Managing clients’ expectations at the outset of online Cognitive Behavioural Therapy (CBT) for depression

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Background Engaging clients in psychotherapy by managing their expectations is important for therapeutic success. Initial moments in first sessions of therapy are thought to afford an opportunity to establish a shared understanding of how therapy will proceed. However there is little evidence from analysis of actual sessions of therapy to support this.

Objective This study utilised recordings to examine how therapists manage clients’ expectations during the first two sessions of online Cognitive Behavioural Therapy (CBT).

Methods Expectation management was investigated through conversation analysis of sessions from 176 client-therapist dyads involved in online CBT. The primary focus of analysis was expectation management during the initial moments of first sessions, with a secondary focus on expectations at subsequent points.

Analysis Clients’ expectations for therapy were most commonly managed during the initial moments of first sessions of therapy. At this point, most therapists either outlined the tasks of the first and subsequent sessions (n=36), or the first session only (n=108). On other occasions (n = 32), no attempt was made to manage clients’ expectations by outlining what would happen in therapy. Observations of the interactional consequences of such an absence suggest clients may struggle to engage with the therapeutic process in the absence of appropriate expectation management by therapists.

Conclusion Clients may more readily engage from the outset of therapy when provided with an explanation that manages their expectation of what is involved. Therapists can accomplish this by projecting how therapy will proceed, particularly beyond the initial session.

Keywords: expectation management; Cognitive Behavioural Therapy (CBT); depression; online therapy; first session openings; Conversation Analysis (CA).

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Background Service user expectations, and the consequences of these expectations, have been a popular object of study in health services research.¹⁻⁸ One expectation relates to the health care process: that is, what a service user will actually do with a professional to address their particular health care needs.⁹ In countries like the UK, for example, most people will have some idea of what to expect when they consult a General Practitioner (GP) about an acute medical condition – that their problems will be solicited by the health care provider, that the provider will initiate a series of questions about history of the problem presented, investigate the problem with methods like a physical examination, deliver a diagnosis, and recommend where treatment may be appropriate.²⁻⁹¹⁰ Such expectations are likely to develop through socialisation across a lifetime of consulting GPs.¹¹
In contrast to longstanding familiarity with GP consultations, people utilising a service like psychotherapy may be unsure about what is involved, or could have unrealistic or incorrect expectations.\textsuperscript{7,12} Given that explanations are a fundamental technique to manage the expectations of others,\textsuperscript{3,13,14} this article focuses on how therapists manage their clients’ expectations from the outset of therapy. Examining first sessions of online Cognitive Behavioural Therapy (CBT) for depression, we identify how expectations can be managed by projecting the therapeutic process, as well as exploring problems that can arise when expectations are not managed in this manner. This provides evidence identifying optimal ways of promoting shared understanding of how therapy will proceed.

CBT continues to emerge as the predominant approach to psychotherapy\textsuperscript{15} and is recommended for treating depression in many countries including the UK.\textsuperscript{16} There have been recent attempts to increase access to treatment by developing computerized psychotherapy and online interfaces for therapeutic sessions.\textsuperscript{17-19} In both traditional and online therapy further evidence about the therapeutic process is required to support optimal clinical practice.\textsuperscript{20,21} For instance, initial moments of the beginning of therapy afford an important opportunity to establish shared expectations that may ultimately influence therapeutic outcome.\textsuperscript{5,7,12} It can be particularly important for clients to appreciate that many sessions may be required to achieve therapeutic benefit\textsuperscript{22-24} and that initial progress may not, therefore, be as rapid as they might have anticipated. Although recommendations for opening first sessions are provided in handbooks,\textsuperscript{25} we are not aware of research exploring how this is accomplished in actual sessions of CBT. This article addresses this gap by describing how therapists open initial sessions with clients and the implications for engaging clients in therapy.

The initial moments of first sessions in CBT, which are predominantly focused on assessing a client’s situation (hereafter referred to as the ‘assessment phase’), afford opportunities for therapists to explain to clients what therapy will be like. This has been described as orienting clients to the structure of therapy\textsuperscript{12} and is crucial for appropriately involving them from the outset of treatment.\textsuperscript{26} There are two main reasons for focusing on first session openings: first, because the strategies that therapists use to open, structure, and manage clients’ expectations are thought to be important for therapeutic success;\textsuperscript{7,26} and second, because how therapy is initiated may influence the relationship between therapist and client.\textsuperscript{5,7,12} Achieving consensus about the tasks and goals of therapy is an important part of therapeutic relationships.\textsuperscript{27-29} Clients require a means to appreciate what therapy will involve to maximise the likelihood they will commit to that process. Our aim is to identify ways therapists can utilise, or indeed miss, opportunities to manage clients’ expectations at the outset of the therapeutic process.

