THERAPIST DISCOURSE IN MANUALISED THERAPY FOR ALCOHOL ADDICTIONS

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Submitted in accordance with the requirements for the degree of
Doctor of Clinical Psychology (D. Clin. Psychol.)
The University of Leeds
Academic Unit of Psychiatry and Behavioural Sciences
School of Medicine

February 2014

The candidate confirms that the work submitted is his/her own and that appropriate credit has been given where reference has been made to the work of others

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Acknowledgements

Firstly, I would like to thank my supervisors Dr Carol Martin and Dr Shona Hunter for their wise words, support and encouragement throughout my research. I don't know what I would have done without them.

I would like to thank Gillian and Duncan for giving me access to the data, and all the research team at the Addiction Unit for their good humoured help with getting to grips with the pragmatics of the data.

I am also extremely grateful to all the therapists and clients who took part in the UKATT trial, which enabled this research to be possible.

Finally, I would like to thank my family and friends especially Paul, Matt, Judy, Phil, and Ellen, for their kind words and even kinder actions which have kept me going when I otherwise would not have been able to.

Abstract

In the context of the rising agenda of evidence based practice, the use of treatment manuals is now common in psychotherapeutic treatments for addiction and other mental health issues. There is debate amongst clinicians and researchers regarding the trade-off between the costs and benefits of manuals; and differing opinions regarding the importance of treatment fidelity. One concern that clinicians often raise is the effect that manuals have on clinical judgement and responsivity, and one benefit that researchers raise is the standardisation of treatment. The purpose of this study was to consider how therapists enact the delivery of manualised through analysing the discourses used. Particular attention was given to how therapists attempted to facilitate behaviour change using both adherent and non-adherent techniques, and how therapists addressed the expression of client emotions.

Two types of manualised alcohol addiction therapy sessions were investigated in this study; Motivational Enhancement Therapy, and Social Behaviour and Network Therapy, both taken from the large scale UK Alcohol Treatment Trial (UKATT research team, 2005). A discursive psychology informed analysis was conducted, spanning nineteen therapy sessions with six therapist-client dyads. The interpretative repertoires that therapists used to promote behaviour change were: therapist actions are responsible for enabling change, clients are responsible for changing their own behaviour, and therapeutic alliance is required for change. These were enacted through the following discursive practices: being paternalistic, being critical, persuading, lecturing, using humour, being collaborative, acting as benevolent expert and constructing oneself as a powerful expert. Therapists managed adherence to the manuals and responsivity to the clients in differing ways; at times prioritising one over the other, at other times attending to both, and at other times attending to neither. Therapists responded to clients' expression of emotions in a variety of ways categorised under two themes of acknowledging and avoiding.

The analysis highlighted the variability of therapist responses within both manualised therapies, which is discussed in further detail. The clinical implications, opportunities for further research, and limitations of the study are discussed.

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Abbreviations

RCT: Randomised Controlled Trial

CBT: Cognitive Behavioural Therapy

IPT: Interpersonal Psychotherapy

MI: Motivational Interviewing

MET: Motivational Enhancement Therapy

SBNT: Social Behaviour and Network Therapy

DA: Discourse Analysis

FDA: Foucaldian Discourse Analysis

DP: Discursive Psychology

IR: Interpretative Repertoire

Chapter 1. Introduction

Given that manualised therapy is common in many fields, including substance dependency treatment, there is a growing amount of research and debate regarding its usefulness. To date, little research has taken place investigating *how* manualised treatment is delivered by therapists. This research study aims to investigate the discourses used by therapists during manualised therapy with clients with alcohol addiction; specifically this study attempts to discover what discourse therapists use when delivering manualised treatments in alcohol addiction to add a new dimension to the debate of manualised treatment application and its effectiveness. This study adds to the research literature regarding manualised therapy by investigating how discursive practices are used by therapists in sessions whilst using a manualised treatment protocol.

The introduction begins with personal reflections, followed by a summary of the focus of this research study. The existing literature, in areas associated with this study, is then explored in order to place the aims and conclusions of this study in a clinical context. Firstly, a discussion of the construction of psychotherapy is explored with a focus on the discourses that are drawn upon by therapists. This is followed by an outline of evidence based treatments and manualised treatment including factors which influence the delivery of therapy, how these factors inform the use of manualised therapy and the debate regarding the use of flexibility when delivering manualised therapy. The influence of therapist factors and the research context in which they are investigated are then discussed. These areas are all further discussed both in the context of general psychotherapy and more specifically within the field of substance misuse treatment.

1.1 Personal experiences and expectations

I was motivated to conduct this study both as a researcher and an interested clinician, having worked with a variety of treatment manuals throughout my clinical practice. I was first interested in the topic of manualised therapies as a drugs worker facilitating Cognitive Behavioural Therapy (CBT) and Motivational Interviewing (MI) based manualised group treatments. Through both reflection on my own experience and my own fallible observations of my colleagues' use of treatment manuals, I developed opinions and interests in their use and effectiveness. I observed painstaking adherence to the manual alongside unresponsive therapeutic delivery which clients found hard to engage with, major drift from the manual which was responsive to the needs of the client producing a seemingly useful intervention, and most combinations

in between these extremes. The flexibility that I sometimes employed when delivering interventions seemed to depend on many factors including my professional training background, the client I was working with, those I had worked with in the past, my personal identity, how competent or anxious I felt or perceived myself to be, and the way I was feeling on any particular day. When delivering therapy I aspire to provide the best treatment for any client, whether that involves maintaining treatment or manual fidelity or not (e.g., developing a more idiosyncratic style or approach that suits the needs of a client). Nonetheless, with my understanding of research in conjunction with my appreciation for service provision and funding, I experience an inner conflict in wishing to maintain treatment fidelity and manual adherence so to appraise the value of an intervention.

These experiences have led me to be interested in how therapists deliver manualised therapy, which has led me to conduct this piece of research.

1.2 Focus of this research study

This study aims to investigate, using discourse analytic techniques, how therapists negotiate the use of treatment manuals through their use of discourse. This is achieved through analysis of manualised alcohol addiction therapy sessions. These sessions are taken from the extant data offered for secondary analysis by the primary researcher of the original research trial. A brief summary of the original study from which the data for this study was taken is given below.

In 2005, the largest UK based alcohol treatment clinical trial was published by the UKATT research team (2005). The study included 742 clients and 49 therapists, and compared the efficacy and cost effectiveness of two therapies: Motivational Enhancement Therapy (MET) and Social Network Behaviour Therapy (SNBT). In the UKATT trial, MET was operationalized as a brief therapy consisting of three 50 minute sessions conducted in week 1, 2 and 8, and SNBT, as a more intensive therapy, consisting of eight 50 minute sessions running over 8 weeks (UKATT Research Group, 2001). Findings indicated that the two therapies produced comparable outcomes. In order to monitor, evaluate and standardise the therapies delivered, all therapy sessions were video recorded with a random selection being monitored for treatment adherence by a senior clinician using the UKATT Process Rating Scale (PRS) (Tober, Clyne, Finnegan, Farrin, & Russell in collaboration with the UKATT Research Team (2008). This research study is a secondary analysis of this data produced by the UKATT Research Group (2005). Both MET and SBNT are looked at in the analysis for this current research study. Fundamental features of each treatment are outlined later in this chapter, with the evidence base demonstrating their efficacy. An explanation of

the rationale for using this data for the current research study is then explored further in the method chapter.

1.3 Understanding of Psychotherapy and discourses used in this context

This section outlines the literature regarding the construction of psychotherapy in order to demonstrate the need for analysing therapist discourse within this setting. Previous studies and emerging discourses that are related to this setting are then discussed.

1.3.1 Construction of therapy

This section outlines some definitions of traditional psychotherapy and discusses these in relation to critical and constructionist understandings of psychotherapy. Several attempts have been made to define what psychotherapy is. Frank (1993) suggested that “treatment typically involves a personal relationship between healer and sufferer. Certain types of therapy rely primarily on the healer’s ability to mobilize healing forces in the sufferer by psychological means. These forms of treatment may be generically termed psychotherapy” (p.1). Clarke (2009) stated that “therapy is about introducing order into the chaos of human emotions and human relationships. All therapies stress orderly induction into therapy and progress through it” (p. 1). Both explanations of psychotherapy assume the therapist as an expert who can ‘help’ the client to change in a way they would not be able to do without such assistance. Both definitions indicate that the client brings some resources to the therapy, to which the therapist must “mobilise” or “bring order” into. These definitions construct the therapist as the active expert, with the power to heal the client with the connotation that the client has something done to them in order to facilitate change.

Similarly, Wampold (2001) stated that: “*Psychotherapy is a primarily interpersonal treatment that is based on psychological principles and involves a trained therapist and a client who has a mental disorder, problem, or complaint; it is intended by the therapist to be remedial for the client’s disorder, problem or complaint; and it is adapted or individualised for the particular client and his or her disorder, problem, or complaint” (p.3)*. This definition stipulates that the therapist is “trained” and that the direction of the course of therapy is the therapist’s rather than the client’s. Furthermore, the therapist makes active decisions regarding how to tailor the therapy to the client. Therefore this definition displays an inherent power imbalance between the therapist as active agent, and client as passive receiver. Parker (1999) noted that psychotherapy positions people into those who help, and those who are to be helped. Parker expanded upon this with suggestions that even if the notion of helping is rejected and replaced with one of empowerment, this still assumes the person who is

empowering the other (i.e., therapist) resides at a higher level than then person who is to be empowered(i.e., client). Kaye (1999) also noted how the therapist is constructed as the active expert by purporting that psychotherapeutic activities involve the discussion of the client's story within the therapist's frame of reference, and attempts by the therapist to promote the reinterpretation of the client's story within this frame of reference in order to develop new behaviours which are synonymous with this. Kaye (1999) conceptualised two distinct frames that therapists draw upon. The first is the "receptive helper" (p. 22) whereby the therapist begins a journey of discovery with a client using empathy to engage with the client's narrative. The second is "re-visioning" (p. 24) whereby the therapist uses their expertise to search for a solution for the client's presenting problem. Kaye (1999) notes that either of these frames can be problematic when used in isolation, though when they are used in combination they can encourage the client to attend to their story in a different conceptualisation that moves them forward.

Not only is psychotherapy a construction, so too is the role of the therapist. As noted above, the therapist is often constructed as the helper in contrast to the client who is the 'helpee' (Parker, 1999). This construction can inform the actions of therapists and thus perpetuate the construction that is largely accepted. For example, McNamee (2006) explained that trainee therapists talk in ways that they feel a therapist should talk, and abandon many of the skilled ways of talking that are natural to themselves as people (e.g., as they would to a friend with a problem or difficulty).

