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Therapists' experiences of delivering CBT for clients with alcohol use problems a thematic analysis

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Therapists' experiences of delivering CBT for clients with alcohol use problems: A Thematic Analysis

by

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Abstract

This qualitative study aimed to understand therapists' experiences of delivering Cognitive Behavioural Therapy (CBT) for clients with alcohol use problems (AUP). Qualitative research on therapists' experience of delivering CBT to clients with AUP is limited; this is particularly the case within the field of counselling psychology. Therapists' experiences provide relevant information that contributes to a deeper understanding of the gap between theory and practice, by exploring their experiences of how CBT works or does not work for clients with AUP.

Semi-structured interviews were conducted with eight participants who had used CBT as a primary intervention to treat AUP. Interviews were transcribed and analysed using thematic analysis (TA), which followed Braun and Clarke's (2006) six phases of analysis. Seven themes were identified through analysis of the data: *"It's still a medical model"; Unravelling the Complexity*; "*In practice, it's a different story"*; *Getting Ready for Change; Experiencing a Human-to-human Encounter;* F*inding Hope in the Hopelessness;* and *Taking Back the Control*. These themes highlight the complexity of delivering CBT to this client group and explore how delivering CBT often takes a multifactorial approach rather than merely delivering rigid protocol-driven interventions.

A multifactorial approach moves away from the dominant medical model approach to treatment. Implications of the findings in relation to therapeutic practice, as well as limitations of the study, are discussed.

CONTENTS

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Glossary

ACT- Acceptance and Commitment Therapy

AUD – Alcohol Use Disorder

AUP – Alcohol Use Problems

BCT – Behaviour Couples Therapy

BPS – British Psychological Society

CBT – Cognitive Behavioural Therapy

DCP – Division of Clinical Psychology

DSM – The Diagnostic and Statistical Manual of mental disorders

GT – Grounded Theory

IAPT – Improved Access to Psychological Therapies

IPA – Interpretative Phenomenological Analysis

MI- Motivational Interview

MET – Motivational Enhancement Therapy

NHS – National Health Service

NICE – National Institute of Clinical Excellence

PHE – Public Health England

PTSD – Post Traumatic Stress Disorder

RCT – Randomised Controlled Trial

SBNT – Social Behavioural Network Therapy

TA – Thematic Analysis

TSF – Twelve Step Facilitation

UK – United Kingdom

UKATT – United Kingdom Alcohol Treatment Trial

CREST- University of Roehampton Centre for Research is Social and Psychological Transformation

List of Figures and Tables

List of Figures

List of Tables

Chapter One: Introduction

1.1 Introduction

This chapter aims to provide an overview of the prevalence of AUP and the challenges with treatment provision for this client group. The chapter will begin by exploring the current epidemiology of AUP to situate the research in the broader social and political context. I will then go on to explore different conceptualisations of addictions and AUP and how they shape current treatment provision, as well as briefly outlining the current psychological therapies used to treat AUP.

The chapter will then outline the terminology adopted within the current study to establish the lens in which this research study is viewing AUP. Lastly, I will discuss my interest and motivations for undertaking the current research project.

1.2 Alcohol use in the United Kingdom

There is a wealth of evidence that identifies the ill effects of AUP. However, alcohol use is an intrinsic part of culture in the United Kingdom, where drinking alcohol is widely socially acceptable and is associated with relaxation, socialisation and pleasure (Morris & Melia, 2019). For many individuals, consuming alcohol does not lead to any harmful effects (National Institute of Clinical Excellence (NICE), 2011). However, alcohol contributes to 4% of global disease, with the burden being higher in the United Kingdom and Europe where consumption and consequences are higher than the global average (Barrie & Scriven, 2014)

Alcohol misuse has a significant cost, with wide-reaching social, economic and individual effects (Morris & Melia, 2019). The burden of AUP is anticipated to cost the

National Health Service (NHS) approximately around £3.5 billion annually (Alcohol Change UK, 2018), which continues to place a significant burden on an under-resourced NHS (Drummond, 2017). One reason alcohol costs are so high is the chronic nature of alcohol problems that have high levels of relapse (Rose et al., 2011). Furthermore, alcohol use is the causal factor of around 60 medical conditions and has been linked to premature mortality (NICE, 2011). In addition to physical health, alcohol use has been associated with a range of mental health problems, with depression, anxiety disorders (including post-traumatic stress disorder or PTSD), personality disorders and self-harming behaviour amongst the most commonly reported. Moreover, statistics show that 41% of individuals accessing alcohol services require mental health treatment, and 20% of those individuals are not receiving any mental health treatment (Alcohol Change UK, 2018).

Alcohol-related harm extends beyond health care provision, with alcohol problems having a wide-reaching impact on the social care and criminal justice systems. Alcohol use has been linked to violent incidences, theft, criminal damage, hate crimes, drink-driving and sexual assaults (Alcohol Change UK, 2018; NICE, 2011), as well as a vast range of social problems: relationship breakdown, domestic violence, child protection issues such as neglect, unemployment, financial difficulties and homelessness (NICE, 2011).

The widespread impact of AUP in the UK highlights the vulnerability of this client population accessing treatment, as well as the need for changes within the current system in which many people fall through the gaps of service provision. Therefore, it is a priority for treatment providers to meet the needs of this population, especially as

effective treatment has been shown to reduce the health and social costs of alcohol-related problems (Public Health England (PHE), 2018). However, service provision in the UK has struggled to engage and support individuals who report being alcohol dependent (Morris & Melia, 2019). Recent statistics show a decline in people accessing specialist treatment services: for example, while it is estimated that in England alone there are around 589,101 dependent drinkers, less than 20% of them are receiving treatment (Alcohol Change UK, 2018; PHE, 2018).

Clearly, the reduction in those accessing treatment is not reflective of a decreased need for specialist services (PHE, 2018). Nonetheless, over the last decade, services have experienced funding cuts and provision to services with many services facing significant cuts to their workforce (Drummond, 2017). Consequently, services have struggled to recruit qualified specialists resulting in reduced provision and lower quality of care, and reduced safety for patients (Drummond, 2017), resulting in a system that is struggling to meet the needs of individuals. The importance of further research to aid necessary improvements is evident. It is within this context that the current research is deemed to be valuable in advocating for the importance of treatment for alcohol-dependent people, a population that is often under-represented and marginalised from society (Morris & Melia, 2019).

1.3 Theories and conceptualisations of addiction

Defining addiction and, AUP more specifically, is a complicated matter as there are multiple ways of understanding the phenomena. West and Brown (2013) identify over a hundred different theories about addiction. Indeed, the vast number of theories illustrate the complexity and challenge in being able to come to a clear understanding of

what is meant by the terms ‘addiction’ and ‘alcohol use problems’. However, conceptualisation of these issues plays a significant role in how alcohol problems are understood at a societal and an individual level, which then influences how treatment is implemented.

While it is beyond the scope of this thesis to explore all the different theories pertaining to AUP, this chapter will aim to explore the most relevant theories and explore how they impact on current treatment provision.

1.3.1. A medical-model approach to addiction

The medical model of addictions is perhaps the most influential theory, and for many decades has been the leading approach for treatment provision. The medical model suggests that addiction is a disease that is incurable (Jellinek, 1960). As a result, addiction is viewed as a lifelong process where the only remedy is abstinence (Jellinek, 1960; Marshall, Humphreys & Ball, 2010). Treatment for AUP is well established within a medical model approach, where there is a marked reliance on pharmacological interventions to treat alcohol dependency. Furthermore, a medical perspective of AUP is embedded in our thinking and language at societal and individual levels. For example, our frequent use of the words ‘alcoholic’, ‘alcoholism’, ‘alcohol dependence’ and ‘problem drinking’ show the widespread acceptance of this concept in professionals and laypeople (Orford, 2001).

Addiction treatment is not unique in being established in the medical model; many mental health services, particularly in the NHS, are rooted in a medical model approach to treatment (Johnstone & Boyle, 2018; Woolfe, 2016). The medical model is

rooted in a positivist paradigm, which views only objective or empirically tested phenomena as valid evidence (Blair, 2010). This perspective is at the forefront of many mental health services, including those treating addiction, where the rise of evidence-based practice has led to an increase in disorder-specific approaches, endorsed by NICE guidelines (Corrie, 2010; Khantizian & Albanese, 2010; Orlans & Van Scoyoc, 2009). This has continued to maintain the current treatment system that separates treatment according to specific diagnoses (Eaton, Rodriguez-Seijas, Carragher & Kruegar, 2015).

The medical model posits that addiction affects neurological pathways in the brain, which fire chemicals and thus maintain the individual's need to keep using, despite the unintended consequences that occur (Khantzian & Albanese, 2013). From a medical perspective, treatment is delivered to eliminate or remove the problems, which stands in contrast to therapeutic interventions that give space for difficult emotions (Gilbert & Leahy, 2009). Understanding the biological mechanisms that underlie addiction can be exceptionally helpful in increasing understanding, reducing stigmatisation, improving treatment outcomes and helping professionals advocate for the rights of individuals to be offered treatment equal to that of other psychiatric and medical diseases (Bettinardi-Angres & Angres, 2010).

The Diagnostic and Statistical Manual of mental disorders (DSM), which has often been referred to as the 'diagnostic bible' for those working in the mental health field (Griffiths, 2018), classifies addiction (substance and alcohol use) as a 'disorder'. The current edition, the DSM-V (2013), defines alcohol use disorder (AUD) as "A problematic pattern of alcohol use leading to clinically significant impairment or distress" (p. 490), diagnosed when patients experience at least two of eleven criteria

over a 12-month period (see Appendix 1). AUD has now been placed on a continuum, with sub-classifications of mild, moderate and severe, providing the opportunity for treatment to be varied and tailored according to the individual's needs.

However, the diagnostic categories fail to capture the onset of human distress as a vital component to understanding the development and maintenance of AUP (Khantzian & Albanese, 2013), instead continuing to pathologise the client with an AUP (Griffiths, 2018). Likewise, Khantzian and Albanese (2010) argue that while addiction has an undeniable physical component, merely viewing addiction through this lens adopts a simplified and judgemental view of "addicted people" (p. 103). They suggest there needs to be an increased understanding of their distress that lies at the root of the AUP. This perspective resonates with broader debates in the field of psychology surrounding the current conceptualisation of mental health problems. The Division of Clinical Psychology (DCP) (2013) has argued for conceptualisations of mental health problems to shift from a medical paradigm to a more complex understanding of human distress that adopts a "multi-factorial and contextual approach, which incorporates social, psychological and biological factors" (p.9).

Adopting a purely medical perspective disregards the fact that addiction is mostly a biopsychosocial phenomenon, a complex interaction between many factors (Griffiths, 2018; Khantzian & Albanese, 2013). It does not explain why people will relapse after years of sobriety, or the complex interactions of how alcohol influences an individual's emotions, ways of thinking and behaviours which maintain the alcohol use. For example, the medical approach does not explain the underlying emotional

dysregulation a person experiences and how alcohol may be used to address or perpetuate the dysregulation (Khantizian & Albanese, 2013).

1.3.2 A biopsychosocial approach

Other theories and approaches have attempted to understand addiction from a singular perspective in a similar way to that outlined above (e.g., social learning theory, personality theory, genetic models and social/environmental theories). However, like the medical model, these approaches have been critiqued for failing to fully explain the complexity of addiction (DiClemente, 2018; West & Brown, 2013). In contrast, the biopsychosocial model moved away from a reductionist understanding of human suffering (Becona, 2018) by integrating the different explanations (DiClemente, 2018). A biopsychosocial approach posits that human distress and AUP are a result of complex interactions between an individual's biological or genetic predisposition, social environment, psychological composition (personality factors, unconscious motivations attitudes, beliefs and expectations), political and economic factors, and the nature of the activity (how alcohol is consumed) (Griffiths, 2018).

This approach therefore provides a more holistic understanding of patients' suffering by emphasising the need for clinicians to attend to biological, psychological and social aspects of illness (Borell-Carrió, Suchman & Epstein, 2004). Accordingly, this draws attention to the need for more complex and multicomponent models for addiction (DiClemente, 2018). Despite the acceptance that addiction is a biopsychosocial phenomenon (Griffiths, 2016), integration across different approaches has not always been successful. Johnstone and Boyle (2018) have critiqued the biopsychosocial model for sometimes assuming pathology or privileging biological

aspects of addiction, which perhaps indicates the challenges in moving beyond the medical model to provide a more integrated and holistic approach.

Moreover, Khantzian and Albanese (2010) highlight the differences between addiction and other mental health services and raise a very pertinent question: "Why should addictions field settle for less?" (p. 103). They suggest that by merely following a unitary approach to treatment, practitioners are doing clients a disservice. Similarly, Brown and West (2018) suggest it is not helpful to focus on one factor at the exclusion of the others.

Although the biopsychosocial approach provides a more complex understanding of addiction, it has not yet provided a clear treatment pathway that can result in true integration (DiClemente, 2018). This highlights the importance of the addiction field to grow and evolve in gaining further understanding about the onset and maintenance of alcohol use problems, and thus refine approaches for treatment. It is within this context that the current research project is situated, seeking to understand how therapy works for this specific client population.

1.4 Current treatment recommendations for alcohol use problems

In the United Kingdom, mental health treatment is guided by evidence-based therapies that are considered effective in treating specific disorders and endorsed by recommendations in the NICE guidelines (Corrie, 2010; Orlans & Van Scoyoc, 2009). The NICE guidelines are developed by systematically reviewing the highest quality of research literature, and randomised controlled trials (RCTs) are often seen as the 'gold standard' for research. Furthermore, research trials often ensure adherence to manuals

and competent delivery of interventions (Mitcheson, Whiteley & Hill, 2018). Approaches that are currently recommended by NICE are predominantly behavioural, which are often easier to test in controlled conditions and manualised approach to therapy to yield positive outcomes.

Currently, the NICE guidelines (2011) for AUD recommend a small selection of approaches: Motivational Interviewing (MI)/Motivational Enhancement Therapy (MET), Behavioural therapies (cue exposure and behavioural self-control training), Social Behaviour Network Therapy (SBNT), Behavioural Couples Therapy and Cognitive Behavioural Therapy (CBT). Out of the five recommended treatments for AUP, CBT has one of the largest evidence-bases for alcohol treatment (Magill& Ray, 2009; NICE, 2011), which may be reflective of how CBT has increased in popularity in mental health treatment, where it is frequently used to treat a wide range of presenting problems (Mansall, Harvey, Watkins & Shafran, 2008).

CBT is rooted in behavioural theory, which emphasises an individual's thoughts and feelings as they connect with behaviour (Mastroleo & Moti, 2013). CBT for alcohol use also draws on Bandura's (1969) social learning theory, which identifies drinking problems mainly as a learnt behaviour. Additionally, CBT emphasises the role of cognition in the aetiology and maintenance of AUP, where emotions and behaviours stem from unhelpful thoughts (Masteroleo & Monti, 2013). Moreover, CBT has a range of different approaches applied to alcohol treatment: (a) standard CBT is derived from the cognitive model for substance abuse (Beck, Wright, Newman & Liese, 1993), that emphasises identifying, changing irrational thoughts, managing negative mood; (b) relapse prevention based on Marlatt and Gordon (1985) that identifies high-risk

situations, changing expectancies and increasing self-efficacy; (c) coping skills training is also a variation of CBT that seeks to increase coping skills with high-risk situations and interpersonal difficulties. More recently, there have been advances in CBT being offered via technology, using structured programmes to develop coping skills (Carroll & Kiluk, 2017). The versatility of CBT in treating addictions could be attractive to some therapists providing them with a range of interventions, with the potential to incorporate biological, social and psychological aspects into the work (Mitcheson et al., 2010).

Although there is currently only a small number of recommended approaches for AUD, substantial evidence is building for the incorporation of other therapeutic approaches such as psychodynamic, mindfulness and acceptance and commitment therapy (ACT) to treat addictions (Carroll & Kiluk, 2017; Davis, Patton & Jackson, 2018). To date, there is not enough empirical evidence to support the incorporation of these approaches into the recommended guidelines, however McGrath and O'Ryan (2018) suggest that despite the limited evidence, such approaches have valuable clinical benefits in treating substance use problems.

While there is significant research demonstrating the effectiveness for several therapeutic approaches for AUP, there remains a significant gap between theory and practice, where evidence-based therapies are not always put into practice (Caroll & Kiluk; 2017; McHugh, Hearon & Otto, 2010). Consequently, in alcohol services, CBT may be offered at a limited level (e.g., some principles of CBT may be included in a group) or in some services, it may not be available as a treatment option at all (McHugh et al., 2010). Therefore, understanding more about how and why CBT works in the

context of AUD could enhance the development of treatment delivery (McHugh et al., 2010).

1.5 Terminology for this research project

Different definitions of AUP hold different meanings, as well as encompassing societal and cultural views (Mitcheson et al., 2010). As discussed above, the terms 'addiction' and 'dependency' are widely used to understand AUP, with both having firm roots in a medical conceptualisation of alcohol use. This terminology still holds sway with many clinicians and the public, as it provides a known or discoverable aetiology and a mechanism of action (West & Brown, 2013).

However, over the years, the terminology has changed as the focus of treatment has shifted. More recently, the term 'alcohol misuse' has been widely used to refer to both harmful alcohol use and alcohol dependency/addiction (NICE, 2011). Harmful drinking is defined as a pattern of alcohol consumption that causes health problems directly related to alcohol use, whereas alcohol dependence is defined as being characterised by cravings, tolerance and a preoccupation with alcohol (NICE, 2011). Although 'alcohol misuse' is often used as an umbrella term for AUP, it may also render a moral judgement about the behaviour of those individuals 'misusing' alcohol (Mitcheson et al., 2010). The term 'misuse' is also ambiguous; for example, one person's idea of alcohol misuse could be another's idea of normal alcohol use (Mitcheson et al., 2010).

I have chosen, therefore, to adopt the neutral terminology of 'alcohol use problems' in the current study. The term 'use' is adopted instead of 'misuse' to avoid taking a moral stance and acknowledging that there are varying degrees of alcohol use that for

some individuals can lead to a problem (Mitcheson et al., 2010). However, in the literature surrounding this topic, 'addiction', 'misuse' and 'dependency' are used interchangeably; therefore, when reviewing the literature, I have chosen to use the terminology of the relevant authors in order to reflect the literature accurately. It is also worth noting that participants often used the terms 'substance use' or 'addiction' during the interview process, which I have also tried to represent in the analysis accurately.

1.6 Reflexivity

Reflective practice is the foundation of counselling psychologists work both clinically and in research (Kasket, 2012). Reflexivity is the process of examining how the researcher and intersubjective components affect or even transform the research (Finlay, 2002). Reflexivity, therefore, allows the researcher to identify their personal and subjective relationship with the process of carrying out the research study (McLeod, 2015). In line with a qualitative paradigm and a critical realist position that acknowledges the role of the researcher's subjectivity and meaning-making to the research process (Donati, 2016; Finlay, 2002; Willig, 2011), it was vital for me to be aware of how my own experiences and preconceptions could either enhance or restrict my insight at each stage (Finlay, 2011). This section will explore my relationship with the research topic and how my perspectives and experiences around AUP may have influenced how I conducted the current research project.

My interest in this field stems from both personal and professional experiences of alcohol use and alcohol 'misuse'. Alcohol has been a prominent part of my life, from a young age to adulthood, with alcohol embedded into many social and family occasions. Unfortunately, alcohol played a significant role in a traumatic experience

during my early adulthood; consequently, alcohol quickly became a coping mechanism to repress painful emotions. For many years, I struggled to recognise the impact alcohol had on me; however, through personal therapy, I came to understand its role in my life. In undertaking this research project, I remained aware that I had personal experiences that shaped how I understood and conceptualised AUP. Throughout the project, I was mindful that it was essential for me to be open to others' experiences while remaining aware of how my own experiences could influence my understandings of participants' experiences during the interview process and later interpretations of the data (Finlay, 2002).

Although my own experiences have significantly impacted my life, my interest in working with AUP grew primarily out of my professional experience of working in the homeless sector, where I worked with individuals with severe addiction. I became aware of how challenging it was for many clients to receive the psychological support they wanted and needed: individuals were being pushed from service to service with mental health services saying it was an alcohol problem and alcohol services suggesting it was a mental health problem. I came to see the system as broken, in that it seemed to repeatedly fail and marginalise this client group. As a young professional, I felt powerless to change the system, and it is this that fuelled my desire to train as a counselling psychologist. Donati (2016) suggests that researchers are often drawn to research areas that they have a personal relationship or have some investment with. It is perhaps a result of the powerlessness felt in both my personal and professional experiences that I became drawn into this research area.

Moreover, during my clinical training, I have encountered various perspectives from therapists and therapy services about working with clients with substance use problems. In one of my placements where I worked with a client who had a long history of substance use problems, I recall my supervisor saying to me in supervision that they did not like working with addicts as they are manipulative. I remember being shocked and saddened by such prejudice from a senior therapist. Again, I experienced powerlessness as a trainee, unable to challenge this view, yet I held a sense that this client group was so often misunderstood and misrepresented. Similarly, working in Improving Access to Psychological Therapies (IAPT), clients were frequently turned away for drinking too much and not being able to engage in therapy. I experienced a deep discomfort with this perspective, and I often found myself engaged in conversations during supervision about this divide. I was also aware that many of my colleagues felt uncertain, out of their depth or nervous about working with clients who have substance use problems as they felt they did not have the experience or expertise required. I often felt frustrated that therapy seemed to be stuck in these age-old debates about dual diagnosis that ultimately seemed to marginalise clients from accessing treatment (Huxley, 2018).

Beginning this research, I initially wanted to give clients a voice, hearing their experiences of treatment. As a result of my different professional experiences, I had questions about how much therapy clients were receiving, and a growing curiosity over whether evidence-based treatment was working for this client group. I was sceptical about the use of CBT, as I felt unsure about whether it adequately addressed the problems. I was aware that my scepticism about CBT was also reflective of my discontent with CBT often being prized above other approaches, particularly in the NHS

(Gillon, 2007). However, I was keen to know what clients felt and whether they thought CBT was helpful.

However, after gaining ethical approval to explore clients' experiences, I struggled to recruit for the project. Services were rarely offering CBT and those that were often felt uneasy about letting me interview clients. During this recruitment process, I spoke with a therapist who shared his reservations about whether clients with AUP could engage in CBT. Consequently, I became curious about how therapists may influence and affect treatment delivery, whether that be through biased judgements or clinical experience. Considering my field research I went back to the literature and became aware of the gaps that exist between evidence-based guidelines and clinical practice. Reflecting on my conversations with therapists during the initial recruitment process, I considered how vital it is to understand therapists' experiences of using evidence-based treatments to contribute to our current understanding of therapeutic practice for this client group. It was out of this curiosity and knowledge of existing literature that I started to form my research aims and questions.

Chapter Two: Literature Review

2.1 Introduction

This chapter aims to situate the current research project in relation to the existing relevant literature. Through the review of the literature, I will seek to highlight the gaps and outline how the current research project aims to bridge the gaps. Finally, I will explore the relevance of this current research to the field of counselling psychology.

In order to provide a comprehensive review of the existing literature of therapists' experiences of delivering CBT for clients with AUP, key search terms were used relating to the topic. Primary keywords, phrases and synonyms were identified and the following search terms were used: 'alcohol use problems', 'alcohol use disorder', 'alcohol misuse', 'alcohol dependency', 'alcohol addiction', 'CBT', 'cognitive behavioural* therapy', 'cognitive behaviour* therapy', 'psychosocial interventions', 'helpful factors', 'helpful aspects', 'unhelpful factors', 'unhelpful aspects', 'change process', 'mechanism of change', 'therapists', 'counsellor*', 'clinician', 'treatment services', and 'drug and alcohol services'. During the search, an asterisk was used for specific words to identify any literature that may have alternative spellings.

Initially, the terms 'substance use' and 'substance use disorder' had been eliminated from the search, as it was assumed that it would identify studies relating to substance use other than alcohol. However, throughout the literature, it became apparent that alcohol use was also included under the broader umbrella of substance use. Therefore, a later search also incorporated the terms 'substance use', 'substance use disorder' and 'substance misuse' to capture any relevant literature that may have been missed from the initial search terms.

A systematic search of the literature was carried out electronically using three databases: PsycINFO, PsychArticles and Web of Science. Boolean operators 'AND' and 'OR' were used to combine search terms, for example, alcohol use disorder OR alcohol addiction AND CBT AND therapists, to narrow or broaden the search across the databases. The search was also repeated on Google scholar and the University of Roehampton library catalogue. The search generated hundreds of research studies, literature reviews and meta-analyses; it was, therefore, essential to select the literature that was most relevant to the current study. Literature was initially sorted based on relevance to the research topic, for example, therapeutic modality and only those with a primary focus on alcohol use were included. The literature search mainly identified quantitative research studies and a small number of qualitative studies. However, there were only a few studies that explored therapists' experiences of treatment, and there are no studies that have explored therapists' experiences of delivering CBT for clients with AUP.

2.2 Improvements to current treatment provision

Although CBT is currently the dominant psychosocial approach for AUP due to high levels of evidence supporting efficacy (Magill & Ray, 2009) and versatility of application (Mitcheson et al., 2010), there is still scope for improving the current treatment guidelines for practice. Apart from some updated reviews, it is striking to note that the NICE (2011) guidelines for AUD have not been updated since 2011. Interestingly, the Clinical Guidelines for Drug Misuse and Dependence (2017) have recently placed emphasises on providing an integrated approach for substance use and

mental health problems, particularly trauma. However, it is interesting to note that the same changes have not been made in recent updated review for AUD (NICE, 2019), which highlights the importance of further research in this field to improve and develop more effective treatments for AUP.

Research into AUP and treatment guidelines are primarily dominated by quantitative research and in particular by RCTs, reflective of a field that is still predominantly rooted in a biomedical approach (Orford, 2008). Although RCTs are viewed as the 'gold standard' approach for determining efficacy for treatment, they are also subject to problems with validity. One such problem is researcher bias, where researchers favour a chosen methodology, and thus it is possible that any reported differences between approaches could be a result of researcher allegiance. However, within substance use research the role of research bias is often not accounted for when considering treatment outcomes (Imel, Wampold, Miller & Flemming, 2008).

Furthermore, RCTs often include studies that compare bona fide treatments such as CBT, SBNT, MET with 'other' or 'alternative' treatments, or 'treatment as usual' (Imel et al., 2008). Often the details of what is involved in these comparison treatments are vague or it is not clear what approach participants have received. These vague descriptions make it difficult to ascertain the effects attributed to bona fide treatments when compared to non-therapeutic approaches (Imel & Wampold, 2008). Therefore, it is worth approaching results with caution that outline treatments as superior when compared with non-specific approaches.

Another critical problem with RCTs is that many community-based treatment services differ from the controlled conditions in which RCTs take place (McHugh et al., 2010; Witkiewitz, Finney, Harris, Kivlahan & Kranzler, 2015). RCTs often follow specific protocols and have exclusion criteria that minimise severity, complexity and risk, which is aimed at reducing a modest response and increasing statistical power (Peacock et al., 2018; Witikiewitz et al., 2015). Unintentionally, outcomes from such trials may overestimate treatment effects for AUP (Peacock et al., 2018; Witikiewitz et al., 2015), where such stringent restrictions may not apply to the general treatment-seeking population, and where individuals often present with a wide range of complexities (Peacock et al., 2018): housing or financial problems, difficulties in early childhood development that may be the onset to the alcohol problems, and co-morbid mental health problems such as depression, anxiety and personality disorders (Buckman et al., 2018; Epstein & McCraddy, 2009; Peacock et al., 2018).

