came out of it was that (.1) ummm > we need to do things
537 a little bit different < (.5) we need to start (.1) > do things a little bit
538 different < ...

In the latter exemplar, he used both a turbulent delivery pattern (Silverman, 2001) to express caution in what he is saying (“that (.) umm > we . . .” line 536) and a couple of restarts (“we talked about a lot of stuff (.2) we talked about (.9)” line 530, “(.) I think (.) ::I think . . . ,” line 534) (Goodwin, 1980). Bob's movement from an insistent to a more tentative turn at talk facilitated how he and Joe, *both*, could begin taking these *small steps* in their dialogue.

Bob and Joe now “walked their talk,” as Tomm had invited them to do throughout the session. Not only was outcome evident in what they talked about (macro-shifts in meaning from two incommensurable positions to a forward-moving one), but it was also demonstrated in how they changed the ways they relate to one another as they enacted “two-way small steps” in their actual talk. As family members speak differently with therapists and each other in their sessions they are better poised to extend such enacted developments beyond the therapeutic context.

CONCLUSION: WHOSE EVIDENCE?

Constructionist social science would benefit from taking seriously the issue of construction. Rather than treating construction as a taken-for-granted start point, it should consider construction and deconstruction as a central and researchable feature of human affairs. (Potter, 1996, p. 206).

Premised as it so often is on a medical metaphor of practice, psychotherapy evaluation has generally looked past the conversational arena where therapy actually takes place for evidence of therapeutic change. This makes sense given that the changes clients typically want are those required beyond the consultation room. Conversation itself can be about mere words—talking *about* states of affairs, present or desired. But, in another sense, psychotherapy evaluation has not escaped conversation entirely either. Arguably, completing a symptom checklist, a client satisfaction rating form, or any of the many other evaluation tools used by therapists to ‘hear’ from clients about their views on outcome involves client self-reports *about* outcomes. The difference between asking about those outcomes in therapy—or afterward—is in how they are asked and by whom. There can be a difference between clients rating their progress in therapy in face-to-face communication with their therapists, and completing an evaluative measure elsewhere. Regardless, either way of evaluating therapy involves clients' accounts of therapy outcomes; one offered in the immediacies of dialogue, the other extending a dialogue (on therapeutic satisfaction or efficacy) by means of paper and pencil.

Our point in looking inside conversations for evidence of change is not to build an argument for eliminating other means of evaluating therapeutic outcomes. For us, whether guided by clients' accounts of change, or attending to changes shown in the course of therapeutic dialogue, both clients and therapists are guided by conversational evidence *as* they talk. They build on that evidence when it seems to offer proof that things are going as preferred for both parties,

or they often depart from it when the evidence suggests things are not developing in ways either prefer. We are genuinely interested in how developments occurring within therapy relate to changes outside therapy, but remain struck by how therapy itself is a primarily rhetorical endeavor. By using words, metaphors, discourses, gestures, tones of voice, and so on, both clients and therapists construct ways of talking, understanding, feeling, and acting from within their dialogue. In our view, these accomplishments in their dialogues are *evident* to the speakers in terms of client accounts and in evidence of shifts in meaning and ways of talking. From our meaning-focused and ethnomethodological perspectives, evidence for clients and therapists in the course of their dialogues is also evidence for those interested in evaluating the little ‘o’ outcomes associated with increments or decrements in the therapeutic process.

One aim of this article has been to suggest that the evidence to which therapists and clients turn in the course of their dialogues—the data that suggest their conversations are “on track”—can help refocus therapists’ attention to their part in the emergent accomplishments of therapeutic interaction. Therapy in our view needs to proceed from a sense of destination clients provide in articulating initial goals or accounts of problems from which they seek better living. But, thereafter, clients do not simply hand their meanings and actions over to therapists—to be awoken once they have arrived at their destination. Instead, clients and therapists actively work out the meanings and actions to be used “en route” to client-chosen destinations. How these efforts to work things out fare is evident at virtually every turn of conversation, or in clients’ accounts of how “on track” things are for them.

We have been putting forward a case for attending to the kinds of evidence we think most therapists pay considerable heed to in their discussions with clients, a case taken up in similar but slightly different ways by Roy-Chowdhury (2003). Therapists typically are guided somewhat by their understandings of the meanings of clients’ accounts of experience, and they track how clients are responding to them as they talk, often shifting what they say as they talk. Rather than a focus only on the big ‘O’ outcomes (“are we there yet”), which clients could confirm with an account of their experience, they attend to many little ‘o’ accomplishments (“are we on track?”) whether clients offer accounts *about* these accomplishments or their sense of evidence suggests these are occurring. The link between client accounts of change (offered in therapy, not outside it) and conversational accomplishments—and the bigger accomplishments most therapeutic evaluations look for—is a matter that could bear a lot of further scrutiny.