Kaye (1996) reported that traditional psychotherapy shows the therapist as having the expertise to formulate a true version of a problem and implement prescribed activities to correct this. Within this approach, the therapist engages in discussion regarding the client's story and behaviour in order to assess and implement change rather than to collaboratively discover a solution together. This is akin to the medical model of mental illness (Laing, 1971) whereby a client's history is taken to inform a diagnosis, which then informs subsequent treatment and intervention. It is noted that newer constructionist approaches to therapy (e.g., Narrative Therapy: White & Epston, 1990) have moved away from assuming the therapist has privileged knowledge about how to produce change.

It has been posited that there is no such thing as psychotherapy as a single entity that can be defined. Therefore any generalisations made about psychotherapy should be approached and viewed with caution (Smail, 1987; Riikonen & Vataja, 1999). These authors suggest that a common factor of psychotherapy is the use of empathy, which is lacking in other areas of society where it should manifest. Smail (1987) noted that by using jargon, psychotherapy is constructed as a unique entity that sounds

efficacious, resulting in therapists being assumed to possess magical powers in addition to expert knowledge. Smail (1987) suggested that psychotherapy is often constructed as promoting change in individual clients who present issues. However, as individual problems are developed in the outside world through experiencing problems within society, psychotherapy serves to promote stigma and blame for those who access it.

1.3.2 Discourses used in Therapy

White (1992) stated that it is necessary to "exoticize the domestic" (p.27) by taking a closer look at what is otherwise taken for granted. In doing so a greater understanding can be gained concerning what the process of therapy constructs and how therapy is constructed. This section addresses some of the discourses that are used in therapy, first in relation to promoting change, and then in relation to negotiating emotions.

Therapist discourses promoting change

This section introduces extant research regarding some of the therapist discourses which can occur in psychotherapy. The introduction of these discourses informs the discursive framing from within which this research study is conducted.

The medical model is prominent in most areas of modern medicine, including psychiatry. The dominant psychiatric medical discourse focuses on diagnosing a person's difficulties by their symptoms, and prescribing a treatment which fits the diagnosis which has been given. Johnstone (2011) is critical of this model noting that it constructs "people with problems" as "patients with illnesses," (p.27) removing their personal agency and locating problems within individuals and increasing stigma. Foucault, who focussed on the construction and use of power through discourse, posited in 'The Birth of The Clinic – and Archaeology of Medical Perception' (1963, trans. 1973) the dehumanisation of individuals through the 'medical gaze.' This essentially involves seeing a person's illness (including mental illness and addictions, perhaps with the exception of personality disorder) as separate from their identity, and thus being treated with a curative aim. This discourse requires an external person (usually a medical doctor) to assess the symptoms and classify them, and so creates an inherent power imbalance whereby the diagnostician is the expert, and the client is a passive recipient. There is a large volume of research (e.g., Charon, 2001; Salmon & Hall, 2003) discussing the discourses used by medical doctors. Though these psychological studies use qualitative methods to investigate how doctors interact with their clients, they do not employ specific discourse analysis techniques. Mischler (1984) reported two competing discourses that were drawn upon by medical doctors

working with clients which were the "voice of medicine", which is reductive and symptom focused and the "voice of lifeworld", which is considered the clients' account of their illness which is meaningful to them in the context of their life. It was noted that the medical discourse often overpowered the lifeworld discourse, sometimes to the detriment of what may have been more useful for the client in terms of developing personal meaning and empowerment. Arguably, the lifeworld discourse is available to both the client and medical practitioner, with the client being more attuned to their own personal discourses, whereas the medical discourse is largely only accessible to those whose training permits this. Therefore, the use of the medical discourse reinforces an unequal power relationship and distribution. An example of this is reported by Abildsnes, Walseth, Flottorp and Stensland (2011) who found that when trying to encourage client change, GPs used 'scare-tactics' and attempted to challenge client explanations, despite an awareness that such tactics were ineffective.

Emanuel and Emanuel (1992) postulated, in an opinion paper, four roles that physicians take when making decisions about treatment with clients. The first was the paternalistic role, whereby they tell the client what to do. The second is the informative role, where they present the potential options and ask the client to make a choice. The third role was the interpretative role, where they collaboratively explore the client's values and then assist them in making a choice according to those values. The fourth is the deliberative role, where they explore the client's values whilst assisting them to adopt new and more useful values, and then assist them in making a choice. They note that physicians often rely on the assumption that there is a shared objective choice for what is best that they project onto the client, which allows little room for acknowledging the rationale clients may have for a particular alternative choice, which may be equally as valid. They reported an assumption by physicians that if the 'best' objective option is enforced, then the client will be content in the long run even if they do not agree at the time.

Whilst much of the literature with regards to the use of the medical model is focussed on medical doctors, including psychiatrists, Kaye (1999) posited that many concepts associated with the medical model (as discussed above) emerge in most psychotherapies with therapists who are not medically trained (e.g., psychotherapists, clinical psychologists). Kaye (1999) wrote that "most psychotherapies incorporate a theory of function and dysfunction as well as an associated set of activities whereby it is assumed that change can be induced in another by the specially trained and accredited"(p.21).

With regards to alcohol treatment, a further discourse which may emerge within therapy is based on the philosophy of Alcoholics Anonymous (AA). AA is an

international influential self-help organisation that has approximately 2 million members worldwide (Alcoholics Anonymous, 2013). The AA philosophy is derived from the 12 steps and 12 traditions and other tenets included in the AA 'Big Book' (Alcoholics Anonymous, 2001) which was first published in 1939. Along with a spiritual influence including repentance, further tenets drawn upon include a need to hit rock-bottom, admitting one is powerless over alcohol, that one's life has become unmanageable, and a strong abstinence message recanted in the phrase "one drink is too many, and a thousand is not enough". These tenets are drawn from an overall discourse that one is powerless or diseased, and cannot be in control of one's own drinking. Randall (2011) found in a mixed method study investigating US psychologists' use of discourses similar to those well known in AA philosophy with addicted clients, that 80% of the sample used such discourse in their own psychotherapy practice. Moving on from the abstinence message from AA is the view that 'harm reduction' is more useful to the client, whereby they are assisted to consider how they can drink in a way that is less damaging. Polich, Armor and Braiker (1980) found that therapist attitudes toward treatment goals affect the recovery process, reporting that therapists who reported abstinence as the goal of therapy achieved a 14% recovery rate with clients at four year follow-up compared with 46% for therapists who ascribed to a harm minimisation approach.

Another discourse that therapists draw upon is that of personal responsibility and clients having to be made aware of how bad their drinking is in order to foster change. This discourse is often drawn upon in the confrontational approach to change (e.g., DiClemente, Bellino & Neavins, 1999). A typical confrontational discourse may be more akin to something you might expect a lay person to say to a substance user (e.g., "You must stop that because it is killing you"). Despite a persuasive amount of research showing that motivational approaches are more efficacious than confrontational ones (e.g. Miller, Benefield and Tonigan, 1993; Pollak *et al.,* 2010), Polcin and colleagues (Polcin & Greenfield, 2006; Polcin, Galloway, & Greenfield, 2006) investigated the use of confrontation within Sober Living Houses in the US using the Alcohol and Drug Confrontation Scale (ADCS). They note that a confrontational approach is often used in therapeutic communities as part of the treatment programme for addictions. They found high levels of confrontation being used, and also noted that service users reported it to be supportive and helpful. They made recommendations to counsellors regarding how the confrontational approach can be used constructively. Aside from this research, the confrontational approach seems to be discussed as anecdotally useful rather than having any empirical evidence base to validate it. In fact, the confrontational approach has been shown to be less effective than MI or even harmful.

For example, confrontation can increase verbal resistance in individuals with alcohol addiction and predict poorer drinking outcomes when compared with MI (Miller, Benefield & Tonigan, 1993). However, it seems that client variables are an important factor in the influence of therapist approach. For example, Miller (1985) recommended that for individuals with greater treatment ambivalence motivation enhancing strategies should be employed over confrontation.

The confrontational approach is a more commonsense approach (albeit counterproductive at times) compared to motivation enhancing approaches such as MI. It has been shown that therapists unintentionally revert back to confrontational discourses at times of anxiety or frustration due to increased client resistance (Francis, Rollnick, McCambridge, Butler, Lane, and Hood, 2005) . If a therapist is to use more primitive or less therapeutic discourses in their deviations from the manual, it may make treatment less effective. As a therapist is likely to enter a session with a client with their own dominant and personal discourses (e.g., their personal biography and experience within clinical training), these may impact upon their approach and inform what they do or how they engage with a client at any particular time in or response to a client's behaviour, thoughts and feelings. Additionally, therapist discourses can be consciously or unconsciously biased by any number of therapeutic models that they have had previous training in. For example, a possible dominant discourse for a trained CBT therapist could be that of encouraging the client to take responsibility for their actions by challenging their 'irrational' thoughts and by evaluating the evidence for and against their beliefs.

In addition to studies investigating there is a small but growing body of research using discourse analysis to illuminate the discursive processes that occur within psychotherapy sessions (see Advi & Georgaca, 2007 for a review), which is discussed further in section 2.1.1.

Therapist management of emotions

When considering the discourses that therapists draw upon, one must consider the range of repertoires they have available to utilise as a result of their personal and professional experiences. One must also consider the immediate context in which the person is drawing upon a particular discourse. One of the research aims in this study is related to the discourses therapists use to manage difficult emotions in sessions. This is an area of study which has not been focussed on in deconstructionist terms, though there is a considerable evidence base that it is an important aspect of psychotherapy to be understood in order to inform best practice.

Literature directly focussing on the importance of a therapist's response to the expression of emotions in session has mostly been limited (although not exclusively) to the psychodynamic tradition. Fosha (2001) suggests that the shared experience of emotions within the therapeutic relationship is integral for change. Advocating an experiential-dynamic psychotherapy approach, she notes that this process facilitates a client's ability to tolerate and communicate troubling and aversive emotions, thus improving a client's interpersonal effectiveness. Fosha (2000) stated that "the experiential component, that is the experience of previously unbearable affect in the here and now of the patient-therapist relationship, is considered the key element of therapeutic change." (p.314). In a meta-analysis of psychodynamic psychotherapy, Diener, Hilsenroth and Weinberger (2007) reported that therapist facilitation of client affect was associated with better therapeutic outcomes. They recommended that researchers and clinicians should pay greater attention to the expression of emotion within the therapeutic relationship. Alexander and French (1946) wrote of the importance of a corrective emotional experience in therapy, whereby clients are enabled to express emotions, which have previously been troubling, within therapy in order to work through them in a constructive way. The importance of the corrective emotional experience is often referred to in the more recent literature as an integral change process (e.g. Hartman & Zimberoff, 2004; Bridges, 2006).