**Methods**

**Data**

This study follows a trial of online CBT for primary care clients diagnosed with depression.\textsuperscript{30,31} This study utilises typed transcripts of online CBT sessions from 183 client-therapist dyads. Clients were referred to the trial by their GP if they were between 18 and 75 years old, had been diagnosed with a new episode of depression within the preceding four weeks, and had not been treated for depression in the previous three months. Depression was defined as a score of 14 or more with the Beck Depression Inventory (BDI),\textsuperscript{32} and an ICD-10 diagnosis conforming to the World Health Organisation’s ICD-10 classification list.\textsuperscript{33} Patients were excluded if they had history of alcohol or substance misuse, a bipolar disorder, or a psychotic disorder, were already receiving psychotherapy, or if they could not communicate proficiently in English.

During the trial, clients and therapists interacted with one another in real-time via a secure online website (http://www.psychologyonline.co.uk/). Each client could access up to ten hour-long sessions
of CBT from one of 15 therapists; on average, clients attended seven sessions. A random sample of therapy transcripts were independently rated using the Revised Cognitive Therapy Scale (CTS-R),34 which confirmed fidelity to the CBT approach.30 As the analysis reported below indicates, however, although these sessions globally conformed to the CBT model, as measured by the CTS-R, there was variation in the specific techniques used by therapists.

This article focuses on interaction between clients and therapists in first and second sessions of therapy, with particular focus given to ways in which client expectations were managed in the initial moments of first sessions. Transcripts were analysed in the same format as the session logs that were available to clients and therapists. Fragments reproduced here have been modified in two ways. First, names have been replaced with pseudonyms, to protect participant anonymity. Second, line numbering has been added as a reference point. Any typographical errors in the original logs have been retained. The study was approved by a UK NHS Research Ethics Committee.

Analytic approach
To study therapy sessions, we used Conversation Analytic (CA) methods to systematically examine interaction between clients and therapists.4 CA is well-suited to studying health care communication,35-37 including psychotherapy,38-40 and has also been adapted to the study of online interaction.41-46 Of particular relevance to our current analytic focus, prior CA research has identified particular ways of opening consultations that can impact on the way those interactions proceed.47 Similar to this, we identify different ways first sessions of online CBT were initiated and the consequences ensuing from this.

Using a standard CA approach,48 first and second sessions for all 183 dyads were systematically examined case-by-case. Our primary focus was to identify recurrent ways therapists opened initial sessions and attempted to manage clients’ expectations of therapy. A secondary focus was to determine whether expectations were managed at subsequent points during the assessment phase, which occupied the first and second sessions of therapy. Seven dyads were excluded from further analysis because information about how the first session was opened was missing, resulting in 176 sessions available for analysis. We made collections of different types of expectation management, studying them to determine what they accomplished and the sequential trajectories that could follow. This identified patterned differences between types of expectation management. Due to space constraints, we reproduce just a few instances here to illustrate our findings.

Analysis
Establishing a therapeutic framework is a task typically undertaken by therapists, and our analysis identifies that it is one that therapists routinely initiate at the very outset of therapy, before they launch the first substantive topic for discussion. The few occasions where clients initiated the first topic reveal the uncertainty faced, by at least some of them, about what to expect from therapy. These occasions are specific evidence of broader uncertainty about psychotherapy that has been highlighted in previous research.7,12 For example, Alison (P45) initiated the first topic by asking “How do we start?” and Isabel (P152) by asking “Do you ask me questions or do I talk?” Their questions indicate these clients do not know what to expect from CBT and provide insight into the basic expectations therapists need to manage at the outset of therapy. Unlike institutional interactions like GP consultations, which most people have experience of across their lifetime,11 clients in this study generally had no prior experience of psychotherapy. Analysis of the assessment phase of therapy found that few clients, when asked by their therapist, reported prior experience of psychotherapy generally, let alone the CBT approach more specifically. Managing their expectations for therapy, therefore, has clear relevance.
Our analysis identified three ways in which therapists managed expectations during the initial moments of first sessions: first, therapists managed clients’ expectations about both the first and subsequent sessions of therapy; second, therapists managed expectations about the first session only; and third, no expectation management was attempted. Some therapists tended to use the same approach in first sessions, while others varied in their approach. In what follows, we explore the three ways in which expectations could be managed in the initial moments of first sessions of online CBT.

Managing expectations about the first and subsequent sessions of therapy

In the first type of expectation management we identified, therapists provided a relatively comprehensive explanation that managed the client’s expectation about the first session and projected what would be attempted in subsequent sessions. In such instances, therapists not only described what would occur imminently (e.g., that the therapist would ask a series of assessment questions) but also outlined what would happen beyond that (e.g., that core therapeutic work such as goal-setting would probably be deferred to the second session). By projecting what is involved in subsequent sessions, therapists provide clients with information that enables them to appreciate that the initial therapy session can be quite different to subsequent therapeutic work. This understanding is particularly important for clients who do not perceive particular therapeutic benefit from early sessions of therapy, as it enables an expectation that the activities of therapy will progressively shift and that benefit may follow later.