Clinically, we are not alone (Gale, Dotson, Lindsey, & Negireddy, 1993; Strong, 2003) in seeing conversational evidence as a useful resource for enhancing practice. In this regard, any audio- or videotape of family therapy offers rich opportunities to see how outcomes are accomplished and relationships shaped by the hows and whats of therapeutic dialogue—turn by conversational turn, or over a sequence of such turns. We hope therapists can enhance their sense of how their talk performs in terms of what it elicits from clients, and vice versa, in family therapy’s dynamic hermeneutic circle. In family therapy, this performance aspect of talk extends to therapists’ observations about the effects family members’ talk has on each other, thus showing possibly beneficial interactions in which to intervene. Finally, we see conversational evidence as the means by which therapists can orient to the moment-by-moment aliveness of therapeutic dialogue, seeing in such moments their participation in what is constructed.

As social constructionist practitioners and researchers interested in evaluating family therapy, we take literally the notion that therapy is about socially constructive processes (e.g., McNamee & Gergen, 1992) that occur on “conversation’s shop floor” (Garfinkel, 2002). For us, evaluation of therapy has held particular meanings for therapists that a generation of developments within qualitative research now can make more robust. This seemed to be one of the messages arising from the recent shift from empirically supported treatments to a wider framing of EBP by the American Psychological Association Presidential Task Force on Evidence-Based Practice (2006). For us, being able to draw on discursive analyses for evaluative purposes—for what we have been calling conversational evidence—can be a welcomed shift for all therapists.

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NOTES

¹This was soon recoined as “empirically supported treatments” by the Division because of disagreement over the inclusion of the word “validated” and its absolutist connotations (i.e., proven or disproven as valid).

²Notably, *Evidence Based Medicine* (est. 1995), *Evidence Based Cardiovascular Medicine* (est. 1997), *Evidence Based Healthcare* (est. 1999), *Evidence Based Medicine Reviews Online* (est. 1998), *Evidence-Based Mental Health* (est. 1998), *Evidence Based Nursing* (est. 1998), *Evidence Based Obstetrics and Gynecology Online* (est. 1999), *Evidence Based Oncology* (est. 2000), and *Evidence Based Dental Practice* (est. 2001).

³But this predicament is not only relevant to family, humanistic, and discursive psychotherapies. There are psychoanalytic, existential, and feminist approaches, for example, that do not suit the prescriptiveness of RCTs.

⁴In addition to the conversational evidence of positive outcome discussed later, the passages that I discuss as illustrating a common forward-moving position were identified by the family as helpful for their future interactions. However, I do not mean to imply that differences are not generative. As I have suggested elsewhere (Couture, 2006) and found while studying this family’s conversations, accepting and developing differences rather than eradicating them through debate can be key to helping families move forward.

⁵I used reflexive discussions with various readers of my analysis to evaluate the plausibility or trustworthiness (Lincoln & Guba, 1985; Mishler, 1990) of the claims I make. In addition, as Potter (1996) suggested, I provide rich and extended transcriptions of conversations to allow future readers to make their own judgements about my claims. I recognize the results are always open to reinterpretation and that readers must continually negotiate the strength of my claims through continuous dialogue.

⁶The family members’ real names have been replaced with pseudonyms to respect the confidentiality of the participants. Dr. Karl Tomm, however, welcomed the open use of his name in this project. Tomm is a renowned family therapist, psychiatrist, and professor in the Department of Psychiatry at the University of Calgary, where he founded the Family Therapy Program in 1973. He is well known in the field of Family Therapy for his work in clarifying and elaborating new developments in systems theory and clinical practice.

⁷See Table 1 for details of transcription notation. In the transcripts B represents Bob, J is Joe, S is Sandy, and T is the therapist, Dr. Tomm.

⁸A respondent’s uptake acknowledges and extends what has been said to him or her.

⁹Conversation analysts would call this a stake inoculation where the speaker manages the risk that he could be perceived as having a stake in what he said and might not be open to other possibilities (Potter, 1996).

¹⁰The absence of contention here is evidence of a developing hybrid position, especially in light of Joe’s earlier nonverbal signs of protest in response to Bob’s use of the word “we.”

¹¹Another more obvious reason to understand Joe as joining the family in a new way of seeing the contract with his utterance “Sure” is that in the postsession interview, Joe described this conversation as initiating further talk between his dad and him.

¹²By invisible teaching I do not suggest that Tomm’s actions are necessarily intentional directives. They develop through his responsive involvement in the conversation. This is in keeping with our earlier comments from Hopper (2005) about “emergent-when” professionalism.

¹³In repairs, speakers use different devices to restore shared understanding together after it has broken down (Schegloff, 1992; ten Have, 1999).

¹⁴Recipient design or “packaging” means a speaker constructs an utterance in a manner intended to fit for its recipient (ten Have, 1999).

¹⁵As Clark (2002) suggests, the word “umm” can be a device used to revise one’s utterance.

¹⁶Although “Sure” is an uptake in relation to other responses Joe offered to Bob earlier, this word is more ambivalent than “Yes.”