In her guidebook for working with emotions in therapy, Maroda (2010) stated that new therapists are often "unprepared for the reality of responding to another person's pain" (p.1). Maroda suggested that therapists should acknowledge, hold and understand their own emotions and those of the client as this is integral to the therapeutic relationship, and demonstrates humanity through promoting engagement with the difficulties clients face with others and themselves. The need to actively attend to emotions has also been discussed in systemic traditions of psychotherapy. Samaniego (2010) outlined the need for systemic therapists to attend to emotions, noting that the understanding of emotions is integral to facilitate any process of change. It is noted that attending to emotions can be challenging for therapists, and focussing on cognitions can be experienced as more comfortable. However this can inadvertently collude with a client's unconscious and conscious psychological defences against their feelings. Samaniego (2010) stated that when emotions are challenging, either for the client or the therapist, they can often be ignored which obstructs the process of change.

Karno, Beutler and Harwood (2002) compared therapeutic outcome of alcohol treatment based on either CBT or family therapy and identified that clients who experienced high emotional distress had better outcomes across both therapies if their

therapy addressed emotional experiences, with the converse shown for clients who experienced low emotional distress. However, Karno and Longabaugh (2003) reported from project MATCH data, that for clients who had high levels of depressive symptoms, a therapeutic focus on painful emotional experiences predicted poorer outcomes both at the end of treatment and at one year follow up. Whilst there is mixed evidence with regards to actively focussing on this as a vehicle for change in substance misuse treatment, it seems that it is important for therapists to attend to the emotions that clients bring to therapy sessions. With regards to the importance of attending to emotion in brief therapy for substance misuse, Baird and colleagues (2007) investigated client attendance to a second follow up brief MI session given to clients presenting at an emergency medicine department with alcohol related injuries. They identified that clients were more likely to attend the follow up session if their first psychotherapy session had focussed more upon emotional support and less on behaviour change, as reported by the therapist. There is little evidence to suggest why, in this context, attending to a client's emotions was important, though one might conclude that it is important to maintain a good therapeutic alliance by ensuring that the client feels heard and validated. The concepts of holding and containment, as previously outlined, may also help to explain why clients value their emotional experiences being validated, even if they are not active ingredients of change in predominant models of substance misuse therapy.

1.4 The use of treatment manuals in therapeutic interventions

In this section the rationale for the use of treatment manuals, the evidence base regarding their use, and debates regarding how they are used in practice are outlined.

1.4.1 Common factors in the context of the movement towards evidence based practice (EBP)

In the current political climate there is a drive to ensure that all public spending is accounted for and justified (Office for Budget Responsibility, 2011). In policy documentation, those who were referred to as patients are now labelled service users or consumers (McLaughlin, 2009). Alongside NHS reform initiated by New Labour (Department of Health, 2000) and the NHS choices initiative (NHS Choices, 2008), this has created an environment where the client is given, or seemingly given, the choice regarding which healthcare services they wish to access. It is, therefore, unsurprising that both policy makers and the general public who may be accessing services wish to be given proof that treatments are effective. The National Institute of Clinical Excellence (NICE) was established in 1999, later merging with the Health Development Agency in 2005 to form the National Institute of Clinical and Health

Excellence (although still referred to as NICE). This organisational body sets quality standards for healthcare based on treatment evidence and cost effective practice by publishing NHS treatment protocols known as NICE guidance. It is in this environment that psychotherapy research is being evaluated, using methods parallel to those used in medical research, where the randomised controlled trial (RCT) is considered the gold standard (Andrews, 1999). As it has not been possible to neatly prescribe and thus evaluate psychotherapy like medicinal dosage, efforts have been made to standardise psychological treatment and explore dose-effect relationships (e.g., Howard, Kopta, Krause & Orlinksy, 1986). This has resulted in the widespread use of treatment manuals in clinical practice (Wampold, 1997).

Kazdin (2008) emphasised the difference between evidence based treatments (EBT) and evidence based practice (EBP). EBT refers to treatments which have been shown to be effective in randomised controlled trials (Chambless & Hollon, 1998), whereas EBP refers to a process whereby clinical practice is informed by EBT alongside skilled decision making and clinical skills and experience regarding individual client care. Also, clients with complex presentations, who are typically seen in clinical practice, are often excluded from research trials in favour of those with a specific disorders or pathologies. Kazdin (2008) noted that only EBT, not EBP has been studied by researchers and so the concept of clinicians following strict guidelines based on EBT in their practice is flawed. Kazdin (2008) also reported that the aims of clinical practice and research trials differ. For example, clinical practice may focus on helping a person to cope with their symptoms, whereas the key measure in research is often the reduction or elimination of symptoms. Kazdin (2008) also noted that therapists often use their clinical judgement to adapt treatments to best meet the needs of each individual client. This is difficult to investigate using large scale quantitative research methods, which presents challenges in demonstrating that the exercise of clinical judgement is efficacious and useful in clinical practice.

Kazdin (2008) suggested that research exploring factors which contribute to therapeutic change adds interest to the issue. For example, research could demonstrate that members of a particular religious group respond less well to an EBT than others. The clinical use of this information is then interesting, as clinical judgement has to be used to decide whether that means a different treatment modality should be used, or whether flexibility and support might be given during the EBT. As RCTs do not provide information for therapists about strategies to use with clients who respond less well to EBT, it is with these clients that more clinical judgement must be used; informed by clinical experience rather than an evidence base. This is where therapist competence and flexibility is required alongside a treatment manual.

Strupp and Hadley (1979) outline 'non-specific factors', otherwise known as 'common factors' (Garfield, 1992), which occur in successful therapies regardless of treatment models. These include, a confiding relationship, a compassionate explanation of a client's distress, psycho-education regarding alternative ways to manage a problem, the arousal of hope, increasing a client's perceived mastery over their problem and their motivation to change. Scaturo (2001) noted that neither specific therapeutic techniques prescribed in treatment manuals, nor common factors are sufficient for change in themselves. These both need to be present to make the outcome of therapy successful. Similarly, Davidson and Scott (2009) noted that both the therapeutic alliance and the competent delivery of specific therapeutic techniques are necessary.

Research exploring the effectiveness of psychotherapy suggests the 'Common Factors Theory', which proposes that different theoretical and evidenced based approaches have common components which account for more therapeutic change than components that are unique to a specific treatment approach or therapeutic modality, where 30-70% of psychotherapeutic outcome is attributable to such common factors (Imel & Wampold, 2008). This in opposition to the dose-effect relationship derived from the medical model which suggests that psychotherapy is successful due to specific therapeutic ingredients (Imel & Wampold, 2008). Treatment efficacy meta-analytic studies have demonstrated no significant difference between the various common psychotherapies (e.g., Leichsenring, Salzer, Leibing, Hilsenroth, Leweke, & Rabung, 2011), resulting in what is commonly known as the 'Dodo-bird Hypothesis' named as such following Rosenzweig (1936) likening psychotherapy research to a scene from Lewis Carroll's 'Alice in Wonderland', in which several characters attempt to win a 'circular race' of which there is no beginning and no end and thus a dodo bird concludes "everybody has won and all must have prizes" (cited in Rosenzweig, 1936, p.412).

Westen (2002) indicated that therapists use more non-specific common factors when working with clients who are more complex. They note that when treatment manuals are used in research, therapists attempt to minimise common factors in order to make the treatments they are comparing as pure as possible and to avoid any overlap between treatments (Lambert & Okiishi, 1997). Westen (2002) also noted that this purification of treatment occurs even at the expense of treatment effectiveness. Chambliss (1996) posited that research studies requiring rigid adherence to manuals and minimising common factors are unhelpful in the quest for the critical components of psychological treatment. Westen (2006) concluded that this research is also less valuable for clinicians, who would rather be integrative and use relevant and useful

aspects from different therapies, however additional research as to what these useful aspects are would be more useful in the quest to promote therapeutic and successful change.

Davidson and Scott (2009) outlined non-specific factors which affect outcome and include common therapy characteristics such as; client factors, client-therapist interactions and therapist factors. In research comparing treatment modalities, the use of manualisation to standardise and control for therapist variability obscures therapist factors and therapist-client interaction, reducing the ‘noise’ of extraneous variables which may cloud outcomes. However it is this ‘noise’ that the current research study is interested in, following a growing evidence base that such common factors are an important component to the understanding of what affects treatment outcome (Wampold, 2001). For example, Scaturo (2001) advocates the need for “clinical wisdom” and “compassion”, noting that they are just as important as the treatment manual itself, noting that therapy is more than just a set of techniques to be delivered.

1.4.2 The debate over use of manualised therapy

This section addresses the application and development of manualised treatments drawing upon the literature from differing therapeutic domains, and substance misuse and addiction to explore the theoretical underpinnings and implications of treatment manualisation.

In light of the move towards evidence based practice, NICE (2011) recommends that psychological interventions for alcohol dependency should be manualised and informed by the evidence base. As manualised therapy is recommended in this field, it seems important that practitioners and researchers alike have a good understanding of the benefits, pitfalls and best practice with regard to using treatment manuals. General debates regarding the use of treatment manuals are explored, in order to set the context for their use more specifically in alcohol treatment.

Westen (2002) suggested that there are two types of treatment manual, the principle-based and the descriptive or prescriptive. The principle-based treatment manuals are more useful for long-term interventions with clients who present with complex problems as they promote more flexibility in their use. This is in contrast to the use of prescriptive manuals, which he thought were useful for short-term interventions for distinct problems, such as phobias.

Addis and colleagues (Addis Wade, & Hatgis, 1999; Addis & Krasnow, 2000) have noted several concerns regarding the use of treatment manuals. These conclusions were drawn from a survey of 891 APA licensed clinical psychologists who were asked their opinions about the use of treatment manuals. Common concerns

were: threats to the therapeutic alliance, client needs remaining unmet, the deskilling of therapists, doubts that manualised treatments are actually more effective in spite of being grounded in the evidence base, fears that skilled therapists would be replaced by those less skilled, and that using manuals would prevent future development in therapies. Clarke (1995) noted that whilst the standardisation and reproducibility of treatment manuals are attractive to researchers, they are less attractive to clinicians, as many prefer an eclectic approach where they can be responsive to client needs. Similar concerns regarding manualisation were also noted by Anderson and Strupp (1996) and Drozd and Goldfried (1996). In a meta-analysis of 119 studies measuring the effectiveness of Motivational Interviewing, it was demonstrated that treatment manualisation predicted significantly smaller treatment outcome effect sizes than non manualised MI (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). Similar findings were also reported by Hettema, Steele, and Miller (2005), however, the authors did not comment on the possible mechanisms behind these findings. Addis, Wade and Hatgis (1999) concluded that whilst some of these concerns may be well founded, there is a benefit to using manuals and protocols in some therapeutic situations. They noted that research should focus on how and when manuals can be used to their best effect and when they should be omitted. In addition to a need for a better understanding of how manuals can be best used, Carroll and Nuro (2002, p.379) outlined recommendations for best practice regarding manual development to ensure that they are "clinician-friendly."

