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"Client choice": How some CBT therapists construct collaboration - Implications for CBT and counselling psychology practice

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"Client choice": How some CBT therapists construct collaboration -

Implications for CBT and counselling psychology practice

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ABSTRACT

Collaboration between therapist and client has been put forward as a core element of successful therapeutic encounters. There has been debate as to the nature of collaboration in cognitive behavioural therapy. In the UK this debate has intensified since the introduction of Increasing Access to Psychological Therapies (IAPT) in 2008 as CBT is the favoured therapeutic modality within IAPT. Collaboration in CBT has been conceptualised in dichotomous ways. From one perspective it is constructed in positivistic terms, in which the therapist implements manualised protocols with little consideration for the therapeutic relationship; from the other perspective collaboration is constructed in dialogic terms, in which therapist and client use CBT interventions to consider new meanings that the client deems to be relevant. The current study used a discourse analytic methodology to investigate how CBT therapists construct collaboration in their therapeutic practices. The aim was to explicate interpretive repertories that participants used in the construction of collaboration. Semi-structured interviews were used with 8 CBT therapists. Questions related to the arguments for and against the nature of collaboration in CBT. A *client choice* interpretive repertoire was used by all participants. It was constructed in various ways in line with either positivistic or dialogic perspectives or elements of both. Individual participants constructed *client choice* from both perspectives suggesting that the dichotomy in perspectives on collaboration in CBT may not be clear-cut. There is an implication for counselling psychology practitioners to reflect on their use of dichotomous perspectives to conceptualise their professional identities.

Keywords: Collaboration, cognitive behavioural therapy, discourse analysis, discursive psychology.

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1. INTRODUCTION

Collaboration between therapist and client is a fundamental aspect of psychotherapy (Tee and Kazantis, 2011; Bachelor, Laverdiére, Gamache and Bordeleau, 2007; Hatcher, 1999; Anderson, 2007). In relation to the practice of psychotherapy collaboration has been defined in terms of the behaviours of therapists and clients; in terms of how knowledge is treated by therapists; and in terms of the power dynamics in the therapeutic relationship (Zimmerman, 2011). The word collaborate derives from the latin 'col' meaning 'with' and 'labore' meaning 'to work'. To 'work with' is an ambiguous statement that has a variety of meanings depending on context (Zimmerman, 2011). This introduction sets out to explicate the varying conceptualisations of collaboration in therapy generally and then discuss these conceptualisations in relation to cognitive behavioural therapy (CBT) specifically.

1.1 Conceptualisations of collaboration in psychotherapy

<u>Collaboration as a set of behaviours</u>

Collaboration in therapy has been defined by the instruments devised to assess the concept (Bachelor, Laverdiére, Gamache and Bordeleau, 2007). According to Bachelor et al. measures developed by researchers assess variables such as client-therapist consensus on therapy tasks and goals. Other variables that are measured include shared responsibility for planning activities, active involvement with therapists' proposals, client compliance and participation in therapy tasks (Ribeiro, Ribeiro, Gonçalves, Horvath and Stiles, 2013).

Bachelor et al. (2007) assessed collaboration using three subscales. Firstly they used the California Psychotherapy Alliance Scales (CALPAS; and Marmar, 1994), which purportedly measures patient commitment, patient working capacity and working strategy consensus. Secondly they used the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss and Cohen, 1976), which is claimed to assess clients overall severity of functioning on a scale of 1-100. Thirdly they used the Motivation for Psychotherapy Scale (MOPS; Rosenbaum and Horowitz, 1983), which is used to measure patients' active participation in psychotherapy. It measures behaviours such as communicating relevant information to the therapist (Bachelor et al., 2007). They identified 22 characteristics of collaboration in therapy that included client self-disclosure and active participation, as well as therapist active listening and adaptation to clients' needs and goals.

Collaboration has been described as the core of the alliance between therapist and client (Allen, Coyne, Colson, Horowitz, Gabbard, Frieswyk and Newsom, 1996; Colson, Horowitz, Allen, Frieswyk, Gabbard, Newsom and Coyne, 1988; Hatcher, 1999; Mackrill, 2010). According to Mackrill (2010) conceptualisations of the working alliance implicitly stress the significance of goal consensus and collaboration. Safran, Muran and Eubanks-Carter (2011) state that ruptures in the alliance can be defined as a tension or breakdown in the collaborative relationship between patient and therapist. Hatcher (1999) investigated therapists' views of the alliance by using multiple regression analyses on therapist responses to the Working Alliance Inventory (WAI; Horvath and Greenberg, 1989) and the California Psychotherapy Alliance Scales (CALPAS; Gaston and Marmar, 1991). Hatcher

identified 'confident collaboration' as the most important aspect of the working alliance regardless of therapeutic orientation. Confident collaboration was defined as therapist's perceptions of patients' steadfast and confident investment in a treatment that feels promising and useful to both parties. Zimmerman (2011) though, argues that the wording of the items on the WAI and CALPAS reflect clients' agreement with the therapists' direction. He states that what is actually being measured is clients' compliant behaviour. Traditional therapy literature has focused mainly on clients' collaboration with therapists' interventions and so should be read specifically as client compliance (Strong and Sutherland, 2007; Gergen and Gergen, 2007).

A consequence of trying to define collaboration as a set of behaviours is that it is constructed as a definite concept with fixed parameters. There may be a danger in doing this that the concept becomes oversimplified in order to observe and measure it. The reduction of collaboration to a pairing of leader-therapist and follower-client, for example by attempting to measure client cooperation has been criticised (Bordin, 1994). It has been argued that collaboration cannot be reduced to a set of behaviours specific to clients and therapists (Sutherland and Strong, 2011). Sutherland and Strong assert that research needs to account for clients and therapists mutually negotiating therapy processes and outcomes. They define collaboration as joint sharing, coordination and construction of meaning moment by moment. For them collaboration occurs in the turn-by-turn developments in how clients and therapists talk in therapy and so cannot be measured by retrospective evaluations, scales and coding systems (Sutherland and Strong, 2011). They suggest that collaboration researchers should focus on discourse (how people constitute meaning) in order to avoid considering collaboration as static and statistically measurable. Their definition

of collaboration from a social constructionist perspective will be discussed in sub section: "Collaboration as power-with clients".

Collaboration as a 'not-knowing' stance

Anderson (2007) states that therapy is collaborative when therapists have a stance of 'not-knowing'. This means they have a sceptical approach to knowledge. All knowledge is treated as tentative and provisional (Anderson, 2007). Therapists do not assume that they can know their clients based on pre-established categories. Anderson views collaboration from a postmodern perspective in which knowledge is linguistically and socially constructed. Knowledge and knower are interdependent and what we 'know' is constructed and communicated in language (Anderson, 1996). Meanings are not inherent in the words themselves but emerge from the way words are used among people within local and general sociocultural contexts (Melito and Rintell, 2013). This is in contrast to a modernist perspective of collaboration as a set of behaviours, which can be discovered and known.

From a 'not-knowing' stance conversations are created with clients through which they may access their creativities and develop new possibilities (Anderson, 2007). There is a non-hierarchical relationship in which therapists act as conversational partners with clients. From this perspective Anderson asserts that clients should be believed and not doubted; clients' subjectivity is what is important as opposed to a hypothetical, objective truth that the client does not yet know. Melito and Rintell (2013) argue that while therapists with a not-knowing stance take a sceptical view of their own knowledge they do not apply the same degree of

scepticism to the client's knowledge. They suggest extending the stance of not-knowing to the client's knowledge. They argue that there can be a fuller participation of the therapist in the therapist-client dialogue while still retaining the collaborative nature of the therapy. Therapists can oppose or question clients in a way that allows clients to both test and find themselves and thus become empowered (Melito and Rintell, 2013). Otherwise there is a paradoxical consequence related to an overly facilitative stance in which clients can feel patronised and not treated as equals. Greater therapist participation allows for greater client agency as clients discover their own resources to solve their problems (Melito and Rintell, 2013). From this perspective clients are still experts in their lives and therapists remain open to clients influence and agency.

Collaboration constructed as 'not-knowing' and collaboration constructed as a set of behaviours are polarised perspectives. From a 'set of 'behaviours' perspective an aspect of collaboration is client compliance with therapist direction, indicating that the therapist has the balance of power. From a 'not-knowing' perspective therapist and client are seen as equal partners. Such polarised perspectives may not be as clearly divided as they are made out to be. For example Guilfoyle (2003) criticises the attempt to position the therapist and client as equal partners. He claims that the not-knowing stance is based on the inaccurate assumption that it is possible to remove power from any relationship. According to Guilfoyle therapists who describe their therapeutic practices as collaborative are not able to escape the inherited and socio-cultural power that pervades the therapeutic relationship. He asserts that framing therapist contributions to the therapy dialogue in a way that allows for uncertainty – for example, "I don't know but it seems like" – does not indicate an absence of power

but the pervasiveness of power that must be constantly countered. Murphy, Cheng and Werner-Wilson (2006) argue that calling a therapy 'collaborative' only serves to deny the power differential that exists between therapists and clients. Guilfoyle (2006) purports that even if therapists' have a wish to disregard their greater power, power is unavoidable in the social and hence the therapeutic domain. Therapists are culturally and institutionally positioned as experts on clients' subjectivity (Zimmerman, 2011). Zimmerman argues that local efforts to challenge this cultural inequality are unlikely to make a significant difference. Therefore constructing collaboration in terms of the presence/absence of power may be an oversimplification of the concept.

Sutherland and Strong (2012) suggest that attempting to work with clients in a collaborative fashion does not mean dismissing institutional and cultural power inherent in the therapist role. For them the important aspect of collaboration is how therapists use power in conversational ways. They argue that focusing solely on therapists' inherent power neglects the rhetorical power of clients to influence the therapist and the process of therapy. They perceive collaborative therapy as 'power-with' clients, as opposed to 'power-over' clients or an absence of power.

Collaboration as 'power-with' clients

Unequal power distribution is an inevitable feature of dialogue (Sutherland and Strong, 2011). They suggest that a therapeutic relationship is collaborative when power distribution is fluid and multidirectional, rather than power being imposed on the client by the therapist. In a collaborative relationship power is co-shared, with

clients and therapists taking turns to offer their expertise and impact on the therapy process (Sutherland and Strong, 2011). They argue that in a collaborative relationship each person feels included in producing action and meaning. This includes having the ability to contribute and contest ideas and actions. If a client refuses or is unsure about engaging in something suggested by the therapist there is an opportunity for the therapist to conversationally propose working towards something more preferable. Not all 'nos' mean 'NO' so it is important how the therapist manages the negotiations (Sutherland and Strong, 2012). This involves having a playful attitude towards language and experimenting with clients in constructing and editing descriptions and understandings. According to Sutherland and Strong therapy is collaborative when clients see their responses and proposals as significantly influential on the process. For them power is not problematic for collaboration in therapy if therapists are sensitive to practices that would minimise or dismiss clients' expertise and preferences. 'Power-with' means 'talking-with' not 'talking-to' clients (Sutherland and Strong, 2012).

The view of collaboration as the co-sharing of power is constructed in a way that suggests it is up to the therapist to implement the co-sharing. For example it is the therapist who needs to be sensitive to practices that would diminish the client's preferences. This implies that there is an element of 'power-over' the client that the therapist has to negate in order to have a 'power-with' relationship. Therefore as with the previous constructions of collaboration the parameters of the 'power-with' construction are not as definite as they are made out to be.

1.2 Collaboration in cognitive behavioural therapy

These three conceptualisations of collaboration – as a behaviour; as a not knowing stance; as *power-with* the client – have all been used in the construction of collaboration in CBT. Firstly an outline of the CBT model of therapy is presented followed by a discussion of the differing constructions of collaboration in CBT and a rationale for investigating these concepts.

Cognitive-behavioural therapy (CBT) is a talking therapy that is used to help people with a range of mental health problems including depression and anxiety (Westbrook, Kennerley and Kirk, 2011). Westbrook et al assert that in CBT problems are viewed as interactions between a person's cognitions, emotions, behaviours and physiology. They suggest that these aspects of a person interact in a complex feedback loop and also interact with their environment. According to Westbrook et al from a CBT perspective people's emotional reactions are strongly influenced by their cognitions. They assert that when a person reacts in what seems to be an unusual way to an event it is because they have unusual thoughts or beliefs about the event. According to Simmons and Griffiths (2009) CBT distinguishes between different levels of cognition – negative automatic thoughts, core beliefs and dysfunctional assumptions. Negative automatic thoughts are negative interpretations that we take from what is happening around or within us and exert a direct influence on our mood moment to moment (Simmons and Griffiths, 2009). They state that core beliefs are a person's fundamental beliefs about themselves, or people or the world. According to Simmons and Griffiths core beliefs are not immediately accessible to consciousness, usually result from childhood experiences and are absolute statements e.g. "I am

unlovable". They state that dysfunctional assumptions are the bridging gap between negative automatic thoughts and core beliefs. Simmons and Griffiths suggest that dysfunctional assumptions are rules for living that help us try to live with negative core beliefs e.g. "because I am unlovable I must always please others or they will abandon me". According to Westbrook et al, when we encounter an event that violates a rule for living then negative thoughts are evoked and unpleasant emotional states result.

CBT educates clients about the interactions between thoughts, feelings, behaviours, physical symptoms and environment (Westbrook, Kennerley and Kirk, 2011). They assert that it helps clients identify negative thoughts and construct new, more balanced thoughts. According to Westbrook et al, CBT uses tools such as automatic thought records (ATR) in constructing new thoughts. They state that the use of ATRs involves clients writing the evidence for and against their negative thoughts. They also state that CBT involves the use of behavioural tools such as behavioural experiments, which are used to test out the validity of newly constructed thoughts in real life situations.

CBT has been described as not having a fixed philosophical stance, instead being more accurately viewed as incorporating a continuum of differing philosophical stances (Boucher, 2010; Grant, Mills, Mulhern and Short, 2004). According to Boucher (2010) at one end of the continuum is CBT from a modernist, positivistic perspective and at the other is CBT from a postmodern, social constructionist perspective. At the positivistic end there is purported to be a focus on pathologising, standardised manual-based interventions, where the evidence base is taken as fact and

the social constructionist end is viewed as having a focus on idiosyncratic formulation-based approaches that value the richness of individual experiences (Grant et al., 2004). There has been much debate in relation to the collaborative nature of CBT and since CBT has been categorised as belonging to more than one theory of knowledge (Lyddon, 1995) it is useful to frame this debate within the positivistic – social constructionist continuum.

<u>CBT viewed from a positivistic/modernist perspective</u>

From a positivistic CBT perspective emotional and behavioural problems arise from an inaccurate perception and interpretation of a person's experience (Lyddon, 1995). For example people are viewed as having 'cognitive errors' such as 'black and white thinking' and 'discounting the positive'. There is an implication that clients' thoughts are wrong. The purpose of therapy then is to help clients correct these errors and see things 'as they are'. There is deemed to be an objective reality that the therapist tries to help the client see (Konstantinou, 2014). At this end of the continuum CBT is technique-orientated and theory driven (Boucher, 2010). According to Boucher clients' presenting issues are dealt with from a prescriptive, directive stance. It is the therapist's job to explore thoughts, assumptions and beliefs with clients and tries to modify them when the therapist finds them unrealistic or unreasonable (Beck and Weishaar, 1989).

The construction of CBT from a positivistic perspective appears to have negative connotations. For example clients' thoughts are labelled 'wrong' and presenting issues are said to be dealt with in a prescriptive way. The implication being

that there is a power imbalance in favour of the therapist. There is a danger of over-simplifying CBT practice by suggesting that it can be done in such a defined, mechanical way. Therapist and client are constructed in mechanistic terms – one doing something to the other that results in change in the other. There is no consideration of the therapist and client as people and the numerous way in which people may interact. Therefore there is a lack of depth to the construction of positivistic CBT practice.

CBT viewed from a social constructionist/postmodern perspective

CBT from within a social constructionist perspective is claimed to not offer a rational guide to discovery of an objective reality but instead provides an opportunity to manipulate meanings, interpretations and beliefs in order to generate new understandings from the client's perspective, not the therapist's (Boucher, 2006). Strong (2000) refers to this as dialogic CBT. It involves a delicate negotiation with clients where new meanings emerge in the immediacies of talking and listening (Strong, 2000). This is in contrast to monologic CBT in which clients are held to a certain view of reality and practice is reduced to a set of steps to follow (Strong, Lysack and Sutherland, 2008). In the latter the therapist-led monologue directs clients to a 'rational' viewpoint (Strong, 2000). In a dialogic approach critical reflection is guided by client judgments and evaluations. There are many ways of talking and understanding and so conversations are not confined to talking within a traditional CBT discourse (Strong, 2000). Cognitions, affect and behaviour are considered in conjunction with the wider contexts in which they occur (Strong et al., 2008). For

example how sociocultural and interpersonal circumstances result in particular meanings and cognitions.

From a dialogic or social constructionist perspective individuals' experiences are supposedly not fitted to a model, rather a model is created around an individual, which takes account of their unique and valid experience (Boucher 2010). According to Boucher this therapy is not based on a rational discovery of objective reality or the treatment of psychopathology and the therapist is not focused on directing the therapy. Instead there is an unfolding cognitive narrative where the individual's unique ways of interpreting events and creating new meanings is the focus (Konstantinou, 2014).

The conceptualisation of collaboration in CBT varies from 'a set of behaviours' at the positivistic end of the continuum to a 'not-knowing' stance and 'power-with' the client at the dialogic end. A lack of clarity regarding the range of epistemological positions that a CBT therapist can hold, along with the treatment of CBT as a single, definable entity has led to confusion about the nature of collaboration in CBT. Proctor (2008) criticises CBT for being founded on the principles of modernism and the rationality of science. She purports that knowledge and research evidence are not questioned but presented as fact and the therapist is seen as being in an objective position to present the knowledge to clients. Proctor conceptualises collaboration as 'power-over' clients. Therapists' objectivity can be used to discount feelings, experiences or thoughts of clients, for example, by using the label 'cognitive distortions'. Power from this perspective is unidirectional. The institutional and scientific power of the therapist is seen to force clients to act in a

certain way. This view is in contrast to Sutherland and Strong (2011) who argue that such conceptualisations of power do not take into account the rhetorical resources of the client to impact the therapy process. In fact Proctor argues that notions of client agency and ability to resist power hides the forces of cultural norms in CBT. She suggests that clients are often in a state of distress and are in no position to resist these norms. She asserts that there is rhetoric in CBT about reducing power imbalances through collaboration but in reality CBT therapists use power to encourage client compliance with accepted models. In this conceptualisation of collaboration the client is encouraged as long as they are following a CBT model of what is best for them (Proctor, 2008). She argues that because rationality is a clear value in CBT there is an implication that there is a right way and a wrong way of thinking. Clients' views that are seen as the wrong way of thinking are labelled as dysfunctional and clients are encouraged by the therapist to see things in a more 'normal' way. She sees the aim of CBT as reconstituting the client according to rational ways of thinking.