Differences between controlled clinical trials and community treatment services can result in a significant gap between research and clinical practice. However, Witikewitz et al. (2015) state that it is imperative for findings from research trials to apply to a 'real-world setting'. Therefore, a more qualitative approach to research, which seeks to understand and uncover phenomenological experiences surrounding treatment, may allow for sophisticated insights into the social and cultural contexts in which alcohol treatment is situated (Drug and Alcohol Review, 2015), and thus provide valuable knowledge about how therapy works or does not work for this client population.

2.3 CBT as a treatment for alcohol use problems

The clinical efficacy of CBT for AUP has been documented in a plethora of RCTs (Berglund, 2005; Irvin, Bowers, Dunn & Wang, 1999; Litt, Kadden, Tennen & Kabela-Cormier; Magill & Ray, 2009; Morgenstern et al., 2007; Morgenstern & Longabaugh, 2000; Project Match, 1998). Although there is a wealth of evidence to support the application of CBT, when comparing CBT with other bona fide treatments such as SBNT, MET, Twelve-Step Facilitation (TSF), research has struggled to consistently identify any one approach as superior in treatment outcomes (Irvin et al., 1999; Morgenstern et al., 2007; Morgenstern & Longabaugh, 2000; Project Match, 1997; United Kingdom Alcohol Treatment Trial (UKATT), 2005). Indeed, these findings are consistent with the general psychotherapy field, which has found a range of therapeutic approaches to be effective in treating an array of mental health problems (Cuijpers, Reihnders & Huibers, 2019). Yet, research has often struggled to identify superiority for any given approach (Cuijpers et al., 2019; Luborsky et al., 2002), which is commonly referred to as the 'dodo bird verdict' (Luborsky et al., 2002).

Although efficacy for various approaches has been established, it does not explain how and why therapy leads to change; in other words, it does not explain the mechanisms by which therapy works (Kazdin, 2009). As different approaches for treating AUP have different theoretical assumptions which underpin how therapy works (e.g., SBNT, TSF, MET and CBT), it is crucial to understand more about the processes of change, especially as they have yielded equal efficacy in treatment outcomes. Therefore, understanding mechanisms or processes of change is essential in continuing to inform evidence-based practice (Longabaugh, Magill, Morgernstern & Huebner, 2013; Mastroleo & Monti, 2013; Miller & Moyers, 2015) by providing improvements

and refinement for clinical practice (Miller & Moyers, 2015; Young, Connor & Fenney, 2011).

Additionally, understanding how therapy works is important from a scientific and public health perspective. For example, understanding how therapy works may help enhance treatment effects by being able to target core processes which could make them more efficient, effective and more aligned to patients' needs (Cuijpers et al., 2019).

2.3.1 Specific treatment ingredients for CBT

To understand why and how CBT works for AUP, research has focused on attempting to understand change mechanisms by exploring its specific treatment ingredients (Longabaugh & Magill, 2011). The understanding is different therapeutic approaches have a specific theory of change, which claim there are different mechanisms of action that lead to change (Cuijpers et al., 2019; Laska, Gurman &Wampold, 2014). For example, CBT theory suggests that low self-efficacy and an insufficient ability to cope (due to social or environmental factors) with life stressors and alcohol cues (stimuli that may trigger cravings or desire to use) are likely to maintain AUP (Moos, 2007; Morgenstern & Longabaugh, 2000). Thus, CBT has been considered to work by improving coping skills (Litt, Kadden & Kabela-Cormier, 2009) and increasing self-efficacy (Morgenstern & Longabough, 2000).

Despite decades of research exploring mechanisms of change, research studies have struggled to establish what happens in the therapeutic change process (Carroll & Kiluk, 2017; Morgenstern & McKay, 2007). Indeed, such findings are also consistent

with research in the wider psychotherapy field (Cuijpers et al., 2019). Although there have been promising results that have shown CBT works through building coping skills (Sugarman, Nich & Carroll, 2010) and self-efficacy (Adekeye &Sheikh, 2009; Young Connor & Finney, 2011), the extent of how these factors work is not fully realised or understood, and there remains much uncertainty about the mechanisms by which CBT works for AUP (Carroll & Kiluk, 2017; Longabaugh et al., 2013: Roos & Witkiewitz, 2017).

There are a number of reasons research exploring mechanisms of change may have struggled to establish consistent outcomes. One critique is that such research might be carried out independently of the healing context in which the mechanisms of change occur (Keene, 2000; Messer & Wampold, 2002), and thus such findings are often not truly reflective of relational components that may influence treatment outcomes (Imel et al., 2008; Miller & Moyers, 2015). Moreover, research exploring mechanisms of change such as coping skills often assumes that coping skills are generic (Sugarman et al., 2010) and not specific to each person (Litt et al., 2009; Roos & Witkiewitz, 2017), especially in real high-risk situations where a client may be tempted to buy or use alcohol (Litt et al., 2009). Roos and Witkiewitz (2017) have suggested that it would be more helpful to consider the interaction between self-regulating behaviour (coping skills and emotional regulation) and contextual factors during the change process. However, research exploring mechanisms of change has been critiqued for isolating specific mechanisms in controlled conditions (Imel et al., 2008; Mastroleo & Monti, 2013; Miller & Moyers, 2015), rather than looking at them alongside other change factors (Longabaugh et al., 2013).

Nevertheless, some studies have revealed that coping skills and self-efficacy are often affected by other factors, which suggests that change is a complex process influence by multiple factors. Initiating abstinence from alcohol at the start of CBT has been found to increase abstinence self-efficacy and coping skills, which indicates there is a bidirectional relationship between self-efficacy and changes to alcohol use (Hallgren, Epstein & McCrady, 2019). In contrast, individuals with a high dependency on alcohol were found to enhance their coping skills following CBT compared to individuals with low to moderate alcohol use (Roos, Maisto & Witkiewitz, 2017).

Furthermore, coping skills have also been linked to underlying problems, such as anxiety. Wolitzky-Taylor et al. (2018) found that patients who had received combined CBT for alcohol problems and anxiety had superior alcohol outcomes – a reduction in their alcohol use. The authors suggest that alcohol use may be a way for some clients to cope with underlying anxiety symptoms, it is possible that by helping clients to cope and manage their anxiety symptoms more effectively, this, in turn, helps negate the clients need to use maladaptive coping strategies such as consuming alcohol (Wolitzky-Taylor et al., 2018). Similarly, an increase in self-efficacy after CBT has also been found to be associated with a higher resistance to stress (Adekeye & Sheikh, 2009). The role of stress in mediating coping responses is in line with the literature on the stress-vulnerability approach, that shows that individuals drink to cope with underlying stressors (Haskings, Lyvers & Carlopio, 2011).

Indeed, the variation in findings indicates that change for addiction is dynamic (Morgernstern & McKay, 2007). As studies to date have struggled to produce consistent outcomes to support for coping and self-efficacy as CBT-specific mechanisms of

change, it likely that different clients will change through different causal processes (Magill, Kiluk, McCrady, Tonigan & Longabaugh, 2015). Moreover, there may be other mechanisms, such as motivation (Ilgen, McKellar, Moos & Finney, 2006) and the therapeutic alliance (Connors et al., 2016; Miller & Moyers, 2015) that are just as important to treatment outcomes.

As the change processes in CBT are still unclear, identifying the process of change is a priority to aid the development of psychological therapies in the treatment of AUP (Jones, Latchford &Tober, 2015; Longabaugh, 2007, Orford, 2008). Therefore, further research from a qualitative perspective, exploring how CBT is helpful or unhelpful could provide valuable insight into the mechanisms by which CBT works.

2.3.2 A common factors approach for alcohol use problems

An alternative explanation for how change occurs is the common factors approach which suggests there are core ingredients or 'common factors', such as the therapeutic relationship, client attributes and therapist attributes, in all effective therapeutic approaches that account for a significant amount of the change process (Imel et al., 2008; Imel & Wampold, 2008; Messer & Wampold, 2002; Miller & Moyers; 2015) and are essential determinants of therapy outcomes (Messer & Wampold, 2002; Imel & Wampold, 2008). Indeed, a common factors approach is not unique to alcohol treatment and is a much-debated perspective in the general psychotherapy field.

Although common factors have been suggested as a possible determinant of therapy outcomes, there has been limited research into common factors in relation to therapy outcomes for AUP (Longabaugh et al., 2013). The common factors model has

been critiqued as being necessary but not sufficient for change, as well as lacking scientific rigour (Cuijpers et al.,2019). Therefore, research has primarily favoured the search for within-treatment factors that can account for treatment outcomes. However, as specific treatment ingredients have yielded disappointing and inconsistent outcomes, research has started to explore the role of common factors in treatment outcomes (Magill et al., 2016). A common factors approach contrasts with the medical model approach that assumes specific treatment effects for specific diagnoses (Messer & Wampold, 2002).

In their review of addiction outcome research, Miller and Moyers (2015) highlight how evidence-based approaches have often neglected the effects of the therapeutic relationship, client and contextual factors — all of which could provide critical understanding or clues into the underlying mechanisms of change. Furthermore, their review included a meta-analysis of 201 studies that found a significant relationship between the therapeutic alliance and treatment outcomes, which shows the importance of non-specific factors to treatment outcome. However, despite the support for common factors like the therapeutic relationship, addiction treatment has often overlooked the impact of such factors (Connors et al., 2016). Miller and Moyers (2015) critique this perspective by stating that if relational aspects have such a significant impact on treatment outcomes then “we owe it to our clients to specify them” (p. 110). This perspective highlights how evidence-based treatment may not work how we think and thus may be subject to more complex interpersonal processes. Thus, a broader understanding of how therapeutic approaches like CBT work for AUP is essential for developing therapy within the alcohol use field. Moreover, a broader understanding of

how therapy works may shift our conceptualisation of alcohol treatment and consequently, how therapy is provided for this client population (Imel et al., 2008).

Similarly, Magill et al. (2016) compiled a secondary analysis of data from Project Match (1997) comparing common factors across three evidence-based treatment: MET, CBT and TSF. Interestingly, the authors found that interventions affirming clients' strengths, autonomy and trust influenced how clients made coping decisions. The authors concluded that this was "the most interesting finding" (p.111), which indicates how the importance of the therapeutic relationship has often been undervalued in alcohol use treatment. Interestingly, they also found that the therapeutic relationship aided the effectiveness of teaching interventions (setting agenda, homework tasks, advising and psychoeducation) across different approaches. Therefore, these findings support the value of further research that seeks to understand the different processes involved in different therapeutic approaches that could provide valuable insight into the processes related to CBT practice.

2.4 Helpful aspects of therapy for alcohol use problems

As identified earlier, change process research has struggled to identify the processes by which CBT works for AUP. Longabaugh (2007) has suggested that research focusing on one factor is too restrictive, and therefore, research needs to develop a more sophisticated analysis to explore the interrelated aspects of change. However, as quantitative studies have struggled to establish clear change pathways, it could be considered that further research requires an approach that compliments efficacy studies, which uses a design that helps gain a more comprehensive understanding of the interaction between client and therapist and therapeutic rationale

(Orford et al., 2006). Qualitative research is one way in which this could be achieved (Elliott, 2012; Jones et al., 2015). Helpful factors research provides a qualitative approach to explore aspects of therapy that may be helpful or unhelpful in psychological treatment from both clients' and therapists' experiences (Elliott, 2012). However, there have been limited qualitative studies in the substance use field that have explored the change processes in CBT from this perspective.

Orford et al. (2006) highlights how the absence of clients' perspectives in the alcohol field could be related to beliefs that clients have no awareness or understanding of their change processes; furthermore, he states how this echoes the "drug metaphor in psychotherapy research which has adopted the model of an active professional applying a technique to a passive recipient" (p.68). Likewise, there has been limited qualitative research that explores therapists' experiences of delivering treatment in alcohol services. As therapy is often a complex interaction between therapist and client, it would stand to reason that therapists' experiences also offer an essential perspective on the therapeutic process.

The limited phenomenological enquiry into both therapists' and clients' experiences of treatment is reflective of a field that is firmly established in a biomedical perspective of addiction (Drug and Alcohol Review, 2015). When conducting the literature review, my search only found a few studies exploring helpful factors of therapy within addiction treatment and only two explored the use of CBT. As there have been limited studies that have explored CBT, this section will also explore helpful factors research that has explored other evidence-based psychosocial interventions, such as MI/MET and SBNT for AUP.

A study by Orford et al. (2006) revealed a more complex picture of change. Orford et al. (2006) explored clients' experiences of what had been helpful or unhelpful during a session of either MI or SBNT. Surprisingly, the findings from this study identified common factors across approaches that were considered helpful: talking with a therapist, belief in progress, being future-focused, having determination and commitment. It is worth noting that these findings differ from the earlier study despite using the same therapeutic approaches, which lends support for a pluralistic view that suggests different things work for different clients at different points in time (Cooper & McLeod, 2012; Magill et al., 2015).

However, the findings from this study also identified distinct treatment effects for MI and SBNT. Four external factors were found to be an essential part of the change process: 'treatment itself'; 'external support'; 'change was down to me'; and 'seeing the benefits of change'. In addition, the findings also uncovered the catalyst system, which included the reasons why people were seeking treatment, as individuals often accessed treatment as a result of external pressures. Therefore, the findings from this study reveal a complex picture of change that may be a combination of multiple factors. These findings illustrate how different approaches may indeed sit alongside each other rather than in opposition (Laska et al., 2014).

The complexity of change and the role of external factors have been supported in a couple of other qualitative studies. Jones et al. (2015) explored helpful aspects of MI and found that alongside relational factors (therapists' actions, therapists' qualities, therapeutic alliance, awareness and motivation) the service context was also considered

essential to MI - where clients' broader experience of the service and external factors outside of treatment affected their experience of therapy. Similarly, Gilburt, Drummond and Sinclair (2015) interviewed clients on their experiences of alcohol treatment and found services could be both helpful (providing support to address the physical and psychological impact of alcohol) and unhelpful (a potential barrier to engagement and attendance) for recovery. Furthermore, they found that establishing a therapeutic relationship was a potential pathway to improving self-efficacy. Again, these findings identify how a range of different factors may facilitate change.

Orford et al. (2009) explored therapists' and clients' experiences of helpful and unhelpful factors following SBNT and MET. The authors identified three outcomes that occurred across both approaches: 'thinking differently', 'support from friends and family' and 'acting differently'. These findings support a common factors approach by showing that change processes may be a result of non-specific factors. Therefore, qualitative studies exploring helpful and unhelpful factors of therapy for AUP have uncovered a broader understanding of the change processes that occur during therapy.

The findings from these studies reveal an intricate understanding of change processes, that is influenced by multiple factors. Further research that continues to build an understanding of how change occurs could therefore be useful in developing a more comprehensive understanding of how psychological therapies work for this client group.

2.4.1 Helpful aspects of CBT

Helpful factors for CBT have been explored across different client populations (Hassan, Bennett & Serfaty, 2018; McGowen, Lavender & Garety, 2005), but results from these studies may not be generalisable to other diagnoses as they are specific to a condition (Hassan et al., 2018). Only two studies were found that have explored therapists' and clients' experiences of CBT for AUP (although no study to date has conducted individual interviews with therapists). The focus on CBT in these two studies was very different: one focused on a 'spiritually modified' version of CBT (Hodge & Lietz, 2014) and the other focused on group CBT (Croxford, Notely, Maskrey, Holland & Kouimtsidis, 2014). Consequently, the findings from the studies were very distinct. However, both studies identified the role of social support, which also supports other approaches like SBNT and BCT that identify social support as a critical role in recovery outcomes (Copello, Velleman & Templeton, 2005), and potentially suggests that there could be other common factors that are essential to CBT outcomes.

Hodge and Lietz (2014) conducted focus groups to explore therapists' and clients' experiences of spiritually modified CBT, a version of CBT that has been adapted to incorporate clients' spiritual beliefs and practices for substance use treatment. The study identified three themes regarding change: (1) horizontal and vertical social support (clients accessing external support from groups such as faith communities); (2) divine coping resources (clients gaining strength from their relationship with God to cope with substance-related problems); and (3) spiritual motivation (CBT helping increase clients' motivation). This study identifies two findings that could be relevant for general CBT for substance use: increasing social support, and increasing motivation. Motivation has been considered a possible common factor in therapeutic change (Ilgen et al., 2006; Wampold, 2015) and further research

would be beneficial to assess the role of motivation in CBT treatment. However, this study also identifies that incorporating a spiritual component to treatment for those clients with religious/spiritual beliefs could increase the effectiveness of CBT treatment for AUP. In line with the research of Litt et al. (2016) and Litt et al. (2018), it could point to the importance of tailoring treatment around the client's individual needs.

Although the findings from this study may point to common factors that are relevant to CBT practice, they have not identified specific factors as to how CBT is helpful and unhelpful. There have not been any other studies like this that have sought to explore therapists' experiences of using CBT to treat AUP. The current study aims to build on this research by gaining insight into how CBT may be helpful or unhelpful in treating AUP.

In contrast, Croxford et al. (2014) explored helpful factors of CBT for alcohol misuse in a group context. They conducted a thematic analysis to explore participants' views of a CBT group before detoxification. Several key themes relating specifically to CBT concepts were identified: dealing with high-risk situations; strategies for cutting down; self-efficacy; lifestyle changes; and aftercare support. Tasks such as drinks diaries, relapse prevention work or cue exposure were all considered helpful aspects that facilitated the reduction or management of drinking. However, some individuals reported negative experiences of CBT, such as inconsistent feedback after completing worksheets, increased drinking, relapses and uncertainty about detox and aftercare.

Interestingly, the findings from this study have generated specific factors of CBT that are consider helpful when completed as part of a group process and,

furthermore, specific factors such as improved coping and self-efficacy were identified as crucial aspects of treatment. However, it is unknown as to whether similar aspects of CBT are helpful or unhelpful in one-to-one treatment. Belonging to the group was cited as an essential part of the recovery journey for participants in this study: completing the tasks became a shared experience, which may impact how participants experienced the helpfulness of CBT. Therefore, further studies exploring CBT after one-to-one therapy would continue to build an understanding of how CBT is helpful or unhelpful for clients with AUP.

The current study aims to build on the current literature by exploring therapists' experiences of using CBT and exploring aspects of CBT that are helpful and unhelpful in facilitating change for clients with AUP. It is expected that the current study will add to the current literature, by identifying both specific factors in CBT and non-specific factors, that are perceived to be helpful in the treatment of AUP.

2.5 Therapists' experiences of alcohol use treatment

As outlined earlier, therapists themselves are a significant factor influencing treatment and treatment outcomes (Nielsen, 2003). Research has shown that therapists and clients may have different perceptions of what is useful in therapy (Cooper & McLeod, 2012; Orford et al., 2009). However, both clients and therapists have 'inside' information about the system that needs to be explored to gain a better understanding of the processes taking place (Orford et al., 2009). Therefore, exploring therapists' experiences ought to provide valuable insight into how therapists work with clients experiencing AUP, what they perceive to be helpful or unhelpful, and how they believe

these practices help their clients. However, there has been minimal research that has sought to explore therapists' experiences of treatment.

To the best of my knowledge, only one study has aimed to specifically explore therapists' experiences of delivering therapy for clients with AUP. Nielsen (2003) carried out a qualitative study of 12 therapists to explore their significance throughout treatment. A narrative analysis was used to explore the therapists' stories of their experiences of delivering therapy and the challenges or conflicts they experienced. The analysis also sought to develop a treatment map of how therapists thought treatment should proceed. Therapists were reported to work in either CBT (which was described as a highly structured treatment) or 'supportive conversations' (defined as a loose treatment based on the clients' needs); theoretical orientation was not ascribed to this intervention although therapists were noted to have a range of theoretical frameworks from psychodynamic to systemic approaches.

The findings from this study showed that therapists often built narratives in a unique way, drawing on a range of different factors to develop a picture of the client and the way to treat them. Participant narratives revealed that therapists constructed stories of their clients fusing two key factors: (1) the client's experience (including personality, everyday life, and life history), and (2) the therapist's knowledge (therapeutic knowledge and experience, and social and moral constructions surrounding a client's behaviour). It seemed that by creating a story of the client it not only provided a platform for therapy, but it also allowed therapists to identify any possible threats to the therapeutic process. Therapists were then able to tailor therapy according to the client's needs. Furthermore, Nielsen stated that therapists' therapeutic approach was only

recognisable when therapists explained the specific techniques or strategies they used. These findings highlight how therapists may work in a highly idiosyncratic way, drawing on a range of different approaches.

The findings also showed how therapists experienced the client's journey from dependence to independence. For therapists, the goal was not only for clients to become free from alcohol, but also to see clients become more autonomous. The findings mapped out the client journey in therapy from dependence on the substance of choice, through dependence on the therapist, into eventual independence and autonomy over their lives. Interestingly, therapists often identified themselves as co-authors in the client's journey to independence. However, the findings highlighted how the therapeutic relationship was essential to this process, as well as in helping therapists facilitate clients to develop more autonomy (rather than therapists being prescriptive and making clients too dependent on them). The therapeutic relationship was seen as a prerequisite for therapy, where establishing trust was essential at the start of therapy.

The findings from this study provide a detailed insight into therapists' experiences of delivering therapy for this client population, and the vital role they have in the therapeutic process. However, the findings do not reveal much about how the specifics of how therapy helps or works for this client group, but rather provide general insights that are relevant to clinical practice, for example, the centrality of the therapeutic relationship.

Although CBT was cited as being one of the therapeutic approaches in Nielsen's study, the findings do not reveal much about how CBT is helpful or unhelpful for this

client group. Therefore further research therapists' experiences of CBT may reveal more specifically what aspects are perceived to be helpful or unhelpful for clients with AUP.

2.6 Rationale for the current research project

Improving alcohol treatment remains a priority for health services as recent statistics have shown a fall in the number of individuals in treatment for alcohol problems over the last few years (PHE, 2018). However, the fall in people accessing treatment is in the context of an increasing level of unmet need in the population (PHE, 2018). Therefore, improving access and treatment provision is vital to helping meet the needs of those with AUP.

Although the use of psychological therapies is well established in the treatment of AUP, currently only a limited number of therapies are recommended as evidence-based treatment (NICE, 2011). Although CBT is consistently found to be efficacious in treating AUP (Magill & Ray, 2009; Morgenstern et al., 2007; Morgernstern & Longabaugh, 2000), it has not shown it to be more effective than other therapeutic approaches (Morgenstern et al., 2007; Morgernstern & Longabaugh, 2000). Consequently, research has sought to understand the mechanisms that may explain how different therapeutic approaches work for AUP (Longabaugh & Magill, 2011). Although extensive quantitative research has explored change mechanisms, studies have struggled to consistently identify the processes by which CBT works. It is a priority for the development of therapy addressing AUP to identify the processes by which therapies such as CBT work (Jones et al., 2015; Longabaugh, 2007; Orford, 2008), as it is essential for therapists to understand why they do what they do (Orlans & Scoyoc, 2009).

As current studies have been unable to identify precise causal mechanism, it has been suggested that qualitative research could complement quantitative studies, and provide an in-depth understanding of the interactions between therapist, client and the therapeutic approach (Orford et al., 2006). The Drug and Alcohol Review (2015) identified there was a dearth of qualitative studies in the field, and concluded a greater integration of qualitative research that explores participants' perspectives could provide valuable insight into substance use treatment. It is worth noting that qualitative research has often been critiqued for lacking credibility and rigour (Drug and Alcohol Review, 2015) which has made it unfavourable as compared with RCTs, despite the potential value it may bring to deepening clinicians' understanding about the underlying processes involved in treatment. However, qualitative researchers have highlighted the importance of quality control to ensure rigour and usefulness of the research undertaken (Coyle, 2015; Yardley, 2000).

As mentioned previously, therapists play a significant role in the therapeutic process and outcomes. Both therapist and client have essential information about the process of therapy that provides valuable insight into the therapeutic change process (Orford, 2009), yet therapists' experiences of treatment are often understated. However, to date, no study has sought to explore therapists' experiences of using CBT for clients experiencing AUP.

The current study aimed to explore therapists' experiences of using CBT when working with clients who are experiencing AUP. It endeavoured to complement existing quantitative research about how CBT works with an alcohol-specific

population. Moreover, it is intended that the current research will provide valuable data to help bridge the gap between theory and practice in therapy by building on existing qualitative research in the alcohol field, developing further insight into therapists' experiences of delivering CBT and what they perceive to be helpful or unhelpful when working with this population.

It was hoped that understanding more about how CBT works might be useful in helping support therapists in facilitating systematic change within the alcohol use field (McHugh et al., 2010). The study also hoped to encourage others to build on the themes that emerge and carry out further research in this area. It was also anticipated that through the specific methodological approach chosen, therapists' experiences of CBT would inform a map of potential pathways to change that may be helpful for therapists offering CBT for clients with an alcohol use problem. Therefore, the findings from this study may provide clinically relevant information for practitioners regarding how CBT can be applied when working clients experiencing AUP.

2.6.1 Research questions

1. What are therapists' experiences of delivering CBT when working with clients experiencing AUP?

2. What aspects (if any) of CBT do therapists find helpful and/or unhelpful when working with clients experiencing AUP?

2.7 Relevance to Counselling Psychology

Counselling psychology is underpinned by humanistic values that emphasise the value and importance of an individual's subjective experience. This perspective aligns itself with a pluralistic approach that suggests there are many versions of reality and truth (Cooper & McLeod, 2012). Likewise, practice guidelines state therapists must "elucidate, interpret and negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feeling valuing and knowing" (Counselling Psychology Division, 2008, p. 1-2). In the same way, a counselling psychologist researcher needs to have an "openness to all the paradoxes, divergences and different perspectives we may encounter in the empirical literature and the methodologies we ourselves employ" (Kasket, 2016, p. 233).

Although counselling psychology emphasises the importance of meaning, subjectivity and humanistic values (Blair, 2010), counselling psychologists are increasingly being employed in the NHS, and thus are having to engage with working within the medical model (Blair, 2010, Larsson, Brooks & Loewenthal, 2012). Therefore, working with diagnoses is inevitable and relevant to the field of counselling psychology (Athansiadou-Lewis, 2017). However, counselling psychology holds a critical stance (Woolfe, 2016) and seeks to challenge the universal health care trends to pathologise clients' problems (Orlans & Van Scoyoc, 2009).

Given that the 'treatment' of AUP is still embedded in a medical model approach, a counselling psychology perspective is invaluable in seeking to bring a different perspective that could help develop the current understanding of AUP and therapeutic practice. Although the current project is focusing on CBT, it is not assuming that this is the only way that can help clients; instead it seeks to understand the

processes that may be helpful or unhelpful when using this approach. Moreover, understanding therapists' experiences of delivering CBT could bridge the gap between theory and practice by providing information on treatment that could help refine treatment, in terms of its applicability to a clinical setting (Carroll et al., 2000). This perspective contrasts the current hierarchy of NICE guidelines evidence that places less value on single qualitative studies (Kasket, 2016).

Unfortunately, addictions generally have often been overlooked within counselling psychology research. However, counselling psychology values are in line with a social justice agenda that seeks to 'give a voice' to those who are marginalised and aims to see a society that meets the needs of all groups allowing them to fully and equally participate in society (Speight & Vera, 2008). Therefore, given the prevalence, personal costs and societal impact of AUP, it is crucial for counselling psychologists to work to help fight against problems in this area (Martens, Neighbors & Lee, 2008). Moreover, considering recent funding cuts and reduced service provision in addictions, counselling psychologists could have an important role in advocating for this client population that often experiences marginalisation and stigmatisation in gaining fair and equal access to treatment.

