Developing Theory in Motivational Interviewing: Academic and Practitioner Perspectives from MICBT integration.

Paul Earnshaw BSc, MSc.

A thesis submitted in partial fulfilment of the requirements of
Sheffield Hallam University For the degree of Doctor of Professional Studies

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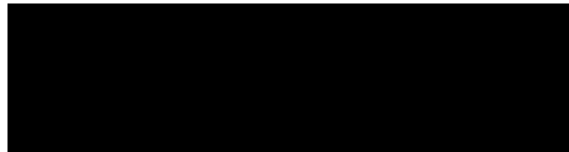
6. Signature:  Date 10.12.20

Name	*Mr. Paul G Earnshaw*
Date	*December 2020*
Award	*Doctorate of Professional Studies (DProf)*
Faculty	*Health, Wellbeing and Life Sciences* *Health Research Institute*
Director(s) of Studies	*Professor Ann Macaskill*

Abstract

Motivational Interviewing (MI) and Cognitive Behaviour Therapy (CBT) are both evidence based psychosocial interventions. Motivational interviewing has not sought to develop its own comprehensive theory (Miller & Rollnick, 2012) although it has developed hypotheses on why MI works. This project has looks at what an integration of these two approaches can tell us about motivational interviewing's theory, hypothesised mechanisms of action and efficacy. It has set out to examine and explore existing theory through qualitative research. This included Semi structured interviews with researchers and practitioners who are experts in the integration of MI and CBT (MICBT). Their views and existing literature were used develop understanding about MI efficacy. A critical realist philosophical framework and Theoretical Thematic analysis was used to explore and test MI theory. A number of themes around hypothesised mechanisms and MI theory emerged from both sets of participants. These included psychological safety, alliance, responding to resistance, acceptance, compassion and positive emotion. A relational rather than a technical practice was emphasised and the theory relating to that observed. Theory around Power, its negative and positive operation in people's lives arose frequently; as did hypothesised mechanisms relating to power differentials and MI as a 'power yielding' approach. Building on insights from evolutionary theory, links were made to a more detailed consideration of the effects of social context on research, practice and the ability of individuals to make change. This project challenges a narrow-individualised approach to research and intervention, emphasising the need to take into account the effects of social inequality and individual social circumstances.
The project has illustrated some of the reality of translating theory into *real-world* practice and suggests expanding MI theory so that it is more contextualised. The centrality of understanding power and power structures may be a useful addition to an understanding of why MI works. An increased awareness of social context and its impacts raise questions about how individual and societal level interventions could work together to improve health behaviour change. Finally, a number of suggestions for future research are made, including that individualised interventions need to be evaluated in *real-world* services, with direct consultation of and involvement of service users.

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CHAPTER 1. INTRODUCTION:

1.1 Background to the study: Context and research area

This research is undertaken as the final part of the Doctorate of Professional Studies in the Department of Health and Well-being at Sheffield Hallam University. I am conducting this research at the same time as working a Senior Psychological Therapist in the National Health Service (NHS). My research area is that of the field of psychosocial interventions and specifically the practice of psychological therapy in working with people who experience a range of mental health, behavioural and life difficulties. My main areas of expertise and interest are in the practice of Cognitive Behaviour Therapy (CBT) and Motivational Interviewing (MI) both as interventions in themselves and in the integration of both therapeutic approaches (MICBT).

1.1.2 My Motivation in Undertaking the Research

I have worked for many years using an integration of MI and various CBT's. This practice first began when working as a therapist in a large Randomised Controlled Trial (RCT) evaluating the integration of MI and CBT for people with substance misuse problems and Psychosis (Barrowclough et al., 2010). As a Psychological Therapist I have continued to develop this practice and research interest working with 100's of clients in mental health services who have experienced a wide range of problem health behaviours. I have also trained 1000's of health service staff including other Psychological Therapists in Motivational interviewing with a view to considering whether it might be a useful to integrate this psychosocial intervention in mental health and other health settings. I have also collaborated in developing training events and in the writing of conceptual articles considering for example how MI might contribute the maintenance of health behaviour change (Naar-King, Earnshaw, & Breckon, 2013). I have also recently coauthored a book that considers the theory and practice of integrating Motivational Interviewing with CBT as a guide for practitioners (Atkinson & Earnshaw, 2019).

My doctoral Study has exposed me to a range of perspectives on knowledge and encouraged me to re-examine the work I have been involved in. This research

project began initially as the qualitative arm of a small controlled trial investigating the effects of an integration of CBT and MI, in an NHS psychological therapy service. This work was curtailed due to service pressures and a lack of resources in this service, prompting the need to rethink my project. This initial work has provided useful background knowledge as I had to reformulate and redesign this current study. This is a qualitative study focusing on the development of theory in MI and hypothesised mechanisms of action relating to outcomes for clients. This topic is being addressed through interviewing academics who are experts in the research on the integration of MI and CBT and also interviewing clinicians who have expertise in carrying out this integration in practice. The interviews focus on asking them both for their views, theories and hypotheses on what they think is happening when you integrate these two therapies. In doing so generating data that can be used to test against the existing theory in this area. My initial research enquiry and literature review has indicated that qualitative studies and theory driven investigation is underdeveloped in this area of mental health work.

1.1.3 Statement of topic and focus on research questions and aims

1.1.4 Aims of research

The primary aim of this research is to explore and understand the perspectives of expert researchers and expert practicing psychological therapists on the integration of CBT with Motivational Interviewing.

1.1.5 Research Questions:

- What has the integration of MI and CBT told us about the theoretical basis of the efficacy of Motivational Interviewing

- What does the integration of MI and CBT for people with mental health problems tell us about the underlying mechanisms of action and how they relate to outcome for these psychological interventions

- What works for whom in MI, in what circumstances and why?

1.1.6 Objectives:

- To develop and carry out in depth interviews with expert academics and psychological therapists based on existing theory of why these psychosocial interventions might be effective.

- To analyse the content of these interviews and develop theory around the underlying mechanisms and social contexts of this therapeutic integration

1.1.7 Summary of Chapters:

This thesis is structured in part by academic convention, also by the subject matter and recommendations for writing up qualitative research (Braun & Clarke, 2013). A summary of the thesis chapters is now provided here.

Chapter 1. The Introduction

This provides the background to the research itself, set in the context of a researching and delivering in practice the integrated psychosocial intervention MICBT in mental health services and in my own therapeutic work. It outlines my motivation in under taking the research. Also, the research Aims, Questions and objectives are stated.

Chapter 2. Overview of CBT and MI

This chapter provides an overview of CBT and MI as psychosocial interventions including a brief comparison of both approaches.

Chapter 3. The Literature Review

This chapter explores the background literature around the integration of MI and CBT. Also, consideration is given to what is meant by theory and theory development from a critical realist perspective. It examines relevant existing research on theory, mechanisms of action, and the contexts that may account for outcomes in MI. It examines mechanisms of action that are proposed in the MICBT integration literature from mental health settings. I provide an overview of the research into the development of this integrative approach and those

hypothesised mechanisms of action. Also, considering why this may be advantageous or not in terms of therapeutic process and outcomes. Particular attention is given to MI which has been largely phenomenological in its development, that is being developed from observations of practice and hypothesis testing. Although MI is a relatively well defined and it is an evidenced based therapeutic approach there is little theory development in this field (Miller, 2017). There are many forms of CBT so a detailed exploration of the literature around mechanism of action and theory development for CBT is beyond the scope of this project. Gaps in the literature have been identified and reflected upon. The comprehensive literature review strategy and process is outlined.

Chapter 4. Methodology and Data analysis

This chapter describes the research design within a critical realist philosophical framework. Also, consideration has been given here to different views of ontology, epistemology and methodology in the field of mental health and psychosocial Interventions. The research design and strategy is articulated, as is the pilot work around the interview development, its design and further development. It also provides a review of methodological approaches and a rationale for the chosen methodology using a critical realist informed philosophical framework. How the core setting and data sources were identified, how I gained access to samples, how the data were collected, and descriptions of the samples are given. The structure of the data analysis, how I arrived at my choice of codes, themes and headings are described. As is the system for presenting the data based on the coding, themes, pattern recognition and analysis.

Chapter 5. Findings and Discussion

The findings themselves and reporting on the process of analysis of the qualitative research data and how theoretically informed thematic analysis was used are described in this chapter. This is structured using the themes and headings derived from the literature with additional headings being generated by the researcher based on the responses of participants. This chapter considers what we can learn from the data in terms of my research questions. Particularly, the testing of existing theory against that generated from the data and enabling

thinking about what this tells us about MI theory. The implications of the data for practice and theory development in MI, as well as ethical considerations are explored. How the current findings fit with existing research, how they challenge it and what they add are discussed. Finally, the limitations of the study and implications for future research, theory and practice are highlighted.

Chapter 6. Conclusion

Here my final comments on all the basic points of my argument are made. There is a summary and synthesis of the main findings and overall conclusions. The original contribution to knowledge the project brings is considered, in terms of MI theory and practice. A final reflection on the impact this project might have on future research, theory development and on the training of neophyte psychological therapists concludes the project.

CHAPTER 2. AN OVERVIEW OF COGNITIVE BEHAVIOUR THERAPY (CBT) AND MOTIVATIONAL INTERVIEWING (MI) IN MENTAL HEALTH:

2.1 CBT

This section provides an overview of CBT and its development. Aaron, T. Beck, (1979) proposed that CBT was based on the underlying theoretical principle that an individual's emotions and thought processes are largely determined by the way in which they understand and structure the world. Cognitive and Behavioural techniques were developed and are used in therapy to help explore and test what are seen as the individual's misconceptions, maladaptive assumptions and strategies. According to Roth and Pilling (2007) three important features of CBT in working with anxiety and depression are identified and summarised below, from Atkinson and Earnshaw (2019, p.13):

"1. That CBT is intended to be collaborative and that the client should be encouraged to share responsibility for the working through the therapy.
2. Therapists should maintain a sense that CBT should promote clients' ability to understand themselves through a process of guided discovery.
3.CBT should help clients learn skills to help them deal with future situations more effectively."

In terms of accepted standards of evidence based psychosocial interventions CBT is well regarded internationally and the United Kingdom (UK) National Institute of Clinical Excellence (NICE) has recommended it as a psychosocial intervention for a range of mental health problems and a number of other health problems, (NICE, 2009).

It might be said that CBT is the dominant psychotherapeutic practice in mental health services in the UK. It developed originally out of a reaction to psychoanalytic therapy in the 1970s in the United States of America. Manifesting initially in the form of behaviour therapy and it was based on the methodology of experimental psychology. During the "cognitive revolution" that took place in psychology in the 1960s and 1970s many behaviour therapists started to call their therapy "Cognitive Behaviour Therapy". The more recent and direct origins of

cognitive behavioural therapy models that I work with now are based on the work of Aaron T Beck (Beck, 1979) and Albert Ellis (Ellis, 1962) who are generally acknowledged as the founders of cognitive behaviour Therapy. Beck was an American psychoanalytic psychiatrist and Ellis a clinical psychologist. Marjorie Weishar (1993) describes Beck as developing his clinical practice and therapeutic method in private practice and in secret because of hostility from the psychoanalytic community. The work of Ellis and Beck has been very influential in the UK psychological therapy services. Beck's work in particular has influenced the field of Cognitive Behaviour Therapy for Psychosis (CBTp), in which I work. Much of this recent CBT and CBTp work has come from the work of British clinical psychologists and Psychiatrists, see (Tai & Turkington, 2009). These latter strands and practices providing the therapeutic roots to my work.

2.1.2 Developments in CBT

There are now numerous forms of and descriptions of different CBTs for example Dialectical Behaviour Therapy (Linehan, 2015) Acceptance and Commitment Therapy (Harris, 2009), Meta Cognitive Therapy (Houghton, 2008) Compassion focused Therapy (Gilbert, 2009,Williams et al., 2014) It is beyond the scope of this project to explore in detail the various models and theories of CBT. It is clear that there are many of them and that they continue to develop. They have been described as first, second and third wave CBTs and some have developed theoretically based on extensive empirical research. These forms of CBT are usually described in relation to psychiatric diagnostic categories, for example: CBT for depression (Beck,1979), anxiety (Tyrer & Salkovskis, 2014), obsessive compulsive disorder (Clark, 2004), post-traumatic stress disorder (Ehlers & Clarke, 2005) and personality disorder (Davidson, Tyrer, Norrie, Palmer, & Tyrer, 2010).

2.1.3 Evidence and Dissemination

Over a long period now clinical psychology in psychiatric services has adopted a medical research methodology exemplified by the use of the Randomised Controlled Trial (RCT) in the development and testing of its therapies (Deacon, 2013). Most clinical problems are described as above in discrete diagnostic categories and they have specific CBT models. They are recommended in NICE

(2011) guidance in the UK for psychological therapies for common mental health problems and CBT is similarly recommended in the USA by the American Psychological Association (2006). Thus, CBT might be said to be diagnostically focused, epistemologically assuming that an underlying cause lies within the individual's cognitions, emotions and behaviours. David (2018, p.1) argues that CBT is the current gold standard for psychotherapy on the basis that:

"1) CBT is the most researched form of psychotherapy. (2) No other form of psychotherapy has been shown to be systematically superior to CBT; if there are systematic differences between psychotherapies, they typically favour CBT. (3) Moreover, the CBT theoretical models/mechanisms of change have been the most researched and are in line with the current mainstream paradigms of human mind and behavior (e.g., information processing). At the same time, there is clearly room for further improvement, both in terms of CBT's efficacy/effectiveness and its underlying theories/ mechanisms of change."

Leichsenring and Steinhart (2017) have argued for plurality in psychotherapy delivery because many CBT studies have been found to be of low quality and had weak comparison conditions for example waiting list rather than another active intervention. David (2018, p.1) acknowledges this, but further argues that many CBT studies had strong comparator conditions giving examples of a pill or a psychological placebo, also treatment as usual, other therapies and that these studies met stringent criteria for empirical study.

Cuijpers, Cristea, Karyptaki, Reijnders and Huuibers (2016) carried out a meta-analysis of CBT for depression and anxiety disorders, they found that 17% of the total trials for depression in their review were of high quality. Also, interestingly that relationship between effect sizes and quality of the studies themselves was not strong. According to David (2018, p.3) in terms of outcomes CBT often had small to moderate effect sizes compared to treatment as usual. Also, that this may still be important clinically, dependent on a cost benefit analysis. In common with other individual psychological therapies CBT research has identified its strengths, shortcomings and areas for improvement. It has also sparked considerable debate around its widespread adoption across a range of behaviours by governments and health commissioners (House & Lowenthal,

2008). Guilfoyle (2009) observes that Lord Layard an economist behind Government promotion of CBT has done so ‘at least in part because it will aid the economy: it will get people back to work more quickly than other therapies and reduce strain on the benefits system.’ Kaye (2008, p.174), suggests:

…” mainstream CBT may be construed as an ideologically infused practice which (a) supports the social order; (b) may serve as an instrument of social control preserving the dominant culture;(c) maintains inequitable social conditions and arrangements which may be constitutive of the problems people experience.”

This is a wide ranging and often controversial debate which I will not be able to consider in detail in this project. CBT itself is not the focus of this project but what the integration of CBT with MI might tell us about mechanisms of action and theory in MI is. The evidence relating to theory development in MI and the integration of MI with CBT, will be considered in Chapter 3. I will now consider a brief overview of MI as a therapeutic approach before considering in more detail its theoretical development and origins.

2.1.4 Motivational interviewing (MI)

Like CBT, MI is a well-established, evidence-based, talking therapy. According to its originator William Miller (1983) MI developed in the substance misuse field out of an integration of behaviour therapy and the person-centered approach of Carl Rogers (Rogers,1980). Along, with Clinical Psychologist Steven Rollnick they have further developed it as a method for building motivation to change problematic health behaviours. (Miller & Rollnick, 1991, 2002, 2013; Rollnick, 2008).

2.1.5 Definitions of MI

Most recently (Miller & Rollnick, 2013. p.29) offered three separate definitions of MI.

- **Layperson’s definition:** “Motivational interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change”.

- **Practitioner's definition:** "Motivational Interviewing is a person-centred counselling style for addressing the common problem of ambivalence about change".
- **Technical definition:** "Motivational interviewing is a collaborative, goal-orientated style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere or acceptance and compassion."

In essence MI is an approach to supporting people in exploring and resolving their own ambivalence about changing their behaviour. In this latest edition of MI (Miller & Rollnick, 2013) three core components are outlined, the Spirit, the Core skills, and the Method.

2.1.6 Spirit

The Spirit is may be thought of as an underlying philosophy based on the therapeutic relationship as a collaboration, Miller and Rollnick (2013, p.15) seeing MI as: "an active collaboration between experts". Spirit is based on four vital aspects, Partnership, Acceptance, Evocation and Compassion, they are described below.

- **Partnership,** here the therapist honours the expertise of the client and their autonomy and their right to choose to change or not. It is a collaboration, not something done to a person rather MI is done for and with a person.

- **Acceptance**, it is assumed that resource and motivation for change lies with client. The therapist accepts the absolute worth of the person through accurate empathy, affirmation, and in supporting autonomy

- **Evocation** is the reinforcement of a focus on client strengths and that in MI interactions change is expected to be enhanced by elicitation rather than persuasion. It is based on a view that eliciting knowledge about change, that is

already there in the client is more effective than trying to install reasons for change or to persuade.

- **Compassion** is a concept that was introduced by Miller and Rollnick (2013) to emphasise that as health workers we give priority to and actively support the needs and welfare of others. This concept also ensures that MI is not misunderstood as an approach to manipulate people as for example in a sales context. In doing so they wanted to distance the approach from such applications.

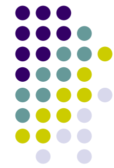
2.1.7 Core Motivational Interviewing Skills

The core communication skills of Open questions, Reflections, Affirmations and Summaries have been extensively discussed in MI (Miller & Rollnick, 1991, 2002, 2013). These skills are not unique to MI and can be to said to represent good practice in communication generally. In MI practice the style that is emphasised is one of reflective listening with judicious use of strategic questions, regular summarising and affirmations. The combination of the Spirit of and the use of MI core skills has been described by Miller (2011) as like the combination of the music and the words of a song, without which neither works.

The motivational treatment integrity scale, MITI 4 (Moyers et al.,2014) specifies what MI researchers think should be observed in a competent MI practitioner based on existing MI research and the latest definition of MI (Miller & Rollnick 2013). In terms of the use of core skills. For example, it specifies a ratio of reflections to questions, 1:1 indicating Fair competence and 2:1 Good competence. This scale also outlines the measurement of the spirit or relational elements of MI through its ‘Global Ratings’ of Partnership and Empathy. It also gives guidelines to researchers around the technical elements of MI described as cultivating change talk and softening sustain talk. These concepts will be discussed in detail in the literature review below.

2.1.8 Motivational Interviewing Method or four processes

Finally, Miller and Rollnick (2013) have described four overlapping processes of engaging focusing, evoking and planning as the method of MI (see figure below).



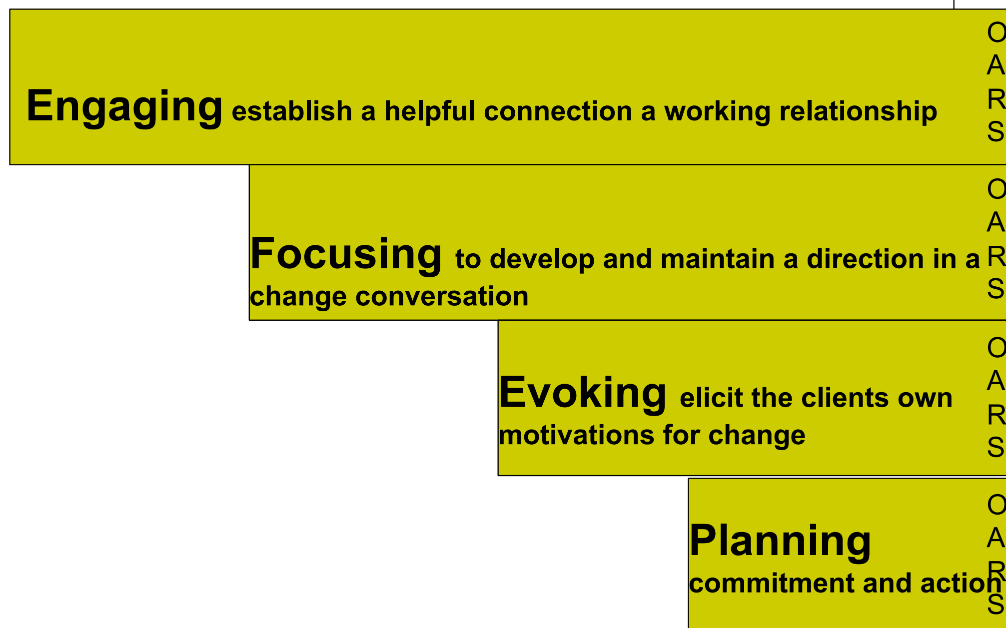


Figure. 2.1

As outlined, in the spirit of MI the therapist is using their core skills to pay attention to engaging with the concerns of the individual. They then focus collaboratively with the individual on those concerns and this focus essentially provides direction to the conversation. The therapist evokes selectively the client's own reasons and arguments for change. When and if the client decides they are ready for change a process of planning may occur. These concepts will be discussed further in the literature review in terms of MI theory and as mechanisms relating to outcome data.

2.1.9 Evidence and Dissemination

MI is one of the most extensively researched behaviour change interventions and Miller and Moyers (2017) cite over 500 controlled trials of MI. Miller (2019), identified over 1,220 clinical trials involving MI and more than 100 meta-analyses

and systematic reviews of MI outcome research addressing a wide range of clinical problems. The efficacy of MI for substance use and other health related behaviours has been demonstrated in a number of systematic reviews and meta-analyses (e.g., Burke, Arkowitz, & Menchola, 2003; Hettema et al., 2005, Lundahl & Burke, 2009). Recently, DiClemente, Megan, Graydon, Wiprovnick, and Knoblach (2017, p. 885) conducted what they called a 'review of reviews', that included 44 reviews and 6 Cochrane reviews of MI studies, carried out in the substance misuse and gambling field. They looked at MI, Motivational Enhancement Therapy or MET (Miller, Zweben, DiClemente & Rychtaric,1992) and brief interventions based on MI, describing them as motivationally enhancing interventions.

They concluded that their review:

"supports use of motivationally enhancing interventions across addictive behaviors with strongest evidence supporting use in alcohol and tobacco, with brief interventions showing strong efficacy. There is strong support for MI with marijuana and some support for gambling"

DiClemente et al., (2017) acknowledge the limitations to their overall conclusion. Observing that the effects are most consistent when the motivational interventions are compared with a no treatment or an inactive control. Further, this conclusion becomes more mixed when the type of control and type of substance is taken into account. Although, for alcohol misuse motivational interventions were seen to be significantly more effective than inactive controls, but there was mixed evidence for this with tobacco and crack cocaine use.

Also, they said they found it challenging to undertake their review as they identified significant heterogeneity in what is called MI or motivationally enhancing interventions. Another challenge was that it was often difficult to verify how the spirit, principles and practices of MI were operationalised, as many studies often did not describe this, a further limitation of this review. Summarising MI outcome research Miller and Moyers (2017) describe it as having effects sizes of small to medium across a range of clinical problems including, substance use, weight loss, eating disorders, diabetes, paediatric, adult health behaviour,

problem gambling and medication adherence. Although, they acknowledge this was not uniformly the case across the therapists delivering MI and across sites and studies. Miller and Moyers (2017, p.3) put it this way,

“Average effect sizes of MI, whether alone or in combination with other treatments are in the small to medium range with wide variability across studies. In multisite trials the efficacy of MI can vary by site (e.g., Ball et al., 2007). Large outcome differences across MI providers are typical even when counselors are trained together, closely supervised, and following a therapist manual (Project MATCH Research Group, 1998)”.

Miller (2019) observes that 2/3rds of MI trials tend to show a positive effect and that 1/3rd of them did not, across sites, therapists and in multisite trials. This raises questions as to why this should be so, Miller and Moyers (2017) suggesting that it may be that the same treatment is not being delivered each time. Observing that psychosocial interventions in general have a wide variation in how they are delivered in practice. These psychological interventions are seen as inseparable from the person delivering them and the person receiving them. Miller and Moyers (2017) highlight a need to maintain fidelity to MI consistent practise and the Rogerian consistent qualities outlined in the Motivational Interviewing Treatment Integrity Coding Manual, MITI,4. (Moyers, Manuel, & Ernst, 2014). Much of MI research has focussed on the practitioner’s behaviour and thoughts in relation to outcomes and to a lesser extent on those of the client (O’Driscoll, 2016). The extent of what each individual brings, and the social context of the intervention will be considered in the next chapter as part of exploring MI theory.

Because of its extensive research base MI is well-established as a behaviour change intervention. It has been recommended in the UK as a psychosocial intervention for alcohol misuse (NICE, 2010,2011) and for substance misuse in psychosis (NICE, 2011). DiClemente et al., (2017, p.24) point out that particularly in the USA: ‘’Brief Motivational interventions…. have become standard practice with many different professionals and are being mandated by various funding agencies and certification”. MI has been adapted to address issues of motivation and ambivalence about change, in a wide range of clinical presentations, including mental health problems for example in Anxiety (Arkowitz, 2008),

Depression (Brody, 2009), Psychosis and Substance use (Baker et al., 2006; Barrowclough et al., 2010).

A systematic review and metanalysis of MI to enhance treatment attendance by Lawrence, Fulbrook, Somerset and Schulz (2017) included 14 RCTS and found that MI increases adherence and attendance in mental health settings. Also, interestingly they concluded their review demonstrates that MI is most beneficial delivered as an opportunistic intervention for people not seeking treatment for mental health problems. Briefer and longer MI interventions were observed to have similar effects, with as little as 15 mins of MI as a pretreatment showing increased attendance. They also point out the limitations in their review and the studies included in it. Although, generally sound in design and execution the studies had a number of common weaknesses. For example, there was limited explanation of blinding procedures, small sample sizes and a lack of data relating to MI intervention quality. Further fidelity assessment for MI was found to be absent in most studies. In spite of these drawbacks, they recommend MI as a useful tool for clinicians in all therapeutic interactions to help motivate people to seek help for mental health problems.

The research into MI integration with CBT in mental health in particular is something that I will explore in the next chapter. Miller (2019), observes that the recent trend is away from carrying out MI stand-alone studies, he observed a range of descriptions in new research. As well as the MI CBT combinations he gave some examples of descriptions of current MI related research, they were:

" used motivational interviewing strategies", "providers received 2 hours of training including MI", "intervention was a mixture of MI, CBT and pharmacotherapy", "integrated MI techniques", "using principles of MI", "in the style of MI", "we used MI as a framework", "utilizing an MI approach".

DiClemente et al., (2017 p.862) reinforces this point, "There are also many adaptations of motivational approaches implemented in different settings and by different professional and para professional providers." MI research has been conducted across the world and the main MI texts have now been translated into 28 languages (Miller, 2019, personal communication). Having gone through four

revisions of the approach, only one form of MI has been described. Although, Atkinson & Woods (2017) suggest that because of theoretical changes across the main Miller and Rollnick publications, that this may have affected the delivery of the method and how training in MI has been undertaken over that period. MI shares an epistemological approach and methodology with CBT that assumes an underlying cause within the individual and focusses on the individuals behaviour change. It also shares a reputation for being evidenced based in the same paradigm and with similar limitations in its outcomes and research.

In the substance misuse field, Moyers and Houck (2011) describe the combination of MI with CBT as 'the norm' and that it is perhaps more effective than a single therapy alone. Miller and Moyers (2017, p.761) say, "In addition to being used as a "stand-alone" treatment, MI has had a second life as an intervention that is combined with other approaches, most commonly cognitive and behavioral interventions". What this integration looks like, the rationale and evidence for it, as well as what this means for MI theory will be examined in the literature review chapter.

2.2.0 Theory, Contexts, Mechanisms and Outcomes in Motivational Interviewing and CBT.

A critical realist or realist informed research perspective stresses the need to understand underlying mechanisms and social contexts in order to explain the outcomes of psychosocial interventions. According to (Pawson, 2013), psychosocial interventions such as MI and CBT maybe seen as programme theories in themselves, and that they consist of interconnected elements. This research is interested in developing theory about those interconnections based on the existing literature and the perspectives of its stakeholders. This will include the perspectives of expert researchers and expert experienced psychological therapists in this field. The study will attempt to address questions around the why and how MI and CBT might work together; for whom and in what circumstances. Also, what the insights knowledge and experience of participants might tell us about those underlying mechanisms of action that lead to client outcomes in MI. Apodaca and Longabaugh (2009, p.9), reviewed possible mechanisms of change within MI and they concluded that in relation to questions

of MI efficacy that... “it may require more sophisticated theory and the application of more recent analytical techniques to identify how MI works for whom and under what set of conditions”.

2.2.1 Theory development and critical realist informed qualitative research

In the MI and CBT research communities there are numerous randomized controlled trials that have shown that they are both seen as effective psychosocial interventions within what might be described as a predominantly positivist research paradigm. Leighton, (2013) points out that from a critical realist perspective that this remains valuable work, but it could also be argued that it tells us little about how these interventions work or why they work. To illustrate this, he cites a concluding paragraph from the Cochrane review of MI published in 2011:

…“This is a field where there is no lack of randomised controlled trials. Perhaps it is time to move from only studying **whether** MI works to also studying **how** it works, that is to study the mechanisms behind MI.” …

(Smedslund et al., 2011 p.28, emphasis in original).

Similarly, CBT has a large randomised controlled trial literature showing positive outcomes across a range of psychiatric diagnoses. However many, for example, Birchwood and Trower (2006) and Goldsmith et al. (2015) have observed that it is difficult to specify what the distinctive active components and mechanisms of CBT are. Further it should be noted that these two large literatures are products of academic research groups in psychology that are quite separate and as Tett, (2016) suggests might be said they exist in silos. Pawson (2013, p.20) sees programme mechanisms as being... “embodied in the subjects reasoning and are best investigated therein by using qualitative interviews”. This study intends to investigate this reasoning using a qualitative methodology and a critical realist informed framework. Exploring MI CBT integration and how that might contribute to the development of programme theory in MI. Using this framework, it is to the literature on MI theory, mechanisms of action and outcomes that I will now turn.

CHAPTER 3.0 LITERATURE REVIEW

3.1 Philosophical framework

This investigation draws on both a critical realist and realist informed philosophy and as such maintains a perspective of curious uncertainty. Existing theories relating to MI and its integration with CBT, are examined and have formed the basis for this literature review. This literature has also been used to develop the questions and areas of focus for the project's semi-structured interviews. The literature search strategy outlined below focused on MI theory, mechanisms, outcomes and contexts in relation to why MI might work. Both as an intervention in its own right and also when it has been integrated with CBT. This project is not a formal realist synthesis, but the investigation and literature review draw philosophically on the core elements of a critical realist informed enquiry. In terms of a realist approach to literature reviews Mutschler, Naccarato, Rouse, Davey and McShane, (2018, p.3) describe … "A realist approach goes beyond identifying the interventions efficacy to examine the underlying mechanisms and contexts in which the interventions work."

This current review synthesises some of the efficacy and effectiveness literature, although it main purpose is exploratory. Its focus is on identifying theory, underlying mechanisms of action and how outcomes are brought about in particular contexts. It focusses primarily on MI theory, its antecedents' and development. This includes a review of the literature on relevant psychological theory and proposed or hypothesised mechanisms of action in MI. The literature reviewed has been focussed on trying to identify underlying mechanisms of action in MI and to a limited extent develop the theory around the efficacy of MI (Miller & Rose, 2009, Copeland, McNamara, Kelson, & Simpson, 2015, de Almeida Neto, 2017). Also, a range of possible underlying mechanisms of action relating to outcomes have been proposed in the MI literature by way of recommending various integrations of MI with CBT in working with mental health and other problems. This literature will be considered here to help address the question of what the integration of MI and CBT tells us about MI Theory and how can this be developed. The MICBT integration literature for mental health interventions is comprehensively reviewed and consideration given to how MI

might be affecting those interventions. This literature and the subsequent study may also help in identifying mechanisms of action that are thought to bring about outcomes in particular contexts. The origins and development of MI theory are reviewed, coming from both the field of substance misuse and mental health. Like all knowledge and interventions MI and MICBT exist in a wider social context. The social context of MI including some theoretical and practical critiques of MI in terms of these contexts are also examined here.

3.1.2 Literature Search strategy

This was not a systematic review, although a mixture of search startegies were used including data base searches, use of experts, and handsearching of references from key articles. The review focused on conducting a background search for MI theory, searching for empirical studies, and searching for critiques of MI theory. From a realist viewpoint the number of articles required to begin theory development can be very small and requires more than one single search. The process of searching used was iterative and generated a comprehensive review of the literature in relation to my research questions. Data base searches used included PsychINFO and PubMed and the time frame was 1983 to the present day. The main focus was on theory and MI but also research articles reacting to context and mechanisms of action.
Search terms used included: Motivational Interviewing, Theory, Mechanisms of action, Active ingredients, Context, Social context, Mental health, MICBT, Critical Realist, Realist analysis. (Appendix 1.) This review aimed to identify what might be described as candidate mechanisms of action and candidate theories based on existing psychological concepts and the existing theory development in MI. Before this is summarised I will consider some definitions of theory and mechanisms of action used in this study and review.

3.1.3 Critical Realism, Theory and practice in mental health

The writings of Bhasker (1979) and others e.g. Sayer (1992) and Lawson (1997) have developed the term critical realism. It has been used theoretically (Pilgrim, 2015) and empirically (Notley et al., 2014) in the field of mental health. Critical realism treats the world as theory laden but not theory determined. Theories are

considered initial and they can promote a deeper analysis to help in developing a more accurate explanation of reality. The ontological premise of critical realism is that the world exists and is real. Also, that our investigations of it are filled with the interests and values of individuals and their different professional groups, in this case those of clinical psychiatry and psychology. The epistemological consequence of using this approach is that we must approach all claims for all knowledge sceptically or critically, hence the term critical realism. It is an approach that might be characterised as one of curious uncertainty. Critical Realist and realist philosophy have been used to inform the project throughout and will be described in more detail in the methodology section of the thesis.

3.1.4 Theory definitions

In terms of defining Theory, according to a realist research paradigm (Jagosh, 2017, p.1)…. "A theory is an attempt to organize the facts – some 'proven', some more conjectural – within a domain of inquiry into a structurally coherent system."

Wong (2018,p.555), describes, ..."Theories are more than just guesses, because they have to be at the very least partially supported by some facts or data…..almost all of our theories are partial and so to make advances we do often need to conjecture."

All realist research regards itself as being based on a logic of mixed methods, in developing evidence and using theory configurations. A realist research question contains some or all of the following elements: What works for whom, how, why, to what extent, under what circumstances, in what respect and over what duration? Pawson, (2013, p.15) asks…. 'Why does a programme work in Wigan on a wet Wednesday and why does it then fail in Frinton on a foggy Friday? According to (Pawson, 2013), psychosocial interventions such as MI and CBT may be seen as programme theories in themselves and that they consist of interconnected elements. According to the Oxford English Dictionary (2018) the term theory can mean:

''1. A set of principles on which the practice of an activity is based 2. An idea used to account for a situation or justify a course of action''. Coles (2002), in discussing theory in conventional health care education says that it is often assumed that

theory must precede practice, it can be applied to practice, or is derived from practice. She sees theory and practice as mutually constitutive and dialectically related domains and suggests this thinking should inform educational programs and initiatives. She makes a distinction between formal theory, which can be taught and learnt, and personal theory, which can only be appreciated through a process of theorizing. This can be reflective, deliberative, deductive, inductive or reproductive.