For Proctor collaboration in CBT is viewed as a set of behaviours. Specifically client compliance with therapist led tasks and techniques. Collaboration is achieved when the client agrees with the therapist's worldview (Proctor, 2008). She argues that even when the client begins to make their own decisions and is seen to be taking on their own power they are actually internalising norms given to them by the therapist. She states therefore that it would be more honest to talk about compliance instead of collaboration in CBT. Guilfoyle (2008) also criticises CBT for diminishing client agency. He suggests that the use of psychiatric diagnostic criteria for labelling clients positions them as 'ill' and therapists as experts with 'cures'. From this viewpoint collaboration means following expert advice.

Both Proctor (2008) and Guilfoyle (2008) conceptualise collaboration in CBT at the positivistic end of the continuum. CBT is viewed as a single entity and so their criticisms do not take account of alternative conceptualisations of collaboration in CBT. Josefowitz and Myran (2005) concede that there are dangers inherent in the structured nature of CBT in which clients may be left feeling unheard instead of being part of a collaborative process. This is in line with the arguments made by Proctor and Guilfoyle, but Josefowitz and Myran argue that these dangers can be overcome by the therapist utilising the core conditions of empathy, genuineness and unconditional positive regard, outlined by Rogers (1957) and are the foundation of person-centred therapy. The challenge for the CBT therapist, according to Josefowitz and Myran, is to combine structured interventions with an empathic stance. They suggest that structured aspects of CBT can be consistent with the values of person-centred therapy. For example therapists can help clients make their general goals for therapy more specific while remaining congruent to clients' aspirations. Making goals more specific can be emotionally difficult for clients as more personal material is disclosed so a non-judgemental empathic stance can help clients feel understood (Josefowitz and Muran, 2005). This is in contrast to clients perceiving themselves as dysfunctional or abnormal, an argument put forward by critics of positivistic CBT.

Agenda setting can also be a collaborative process when the client has an active role in setting the direction of therapy and the therapist has respect for clients' concerns (Josefowitz and Muran, 2005). They view collaboration in CBT as 'power-with' the client and advocate for the practice of CBT at the dialogic end of the continuum. For example in relation to the use of thought records in CBT, where evidence for and against a negative thought is examined and an alternative thought

proposed, they suggest that the meaning of the thought to the client is what is important. They argue that thoughts should not be judged as 'dysfunctional' but should be explored with openness and understanding. From this standpoint the therapist helps the client explore the idiosyncratic meaning of a situation. They also defend the use of labelling thoughts, for example as 'catastrophic thinking' or 'mindreading'. They argue that such labels do not mean clients are being held to a 'rational' view of reality because such labelling occurs after a collaborative exploration of the clients thought processes and the given label is a word/phrase that resonates with the client. It provides a shorthand way of referring to the clients thought processes and can be experienced as the therapist's empathic understanding of the client's thought processes (Josefowitz and Muran, 2005).

Hemmings (2008) highlights the danger of improper use of CBT techniques, which he argues is more likely to occur when CBT is practiced from the positivistic end of the continuum. He argues that when a CBT technique is used without consideration for the client-therapist relationship in which it is being used, it can be destructive and dangerous. For example using the downward arrow technique therapists ask clients to elucidate possible deeper meanings of their cognitions (Gilbert and Leahy, 2007). This can result in the elicitation of painful core beliefs; without consideration of the possible impact on the client and an awareness of the need for sensitivity it can be very distressing for clients (Hemmings, 2008). He suggests that there is a danger of power abuse when CBT practice is mechanistic, simple diagnostic criteria are used and there is a focus on the technical aspects of therapy. For Hemming CBT is collaborative when there is an overt attempt to

recognise the power imbalance in therapy and clients are able to resist therapist's suggestions or attempts to impose a CBT agenda.

The division of CBT practice into positivistic and dialogic perspectives are examples of polarised constructions. Hsu (2015) argues that in order to explore the complexities of a concept, thinking in dichotomous terms should be avoided. According to Ní Laoire (2007) polarisation often leads to the overemphasis of the 'good' properties of one group and the underrepresentation of their 'bad' properties. Constructing practice as either the mechanical implementation of techniques or as the sharing of power and exploration of meanings infers that one type of practice is bad (positivistic) and that the other is good (dialogic). Therefore there may be a danger that undesirable elements of dialogic practice may be minimised. Ní Laoire (2007) states that highly polarised perspectives can lead to an idealised construction of a concept. CBT from a dialogic perspective is constructed in idealised terms. The balance of power in the therapeutic relationship is seen as always even, the therapist never tries to impose their view and the client always has the ability to resist the therapist's suggestions. This is in contrast to the construction of practice as mechanistic and prescriptive. A more balanced perspective of practice may include elements of both positivistic and dialogic CBT.

Validity v Viability

One way of framing the differences between CBT at the positivistic end of the continuum and CBT at the dialogic end is in terms of validity and viability. Winter (2008) distinguishes between rationalist therapists who he describes as being

primarily concerned with the validity of the client's worldview and constructionist therapists who place importance on the viability of the client's worldview. In the former there is a focus on the correction of 'cognitive errors' and in the latter there is a focus on process over content and the context in which events and experiences are viewed (Winter, 2008). Knowledge evaluated in terms of viability means evaluating its functional value within a particular social context that is constantly changing (Lyddon, 1995), not evaluating whether the knowledge is right or wrong.

CBT practiced from a positivistic perspective evaluates clients' appraisals by comparing them to objective reality (Strong, Lysack and Sutherland, 2008) i.e. it tests the validity of clients' appraisals. From a social constructionist perspective knowledge is not something people possess in their heads but something they do together (Potter, 2012). It is found in the relational processes of exchange and interaction (Lyddon, 1995). A big contribution of CBT has been a focus on how clients define their problems in their own terms (Strong et al., 2008). This focus in CBT on the interpretation of events as opposed to the events themselves is compatible with a social constructionist epistemology when the interpretations are explored in terms of their viability for the client (Boucher, 2010). Clients' cognitions are viewed as emerging in the interactions with therapists and neither client nor therapist can objectively 'discover' the material (Strong et al., 2008).

CBT practiced from a social constructionist perspective purportedly does not attempt to change clients' beliefs in the direction of therapist-defined objectivity because there is no standard objectivity that can serve to test the validity of these beliefs (Lyddon, 1995). According to Lyddon collaboration involves having respect

for the multiple views and possible interpretations of a problem. It is a process of searching for more viable language (in the client's eyes) to articulate ways forward (Strong et al., 2008). Collaboration in a dialogic practice of CBT, suggests Strong et al., involves actively engaging clients in constructing preferred ways of understanding and acting. 'Preferred' implies that there is a range of ways of understanding, none of which is the 'correct' or 'valid' one.

Boucher (2010) suggests that the difference between positivistic and dialogic CBT is that attention is paid to 'being with' an individual's experience in the latter, rather than solely 'doing to' their experience in the former. From a dialogic perspective a client's experiences are not fitted into a model. A model is created around an individual, which takes account of their unique and valid experience (Boucher, 2010). There is no experience that a client brings that is deemed invalid. CBT that is focused on the viability of clients' meanings and understandings is focused on how therapists and clients collaboratively talk beyond ineffective understandings to new understandings that the client finds useful (Strong, 2010). Differences on how the conversation should develop are treated as legitimate aspects of conversational work (Strong, 2010). Power is shared between the therapist and client; either can put forward and contest possible new meanings.

Dividing CBT practices in terms of viability reinforces the polarised perspectives of positivistic and dialogic CBT. Viability is constructed as something positive while validity is constructed as something negative. Suggesting that there is one type of CBT practice that focuses on viability and one that focuses on validity

creates idealised and demonised versions of CBT practice. A more balanced perspective of practice would include elements of both concepts.

Collaborative Empiricism

Within CBT collaborative empiricism (CE) has been put forward as the mechanism of interaction underlying the therapeutic relationship (Beck, Rush, Shaw and Emery, 1979). It encourages client identification, observation and evaluation of introspective beliefs (Beck et al., 1979). Since it was first used varying conceptualisations of CE have emerged, with some at the positivistic end of the continuum (Beck, 2005; Scott and Freeman, 2010; Merali and Lynch, 1997) and others that are closer to the social constructionist end (Overholser, 2011; Kazantzis, Cronin, Dattilio, and Dobson, 2013; Tee and Kazantzis, 2011). There has been confusion as to whether CE is a technique or an aspect of the relationship between therapist and client or a combination of both (Tee and Kazantzis, 2011).

Dattilio and Hanna (2012) state that CE involves cooperation between therapist and client in constructing a treatment plan in order to discover together what is contributing to the client's problems. The therapist and client use experimentation to discover the factors that are causing and maintaining dysfunction in the client's life (Dattilio and Hanna, 2012). They assert that selective aspects of client material is analysed and reprocessed together. It is unclear though how much input the client has in selecting aspects to be reprocessed. Dattilio and Hanna state that it is the therapist who alters client cognitions using CE. From this perspective CE is a tool used to 'do' something to the clients' cognitions. This suggests that the therapist may have a

bigger role in selecting aspects to work on. Scott and Freeman (2010) state that the function of CE is to help clients develop a range of cognitive and behavioural techniques that will be beneficial in their future functioning. Collaboration is deemed to have been successful when the client adopts these techniques in their lives.

According to Merali and Lynch (1997) CE facilitates treatment adherence by making interventions meaningful and relevant from a client's perspective. This suggests that even though CE involves acknowledging and respecting the client's perspective the end goal is to achieve client compliance with a CBT model. Collaboration from this perspective is conceptualised as a set of behaviours that fall under the banner of client compliance. Compliance with the CBT model is encouraged because clients' cognitions and behaviours are evaluated in relation to their validity, not their viability. For example, Beck (2005) states that CE enables the therapist and client to explore misconceptions together and test the validity of clients' thoughts. Kuyken, Padesky and Dudley (2009) assert that collaboration works to elicit shared understandings of clients' problems while empiricism allows these understandings to be checked for accuracy. They state that inaccurate information is filtered out by testing it empirically. With a focus on validity there is a right way and a wrong way to think and behave. It is the therapist's job to help clients think and behave the right way. If a therapist relies solely on clients' self-reports the wrong intervention may be used (Merali and Lynch, 1997). Judging clients cognitions as valid/invalid justifies the encouragement of client compliance with the therapist-led interventions.

Ekberg and LeCouteur (2014) define collaboration in CBT in terms of 'co-implication' of the client in the decision-making process. 'Co-implication' refers to instances where the therapist invites clients to participate actively in the institutional activity that is underway (Ekberg and LeCouteur, 2014). They suggest that although therapists can guide clients towards actions that may be helpful it is better if clients make the choice. Co-implication is a way of involving clients in the decision-making process while at the same time guiding the process in terms of a CBT mandate (Ekberg and LeCouteur, 2014). Collaboration here seems to be a way to encourage client compliance under the guise of client agency. Using conversation analysis Ekberg and LeCouteur analysed aspects of 20 CBT sessions that focused on the construction of a client behavioural experiment. They found that the client was often positioned as the knowledgeable party. This was achieved by the therapist asking information-soliciting questions. They also found that the therapists directed clients implicitly by framing client responses in ways that directed the trajectory of the sequence to a therapist-favoured outcome. They assert that when working collaboratively with clients there is a danger that therapists may lose sight of the goals of the sessions; so they should use specific turn by turn structures to 'co-implicate' clients while remaining the director of the sequence in progress. Ekberg and LeCouteur argue in favour of using conversational techniques to develop an atmosphere of collaboration while the therapist actually directs therapy. This is an example of how the idea of collaboration can be used to both encourage and hide client compliance.

An important aspect of CE for Tee and Kanzantzis (2011) is that the client decides the criteria for judging the validity of beliefs and cognitions. Their

conceptualisation of CE fits between the positivistic and dialogic positions. CE is positivistic in that beliefs are tested empirically and it is dialogic in the sense that it is the client's interpretation of an experiment that is taken into account (Tee and Kanzantzis, 2011). They state that CE is directive in that clients are encouraged to engage in the process of empirical testing and it is collaborative in that clients actively exercise choice in the design and evaluation of the experiments. The 'accuracy' of automatic thoughts is based on client-derived data, not some rational-objective 'truth' (Cohen, Edmunds, Brodman, Benjamin and Kendall, 2013). It is essential that the therapist is respectful and responsive to clients' beliefs and preferences including those that are culturally based (Kazantzis, Tee, Dattilio and Dobson, 2013). From this perspective it is the viability of meanings to clients that is important. Tee and Kazantzis suggest that a client's sense of efficiency and autonomy is increased by focusing on the client's intrinsic data that is evaluated by criteria generated by the client.

Overholser (2011) asserts that when a therapist behaves like an expert they tell clients what to do and they minimise client agency. He describes CE in terms of a *not knowing* stance, in which the therapist attempts to understand the client's experience from the client's perspective. This *not knowing* stance is akin to the one proposed by Melito and Rintell (2013), in which both therapist and client knowledge is questioned. Therapist and client work together to explore new ideas, test different options and discover the best alternatives for the client (Overholser, 2011). For Overholser it is the viability of certain meanings and beliefs for the client that is important, not whether they are objectively valid or not. He asserts that an overreliance on treatment manuals

and a predetermined structure diminishes the flexible nature, spontaneous dialogue and individual client needs that occur in session.

Kazantzis, Cronin, Dattilio and Dobson (2013) state that a central aspect of CE is the idea of "shared work". The therapist takes greater responsibility for the work in the early stages of therapy and the client takes greater responsibility in the latter stages (Kazantzis et al., 2013). They conceptualise CE as 'power-with' the client; where power shifts between therapist and client. From a 'power-with' perspective the role of the client in CBT is one of highly influential contributor, not passive recipient (Wright and Davis, 1994). Productive therapy is a didactic interaction against a background of warmth and empathy (Muran and Safran, 1993). Tyron and Winograd (2011) asserts that clients take on a more active role in CBT than in some other therapies, for example by guiding the agreement about what they will do. He also describes collaboration as a 'sharing of work'.

Collaborative empiricism is a key concept in CBT but the construction of this concept in the CBT literature is divided between positivistic and dialogic perspectives. For example the construction of CE put forward by Ekberg and LeCouteur (2014), in which client compliance is attained through co-implication in the decision-making process, fits with a positivistic perspective. The construction of CE put forward by Overholser (2011) on the other hand, in which the best alternatives for the client are explored, fits with a dialogic perspective. If such a division of CE exists within the literature it raises the question whether individual CBT therapists view CE in their practice from a polarised perspective. As noted earlier there is a

danger of emphasising desired aspects of practice and minimising other aspects when coming from a polarised perspective.

Socratic dialogue

One way in which collaborative empiricism is implemented in CBT is through the use of Socratic dialogue. Socratic dialogue is a verbal method that uses questions, reflections, summaries and suggestions to help broaden the client's perspective and to draw attention to information that is relevant to the beliefs and behaviours that are being tested (Kazantzis, Fairburn, Padesky, Reinecke and Teeson, 2014). The therapist asks a series of carefully selected questions to help define problems, assist in identification of thoughts and beliefs, examine the meaning of events or assess the ramifications of particular thoughts or behaviours. Such questions are ones which the client has the ability to answer and which promote an alternative perspective. The Socratic approach combines major views from ancient philosophy with the strategies of CBT (Overholser, 2010). Clark and Egan (2015) suggest that Socratic dialogue encourages clients to re-evaluate their thinking and consider their thoughts in relation to information previously not in their awareness in order to reach their own conclusions about the validity of their thoughts. The major assumption of this method is that if the client arrives at their own understanding there will be a greater impact on detrimental attitudes and beliefs and a greater reduction in emotional distress.

According to Overholser (1993) the basic components of the Socratic method are systematic questioning, inductive reasoning and universal definitions. The process

of questioning is more complex than just asking numerous questions (Overholser, 2010). Overholser asserts that the content of Socratic questions is designed to foster independent, rational problem solving in clients. Good Socratic questions allow the therapist and client to explore different topics, gather relevant information and help clients to think about their core issues in an alternative way. Information that is brought into awareness through questioning is then subject to inductive reasoning processes (Clark and Egan, 2015). Through inductive reasoning clients are helped to view their attitudes, interpretations, expectations and beliefs as hypotheses to be examined and sometimes replaced (Overholser, 2010). Overholser suggests that that inductive reasoning helps keep the dialogue focused on logic, reasoning and a critical review of the evidence. The idea is that clients recognise logical inconsistencies and discrepancies in reasoning (Clark and Egan, 2015). Clark and Egan assert that when logical inconsistencies amongst interrelated beliefs become salient these beliefs modify to become more internally consistent.

A mixture of question formats are used in the Socratic method in order to promote conceptually integrated understanding (Overholser, 1993). These questions are interlaced with dialogue so that sessions do not feel like and interrogation (Overholser, 2010). Padesky (1993) outlines this process in four steps: firstly informational questions are asked in order to bring relevant information into awareness and help make the client's problems concrete and understandable for both therapist and client; secondly the therapist listens carefully to client responses and is open to discovering unexpected information; thirdly the therapist summarises what has been discovered so far to check if the therapist and client are understanding things in a similar way; finally after new information has been discovered, meanings

explored and summarised, synthesising questions are used to apply the new information to the client's original belief.

Overholser (2011) suggests Socratic dialogue creates an interactive flow between the therapist's professional background and the client's personal experiences, joining these two different sets of knowledge, skills and backgrounds. There is no presumption that the therapist has an ownership of truth just a presumption that the way the client is thinking isn't working for them. Overholser (2010) asserts that Socratic dialogue is active but not directive; both therapist and client are equals in a search for knowledge, wisdom and new insights and meanings. Padesky (1993) describes the process of Socratic dialogue as one of guided discovery. According to Padesky the therapist asks a series of questions but is not quite clear where the client is headed. They guide without knowing where they will end up. The therapist's questions are meant to push the dialogue forward but the client's answers steer the direction (Overholser, 2010). The therapist should have a stance of genuine curiosity (Padesky, 1993), which is achieved through a disavowal of knowledge on the part of the therapist (Overholser, 2010). The therapist accepts the limits of their understanding and professional knowledge which promotes intellectual curiosity and a sincere search for new information. The therapist should not steer the client towards a predetermined answer (Overholser, 2010).