The current research may have implications for the field of counselling psychology and the broader field of counselling and psychotherapy. The exploration of therapists' experiences of working with AUP may aid therapists' learning and understanding about working with clients experiencing alcohol problems – especially for therapists who do not work in addictions but encounter clients experiencing alcohol-related problems. It could also inform therapists' clinical practice by providing relevant

information about how CBT may be helpful or unhelpful and identifying possible change pathways that could be useful in clinical practice. Finally, it may also provide information that could help inform therapists to make a systematic change in the field (McHugh et al., 2010).

Chapter 3. Method Section

3.1 Introduction

This chapter will address the rationale for choosing a qualitative paradigm for this research study. The chapter will also discuss the ontological position the study is taking and explain why thematic analysis (TA) is considered to be the most appropriate methodological approach to answer the two research questions the current study is aiming to address.

The second part of this chapter will outline the procedures, ethical considerations and evaluation criteria for this research study.

3.2 Qualitative Paradigm

Psychological research has been primarily dominated by positivist and post-positivist approaches that are most commonly associated with quantitative research (Madill, Jordan, & Shirley, 2000; Ponterotto, 2005). Positivist research tends to assume a realist epistemological stance by assuming the truth about reality can be uncovered through scientific investigation (Danermark, Ekström, Jakobson & Karlsson, 2002). In contrast to quantitative approaches, a qualitative research paradigm tends to assume there are multiple truths about reality that can be uncovered and discovered (Braun & Clarke, 2013).

Positivist research seeks to establish causal links to the research phenomena. For example, research has shown that CBT is effective in reducing clients' drinking (Magill & Ray, 2009; Morgenstern et al., 2007; Morgernstern & Longabaugh, 2000). However,

while quantitative research provides a clear and robust picture of causal links, it often fails to provide a more in-depth picture of how and why these links might occur (McLeod, 2011).

In recent years, qualitative research has had a surge in popularity (Rennie, 2012), particularly in the field of counselling psychology (Ponterotto, 2005). Qualitative research is often interested in understanding or exploring meanings and the ways people make meaning (Braun & Clarke, 2013). Moreover, qualitative research is often exploratory in nature, producing in-depth, rich and detailed data (Braun & Clarke, 2013). It creates an openness, in which the knowledge generated values both multiple perspectives and the subjective experience of each participant (Braun & Clarke, 2013; Vossler & Moller, 2015). Therefore, a qualitative paradigm is consistent with the values and philosophy of counselling psychology (Ponterotto, 2005) that values subjective experiences, interpretations and meaning within a particular context (Orlans & Van Scoyoc, 2008).

Likewise, Pidgeon and Henwood (1997) suggest that human science needs to be sensitive to participants' own understanding. However, this perspective is often limited in the substance use field where research has been dominated by traditional quantitative approaches which employ strict experimental, sometimes quasi-experimental methods that often follow standardised and structured methods (Orford, 2008). Consequently, addiction research is often situated within a biomedical approach, which can result in the field of addiction research being averse to questioning its approaches to how to conduct valid scientific research (Orford, 2008). The aim of this research project is consistent with recommendations for addictions research to start focusing on

understanding change processes and how and why treatment might be effective (Orford, 2008). By conducting research that is uncovering and hearing therapists' experiences, it is anticipated that findings will also build an understanding of what aspects of CBT might be helpful or unhelpful/challenging when working with this client group. Therefore, it is intended that the current study will provide valuable data to help bridge the gap between theory and practice, which may also be essential to help support therapists in facilitating systematic change within the alcohol use field (McHugh et al., 2010).

Given that the current research is aiming to gain a more detailed picture into how and why CBT is effective in treating AUP, a qualitative paradigm would be able to provide a richer and more detailed picture into how CBT is helpful or unhelpful. It will also provide a detailed understanding of therapists' experiences of using CBT when working with clients who experience AUP.

3.3 Ontology

3.3.1 Introduction

Ontology is concerned with understanding how we know reality (Timulak, 2015). In other words, ontology describes ways in which humans attempt to understand and make sense of the world around them (Willig, 2013). Qualitative research is often guided by a set of ontological assumptions that provides a lens with which we can interpret and make sense of the data.

Approaches such as Interpretative Phenomenological Analysis (IPA) and Grounded Theory (TA) are wedded to certain epistemological and ontological positions

(Braun & Clark, 2013; Willig, 2013). Unlike IPA and GT, TA is known for its epistemological and ontological freedom. Depending on the research question being asked, it can be situated in either a realist or constructionist framework (Braun & Clark, 2006), including critical realism (Harper, 2011). Therefore, to prevent the research from lacking theoretical rigour, Braun and Clarke (2006) highlight the importance of "a 'named and claimed' thematic analysis" (p.81), which clearly outlines its ontological, epistemological and theoretical stance of the research. The current study will adopt a critical realist stance, which acknowledges the role of subjectivity in the development of knowledge (Madill et al., 2000).

Critical realism offers a balance between an objective reality to be understood and a social world that shapes our understanding of reality. Understanding the influence of the social world was important for the present study as our understanding of AUP are continually influenced by social and cultural discourses. Moreover, due to participants' subjective experiences and considering my experiences of AUP and CBT (personally and professionally), it was considered impossible for knowledge developed in the present study to be completely objective and independent of social influences. Critical realism views the researcher as being actively involved in the construction of knowledge and emphasises the importance of the researcher's reflexivity in developing an awareness of one's conceptions and interpretations when making sense of participants' experiences (Braun & Clark, 2013). Considering my experiences of AUP and CBT, adopting a reflexive stance was considered paramount for the present study.

3.3.2 What is critical realism?

Critical realism is an alternative position to the dominant positivist stance in psychology research. Critical realism developed as a critique to positivist approaches (Danermark et al., 2002) and sits within a post-positivist paradigm. Unlike positivist approaches that claim reality can be objectively understood, post-positivists argue that human intellect is flawed, and thus reality can only be imperfectly understood (Ponterotto, 2005). Although there are differences between positivism and post-positivist approaches, post-positivist approaches have been most commonly associated with quantitative research as both approaches shared the idea there is an objective truth that can be studied, identified and generalised (Ponterotto, 2005). However, the increasing popularity of critical realism in social science has influenced qualitative research, as it sits in between positivism and constructivism (Braun & Clarke, 2006; Madill et al., 2000), offering an alternative approach.

Critical realism views the world as being stratified, which means that reality exists on different levels: the empirical (observable events), the actual (events that occur) and the real (underlying mechanisms or processes that generate certain events) (Bhaskar, 2014; Danermark et al., 2002; O'Mahoney, 2011). In a positivist paradigm, researchers often adopt a realist ontology that places emphasis on uncovering truths about the reality of the world and human behaviour, which can be discovered and tested through empirical research (Danermark et al., 2002). A critical realist position starts from an ontological question: "what properties do societies or people possess that make them possible objects for knowledge?" (Bhasker, 1978, cited in Danermark et al., 2002, p. 18). Therefore, for critical realists, it is essential to understand the connection between assumptions about the existence of the world and society and the idea of how knowledge is possible (Zachariadis, Scott & Barrett, 2013). As with a realist approach,

critical realism acknowledges there are external truths outside of our direct knowledge that can be discovered. However, a critical realist position does not see these as absolutes. Instead, critical realism suggests that our attempts to capture knowledge is fallible and subject to change (Danermark et al., 2002; Ponterotto, 2005). As Bhaskar (2014) states, "we are surrounded by our systems of thoughts and beliefs which leave much to be desired and effectively act as obstacles to gaining knowledge of the world" (p. 7). Therefore, critical realists' believe that while the data can tell us about reality, it is not viewed as a direct mirroring (Harper, 2011).

While critical realism acknowledges there are truths about reality, a crucial distinction from naïve and scientific realism are the roles of social influence and processes. A critical realist position states that our understanding of knowledge and reality is shaped within the context of social influences, such as culture and language (O'Mahoney, 2011). However, unlike constructionist approaches, critical realism does not posit that reality is created through language; rather, that there needs to be an understanding of both conceptual (social) reality and material reality (Bhaskar, 2014).

By sitting between naïve realism and constructionism, critical realism is a vehicle by which causal mechanisms of a given phenomenon or construct can be understood. Critical realism suggests that it is not enough to merely generate empirical facts about a particular construct, but instead, we need to understand the underlying causal mechanisms that may be mediated by the existence of culture, social or discursive processes (O'Mahoney, 2011). In such a way, critical realism acknowledges that knowledge of reality is produced by a multiplicity of mechanisms and structures, and is always dealing with complexity (Bhaskar, 2014).

3.3.3 Rationale for adopting a critical realist stance

A critical realist position has been chosen for this research project, as it was deemed the most appropriate position from which to answer the posed research questions. A naïve realist position was rejected for the present project as the research is primarily seeking to understand therapists' experiences of delivering CBT. Although the research is exploring events and actions that occur in reality; these events cannot be exact 'truths' as the researchers own subjective experience of reality will shape participants' experiences (Willig, 2011). In contrast, a critical realist approach holds both realism and subjectivity. Critical realism holds onto an ontological realism, that says an independent world exists independently of our perceptions, theories and constructions; at the same time, it accepts a more constructivist and relativist stance that says individuals' understanding of the world is developed through their perspectives and standpoints (Maxwell, 2012).

In addition to understanding therapists' experiences, the current research is also seeking to explore factors of CBT that may be helpful or unhelpful for the treatment of AUP. The adoption of a critical realist position presumes that there are helpful and unhelpful factors to be discovered. However, a critical realist approach accepts that it cannot obtain direct access to reality (in this case, objectively helpful and unhelpful factors), but that these are accessed through subjective and intersubjective interpretations and experiences (Harper, 2011). Therefore, it acknowledges that while commonality of helpful factors may be discovered, helpful factors are being explored through the lens of participants' perceptions, rather than understanding them as discursive constructions.

As outlined above, a key feature of critical realism is the understanding of underlying causal mechanisms or processes. Critical realism seeks to go beyond the fact that A causes B; instead it seeks to understand and identify the underlying processes and mechanisms *by which* A causes B (Collier, 1994). The current study seeks to go beyond the understanding that CBT is an effective form of treatment for AUP, by exploring *how* and *why* CBT is effective in this area. By adopting a critical realist stance, a thematic analysis will be used as a way to "to unpick or unravel the surface of reality" (Braun & Clarke, 2006, p.81).

Within a qualitative approach, the researcher is often considered to be actively involved in the research process, thus having some influence on the data (even if their assumptions are bracketed). In a positivist paradigm, the researcher is an *observer* to the knowledge, whereas a more relativist approach actively places the researcher as an *active agent* in the research process. Similarly, a critical realist approach acknowledges that the researcher will not be able to accurately produce knowledge without imposing their own experiential views of the data (Willig, 2013). Instead, the data produced will be a considered account of the participant making sense of their actual reality thus producing a critical realist analysis of the data (Willig, 2013).

In summary, it was considered that critical realism would be the best lens through which the data could be interpreted and understood; a position that would provide a balance between an objective reality being understood on the one hand, and a social world that influences the participant, their world and the researcher on the other.

3.4 Links to counselling psychology

Research has been at the heart of counselling psychology since it first began (Orlans & Van Scoyoc, 2009), and contributed to the identity of counselling psychologists being identified as 'scientist-practitioners' (Kasket, 2012; Orlans & Van Scoyoc, 2009). For many years, the field of counselling psychology has had a strong interest in research that informs clinical practice (Kasket, 2012). More recently, importance has also been placed on how counselling psychologists share their knowledge beyond clinical practice, into the wider world (Milton, 2010).

Despite the importance being placed on counselling psychologists to be actively involved in clinical research, to date there is a lack of research in the field of alcohol within counselling psychology literature. This is part of a broader narrative, where substance use (including alcohol research) has historically fallen behind treatment research for other mental health problems, such as depression and anxiety (Miller & Brown, 1997). That being said, the field of alcohol use has also seen an emergence of the effectiveness of evidence-based treatments such as CBT (NICE, 2011)

Although research in the substance use field may have lagged behind other mental health problems, there has been extensive quantitative research that has explored the effectiveness of different therapeutic approaches, such as CBT (Morgernstern & Longabaugh, 2000). However, over the years, psychologists have tended to shy away from treating clients with AUP unless they have specialist knowledge (Miller & Brown, 1997). Despite the trend to lean towards 'specialist' treatment, many psychologists (whether in mainstream services like the NHS or in private practice) will treat or encounter clients who are experiencing substance use problems, and alcohol problems

in particular. Alcohol problems are co-morbid with other mental health problems such as depression, social anxiety and PTSD (Miller & Brown, 1997); therefore, despite the trend to refer on for 'specialist' support, psychologists do already have a lot of skills and experience they can draw on to treat AUP, as well as the training to address other co-morbid presentations as part of the therapy. Therefore, psychologists have an essential role to play in addressing and treating such common and highly treatable problems (Miller & Brown, 1997).

Counselling psychologists can be seen to have a valuable role to play in helping develop treatment for AUP, both through current research and in clinical practice. The current research aims to provide valuable insights for the field of counselling psychology by providing a detailed picture into clinical practice for psychologists working with clients who experience AUP. However, this research is not exclusively pertinent to the field of counselling psychology, but also relevant to the wider counselling and psychotherapy field.

3.5 Thematic Analysis

Thematic analysis (TA) is a unique qualitative approach that solely provides a method for analysis (Braun & Clarke, 2013). Unlike other qualitative approaches, it does not set out a prescribed method for data collection, theoretical positions or epistemological and ontological assumptions (Braun & Clarke, 2013). This makes TA a flexible research method that allows the researcher the opportunity to set the framework from which the analysis takes place (Braun & Clarke, 2006). However, Braun and Clarke (2006) state that epistemological, ontological and theoretical assumptions must be set and made clear before the analysis. This project will undertake an inductive

approach to analysis. An inductive TA allows the analysis to be rooted in the data set. It is hoped that the analysis will generate rich and detailed themes derived from the data and will inform a map of potential pathways of change.

The chosen research aims, questions and ontological position require a research method that will facilitate the research in gaining detailed accounts of therapists' experiences of delivering CBT for patients with an alcohol use problem. Before TA was decided upon, other approaches were carefully considered to decide which approach would be most suitable to answer the research aims, objectives and research question.

IPA was initially considered as a suitable approach. The current research is firstly seeking to explore therapists' experiences of delivering CBT with clients' who are experiencing AUP. IPA emphasises the role of subjective experiences and with a phenomenological epistemology (Smith, Flowers & Larkin, 2009; Braun & Clarke, 2006) could have been suitable to address the main research question. However, one of the critical components of IPA is to recruit a homogenous sample (Smith et al., 2009), whereas the current study is also interested in commonly perceived helpful and unhelpful factors of CBT in a broad range of participants. Furthermore, an IPA analysis takes an idiographic approach, whereas TA takes a cross-case approach which explores commonalities across the data set. Therefore, TA was considered to be the most suitable approach to address the research aims and questions.

Various versions of GT have been used in previous research exploring helpful factors for alcohol misuse, with many using a grounded theory 'lite' version that is much akin to TA (Braun & Clarke, 2006). Like an inductive TA, a GT analysis is

grounded in the data, with a rigorous and structured approach to analysis. However, a full GT requires the application of a full range of GT procedures, including theoretical sampling, that seeks to build a theory at the end of the analysis (Braun & Clarke, 2019). Whilst this study is seeking to identify change processes in CBT, the study is not seeking to conclude that this is an exhaustive list of helpful or unhelpful processes and build a theory at the end of the research, but rather it seeks to produce a conceptually informed interpretation of the data (Braun & Clarke, 2019) that uncovers therapists' experiences of using CBT in the treatment of AUP.

Although a grounded theory 'lite' approach might be a suitable form of analysis, Braun and Clarke (2006) propose that a full named and claimed TA is more comprehensive and provides a richer analysis of the data. Therefore, it was decided that TA would be the best fit for the proposed research study to address the aims, research questions and ontological positions of the study.

3.6 Research Design

3.6.1 Sample

Purposive sampling is often used in qualitative research as it allows the researcher to purposefully choose participants who have experienced the concept being explored (Hanley, Jordan & Wilk, 2015). For this reason, purposive sampling was used to recruit participants initially. Eight local alcohol services were contacted to ask if they would advertise the study and fifty-one therapists were contacted to ask if they were interested in taking part in the study (Appendix 2). Therapists' details were obtained from social media sites such as LinkedIn, as well as websites, such as the British

Association of Counselling and Psychotherapy (BACP) and British Psychological Society (BPS) register for qualified therapists. Following this, snowballing was also used as an additional recruitment strategy, where therapists could recommend other therapists to contact.

An inclusion/exclusion criterion was designed to ensure the suitability of participants in relation to the research question be explored (Appendix 3). Participants were included if they were a qualified counselling psychologist, clinical psychologist, counsellor, psychotherapist or CBT therapist and had experience of delivering CBT one-to-one as a primary intervention for clients with AUP. Given the applicability of this study to the wider psychotherapy field, the inclusion of therapists taking part was not limited to counselling psychologists, but rather open to all therapists who had used CBT as a primary intervention. Although it was acknowledged that therapists might use integrative approaches, this study was seeking to explore therapists' experiences of using CBT, and so only therapists with experience of using CBT as a primary rather than secondary intervention were included. Likewise, participants who were in training or were not accredited by an appropriate registered body were excluded from the current study.

Upon showing interest to participate in the study, participants were vetted against the criterion via email or over the phone (Appendix 4). Participants were asked the following questions:

- Are you a qualified counselling psychologist/clinical psychologist/counsellor/psychotherapist/CBT therapist?

- When did you complete your training?
- Do you offer CBT as a primary intervention for clients with alcohol problems? Was this integrated as part of the work or was it the sole intervention?
- Are you accredited with any registering body, if so, can you provide me with details of your accreditation?

If therapists did not meet the criteria, it was explained that they would not be able to take part in the research project and were thanked for their time and interest in the project. Those who met the inclusion criteria were then invited to take part in an interview.

Eight therapists who had used CBT as a primary intervention to treat AUP were recruited to take part in the research project. Three participants were female, and five were male. Out of the eight participants, five identified as White British, one identified as Black British Caribbean, one identified as White Italian and one identified as Irish. The age of participants ranged between 36-56+ years. Four participants identified as having no religious beliefs, three identified as atheist and one identified as Christian. Participants also worked in a range of different services, ranging from NHS, joint-commissioned services between the NHS and third-sector organisations, third-sector organisations, private sector and private practice. Five therapists worked full-time, and three worked part-time. The therapists had a range of professional experience: four participants identified as being qualified psychologists (two clinical, one counselling and one applied psychologist), three therapists were solely trained in CBT, and one was an integrative psychotherapist. All were accredited with the BPS, BACP or BABCP. Their experience of working in addiction ranged between 4 and 20+ years. Table 1

provides an overview of the participants' demographic profile; participants were allocated pseudonyms in line with the confidentiality procedure (section 3.7.1).

Table 1
Summary of participants demographic profile

Pseudonym	**Age group**	**Gender**	**Ethnicity**	**Qualification**	**Accreditation**
Sally	36-45	Female	White-British	Applied Psychologist	BPS
Clive	46-45	Male	Black-Caribbean	Integrative	BACP&UKCP
Andrew	36-45	Male	White-British	CBT Therapist	BABCP
Michael	36-45	Male	White-Italian	CBT Therapist	BABCP
June	46-55	Female	Irish	CBT Therapist	BABCP
Mark	36-45	Male	White-British	Counselling Psychologist	BPS
David	46-55	Male	White-British	Clinical Psychologist	BPS
Mary	56+	Female	White-British	Clinical Psychologist	BPS

3.6.2 Procedure

Once ethical approval had been gained by the University of Roehampton ethics board (Appendix 5), participants were recruited as outlined above. At the start of the interviews, participants were given an information sheet (Appendix 6), consent form (Appendix 7) and a demographics questionnaire (Appendix 8) to complete before the interview.

A semi-structured interview was conducted, which lasted approximately an hour and a half. An interview guide was developed (see below and Appendix 9) using open-ended questions to help direct participants towards answering my research questions as well as being open-ended to allow the participants' experience to emerge and giving them the space to redefine the research topic and generate new and interesting insights (Willig, 2013). The interview guide drew upon some questions from Elliott, Slatick and Urman's (2001) *Helpful Aspects of Therapy* form, and Elliott's (2010) *Change* interview guide. As change process interviews can be used to explore either therapists' or clients' experiences of therapy retrospectively (McLeod, 1999), it was decided this would be helpful in potentially mapping out change processes from therapists' experiences.

A pilot interview was carried out to test the questions being asked, making sure they were directed towards answering the proposed research question. Additionally, the pilot interview provided the opportunity to establish the correct order of the interview questions. However, a semi-structured interview provides the researcher freedom and flexibility to ask the prepared questions in any order and without needing to use the exact wording (Braun & Clarke, 2013). This is because the order and wording of

questions are contextual and responsive to the participant's emerging account (Braun & Clarke, 2013), which means being able to keep the interview "on target while hanging loose" (Rubin & Rubin, 1995, p. 42). To be able to maintain this balance, it was essential to first establish a good rapport with the participant (Willig, 2013). Therefore, to maintain consistency and continuity, I felt it was vital for me to be able to follow the participant's emerging experience with reflections, as well as further questions, at times using the participant's own words to reform or lead into the next question (Willig, 2013). This was an essential way to show that I was listening to the participant and also allowed me to check that I had fully understood what was being said. Furthermore, it was a way to seek further clarification and gain a deeper understanding into the participant's experience. At other times, simple prompts such as "can you say more?" or "can you recall a specific example where this worked or did not work well?" were also used to help gain further insight and understanding into the participant's experience.

After the interview, participants were given a debriefing sheet (Appendix 10) outlining details on how to have their data removed from the study. The debriefing form also went through some questions to be discussed in the debriefing session, as well as detailing information about where they could seek support if issues had not been resolved at the debriefing stage.

3.7 Ethical Considerations

The research was submitted for ethics consideration under the reference PSYC 16/245 in the Department of Psychology and was approved under the University of Roehampton's Committee on 19.01.17.

The present study was compliant with the BPS (2014) code of ethics and followed ethical practice throughout the research project to ensure that all potential ethical issues were accounted for to protect the participants from any undue risk or harm during the research process. Participants taking part in the present study were all therapists, whereby they were considered to be equipped to manage their distress sufficiently. However, it was also acknowledged that, like vulnerable participant populations, therapists might also have encountered painful or challenging experiences and emotions both personally and professionally. Therefore, procedures needed to be in place to mitigate against any potential distress and to be able to appropriately manage any problems that could have occurred during the research process. For example, it was vital to give participants the space to discuss any questions or difficult emotions following the interview process and provide participants with the appropriate follow-up support, if required.

In addition to specific ethical practices, ethical implications for the present study were considered throughout the project. Following the analysis of the data, it was essential to consider the broader impact of the research findings, such as what is the potential harm that could occur from the wider dissemination of the findings? How can the findings be applied? Who will benefit from the findings? By asking these questions throughout the research project, it was maintained that ethical practice was not just a stage of the research journey, but rather it was a continuous process throughout the research process (Braun & Clark, 2013; Steffen, 2015).

The relevant ethical issues accounted for in this study are informed consent, the right to withdraw, confidentiality, risk of harm to participants, debriefing, anonymity and health and safety.

3.7.1 Informed consent

Informed consent was obtained by both recruitment organisations and individual participants.

Organisational consent

Recruitment organisations were sent an email with an information sheet (Appendix 11), which explained the research project in further detail. Consent from the alcohol services was obtained before recruitment in the form of an email or written letter.

Participant informed consent

Participants who met the inclusion criteria were given a copy of the information sheet (Appendix 6) to have for their records. The information sheet gave details of how to contact the researcher or an independent party at the university. Before commencing the interview, participants were allowed to discuss this and ask any questions about anything that was unclear before their interview took place. Participants were informed that participation in the research was voluntary and that they had the right to withdraw from the research study at any time. Once participants agreed to take part, written consent was then obtained (Appendix 7). The written consent form detailed that

participants had read and understood the information sheet and were willing to participate in the research.

3.7.2 The right to withdraw

All participants were informed that they had the right to withdraw from the study at any point. Participants were also informed of their right to withdraw after the interview and before the point of analysis. In accordance with the BPS code of ethics guidelines, participants were informed that they have the right to request that all or part of their data be destroyed and not be used in the study report or any subsequent publications.

3.7.3 Confidentiality

Following the Data Protection Act 1998, all information provided by participants was treated as confidential unless otherwise agreed in advance. If there has been a concern that a participant was a serious risk of harm to themselves or others then confidentiality may have needed to be broken. Following the interview process, it was established this was not needed in this study.

The collection and storage of data were carried out following the guidelines set out by the Centre of Research for Social and Psychological Transformation (CREST) (Appendix 12). Personal, non-anonymised data includes signed consent forms, participants' demographic details, audio recordings and verbatim transcripts of audio recordings. Identifiable details were deleted from the transcripts and will be considered as anonymised data. Partially anonymised data refers to any documentation or media

(electronic or non-electronic) where it is unlikely, but still possible, for participants to be identified. For this research project, partially anonymised data included audio recordings of interviews. If participants provided clearly identifiable content (for example, names of people, or the name of their alcohol support service), this data would be treated as personal non-anonymised data. If no such content is verbalised, the audio recording can be considered partially anonymised data. Anonymised data refers to any documentation where the participant is in no way identifiable. For this research study, it includes transcripts where all identifying details have been removed.

Transcripts of recorded interviews were kept in accordance with the data protection guidelines outlined above. All identifying information of the participant was removed, such as names, name of the counselling service or individual counsellors, and references to places. As stated above, anonymised transcripts were kept separately from other identifying information. Transcripts were labelled with an identifying code only identifiable by the researcher and were stored in a locked and secure location.

3.7.4 Risk of harm to participants

Risk is defined as potential physical or psychological harm, discomfort or stress to human participants that a research project may generate (BPS, 2010). The main risk of harm in this research study is that participants could have become distressed when talking about their experience of delivering therapy. While it was hoped that most participants would have had a positive experience of delivering CBT, not all participants may have had a positive experience. Therefore, the interview could bring up difficult emotions, such as anger, sadness and disappointment. Additionally, participants were giving up their time for the interviews without any incentive, and it is possible

they may have found the recording of their interview uncomfortable. However, these risks were reduced because of the right to withdraw, and the assurance of data protection and confidentiality.

This risk was mitigated by my training in counselling psychology, where I am equipped to manage and respond to distress sensitively. Over the last five years, I have worked with clients in varying degrees of distress. Therefore, I am confident of being able to carry out interviews sensitively and ethically, understanding when a participant may be experiencing distress. In the event of a participant becoming distressed during the interview process, it would be my ethical responsibility to work collaboratively with the participant to find out how they can be helped to feel comfortable or to terminate the interview process where necessary. In any case, all participants were fully debriefed at the end of their interview and provided with details of follow-up support (e.g., service manager, supervisor or Samaritans) should they experience any future distress following the research project. Additionally, all the participants were therapists themselves; it was therefore expected that they would have the skills to understand and manage their distress.

3.7.5 Debrief

Participants were provided with a written debrief (Appendix 10), which was discussed following the interview. Participants were given the opportunity to discuss any problematic feelings that had arisen during the interview process, and to ask any questions following the interview process. If any issues had arisen that could not be resolved during the debrief process, participants were to be signposted to their service manager or supervisor, or relevant external services, for further support.