Dalgetty, Miller, & Dombrowski, (2019) investigated the claim that theory use leads to more effective behaviour change interventions by analysing published systematic literature reviews of behaviour change interventions in adults. This systematic review of systematic reviews revealed that theoretically derived interventions fared no better in terms of outcome than those without a theoretical basis. The authors acknowledged several limitations in their review particularly the suboptimal reporting of theory use in their selected studies and many of the RCTs included showing unclear or high risk of bias. Also, that certain health behaviours were overrepresented in their sample and that this may limit generalisability. They also point out that behaviour change interventions may be based on implicit theory rather than an explicit underlying theory. In the mental health field, Tarrier, Gooding, Pratt, Kelly, Awenat, Maxwell, (2013) say that it remains generally accepted that a theoretical basis for psychological interventions is necessary for mechanisms of action to be identified and tested. Dalgetty, Miller, & Dombrowski, (2019, p.20) conclude that theory use should be promoted,… "using a multifaceted argument, and assertions for increased effectiveness of theory-based interventions should only be used in domains where specific evidence exists to support this claim''.

What constitutes specific evidence may be difficult to define especially if empirical investigation is only focused on outcomes and not on developing an understanding of how an intervention works. There are many definitions of what constitutes a theory in health care interventions and education. To what extent clear distinctions are being made between mechanisms of action, mechanisms of change, processes, models and theory in MI and in other literatures seems

unclear. From the world of Physics research Einstein and Infield (1938 p.159) have put it this way,

…. "Creating a new theory is not like destroying an old barn and erecting a skyscraper in its place. It is rather like climbing a mountain, gaining new and wider views, discovering unexpected connections between our starting point and its rich environment. But the point from which we started out still exists and can be seen, although it appears smaller and forms a tiny part of our broad view gained by the mastery of the obstacles on our adventurous way up."

Climbing this mountain is a task for this review and the project in the hope of gaining a wider view and broadening the theoretical horizon.

3.1.5 Outcomes, mechanisms and contexts in behaviour change

From a critical realist perspective, it can also be said that where there is an **outcome (O)** of interest for example a health behaviour change that was generated by a relevant **mechanism(s) (M)** contained within a psychological intervention and that this outcome is being triggered in a particular environment or **context (C).**

Jagosh, (2017, p.1), sees mechanisms as usually although not always hidden, they are sensitive to variations in context and are responsible for generating outcomes. He states…." For social interventions, we use mechanism to refer to the cognitive process or what 'turns on' (or not) in the minds of the participants when they are offered or asked to engage with a program or intervention."

For the client the mechanism or mechanisms may relate to what is going on cognitively for them as a result of the interaction or intervention taking place. In this case the resource is provided through the therapy and the therapist themselves. We might also be asking what meaning or reasoning is taking place in the mind of the client that might lead them toward making a change in their behaviour. Similarly, we are also interested in what is going on cognitively for the therapist in this relational interaction. What is their model, their attitude or philosophy in terms of human mental distress and how to work with it? What does

their training and experience suggest to them that they need to provide in order to help produce behaviour change for the client?

This complex interaction is always taking place in a real-world context. There are according to (Jagosh, 2017) many different contexts containing many different elements, for example: there are cultural norms and values, historical factors, economic and financial realities, geographical and socio political elements, existing public policy, previous experience of interventions, gender, sexuality, race, social class and anything else in the physical and social environment. So, what is called empirical research is always context sensitive knowledge. We know that not all interventions work all of the time and in all contexts. Also, that the same intervention can produce different outcomes depending on the person who delivers it for example in MI studies (Miller & Moyers, 2015).The definitions have given some guidance to this project and provided a structure for examining and developing theoretical constructs.

According to Miller (2017, pg.1)

…. ‘‘Motivational interviewing (MI) has been criticized for lacking a theoretical explanation of its efficacy. Indeed, as with the person-centred approach of Carl Rogers, the origins of MI were atheoretical, arising inductively through observed practice by posing and testing tentative hypotheses. Logical linkages have been made to various psychological theories that reflect but do not really explain the emerging observations of MI. A useful theory does more than rename currently-observed phenomena. A good theory organizes observations and suggests yet to be tested hypotheses.’’

Apodaca and Longabaugh,(2009,p.65) reviewed a number of mechanisms that may be thought to underly behaviour change in MI in the substance abuse literature. They concluded that in relation to questions of MI efficacy that, …. ‘‘it may require more sophisticated theory and the application of more recent analytical techniques to identify how MI works for whom and under what set of conditions.’’ This project aims to develop both formal and personal theory based on the literature and on the data provided by the interviews of participants. This research could also be said to be theory driven in identifying those mechanisms

of action that have been proposed to explain how MI works and to seek to develop its theory. I will now turn to the existing literature and background theory relating to the development of and the efficacy of MI.

3.1.6 Origins and developments Motivational Interviewing theory

According to (Hettema, Steele, & Miller, 2005) MI was not originally derived from theory. It arose through examining the principles underlying its clinical practice and they were stated prior to specific empirical support for them. A number of underlying psychological concepts and theoretical influences have been identified and acknowledged in the MI literature and these will now be considered.

3.1.7 Humanism and the Work of Carl Rogers

According to (Constantino, DeGeorge, Dadlani, & Overtree, 2009) MI's theoretical basis draws heavily on Rogers', 1951, personality theory and the notion that psychopathology reflects a discrepancy between one's perceived or experienced self and his or her ideal or valued self. MI is said to adopt the client-centred value of the therapeutic relationship as a primary change agent. This is partially achieved through its provision of core conditions for optimal growth, they are said to include: empathy, acceptance, (including unconditional positive regard) and congruence. Carl Rogers client centered approach is based directly on the principles of humanistic philosophy and Miller and Rollnick (2002) say they regard MI as an evolution of this client centered counselling. Bricker and Tollison (2011) describe MI as being consistent with the philosophy of humanism in that it focuses on the dignity and worth in all people.

Also, Miller and Moyers (2017), and Csillik (2013) described MI as an evolution of the theory of Carl Rogers, that specifically addresses motivational problems. In that MI combines a client-centered, supportive and empathic counselling style with specific communication techniques. Humanistic philosophy emphasises both empathic understanding and acceptance as possible triggers for behaviour

change (Csillik, 2013). MI is characterised as an approach that is collaborative and respectful of client autonomy. The client centered phenomenology of Carl Rogers (1959) and the wider humanist philosophy can be said to have been particularly influential in defining the 'spirit' of MI. The spirit or philosophy of MI being described as 'a way of being with people' (Miller and Rollnick, 2002 p.34), which is closely related the title of Rogers (1980) book 'A way of being'. The most current descriptions of MI spirit include, Partnership, Acceptance, Collaboration and Evocation (Miller & Rollnick, 2012). This is represented in the figure 3.1 below, adapted from Miller and Rollnick, 2012.

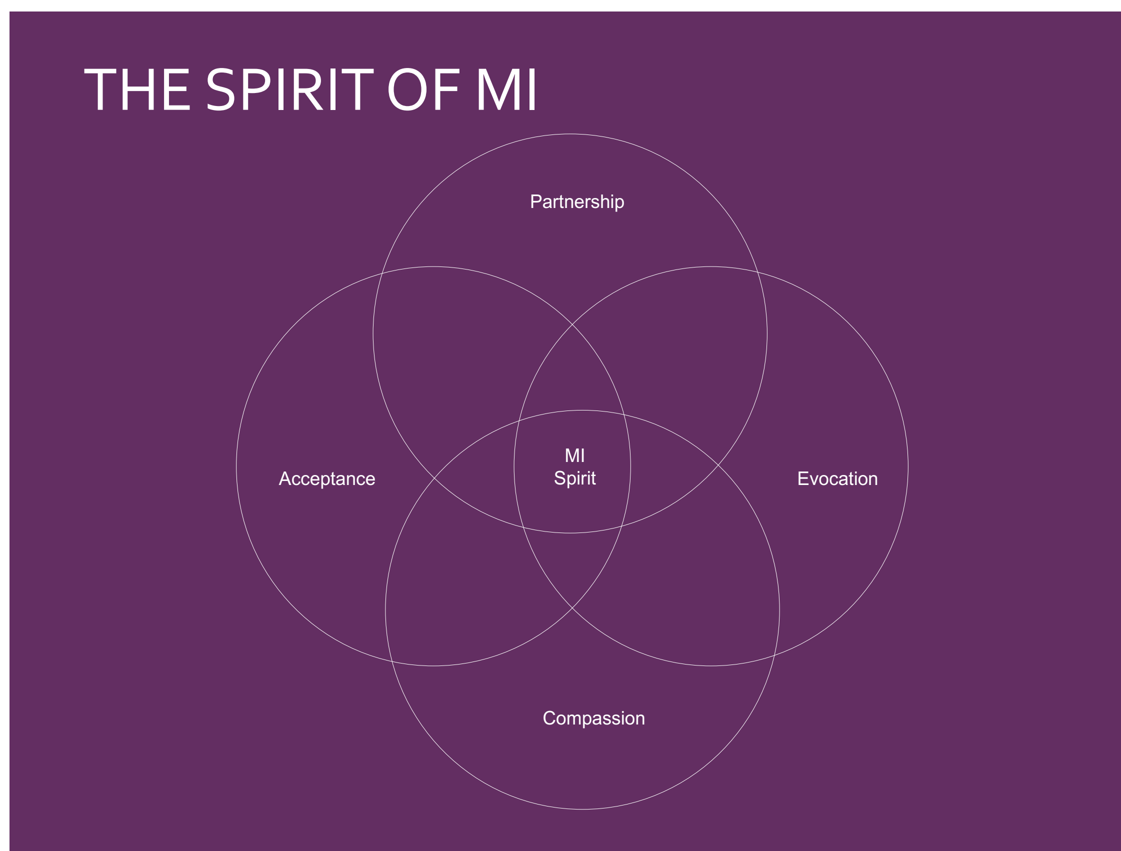


Figure.3.1

Acceptance in particular contains clear reference to Rogerian and humanistic concepts, it is said to consist of four elements: absolute worth, accurate empathy, affirmation and autonomy. Absolute worth is synonymous with the Rogerian ideal of recognising the potential and inherent worth of every person. Also, within the concept of accurate empathy, there seems to be a clear crossover with the Rogerian empathic core conditions. MI is said by Csillik, (2013, p.360), to apply

to most of Rogers therapy attitudes and techniques as described above, further that,

…."Rogers' theory offers a potential theoretical foundation for MI and especially for its relational component, which is clinically appealing as it addresses the question of therapeutic relationship development and of the conditions necessary for therapeutic change."

3.1.8 Empathy

Moyers & Miller (2013) has highlighted the central importance of empathy within MI, finding from their process research that clients made less change when clinicians were low in empathy. Clearly empathy remains a central relational psychological concept across therapeutic approaches. Although it is arguably less visible in the last edition of MI (Miller & Rollnick, 2012), no longer featuring in the key components, processes, skills and spirit. They describe accurate empathy as being a key aspect of acceptance and acknowledge it as one of Rogers critical conditions for change. It is also retained as a central construct in the Motivational interviewing Treatment integrity scale, MITI.4 (Moyers, Manuel & Ernst, 2014) which specifies and rates what is meant by empathy in MI practise. Csillik (2013, p.360) acknowledging Rogers influence on MI theory

says... "Rogers' work provides a testable theoretical basis for the mechanisms of MI effectiveness. Further MI research should operationalize more than just empathy in the relational component ".

3.1.9 The influence of experimental Social Psychology in Early MI Theory

William R. Miller's, (1983) initial description of MI indicates that it was also developed from the principles of experimental social psychology and the theoretical influences cited included: Cognitive Dissonance Theory (Festinger, 1957), Self- Perception Theory (Bem, 1967) and the Transtheoretical Stages of Change Model (Prochaska & DiClemente,1983). In the first 1982, draft of MI published retrospectively by Miller (Miller, 2008) and in the subsequent first 1983 publication of MI (Miller,1983) he describes 4 key principles of motivation. Firstly,

to deemphasise Labelling, in traditional alcohol services at the time the acceptance of the label 'alcoholic' was seen as necessary for successful treatment. In what was a radical departure at that time Miller (1982, p.5), took a different view, ….''rather what matters is this: What problem is the individual having in relation to alcohol, and what needs to be done about that?''. No value is placed here on persuading the individual to ''accept'' a self-label; the importance of a label is, in fact actively deemphasised.

Secondly, that it is important to promote Individual responsibility. Miller (1982, p.9) states, …."MI places responsibility on the client to decide for him or herself how much of a problem there is and what to do about it.'' Again, this was seen as an alternative view to the dominant disease model of the time. This principle is also consistent with humanistic philosophy that believed the individual had the necessary ability and wisdom to make decisions about change themselves. The counsellor's role being to provide the supportive atmosphere to facilitate this.

Thirdly, the concept of internal attribution. Where emphasis is placed on developing an internal attribution for behaviour and for the changing of it. This was a further contrast to models or explanations at the time which emphasized the need to acknowledge a lack of control and disease label, for example, ''I am an addict''; leading to the people making external attributions about their behaviour and behaviour change. Miller (1982), also makes reference here to Learned helplessness theory (Seligman, 1974) suggesting that the effect of labelling and externalising approaches encourages an individual to view efforts to change as fruitless.

Finally, a conceptualisation of human Motivation is described where motivation for change is seen as an interpersonal process and not as a personality trait. (Miller, 1983,p.10) describing it thus, ….''This motivational process is understood within a larger developmental model of change in which contemplation and determination are important early steps which can be influenced by therapist interventions.''

Miller (1982), describes MI as being drawn out of him during a period he spent on sabbatical in Norway working with a group of psychologists in an alcohol clinic. This helped him to articulate his first version of MI with the 1982 draft of MI being written on sabbatical and then later published in 1983. These key principles remained in the final 1983 article forming the basis for MI as it began to be adopted as an approach to working with substance use. In 1989, Miller met Clinical Psychologist Steven Rollnick who was using the method as outlined by Miller in the UK. They have since produced 3 core MI texts together, (Miller & Rollnick, 1999, 2002, 2012). This might be said to represent the ongoing development of a clinical method based on extensive empirical research that has taken place subsequently (Hettema et al.,2005). This elaboration of and development of MI has been said to have arisen out of the 'interactive raves' of Miller and Rollnick (Miller 2004).

Miller credits Rollnick for the addition of ambivalence to MI as a central construct and the use of conflict theory at an individual level, related to ambivalence. Ambivalence is a concept that explores how individuals feel and think about change. In MI ambivalence around problematic behaviour is explored and may help the individual move toward its resolution. Conflict theory is said to be related to ambivalence where individuals hold differing views beliefs or values about a particular behaviour or a course of action. This conflict produces psychological discomfort or dissonance (Festinger,1957) and often occurs when individual beliefs, values and actions are in conflict.

3.2.0 Theoretical changes across publications

Atkinson and Woods (2017), suggest that particularly the revisions to MI between 2002 and 2012 represent fundamental changes to its core structure. Also, from their point of view they see MI as lacking in theoretical stability and consistency for an intervention that is now 35 years old. They illustrate how MI has developed or changed its structure over that time by publication. This is illustrated below and is based on the table in their article.

First edition, Miller & Rollnick (1991)

Definition of MI ... ‘’MI is a particular way to help people recognize and do something about their current problems. It is particularly useful with people who are reluctant to change and ambivalent about changing.’’ (p. 52)

The spirit of MI is not specifically defined here.

Principles, five principles are outlined: express empathy; develop discrepancy; avoid argumentation; roll with resistance and support self-efficacy.

Second edition Miller & Rollick (2002)

Definition of MI .... ‘A client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence’ (p. 25)

This spirit concept is now introduced and has three elements: collaboration, evocation and autonomy.

Principles, MI now has four principles: express empathy; develop discrepancy; roll with resistance and support self-efficacy.

Third edition Miller and Rollnick (2012)

A new three levels definition of MI is proposed as described above: a Lay Persons definition, a Practitioners definition and a Technical definition.

The Spirit now has four elements – acceptance, collaboration, compassion and evocation. Drawing on principles from major religious traditions the concept of compassion seems to have been introduced partly as a reaction to requests for applications of MI in sales and business.

The principles of MI, as previously defined interestingly do not appear at all. The authors are now choosing to define ‘four processes’ of – engaging, focusing, evoking and planning. Hilton, Lane and Johnston, (2016), noted that there seemed to be a lack of clear empirical evidence for the introduction of these four

processes into MI. Also, they noted a similar a lack of evidence for the removal of one of the principles from MI, namely, that of psychological resistance.

Atkinson and Woods (2017), suggest that each version of MI has been different from the others theoretically and may have affected the way each is taught and delivered. They cite the new emphasis on an emerging theory based on the language of change and MI consistent techniques to evoke it, as one example. Potentially, they argue that each version of MI represents a separate evidence base. Hilton, Lane and Johnston, (2016) suggest that MI's focus on RCTs and outcome data has made it difficult for it to develop theoretically because it has moved away from the inductive practice focussed method, that provided the basis for its original development.

Although MI avows itself not to be based on or to have developed its own theory it clearly has clearly been linked to, been influenced by and used a range of theoretical concepts from social psychology. Each description of MI by Miller and Rollnick, has seen them develop MI based on its ever-expanding empirical research base, without further developing a specific theory of human behaviour change. Although some of its core elements are based in theoretical concepts and some attempts have been made to consider theoretical frameworks for understanding its efficacy. I will now consider briefly these psychological models and theories that might help to illustrate candidate underlying mechanisms in MI. I will then move on to discuss MI's more recent theoretical developments.

3.2.1 Logical Theoretical links and psychological concepts

3.2.2 Transtheoretical Model (Prochaska & DiClemente,1983)

This model of behaviour change proposes that people potentially pass through a series of stages when changing their behaviour. The initial model of MI was clearly linked to the Transtheoretical model of behaviour change or TTMs (Prochaska & DiClemente, 1983).This is acknowledged by Miller, 2008, describing the early system of MI as best understood within the context of a developmental model of change of this kind.
Atkinson and Earnshaw (2020, p.37) highlighted that:

…''MI and TTM emerged at around the same time and in the first edition of *Motivational Interviewing* (W. R. Miller & Rollnick, 1991) the Model of Stages of Change was proposed as useful in making assessments about client readiness for change and guiding practice. However, by the time MI was redefined in the second edition (Miller & Rollnick, 2002) the TTM had become much more peripheral, with overlaps between the TTM and MI presented in a contributed chapter (DiClemente & Velasquez, 2002).''

Following, and perhaps as a result of some high-profile criticism of the TTM (West, 2005), Miller and Rollnick (2009, p.130) specifically distanced themselves from it, in the article 'ten things motivational Interviewing is not'. Stating that, … "MI is not based on the transtheoretical model". In practice though they have continued to be taught alongside each other and interestingly Miller and Rollnick (2012), used it to draw a parallel between the progression of talk about the language of change and the TTM's stages of readiness to change (Prochaska and DiClemente ,1983).

Atkinson and Woods (2017) described the TTM as not being a theory at all in that although it has descriptive qualities it has no explanatory power. They suggest that due to its centrality in the emergence of MI, it has remained a useful clinical heuristic for guiding practitioners and clients in therapy. In addition, it can be also be used to help normalise the process of relapse in behaviour change. It could therefore be said to have retained some relevance in the practice and training of MI, if not in its theory.

3.2.3 Cognitive Dissonance theory (Festinger 1957)

Based on the work of Leon Festinger (1957) and described by Bill Miller in his first draft of MI (Miller,1982 p.11) as:

…. 'if a person believes that his or her behaviour to be seriously discrepant with his or her beliefs, attitudes, or feelings, a motivational condition is created to bring about change in one or another of these elements so that consistency is restored'.

Miller and Rollnick (2002), saw this theoretical concept as related to the MI strategy of developing discrepancy, whereby motivational discussions seek to explore the discrepancy between a person cherished values and goals and a person's current behaviours. They also talk about the need for practitioners to use their 'dissonance detectors'. That is to be vigilant in detecting dissonance and consonance, paying attention to therapist as well as client reactions in motivational Interviews.

3.2.4 Psychological Reactance Theory

According to Brehm and Brehm (1981), psychological reactance may occur when individuals feel that their own right to choose a particular behaviour is being restricted by others. This theory asserts that people have a tendency to defend themselves against threat when they feel their own freedom is threatened and especially when this threat is perceived as unfair. Also, any attempts to restrict behaviours may make them more attractive to people and may provoke responses in them that are aggressive, avoidant or a retreat into passive acceptance. Also, when relationships are overly directing or confronting this may also provoke psychological reactance.

MI originally developed out of a reaction to confrontational approaches in the alcohol field, offering an alternative perspective. The concept of psychological reactance is found in and referenced in all three editions of the main MI texts and has been used in MI as an explanation of how confrontational approaches might cause psychological resistance. Miller and Rollnick (2002) later specified the practice of 'rolling with resistance' and in a later development 'responding to discord' (Miller & Rollnick, 2012), which was considered as a way of responding to psychological reactance. The concept of reactance has recently been reemphasised in MI theory (Miller, 2017) and will be considered in more detail in the theoretical developments section below.

3.2.5 Self-Determination Theory (SDT) (Ryan & Deci, 2002).

Markland, Ryan, Tobin and Rollnick, (2005), have considered how Self-Determination Theory (SDT) might help to explain MI's efficacy. They suggested that MI may provide a social environment that meets people's psychological

needs and helps to provide them with the energy that is required to participate in psychosocial interventions; facilitating other growth-promoting behaviours. SDT has identified and defined those psychological needs in terms of the concepts of autonomy, competence, relatedness, aspirations and vitality. Mutschler et al., (2018) have used SDT as a theoretical basis for understanding MI. From this perspective if people feel safe and cared for by significant others, they are more likely to make behaviour change. Also, if this social environment is providing structure, autonomy support and involvement of others then individuals will be able to achieve self-determination. They summarise it this way…'' Structure facilitates competence; autonomy support facilitates the development of autonomy; and lastly, involvement, or the perception that others care about your well-being, facilitates feelings of relatedness" (p.4).

Vansteenkiste and Sheldon, (2006) suggest that by assessing processes mechanisms and mediators identified by SDT, researchers might be able to identify why MI improves engagement and or outcomes for example in CBT (Hettema, Steele, & Miller, 2005) and potentially improve its effectiveness. Also, they suggest that the MI techniques of expressing empathy and reflective listening convey to the client that the clinician understands the client's perspective, which in turn may support the client's need for relatedness. Vansteenkiste and Sheldon (2006), further proposed SDT could potentially provide a theoretical underpinning of MI. Although, Miller and Rollnick (2012), have acknowledged the parallels between MI and SDT, particularly in terms of supporting client autonomy and creating a supportive environment, they have not pursued any systematic integration with it. They have acknowledged that SDT may provide a theoretical lens through which MI might be viewed.

Romano and Peters (2016), suggest that both SDT and Cognitive Dissonance Theory may be relevant to understanding MI efficacy. They cite two studies, one where clients receiving MI perceived more autonomy support, a feature of SDT and in another study they perceived enhanced self-discrepancy which is a condition of cognitive dissonance. Ramano and Peters (2016) further hypothesise that according to SDT, MI supports the clients' fundamental

psychological needs. In doing so it is expected to reduce their suffering and increase the energy they have to dedicate to treatments such as CBT.

3.2.6 The Role of language

Several different theoretical contributions and concepts relating to language, its use and meaning have been put forward in relation to theory and proposed mechanisms of action in MI. These will now be considered briefly here.

3.2.7 Self-Perception Theory (Bem, 1967).

According to Self-Perception Theory (SPT), people who are ambivalent about an issue determine what they believe and do by listening to themselves (Bem, 1967). This is based on the reasoning that when people have to justify verbally their behaviour change, they are more likely to follow it through, this is acknowledged as a theoretical contribution in the first edition of MI (Miller and Rollnick, 1991). Also, because the core skills of MI emphasise a person-centered evocative exploration of ambivalence and a reflective listening style; it provides an opportunity for people considering change to hear their own thoughts and commitments about that change out loud. MI emphasises the elicitation or evoking of the client's own thoughts, perceptions, their values and motivations for change. In this way MI is applying SPT in encouraging clients to generate their own arguments for change, in what has become known as 'change talk'. Also, SPT informs MI 's strategies for reducing the opposite type of language described as 'counter change or sustain talk' (Miller & Rollnick, 2012). In an MI conversation, it is the client who hears or thinks about their own arguments for changing their behaviour. The therapist job is to avoid arguing for change and this is consistent with the (Bem, 1967), robust finding that people tend to become more committed to the positions they defended verbally. So, in effect people can talk themselves out of or into behaviour change.

3.2.8 Speech Act Theory (Austin, 1975)

Originally conceived by Philosopher J.L Austin (1975), Speech Act Theory (SAT) is concerned with ways in which words can be used both to present information but also to carry out actions. It has been used in the fields of linguistics, philosophy, psychology, law and in literary theorising. According to Richard Nordquist, (2019):

….''It considers three levels or components of utterances: locutionary acts (the making of a meaningful statement, e.g. saying something that a hearer understands), illocutionary acts (e.g. saying something with a purpose, such as to inform), and perlocutionary acts (e.g. saying something that causes someone to act).''

SAT has also been applied in MI research by Amrhein, (2004) who identified that people making statements obliging them to make a change in behaviour in the future e.g. 'I will stop using drugs' are thought to be making a greater commitment to that behaviour change and are therefore more likely to do so. Amrhein, Miller, Yahne, Palmer, and Fulcher (2003), called this 'commitment language' and put forward initial evidence from their studies supporting this hypothesis. This and other MI studies by (Amrhein, 2004, and Hodgins, Ching & McEwan, 2009) have observed that this type of commitment language resulted in an increased incidence of behaviour change in drug misuse and with gambling problems.

Bricker and Tollinson (2011), highlight that Self Perception Theory (Bem ,1972) and Speech Act Theory (Austin, 1975) are both psychological theories that have been applied to understanding how MI works. Their particular emphasis is with understanding the role of language in MI interactions, we will now go on to consider this theory and some of its outcome evidence further.

3.2.9 Language of Change and MI

The role of the language of change has received considerable attention in MI, in their first edition of MI (Miller & Rollnick, 1991) introduced the idea of 'self-motivational statements' as being statements or arguments in favour of behaviour change. In the second edition (Miller & Rollnick, 2002) they developed this further into 'change talk' as 'self-motivating speech', a concept unique to MI. They saw

this client language as a reasonably good predictor of behaviour change, based on their clinical experience and their theoretical influences, although it was not evidenced empirically. In 2002 they described the goal in MI as being to reinforce change talk and reduce resistance talk.

In 2003, a collaboration with psycholinguist Paul Amrhein led to more detailed description and understanding of the role of change talk in MI, in relation to behaviour change outcomes using data from empirical studies (Amrhein, 2004). Amrhein's studies used psycholinguistic analysis of recordings of MI sessions and drawing on Speech Act Theory, broke down 'change talk' into 5 categories. They were described as: Desire, Ability, Reasons, Need and Commitment to change talk, (or DARN). He particularly emphasised the importance of 'Commitment talk' as an indicator that someone is more likely to make change in their alcohol or drug misuse. Based on the outcome data of his study which found more commitment talk was associated with increased levels of change at 12 months follow up. The other 4 categories described did not predict behaviour change but were said to increase the likelihood of commitment language being produced (Miller and Rollnick, 2004). Also, Amrhein et al.'s. (2003), analysis identified that the strength of Commitment language heard and particularly that heard toward the end of an MI session made it more likely that behaviour change would result in positive changes.

Amrhein, (2004) also identified a concept that he called 'mobilising change talk', which signalled a move towards the resolving of ambivalence in favour of change. For, Miller and Rollnick (2004, p.302):

…. "This his clarified what had been a serious problem for the theory of MI. Previously, we had failed to find the expected relationship between change talk during an MI session (mean frequency, measured during the first 20 minutes) and behaviour change."

Miller and Rollnick (2002), divided this change language into preparatory change talk, mobilizing change talk and its opposite sustain talk; the latter being that

language in favour of the status quo or not making change. This concept of change talk is developed further in the third edition of MI (Miller & Rollnick, 2012) where they emphasise the importance of recognising these different types of change language and working with it in a way that helps to resolve ambivalence and also to reduce resistance. This emphasis on the importance of language, its evocation and reinforcement by what are described as MI consistent (MICO) practitioners represents a significant shift towards identifying mechanism of action in MI and in the development of theory. Clearly the work of Amrhein and collaborators (Amrhein, et al.,2003; Amrhein, 2004) helped to underpin the first attempts by Miller and Rose (2009) to develop what they described as an 'emerging theory of MI' and also gave impetus to further process research in an attempt to understand mechanisms of action in MI (Magill et al.,2014). This will be now considered in detail below.

3.30 Existing Theory its development and proposed mechanisms in MI

Miller and Rollnick (2012) said that they have not sought to develop MI theory beyond those logical links to existing psychological theory and some of the hypothesised mechanisms as described above. Although, they have clearly embraced theoretical concepts in their work and responded to research findings by developing their method across their three books and in numerous articles. At the same time, they have not sought to develop MI as a comprehensive theory of health behaviour change, although they have maintained in an interest in how MI might work. They regard theory development as a task for others and it is also one of which they are supportive (Miller & Rollnick, 2012). According to Romano and Peters (2016), in relation to theoretical frameworks and the empirical research of MI, two components are emphasised across the main MI texts (Miller & Rollnick 1991, 2002, 2013). These are the humanistic client centered therapy style and the facilitation of the client's expression of 'change talk'. These have been described by Miller and Rollnick (2004) as 'relational' and 'technical' factors.

As discussed, above, it was Amrhein (2004,p.39) who presented a linguistic process model of how MI works, one that elaborated different types of change talk and emphasised in particular 'commitment language', it described,… "a mediational role for client commitment in relating underlying factors of desire,

ability (self-efficacy), need, and reasons to behaviour, but also a pivotal role as a need-satisfying enabler of a social-cognitive mechanism for personal change."

Amrhein (2004), proposed a simple pathway model which is outlined below based on his original diagram, in Figure 3.2 below.

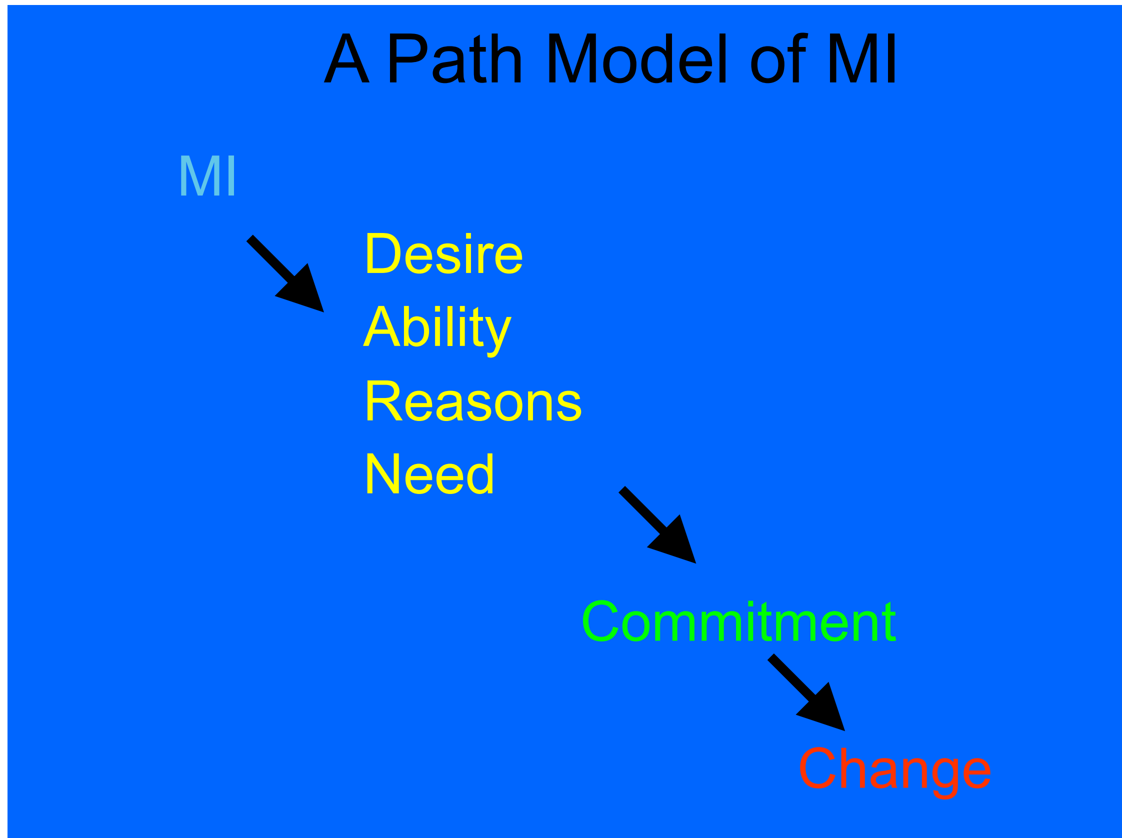


Figure 3.2 Simple pathway model

This linguistic research prompted further thinking around the language of change or 'change talk' in MI. Miller, Moyers, Amrhein and Rollnick (2006), began to describe client language in MI conversations as being able to be coded on a continuum. One end of which represented movement toward change and the opposite end representing the status quo and the mid-point being ambivalence. According to Magill et al. (2018) this led to further linguistic process research where the language in client therapist interactions where analysed in terms of behaviour change outcomes. In the 2008 publication, *Motivational Interviewing: In the treatment of Psychological problems*, which looked at integrations of MI with mental health interventions and therapies including CBT. Arkowitz, Miller,

Westra and Rollnick (2008) asked the question why does MI work? In response to this they outlined three hypotheses:

- **The Technical Hypothesis**, emphasising the client's language of change and the therapist's eliciting of and differential reinforcement of change talk. This was described as a 'directive hypothesis' and later a 'technical hypothesis' (Magill, 2018).

- **The Relational Hypothesis,** described as a relational as it is said to be based on the provision by the therapist of a client centered, accepting, affirming, atmosphere underlying a humanistic spirit (Rogers 1980).

- **Conflict Resolution Hypothesis,** proposed that a thorough exploration of both sides of ambivalence, in an empathic, accepting atmosphere, was necessary for the client to move toward the resolution of their own ambivalence or conflict. There is an assumption here that therapy is incomplete if it does not explore both sides of ambivalence and this separates it from a classic client centered perspective.

Arkowitz et al. (2008) recognised that these three hypotheses may represent alternative explanations. They concluded, that there was existing evidence for the relational and directive components of MI, but that the conflict resolution component needed to be operationalised and tested empirically. Magill et al., (2018) subsequently observed that perhaps all three of these hypotheses together may in fact represent three of the necessary conditions for therapeutic change in MI.

3.3.1 Relational and Technical as an emerging theory

Miller and Rose (2009), proposed what they described as an 'emergent theory of motivational Interviewing' and they examined just two of these causal hypotheses thought to account for the effects of MI in relation to bringing about behaviour change. This early theory or model was based on the existing MI therapy process research literature and also a more general therapy literature. This model is described by them as one,

…. "that emphasizes two specific active components: a relational component focused on empathy and the interpersonal spirit of MI, and a technical component involving the differential evocation and reinforcement of client change talk." (Miller & Rose, 2009. p. 527)

The **technical hypothesis** regarding MI's efficacy asserts that competent use of MI, with a therapist using MI-consistent skills and techniques will increase the amount of change talk in sessions and also reduce sustain talk, in turn this will predict behaviour change outcomes.

The **relational hypothesis** asserts the importance of the interpersonal style and qualities of the MI therapist in a relationship with a client, particularly the skills of empathic understanding, congruence and positive regard as outlined by Rogers (1959), referred to as MI spirit. These relational factors in turn are thought to foster intrinsic motivation for change. Miller and Rose (2009), cite the strong relationship between therapist empathy and behaviour change in the alcohol misuse field prior to the development of MI as support for this hypothesis. They see MI spirit and accurate empathy as fundamental to the underlying relationship.

Also, they are clear that they did not see these hypotheses as contradictory but saw them in the tradition of psychotherapeutic practices in general that have emphasised the need for both relational and technical factors. Their Hypothesized relationships among process and outcome variables in MI is outlined below in the Figure 3.3 below, adapted from Miller and Rose (2009), Ramano and Peters, (2016). They used the existing empirical data from MI process research to examine these two hypotheses and linking them to client outcome data.