In other psychotherapeutic arenas, Hollin (2009) has further brought to life the debate regarding the treatment manualisation of sexual offenders within the criminal justice system by using the metaphor of car mechanics. He noted that there is value in both the views of Mann (2009), who states that manualisation is essentially from an economical and standardisation perspective and of Marshall (2009), who states that manuals 'restrict' the use of a clinician's skills. Hollin (2009) suggests that having a car mechanics manual would help him to perform basic car maintenance under supervision, though he would not be able to complete more complex repairs. Likewise he noted that treatment manuals are of use to treat simple presentations cost effectively, though there are limited in what they can achieve. Similarly, Castonguay, Schut, Constantino and Halperin (1999) noted that manuals can be useful for treatment of simple clinical presentations but are less efficacious for greater complexity. In a less positive conclusion, Kazdin (2008, p.149) states that "we know from everyday life that when we are told '*one size fits all*', the garment in question tends not to fit anybody very well".

In addition to concerns that clinicians may have with regards to treatment manuals, it is possible that clients do not directly value the structure that they bring to the therapeutic encounter. Data from the UKATT trial (UKATT research team, 2005) has been used for secondary analysis to explore the mechanisms of the manualised treatment approaches in alcohol treatment. Orford, Hodgson, Copello, Krishnan, de Madariaga, and Coulton on behalf of the UKATT research team (2009) investigated what clients and therapists perceived were most and least useful about each session of MET or SBNT they participated in. A statistical analysis was performed on coded sentences written by clients and staff following each session. Findings of particular relevance to this current study are that therapists valued the structure of the session more than the clients. Also, clients rated repetition as less useful than therapists.

A further concern that emerges in the clinical literature is that treatment manuals might be used in an attempt to save costs by employing staff with less training and fewer skills (Scaturo, 2001; Castonguay, Schut, Constantino, & Halperin, 1999; Strupp & Anderson, 1997), though these concerns are yet to be fully researched. Scaturo (2001) argued that manuals are not a step-by-step guide for anyone to be able to perform therapy, but instead are a tool to help appropriately trained therapists to pinpoint what they do more specifically. With regards to alcohol treatment, this was echoed in an editorial for Drink and Drug News, whereby Ashernhurst (2011) described a concern amongst his peers that drug workers were becoming less skilled and receiving less training, whilst still expected to deliver the same specialised high level interventions. It was noted that by encouraging the use of manualised approaches and delivering less training, service providers were instigating a shift within services whereby therapists only have knowledge of the techniques they use directly with clients rather than the wider principles that underpin them.

1.4.3 Fidelity when using manuals

Treatment adherence refers to the amount that a therapist follows the protocols set out in treatment manuals denoting how therapeutic techniques should be administered. Forgatch, Patterson and DeGarmo (2005) define treatment fidelity as a combination of both adherence to the manual and competent delivery of the material using accomplished clinical skills. The terms of treatment 'fidelity' and treatment 'integrity' are used interchangeably to mean the same. Schoenwald, Garland, Chapman, Frazier, Sheidor and Southam-Gerow (2011) reviewed the literature regarding the measurement of treatment fidelity when using manuals. They found that there was insufficient research in reliably monitoring treatment fidelity. Generally, research has tended to focus only on adherence and, as fidelity is multifaceted, it is a challenge for future research to capture its totality. Similarly Leichsenring *et al* (2011) reviewed the

literature on treatment integrity. They noted that treatment integrity is also a multifaceted concept which is difficult to measure, leading to poor external validity in much of the research. They noted that when a positive relationship is found, it only accounts for 10-30% of outcome variance, so that the majority of variance cannot therefore be accounted for by specific therapeutic techniques. They note that the shift from highly standardised treatments for specific disorders, to a more flexible use of interventions will affect how treatment integrity is conceptualised in the future. An example which demonstrates this multifaceted nature is given by Strupp and Anderson (1997) who noted in the clinical literature that there is great variance in the ways that manuals are delivered by individual therapists, and that the adherent delivery of a particular technique can come across as warm and directive, or harsh and controlling, depending on the way it is implemented. They also note that therapists who implement new or unfamiliar techniques from manuals often do so in a forced or mechanical manner which is adherent but not particularly useful for the therapeutic process. In essence, measuring adherence does not allow us to appreciate the whole story of a therapeutic encounter.

It seems that adhering to some protocols can be detrimental, in particular at times of rupture or impasse within the therapeutic relationship, whereby the conscious or unconscious collaboration between therapist and client is broken (Safran & Muran, 2006). Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) investigated mechanisms of change in CBT for depression, using clinical trial data. They identified that when therapeutic rupture occurred, rigid manual adherence only reduced the therapeutic alliance further, and therefore promoted greater rupture and less successful therapeutic outcome. In a later clinical opinion paper, Castonguay and colleagues (Castonguay, Schut, Constantino & Halperin, 1999) suggested a possible mechanism for the reduced alliance in these situations was the therapist focussing on the client's view of the problem (a CBT principle) rather than the problem itself. In such instances they recommend deviating from the manual and using interpersonal strategies to address therapeutic rupture in order to achieve better therapeutic outcomes. This is, in part, supported by Spektor (2007) who noted that CBT therapists adhered less to the manualised CBT techniques when working with therapeutic ruptures, suggesting that they used their clinical judgement to decide that other techniques would be more appropriate in that particular situation.

Perepletchikova and Kazdin (2005) noted that it is harder to maintain treatment integrity with more complex treatments. This is likely to be because when there are multiple tasks to cover in a session, and if extra clarification or support is needed, this leaves less time to cover the protocol thoroughly. Gresham *et al.* (2000)

noted that when working therapeutically with people with learning disabilities, therapists often deviated from manuals to add techniques more suited to a client, especially when a client's presentation is particularly complex. They noted that this lower treatment integrity could either raise or reduce effectiveness depending on how the deviance from the manual was managed by the therapist, and how meaningful the rationale was for the deviation.

The idea that treatment effectiveness is sometimes augmented, and sometimes diminished by following a manual less closely is supported by the mix of reporting in the literature. Jones, Cumming and Horowitz (1988) found that therapists who were most successful with complex clients deviated from the treatment protocol to best address specific needs of their clients. Similarly, Margison *et al*. (2000, p.125) noted that there is evidence that this flexibility leads to better outcomes concluding that this "calls into question one of the main paradigms of psychological treatments research: the so-called 'drug metaphor' implies that 'pure' or 'unadulterated' forms of treatment are likely to be most efficacious". In contrast, Kendall and Chu (2000) found no significant relationship between the degree of flexibility that therapists reported using when implementing a manualised treatment with children with anxiety disorders, and therapeutic outcome as assessed by standardised measures. In contrast, Luborsky, McLellan, Woody, O'Brien and Auerbach (1985), reported that therapists who deviate significantly from treatment protocols, produced a less 'pure' treatment and a less positive treatment outcome. One explanation for this could be situated within the context in which therapists deviate from the manuals. If they deviate due to lack of understanding or focus on the aims of the treatment manual, or because of high levels of anxiety, this 'flexibility' is not due to an effort to meet the client's needs and so is less likely to add anything positive to the treatment. An example of this is discussed earlier in this chapter in relation to the use of confrontational approaches as a deviation from motivational interviewing when working with clients with substance misuse issues.

Connolly Gibbons, Crits-Christoph, Levinson and Barber (2003) recommend that manualised therapies can and should be used flexibly. In an analysis of the content of sessions from large scale RCT for depression, they identified that therapists using manualised therapies asked more questions and garnered greater clarity with more depressed clients, and used more self-disclosure with less depressed clients, concluding that this difference was due to appropriate responsivity to the client. Similarly, Strupp and Anderson (1997) noted that adhering to manuals too rigidly can distract attention from the individual client's needs and that the process of flexibility is something that often happens quite naturally in clinical practice. Some researchers have developed this argument, stating clinicians using a manual flexibly should not be

something that researchers should view with disdain, regardless of its effect on clinical outcome. Instead it is noted that researchers and clinicians alike should accept that manuals are intended to be used flexibly. Kendall, Gosch, Furr and Sood (2008, p.987) note that there are many concerns from clinicians regarding treatment manuals, citing Addis and Krasnow's (2000) findings that 33% of clinicians felt they reduced the "authenticity" of the therapy, and that many of these "arise from misperceptions about how these treatments are optimally implemented in practice." Kendall *et al.* (2008, p.88) noted that manuals are intended to be used creatively and "flexibility within fidelity is encouraged" and provide examples of how a treatment protocol can be used flexibly with reference to CBT interventions. Connolly Gibbons, Crits-Christoph, Levinson, Gladis, Siqueland and Barber (2002) coded therapist speech taken from 548 treatment sessions in a large scale RCT researching the efficacy of CBT for depression. It was noted that differences in the clients' presentation affected the different responses that therapists gave in sessions. They concluded that this demonstrated that manualised therapies can and should be delivered flexibly to meet the needs of the individual client. Hogue, Henderson, Daubers, Barajas, Fried and Liddle (2008) found that when controlling for treatment alliance in therapy with adolescent drug users, high adherence predicted better outcomes with regards to levels of drug use in both CBT and family therapy. However, intermediate levels of adherence had better outcomes with anxious and depressive symptoms than high or low levels of adherence. Garfield (1996) stated that both therapists and treatment manuals need to be flexible enough to deviate from the core intervention if there is a clinical need.

Although the majority of research recommends that flexible delivery of treatment manuals is useful, there is evidence to suggest that this is not always the case. Langer, McLeod and Weisz (2011) demonstrated in a naturalistic study of manualised vs. non manualised interventions for teenagers with anxiety or depression that, despite the popular criticism that manualisation undermines the therapeutic alliance, manualisation actually increased alliance ratings in early sessions and made no difference to client ratings of overall alliance. Similarly, Robbins, Feaster, Horigan, Puccinelli Henderson and Szapocznik (2011) demonstrated that higher levels of adherence to a principle based family therapy manual led to better outcomes. Waller (2009) noted in an reflective paper that drift from CBT manuals often occurs when therapists wish to protect a client, which can result in therapists becoming drawn into immediate crises rather than helping the client to move forward with their presenting problem. Alternatively, the impact of the degree of adherence to treatment manuals could be mediated by client characteristics. For example, Blow, Sprenkle and Davis (2007) reported in a review of the literature that reduced directive approaches or

interventions produced better therapeutic outcomes when clients presented with greater resistance.