3.7.6 Lone working

The university's lone working policy applies to students undertaking research projects during their academic programme without direct supervision (University of Roehampton, 2010). As interviews were conducted off-site at counselling services in the community or at a therapist's office, lone working was unavoidable. To mitigate any potential risk, the lone working policy was upheld, and appropriate measures were put in place. For example, I informed the supervisory team when and where interviews took place, and when I left the organisation after completing an interview. Where interviews took place at services that had agreed to participate, the researcher ensured a member of staff from a participating organisation was aware when I was on and off-site.

3.7.7 Transcription

Interviews were recorded on an Olympus digital audio recorder, transferred to a computer and stored in a password-protected folder to ensure confidentiality. The recordings were then listened to and transcribed verbatim. The transcription took place as soon after the original interview as possible, in order to enable any specific context that may have influenced the interview process (e.g., my own processes) to be recorded.

To preserve confidentiality, the names of the participants were replaced with pseudonyms. All names of identifying services that participants disclosed were also removed to protect confidentiality.

3.8 Analytic method

The analysis of the data followed Braun and Clarke's (2006) six phases to analysis, which is as follows:

3.8.1 Familiarisation with the data

At this stage of analysis, it was important to be immersed in the data. The first step in this stage was to transcribe the data. This involved listening to the interviews multiple times, both to ensure familiarisation with the data, and to ensure the accuracy of the transcriptions. Likewise, transcripts were re-read to check for accuracy; this also became a beneficial way to immerse myself in the data. Following this initial step, I made notes of areas of particular interest and marked ideas for codes (see below) to go back to at later phases of analysis. Detailed notes were added to the right-hand side of the margin.

3.8.2 Generating initial codes

Following familiarisation with the data, I started to code the data. Coding identifies aspects of the data that appear to be interesting to the analyst with regard to the research question. For this analysis, the data was coded in chunks of five lines at a time. For this part of the analysis, it was important for the codes to be concise. See Appendix 13 and 14 for illustrative examples of transcripts with initial coding.

3.8.3 Searching for themes

A theme "captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p.82). Therefore, once I had generated the initial codes, I then shifted to look for larger patterns across the data set. To establish patterns across

the data set, I sought through the codes to find those that were most meaningful in being able to answer my research questions. Initial codes were clustered together to begin searching for patterns across the data. This part of the analysis was an active process by choosing the codes that help created and sculpt the themes across the data set (Braun & Clarke, 2013).

3.8.4 Reviewing the themes

Reviewing themes is a two-phased approach with the aim of developing a coherent thematic map, which provides an overall story of the data. This stage of the analysis was akin to quality control, as it allowed me the chance to check that the themes generated fitted with the coded data and the data set that had been collected.

The first step was to go back to my coded and collated data. I needed to make sure the themes worked in relation to these codes, and most importantly, ensure that the themes were answering the research question. The next step was to go back over the whole dataset, which involved going back to the uncoded data and making sure the themes captured the meaning of the dataset in relation to the research questions. During this stage, the themes were refined, some were collapsed, and others were reworked or discarded.

In thematic analysis, two types of themes are generated: semantic and latent. Semantic themes closely tell the story of the data (Braun & Clarke, 2006/2013), whereas latent themes are more interpretative. TA can use both types of themes, starting with more semantic descriptive beginnings, but ending with latent interpretative

endings. For this research to address the research question, both semantic and latent themes were generated to answer the two research questions.

3.8.5 Defining and naming the themes

Following the identification of the themes for the data, the next step was to carry out deep analytic, interpretive work, to make sense of and interpret the patterns identified in the data (Braun & Clarke, 2013).

The first step was to define the themes generated, which involved writing about each theme and stating what was unique and specific about each one, and ensuring that all the themes were clear. Each theme has its own purpose and focus, and together the themes created a rich and meaningful picture of the data that addresses the research question being asked.

Defining the theme names was a challenging process of balancing my analytical interpretation of the data with a clear identification of what the theme encompassed. In developing the theme names, in some cases I chose to use direct quotes, as they most clearly expressed what the theme captured, whilst also remaining close to participants' language.

3.8.6 Producing the report

The final stage in the analysis was to write up the data and choose extracts that clearly captured the themes that were generated through the analysis, supporting and identifying what was interesting about the data. Braun and Clarke (2012) state that the

purpose of the report is to provide a "compelling story about the data based on the analysis" (p.69). This involved the writing and rewriting of individual themes to provide a convincing yet sophisticated account of the analysis. Consequently, this was a process of refining the analysis and developing a deeper understanding of the data.

It became apparent that some aspects of the data had to be discarded due to limitations on the word count. This process of refinement was guided by feedback and consultation with my supervisor.

3.9 Evaluation criteria for research

The evaluation of quantitative research is well-established: representative sample sizes, design to minimise confounding variables, reliable measures and appropriate analysis (Yardley, 2000). In contrast, qualitative research explores how people make meaning (Braun & Clarke, 2013) where there is no fixed criteria for determining 'truth' (Yardley, 2000). Therefore, Yardley (2000) specifies four criteria for qualitative researchers to follow to ensure quality control and avoid unfavourable outcomes.

3.9.1 Sensitivity to context

Yardley (2000) suggests sensitivity to context involves researchers having an extensive understanding of the theory surrounding the topic and a sound awareness of previous research in the field of interest, including similar studies or methods to the topic being researched. Likewise, researchers should have an awareness of the socio-cultural context that influences the topic under study. Lastly, the researcher must have

an understanding and awareness of the social context between researcher and participants.

For the current study, the introduction and literature review located the current study in the context of previous research and the broader social context. Given that addiction has been considered a social construction, it was pivotal to have an overview and understanding of the social contexts that influence treatment. The social context between researcher and participants was considered through reflexivity, which was ongoing throughout the research project, allowing me to recognise how my personal and professional experiences could shape my understanding throughout the research process. Moreover, a reflexive stance also allowed me to be more open and curious about participants' experiences.

3.9.2 Commitment and rigour

Coyle (2015) defines commitment and rigour as the researcher's prolonged engagement with the topic and a 'completeness' of the data collection and analysis (p.23). This involves the researcher having skilled in-depth engagement with the topic, competence and skills (Yardley, 2000). Braun and Clarke (2006) outline a six-phase approach to TA, which enables the researcher to carry out an in-depth analysis of the data (see Section 3.9).

Braun and Clarke (2019) have also outlined the importance of the reflexive TA, which acknowledges the centrality of the researcher's subjectivity and reflexivity on the process of TA. In such a way, this highlights the importance of the researcher's in-depth engagement with the project.

3.9.3 Transparency and coherence

Transparency and coherence address the fit between the research question and the philosophical assumptions adopted, as well as the importance of the researcher's reflexivity (Yardley, 2000). Both these aspects are deemed central to a rigorous TA; Braun and Clarke (2006, 2018) highlight the importance of researchers being open and transparent about the theoretical, ontological and epistemological framework adopted within a TA research project (see Section 3.5 for a more detailed discussion). As discussed, reflexivity is central to TA and was ongoing throughout the research process.

3.9.4 Impact and importance

Finally, Yardley (2000) highlights the importance of research findings having theoretical, practical and cultural impact. As discussed in chapter one, AUP have wide-reaching social and economic effects. Therefore, the importance of research that seeks to improve and develop treatment for this client group is essential. The implications for the current study on clinical practice, policies and procedure and research are discussed further in Chapter Five.

Additionally, Braun and Clarke's (2006) 15-point checklist (Appendix 15) for a good thematic analysis was used to assess the validity and reliability of the current study.

Chapter Four: Analysis

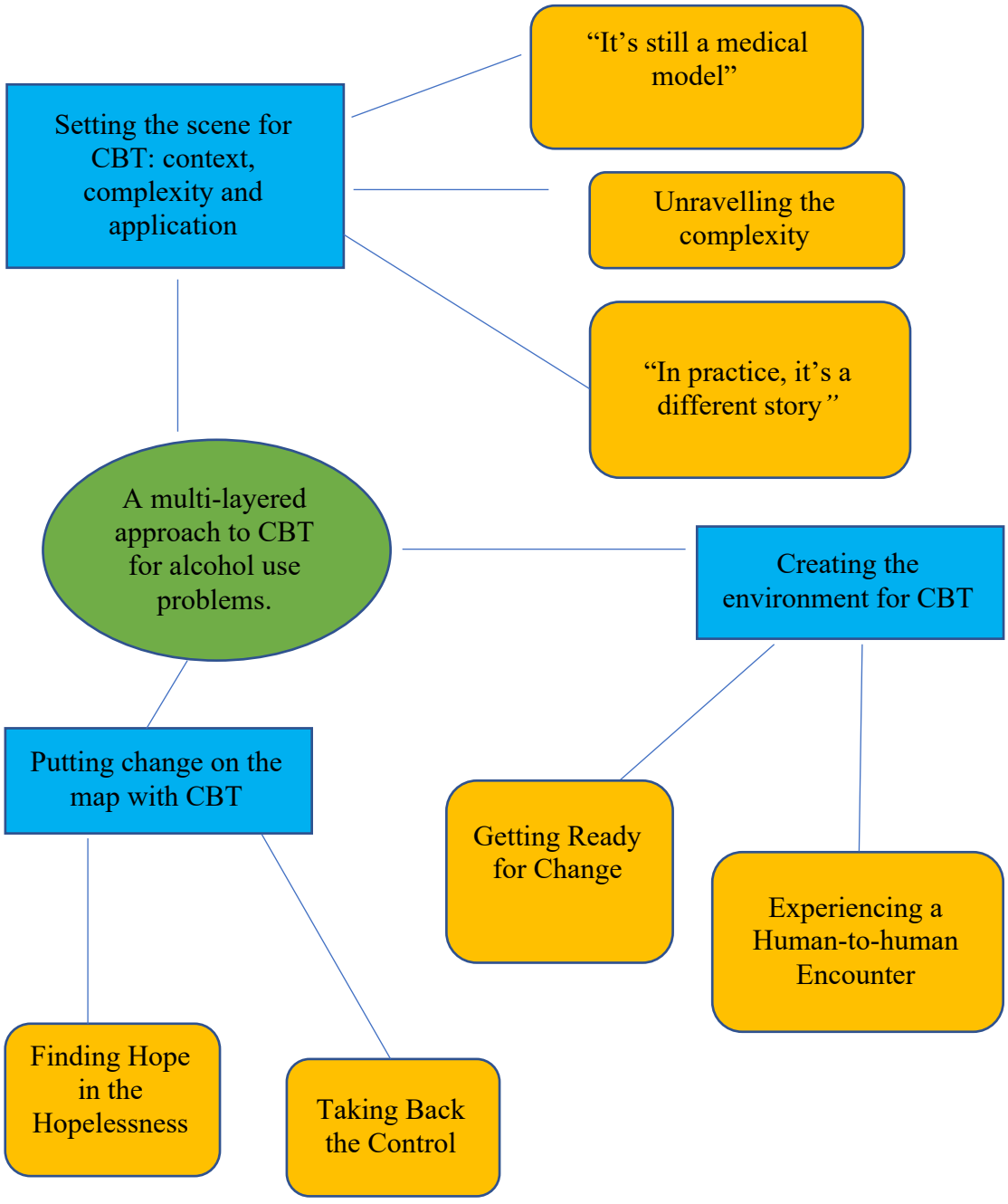
4.1 Introduction

This chapter will outline the themes that have been identified through the researcher's interpretation of the data using TA. The themes were repeatedly checked against the data to ensure the analysis was grounded in the data. Seven themes were identified through analysis of the data, and from the seven themes, three overarching themes, "Setting the scene for CBT: context, complexity and application"; "Creating an environment for CBT"; "Putting change on the map with CBT", were developed (see thematic map in Figure 1.). The seven themes identified are as follows: *"It's still a medical model"; Unravelling the Complexity*; "*In practice, it's a different story"; Getting Ready for Change*; *Experiencing a Human-to-human Encounter*; *Finding Hope in the Hopelessness*; *Taking Back the Control*. The overarching themes will be presented sequentially followed by their themes and illustrative data examples.

Pseudonyms are used throughout the analysis to protect participant confidentiality; all identifying information has been removed or changed where required. The ellipsis and square bracket […] have been used to indicate where original data has been omitted from a quotation.

Figure 1.

A Thematic map showing the themes developed from the data.



4.2 Overarching Theme One: Setting the scene for CBT: context, complexity and application

The first overarching theme was the most surprising to develop from the analysis. Although it was expected that contextual factors would be pertinent to treatment delivery, it was surprising how reportedly important this was to participants' CBT practice.

It soon became apparent that understanding the context of treatment delivery was an important place to start, as it formed the basis for how many of the participants practiced. The context influenced the duration of treatment, how participants were able to work with complex presentations, whether they used CBT in a structured or flexible format, and whether participants implemented evidence-based practice.

Therefore, due to the centrality of context in participants' accounts, it was essential to consider participants' experiences of using CBT to treat AUP in the context of broader social and political agendas to treatment. These are broken down into the three themes below.

4.2.1 Theme One: "It's still a medical model."

Participants' narratives captured the wrestle of providing CBT in alcohol services that were still predominantly embedded in a medical model approach to alcohol treatment. Consequently, participants described how this influenced which treatments were prioritised through funding and commissioning. For many participants, there was a

sense that psychological treatment was still inferior to medical approaches, which ultimately impacted how they were able to deliver CBT.

> "I still think that we're out of dark times, but I still think we are in a time where it's still basically a physical medical model and so much is around prescribing, and so much is around more recently around recovering, what that means social recovery but people are still missing that in order to get people there, there needs to be this psychological component and our best guess psychological component at the moment is a more cognitive understanding." (David, line 298-310)

The above illustration highlights the gaps that exist in alcohol treatment. David's use of the words "people are still missing" refers to the social construction of addiction that for many years, has been rooted in a medical understanding. Most participants viewed the medical approach to treatment as a necessary component, particularly for individuals who were dependent on alcohol and required medication to assist with detoxing or managing cravings.

However, some participants expressed the challenges in integrating these approaches. For example, Sally shared her challenges of working with clients who consume alcohol before their session due to medical advice about managing detox symptoms and how this often clashed with CBT that is focusing on challenging thoughts and changing their drinking behaviour. Sally captures the disjointed nature of treatment, where medical and psychological interventions are often pitted against each other (Khantizian & Albanese, 2013).

Similarly, in the above extract, David refers to the missing links that psychology and particularly CBT can provide. Likewise, Michael pointed out how "the whole discussion about CBT has been missing for years" (line 742-743). Both these examples reveal how a psychological perspective of AUP appears to be in the shadow of the dominant medical approach. Consequently, some participants perceived CBT to be misunderstood in how it could treat AUP.

Some of the participants acknowledged that the recovery approach had been an attempt to bridge the gap, to create a more inclusive treatment approach. Although, some participants felt the recovery approach had failed to deliver. For example, Andrew described it as "recovery lite" and stated that the recovery agenda had taken away from specialist services. Sally echoed this perspective as she described how the recovery agenda had been responsible for the "deskilling" of services, which had moved from employing specialist and qualified staff to employing 'unqualified' staff such as "key workers" or "recovery workers" to deliver psychosocial therapy, including CBT. From participants' narratives, it seemed that this was reflective of a system that is politicised and being driven by a medical framework to be "cost-effective" rather than creating a holistic approach to meet clients' "complex" needs.

Moreover, participants' narratives captured how the recovery approach was contradicted by the commissioning of services that was still established in a medicalised framework. Some participants expressed their frustrations of the current commissioning of services, where commissioners were more focused on "targets" and "outcomes" rather than the needs of the clients accessing services. Michael described how starting services with funding could "push certain clients away in order to increase their

outcomes" (line 1178-1180). Michael points out, when services base their treatment around funding and targets, they run the risk of becoming part of the problem by marginalising "certain clients" from accessing treatment.

> "[...]it is generally it is quite difficult to introduce psychological therapies in addiction, funnily enough. Because I think people think that the clients are not able to do it, that it costs quite a lot, it took us a while to have an in-house psychologist." (Michael, line 501-507)

Michael's use of the words "funnily enough" is in the context of his perceived paradox that psychological therapy is difficult to integrate into the treatment of addiction. Michael's experience not only points to the limited financial resources but the problematic perception that psychological therapy is a costly form of treatment. Although he does not explain his reasons for this, perhaps his previous words, "people think that clients are not able to do it" points to the observed perception that psychological therapies are not as "cost-effective" as medicalised interventions. Moreover, people with dependencies are somehow unable to 'do' therapy; this may reflect the common beliefs that clients do have not awareness or understanding of their change processes (Orford et al., 2006).

> "In terms of the funding, […] there will never be the funding for psychologists unless local commissioners specifically request that there is a psychologist on the team, which some commissioners do in some boroughs and some haven't so far been able to do." (Sally, line 823-830)

Likewise, Sally outlines the scale of the problem that psychological therapies in addiction services are faced with, where the implementation of psychological therapy is dependent on the commissioners themselves. However, some participants felt uncertain about whether commissioners had a comprehensive understanding of psychological processes that inform AUP. Accordingly, participants' narratives revealed the centrality of treatment adopting a broader conceptualisation of AUP.

Furthermore, participants' narratives also revealed how working in the current system with reduced investment had a high cost on the application of CBT as it meant that CBT was often short-term therapy (6-12 sessions), compared to previous "longer-term work". Consequently, participants echoed concerns that reduced interventions may not be adequately addressing the problems.

> "So, the reasons why people drank or started to drink or used alcohol or other drugs, you know those reasons might need therapy of their own and a) we're not funded to provide that and b) most people aren't skilled to identify it, let alone provide it."
>
> (Sally, line 904-911)

Sally shows how therapists are restricted to provide treatment in the most effective way, where CBT is tailored to fit the system rather than meets the needs of the individuals accessing treatment. Similarly, most participants' narratives revealed how therapy in alcohol services is welded to a medicalised and politicised system, which has the potential to marginalise a vulnerable population from receiving appropriate treatment to overcome their AUP.

4.2.2 Theme Two: Unravelling the Complexity

The complexity of working with AUP was widespread throughout all participants' narratives. Participants revealed the centrality of unravelling the complexity to "sort out what is a priority and what is maintaining what" (David, line 1251-1254). Most participants shared the view that CBT facilitated them to work across a range of different problems. Indeed, one participant described CBT as "a bridge that allows you to work across both problems" (David, line 542-544), which differs from current NICE guidelines that states treating alcohol use should be a primary intervention (NICE, 2011). However, all participants felt it was essential to not just focus on reducing the alcohol use but to help clients understand the problems that underpin it.

> "When you add CBT, you gain another layer because there is an understanding that of course, people are using substances for a reason […]. Those are now triggering anxiety, and the way that person has learnt to deal with it is a particular substance." (Michael, line 70-85)

In the above example, Michael illustrates the interrelated and multi-layered nature of clients' distress. He reveals how CBT can provide an alternative lens to the current medical approach, that seeks to treat clients according to the substance use problem. In using the words "you gain another layer", Michael reveals how CBT gives a deeper understanding of the processes that precipitate and maintain an individual's alcohol use. Likewise, all participants felt CBT helped them go beyond the surface of clients' alcohol use and provide a more in-depth understanding of the reasons why

clients use alcohol. However, most participants felt that the process of working with clients could be “complex”, “complicated” and “chaotic”.

> “[…] it took a good few months to work out those three components work, how they interacted with each other, and what we arrived at was that out of the three of them one would be shouting the loudest at any one point that’s how we kind of used it.” (June, line 1798-1805)

The above example illustrates how making sense of the interrelated nature of clients’ problems is not a simple process. Indeed, it seemed that to understand the connections between problems and how they interact was a process that took time, which was echoed by all participants. June described how this process often involved working through lapses, relapses and breaks from therapy before they were able to establish clear links that made sense to the client. For June, it appeared it was essential to have a flexible and individualised approach to CBT to facilitate this process, which stood in contrast to the way CBT is often provided in treatment services.

> “[…] she has a primary diagnosis of PTSD brought on by rape and secondary drinking because she is self-medicating. So, we had to break that link, and so we’ve been treating the PTSD first because the hypothesis is, if we treat the PTSD, the alcohol will clear up. Unfortunately, the trauma and her experience are so difficult to talk about she refused to talk about what happened to her, […] which maintain the problem and continued on drinking […] So, rather than doing memory focused work which is predicted by the Ells and Clark cognitive model, we went to do more stabilisation work […] and now she’s more able to

> cope with some of her symptoms, she's reducing her drinking […]." [David, line 632-666]

Similarly, David identifies the complex process of unravelling different aspects of clients' problems. In this example, David shows the importance of therapists having a range of skills and interventions to tailor treatment to the individual rather than strictly following a CBT model. This perspective was shared in other participants narratives, as they described the intricate process of unravelling the multiple layers of clients' distress.

Although the importance of unravelling the complexity of clients' problems was widespread throughout participants' narratives, unsurprisingly, most participants felt the current service provision restricted their ability to work in this manner. Consequently, many participants felt they were not permitted to work with clients' underlying problems, but rather their role was to "treat" the alcohol use. This perspective captures a system that is still caught in a medical framework to treatment that seeks to separate and treat clients according to diagnosis (Orlans & Van Scoyoc, 2009), rather than seeing clients' AUP in its entirety.

> "There is also the issue of, well, overlapping with mental health services. The more psychology you use, the less other services will accept your clients. There is quite a lot of especially in terms of in times of poor funding." (Michael, line 508-513)

Similarly, Michael illustrates the age-old story of dual diagnosis that often treats alcohol use and mental health problems separately. Michael recognises how the push-and-pull across services can limit therapists' capacity to offer appropriate therapy that addresses the complexity of the individual's needs. Likewise, Sally captured the wrestle with service provision by describing it as a "chicken and egg situation" (line 1715). The impact of the "chicken and egg situation" was echoed by most participants, who talked about the battle of care between substance use services and mental health services, which ultimately results in many clients' "falling through the gaps" of service provision, unable to address the interrelated nature of their problems.

> "If you think the one thing that has been keeping them well in far as they can tell you and imagine symptoms of trauma is you know you are asking them to take that away, and that is quite a big ask and then this hole, what are they left with?" (Mark, line 1088-1094)

> "what do they do with their feelings when they are sober, and the mental health team still won't see them for three months." (Sally, line 471-474)

The above extracts capture the challenges in clients' problems being treated separately. Mark and Sally emphasise the perceived misunderstanding that mental health services have of AUP; rather than viewing alcohol use as a coping mechanism, they see it as a separate problem to be "controlled" and "managed" before treatment. This perspective is reflective of the current system that seeks to control alcohol use (NICE, 2011). Nonetheless, these challenges point towards a system that is set up to fail clients with substance use problems by not equipping them with the right tools and thus

keeping clients in this unhelpful repetitive cycle. This situation is distinct from the earlier examples that show the intricate process of understanding the complexity of clients' problems and unravelling how the different components interact, which ultimately helps them learn to manage their alcohol use.

4.2.3 Theme Three: "In practice, it's a different story."

When talking about delivering CBT, all participants shared the importance of evidence-based practice while acknowledging that there were often challenges in strictly adhering to an evidence-based approach. It seemed that participants were often holding the tensions between the need for evidenced-based therapy, that offers some guidance and structure to anchor their work, assuring them they were intervening in the right way, and asserting their clinical judgement and experience by being flexible to meet their clients' needs. For example, when talking about using theory and models to guide practice, June often said, "if I was a good CBT therapist then perhaps, I should be..." (line 121-123), which could be suggestive of the internal tensions between applying theory and the reality of working with clients in practice.

> "[…] Unfortunately for me, I suppose maybe it's my caseload and so on, but it does it feel almost like in theory you know, but in practice, it's a different story." (Mark, line 614-618)

Mark uses the words "in practice, it's a different story" to capture the disconnection between theory and practice. Mark further described how in practice CBT was not "textbook" which gave the sense that CBT practice was often more complex than the literature may suggest. As such, most participants revealed the value of relying

on practice-based evidence to determine what may work best, rather than solely relying on the current evidence-based. Likewise, Mary also described the challenges in a strictly evidence-based approach, as she described using a purest approach with 'less than a handful of people' (line, 459-460) over her career. She described how clients often struggled to engage with aspects of CBT like thought records and diaries and consequently, she has 'stopped using them' (line, 481-482).

The challenges in a strictly adopting a "purest" or "model-specific" approach were echoed through all participants' experiences, especially when working with co-morbidity, which seemed to require a flexible and integrative approach.

> "And I, to be honest, I make it up slightly as I go along because there isn't a validated model that incorporates both of them." (June, line 141-144)

In this statement, June illustrates how the current evidence-base has failed to acknowledge the interrelated nature of addiction and mental health problems. Consequently, June reveals how she relies on her clinical judgement to determine how best to work with clients' multiple needs. However, participants' narratives showed that just because the evidence-base wasn't there to support an integrative approach did not mean it was not useful for clinical practice (Davis et al., 2018).

> "I believe that you can treat both at the same time and I've got plenty of evidence, anecdotal and my own clinic level has proved that." (David, line 526-527)

Indeed, this seemed to suggest that delivering CBT is a complex process that requires therapists to integrate, evidence, clinical judgment and clients' needs (Blair, 2010; Pagoto et al., 2007). However, the tension between evidence-based practice and practice-based evidence appeared to be reflective of how alcohol treatment is still influenced by a medical approach that seeks to treat alcohol as an isolated problem (Khantzian & Albanese, 2013).

Surprisingly, the evidence for CBT and alcohol use was often described as "okay", "isn't that great" and "outdated" which captured participants' perceived weakness of the current evidence-base to support therapeutic practice.

> "It is outdated, and some people use it and some people that don't, there's hybrids out there. When you look at other disorders […] when you look at CBT therapists delivering panic-based interventions, I'm sure pretty much nationally now the rigour that's gone behind IAPT, the majority of people will be delivering David Clark's model and the systematic interventions that fit with that. That same cohesion is not happening in addiction services." (David line 242-256)

In the above example, David makes a stark comparison as he captures how addiction treatment is often lagging behind mental health treatment through limited investment. This could be reflective of how addiction treatment is still embedded in a medical model approach which favours medical-based interventions. Consequently, David felt treatment was "piecemeal" with multiple models influencing treatment delivery and making consistent evidence-based practice difficult. David identified the

need for a "good model", where interventions are delivered in accordance with that model.

> "When you contacted me, I was thinking crikey do I really know the CBT models? And maybe that is just the sign of the weakness in our own research on doing clinical trials. You know, what is our CBT?" (Andrew, line 959-964)

Likewise, Andrew's use of the words, "what is our CBT?", captures how no model guides practice which possibly points to a broader problem within the field where CBT has struggled to establish its own identity against the dominant medical model. Moreover, Andrew's question "do I really know the CBT models?" could be reflective of how CBT has struggled to establish a strong evidence-based in showing how CBT works in the treatment of AUP (Magill & Ray, 2009).

> "There is a block and a bias in how research is done because it is very difficult to a) getting addictions clients, doing therapy with addictions clients and proving it works, and the other thing is there is so many different types of addiction or substances that it makes it difficult to do a good RCT...." (David, line 1416-1423)

> "[…] it's difficult to research though because you know it's hard to isolate the alcohol, […] so it's difficult to represent it in more scientific form to evidence it." (Mark, line 1118-1124)

> "people with other problems that make it hard to do, get on a roll with CBT, and you've diverted. Anyway, and obviously those people don't enter research trials where you get enough of the outcomes." (June, line 1573-1578)

The debates of evidence-based practice are widespread in the psychotherapy field (Corrie, 2010); however, the above examples reveal some of the challenges of researching alcohol use as an isolated phenomenon, separate from the complexity and reality of everyday clinical practice. However, participants' narratives seemed to indicate that there needed to be a change in how therapies for AUP are evidenced and ultimately, how this translates into practice.