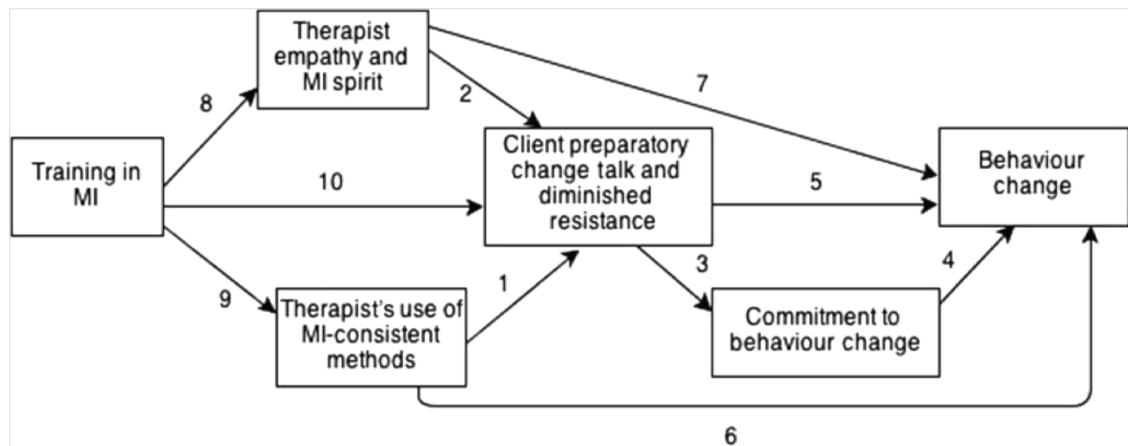


Figure.3.3 MI Relational vs Technical pathways.

Miller and Rose (2009) in summarising the available MI linguistic process research, concluded that there was sufficient and promising evidence to support a link between skilled use of MI and the generation of change talk in sessions. Also, that change talk seemed to be acting as the mediator in relation to client outcome in the alcohol field (Miller, Zweben, DiClemente & Rychtarik, Project Match MET, 1992, Amrhein et al.,2003, Strang and McCambridge (2004). They used only studies that assessed competence with recognized fidelity measures of MI (MITI, Moyers et al., 2004) and the MISC, (Miller, Moyers, Ernst & Amrhein,2003). They also acknowledged the number of studies used was small and that further research was required in the area.

Miller and Rollnick (2012), also identified that behaviours inconsistent with MI, e.g. confrontation, warning and directing were likely to lead to negative outcomes. Such behaviours, are described as MI inconsistent therapist behaviour (MIIN) and are likely to get in the way of a collaborative partnership, reduce feelings of autonomy, elicit resistance and talk about sustaining the status quo or 'sustain talk'. The relationship between MI's efficacy, client outcomes and therapist style or qualities were briefly examined by Miller and Rose, (2009). They concluded that there was early evidence from the MI literature linking MI spirit, change talk and subsequent changing of alcohol use (Miller et al.,1993). Also, they identified that from the process research came a positive outcome between rated therapist empathy and 12 months follow up in alcohol use outcomes for brief interventions (Guame et al., 2008). They highlighted accurate empathy as a good candidate mechanism for further research. Moyers, Miller and Hendrickson (2005) found

that MI therapy skills, for example, …'' empathy, acceptance, egalitarianism, warmth, genuineness, and "overall MI spirit." were shown to form a latent or underlying construct and named as "interpersonal skills".

This correlated positively, between .74 and .91, with client involvement in therapy and outcome. Although, they note considerable variability in outcomes across individual therapists, and the different sites across a range of their studies. Miller and Rose (2009) also conclude that it is very difficult to separate out the relative effects of either hypothesis. So that once either the techniques or the spirit of MI is taken away, it is no longer MI. They saw their path model as being testable theory where the different elements could be measured and related to client outcome. Subsequent research has been conducted and three systematic reviews and metanalyses have reviewed the testing of this theory. This evidence for these hypotheses is reviewed below.

The first metanalyses looking at the technical hypothesis as a key component of this theory of MI efficacy was undertaken by Magill et al.,(2014).This review was conducted and identified 16 reports and 12 published studies in this area representing in their view the growth in interest in how MI works and MI theory. They describe their analysis as being an aggregate test of the technical hypothesis. Using aggregate measures of the size and significance of the relationship between MI skills and client change language and also the relationship between this language and behaviour change outcomes. They concluded that MI consistent (MICO) skills where associated with higher rates of change talk overall. Also, that MI inconsistent (MIIN) therapist behaviour was associated with more sustain talk. Further that these high rates of sustain talk where associated with worse outcomes for clients.

They also conclude from the aggregated data that MI consistent practise might also be increasing both the change and sustain talk. They affirmed that the data examined provided support for the pathway that MI is operating as hypothesised in Miller and Rose's, 2009 model. They also cautioned that the path effect sizes were small and that perhaps other MI mechanisms we're going untested and unmeasured in the research. This meta-analysis did not address the second

component of this model the relational factors. Also, this review surveyed only peer-reviewed publications and was only a small sample and they cautioned that this should be only be considered a preliminary study.

Romano and Peters (2016) subsequently built on this process analysis in a qualitative review of the literature of proposed mechanisms of action in MI. They emphasise language analysis as an important part of looking at what happens between client and therapist in psychotherapy process research. They also point out that whilst these theories provide frameworks and insights, they have generally not been empirically tested in the context of MI. They systematically reviewed the evidence for the causal chain suggested by Miller and Rose (2009). In reviewing 37 studies of MI process they examined both the relational and technical hypotheses. They felt the pathways suggested in the model were understudied although they acknowledged the work of Magill et al. (2014) in identifying … ''a positive relationship between therapist MI consistent behaviour and client CT, and an association between client ST and worse client outcome''.

Romano and Peters (2016) review was based on 37 published studies and unpublished dissertation studies. They believe their review supported the link between MI's emphasis on change talk and behaviour change at follow-up. The authors acknowledge that as a qualitative review many of the study samples were drawn from large RCTs and therefore it may have suffered from publication bias. They also, suggest that it may have provided a more complex analysis than a quantitative review. From their evaluation of the evidence they tentatively suggest that, …'' both the therapeutic style of MI and the specific techniques used in MI can directly affect client outcome or may facilitate client expression of CT, which in turn is related to client outcome.'' (Romano & Peters p.11).

They also conclude from their review of this evidence that trained MI clinicians using MI consistent skills in an MI Spirit, with empathy are more likely to see an increased expression of CT and also a reduction of resistance in MI therapy. This reduction of resistance might be conceptualised as reducing the ST which in turn then effects behaviour change and could be seen as a possible mechanism of change in MI.

Further, Ramano and Peters (2016) suggest their review also supported the MI technical hypothesis in relation to increased change talk and in the reduction of client resistance language and that it is affecting outcome positively. Also, their review is supportive of the importance of the use core clinical MI techniques, that is, of open questions, affirmations, reflections and summarising, in generating CT. Further, that the use of skillful reflective listening was consistently related to the generation of CT.

The relational style itself was not found consistently to be related to change talk in this review, but the authors note that it is difficult to separate out, for example reflective listening as being part of the relational style and also being a specific MI skill. They also suggest that perhaps the relational style of MI is more related to engagement and active involvement in therapy. They point to the previous research by Moyers, Miller and Hendrickson (2005) and Pirlott, Kisbu-Sakarya, DeFrancisco, Elliot and Mckinnon (2012) that has demonstrated a positive link between therapist spirit and engagement, disclosure, involvement and cooperation by clients in MI sessions. They further acknowledge the limitations in their review, in that the majority of studies, although not all where in the alcohol field, limit the generalisability of the findings. They also note the extended use of MI outside of the substance misuse field and suggest an urgent need to develop more research in those fields. Also, that even though most of their included studies used recognised MI fidelity measures several of them did not.

Magill et al., (2018), interestingly identify two major influences on the search for mechanisms of action in MI. Firstly the drive for the data to examine the proposed relational vs technical or two paths model described above. Secondly, they note a shift in the orientation of national health interventions research in the USA. Resulting in a moving away from just focusing on treatment outcomes research, towards looking at how proposed specific mechanisms affect behaviour change. Magill and Longabaugh, (2013) note this research is also focused on developing evidence-based guidelines for the delivery of interventions, the training of therapists, their supervision and how agencies implement these evidence-based practices.

Magill et al' s (2018) metanalysis of studies relating to the technical hypotheses found that MI consistent therapist skills were related to client change talk statements in favour of behaviour change. Also, that a balance of both change talk and sustain talk was elicited and that this was also related to outcomes at follow-up. Their review suggest therefore that MI seems to be exploring both positive and negative aspects of ambivalence, even though recent theory had promoted an emphasis toward change talk. This suggests that increased change talk on its own did not predict behaviour change. Finally, this review also found that increased instances of sustain talk did in itself predicted worse behaviour change outcomes.

Magill et al's., (2018) Meta-analysis of MI process is the most recent and up to date reflections on this part of MI theory. This review used larger and more recent samples of primary studies than previous reviews. Replicating some of the findings from their previous review they said the findings from the most recent literature were mixed. They found that change talk in itself was not associated with reducing risky behaviours and that sustain talk was associated with worse outcomes for such behaviours. They go on to suggest that client change language could be seen as a balance of pro change and anti-change statements. Also, they suggest that a clinically successful motivational interview would involve not only the exploration of ambivalence, but also its resolution. They say this returns us to the question of how to study the resolution of ambivalence and also brings us back to the theory of conflict resolution raised by Arkowitz et al., (2008). In doing so they are suggesting that sustain talk needs to be explored and responded to and not just have an emphasis on change talk.

Magill et al., (2018) also felt their review was supportive both of the technical hypotheses and relational hypotheses and saw this model as a coherent, stable and explicit framework for understanding MI efficacy. Although they note the evidence for the technical model is stronger partly because it easier to measure in controlled trials. They do acknowledge that the effect sizes seen in their review were small and wonder if other mechanisms may be active and that they are not captured in this theoretical model. They go on to suggest that measuring working alliance and resistance in future MI process research, as these may be candidate

mechanisms of action. They acknowledge a further limitation of their data was a restricted range of relational measures from highly monitored research trial therapists. They called for future studies of MI process to be based in more real-world clinical practise. They also emphasise a need to look beyond this linguistic process research mode.

… "most importantly because health behaviour change is affected by a broad range of contextual factors (e.g. genetics, cognition,' self-regulatory capacity and environmental influences and resources)." (Magill et al., 2018, p.154)

Hilton, Lane and Johnstone (2016) expressed their concern about the direction of MI theory development, in particular the research emphasising the evocation of change talk and minimising of sustain talk, as underlying mechanisms. They ask the question of whether MI has fallen in to its own premature focus trap. They argue that the narrow focus on these mechanisms described above in MI research, training and practise has potentially undermined the development of a comprehensive causal process model. Magill et al., (2018) in acknowledging these challenges to the MI process model, at the same time suggest that tremendous gains in theoretical development, training infrastructure, and resources for implementation had been made. Finally, Magill et al., (2018, p.147) summarised the current state of the MI process research in this way:

… ''In a relatively brief history of research on MI process, some key methods and insights have been established. There are guidelines in place for measuring MI in-session variables and a well-considered and testable theoretical model. The technical skills and relational capacities of MI are well-defined, they relate to their intended in-session client mechanisms (e.g. change talk, engagement in session), and they are trainable. We understand less about why these elements are important to the client' s post- intervention behaviour, and this is despite the literature showing MI has well-supported effectiveness and efficacy".

Although the relational skills of MI are well defined the literature reviewed above has not supported the relational element as described in the two paths model (Miller & Rose 2009). However, there is a general psychotherapy literature that has identified aspects of the therapeutic relationship, the therapeutic or working

alliance. This is a large literature and is beyond the scope of this review, but I feel it should now be mentioned in terms of MI.

3.3.2 Therapeutic Alliance

The concepts of Therapeutic Alliance or working alliance has for many years been seen as an important factor on outcomes for clients across a range of therapies. Originally developed in psychoanlaysis the concept has been applied in Rogerian client centred counselling and more recently as a pan theoeretical concept seen to explain part of the outcomes across a range of therapies. This is a large literature and cannot be considered in detail here; but as a possible mechanism that may be relevant to MI theory, it is considered briefly.

Psychotherapy research has tended to show the benefits of receiving therapy compared to not receiving it and a meta analysis of psychotherapy outcome data (Smith & Glass, 1977) showed large effect sizes in favour of therapy of up to 0.85. Also, no particular psychotherapy was found to be more effective than another; this finding has been replicated a number of times in other therapeutic fields and therapies (see Babor, Miller, DiClemente & Longabough 1999; Cuipers, Straten, Anderson & Van Oppen, 2008; Cutler & Fishbain, 2005).

Bentall (2009) describes how this gave rise to the Dodo bird conjecture, 'Everybody has won and all must have prizes', from Lewis Carroll's Alice in Wonderland. This gave rise to reflection on the effectiveness of particular psychotherapies and focused research onto studying the 'therapeutic alliance' between patient and therapist. Bentall (2009, p.248) maintains that, … ''non-specific factors, and specifically the quality of the relationship between patients and therapist have significant influence on outcomes''.

Using data from the SoCRATES trial (Lewis et al., 2003) a large RCT using CBT for psychosis, found that the quality of the alliance as rated by patients, predicted improvements in both positive and mood symptoms. At eighteen months after the start of the therapy, treatment differences could be entirely accounted for by the therapeutic alliance rated by patients at the end of the third session. Other meta-analyses of therapy outcomes summarised by Cooke (2014) have drawn similar

conclusions. The therapeutic alliance is seen to account for most of the within therapy variance in psychological therapy research trials. Cooke (2014) concluded it is up to 7 times more influential in promoting change than the treatment model itself. According to Wampold (2001), the most common non-specific factor claimed to have a causal effect on outcome is the Therapeutic Alliance as defined as the quality of the relationship between client and therapist. It is characterised as experiencing a sense of trust and of having a common purpose. From a Rogerian point of view this Alliance might be thought of as a bond between client and therapist. Wampold (2001) and others (Horvath and Simmons (1991), Martin et al (2000), Horvath (2001), Orlinsky (2004) have identified what they see as basic qualities of a therapeutic relationship. This extensive research literature has demonstrated that empathic, collaborative, client centered attributes of an intervention contribute to a positive working alliance. Goldsmith's (2015) study of the therapeutic alliance in CBT for psychosis has shown for the first time a causal relationship rather than a correlational relationship for therapeutic alliance, in that poor alliance has a negative effect on outcome in therapy.

3.3.3 MI and Therapeutic alliance

The qualities and features of a positive therapeutic alliance which are often described as 'non specifics' or common factors are described in MI spirit and MI core skills. One of the strengths of MI in this respect may be that it emphasises, operationalises and measures (Moyers et., 2015) those qualities that the therapeutic alliance literature suggests correlates with a positive working alliance.

Specific research relating to measures of therapeutic alliance as a mechanism related to MI and outcomes is small. Boardman, Catley, Grobe, Little, and Ahluwalia (2006) used the working alliance measure (Horvath & Greenberg,1989) in an MI and smoking cessation study. They measured alliance between clients and clinicians practising MI skills. They found that clients showing a strong working alliance were high in engagement with their MI therapists. Also, that the MI therapists showed high levels MI consistent practise, demonstrated the qualities of empathy, egalitarianism, and collaboration. Their practise was associated with a significant and positive relationship with working alliance and

also with client engagement. This finding although limited to smoking cessation is consistent with research discussed above (Moyers et al., 2005) showing a correlation between MI practice and positive within session client behaviours, for example cooperation and engagement. Although, correlation in itself does not necessarily confer a causal relationship. Boardman et al., (2006, p.336) conclude:

… "This finding is consistent with previous research by Catley et al., (2006) and Moyers et al., (2005) demonstrating significant associations between therapist MI style and positive within session client behaviours such as cooperation and engagement. Taken together, these findings provide support for Miller and Rollnick's (2002) view that therapist adherence to MI principles can reduce resistance and increase client collaboration and engagement. "

Apart from Boardman et al's., (2006) study, Therapeutic Alliance as a possible mechanism related to MI efficacy has not been demonstrated empirically. Although, those qualities of the therapeutic relationship promoted in MI particularly in the Rogerian sense are clearly specified in MI texts and in training practice (Csillik,2013).

3.3.4 The role of emotion in MI

Wagner and Ingersoll (2008) and Silverman, (2014) have considered the role of emotion and emotional reasoning in MI as a possible mechanism of change. They both observe that MI, generally places on emphasis on cognitive rather than emotional aspects of change (Miller & Rollnick, 2002). Although the evidence for the centrality of emotion in MI is limited according to Silverman (2014), I will consider it here in terms of MI theory. Wagner and Ingersoll (2008, p.8) in their attempt to identify emerging theory of MI have emphasised the role of negative and positive emotions. They say:

… ''Elicitation of negative emotions (e.g., in developing discrepancy) helps clients by narrowing their focus to areas in which they feel discontent, which leads toward them wanting to escape from the current unsatisfactory situation or avoid a future unsatisfactory situation. In contrast, the concept of positive reinforcement involves seeking positive emotional states through behaviours that lead toward

more satisfying conditions. From this perspective, motivation involves a desire to experience positive emotions. A positive emotions model encourages a view of motivation that emphasizes opening up to new experiences and actively seeking to build resources to support change and is consistent with the Broaden and Build model of positive emotions in motivation.''

The Broaden and Build model (Freidrickson, 2004) maintains that positive emotions allow individuals to access cognitive processes more flexibly and to draw on a higher-level connection and in doing so widen their thinking and ideas about actions to be undertaken. Wagner and Ingersoll (2008, p.3) after comparing MI techniques and strategies with the Broaden and Build model concluded,…"that motivational Interviewing elicits positive emotions of interest, hope, contentment and inspiration by inviting clients to envision a better future to remember past successes and to gain confidence in their abilities to improve their lives". From this theoretical standpoint in MI the therapist is trying to create a context in which individuals may experience both positive and negative emotions in sessions and this is thought central to achieving therapeutic aims. According to Silverman (2014), the empirical evidence to support the centrality of affect in MI remains limited. Nevertheless, it is hypothesised by Wagner and Ingersoll (2008) that a number of key strategies used in MI including the creation of discrepancy, the use of empathy and affirmation are designed to increase motivation for change through the experiencing of affect.

Affirmation is a core skill in MI, where the therapist identifies positive qualities, strengths, skills attributes of the client and reflects this back to them. According to Apodaca et al., (2014, p.634) who undertook process research in the MI field and found that…"Affirm is the only therapist behaviour that is more likely to be followed by change talk and also less likely to be followed by sustain talk". Also, research outside of the MI field has shown that defensive adaptions to threat can be reduced, or even eliminated, through the process of 'self-affirmation'. Research by Creswell, Dutcher, Klein, Harris & Levine (2013) whereby people were encouraged to discover strengths and qualities about themselves, has shown this process of self-affirmation improves problem solving under stress. Empathic reflective listening is also core to the practice of MI and this type of

skilled reflective process can be used to identify uncomfortable feelings and build discrepancy between a person's current behaviour and their cherished values and goals (Miller & Rollnick, 2012). In MI identifying and reflecting back emotion is regarded as a higher-level reflective strategy (Moyers et al., 2014) and is termed complex reflection. Clearly identifying and addressing emotional responses both negative and positive are part of the practice of MI and may be seen as another possible mechanism that could influence outcomes. Although the current empirical evidence to support this hypothesis is underdeveloped.

3.3.5 Recent Theoretical developments

The most recent theoretical development in MI has sought to build upon the concept of Psychological reactance (Brehm & Brehm, 1981) and also evolutionary theory as a way of explaining how and why MI might support behaviour change consultations. Cesar de Almeida Neto, (2017) has observed that although MI had been delivered across diverse contexts, this has been based on the data for its efficacy, rather than having an integrative theoretical basis. He thought theory development as necessary to develop a comprehensive understanding of how MI works.He describes the human trait of psychological reactance as being an evolutionary adaptive system facilitating the functioning of social dominance hierarchies. The phenomenon of social dominance is observed in many species. In humans it has allowed us at different periods in history to help define and maintain the best possible social rank in our hierarchies. Psychological reactance seen in this way communicates social dominance information to potential adversaries, for example: if you do not feel you have a say in a social interaction this indicates submissiveness, whereas if you are acting contrary to the advice and recommendations of others this can signal dominance within a group.

When humans observe the reactions of potential social opponents to their reactance, they can determine whether they will continue to try to assert dominance or to yield. This might also be said to operate at a societal, group as well as the individual level. Faced with a threat or a perceived challenge to a person's position in a social hierarchy people will react to this threat. Humans may respond through counter attacking, yielding or withdrawing. This is also

similar to what has been described as the ‘fight, flight or freeze’ stress responses thought to have developed in humans to survive threat, (Dana, 2018). Being alone or outside of the social group from an evolutionary perspective could result in danger harm or death. From an evolutionary perspective human dominance struggles are inherent and outside of our conscious awareness much of the time. For de Almeida Neto, (2017) the reactance process could be said to be ‘hard wired’ in that it seems to utilise non- conscious subcortical mechanisms. From this evolutionary perspective early humans would have needed to react quickly to assess and avoid being physically harmed. This could be said to have implications for psychotherapeutic interactions as these older or more primitive human reactions,…“became detached from their specific contexts to become active in any situation in which humans sense they are in a position of power.’’ (de Almeida Neto, 2017 p. 141).

In responding to perceived threat to their position in social hierarchies’ people may react in a number of ways including, agreeing, disagreeing, arguing or avoiding. De Almeida Neto, (2017) regards MI as adaptive because it mimics strategies to reduce antagonisms in social groups, which allows them to function efficiently. He sees MI as avoiding these reactance responses because it avoids direct argument or instructions to clients within consultations. Further, in a therapy context MI cedes the ultimate decision making to the client thereby signaling to them a non-threatening environment. Clients are received as the experts on themselves and the therapist avoids the temptation to take control and provide solutions, avoiding the ‘righting reflex’ (Miller & Rollnick 1991). This may increase engagement and resonates with findings from the alcohol field, where MI was found to be more effective with angry clients (Babor et al., 1999)

Miller (2019), suggests that MI research indicates that: ‘‘MI may be differentially more effective with disadvantaged populations and marginalised groups, compared to more privileged groups or strata’’. He cites a meta-analysis in the use of MI in physical health and substance misuse (Hettema, Steele & Miller, 2005) which found the average outcome effects sizes for ‘minority’ groups receiving MI compared to ‘white non-Hispanic groups’ in USA where more than three times greater .He also gives examples of MI studies where marginalised

groups had significantly better outcomes. Vilanueva et al., (2007), where native American client's showed greater alcohol reduction, Sakher et al., (2019) where African American males showed the largest effect for reduction in alcohol and drug use. Faustino Silva et al., (2019) where low income families and greater reduction of child dental cavities.

Miller (2019) hypothesises that this may be due to a contrast effect as people with privilege are accustomed to being respected and people without it are not. MI provides the opposite in explicit privileging of clients through, affirmation, empathic listening, autonomy support, partnership, acceptance, compassion and evocation. This practise may be seen as a contrast to other relationships and MI practice might be said to be more egalitarian. Although, MI practitioners are often white and privileged themselves, the MI practice of having a 'beginners mind' i.e. not assuming that you know the answer and that the clients are experts on themselves; may explain the difference in response to MI interventions.

In discussing de Almeida Neto's contribution to MI theory (Miller, 2017) draws on this and supports this theoretical work, he argues that:

…"the techniques used in MI are adaptively significant, signalling to the client that he/she is socially hierarchically and physically safe. By not directly providing advice to change and by enhancing the client's perception of social support, the interventionist is not perceived as attempting to impose social-hierarchical discipline. This, in turn, bypasses the unconsciously primed, evolutionary salient human trait of psychological reactance, which is argued, in this paper, to have evolved, in part, to facilitate the maintenance of social dominance hierarchies. This non-socially threatening environment created by MI allows the human cortex to process information and engage in cognitive reasoning and decision making without strong influence from unconscious instinctual subcortical processes that ruled behavior prior to cortical evolution."

De Almeida Neto, (2017), citing other research (Brehm & Brehm, 1981) into psychological reactance suggest that the maximising of free choice restores a sense of autonomy in individuals and reduces reactant or non-adherent behaviour. He sees the micro skills of MI as creating basis for a warm caring

relationship. De Almeida Neto (2017), also sees MI as enhancing the client's perception of social support and showing that a potential social opponent is caring about the individual, communicating again that they are socially hierarchically safe. Similarly, he sees the empathic non-judgmental approach of MI communicates safety and a lack of threat. Also, because MI is supporting client autonomy, it is potentially providing a non-threatening environment in terms of social hierarchy. Further, de Almeida Neto, (2017) importantly identifies that this psychological reactance lies on a continuum within individuals and he describes scales that have been developed to measure susceptibility to reactance. This ranges from very low to very high (Dowd et al., 1991) and he sees MI as maybe more important for people at the most reactant or disempowered end of this spectrum. Although this impact has not been determined empirically, the evidence that MI is more effective with people who are angry (Babor et al., 1999) which could be seen as one manifestation of its ability to respond to reactance or other responses to threat in humans.

3.3.6 Evolved responses to threat and trauma

This theoretical development described above fits with other psychological research where people who have been exposed to traumatic life events or upbringings and rely on responding automatically to preserve their sense of self and safety. A recent document produced by the British Psychological Society, the *Power Threat Meaning framework* (Johnstone & Boyle, 2018) draws on evolutionary theory and trauma research showing that people who are desensitised as a result of long exposure to threat are more likely to be highly reactive. This framework has been used to help explain how people's reactions to stressful life events can be manifested in a range of mental health or behavioural problems. These range from mood swings, extreme anxiety states, compulsive checking behaviours, suspiciousness and voice hearing; through to eating problems and alcohol, drug overuse. These behaviours can be seen as responses to threat that at some stage may have been helpful in dealing or coping with traumatic threats, but then have become unhelpful overtime.

These coping behaviours or responses to threat parallels other evolutionary and neurobiological research into the development of the human autonomic nervous

system (Dana 2018). This is a large and complex literature and we will only consider it briefly here for its relevance in human social interactions such as therapy. The human nervous system is made up of two main branches, the sympathetic and parasympathetic, where according to Stephen Porges (2007) we respond to sensations and signal via three main pathways, “in the service of survival”. Dana (2018) highlights the evolutionary development of these three pathways, the ventral vagal, the sympathetic and the dorsal vagal pathways as having developed over time to maintain human survival.

- The ventral vagal system moderates our social engagement system where we feel safe and can connect with our social world. When we feel safe and connected with others we can maintain a healthy immune system and have reduced vulnerability to illness, we sleep well and generally have healthy vital signs.

- The sympathetic system is activated when we feel in danger and this is where our fight or flight responses are activated, during feelings of anxiety or anger, adrenaline production is increased, we are hypervigilant for signs of threat and have an inability to focus and are distressed. We sense danger and look to protect ourselves from harm. The health consequences of this are the opposite of above.

- Finally, the oldest neural pathway is that of the dorsal vagal pathway. When action responses fail the more primitive vagus moves us toward shutting down, to collapse and to dissociation. People may see themselves as hopeless, exhausted and have a negative view of the world. We may dissociate, feel low in mood, lack energy for tasks, have digestive problems, a low blood pressure and an increased risk of type 2 diabetes. Ideally these systems should work together to maintain a healthy and safe life. Where they do not or have been overwhelmed for example with constant exposure to threat, through deprivation or living in traumatic violent environments we may overly rely on automatic or instinctual responses for survival.

There is not space to explore in depth the literature on instinctual human responses to threat but the highlighting an evolutionary perspective may help us to understand theoretically how MI is working. For more detailed research and its application in this area of therapy (see, Dana, 2018). Psychological reactance towards recommended change or changes in behaviour could be seen as a way of a person maintaining their social rank, or their sense of social safety and survival. It may be one of a number of evolutionary responses to threat that are relevant to an understanding MI practice and therapeutic interventions in general. The concept of psychological reactance may also relate to psychological resistance a concept previously used in MI (Miller & Rollnick 1991,2002) which we will now consider.

3.3.7 Responding to Resistance or discord in relationships and repairing rupture

Reducing client sustain talk and resistance to making change has already been referred to above as part of an exploration and resolution of ambivalence, linked to behaviour change outcome. MI has emphasised over its history the need to identify and respond to this and has identified strategies for rolling with resistance (Miller & Rollnick, 2002) and then in a later theoretical development responding to discord (Miller & Rollnick 2012).People being described as resistant to change is not unique to MI, although MI as an approach has expended considerable effort in trying to understand this theoretically and in practise. In the first edition of MI (Miller & Rollnick,1991) talk about resistance and references reactance theory as theoretical explanation of how confrontational approaches might cause resistance in a therapeutic relationship. This reference to reactance continues to be made in the later 2nd and 3rd editions (Miller & Rollnick, 2002, 2012).

Although in the 3rd edition the concept of resistance is removed and replaced with sustain talk and discord. Miller and Rollnick believed using the term resistance to describe a person can be judging and stigmatising, focusing on an individual pathology and underemphasising the interpersonal elements of the relationship. They suggest based on MI interactive processes research (Moyers et al., 2017) that much of what is described as resistance is better described as sustain talk.

That is seeing the ambivalent client's motivations and talk in favour of the staying the same as sustain talk. The other side of this ambivalence being talk about change, in terms of the target behaviour change.

Miller and Rollnick (2012), decided to call what is left over as discord and that this is signaling dissonance in the working alliance. That is when clients are seen as disagreeing or arguing with or interrupting, ignoring or discounting the therapist. They see it as a dynamic and being about the therapeutic interaction itself. In terms responding to this discord particular attention is paid to listening out for signs of it and also asking the therapist to think about their own mood, thoughts and behaviour.

MI as an approach has specified ways in which practitioners should respond to resistance (Miller & Rollnick, 2002), sustain talk and discord (Miller & Rollnick ,2012) by using MI consistent skills and strategies. For example, in using reflective listening and emphasising client autonomy, using reframing, agreeing with a twist, running ahead start and coming alongside are emphasised as a way of responding to sustain talk and to discord. In addition, for Miller and Rollnick (2012) reflective listening remains a key tool for responding to ruptures in and restoring a working alliance. As does apologising, affirming and shifting focus away from discord. MI has developed training exercises in order to practise responding to discord illustrating that depending on how therapist responds can affect the levels of sustain and discord (Miller & Rollnick 2012).

For some the concept of psychological resistance has been retained in MI training (Reniscow et al., 2019). Resistance is seen as what the client brings to the interaction and discord is what is generated when the therapist slips into MI non adherent behaviour. Reniscow et al., (2019) also link this in with Self Determination Theory (Ryan & Deci, 2002) and their concept of controlled motivation. They also make a link with psychological reactance theory in highlighting the need that some people have to restore their sense of freedom when they feel controlled. According to reactance theory there are essentially two modes of restoration. Firstly, Direct i.e. do the forbidden behaviour and secondly Indirect i.e. attack the source or the message of control. Thereby increasing the liking of or desire for the threatened choice, in what Reniscow et al., (2019) call

‘boomerang attitudes’. Also, this supports the denying of the existence of the threat and the exercising a different freedom in order to gain a feeling of control and choice.

Although the term resistance received revision in Miller and Rollnick (2012) a number of MI therapy process studies have used the concept to examine the effects of MI and its integration with CBT, for example with anxiety and GAD. A study by Kertes, Westra, Angus and Marcus (2011) identified the impact of MI on resistance inside therapeutic relationships. This Integration of MI in their study was seen to reduce resistance in relationships and to improve outcomes for the MI group compared to a CBT alone group. This is complimentary to other MI research that shows how therapist MIICO behaviours are associated with higher levels of resistance, lower client engagement, and worse outcomes in the substance misuse field (Apodaca & Longabaugh, 2009). This is discussed further below in MI CBT integration section below.

This also links into the concept of psychological reactance referred to in MI texts for example Miller 1983, Miller & Rollnick 2002. So, that responding to reactance in a way that reduces it may have an effect on the therapeutic relationship; that may increase motivation and to prevent or help to repair rupture. Working with ambivalence as MI is designed to do, may in itself be a way of minimising resistance and facilitating the promotion of an effective working alliance. Discord may therefore be seen as a response to threat, either to an individual’s freedom through being controlled or a threat to their social rank in a therapeutic relationship. It could be argued that the identification of resistance and responding to it appropriately may be an important feature of MI. Miller and Rollnick (2012), Behm (1966), de Almeida Neto (2017), Reniscow et al., (2019) all recognise that this may involve both subconscious or unconscious reactions, and therefore how the practitioner responds to this may be seen as a mechanism for change. Whether this is called responding to reactance, responding to resistance or responding to discord as a theoretical concept it has consistently appeared across different versions of MI. In Miller’s, 2017 paper ‘taking the lower place: motivational Interviewing and social dominance’ he takes this further. He describes MI as a ‘power yielding’ approach in that using accurate empathy and

accepting and affirming of what is already in fact the case, that the client is already the expert on themselves. He accepts that MI has not really considered issues of power inside the therapeutic relationships nor has it considered the social context of these interactions.

3.3.8 Social Contexts, Power and MI

Miller (2017), acknowledges that issues relating to power and social contexts have not been addressed in MI. He suggests that MI might be differentially more useful in certain social circumstances. For example, in contexts that are characterised by high social dominance or competition, such as in sport. Also, MI might be less impactful in contexts that require a culture of deference such as the military. He also asks whether it might be more important for those professionals such as doctors or clinical psychologists who are seen to have a higher status and occupy positions of power in society, to practice MI. Although, he also points out that power dynamics operate as a general factor across all interpersonal interactions and in his view a style that yields power e.g. MI with its component of accurate empathy, is associated with better clinical outcomes across various kinds of psychotherapy (Rogers 1959).

According to Stanton (2010), he was surprised that Miller and Roses', (2009) proposed theoretical pathways did not include social variables. He believes it is important that a theoretical model of MI should include factors from our social contexts. These conditions may enhance or diminish the efficacy of MI and clients attempts at behaviour change. While the addition of de Almeida Neto's (2017), evolutionary perspective which highlights a social context in terms of social rank, MI theory and practise have remained focused on individual responses. Although, as we have described already individual relationships have their own social context. Stanton (2010), describes research that has shown significant others to have an impact on readiness to change and in maintaining change in substance misuse behaviour. Miller and Rose (2010) acknowledge this in their reply to Stanton's critique. Looking at the data from Project MATCH, Babor et al., (1999) noticed that people with higher levels of social support fared better in in terms of sobriety than those with lower levels of support. The latter group seemed to do better in twelve step facilitation which involved group support. Although there are

recent developments in the delivery of MI in a group format (Wagner & Ingersoll, 2013) focusing attention on interpersonal processes and group interactions, this remains an under researched area. Stanton (2010), also says that the client readiness for MI may be affected by the withdraw-demand interaction, for example where significant others are frustrated by someone's behaviour they may demand change. In these circumstances he speculates that clients who have received these demands previously may be more responsive to MI because it differs from their current or past experiences. This may also be consistent with the social dominance and reactance theory mechanisms described above.

Miller and Rose (2010) accept this is as a reasonable hypothesis, in that MI may be seen as a welcome contrast to previous relationships within the person's life. They cite the finding of Hettema et al., (2005) that the effect size for MI in Ethnic Minority populations was double that for a comparable white majority population. Suggesting that It was possible that the empathic, collaborative and respectful style of MI may present a contrast to previous relationships and therefore be more acceptable to ethnic minority groups. As already discussed above this finding has been observed in other marginalised groups e.g. African-American men, Native-American clients and low-income families. Who had better health outcomes comparatively across a range of health behaviours in MI interventions.These social variables might also be relevant to other situations where the effects of previous negative power relationships might be affecting the current interaction. For example, someone's previous experience of abuse, of discrimination or overly controlling or directing relationships. It is not uncommon in psychological therapy services for example for women who have been abused or raped to prefer seeing a female therapist. Nor is it unusual in therapy or counselling settings for the interventionist to be a powerful, highly educated, well paid individual; working with individuals from multiply deprived back grounds who have little access to economic power or social capital (Coleman,1988).