Comprehensive expectation management occurred in 36 of the 176 (20.5%) first sessions in our corpus. The following is one instance. It comes from the beginning of a first session involving a therapist Holly and her client Hannah. In her opening, Holly explains the typical structure of a CBT session before continuing to outline her plan for the first and subsequent sessions.

Fragment 1 [Online CBT: P60-T5-S1]

| [01] Holly | Hello Hannah |
| [02] Hannah | Hi Holly. |
| [03] Holly | Welcome to online CBT. Any questions you want to ask at this stage? |
| [04] Hannah | No questions at present, Just feel really nervous. |
| [05] Holly | Anything you are particularly nervous about? |
| [06] Hannah | Talking about my feelings, not good at it. |
| [07] Holly | In CBT we concentrate as much on what you are thinking and doing as how you feel as they are all seen to be interlinked. At the beginning of each session we usually agree an agenda and at the end homework. Today I thought it would be useful to discuss what the main difficulties are and get to know you. A first assessment really. This usually continues in the second session where we agree what you want to achieve in therapy and set your therapeutic goals which we evaluate regularly as we go along. How does that sound? |
| [10] | |
| [11] | |
| [12] | |
| [13] | |
| [14] | |
| [15] Hannah | sounds good. |
| [16] Holly | Ok do you want to dive in there then and talk about what brings you here. |
| [17] | |

Holly’s attempts to manage Hannah’s expectations for the session have a prospective quality. Her turn beginning at line 7 is constructed as preliminary to further activity. For example, although she mentions discussing Hannah’s difficulties (at lines 10-11) she does not, at that point, explicitly ask Hannah to tell her about them. Rather, she projects that an assessment of Hannah’s situation will be their initial focus, before explaining that other therapeutic work (e.g., goal-setting) will be deferred to the next session. She seeks Hannah’s assent to this by using a response solicitation (How
does that sound?, line 14).\textsuperscript{51} Constructing her turn in this way initiates a pre-sequence, a practice commonly used to support the viability of the action it projects.\textsuperscript{50,52} It is only after Hannah responds affirmatively to the solicitation (lines 14-15) that Holly is in a position to begin the activity she has projected by eliciting Hannah’s difficulties (lines 16-17). Although not all preliminary explanations are constructed in this way, the majority of instances in our corpus are pre-sequences that occasion a response from clients, thereby explicitly seeking to co-opt them into the plans for therapy.

Holly’s pre-sequence is an example of a practice commonly employed by therapists in our online CBT data. Not only does it project an imminent course of action for the current session (an assessment phase), it also projects future activities that will extend beyond the current session. It is this feature that is common to this type of opening. As the next fragment shows, although the detail of what is projected may differ, what is common amongst these projections is that they involve managing expectations for future sessions of therapy, in particular that they will involve different activities than those undertaken during an assessment phase. It also comes from the beginning of a first session and involves Pete, a client, and Jenny, his therapist.

**Fragment 2 [Online CBT: P141-T11-S1]**

|   |   |
|---|---|
| 01 [Pete] | Hello |
| 02 [Jenny] | Hi Pete. Welcome to our first appointment! Today's session will allow |
| 03     | us to talk about what your current situation is, and the type of support |
| 04     | you feel you would like right now. At the end of the session we can make |
| 05     | a plan as to how you would like to progress. How does that sound? |
| 06 [Pete] | Wonderful |
| 07 [Jenny] | Great. OK, so could you tell me just a little bit about yourself, just so that |
| 08     | I can understand your current circumstances, and also an outline of |
| 09     | what you feel you would like some help with right now? |

There are notable differences between the projections made in Fragments 1 and 2. For example, in Fragment 1 Holly projects homework as an activity that will be set at the end of the session, whereas in Fragment 2, at the same juncture, Jenny makes no mention of such an activity. What is common between the two projections, however, is that they extend beyond projecting an imminent next action to include a subsequent activity or activities. In Fragment 1, an assessment is projected as a next action and goal-setting is projected as a subsequent activity. In Fragment 2, discussion of Pete’s current situation (arguably another way of describing an assessment) is projected as a next action and a plan for therapy is projected as a subsequent activity. By explaining that their initial work together is preliminary to subsequent therapeutic tasks, therapists provide clients with information that may enable them to appreciate that initial therapeutic work differs from subsequent work, an understanding that would be particularly important for clients who do not experience immediate therapeutic benefit. The type of expectation management considered so far has been relatively comprehensive, projecting beyond the task that is to immediately follow to outline a broader trajectory that therapy will follow. However, as we shall show in the following section, most expectation management was not as comprehensive.