4.3 Overarching Theme Two: Creating the environment for CBT

Participants' narratives captured the importance of creating an environment for CBT to be most effective. Throughout the interview process participants frequently spoke about the importance of a client's readiness to change and developing a therapeutic relationship as vital aspects of their CBT practice.

Although both readiness to change and the therapeutic relationship are well-established concepts in addiction and the general psychotherapy field, the value of these factors to participants CBT practice evoked a powerful sense that the effectiveness to CBT was more than a set of interventions or techniques. Instead, it seemed it was essential for participants to create a therapeutic environment that encourages growth, and thus begins the process of facilitating change and setting the foundations with CBT to bring about change.

4.3.1 Theme Four: Getting Ready for Change

Participants' narratives revealed the importance of a client's readiness to change for CBT to be effective in bringing about change in the client's life. Sally captured the centrality of readiness by describing how clients must "need to" or "want to" change their alcohol use. It appeared that without readiness "CBT isn't very useful" (Sally line 65) because clients are unable to engage in the process of making changes to their alcohol use and other aspects of their lives. Likewise, June described how using CBT when a client is ambivalent was like "flogging a dead horse" (line 1271), which gave a vivid sense of how difficult and pointless CBT is without a client's readiness to engage with change.

Although participants' narratives revealed how readiness was primarily the client's responsibility, all participants felt preparing a client for change – often through using MI, was a vital aspect of the therapeutic practice.

> "Other approaches can help to prepare someone to begin their CBT for alcohol. I think motivational interviewing is another way to work with that, leading up to that point where they are ready to really address the changes. I think once you are there and they are still with you then I think it could be really useful." (Mark, line 1095-1104)

In the above example, Mark paints a picture of the gradual process of preparing a client for change to occur, which gives the sense that preparation for change may not be a quick or easy process. However, it also seems to suggest the importance of then switching approach and working with change once clients are indeed ready, which is

when CBT was perceived to be most effective. It could be understood that CBT is more effective at a later stage in a client's recovery journey, where CBT surpasses MI by working on changing behaviours when the client is in the action stage of the cycle of change, rather than at the early pre-contemplation and contemplation stages (Norcross, Krebs and Prochaska, 2011).

Most participants described motivation to change as vital to a client's readiness to change that was fluid and continually shifting. Given the changing nature of motivation, a few participants felt it was important to "catch" clients at the point of motivation to engage in CBT. This perspective seemed contrary to clients going through the system and missing the opportunity to engage with treatment.

> "[. . .] the tricky thing is that when you are working in services with like you know, five-month waiting lists to see people for one-to-one support, maybe their marriage has broken down, they're struggling to access the right housing support, you know? Their motivation is gone by the time they come into treatment." (Andrew, line 324-332)

Andrew uncovers how precious it is to provide treatment at the right point of motivation. In the above example, he illustrates how services have a small window of opportunity to catch clients, but more often, the system can indeed be wasteful and miss the opportunities to help clients. Andrew described how it was too easy for services to blame clients for "not being ready" rather than acknowledge the centrality of service provision in engaging clients when they are ready and motivated. This perspective was

shared by other participants who described how ‘services maintain people’s inability to change’ (David, line 1317-1318).

Moreover, clients’ reasons for accessing treatment were often described as a crucial aspect of motivation and readiness to change. For many participants, their clients were not accessing treatment out of choice. For example, probation, securing housing, accessing mental health treatment, relationships, childcare, or accessing detox were named as some of the reasons why clients would seek treatment from alcohol services.

> “[…] some people are literally not entering the service for any substance [treatment] by choice, in which case they’re not even thinking about initiating change.” (Sally, line 219-223)

This example shows how understanding the client’s reasons for accessing treatment helps to identify their underlying motivation for change because if they are not there out of choice, then change may not be on their agenda. Moreover, if change is not on the agenda, then they were often not considered ready to engage with CBT. For example, Sally described how “making inroads in the session can be very hard” (line 1363-1364) if they are not ready for change. Likewise, other participants experienced CBT to be challenging if a client was not accessing treatment out of their own choice and had no desire to change their alcohol use.

Some participants frequently described the importance of clients taking responsibility for their alcohol use problem and their recovery. From participants’ narratives, it seemed there was a reciprocal link between a client’s readiness and taking

responsibility. Readiness was viewed as the initial stage of a client's change process, but part of a client's readiness included being able to take responsibility, which begins with acknowledging and admitting that there is an alcohol problem.

> "Once they're saying, yes, I've got a problem, yes, I'd like to do something about it, let's start trying, then, of course, CBT can be used." (Sally, line 83-87)

This extract illustrates the importance of clients taking responsibility for their alcohol problem by first acknowledging there is a problem and then acknowledging they would like to "do something about it". From this extract, it could be considered that without this sense of ownership and responsibility, a client may struggle to be ready to make changes to their alcohol use problem. Therefore, it may be that holding responsibility for the problem is an integral part of readiness to change. Sally seems to suggest that once a client is fully acknowledging and taking responsibility for the problem, "I'd like to do something about it", then CBT can begin to be effective. All participants shared this perspective as they frequently referred to the importance of clients taking ownership of their alcohol problem throughout the therapeutic process.

Despite the importance of clients taking ownership, participants often described challenges that would hinder clients from taking responsibility.

> "People come to the therapy to talking therapy thinking you are going to fix them, and I am like, "no sorry it doesn't work like that, you've got to do the work", and they are like, "what" and I'm like, "yeah, you do."" (June, line 720-725).

The above quotation illustrates the difficulties that clients may have in taking responsibility for the change process. In this example, June shows how clients continually seek external fixes rather than taking responsibility for the changes they need to make. June describes how clients often look to their therapist to provide the "fix" and give them the answers. In this example, June shows the importance of setting a client's expectations and helping them to take responsibility for change at the start of CBT. Most participants shared similar experiences of client's placing responsibility on them for the "fix".

> "You give them a mood diary, or you give them something to go away and say we can come back and look at it and they don't do it, but they still want you to fix them in some sense." (Clive, line 180-185)

In this extract, Clive demonstrates the challenges of delivering CBT when a client is not ready to take responsibility for their problems. In Clive's description, he shows how clients who are not ready to take responsibility for the change can go through the motions of CBT without engaging fully with the process. Although some participants shared a sense of responsibility in helping clients to "work" or gain "clarity", nearly all described how changing the alcohol use problem was fundamentally the client's responsibility.

> "I've got a few clients have been referred they are looking for CBT because they're looking for that quick fix. That's what they see CBT is a quick fix, I

wave my magic wand, and do A, B and C, and you'll be all right, but sometimes it's a process with CBT to understand it." (Clive, line 168- 175)

The above quotation highlights how clients can perceive treatment as a "quick fix". Clive's use of the words "I wave my magic wand", not only reinforces how clients expect the therapist to fix them, but how they want it to be quick without anticipating they will have to be actively involved in making a change. However, for CBT to be effective, participants described how clients needed to be "committed" to change and "prepared to work on themselves".

4.3.2 Theme Five: Experiencing a Human-to-human Encounter.

Participants' narratives uncovered the importance of **e**stablishing a therapeutic relationship - where there is a genuine connection and experience of the other. Nearly all participants described the therapeutic relationship as being "foundational", "crucial", and a "vehicle for change" in CBT. The therapeutic relationship is well established in general psychotherapy literature, yet, within the addictions field, the centrality of the therapeutic relationship has been given limited focus within the literature. Likewise, a few participants echoed this perspective as they felt the importance of the therapeutic relationship was the missing component of CBT practice for addictions.

However, participants' narratives captured the sense that participants' CBT practice was a unique and individual process that involved looking beyond the alcohol symptoms to know and understand the individual's experience. This stance appeared to be a profoundly relational and authentic encounter which appeared to be the cornerstone to future therapeutic interventions. This approach to therapeutic practice appeared to

contrast the descriptions many participants had shared about working in settings that provided limited, symptom-focused CBT. However, the centrality of establishing a therapeutic relationship seemed a vital aspect of many participants work, especially as many clients enter therapy with past painful and traumatic relational experiences.

> "I think it has to be emotionally meaningful and I think again this is just anecdotal my experience of working with clients here is that because of people's backgrounds, quite complex trauma histories, abusive childhoods and so on and I think that makes people very sensitive to anything that doesn't appear fully genuine." (Mark, line 917-927)

Mark's use of the words "emotionally meaningful" evoke the sense that CBT is not just about delivering a set of interventions, but instead it was about having an authentic human-to-human encounter, which is counter to many clients' previous relational experiences. Indeed, Mark felt the relationship had the potential to be a healing intervention itself (Cuijpers et al., 2019). Conversely, a couple of participants felt that CBT did not offer a deep relational experience like other therapeutic approaches. This view could be reflective of the current system that is established in a medical framework that advocates a structured symptom-focused approach to CBT practice.

Furthermore, Mark goes on to describe how clients are "sensitive to anything that does not appear fully genuine", which captures a sense of clients' fragility and vulnerability at the beginning of therapy. Similarly, June described the importance of clients being able to trust their therapist as they had often been let down by past

relationships and previous treatment. Therefore, June felt it was essential for therapists to be "credible" to clients by being themselves rather than having a professional façade. From participants' narrative, it appeared that it was essential for CBT to be established within Rogers (1957) core conditions: empathy, congruence and unconditional positive regard; to facilitate and establish a safe and trusting environment in which CBT interventions can be utilised.

> "You could be the best therapist in the world, you could quote chapter and verse protocols and I could without even looking I could draw you full PTSD model what have you, but if you are not warm as a human being then […] there's no way I would tell you anything." (June, line 1644- 1667)

The above extract illustrates the value of therapists having relational qualities such as warmth and genuineness (Rogers, 1957) at the foundation of their work. Although having a sound theoretical understanding of CBT is vital to therapeutic practice, the above extract identifies how theory alone is not enough, CBT must start with a genuine human connection to establish trust.

> "I think because this human contact there and kindness and compassion, I think that it makes people feel valued that I made the effort to walk down the road with them, not just sit in a room with them." (Mary, line 402-407)

In the above example, Mary use of the words "makes people feel valued" reveals how a genuine human connection can be an emotionally transformative experience. Mary highlights the importance of therapists not just being professional but being

human through genuine “kindness and compassion”, this sentiment was frequently shared by most participants.

Unsurprisingly, all participants felt that establishing a collaborative relationship was a crucial part of working relationally within CBT. Nevertheless, most participants’ narratives revealed that establishing a therapeutic relationship appeared to be more than merely working collaboratively. One participant captured this as he described the relationship as giving “meaning” to CBT, which gave the sense that the relationship was the foundation of CBT that gives purpose and direction to CBT interventions.

> “The relationship is one of the most important things. I don’t think you can do CBT unless you start building that relationship, cos they are not going to be able to do the work.” (Clive, line 1002-1007)

Clive’s use of the words “building that relationship” illustrates how the relationship cannot be assumed as a given, but rather it is actively developed and co-constructed between therapist and client, which seemed contrary to the medical approach to alcohol treatment that sees the professional “treating” the individual. Furthermore, Clive uses the words “one of the most important things” to reinforce how integral the therapeutic relationship is to CBT practice.

Likewise, a few participants felt a genuine relationship was essential to creating an environment for clients to “learn” CBT tools. From participants’ narratives, it seemed that without a relational connection, CBT tools had the potential to become “academic”, “punishing” or a “stick with which to beat themselves with” (Mark, line

256-257), particularly if they have experienced a lot of "invalidating experiences" or abuse. Similarly, June described how CBT could expose a client's vulnerability. Therefore, it appeared that establishing a genuine connection was crucial in facilitating a safe environment for clients to feel free to explore their difficulties and start testing out whether change is possible.

Moreover, participants' narratives illustrate how CBT cannot just rely on interventions alone, which shifts away from a medical perspective that seeks to treat a set of symptoms. However, Clive remarked on how therapists often forget the value and importance of developing a relationship before using CBT interventions, which indicates that the therapeutic relationship may not always be deemed as an essential aspect of CBT practice and, moreover, how alcohol treatment is still rooted in the medical model.

4.4 Overarching Theme Three: Putting change on the map.

The final overarching theme explores participants' narratives about how CBT facilitates change in clients. The complexity of addictions often meant that addictions were viewed as "difficult to change" and participants' narratives often acknowledged that change was not "easy," "comfortable" or "straightforward". Nevertheless, all participants felt CBT had the potential to bring about change in their clients' lives.

Despite the challenges of service provision and complex presentations, it was exciting to see how participants felt CBT helped bring change to clients' lives. Participants' experiences demonstrated how CBT builds clients up by explicitly showing them change is indeed possible. As David said, "CBT with a therapist allows

people to just put that on the agenda, to bring it to people's mind" (line, 495-498). Analysis of the data identified two themes concerning change: Finding Hope in the Hopelessness and Taking Back the Control.

4.4.1 Theme Six: Finding Hope in the Hopelessness.

Throughout the data, participants often portrayed their clients in a state of hopelessness; battling with the despair about changing their addiction. Hopelessness was often attributed to clients' experiences of rejection (personally and by service provision) and previous "failed attempts" to change their alcohol use. Consequently, change was frequently described as a "difficult process" where addiction was described as "difficult to beat" or alcohol use as "difficult to change". However, all participants felt that CBT could offer clients hope that change is possible.

Indeed, most participants felt they had a responsibility to bring hope to their clients; some participants felt they had to hold hope for change when their clients could not, and most participants described having an active role by "teaching", "showing" or "facilitating" them through the "process".

> "It is you trying to instil hope and encouragement and building a kind of positive sense of self, and so often self-esteem is so very low in addictions. It would be quite nice to have some level of belief in their self-efficacy in order for them to really engage in CBT because people will give up very easily." (Mark, line 399-408)

For Mark, hope and belief in change is a necessary condition for clients' engagement with CBT and for change to occur, as he says: "people will give up easily." Similarly, David felt clients needed to know that change is possible.

> "People need to know that they can be changed, and CBT can offer that hope. Even though they may not know it at the time or believe it, the model still shows them that it is possible, and I think that is important for some people." (David, line 382-388)

Moreover, David explicitly suggests that CBT can provide clients with the hope that change can occur. David's narrative often referred to CBT as putting "change on the agenda" by showing clients exactly what needs to change and how they need to change. This view was shared in other participants' narratives, as they felt CBT helped clients to develop an insight and understanding of their problems and actively experience change.

All participants felt CBT helped clients to develop a greater understanding of their problems which increased their sense of hope for change. Gaining insight seemed to give clients a rationale for their alcohol use by identifying the underlying triggers like relationship stressors, mental health problems and employment difficulties. David felt CBT helped give clients a language to explain and make sense of their problems. Furthermore, gaining understanding helped clients identify changes to be made, thus giving them hope that change is possible. Developing insight seemed particularly crucial as clients were often described as "lacking understanding" and "insight" into the reasons why they use alcohol and the severity of their AUP.

> "They will come and go, "I don't know what's wrong with me", and actually I've got to give them, show them some clarity, that it is a process here, and they are not mad." (Clive, line 1031-1035)

Clive illustrates how clients have limited understanding of their alcohol use as they see the problem as internal to themselves rather than a coping response. Clive identifies his active role in helping show clients the underlying processes taking place. Showing clients they "are not mad" and that there is a process, seemed to offer hope that the problem can be changed.

Moreover, it seemed that gaining understanding provided clients with a reason for hope, which appeared to facilitate change in clients' emotional response to their problems.

> "[…] the process of keeping the diary I find raises people's awareness of their drinking, and it starts to create a bit of a gap between them and their use of alcohol and so it shifts slightly from one more sort of subjective relationship with alcohol to a more objective stance" (Mark, Line 115-123).

The use of the word "subjective" captures how clients can have an emotive relationship with their alcohol use. Mark illustrates how through CBT, clients build awareness and consequently may shift from a "subjective" to a "more objective stance" or "balanced" perspective, allowing them to see that change is possible.

> "It is some kind of clarification or some kind of understanding about what's actually, going on. So, for clients who just feel that this is a bit of a mess, or this is something they have no control over or just something that happened they just have to do it, "I just have to drink", "I just have to use", it slows down a process and shows that it is a process that there are other things going on and gives people some hope and optimism that they can actually intervene." (Mary, line 152-165)

Likewise, Mary shows how CBT helps clients develop hope about change as they gain clarity into the reasons why they use alcohol and consequently regain control of the problem, rather than feeling they have no choice but to drink alcohol. All participants felt CBT formulations were a vital intervention which increased clients' hope by developing insight about the underlying processes maintaining the alcohol problems.

Furthermore, most participants felt therapy for this client group had to be active rather than "just talking about our problems" (Sally, line 566), which seemed to fuel clients' hopelessness, as Andrew said, "it can fuel the poor Me's" (line 948). In contrast, CBT offers an experiential process that focuses on the problems in the here-and-now, thus helping clients to "brave that learned helplessness" (Andrew line, 952). Participants felt that CBT was an active approach that allowed them to test and experience change, thus giving them hope for further change.

> "CBT allows you to not only understand that but also then to target an intervention to break that chain of deadlocked events." (David, line 1254-1258)

Through using the words “deadlocked events”, David captures clients’ sense of hopelessness, where problems often feel stuck. In contrast, David feels that CBT shows clients how to “break that chain” by directly addressing the problem with specific interventions.

> “CBT can be really good at giving you a sense of self-efficacy, like a behavioural experiment you made a plan and you see it through, and it works out, and then you feel good about yourself, and it gives you some motivation to do a bit more.” (Mark line, 605-612)

Interestingly, Mark shows how experiencing change can increase self-efficacy and engagement with CBT, as it allows clients to experience an alternative way of behaving and gain motivation. Likewise, most participants felt that CBT helped build confidence and self-efficacy through experiencing gradual changes.

Surprisingly, a few participants spoke about the use of behavioural activation (BA) as an essential intervention in “kickstarting change”. BA is most often associated with depression as it helps clients counter their avoidance and withdrawal by building their activity levels and increasing pleasurable activities (Jacobson, Martell & Dimidjian, 2006). In the same way, BA for addictions seemed to help clients to look beyond their alcohol use and experience pleasure other than alcohol.

> “When you do that BA stuff, they will start discovering other enjoyable things.” (Andrew line 142-144)

Andrew described how helping clients increase their activities outside of alcohol helped them to reconnect to other aspects of life. Likewise, other participants shared Andrew's sentiment as they felt BA helped clients to evaluate their day-to-day lives and also helped clients find meaning. Therefore, participants seem to suggest that CBT can expand a client's experience and give them hope of an existence where they are not dependent on alcohol.

Although CBT seemed to offer clients hope, interestingly, some participants shared the challenges they experienced in holding hope for change in their clients. In reality, participants often experienced the complexity of delivering CBT in addiction services with complex presentations and a challenging working environment. Clive captured these challenges as he described how therapists needed to be prepared for CBT not to work. Moreover, the challenges of working in addictions were often echoed in participants descriptions of "revolving door clients", and the inevitability of clients relapsing, which possibly indicates the constant cycle of addiction that is difficult to penetrate. Therefore, participants' narratives often gave the sense that they were holding the tensions of having hope and the reality of changing an addiction.

4.4.2 Theme Seven: Taking Back the Control

Participants' narratives revealed how many clients with AUP became consumed by their addiction. As Mark so clearly described: "they've come to rely on that as a way to regulate their emotions" (Mark, line 780-781), which indicates both the physical and emotional dependency that clients may have on their alcohol use. Participants often portrayed a sense of clients' disconnection from themselves and the world around them.

This theme continued to build on the previous theme as it captured how increasing hope helped clients to start gaining control. Mary captured this as she described how clients enter therapy having "no control" over their problems but how showing clients the process gave the "hope and optimism that they can actually intervene" (line 164-165). Participants' narratives revealed how CBT empowers clients to have more choice and autonomy about their alcohol use, as well as to equip them to manage life's challenges.

Unsurprisingly, changing alcohol use, whether that be controlling their drinking or becoming abstinent, was the primary way that participants felt clients took back control of their lives. Although change was often viewed as a dynamic process, changes to alcohol use were often viewed as a catalyst for clients to make further changes, such as relationships, employment, and developing a more extensive social network.

One key aspect of changing alcohol use centred around clients learning to manage their cravings, which for many participants, was just as much a psychological aspect as it was a medical one. June described the importance of helping clients to recognise their cravings and gain more control over their response to a craving, which involved three key steps: normalising the craving, recognising the craving and having a plan B.

> "I think a greater sense of control particularly in managing cravings and because of that people start to feel good about themselves, it helps with self-esteem, self-efficacy and then because of that people's worlds are opened up a bit more, and they start to see possibilities, employment, education and relationships, so things can start to look a lot more hopeful." (Mark, line 695-705)

In the above example, Mark illustrates how hope and control are potentially linked, as he shows how hope moves beyond a cognitive or emotional attitude by behavioural change which provides small bits of experiential evidence that change is possible. This example shows how CBT is particularly good at small experiential change as "people's worlds are opened up a bit more". Mark's use of the words "a bit more" emphasises how changes may be seemingly small, but it is enough to be a catalyst for further change.

However, change was not just limited to alcohol-specific processes; all participants shared the sentiment that cognitive restructuring, such as alcohol-specific beliefs, negative thoughts, or core beliefs, were an essential part of regaining control.

> "He's now able to pause in between thoughts and behaviour, and he is able to actually spot the thought as it arrives, and he decides whether it is warranted or not. So, this has increased the quality of his life. He's able to maintain a family […], and he is able to return to work because he was known as an extremely angry person, shouting all the time and difficult to be around with. Now he tells me people seem surprised by how calm he is." (Michael, line 653- 667)

Michael illustrates how CBT helps clients to create a distance between their thoughts and actions by learning to "pause", which consequently gives clients the control and choice over their behaviours.

> "It really helped her recognise her schemas, where they came from, never being good enough, always trying to maintain that and how that is a trigger for her relapsing. And now she's made those adjustments in her beliefs, more flexible rules […]." (Andrew 167-line 174)

Similarly, Andrew illustrates the links between unhelpful schemas and relapsing. It seemed that adjusting beliefs may help clients gain more control over potential triggers. Both Andrew and Michael show how changing the way a client thinks or what they believe (about themselves, others and alcohol) can potentially change the way clients live their lives.

The above extract from Michael also shows how CBT may help clients to manage their emotions. Participants often spoke about their clients experiencing emotional dysregulation, where emotions were either heightened or disconnected. As previously discussed, alcohol use was seen as a "coping mechanism" or a "crutch" to manage underlying distress. An inability to cope with distress was often thought to be a trigger for relapsing or for clients to remain stuck in their alcohol use. Therefore, CBT seemed to help clients learn to tolerate their distress by developing new coping strategies to manage relapses.

> "I remember a client had walked into a pub, really had difficulty, and then he had gone to write it down, and he had identified it was a sense of loneliness […]. He was lucky on that occasion cos he realised and got himself out of there, […] he could see how he walked himself down there and see how his feelings contributed to it, that he hadn't acknowledged." (Clive, line 869-889)

In this example, Clive shows how CBT helps a client to identify and tolerate painful emotions on the brink of a relapse. Therefore, learning to accept painful emotions rather than avoiding seemed to be essential in helping clients to prevent relapse and have more conscious control over their behaviours.

> "CBT is more of an acceptance that giving up alcohol isn't going to make all other life's problems go away, so more of an acceptance and more realism. Accepting that it would be lovely, but it's illogical to expect that everything would be better sober and in fact, some things might be harder to bear." (Sally line 114- 1126)

Similarly, Sally highlights the importance of creating acceptance to helps clients cope with 'life's problems. Likewise, all participants felt to regain control, clients needed to be realistic about the challenges of life without alcohol. Otherwise, there was a sense that clients would be "pulled back" into alcohol use. For many participants, CBT seemed to equip clients by developing "life skills" and new coping strategies, which gives them an alternative to their alcohol use.

> "If you sell CBT to them as teaching you something that you take away from here that you've got for the rest of your life, then you are giving them something that if they really get it, they can use to re-anchor themselves. It does it anchors you." (June, line 1618-1625)

June use of the word “anchor” evokes the sense that CBT helps root and support a client by equipping them with lifelong tools. This view was often shared amongst participants who felt CBT equipped clients with tools that they could continue to use beyond therapy, resourcing them to manage triggers and relapses. However, a few participants felt it could be challenging for clients to utilise those tools during difficulties or even to remember to utilise them when close to relapse.

A few participants also noted the personal changes that clients made during CBT. June felt identifying change was not always measurable and could be hard to capture; which points towards the intricacies of change that are more pertinent to a client’s inner world and goes beyond a reductionist diagnostic paradigm (Orlans & Scoyoc, 2009).

> “It’s not ones I’ve recorded; it’s noticing the funny little things. It’s the fact that she is putting on a bit of weight and she’s kept that weight on and she dresses differently, and she has a different hairstyle and these things you notice as a woman to woman, I don’t know I’ve noticed them.” (June, line 1734-1741)

June captures the changes to the client’s inner world, which are reflected by changes in her outward appearance. In this example, it shows a client becoming more in touch with her needs. As June said, “she’s becoming more her own person; this is who she wants to be” (line 1746-1748). June went on to explain how her client had consequently broken free from an abusive relationship. This example pinpoints how CBT can help clients to identify and value their own needs.

Similarly, Clive felt that once clients understood the connections between their thoughts and actions, they could then say, “okay that’s why we drink. So, if I challenge this thought process, maybe I won’t drink and damage myself as much” (Clive, line 942-945). Both these accounts provide a compelling picture of how CBT facilitates clients to experience a deeper connection with themselves and the world around them and ultimately have more autonomy over their lives.

4.5 Change Pathways

It was anticipated that the analysis of the data would inform a change pathway map by showing how CBT is helpful. During the initial coding process, specific aspects of CBT were identified as being helpful and unhelpful and were coded under ‘techniques and practice’. These aspects were collated in a table to identify specific aspects of how CBT could be helpful or unhelpful (see Table 2). The table shows how some aspects were perceived as both helpful and unhelpful; for example, formulations were often considered helpful, but therapists also acknowledged that for some individuals, they could be unhelpful. For this purpose, formulations have been included in both categories.

Furthermore, the themes above have identified how participants experienced CBT to help facilitate change in their clients (see Figure 2). As the current research is based on eight therapists’ narratives, these potential pathways are not identified as absolutes, but instead, they have been identified as being vital areas that were most relevant for these eight therapists’ experiences when working with this client group. It is hoped that this pathway may be helpful for other therapists to consider when working

with clients experiencing AUP. It is acknowledged that many factors can lead to change, which are not included in this process map.

Perhaps the most surprising finding is the multi-layered approach that participants took to CBT for alcohol use (see Figure 3), to incorporate the complexity of clients' problems and the social and political framework in which treatment is situated. These findings may point to the importance of CBT situating itself in a transdiagnostic approach to therapy for clients with AUP. Further implications for these findings will be discussed in the following chapter.