The construction of Socratic dialogue as guided discovery, in which the therapist takes a 'not-knowing' stance and there is a 'power-with' relationship between therapist and client, fits with a dialogic perspective of collaboration in CBT. Other constructions though could be argued to fit more with a positivistic perspective.

For example Clark and Egan (2015) state that clients are guided in an open and curious way towards particular insights. They assert that by exploring the validity of cognitions, Socratic dialogue allows clients to differentiate between their thoughts and the truth. In this construction of Socratic dialogue the function of a curious stance by the therapist appears to be to lead the client to a particular 'truth'. According to Beck (2011) when an unhelpful belief is identified it is the therapist who formulates more adaptive beliefs before addressing the unhelpful belief. This would imply that there is therapist direction contained within any Socratic evaluation of the unhelpful belief. This is in contrast to the notion of guided discovery outlined by Padesky (1993) and Overholser (2010). Frogán-Parga, Calero-Elvira and Montaño-Fidalgo (2011) studied the verbal behaviour of six clinicians who used the Socratic method within cognitive restructuring. They found that therapists had 'target verbalisations' which they expressed approval for when uttered by the client. There was an inference that therapists were directing their clients through their approval of certain utterances and not others. Calero-Elvira, Frogán-Parga, Ruiz-Sancho and Alpañés-Freitag (2013) analysed therapist and client verbalisation during Socratic dialogue. They found a process of 'verbal-shaping' whereby the therapist modified the clients 'non-adaptive' behaviour. The contrasting constructions of Socratic dialogue from both positivistic and dialogic perspectives reflects the contrasting constructions of collaborative empiricism in the previous section. Clark and Egan (2015) suggest that CBT therapists balance a desire to be curious and collaborative against actively guiding clients to a particular conclusion. Therefore it may be that the way in which Socratic dialogue is constructed is dependent on how individual therapists view the balance between genuine curiosity and directing clients to particular conclusions.

Collaboration in other therapy modalities

Issues around collaboration in therapy are not limited to CBT. In psychodynamic psychotherapy collaboration is seen as having two main aspects: alliance fostering and meta-communication (Wiseman et al, 2012). Alliance fostering includes goal setting and reviewing, which allows the client to have an active role in the therapy. Meta-communication refers to communication of client-therapist interactions. The therapist focuses on the here and now experience in the room using the transference-countertransference matrix (Wiseman et al, 2012). The client and therapist work what they are experiencing together. Spinelli (1994) argues however that the use of transference in psychodynamic therapy is highly influenced by the therapist because it is often the therapist that decides what is transference and what is not. Wiseman et al (2012) claims that the therapist's contribution is open for discussion with the client. However Spinelli (1994) asserts that even though clients have the opportunity to question therapists' views they often do not because they presume the therapist knows more than they do.

Hook (2003) asserts that normalising interventions, criticised by Proctor (2008) as being an inherent part in CBT, can be found in more subtle forms in other therapies. Referring to person-centred therapy (PCT) Hook argues that even though there may be no overt expression of judgment there is a strong tendency towards normative self-evaluations on the part of the client. Besley (2002) argues that the idea of an actualising tendency, which is central to PCT, encourages people to believe that they have to grow or improve in some way. The actualising tendency is the tendency of an organism to grow, develop and reach its full potential (Mearns and Cooper,

2005). Besley (2002) asserts that this reinforces the power of experts and institutions that claim to be able to help achieve these improvements.

The examples from other therapy modalities suggest that constructions of collaboration in therapy generally contains both positivistic and dialogic perspectives. There is a tendency in these modalities also though to emphasis one perspective over the other. Collaboration specifically relating to CBT was chosen for the focus of this study because CBT has featured prominently in psychotherapy debate and has been put forward as the most effective method of treatment for many mental health problems (Lees, 2008). In 2008 Increasing Access to Psychological Therapies (IAPT) was introduced in the UK. IAPT adopted CBT as the therapeutic model of choice based on the National Institute of Clinical Excellence (NICE) guidelines (Konstantinou, 2014). Evidence-based practice is currently the criteria set for models of psychotherapy and CBT is ahead of the rest in this regard (Konstantinou, 2014). The substantive evidence base for CBT is mainly in the form of randomised controlled trials (RCTs) (Konstantinou, 2014). RCTs use a manualised methodology that attempts to control psychotherapeutic variables in order to assess if a model of treatment can be empirically validated (Fairfax, 2008). It has been argued though that the claims made in relation to RCTs and psychotherapeutic outcome are not justified. Fairfax (2008) argues that psychotherapy and the requirements of the RCT methodology are incompatible, for example the requirement to match treatment and control sample. Other criticisms of the use of RCTs as the main evidence of CBT efficacy include the fact that CBT treatment protocols are heavily manualised in RCTs in order to control for variables (Mollon, 2009). According to Mollon they do

not reflect actual protocols used in practice. RCTs also exclude people with complex, chronic or multiple presentations (Konstantinou, 2014).

There has been a call for practice-based research in CBT, in the form of qualitative studies to be used in addition to RCTs (Midgley, Ansaldo and Target, 2014). Relying on RCTs results in a narrow view of scientific evidence and in order to facilitate a more holistic picture qualitative methodologies that focus on the process of CBT should be utilised (Fairfax, 2008). Collaboration is a central aspect of the process of psychotherapy (Mackrill, 2010). The current study aims to investigate how individual therapists view collaboration in their therapeutic practices. Given the varying conceptualisations of collaboration in CBT discourse analysis was considered to be a good fit for this research topic. Discourse analysis is concerned with how people construct their world through talk and text (Potter, 2005). It proposes that language is more than just a code of communication. Language constructs specific realities and diverse social worlds (Potter and Wetherell, 1987). Therefore there is an action element to language. From a discourse analytic perspective individuals do not produce consistent, fixed accounts; they produce varying accounts in order to fulfil certain functions (Potter and Wetherell, 1987). Therefore this methodological approach can illuminate how participants construct varying conceptualisation of collaboration, for example in line with a positivistic or a dialogic viewpoint. Discourse analysis involves making visible ways in which we construct our society including professions such as counselling (Spong, 2010). It can therefore help us answer questions relating to how counselling practitioners and clients are constrained and liberated by their engagement in counselling discourses.

Spong and Hollanders (2005) used a discourse analytic approach to investigate how cognitive counsellors talk about social inequality and social power in relation to their counselling. They defined social power as the exercise of control by members of one group over another. They interviewed 5 cognitive counsellors and analysed ways in which counsellors constructed social power in their discourse. Spong and Hollanders were not anticipating simple and coherent accounts but were looking out for variation and contradictions within each participant's account. They were coming from the viewpoint that people are not necessarily consistent in the discourses that they construct. They used the notion of interpretative repertoires described by Gilbert and Mulkay (1984) in order to explain participants' discourses. Gilbert and Mulkay suggest people have a range of different explanations (repertoires) available to them, rather than just one viewpoint on a topic, which they can draw on for different purposes in conversation. Even though Spong and Hollanders did not anticipate consistency in participants' explanations they did anticipate consistency in the way interpretative repertoires were used to perform different functions. Their analysis identified four interpretative repertories: (1) worlds apart, (2) problems cause other problems, (3) changing that environment (4) we all exist in society.

Spong and Hollanders found that 'Worlds apart' was the dominant repertoire. In this repertoire the participants saw counselling and social power as being in different frames, for example:

"*and I just feel that as a therapist ya know I'm just not in a position to um tackle, ya know, a person's socio-economic ya know um um er disadvantages*".

They found that the second repertoire 'problems cause other problems' was used to acknowledge that social powerlessness and social deprivation have an influence on

clients' psychological well-being and at the same time maintaining a view of clients as autonomous self-determining individuals. According to Spong and Hollanders from the perspective of this repertoire the 'other problems' that are influenced by environmental factors (e.g. depression) can be dealt with by working with clients' cognitions and emotions. They suggest that 'problems cause other problems' was used to support the 'worlds apart' repertoire.

According to Spong and Hollanders the third repertoire 'changing the environment' constructed counselling as a force that can address problems in the social environment. They state that it was used much less frequently than the other repertoires. They found that the fourth repertoire 'we all exist in society' constructed counselling as a force that helps the individual fit better into society. They suggest that this repertoire was used to justify the common-sense practical aspects of CBT.

Moore and Rae (2009) is an example of discourse analytic research on counselling psychology practice. They examined discursive resources counselling psychologists' use in talking and reasoning about themselves and their work. They suggested that there was difficulty defining a coherent identity for counselling psychologists because the profession attempts to integrate two disciplines which seem at odds (counselling and psychology). Moore and Rae interviewed eight counselling psychologists about their professional practices and analysed the data in terms of interpretative repertories. The main repertoire they found was the 'maverick/outsider' repertoire; participants constructed a sense of being outside the mainstream. According to Moore and Rae the term 'maverick' in western culture is connected with individualism and a refusal to conform. They suggest several functions for the

'maverick' repertoire: it is used to construct a sense of value and independence; it is used to construct counselling psychology as progressive because it avoids traditional constraints and so can innovate. They suggest it is also used to justify a sense of anger due to a lack of support and exclusion from other groups.

The current thesis aims to investigate interpretative repertories CBT therapists have in talking and reasoning about the nature of collaboration in their counselling practices. As stated earlier Guilfoyle (2006) suggests collaboration may be used to conceal power within therapy and Proctor (2008) argues that social norms are used in CBT to encourage clients to a 'right' way of thinking. In particular the current study aims to investigate the resources participants have in dealing with the claim that CBT is directive, leads the client to see their problems in a certain way and therefore is not compatible with the idea of a collaborative relationship. Also what resources participants have in dealing with the claim that the use of rational v dysfunctional thinking in CBT means clients are expected to move towards the therapist's viewpoint and so the therapy cannot be defined as collaborative. The proposed research aims to answer the following questions: What interpretative repertoires do cognitive behaviour therapists use when talking about the nature of collaboration in their therapeutic practice? What are the functions of these repertoires?

The thesis aims to contribute to an understanding of the nature of CBT in terms of how therapists talk about or discursively construct aspects of their practice. Specifically it aims to extend the work done by Spong and Hollander (2005) on therapists' discourse about how external social issues impinge on their clients, in order to show how therapists construct the therapeutic relationship itself. By

researching which interpretative repertoires are used by some CBT therapists it is hoped the findings will encourage counsellors to consider their relationships to any interpretative repertories identified and the ways in which they construct their counselling in terms of collaboration with clients. It is thought the relevance of this study will not be confined to CBT therapists because, as stated earlier, issues around collaboration are not confined to CBT.

1.3 Relevance of this study to counselling psychology practice

Counselling psychology is a broad discipline that has a foundation in humanistic values and pluralistic practices (Strawbridge and Woolfe, 2010). From a pluralistic stance multiple perspectives are held, in which creative tensions are created between therapeutic perspectives (McAteer, 2010). Counselling psychology moves beyond diagnostic criteria to a focus on well-being and personal development in line with a humanistic perspective but also subscribes to a scientist-practitioner model which is a model of treating (Martinelli, 2010). There is a dilemma in privileging individual experience and a commitment to evidence-based practice (McAteer, 2010). According to McAteer a pluralistic perspective facilitates engagement with seemingly conflicting perspectives. Variation in the conceptualisations of collaboration in CBT, from positivistic to dialogic perspectives, reflects the variation in philosophical perspectives that counselling psychologists contend with i.e. empirical scientist and subjective practitioner. Investigating how these differing perspectives of collaboration in CBT are constructed may help counselling psychologists reflect on how they view these differing perspectives in their practices.

CBT is included in all counselling psychology courses in the UK (Konstantinou, 2014). Counselling psychology trainees have to engage with CBT and this might be a challenge for them if there is a difference in their perception of the CBT theoretical model and their personal value systems (Fear and Wolfe, 1999). It is important therefore that trainees and practitioners reflect on how they engage with CBT and use it in their practice (Konstantinou, 2014). The current study may help counselling psychology practitioners clarify how they conceptualise collaboration in CBT, helping them reconcile contradictory value systems. Collaboration between therapist and client is at the heart of the pluralistic framework (Cooper and McLeod, 2007) therefore investigating how collaboration is constructed in various ways may facilitate counselling psychologists critically reflect on how a pluralistic stance impacts on their therapeutic practices.

2. METHODOLOGY AND METHODS

2.1 Methodological considerations

Discursive psychology will be the methodological basis for this study although a critical discursive psychological approach will be used as put forward by Wetherell (1998) and supported by Edley (2001). This is a qualitative methodology with a relativist ontology and constructionist epistimology. Qualitative research from a constructionist perspective considers research data as constructed within a particular research context rather than as an objective reflection of reality (Burck, 2005). Ways of knowing are considered to be negotiated through social interactions over time (Shotter, 1993). This is in contrast to traditional psychological perspectives, which focus on explicating actual psychological states and processes that underpin action (Potter, 2005). Potter states that it is difficult to precisely define constructionism because this would imply that it is a definable thing that can be neutrally and objectively described and defined. This would be a realist account of constructionism (Potter, 1996). According to Potter though, constructionist approaches do share common features. Firstly minds are not viewed as having fixed essences but as being built from the symbolic resources of a culture; secondly, discourse is the central organising principle of construction.

Discursive psychology falls under the broad umbrella of discourse analysis. Discourse analysis is a broad interdisciplinary field with a variety of research practices and a number of differing aims and theoretical backgrounds (Potter, 2012). It evolved within linguistics, sociology, cultural studies and psychology (Potter,

2012). All discourse approaches though, are concerned with the study of patterns of language in use (Potter, 2005). According to Wetherell (1998) boundary lines are drawn between types of discourse analysis that lean towards conversation analysis and types that subscribe to post-structuralist or Foucauldian ideas. On one end of the spectrum is discursive psychology, involving detailed, minute analysis of the action orientation of talk and on the other are types of critical discourse analysis such as Foucauldian discourse analysis (FDA), which are concerned with how discourses legitimate and reinforce existing social and institutional structures (Burr 2003). Critical discursive psychology represents a synthesis between these opposite ends of the spectrum and enables exploration of both micro and macro levels of discourse. A description of both discursive psychology and Foucauldian discourse analysis will be outlined below followed by an explication and rationalisation for the use of a critical discursive psychological approach.

Discursive psychology is an approach rather than a method (Potter, 2012). It starts with discourse not because of an interest in the psychology of language but because discourse is the medium through which action occurs (Potter, 2012). It focuses on talks and texts as social practices and on the resources that are used to enable those practices (Potter, 1996). It examines how people construct versions of the world, build identities and legitimate their actions; it looks to the micro-processes of interaction to answer these questions (Burr, 2003). Discursive psychology requires an understanding of the context in which versions are constructed and an appreciation of the conversational techniques and organisations in which the versions are grounded (Potter, 1996).

According to Potter (1996) much of the focus has been on issues of stake and accountability – how descriptions are put together to perform actions such as blaming and assigning responsibility. The focus on accountability can happen on two levels at once. Firstly there is the speaker's construction of accountability in their description of an event and secondly there is the speaker's construction of their own agency and accountability, including what they are doing through their speaking (Potter, 2005). From a discursive psychological perspective claims and descriptions are often rhetorical in nature (Potter and Edwards, 2001). This means they are designed to counter potential alternative versions and to resist attempts to have their accounts deemed false or biased (Burr, 2003).

Willig (2008) criticises discursive psychology for being unable to account for why individuals or groups pursue particular discursive objectives despite having a focus on the action orientation of talk. Proponents of discursive psychology state that they are interested in the discursive construction of psychological concepts rather than hypothetical questions of subjectivity (e.g. Potter, 1996). Willig though, argues that discursive psychology relies on notions of stake and interest, which it then fails to theorize in terms of motivation or desire.

Another form of discourse analysis that was considered for this research project was Foucauldian discourse analysis (FDA). FDA lies on the critical discourse analysis end of the spectrum. It has in common with discursive psychology an interest in instances of language. From an FDA perspective though, discourses are viewed as a set of statements that construct objects and a range of subject positions, which in turn make available certain ways of being in the world (Willig, 2008). Instead of

taking participants talk-in-interaction as the organising principle critical approaches to discourse analysis focus on the structuring effects of discourse, which constitute institutionalised forms of intelligibility (Wetherell, 1998). Such discourses are therefore strongly implicated in the exercise of power and this type of analysis draws conclusions that go beyond the bounds of specific instances of talk in action.

Given the issues of power inherent in the concept of collaboration FDA may have been a good fit for this project. According to Spong (2010) 'macro' forms of discourse analysis are important in counselling research because it is possible to ask how clients are constrained and liberated by their engagement in counselling discourse. Such forms of critical discourse analysis have been criticised though for not taking sufficient account of the local, interactional nature of discourse (Willig, 2008). Schegloff (1997) criticises critical discourse analysis approaches for developing accounts of power relations, because knowledge of who society considers 'victims' or 'persecutors' are imposed on the analysis. Theoretical concepts emerge in abstract based on implicit assumptions about the nature of interaction, language and social life (Wetherell, 1998). According to Schegloff participant orientation should be the focus of analysis and all analytic claims should be empirically grounded.

It has been argued that the division of labour in discourse analysis has been a mistake and that discursive approaches need a more eclectic base (Wetherell and Edley, 1999). Potter and Wetherell (1995) support a mixed approach and have advised against distinguishing too sharply between discursive psychology and focauldian discourse analysis. Although there is a lot of difference in the epistemological underpinnings of discursive psychology and critical discourse

analysis approaches there is also huge overlap (Edley, 2001). Edley asserts that a twin focus supposes that when people speak their talk reflects not only the local pragmatics of that specific interaction but also broader patterns in the sense-making and understandings. Wetherell (1998) states that critical discursive psychology can locate analyses within a relevant context of ideology or power relations while at the same time being grounded in microanalysis of talk in interaction. Action orientation is the primary area of focus yet critical discursive psychology assumes that all sequences are embedded within a historical context (Edley, 2001). According to Potter (2005) one of the aims of discursive psychology is to show the ways institutions are characterised by specific 'psychological business'. He asserts that analysis of this kind can illustrate both the specifics of the psychological business and the nature of the institutions. Critical discursive psychology was therefore chosen for this project because it can attend to both 'micro and 'macro' levels of analysis.