**Managing expectations about the first sessions only**

In the second type of opening we identified, therapists gave some preliminary explanation that managed clients’ expectations about the first session, but did not project beyond that session. This second type was the most common in our dataset, occurring in 108 of 176 (61.4\%) first sessions. In these instances, therapists tended to outline what would happen during the first session only without explaining what would happen in subsequent sessions.
An example of this type of expectation management occurs in the following instance, involving a therapist Nicole and her client Janet. In her preliminary explanation, Nicole projects a particular structure for therapy, although unlike Fragment 1 this explanation does not project beyond the current session.

Fragment 3 [Online CBT: P36-T3-S1]

01 [Nicole] Hello Janet, how are you this morning?
02 [Janet] Janet Bressington has entered the room
03 [Janet] Hello Nicole I am fine thanks but very slow with keyboard skills!
04 [Nicole] Don't worry about that. I always tell people not to worry about spelling or grammer otherwise we could spend the whole session checking what we have written is that ok with you?
05 [Janet] great!
06 [Nicole] Ok. In this first session I need to get some background information from you that will help me assess you and your problems is that ok?
07 [Janet] yes happy to supply you with apotted history of my life and living with depression
08 [Nicole] ok. I will do this by asking you a series of questions. If at anytime you think i am going to quick, you don't understand or you need a break, or you don't agree with anything I say please do not hesitate to tell me. as this therapy is for you. We will work together to find suitable solutions to your problems is that ok?
09 [Janet] That's fine
10 [Nicole] Can you confirm your name, date of birth, occupation, marital status, in or out of a relationship, do you have any children and your GP

As in Fragments 1 and 2, Nicole initiates a pre-sequence to establish, in advance, space to assess Janet’s reasons for seeking therapy. However, unlike the earlier instance, Nicole does not project what will happen beyond that assessment. She does not utilise this opportunity to project a range of therapeutic tasks that will take place in future sessions, therefore eschewing an opportunity to outline more broadly the therapeutic process. Nicole does claim that therapy will be collaborative (lines 15-16), but does not provide Janet with details that would enable her to appreciate that subsequent sessions will involve different therapeutic activities from those that are to be undertaken in the first.

Although Nicole does not project beyond the first session, she does nevertheless seek to manage Janet’s expectations about what will immediately follow. Nicole initially explains that she will conduct an assessment (lines 8-9) and subsequently explains that she will do so by asking a series of questions (line 12). She also uses this opportunity to explain to Janet that this activity can be interrupted for any reason (lines 12-16). On two occasions, at lines 9 and 16, she seeks Janet’s assent to her projected plans. In this way, Nicole seeks to manage Janet’s expectations for their imminent work together. A similar practice of managing expectations about the imminent future is used in Fragment 4, involving Paul, a client, and Stephanie, his therapist.

Fragment 4 [Online CBT: P51-T4-S1]

01 [Paul] Good Morning
02 [] Stephanie Moore has entered the room
03 [Stephanie] Hello Paul
04 [Paul] Hi
05 [Stephanie] Welcome
06 [Stephanie] Perhaps we could start off the session today with you telling me a little bit
07 about yourself and what has brought you to have some CBT (cognitive
08 behaviour therapy). How does that sound?
09 [Paul] Sounds good to me.
10 [Paul] Erm How to begin is a tough one, ((continues))

As in Fragment 3, here Stephanie projects (at lines 6-8) a particular course of action that she and
Paul subsequently engage in. Unlike in Fragments 1 and 2, her projection does not extend beyond
the imminent next action to outline activities the dyad will engage in subsequently. The activity is
constructed, however, as time-limited. Stephanie suggests that Paul’s description of himself and his
reason for seeking therapy will “start off the session” (line 6). In this sense, there is a means for Paul
to appreciate that at least a further activity, if not activities, will follow his initial description.
Nevertheless, Stephanie’s projection provides no details of what subsequent activity will be. This is
the crucial difference between the two types of action projections we have considered so far.

Explanations are a method for managing the expectations of others3-13,14 and the two types of
explanation considered above illustrate how therapeutic process can be projected to varying
degrees. This may have consequences for the subsequent interaction between therapist and client
and the longer-term progress of therapy. A more immediate consequence of expectation
management, however, is that it appears to facilitate smooth progress to the therapist’s assessment
of their client’s situation and circumstances. This consequence is apparent in instances where
explanations are not produced and expectations are not managed.

No expectation management at the outset of therapy
One way to appreciate how explanations manage clients’ expectations is by observing occasions
where this does not occur. In the final type of therapy opening we identified, therapists ask a
therapy-oriented question without first attempting to manage clients’ expectations about what
therapy will involve. This type was identified in 32 of 176 (18.2%) first sessions in our corpus. Only
two of the 15 therapists in our study opened first sessions in this manner. Where this did occur,
however, it often occasioned a disavowing (that is, a ‘non-answering’) response from clients.
Although uncommon, these instances are useful ‘deviant cases’53 to identify the value of expectation
management. The following is one such instance. It involves Stephanie, the same therapist as in
Fragment 4, and her client Jennifer. As with the above fragments, it comes from the beginning of a
first session of therapy.