Stanton (2010) recommends the addition of a social influence's variable to the Miller and Rose (2009) model, Also, he points out that I or 2 hourly sessions of MI will represent a very small part of a person's life. He suggests it is important for the MI practitioner to include consideration of the client's social context when

delivering the intervention. In order for them both to think about how they can implement change within that individual’s social context. Stanton (2010) goes on to recommend the involvement of significant others (SOs) in MI work and in some cases teaching SOs MI skills to support change. However, Miller and Rose say they prefer the Community Reinforcement and Family Training (CRAFT) model (Roozen, de Waart, & Kroft, 2010) which is specifically designed for this work. Miller and Rose (2010) have said they are not supportive of training significant others in MI as a way of improving outcomes as suggested by Stanton, (2010). They caution against the use of MI where one has strong personal investment in the outcome, for example with family members.

Miller and Rose (2010) in their response to Stanton’s critique similarly reflect on how 1 or 2 sessions of MI without consideration of the social context can work at all. They also point out that it does. They say their model does not attempt to focus on all the influences on behaviour change and that it is purposely more focused only on the individual interaction. They cite the fact that most MI research available to them and the research into other therapeutic approaches has this focus. Miller (2012, p.1), responding further to this criticism in an article entitled *MI and Social justice* stating:

… ‘’Living in an unjust society is bad for us all’ and he goes on ...” But I want to go Stanton one better with a call for a consciousness of social justice that is implied by and reaches beyond the spirit of MI’’.

Consideration of the social context like theory development does not seem to be have been a priority for MI and its research. There is also an obvious lack of literature in this area which is not surprising given this lack of research. Stanton (2010) considers this lack of consideration of a wider social context in MI as surprising given that MI clearly prioritises interpersonal factors as well as therapist behaviours. I will now move on to consider this small literature of more recent critiques of MI in which have considered MI in a wider social context.

3.3.9 Wider Social Context and recent critiques of MI

The small literature described here comes from sociological perspectives which according to Carton (2014) has rarely been seen in what he describes as the ‘Psy-Sciences’. He also suggests that MI has escaped scrutiny partly because of its ontological orientation, but also because of its lack of concern for wider social contexts. Lauri (2019) observes that studies critically examining MI are scarce. Snertingdal (2013) used Foucault’s theoretical concept of governmentality in her analysis of MI as a brief intervention in Norwegian natal care. She observes a shift away from a public health approach which has targeted populations rather than individuals. These public health approaches having been used for fear of stigmatising individuals. They describe a shift towards a neoliberal social policy which emphasises the role of the individual, the individualisation of social problems and resulting diminishing of the role of the state. MI is described as:

…’’a perfect example of a neoliberal mode of governance, because it is an indirect way of governance, which casts healthcare workers as a part of the state that wants to make pregnant woman self-governing and responsible.’’ (p.36)

MI can be seen as enabling a blurring of the line between the power of the state and social responsibility, through its individualising research perspective and its practise of encouraging an emphasis on the power of the self. Also, that MI as an intervention can promote moral judgements around what is regarded as healthy behaviour. Carton’s, (2014) review of training materials for teaching MI in New Zealand also used Foucault’s theoretical framework of governmentality in his analysis. He identifies that MI was originally developed as an empowering approach but that its continued emphasis on an individualised context now makes it a good fit with a neoliberal agenda. In doing so it is repositioning the client, … “as an active self-governing autonomous subject while the clinician is professionally and spiritually imprecated in the manufacture of a neo liberal subjectivity within the client’’ (Carton 2014 p.192). He sees MI as a paradox as an approach, in that it can also be seen as liberating, strengths based, resisting of labels and avoiding of dependency between client and clinician. However, MI’s emphasis on individual responsibility may inadvertently be absolving the state and a neoliberal society of its responsibilities. He goes on to argue that 3

elements of MI spirit, collaboration, evocation and autonomy, can encapsulate the spirit of neoliberalism and might well be describing a business transaction carried out in a free market place.

Lauri (2019), carried out qualitative interviews with workers advocating MI in work with men's violence against women (MVAW). Noting the expansion of MI in Sweden and its use in work with MVAW he notes MI as having a lot in common with empowerment theory (Perkins & Zimmerman,1995). He notes also an important difference with it, in that MI shows no interest in the surrounding context nor does it apply a structural theory perspective. As a method for individual conversations it shows no interest in collective awareness raising or formation of a political subject. According Lauri (2019, p.4) in Foucault’s theory,

… ‘’ the interwoven relations between power/knowledge and how power is exercised by shaping subjects in ways that make them amenable to governing, makes important contributions to what is often referred to as a governmentality perspective.’’

Thus, seeing MI as ‘governmentality’ places responsibility on the individual through self-regulation to make the right choices obscuring social problems and achieving governance for the state. As stated in other examples this can be seen as being helpful to neoliberal governments as they seek to reduce state responsibility through austerity policies and implementing interventions at a reduced cost. MI is generally seen as a brief intervention and therefore cheaper. Other authors in the MI world have agreed with this perspective, e.g. Wahab (2019, in press, personal communication) says ‘‘MI reinscribes neoliberalism's focus on individual responsibility for social problems.”

All health behaviour change is often difficult for individuals for a number of reasons. These critiques suggest it may be helpful to see that individual psychological Interventions exist in a wider social context e.g. that of family, community and society. In MI practice these wider social contexts have been acknowledged but ignored theoretically and in practice. Miller & Rose, (2009) have considered them but did not want to incorporate them into a theoretical model. From a critical realist perspective, research into both the individual and

social contexts would seem to be important real-world level of analysis. Especially if we are to develop our understanding of how they interrelate in terms of behaviour change theory.

3.4.0 What does the integration of MI with CBT in Mental Health tell us about MI theory?

The recent literature on the integration of MI with CBT in mental settings has described a number of different integrations or combinations of MI and CBT for a range of psychiatric diagnostic categories. It has suggested it may be beneficial to integrate them in terms of client outcomes. Two volumes of ‘’Motivational Interviewing In The Treatment of Psychological Problems’’ have been published describing integrated interventions for anxiety, depression, eating disorders, co morbid substance misuse and psychosis. (Arkowitz, H. 2008; Arkowitz, Miller, & Rollnick, 2015). Westra, (2012) has produced a book focussing specifically on MI integration with CBT in the treatment of anxiety. Also, a special edition Cognitive and behavioural practice Westra and Arkowitz (2011), summarised some early research into this integration for a range of mental health problems. In addition, two recent books, Motivational Cognitive Behaviour Therapy, (Atkinson & Earnshaw, 2020) and Motivational Interviewing and CBT (Naar & Safren, 2017) have addressed the theory and practise of this integration. A meta-analysis of MI studies across a range of behaviours by Hettema et al., (2005), concluded that MI may be said to have a ‘synergistic effect’ when integrated with CBT. They also observed that one reason for the wide appeal of MI lies in its ability to complement or supplement existing effective therapies rather than in replacing them. Miller (2017, p.7), writing a forward to Naar and Safren, (2017), says, ... “that it is clear to me that MI and CBT are not only compatible but complementary.” In the substance misuse field, Moyers and Houck (2011) describe the combination of MI with CBT as the norm in research studies and their evaluation of a combined intervention suggest this is perhaps more effective than a single therapy alone. At the same time there have no direct comparisons between CBT alone and MI integration with CBT in mental health settings (Naar & Safren, 2017).

Randall and Mcneil, (2017,p.14) in their review of the integration of MI and CBT in working with anxiety say "MI and CBT are like half-siblings who share one parent. Their partially shared theoretical backgrounds make the two approaches well suited to be paired." The next section of the review will look at this literature on integration in the mental health field with a view to identifying theory and mechanisms of action related to outcomes that the integration of the two methods may bring.

3.4.1 Reasons and evidence for Integrating MI with CBT

As described a number of integrations of MI and various forms of CBT in mental health settings have been undertaken for a number of different contexts for example: anxiety (Westra, 2012, Marker & Norton, 2019), severe anxiety disorder (Westra, 2016), Depression (Flynn, 2011) OCD (Simpson & Zuckoff 2011), Personality Disorder (Mcmurran, 2013) Substance misuse and Psychosis (Baker et al., 2012; Barrowclough et al., 2011) Suicide Prevention (Brittan 2011,2017), Eating disorders (Geller & Dunn 2011; Treasure & Schmidt, 2008) , 'at risk' mental states (Bucci), Bipolar disorder (Jones, Barrowclough, Allott, Day, Earnshaw & Wilson 2011).

3.4.2 How has that integration taken place?

In the introduction to the special edition Arkowitz and Westra (2011) describe a number of ways that MI has been used in addition to being a stand-alone therapy. These are:

Firstly, as a prelude or pre- treatment used to build motivation for and engagement in action orientated interventions e.g. CBT (see Angus and Kagan, 2009).

Secondly, in combination with for e.g. being used as Motivational problems arise in therapy (Arkowitz & Westra, 2004)

Thirdly, as an integrative framework into which other therapies can be incorporated (Arkowitz & Burke ,2008; Barrowclough et al.,2011). This could also be described as full integration.

According to Arkowitz, (2011), few of these studies have involved a full integration and most have either been a prelude to or a combination of both interventions. He says this has made it difficult to assess this literature because of the diversity

of interventions in terms of the degree of integration undertaken.The specific literature evaluating an integration of MI and CBT in mental health is small and still developing. (Hettema, Steele & Miller, 2005) have said they think that an integration of these two evidenced based approaches might be feasible both theoretically and practically. Observations have been made from integration researchers (Moyers and Houck, 2011, 2010 ; Naar and Safren, 2017) that this may not be so straightforward and may have a number of drawbacks. They cite the extra training time required for therapists and conflict between more directive and more evocative styles.

Kirby et al., (2017) have pointed out that the effects for CBT for a range of mental health problems tends to be moderate. Integration researchers, (Barrowclough, 2011; Haddock, 2012; Steindl, Kirby, & Tellegan, 2018) have all recognised whilst moderate evidence is promising, there is room for improvement in these CBT interventions. They have suggested how MI CBT integration in theory and practise might improve outcomes for clients. Steindl, Kirby and Tellegan, (2018,p.272) summarise the reasons for integration of MI and CBT this way:

…"MI is often used as a prelude to treatment (Merlo et al., 2010; Westra, Arkowitz, & Dozois, 2009; Westra & Dozois, 2006; Zuckoff, Swartz, & Grote, 2008), and it has been shown to improve treatment outcomes (Merlo et al., 2010; Westra et al., 2009; Westra & Dozois, 2006), as well as to predict higher self-efficacy (Westra & Dozois, 2006), greater homework adherence (Westra et al., 2009; Westra & Dozois, 2006), and decreased resistance (Aviram & Westra, 2011) among participants.''.

Steindl, Kirby and Tellegan, (2018) also propose an integration of MI with compassion focussed therapy (CFT) a 'third wave' CBT, as it may offer increased engagement, adherence to therapy and behaviour change. The research undertaken so far has encouraged those researchers to put forward reasons why they think this integration is beneficial. In the absence of large randomised controlled trials evaluating these various integrations of MI and CBT this work may be thought of as theoretical. The reasons put forward for doing it might be

thought of as a way of identifying candidate mechanisms to explain what MI is adding to CBT and vice versa. Given that Moyers and Houck (2010) suggest this is now the 'norm' it would seem the practice of doing so is ahead of the evidence. We will now go on to consider further some of those reasons put forward in terms of theory and practice.

3.4.3 Engagement and Motivation in Therapy

CBT and psychological therapy in general can attract low levels of engagement and have high attrition rates. Meta- analyses by Hatchett, (2004) and Greenberg, (2012) report considerable attrition rates, ranging between 50% and 20% in psychological therapies. Wang et al. (2006) see poor attendance as generally accepted as an indicator of non-engagement in therapy. Holdsworth, Bowen, Brown and Howat (2014), reviewed 79 studies on client engagement in psychotherapeutic treatment and looked at associations between client characteristics, therapist characteristics, and treatment factors. They found that strengths-based approaches to therapy for example MI , Motivational Enhancement or Solution-Focused Therapy, appear to foster those therapist qualities and behaviours related to engagement. These characteristics include therapist warmth, optimism, humour and professional self-doubt. They also cite an established literature (Martin et al.,2000) consistently linking these therapist qualities to therapeutic alliance and therapeutic relationship (Norcross, 2011) to positive client outcomes.

Therapist alliance has been discussed above and the findings from the Holdsworth et al (2014) research may lend further support the relational hypothesis of MI efficacy. They also suggest that client participation or involvement in therapy sessions including the completing of homework may be a more accurate reflection of engagement rather than simple attendance. Daley, Zuckoff, Kirisci and Thase, (1998), hypothesised that low levels of motivation to change in therapy often leads to lack of engagement, adherence to or completion of therapy. Westra and Arkowitz (2011), Westra (2012), Westra and Dozois (2006) suggest that their research provides evidence that adding MI to CBT can increase engagement with and response to CBT for anxiety. They found that in doing so there was an increase in adherence to in- between session or homework

tasks. Further that this is likely to increase readiness to change and reduce resistance and therefore dropout rates from therapy (Arkowitz, 2008; Arkowitz, Miller & Rollnick, 2015; Aviram & Westra et al., 2011). Romano & Peters, (2016) meta-analysis of the use of MI in mental health settings found MI increased client motivation to engage in treatment. Although as previously discussed, their review focussed mostly on substance misuse studies. This evidence and reasoning may fit also with the relational hypothesis discussed above.

Lawrence, Fulbrook, Somerset, and Schulz, (2017) carried out a systematic review and Meta-analysis of MI interventions and those described as based on the principles of MI. They concluded that MI increases treatment attendance in both mental health and non-mental health settings. That it can be used to promote and facilitate behaviour change particularly for those patients who are resistant or ambivalent to change. In addition, they found that even brief MI interventions delivered by telephone are a viable low-cost option in promoting continued involvement in mental health care. This review concluded MI to be a useful approach for clinicians in all therapeutic interactions to motivate the client to seek further assistance for their mental health issues. Atkinson and Earnshaw (2020) observe that motivation has not been seen as a key issue in CBT and that no specific motivational strategies or theories have been forward in CBT. Yet motivation remains an important issue in CBT and in all therapies (Brittan et al. 2011).

Lawrence et al., (2017) viewed MI as a feasible pre-intervention to other interventions therapies and treatments. They concluded that it heightens motivation with individuals and encourages them to seek and engage in further help. For example, a 10-session integration of MI/ CBT for people with comorbid psychosis and drug and alcohol use demonstrated effectiveness in the reduction of excessive drinking (Baker et al., 2012). Although this intervention was not as successful with other substances such as cannabis and amphetamine. A similar larger RCT 26 session MI/CBT study in the UK (Barrowclough et al., 2010) produced similar outcomes in terms of reducing alcohol misuse and increasing readiness to change in this psychosis population. Although, the alcohol use finding was limited to an unplanned secondary analysis. Also, this study did not

show any difference between the control group on outcomes for psychotic symptoms and death.

Westra and Arkowitz's (2011) review of the emerging evidence for integrating MI into mental health work, concludes that it is strongest in psychosis and substance use research because of the large size and methodological rigour of those studies mentioned here. They recommended, based on their preliminary research, that MI should be routinely added to existing treatments for most major mental health problems. The area where most research and particularly process research has taken place is in the area of CBT for anxiety and generalised anxiety problems. Marker and Norton (2018) carried out a literature review and metanalysis of the incorporation of MI with CBT in anxiety disorders. They acknowledge CBT has a large evidence base (Tolin, 2009) and is recognised as one of the most efficacious interventions for a range of anxiety diagnoses. Marker and Norton (2018, p.5) also acknowledge that in CBT:

…''Despite the overwhelming evidence, there remains room for improvement ,15-50% of individuals not responding to treatment (Otto, Behar, Smits, & Hofmann, 2008). Furthermore, meta- analytic findings reveal that dropout rates in CBT for anxiety are approximately 23% (Hofmann & Smits, 2008).''

They also describe CBT approaches as assuming that clients entering therapy are ready and motivated for change. When according to research by Prochaska and Norcross, (2013) around 80% are not. They describe how other MICBT researchers e.g. Westra (2004) sought to address this issue of motivation for change by adding MI to CBT. They note numerous case studies, open trails and RCTs of this integration across a wide range of anxiety and anxiety related diagnostic categories. Some of these studies e.g. Aviram and Westra (2011) have demonstrated the benefits of this combination and others e.g. Blain (2013) have not. Their meta-analysis included 12 RCT studies and is the first meta-analysis to examine MI as an adjunct to CBT for anxiety.

Marker and Norton's (2018) analysis of these studies noted an improved symptom reduction in the MICBT group at 12 month follow up compared to CBT

alone. This improvement is described as small but could be said to be clinically significant. They caution that this result held regardless of the number of MI sessions included, typically it was 1-4 as a prelude. Also, they observe the results of the included studies did not take into account client readiness to change and that some individuals may need less MI if they are already prepared to take action through CBT. Also, a limitation of their review was that most studies did use MI as a prelude, only three studies integrated MI throughout. Also, how this was done was not well documented but generally the therapist was allowed to use MI when resistance was encountered. Also, most studies reviewed did not adequately report their procedures of randomisation. Overall as they summarise the results of the review for the MICBT integration as mixed or inconclusive and that this may be problematic as MI has already been incorporated into a number of treatment manuals for anxiety.

Marker and Norton (2018) conclude that their analysis provides support for including MI with CBT for anxiety, in terms of improving symptoms. However, the meta-analysis was unable to address whether MI has an impact on levels of motivation, treatment adherence and engagement. They recommend more research to identify mechanisms of change and a greater focus on client characteristics. In order they say to develop an understanding of how MICBT integration works, for whom and how much of it needs to integrated into CBT.

Westra and Norouzian (2017) summarise the evidence for integrating MI and CBT in people with a diagnosis of anxiety disorder and Generalised Anxiety Disorder (GAD).They also reviewed the literature on resistance and ambivalence in CBT and looked at how MICBT integration might help in responding to it in terms of client outcomes. Their review describes this work as promising and in the early stages. They describe MICBT interventions reviewed as demonstrating an increase in, treatment seeking, problem recognition, treatment attendance and in the uptake of exposure-based interventions and an improved response to CBT. They cite one RCT (Westra, Arkowitz & Dozois, 2009) where they compared MICBT consisting of a 4 session prelude of MI + 14 sessions of CBT with a CBT of 14 sessions with no pre-treatment. From a sample of 67 treatment completers they found an effect size for worry reduction of d = .47 in favour of the MI-CBT

group. Also, the MICBT group completed more homework with a between groups effects size of *d* =.59.

An even larger RCT, (Westra, Constantino & Anthony, 2016) studied a sample of people with high severity GAD. They compared an MICBT consisting of 4 session prelude plus 11 CBT sessions with 15 sessions of a CBT intervention. No immediate differences were found, but at 1 year follow up the MICBT clients had continued to improve on the trial's primary outcomes of worry and distress reduction. This compared to the CBT alone group who just maintained gains. Also, the MICBT clients were 5 times more likely to no longer meet criteria for GAD at 12 months that is, 60% of MICBT group vs 25% of CBT alone group. The CBT group also had double the dropout rate from therapy. Also, according to Westra, Constantino and Anthony (2016) they found strong interpersonal process differences between the two groups. The process research undertaken saw MICBT therapist demonstrate higher levels of empathy and facilitative interpersonal skills for example autonomy support, evocation and collaboration.

Finally, in both these RCTs the MICBT group was found to have lower levels of client resistance which Westra and Norouzian (2017) suggest mediated the differences in outcome also suggesting that it is the integration of MI that helps the therapist develop skills in recognising and responding to resistance. Di Clemente et al.'s, (2017) review of the efficacy and effectiveness of MI conclude that although it is an evidence-based intervention it was often difficult to establish the nature of the MI intervention for their review. The literature explored above also suggest that the variety of combinations of MI and integrations of MI with CBT, makes it difficult to establish the exact nature of the intervention. Marker and Norton (2018) reflect that perhaps the evidence and evaluation of MICBT integration has not kept pace with its implementation and the optimism to integrate MI with a range of CBTs. This MICBT integration literature in mental health continues to develop and is perhaps best described as promising.

3.4.4 MI as an Integrative framework for CBTs

Allott and Earnshaw (2007) , Naar-King, Earnshaw and Breckon (2013) suggest that MI may provide an integrative framework or structure to deliver CBT and

facilitate the maintenance of behaviour change. If it used in this way it can be utilized across a range of problems and behaviours, providing a core style and a philosophy that specifies good therapeutic practice. This does require that therapists are trained to a competent standard and assessed on recommended fidelity measures, which is more time consuming. It has also been noticed by Houck and Moyers (2010) that sometimes therapists find it difficult to accept and switch between the different styles. Earnshaw, (2010), when working as a research therapist using a full integration of MI and CBTp in the UK Midas trial (Barrowclough et al,.2011), suggested that MI could be seen to act as a trellis upon which other psychosocial interventions might thrive. Also, that some approaches might be more compatible with MI than others theoretically and in practice. Using this analogy, the therapist might be seen as the soil in which the intervention grows and the intervention itself the plants. See the figure below.

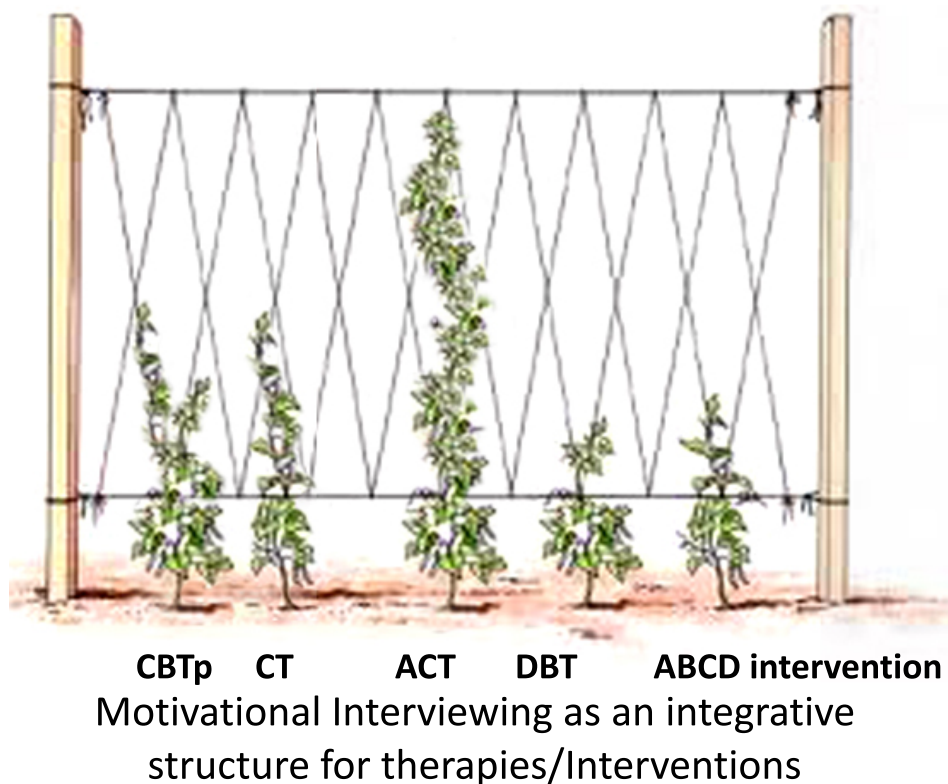


Figure 3.4.(Earnshaw, 2013).

Like CBT MI was not based initially on formal theory and might be better described as initially based on a phenomenological approach. Being based on implicit principles derived from clinical practice which have then been submitted

for verification via a scientific method. I will now consider the differences and similarities between the two approaches to see what this might recommend in terms of theory development and mechanisms.

3.4.5 Differences and Similarities between MI and CBT

Neither CBT nor MI developed out of theory, and both initially derived from clinical practice, although arguably the origins of MI in particular are theoretically informed as described above. Both approaches originate from different professional frameworks that were prevalent in the late 1970s and early 1980s. In terms of emergence within professional fields, key proponents of CBT, for example Aaron Beck and Albert Ellis, were psychoanalytically trained. In relation to MI, the main protagonists – William Miller and Stephen Rollnick – were clinical psychologists with behaviour therapy backgrounds. CBT developed in part out of a reaction to psychodynamic practice and might be described as an integration of behaviour therapy and cognitive therapy. MI is grounded in humanistic, client-centred therapy and includes some elements of behaviour therapy. Within MI limited attention is paid to cognitive processes, although cognitive change is both a mechanism and a goal. MI (Miller & Rollnick, 2013, p.29) is defined as a,…"collaborative, goal-orientated style of communication". It places more emphasis on creating a safe space where people are free to explore thoughts feelings and behaviours in relation to a specific goal. By contrast, CBT's main focus is on the interrelationship between thoughts, feelings and behaviour.

Both MI and CBT can be said to be person-centred, but each might dispute how genuinely this is the case. For example, MI is more directional than Rogerian counselling in that there is often a specific reason why the therapist would be looking to help the client reduce their ambivalence (e.g. improved adherence to medical treatment or reducing risk of harm through alcohol use). CBT uses a Socratic approach to guide individuals towards a cognitive or behavioural discovery. MI places emphasis not only on building motivation through exploration but also on the differential reinforcement of talk about change as discussed earlier. The underlying philosophy or spirit of MI is specified and also observable and measurable at the level of skill (Moyers, Manuel and Ernst , 2014).In practice CBT pays less specific attention to this relational element and

arguably pays insufficient attention to addressing motivation in those who are ambivalent, both in terms of identifying it as an issue and offering strategies for building client motivation. However, it could be contended that the acquisition of new skills and knowledge offered through CBT may be seen as motivating in itself.

In their paper, "Ten Things that Motivational Interviewing Is Not", Miller and Rollnick (2009,p.134) specified (at number 6) that, "MI is not a form of cognitive-behaviour therapy". Specific reasons provided for this included:

- Unlike MI, CBT generally involves providing clients with something they are presumed to lack (e.g. coping skills, psychoeducation).
- MI does not seek to correct erroneous beliefs.
- The therapist takes the position of companion, rather than an expert.
- The conceptual basis of MI is humanistic, rather than behavioural.

Miller (2017) argued that at some levels CBT and MI seem completely opposite, with CBT practised from a directive, expert model, focussed on installing what the client lacks, while MI is about building on the client's existing motivation, wisdom and ideas. In practice MI has established itself as an approach that is effective at building motivation for change and has now begun to develop theory as to why it is an effective behaviour change intervention (de Almeida Neto, 2017; Miller & Rose, 2009). MI emphasises that the client is the expert on themselves, while CBT is more educational and generally assumes that expert information and formulation will be helpful. MI promotes information giving with the client's permission but emphasises eliciting what the client knows already.

MI and CBT can be seen to be trans-diagnostic and can be applied with a range of presenting behaviours. MI was originally developed from Miller's (1983) work with problem drinkers but has since become more prominent across a whole range of health, educational, social care and forensic behaviours. However, while both approaches are trying help people understand the origins of their problematic behaviours, CBT offers diagnostically specific models (e.g. for obsessive-compulsive disorder (OCD), depression, anxiety, psychosis and specific formulations to discuss the impact of current thoughts, feelings and

behaviours. Conversely, MI is not diagnostic or model-specific and instead focuses on the person and their strengths and capabilities. Individualised formulation (Johnstoen & Dallos, 2006) has developed in CBT over a number of years and may have led to some practice becoming more person-centred. MI has avoided labelling and being a diagnostically based intervention. Both CBT and MI are individualised therapies although both have developed group interventions and CBT has developed adaptations for working with families.

3.4.6 MI and CBT theoretical comparisons in therapeutic approaches

Some examples of CBT integration have been outlined previously. Also, some CBT approaches have been compared conceptually with MI and suggestions have been made about what each could add to the other. Looking at these comparisons may also tell us something about MI theory and mechanisms of action. I will now consider briefly two so called third wave CBT's that have been directly compared with MI, they are Acceptance and Commitment Therapy (Hayes, Strosahl and Wilson 1999) and said as the word ACT and Compassion Focused Therapy (CFT) (Gilbert 2010). The comparisons described here highlight some of the differences and similarities between the approaches and suggest aspects of MI practise thought to be important from a theoretical point of view. Bricker and Tollinson (2011) and (Steindl, Kirby, & Tellegan, 2018) have compared MI and ACT, and MI and CFT from theoretical and practical standpoints. I will summarise what these comparisons and consider how they might contribute to the discussion on MI theory.

3.4.7 ACT (Acceptance and Commitment Therapy) and MI.

Derived from the work of Stephen Hayes in the late 1980s, ACT is a third wave CBT approach in which action is guided by the client's core values and aspirations as well as by mindful action. (Bricker & Tollison, 2011) note that ACT and MI share a number of common elements including:

- Enhancing commitment for behavioural change.
- Using the client's values and aspirations to promote commitment.
- Working within the medium of the client's language.

- Expressing empathy.
- Developing an awareness of the discrepancy between the current behaviour, and important goals or values.
- Avoiding struggling with resistance.

Atkinson and Earnshaw (2019), observe that unlike MI, ACT offers education in the teaching of specific skills to promote acceptance of difficult thoughts, feelings and sensations. ACT also seeks more actively to change patterns of language which inhibit change, whereas MI is more focused on exploring, harnessing and amplifying change talk. In terms of developing a therapeutic relationship, ACT places more emphasis on shared suffering and self-disclosure from the therapist than does MI. Also, while MI focuses on the core OARS skills within communication, ACT tends to use metaphor and experiential activities in therapy to allow clients to experience the ACT process.

Bricker and Tollison, (2011), acknowledge that although MI and ACT have distinct approaches to the therapeutic relationship, MI's theoretical base focuses on language content, whereas ACT focusses on the language process. They describe MI as being consistent with other psychological theories focusing on language processes in behaviour change and motivation. They highlight Speech Action Theory (SAT; Austin.1962; Searle,1969) and acknowledge how Miller and Rose's 2009, theoretical model described above uses and builds upon this. Also, they observe that MI process research has identified that simply talking about change can result in behaviour change. Further that these change statements are facilitated by the specific behaviours and the global attributes of MI therapists.

Bricker and Tollison, (2011), see MI in its practice as undermining that language process that limits psychological flexibility, i.e. sustain talk and is therefore helping to increase psychological flexibility. Also, relatedly the MI practice of avoiding confrontation, labelling and judgement, may differentiate MI from other approaches and this is helping to contribute to the change process. Bricker and Tollison, (2011), hypothesise that MI and ACT are having similar effects on motivation to change through their practices that focus on language and values.

In doing so they may simply be taking different routes to arrive at the same place, i.e. an enhanced commitment to behaviour change.

3.4.8 The role of values

A key in both approaches is in appreciating another person's internal frame of reference is to understand his or her core goals and values. A values interview explores the person's core goals, why they are important to them and how they are expressed. Miller & Rollnick (2012, p.85) state that… ''To live with integrity is to behave in a manner that is consistent with and fulfils one's core values''. The ACT theorist Kevin Polk (2014) sees a value as a chosen direction that is, one towards the who and what is important to us. In ACT he sees values as moving us toward our behaviour and goals. An MI intervention focusses on values and goals and in doing so aims to build discrepancy between a person's current behaviours and their life goals. Clearly both approaches are emphasising the importance of a detailed consideration of these values across someone's life and behaviour. Also, that this focus on values should be part of the exploration and resolution of ambivalence and this focus may be seen as candidate mechanism in building motivation toward behaviour change. Bricker and Tollinson (2011) describe ways in which ACT and MI could be mutually complementary in practice. These included:

- Encouraging therapists working within ACT to roll with resistance
- Using OARS skills in an MI Spirit within ACT
- Clinical use of the values card sort from MI within ACT.
- Making greater use of metaphor within MI.

3.4.9 Compassion Focused Therapy (CFT) and MI

Developed by Paul Gilbert (Gilbert, 2010), CFT was developed on the premise that human evolutionary responses fall into three basic motivational systems:

- the threat/self-protect system
- the drive/reward system
- and the affiliative/soothing system

Steindl et al., (2018), has highlighted how humans trapped within the threat and drive systems can experience emotions such as shame or self-criticism, and that therefore activities which facilitate compassion via the soothing system can have therapeutic benefits. MI is hypothesised by de Albilo Neto (2018) above, to be an intervention that responds well to the threat / self-protect system. We have already seen how MI may be a good fit for perceived threat as described above, it may also be that it facilitates the affiliative and soothing system, which in turn may facilitate the motivation to change. The integration literature described above across a range of behaviours places evolved human reactions to threat at their core for example these responses are seen in anxiety, OCD, PTSD and Psychosis (Johnstone & Boyle, 2018). Recently a study evaluating CFT for voice hearing (Maitland, Jones, Longden & Gilbert, 2019) has suggested that MI should be integrated with CFT in order to help people in the shifting between different motivational systems. That is towards those systems that are more soothing.

Steindl et al., (2018) comparing MI and CFT noted that CFT incorporates a range of exercises to develop self-compassion, including psychoeducation; body posture, mindfulness; imagery; breathing; and behavioural rehearsal (such as compassionate letter writing or method acting). Client autonomy is promoted in allowing the client to engage in relevant activities meaningfully, rather than seeing them as prescriptive. The concepts of client autonomy and compassion are both central to the spirit of MI and to CFT. In relation to the language of change, Steindl et al., 2018 noted that MI has resonance with CFT, which tries to draw upon the client's own knowledge and language in deciding which CFT based exercises to engage in, as most meaningful to them. This also fits with Miller and Rollnick's (2012) advocacy of clients being seen as the experts in themselves. Steindl et., al (2018) also suggested that notions of change talk and sustain talk can be useful in allowing clients to explore the facilitators of compassion. This includes exploring the benefits of change, the links with personal values, with increasing confidence and coping strategies. Also, that MI can be useful in considering and working with the fears and blocks to engaging with the activities of therapy. Atkinson and Earnshaw (2020), suggest that the exploration of motivation and confidence to change a particular behaviour could include client's cognitions as a behaviour in themselves, which is a core task in CBT.

While MI can offer an opportunity to promote motivation and commitment for engagement with CFT practices, Steindl et al., (2018) argues that CFT offers practical, tangible and technical interventions which can promote change, as well as emotional health and wellbeing. They also suggest that CFT exercises could provide the client with a range of potentially meaningful avenues for self-exploration and compassion-based living, at the point where they are ready to change their behaviour or lifestyle. As with other CBT's, CFT can potential offer greater directionality and focus to MI for clients who are preparing for change, or actively trying to change behaviour. Gilberts emphasis on an evolutionary perspective in CFT also recommends that a different form of CBT is needed for people high in shame and guilt. Perhaps those people high in psychological reactance as described by Abilo de Neto (2018) above and may be more responsive to MICBT integration.

3.5 Summary of similarity and difference in MI and CBT

We have reviewed some theoretical concepts and proposed mechanisms of action relating to outcome in MI and also some integrations of MI with CBT in this review. It would seem there are many similarities and many differences between the two including their theoretical origins and the perceived role of the therapist. They both see therapy as a collaborative, client-centred, compassionate endeavour and to be working in a partnership with clients to varying degrees. Earnshaw and Allott (2009), Earnshaw and Naar-King (2010) and Atkinson and Earnshaw (2020) have summarised the differences and similarities in terms of context and practise between CBT and MI. This is summarised in the table below.

CBT	MI
Formulation led	Target-behaviour led
Schema / Core beliefs	Values and Goals
Expert-led	Expert-trap & avoids the righting reflex
How? To change	Why? To change
Thoughts-Feelings-Behaviour	Values-Goal & Dissonance-Behaviour
Change as a function of the individual	Change as a function of the relationship
Psychological-Medical	Humanistic- Psychological
Therapist relational skills assumed or poorly defined	Therapist relational skill taught, measured, researched
Cognitive Model	Spirit or Philosophy
Protocol or model Structured	Less structured less manualised
Diagnostically focussed	Avoids labelling / Transdiagnostic
Discord resistance not emphasised	Specifies responding to discord and resistance
Language processes only in 3rd wave	Language content & Change talk a unique concept
Many forms of CBT	Only one MI
Training of method is not researched	Training in MI is researched
Motivation little emphasis on	Building motivation emphasised
Alternative to psychoanalysis	Alternative to confrontation and labelling

Table: 3.1

3.5.1 Key concepts for integration of MI and CBT

Atkinson & Earnshaw (2020) also, make suggestions for therapists in using MICBT approach when their main modality is either CBT or MI. They propose it might be useful to draw on some of the components of each other's approach to strengthen their practice. Possible key concepts to integrate have been identified and listed in the table below based on Earnshaw and Allott, (2009) and Atkinson and Earnshaw, (2020) and added to by this review.