The explication of interpretive repertoires is one way that critical discursive psychology can attend to both micro and macro elements of analysis. Interpretive repertoires are systematically related sets of terms that are often organised around one or more central metaphors (Potter, 1996). They are historically developed, make up an important part of the common sense of a culture or institutional domain and are available with an 'off the shelf' character (Potter, 1996). Therefore the elucidation of such repertoires can have implications beyond the immediate social situation. Interpretive repertoires do not belong to individuals but are a social resource and are available to all who share a language and a culture (Burr, 2003). They emerge though, from detailed microanalysis of specific instances of talk in interaction. Burr states that one person may use different repertoires in their talk depending on their accounting

needs and the same repertoire may be used by different people to achieve different ends. They have flexibility, which allows them to be selectively drawn on and reworked according to the setting (Potter, 1996). In relation to accountability, Wetherell (1998) describes repertoires as the common sense which organises accountability at the level of locally managed positions in actual interaction. It is this accommodation to flexible, local use that differentiates interpretative repertoires from Foucauldian notions of discourse (Parker, 1992). Interpretive repertoires are conceptualised in critical discursive psychology as existing on a smaller scale and are resources for speakers rather than structures that impose certain ways of being on groups or individuals (Burr, 2003).

2.2 Outline of method procedures

From a critical discursive psychological perspective both mind and reality are constructed by people through language (Potter and Edwards, 2001). According to Potter and Edwards cognitive processes and entities are viewed as participants' ways of talking as opposed to the main analytic resource. The focus is on how discursive practices produce versions of external reality and of psychological states (Potter and Edwards, 2001). Discourse is viewed as constructionist in two senses: it is constructed and it is constructive. It is constructed in the sense that words, descriptions, rhetorical devices etc. are drawn on and built in the course of interaction; it is constructive in that it constructs versions of the world that are put forward as factual and independent of their producer (Potter and Edwards, 2001). As interaction is the point where

versions of reality are built, it is important to take account of the role of the researcher in co-creating the research with the participants.

Participants

Purposive sampling was used to recruit participants. According to Merriam (2009) purposive sampling is defined as selecting participants from which most can be learned. All qualitative research has in common a central purpose to contribute to a process of revision and enrichment of understanding rather than to verify earlier conclusions and theory (Elliot, Fischer and Rennie, 1999). Therefore it is important to seek out participants who can fill out the structure and character of the concept under investigation (Polkinghorne, 2005).

Although the term sampling is generally used in qualitative research, Polkinghorne (2005) recommends caution in its use as it is a term that has been adopted from quantitative research. According to Polkinghorne sampling implies a sample of the population in which the purpose of their selection is to enable findings to be applied to a population. Participants for a qualitative study are not selected because they fulfil the representative requirements for generalisation to a population. The concern is not how many sources data is gathered from but whether the data collected is sufficiently rich to bring refinement and clarity to understanding the concept being studied (Polkinghorne, 2005). The unit of analysis in qualitative research is the concept under study, not individuals or groups (Starks and Trinidad,

2007). Starks and Trinidad suggest that because an individual can generate many concepts large samples are not necessary to generate rich data.

Eight CBT therapists were recruited to take part in the study. The inclusion criteria was that participants must hold a CBT qualification of at least postgraduate diploma level or they must be accredited with the British Association of Behavioural and Cognitive Psychotherapists (BABCP). They also had to have one year post qualification experience in order to ensure they had enough experience to reflect on the nature of collaboration in their practices. They were recruited by placing an advert with the BABCP and by contacting institutions which employed or trained CBT therapists. Six of the participants were female and two were male. Five participants were recruited in the south-east region of England and three were recruited from Northern Ireland. Four participants identified as white English, three as white Northern Irish and one as white Irish. All participants worked in the private sector. Years of post-qualification experience ranged from 5-12 years. Two participants had also trained in other models of psychotherapy.

Data-gathering

Participants took part in one interview which lasted approximately one hour. In contrast with semi-structured interviews, in the current study interviews were more interventionist than formal. Follow up questions to responses often posed alternative or problematic views for the participant. A schedule of the interview questions can be found in appendix 5. According to Potter and Wetherell (1987) this type of interviewing helps to elicit resources and devices that participants use to construct

certain discourses. For example Gilbert and Mulkay (1984) describe how towards the end of an interview with a scientist he was asked if there was anything he thought important about his field that hadn't been touched on. The interviewee responded that they hadn't touched on personalities but he was hesitant to do that. The interviewer asked him to say something about it without naming names (example of a more interventionist style of interview question). The interviewee talks about personal feelings between researchers getting in the way of objectivity. He states that there is a subjective element to science. The interviewer then asks if he has any idea how the subjective element gets eliminated. The interviewee answers by referring to the objectivity of experimental science and how this gets to the truth eventually. According to Gilbert and Mulkay challenging the interviewee to explain how the subjective element gets eliminated from science resulted in him using a discursive device. He could have said that the subjective element cannot be eliminated from science but instead he uses 'the truth will out' device to claim that it can.

In the current study participants were given an information sheet and consent form prior to the beginning of the interview. After the interview participants were given a debriefing sheet outlining details on how to have their data removed from the study and information on support services in the event that the interview raised any issues for them. The information sheet, consent form and debriefing sheet can be seen in appendices 1-4.

Despite the advantage of eliciting resources that are used to construct discourses there have been criticisms of using interview talk as the focus of analysis in discursive psychological research. Potter and Hepburn (2005) argue that issues of

footing and interviewer's stake and interest make interview material profoundly complex and that it is a major challenge to take these issues into account during analysis. Footing refers to the speaking position of the interviewer and interviewee i.e. the different basis on which the interviewer or interviewee is speaking (Potter and Hepburn, 2005). For example the interviewee may be speaking as a category member or as an individual and the interviewer may be positioned as the full recipient of the participant's talk or as a conduit to a third party recipient e.g. readers of the research report. How the interviewer responds to the interviewee can display different footing positions. For example the interviewer may position themselves as an active participant with their own knowledge and views by agreeing with or challenging a participant's statement; or they could be positioned as a conduit for the collection of knowledge by providing sparse acknowledgement tokens. According to Potter and Hepburn footing generally varies throughout an interview making analysis extremely complex. Related to varying footing is the issue of how the interviewer's stake and interest are managed. Interviewer agreements and disagreements can display broader alignments and interests in topics, influencing what is said by the participant (Potter and Hepburn, 2005). They state that analysis often highlights just how much interviewee's talk is a product of specific features of the interview. Potter (1996) argues that it is a major challenge to extrapolate from the kinds of actions done in interview talk to kinds of actions done elsewhere.

Naturalistic records are the preferred source for analysis in discursive psychology (Potter and Hepburn, 2005; Potter, 1996). Naturalistic records are defined as records of activity that would have happened anyway of the researcher had never been born (Potter and Hepburn, 2005). The aim is to minimise active researcher

involvement. The advantage of using such records, according to Potter and Hepburn, is that they avoid some of the complexities associated with interviewer/interviewee footing and they avoid flooding the interaction with psychology or social science agendas. Also stake and interest are tied to the particular relevant practices in the domain under study.

Speer (2002) criticises the distinction made in discursive psychology between 'natural' and 'contrived' data. She asserts that from a discursive psychological perspective it makes little sense to map the natural/contrived distinction onto discrete 'types' of data because meanings are considered to be constructed jointly by all members involved in an interaction. This includes joint construction by interviewer and interviewee in interview talk. The 'method' is not a resource to get at something separate from it, but constitutes its very object and the interaction embodied within it (Speer, 2002). She makes the point that bias need not be regarded as a problem; interviewers can be active participants arguing with members and questioning their assumptions just as participants can ask researchers to explain their questions and offer opinions. There is therefore a contradiction, argues Speer, in the stance of discursive psychologists who advocate the use of 'natural' over 'contrived' materials: on the one hand they argue that bias in the form of context effects is not a problem but a feature of all interaction; and on the other hand they state that naturally occurring talk is better than contrived materials because there is much less potential for the researcher to be a contaminating force.

Speer (2002) argues that by making the researcher central to the distinction of natural/contrived data means the contribution of the researcher to the interaction, by

virtue of their mere presence, is of a different status to the participant's contribution which is not in line with a discursive psychological perspective. In relation to the argument made by some discursive psychologists (e.g. Potter, 1996) that analysis of interview talk only sheds light on specific features of the interview Speer proposes exploring how participants attend to the fact of their taking part in a research interview and then considering what such orientations tell us about the impact of the research context and the researcher on their interactions. In the current study interview talk was preferred over 'natural' materials because the focus of the study was on how practitioners constructively reflect on therapeutic collaboration as opposed to analysing 'therapeutic collaboration in action'. A core skill of counselling psychology practitioners is the ability to reflect back on their work in order to recognise how they are communicating with clients (Hedges, 2010). Given the relationship between varying conceptualisations of collaboration in CBT and the varying stances that counselling psychologists have to contend with, how CBT therapists construct reflections on collaboration was considered relevant for counselling psychologists' reflections on their own practices. The impact of the researcher on how participants' reflections of collaboration were constructed was also considered. The researcher completed a postgraduate diploma in CBT prior to commencing a practitioner doctorate in counselling psychology. He has held contrasting views on the nature of collaboration in CBT, influenced by training in various psychotherapeutic modalities. At the commencement of the current study the researcher had a suspicious view of the nature of collaboration in CBT. The impact of this bias will be evaluated in section 4.2.

Data Analysis

The overall analytic goal in this study was the identification of interpretive repertoires used by participants and how these repertoires aided in their constructions of collaboration in their therapeutic practices. Wetherell (1998) defines interpretive repertoires as culturally familiar and habitual lines of argument comprised from recognisable themes, common places and tropes. Potter outlines two main components of interpretive repertories: (1.) they are available with an off-the-shelf character that can be used in a range of different settings to do particular tasks, (2.) they are flexible in a way which allows them to be selectively drawn on and reworked according to the setting. Participants will often draw on a number of different repertoires as they construct the sense of a particular phenomenon or as they perform different actions (Potter and Edwards, 2001).

An important part of the analysis was searching for patterns of variation within and between participants' talk in order to elucidate interpretive repertoires that were being used. The second task of the analytic process was the analysis of function. Analyses of function are generally not directly available for study as it involves interpretation and developing hypotheses (Wetherell, Taylor and Yates, 2001). They assert that the analysis of function is not simply a matter of categorising pieces of speech; it depends on how the analyst reads the context. However functions of discourse can be revealed through the study of patterns of variation within the talk or text because variation is a consequence of function (Wetherell and Potter, 1988). Variation can be used as an analytic clue to what function is being performed in a particular discourse. Predictions can be made that certain kinds of function will lead

to certain kinds of variations and these variations can be searched for (Wetherell and Potter, 1988).

Reliability and Validity are important considerations in the analysis of discourse work (Potter, 1996). These terms are constructs though, that were developed in relation to quantitative research that values statistical design (Polkinghorne, 2005). Reliability and validity have specific technical meanings and so their adoption to describe qualitative processes can lead to misunderstandings (Polkinghorne, 2005). Qualitative approaches to reliability and validity are largely unworkable in discourse work (Potter, 1996). Morrow (2007) suggests the use of standards of trustworthiness or rigour established from within the qualitative genre itself rather than imposing such terms as validity and reliability from the quantitative tradition. Standards of trustworthiness are determined in part by the paradigm underpinning the study while certain criteria cuts across paradigms (Morrow, 2007). Criteria that cut across paradigms, states Morrow, are researcher reflexivity and attention to the research context. The research context is an additional environment in which participants make meaning and should be reported (Morrow, 2005). It must include sufficient information about the researcher's perspective, the participants' themselves and the research process that the audience can assess the relevance or transferability of the findings to her or his own research (Morrow 2005).

Potter (1996) outlines a number of relevant considerations in relation to standards of trustworthiness and rigour specific to discursive psychology:

1. Deviant case analysis – the aim is to show a pattern of regularity in a phenomenon when doing discursive psychological research. When cases go

against the pattern though, in some deviant way, it can actually be useful. Their special features may help confirm the genuineness of the pattern. For example by showing up a problem in the interaction, inferring why the standard pattern should take the form it does.

2. Participant's understanding - instead of the analyst saying that a turn of talk is a compliment for example, the focus is on how the participant's treat it. A close attention to participants' understanding provides one kind of check. A turn may be responded to as a question, a criticism, an invitation etc. and in responding to it in this way the speaker displays their understanding.

3. Coherence - Coherence relates to the cumulative nature of discourse work. Studies build on insights of earlier work. For example work on fact construction builds on insights about accountability from earlier studies and its success provides a further confirmation of the validity of those studies.

4. Reader's evaluation - In discursive psychology presentation of rich and extended materials are important as these allow readers to evaluate the adequacy of the research.

The interview talk in the current study was analysed for ways in which participants discursively constructed the notion of collaboration in their practices, especially in response to the interviewer's claims of directivity in CBT. Their constructions were analysed in terms of variations and inconsistencies. From these inconsistencies patterns began to emerge that were formulated in terms of possible

interpretive repertoires that participants were using. This was a cyclical process in which the patterns that emerged were then searched for in the text. The variation in constructions of collaboration facilitated the hypothesising of possible functions of identified interpretive repertoires.

3. ANALYSIS

The main interpretive repertoire that emerged from the analysis was the client choice repertoire (CCR). All eight participants drew on this repertoire. It was constructed in several ways and displayed a range of choices available to clients in the CBT process. It was mainly used when the researcher put criticisms to participants that CBT was overly-directive and not collaborative. The criticism that CBT is overly-directive implies that the therapist has power over the client and therapy is not collaborative. Clients are positioned as passive recipients with no autonomy or agency. Positioning refers to the way an individual emerges through the processes of social interaction and how they are constituted and reconstituted through various discursive practices (Davies and Harré, 1990). According to Davies and Harré positioning can be interactive, in what one person says positions another. They also state that it is also not the case that positioning is necessarily intentional. The analysis will explicate how participants dealt with the positioning of clients as passive, using the CCR. The CCR was constructed in five different ways. The first way in which it was implemented was through the use of *menu* and *tools* metaphors.

3.1   Implementation of client choice repertoire using *menu* and *tools* metaphors

Interpretive repertoires are often constructed using metaphors (Potter, 2012). The menu metaphor was used by one participant to reconcile any contradictions between therapist direction in her practice and clients having agency. This metaphor was used to elicit a sense of the therapist guiding the client towards choices as outlined in extracts 1 and 2.

Extract 1 (Participant 1)

57 **P**   But you're collaborating at every kind of level actually when you're working
58   together, aren't you?
59 **R**   And, can you expand on that a little bit?
60 **P**   Yeah. Because uhm, what I often say to clients is 'My job is to give you a
61   menu, yeah, to show you lots of different ((slight pause)) ways of tackling
62   whatever it is that's bothering you.'
63 **R**   Yeah.
64 **P**   And then it's not for me to say 'Now you must go away and do this', 'but it's
65   for you the client, to find one that works for you'.
66 **R**   Okay, so there's, there's different interventions in CBT, and ((slight pause))
67   you can work with the client to find out
68 **P**   Yeah.
69 **R**   Which intervention is most suitable for them, or which they connect with the
70   most is that right?
71 **P**   Yes, that's definitely right. So for instance, umm, when you come to the end
72   of your, your sessions...
73 **R**   Yeah.
74 **P**   And you're finding that-- you're doing a review session, finding out what works
75   and what didn't work so well, I might say to a client, you know, 'What are you
76   going to do most?' 'What are you, what are you going to take away from here?'
77   And, one thing that we do is, when we've used the Hot Cross Bun. I'm sure you
78   know how to define the hot cross bun. Uhh, when we've used the Hot Cross
79   Bun, we do talking to yourself as if you're your own best friend.

R = Researcher P = Participant

The menu metaphor in lines 60-62 elicits a sense of choice for clients. They can choose "lots of different ways of tackling" their problems, which suggests that their choices are contained within the different elements offered by CBT. Client choice within a CBT framework is highlighted again in line 64 where the participant uses directly reported speech to demonstrate how CBT interventions are not imposed on clients. It is up to the client to find which aspect of CBT works for them (line 65). This implies that clients are being directed to choose some aspect of CBT. The menu metaphor deals with the claim that CBT is directive by introducing an element of choice while also acknowledging directedness in CBT. Clients are directed to the menu; they are directed to choice. This choice leads to increased autonomy for clients as suggested by the directly reported speech in lines 75-77.

In lines 77-79 the participant gives examples of some elements that are on the 'CBT menu'. The sequence of using the 'hot cross bun' technique and 'talking to yourself as your own best friend' is constructed in a rigid way – one follows the other. This erodes the sense of clients having a choice. This may imply that the function of this repertoire is to make therapist direction implicit.

In extract 2, participant 1 uses *menu* and *tools* metaphors to implement the CCR. The *tools* metaphor implemented the *client choice* repertoire in a similar way to the *menu* metaphor – clients are directed to a range of choices or *tools*.

Extract 2 (Participant 1)

115	P	Yeah. So you're collaborating by saying 'Look, there's lots of different ways
116		((slight pause)) of making a difference...
117	R	Yeah.
118	P	With whatever it is that you're dealing with, why don't you ((slight pause))
119		choose one?'
120	R	Okay, yes.
121	P	Effectively.
122	R	That, sorry, that sounds to me like there's a balance between, y'know, giving
123		a client tools, or telling- or a kind of, like a psycho-education about ((slight
124		pause)) CBT. But then, handing over to them to, ah-
125	P	Yeah, to pick and choose.
126	R	To pick and choose.
127	P	So you've got collaboration right down at, y'know, minute- minute by
128		minute...
129	R	Yeah.
130	P	minute. But then you've also got sort of like a, a higher level of collaboration.
131	R	Okay.
132	P	Because you don't say 'Right, you're coming to me for CBT ((claps hands
133		twice)). My goal is to get you to think...'
134	R	((chuckles))
135	P	'Like me.' yeah, 'To change your view of yourself so that it fits in with mine.' I
136		take a view that, that it's, 'Well look, here are some tools, here's a menu.'
137	R	Yeah.
138	P	'My job is to guide you round the menu so that when you leave...'
139	R	Yeah.
140	P	'You can do it for yourself.'

As in extract 1 the metaphor menu is used (line 136) and clients' choice is referenced twice (lines 118-119, 125). The words 'menu' and 'choose' both elicit a sense of the client having input into the process while at the same time acknowledging that the therapist acts on the client in some way - through giving them the menu and the range of tools to choose from (line 136). Clients have a choice but only within defined parameters (lines 115-119). The participant uses the word 'guide' (line 138) to describe her job. This erodes the sense of clients' choice elicited by the menu metaphor. 'Guide' implies someone who directs but is not forceful in their direction – it implies that the client is not obligated to go in the suggested direction. This is in contrast to the extreme case formulation described earlier. 'Client choice' implemented by the menu metaphor therefore works to defend against criticisms of directedness in CBT while at the same time allowing for directedness by framing it in gentler terms such as 'guide'.