Fragment 5 [Online CBT: P53-T4-S1]
01 [Jennifer] hello stephanie I am early just to make certain everything goes
02 according to plan. the time is 7.40.
03 [Stephanie] Hello Jennifer
04 [Stephanie] glad things have gone smoother this time.
05 [Jennifer] hi i am here
06 [Stephanie] how can i help?
07 [Jennifer] oh I don’t know hoping you would have all the answers
08 [Stephanie] what kind of situations are problematic for you at the moment?

Following discussion of some apparent difficulty with an earlier session (lines 1-4), Stephanie moves
to initiate the business of therapy. Instead of the explanations observed in the earlier fragments,
however, Stephanie directly proceeds to seek information. Her question (how can i help?, line 6), is
formatted as a general inquiry.47 Although such questions are readily answerable in GP
consultations,47 a type of institutional encounter most people have experience of,11 this question can
be difficult for psychotherapy clients to answer, which is further evidence that they may have
unclear expectations about therapy. This is indeed the case for Jennifer, who replies with a
disavowing response (line 7). She treats Stephanie’s question as anticipating that she will be able to articulate how psychotherapy can help her. By typing “hoping you would have all the answers” (line 7), Jennifer defers responsibility for this to Stephanie as her therapist. Jennifer’s disavowing response puts Stephanie in the position of having to attempt to begin the business of therapy all over again, which she does with a more specific question at line 8.

The opening moments of the session in Fragment 5 lack key elements observed in previous fragments. By projecting what will happen in the first session, and perhaps beyond, therapists provide clients with means to understand how they should contribute to the therapeutic process. In contrast, with no expectation management, clients have little structure to appreciate how they can contribute. It is important to be clear, however, that this is not necessarily the case. Although Jennifer struggled to respond to Stephanie’s question, the following fragment shows a client, Danielle, who displayed no difficulty responding to a near identical question from her therapist Tim. Prior to the beginning of the fragment, Tim has been explaining confidentiality and aspects of the online modality that they are using to interact with one another, but has not yet moved into the assessment phase of the session.

**Fragment 6 [Online CBT: P17-T2-S1]**

14 [Tim] Okay. So, how can I help you?
15 [Danielle] Well - my life is one big mess. I am now a house wife looking after 3 children. One at school and two liyyle ones at home. I should be on top of things but I’m not. I can’t seem to cope with everyday things like cleaning, ironing etc, The day seems to go by and I haven’t got these things done. As the months have by this is starting to upset me more and more...I also have the most terrible mood swings. I would like to sort myself out and go back to the kind, patient person that I once was.
16 [Tim] Tell me about the person you once were?

Danielle’s response to Tim’s question displays that she has some understanding of her role in the therapeutic process. Her understanding is that her role is to articulate the current problems in her life and the change she seeks to achieve. Irrespective of whether Danielle’s understanding is appropriate, a comparison of responses in Fragments 5 and 6 suggests that clients bring different levels of expectations to psychotherapy. Although general inquiries that are not prefaced with preliminary explanations will not always occasion disavowing responses, this is nonetheless a risk faced by therapists using this approach. In the absence of some form of preliminary explanation, clients may not appreciate that therapists’ initial questions are part of a process, and may not understand their role in that process and how it might benefit them.

In summary, most therapists did attempt to manage clients’ expectations at the outset of therapy. Such attempts typically oriented the client to the process of the first session, sometimes projecting beyond to future sessions, thereby managing clients’ expectations of the therapeutic process more broadly. Our analysis suggests opening a first session of therapy with some expectation management is more beneficial for the therapeutic interaction than opening a session without such an explanation. Initial moments of first sessions provide a unique opportunity to manage clients’ expectations. As we shall show in the following section, therapists are far less likely to manage expectations during the remainder of the assessment phase.

**Subsequent expectation management**

In addition to examining the initial moments of first sessions, our analysis also included an inspection of the entire assessment phase of therapy. The aim of this examination was to evaluate the extent to which expectations about therapy are managed before therapists and clients move from assessing
the client’s situation to specifically addressing the aspects of their situation that may be contributing to their distress. Given the assessment phase sometimes extended into the second session, our analysis of a dyad continued until a clear move had been made from the assessment phase to the standard session format that defined the subsequent sessions of therapy. Our analysis identified that, in principle, therapists could manage client’s expectations at a variety of points during the assessment phase. The first session between a therapist Nicole and her client Fiona is an example of this. In addition to managing the Fiona’s expectations during the initial moments of therapy, Nicole also provides additional explanation of the therapeutic process during the closing moments of that same session, immediately after Nicole and Fiona have arranged their next meeting. The following fragment shows this expectation management at both the beginning and end of the session.