What to integrate from CBT	What to integrate from MI
Agenda setting	Listening for and responding to readiness for change and sustain talk
Skills training / education	Identifying core values
Formulation	Centrality of working with ambivalence and dissonance
Identifying thoughts, feelings beliefs, behaviours	Evocation
Explicit roles in therapy	Autonomy support client as an agent for change
Self-monitoring	Supporting self-efficacy
Behavioural experiments	Affirmation
Use of metaphor	Reflective listening
Change strategies or exercises	Responding to dissonance, resistance discord or rupture

Table: 3.2

In theory there seems to be a number of compelling reasons to try to integrate MI with CBT, potentially practising this integration may help develop practice in both approaches and improving outcomes for clients. In practice it seems there may be a number of reasons why this has not happened in UK mental services other than in substance misuse provision. There are very few Psychological Therapists in the UK working in mental health who have been trained in both therapies to a competent level. This research study has identified a number of therapists and expert academics who have been trained in this way. It is they who will be interviewed using the Semi Structured Questionnaire that is based on the concepts identified in this literature review. It is hoped that the data generated will allow further exploration of these theoretical concepts and the identification of mechanisms and contexts in which outcomes are produced.

3.5.2 Gaps identified in the literature:

CBT and MI research have much in common they are both evidence-based interventions that have been widely adopted. This is a professional literature of the academy across the Western world, principally the USA, UK / Europe and Australasia. This literature is based mostly on efficacy rather than on effectiveness research. There is only a small amount of qualitative research considering whether the addition of MI to CBT in mental health may be beneficial for service users and professionals. (Angus, & Kertes, 2011). Similarly, there are few qualitative studies of MI (Angus & Kagan, 2009; Marcus, Westra, Angus, &

Kertes, 2011, O’Driscoll, 2016) and none the reviewer is aware of that consider MI theory. The evidence for MICBT integration in mental health interventions remains in the early stages although it has been described as promising. This literature review has been able to identify only one realist informed review of MI which was for adolescent health behaviours and did not include mental health. Although, this may be reflected in the small number of qualitative studies who tend to state their philosophical stance whereas other approaches to research do not see the need. Some of the attempts at theory development so far in MI and in the MICBT integration have been described in the review above. It has been said that this is an underdeveloped area and therefore an area that might benefit from further theoretical analysis and development

3.5.3 Summary: Theory and Mechanisms in MI

Dalgetty et al., (2019) and Samdal et al., (2017) have considered that MI in itself is a theory of change, although the founders of the method have not sought to describe it as such. As we have seen it has drawn upon and is linked with a wide range of psychological theories, it could be said to be rich in theory. Atkinson and Earnshaw (2020), have argued that theory is at the very heart of MI and that an understanding of the theory that sits at its core might help to enhance motivation in other therapeutic approaches such as CBT.

I will now attempt to list those theories and mechanisms that have been related to explaining MI efficacy, based on the above literature and on my definitions of theory and mechanisms relating to client outcomes. These might be described as initial programme theories which are to be tested and developed later against the data collected from the academic specialists and expert practitioners’ interviews. Ideally the views and theories of service users receiving an MI or MICBT intervention would be part of this process. The difficulties of collecting this data has meant this has not been possible in clinical practice, although this was the intention of the initial project. This work is very important for understanding

mechanisms and developing theory but is beyond the scope of this project and represents an area for further study.

3.5.4 Theoretical concepts underpinning and linked with MI

Humanistic Theory (Rogers 1951,1969)
Cognitive Dissonance Theory (Festinger, 1957),
Self- Perception Theory (Bem, 1967,1972)
Transtheoretical Stages of change model (Prochaska and DiClemente,1983)
Labelling Theory (Goffman 1963)
Motivation as an interpersonal process (Miller, 1983)
Conflict Theory (Marx 1818-1883, Festinger,1957)
Speech Act theory (SAT, Austin 1962 1969)
Psychological Reactance (Brehm & Brehm,1981)
Self-Determination Theory (Ryan & Deci 2002),
Emotional reasoning - Broaden and Build model (Freidrickson 1998,2003,2009)
Social Rank theory (Tooby & Cosmides,1990)
Evolutionary Theory (Gilbert, 2010, Shackelford & Liddle, 2014)

3.5.5. Mechanisms related to behaviour change outcome in MI

These theoretical concepts should help us explain what is going on cognitively and emotionally for the client and therapist in a psychosocial intervention. This in turn can be thought of as possible mechanisms that underly MI conversations and how they might influence behaviour change. We know that MI specifies a combination of a philosophy and core skills, in its practice and the training of therapists. The manifestation of this in practice is thought to be responsible at least in part for promoting behaviour change. This is a complex relational interaction; it is always taking place in a real-world context and many other factors or mechanisms may be at play at the same time. Including, what the client and therapist are both bringing to the interaction, their beliefs, models, philosophies, instinctual responses, histories, experiences of gender, race, class, sexuality and power. Based on the literature considered above I will list here some possible mechanisms likely to form part of that interaction and that may form part of the thinking and intentions of the therapist when working with clients. These will also

be explored and tested against the data collected from interviews with our expert samples.

3.5.6 Hypothesised Mechanisms

Establishing a Therapeutic or Working Alliance

Client-centered valuing

Client as expert

Autonomy support promoting Individual responsibility

Avoiding the righting reflex

Deemphasise Labelling

Evoking of client’s perceptions feelings and values

Focus on cherished values and goals

Development of discrepancy enhancing self-discrepancy

Showing empathic understanding and acceptance

Adopting an ‘MI Spirit’ as a philosophy and as an Interpersonal style

Being compassionate and collaborative

Using core communication skills in an MI spirit, MICO practice

Avoiding MI IIN responses

Expression of empathy e.g. reflective listening,

Conveying understanding, safety, relatedness, autonomy, competence, aspirations, and vitality.

Providing a supportive accepting atmosphere

Providing a social environment that meets people's psychological needs

Eliciting and differentially reinforcing of change talk

Responding to sustain talk and softening of sustain language

Responding to resistance or discord

Managing and repairing rupture

Exploration and resolution of Ambivalence

Promoting change through conflict or dissonance

Helping to resolve dissonance

Yielding power

Giving non socially threatening signals

Acting non judgmentally

Effectively responding to unconscious biological responses to threat or restrictions

Emotional broadening through Affirmation

Creating a context where both negative and positive emotions are experienced

Increasing Psychological Flexibility

These theoretical concepts and hypothesised mechanisms have been used to develop the semi-structured interviews used in this project. The philosophical framework of critical realism and research concepts drawn from the world of realist research also form part of the structure for the project and inform it throughout. How this relates to the project methodology, the research activities themselves and the data analysis will be described in the next chapter.

CHAPTER 4. METHODOLOGY

This chapter describes the research design from within a critical realist philosophical framework. Also, consideration is given here to epistemology, ontology and methodology in the field of mental health and psychosocial Interventions. It also provides a review of methodological approaches and a rationale for the chosen methodology and methods. The research design and activity is articulated, as is the pilot work around the interview development, its design and also its further development. The core setting and how I gained access to samples and how the data were collected are outlined. The structure of data analysis and how I arrived at my choice of codes, themes and looked for patterns in the data as well as the system for presenting is described.

4.1 Conceptual framework

As I began this project, I asked a leading psychiatric researcher in my department about the use of qualitative study in the field of mental health work. Their response began with a nervous laugh and then a statement to the effect that the commissioning of services by the Department of Health depended on there being Randomised Controlled Trials (RCTs) of interventions. The dominance of this form of evidence has driven the development and practice of my working world; with the RCT and meta-analyses being seen as at the top of this hierarchy. This is a methodology and epistemology shared by clinical psychology and psychiatry. It is also a methodology shared by researchers and practitioners in both the fields of CBT and MI.

4.1.1 My views on 'scientific' knowledge in my working world

In this section, I acknowledge and outline my own biases and how these affect my research interests. According to Woolfolk & Richardson (2009, p.53):

…"the notion that all knowledge arises out of a social context and that, hence a complete account of any system of thought must encompass its cultural and ideological foundations has its roots in the philosophies of Hegel and Marx, and has found strong expression in recent times in three related intellectual

movements the sociology of knowledge, critical theory and hermeneutic philosophy.''

I have previous experience sociology and critical theory through my training and study in Social Work. I have been drawn toward Marxist and Humanist philosophy through social work studies and my experiences of campaigning against inequality and discrimination. In Marxist philosophy, ideology and beliefs are said to have a material basis, which is in the day-to-day social, economic and cultural experiences of our everyday life. Crotty (1998, p.120) in discussing Marxism as a critical perspective in research puts it this way:

…"Marx is ready to claim, 'It is not the consciousness of men that determines their being, but on the contrary their social being determines their consciousness.' The social being he refers to is, before all and above all, economic being. This means that those who hold economic hegemony are able to shape the perceptions and viewpoints of those who do not."

The world of mental health care, psychiatry and psychology are intensely political, but they insist on seeing themselves as neutral. The social and economic contexts of people with mental health problems are not prioritised for research or they are generally regarded as background variables, not to be studied in themselves in psychological research. In the world of psychosocial Interventions such as MI, they are seen as complications for scientific investigation. In order to measure outcomes for interventions social contexts are seen as variables to be overcome through a process of randomization, thus allowing researchers to be seen as neutral bystanders. I do not see psychological science as a neutral endeavour, but as a research practise influenced by and driven by the dominant ideology, economics and politics of our society. In my experience as a practitioner and now as a researcher there has always been a gap between the practice of *real-world* services such as my own and those formed in academia. Although, both are driven and shaped by funding streams and requirements and a need to fit the political agenda of the time. I have observed in practice and research, the economic drive toward briefer more cost-effective psychological interventions.

The nature of interventions and services changing over time due to cut backs in overall mental health budgets.

In addition to these *real-world* services I have worked in two large Randomised controlled trials of CBT. Although, both studies were physically located in *real-world* settings in the NHS, they both had distinctly different parameters. For example, both the research trials had protected and small caseloads, intensive regular supervision and fidelity assessment for therapists. Also, as research therapists we faced little of the responsibilities faced by services as usual, such as meeting basic social needs, housing finances etc. or in managing risk for example in the need for hospital admission. There is clearly a difference between knowledge obtained under these circumstances and the reality of implementing that knowledge into real world settings that have a different social context. This has frequently been called the gap between research and practice. Although the constraints placed upon University departments in terms of funding over the last 10 years has brought them into a version of the world similar to our public health settings. This gap between research and practice is something I am well placed to reflect upon.

From my reading of the literature the originators of CBT and MI did not live in or work in deprived areas or in under resourced communities. They did not face the pressures on service delivery and government cutbacks in an era of austerity. These interventions did not originate from hard pressed clinical services, in the areas I have worked in, such as those in Wigan, Salford or Manchester. Their interventions were developed in relatively well funded University laboratories or in private medical practices. Subsequently, researchers although still remaining based in University departments have been encouraged to locate their research in those *real-world* services. As a result, many clients in *real-world* settings will have now received these interventions but the effectiveness of them has not been systematically evaluated in those settings. There has been little emphasis on effectiveness studies and therefore the knowledge base for psychosocial interventions is largely one of efficacy. That is, the evaluations of these interventions rely almost exclusively on well controlled experimental trials or efficacy research (Magill et al., 2018). One leading researcher in the MI process

research field I contacted about her metanalysis, said that this kind of *real-world* research seems to present at least two difficulties. Firstly, it is difficult to obtain data of the kind required and secondly it is difficult to get funding. The latter being and illustration of political and economic constraints on knowledge and its production. I will now go on to consider why this might be so.

4.1.2 Ontology Epistemology and Methodology in Human science

Pilgrim, (2015, p.4) maintains:

… "Human science can be said to exist in the ambiguous spaces between the apriori sciences (such as mathematics), the posteriori sciences such as biology, and philosophical reflection. (e.g. Foucault 1973)'....'Like all human sciences, broadly conceived from economics and anthropology to sociology and history, psychology is characterised by constant contestation about what exists (ontology) what is legitimate knowledge (epistemology) and how to plausibly study human experience and behaviour (methodology). In this philosophical tradition we find postmodern psychiatry and psychology, but another can also be noted: critical realism (Bhaskar, 1986)".

For Braun and Clarke, (2013, p. 26)

…. ''In setting out a framework for research practice, methodology relies on ontology and epistemology (Ramazanoglu & Holland,2002). These complicated-sounding words refer, respectively to theories about the nature of reality or being and about the nature of knowledge. Each demarcates what can and cannot count as meaningful knowledge and informs our methodology and the process of producing that knowledge.

All three are related to each other. Epistemology is about what constitutes valid knowledge and also how we can obtain it. It is influenced by our beliefs about how we might discover knowledge about the world. Ontology is how we see what constitutes reality and how we understand human existence? It is to do with our assumptions about how the world is made up and the nature of things. Finally, there is methodology which refers to that framework within which our research is

conducted. It is often used interchangeably with methods, which is probably a better description of the tools and techniques of research that we use for collecting or analyzing data. For example, I have used semi structured questionnaires to collect data in this project and a theoretically informed thematic analysis to analyse it. In addition to this methodology section a separate methods section is detailed below in section 4.1.5. in line with a recommendation from my VIVA voce.

Concerns have been raised about approaches to research and knowledge that promote individualised and diagnostic perspectives of human mental distress and behaviour. Johnstone and Boyle (2018) propose that these concerns can be summarised under four philosophical questions and that they are relevant to any form of human science.

1. How do we demonstrate what is real about human experience and behaviours?
2. How do we demonstrate what set of 'things' should be assumed to exist by our theories and systems?
3. What form of knowledge should be used to interpret, explain or describe such human experience and behaviours.
4. What values should be applied to the first 3 activities in scientific investigation of human behaviour?

They regard the first two activities as ontology. The third as epistemology, as it relates to the study of knowledge claims about human experience, behaviours and the justifications for that knowledge. The final activity is said to relate to the role of moral assumptions and intentions in human behaviour studies and can be referred to as ethics. Human behavioural investigation whether it be psychology, psychiatry or sociology, either explicitly or implicitly, all take a position in relation to these areas. Pilgrim (2015) identifies at least three philosophical positions in mental health research and practice. They are positivism, radical constructionism and critical realism. Critical realism has been chosen as a philosophical framework for this research because it fits well with my previous values ideas and beliefs. It could be said to offer a 'third way', as an alternative to the dominant

paradigms of positivism and radical constructionism. I will now consider these philosophical positions.

4.1.3 Positivism

Sometimes also known as naïve realism has its origins in the philosophies of Plato, Socrates and Parmenides, who argued that the world exists before us in detailed but fixed complexity offered by the gods. These ideas were further developed during the Enlightenment movement in Europe during the 17th and 18th centuries by figures such as Descartes, Locke, Berkeley and Hume, Bacon, Voltaire, Rousseau and Kant. They took reason and scientific progress as its source of authority, rather than church and state. Auguste Comte coined the term positivism in the 19th Century and argued that the methods of natural science that had been used successfully to study the natural world should be extended to studying human affairs. Further that this investigation should only use these methods. For example, humans may been be seen as machines acted on by external forces, they may be liable to physical or psychological malfunctions and as such require a technological fix or treatment.

Johnstone and Boyle (2018), observe that this world view has had a widespread influence on Western thought over the past 200 years. As such these ideas are not the sole province of any particular discipline or profession. Johnstone and Boyle (2018, p.39) summarise it thus:

…''However, this worldview has limitations as well as advantages, especially in relation to the understanding of our main subject matter, human behaviour and human emotional distress. Nevertheless, the idea that the world, including human behaviour and experience, is characterised by features and processes which can be objectively described in universal causal terms across time and place, remains very influential (Bhaskar, 2011; Harding, 1991)".

In Psychology and Psychiatry, the influence of positivist ideas is often apparent in their dependence on experimentation, quantification and measurement of human behaviours. The exemplification of which might be seen in the reliance on the RCT as being seen as the pinnacle of scientific investigation. Whereby methods are used to remove bias and collect 'objective' empirical data. This

dominant research paradigm though not exclusively has its roots in a positivism and which according to Crotty (1998, p.40), … “it postulates objective existence of meaningful reality to be value neutral, ahistorical and cross cultural.”

Bentall and Varese, (2012) note in psychotherapy that RCTs still predominate and like all scientific methodologies they are not objective nor are they socially neutral. Deacon (2014, p. 846) suggests this approach although successful in many ways, … “has neglected the treatment process, inhibited treatment innovation and dissemination and has divided research from practice.” This view of studying human experience and behaviour rest on two related assumptions, according to Boyle and Johnstone (2018, p.40).

…’’First, that human characteristics, behaviour and experience – including problematic forms of emotional distress, behaviour and relationships – can be represented as a series of discrete, measurable variables and, second, that the nature and interactions of these variables, and how they relate to ‘mental disorders’ can be described independently of particular historical and social contexts’’

For Pilgrim (2015) in psychiatric or psychological positivism, the ontological assumption is that mental distress simply exits and is waiting to be verified by expert observers such as psychiatrists, or psychologists. Epistemologically, it assumes that there are naturally occurring diseases, which are inherently pathological. This gives rise to a form of professional knowledge and practice known as phronesis; for example, in the practice of diagnosis and assessment. In the case of psychosis and other mental health problems there is a predominant assumption that this is biologically or genetically determined and there is a fixed and deteriorating disease within the person.

4.1.3 Radical Constructivism

According to Pilgrim (2015) radical constructivism sees mental disorder as a social construct and the ontological reality is socially constructed. The underlying epistemological assumption here is that we can only know the world in the ways in which we present it. Scientific knowledge is therefore about situated or

contingent accounts and discourse on discourses. Research practice or phronesis in this paradigm is characterised as cautious, experimentally testing things out in different circumstances under different conditions. It could be said to be a process of democratic exploration.

4.1.4 Critical Realism

For critical realism the ontological premise is that the world exists and it is real, but our investigations of it are filled with the interests and values of its academic researchers and mental health workers. The epistemological consequence of this is that we must approach all claims for all knowledge sceptically or critically and hence the term critical realism. According to Pilgrim (2015), the origins of a critical realist perspective are to be found in the Psychobiology of Adolph Meyer (1886-1950). This perspective emphasises social and biological aspects and how they affect the health of the person. It promotes a perspective that asks the questions, why is this person presenting with this mental health problem at this time in their life and in their particular context. It also incorporates ideas from the system thinking of Paul Weiss and Ludwig Von Bertalanfy developed in Vienna in the 1920's, this encourages us to expect complexity, empirical irregularity and difficulty in prediction in our world and work. The social and personal context is seen as vital for understanding human behaviour and mental distress. Finally, there is also the work of the neo Marxist philosopher Roy Bhaskar (1944-2014) who is often described as the philosopher and founder of critical realism. According to Pilgrim (2015, p.14).

…''Critical realism rejects the claims of positivism to be value free and argues that human experience and action can only be studied in and as, open systems in flux. Accordingly, it suggests that human science should be able to accommodate ontological realism, epistemological relativism and judgmental rationality''

It seems that critical realism can help us as researchers and psychological therapists to formulate human mental distress. This can be done in a way that incorporates both the causes, for example the reality of social adversity, experiences of early trauma and the meanings that clients place upon their

experiences. For example, in holding beliefs about hearing voices or having interpretations of seeing things others cannot. It is also accepting of the fact that people are both victims of their circumstances and agents of their own destiny. That is, we are all able to determine our circumstances and we are all determined by them. The philosophical framework to be used is that of critical realism an approach thought to be useful in analysis of social events and for suggesting practical policy recommendations (Fletcher, 2016). The writings of Bhasker (1979) and others e.g. Sayer (1992) and Lawson (1997) have further developed the term critical realism. It has been said to offer a third or middle way between positivist and constructionist approaches. It has been used theoretically (Pilgrim, 2015) and empirically (Notley et al., 2014) in the field of mental health. Fletcher (2016) observes that critical realist qualitative researchers may find themselves without methodological guidelines. In that critical realism is not associated with a particular set of methods or a methodology, it is to be used here as a general philosophical framework.

In an earlier version of this project and at quite a late stage, I was encouraged by reviewers assessing my progress to consider and refer to other recent realist perspectives particularly that of Pawson and Tilley (1997) and Pawson (2013). The critical realist and realist traditions are intertwined but also represent significant, separate and developing communities of research practice. For the purposes of this work I have embraced their insights and also used that as part of my philosophical framework without fully embracing their philosophy and using their developing research methods in detail. With this in mind I participated in an email discussion with leading figures in the realist community list serve, (Rameses project) about the nature of my study. Their view of my project was that it is legitimate to describe it as ‘realist informed’ rather than a formal realist evaluation or synthesis. In order to do latter, I would have had to start my project from scratch which was not realistic.

4.1.5 Methods Section

The rationale for the methodology chosen and methods used in this section is presented in a more formal third person style and is described here. This change has been made following recommendations for amendment from my Viva Voce. It includes a description of the research design and strategy; data handling and analysis, participant information, procedures and pilot work.

4.1.6 Rationale for the chosen methodology and methods.

As already described above in more detail this is a qualitative study and the methodology utilises a critical realist informed philosophical framework. It incorporates the realist concepts of context, mechanism and outcomes; using them as a structure to develop theory and identify mechanisms of action. Whilst the efficacy literature reviewed above is useful in informing us as to whether interventions works or not. The questions of why it works, for whom and in what circumstances may require a different approach. The importance of considering the social context of interventions is something emphasised in critical realist philosophy. Further, Thematic analysis has been chosen here as the qualitative method for organising and analysing the data collected in uncovering themes relating to theory development from our professionals' experience.

4.1.7 Why Thematic Analysis (TA)?

Thematic analysis (TA) has been chosen as a qualitative method for data analysis for a number of reasons. According to Braun and Clarke (2013, pg. 174)

… ''some sort of thematic coding is common across many qualitative methods within the social sciences. TA is a systematic approach for identifying and analysing patterns and themes across data. This is not tied to a particular theory and uniquely only provides a method for data analysis. Braun and Clarke (2013) say, …"it does not prescribe methods of data collection, theoretical positions, epistemological or ontological frameworks".

There are 4 varieties of TA and Theoretical TA has been chosen here because of the theoretical emphasis of the research. This type of TA is guided by existing theory, theoretical concepts and the researcher's disciplinary knowledge, my

standpoint and epistemology. Critical realist theory has been used to inform and structure the TA process throughout. TA0 is a method widely used in psychological research, is relatively well defined and is suitable for small qualitative projects such as this one. In addition, TA is thought by its originators and developers (Braun & Clarke, 2013) to be easily learned by those new to qualitative research.

Critical realism treats the world as theory laden but not theory determined. Theories are initial and they can promote a deeper analysis to help in developing a more accurate explanation of reality. A qualitative methodology is chosen here to allow us to ask the expert academics and psychological therapists about their explanations and their experiences of these psychosocial interventions. This may help us to contextualise their complex human reactions to the social reality of these interventions. It is hoped that this approach may help to reveal common and distinct elements or themes derived from their experiences of the integrated therapy. This qualitative methodology as previously outlined is therefore seen as most appropriate for examining our research questions. The original intention was to collect our qualitative data from a small RCT being carried out across a range of stake holders, including service users. However, that trial collapsed due to the lack of resources in that NHS service, around making time for the training and supervision of the staff.

4.1.8 The research design and strategy

Given this change in circumstances it was decided to try and collect relevant data in other ways. That was to continue with a qualitative research project for the reasons outlined above in terms of being the most appropriate for considering theory and mechanisms of action in MI. It was therefore decided to collect data from two groups, expert researchers and experienced MICBT therapists who had the experience of being researchers and of integrating MI and CBT in practice at a high level. The research design, methodology and methods of data collection and analysis were rewritten in the form of a SHUREC2B application for research ethics (Appendix 2.). Application was made and approved by Sheffield Hallam Research Ethics committee. The research explores the views and theories of expert academics and therapists of what they think or hypothesise is going on in

this therapeutic process. The aim of this research being to use their reasoning in developing understanding of mechanisms and ultimately developing theory. The focus is therefore on the views of the participants and their expertise and insights.

4.1.9 Outline of research activities and data collection

The next section describes how the core setting and data sources were identified and how the data was collected and analysed. Also, how the researcher gained access to these samples; the recruitment process and the criteria for inclusion in the study are outlined.

4.1.9 Pilot Work

The research methods including practice in the development of semi structured interview questionnaires, plus practice in the use of thematic analysis were completed prior to the project pilot in the doctoral research methods course work assignment. Based on this experience and a comprehensive literature review of MI, CBT and MICBT, semi-structured interviews were developed. They were designed and aimed at eliciting and developing theory around the underlying mechanisms of change in these psychosocial interventions. Initially these semi-structured interviews were developed within my research team through a process of reflection, guidance and piloting from my doctoral supervisors. The semi- structured interview was also piloted using experienced psychological therapist colleagues and also experienced academics who were familiar with MI and CBT integration. The pilot participants were chosen for the pilot work as they would not have met criteria for inclusion in the study, which is outlined below. Based on this experience and their feedback adjustments were made to the interviews particularly in terms of the number of questions. The initial interviews had taken too long, and it was felt that a maximum of an hour was desirable. Also, experience was gained by the researcher in the pacing of the interview and clarifying of questions, consideration being given to making sure all areas in the questionnaire were covered.

4.2.0 Data Collection

The data was collected through the use of these semi-structured interviews based on the pilot work, the research literature and drawing on existing theory of why these psychosocial Interventions might be efficacious. The interviewing of participants took place in two Phases and is described in more detail below:

4.2.1 Participants

4.2.2 Expert Researchers (Identification, Recruitment and Inclusion).

Expert researchers who had experience of leading research studies involving the integration of MI and CBT were identified and approached for inclusion in the study. Identification for inclusion was based on publications that showed they had been a principle or leading researcher on MICBT integration projects; that had been published in peer reviewed journals. These experts were further divided into those coming from the MI academy and those from the CBT academy. The MI expert academics where identified through the MICBT literature and through the Motivational Interviewing Network of Trainers (MINT). This is the world's leading MI training body in MI and it provides a forum for the dissemination of existing research on MI . It comprises a membership that includes the original founders of the approach and numerous expert researchers in the field. The researcher is also a member of this network. The CBT expert academics were identified and approached for their participation through the MICBT literature and from the British Association of Behavioural and Cognitive Psychotherapy (BABCP). This is the UKs leading training and accreditation body for CBT in the UK. It disseminates existing research into CBT though its forums and journals worldwide. The researcher is also a member of this network.

4.2.3 Recruitment

The recruitment took place through direct email invites based on publications that showed they had been a principle or leading researcher on integration projects. Numerous invites were issued, and the intention was to recruit and interview between 6-8 participants and interview until it was felt saturation was reached. In practice the recruitment and setting up of interviews with such a busy and prestigious group was not easy and many invites were not answered. As we have previously noted the literature on the integration of MI with CBT in mental health was small and therefore it might have been expected it would be difficult to recruit participants. Given the time constraints the eventual sample was felt to be sufficient for the purposes of the project and because it had generated considerable data for theory development.

4.2.4 Sample 1: Expert Researchers

A total of 6 participants were eventually recruited and made themselves available for interview either in person or by electronic video communication using skype and Zoom. Of this group 3 were UK based, 2 based in North America and 1 based in Canada. 5

women and 1 man were included in this sample. This group included people who had been principal investigators on MICBT integration studies, were published authors in the MICBT integration field in mental health. 3 people were leading figures in the International CBT community and 3 participants were leading figures in the international MI community. Although, they may not have liked being called expert or academics and some indicated that, they were an accomplished professional sample. All were based in research groups at leading UK, US and Canadian Universities. The researcher chose to anonymise the participants throughout this publication, although nearly all of them said there were fine with being quoted publicly. Being unfamiliar with this process of anonymization it was decided to use randomly chosen Japanese first names, based on a novel currently being read by the researcher. Braun and Clarke (2013) recommend that we, " humanize participants by using pseudonyms rather than participant codes or numbers".

4.2.5 Expert Therapists (Identification, recruitment and inclusion).

In the second phase interviews were to be conducted with psychological therapists experienced in the delivery of integrated MI and CBT in mental health services. Potential participants were identified through the international MINT, the UK MINT and the UK BABCP professional networks and asked to participate via email. Numerous responses and offers to participate in the project were offered, however only a small number met the inclusion criteria and were eligible. It was decided to include only those therapists who could demonstrate that they had reached competence in both MI and in CBT at a generally agreed level of competence and on recognized fidelity measures. In order that we could be relatively sure that this group understood the methods in theory and in practice at a high level. Also, that they had experience of ongoing practice of an integration of the two methods. Interviews took place in person and over the telephone.

4.2.6 Sample 2: Expert Therapists.

A sample size of 6 psychological therapists was achieved in the time frame available. 4 men and 2 women were included in this sample. These therapists had all been trained to post graduate or doctoral level in CBT and also had extensive training in MI and experience in practice of the integration of the two approaches with mental health problems They had all demonstrated high levels of competency in MI and in CBT. Those included had been assessed as competent on the Motivational Interviewing Treatment integrity scale (MITI, Moyers, Martin, Manuel, Miller and Ernst, 2007). Similarly, they had all met competency on a recognized CBT fidelity measure for example the CTS-R

(James, Blackburn and Reichelt. 2001) or similar. Other acceptable examples for fidelity included the Cognitive Therapy Scale for psychosis CTS-P (Haddock, Devane, Bradshaw, McGovern and Harris, 2001) or the MICBT fidelity scale (Haddock, Beardmore, Earnshaw, Fitzimmonds and Barrowclough, 2012).

Interestingly, numerous people responded and offered to participate because they had had training in both methods, either through their professional training or in subsequent post graduate training. Some were able to demonstrate competence in one but not the other method and considered themselves as practicing MICBT. They were not included unless they could not demonstrate competence in both approaches in mental health settings as defined above. All of the individual therapists included had all worked in large Randomized controlled trials evaluating integrated MICBT as a therapy for people with a range of diagnostic categories. This included psychosis and substance misuse, bipolar disorder and alcohol misuse and eating disorders. They were required to be assessed as competent in both CBT and MI using the recognized fidelity measures. This sample consisted of psychological practitioners currently working in UK mental health services and none were currently working in research projects. They were predominately located in the North West of England with one based in Scotland and the other in the South of England. Japanese first names, based on a novel currently being read by the researcher. As mentioned above Braun and Clarke (2013) recommend that we, "humanise participants by using pseudonyms rather than participant codes or numbers". In this sample names were inspired through reading a novel based in Pakistan.

4.2.7 Interviews

The interviews took place in a variety of confidential locations suitable to the participants in both groups. In total 4 expert researcher and 4 integration therapist interviews took place face to face. 2 therapist interviews were conducted by telephone and 2 expert researcher interviews took place face to face using skype and Zoom. Between October 2017 and May 2018 was the time frame. The same semi structured interview was used across both sets of interviews with little variation across topic areas. In practice individual participants had more to say about some topics and flexibility was allowed for people to go back to topic areas later on in the interview. The participants in both groups said they found the interview stimulating and remarked that is was rare for them in their working lives to have time to reflect upon the issues raised relating to mechanisms of action and theory. One participant reflected it was like supervision for the supervisors. The

interviews lasted between 40 mins and 61 mins and across 12 recordings the average time of interview was 45 mins, producing 541 hours of data. The interviews were recorded using Voice Recorder pro software and uploaded into drop box for later analysis and transcribing. Each interview was anonymized prior to uploading.

4.2.8 Transcription

The initial transcribing of the first two interviews was undertaken by the researcher. This was in part about immersion in the data and developing awareness of the process of transcription. This was a very time-consuming process as the researcher is not a skilled transcriber and the quality of the transcription was poor and required considerable re reading and correction. Subsequently, 11 of the 12 interviews were professionally transcribed using a service recommended by Sheffield Hallam University. The style of transcription was orthographic which reproduced verbatim the spoken words of the participants and the interviewer. The content of the transcribed interviews as checked against the original recording and was seen to be of high quality and an accurate representation of the original speech.

4.2.9 Data Analysis

4.3.0 The structure of data analysis

As already described above Theoretical TA was chosen as the method for data analysis, Braun and Clarke (2013 pg.175) describe Theoretical TA in this way … "Analysis is guided by an existing theory and theoretical concepts (as well as the researcher's standpoint, disciplinary knowledge and epistemology)." This approach fits well with the philosophical position outlined so far and the requirements of this professional doctorate. The data analysis described here is guided by existing theory and research and my own view of science, my disciplinary knowledge and epistemology, as outlined above. The data generated from the interviews was semi-structured, but it provided an initial systematic structure for the analysis to begin. The data analysis itself being a product of both the researcher's and the participants theories. The critical realist philosophical frame encouraging an analysis that identifies theory, mechanisms of action and social contexts that relate to outcome.

Braun and Clarke (2013) give an outline for how thematic analysis should proceed. They suggest it is not it's not about following strict rules, but the skillful reading of the data and its interpretation of it through a practical theoretical lens. They intention being that this in turn can produce insights into the meaning of the data that go beyond the surface level. There is no specific guidance on how to conduct Theoretical TA and as such this analysis used a systematic approach based on theory to identify and analyse patterns and themes across data.
The content of the data analysis is described below and how attempts are made to identify patterns and meanings within it.

4.3.1 Coding of data, themes and headings.

To begin with I have already described a process of immersion in the data, which took the form of listening to and rereading of the transcripts for both groups. In doing so I identified a number of broad psychological and social concepts. I then actively started to think critically about what the data meant. Initial coding and identification of themes and headings that might be represented in the analysis of the data was begun, using sheets of paper. A code was represented by a brief phrase or word that is intended to capture what it is about the particular piece of data in this case the interviewer's reflections how that might be useful in the overall process theory development. A selection of examples, not an exhaustive list is given below:

- Psychological Safety
- Alliance
- Therapeutic Relationship
- Therapist skills
- Resistance and rupture
- MI Spirit or philosophy
- Formulation
- Autonomy
- Feeling good empowered
- Cognitive restructuring
- Confidence

- Motivation
- Differences and Similarities CBT and MI
- Effects of Social context

These codes were based on what might be described as the semantic meaning of the data and are seen as a broad representation of the language used in the interviews. They have also in part been arrived at or invoked by the researcher from my described theoretical and conceptual framework. They were seen as an initial attempt to identify implicit meanings in the data, for example with reference to some of the theory already discussed in the literature. For example, Self Determination Theory (Ryan & Deci, 2002), Social rank theory (Gilbert, 2009) and Evolutionary Theory (de Almeida Neto, 2017) and that these could be seen as lenses to look at participant views around social context, resistance or reactance and psychological safety. After this initial stage it was decided to use QUIRKos a qualitative software programme to assist in the organisation and presentation of the data. Each of the transcriptions was uploaded into this program and a secondary process of identifying themes thought to be relevant to the research questions posed was undertaken. Particularly attention was paid to the identification of those mechanisms of action, theory and social contexts identified by the participants.

4.3.2 Patterns and Themes in the data

After focusing on the coding of the data, this thematic analysis moved on to identifying patterns in the data. According to Braun and Clarke (2013, p.222), … "Pattern based analysis rest on the presumption that ideas which recur across a data set capture something psychologically or socially meaningful." In moving on to developing themes, patterns in the data were considered in terms of frequency of ideas but also of their meaning or relevance to my research questions. The distinction of a theme was that it was or is in some meaningful way a central organising concept and existing codes were combined under themes. This was a labour-intensive task and also an active process undertaken by myself. The choice of themes was based on my philosophical framework, the existing literature and my research questions. For various logistical and personal

reasons there was a regular distancing from the data in terms of time, as a result there was a revisiting of the data several times.