Table 2

Helpful and unhelpful aspects of CBT from participants' experiences

Helpful aspects	**Unhelpful aspects**
Therapist Activities	**CBT interventions**
Relational Skills	Formulations (5)
Listening (5)	Homework (6)
Empathising (4)	Focusing on cravings (3)
Genuineness (4)	
Collaborative (8)	
Being flexible(8)	
Being facilitative (4)	
Teaching the client (4)	
CBT Framework	**Challenges to CBT**
Assessment and formulation (6)	Client ideas about change (5)
Goal setting (6)	Relapsing (5)
Setting homework (5)	Working with emotions (3)
Setting the agenda (4)	Working cognitively (4)
Checking understanding at the end (2)	Understanding the CBT model (3)

	Getting on board with the model (3) Developing a therapeutic relationship (1)
CBT Interventions	**Other aspects**
Alcohol Specific interventions	Just talking (4)
Challenging alcohol beliefs (8) Relapse prevention (7) Craving management (7) Monitoring drinking - drink diaries (6) Taking a break from alcohol (5) Consequences of alcohol use (5) Pros and cons of drinking (4) Psychosocial interventions (3)	
Behavioural Interventions	
Behaviour activation (4) Behavioural experiments (7)	
Cognitive Interventions	
Identifying unhelpful thinking patterns (8) Thought records (6) Challenging negative thinking (3) Core beliefs/schema work (4)	
Emotional interventions	
Distress tolerance (6) Identifying and naming emotions (4)	
Relapse prevention interventions	
Identifying needs (4) Identifying high-risk situations (4) Developing a relapse plan (3)	

Other Interventions
Mindfulness (5)
Imagery (3)
Roleplay (1)
Relaxation (1)

**The numbers in brackets indicate how many participants identified these aspects.*

Figure 2. A process map of identified potential change pathways for CBT practice.

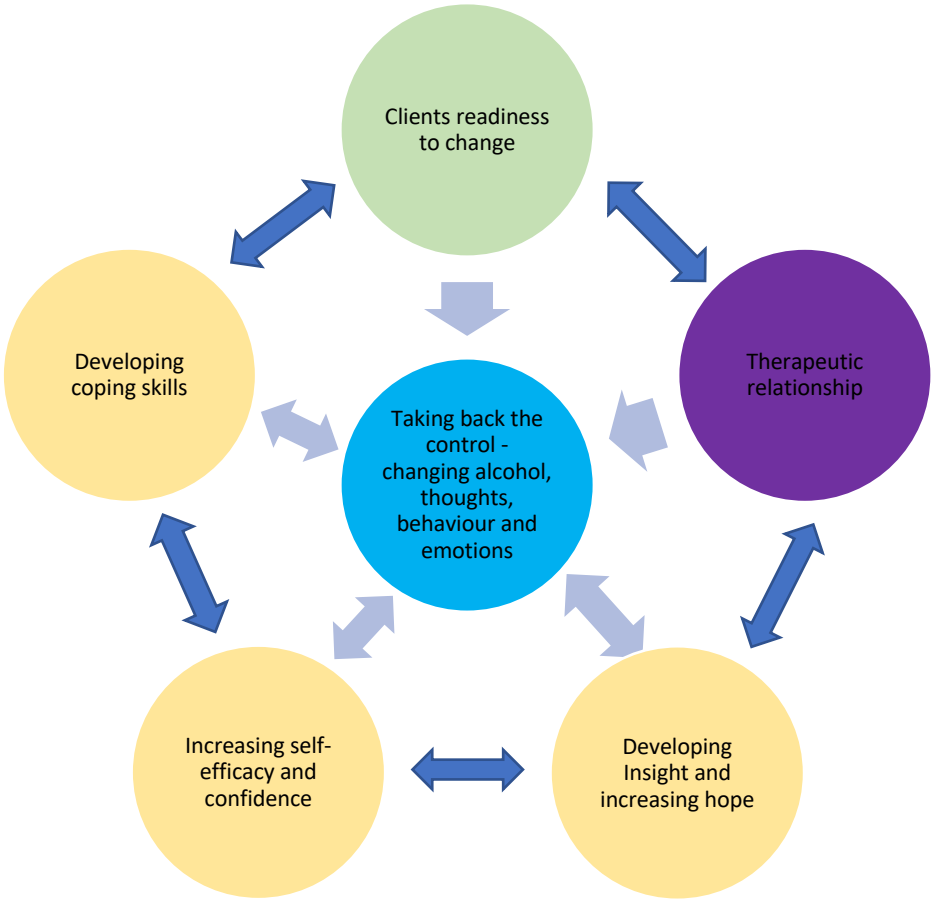


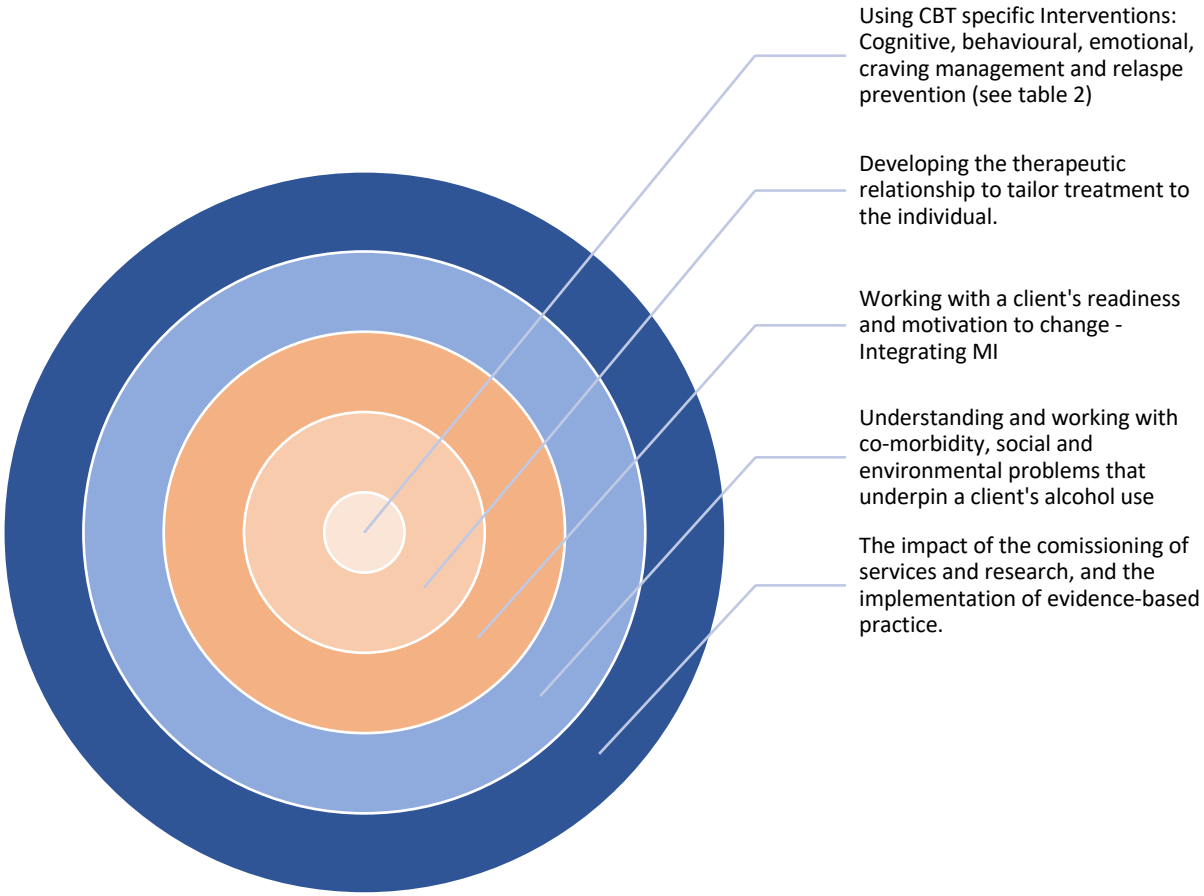
Figure 2. identifies a process map of potential pathways which have been generated from the themes three to seven. The map identifies how each of the specific aspects can lead to change whereby clients can take back control of their alcohol use and broader areas of their lives; however, the map identifies how this can be a bidirectional process. For example, taking back control was also described by participants as increasing hope. As discussed above, each of these aspects was considered essential in facilitating change through CBT.

Moreover, Figure 2 also identifies the interrelated nature of these aspects. For example, theme six revealed how testing out change helped clients to increase motivation to change. This potentially shows the complex nature of change that relies on numerous pathways to bring about change, which are often a mix of specific factors pertaining to CBT as well as non-specific or common factors. Further implications for these findings in relation to relevant literature will be discussed in the following chapter.

Figure 3 identifies a broader view of change as it identifies a multifactorial approach to CBT practice. The themes developed identified a complex process of delivering CBT that was not just dependent on CBT-specific interventions but instead adopted a multi-layered view of change. For example, themes one to five explored the different factors that affected CBT practice, from context, comorbidity, readiness to change and the therapeutic relationship. Therefore, Figure 3 identifies these layers that therapists may go through before using CBT or integrate as part of their therapeutic practice. Figure 3 provides a potential map of extra-therapeutic factors that therapists may wish to consider when delivering CBT for this client group. Considering the findings from this study, it may be helpful for therapists to adopt a transdiagnostic approach to CBT. Further implications for clinical practice will be discussed in the following chapter.

Figure 3

A structural map showing a multifactorial approach to CBT for alcohol use problems.



Chapter Five: Discussion

5.1 Introduction

This final chapter will present an overview of the findings, considering each of the seven themes identified in the analysis alongside existing literature in both the alcohol use field and the wider psychotherapy field. A critical appraisal of the research process will then be discussed. The chapter will go on to explore the implications of the findings for clinical practice, policy and procedure in the field of counselling psychology, as well as identifying opportunities for future research in the field. The chapter will conclude with a reflexive exploration of the research process.

5.2 Overview of the findings

The current study aimed to understand how therapists perceived CBT to be helpful or unhelpful in bringing about change for clients with AUP. Seven themes were developed from the participants' narratives, which seemed to reflect a multifactorial approach to CBT practice: CBT delivery was more than just a set of standard interventions; instead it included non-specific factors (such as motivation and the therapeutic relationship) which were perceived as being essential aspects of therapists' use of CBT.

The first three themes (*"It's still a medical approach"*, *Unravelling the Complexity*, and *"In practice, it's a different story"*) related to the challenges participants experienced in delivering CBT in the context of current service provision for clients with AUP. The fourth and fifth themes (*Getting Ready for Change* and *Experiencing a Human-to-human Encounter*) captured the importance of creating a therapeutic environment that encourages growth, setting the foundation for

CBT to bring about change. The sixth and seventh themes (*Finding Hope in the Hopelessness* and *Taking Back the Control*) reflected participants' experiences of how CBT was effective in bringing about change in the lives of clients.

The findings reveal that for CBT to be most effective it required participants to adopt a multi-layered approach that was flexible and allowed participants to tailor CBT to the client's individual and multiple needs. However, it seemed that the extent to which CBT helped depended on the context in which it was delivered, as CBT was often delivered in less than ideal contexts that consequently restricted participants from delivering CBT in the most efficacious way. It seems, therefore, that change through CBT was not just a result of therapeutic factors, but best considered in a broader therapeutic context in which therapy is delivered.

5.3 Contextual factors to CBT application

The analysis identified the vital role external factors can play in therapeutic change. These findings are consistent with previous research which found MET and SBNT were immersed in a "larger system of change-promoting elements" (Orford et al. 2006, p.67) which were often described by clients as an important part of their change process. Likewise, other studies have also identified how the context in which treatment is delivered can have a positive and negative impact on therapy outcomes (Gliburt et al., 2015; Jones et al., 2015).

The first theme, "It's *still a medical model",* captured how service provision was perceived to be embedded in the medical model, despite shifts to move towards a recovery approach (Best et al., 2010). Indeed, these findings are reflective of a mental health system that is established in the medical model and is influenced by political and

social agendas with an increasing emphasis on cost-effective, evidence-based treatment (Johnstone & Boyle, 2018; Larsson et al., 2012; Woolfe, 2016).

Although CBT is a recommended evidence-based approach for AUP (NICE, 2011), participants still perceived it was difficult to fully integrate and establish psychological therapies such as CBT as a vital part of treatment, which was often reinforced by how service provision was currently commissioned. Instead, psychological therapies were described by participants as being poorly resourced and under-funded (McHugh et al., 2010). Indeed, these findings appear to be reflective of changes to the funding of alcohol use services that have moved from the government to local authorities (Day, 2019; Drummond, 2015). These findings may also imply that addressing AUP are still primarily considered a medical or biological problem (Marshall et al., 2010; Orford, 2001; Orford 2008) with medical interventions being prioritised as the primary intervention.

Moreover, the challenges in integrating different approaches to AUP are consistent with previous literature that has shown how services often struggle to integrate fundamental aspects of addiction treatment: medical, psychological and spiritual (DiClemente, 2018; Gilburt et al., 2015). This in itself can be a barrier to effective treatment. In accordance with these findings, the current study identified how psychological approaches are still undervalued in terms of how they may be useful in helping clients with AUP. These findings sit in the wider psychotherapy literature on mental health treatment which has suggested the importance of developing an alternative understanding to the dominant medical model towards a more sophisticated understanding of human distress: moving beyond a biological understanding of suffering to a multifactorial approach that identifies the importance of social and

psychological factors (Johnstone and Boyle, 2018). From participants' narratives, it seemed that developing a broader conceptualisation of AUP and how to address them was essential to improving and developing therapeutic practice for this client group.

The second theme, *Unravelling the Complexity,* continued to shed light on how contextual factors impacted participants' CBT practice, namely by highlighting the importance of working with factors that underpin clients' alcohol use. It is widely acknowledged that individuals experiencing AUP often have a multitude of problems (Buckman et al., 2018; Epstein & McCraddy, 2009; Peacock et al., 2018; Wolitzky-Taylor et al., 2018). Despite the wide acceptance of this complexity, the current NICE guidelines (2011) for AUD recommend addressing the alcohol use problem as primary, and independent of underlying mental health problems. However, the findings from the current study highlighted how this approach to treatment is outdated and incompatible with the needs of many individuals seeking treatment, for whom co-morbidity is more often the rule rather than the exception (Eaton, Rodriguez-Seijas, Carragher & Kruegar, 2015).

The importance of working with co-morbidity has been identified in previous literature, which has suggested that substance use treatment should adopt a transdiagnostic (Eaton et al., 2015; Kim & Hodgkins, 2018) or multifaceted approach (Peacock et al, 2018) that seeks to work across a range of problems rather than viewing them as independent of one another (Eaton et al., 2015). Previous research has found clients have a significant reduction in their alcohol use when they have received a combined CBT approach, targeting anxiety and alcohol use, compared to a purely alcohol-focused approach (Wolitzky-Taylor et al., 2018). Likewise, participants in the current study described how working adopting a transdiagnostic approach might allow

clients to develop a greater insight into the interactions between the interrelated processes and develop better coping strategies for the reasons they may be self-medicating. These findings are consistent with previous literature that has shown clients use alcohol to cope with underlying distress (Liese & Tripp, 2018; Wolitzky-Taylor et al., 2018).

A transdiagnostic approach has been suggested to build on a common factors model, which sees co-morbidity as a set of common findings (Eaton et al., 2015). Therefore, the current findings continue to build on the existing literature by suggesting there are wider factors that may effect how CBT can be helpful for clients with AUP. Although *Unravelling the Complexity* was considered a vital part of participants' CBT practice, it was often acknowledged that this approach was difficult to apply in practice due to the way services are currently commissioned and funded to treat clients according to diagnoses (Eaton et al., 2015); as such, it would seem that in practice such services more often than not provide short-term treatment to manage alcohol use rather than adopting a longer-term view of treating AUP in all their complexity (Day, 2019).

The third theme, *"In practice, it's a different story"* captures the perceived challenges of delivering evidence-based CBT, which was considered more complicated than manualised or evidence-based approaches suggest. Instead, CBT practice appeared to be an intricate process of integrating evidence, clinical judgement and patients' needs into the therapeutic process (Blair, 2010; Nielsen, 2003; Pagoto et al., 2007). Previous research has identified numerous challenges in the way evidence-based practice is determined (Peacock et al., 2018; Witikiewitz et al., 2015) and applied to clinical practice (McHugh et al., 2010; Witikiewitz et al., 2015), with consistent acknowledgements that the stringent conditions applied to clinical trials may not be

applied to many treatment-seeking patients and service providers (Orford, 2008; Peacock et al., 2018; Witikiewitz et al., 2015). The findings from the current study are consistent with previous research: participants struggled to apply the current evidence-based CBT, as it was perceived as being over-simplistic and not reflective of the multiple problems that clients experience. Instead, it seemed that participants often drew on their own anecdotal experiences of what works in therapy for this client group. Orford (2008) points out that therapists' tendency to deviate from stringent approaches could indicate that they believe they are doing something that research is failing to account for. Likewise, the current findings showed that participants developed their own approach to practice, based on their experience, implying that therapists' practice experience was considered more reliable than the current evidence base.

In line with Orford (2008), these findings imply that the approach to determining evidence- base approaches could benefit from incorporating a multiplicity of research methods, which would help evidence relate more directly to clinical practice (Orford, 2008; Witkiewitz, 2015). This perspective shifts away from the current allegiance towards the medical model that favours objective or empirically tested evidence (Blair, 2010). The current findings show that therapists have a wealth of experience and knowledge pertaining to therapeutic practice with clients with AUP, and imply that such experience would be helpful in developing practice guidelines that are highly relevant to clinical practice.

5.4 Creating an environment for change

Two themes highlighted the importance of creating an environment for change to occur within therapy, from which clients are ready to engage with CBT practice. The fourth theme, *Getting Ready for Change,* highlighted that working with a client's

readiness to change was a vital aspect of CBT practice. The role of readiness to change has long been established within the alcohol field, and it was not surprising that therapists in the current study felt that this was an essential part of engagement with CBT. However, the participants interviewed specified two main areas that were essential aspects of readiness to change: motivation and taking responsibility for change. These findings are consistent with previous research identifying these factors as vital aspects of change within SBNT and MI (Orford et al., 2009), and provide direct evidence for the importance of readiness to change in CBT practice specifically. This is especially important given the surprising deficit in the literature exploring readiness to change in relation to CBT practice and its outcomes (Ilgen et al., 2006).

Participants described how understanding motivation was a crucial component in preparing clients for CBT, as clients were often accessing support due to other factors such as probation, housing, family, rather than through their own choice. These findings are in line with previous research that showed clients access treatment following family or professional advice, which was experienced as being either supportive or controlling (Orford, 2006). However, the current study revealed the challenges of clients engaging with CBT when they are not motivated, not wanting change or not able to take ownership of the problem. In previous research, Orford et al. (2006) found that clients reported change had been their choice, which highlights the importance of clients' decision to change and engage in therapy. Similarly, participants in the current study described the importance of CBT being tailored to the client's choice and the stage of their recovery journey (Liese & Tripp, 2018) rather than going through the motions of delivering a fixed CBT approach. These findings imply that building motivation and facilitating a client's sense of ownership and autonomy is essential to preparing them to start making changes through CBT.

CBT was perceived as being more effective at the later stages of treatment once clients were ready to make changes. The importance of delivering therapy at the right stage of change is consistent with literature that has suggested CBT is more useful during the action stage of the cycle of change (Norcross et al., 2011). Likewise, participants in the current study described the importance of helping prepare clients for change as a crucial part of CBT practice, which is consistent with Norcross et al. (2011) who propose that therapists may need to adopt different therapeutic stances depending on a client's readiness to change. However, there has been little attention given to the dynamic role of motivation and how that can change a client's readiness throughout the therapeutic process. Instead, readiness to change (and motivation) are commonly considered a pre-requisite for engagement in treatment (NICE, 2011). However, participants from the current study highlighted the dynamic nature of readiness to change as they described how working with motivational components of change were not limited to the early stages of therapy (Moyers & Houck, 2011) but rather it was a continuous process throughout therapy.

The fifth theme, *Experiencing a Human-to-human Encounter,* revealed the importance of developing a therapeutic relationship for CBT interventions to be effective. Previous research has identified the therapeutic relationship as a crucial part of the change process that affects alcohol outcomes (Connors et al., 2016; Magill et al., 2016; Nielsen, 2003). However, limited attention has been given the importance of the therapeutic relationship per se, with the exploration of specific treatment mechanisms involved in the change process being given more focus (Magill et al., 2016). Participants in the current study also shared this sentiment as they described how the importance of the therapeutic relationship was often missing within CBT practice and

research. The therapeutic relationship appeared to be foundational to participants' CBT practice, however.

Although there has been limited research on the importance of the therapeutic relationship, Magill et al. (2016) found that it was essential in helping aid clients' engagement with CBT tasks for AUP. In the same way, participants in the current study described the therapeutic relationship as vital in enhancing engagement with CBT interventions. It was described that an authentic therapeutic relationship helped give meaning and purpose to the tasks or activities clients undertake in therapy. Participants often described the relationship as being the most essential aspect of CBT; in fact, CBT was considered ineffective without it. The necessity of the therapeutic relationship in CBT practice highlighted in this study calls into question some of the current literature that is focused on developing technology-based CBT, independent of a healing relationship (Caroll & Kiluk, 2017). The participants in the current study were adamant that the relationship was crucial in CBT for clients to engage with the tasks to implement change.

Additionally, CBT has the potential to be perceived as an academic exercise, which for some clients could be punishing. These present findings support CBT literature which has shown that clients can become self-critical when CBT does not work, or their expectations are not met (Omylinska-Thurston, McMeekin, Walton & Proctor, 2019). However, in the current study, it seemed that the therapeutic relationship could act as a counterbalance to such negative experience, creating a safe environment that enables clients to experiment with behaviour change.

In addition to improving CBT engagement, the therapeutic relationship also seemed to be integral to providing a more emotion-focused approach to CBT, allowing

therapists to respond to the client's emotional needs. It appeared this was especially important given the vulnerability and fragility of many clients' previous relational experience, and the potential for CBT to expose clients to painful and challenging experiences. The importance of working with difficult and painful emotions is counter to the medical model that seeks to remove the pain and suffering (Gilbert & Leahy, 2009) and stands in contrast to how CBT is perceived to favour techniques over a client-therapist relationship (Liese & Tripp, 2018). Therefore, the present findings show the necessity of a relational approach to CBT that places the relationship at the heart of therapy and embraces the client's suffering in all its complexity.

5.5 Change through CBT

CBT was described by the participants in the current study as an approach that was effective in bringing about change. The sixth theme, *Finding Hope in the Hopelessness*, captured how CBT brought about change through increasing clients' hope that change was possible. Although this could be perceived as being similar to self-efficacy, it appeared from participants' narratives that hope was a distinct concept that was integral to how CBT worked. Hope as a mechanism of change has not been explored widely in the psychotherapy literature, although previous literature has identified that hope may be a distinct concept that is common across different therapeutic modalities (Gallagher et al., 2019; Synder, 2010). There is limited literature that has explored the connection between hope and CBT outcomes (Gallagher et al., 2019), and currently, there is no previous literature that has explored hope in relation to CBT for AUP.

Nevertheless, CBT was frequently described in the current study as giving clients hope by increasing awareness and understanding into the reasons why they drink

alcohol. In particular, the use of initial formulations was often referred to as essential in helping instil hope into clients. It seemed that having hope for change was a vital part of the change process. By increasing awareness, it appeared that it also increased hope and motivation to change, which suggests there may be a bidirectional relationship between motivation and hope (Gallagher et al., 2019). Therefore, hope may be an essential part of the multifaceted change process within CBT for AUP. These findings are consistent with psychotherapy literature which has identified how increasing understanding and awareness can contribute to the development of shared goals between therapist and client, as well as the ongoing development of a collaborative relationship, which then increases motivation and hope that change is possible (Gallagher et al., 2019; Gallagher and Resnick, 2012).

In the same way, participants appeared to link an increase in hope with an increase in self-efficacy, which continues to build on existing research which has identified that self-efficacy is mediated by several other factors (Adekeye & Sheikh, 2009; Hallgren et al., 2019). These findings support the view that self-efficacy may be a common factor rather than a unique factor to CBT; but they also suggest that hope could be a relevant factor in the mechanism by which CBT increases self-efficacy. The findings show that there are other processes by which CBT (or therapy more generally) for AUP may work and therefore imply that there is value in developing research to look beyond the specific factors of coping and self-efficacy. In light of the present findings, the role of hope in CBT for AUP could warrant further investigation.

The final theme, *Taking Back the Control*, identified how CBT helped clients regain control of their lives. Previous research by Nielsen (2003) showed that therapists felt the goal of therapy was not just to consider changes to a client's alcohol use, but to

help the client become more autonomous over their lives. In the same way, participants' narratives in the current study revealed how CBT enabled clients to take back the control of their lives by empowering them to have more autonomy and choice about their AUP, as well as equipping clients to manage the many challenges of life. This perspective contrasts with the medical position that posits the 'addict' as not having control, where the only solution is abstinence (Palm, 2004). These findings show how therapists adopt a more holistic view of change in practice, where change was considered in the context of the client's whole life rather than merely controlling or stopping the client's alcohol use (NICE, 2011).

Additionally, participants acknowledged specific ways that CBT helped clients to regain control through developing coping skills in different areas of their lives, by making behavioural (managing cravings, reducing alcohol and managing relapse situations), cognitive (addressing alcohol-related beliefs, negative thoughts and core beliefs about themselves, others and the world) and emotional (emotional-regulation, acceptance and tolerance) changes in their lives. Indeed, these findings offer support for the role of coping skills within CBT practice (Croxford et al., 2014; Litt et al., 2009; Mastroleo & Monti, 2013). Whether these skills are specific factors to CBT is less clear, but participants' experiences certainly seemed to suggest that CBT may be superior to other approaches in bringing small and gradual behavioural changes.

Interestingly, working with emotions was viewed as central to CBT, in helping clients regain control of their lives. While this may be reflective of the participants' perceived importance of CBT being framed within a relational approach, previous research has identified that working with negative emotions is essential to prevent relapse and is a critical part of coping skills training (Connors, Longabaugh & Miller,

1996; Liese & Tripp, 2018). However, participants in this study felt that addressing emotions was not just about changing emotional responses (as is consistent with CBT practice), but rather that it involved helping clients learn to tolerate and accept uncomfortable and painful emotions. These findings build on current literature that has shown the importance of acceptance-based approaches in alcohol treatment (Vieten, Austin, Buscemi & Galloway, 2010). Therefore, building acceptance often required participants to integrate other approaches such as mindfulness and ACT into their practice, which focus on developing and mastering this skill. These findings again indicate the importance of adopting a flexible approach to CBT that allows therapists to draw on a range of tools to help clients gain mastery over their alcohol use and their lives.

5.6 Critical appraisal of the current study

Qualitative research has often been critiqued as lacking rigour and credibility (McLeod, 2015). However, the current study followed Yardley's (2000) criteria for quality control in qualitative research (see Section 3.10) ensuring the research met the standards required for acceptable qualitative research.

Yardley's framework highlights the importance of research having a wider impact beyond the study. Through qualitative inquiry, the current study has continued to build on both quantitative and qualitative research in the field by providing more detail explaining the complex process of change processes within CBT for clients with AUP. This has facilitated recommendations for progress in clinical practice, policymakers and future research both within the area of therapy for clients with AUP specifically, but also within CBT and AUP research more widely.

Another strength of the current study is the choice of a reflexive TA and critical realist ontological position adopted by the research. Through ongoing reflexivity, I was able to continually explore my personal position and emotional involvement with the project, allowing me to be aware of how my experiences affect the lens through which I have carried out this project (see Sections 1.6 and 5.8).

The current study also fills a gap within the current literature by providing a deeper understanding how therapists perceive CBT to be helpful and unhelpful for clients with AUD. Research exploring AUP from a counselling psychology perspective is scant within the existing literature, therefore, the current study provides a different lens from which therapy for AUP can be explored.