This research study attempts to consider some aspects of the many debates about manualised therapy by exploring the discourses used by therapists when delivering manualised therapy. The literature invites considerations of the discursive practices used when manualised treatment is being adhered to, when the therapist is being flexible with a manualised treatment in a seemingly beneficial way, and when there is manual drift which does not appear to be positive. This study, unlike the majority of the literature discussed above, does not attempt to match the use of any of these discourses to clinical outcomes, but instead intends to show a snapshot of how therapists use discourse to negotiate the context of delivering therapy informed by a treatment manual.

1.5 Therapist factors affecting therapeutic outcomes

In this section the influence of individual therapist factors on the delivery of therapy is discussed. The discussion of these factors locates the importance of understanding the influence of therapists on the process of therapy, and sets the context for this study using deconstructionist principles to understand these processes.

1.5.1 Research context of therapist factors

Amongst other factors, the use of EBP and manualised therapies depends on several factors specific to the delivering therapist. This section discusses the literature regarding the influence of therapist characteristics on the process of therapy. The APA Presidential task force on EBP (2005) noted in their report that individual therapists have an impact on outcomes and that better understanding of these factors is important. However, investigating the characteristics and actions of effective therapists is not currently a focus of EBT research (Wampold, 2007) despite suggestions that the variance in outcome that can be accounted for by therapeutic alliance is as high as 30-35% (Lambert, 1992) and that therapist characteristics contribute to therapeutic alliances (Imel & Wampold, 2008). Spenkle and Blow (2007) noted that further research investigating therapist effects upon therapeutic outcome needs to be conducted, as therapist differences are likely to be more influential than effects of different therapies. Lambert (1989) noted that variance in treatment outcome is affected mostly by client characteristics, then therapist factors, and finally the type of therapy.

Psychotherapy research has shown that effect sizes concerning the impact of therapist factors overshadow the differences between treatments (Luborsky, Crits-

Christoph, McLellan, Woody, Piper, Liberman, Imbe & Pilkonis, 1986; Lambert & Okiishi, 1997). This has also been reported in alcohol addiction therapy by Longabaugh, Donovan, Karno, McCrady, Morgenstern, & Tonigan (2005) in a review of the project MATCH alcohol treatment study.

1.5.2 Impact of therapist factors

As discussed in the section immediately above, the impact of therapist factors is an important area of research, although still largely overshadowed by research investigating treatment factors. Bergin (1997) suggested many researchers see clients as dependent variables and therapies as independent variables, similar just as drug therapies in medical trials. If the therapy rather than the therapist is conceptualised as the active agent of change, this drives the focus of research in this direction, leaving relatively little attention paid to therapist factors. This reflects the attempt of clinical guidelines, professional bodies and government agendas to justify service provision and expenditure by aligning psychotherapy (both manualised and not) with medical models investigating treatment outcome. In this section, the research focussing on the impact of therapist factors on outcome is discussed.

Orlinsky and Howard (1980) analysed the outcome data of 23 individual therapists covering 143 clinical cases showing a distinct range in outcomes, with the lowest therapist outcome group averaging a 41% rate of client improvement, and the highest therapist outcome group averaging an 81% rate client improvement. High levels of outcome variance across therapists have also been found by Najavits and Strupp (1994) who reported significant variability across a sample of 16 therapists each with a matched caseload of 5. Garfield, Affleck, and Muffly (1963) rated therapists they found most 'favourable' with regards to competence and compassion in introductory sessions with clients and cross referenced this with how many of their clients attended a second session. Six therapists each conducted four introductory sessions. The two therapists rated as most favourable had 3 of 4 of their clients return, the two least favourably rated therapists had 1 of their 4 clients return, and the middle two therapists had 2 clients return. Results indicated that more effective therapists displayed more positive behaviours such as warmth and alliance and fewer negative behaviours (e.g., attacking and blaming) and greater self-criticism than less effective therapists. Furthermore, significant positive outcomes were relationship orientated. These findings appear to suggest that therapist factors are important in determining clinical outcome, and that how a client may experience a therapist within a therapeutic dyad is critical for therapeutic outcome.

Although limited, research has attempted to investigate which therapist factors have an effect on outcome and what each impact has. Laska, Smith, Wislocki, Minami

and Wampold (2013) investigated the effectiveness of therapists delivering CPT (Cognitive Processing Therapy) for PTSD (Post Traumatic Stress Disorder). Therapists were rated blindly by an independent CPT trainer rating effectiveness on a list of potential markers, and when this was cross referenced with the reduction of client symptoms, it was found that there was a 12% variance on outcome associated with therapist ability to address client avoidance, flexible interpersonal style, and ability to develop a strong therapeutic alliance, as measured by supervisor judgement and assessment.

Beutler, Malik, Alimohamed, Harwood, Talebi, Noble and Wong (2003) outlined four types of therapist variables that affect client outcomes to differing degrees. The first two, 'observable traits' such as gender or age and 'observable states' such as training and experience, showed little relationship to outcome. The third therapist variable type was 'inferred traits' such as personality, wellbeing, and values. It was noted that some of these, in particular cultural competence and good personal wellbeing, do have a significant impact on outcome. The fourth variable type was 'inferred states', dynamic variables such as the therapist's view of the client or the therapeutic relationship. They noted that this had the most significant impact on outcome of the four categories of variables with therapists who showed compassion, genuineness and flexibility with the client having better outcomes.

Interestingly, in a review of the literature Blow, Sprenkle and Davis (2007) noted that the therapist factors known to affect outcome are allegiance building, engagement, hope building, being flexible to meet the client needs, and cultural competence. They recommended that clinicians and researchers alike focus more on these, rather than focussing entirely on levels of adherence to the EBT intervention, which supports the findings of Beutler *et al.* (2003).

Ackerman and Hilsenroth (2003) reviewed the literature regarding therapist factors which contribute to a good therapeutic alliance. They divided them into two categories; therapist attributes and therapist techniques, which were both found to influence the development and maintenance of a positive therapeutic alliance and to repair ruptures to the therapeutic alliance. Therapist attributes included, being honest, open, flexible, respectful, trustworthy, confident, warm, friendly, enthusiastic, and interested. Therapist techniques included, accurate interpretation, being supportive, active, and understanding, noting past therapy successes, using exploration and enabling the discussion of feelings. These factors all fostered an egalitarian relationship which promoted positive therapeutic alliance.

With regards to therapists in the addiction field, linking professional identity with therapist responses to clients, Saarnio (2011) investigated addiction therapist's

responses to a clinical vignette against various therapist factors. It was found that therapists who had completed more lengthy therapeutic training expressed more empathy and respect for the client vignette. Therapists who described themselves as more eclectic presented as more genuine in their approach to the vignette than those who identified themselves as ascribing to a single therapeutic model.

Although this is a developing area of research, it is challenging to identify which particular aspects of a therapist's behaviour impacts upon which aspects of therapy and in what ways. Strupp and Anderson (1997, p.78) note that "therapist characteristics cannot be culled out of some sort of 'psychic centrifuge' for the purposes of empirical study".

1.5.3 Therapist factors and manualised therapy

Following the general premise that therapist factors influence therapy process and outcome, it is perhaps unsurprising that they also influence the process and outcome of manualised therapies. As discussed previously, Perepletchikova and Kazdin (2005) reported inconsistencies in the literature as to whether integrity to treatment protocols improve outcomes or not. They suggest these inconsistencies may be due to measures of integrity being unreliable, and note that treatment integrity requires both adherence to the manual and therapist competence, the latter of which is particularly hard to measure. A treatment can fail when adherence is good, and therapist delivery is not, and conversely can be successful when the therapist is skilled but uses techniques which are not part of the prescribed treatment. Emphasising the need to consider therapist competence rather than a sole focus upon the efficacy of the intervention itself, Nezu and Nezu (2005, p.80) note that "the interventionist does not always equal the intervention". Shapiro and Firth (1987) reported that in an RCT comparing manualised CBT with psychodynamic psychotherapy, one CBT therapist emerged as having consistently better outcomes than all the other therapists, despite using the same manual as the other therapists in the CBT treatment arm of the study. They noted that the same techniques can be used in very different ways (e.g., warm and understanding vs. rejecting and attacking). Interestingly, this study aimed to minimize therapist effects, however these still surfaced and were commented upon. This infers that therapist differences cannot be minimised entirely and can be an important factor when considering outcomes.

One factor which links therapist characteristics and manualised treatment delivery is that of therapist experience. Perepletchikova and Kazdin (2005) note a popular assumption that more experienced therapists adhere to protocols less than those who are less experienced. This could be due to a variety of reasons including their learning having been set in a specific modality, increased confidence in their

autonomy, or having more useful experiences to draw upon in addition to the manual. This is supported by Reimers, Wacker and Koeppl (1987) who identified that novice therapists are more suggestible in training for manualised treatments, and are more accepting of such treatments. They also note that all therapists must understand the aims and rationale of the therapy to increase their acceptance of an approach, and thus increase their adherence to the treatment. Raistrick, Heather and Godfrey (2006)stated that experienced therapists should not be expected to adhere strictly to a manual. They noted that how close a therapist has to remain to a specific approach in order for it to be efficacious is still under debate, and highlights the importance of training clinicians in how to use manuals effectively.

Blow, Sprenkle and Davis (2007) noted that both being a competent therapist and being comfortable with the treatment they are delivering is integral for the effective delivery of manualised therapies. They noted that therapist effects cannot completely be controlled for with manualisation, though studies using manuals to control for therapist effects did have smaller therapist effects than those that did not. Similarly, Luborsky, Mclellan, Diguer, Woody and Seligman (1997) note that in research trials, there are marked differences in outcome across therapists despite the use of a treatment manual. Stiles, Shapiro and Firth-Cozens (1989) compared the use of verbal responses that two therapists used across 33 clients, both using manualised IPT and CBT approaches. They reported that though both therapists' delivery was adherent to the manual, their verbal responses differed. One therapist used more acknowledgement and disclosures, whereas the other used more interpretation and reflection. This demonstrated that there are different ways of delivering a therapy whilst still being adherent.

With regards to alcohol treatment, Karno, Beutler and Harwood (2002) reported interactions between therapist delivery of manualised therapy and client characteristics in the large scale Project MATCH alcohol treatment outcome study (n=1727). The MATCH study was undertaken in the US, and took place two years prior to the UKATT trial with similar aims of comparing alcohol treatment therapies for effectiveness. This multisite research compared outcomes of CBT, MET, and 12-step therapies, and also investigated the impact of matching clients to specific therapies which were best suited to their needs. The results of the trial were disappointing in that very little evidence was found for treatment matching across markers such as readiness to change, levels of social support, or alcohol severity. However, the authors identified higher levels of therapist directiveness predicted fewer days of abstinence for clients with higher levels of reactance or anger. In contrast, higher levels of directiveness predicted more days of abstinence in clients with low levels of anger.