Candidate themes were identified and Quirkos reports generated including direct quotes from transcripts to illustrate content. An illustration of the initial coding process from expert academics is included as a screenshot here.

Figure 4.1

The content of the process will be described in the Findings and Discussion section. Below are examples of overarching themes that were used to identify theory in the Expert therapist group they included: Why does MI work, How might MI impact on CBT, What does CBT add to MI and in What circumstances should they be integrated. The focus being on identifying contexts , mechanisms of action, MI Theory and candidate theories for development. A screen shot of how this process was undertaken with expert therapists is included below.

Figure 4.2

The initial themes identified at this stage were best described as candidate themes. These and other candidate themes were presented to my research supervisors who approved of and commented on the process of data analysis. They made useful observations and comments including that the method and the current themes identified seemed to be logically based on the data presented and had been thoroughly undertaken. The analysis is mine as a researcher and I recognise that in qualitative research there may be different interpretations of the same data.

The Quirkos diagrams above give a visual representation of the early stages of analysis and an indication of how the themes were structured with indications of

frequency and meaningfulness in terms of the research questions evident. Following feedback from my Viva Voce the numerical frequencies have been removed because the emphasis in the analysis is upon meaning not quantification. In producing the summary reports I began to look for overarching themes and I identified a number of them to help in the capture of and organising of ideas. Also, they were used to examine related ideas and the relationship between them. An example of the reports generated are included in Appendix.3. In going through this process, I reviewed the data again to see if themes needed to be revised in order to capture the elements of the method and philosophy; including the meaning or spirit of the data collected. A further final reread all of the data was undertaken in terms of the research questions. This process of qualitative analysis looks back and forth on itself and decisions were made to let themes go, to amalgamate others and to develop new ones in order to move forward. The more I went through the data the more I acquired the skill of analysis and also the skills in using the Quirkos software. The findings of the analysis are presented and discussed below within the context of the wider literature and a critical realist philosophy.

CHAPTER 5.0 FINDINGS ANALYSIS AND DISCUSSION

5.1 Sars-CoVid-2 a Context for Findings and Discussion

This section is being written in the social context of a world viral pandemic. The Sars-CoVid-2 catastrophe has illustrated in my view the importance of the need to understand the impacts of social context on human physical and mental health. The impact of this deadly virus had demonstrated how social inequality and the provision of public health services impacts upon people's chances of living or dying. In the UK the virus has been most deadly in populations suffering from greatest discrimination, in Black and ethnic minority, low paid, public facing workers such as taxi drivers, bus drivers, health and social care workers. Many of these discriminations intersect within these populations who have been living in often-overcrowded accommodation with only access to run down underfunded and increasingly privatised public services (Khunti, Pollock & Pareek, 2020). For example, over a long period now in the UK significant numbers of people have needed to access food from charity foodbanks and many children having starved during this pandemic have become malnourished to the point they have needed admission to hospital (Guardian 14.07.20). This is a social reality in existence prior to a pandemic which has only exacerbated and laid bare these inequalities. According to a study published in the British Medical Journal in 2017, years of austerity has already resulted in over 120,000 extra deaths over a 10-year period in the UK (Watkins, Wulangingsih, Zhou, Sylianteng & Maruthapu, 2017). According to a study by Amster and Chair (2020,pg.1), historically previous pandemics have disproportionally affected the poorest and most disadvantaged, they summarise it thus …'' Inequality of income, housing, work and opportunity are the inequities that made death a social disease for social reformers Chadwick, Villermé and Virchow. We now call these factors the social determinants of health''.

The United Nations special Report on Mental health in June 2017, outlined: "The urgent need to target social determinants and abandon the predominant medical model that seeks to cure individuals by targeting "disorders". Further that, "Mental health policies should address the "power imbalance" rather than "chemical

imbalance". This recommendation underpins and illustrates many of the difficulties of current health crisis. There is a large literature on the social determinants of health both physical and mental which I have not considered specifically in this project. Although, I have highlighted in the literature there is a lack of consideration of it in the theory relating to psychosocial interventions such as MI. In spite of an extensive literature that has empirically demonstrated the impact of social and economic factors on human distress, psychological science has largely ignored this in its theorising.

Personally, the impact of this pandemic on my writing up of this research project has been profound. I have experienced this illness myself and it has caused major disruption to my life. Although, thankfully I live in a relatively affluent and supportive environment with access to green space and an adequate income. This period of disruption has prompted me to reflect upon the changes in all our lives and to our world, ravaged and laid bare by this viral pandemic. It has emphasised an already existing need in my view for all human science to incorporate a more detailed understanding and recognition of the social determinants of health. This project draws upon critical realist philosophy, which emphasises the location of knowledge in a real-world context. I believe I could not have continued to write this project without some reflection upon the ontological reality we all face currently in terms of our public health. The knowledge that has been created through a positivist science in mental health is valuable but, in my view, has a tendency to obscure the effects of social reality. This reality is seen often seen as either too 'complex' to study or it is something we can do nothing about and although concerning it is effectively ignored, exemplified in my experience by the phrase 'it is what it is'.

It is a puzzle for me that much of Psychology as a social science contains little or no social and places little emphasis on the need for collective behaviour change. It is taken for granted that psychological research is seeking to mitigate harm at the level of the individual; yet it could be argued that more psychological harm is inflicted upon people because of their belonging to particular social and economic groups. This raises an ethical question for me, in that a failure to address social

and contextual issues by maintaining a stance of scientific neutrality, seems dubious. Pilgrim (2020, p.175) describes a weakness of modern psychology thus:

… "The preoccupation with separating facts and values has led to psychology avoiding societal matters because this might be 'too political'…. objectivity is a legitimate goal (being true and honest about our object of enquiry) but neutrality is a wild goose chase in human science".

Social Psychologists, Jetten, Haslam, Reicher, and Cruwys, (2020) suggest that in the absence of individual interventions such as medicines and vaccines, Sars-CoVid-2 can be controlled by changing our behaviour collectively and from putting into place social interventions to support this. There is also compelling evidence that social interventions could address those problem behaviours that MI has been used and developed for; this is a theme that emerges in the findings and discussion section considered below. We have already seen there has been a tension in existing debates about MI theory, which has focused almost exclusively on the individual and individual change processes. Miller & Roses' (2010) debate with Stanton (2010) is an illustration of a difference in emphasis between a theory based on individually focused research and one that argues for a broader, although limited socially contextualised knowledge. The MI theory we have to date has focused on examining the relational and technical hypotheses in terms of client outcomes overwhelmingly in quantitative controlled trials. O'Driscoll (2016) has observed there has been very little qualitative research on the individual experience in MI. It is confusing that a client centred approach like MI relies so heavily on an individualising science that has little interest in the views of clients and other participants in its research.

Braun and Clarke (2013, pg 308), recommend that combining the results and discussion section in particular suits critical approaches in qualitative research, where ... "you contextualise your results in relation to the relevant literature, expanding your interpretation beyond the data."
They further note … " that if you keep spotting links between your analysis and the wider literature , and or want to use existing research and theoretical concepts to deepen your analysis of your data, then combine your results and discussion."

The findings, analysis and discussion presented here refers to existing theory and literature already discussed above, it is theory focussed. The views of our individual expert researchers and experienced therapists have been captured here and present a rich and unique source of original data. These participants have considerable experience of integrating two major therapeutic modalities. Their insights and views on mechanisms of action and Theory in MI, represent a unique contribution to knowledge in my view.

A large amount of qualitative data has been produced in this project and the findings are organised for discussion in line with Braun and Clarke‘s (2013) description of theoretical thematic analysis. I have tried to present this qualitative data in line with good practise on the supervision of qualitative research projects (Gough, Lawton, Maddill & Stratton, 2003). For example, the term findings is being used as opposed to results because this is thought to be a better descriptor in a qualitative project. I have particularly tried to focus the findings and discussion in terms of my research questions and also with a view to theory development from a critical realist perspective. The original research questions were:

- What works for whom in MI, in what circumstances and why?
- What does this integration of MI and CBT for people with mental health problems tell us about the underlying mechanisms of action and how they relate to outcomes for these psychological interventions.
- What has MI and CBT integration told us about the theoretical basis of the efficacy of MI?

I am particularly interested in what theoretical insights are suggested by our participants are and as to why they think MI works, based on their experience of this integration. The project is concerned with theory development in MI and existing theory is being tested against the data collected. Also, participants insights for theory development are considered as are their suggestions for areas of theory development. With this is mind and stepping back from the data I

decided to organise this section into 3 overarching main areas or higher order themes for discussion and comparison. The experiences and views of our two groups of experts are summarised under the following headings:

- **Social Contexts and Power**
- **Mechanisms of action**
- **MI Theory and Theory development**

As I went through the process of presenting the findings, I discovered repetition around themes both within and between groups. I have edited the findings so as to avoid repetition but also to include participant views that extend hypotheses about mechanisms and theory. There were a number of aspects of the data that could've been explored including more explicit comparison of expert researcher and expert therapist perspectives. The project was concerned with examining exploring and developing theory. I have included brief comparisons between groups that address what might be seen as differences and similarities between research and clinical practice at the end of each section.

5.1.1 Social Contexts and Power.

Both groups of participants were asked specifically for their views on the impact of social and other contexts on the MICBT psychosocial interventions they had researched and delivered. In addition, I identified from the transcripts other descriptions of context being made, that I thought relevant to intervention delivery and how that related to MI theory and to its efficacy. The summary below represents the themes that were identified and used to organize data in the academic sample in relation to social context.

- Impact of Social Context on the individual and how the context affects the client
- Researchers views and their perspectives on social contexts
- How the social contexts were seen to affect the psychosocial interventions
- Researchers context, the social and work location of researchers

- The difficulty in overcoming the social context and how to adapt the intervention to context

The content of these themes is summarised in the next section and covers the participant views on their experience of the relevance of social contexts in PSI delivery. Their thoughts on how this affects the client, the intervention itself and how in practise to take account of this is presented and discussed. As recommended by Braun and Clarke (2013) the extracts are selected to illustrate the different facets of each theme and a narrative was constructed around them.

5.1.2 Expert Researchers Views on the impact of Social Contexts

All participants identified social contexts in various ways and overwhelmingly tended to see the importance of understanding the nature of them for people in receipt of their interventions. They highlighted a number of areas that might be taken into account when working therapeutically and in research trials. For example:

‘’ you need to understand the wider social context. I don’t think you can just work with people and formulate on a one-to-one level; you need to think broader about what kind of factors are influencing, who’s in their network in the wider political and social context as well and societal perceptions and how that influences somebody in terms of their sense of their self and their sense of their problems.” Source: Riku

Several participants made explicit causal links between what has happened to or is happening to people in their lives and their psychological problems.

“You know, because if we knew that things like that caused physical health problems, there’d be a lot more investment in it than there is, when we know clearly that these factors cause psychological problems, mental health problems.” Source: Riku

This is perhaps an illustration of or an acknowledgement that in their scientific research there is an understanding of but little explicit research into the social

causes of psychological problems. Most participants highlighted a number of dilemmas in relation to working in academia and in the running of RCTs. This included identifying a difference between working as a ‘jobbing clinician’ and working as an expert researcher in an RCT. The latter seemingly diminishing their ability to see their research participants as a contextualised whole person, for example,

“So when I worked in the context of a trial, so there’s different, in the context of a trial and in the context of being the jobbing clinician I worked differently and found being the jobbing clinician liberating. Because I felt like I could take the person as a whole into account; whereas on a trial I felt like you were having to work, you have to stick to a protocol and if other bits and pieces came in it was hard to be truly person-centred” Source: Sayoko

Also, there was an acknowledgement that this type of scientific investigation may be lacking in sensitivity, because it is not recognising what is going on for an individual in their social context. Thus, making it more difficult to work with them effectively and to uncover any processes or mechanisms that underly what is going on in research therapeutic relationships. Social context is therefore presenting challenges with measurement for some researchers.

“And for example if substance misuse is your outcome and you had a slip the week before they measured the outcome and it was the past week, well it looks like you haven’t had a good outcome when actually you’ve just spent six months, nine months of having some really powerful meaning conversations that aren’t captured in the trial data”. Source: Sayoko

Further, that the outcomes from these research trials may not be a reflection of the high-quality therapy being delivered or that the right outcomes are being measured.

“I think because the trials haven’t shown the outcome, but I know having been a therapist on these trials what is frustrating is you feel like it’s failed. But actually, the human experience I had with people in the trials really felt like we’d done

some fantastic work. And certainly, lots of tapes I've listened to I think this is remarkable and the conversation that is being had is powerful and really important, but it's not being reflected in the outcome measures. Source: Sayoko

Both of these reflections are perhaps emphasising that something important is being missed in relation to outcome measures, because if the therapy is of a high standard it should be producing outcomes according to this methodology. Why this is not happening needs to be understood theoretically in terms efficacy and seems to be missing from this type of research. This view contrasts starkly with one very assertive statement from another researcher,

"I'm a researcher I think we can measure anything" Source: Akiko

Indicating a belief that measuring psychological qualities is both possible and desirable. Also, that most expert researchers have to work in a paradigm that it is about measuring qualities or psychological concepts regardless of any limitations. This may not fit with some researchers' original conceptions of psychological knowledge but is necessary for their academic careers. One participant acknowledged how this has changed over their career and the difficulties this presented for them in terms of ontology.

"I come out of a tradition, my original training was not just sceptical, but just completely opposed to the idea that anything psychological could be measured in a way that was meaningful. But I have now spent the last 20 years of my career doing controlled clinical trials and other things that have shifted me on a lot of that. But that's still a hard question for me to answer." Source: Kaito

What is puzzling is that although social context is seen as relevant and important by researchers it is largely absent from their research paradigm. Also, that although this may help them to explain limitations in their psychological research paradigm the benefits of remaining within in it are outweighed by any potential insights a focus on social context may bring. Their views on the impact of social context on interventions is examined in the next section.

5.1.3 Impact of Social context on the Individual and the Intervention

When asked about the impact of social contexts our expert academics where generally clear about identifying this as a constraint on researching therapy and on psychological therapy in general. For example, the two participants views below illustrate the impact on and the limits of their research interventions:

“I think it makes a huge difference actually because when you think about it, when you see people for therapy once a week you might do some really positive work within that hour, but then people go back to their own shit lives really .” Source: Riku

And “Oh I think it has, yeah, it has a powerful effect in a couple of different ways. One is environmental. We’re foolish if we forget that the person spends one hour or 45 minutes or an hour with us and however many other hours are in the rest of the week outside of our office” Source: Kaito.

So, both participants have a realistic attitude to what can be achieved with people who are living in difficult circumstances and how this highlights the limitations of their research interventions. Yet having acknowledged how these factors limit and confuse what is efficacious about these interventions, there is no attempt to identify what is going on socially or to contextualise the circumstances of the individual. It seems these factors are randomised away and the interventions efficacy is assessed regardless. What is also interesting here is there questioning around the amount of time being offered to an individual as part of an intervention. This begs the question of whether for example the therapy hour or increasingly a 45 mins or less is a mechanism. Katsuko, states explicitly… “also number of sessions as well as session length it goes there, I think time as a mechanism”

Clearly then the therapy or intervention frequency, length and duration of time is being highlighted. This connects with my earlier observation on how interventions are adapted to meet the needs of funders and commissioners. In terms of future service delivery, researchers are asked to consider delivery of interventions in the shortest time frame possible in order to maximise cost effectiveness. It is also

interesting because this type of expert research is generally being used to inform policy and the implementation of research into practice. How this might translate into practice and its limitations is exemplified by this researcher's extract below,

''The NICE guidelines for psychosis say you should have 16 sessions. Well, that was made up. I mean, that was on the back of an envelope. There's no sense in that. And I guess our experience tells us that some people do really well with half a dozen sessions, but some people are 40 sessions are still feeling like their life's crap. And I sort of think that there's a lot of other things in people's lives that impact on the state that they are, and that therapy may not really have any impact. Source: Katsuko.

Generally, most researchers acknowledged the negative impact of negative social circumstances and people's basic needs not being met in research and individual psychological interventions for example, … "If you're in therapy then you are hungry most of the time, right? "Source: Katsuko. Also that,…"And most people, if not all people, have had a rough ride in terms of earlier experiences so you can't ignore it really". Source: Riku. My own experience of mental health research trials is they do not routinely assess whether people have access to sufficient food or other resources. Only one researcher in our sample did not encounter this as a problem in their research, as their trial participants tended not to be impeded due a relative social advantage. In experiencing psychological problems their main difficulty seemed to be one of low agency.

"I can certainly envision that, but in the people that I deal with, typically not. Like even for things like kids, for example, you know. Yeah. I always say it's much more complex in that situation to use MI. But certainly, in populations that I see, who are typically adults who are semi-higher functioning, that low agency is the only one that I've really encountered." Source. Hinata.

Although, seeing this as possible limiting factor this researcher rarely came across it, as the context for their research was with clients who are described as ''semi higher functioning". And a final contrasting view is given by Akiko,

“ I mean one reason interventions don’t work is because motivations, let’s assume that everything works like the way it’s supposed to do MI works the way it’s supposed to do and CBT works the way it’s supposed to do there could still be societal factors that are going to impede progress you will have to do maybe extra work to overcome.”

Working with motivation and cognitive processes are hypothesised to be important mechanism in the MI and CBT literature. The extent to which this it is possible to address these processes in certain research contexts has been explored. The extent to which these limitations on research can be overcome are considered in the next section.

5.1.4 Overcoming difficulties of Social Context

To the extent to which social contexts are impactful and to which research trial therapists and therapies are unable to respond to them is illustrated by this expert researcher participant’s view:

“I think that actually if people, and staying with it, you've got no money, you live in a terrible, terrible environment, your medication's in a complete mess, sort of that needs to be sorted out for the individual before it's worth – because your CBT's a bit useless really if the whole social context is really what's more of a problem. Source: Katsuko

The implication here being that intervention might need be stopped or not started if basic social concerns and needs are not met. In a research trial unless the intervention is about specifically targeting such difficulties this unlikely to happen. A question might be asked whether it is worthwhile trying to provide the intervention under these circumstances at all. From a critical realist perspective individuals exist in open systems and have their own unique circumstances and needs. Where an individual’s social context makes it difficult for them to participate in therapy, then just carrying on with providing it makes it difficult to answer the question of whether the intervention works or not for a particular behaviour change. My own experience as a research therapist has been that we

are asked to plough on regardless of the social difficulties. There is a hope that by just carrying on that some aspect of the intervention will provide some sort of help that assists people; either in just coping with present social difficulties or in making changes in it. Under these circumstances we are not testing specific elements or proposed mechanisms of action in the research intervention itself. It may be more that just having a therapist who is enabling and socially helpful in some unspecified way, makes a difference.

Several other suggestions were made by expert researcher participants for overcoming social problems which impact on the individual and the intervention. For example, Formulation, where a shared understanding is reached with the individual and that this incorporates the addressing their basic needs within the therapeutic relationship. For example, Katsuko suggests... “I think formulation is an important component and there is research that does show that a shared formulation, a collaborative formulation, is really important.”

Also, the use of the therapeutic process to model better attachments with individuals living in impoverished environments is recommended.
…“thinking about how attachment might play a role in terms of say someone who's in a very impoverished environment and they’ve had terrible attachment relationships and still have, how your therapeutic relationship can be established under those conditions.” Source: Katsuko

These are both examples of how therapeutic style and practise might incorporate the social realties of our client’s lives. Formulation is often cited as a core mechanism in CBT but the research on how effective this is in terms of outcome by itself is underdeveloped. The suggestion to link it in with social difficulties is an interesting one acknowledging the limitations of a purely individualised approach. The process of formulation should be a collaborative and shared process and this suggestion perhaps points us in the direction of power yielding as a mechanism. Formulation uses psychological theory to help draw links to possible interventions from the existing evidence base for particular problems (Johnstone & Dallos, 2015). Psychological formulation is not a formal part of MI

but the collaborative sharing of power is; MI's attention to collaboration and partnership may fit well with formulation because of this.

Interestingly developmental psychologists working on attachment theory have provided evidence that socio economic status of a person has more effect on their psychological functioning later in life, than their personal attachment style in infancy (Kagan, 2016). Perhaps what is important to understand for psychological interventions is how a negative socio-economic status affects attachment style and therefore affects how people respond to threat and make meaning. If we are modelling an MI consistent approach, we may be modelling a more effective or more facilitating attachment style through the sharing of power. These suggestions to incorporate and understanding of social circumstances and their effects into a therapeutic relationship are interesting. They are valid but also puzzling as RCT based research interventions tend not to incorporate these features. These are more akin to broader system level interventions that tend to occur in more in routine services and using more of team-based service approach. Relatedly Akiko, suggested taking this a step further…"I would do is more partnering with people involved in public policy with folks who do organisational change that kind of stuff". This 'partnering' or becoming involved with public health bodies to effect wider system change in local communities would seem to be a feasible option for many expert academics who are well placed to do this.

Finally, it was suggested that simply using MI with individuals from groups who are marginalised, disadvantaged and discriminated against is as a way to respond to the effects of social context. This claim is based on the literature of MI's differential effectiveness with Marginalised groups (Vilanueva et al., 2007, Sakher et al., 2019, Silva et al., 2019). This literature and our participants views suggest that MI is theorised to be responding to or managing relational threat issues arising as a result of inequality, discrimination and an imbalance of power. Kaito, describes it thus:

..."everybody's favourite finding that minority clients show bigger effects from MI than the majority, right, and that's not, that's the opposite of almost every other form of therapy when you look at the research on other forms of therapy."

There seems to be emerging evidence suggesting MI enhances therapeutic relationships and that in some way is facilitating change. This may be pointing us toward and underlying mechanism in MI that actively engages with and mitigates the consequences of inequality and discrimination. Perhaps MI can be seen as a way of responding to embedded social and interpersonal dynamics faced by minority and disadvantaged groups who are often threatened by negative social norms. I will now go on to explore the views of the expert therapist participants in this area.

5.1.5 Therapist views of the impact of social context on interventions

A summary of the themes that were identified within the therapist sample is listed here:

- Therapists own context and the wider contexts for their own training.
- Impact of the social context on individual clients and how therapist saw that.
- How that context impacted on the intervention, how it might change the intervention or its delivery
- Overcoming difficulties of social context and where adaptations or other solutions are needed
- Therapist view on theory, how relevant theoretical understanding is.
- Whether theory development is needed to account for social context or in their training or therapy guidelines.

These themes were used to identify relevant extracts for analysis,theory development and this discussed below. Consistently participants from our expert therapist group emphasised the need to locate their work in an understanding of the effects of their clients' social contexts. Illustrating a number of ways in which the delivery and practice of psychosocial interventions is impacted in *real world*

settings. For example, one participant summarized a range of important factors to be considered when delivering a psychosocial intervention:

"That whilst I might be considering somebody's social circumstances and network, whether that might be anything from the context of their upbringing to the nature and extent of their support network, their social and housing situation, their social status, their class, their race, their gender, their age and all those kind of things. Those are all things I'd be looking at pretty instantly". Source: Riz

This is a broad and inclusive statement of what might need to be taken into account when delivering a psychosocial intervention in routine service provision, this is not generally the practice of research trials and often requires a multi-disciplinary team approach and mobilising community resources. As in the expert researchers' group the influence of time constraints and resource considerations were highlighted. Some therapist also acknowledged that variations across social contexts are important factors in the delivery and effectiveness of interventions. For example, it was suggested by participants that certain groups in particular social contexts needed longer and more intense periods of intervention and support.

"I work in an early intervention team with people with psychosis who I might be seeing for two years, you know, weekly, yeah, as compared to a smoking cessation worker who sees a client for one session for 20 minutes and is hoping for some outcome". Source Razak.

Clearly this type of intervention suggests that a longer time frame is required when working with people who have a complex set of problems in complex social contexts. According to Moeen,

… "So services have got to be realistic and time-limited and we do have to evaluate this. So, X, for example, in a very engagement focused CBT for psychosis talks about maybe after about, I think he says about after six sessions, if you're not working to any kind of collaborative goals, maybe you've got to wonder if it's helpful."

We have two examples here of how in practice intervention and delivery is very different than in research settings. The second quote above illustrating how in NHS services there is also time pressures in assessing progress. Suggesting that those precious and limited resources might be allocated to someone else who is currently in a position to engage in therapy. This could be seen as an economic and ultimately political decision, Moeen, suggests that psychosis clients are often already marginalised in this respect,

“one of the things that attracted me to work in an early intervention was the inequity of people who have a diagnosis within the psychosis cluster not really having a reasonable access to therapy and services. And that was quite a political thing…”

Acknowledging this socio-economic and political context one participant also identified what they think might be going on cognitively and emotionally for these marginalised clients. Further, how this might affect therapeutic relationships in terms of power dynamics.

“So people’s social context could lead them on to a threat reaction to a perception of their own experiences of authority and power and social rank, which could lead people to completely disengage from intervention and you’ve sometimes got a very limited window of opportunity to help people to feel OK, sometimes it’s in that first few minutes.”. Source: Moeen.

Razak also connects this to how the therapeutic relationship, might be impacted by social rank and gives an example of clothing worn by practitioners in different social settings is important.

… “suggest that that probably is related to social rank and attempting to have a high social rank when you’re dressing. I’m going to court today. I’m going to wear a jacket, a suit jacket. I never wear a suit jacket. And that is because I’m expected to be a certain social rank in that setting, so yes.” Source: Razak

Therefore, when working with marginalised and disadvantaged groups such as people in psychosis services there is a need to be sensitive to embedded social norms. This includes responding to threat real or perceived that are posed by differences in social rank. This may be facilitated by a power yielding response on the practitioner's part that pays attention to such interpersonal details. This may not always be possible as Razak frustratingly points out from clinical experience,

"One guy said I expected you to be in a Prius because you're a helping sort of guy, I thought that you'd be wanting to save the world. So, it was all about energy and the other guy said that he thought I'd be driving a VW because I wouldn't be flashy, that I'd want to be understated. But he knew that I'd want to drive a car that was reliable. And so I think it's a huge impact isn't it? Just, I mean like the fucking car that I arrive in at the appointment becomes the focus of whether these people are going to trust me or not. And I can't change my car every week ".

It cannot always be possible to manage all of the issues of power and social rank when working as a professional but it is theoerised here that having an approach and therapeutic style that responds well to power imbalance is an asset. This might be achieved through a mix of philosophy, values and skilled practice that may improve responsiveness and outcomes. Internalising and prioritising an understanding of social context and how that affects therapeutic relationships and their effectiveness may be part of the process of power yielding. This may or not be necessary as perhaps the existing MI philosophy and skills are enabling this at an individual level. In the same way that human dominance struggles are often unconscious perhaps their mitigation through MI practice is also unconscious for some. The next section goes on to examine impact of social context on delivery of interventions in day to day practice of NHS service provision in more detail.

5.1.6 Impact of Social context on the Individual and the Intervention

An individual's social context may affect very practically their ability to access services. For example, being able to engage with services can be made more difficult because they have less in terms of economic resource or relational

resources. This is often referred to as social capital and in addition to finances was regarded as factor impacting on interventions. The importance of this is identified by expert therapist Razak,

“Well just practically people in different social contexts are able to make appointments or not…. that people in less resourced, materially resourced, but also relationally resourced settings probably find it difficult to get to appointments in clinics, let’s say. I think there’s some research out there that ethnic minorities don’t turn up to their GPs as often or therapists as often. So clearly somebody’s social context can interfere with their ability to engage in health professional’s consultations, so just through turning up for one.” Source:Razak

Further that once this hurdle has been overcome there is still a complex range of contextual factors to overcome; a dynamic that both client and therapist have to negotiate,

… “and then when they actually manage to turn up and you’re actually sat with the person then their perceptions of you and your power and dominance and whiteness, I’m white, I’m male, I’m middle class, will all impact on both your credibility with them, but also their self-perception and their, yeah, I guess it comes a little bit back to that social rank stuff. I’ve had people say to me things like I’m not sure I’m going to be able to do this because I’m just not as clever as you Raz.” Source: Razak

Lita, offers a view that reinforces the effects of these social difficulties on the ability of therapists across a wide range of service settings in providing the psychosocial interventions themselves,

… “And I think that’s what some primary care psychologists have said to me. That it’s hard because they’re just doing care coordination roles in a way, and it’s then difficult to get to the therapy. Because obviously social needs often trump psychological needs”. Source Lita.

Further, the importance of recognising power dynamics and limitations in all professional relationships; particularly those that relate to the power of the state is illustrated in the experience of another expert therapist, who puts it this way,

... “the social context of people will massively determine that and again coming to all those kinds of social rank and threat theory, their relationship to others and the outside world and to authority, because I think as collaborative as we try to be, we still represent a professional service, part of a governmental service, we’re still part of The Man”. Source: Mooen

My own experience of this as a practitioner is that this is often a difficult hurdle to overcome in relationships as people often have negative experiences of the state power throughout their lives. Whether that be in education, social or health services. People who come under the jurisdiction of mental health services have the added threat, for example of involuntary incarceration in hospital. Resulting in questions being raised about their abilities to work, join the armed forces or police force, to be a parent and to whether they can manage their own finances. Further that if and when people overcome the obstacles described above, become engaged in intervention and move toward change and progress; they are once again faced with the economic reality of what is available to support them after an individual therapeutic intervention, as Lita, puts it from an expert therapist perspective,

… “ it’s just prioritising resources isn’t it? I think that’s the problem without going off on a political rant. All the third sector organisations that props up like the NHS have all been cut. So, when you’re trying to move people on from secondary care services now it’s difficult to link them in with anything because a lot of it’s been stripped away.” Source:Lita

The views of our expert therapists in practice paint a challenging picture, much of which we can try to address at an individual level or by working in concert with multi-disciplinary groups and agencies. I will now consider their perspectives on overcoming or mitigating the effects of this social context and disadvantage.

5.1.7 Overcoming the difficulties of Social Context

The need to empower people in some way was seen as an important social mechanism. This fits in my view with theoretical concepts relating to power yielding, power meaning, threat responses and taking into account the effects of this upon the individual, Mooen described it this way,…"The likes of John Read kind of behind it and trying to empower people within a disempowering psychiatric system is core".

While empowerment theory (Perkins& Zimmerman,1995) has not been considered in detail, it is a well-established and has numerous definitions, in community psychology and social work. It concerns the perceived efficacy and control over socio, economic and political aspects of the life of individual. It can be seen as a multi-level construct existing at the individual, family, organisational and community levels. In terms of the current discussion it can only be briefly discussed. However its theory maybe worth more detailed consideration in another project.

In therapy practice one expert therapist suggests empowerment through MI practice, as a way of overcoming social difficulties… "Yeah, I suppose sometimes you've just got to almost put the models down and just get to know someone, but you're still doing MI when you're doing it and that's OK."

Interestingly this description sees MI as a way to engage when the CBT models are 'put down'. Additionally, another form of empowerment was invoked in the taking of time away from a therapeutic model to talk more about the therapists situation and this was found to be helpful by Nona… " so self-disclosure is a way of giving people back some power." Also, another participant suggeste that having policies in place that promote the involvement of local communities; for example that ethnic minority groups are not excluded from accessing services,

… "you do have to match your population's needs and the people in that population to the therapists. So, it does come right back down to recruitment and training at the very beginning, that if we have no Urdu-speaking motivational

interviewing speakers, therapists, then we can’t know how to deliver motivational interviewing to Urdu-speaking populations, yeah.” Source: Raz.

5.1.8 Social Context in Theory and in Practice

We have seen that expert academics see the importance of the effects of social contexts on individuals and how this might affect their ability to engage therapeutically and make behaviour change. Their research methodology is focused on testing out and developing individualised therapies for psychological problems. Their theory is set in that context and is consistent with the existing theory on MI efficacy that is an individualised one. Both the expert researchers and expert therapists seem to agree that disempowering social contexts and systems are often responsible for individuals’ mental health problems and other difficulties. Also, that at some level they are trying to think of ways in which this can be changed to support or empower the individual client in this individualised therapeutic relationship. The expert therapist or ‘jobbing clinician’ seems to be more focused on thinking about how social circumstances have impacted on people, are impacting on them now and how they can mobilise resources in their services to address these real-life issues. Also, for both groups power structures and the way this relates to threat responses and the meanings that clients and therapists give to them, are emphasised as important in their clinical experience.

Expert researchers did not consider social context explicitly in their research. Although, they measured psychological qualities they did not seek to measure aspects of social context. Whereas expert therapists not only take it account but sought to find ways to address it, both at an individual level and through a multi-disciplinary team. In real-world NHS services need to adapt to financial constraints and Individual interventions may be rationed. Also, individual interventions usually require a range of community resources and external support to enable changes that have been identified in therapy. For, researchers the interventions in trials carry on regardless as per protocol, for expert clinicians interventions may need to be adapted in practice. This may involve delivering only some aspects of them, for example as ‘MI informed’; ‘CBT informed’ or by changing the intervention by increasing or decreasing its intensity and time

periods. Also, interventions in clinical services may not be offered at all until more basic social needs have been met. Ironically, the social reality for real-world services is that often the only way for clients of services to access psychological therapy is for them to be involved in a research trial. Both groups emphasised the importance of psychological formulation and an empowering practice. The latter received more emphasis from expert clinicians as helping to mitigate threat reactions in relationships in terms of authority, power and social rank. Some practitioners saw empowerment as a mechanism in combatting the effects of disempowering social systems, such as the psychiatric system.

5.1.9 Theory MI efficacy and Social Contexts.

I have considered some literature above relating to human biological and social evolutionary responses to threat for example: in Polyvagal Theory (Dana, 2018), Compassion focused therapy (Gilbert, 2009), Psychological Reactance Theory, (Brehm & Brehm, 1981), Evolutionary perspectives on Reactance (de Almeida de Neto, 2017) and also the Power Threat Meaning Framework (Johnstone and Boyle, 2018). The theoretical constructs contained in these all contribute to an understanding of the issues highlighted by the participants in terms of social contexts and how that affects MI therapeutic interactions. They are all theoretical lenses that we can use to understand MI efficacy, and all have in common the need to understand how power may operate in therapeutic relationships. This in my view is a promising area for theory development in MI. Having examined social contexts and how that might relate to MI theory; I will now go on to consider the views of participants on mechanisms of action and again relate that to existing theory and theory development. By using a critical realist framework, I have used a process of retroduction which is a form of contextualised inference, that seeks to identify underlying mechanisms and explanations. In this case from those hypothesized by our participants to account for MI efficacy.

5.2.0 Expert researchers views on Mechanisms

A summary of themes identified as mechanisms of action in MICBT integration is displayed below in Figure 5.2. It is a screen shot taken from the Quirkos software and based on the extracts from the expert researcher group.

Figure 5.2

5.2.1 Mechanisms from MIBT integration themes identified

The candidate mechanisms hypothesising why MI might work were identified from the expert researcher group transcripts are summarised in the diagram above and are discussed below. From a critical realist viewpoint, mechanisms of action are seen as cognitive processes occurring both in the mind of the client and the therapist. They are about what is being turned on or needs to be turned on in order achieve an outcome. These mechanisms are sensitive to variations in context and the behaviour of the therapist. How the data relates to existing theory as outlined earlier and how the data generated from the interviews relates to that are discussed in the sections that follow. I have asked what the integration

of MI with CBT is telling us about MI mechanisms and proposed theories. Existing MI theory and research have tended to emphasise the view that there are both technical and relational mechanisms at play (Miller & Rose, 2009). Themes identified from the interviews are outlined below and linked to existing theory. Identification of Mechanisms of action in MI and CBT remains underdeveloped (Magill & Hallgren, 2019) and one of the expert academics summarised it this way, … "maybe there are different things that suit different people. So, I don't know really. I think mechanisms is really, really interesting and it's something that we've never really got to the bottom of". Source: Katsuko

5.2.2 The role of Psychological Safety and Alliance

A prominent candidate mechanism of action suggested across this sample was that of the working or therapeutic alliance. Participants suggesting that a relational mechanism is being activated by MI practice that also impacts on alliance. This is outlined from the experience of integrating MI and CBT by one of our participants,

…"That often and more directly impacts the bond if we're thinking of using the classic alliance model. It can much more rapidly establish, help that become established than I think would typically occur in CBT, so there's a relational mechanism there that is being activated". Source: Kaito

MI was also identified as enhancing the therapeutic alliance through facilitation of psychological safety and through promoting trust, Kaito, continues… "One is it creates a level of trust and you can talk about that as alliance,".