Although Yardley's (2000) criteria of quality control were used to assess the rigour and usefulness of the current study, the study was still subject to limitations. As with all qualitative studies, it is worth noting that there are limits to the generalisability of the findings due to the small and selective sample used. While further studies of this type are needed to establish generalisability of the findings outlined here, they have nonetheless generated relevant and useful implications for clinical practice and policy.

A possible limitation of the current study is that it specifically focused on AUP. While this means that the findings are somewhat limited to this specific area of therapy, they may also have implications for the treatment of other substance use problems, as the processes across different addictions are often the same (Kim & Hodgins, 2018). However, given that alcohol and substance use problems are treated independently (Gilburt et al., 2015; Rose et al., 2011), exploring alcohol use in isolation was considered appropriate and relevant for the current study. Future research may wish to

extend the current study and explore CBT change mechanisms for substance use more generally.

The current study explored the use of CBT from therapists' perspective, which has provided useful and relevant information about how CBT is perceived to be helpful or unhelpful for clients experiencing AUP. However, exploring therapeutic processes purely from therapists' perspective provides a limited view of how CBT may be helpful or unhelpful, as therapy is a complex interaction between a therapist and a client (Orford, 2008). Indeed, it has also been suggested that clients may be the best source of knowledge to describe how therapy works (Cooper, McLeod, Ogden, Omylinska-Thurston & Rupani, 2015). Therefore, further research exploring clients' experiences would provide greater insight in how CBT is helpful for this client group. However, as there has been no research that has sought to explore therapists' experiences of CBT for this client group, the findings from this study provide a valuable contribution by providing an alternative perspective on treatment to the dominant quantitative studies in the field.

The final limitation is around data collection. The current study used semi-structured, one-to-one interviews, as they were considered to provide a flexible approach which would facilitate the sharing of experiences by participants, and generate rich and contextual data (Willig, 2013). However, it is possible that another form of data collection may have been beneficial for the current study. Focus groups, for example, may have empowered participants to share more about their experiences as part of a group process, in which they might be able to justify, disagree or elaborate on their experiences (Braun & Clarke, 2013). This may have provided more in-depth information about therapists' experiences of CBT for AUP.

5.7 Implications for clinical practice

The findings from the current study have several implications for clinical practice in the use of CBT for AUP. The current study revealed how participants often incorporated a range of interventions to address the multitude of problems that clients experience. Given the reported complexity of clients' problems, therapists working with this client group may want to consider adopting a flexible approach to their practice that draws on a range of different therapeutic skills and interventions, depending on the client's needs. This approach moves beyond a single diagnostic approach to AUP and is consistent with a pluralistic stance that views the client as a unique individual with a different and individual needs.

As discussed previously, working with the clients' motivation was considered to be an essential aspect of participants' CBT practice to tailor therapy according to the client's needs. In doing so, therapists may be required to draw on a range of interventions, like MI or non-directive approaches to help build a client's motivation. Working with motivation may be an ongoing process at different points of therapy. Therefore, therapists need to be attuned to their clients' needs, collaborating and adapting therapy and may need to be prepared to drop the CBT agenda to meet the client where they are in their recovery journey.

The findings from the current study also highlighted the importance of developing a therapeutic relationship. Accordingly, therapists working with this client group may want to develop a relational stance to CBT that is rooted in therapists' interpersonal skills of listening, expressing empathy to create a warm, safe and trusting environment, prizing and valuing (Rogers, 1957) before implementing CBT based interventions. Additionally, therapists may want to give space to facilitate clients'

emotional processing that could involve working with a client's sense of self, interpersonal difficulties and working with relational dynamics that occur between therapist and client. Given the important nature of the therapeutic relationship for this client group, technology-based CBT may not be the best approach as a primary intervention.

The experiential nature of CBT was considered to be vital to developing hope and motivation in clients with AUP. CBT for this client group might benefit from adopting an experiential component, which could involve therapists work beyond the therapy room and actively engaging more in behavioural interventions within their sessions.

The finding that hope for change was pivotal means therapists need to hold hope for change for their clients. Accordingly, therapists working in this area might benefit from engaging in regular supervision that provides space for reflective practice to help them manage the many emotional effects of working with this client group, to maintain hope and belief in change.

5.8 Implications for policy and procedures

In the UK, service provision for AUP is currently determined by local government funding, which is disseminated on a cost-effective basis (Day, 2019; Drummond, 2015). Over the last decade, services have experienced significant funding cuts, which has led to reduced resources (Day, 2019; Drummond, 2015) and reinforcing the medical model approach to 'treatment.' Consequently, participants from this study perceived that psychological therapies were often not as prioritised or well-resourced as

medical-based interventions, highlighting the dominant view that AUP are primarily a medical problem. This view is supported by current policies that include the recovery approach (which is often defined as abstinence) and 'harm reduction' strategies to reduce the risk of alcohol-related harms to self and others (Kim & Hodgins, 2018; PHE, 2018). However, the current policies often adopt a short-term view of what is required to treat complex problems (Day, 2019). For example, participants in the current study perceived the separation of mental health and AUP to be a longer-term barrier to clients' recovery journey. Furthermore, participants described how limited resources into psychological therapy have resulted in psychosocial therapies such as CBT being delivered by unqualified staff with limited training (Drummond, 2015). Therefore, the findings from this study imply that psychological therapies such as CBT could be particularly useful in working across a range of co-morbid problems, which might be cost-effective in the longer-term, and help prevent clients falling through the system as many do.

In light of the present findings, policymakers might want to consider developing an approach to AUP that shifts away from the primary emphasis of AUP as a medical problem, but instead adopts a broader approach that places greater emphasis on utilising and developing psychological approaches as a key intervention for AUP. It is acknowledged that this would require greater financial resources to support a change in service provision, as well as an increase in qualified therapists to deliver psychological therapies such as CBT. However, it would be anticipated that developing an alternative transdiagnostic approach to AUP would result in an improvement in both symptoms and drop-out rates, thus saving money in the long run.

5.9 Suggestions for future research

Further to the recommendations made for clinical practice and policy, this study provides possible directions for future research. As previously discussed, the findings from this study identified that therapists appeared to adopt a multifactorial approach to their CBT practice. The findings showed that both common and specific factors were perceived to be pertinent to participants' CBT practice. The findings revealed a possible link between hope and control, therefore, there is a need for this to be studied further. It could be that quantitative studies such as mediation and moderation analysis (commonly used in mechanisms of change research) or RCTs may wish to explore further the role these factors may have on CBT outcomes. Although quantitative research may detract from therapists' experiences, quantitative research may help establish more direct causal links in pathways to change by comparing treatment and control groups. Combining both qualitative (clinical judgement and experiences) and quantitative research (what is 'known') could provide a diverse and robust understanding of how to develop therapy for AUP (Drug and Alcohol Review, 2015). This approach might ensure the findings generated are more reflective of clients seeking treatment, with greater relevance and applicability to therapeutic practice.

The impact of service provision on participants' CBT practice was widespread throughout the analysis. Participants often described how the structure and provision of treatment impacted how they were able to deliver therapy. Although a few studies have identified the role of the treatment context on the therapeutic process (Gilburt et al., 2015; Jones et al., 2015; Orford et al., 2009), there has been limited attention given to this area. Given the relevance of the context of therapeutic practice, future research may wish to explore this further, which could provide valuable understanding in how to

develop and improve service provision and therapeutic practice for this client group, for example, tailoring treatment to the client's motivation.

The findings from the current study revealed the importance of qualitative research that provides valuable insight into the processes of therapy from an experiential perspective. As discussed earlier, there are limits to which the findings of the current study can be generalised. Therefore, further research exploring processes of change from a qualitative paradigm would continue to build on the findings from this study by providing greater insight and understanding into the complex processes of change that have been identified.

As mentioned previously, clients' voices are often missing within substance use research, as they are often unjustly assumed to lack insight into their change processes (Orford, 2006). However, research has shown therapists and clients have been found to have different perspectives of what they deem to be helpful or unhelpful (Cooper, 2007; Cooper & McLeod, 2012; Orford, 2009). It would, therefore, be especially beneficial to explore clients' experiences of therapy, including CBT. Understanding both therapists' and clients' perspective could be valuable in bridging the gap and helping provide an approach that is more aligned with clients' needs, which may help them to successfully engage in treatment (Omylinska-Thurston et al., 2019).

The process model of change developed in the current study suggests that a multifactorial approach to CBT practice may facilitate a more inclusive approach to capture a range of clients varied needs. These findings are particularly important given the high levels of co-morbidity reported for clients accessing alcohol treatment. A multifactorial approach lends support for developing a more transdiagnostic approach to treatment for clients with AUP. Further research may wish to explore the effectiveness

of a transdiagnostic approach to CBT compared with a single diagnosis approach for this client group.

5.10 Implications for counselling psychology

Although the findings from the current study are relevant to both counselling psychology practice and the wider psychotherapy field, they also have specific relevance to the field of counselling psychology. Firstly, the findings from this study challenge a purely medical understanding of AUP and promote a more comprehensive approach, which is in accordance with a counselling psychology ethos that does not favour one perspective above the other (BPS, 2008), but rather embraces a multiplicity of different models of pathology. This approach sits within a pluralistic approach to understanding distress and how to treat it (Cooper & McLeod, 2007; Kasket, 2016). At present, approaches to working with clients experiencing AUP prioritise behavioural approaches that are heavily focused on techniques to manage clients' alcohol symptoms. While it is of course vital to address AUP and help clients to reduce their alcohol use, the current study also highlights the interrelated nature of clients' multiple problems that underpin their alcohol use. Counselling psychologists would, therefore, be well-positioned to carry out further qualitative research in this field, to develop theoretical models and ways of practicing that can engage with the client's subjective world by focusing beyond the alcohol use.

As previously mentioned, counselling psychology is in line with a social justice agenda that seeks to help reduce marginalisation from society (Speight & Vera, 2008). Drummond (2017) noted that individuals experiencing substance use problems are often stigmatised, where drug and alcohol services are often the first to be cut due to limited funding. Therefore, counselling psychologists may be able to provide further support to

advocate for policies and procedures to best support this client group and ensure fair access to treatment for all.

Furthermore, the therapeutic relationship was identified as a vital aspect of CBT for this client group. Counselling psychology is underpinned by humanistic values where the therapeutic relationship is viewed as the primary vehicle of change (Donati, 2016). As previously discussed, there is a notable absence of research into the importance of the therapeutic relationship in the extant literature for AUP. Unfortunately, there is also a deficit of counselling psychologists working in this field. However, given the centrality of the therapeutic relationship and the value of reflective practice to counselling psychologists (Donati, 2016; Woolfe, 2016), it is imperative that counselling psychologists do not shy away from working in the field. Instead, they should consider how they have something distinct to offer and bring to the field that could help it to progress and move it forward.

5.11 Reflexivity

At the beginning of this thesis, I acknowledged that my personal and professional experiences of alcohol use would inevitability influence my approach to the present research study. As previously discussed, the role of reflexivity is crucial to qualitative research and counselling psychology research (Kasket, 2016). Moreover, a reflexive stance is consistent with thematic analysis (Braun & Clarke, 2019) and a critical realistic position (Willig, 2013). In keeping with these perspectives, this final section will explore how my experiences have shaped this research process.

Although I initially acknowledged the influence my personal and professional experiences could have on the current study, I attempted to ‘bracket off’ my experiences to accurately and honestly attend to and reflect my participants’ experiences (Finlay,

2002a). While this was a necessary part of the process, it was important not to detach from the process. In researching therapists' experiences, it was necessary to acknowledge where there could be a shared perspective while remaining open to new and different viewpoints (Finlay, 2002b). However, the ability to bracket or 'box' my experiences was a strategy that I was well-versed in, and I feel that by attempting to reduce my imposition on the research process, I inadvertently distanced parts of myself from the research process.

Despite keeping a journal throughout the process, during the write-up phase, it became apparent that I had slightly removed myself from the research process; it seemed that I struggled to locate myself inside the research (Denzin & Lincoln, 2000) and instead had adopted a distant external role. Consequently, my supervisor identified how I appeared absent in my written work, as though I had dissociated during the writing process. I was aware that being removed from the research was inconsistent with qualitative research and my ontological position, which acknowledges the researcher's active role in co-construction of the research process (Etherington, 2004; Finlay, 2002b). Upon reflection, 'dissociation' was perhaps reflective of my struggle to acknowledge my 'insider' status.

My 'insider' status operated on two levels: my past experiences with alcohol use, and my role as a trainee psychologist – both were levels in which I could identify with my participants' experiences. As previously mentioned, my past relationship with alcohol use had the potential to affect my understanding and interpretation of the data. However, out of fear that this could water down my insights (Finlay, 2002a) or not be 'credible' due to personal involvement (Lees, 2001), I adopted a detached researcher stance (Finlay, 2002a). Braun and Clarke (2019) highlight the importance of researchers

accepting their 'insider' status; but it seems that rather than embracing my 'insider' status, I was trying to push it away. In doing so, I was potentially blocking a deeper level of interpretation and unintentionally seeking to find 'truths' that lie in the data rather allowing a deeper meaning and interpretation to develop. As I became more attuned with my process, I found I was still able to achieve deeper insights and still accurately reflect my participants' experiences.

Seeking 'truths' in the data was also reflective of the wrestle I experienced as a therapist in navigating the tensions between positivism and subjectivity. Rizq (2006) captures the challenges trainee counselling psychologist encounter as they battle with the 'emotional difficulty in getting to grips with the dilemma of plurality' (p.617). As a novice qualitative researcher, I struggled with the complexity of critically engaging with these two opposing perspectives (Blair, 2010; Woolfe, 2016). Consequently, I found myself being pulled into a positivist mindset which perhaps was reflective of the way positivism is enshrouded in my thinking: the benchmark of 'good' research (Etherington, 2004) to working in an NHS service that is established in the medical approach to treatment and prizes the use of evidence-based practice.

The pull toward such a positivist approach was also reflected in using the word 'treatment' during this project. Treatment is a word used throughout the literature, which highlights the prevalence of the medical model within the alcohol use field. I was aware that the word is associated with a medical approach (Blair, 2010), which has connotations of the professional that is seeking to 'treat' and eliminate the problem. Uneasy with this stance, I sought to think about how I could re-word and soften the language where possible. However, I realised that eliminating the word 'treatment' was not entirely possible and would not be reflective of the alcohol use field. Indeed, there is

a physical component to AUP that may require medical treatment, and in such a way, treatment is the right word. However, within the literature, 'treatment' is often used to described therapy. Larsson et al. (2012) suggest, that counselling psychologists have a "moral-political choice about where their allegiance should lie" (p. 59). Therefore, I had to decide how much to engage in keeping the medical model language. As I wrestled with these two conflicting views, I felt that keeping the language would accurately reflect the current position of how AUP are perceived and addressed, but where possible, I attempted to change the language used. I chose to position myself inside the field, but with a critical understanding of what the language means and implies. This approach seemed to fit with a counselling psychology ethos that respects and values multiplicity of approaches in understanding distress (BPS, 2013).

The journey to embracing a more subjective and reflexive stance, while critically engaging with a positivist view, was not always easy or comfortable. However, in allowing myself to engage in these two views, I have explored new depths in my thinking and been challenged on views I previously held. This project has been a process of learning and uncovering for myself, a process of becoming (Etherington, 2004), professionally, academically and personally.

5.12 Conclusion

This project sought to explore therapists' experiences of using CBT to treat AUP and to find out what they perceived to be helpful or unhelpful in such treatment. Participants identified that whilst CBT is indeed helpful and effective in treating AUP, it is most effective when utilising a multifaceted approach: one that seeks not only to rely on CBT interventions, but also draws on a range of common factors such as motivation, the therapeutic relationship and hope as crucial aspects to CBT for this

client group. Additionally, it seemed that the broader treatment context in which CBT is delivered was also perceived as having a crucial impact on the therapeutic process.

CBT for AUP seemed to require a flexible and contextual approach that works across different facets and meets the clients where they are. For therapists, it seemed that while addressing the alcohol problem was crucial, it needed not to be viewed in isolation, but instead embracing the client with all their complexities to see the whole person and not just the alcohol use problem. These findings give rise to the question of whether the field can dare to move beyond the dominant medical approach and embrace addressing AUP in all their complexity.

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Appendices

Appendix 1: The DSM-5 criterion for Alcohol Use Disorder

"A problematic pattern of alcohol use leading to clinically significant impairment or distress as manifested by at least two of the following, occurring within a 12-month period:" (p. 490)

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfil major role obligations at work, school or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations which it is physically hazardous.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following:

11. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
12. A markedly diminished effect with continued use of the same amount of alcohol.
13. Withdrawal, as manifested by either of the following:
14. The characteristic withdrawal syndrome for alcohol.
15. Alcohol (or a closely related substance, such as benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Appendix 2: Initial contact with organisations/therapists

To Whom It May Concern/ Name if known,

I am a trainee counselling psychologist at the University of Roehampton. I am in the process of recruiting for my doctoral research project, which is exploring **Therapists' experience of delivering CBT for clients with alcohol use problems.**

I have now obtained ethical approval from the University and I wondered if your service would kindly consider advertising my study to therapists offering CBT for clients with alcohol use problems? / (if directly to therapists) I wondered if you would kindly consider taking part in my research?

I would be delighted to send you further detailed information and discuss this further. I also wondered, if you know of any other alcohol services or therapists that I can contact who offer CBT for this client population? I would be grateful for any links you may be able to give me.

I look forward to hearing from you.

Best Wishes,

Laura Tinsley
Counselling Psychologist in Training
University of Roehampton

Therapists' experiences of CBT for alcohol use problems.

Dear Therapists,

I am a Counselling Psychologist in Training at the University of Roehampton, carrying out research into therapists' experiences of delivering CBT for clients with alcohol use problems. I am seeking to interview 8 therapists who would be interested in reflecting on their experiences of using CBT when working 1-1 with clients experiencing alcohol use problems.

Have you delivered CBT for clients with alcohol use problems? If so, were there aspects that you found helpful? Or perhaps there were aspects that you found unhelpful/challenging? Did CBT help bring change to your clients' drinking problems? Or maybe your experience has been very different? Either way, I would you be interested in hearing from you.

If you are a qualified therapist and have used CBT when working 1-1 with clients experiencing alcohol use problems, and you would be willing to talk to me about your experiences, please get in touch by contacting me using the details below.

All interviews will take place at _____/ or over skype (*delete as appropriate*). The interview process should last about an hour and a half (but it may be shorter or longer). Interviews will be confidential and your identity will be protected.

Kind Regards,
Laura Tinsley

Email: tinsleyl@roehampton.ac.uk Phone:07967815316

Appendix 3: Inclusion/Exclusion Criteria for the study

Inclusion criteria

All participants must:

- Be a qualified Counselling Psychologist, Clinical Psychologist, Counsellor, Psychotherapist or CBT Therapist.
-
- Have experience of delivering CBT 1-1 as primary intervention for clients with alcohol use problems.

Exclusion criteria

Participants will be excluded from the study if they meet any of the following criteria:

- They are therapists in training
-
- They are therapists who have not used CBT as a primary intervention when working 1-1 with clients experiencing alcohol use problems.

- They are therapists who are qualified but not accredited by the BPS, BACP or the BABCP.

Appendix 4: Initial Screening Questions (Eligibility) for email/phone contact

University of Roehampton London

Participant Name ……..

Thank you for your interest in the research, before we can arrange an interview date, I need to explain a bit more about the research and ask you a few questions to check your eligibility to take part in the research and then if you are eligible to take part in the research we can arrange a time for the interview at the end of the call.

Introduce myself and the research (if not already done through initial contact): I am a counselling psychology trainee at the University of Roehampton and I am researching therapists' experiences of delivering CBT in the treatment of alcohol use problems. I am particularly interested to know what therapists' experiences are of using CBT for clients with alcohol use problems and what moments in therapy led to any significant changes or were most helpful/challenging. I am aiming to interview 8 individuals to find out about their experience using CBT for this client group.

Explain commitment of the interview: The interview process is expected to take an hour and half, but this may be more or less depending on how much time you need.

Inclusion criteria: To be able to take part in this research you need to be fully qualified and have experiences of delivering CBT as a sole intervention for clients with alcohol use problems. To be eligible for the research it is important that you meet this criteria, please can I ask you a few questions to check?

1) Are you qualified counselling psychologist/clinical psychologist/counsellor/psychotherapist/CBT therapist?
2) When did you complete your training?
3) Do you offer CBT as a primary intervention for clients with alcohol problem? (prompts include – was this integrated as part of the work/ was it a sole intervention)

Exclusion criteria: I am afraid I cannot include people in the research who are not currently accredited.

Are you accredited with any registering body, if so, can you provide me details or your accreditation?

If person meets exclusion criteria (e.g. in-training or not accredited or offering CBT as sole intervention) explain that I cannot invite him/her to take part in the research. Mention that I am aware they have taken time out to take part today and they may feel disappointed that they cannot continue to share their experiences.

Concluding telephone/email call if deemed eligible: I would like to invite you take part in an interview to hear more about your experiences of delivering CBT. When would you be able to attend an interview? What days' work best for you? Could we arrange an interview on _____ *(day)* at _____ *(time).* The interview will take place at _____(*specify alcohol service/office/skype/Roehampton).* I would like to call you back in a few days to confirm the interview and to check that you would still like to take part. There is no pressure for you to take part in the research and you can withdraw from the study at any time.

Concluding the call/ email if deemed ineligible: Thank the participant for getting in touch and for showing an interest. Explain that they do not meet the criteria to be involved in the research study at present. Acknowledge they have taken time to be involved today and that I understand they may feel disappointed to not be involved any further.

Appendix 5: Letter of ethical approval from Roehampton University.

University of Roehampton London

Dear Laura,

Ethics Application
Applicant: **Laura Tinsley**
Title: **Clients' perspectives of helpful and unhelpful factors of CBT for alcohol misuse problems: a thematic analysis**
Reference: **PSYC 16/ 245**
Department: **Psychology**

I am pleased to advise you that HR have now sent confirmation of your DBS. Under the procedures agreed by the University Ethics Committee I am therefore pleased to advise you that your Department has confirmed that all conditions for approval of this project have now been met. We do not require anything further in relation to this application.

Please note that on a standalone page or appendix the following phrase should be included in your thesis:

The research for this project was submitted for ethics consideration under the reference PSYC 16/ 245 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 19.01.17.

Please Note:
- **This email confirms that all conditions have been met and thus confirms final ethics approval (it is assumed that you will adhere to any minor conditions still outstanding, therefore we do not require a response to these).**
- **University of Roehampton ethics approval will always be subject to compliance with the University policies and procedures applying at the time when the work takes place. It is your responsibility to ensure that you are familiar and compliant with all such policies and procedures when undertaking your research.**
- **Please advise us if there are any changes to the research during the life of the project. Minor changes can be advised using the Minor Amendments Form on the Ethics Website, but substantial changes may require a new application to be submitted.**

Many thanks,

Jan

Jan Harrison
Ethics Officer
Research Office
University of Roehampton | London | SW15 5PJ
jan.harrison@roehampton.ac.uk| www.roehampton.ac.uk
Tel: +44 (0) 20 8392 5785

Appendix 6: Participant information sheet

University of Roehampton London

Information Sheet

Thanks for reading this information sheet about our study

We would like to invite you to take part in our research project. We are looking to interview 8 therapists –to find out more about their experience of delivering CBT for clients with alcohol use problems. We think it is really important that therapists have the chance to share their experiences of delivering therapy.

Before you decide if you want to join in, it is important that you understand why we are doing this research and what we are asking you to do. This is important because it will help you decide if you want to take part. If you have any questions, please feel free to ask.

Why are we doing this research?
Within the UK, psychological treatment for alcohol use problems is not currently informed by strong evidence-based practice. NICE Guidelines (2011) for the treatment of alcohol use problems recommend a small selection of psychological therapies. CBT is one of the recommended therapies. Research has shown CBT to be effective in treating alcohol use problems, however, there is still limited information about how CBT is effective for clients with alcohol use problems. Research is helpful as it helps us find out more about the things we don't know about, and it can help us to improve or develop current psychological practice.

We are looking to find out how you have experienced using CBT for clients with alcohol use problems. Additionally, we want to find out whether there were particular moments or aspects of therapy that you felt were particularly helpful or challenging in the change process.

To take part in this study you need to:

- Be a qualified Counselling Psychologist/Clinical Psychologist/Counsellor/Psychotherapist/ CBT Therapist.
- Have experience of delivering CBT as a primary 1-1 intervention for clients with alcohol use problems.

Do I have to take part?
No, it's completely up to you. Taking part in this research is voluntary, which means you don't have to take part if you don't want to. If you agree now you can still change your mind later.

What would I have to do?

If you decide to take part, you will be invited to meet with the researcher, who will ask you to fill in a short form with some details about yourself. After this, she will ask you some questions about your experience of delivering CBT. You can say as much or as little as you feel comfortable saying. The conversation will be audio recorded, so that we can later type out what was said and use this information when we write reports or give presentations about our findings. At the end, you will have the chance to talk about what the interview was like for you, and to ask any questions you might have. The whole process is expected to take an hour and a half, but this might be more or less.

Where will this take place?
Interviews will be held either in *the alcohol service you work for, your office*, University of Roehampton or via Skype at a time that is good for you. The whole process will take an hour and a half, but may be shorter or longer.

Consent
Giving consent means you fully understand what the study is about, and what taking part involves for you. If you agree, and want to join in, you will be given a consent form to sign just before the interview starts.

What are the possible disadvantages/ risks of taking part?
There are not many risks involved. You will have to give up some of your time to take part, and might feel uncomfortable answering some questions about your experience of delivering CBT. If you do feel uncomfortable at any point, you can choose not to answer a question, or to stop the interview. You would not need to give us a reason for leaving the study.

What are the possible benefits of taking part?
Some therapists find it useful to reflect on their experience of delivering therapy. By taking part in this study, you will be helping to improve therapy for other people in the future.

Will anyone else know what I say?
What you tell us is confidential, which means that it will not be passed onto anyone else. However, if you tell us that you or someone else might be at risk of getting hurt, we will have to pass this on so that we can get help and make you safe.

Will people know it is me?
When we write up our findings, we will do our best to make sure that no one knows it is you. We do this by removing your name, and any other details that could give away something about you.

What if there is a problem or something goes wrong?
If you feel something is wrong, please talk to us about it as soon as possible. This can be before, during, or after the interview. You can also contact the people whose details are at the end of this sheet if you need to. At the end of the interview, we will give you a

debriefing sheet that will provide you with details of who to contact if you need more time to discuss anything else.

What will happen to the results of the research study?

The results of this study will be written up in a report, and might be published. Audio recordings and transcripts will be destroyed after 10 years, in which time they might be used for other research projects and data analyses (if the researcher gives permission for this).

Who is organising the research?
This research is being organised by the Department of Psychology at the University of Roehampton.

Who has reviewed the research?
For research to go ahead it needs to get permission from an Ethics Committee, who are there to make sure the study is safe. This project has been approved under the procedures of the University of Roehampton's Ethics Committee, which means it is safe and has a very low risk of causing harm.