They also found that MET (a non-directive therapy) was more effective than CBT (a directive therapy) for clients with high levels of anger. They note that more study of therapist behaviours is needed to inform how to develop treatments and inform policy making.

1.6 Treatment considerations for alcohol addiction

This research study focuses on the use of two manualised treatments for alcohol addiction. The rationale for a specific focus upon manualised treatments for alcohol addiction evolved from an opportunity to access readily available data (with ethical approval) which appeared fit for purpose to explore therapeutic discourses. It is therefore important to consider the context in which they are delivered, and to consider the above generalised psychotherapy debates in the context of alcohol addiction treatment. This section introduces the treatment of alcohol addiction in order to incorporate what is already known about this in the formulation of the research questions.

The diagnostic criteria for alcohol dependence in the International Classification of Diseases: Version 10 (ICD-10) (World Health Organisation, 1992) state that in order for a diagnosis to be made three of the following criteria must be met: a strong desire to take the substance, difficulties in reducing substance use, psychological withdrawal when a substance is not taken, increased tolerance to a substance, substance use or related activities resulting in the neglect of previously enjoyed activities, and continuing to consume the substance with the awareness of negative consequences[1]. It is estimated that the one year prevalence of alcohol dependence in working age adults is 9.3% of men and 3.6% of women (Adults Psychiatric Morbidity Survey, 2007). Hasin, Stinson, Ogburn and Grant (2007) reported an estimated lifetime prevalence of alcohol abuse as 17.8% and alcohol dependence as 12.5% taken from a representative US adult sample of over 43,000 people. They noted that of their sample, only 24.1% of their sample who met the criteria for alcohol dependence had accessed any treatment. Similarly, Dawson, Grant, Stinson, Chou, Huang and Ruan (2006) followed up a sample of people who met the DSM-IV criteria for alcohol dependence after one year. They found that 25% of the original sample had received some form of treatment. Statistics from the National Alcohol Treatment Monitoring System (NATMS, 2011) note that in 2009/10 111,381

[1] This diagnosis of alcohol dependency is constructed within the medical model. This is noted here for the purposes of operationalization of drinking problems in order to report prevalence statistics. Client participants in the original UKATT trial were not required to meet the criteria for a diagnosis of alcohol dependency provided that alcohol was the primary source of their difficulties and they would normally have been eligible for treatment if the trial had not been taking place (UKATT research team, 2001).

adults engaged in substance use treatment and cited their primary substance of choice as alcohol.

It is of interest as to why the majority of people who have some issue with their alcohol consumption do not access treatment. Cunningham, Sobell, Sobell, Agrawal and Toneatto (1993) surveyed people who had an alcohol addiction who were either in treatment, had not sought help and were still drinking, or those who had stopped drinking independently. They reported that people delay accessing treatment for alcohol addiction for a variety of reasons including pride or embarrassment, perceived stigma, feeling unable to share their problems and having a negative attitude towards treatment. Additionally, those who did not access treatment noted feeling they did not have a problem, and wanted to manage their problem independently. The authors concluded that the majority of respondents from all three groups perceived treatment as stigmatising, and felt that seeking treatment would reflect negatively upon them.

Given that alcohol dependence prevalence rates are significant, it is important to understand the mechanisms behind the treatments that are available to people. This is important to provide high quality care to the significant minority who are accessing treatment, and could possibly aid understanding as to some of the possible reasons (i.e. those related to the delivery of psychotherapy itself) that the majority of people with alcohol issues do not access treatment.

1.6.1 Current treatment guidelines

The NATMS (2011) report identified that 'structured psychosocial' treatment was the most common treatment accessed for alcohol problems. NICE guidelines (NICE, 2011b, p.7) on the treatment of alcohol dependence state that psychological interventions should "build a trusting relationship and work in a supportive, empathic and non-judgmental manner" and "take into account that stigma and discrimination are often associated with alcohol misuse". This informs an interest in the discursive practices that therapists use in order to address the stigma and difference that can be apparent when working with alcohol addiction clients in addition to prescribed treatments themselves. However, given the influence of the 'medical world' versus the 'lifeworld' discourses upon client-clinician relationships within medicine (e.g., Mischler, 1984; Barry, Stevenson, Britten, Barber & Bradley, 2001) adhering to the tenets of clinical guidelines may be particularly difficult.

1.6.2 Specific alcohol treatments

NICE (2011b) guidelines for the treatment of alcohol dependency note that therapist competence has a significant effect on client outcome, and so must be considered alongside the type of therapy delivered. This is supported by Raistrick,

Heather and Godfrey (2006) who report that therapist characteristics are important to consider when thinking about treatment outcome. They report that therapist characteristics have been estimated to account for between 10% and 50% variance of therapeutic outcome. Raistrick, Heather and Godfrey (2006) note that many RCTs investigating the therapy effects in the substance misuse field, including the UKATT trial (2005), control for therapist differences as much as possible by closely monitoring adherence to protocol. Several tools for monitoring adherence to treatment protocols have been developed for the purposes of psychotherapy research such as the Yale Adherence and Competence Scale (YACS) (Carroll, Nich, Sifry, Nuro, Frankforter, Ball, Fenton & Rounsaville, 2000) and an audio tape system developed by Sheidow, Donohue, Hill, Henggeler and Ford (2008).

1.6.3 Motivational Interviewing and Motivational Enhancement Therapy

Motivational Interviewing (MI) was developed as an alternative to the more traditional confrontational approach, developed by Tiebout (1944), which was popular though it lacked evidence demonstrating its efficacy and increasing evidence showing that it was actually counterproductive. For example, Miller, Benefield and Tonigan (1993) found that at one year follow up, the amount a client was drinking was positively correlated with the extent of confrontational techniques their therapist used during treatment. Similarly Pollak *et al.* (2010) found that when physicians used confrontational techniques when they talked about weight to obese clients, they maintained or gained weight. This was compared with clients whose physicians used MI techniques to talk about weight; this group lost weight at 3 month follow-up. The approach has been demonstrated to be as effective as other brief interventions for problematic drinking in several meta-analytic studies (e.g., Burke, Arkowitz, & Menchola, 2003; Rubak, Sandboek, Lauritzen, & Christensen, 2005; Jensen, Cushing, Aylward, Craig, Sorell, &. Steele, 2011). A reciprocal relationship has been shown between therapists and clients with regards to the level of MI consistent speech the therapist uses and the amount of change or counter change talk the client uses. Additionally, the reverse was also observed whereby if the client uses change talk, the therapist is more likely to use MI consistent talk, whereas if the client uses counter change talk, the therapist is more likely to use MI inconsistent talk (Gaume, Bertholet, Faouzi, Gmel, & Deppen, 2010).

MET is a therapy based on the principles of Motivational interviewing (MI) (Miller & Rollnick, 1991), which is the most popular brief intervention for substance dependence (Raistrick, Heather, & Godfrey, 2006). The motivational interviewing approach is aimed at resolving the ambivalence a person feels about changing in order to increase their motivation to change. The key principles for therapists to follow are:

to express empathy, avoid argument, develop discrepancy (e.g., to develop cognitive dissonance between actual and desired behaviour, Festinger, 1957), to roll with resistance and to support self-efficacy (Miller & Rollnick, 2002). An assumption made by MI proponents is that change talk is strongly correlated with behavioural change (Miller & Rose, 2009). The use of MI consistent talk by therapist has been shown to promote change talk in clients (Gaume, Bertholet, Faouzi, Gmel, & Daeppen, 2010; Moyers & Martin, 2006), whereas MI inconsistent talk promotes counter change talk in client.

1.6.4 Manualised Motivational Interviewing (MI)

The debate outlined earlier regarding the costs and benefits of manualised therapies is shown within the substance misuse field, with specific research focusing on the effects of manualisation of MI, which is one of the philosophies that underpins one of the treatment modalities this study investigates. There has been research that suggests that the manualisation of MI can make it less effective. Hettema, Steele and Miller (2005) conducted a systematic meta-analysis of 72 clinical trials looking at the efficacy of MI. They noted an unexpected finding that manualised MI produced smaller effect sizes than non manualised MI interventions. Hettema *et al.* (2005) offer a possible explanation for this by interpreting the reported findings of Amrhein, Miller, Yahne, Palmer and Fulcher (2003) who reviewed the sessions from an RCT looking at the efficacy of a sample of single sessions of manualised MI conducted by Miller, Yahne and Tonigan (2003). The trial found no significant benefit of the MI session when compared to treatment as usual. Amrhein *et al*. (2003) identified that most clients showed increasing commitment to change over the course of the session. The difference between responders and non-responders was that the non-responders' commitment and motivation drastically fell in the final moments of the session. Hettema, Steele and Miller (2005) attempt to put this finding into context by noting that the treatment manual instructed therapists to elicit a behaviour change plan from all clients at the end of the session. If clients were not ready to commit to this plan, then this would increase resistance and undermine the changes that were made during the session. Hettema, Steele and Miller (2005) suggest that by retaining integrity to the manual, and eliciting a change plan in the face of client resistance, the therapist had inadvertently broken one of the tenets of MI.

1.6.5 Social Behaviour and Network Therapy (SBNT)

Social behaviour and network therapy is a relatively new approach for alcohol addiction, developed and published in manual form by Copello, Orford, Hodgson and Tober (2009), and aims to create a positive social network within which the client is

able to change. The treatment manual created by Copello and colleagues has received largely positive reviews by those working in the field (Gardin, 2010; Smith, 2010). This approach builds upon pre-existing treatment modalities which involve a social component and involve the therapist working with the client to identify and strengthen supportive relationships. This therapeutic modality often involves significant others attending the therapy sessions with the client. SNBT is not considered a family therapy as it aims to identify and strengthen positive support networks, with "no attempt to understand interpersonal dynamics" (Copello, Oxford, Hodgson & Tober, 2009, p.19). When contrasted with MET, the therapist takes a more active role in promoting change in SBNT and it is more focussed on action rather than motivation. SBNT takes the form of 8 sessions delivered over 12 weeks. The treatment contains three phases; phase one (session one) involves identifying social networks, phase two (sessions two-seven) involves working positively with these networks, and phase three (session eight) involves consolidation and preparation for the future. Williamson, Smith, Orford, Copello and Day (2007) conducted a qualitative analysis of post therapy interviews with clients, network members, and therapists. Identified key emerging themes included, increasing awareness of the value of increasing a supportive network and decreasing an unsupportive network, and creating opportunities for useful conversations between clients and support networks regarding alcohol use.