The participant uses an extreme case formulation in the form of directly reported speech to demonstrate what a directive CBT therapist might say (lines 132-133, 135). This is followed by an example of how the *menu* and *tools* metaphors might be used. Contrasting these metaphors with an extreme example of direction increases the sense of choice contained within these metaphors.

The tools metaphor gives a sense that what the therapist is directing the client to is something useful. Tools are implements that are used to aid in getting work done. CBT tools aid in working on clients' mental health problems. Tools also suggest something practical that clients can use by themselves. They are something that clients can use when they leave. This metaphor therefore positions the client as

someone with increasing agency – "you can do it for yourself" (Line 140). Not only are clients more active agents after they leave therapy but they have increasing agency during therapy by having the power to choose which tools they want. The construction of *tools* as something useful and beneficial is also demonstrated by participant 3 in the following extract.

Extract 3 (Participant 3)

359	**P**	Umm, so, er, ((slight pause)) you- I suppose you... It in- it gives them some
360		tools
361	**R**	Mm-hm.
362	**P**	Which is autonomous in a way. Which they can then choose to use, or use
363		some of them or throw them away.
364	**R**	Okay.
365	**P**	It's sort of that model of, y'know, if you go to a less-developed country, um
366		((pause)) er, rather than giving them food you give them the- the tools to be
367		able to farm.
368	**R**	Mm-hm.
369	**P**	Umm, you have to give them some tools...
370	**R**	Okay, yeah.
371	**P**	For them to then be able to help themselves, and maybe ((slight pause)) I
372		suppose maybe give them some tools, and then they ((slight pause)) they
373		improve their confidence, and develop more, different tools.
374	**R**	Okay.
375	**P**	I don't know. Or, be able to talk to people more so that they develop their own
376		support networks. So it's not ((slight pause)) the case that you ((slight pause))
377		sort of, give them tools and then they are dependent on CBT forever.
378	**R**	Okay. So in a way, ((slight pause)) it's up to the- up to them what they do with
379		the tools then, afterwards?
380	**P**	Yeah. And which tools they choose to ((slight pause)) use and not use. They
381		see it as like a toolbox, and you get your hammer, your spanner, this, that, and
382		y-you can then take what you want from it.

The tools metaphor is also used by this participant to elicit a sense of client choice. They can "choose to use, or use some of them or throw them away". This metaphor is used to position clients as having agency, for example by linking tools with autonomy (lines 359 and 361). The tools metaphor is expanded in lines 364-366 to a farming metaphor. It is another example of positioning clients as active agents. The therapist doesn't give them the 'food' but the ability to 'grow their own food'.

Tools are constructed as something useful. Clients are active agents in that they can choose which tools they want from the 'toolbox' and they can choose to use these tools by themselves after therapy has ended.

The client choice repertoire, implemented through a tools metaphor, is being used to reframe the criticism that CBT is directive in a way that positions clients as active agents. The participant does not deny that there is direction in CBT but frames the direction as 'tool-giving' which leads to increased client agency and autonomy. The 'CBT is directive' criticism implies that the therapists have power over clients. Positioning clients as having agency serves to diminish the sense of therapist power and hence diminish the sense of CBT as a directive therapy. The comparison of clients to a 'less-developed' country though (line 364) could be viewed as constructing clients as being in an inferior position to the therapist, implying that therapists do have power over clients. This may suggest that the *tool* metaphor in this example is working to make therapist power implicit. This metaphor was also used by participant 4 to position clients as having agency.

Extract 4 (Participant 4)

444	**R**	So what do you think then makes CBT more collaborative than those sort of
445		therapies?
446	**P**	((slight pause)) Umm, ((slight pause)) oh, it's just really what I've said to you. I
447		think what makes it <u>more</u> collaborative is ((pause)) just that, um, quality of the
448		<u>partnership</u> ((slight pause)) between the therapist and the client. That <u>neither</u>
449		one of ye has the answer.
450	**R**	Okay.
451	**P**	You know, the therapist has some tools that may or may not ((slight pause)) be
452		helpful. The client knows what goes- what's going on for them. And the client
453		knows ((slight pause)) what <u>works</u> for them, and what they're comfortable
454		doing. So if you can get those two things working together, that's real
455		collaboration.

456	**R**	So, is it- what you're bringing, are, sort of, tools, sort of expertise maybe, and,
457		((slight pause)) they're- th-th-they're deciding whether- which ((slight pause))
458		things work.
459	**P**	Which ones work, yeah.
460	**R**	Okay.
461	**P**	Yeah. So in a way, I mean, I'm giving them a- a toolbox.
462	**R**	Mm-hm.
463	**P**	And they can decide which ones are useful for them.

This extract is another example of how the tools metaphor is used to implement the client choice repertoire. In lines 451-455 collaboration is described as being the combination of the therapist bringing tools and the client knowing what works for them. The client is positioned as having agency in relation to the tools. They will know which tools work (line 459) and they can choose which ones they find useful (line 463).

The toolbox metaphor is also used by this participant (line 461). This elicits a sense of having a limited range of tools to choose from. The choice is constrained by the limitations of the box. It suggests that clients have choices but these choices are contained within a (CBT) framework.

In extracts 1-4 therapist direction is reconciled with client agency by implying that therapist direction led to clients having increased choices. In both these metaphors there is a restriction to the choices that clients have. They are restricted to the choices on the menu and the tools in the toolbox. These metaphors therefore enabled the participants to position the clients as active agents who make choices while at the same time acknowledging the restrictions imposed by the CBT model. The *menu* and *tools* metaphors framed client choice in terms of choosing between different CBT interventions. In the next section client choice is framed in terms of

engaging or not engaging in CBT. The way this choice is constructed in extracts 5-7 implies that CBT is the right choice.

3.2   Interaction of *client choice* and *CBT works* repertoires

There is another repertoire *CBT works* acting on the client choice repertoire. Given that *CBT works* then choosing not to engage with CBT means clients are choosing not to help themselves. There is a negative connotation to not choosing CBT. The impact of this negative connotation is outlined in extract 5.

Extract 5 (Participant 1)

237   **R**   Yeah, like it's used to conceal, ((slight pause)) yeah... It's- They say it's
238   collaborative but ((slight pause)) uhh, it actually ((slight pause)) is more
239   about client compliance. That's some of the arguments some people out
240   there put.
241   **P**   Uhm, what about client compliance. Uhh, ((slight pause)) I don't, I don't think
242   clients comply ((laughs)).
243   **R**   ((laughs))
244   **P**   ((rushed)) In my experience. Uh, very compliant clients will comply to
245   anything, so it doesn't really matter what kind of therapy they have.
246   **R**   Yeah.
247   **P**   Uhh, I don't, I just don't see it as that. I see it more as ((slight pause)) uh, a
248   salesman's job.
249   **R**   Okay.
250   **P**   Effectively. I, I know that the CBT techniques work.
251   **R**   Okay.
252   **P**   There's plenty of research to show it and I've got my own private ((slight
253   pause)) data bank. I know that they work. So my job is to some extent, is to
254   ((slight pause)) sell them. Ooh, is that a bad word, does that, does that...
255   **R**   No.
256   **P**   Imply c... Commercial... I don't think so. It's a- Bec- because it's always, at
257   the end of the day, it's always up to the client what they do.
258   **R**   Yeah.
259   **P**   'Kay. It's a structured way of thinking. If they want to buy into it, it'll probably
260   do them some good. Great! You know. If they don't, fine.

The participant deals with the issue of client compliance raised by the researcher by suggesting that compliance is a characteristic of certain clients not the

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CBT model of therapy (lines 244-245). She then describes CBT as a salesman's job (line 247-248) which links to the menu metaphor described in extract 1. This implies clients' have choice as opposed to engaging in compliant behaviour. They have a choice in whether or not they accept what the therapist is offering "at the end of the day it is always up to the client what they do" (line 257). Clients are positioned by the interviewer as being passive (client compliance). The participant then repositions the client as having agency by using the salesman metaphor – clients have the power to buy into CBT or reject it.

There is an implication that what the therapist is 'selling' is the truth – "I know that CBT techniques work" (line 250) "if they want to buy into it it'll probably do them some good" (lines 259-260). The client has the choice to accept 'the truth of CBT' or not. The truth of the effectiveness of CBT makes the selling of CBT permissible. The truth of CBT is strengthened by reference to research (line 252).

In lines 254-256 the participant deals with the possible negative connotation of describing her CBT work as 'selling' by naming the negative connotations of the word and then stating her disagreement with such connotations. This shows she has reflected on the point and rejected it. By doing this she pre-empts a possible argument from the researcher about the negative connotations of the salesman metaphor.

In this extract the CCR is used in relation to accepting or rejecting CBT. The client is an active participant in the process in that they can decide not to engage with what the therapist is offering. By framing CBT as 'the truth', *client choice* becomes somewhat loaded. They have a choice to help themselves or not help themselves.

Therefore choosing not to engage with CBT is inferred as something negative. This is summarised in a statement soon after this extract:

P   "So you're always giving the permission, the client the permission, to kind of ((slight pause)) buy out, effectively. To go 'Thank you very much, I've fully understood how that might benefit me but I'm not going to bother'". (lines 276-279).

The client is inferred as being lazy if they don't engage with CBT: "I'm not going to bother". Participant 1 is explicit in her use of the *CBT works* repertoire and in the implications of not engaging with CBT. In extract 6, participant 2 also uses the *CBT works* repertoire to frame CBT as the right choice. This is done in a much more implicit way than in extract 5.

Extract 6 (Participant 2)

800	**R**	So how would you present that in a way that wasn't, um, coercive, I suppose?
801	**P**	((pause)) ((laughing)) I-i- I, you know, kind of, I- I- I think it's like, somebody
802		((slight pause)) is kind of locked down in black and white thinking...
803	**R**	Yeah.
804	**P**	Okay. And, you know, so everything gets kind of polarised, kind of. And we
805		take that as ((slight pause)) one of the unhelpful thinking...
806	**R**	Mm.
807	**P**	Styles okay. Well then, y'know, kind of, ((slight pause)) I would present it
808		exactly like that, y'know. You're, kind of, in CBT, ((slight pause)) there are
809		identified unhelpful thinking styles. This kind of black and white thinking that
810		we're looking at here, is one of them. And there are ways to think about it
811		differently. And, ((slight pause)) just in- in that kind of, or if somebody has a
812		tendency to catastrophise, that's another unhelpful thinking style. But you
813		present it kind of on the table t-to them. Ehm, and ((slight pause)) y'know,
814		again, I think kind of, there might be a ((slight pause)) some truth in the critique
815		you're leading people from irrational to rational. You're, what you're doing is
816		you're giving them a choice...
817	**R**	Mm-hm.
818	**P**	About whether they want to, ((slight pause)) kind of, begin to ((slight pause))
819		change or ameliorate, or do something different with their cognitive process.

This participant acknowledges that there is truth to the criticism that the therapist leads the client (lines 814 – 815). The client choice repertoire is used immediately before and after this acknowledgement by using a metaphor of 'presenting it on table' (line 813) and explicitly saying clients have a choice (lines 815-816). The client choice repertoire serves to combat the implication that 'leading the client' is anti-collaborative because the client is positioned as having input into the process – they have the choice to engage with CBT or not.

Client choice is constructed in a way that suggests if they do not engage with CBT they are choosing not to help themselves. For example in line 819 the word 'ameliorate' suggests clients have a choice to 'make things better' if they want. The use of CBT terminology to describe clients' problems functions to set CBT up as a helpful solution. Clients have 'unhelpful' thinking styles (line 805) such as 'black and white thinking' (line 809) and 'catastrophising '(812). CBT offers clients a choice to 'do something different with their cognitive processes', to 'ameliorate' them. CBT is therefore constructed as the 'helpful' choice for 'unhelpful' thinking styles. Leading clients 'from irrational to rational' (line 815) also suggests that choosing to engage with CBT is choosing to help themselves. The use of a CBT discourse to frame CBT as the *right* choice is a circular argument and is demonstrated again in extract 7.

441   **P**   Of thinking. If- if- if- if in therapy we're trying to help people to be less depressed
442   or less anxious, and this particular way of thinking is causing you to <u>feel</u> very
443   low, or very angry, or very sad or whatever, i- is there a different way?
444   **R**   So you're framing it in a way that's gonna give them an option, and...
445   **P**   Yes, 'You could <u>choose</u> to continue to think this...'
446   **R**   Yeah.
447   **P**   'And look, this is how you feel.' Or, 'Having gone through the process of a
448   thought record...'
449   **R**   Yeah.
450   **P**   Y'know, 'you've- you've looked at all the- these different sides of the coin, and,
451   y'know, you've- you've come up with, potentially, this would be another way of
452   thinking. Which one of these is more helpful to you?' Which I think is quite
453   different to saying 'This is wrong and this is right.' There's just <u>different</u> ways.
454   **R**   Okay
455   **P**   Which one is likely to make you feel better?

In this extract client choice is framed as choosing to continue thinking in the same way or choosing to think in a 'different' way. The words 'different' (line 443) and 'another' (line 451), used to describe alternative ways of thinking, are neutral terms. They do not signify better or worse. The function of such neutral language may be to show that the therapist is not influencing clients' choices – clients have agency in the choices they make. A closer examination of the extract though suggests that there is implicit coercion to get clients to change their thinking in line with a CBT viewpoint. For example clients' issues are framed within a CBT framework – "you could continue to think this……and look this is how you feel". This results in CBT skills being constructed as the more beneficial choice for dealing with clients issues without explicitly saying so – "having gone through the process of a thought record…….this would be another way of thinking. Which one is more helpful?". In this context the difference between framing clients' thinking as 'right/wrong' or 'different/another' is that the former is explicitly directive and the latter is implicitly directive. Clients' choices are loaded in favour of engaging with the CBT skill. *Client choice,* implemented

through the use of neutral language, is used to construct the CBT skill of thought reconstruction as a collaborative process while at the same time minimising therapist direction by making it implicit.

Extracts 5-7 demonstrated how the interaction of the *client choice* and *CBT works* repertoires functions to position clients as having agency (they can accept or reject CBT) while at the same time justifying a CBT framework for therapy. The result of this is that clients are not only positioned as having agency but they are also positioned as being either right or wrong depending on which choice they make. There is a sense of the therapist influencing the client's choice to engage or not with a CBT discourse. The use of the CCR in these extracts positions clients as autonomous. Therapist erosion of client autonomy is made implicit by using a CBT discourse to frame client issues in CBT terms and thus setting CBT up as the *helpful* choice. Another way in which CBT was constructed as the *helpful* choice was by deflecting criticisms of CBT away from the theoretical model and toward individual therapists who may implement CBT interventions 'badly'. The division of CBT into 'good' and 'bad' practice provides a disclaimer that although the CBT model is not inherently anti-collaborative it may be practiced in an anti-collaborative fashion.

3.3 *Client choice* associated with 'good' CBT

Two participants split CBT into 'good' and 'bad' in order to deal with the criticism that CBT is directive. Extract 8 demonstrates how 'good' CBT is constructed in terms of clients having choice.

Extract 8 (Participant 2)

735   **R**   I think it's, yeah, that, I think that is what ((slight pause)) some people would
736   have ((pause)) uh, some people that s-, would have an image ((slight pause))
737   of CBT as being that kind of, y'know, 'This is what the problem is, this is what
738   you need to do...'
739   **P**   Yeah.
740   **R**   'These are the steps we're going to take.'
741   **P**   Yeah. But I- but I think that's an ill-inf- ill-informed opinion of CBT.
742   **R**   Yeah.
743   **P**   My-my-myself. Ehm. And...
744   **R**   Can you just tell me wh- a little more just why that is?
745   **P**   Well, because I- I- I think, I think good CBT isn't about ((slight pause)) telling
746   somebody what the problem is. And telling them how we're going to solve it.
747   **R**   Mm.
748   **P**   Y'know. That's not good CBT. I believe good CBT is sort of exploring together
749   what the problems are. And exploring together in agreement about working
750   what the problems, what- And then exploring together what the goals might be.
751   And then exploring together, and agreeing ways to- to address the problems
752   through the goals. I think that's good CBT.
753   **R**   Mm.
754   **P**   Ehm, and yes, y'know, kind of, if we think of er, a manualised formulation-driven
755   model like social anxiety, yeah, I might have, kind of, knowledge, about what I
756   think would be helpful ((slight pause)) in terms of ((slight pause)) kind of,
757   helping with the symptoms of that.
758   **R**   Mm.
759   **P**   And, I think it would be ((slight pause)) withholding, and a bit mean, to not share
760   that, kind of. But, y'know, kind of, with the ((slight pause)) the client having a
761   choice, and saying 'That sounds great, let's try that.' or 'No, actually. I- I can't
762   do it.' for whatever reasons, or 'It doesn't sound helpful.'

In line 745 the participant rejects the criticism put to him by the researcher. The rejection is in relation to 'good CBT' instead of just 'CBT'. By not rejecting the criticism in relation to all CBT there is an implication that the criticism does hold for 'bad CBT'. Good CBT is described in terms of client choice. In line 751 "exploring together and agreeing ways" implies that clients have choices about what they agree to and what they don't.

Directive elements in CBT are acknowledged – "manualised formulation-driven model" (lines 754-755) but in good CBT clients have the choice to accept or reject particular directive elements (lines 760-762). There is an implication here that in 'bad' CBT clients don't have this choice. The difference between 'good' and 'bad'

CBT is therefore the presence or absence of client choice. 'Good' CBT is constructed as facilitating client autonomy. Participant 4, in the following extract, also constructs 'good' CBT in terms of client autonomy. Her construction of client autonomy also indicates implicit therapist erosion of that autonomy.