……

If you have any further questions, please contact Laura Tinsley (primary investigator) for more details:

Laura Tinsley
Department of Psychology
Whitelands College
Holybourne Avenue
London, SW15 4JD
Email: tinsleyl@roehampton.ac.uk

Phone: 07456583800

Please note: If you are worried about any aspect of this study, or have any other questions please ask Laura Tinsley (or the Director of Studies). However, if you would rather talk to someone at the university who isn't directly involved in the research, you can contact the Head of Department:

Director of Studies Contact Details:

Dr. Catherine Gilvarry
Department of Psychology
Whitelands College
Holybourne Avenue
London, SW15 4JD
Email:
c.gilvarry@roehampton.ac.uk
Phone:020 8392 3449

Head of Department Contact Details:

Dr. Diane Bray
Department of Psychology
Whitelands College
Holybourne Avenue
London, SW15 4JD
Email:
D.Bray@roehampton.ac.uk
Phone: 020 8392 3627

Appendix 7: Participant Consent Form

Title of Research Project: Therapists' experience of delivering CBT for clients with alcohol use problems: a thematic analysis.

Brief Description of Research Project and What Participation Involves:

The research project is seeking to explore 8 therapist's experiences of delivering CBT when working with clients who are experiencing alcohol use problems. Additionally, we are interested to know whether there were particular moments or aspects of therapy that you felt were particularly helpful or challenging in the change process.

The research involves completing a brief questionnaire, followed by an interview. On completing the interview there will be an opportunity to debrief and discuss how you found the interview. Interviews will be held either in the alcohol service you work for, your office, University of Roehampton or via Skype at a time that is good for you. The whole process will take an hour and a half, but may be shorter or longer. Interviews will be audio recorded and transcribed verbatim.

Investigator Contact Details:

Laura Tinsley
Department of Psychology
Whitelands College
Holybourne Avenue
London, SW15 4JD
Email: tinsleyl@roehampton.ac.uk

Phone: 07456583800

Consent statement

I agree to take part in this research, and am aware that I am free to withdraw at any point without giving a reason, although if I do so I understand that my data might still 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, and that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University's Data Protection Policy.

(Please tick if you agree):

University of Roehampton London

1.	I have read and understood the Information Sheet about the study.	☐
2.	I have had the chance to ask questions about the study, and know what I am being asked to do. I know who I can contact about the study if I need to.	☐
3.	I agree to take part in the project. I understand that I am a volunteer.	☐
4.	I understand I can leave the study at any time without giving reasons.	☐
5.	Confidentiality has been explained to me, and I understand that if I say anything that suggests that either I or someone else is at risk of harm, confidentiality might be broken.	☐
6.	I agree that my interview will be audio recorded and transcribed.	☐
7.	The use of the data in research, publications, presentations, sharing and storage has been explained to me.	☐
8.	I understand that my identity will be protected in any write ups or articles of this study.	☐
9.	I understand that audio recordings and transcripts will be destroyed after 10 years. I understand that in this time (and with the permission of the researcher), other researchers may be able to use the data if they agree to treat it confidentially.	☐
10.	I understand that the data I provide may be used in future research.	☐
11.	I agree to sign and date this consent form.	☐

Name …….

Signature ……

Date ……

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact the Head of Department.

Director of Studies Contact Details:

Dr. Catherine Gilvarry
Department of Psychology
Whitelands College
Holybourne Avenue
London, SW15 4JD
Email:
c.gilvarry@roehampton.ac.uk
Phone:020 8392 3449

Head of Department Contact Details:

Dr. Diane Bray
Department of Psychology
Whitelands College
Holybourne Avenue
London, SW15 4JD
Email:
D.Bray@roehampton.ac.uk
Phone: 020 8392 3627

Appendix 8: Socio-demographic questionnaire

Socio-demographic questionnaire

Thank you for agreeing to take part in this research.
Please fill in the following information:

1) I identify as:

☐ Male
☐ Female
☐ Transgender
☐ Prefer not to say
☐ Other (please give details): .....

2) How old are you?

☐ 20-25
☐26-35
☐36-45
☐46-55
☐56 +

3) Which is your ethnic group?

A White

☐ English/Welsh/Scottish/Northern Irish/British
☐ Irish
☐ Gypsy or Irish Traveller
☐ Any other White background, please describe:

.....

B Mixed/Multiple ethnic groups

☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any other Mixed/Multiple ethnic background, please describe:

.....

C Asian/Asian British

☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Chinese
☐ Any other Asian background, please describe:

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……

D Black/ African/Caribbean/Black British

☐ African
☐ Caribbean
☐ Any other Black/African/Caribbean background, please describe:

……

E Other ethnic group

☐ Arab

☐ Any other ethnic group, please

describe:……

4) Out of the options listed below, which best describes your religious beliefs?

☐ No religious beliefs
☐ Atheist
☐ Christianity
☐ Judaism
☐ Islam
☐ Buddhism
☐ Sikhism
☐ Hinduism
☐ Other Please State …….

5) How would you identify your current employment status

☐ Employed full-time
☐ Employed part-time
☐Other Please State …….

Appendix 9: Interview Guide

Interview guide

1) Can you tell me a bit about your training – integrative/CBT trained?

2) How long have you worked with clients with alcohol use problems?

3) How would you describe your overall experience of using CBT for clients with alcohol use problems?

4) Do you find that CBT is effective as a sole intervention? (is it more effective when combined with other approaches….)

5) Can you tell me what aspects of CBT you have found helpful for clients with alcohol use problems? (general factors or specific events – it could be something you said or did, something the client said or did). *Prompts required may be can you elaborate or tell me more about that…)*

6) Can you tell me about what you have found unhelpful or challenging when using CBT for clients with alcohol problems? (general factors or specific events – this could be things that have found hindered therapy, unhelpful, negative or disappointing)

7) Overall, do you find that CBT is an effective approach to bring about change for clients with alcohol use problems? (prompts required may be, what makes it effective or can you explain that further…)

8) What are the main changes you notice in clients having CBT alcohol use problems?

9) Do you feel there has there been anything missing from the treatment you offer clients with alcohol use problems? (Prompts required may be what would you do differently? What would you want to add?...)

10) Is there anything that clients often want to change at the beginning of therapy that hasn't happened as a result of using CBT?

Appendix 10: Debriefing form

University of Roehampton London

Debriefing Form

Thank you for taking part today.

The purpose of this research
Our aim in talking to you today was to find out more about your experiences of delivering CBT with clients with an alcohol use problem. Additionally, we wanted to find out what aspects of CBT you found to be helpful and unhelpful in treatment for clients with an alcohol use problem.

The reason for doing this research was to improve our understanding of how and why CBT is helpful or unhelpful in treating alcohol use problems. We wanted to get an understanding of how useful CBT is in treating alcohol use problems from your perspective and experience.

Post-interview debrief
Sometimes during an interview, people get thoughts, feelings, concerns, or questions that they want to talk about.

It's important that you have the chance to reflect on the interview, and to take a moment to consider whether there is anything you want to talk about. The following questions might help you to do this:

- How do you feel having completed the interview?
- How did it feel to be interviewed?
- Has the interview brought any thoughts of feelings up for you?
- Do you have any questions or concerns about the interview process, or about what happens next?
- Do you think there were any questions I should have asked that I didn't?
- Do you have any other ideas about how to make the interview better?
- Is there anything else you would like to share at this point?

Thank you for your contribution to this research, and I hope you enjoyed taking part.

If you think of any questions you would like to ask once I have gone, or if you need further support, then you can contact me:

Laura Tinsley
Department of Psychology
Whitelands College
Holybourne Avenue, London, SW15 4JD

Email: ltinsley@roehampton.ac.uk
Phone: 07456583800

Alternatively, if you would like to speak to someone following this interview then you can speak to your service manager or supervisor. Additionally, you can contact external support services if you would prefer to. You can contact the Samaritans on: 116 123.

Please note: If you are worried about any aspect of this study, or have any other questions please ask Laura Tinsley (or the Director of Studies). However, if you would rather talk to someone at the university who isn't directly involved in the research, you can contact the Head of Department:

Director of Studies Contact Details:

Dr. Catherine Gilvarry
Department of Psychology
Whitelands College
Holybourne Avenue
London, SW15 4JD
Email: c.gilvarry@roehampton.ac.uk
Phone:020 8392 3449

Head of Department Contact Details:

Dr. Diane Bray
Department of Psychology
Whitelands College
Holybourne Avenue
London, SW15 4JD
Email:
D.Bray@roehampton.ac.uk
Phone: 020 8392 3627

Appendix 11: Information Sheet for recruiting organisation

Information Sheet

Thank you for reading this information sheet. This document will explain why we are doing this research, and sets out what will be involved for services that choose to disseminate information.

The Research Project

This research aims to explore therapists' experiences of delivering CBT for clients with an alcohol use problem. This research will help us improve our understanding of:

- Therapists' experiences of using CBT with clients with alcohol use problems.
- What factors of CBT are helpful when working with clients experiencing alcohol use problems?
- What factors of CBT may be unhelpful when working with clients experiencing alcohol use problems.
- Map out possible change pathways of CBT for clients with alcohol use problems.

It is hoped that developing a better understanding of how and potentially why CBT is helpful or unhelpful for alcohol use problems will hopefully help to improve the quality of treatment provided for alcohol misuse problems.

Research procedure

This research is looking to interview 8 therapists who are qualified and have experience of delivering CBT as a main intervention for clients with alcohol use problems

Inclusion criteria

All participants must:

- Be a qualified Counselling Psychologist, Clinical Psychologist, Counsellor, Psychotherapist or CBT Therapist
- Have experience of delivering CBT 1-1 as primary intervention for clients with alcohol use problems.

.

Exclusion criteria

Participants will be excluded from the study if they meet any of the following criteria:

- They are therapists in training
- They are therapists who have not used CBT as a primary intervention when working 1-1 with clients experiencing alcohol use problems.
- They are therapists who are qualified but not accredited by the BPS, BACP or the BABCP.

Therapists' will be invited to attend an interview, which will take place at the recruiting alcohol support service/University of Roehampton/ Therapists' offices/over skype. During the interview, participants will be asked about their experience of delivering CBT. Following the interview, participants will be fully debriefed by the researcher.

The entire interview and debrief should take between one hour and one and a half hours. Interviews will be audio-recorded and transcribed.

Alcohol services involvement

Services interested in taking part will be provided with posters and leaflets to advertise the study to their therapists in their service.

Services will be involved in the recruitment of participants through advertising the research project or identifying eligible therapists for the researcher to contact. Therapists have a choice to opt into the research study and there is no compulsion or pressure for therapists to participate in the research project.

Services taking part will be also be able to provide a private room for interviews to take place, if required. The researcher will contact the service to make arrangements for a time that works best for them.

Consent to take part?

Consent will be obtained from the participants prior to the interview. Participants can decline to participate in the research at any point and have the right to withdraw from the study at any point prior to data analysis.

Data collection will not begin until consent has been obtained from all relevant parties. All consenting parties will have the right to withdraw consent at any stage of the research.

Interview process and debrief

Interviews will be held at an agreed location (in the alcohol service/University of Roehampton/Therapist's office/over skype). Participants will have another opportunity

to discuss the research with the researcher before deciding if they want to participate. The overall process is anticipated to take around an hour and a half, but this may be longer or shorter depending on each participant. After signing a consent form, participants will be asked to fill out a form with their demographic details. Interviews will then take place and are expected to take 50 minutes.

Following the interview, the researcher will debrief all participants. During the debriefing process participants will have the opportunity to discuss any thoughts or feelings that have arisen from the interview. Should further support be required following the debriefing session, participants will first be referred to their service manager/supervisor as well as being provided with details of other relevant services.

Potential disadvantages/ risks to participants

There are no expected risks for participants who take part in the study. However, some participants may experience some discomfort answering questions about their personal experience of delivering CBT. Alternatively, some participants may feel inconvenienced at having to give up their spare time to participate in the research. If a participant does experience any discomfort due to participation in this research, they will be able to miss out questions or to withdraw from the study without providing a reason.

Potential benefits to participants

There are no direct benefits for participants taking part in this study, although some people may find it useful to reflect on their personal experiences. The information gathered from this research will contribute towards improving our understanding of therapy for alcohol use problems, with the aim of producing a map of change pathways, which may help improve therapy for clients in the future.

Confidentiality

All information provided will be kept confidential, and only accessible to members of the research team. All collection, storage and processing of data will comply with the principles of the Data Protection Act 1998, and has been approved under the procedures of the University of Roehampton Ethics Committee. All of the information provided will be stored securely and where possible, anonymized. Under no circumstances will identifiable responses be provided to any third party. All data included in the publication or presentation of this research, and any subsequent research publications, will be fully anonymised to ensure that no individual is identifiable. Limits to confidentiality will apply in situations where research participants disclose information that they or someone else is at risk of harm. In such situations, it is the ethical obligation of the researcher to follow safeguarding procedures enforced by the service in which the participant is being seen, and where appropriate to disclose

information to the appropriate authorities. In such situations, where possible, this will be discussed with participants before a suitable course of action is taken.

Anonymity and data storage

All data generated from this study will be stored securely to the highest possible standard of confidentiality. Transcribed data will be anonymised (meaning all identifying information will be removed), to ensure that individuals are not identifiable should the research be published.

Anonymised data generated from this study will be stored for an indefinite period of time following the study, and may be used for publication, presentation, or for subsequent research projects or data analyses. Audio-recordings and transcripts will be destroyed after ten years, in which time they might be used for other research projects and data analyses (at the discretion of the researcher).

Dissemination of findings

The results of this research study will be written up in partial fulfilment of the requirements for the Doctorate in Counselling Psychology from the University of Roehampton. The results of this research may be published in academic journals, or presented at conferences.

Who is organising the research?

This research is being undertaken by the Department of Psychology at the University of Roehampton. This project has been approved under the procedures of the University of Roehampton's Ethics Committee.

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If you would be interested in supporting this research, or if you have any further questions, please contact Laura Tinsley (primary investigator):

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Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies). However, if you would like to contact an independent party please contact the Head of Department.

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Appendix 12: Crest Data Guidelines

CENTRE FOR RESEARCH IN SOCIAL AND PSYCHOLOGICAL TRANSFORMATION (CREST)

DEPARTMENT OF PSYCHOLOGY

DATA STORAGE AND PROTECTION PROCEDURES

SOURCES

These procedures are informed by, and consistent with, the following sources:

- Roehampton *University Data Protection Policy*, University of Roehampton, May 2010 (revised).
- *Ethical Guidelines for Researching Counselling and Psychotherapy*, British Association of Counselling and Psychotherapy, 2004.
- *Encrypting Confidential Data using Windows XP*, Counselling and Psychotherapy Research Guidelines, Counselling Unit, University of Strathclyde (available via Google Group).
- *Ethical Principles for Conducting Research with Human Participants*, British Psychological Society (accessed Sept. 2008).
- Personal communications with Ralph Weedon, Data Protection Officer, University of Strathclyde

RESPONSIBILITIES

- The Chief Investigator has overall responsibility to ensure that the appropriate data storage and protection guidelines are followed.

NON-ANONYMISED/PERSONAL DATA

- Non-anonymised (or 'personal') data refers to any form of documentation or media – electronic or otherwise – in which an individual is identifiable. This includes, but is not limited to:
    - signed consent forms
    - client identity forms (including DOB, GP details, gender etc)
    - video recordings

  Note: even if no name or other obvious data is involved that would identify an individual, data such as date of birth, student matriculation number, national insurance number can be 'triangulated', perhaps with other data a third party has acquired, in such a way as to effectively identify someone. Anything that can be used in this way is therefore to be considered personal data.
- Collection of non-anonymised data will be kept to a minimum, and will only be obtained where it is ethically necessary (as in the case of signed consent forms), or where it clearly adds to the scientific value of a project (for instance, the video recording of counselling sessions).
- Non-anonymised data will be kept for ten years.

- All non-anonymised data will be clearly labelled with a date at which it should be destroyed.

- Non-anonymised data will be destroyed in a way which ensures that the data cannot be recovered in any way.

- Non-anonymised data will be kept physically and/or electronically separate from related anonymised data so that links can not be made between the two sets of data.
- Non-electronic personal data, such as tape recordings and signed consent forms, should be kept in a locked and secure location at all times, and, wherever possible, at the University of Roehampton.
- Electronic personal data will be encrypted and should always be kept on a password protected storage device: wherever possible a PC or network drive located at the University of Roehampton.
- Personal data should not be kept on – or transferred to – laptops, USB sticks, CDs or other mobile/portable devices unless absolutely necessary. As soon as such data is transferred to a secure University location, it must be removed from the portable device such that it cannot be recovered in any way.
- *Should it be necessary to transfer personal data from person to person, this should be done in a secure manner (i.e., by hand or by recorded delivery), always separate from any anonymised data. Any posted materials should be marked 'private and confidential' and sent recorded delivery.*
- For the duration of a study, non-anonymised data may, if absolutely necessary, be stored (in the manner identified above) by investigators other than the Chief Investigator (for instance, where a student is analysing video tapes of counselling sessions). However, on completion of the write-up of the research, all non-anonymised data will be returned to the Chief Investigator for storage, and any copies destroyed.

ANONYMISED DATA

- Anonymised data refers to any form of documentation or media – electronic or otherwise – in which an individual is in no way identifiable. This includes, but is not limited to:
    - SPSS spreadsheets in which identifying characteristics (such as age) are not recorded
    - completed questionnaires: qualitative or quantitative
- Anonymised data may be kept for an unlimited period, and may be used for subsequent research projects and data analyses at the discretion of the Chief Investigator (provided that this is made explicit to participants in consent forms).

- Non-electronic anonymised data will be kept in a locked and secure location at all times, ideally at the University of Roehampton.
- Electronic anonymised data may be stored electronically. This should always be to the highest possible standard of confidentiality: for

instance, storage in an encrypted folder. It may also be kept on a password protected storage device, ideally at the University of Roehampton and, wherever possible, will be encrypted. Transfer and storage on portable/mobile devices (such as USB pens) should be kept to a minimum.

- Transfer of anonymised data should be conducted to the highest standards of confidentiality, always separate from any non-anonymised data. Any posted materials should be marked 'private and confidential.' If anonymised data is transferred via email, it should be transferred by the receiver to an encrypted portion of a hard disk as soon as possible, and both sender and receiver should hard delete the email/attachments from their email server.
- For the duration of a study, anonymised data may be stored (in the manner identified above) by investigators other than the Chief Investigator. However, on completion of the write-up of the research, all anonymised data will be returned to the Chief Investigator for storage, and any copies destroyed.

PARTIALLY ANONYMISED DATA (ALSO KNOWN AS PSEUDO-ANONYMISED DATA)

- This section refers to any form of documentation or media – electronic or otherwise – in which it is highly unlikely that research participants can be identified, but in which the possibility of triangulation exists. This may include, but is not limited to:
    - audio recordings

  Note, if such media includes clearly identifying content (for instance, an interviewee reveals their name or that of their husband on an audio recording), then it will be treated as non-anonymised data until those identifying characteristics are removed.
- Wherever possible, partially anonymised (and non-anonymised) data should be scrutinised and all identifying details should be deleted/erased (for instance, identifying features on transcripts, such as names of partners, should be deleted or blacked out).
- Where all identifying details of partially anonymised data have been deleted/erased, this data will be treated as anonymised data, and subjected to the same procedures as above.

- In instances where partially anonymised data can not be fully anonymised (for instance, audio recordings in which the participant may be identifiable from their voice), this data will be kept for ten years, and will be stored according to the protocols for non-anonymised data.
- Within this ten year period, partially anonymised data may be used for subsequent research projects and data analyses at the discretion of the Chief Investigator (provided that this is made explicit to participants in consent forms).

THE EIGHT GENERAL PRINCIPLES OF THE DATA PROTECTION ACT, 1998

- Personal data shall be processed fairly and lawfully (with specific requirements regarding sensitive personal data).

- Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.
- Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.
- Personal data shall be accurate and, where necessary, kept up to date.
- Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes.
- Personal data shall be processed in accordance with the rights of data subjects.
- Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against loss or destruction of, or damage to, personal data.
- Personal data shall not be transferred to a country or territory outside the European Economic Area, unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

Appendix 13: Examples of initial coded transcript

Transcription	Initial codes
[243] and the sheets [mmm]. Sometimes [244] the activating situations, the thoughts [245] and behaviours and the core beliefs [246] are really helpful to show people [247] [yeah], cos you understand their core [248] beliefs and they can understand like [249] being perfect and stuff like that and [250] they can see how that affects them in [251] the world [yep] and how they may not [252] like failure and how that contributes to [253] their drinking. So, yeah there's really [254] good aspects of it, yeah, it's a good [255] format.	Understanding links between beliefs and the here-and-now. Understanding how core beliefs affect their experience. Building awareness of their experiences. Identifying links between core beliefs and drinking There are good aspects of CBT. CBT is a good format to use.
[256]I: And so some of the more practical [257] tasks (yeah,yeah) then can be quite [258] helpful?	Collaborative process, therapist and client both actively engaged
[259] P: Yeah, yeah, I'm breaking down and [260]then they can be evidenced based [2601]because they actually doing the work [262] and bring back and then they can [263]experiment with it and come back and	Testing out beliefs through experiments and reporting back.

[264]let you know if it's successful that's [265] really useful.	
[267] I: Can you think of an example of [268] where any of those have worked [269] particularly well with a client? [270] P: Umm...let me think, with the [271] thought diaries [mmm], as such, yeah [272] I've had a client with the negative [273] thoughts and they were really [274] successful at work, but in their social [275] life they found it really struggling [276] [yep]. So, from the thought diaries [277] they could see that they had pinned [278] all their, they could see all their core [279] beliefs and all their core beliefs were [280] built around work and they could see [281] how out of work how they lacked in [282] the structure and relationship that [283]they didn't have, which was really [284] useful, if that makes sense? [yeah, [285] yeah]. And there are other clients, [286] yeah, I've had a lot of clients where [287] yeah, it's been really useful around [288] the relapse prevention process [289] [Okay]. The relapse proces which is [290] really important, where you sort of [291]	Using thought diaries to identify negative thoughts. Pinning down the problems. Clients hold a narrow focus. Gaining insight into core beliefs. Identifying the triggers for drinking. Bringing the problem into awareness. CBT is counter their experiences? CBT is useful for relapse prevention. Working on the relapse process is really important. Walking clients through the process of relapse. CBT is an active process. Clients denial about the problems.

walk them through it, and they say, “Oh, it's not been like that”, and then what happens is they go out and for that weekend and they drink too much [yeah]. And then they'll come back with the sheet and they’ve actually gone... so you go, “Okay what happened there? Where's the activating situation?” “There's my thoughts around it, I only had one, there was the result, actually I drank twenty.” So, you can see the whole process [yeah], so that's really beneficial.	Identifying the activating situation that lead to drinking. Therapist facilitating the client to weigh up the evidence. Facing reality of the problem. Seeing the whole process.

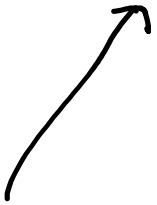
Appendix 14: Example of Transcript and Coding

Transcript	Initial coding
I: I mean you've definitely had a long length of time working in the addictions field (yes) and as I have said to you my main interest is thinking about CBT and I wondered if you could tell me a bit about what your experience has been of using CBT as a treatment for clients who have got alcohol use problems.	
P: Okay, well I guess it's the kind of it is the it's a foundation of what we do within the service, so in this service any client who comes into this service is then allocated a key worker immediately [yeah] and the key worker works with them and will deliver basic psychosocial interventions and those psychosocial interventions will be around substance use and will be CBT [yeah] based. It's kind of at the nub of everything [mm-hmm] and you know it's recommended NICE guidelines for alcohol problems [yeah] and it's kind of written large in the latest guidance the orange guidelines erm recently updated so, it's sort of it pervades all of what we do [mm] I think. And then in terms of the people that I see, I would then as the psychologist in the service, the key workers would refer to me clients who were struggling to make or maintain changes to their substance	CBT is the foundation of all work. Unqualified staff delivering CBT Psychosocial interventions focus on alcohol. CBT base for psychosocial interventions. Using the evidence-base Clients struggling to make or maintain change. Further psychological support required. Clients with additional difficulties. Addressing underlying difficulties to make change to alcohol.

use because erm their felt to be a sort of additional psychological difficulty [yeah] erm and a sense that you know and until there was some attempt to address or acknowledge that [mm mm] or address it then making changes to their alcohol or drug use or maintaining changes would be very very difficult [mmm]. So typically people I see will be people who are experiencing symptoms of anxiety erm, low mood, erm but probably the biggest thing would be around trauma [mm-hmm], complex childhood trauma [yeah] erm where alcohol and drug use has become a way of managing emotional distress around that [mmm] and has then become a problem in itself [yeah] and so then what I do is deliver interventions that are not strictly CBT [yeah] but would often be CBT formulated [yeah] but then not necessarily working in a strictly CBT [yes] way. I might CBT formulation to help them understand the links between their experience and their thoughts and feeling [mm-hmm] and their behaviour but wouldn't necessarily then go on to deliver a pure CBT intervention [mmm]. I would work integratively on whatever way felt appropriate [mmm] for that clients [mmm] presentation [mmm]. Does that make sense? I: Yeah it does. So really what you are saying is that once clients come to see you (yes) they're coming because there	Underlying problems make maintaining change difficult. Mental health problems affect alcohol problem. Alcohol to manage mental health problems. Alcohol use to manage emotional distress. Alcohol as a secondary problem. Alcohol becoming a problem itself. Using CBT informed interventions instead of following a rigid CBT approach. Using a CBT based formulation to make links and provide understanding. Not using a strictly CBT intervention Working integratively to meet the client's needs.

Other problems to alcohol

More than alcohol

is other psychological difficulties (yes) that are making sort of change in the substance use more challenging (yes) and within that that may then mean that you need to not just strictly stay within a CBT approach (yes) but draw on other interventions. But it sounds like one thing you were saying is that sounded very key potentially using a CBT formulation (yeah) as a base for a formulation (yeah), is that right?	Social and political implications of treatment? 
P: That's right and we do that here, so we also doing training with the team here to deliver the basic psychosocial interventions and one of the things we use a lot is the erm padesky and greenberger five part formulation [yes] the hot cross bun [yes yes] and so we always and our key workers will regularly use that as a way of you know with a blank sheet of paper just drawing up for clients the links between thoughts and feelings and physical sensations [yeah] and behaviours [mm] the key being substance use [mmm] and that's very very commonly used as a first step with people that are then thinking about making changes [mm].	Psychologists train the team in psychosocial interventions. Hot Cross bun formulation at the start to link the cycle together.
I: And what do you think it is about that that is particularly helpful for clients who have got alcohol use problems? Or how do you see that having worked?	Bringing in the substance use to the Hot cross bun is first step to treatment. Formulation to help clients think about change.

P: I think it just clarifies things [mmm]. I think in any therapeutic intervention the first step in terms of erm getting any benefit from it is sort of some kind of clarification [yes] or some kind of understanding about what's actually going on [mmm], so for clients who just feel that this is a bit of a mess or this is something they have no control over [mmm] or just something that happened they just have to do it, "I just have to drink", "I just have to use" [yes], it kind of slows down a process [mm] and shows that it is a process that there are other things going on [yes] and gives people some hope [yeah] and optimism that they can actually intervene.	Formulation give clarity to clients. Clarification and understanding is the first step to getting benefit from treatment. CBT makes sense of the mess. Formulation to slow down the process Showing clients there is a process Giving clients hope for change.

Appendix 15: Braun and Clarke's (2006) 15-point checklist of criteria for good thematic analysis.

Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead, the coding process has been through, inclusive and comprehensive.
	4	All relevant extracts for all themes have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have an analysed – interpreted, made sense of – rather than just paraphrased or described.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organized story about the data and topic.
	10	A good balance between analytic narrative and illustrative examples is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim to do, and what you show you have done – ie, described method and reported analysis is consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as *active* in the research process; themes do not just *'emerge'*.