There are currently few studies demonstrating the effectiveness of SNBT, aside from an early trial (Copello, Orford, Hodgson, Tober, & Barrett, 2002) and a feasibility study (Copello, Williamson, Orford, & Day, 2006), both producing promising results. The main evidence base comes from the large scale UKATT trial (UKATT research group, 2005) described later in this review. In the UKATT trial SNBT was found to be as effective as MET.

1.6.6 The dodo bird in alcohol treatments

With regards to what clients themselves attribute change to, Orford, Hodgson, Copello, Wilton, and Slegg on behalf of the UKATT Research Team (2009) also conducted an analysis of UKATT client change attributions. By interviewing MET and SBNT clients at 3 and 12 month follow-up they identified that, whilst MET clients attributed change more to motivational factors, SBNT clients attributed change more to social factors. These attributions match the different clinical focuses of the two treatments suggesting that clients do value, at least in part, the theorised active agents the therapy they received. However, both MET and SBNT clients were most likely to attribute change to general factors such as the therapeutic alliance, which are not

specific to a particular treatment. This supports the view that general therapeutic factors are valuable and influential to the change process.

Bergmark (2008) posited, in an opinion paper, that the results of all three of the large scale alcohol treatment trials of the past decade: COMBINE (Anton, O'Malley, Ciraulo, et al. for the COMBINE Study Research Group (2006), MATCH (Project MATCH research group, 1997), and UKATT (UKATT research team, 2005) supported the hypothetical "Dodo-Bird Effect" (Rosenzweig, 1936), whereby all treatments were effective and there was little differentiation between them. Bergmark (2008) concluded that these findings show the need to shift the focus of research in alcohol treatment onto common factors which are known to account for more variance in outcome than different therapeutic modalities (e.g. Wampold, 2001; Imel & Wampold, 2008). This was supported by Orford (2008) who recommended a move towards research focussing on empirically supported treatment processes rather than empirically supported treatments in alcohol treatment. Orford (2008) noted this has not yet occurred due to the adherence of researchers to the drug trial metaphor which investigates named therapies as if they were discrete treatments and ignores much of what is actually happening.

1.7 Summary of literature and links to research question

In review of the above literature, I have highlighted a clash of ideologies that has emerged between some clinicians and researchers whereby research has focussed on comparing treatments, whilst clinicians are focussed on offering treatment to suit their individual clients. This has led to a range of attitudes with regards to the usefulness of treatment manuals, whether they improve practice, impede practice, or do neither but instead are merely an aid to research.

Within the context of a growing interest in the construction of therapy in postmodernist traditions, this study aims to consider some of the issues at the heart of the debate regarding the use of treatment manuals. There is little research attempting to understand the mechanisms of therapist discourse with regards to use of manuals that underpin this debate. Through being critical of or deconstructing psychotherapy, no attempt is made to outline how it 'should' be, but instead to understand "how we come to stand where we are" (Parker, 1999, p.4). This study does not intend to uncover whether manuals are useful or not, nor what elements of therapist delivery of manuals affect outcome. Instead this research study intends to deconstruct and illuminate the 'talk' that therapists use when delivering manualised therapy, with consideration to the discourses that are utilised and drawn upon with regards to facilitating change, the functions that these serve, and how these interact with levels of

treatment fidelity. In addition to these issues, a particular focus is given to how therapists negotiate the exploration of difficult experiences, because the importance of negotiating emotions in therapy is well documented whilst there is little understanding about how this is achieved.

1.8 Research question and aims

1.8.1 Research Question

How do therapists working in services for alcohol addiction use discourse in manualised therapy sessions?

1.8.2 Research aims

- To identify the taken for granted assumptions drawn upon by therapists and how these are enacted in the practise of therapy
- To examine the practice of the therapists with reference to both adherence to the manual, and clinical judgement.
- To examine how therapists negotiate difficult experiences within the practices of therapy.

Chapter 2. Method

2.1 Theoretical rationale for methodology

The research questions for this study require an inductive approach to data analysis therefore a qualitative method was selected to answer them. The method chosen allowed conclusions to be drawn from analysis of naturalistic data, rather than situations being created in order to test specific hypotheses. Several qualitative methodologies were considered and excluded as they focused on a different aspect of analysis which would not suit the research questions generated. For example Interpretative Phenomenological Analysis (IPA) focuses on individuals' experience and making of meaning (e.g. Reid, Flowers, & Larkin, 2005); and thematic analysis focuses on generating emerging common themes from coding data which create a comprehensive explanation of data (e.g. Glaser & Strauss, 1967; Charmaz, 2006). It was decided that a discourse analysis (DA) approach would best answer the research questions generated by this research study. In the field of psychology there are two main ways of using DA methodologies; Foucaldian discourse analysis (FDA); and discursive psychology (DP) (Willig 2008). FDA involves defining ways that power is constructed by use of discourse (e.g., though social categorisation, and the impact this has on society and vice versa). In contrast, DP is focussed on understanding the actions people take through using particular discourses. Discursive psychology (DP) was used to analyse this research data, as the research questions primarily investigated the actions that are performed through therapist discourse (Edwards & Potter, 1992).

2.1.1 Discourse Analysis of psychotherapy interactions

In her introduction to understanding the contribution of discourse analysis (DA) to psychotherapy, Spong (2010, p.68) summarises the basic tenet of DA: "I am implying here that the way we talk about things does not merely *describe* the world, but it *makes* the world what it is… As counsellors we need to see how our clients' problems are constituted in our discourses, and how we respond to them from within particular discourses." This is important, as only through accepting therapist discourse as action, and attempting to better understand it, can we attempt to draw conclusions on how therapists can use discourse in psychotherapy to facilitate successful outcomes for clients.

Discourse analysis can be used as a method by researchers to better understand the interactions that occur within psychotherapy. It is a relatively recent method with a growing research interest (e.g., Advi, 2005; Crowe & Luty, 2005; Sutherland & Couture, 2007; Butler et al., 2010; Couture & Strong, 2010; Karatza, &

Avdi, 2011). Advi and Georgaca (2007) noted that studies to date have mainly investigated the discourses used by clients rather than therapists. This focus seems to have shifted in recent years towards analysing therapist discourse also (e.g. Kogan & Gale, 1997).

There has been little research published with a primary focus on the discourses used by therapists. Much of the research literature has focused upon discourses in the context of a particular therapeutic modality or on interactions between clients and therapists. Advi and Georgaca (2007) reviewed the literature on discourse analysis in psychotherapy and noted a range of stances taken. They noted that most studies have used discourse analysis to demonstrate (and not evaluate) the micro linguistics that therapists use when implementing particular therapeutic models (citing examples of Foreman & Dallos, 1992; Hare-Mustin, 1994; Kogan & Brown, 1998; Weingarten, 1998), rather than employing the method to deconstruct the process of therapy and link this with wider social meanings. Advi and Georgaca (2007) noted that more recent research using DA has begun to look more critically at the language used in psychotherapy and links between therapist use of language and wider social and institutional power (e.g., Advi, 2005).

Advi & Georgaca (2007) note that whilst deconstruction of social meanings is an important endeavour, such research is criticised for lacking utility in influencing the practice of individual clinicians. With regards to the analytic stance taken in this study, in order to answer the research questions, a direct focus on linking therapist discourse to the wider social context was not a priority. Whilst a more specific focus on the critical deconstruction of manualised therapy would be both interesting and useful, given the current debate, a more neutral investigative stance was taken with a focus on how the therapists negotiate the delivery of a manualised therapy through discourse. Georgaca (2012) noted several aspects of the therapist's position which should be analysed, which were: the therapist as an addressee both to and of the client's talk, as assuming an institutional role, and as implementing prescribed interventions. This informed my analysis by directing attention to the nature of the therapists' talk in the context of the therapy as a whole and as a collaborative construction alongside the clients' talk. This study is focused on the micro level discursive strategies that therapists use to promote change whilst delivering manualised therapy. This required investigating the function of therapist talk and the impact it has on the client and the dialogic process of therapy. This focus was chosen in order to allow for meaningful clinical recommendations to be drawn from the analysis in order to influence clinical practice and policy making.

2.1.2 Discursive Psychology (DP)

Discursive psychology is a form of Discourse Analysis developed from Conversation analysis by Wetherell and Potter (1986). Edwards and Potter (1992, p.103) offer a simple definition of discursive psychology assuming an understanding of DA: "Discursive social psychology is the application of ideas from discourse analysis to central topics in social psychology… it is an approach to psychology that takes the action-oriented and reality-constructing features of discourse as fundamental". The use of discursive psychology principles takes a social constructionist approach to investigating human interactions (Willig, 2001). The emphasis moves away from the traditional cognitive assumptions that people have concrete internal processes which are enacted through discourse, and instead focuses on the context of a person's experience and the actions (through discourse) that they take to negotiate this.

Edwards and Potter (1992) note that all discourse is situated, action-oriented, and constructed. Discourse is seen as a tool used to perform particular actions in social interactions for example, to deny responsibility, or to construct oneself as knowledgeable. Talk is not taken at face value, as mere reporting of internal processes, and instead is seen as a construction of self, other, and context, in a particular way to manage a particular interaction. As DP is focussed on how people use discourse as an action to serve a particular function and as this study is interested in how therapists negotiate the delivery of manualised therapy through discourse, it was decided that a DP approach would best answer the research questions.

2.1.3 Using naturalistic data

Potter and Edwards (2001) note the importance of using naturalistic data when using discursive psychology techniques to investigate a phenomenon. This is due to the three tenets that all discourse is situated, action-oriented and constructed. Only through analysing the discourse occurring naturally can one be sure that what is produced is as a result of the particular situation that one is interested in. Potter and Hepburn (2005) note that using naturally occurring data should be the "default technique" when analysing talk interactions.

I am interested in how discourse is naturally used by speakers to manage the specific interaction of manualised therapy for alcohol addiction. If research interviews or focus groups were used, and I interviewed the client or therapist about the talk they use in therapy, the respondent's discourse would be influenced by the format of the interview and assumptions about what is expected of them in that situation. Therefore interviews would risk providing only a constructed version of a commentary on the phenomenon that I intended to investigate.

However, it is noted that when using naturalistic data, one must be aware that this does not automatically distance the researcher from influencing the data through processes of analysis (Griffin 2007). This is further discussed later in this chapter.

2.2 Use of secondary data

The study uses a DP approach to analyse extant DVD recordings of MET and SBNT which were collected as part of the UKATT trial (UKATT Research Group, 2005). Permissions have been given for this data to be used by the lead researcher from the UKATT research group.

As discussed in the introduction chapter, treatment manuals have a particular function in standardising therapist effects in research trials. This is taken into account in the analysis, and is discussed further in the discussion chapter. Other issues related to using secondary data are also considered, in particular not having access to all the data or detailed information regarding the context in which the original data were collected.