Extract 9 (Participant 4)

101　**R**　Um, because yeah, actually, I was going to say ((slight pause)) you know, that
102　　　idea of client autonomy within a CBT framework, I think some critics would
103　　　argue that ((slight pause)) that's not- that that might not be collaborative
104　　　because ((slight pause)) that- that might be seen as more directive.
105　**P**　Yeah, I mean, I wouldn't agree ((slight pause)) that it seems more directive. I
106　　　think ((slight pause)) umm, there are ((slight pause)) I think CBT can be done
107　　　very <u>badly</u>, ((laughing)) and in that case...
108　**R**　((laughs))
109　**P**　In that case it <u>becomes</u> directive. But I think if you're doing the job <u>properly</u>,
110　　　((slight pause)) a client has autonomy. But of <u>course</u>, that level of autonomy is
111　　　still within the CBT framework if you're doing CBT.
112　**R**　So can you give me an example then of <u>bad</u> CBT as compared to good CBT?
113　**P**　Yeah, absolutely can. Ehm, I would say I have ((slight pause)) no, I should
114　　　have... I'm not saying what I was gonna say there. But yes, clients who, um,
115　　　((slight pause)) are uh, working with a therapist where really all they're doing is
116　　　looking at a protocol, for a particular disorder. And, um, very narrow <u>focus</u>,
117　　　((slight pause)) and, umm, where actually a client <u>doesn't</u> get any sense of
118　　　autonomy about it. Y'know, we're going through this protocol, and we're going
119　　　from here to here to here...
120　**R**　Yeah.
121　**P**　To here. And, I would class that as <u>bad</u> CBT.
122　**R**　Okay.
123　**P**　So, ((slight pause)) well, different point. I don't need to defend good CBT
124　　　((laughing)) I don't think but there's certainly a lot more autonomy with the
125　　　client, and there's a breadth you're not ((slight pause)) uh, <u>slavishly</u> stuck into a
126　　　protocol. And, ((slight pause)) you're- you're very <u>carefully</u> looking at the role of,
127　　　um, some of the deeper stuff, some of the schemas...

The interviewer puts claims of directedness and lack of client autonomy in CBT to the participant. The participant defends against these claims by referring to the presence of client autonomy but qualifying this statement by saying autonomy is contained within a CBT framework (lines 110-111). Autonomy is defined as freedom in one's actions. Stating that autonomy is contained within a CBT framework implies that clients' freedom is restricted. They only have freedom within the therapeutic

process if they comply in working within a CBT perspective. There is an implicit sense of the CBT therapist directing the client towards a CBT perspective. The participant is using an *autonomy* discourse to defend against criticisms of directedness but contained within that discourse are implications of directedness. The use of *autonomy* functions to incorporate the conflicting positions of therapist direction and client freedom.

The use of the phrase "if you're doing your job properly" (lines 109-110) and "I think CBT can be done very badly" suggest that there are times when CBT does not lead to client autonomy but this is due to therapist error as opposed to something inherent in the CBT model. This allows CBT to be constructed as non-directive while countering any possible claims of directedness by explaining them in terms of therapist error.

The participant uses a 'lack of choice' repertoire to describe 'bad' CBT. For example "narrow focus" (line 116), "client doesn't get any sense of autonomy" (lines 117-118), "we're going from here to here to here" (lines 118-119). The repetition of the word 'here' serves to heighten the sense of rigidity and lack of choice. By framing 'bad' CBT in terms of 'lack of client choice' there is an implication that 'good' CBT includes client choice. It involves not being slavishly stuck into a protocol (lines 125-126.) and the client has autonomy (line 110). CBT is defended against the criticism of being directive by sectioning off the criticism as 'bad CBT'. Other elements of 'good CBT' include looking at the role of "deeper stuff" (line 127). In the next extract this participant uses 'client choice' in relation to this aspect of 'good' CBT.

177	**P**	Well, all I'm saying to them is 'From <u>my</u> perspective, as a CBT therapist, ((slight
178		pause)) <u>this</u> can play a part...'
179	**R**	Okay.
180	**P**	'Core beliefs <u>may</u> play a part in, ehm, how people are feeling, and err, people's
181		thinking patterns.'
182	**R**	Yeah.
183	**P**	And, ehm, i-it's very much then, y'know, I'm- I sort of let that sit ((slight pause))
184		with the client then for a while. Um, about whether or <u>not</u> ((slight pause)) they
185		choose to do that. And that's what I was saying right back at the beginning.
186		Some clients may not want to get into that.
187	**R**	Mm-hm.
188	**P**	Some clients may want to do ((slight pause)) the purely behavioural stuff,
189		y'know, the more <u>surface</u> stuff.
190	**R**	Right.
191	**P**	And that's fine. That's- that's fine. ((slight pause)) But, I will <u>open</u> up ((slight
192		pause)) just that world of...
193	**R**	Yeah.
194	**P**	Of core beliefs for people. Sometimes even some of the ((slight pause))
195		schema ((slight pause)) stuff. And it's very much for a- a client to choose
196		((slight pause)) whether or not...
197	**R**	Mm.
198	**P**	That's a direction that they want to go in.
199	**R**	Okay, so you're giving them.. ((pause)) You're giving them the CBT way of
200		seeing things and then it's up to them whether they want to engage with that or
201		not?
202	**P**	They're coming to me. They know I'm a ((laughing slightly)) CBT therapist when
203		they come to me.
204	**R**	Yeah, ((laughs)) yeah.
205	**P**	So, obviously, I'm not gonna go into some <u>other...</u>
206	**R**	Yeah.
207	**P**	Kind of therapy with them. But what I <u>am</u> giving them is choice <u>within</u> that

In the previous extract the participant talked about "carefully" introducing "deeper stuff". In this extract she elaborates on how this is done. The introduction of core belief and schema work is constructed in a way that allows for client choice. In lines 183-184 a sense of clients having space and time to reflect is elicited by the phrase "let that sit with the client". The function of this may be to give a sense of clients having agency in the choices they make – they are not pressured to choose the particular aspect of CBT that the therapist is offering at that point.

In line 192 the participant describes the introduction of deeper work in terms of opening up that world. This elicits a sense of offering this work to clients as opposed to pushing it or even encouraging it. There is a sense of non-forcefulness with the description that works to construct client choice as freely made. The interviewer summarises his interpretation of the participant's description of 'good' CBT as the choice to engage with a CBT perspective or not (lines 199-201). The participant responds by saying "they know I'm a CBT therapist" suggesting that the interviewer's summarisation was not in line with the point that the participant was making. To explicitly refute the interviewer's summarisation though would imply a restriction to the choices clients have. By referring to client's awareness of her role as a CBT therapist there is a suggestion that clients want to engage with CBT. The participant is therefore able to deny claims that clients have a choice not to engage with CBT without it seeming like client choice is being restricted.

The description of 'good' CBT in this extract contrasts sharply with the description of 'bad' CBT in the previous extract. Good CBT opens up possibilities and offers aspects of CBT to clients. It gives them time to sit with and reflect on these possibilities and allows them to make choices freely; it encourages autonomy. Bad CBT on the other hand enforces aspects of CBT step by step. It is inflexible and does not allow for client autonomy.

In extracts 8-10 'good' CBT is constructed in terms of client choice. It involves therapist and client exploring issues together and agreeing on goals and interventions with the client having space and time to make choices freely. Client choice here is framed in a similar way to the *menu* and *tools* metaphors in that the choice is between which interventions to use; it is not about whether to engage in

CBT or not. 'Bad' CBT is constructed as not allowing client autonomy; the therapist is narrowly focused on following a manualised protocol. It is constructed in a way that suggests clients have no choice. The therapist is doing CBT 'to' the clients, who are positioned as passive recipients of the therapist's interventions. 'Bad' CBT is described in terms of some of the main criticisms of CBT – it is overly-directive and clients have no agency. By splitting CBT into 'good' and 'bad' the participants are able to section off criticisms of CBT and explain them away as bad practice. This allows them to acknowledge some validity in the criticisms while protecting the CBT model from these criticisms. Another way that participants dealt with criticisms of therapist direction and client passivity was by relating these aspects to the beginning of therapy and relating increased client autonomy to later in the therapy process. By locating overt therapist direction at the beginning of therapy participants were able to justify this direction as it was constructed as leading to client autonomy later in therapy. This discursive move is demonstrated in the following three extracts.

3.4   Increasing client choices as therapy progresses

Extract 11 (Participant 4)

```
34   P     Well, I suppose when I say it's probably worth, I need to define what I mean
35         when I say  we're setting...
36   R     Yeah,.
37   P     The direction. Because a client coming at the beginning has no idea ((slight
38         pause)) what we're gonna do. So all I mean is that in the first session, for
39         example, I'll be, um, ((slight pause)) y'know, getting from the client what is it
40         that they want to get out of therapy. So, "what's the problem?"  "how do we
41         turn that into some kind of aims and objectives?"
42   R     Mm-hm.
43   P     And then, I'll be making the decision in the first session, about what techniques
44         are gonna be helpful ((slight pause)) to that client at the beginning.
45   R     Okay.
46   P      Now, it is sometimes they're are choices, that you can ((slight pause)) give the
47         client, but in the beginning, ehm, you can't say to the client 'Okay, ehm, ((slight
48         pause)) er, so, your mood's very low. What would you like to do about it?'
```

49	**R**	Okay.
50	**P**	So in the beginning, I know the <u>techniques</u> that will be helpful to that client.
51		And I'll suggest to them 'Here's what I think might be helpful in the beginning.'
52		<u>After</u> a while, clients get to know the different techniques that we can use, so
53		when I'm talking about, I'll ((slight pause)) set the direction to <u>start</u> with...
54	**R**	Mm-hm.
55	**P**	It's '<u>I</u> have the knowledge' ((slight pause)) y'know, that's ((slight pause)) part of
56		the reason for training. But ehm, it's a collaborative process between me and
57		the client, ((slight pause)) about how we <u>use</u> those tools.

The participant describes being explicitly directive with clients at the beginning (lines 43-44) because she has the knowledge (line 55). She decides which techniques to use at the start and clients have more choices as they become familiar with the techniques. Her initial direction therefore, is constructed as leading to client choice. This choice is contained within a CBT framework. Clients are only free to collaborate with her on her terms "about how we use the tools" (line 57).

In line 43 she states that she will be "making the decision". In line 51 though she does not 'tell' the client what her decision is. It is constructed as a suggestion, which implies clients have choice to accept or reject whatever technique she puts forward. This contradicts the statement that the therapist makes the decisions at the beginning of therapy. Even though the participant is being explicit about directing therapy at the beginning, client choice is stated implicitly. This suggests that 'client choice' is used to weaken the acknowledgement of therapist direction - clients' always have choices even when the therapist is making the decisions.

CBT techniques are concretely put forward as being beneficial to clients (line 44). There is a suggestion therefore that the therapist is directing clients to a range of 'helpful' tools -therapist direction leads to client choice which leads to client improvement. This sequence is again demonstrated in the following extract.

Extract 12 (Participant 7)

61 **P** Now probably my tendency at that point is to be slightly less collaborative than
62   some other people are to be honest, perhaps probably in the early stages I'm more
63   kind of going, "Okay you go away and try these things out, thought records, activity
64   diaries," those sorts of things in the early stage.
65 **R** So that is more directive then is that was you mean?
66 **P** Yeah I would say so.
67 **R** And how does it change over the course of therapy then?
68 **P** It's not over the course of therapy, I'd be saying it to them kind of adopting some of
69   the ideas, they're increasingly learning about using CBT, what seems to be working
70   for them…
71 **R** Yeah.
72 **P** …and more them going away okay and discussing and saying, "What do you think
73   is a good thing to try next? What's the next bit of stuff to kind of tackle here? Where
74   do you think we should be going with this?" So them kind of learning to be their
75   own therapist.

'Client choice' is constructed in this extract through the use of directly-reported speech (lines 72-74). These are examples of questions that the participant asks clients. Clients have choices to make regarding what they try next and what direction they go in. They only have choices once they have followed the therapist's direction and adopted CBT ideas (lines 68-69). These choices are not available at the beginning (lines61-64) because clients are not yet familiar with CBT techniques such as thought records and activity diaries. Therefore this is another example of how client choice is limited by the therapist. The therapist leads the client to a range of choices. Once the clients become familiar with these choices they can direct themselves – "learning to be their own therapist" (lines 74-75).

The client choice repertoire is used here to link therapist direction to client autonomy. Because client choice is constrained by a CBT framework though, there is an implication that clients are only autonomous within a CBT framework. It could be argued that this is not actually autonomy because there are specific forces (CBT framework) acting on clients' decision-making. Extract 13 provides another example

of clients being constructed in terms of *learning to be their own therapist* without explicitly using this phrase.

Extract 13 (Participant 7)

259 **P** …yeah, um, so I'd say maybe…maybe the one I can think of mostly kind of working
260   with people with OCD would be something where actually kind of working with
261   them at the start and thinking about what the problems are and quite often with
262   them finding that after a couple of weeks they pretty much know what to do and I'm
263   just checking in with them. So we've come to some mutual understanding of what
264   the problem is…
265 **R** Okay.
266 **P** …kind of framework within that CBT framework or what the maintenance cycle is,
267   kind of do a little bit of kind of maybe experiment to test out what happens when
268   they stop doing things…
269 **R** Yeah.
270 **P** …and then saying to them, "Okay what do you think is the next thing? You need to
271   work out, we've got this list of problems you've identified where do you think you
272   can go next?"
273 **R** Okay.
274 **P** We've identified problems there, what can we do about it? Okay let's think and
275   then…and more or less just checking with them, letting them get on with it.

In this extract the participant is again implementing the client choice repertoire using directly-reported speech (lines 270-272). He is demonstrating that it is the client who chooses the direction once they have both come to a "mutual understanding of what the problem is". This understanding is contained with a CBT framework (line 266) so client choice is limited to aspects of CBT they have acquired since beginning therapy. Clients have autonomy in relation to doing the CBT work – the therapist is "letting them get on with it" (line 275).

The participants in the previous three extracts attempted to reconcile the idea of therapist direction with client agency by suggesting that the former decreases and the latter increases over the course of therapy. This was done by differentiating between the level of client choice at the beginning of therapy and in later sessions.

Participants acknowledged being directive at the beginning but justified this by stating that this direction led to increased client autonomy through increased choices available to clients as therapy progressed. Similar to the use of tools and menu metaphors this allowed participants to acknowledge that CBT contains direction while at the same time positioning clients as active agents as opposed to passive recipients.

The following section expands on the use of *less* directive language to implement *client choice* that was touched upon in extract 7. In that extract the participant described using terms such as *different* or *another* instead of *right/wrong* when discussing thoughts with clients.

3.5   Client choice implemented through the use of *less-directive* language

The participant in the following extract construes her struggle with the issue of directivity in CBT. She conveys how she used *less directive* language to deal with this issue.

Extract 14 (Participant 6)

428	P	Yeah, when I was doing my training I really struggled with that. For that reason.
429		That you're practically saying to somebody 'Well, this isn't the right way to think,
430		you should think like this.' and 'That's irrational.' And actually, as I've got more
431		experienced, I just don't- I don't use those terms any more, for starters. So, I
432		don't call it irrational thinking, I don't- I don't refer to right and wrong ways of
433		thinking, I talk about, um, ((slight pause)) whether <u>a</u> way of thinking is helpful to
434		them.
435	R	Okay.
436	P	Or not. Um, and whether or not there might be other ways of thinking that don't
437		make them feel so sad and angry and anxious, or whatever. And then they
438		could, if they wanted to, they could <u>choose</u> to think a different way. So that's
439		how I now work with that, rather than talking about irrational thoughts, rational
440		thoughts, unrealistic thoughts, I talk more about, um, "is there a more helpful
441		way?"

The participant portrays how she dealt with her struggle by changing the language she used with clients, for example "Is there a more helpful way?" instead of "you should

think like this". She argues that framing questions in this way offers clients the choice to think in a different way. The CCR is therefore being implemented through the use of less directive language. In extract 15 this participant illustrates in more detail the difference between using explicitly directive and *less directive* language.

Extract 15 (Participant 6)

```
476   P   Out of a session. Well, there- there's- you- you've got, um, you've got a
477       therapeutic relationship with your patient, there's a style between you, a dynamic
478       between you in sessions. And, it- it- it's not as- it's just not as straightforward as...
479       ((slight pause)) I- It's not as black and white as ((slight pause)) it sounds when
480       you take it out of a session. Um, ((slight pause)) we're constantly... ((slight
481       pause)) ((laughing)) not chatting, chatting's not the right word, we're not chatting,
482       we're constantly checking out with each other in session, y'know, 'Now we're
483       doing this, that, and we've just done this, and we've just talked about that.', 'How
484       did you find that?', 'Are we ready to move onto this?', 'Shall we spend longer on
485       this?', 'Maybe we need to look at this further' Y'know, it's not just 'Right, we're
486       doing a thought record. Column one, two, three, four, five, six, seven. Now what
487       do you think? Good. Right, ((laughing)) now we're...'
488   R   ((laughs))
489   P   ((laughing)) 'Now we'll do this.' Y'know, it's not... I- i- i- it's much more fluid,  and, I
490       I- I- I find it quite, sort of, ((intake of breath)) ((groans)) God, I sound a bit flouncy,
491       a bit sort of, like, a bit art- a bit artful, and, um...
492   R   Okay.
493   P   A bit like a dance.
494   R   Yeah.
495   P   It's not just a clinical, scientific 'Let's sit down, do a thought record, now let's  do
496       a responsibility pie chart, and there you go...'
497   R   Okay.
498   P   'And your thinking's changed.'
```


In this extract the participant contrasts the use of explicitly directive language with less directive language (lines 482-487).   The client choice repertoire, implemented using directly-reported speech, constitutes the 'less' directive language. Instead of telling the client "now we're doing this" the client is offered choices – "shall we spend longer on this?" These choices are specific to aspects of CBT. Using the client choice repertoire the participant reconciles 'therapist direction' with 'collaboration' by directing clients to a range of choices where they have an input into the direction of therapy. Any direction a client makes though is within a CBT

framework. The 'client choice' repertoire allows for the participant to hold two apparently contradictory positions – 1. Someone who leads clients and 2. Someone who collaborates with clients. Therefore the criticism that CBT is directive, not collaborative is nullified – direction leads to collaboration.

The use of directive language is described as "clinical" and "scientific" while the use of 'less' directive language is described as "fluid" and "like a dance". The former elicits a sense of rigidity and formality, precisely following steps with no room for deviation. The latter strengthen the idea of 'client choice' and autonomy because they elicit a sense of individual expression, free of constraints.

So far *client choice* has been constructed as a positive aspect of the therapy process. In extract 16 the participant constructs client choice as something that can hinder the process. She also warns against the use of directive language though suggesting that therapists should direct in an implicit way.