Fragment 7 [Online CBT: P43-T3-S1]
001 [Nicole] Hello Fiona, how are you this morning?
002 [Fiona] Fiona Robinson has entered the room
003 [Fiona] Hi Nicole, I am fine thank you
004 [Nicole] Great! In this first session I need to get some background information
005 from you that will help me assess you and your problems. I will do this
006 by asking you a series of questions, is that ok?
007 [Fiona] yes ,that will be ok
((94 lines omitted))
101 [Nicole] ok I want to say to you thank you for working very hard and next week
102 we will finish the assessment and start the work on the therapy. Take
care and speak next week bye for now
103 [Fiona] Bye

Nicole is the same therapist as considered in Fragment 3. Here, in her session with Fiona, she uses a similar explanation at lines 4-6 as she provided to Janet at lines 8-9 of Fragment 3. Both explanations provide a means for managing clients’ expectations about the activity that is to follow, but they do not outline subsequent activities that will constitute the therapeutic process. In her session with Fiona, however, Nicole provides additional information about the therapeutic approach to that outlined during the initial moments of therapy. At the end of the session, she explains that in their following session they will complete their assessment of Fiona’s situation before moving to commence therapy (lines 101-102). Just as expectation management during the initial moments of first sessions may help orient clients to the structure of therapy, expectation management at subsequent points provides further opportunities for clients to understand the process and trajectory of therapy.

Although not common, there were other occasions like the above instance involving Fiona and Nicole. In 27 out of 176 dyads (15.3%), expectations were managed at some point after the opening moments of the session. In 20 dyads (11.4%) the therapist had already managed the client’s expectations in the initial moments of the first session. Fragment 7 is an example of this. In only seven dyads (4.0%), however, were expectations managed at a subsequent point in the assessment phase but not during the initial moments of the first session. Our analysis therefore reveals that most common point during the assessment phase at which clients’ expectations are managed is during the initial moments of the first session. At this point in the interaction 144 clients (81.8%) had their expectations managed to some extent. The initial moments of therapy therefore afford a critical opportunity for therapists to explain the process of therapy to their clients.

Discussion
Aligning the expectations of clients and health care providers regarding their work together is an important factor in treatment success and client satisfaction. This article addresses one
component of this, examining how health care professionals can manage clients’ expectations about the treatment process. Focusing on online CBT for depression, we explored ways in which therapists manage clients’ expectations at the outset of therapy. On this basis, we distinguished initial moments of first sessions into three types. In the first type, therapists gave relatively comprehensive projections of the activities involved in therapy. This involved describing activities that would constitute the first session, as well as what would be involved in subsequent sessions. In the second type, therapists outlined what would happen in the first session, but did not mention what would happen in subsequent sessions. In the third type, therapists made no attempt, in the initial moments of the first session, to manage clients’ expectations about the therapeutic process.

Our analysis also identified evidence in support of managing clients’ expectations at the outset of therapy. First, occasions where therapists made no attempt to manage clients’ expectations were liable to occasion difficulties. Most commonly, clients displayed uncertainty about how to respond to their therapist’s first assessment question. Initiating the process of expectation management at the beginning of therapy is a clear way for therapists to enhance the likelihood that clients will engage in the therapeutic process from its outset. It is also an opportunity to convey that clients may need to remain in therapy for many sessions to derive an optimal therapeutic benefit. Finally, given that people can hold themselves, and one another, accountable to explanations they provide, managing expectations at the outset of therapy may help to make both therapists and clients accountable to the process they have agreed to follow.

This study follows calls for evidence-based explanations of the psychotherapeutic process that can be used to improve treatment. Although there are suggestions for how therapy sessions should be opened and clients’ expectations managed, we believe this is the first attempt to observe how this is accomplished in actual sessions of psychotherapy. We explore the local consequences of using different ways of opening first sessions of online CBT, finding those that project a more likely to result in productive responses from clients. Some therapists consistently used the same approach in first sessions, while others varied in their approach. In another article, we report a quantitative study based on the analysis provided here that shows managing expectations from the outset of therapy is associated with increased retention of clients in online CBT.

More broadly, our study highlights ways in which different types of health care encounters can require managing clients’ expectations in different ways. For example, although existing research has identified that service users visiting a GP can readily answer general inquiries, our research demonstrates that people may struggle to answer to that same question when asked in a different institutional setting like online psychotherapy. It is likely that such questions are more readily answered in settings like primary health care encounters, as service users have been socialised into the process across a lifetime of encounters. Such extensive socialisation is unlikely to be the case, however, for the vast majority of clients attending psychotherapy. They may have no prior experience of therapy, or their experience may be with a different therapeutic approach. This highlights important institutional differences can exist that impact on expectation management. Our research suggests managing expectations is particularly important for types of health care services that clients do not routinely visit. It is also important to consider differences in levels of expectations that are likely to exist between clients and to manage these accordingly.