Another participant reinforced this view, …"So I think once you've got that therapeutic alliance with somebody you can start to; they start to trust your opinion a bit more and you can have a bit more of an open discussion about what changes might be" Source: Riku

Further, it was suggested that psychological safety is increased in CBT when it its integrated with MI. One participant describes why this might be so… "the idea

of psychological safety as a key mechanism and I defined psychological safety as the absence of the perception of negative judgment and/or absence of control.” Source: Kaito. Crucially this creation of a psychologically safe atmosphere through MI practice is seen as a mechanism because it is thought to facilitate CBT, and this suggests it enables cognitive processing for clients. For example: … “Well, I guess it's creating an atmosphere for people to be able to express their thoughts and beliefs about their situation in a non-judgemental and an accepting way”. Source: Katsuko

Also, other core elements of MI for example empathy are being suggested as key in the promotion of psychological safety, according to Hinata, … “I think one of the things when we talk about empathy is safety”. Another academic participant based on their own therapy process research emphasised psychological safety as a key mechanism in MI this way,…“Certainly empathy and prizing or unconditional positive regard are, at least from my perspective, what would create that, that psychological safety that’s the opposite of judgement and control, so they convey messages of safety”. Source: Kaito

Further, in addition to this,

… “So, I think empathy and the ability to preserve autonomy, especially at key moments allows clients to relax. So, it creates a sort of safe environment. It's like the sort of attachment theory. When you're in a safe environment, you can explore more.” Source: Hinata

Theoretically the emphasis being placed on psychological safety by the academic experts’ points us toward those theoretical insights already considered in the literature. For example those from Self-Determination Theory (Ryan & Deci, 2000), Evolutionary Theory (de Almeida Neto, 2017), Social Rank Theory (Gilbert, 2009) and Attachment Theory (Purnell, 2004). Also, this reinforces the theoretical position that MI might have an impact on psychological safety because as a power yielding approach it helps to mitigate issues around how power threat and meaning operate in therapeutic relationships. Further this emphasis on

psychological safety as an MI mechanism supports humanistic theory's emphasis on the core conditions for optimal growth (Rogers,1959,1980).

5.2.3 Preserving and promoting autonomy as a Mechanism

The humanistic person-centred nature of MI means that it emphasises individual responsibility and autonomy in making decisions about behaviour change (Csillik, 2013). From a practise point of view one participant articulated it this way,

… "it's being able to say you know what you're the boss and I'm not going to force you to do anything. I think there's something magic about autonomy…it strikes me that in MI you're not just supporting autonomy, you're demanding it." Source: Hinata

Our experts generally emphasised promoting and preserving autonomy as an important MI mechanism. At some level it is both encouraging people to feel good about themselves and is implicated in building confidence as this next two statements from one expert academic illustrates below.

…"I definitely think empathy and spirit, but I also think more emphasizing autonomy builds importance and definitely intrinsic importance and also to some degree confidence."
…"I mean when I say feeling good, I mean that like that you can use bigger terms like empowerment and feeling like more autonomous those would be some of the big ones." Source: Akiko

So here a mechanism related to promoting and preserving autonomy within a relationship is being identified and MI practise is hypothesised to be contributing to or enabling a feel-good element. Theoretically this is consistent with Broaden and Build model of positive emotion (Fredrickson, 2004). This emotional element is also hypothesised by Ingersoll and Wagner (2010) in their theoretical questions as to why MI might work. It also offers a link to MI theory that prioritises power sharing and MI being a practice that is empowering. Further there is another

emotional component for MI efficacy being suggested here and that is the need for therapist optimism which may or not be an aspect of MI practice. Akiko, goes on further to linked this back to social rank theory,

,… "and feel good remember that's why I said you feel good when you're socially dominant… I mean there's just something about feeling good in the session right and I think again you know emphasizing autonomy is one of those ways feeling good in sessions affirming makes people feel good in sessions and therapist optimism". Source: Akiko.

Preserving and promoting autonomy was regularly identified as a mechanism that is thought to be related to outcomes and also one that attempts have been made to measure in MI research . It seems to have been seen as being so important that it became a code, something to be measured in the Motivational Interviewing Treatment Integrity scale (MITI 4.0 Moyers et al.,2015). For example:

…"so we took a relational component and made it technical so that we could teach it and code it and study it and now we actually will code emphasizing autonomy skills and we find them directly related to change talk''. Source: Akiko

The fact that MI has recognised the importance of relationship and attempted to break that down and then measure aspects of it, is acknowledged by expert academic Hinata,… "MI has specified and researched what the elements of the relational component are coded it and related it to outcomes". Source:Hinata

This practice and research has brought a number of insights into why MI might work and it sits firmly within a positivist research approach to human behaviour. In this research paradigm relational mechanisms are being represented as a distinct set of measurable variables and are described independently of social contexts. Thus, reinforcing a particular type of knowledge which is dependent on and celebrates experimental method. Preserving and promoting autonomy is a complex interaction of therapists' behaviours and the client's interaction with it. It has been defined, measured and tested experimentally in relation to outcomes in

MI, for example amount of change talk in sessions. It has been consistently highlighted as an important mechanism in our participants.

5.2.4 Responding to Resistance or discord and avoiding ruptures in Alliance.

Promoting the management of and avoidance of ruptures in the relationship through the use of MI consistent practise was seen as an important mechanism in this sample, three examples illustrating this are cited here :

…"So often in these resistance episodes, we see that it's the client who's working hard to preserve the alliance, but the therapist is just like a dog with a bone, just stomping all over it. And so I think that's a threat. So why alliance ruptures are so important is because you have just stuck a knife in the safety of the relationship" Source: Hinata

And …"the relationship is key and as soon as I feel like something's going wrong I back right off and try and preserve that. Source: Sayoko

Also, stressing how important it is as a marker within a therapeutic relationship one expert researcher described that... "Everything to me is zeroing in on resistance. It's like a laser beam…resistance arises in the context of an ambivalent client where the therapist is making a demand that the client's not ready for". Source: Hinata

The term resistance was used by most participants although acknowledging that it had been replaced in MI texts it was still seen as useful. Making observations from MICBT process research, one expert researcher saw that MI trained therapists behaved in a way that reinforces the importance of rolling with resistance as an MI mechanism… "the moment they saw resistance to something they suggested or the moment they saw a re-emergence of ambivalence, they were able to shift back into an MI stance proper". Source Hinata.

This ability of the MI practitioner to respond to resistance through specific MI technique and its being embodied in the philosophy or style of the method itself; is suggested as an important mechanism. It is hypothesised by our participants to promote client centred responses to discord, avoid rupture in relationships and maintain alliance. The fact that this was consistently highlighted by participants as something lacking in CBT points us towards this ability of MI trained practitioners to respond to discord as mechanism. This shortcoming in CBT highlights both how that might be a problem for the relationship and how MI might improve outcomes in CBT. At an experimental level we have also seen some evidence for this suggested above (Kertes et al., 2011). Also, according to one participants this ability to respond to discord is part of working with ambivalence, "on the CBT side you know there's always ambivalence present and at some point, you never move forward with CBT if there is ambivalence". Source Akiko.

Katsuko, suggested how this might be addressed through integrating MI because,

"it provides you with techniques or ways to facilitate that which are not so explicit in your CBT manual or whatever, sort of the rolling with the resistance, the sort of being sensitive to resistance and looking out for motivational statements". Source: Katsuko

Finally, an important point was made in relation to this ability to work with resistance or discord as an MI mechanism in CBT. In terms of what MI is adding to CBT through the ability of therapist to respond to changes in the relationship through what might be called context responsiveness.

"I think the MI-informed therapist is able to pick up key moments of deviation from a chronic interpersonal pattern. And by saying whoa, the client is being assertive there, I don't need to shut them down, I need to say tell me more about that and being able to navigate that impasse turns out to be critical." Source: Hinata

So here the MI relationship and its specific emphasis on responding to discord or resistance as a mechanism supports theoretical explanations that relate to this

for example the concept of psychological reactance, how power is shared, how the elements of power threat and meaning in a relationship is negotiated.

5.2.5 Client Mechanisms what is going on cognitively for the client?

Although this was not a question that could be asked directly of any clients in this research, a number of themes relating to cognitive and emotional processes in clients were identified by participants. I present some of these findings here as they are relevant to a critical realist analysis in terms of hypothesised mechanisms. That is 'what is being turned on or needs to be turned on', in the person. Some of this the client may be conscious of and some of it they may not, for example:

"the client actually tests for that, that the client engages in a series of tests, of which they're not aware, by offering some level of intimate disclosure and being very attuned to whether judgement or control is in the response and to the extent that it's not, the level of trust deepens and the sense of psychological safety increases and the person becomes not only more open to the therapy, but more able to access their own inner resources, their own internal thought processes and I think ".Source: Kaito

A complex cognitive process is being described here through which client's capacities are mobilised by discovering strengths, resources and qualities within themselves. This is also linked further by this participant with how much more powerful this impact might be on clients coming from groups facing discrimination.

"Clearly being from a stigmatised repressed group makes it very likely that when you feel profoundly respected and valued on your own terms, that that will have a more powerful impact for you ". Source: Kaito

Finally, this participant describes a cognitive process whereby MI is helping to relieve people from a state of being self-critical, self-controlling and immobilized.

"I think a big part of what MI does is actually help people, help clear that, help people relieve people of that state and once again free themselves up to access their own flexibility, creativity, thoughtfulness, at which point they often then see the way forward."

What is hypothesised to be going on here internally for clients, either consciously or unconsciously is only being guessed at based on this participants clinical experience and research. Whilst this is an important insight, this whole area of client perspectives on MI theory, does require further direct empirical, person-centred research.

5.2.6 Relational vs Technical mechanisms in MICBT

Reflecting on the participants views and hypotheses on MICBT mechanisms, in general they emphasised relational elements of MI rather than specific skills or techniques in either approach. It has been reflected upon above that it is difficult to separate out MI skills from its spirit or philosophy, although we have seen that researchers have continued to try do this. Most of the mechanisms emphasised by participants here were fundamentally relational ones rather than technical. According to Magill (2018) there has been less research into relational mechanisms and that more evidence for a technical hypothesis has been produced, perhaps because they are easier to quantify. The data collected here from our academic experts would seem to point to the importance exploring and further researching relational mechanisms identified here. So far, I have identified expert academics views and hypotheses on mechanism of action in MI. I have cross referenced this with theory that has been identified from the existing MI literature and incorporated wider perspectives from other sources. I will now go on to present and discuss the views of our expert therapist participants.

5.2.7 Therapist identified themes on Mechanisms

The figure below is a screenshot from Quirkos software. It illustrates and summarises the identification of themes from the expert therapists for mechanisms in MICBT. The mechanisms proposed are presented and analysed in terms of existing theory.

Figure 5.2 Identified Themes on MI Mechanisms expert therapists.

5.2.8 The importance of engagement in therapeutic relationships

Engagement as a mechanism in an MI relationship was consistently highlighted by expert therapists in this sample. It is interesting that this was given prominence by practitioners in a way that it was not by our expert researchers. One expert practitioner highlighted engagement in this way.

"I guess when I first started with MI the approach was around using MI in a more pure way to do that engagement" … so, not just engagement in terms of meeting

up with people, but engagement in terms of starting to have potentially meaningful discussions with people". Source: Latif

Perhaps suggesting that there is something about MI that involves not just having a skilled conversation, but having ones that are meaningful and therefore more engaging. One participant described clearly how MI philosophy and skills come together to facilitate this need to have meaningful conversations and how that might help with CBT practice,

… "as I learnt more about MI, when I was being engagement focused to deliver CBT, I felt like I was drawing on MI principles, clearly there to ask evocative questions, to avoid arguing, to respond well to resistance and using lots of reflections, that just felt like the engagement bit of CBT." Source: Mooen

Further, this participant goes on to link this with the need as a practitioner to engage quickly with distressed people from marginalised groups who have had negative experiences of power;

"So people's social context could lead them on to a threat reaction to a perception of their own experiences of authority and power and social rank, which could lead people to completely disengage from intervention and you've sometimes got a very limited window of opportunity to help people to feel OK, sometimes it's in that first few minutes. So, MI gives you a structured model and format to achieve that really." Source: Moeen

Given that expert practitioners in routine services have to meet a wide range of people many of whom find engaging difficult, it is interesting that engagement is highlighted as an MI mechanism. Their identification of this suggest they see MI consistent as an approach promoting engagement.

5.2.9 The Importance of Relationship

Also, most practitioners identified the relationship or relational practice as a core mechanism in MI, for example one expert therapist described , “I think it’s all about the relationship. And then once you’ve got the relationship it’s about what you do with that”. Source: Latif. In thinking about the Miller and Rose (2009) relational vs technical hypothesis this participant expressed this view of it, as a practitioner,

“I think for me it’s relational trumps everything. Even if you’re technically good, if you can’t relate to the client or engage them, the technical stuff isn’t going to work. That might be very black and white. “

There are frequent and understandable pressures to be technically competent in therapeutic practice. This is often based on a theoretical model or a fidelity scale and as one participant observed there may be some the drawbacks to this. This tension is illustrated by this example,
“I’ve tried to be much more technical in my approach, and it just doesn’t work. They don’t like it; they can see it a mile off and they don’t like it. Source: Nona

This process of emphasising the technical aspects of MI over the relational ones may be counterproductive from the client and therapist point of view. In my own practise, I have observed this to be a common experience in therapists particularly when learning new approaches and also in practitioners that have approaches that don’t emphasise the need for a relationship. Razak describes one experience of different styles of relationship and how they can create responses in clients that result in a lack of genuine commitment to a course of action. This example below illustrates this point.

“when I see a doctor telling someone that they have to take a medication, there is definitely a social rank going on. They are the powerful dominant

force and the client either submits and either just says yes and then doesn't do it or they become confrontational. Whereas when I then take over the interaction, I can see a completely different relationship where either we're equals or in this case I submit. Source: Razak.

5.3.0 Technical skills in Therapy

As with the expert researcher group less emphasis was placed upon specific core skills as mechanisms by the expert therapist participants. Only the skill of reflective listening was suggested as a relational skill or conversational technique that might be thought of as a mechanism for bringing about change. One participant made this point, "Yeah, it's interesting, isn't it, because MI's real strength is on those really skilful conversational techniques". Source: Mooen. Also, then going on to hypothesise that from their clinical experience that reflective listening is a mechanism in itself, in that it is facilitating a cognitive processes.

… "being aware of, there's a lot of skill in reflection, a tremendous amount of skill in reflections and I think the thing about MI is it's less is more,… compared to MI where one cheeky well-timed reflection can just like click something for someone and that there can be a cognitive change''. Source: Moeen

5.3.1 Identifying values and goals

Most of the therapist participants placed a great deal of emphasis on MI's practice of identifying clients personal values and goals as a mechanism of action. This practice might be described as a conversational technique and guidelines have been suggested for focusing MI conversations in this way. An example of how this might be working in clinical practice is presented below:

"I think pulling out values really. The people that I was really stuck with I think are things that really changed was around the values. That it needed

to be important enough for them to make changes, because change is hard isn't it? So, you have to think it's what you need to do. Source: Lita

It is hypothesised here that MI's focus on important values is helping people to become unstuck cognitively and to be able to think about making change. Razak also proposes this mechanism is producing connection in the individual client at an emotional level,

… "alongside the relationship, which is a prerequisite for this next step, that the mechanism of change relates to the ability of the MI therapist who identify core cherished goals and values in that individual and for them to say them out loud and connect with them emotionally such that they then commit to change''. Source: Razak.

This participant interestingly went on to propose a cognitive and emotional mechanism relating specifically to how this might be experienced by a client: "I guess that some more cognitive theories might be that in voicing and connecting with values that actually people can live in a homeostasis where they're no longer distressed and therefore, they become self-regulators of their mood through a changed behaviour". Source: Razak

Further, in thinking about the role of values identification in MI this participant went on to offer a hypothesis for a development of MI theory in terms of what might underly change talk,

"And coming back to the values stuff, that I reckon if you have a clear theory on motivational interviewing you could test out my hypothesis that it's not change talk, but it's specific types of change talk that are related to connecting with higher order values that might be the mechanism for change."

The hypothesis proposed here is that MI is working because it is connecting people cognitively and emotionally with their higher order values. This

process may be also be connected to exploring and resolving ambivalence, developing discrepancy, and the resolution of conflict, as much as in the targeting and reinforcement of change talk itself.

5.3.2 Responding to resistance and discord in therapy

As in our academic expert group, the expert therapists sample saw MI's strategies and relational ability to respond to discord and avoid rupture as an important mechanism. For one participant MI's thinking about how to respond to it helps us to understand what resistance is, "I suppose it's all about resistance isn't it, it's understanding what that resistance is." Source: Lita. Further, another participant identified that MI provided clarity on what strategies can be used within an MI relationship, "I think that what MI clarifies is a framework for conceptualising discord within the terms of the relationship between the client and therapist." Source: Riz

Finally, the fact that MI promotes understanding of resistance or discord and has well developed strategies and skills for responding to it, makes it stand out compared to other approaches that have not done this e.g. CBT. It may therefore be effective because it represents a contrast to other professional relationships. Razak summarises it thus:

"that many of the behaviours that we come across that we would like clients to make changes in respond badly to confrontational approaches or approaches that are ill thought out, and motivational interviewing provides a very clear operationalised way of responding to people who are resisting change".

5.3.3 Psychological Safety in therapy

Several of the expert therapists emphasised establishing psychological safety in a relationship with clients as a mechanism of action. One participant Lita, described it as key,

“I think them feeling safe in a relationship and not judged is key”. Suggesting that safety is being engendered through a non-judgemental relationship. Another participant outlines why this should be so and thinks an affirming relationship promotes a feeling of comfort in the therapy encounter, …“in therapy we’re asking people to step into very uncomfortable rooms and spaces of reflection. What MI does and in particular affirmation is helps to make that place more comfortable.” Source Moeen.

Understanding the need for safety in relationships with people who have activated threat responses can help to increase safety. At the same time, it may free people up cognitively and emotionally if psychological safety is maintained. In this participants experience,

“Yeah, because you have to manage people’s threat system, otherwise they’re just going to be focused on threat. As you say the attention gets very narrowed, it’s difficult for us to reflect in a more broader sense on stuff if we’re feeling threatened. It’s hard to process information.” Source: Lita

Further, that this sense of safety as an MI mechanism is a possible explanation for the development and maintenance of a working alliance, for example:

"when I think that the relational components of alliance, collaboration and, you know, the recent offerings about social rank and motivational interviewing providing a lower social rank so that someone feels safe in the relationship, yeah, probably explain or try to explain the alliance building.” Source: Razak

5.3.4 Elements of MI Spirit as mechanisms

For our expert therapists two aspects of MI spirit were emphasised those of compassion and collaboration.

5.3.5 Compassion

Some expert therapist participants suggested that compassion maybe an important mechanism itself as contained within the spirit or philosophy of MI. For example,

"As a mechanism I would suspect that if you get back to the spirit of MI that what you are modelling is compassion, a wise, tolerable compassion. …because it's warm and it's got elements of compassion, so we model something that I don't believe that they've had in their lives sometimes." Source: Latif

The concept of compassion was introduced into MI by Miller and Rollnick (2012) to emphasise that practitioners are there to promote the welfare and best interest of the client. That is MI practise communicates that the interaction is about the needs of others and not of the therapist or their organisation. Theoretically this might be said to be operating on a number of levels. It is power yielding and accepting in that it signals the inclusion within the social group and in doing so seeks to mitigate the power dynamics around differences in social rank. It also communicates warmth and caring. Miller & Rollnick (2012) introduced it to distinguish MI as a health care intervention and not as technique that might be used for self-interest for example in sales or marketing. As a concept compassion might be said to cement or anchor the other three elements of spirit, i.e. Acceptance, Evocation and collaboration.

5.3.6 Collaboration

MI itself was felt by many participants to enhance collaboration in CBT a method that aspires to be collaborative itself, Riz offered this observation, "I think MI, motivational interviewing I think enhances the collaborative aspects of CBT primarily." Another participant offered this thoughtful and complex reflection on collaboration and compassion as experienced and contrasted in MI and CBT.

"CBT actually being led by an understanding of how a traditional straightforward approach to CBT could be a shaming of people as well. So the collaborative elements of CBT have always been there strongly for me and the potential for it to evoke shame rather than compassion and collaboration and that sort of blends with MI and I think that's blended with a wider political context of trying to stand up for patients who were often disempowered within the messy system." Source: Moeen

Compassion and collaboration by this definition requires the individual practitioner to internalise not only these elements of MI spirit but also to understand and incorporate the effects of the wider social system in the pursuit of compassionate practise. Something interestingly that Compassion Focussed Therapy (Gilbert, 2019) compared above has considered in detail.

5.3.7 Summary of Mechanisms in research and practice

In terms of hypothesised Mechanisms of action in MI there was a broad agreement between researchers and practitioners. Both groups emphasised psychological safety and alliance as a relational mechanism activated through MI consistent practice. This practice was hypothesised to create a safe atmosphere and trust; freeing up clients cognitively and helping to manage peoples threat system in therapy practice.

Responding to resistance was highlighted by both groups as a way of maintaining alliance and the relationship. Resistance as a concept was retained by both as useful theoretically and in practice and was seen as something lacking in CBT, that MI might add. Preserving and promoting autonomy received more emphasis in the expert researcher group as did connections with 'feeling good' and therapist optimism. Both groups emphasised relational practice rather than a technical practice. For expert therapists, technical ability did not necessarily translate into effective relationships in practice. The technical skill of reflective listening as a mechanism in facilitating client cognitive processes was highlighted

by practitioners. Only the expert researcher group emphasised the quantification of these relational components.

A notable difference between the two groups was that expert therapists identified engagement as a specific mechanism in MI. A sense that MI gave more emphasis in initial meetings with people, allowing meaningful conversations and seen as more engaging than CBT and potentially adding something. Engagement as a task is perhaps seen as more necessary and primary task for *real-world* services. Perhaps, for a number of reasons, not present in research, particularly those around the management of risk. Expert therapists also saw the identification of values and goals as a motivational mechanism useful in their practice in helping people to become unstuck cognitively. Allowing for the development of discrepancy, exploring and resolving ambivalence, helpful in the resolution of conflict. Expert therapist also specified compassion and collaboration as prominent aspects of MI spirit they found helpful in their therapeutic practice. In that it assisted communication of warmth, caring and the yielding power. It was also suggested that these relational elements enhanced their CBT.

This section has concentrated on what participants views were of mechanisms in MI based on their experience of integration with CBT, this has been guided by our critical realist definition of mechanism. With particular emphasis on what is going on cognitively and emotionally for the client and therapist in intervention. I will now turn to the views of our participants on what their experience of integration has told then about MI theory and its development, in terms of what works for whom, in what circumstances and why. The distinction between hypothesised MI mechanisms and participants theories is a blurred one in my view. Where participants have explicitly referred to a theory or their own theory, I have summarised their views in the next section. At this point I have decided to present the findings from both groups together to avoid repetition from the previous section on mechanisms and only to add in findings that have not been reported.

5.3.8 Expert researcher and therapist perspectives on what MI/CBT integration is telling us about MI theory

Interestingly although the semi structured interviews were open in terms of the effects of integration overwhelmingly the participants in both groups seemed more focussed on what MI was bringing to CBT practise. I focus here on their views on why they think MI is working with CBT, for whom and in what circumstances. I have found a lot of repetition and overlap in themes from the mechanisms and social contexts sections presented so far, so only additional theoretical insights are being reported here.

5.3.9 Why MI works in integration

5.4.0 Operationalising what is important in the relationship

MI's relational style and its emphasis on operationalising the nature of interactions was cited by one expert academic as part of their theory of why MI works with CBT. Hinata said,

"And in fact the person says hey let's go with your way of thinking rather than with my way of thinking. Tell me more about your important way of thinking about this and let's be informed by that. It's like wow! They think that's never happened to me before."

Suggesting that MI conversations are a contrast to previous interactions in people's lives including those with services. The result of this skillful interpersonal stance and philosophy was proposed to have the following effects in theory, by this participant.

“So, our hypothesis is that clients then end up with increased self-trust in their own thoughts and a sense of increased self-efficacy and we think that’s why they actually, in our study, continued to improve in MICBT after the treatment ended. So anyway, that’s our theory in a nutshell. Source: Hinata

MI’s relational style is hypothesised by this researcher to promote self-trust and self-efficacy in the client Also, going further that MI is able to do this because its specifies very clearly what relational elements should look like and therefore benefited CBT outcomes in their research. This “Increased self-trust and self-efficacy is promoted through paying attention to the relational process which is beautifully specified in MI but not in CBT.” Source: Hinata

During this interview I suggested that some in the CBT community might dispute this point, I think it worth reflecting on Hinata’s reply which was, “show me where it is in the manual”. From my own experience in the rating of clinicians practice on both CBT and MI integrity scales, it is difficult to counter this point. The MITI 4 (Moyers et al., 2014) specifies and gives examples of different levels of relational skills including empathy, partnership, collaboration and power sharing. The Manual of the Cognitive Therapy Rating scale CTSR (James, Blackburn, Reichelt, 2001) does have a section on ‘Interpersonal Effectiveness’ and says there should be a ‘good therapeutic relationship’, but it does not operationalise how therapist should demonstrate this in their behaviour. Interestingly what Empathy should look like is in terms of therapist behaviours in the MITI 4.0 (Moyers et al.,2015) emphasises not only demonstrating accurate understanding, but showing ‘power sharing’ that facilitates the clients contribution .The attention MI gives to defining and training therapists in what it sees as core relational skills and philosophy is theorised to promote efficacy.

For the expert researcher Katsuko, one distinctive element of those relational skills is affirmation, which is also not a feature of CBT training nor is it rated in CBT scales,…“there's a big emphasis in MI on affirmations and I think that’s a good thing, so the way that’s influenced me is that I do that

loads in CBT, when I'm doing a more change-type thing anyway.” Source: Katsuko

The promotion of self-trust and self-efficacy in the context of MI relational skills and MI consistent behaviours is therefore being theorised to be helping people to make behaviour change. These elements of an effective relationship are clearly specified and operationalised in the MI fidelity rating scale, as is genuine collaboration, person centeredness and an egalitarian relationship. The following two statements from participants illustrate aspects of this and how this is thought to affect the relationship in CBT and in MI. First of all,

“CBT is a way of facilitating change. MI is oriented towards making the client the expert on themselves. CBT gives lip service to that, in my experience, to being collaborative and so on. But in reality, the way most CBT is practised and even taught, the practitioner sets himself or herself up as the expert on the client”. Source: Kaito

Secondly, MI is contrasted as a different type of therapeutic relationship to the one typically seen in CBT,

“MI doesn’t assign homework! The idea of talking about it in that language is, at some level, profoundly offensive to the MI practitioner, both the concept of assigning as well as, for me, the concept of homework, which sets up a kind of teacher/student dynamic that, I think, is not the egalitarian relationship that we try to create in MI. Source:Kaito

One expert therapist summarised it this way, “Well I think MI, basically MI that’s what it does. MI talks about the relational stuff in a way that CBT text books doesn’t" Source: Lita. I have previously described how both sets of participants have emphasised the MI relationship as core and here there is an acknowledgement that it is identified clearly in MI and that it is seen as a different type of relationship to CBT.

5.4.1 Context responsive Integration

One expert researcher highlighted more detailed analysis of the importance responding to resistance and discord, citing findings from their own research in that area, “I think it's really the responsive integration of MI that is critical” Source: Hinata. Also, further citing findings from their research studies that: “doing the right thing at the right time was ten times more powerful than doing the right thing at any time. So again, this key moment idea: being empathic at the right time, not empathic generally, is what matters,” Source: Hinata

Further, that it is the ability of MI to respond to key moments of potential rupture or discord empathically that made the difference in outcomes in their research,

“But even empathy got wiped out by resistance. So, the mid-treatment resistance was virtually non-existent to the MICBT and was three to five times higher in CBT alone, but that factor alone accounted for almost 90% of the difference in outcome in both treatments.” Source: Hinata

These views extend what is known about MI’s response to discord or resistance. Not only are they thought to be important for an effective relationship but having that MI therapeutic ability to do that at the right time, can affect outcome and efficacy.

5.4.2 For whom does MI work in integration

In one expert researchers experience integrating MI was particulary useful for,

… “people who were aggressive and violent, they often weren't motivated to engage in therapy either…people who are not engaging with things anyway, so

their motivation to engage with therapy is probably much the same as their motivation to engage with any services really.”

There is something about the integration of MI that that seems to improve the responsiveness of what might be described as more challenging clients. One expert therapist provided a practical illustration of this point based on their experience,

“So MI actually saved my career I would say. So, it has become a very natural thing for me to do, to integrate it as much as I can. It makes angry clients completely not scary to me anymore, because I know that there’s not going to be anything for them to push against. So, then they tend to go very melty, so it means that I’m not afraid of working with anybody. And that’s a massive difference isn’t it?” Source: Nona

In one expert researchers own trials experience,… “the only people that really benefitted significantly from the integrated treatment were those people that were more ambivalent at the outset”. This is consistent with MI having been developed as a way of working with people who are ambivalent about change and ambivalent about therapy and services. As Kaito, describes MI,

“it’s more a trans-diagnostic process isn’t it? It’s a motivational issue that’s common to all people, not just people who are diagnosed with a mental health disorder, where there’s that ambivalence it feels like that’s where it holds its own.”

That people are ambivalent about making change in mental health services is common, but if this ambivalence is not present, people may just respond well to a more directive approach for example CBT. One expert therapist put it this way, “If what you’re doing works, fine, but this is for people who struggle with their problems”. Source: Nona. On the other hand those people lacking agency may find an approach like MI uncomfortable in it that promotes autonomous decision making. This is something experienced by another expert researcher ,

…“Clients who really lack agency, so those people who really hate taking autonomy, do not like MI. That’s a broad statement, but back to that idea of demanding autonomy. People that really want to be told want to do or really have very, very low agency are very uncomfortable with the lack of scaffolding.” Source:Hinata

The implication here is that people may not want an approach that seeks to promote autonomy and self-efficacy and may find other approaches helpful, for example, “Listening to a PWP doing guided self-help on the telephone makes me cringe all the time because they’re so bossy. But for some people it really works”. Source: Nona

Several of our participants raised the issue of using MI inappropriately when people were ready for action but in general, they believed it appropriate to integrate it with CBT. For example one of the expert researchers saw it this way “From my perspective MI, particularly incorporating MI in the beginning of therapy is, I can’t think of any problem or any form of CBT that ought not to include it, …so MI ought to be universally integrated.” Source Kaito.

And finally, an expert therapist summarised the benefits of integrating MI with CBT it this way, “I think that MI should be integrated with all CBT, with all clients that you work with”. Source: Latif. Both sets of participants overwhelming thought it beneficial to integrate MI with CBT in general because it seemed to be improving efficacy in their CBT work. I have summarised hear their theories about why this might be the case, in what circumstances and for whom. I did ask participants why they thought this had not been adopted more widely in mental health services. Unfortunately for reasons of time and space I have not included these findings, choosing to focus more on data directly relevant to my research questions.

5.4.3 MI Theory and Theory development.

I have described in previous sections theoretical contributions and attempts to develop theory in Motivational Intervening. When asked specifically about their views on the role of theories of why MI works a number of statements were made. The views from both samples are presented here on the basis that they are adding to what has already been presented and explored in the findings so far. The expert academic and expert therapist views are considered and contrasted separately in this section.

5.4.4 Expert Researchers views

Clearly MI has drawn on a wide range of psychological theory and could be described as theoretically rich. The need to have or to develop theory about why MI works was explored in both groups. In the academic expert group there was consensus around the need for theory, although one participant described their view of theory in this way, “I’m not a theory person a more practical person and I don’t think we need new theories I think I think there’s plenty you know”. Source: Akiko

This view was reinforced and also questioned the assertion that MI is atheoeretical, by Katsuko,

“I think it's essential that we have theories about human behaviours because I'm a psychologist, so I don’t agree that motivational interviewing is atheoretical, because it's about motivation and we have theories about motivation and how that impacts on behaviours and how it impacts on how we think about change. So I don't think it's atheoretical at all.”

Existing psychological theory about MI efficacy and its influence has been referred to throughout this project, the need for different types of theory was summarised by another expert researcher,

…“yeah, from my perspective there is always theory behind what we’re doing, it’s either that that theory is well-articulated, well-developed and explicit or it is

not well-articulated, under-developed and left implicit, but I think the idea that we can ever be atheoretical is wrong, it's just absurd. "Source: Kaito

The nature, definition and standing of existing MI theory was questioned by several participants, for example:

"I'll just say straight out if I'm going to do a same with this you've got a theory of so you know you got change talk and you've got MI consistent strategies which leads to change talk which lead to outcome. Is that a theory? People present that as at theory". Source : Akiko

Similarly, the theory based on the relational vs technical hypothesis (Miller & Rose, 2009) was questioned by a number of participants, for example:

"The idea that there's a relational thing you do and then you can add on or not the technical thing doesn't really make sense to me, I don't think it's a good account of what we're doing, although it felt to me like maybe a step, a necessary step, a first halting step towards trying to articulate theory, but I think it's just that." Source: Kaito

Further, that different types theories should not be prioritised over others and in noting the recent trend in MI research for neuroimaging studies Kaito went on to say this,

…"some of the other things, the neuroimaging study, those I find fascinating in one way. I don't think that what goes on at the level of neurochemistry is more real than what goes on at the level of experience and so the idea, the reductionist frame of trying to really explain what's happening by talking about which parts of the brain are active and when, is an error, yeah, it's an error of thinking to do that. I think a theory like evolutionary psychology and finding some social dominance, from my perspective that's an interesting lens to look through and to be able to say oh so some of what we already know is happening in MI might be explainable that way. But I think there are other lenses that also shed at least as much light and I certainly wouldn't want to privilege that one."

Reflecting on this highly technical form of research that is trying to understand what is going on at neurological level in individuals, I wonder whether research that directly asks people about their experiences of an intervention might yield more accessible and real-world insights. One researcher saw the role of theory as facilitating better training for therapists by focusing on those elements that are theorised to improve client outcomes, for example: “So I think you need a theory about what the relevant bits are to bring about a change for somebody so that you can make sure that therapists are implementing the right bit’’. Source: Riku.