Extract 16 (Participant 5)

122	P	Clients ((slight pause)) don't just like sitting about in quietness while somebody
123		waits for them. and some people say to me "I find that more damaging somebody
124		just waiting for me, just watching you think", and "what would you like to do?"'.
125		((laughingly)) They find that quite damaging.
126	R	Okay.
127	P	I've heard that quite a lot. They want somebody to take a bit of a lead. We would
128		not as CBT therapists tell them what to do, that's not right, you wouldn't tell the
129		client what to do. You hand it back to the client to make those changes.
130	R	Alright.
131	P	To do the work. Because only they can make those changes.
132	R	So you- you don't tell them what to do.
133	P	No.
134	R	Well, what- what do you do then?
135	P	Well, through our questioning, socratic questioning, you could say to them, like
136		'What- what's going through your mind?' 'What- what's going through your mind?'
137	R	Mm.
138	P	What are you reacting?. 'What are the chances that that would happen? what are
139		the chances ? And get them to think that's your opinion "oh it's opinion, it's not a
140		fact"

Client choice is implemented in this extract using directly-reported speech (lines 124-125). Unlike previous extracts though it is framed as something negative – it is "damaging". Using *client choice* in this way works to justify therapist direction – "they want somebody to take a bit of a lead" (line 127). Instead of using 'client choice' to defend against criticisms of therapist direction in CBT, it is used to portray direction as favourable.

The participant qualifies her declaration that clients want therapists to lead by stating that therapists don't tell clients what to do. This implies that the language that therapists' use when taking the lead is important - they must not be explicitly directive. She reconciles the difference between 'taking the lead' and 'telling clients what to do' by stating that socratic questioning is used with clients. Using this method therapists do not tell clients what to do; they ask questions that direct the client in a certain direction in order to reach a conclusion "and get them to think that's your opinion" (line 141). The purpose of using language like this is to position the client as having agency – they are the ones making the change, not the therapists.

Extract 17 elucidates the use of *less directive* language in guiding clients in the skill of thought reconstruction. It provides another example of how *client choice* is facilitated by constructing therapist interventions in tentative instead of definite terms.

Extract 17 (Participant 8)

440	**P**	I think the way…the way you challenge it is important in it. So if you just say,
441		"Well that's…that's wrong because that's overly negative, and if you were
442		thinking rationally you would think this." It's like, you're going about it like if…if
443		your friend had that that thought, you know, what would you say to them? So
444		they're coming up with their own evidence of why this thought mightn't be true
445		all the time. So you're not telling them it's wrong you're saying, "Okay that's the
446		thought you had, um, you know, if somebody else had that thought what would
447		you say? Or in five years' time if you thought back on this would you still think

448		the same way?" so you're challenging but they're still coming up with the
449		answers.
450	**R**	So then would you say that directiveness is not…you know, you can be directive
451		and collaborative in therapy that they're not totally opposites?
452	**P**	Yes I think they can be together in that you're directing them to think about
453		something at that time and give it a go, the information is collaborative because
454		you're working together to come up with the information of how they challenge
455		and then the decision is on them whether they want to continue to use this
456		technique or whether they felt it wasn't useful. So the decision… the ball's still in
457		their court if they feel that this is something that would benefit them, if it's helpful
458		to think in this way instead…
459	**R**	Okay.
460	**P**	…and if not then that's fine.

Clients are not told their thoughts are wrong; the therapist asks questions that challenge clients to consider if their thoughts are wrong. The benefit of using *less* directive language is described in terms of client choice – by framing their interventions in a way that does not insist on the therapist's viewpoint clients are able to accept or reject the CBT technique. Client choice is used to construct a sense of client agency, which defends against criticisms of therapist direction.

The participants in extracts 14-17 described the importance of the language they used with clients. They suggested that when therapists propose interventions to clients it should be done in a way that puts the responsibility for action on the client. They talked about the importance of not telling them what to do directly. The use of less-directive language functions to open up possibilities for clients – it offers them choices about which interventions they would like to use. It may also function to make overt therapist direction implicit by framing client choices in a way that encourages clients towards certain interventions.

The client choice repertoire, implemented through the use of less-directive language, constructs collaboration in a way that includes both therapist direction and client agency. One participant though (extract 16) constructed client choice as

something negative, which justified therapist direction. Less-directive language in this case was explicitly constructed by the participant as a way of directing clients without telling them what to do.

3.6   Summary of Analysis

The experience of contradictory positions can be problematic and usually need to be reconciled (Davies and Harré, 1990). The claims of therapist direction and client compliance with the CBT model, that were put to participants by the researcher, positioned clients has passive recipients of therapy and therapists as having 'power-over' clients. The CCR functioned to reposition clients as active agents in the therapy process while at the same time acknowledging elements of therapist direction. Positioning is a second-order phenomena; it describes the effect that certain discursive actions have for establishing identities (Korobov, 2010). Positioning underscores the way rhetorical devices can sometimes be employed in the construction of social identities (Korobov, 2010). The CCR facilitated the reconciliation of the seemingly contradictory positions of therapist as director of therapy and the client as someone who influences the direction of therapy. It did this in several ways. Firstly, by using *menu* and *tools* metaphors to suggest that therapists direct clients towards a range of possible interventions that they could choose from. Clients were positioned as having agency because they decide which interventions to use while therapist direction was acknowledged in that they direct clients to a range of choices. Therapist direction was therefore constructed as leading to client agency and autonomy. Secondly, the interaction of the CCR and the *CBT works* repertoire suggests that clients are implicitly influenced to engage with CBT while explicitly having a choice to engage or not. Thirdly, the splitting of CBT into 'good and 'bad' worked as a defence against

criticisms that CBT does not allow for client choice. Fourthly, *increasing client choice as therapy progresses* located explicit therapist direction at the beginning of therapy and increased client choice later in therapy with the inference that therapist direction eventually leads to client choice. Finally the use of *less directive* language constructed therapist interventions as 'offerings' as opposed to 'commands', implying that clients had choice in engaging with these interventions or not. The function of these varying constructions of the CCR will be discussed in relation to the varying conceptualisations of collaboration in CBT. Implications for counselling psychology practice will be outlined.

4. DISCUSSION

The client choice repertoire (CCR) helped participants construct collaboration in a way that reconciled the notion of client agency with the notion of therapist direction. Two contrasting ways in which client choice was used to reconcile the notion of client agency with that of therapist direction was in terms of (a) making possible client compliance implicit and (b) constructing therapist direction as a pathway to increased therapeutic possibilities. In the first instance client compliance was made implicit while positioning clients as active agents in line with notion of 'co-implication' put forward by Ekberg and LeCouteur (2014). In the second instance therapist direction was constructed in a way that suggested that it leads to an opening up of possibilities, in line with the conceptualisation of collaboration outlined by Sutherland and Strong (2011).

Ekberg and LeCouteur (2014) favour therapist responses that offer clients choices while maintaining therapist control over the process. Their concept of 'co-implication' constructs client agency as a tool to encourage client compliance with the therapist's perspective. Sutherland and Strong (2011) assert that collaboration in therapy involves the therapist presenting their contributions as contestable and incorporating clients' meanings and preferences as part of their developing interactions. By presenting contributions as genuinely contestable there is space for new possibilities and avenues of exploration (Sutherland and Strong, 2012). These contrasting conceptualisations of client choice differ in terms of how they construct therapist direction. The model put forward by Ekberg and LeCouteur views therapist direction in terms of validity while Sutherland and Strong view therapist direction in

terms of viability. Framing therapist direction in terms of its validity justifies implicitly encouraging the client in a certain direction because the therapist is leading the client to the right choice. Framing therapist direction in terms of its viability suggests the therapist's contribution is only one option that may or may not work for the client. Individual participants drew on both these constructions of client choice, highlighting within and across participant variance in the construction of collaboration through the CCR.

Participant 6 demonstrates how individual participants drew on both the contrasting constructions of the CCR. In extract 7 she constructed choice as the choice to continue thinking the same way (line 445) or they could choose to think another way (line 451). Choosing to think another way is implied as being the right choice. The interaction of the client choice repertoire and the 'CBT works' repertoire not only positioned the client as having agency (they could accept or reject CBT) but it also positioned them as being right or wrong depending on the choice they made. If they did not choose CBT they were choosing not to help themselves. Framing client choice in such a way could be argued to include implicit coercion to choose CBT as there was a negative connation to not choosing CBT. Hemmings (2008) suggests that CBT is collaborative when clients are able to resist therapists' attempts to impose a CBT agenda. Client choice was constructed in terms of being able to reject a CBT agenda but the interaction of the 'CBT works' repertoire eroded this choice because possibilities are presented to clients in such a way that positions CBT as the 'helpful' choice. From this perspective clients may feel pressure to go along with the 'helpful' choice which some (e.g Proctor, 2008) would argue is an example of client compliance not client agency. Libertarian paternalism is a term used to describe how

medical professionals help patients make decisions which promote their own welfare without limiting their freedom of choice (Aggarwal, Davies and Sullivan, 2014). Aggarwal et al. assert that by changing the 'choice architecture' for decision-making individuals can be 'nudged' into making the right choices. Aggarwal et al. argue that collaboration should allow for the preservation of choice without the professional giving up their clinical responsibility or professional judgement. The concept of libertarian paternalism emerged from the medical model of the doctor-patient relationship but it fits with the idea of 'co-implication'. By framing CBT as the helpful choice, the participant was constructing collaboration using the CCR in terms of *nudging* clients toward her perspective.

Participant 6 also implemented *client choice* through the use of *less directive* language, eliciting a sense of playing with different possibilities in line with a dialogic perspective of collaboration. In extract 14 she described using the term helpful/unhelpful ways of thinking instead of right/wrong or rational/irrational ways of thinking. Helpful/unhelpful constructs thoughts in terms of their viability as opposed to their validity. Asking clients whether their thoughts are helpful/unhelpful fits with a dialogic, social constructionist perspective of CBT. For example Strong, Lysack and Sutherland (2008) state that clients cognitions should be viewed as emerging in the interactions with therapists and both parties 'play with' and edit meanings and understandings. *Client choice* implemented through 'less-directive' language works to refute positivistic constructions of thoughts as valid/invalid such as the one put forward by Beck (2005) who asserts that therapist and client explore misconceptions together and test the validity of the client's thoughts.

In extract 9 participant 4 states that client autonomy is a characteristic of 'good' CBT. Unlike 'bad' CBT clients they are "not slavishly stuck into a protocol" (lines 125-126). The declaration of client autonomy is qualified by stating that it is contained within a CBT framework. The implication that clients have increased choice once they accept a CBT framework suggests that the participant is constructing collaboration in terms of *nudging* clients in a therapist-preferred direction. It could be argued that clients are being *co-implicated* in the decision to engage with a CBT discourse. In contrast to the positivistic construction of *client choice* in extract 9, in extract 10 participant 4 describes "opening up the world" of deeper issues. Clients are proclaimed to be free to choose to go in that direction or not. The use of the phrase "let that sit with the client" (extract 10, lines 183-184), suggests clients have time to reflect on their possible choices without any pressure from the therapist. *Client choice* in extract 10 is constructed in terms of its *contestability.*

The variation in the constructions of client choice in terms of *co-implication* and *contestability* within individual participant discourse suggests that the dichotomy of positivistic and dialogic CBT is not as clear-cut as purported in the literature (e.g. Boucher, 2010; Grant Mills, Mulhern and Short, 2004: Lyddon, 1995). Individual participants constructed collaboration using the CCR in a way that could be argued is located within a positivistic perspective (i.e. client choice implicitly constructed as client compliance) and in a way that may be located within a dialogic perspective (i.e. the opening up of possibilities). The dichotomy of positivistic-dialogic practice may be useful as an aid in reflecting on therapeutic practice but it may not reflect a reality 'out there', for example if a practitioner declares "my practice is dialogic". Instead

positivistic and dialogic perspectives emerge through interaction and individual practitioners can construct collaboration from either perspective, or a combination of both at different times. This variance is related to the function a particular construction serves within a particular interaction. In the current study the construction of collaboration from either perspective was frequently done in order to position the clients as having agency. Examples of how these different perspectives served this function in terms of *contestability* and *co-implication* are outlined below followed by a rationale for positioning clients as having agency.

Client choice, implemented through the *menu* and *tools* metaphors, was constructed in a way that incorporated both positivistic and dialogic conceptualisations of collaboration. These metaphors were used to construct collaboration in terms of how clients and therapists work together to implement CBT techniques and as clients having power in choosing which interventions they prefer. Participants using these metaphors were drawing on a similar discourse as the conceptualisation of collaborative empiricism outlined by Tee and Kazantzis (2011), in which clients are encouraged to engage with CBT techniques but have choice in how this is done. Clients can decide "which tools they choose to use and not use" (extract 3, line 380). The CCR is constructed in terms of *contestability* in line with a dialogic perspective. Therapist direction, in the form of encouraging clients to engage in CBT techniques, is constructed as leading to the opening of possibilities. Therapist direction is therefore constructed as facilitating client agency.

The *menu* and *tools* metaphors also constructed *client choice* as being restricted – either to the range of *tools* in the *toolbox* or the number of *items* on the

menu. This implies that clients have power once they accept the limitations of a CBT framework. From this perspective client compliance with the CBT model is required before client autonomy is achieved. Clients are positioned as having agency with an implicit implication that they are being *nudged* or *co-implicated* into engaging with a CBT discourse.

'Increasing client choice as therapy progresses' also constructed collaboration as 'power-with' the client. Therapists were viewed as having power at the beginning of therapy and this power was purported to gradually move to the client in the form of increased decision-making responsibility. According to Dryden (2009) as therapy progresses the therapist encourages clients to take increasing responsibility for using CBT skills. The therapist adopts a prompting style of interaction. In relation to collaborative empiricism, Kazantzis, Cronin, Dattilio and Dobson (2013) suggest that the balance of contributions to collaboration is even – therapists take greater responsibility in the early stages and clients take greater responsibility in the later stages. It could be argued that this 'power-with' construction of collaboration actually contains elements of 'power-over' the client in line with a positivistic perspective of CBT. According to Sutherland and Strong (2011) a therapeutic relationship is collaborative when power distribution is fluid and multi-directional. 'Increasing client choice as therapy progresses' did suggest fluidity and multi-directionality in the power distribution between therapist and client but it also suggested that clients only have power once they assimilate a CBT model for dealing with their issues. Proctor (2008) argues that even when clients make their own decisions they are actually taking on internalised norms given to them by the therapist. From this perspective

client decision-making is actually the *co-implication* of clients in engaging with a CBT framework.

Both the conceptualisations of the CCR - as opening up possibilities or making client compliance complicit - add weight to the hypothesis that a main function of the CCR was to position clients as having agency. Agency is part of the notion of self-contained individualism that is an inherent aspect of Western culture (Madill and Doherty, 1994). An active as opposed to a passive subject is offered as the standard of health and normality for adults in general. Positivistic conceptualisations of CBT have been criticised for positioning clients as passive. For example, Hemmings (2008) argues that there is a danger of power abuse when CBT is practiced from the positivistic end of the continuum. This may explain why participants made positivistic characteristics such as client compliance implicit and dialogic characteristics explicit. Purportedly positivistic CBT was constructed in terms of passivity and supposedly dialogic CBT was constructed in terms of agency. This is clearly demonstrated in participants' splitting of CBT into 'good' and 'bad'. Participants' descriptions of 'good' CBT are in line with conceptualisations of dialogic CBT and descriptions of 'bad' CBT are in line with positivistic conceptualisations of CBT. For example 'bad' CBT involves a focus on a "manualised, formulation-driven model" while 'good' CBT involves "exploring together and agreeing ways". This view of client agency as positive and client passivity as negative can be found in the psychotherapy literature as outlined in the following section.

Client agency and client choice as cultural resource for participants

It has been argued that the fundamental ethical dimension in collaborative relationships is that people should be treated as agents of their own lives (Madill and Doherty, 1994). The agency of both the client and the therapist is implicit in the notion of a collaborative therapeutic relationship (Mackrill, 2009). Client agency has been defined as a client's disposition to actively make choices about therapy (Hoener, stiles, Luka and Gordon, 2012). Oddli and Rønnestad (2012) investigated how therapists introduce techniques in the initial phase of therapy using a grounded theory approach. One of the main categories that emerged from the data was supporting the client's agency through underscoring client choice and authority. Knight, Richert and Brownfield (2012) state that in relation to client agency clients select from a range of therapist-provided learning opportunities and then creatively use them to bring about desired change. According to Tompkins, Swift and Callahan, (2013) many therapists work collaboratively with their clients by using client preferences and choice to guide treatment decisions. They assert that allowing clients to choose between treatment options is likely to result in higher levels of client participation in the therapy process. Swift, Callahan and Vollmer (2011) completed a meta-analysis of 35 studies that compared drop out rates of clients whose preferences were taken into account (i.e. clients who had choices available to them) and clients whose preferences were not taken into account. They found that drop out rates were much lower for preference-matched clients. These examples from the psychotherapeutic literature suggest that the concept of *client choice* exists in the psychotherapy domain as a positive aspect of the therapy process. They support the proposal that the *client choice* interpretive repertoire is a cultural resource that

participants could draw on to locate their therapeutic practices within a dialogic framework and defend against criticisms of their practices as positivistic.

Participants had a stake in locating their practice at the dialogic end of the continuum, where client agency is of upmost importance, as this has been put forward as a positive characteristic of therapeutic practice (Boucher, 2010; Hemmings, 2008; Sutherland and Strong, 2011; Mackrill, 2009; Knight, Richert and Brownfield (2012); Madill and Doherty, 1994). At times this led to minimisation of positivistic elements of participants' practices such as *nudging* clients into making the *right* choice. Constructions of collaboration, implemented through the CCR were constructed in varying ways though, that subscribe to both positivistic and dialogic perspectives. Also Individual participants fluctuated in how they constructed the CCR over the course of their interview. These findings suggest that collaboration in the participants' practices is not one definable 'thing' that can be located within one philosophical stance. It is a fluid concept that is constructed in varying ways in interaction with others to serve certain functions such as positioning clients as active agents.

4.1 Implications for CBT practice

For CBT therapists it is important to reflect on their use of a collaboration discourse to support the notions of client agency and client autonomy. Otherwise positivistic aspects of their therapeutic practices may be made implicit. They may 'nudge' clients in a certain direction without knowing they are doing it. This was demonstrated in the current study by the use of the CCR that made client compliance

complicit. It is therefore important for practitioners to develop reflective skills in order to examine how they construct elements of their therapeutic practices.