Managing clients’ expectations is important across different types of health care encounters, although it appears the manner in which this is attempted differs across different types of encounters. In online CBT, we find that managing expectations at the very outset of therapy is a means to circumvent initial problems in engaging clients in the therapeutic process. More broadly, all health care providers should consider appropriate ways of managing their clients’ expectations about the consultation and treatment process.
References
1. Hopkins JE, Loeb SJ, Fick DM. Beyond satisfaction, what service users expect of inpatient mental health care: A literature review. Journal of Psychiatric and Mental Health Nursing 2009;16:927-37.
2. Kenten C, Bowling A, Lambert N, Howe A, Rowe G. A study of patient expectations in a Norfolk general practice. Health Expectations 2010;13:273-84.
3. Heritage J, Stivers T. Online commentary in acute medical visits: A method of shaping patient expectations. Social Science & Medicine 1999;49:1501-17.
4. Drew P, Chatwin J, Collins S. Conversation analysis: A method for research into interactions between patients and health-care professionals. Health Expectations 2001;4:58-70.
5. Greenberg RP, Constantino MJ, Bruce N. Are patient expectations still relevant for psychotherapy process and outcome? Clinical Psychology Review 2006;26:657-78.
6. Bowling A, Rowe G, Lambert N, et al. The measurement of patients’ expectations for health care: A review and psychometric testing of a measure of patients’ expectations. Health Technology Assessment 2012;16:1-509.
7. Constantino MJ, Glass CR, Arnkoff DB, Ametrano RM, Smith JZ. Expectations. In: Norcross JC, ed. Psychotherapy Relationship that Work: Evidence-based responsiveness. New York: Oxford University Press; 2011:354-76.
8. Kravitz RL. Patients’ expectations for medical care: An expanded formulation based on review of the literature. Medical Care Research and Review 1996;53:3-27.
9. Byrne PS, Long BEL. Doctors talking to patients: A study of the verbal behaviours of doctors in the consultation. London: Her Majesty's Stationery Office; 1976.
10. Heritage J, Clayman S. Talk in Action: Interactions, identities, and institutions. Chichester: Wiley-Blackwell; 2010.
11. Roberts C, Sarangi S, Moss B. Presentation of self and symptoms in primary care consultations involving patients from non-English speaking backgrounds. Communication & Medicine 2004;1:159-69.
12. Persons JB. Structure of the therapy session. In: Persons JB, Davidson J, Tompkins MA, eds. Essential Components of Cognitive-Behavior Therapy for Depression. Washington D.C.: American Psychological Association; 2001:57-87.
13. Heritage J. Explanations as accounts: A conversation analytic perspective. In: Antaki C, ed. Analysing Everyday Explanations: A casebook of methods. London: SAGE Publications; 1988:127-44.
14. Parry R. Practitioners’ accounts for treatment actions and recommendations in physiotherapy: When do they occur, how are they structured, what do they do? Sociology of Health & Illness 2009;31:835-53.
15. Tolin DF. Is cognitive-behavioral therapy more effective than other therapies? A meta-analytic review. Clinical Psychology Review 2010;30:710-20.
16. National Institute for Clinical Excellence (NICE). Depression in adults quality standard. NICE quality standard 8 http://guidance.nice.org.uk/qs8 (accessed 3 January 2013), 2011. at guidance.nice.org.uk/qs8.)
17. Barak A, Klein B, Proudfoot JG. Defining internet-supported therapeutic interventions. Annals of Behavioral Medicine 2009;38:4-17.
18. Castelnuovo G, Gaggioli A, Mantovani F, Riva G. New and old tools in psychotherapy: The use of technology for the integration of traditional clinical treatments. Psychotherapy: Theory, Research, Practice, Training 2003;40:33-44.
19. Wade AG. Use of the internet to assist in the treatment of depression and anxiety: A systematic review. Primary Care Companion to the Journal of Clinical Psychiatry 2010;12:e1–e11.
20. Strunk DR, Brotman MA, DeRubeis RJ, Hollon SD. Therapist competence in cognitive therapy for depression: Predicting subsequent symptom change. Journal of Consulting and Clinical Psychology 2010;78:429-37.
21. Kazdin AE. Understanding how and why psychotherapy leads to change. Psychotherapy Research 2009;19:418-28.
22. Howard KI, Kopta SM, Krause MS, Orlinsky DE. The dose-effect relationship in psychotherapy. American Psychologist 1986;41:159-64.
23. Hansen NB, Lambert MJ, Forman EM. The psychotherapy dose-response effect and its implications for treatment delivery services. Clinical Psychology: Science and Practice 2002;9:329-43.
24. Harnett P, O'Donovan A, Lambert MJ. The dose response relationship in psychotherapy: Implications for social policy. Clinical Psychologist 2010;14:39-44.
25. Beck JS. Cognitive Behavior Therapy: Basics and beyond. New York: Guilford Press; 2011.