5.4.5 Expert therapists views

Had similar views on theory but seemed they seemed more interested in how that theory translated into practice, one participant talked the how they saw the importance of MI theory,

“I don’t think it’s that important. I think it would be interesting to know, because maybe then we can enhance those things, or integrate them more easily into current practice. But for me personally I know that MI works. That’s kind of enough for me.” Source: Lita

Also, that theories may need adaptation in practice for differing contexts. In terms of the Miller and Rose’s (2009) relational vs technical hypothesis, Razak had this to say,

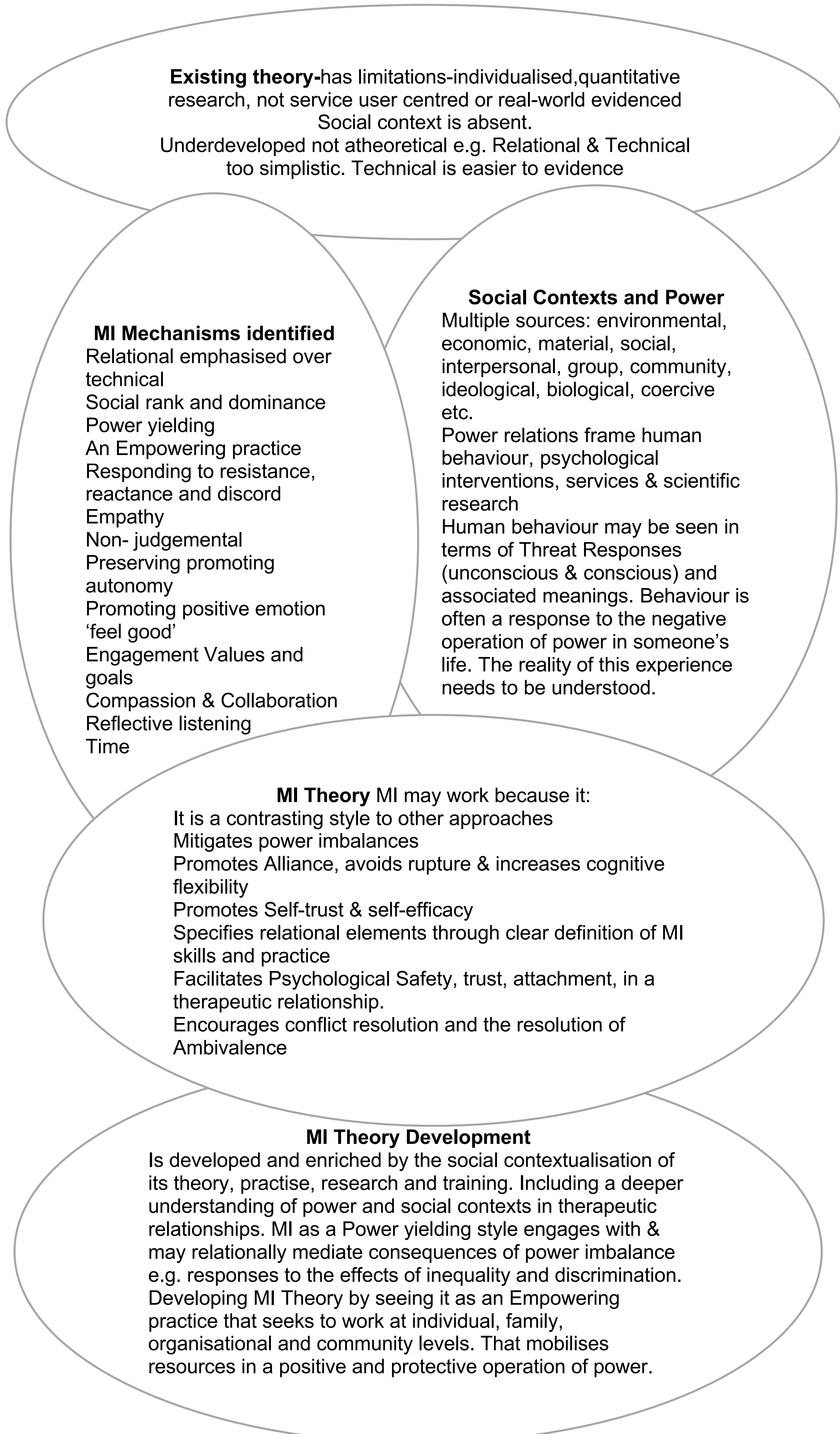
“So I suspect that the theories are going to have to be different for the contexts. And in my context, it would be helpful to know whether I should place my emphasis on technique or relationship because that is often a decision that I’m making in session.”

From a practise point view this participant would find theory based findings practically helpful. In terms of areas for further theoretical research expert therapist Moeen thought, “so like there are elements of CFT and social rank theory and all those kinds of social things that activate threat. I could see that being really fruitful looking at that.”

5.4.6 Discussion

I was encouraged through some feedback given following my Viva Voce exam to define more clearly the following aspects of my research project in a separate discussion section. This section will now focus on summarising reflections on MI mechanisms and theory from a critical realist viewpoint. It will include a conceptual summary diagram and considers how these findings fit with existing research, how they challenge it and what they add. The limitations of the study and some implications for future research are described. I include the conceptual diagram here in Figure 5.3 below based on the study findings and its theoretically informed analysis. It provides a summary of findings on MI Mechanisms, theory and suggests potential developments for MI which is further discussed in more detail below.

Conceptual Summary of findings: MI Mechanisms, Social Contexts, MI Theory and its development Figure 5.3



5.4.7 MI mechanisms and theory within a critical realist framework.

The findings presented here from our participants represent a unique set of views on MI mechanisms and MI theory based on the experiences of expert researchers and expert therapists. The participants in this study have theorised or hypothesised what they see as causal mechanisms in MI practice, and these have been presented above. From a critical realist point of view no theory is to be seen as the sole explanation and critical realism aims to avoid reductionism. Whether that is, it's all about the relationship or it's all about social context or it's all socially constructed or scientific progress can only happen through experimental method and the measurement of social phenomena. Fundamentally, it seeks to contextualise knowledge, focuses on ontology, how we see what constitutes reality and how we understand human existence. That includes our assumptions about how the world exists made up and the nature of things. A good critical realist theory should help us to organise the information available to us and offer explanations within the context of the real world. How this project fits with existing MI theory, whether it challenges it, what it might be adding to that theory will now be summarised.

5.4.8 How do these findings fit with existing research?

The relational vs technical hypothesis has remained a central concept for MI research ever since its introduction by Miller and Rose (2009) in their article 'Toward a Theory of Motivational interviewing'. Essentially the relational style and a more technical reinforcement of client speech about change, where hypothesised to be promoting behaviour change. It has been referred to by our participants, with their emphasis being on relational mechanisms and the spirit of MI, particularly compassion and collaboration. Miller and Rollnick have not sought to develop MI theory in their texts, but in the article 'MI and Social Dominance' (Miller, 2018) made explicit links with de Almieda de Neto's (2017) Evolutionary perspective. It was hypothesised that mechanisms relating to power yielding in MI relationships were at play, are adaptive in social interactions from an evolutionary perspective and this is supported here. As is MI's emphasis on warmth, acceptance and a non-judgmental style as being important in creating psychological safety. Core MI concepts around the promotion and

preservation of Autonomy are highlighted too and support existing MI practise and theory. As does therapist optimism and affirmation as 'feel good' mechanisms, something already hypothesised in MI theory (Ingersoll & Wagner, 2010) and non-MI research e.g. the Broaden and Build theory of positive emotion (Fredrickson,2004). Support for Humanistic theory and the Rogerian core conditions for change have been seen as important too, including seeing MI as an egalitarian philosophy within a humanistic paradigm. The identification of an individual's values and goals are seen as important by our participants particularly the expert therapists, as a mechanism that may be freeing up cognitive change in individuals. Finally, MI's emphasis on specifying, measuring and teaching both MI relational elements as well as its technical elements was also supported and was seen as a key mechanism and one not evident in CBT.

5.4.9 How do they challenge it?

The relational vs technical hypothesis was not accepted as a theory by most participants preferring to see it as a first step toward one and perhaps being too simplistic. MI tended to be seen as a whole and as a complex relationship, not a set of discrete mechanisms. The focus on the language of change and its measurement in relation to MICO skills was not emphasised by our group of participants. It was generally not accepted that MI is atheoerical because it draws on a wide range of psychological theories and concepts. With some participants suggesting there was enough theory already and others that further theory development is necessary. A focus on the psychological concept of resistance as a key mechanism was emphasised by all participants. They saw it as useful construct in practice and highlighted the MI style and specific techniques for responding to resistance or discord. The findings also challenged MI's narrow emphasis on the individual context and provided numerous examples of how the wider social context needed to be taken into account in its theory and in practice.

5.5.0 What do they add?

As a qualitative project these findings are adding in unique insights from experienced researchers and therapists from the MI, CBT and integration field. It is also a critical realist informed analysis of MI and as far as I am aware the first in MI and mental health. The findings represent the reality of the researching of and putting research into practice integrated MICBT. The views of expert academics and expert therapists of this integration offers a layer of analysis on MI theory not previously explored. It expands the theoretical horizon beyond what has so far been an individually focused and largely positivist endeavour. The findings have illustrated the effects of social contexts on research practice, on therapy provision and on the individual. They have revealed a need to incorporate an understanding of social contexts into MI therapeutic relationships, theory and research. MI theory, its scientific investigations and practice have been found to be situated in wider social, political and cultural contexts, although this is something it has resisted.

The centrality of power and power structures is not something contained within MI Theory or its texts and these findings suggest that this may be a useful addition. Incorporating definitions of power and the effects of social contexts, into theory can develop our understanding of how therapists should work with individuals. For example, in terms of understanding threat responses and reactance in the context of an imbalance in social rank, authority, culture and power relations. Power can operate both negatively and positively in the lives of individuals groups and societies. The ongoing cycles of intergenerational risks has been identified in the Power Threat Meaning Framework (Johnstone & Boyle, 2018) and may be a useful theoretical lens and addition to MI theory. MI theory as we have seen has an emphasis on promoting self-efficacy and identifying strengths and resources within individuals. It might also be helpful for MI to look at how power operates positively and protectively. For example, through friends, partners, family, communities, material resources, social capital, positive identities, education and in access to knowledge.

Relatedly our participants also identified empowerment and empowerment theory as something that could be incorporated into MI theory and practice. MI could be seen as an empowering approach that looks outside of the consulting room or clinic into people relationships, families, local neighbourhoods and societies. Alternatively, it could be seen as an intervention that individualises and obscures social problems and in doing so meets the need of a neoliberal economy. Incorporating empowerment into MI theory and practice might have the effect of distancing MI from a philosophy of marketisation and individual responsibility. Perhaps in the same way that compassion distanced MI from sales and marketing. From both from a relational and evolutionary standpoint these findings restate and develop the importance of understanding and responding to resistance or discord in a context specific way.

The contributions highlighted here from evolutionary theory including, polyvagal theory (Dana, 2018) and the insights from CFT (Gilbert, 2009) and SDT (Markland, 2005) are also explanatory in terms of why MI might work, particularly in terms of psychological safety. Stressing psychological safety as a mechanism is thought to be freeing up clients cognitively by helping them to manage their activated threat systems and in reducing threat. Attachment Theory (Purnell, 2004) is also something not considered in MI. In the views of our participants its addition to MI theory may offer explanation around how safety is established in therapeutic relationships. Also, the importance of a Working or Therapeutic Alliance is generally accepted in MI and has not been researched widely, but it is emphasised by our participants.

Within a more contextualised MI theory, these findings suggest that there is a need to consider behaviour change interventions at family, group, community and societal level. At the theoretical level several levels of explanation have been offered here and all of those presented and all are valid. In my view social context has emerged here as an important addition to MI theory for a number of reasons. Firstly, that it has not previously been prioritised. Secondly, that it reflects my own bias and is also one major element of critical realist analysis that has structured the investigation. Finally, I chose critical realism as a

research philosophy because it fitted with my existing views of human existence and how the world works. Acknowledging researcher bias in terms of their views of ontology, epistemology and methodology may also be a useful addition to MI research and theory.

5.5.1 Limitations of the study

Only professional stakeholders and not clients where interviewed and is a serious limitation. Finding a way to directly ask clients about their experiences of therapy, in clinical trials and in real world settings, is difficult but essential. A large amount of data has been collected here and may have benefited from further analysis, if time had allowed. As a new qualitative researcher this has been a challenging learning process and has involved the synthesis of a several knowledge bases. This knowledge like all knowledge is situated in a particular social context, our samples are highly educated, overwhelmingly white women and men from a relatively privileged professional class. They are based in prestigious Western Universities and in the UK national Health service.

5.5.2 Implications for Future research

In my view, a number of areas for future research stand out from both our participants views and the literature reviewed, they are:
More qualitative and theoretically driven work and more effectiveness research carried out in *real life* services.
Also, the direct involvement of service users and consideration of their views and experiences.
Future research should attend to the effects of social inequalities and social contexts in mental and physical health and how that impacts on outcomes.
Also, consideration could be given to interdisciplinary working for example, with health behaviour psychology, public health practitioners, social psychology and sociology.
The centrality of concepts and realities relating to power and power structures could be integrated into MI theory and research as could empowerment. Developing the idea of MI as an empowering approach that promotes autonomy

at the individual, community and societal level. Given that it is suggested here, that MI promotes or facilitates Alliance.
Further studies could include measures of the working or therapeutic alliance in MI process research.
One practitioner suggested that more research on identifying the role of higher values and goals in relation to change talk would be helpful.

Finally, consideration could be given to exploring the underdeveloped conflict resolution hypothesis and how combining that with the relational and technical hypothesis may represent a more comprehensive individualised MI theory.

CHAPTER 6. CONCLUSIONS

The aim of this research was to examine and develop MI theory based on the experiences of expert researchers and expert therapists in the integration of MI with CBT. It has fulfilled that aim and has some ways gone beyond it, as the project developed. I acknowledge the contribution of both groups of participants in this process who provide their insights and a vibrant sounding board for theory development.

6.1 Original Contribution to knowledge

This study is the first to address MI theory from both the perspective of clinical trials researchers and psychological therapists in *real world* settings. It has reviewed MI theory, utilising the views of expert researchers and expert therapists who have had experience of integrating MI and CBT, at a high level of competence. It has provided support for and has challenged existing MI theory. It has made suggestions about what might be added to MI theory, to its research, training and to practice. The importance of contextualising knowledge in terms of social contexts and the centrality of power and power structures relating to MI theory has been emphasised. Overwhelmingly the participants in both groups identified mechanisms and theory that related to elements of effective relationships and issues of power in relationships; rather than the technical skills of therapists. For example, working alliance, psychological safety, affirmation, and responding to resistance or discord, where emphasised as most important. This relational style is hypothesised to promote self-efficacy and self-trust, identify strengths and resources within individuals, enabling a sense of self agency.

This relational practice is based on core skills, attitudes and values that are contained within the philosophy of MI, they can be and are taught in MI training. Our participants believed this to be something valuable that MI could contribute to CBT practice and training.

6.2 What are the implications of this research?

We have seen varying opinions of the value of MI theory development, although there is a consensus on the need to put research into practice in the training of therapists. This is a small qualitative project but the insights from its participants may well have implication for training of others. For example, with the expansion of training of psychological practitioners in CBT from a range of professional backgrounds it may be useful offer them MI training in terms of developing their relational practice. They may not have backgrounds in psychological theory and are only being exposed to the technical elements of the CBT modality they train in. MI is well placed to do this because it specifies the relational elements of therapy, which is missing from CBT. What Arkowitz (2012) has described as MI "returning humanism to CBT" and Miller (2019) on MI and leadership says. "it helps to humanise environments".

For MI itself as an approach that emphasise power sharing or power yielding perhaps it needs to look at how power operates both negatively and positively in the lives of people we work with. Currently it does not define power, nor does it contextualise MI in terms of the effects of social inequality on health and how that operates at the biological, interpersonal, community, social and economic level. Contextualising interventions in this way could facilitate an enhanced understanding in MI practise of the impact this has upon individuals and communities. The effects of deprivation, discrimination, marginalisation and trauma are real and that effects people's ability to participate in interventions and to make change. Not to take this into account allows reductionist and neoliberal accounts of behaviour change to dominate. Neophyte clinical psychologists and psychological therapists could be trained to avoid reductionist explanations and to consider the value in declaring their own approach to ontology, epistemology and methodology. Recognising that Science is not neutral and that we all bring our own values and beliefs into our research and practice is an honest step in a different direction. As I noted earlier Bill Miller, (2012,p.1) view was that … ''Living in an unjust society is bad for us all' and

that, ..."But I want to go Stanton one better with a call for a consciousness of social justice that is implied by and reaches beyond the spirit of MI''.

Developing awareness of MI's impact on relational processes is particularly important if therapists are to respond in a way that promotes change and consistently so. Therefore, it is important for therapists and researchers to become attuned to issues of power in their practice and in the development of MI theory.

6.3 A final reflection

How people respond to therapeutic interventions is sensitive to variations in context and the mechanisms underlying behaviour change are not only not always visible, not always measurable and often not studied. We cannot expect universal explanations from psychological research, as it is situated in open human systems that are in flux and unstable. All knowledge it situated in its particular context and a science that seeks to atomise and decontextualize, is obscuring its social reality. Nearly 40 years of MI research from its own particular context and culture, has yielded important insights into the understanding of human interactions and why change might happen. Although, its originators have not sought to develop a comprehensive theory of MI, this is valuable work, underpinned by psychological theory and practice. At the beginning of this project I was drawn to Einstein's analogy of theory development as being like climbing a mountain, to gain a broader view. Climbing mountains is one of my passions in my life and at times that analogy has seemed very appropriate in the completion of this thesis. I believe this project has explored existing MI theory and provided that broader view, through the lens of critical realism. This project has been about theory development but also how theory informs practice and how that practice can inform theory. Benjamin Brewster (1882) captures the nature of this relationship nicely, he wrote, "In theory, practice and theory are the same thing. In practice they are not." By maintaining a sceptical approach that avoids the safety of reductionist answers to complex questions about human behaviour, we might stay more connected to the realities of our world.

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8. APPENDICES

Appendix 1: Literature search strategy Summary

Literature searches were conducted from all eligible published studies from 1983 to the December 2019. Including PsychINFO, PubMed using Sheffield Hallam Advanced Library Search tool. The initial original focus was on the Integration of MI and CBT but as the project needed to be redesigned the main focus was on Theory and MI and also social context and mechanisms of action.
Motivational Interviewing and CBT.
Search terms used included: Motivational Interviewing and Motivational Enhancement: and Cognitive Behaviour Therapy or Mental Health or Psychiatry or Anxiety or Depression or Psychosis.

These terms were searched for in the abstracts of studies and only those relating to mental health or mental health services were included. Although substance misuse is a mental health service it was generally excluded as part of this search. Other exclusions included Physical Health related interventions.

In addition, reference lists from articles identified were checked for other potential studies and sources.

Search terms focused on Theory and theory development included:

Motivational Interviewing: and Theory or Mechanisms or Mechanisms of action or Critical Realist or Realist or context or social context.

In addition, reference lists from theory-based article were checked for other potential studies and sources.

The total number of sources identified and selected for each area were as follows:

Motivational Interviewing and CBT and Mental Health	154 items
Critical Realist or Realist and Theory	62 Items
Context and Social	138 Items
Motivational Interviewing and Theory or Mechanisms	150 Items

As a theory orientated project searches for realist and critical realist research relating specifically to MI where made although only 2 or 3 studies were identified.

Critiques of MI were identified through this process and only 3 published articles were identified.Use of experts included consultation through the MINT email list serve was made although only a few extra sources were identified in addition to literature searches. Additional resources were used as identified in this iterative process and are referenced in the document.

Appendix 2. SHUREC2B application for research ethics:

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR BIOSCIENCES /BMRC, FOOD SCIENCE AND SPORT AND EXERCISE SCIENCE (SHUREC2B)

SECTION A: Research Protocol

Important Note - If you have already written a research proposal (e.g. for a funder) that answers the methodology questions in this section please include a copy of the proposal and leave those questions blank. You **MUST** however complete **ALL** of Section B and C (risk assessment).

1. Name of principal investigator: Paul Earnshaw

Faculty: Department of Health and Well-being

Email address: [redacted]

2. Title of research: Exploring researcher and psychological therapist experiences of integrating Motivational Interviewing (MI) and Cognitive Behaviour Therapy (CBT)

3. Supervisor (if applicable)**: Professor Ann Macaskill**

Email address: [redacted]

CONVERIS Proposal Tracking number (applicable for externally funded research):

Other investigators (within or outside SHU)

Title	Name	Post	Division	Organisation

Proposed duration of project

Start date: 15.06.2017 **End Date: 15.06.2018**

7. Location of research if outside SHU: International

Main purpose of research:

X Educational qualification
☐ Publicly funded research
☐ Staff research project
☐ Other (Please supply details)

Appendix.3. Quirkos Report example.

This report was generated by Paul Earnshaw on Thu Jun 25 2020 13:43:32 GMT+0100 (BST) for the following file: home/bubbles/Documents/delete/Candidate_themes_Mechanisms.QRK.

Source Summary

Title	Author	Length	Quotes #
Sayoko mechanisms of action Summary	Paul Earnshaw	2589	10
Hinata mechanisms summary	Paul Earnshaw	6851	23
Akiko mechanisms summary	Paul Earnshaw	4643	25
Kaito mechanisms summary	Paul Earnshaw	4265	22
Riku mechanisms summary	Paul Earnshaw	3564	16
Katsuko mechanisms Summary	Paul Earnshaw	6330	35

Quirks Summary

Quirk Title	Parent	Grandparent	Description	Author	Total Codes
Responding to Resistance			Response to discord avoiding & repairing rupture	Paul Earnshaw	7
Formulation Conceptualisation			collaborative understanding of nature of difficulties shared	Paul Earnshaw	7
Belief Change Flexibilty			Increased development in cognitive processing in client	Paul Earnshaw	5
Therapist qualities			Perspectives and philosophy plus technical skill	Paul Earnshaw	9
Therapeutic Alliance			maintaining and promoting alliance in relationship	Paul Earnshaw	12
Hearing self			one’s self outloud	Paul Earnshaw	2

Preserving and promoting Autonomy			A sense of Agency feeling able	Paul Earnshaw	11
Empathy			A core therapist skill quality	Paul Earnshaw	3
Therapy process			Therapy skills specified	Paul Earnshaw	4
Context Responsiveness			Responding to and navigating rupture, not push for change	Paul Earnshaw	3
Safety			Creating a sense of safety, a safe environment	Paul Earnshaw	10
Building Skills			practice in new behavioural or cognitive processing	Paul Earnshaw	3
Importance Confidence and ability			Building confidence to practice skills & change cognitions	Paul Earnshaw	8
Techniques			Motivational and Cognitive Behavioural strategies	Paul Earnshaw	9
Exploring Ambivalence			examining my motivations for behaviour	Paul Earnshaw	6
Client Processes			Cognitive process in resolving ambivalence beliefs about change	Paul Earnshaw	12
Self Efficacy				Paul Earnshaw	4
Affirmation			Feeling good	Paul Earnshaw	2
Motivational Mechanisms			strategies or approach to consider reasons behind change motivation	Paul Earnshaw	7
Cognitive Behavioural Mechanisms			Skills Building learning and practice Collaboration	Paul Earnshaw	4
Developing Discrepancy			identifying whats important	Paul Earnshaw	3

TOTAL NUMBER OF CODES	131
TOTAL NUMBER OF QUIRKS	21

Appendix 4. Semi- Structured Interview outline

Title: Integrating Motivational Interviewing (MI) and Cognitive Behaviour Therapy (CBT): Mechanisms and Contexts - Paul Earnshaw

Draft SSI Questions (subject to further initial theory refinement)

Introduction:

Thank you for your time.

Check consent form and participant information understood. Leaflet read

This interview is interested in your views and theories on the integration of MI and CBT. Its focus is on identifying contexts and mechanisms that might underlie the client outcomes for this therapeutic intervention.

There are many types of CBT, eg. CT, CBTp, DBT, MBCBT MiCBT,ACT, etc across a range of problem behaviours, eg. substance use, mental health physical activity. It is beyond the scope of this study to consider of al of these psychosocial interventions. This study is interested in the CBTs you have integrated and implemented. Most of PSI research asks the question does this intervention work. This research is interested in how and why of MI and its integration with the CBT you are familiar with. It seeks to develop theory around the underlying contexts and mechanisms of action that produce client outcomes. You are being interviewed because of your research experience in the integration of MI and CBT in mental health contexts.

1. Personal context of therapeutic approach and research in MICBT

Q. How would you describe the core elements of your approach to therapy and research practice?

Q. Why have you chosen to work in that way

Q. How in practice have you integrated MI and CBT (e.g. prelude, combination, integration)? What determined this?

Q. How and under what circumstance do you think MI should be integrated with cognitive behaviour therapy, e.g for which clients and what problems

Q. What in your view are the main differences and similarities between MI and CBT?

Q How do you differentiate an MI intervention from a CBT intervention?

Q If CBT practitioners learn MI does that require them to suppress some of their previous practices and replace them with new ones (Hall et al 2016)

Q What has your practice and research on the integration MI and CBT told you about what is important for clients in psychosocial interventions?

2. Hypothesised Mechanisms in MI and MICBT

Within the MI and MICBT literature a number of mechanisms of action have been suggested that potentially produce or improve behaviour change outcomes (Eg. Copeland et al., 2015, Kertes, 2011, Atkinson 2017).

They might be divided into those that are observable and measurable and some that are not.
EG. Therapist and Client behaviours, MI consistent (MICO) and MI inconsistent (MIIN) behaviours, OARS, Differential reinforcement of change talk/softening of sustain talk. Giving feedback, working on a change plan etc. Change talk Strength of client commitment language. Reduced or diminished resistance,
and enhanced treatment engagement (Romano, Aviram and Westra, 2011)

Q. How do these mechanisms impact on outcomes in an integration MI and CBT?

2. Also more complex or covert mechanisms are hypothesised and these can be activated under certain circumstances or contexts. For eg.

Empathy
MI Spirit
Stage of change
Client motivation
Client self efficacy / confidence about change
Therapeutic Alliance
Autonomy support
Client perceived behavioural control
Acceptance, readiness, decision to change with a shift in a perception of self

Q. What do you suspect or hypothesise are the main underlying or perhaps hidden mechanisms of action in MI and in MICBT intervention.
Why?

Q. How do these mechanisms impact on the client in a way that produces or causes cognitive, emotional and behavioural responses toward change.

Q. Why should this be so?

Q. How does MI add to the behaviour change process when integrated with CBT
Why

Q. What are the mechanisms for change within MI that are also present in CBT.

3. Theory questions**.**

Until recently MI has been described as atheoretical in nature (Miller 1999). Apodaca and Longabaugh (2009) noted that while theories underlying MI are rich, they have yet to be integrated into a comprehensive philosophy. (Romano 2016 and Atkins 2017 Eg.s might be SDT and TTM, Self Perception Theory, Self talk theory.

Q What is your view on the need to develop theory in MI for eg. about how it works and why and for whom and in what circumstances

Miller and Rose (2009) have talked of 'An emergent theory of MI that emphasizes two specific active components: a relational component focused on empathy and the interpersonal spirit of MI, and a technical component involving the differential evocation and reinforcement of client change talk'.

MI Spirit and Empathy should be enough to trigger behaviour change (Miller and Rose 2009).
Also that exploring and resolving client's ambivalence about making a change (Miller and Rollnick 2013)

They suggest a causal pathway toward the triggering of change

These are complex interactions clearly difficult to disassemble, however

Q. How do these relational components for e.g empathy, spirit or working alliance activate change and client outcomes in MI and MICBT?

Q. How are relational aspects of the therapeutic process affected when you integrate MI with CBT

Q Both MI and CBT contribute to the development of working alliance, how do they do this? What are they both providing for the client?

Q. Why is the elicitation and reinforcement of client change talk so reliably linked to client commitment and behavior change?

Q. In recent years MI has increasingly emphasized its spirit or philosophy, why do think that is so?

Finally from biological perspective (Abiliob C de Almeida Neto, 2017) says MI provides a 'non-socially threatening environment ' that allows the human cortex to process information and engage in cognitive reasoning and decision making without strong influence from unconscious instinctual subcortical processes that ruled behavior prior to cortical evolution'

Q. What is it about MI that facilitates the provision of a safe environment in which to explore cognitive emotional and behavioural concerns?

The social context:

for example, cultural norms and values, history, home life, relationships, economic/financial conditions, such as poverty, social justice, racism, abuse bullying, poor working conditions and domestic violence , existing public policy, current status of the intervention etc.

Q. How might a person's social context affect whether the psychosocial interventions they are offered work or not.

Q. How do you take into consideration a person's social context when offering them a psychological intervention.

Q How might the social context of a psychological intervention affect

Q. What social conditions are essential or desirable for psychosocial interventions to help produce behaviour change

Q. Have you any thoughts on how to make the social context more fertile for change and what if anything does an integration of MI with CBT contribute to that.

Q. How does MI take account of the social complexity of people's lives?

In Conclusion:

Q. What are the main things that have stood out for you from the integration of MI with CBT in terms of understanding the mechanisms that underlie behaviour change.

A nugget or take home message, or even though I dont like the term epiphanies

Q What other thoughts do you have or what suggestions do you have for areas that this interview should explore. Many thanks for your time

Appendix 5. Letter to therapists:

Hi all,

I hope it is Ok to post this to the whole group or at least what I can see on my email list.

I am looking for people who are prepared to be interviewed for a qualitative research study that I am doing for a doctoral degree.

I am looking for people who have practised MI and have been rated as competent on the MITI scale and who have also practised CBT (of any kind) and been rated as competent on a recognised CBT scale e.g. CTSr.

I will send details for the study to anyone who is interested. Briefly the study is primarily interested in developing theory around why MI works and what if anything different stakeholder perspectives on the integration of MI and CBT might tell us about this.

I will arrange interviews to suit your busy working lives and the interviews themselves will be anonymised and destroyed following analysis.

I am looking to do this as soon as possible as I am coming to the end of my data collection period a need only a few volunteers.

Best wishes to you all

Paul Earnshaw

Appendix 6. Letter to Academic experts

Sheffield
Hallam
University

Dear colleague,

I am currently conducting a Doctoral study entitled:
Integrating Motivational Interviewing (MI) and Cognitive Behaviour Therapy (CBT): Mechanisms and Contexts.
Aim:
The primary aim of this research is to explore and understand the perspectives of researchers and psychological therapists of the integration of CBT and Motivational Interviewing.

Objectives:

To develop and carry out in depth interviews with researchers and psychological therapists based on existing theory of why these psychosocial interventions might be effective.

To analyse the content of these interviews and develop theory around the underlying mechanisms and social contexts of this therapeutic integration

I am writing to you as someone with recognised expertise within the academy of conducting research trials in this area. I would like to interview you on this topic to develop and explore these initial theoretical positions on the mechanisms underlying these psychosocial interventions.
You are being approached for phase 1. I attach a participant information leaflet and consent form.
If you would like to be involved in this research please email me at this address:
[redacted] or contact me by phone on [redacted]
Many thanks

Paul Earnshaw (Principal Investigator)

Appendix 7. Participants Information sheet

Participant Information Sheet

Title of research: Integrating Motivational Interviewing (MI) and Cognitive Behaviour Therapy (CBT): Mechanisms and Contexts

Chief Investigator: Paul Earnshaw

We are asking you to take part in a study of researcher and therapist experiences of the integration of Cognitive Behaviour Therapy (CBT) and Motivational Interviewing (MI). Please read the following information about this study carefully, feel free to ask me any questions you like and take the time to decide whether or not this is for you.

Why are we doing this study?

Numerous randomized controlled trials have shown that both CBT and MI are seen as effective psychosocial interventions across a range of problems. It has been argued that while this is valuable work, it tells us little about how these interventions work or why they work and in what circumstances, (Leighton, 2013, Birchwood and Trower (2006) and Goldsmith et al. (2015).

This qualitative study will use a critical realist informed framework. This stresses the need to understand mechanisms and contexts in order to explain the outcomes in psychosocial interventions. Psychosocial interventions such as MI and CBT maybe seen as programme theories, that consist of interconnected elements. These can be configured in terms of Contexts, Mechanisms, and Outcomes or CMO configurations. This research is interested in developing theory based on the existing literature and the perspectives of expert researchers, psychological therapists and service users.

Who can take part in this study?

Initially expert researchers who have led research studies involving the integration of MI and CBT will be identified and approached for inclusion in the study. These experts will be further divided into those coming from the MI academy and the CBT academy.

Secondly, psychological therapists who have experience of the delivering these two psychosocial interventions as an integrated therapy will be identified. Ideally these practitioners will be trained in CBT to postgraduate level or above. They will also be eligible for accreditation or be accredited, for example by the (British Association of Behavioural and Cognitive Psychotherapies (BABCP) or a similar body. They will also have been trained in MI and will have been assessed as reaching competency on for example the MITI (Motivational Interviewing Treatment Integrity) scale.

Do I have to take part?

No, you do not have to take part in the study if you do not want to. Taking part in research is entirely voluntary; this means it is completely up to you to decide whether or not to join the study. If you decide to take part and sign the consent form but change your mind later, you are free to withdraw at any time during the study without giving a reason.

What will taking part involve?

If you are interested in taking part then we will arrange a suitable time, date and location to meet with you. We will interview you using a semi-structured questionnaire, to engage in a discussion with you about your views and experiences of the integration of CBT and MI. The interview is designed to promote a discussion and you do not have to comment on anything you would prefer not discuss. The discussion will be audio recorded with your permission. We will then write this up in order to study all of the views provided by those people taking part. Everything that you say will be anonymised.

There are no right or wrong answers we are simply interested in your views, if you choose to participate in this study.

How long does it take?

The interview will take no longer than 1 hour to complete.

What are the possible benefits of taking part?

There are no direct benefits for those taking part in the study. However participants will be contributing to the development of psychological theory and in the understanding of the mechanisms and contexts of action in psychosocial interventions. Based on this understanding tentative recommendations may be made for practice, training and further research.

What are the possible disadvantages and risks of taking part?

None are envisaged. It is acknowledged that finding time from busy academic and clinical routines may be inconvenient and we thank you in advance for your time. It is intended that plenty of notice will be given to participants and the interview time will be limited to a maximum of 1 hour. The participant will determine the location of the interview.

Will my taking part in the study be kept confidential?

Yes, all information we collect from you will be kept confidential. Any data collected from you will be stored via encrypted software and this data will be securely stored in line with Sheffield Hallam's research governance protocols. All audio recordings will be transcribed and securely stored. The originals will be destroyed once we have completed our analysis of the information. All other records will be destroyed 5 years after the end of the study in line with Sheffield Hallam University's and the NHS standard research procedures. Individuals from the University, regulatory authorities or NHS Trust may need to access the data collected to make sure that the study is being carried out properly. All individuals will be authorised representatives from each organisation and will have a duty of confidentiality to all research participants.

What will happen if I do not want to carry on with the study?

You can withdraw from the study completely at any time without giving a reason. No further data will be collected from the moment you withdraw.

What if I have a problem with the study?

If you have a concern about any aspect of this study, you should speak to the researcher or his supervisor who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact: Helen Williamson, Senior officer: information governance Sheffield Hallam University, University Secretariat, City Campus, Sheffield, S11WB.

In the event that something does go wrong and you are harmed during the research you may have grounds for a legal action for compensation against Sheffield Hallam University, but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

What will happen to the results of the research study?

It is hoped the results of the study will be published in professional journals and presented at professional meetings, meetings of service users and carers. We will also email or send a written brief summary of our results to all individuals that complete the study who would like us to do so. If at any stage you would like to talk with us about the study please do contact us.

Who is organising the research?

The research is being organised and conducted by Paul Earnshaw who works as a Senior Psychological Therapist at GMMH NHS foundation trust. He is also a part-time doctoral research student at Sheffield Hallam University. His academic supervisor for the project is Professor Ann Macaskill (Sheffield Hallam University)..

Who has reviewed the study?

This Research Project and Supervisory team has been approved by the Sheffield Hallam Research Degrees sub-committee, via the DPS1 process. The project has been approved by the Sheffield Hallam research ethics committee.

Further information

If you have any questions or require any additional information feel free to contact Paul Earnshaw at:

Or

Professor Ann Macaskill,

Appendix 8. Participant Consent Form

PARTICIPANT CONSENT FORM

Title of research: Integrating Motivational Interviewing (MI) and Cognitive Behaviour Therapy (CBT): Mechanisms and Contexts

Please answer the following questions by ticking the response that applies

		YES	NO
1.	I have read the Information Sheet for this study and have had details of the study explained to me.	☐	☐
2.	My questions about the study have been answered to my satisfaction and I understand that I may ask further questions at any point.	☐	☐
3.	I understand that I am free to withdraw from the study at any time, without giving a reason for my withdrawal or to decline to answer any particular questions in the study without any consequences to my future treatment by the researcher.	☐	☐
4.	I agree to provide information to the researchers under the conditions of confidentiality set out in the Information Sheet.	☐	☐
5.	I wish to participate in the study under the conditions set out in the Information Sheet.	☐	☐
6.	I consent to the information collected for the purposes of this research study, once anonymised (so that I cannot be identified), to be used for any other research purposes.	☐	☐

Participant's Signature: ____**Date:** ___________

Participant's Name (Printed): ____

Contact details:

____

____

Researcher's Name (Printed): _____________________________________

Researcher's Signature: ____

Researcher's contact details:

Please keep your copy of the consent form and the information sheet together.

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