Reflective practice involves observing, interpreting and evaluating our own thoughts, emotions and actions (Bennett-Levy, 2001). In relation to psychotherapy Neufeldt, Kamo and Nelson (1996) state that the reflective process involves a search for understanding the phenomena of the therapy session with attention to the therapist's actions, emotions and thoughts as well as the interaction between the therapist and client. Mastering theories and techniques are only one aspect of learning and doing therapy, examining the therapist's personal and professional self, attitudes and goals are another important aspect (Niemi and Tiuraniemi, 2010). Laireter and Willutzki (2003) argue that practice-based self-exploration is an important element of therapists' skillsets. They define this as an exploration of the experiences, behaviours and interpersonal performances of the therapist during his/her therapeutic work. A critical component of self-reflection is self-awareness (Ridley, Mollen and Kelly, 2011; Fauth and Williams, 2005). A master therapist, according to Fauth and Williams, strives to learn more about their work and themselves in order to heighten their awareness of themselves and others. Ridley et al argue that the more self-aware therapists are the more interpersonally engaged they become in the session.

The results of the current research could aid CBT therapists in their self-reflective practice. For example in examining whether they have a fixed perspective on how they collaborate with clients or examining whether they draw clear lines between what they consider 'good' CBT and 'bad' CBT. The analysis in the current study indicated that participants considered dialogic CBT as good and positivistic

CBT as bad while also constructing collaboration in line with both positivistic and dialogic perspectives. Positivistic elements were made implicit though as they did not fit with what participants considered good practice. It may be important therefore for CBT therapists to reflect on whether there are elements of how they construct collaboration in their practices that they are making implicit because those elements do not fit with what they consider good practice or do not fit with their self-as-therapist schema. For example Socratic dialogue and guided discovery are key concepts relating to collaboration in CBT (Overholser, 2010). There may be a risk though that these terms are used to construct collaboration from a dialogic perspective without considering if positivistic elements are contained within these constructions. By softening the division between dialogic and positivistic, CBT therapists may be better able to reflect on whether positivistic elements are contained within their constructions of concepts such as Socratic dialogue and guided discovery. They may develop a deepened sense of how these terms relate to their practice and consider, for example, if there are times when they lead clients to a particular conclusion under the label Socratic dialogic. It is not that directive elements of practice are necessarily a 'bad' thing. It is the lack of awareness concerning aspects of the relationship with clients that make such elements problematic. In relation to CBT, Hemmings (2008) suggests that it is easy to view 'technical' therapy as bad and subtle idiosyncratic approaches as good. In his view there is a place for simple pragmatic interventions for some people. To know when and how to implement such strategies though, requires an understanding of the therapist's relationship with the client (Hemmings, 2008).

Several benefits of such deepened self-reflection in CBT practice, as described above, have been noted. Gale and Schröder (2014) conducted a meta analysis of 10

qualitative papers exploring the experiences of therapists' self-reflective practice in CBT. They identified 14 constructs relating to self-reflective practice such as: reflective practice can lead to a deepened self knowledge and help therapists understand how they view themselves and others; it can result in increased self-awareness that allows therapists to transfer their deepened conceptual understanding of their own behaviour to that of their clients; self-reflective practice can lead to an increased appreciation of the therapeutic relationship by acknowledging and understanding the therapist's contribution; self-reflective skills enables therapists to become more aware of their own internal process such as their own schemas and how these impact on the therapeutic relationship. Laireiter and Willutzki (2003) suggest that self-reflective work may be helpful in developing interpersonal competencies such as self-knowledge about blind spots. By reflecting on possible blind spots in their constructions of collaboration therapists may develop a deeper conceptual understanding of their own behaviour and that of their clients. Safran Muran and Shaker (2014) argue that a therapist's ability to reflect on their relationships with clients increases the likelihood that therapists will notice and attend to ruptures in the therapeutic alliance. Therefore by reflecting on a key aspect of the alliance such as collaboration therapist may be better able to notice ruptures and hence strengthen the therapeutic relationship.

4.2 Implications for counselling psychology practice

Although no counselling psychologists were included in this research the findings do have implications for counselling psychology practice. Pluralism is a core philosophical stance of counselling psychology (Kasket and Gil-Rodriquez, 2011). It acknowledges the wide diversity in the world around us and involves valuing and being inclusive of others worldviews (Cooper and McLeod, 2007). The dialogic approach to CBT, outlined by Sutherland and Strong (2011) correlates with a pluralistic philosophy. Counselling psychologists are encouraged to engage with pluralism and the range of perspectives that arise from it (McAteer, 2010). Such a framework is open to a wide range of ways of engaging with others. Cooper and McLeod state that a pluralistic approach to counselling opens up possibilities for working creatively with clients in order to meet their individual needs.

Counselling psychology prides itself on a holistic view of clients (Steffen and Hanley, 2013). One of its core principles is a commitment to a democratic, non-hierarchical therapeutic relationship (Harrison, 2013). From a pluralistic standpoint counselling psychology questions the medical model and emphasises well-being over diagnosis (Strawbridge and Woolfe, 2010). It has been argued that 'prescriptive' CBT does not align with the pluralistic value base of counselling psychology (Konstantinou, 2014). Rejecting positivistic perspectives in favour of pluralism may paradoxically contradict a pluralistic stance because a certain viewpoint is being closed off. From a pluralistic stance clients' understandings and expectations are taken into account (Cooper and McLeod, 2007). This implies that if a client wishes to have a directive form of therapy this should not be dismissed. From a pluralistic

perspective it is helpful to move away from an either/or standpoint to one of both/and (Cooper and McLeod, 2012).

Integrating pluralistic philosophy into practice can be difficult for even the most experienced practitioners (Thompson and Cooper, 2012). In claiming to have a pluralistic stance there is a danger that counselling psychologists may not be aware of 'unwanted' positivistic aspects of their practices that they feel do not fit with the philosophy of pluralism. From a discursive psychological perspective such philosophical stances are not inherent or fixed. They emerge in social interaction and can vary depending on the context of the conversational situation (Potter and Edwards, 2001). The varying conceptualisations of *client choice* in the current study indicate that therapists were not coming from a dialogic or positivistic stance per se. Their stance varied based on the function of positioning clients as having agency.

It may be that counselling psychology as a field feels that negation of power is going on elsewhere but not in its own backyard (Steffen and Hanley, 2013). Steffen and Hanley argue that we cannot remove ourselves from power relations but as counselling psychologists we have the tools to perform self-examination. Counselling psychology is well placed to deal with this issue through the practice of reflexivity (Strawbridge and Woolfe, 2010). By developing a stance of curiosity towards positivistic perspectives counselling psychologists may be better able to reflect on positivistic and dialogic elements of their own therapeutic practices. Counselling psychology is influenced by both the scientist-practitioner and reflective practitioner models of psychology (Woolfe & Strawbridge, 2010). A key struggle in the discipline is reconciling these two perspectives (Kasket and Gil-Rodriquez, 2011). By simply

using the notion of pluralism to define our professional identity the struggle to accommodate scientist-practitioner and reflective-practitioner perspectives may be exacerbated. Engaging with a pluralistic perspective to critically reflect on our practice, for example by taking a both/and not an either/or standpoint towards positivistic aspects of therapeutic practice, pluralism can ease the struggle between conflicting perspectives.

My own personal stance has been an either/or engagement with the nature of collaboration in CBT. My first training in any model of psychotherapy was a postgraduate diploma in CBT. At that time I viewed collaborative empiricism as the only way to truly empower clients. I viewed CBT as the only democratic model of therapy, in which clients' views were of primary importance. My stance on this issue completely reversed when I engaged with practitioners of other modalities during group supervision sessions. This happened while working in a secondary care setting in which I was the only CBT therapist among a number of integrative practitioners. I then began to see CBT as a directive model of therapy, in which collaboration was used to encourage client compliance with CBT perspectives. Until the point of conducting this research project I have only viewed collaboration in CBT either at the positivistic end of the continuum or at the dialogic end. The process of analysing the interview talk in this study has changed my either/or relationship to the nature of collaboration in CBT to one of both/and. As the varying constructions of the CCR demonstrated, an individual's therapeutic practice can contain both positivistic and dialogic elements. I can think of times when I have been *nudging* clients in a certain direction and times when I felt I was truly facilitating the opening up of possibilities. Engaging with this thesis has helped me question how I construct my identity as a trainee counselling psychologist. For example, reflecting on how I use discourses

around facilitating client agency and autonomy and how these actually relate to my therapeutic practice

4.3 Critical Review of the current study

The present study is limited in the extent to which it can be generalised. Discourse analysis allows for the exploration of the constructive and functional aspects of specific instances of talk but it has been argued that it cannot say anything beyond this (Edley, 2001). Edley asserts this is because reality is viewed as being constructed in discourse and when we begin to reflect on talk about the world we are constructing new discourses. So although the CCR may be a cultural resource that individuals can draw on, the act of reflecting on it through engaging with this study constitutes a newly constructed reality. The fact that the study was restricted to CBT therapists also limited the generalizability of the study. Although issues of collaboration are relevant to other modalities these issues may have a different structure to the ones outlined in this study.

Another limitation was the fact all participants worked in private practice. Some of the main issues regarding collaboration in CBT have been directed towards CBT as implemented through IAPT. For example Konstantinou (2014) criticises CBT within an IAPT framework for only constituting a set of techniques and manualised interventions that can be delivered by semi-trained professionals. During the course of the interviews several participants commented on the different pressures faced by their colleagues working in the public health service. For example having to meet

specified targets based on client scores on psychometric tests. To further illuminate the debate around collaboration in CBT it would be useful for future research to focus on IAPT delivery of CBT services to extrapolate how practitioners in those services construct collaboration.

The purpose of the study was to investigate how CBT therapists reflect on and construct the notion of collaboration therefore interviews were considered to be applicable for facilitating such reflection. My own personal stance at the beginning of this process is likely to have had an impact on participants' reflections and constructions. It is inevitable that participants' talk will have been shaped by the discursive context of the interviews (Potter and Hepburn, 2005). I came from the perspective that CBT was directive not collaborative. Therefore the questions I asked in the interviews mainly came from the perspective that CBT is directive. This may have lead to participants constructing their reflections on collaboration in a defensive way, which is most likely in contrast to how they reflect on collaboration in their practices with other individuals such as supervisors. Future research could analyse instances of recorded interaction between therapists and supervisors or therapists and clients in order to explicate how collaboration is constructed in 'non-contrived' settings. Feedback from participants did indicate though that the nature of the interview questions helped them reflect more deeply on how they collaborate with clients. The interview setting was very different from a therapeutic one but taking a both/and approach to collaboration, in which dialogic and positivistic aspects of collaboration are considered, then it could be said that the researcher and participants worked together from a 'not-knowing' stance to facilitate a deeper reflection of

therapeutic practice. The 'not knowing' stance being in line with the one proposed by Melito and Rintell (2013) in which all knowledge is questioned.

4.4 Conclusion

The debate around the nature of collaboration in CBT has been complicated by dichotomous perspectives regarding how CBT is practiced. CBT is seen as either eliciting client compliance with CBT perspectives or facilitating the creation of new meanings and possibilities that the client can accept or reject. The varying constructions of the CCR suggest that an individual's practice may involve both positivistic and dialogic perspectives. These findings highlight the need for practitioners to be wary of a paradoxical situation in which they define their practices rigidly in terms of pluralism. The findings highlight the need for reflection on any disparities between how we construct our practices theoretically and our actual interactions with clients.

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University of Roehampton
London

CBT Therapists' Constructions of Collaboration in their Therapeutic Practices

My name is Ronan Collins and I am a student on the Counselling Psychology Doctorate Programme at the University of Roehampton.

As part of my training I am conducting research into the nature of collaboration in CBT. There is a lot of debate about what collaboration in CBT actually is. The purpose of this study is to gain an understanding of how CBT therapists themselves view collaboration in their therapeutic practices.

I am looking for CBT therapists to take part in an interview (1 hour approx.). Participants must hold a CBT qualification of at least postgraduate diploma level or they must be accredited by the BABCP. They must also have at least one year post qualification experience.

Interviews will take place in a location convenient for participants.

This project has been approved under the procedures of the University of Roehampton's Ethics Committee

Please contact me using the details below if you are interested in participating:

Email: collinsr@roehampton.ac.uk   Tel: 075 7062 2842

Address: Department of Psychology, University of Roehampton, Whitelands College, Holybourne Avenue, London, SW15 4JD.

Thank-you for taking the time to read this advert and considering taking part

University of Roehampton

London

PARTICIPANT INFORMATION FORM

Title: CBT therapists' construction of collaboration in their therapeutic practices.

Thank-you for considering taking part in this research project and taking the time to read this information. The function of this sheet is to provide details about the project to help you understand what it is about, why it is being conducted and what participation will involve in order that you can make an informed decision about whether to participate or not.

In recent years there has been a lot of debate about the pros and cons of CBT. One area of debate has been about the nature of collaboration in CBT. Critics of CBT argue that the term 'collaboration' is used to conceal therapists' power and encourages clients to see things from a CBT perspective. Proponents of CBT argue that collaboration involves co-operation between therapist and client in exploring the client's problems and formulating treatment plans. They state that it does not involve the therapist telling the client what to do. The purpose of the current research is to discover how CBT therapists' view collaboration given their individual experiences of working with clients. It is hoped that this research will help therapists across the board reflect on the nature of their therapeutic relationships with clients.

Participation will involve taking part in an individual interview (approx. 1 hour). The interview will be audio-recorded. Signed consent has to be obtained before the interview takes place. It will take place at a suitable location convenient to the participant. At the end of the interview participants will be given a debriefing form and asked how they found the process. They will have an opportunity to discuss any concerns that may arise as a result of participation.

All material that is collected will be anonymous. Participant names and any identifying details will be changed so that they are not recognisable to anyone else. Material may be used for publication in academic journals should the study be submitted for publication once finished. Participant confidentiality will be maintained unless there is a concern that there is a risk of serious harm to themselves or others. It can be arranged to have a copy of the final report sent to participants if they want one.

Participants have a right to withdraw consent at any stage without giving a reason. In order to withdraw participants can contact me or my supervisor with their ID number which appears on their debriefing form. Your participation would be greatly appreciated. Contact details are given below if you would like to take part or have any further queries.

Name: Ronan Collins   Email: collinsr@roehampton.ac.uk   Tel: 075 9437 1654

Address: Department of Psychology, University of Roehampton, Whitelands College, Holybourne Avenue, London, SW15 4JD.

University of Roehampton
London

ETHICS COMMITTEE

PARTICIPANT CONSENT FORM

Title of Research Project: **CBT therapists' construction of collaboration in their therapeutic practices.**

Brief Description of Research Project:

The purpose of the current research is to explore CBT therapist's views of the different positions regarding collaboration in CBT therapy given their individual experiences of working with clients. It is hoped that this research will help therapists across the board reflect on the nature of their therapeutic relationships with clients.

Participants will take part in a one-hour interview (approx.) in a location convenient for the participant, in which confidentiality can be maintained.

Investigator Contact Details:
Name: Ronan Collins
Department: Psychology
University address: Department of Psychology, University of Roehampton,
                          Whitelands College, Holybourne Avenue, London, SW15 4JD.
Email: collinsr@roehampton.ac.uk
Telephone: 075 9437 1654

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point but data still may be used in a collated form. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings. I understand that confidentiality will be maintained unless there is a concern that there is a risk of serious harm to myself or others.

Name …………………………………   Date ……………………………..

Signature ………………………………

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Director of Studies or Head of Department using the details below:

Director of Studies Contact Details:
Name: Dr. Anastasios Gaitanidis
Address: Department of Psychology, University of Roehampton, Whitelands College,
             Holybourne Avenue, London, SW15 4JD.
Email: Anastasios.Gaitanidis@roehampton.ac.uk
Tel: 020 8392 4529

Head of Department Contact Details:
Name: Dr. Diane Bray
Address: Department of Psychology, University of Roehampton, Whitelands College,
             Holybourne Avenue, London, SW15 4JD.
Email: D.Bray@roehampton.ac.uk

Debriefing Information

Title: CBT therapists' construction of collaboration in their therapeutic practices.

Thank-you for taking part in this study. The purpose of the interview was to gain an understanding of how you view collaboration in your therapeutic practice. It is hoped that this research will help therapists in general reflect on the nature of collaboration in their therapeutic practices. Your identity and any identifying features will be changed in order to ensure your anonymity.

If you have any further queries or would like to withdraw from the study at any stage please contact me using the contact details below:

Name: Ronan Collins   Email: collinsr@roehampton.ac.uk   Tel: 075 7062 2842

Address:
Department of Psychology, University of Roehampton, Whitelands College, Holybourne Avenue, London, SW15 4JD.

Please quote the following ID number when making contact: **05**

Participants have a right to withdraw at any time. Please note however that data may still be used in a collated form.

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Director of Studies or Head of Department using the details below:

Director of studies:

Name: Dr Anastasios Gaitanidis.   Email: Anastasios.Gaitanidis@roehampton.ac.uk

Address: Department of Psychology, University of Roehampton, Whitelands College, Holybourne Avenue, London, SW15 4JD.   Tel: 020 8392 4529

 Head of the psychology department:

Name: Dr. Diane Bray   Email: D.Bray@roehampton.ac.uk

Address: Department of Psychology, University of Roehampton, Whitelands College, Holybourne Avenue, London, SW15 4JD.   Tel: 020 8392 3627

If you would like a copy of the final report please contact me with a postal or email address.

If as a result of taking part in the interview you experience any emotional issues please feel free to bring it to your own supervision. Alternatively you can access help from the organisations below:

BACP
Website: www.bacp.co.uk Tel: 01455 883300
Address: BACP House, 15 St John's Business Park, Lutterworth LE17 4HB.

BABCP
Website: www.babcp.com Tel: 0161 705 4304
Address: Imperial House, Hornby Street, Bury, Lancashire BL9 5BN.

University of Roehampton
London

Title: CBT therapists' construction of collaboration in their therapeutic practices.

Interview Questions

1. What does collaboration mean for you in your therapeutic practice?
2. Do you try to foster a collaborative relationship with clients? If so how?
3. What would you say to someone who says the idea of collaboration is used to conceal therapist power in CBT?
4. What would you say to someone who argues that CBT does not allow for real client autonomy because it encourages clients to see things from a CBT point of view?
5. Can you give examples of collaboration in your practice leading to client autonomy?
6. Opponents of CBT claim that psychoeducation is directive, leads clients to see their problems in a certain way and is therefore not compatible with the idea of a collaborative relationship. What is your view on this?
7. How do you use psychoeducation in your practice? What issues arise from this?
8. Have you experienced obstacles to collaboration in your practice? How have you dealt with these?
9. How important is collaboration in you practice? Why?

Appendix 6

The research for this project was submitted for ethics consideration under the reference PSYCH 13/107 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 02/12/2013.