26. Hill CE. Therapist techniques, client involvement, and the therapeutic relationship: Inextricably intertwined in the therapy process. Psychotherapy: Theory, Research, Practice, Training 2005;42:431-42.
27. Horvath AO. The alliance in context: Accomplishments, challenges, and future directions. Psychotherapy: Theory, Research, Practice, Training 2006;43:258-63.
28. Castonguay LG, Constantino MJ, McAlavey AA, Goldfried MR. The therapeutic alliance in cognitive-behavioral therapy. In: Muran JC, Barber JP, eds. Therapeutic Alliance: An evidence-based guide to practice. New York: The Guildford Press; 2010:150-71.
29. Bordin ES. The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy: Theory, Research and Practice 1979;16:252-60.
30. Kessler D, Lewis G, Kaur S, et al. Therapist-delivered internet psychotherapy for depression in primary care: A randomised controlled trial. Lancet 2009;374:626-34.
31. Beattie A, Shaw A, Kaur S, Kessler D. Primary-care patients' expectations and experiences of online cognitive behavioural therapy for depression: A qualitative study. Health Expectations 2009;12:45-59.
32. Beck A, Steer R, Brown G. Manual for the Beck Depression Inventory. San Antonio: The Psychological Corporation; 1987.
33. WHO. International Statistical Classification of Diseases and Related Health Problems: 10th revision. Geneva: World Health Organization; 2007.
34. Blackburn I-M, James IA, Milne DL, et al. The Revised Cognitive Therapy Scale (CTS-R): Psychometric properties. Behavioural and Cognitive Psychotherapy 2001;29:431-46.
35. Barnes R. Conversation analysis: A practical resource in the healthcare setting. Medical Education 2005;39:113-5.
36. Gill VT, Roberts F. Conversation analysis in medicine. In: Sidnell J, Stivers T, eds. The Handbook of Conversation Analysis. Chichester: Blackwell Publishing Ltd; 2013:575-92.
37. Heritage J, Maynard DW. Problems and prospects in the study of physician-patient interaction: 30 years of research. Annual Review of Sociology 2006;32:351-74.
38. Peräkylä A. Conversation analysis in psychotherapy. In: Sidnell J, Stivers T, eds. The Handbook of Conversation Analysis. Chichester: Blackwell Publishing Ltd; 2013:551-74.
39. Madill A, Widdicombe S, Barkham M. The potential of conversation analysis for psychotherapy research. The Counseling Psychologist 2001;29:413-34.
40. Peräkylä A, Antaki C, Vehiläinen S, Leudar I. Conversation Analysis and Psychotherapy. Cambridge: Cambridge University Press; 2008.
41. Garcia AC, Jacobs JB. The eyes of the beholder: Understanding the turn-taking system in quasi-synchronous computer-mediated communication. Research on Language and Social Interaction 1999;32:337-67.
42. Ekberg S, Barnes R, Kessler D, Malpass A, Shaw A. Managing the therapeutic relationship in online cognitive behavioural therapy for depression: Therapists' treatment of clients' contributions. Language@Internet 2013;10:Article 4.
43. Harris J, Danby S, Butler CW, Emmison M. Extending client-centered support: Counselors' proposals to shift from e-mail to telephone counseling. Text & Talk 2012;32:21-37.
44. Schönfeldt J, Golato A. Repair in chats: A conversation analytic approach. Research on Language and Social Interaction 2003;36:241-84.
45. Rintel ES, Pittam J, Mulholland J. Time will tell: Ambiguous non-responses on internet relay chat. The Electronic Journal of Communication / La Revue Electronic de Communication 2003;13: http://www.cios.org/EJCPUBLIC/013/1/01312.HTML.
46. Rintel ES, Mulholland J, Pittam J. First things first: Internet relay chat openings. Journal of Computer-Mediated Communication 2001;6.
47. Heritage J, Robinson JD. The structure of patients’ presenting concerns: Physicians’ opening questions. Health Communication 2006;19:89-102.
48. Sidnell J. Conversation Analysis: An Introduction. Chichester: Wiley-Blackwell; 2010.
49. Schegloff EA. Preliminaries to preliminaries: 'Can I ask you a question'. Sociological Inquiry 1980;50:104-52.
50. Schegloff EA. Sequence Organization in Interaction: A primer in conversation analysis. Cambridge: Cambridge University Press; 2007.
51. Jefferson G. The abominable ne?: Post-response-initiation response-solicitation. In: Schroder P, Steger H, eds. Dialogforschung: Jahrbuch 1980 des Instituts für deutsche Sprache. Düsseldorf: Pedagogischer Verlag Schwann; 1981:53-88.
52. Sacks H. Lectures on Conversation. Oxford: Blackwell Publishers Ltd; 1992.
53. Maynard DW, Clayman SE. Ethnomethodology and conversation analysis. In: Reynolds LT, Herman-Kinney NJ, eds. Handbook of Symbolic Interactionism. Walnut Creek, CA: Altamira Press; 2003:173-202.
54. Ekberg S, Barnes RK, Kessler DS, et al. Relationship between expectation management and client retention in online Cognitive Behavioural Therapy. Behavioural and Cognitive Psychotherapy (in press).