Though the recorded sessions were available on DVD in an integrated visual and audio format, it was decided that for the purpose of this research, that only the audio data would be used for analysis. The visual recording showed only the therapist with the client not in view. Therefore whilst utilising this additional visual data could potentially offer useful information, it could only provide this information about the therapist and not the client, which could introduce an unnecessary bias in the analysis.

2.3 Ethical Issues

Ethical approval was attained for this study by Yorkshire and the Humber REC committee (See Appendix 2). The study was also approved and registered by Leeds and York Partnership NHS Foundation Trust (LYPFT) Research and Innovation department (See Appendix 3).

2.3.1 Informed Consent

All therapists and clients participating in sessions accessed for this study gave informed consent for all information collected in the original UKATT trial, including session recordings, to be used for secondary analysis. The data from any therapists or clients who did not give consent for their data to be used for secondary analysis were separated from the data that was made available to me as the primary researcher for this study. A copy of the original consent form can be found in Appendix 1.

2.3.2 Confidentiality

The DVD data were transcribed at the secure site where the data was stored. The data was transcribed by the primary researcher and an external transcriber who signed an agreement of confidentiality and was employed in another role by the NHS Trust in which the data was stored. It was agreed with the NHS Trust R & I Department that in order to access the data, the transcriber had to be employed by the Trust to ensure they had appropriate clearances, had attended Trust information governance training, and were known to be trustworthy. The transcripts were immediately anonymised by removing names and other identifiable information (e.g., locations, ages). The transcripts were assigned a unique code to identify each therapist-client dyad and session number (e.g. MET 1 –S1, SBNT 2-S4). Later, in the writing up stages of the analysis the therapists and clients were given pseudonyms which are referred to in the analysis section of this research.

Hard copies of the transcripts and subsequent analyses were stored at the primary researcher's home in a locked cabinet as per recommendations by the University of Leeds and Data Protection Act (1998). Electronic versions of this data were stored on the University of Leeds encrypted server, to which only the primary researcher had access. Hard and electronic data containing demographic information about the participants taken from the UKATT database was stored in the same locations as the transcripts. All information taken from the database was already anonymised in the original UKATT trial. This data was then assigned the same coding system as the transcripts described above.

2.4 Sample

2.4.1 Rationale for the sample size

There is little published guidance regarding the acceptable sample size of qualitative research, both with regards to number of 'participants' and amount of transcript to be analysed. The required sample size depends largely on the particular research questions and methods used in the study. Previous discursive psychology studies focussing on psychotherapy processes have used 12 sessions with one family (Advi, 2005), 14 sessions with one client (Crowe & Luty, 2005), 1 session plus 2 follow up interviews with one family (Sutherland & Couture, 2007), and 7 sessions across two patients (Karazta & Advi, 2010).

It was decided that a sample of six therapist-client dyads would be sufficient to answer the research questions within the time and resource constraints of this study. Once this sample had been generated it emerged that this resulted in nineteen potential therapy sessions to analyse totalling around 15 hours. Due to the detailed

and time consuming nature of the transcriptions conventions required for DA, it was decided that it was not practicable to transcribe and analyse each session in its entirety. It was decided that sections from all the sessions would be transcribed and analysed to provide a cross section of the talk across the sessions. The process of this selection is detailed in section 2.4.3.

2.4.2 Selection of client-therapist dyads

As the study was a secondary analysis of existing data, no recruitment was necessary. The client-therapist dyads were selected from a database of all client-therapist dyads included in the original UKATT study who gave consent for their data to be used for secondary analysis. Six client-therapist dyads were selected for analysis, of which three were from the MET arm of the study and three were from the SBNT arm. Equal numbers of each therapy type were selected as the two therapies had contrasting key features and protocols. It was decided that it was important for both to be represented sufficiently, though no attempt would be made to compare the two.

Therapist-client dyads that did not complete the full course of treatment (i.e., 8 SBNT sessions or 3 MET sessions) were included in the sample. This was decided as it was the norm, not the exception for this to occur, particularly in the data from the SBNT arm of the original study. Also, if the sessions had been terminated early for reasons to do with the therapy or some aspect of the therapeutic alliance, then rich data would be lost if this were an exclusion criterion. In some SBNT sessions, members from the client's support network attended the sessions, most often family members. These sessions were also included in the sample. These sessions were included because they were relatively high in frequency, and were recommended as best practice in the manual. If they were to be excluded there would be a risk of excluding rich data for arbitrary reasons.

There were some sessions, for which DVD recordings were not stored for unknown reasons, so client-therapist dyads that had more than one of the session recordings missing were not included in the sample. This eliminated a significant minority of the potential therapist-client dyads from the sample.

The client-therapist dyads were selected from the database to gain as rich a variety as possible with regards to both therapist demographics, client demographics, and the interplay between the two. They were selected in a non-random stratified manner according to the priorities shown in the tables overleaf:

Table 1: Table showing characteristics sought from therapists in priority order

Therapist demographic information considered in the sample
Professional background (in addition to 'alcohol addiction counsellor')
Gender
Age
Ethnicity

Table 2: Table showing characteristics sought from clients in priority order

Client demographic information considered in the sample
Gender
Age
Ethnicity

Table 3: Table showing general characteristics sought from therapist-client dyads in priority order

General factors considered in the sample
Number of sessions completed during the therapy
Geographic locality of therapy
Statutory vs. non-statutory services

Though the factors in the above table of geographic locality and statutory vs. non-statutory services were considered during sampling, this data has not been included in this report in order to preserve the anonymity of both the therapists and clients whose data was used. This was decided as individual therapists could potentially be identified with the noted demographic information in combination with the geographic location and type of service.

Attention was paid to gaining a variety of combinations between therapist and client demographics, for example having a young male therapist working with an older male client, or having an older female therapist working with a young male client. Unfortunately no ethnic diversity was achieved in the sample as all of the therapists and clients came from a white British background[2]. However, there was significant geographical diversity, though this is not explicitly noted in this document for reasons previously discussed. Only one of the client participants is female which is

[2] Both non-problem and problem drinking are significantly higher in the white population than any ethnic minority population in the UK. Problem drinkers from ethnic minority are underrepresented in their access to treatment. (Hurcombe, Bayley, & Goodman, 2010) In the original UKATT trial, 95.6% of participants were white british (UKATT research team, 2005).

representative of the participants in the original UKATT trial (UKATT research group, 2005), whereby only 25.9% were female.

Table 4: Table showing key characteristics of therapist-client dyads

	Therapist Name	Therapist 'core' profession	Therapist Age	Therapist Sex	Therapist Ethnicity	Client Name	Client Age	Client Sex	Client Ethnicity
SBNT 1	Donna	Nurse	20-29	F	White British	Craig	30-39	M	White British
SBNT 2	Sandra	Counsellor	30-39	F	White British	Tom	30-39	M	White British
SBNT 3	Sally	Nurse	50-59	F	White British	Polly	40-49	F	White British
MET 1	Jenny	Therapist*	20-29	F	White British	Peter	40-49	M	White British
MET 2	Nick	Counsellor	20-29	M	White British	Gregory	40-49	M	White British
MET 3	Jon	Psychiatrist	20-29	M	White British	Colin	60-69	M	White British

*No further information available on type of therapist

2.4.3 Selection of material to analyse

Table 5 below shows the number of session recordings for each client therapist dyad. There were no SBNT dyads that completed the full 8 sessions. For one dyad, the original research trial ended before all the sessions had taken place. It is unclear why the other two SBNT dyads did not complete the prescribed number of sessions. All of the sampled MET dyads completed the prescribed 3 sessions.

Table 5: Table showing the number of sessions analysed for each therapist-client dyad

	Prescribed number of sessions	Number of sessions that took place	Number of sessions that were recorded and analysed
SBNT 1	8	4	4
SBNT 2	8	4	3
SBNT 3	8	3	3
MET 1	3	3	3
MET 2	3	3	3
MET 3	3	3	3

All sessions from the six selected therapist-client dyads were viewed twice by the researcher in their entirety, and initial notes were taken with general thoughts about the topics discussed and tone of the sessions. This allowed for a brief synopsis of the course of therapy for each dyad, in order to set the main analysis within context. These initial viewings also allowed interactions that were particularly 'interesting' to be flagged. To begin with, this process allowed general discussions which were

focussed more on pragmatics of therapy such as explaining the research study or therapy process, or organising session times to be eliminated as potential sections to transcribe. The process of flagging 'interesting' moments was informed by considering a wide range of events and patterns of interaction such as level of adherence, flexibility, rupture, power imbalance, heightened emotions, awkwardness, and ease. Moments were in initially selected as 'interesting' when unfolding discursive events showed interactions which provoked feelings for the researcher. Many of these moments were flagged as interesting by the researcher because she felt uncomfortable in some way. For example, when the flow of conversation between client and therapist seemed disjointed, or the therapist's response to the client at face value raised feelings of anger or disappointment in the researcher. Other events were selected as 'interesting' because the researcher felt surprised by the direction of the therapist dialogue for some reason. This process of the researcher using their own personal feelings and reactions to select sections to transcribe is acknowledged as inherently subjective in nature. This is affected by the researcher's own general life experience, own clinical experience, and relationship with the data over time. This was logged through the use of a reflective diary[3] and discussed with research supervisors. From the initial viewing notes, extracts from each session were chosen which showed a variety of interactions across each therapist-client dyad. In order to situate the events of interest in context, the extracts which were transcribed from each session were at least 10 minutes in length. In cumulative time, approximately two thirds of the total session time was transcribed for in depth analysis.

As noted above, the selection of material was largely subjective, with data being selected for analysis based on my personal interpretation of it being 'interesting'. The reflective nature of this process is explored in detail in the discussion chapter. No attempt was made to select a representative subsample of data from all the sessions viewed, as every moment of interaction had different qualities and thus could not be categorised in any way that would enable this. Instead, the 'interesting' moments were selected for analysis in order to highlight the range of ways in which manualised therapies are used that are not commonly acknowledged. For the purposes of transparency table 6 is shown overleaf detailing the number of extracts that are referred to in the analysis chapter from each therapist-client dyad.

[3] Reflections on this process are detailed in the discussion chapter. Attempts were not made to eliminate bias, but instead to be aware of the influence that I had on the analysis.

Table 6: Table showing number of extracts from each dyad included in analysis chapter

Client Therapist Dyad	No. of extracts included
SBNT 1: Donna and Craig	VIII
SBNT 2: Sandra and Tom	IV
SBNT 3: Sally and Polly	VII
MET 1: Jenny and Peter	VII
MET 2: Nick and Gregory	VI
MET 3: Jon and Colin	III

2.5 Transcription

Sections of the sessions that were selected by the primary researcher for analysis were given time codes. These time coded sections of the DVDs were then transcribed by either myself or an external transcriber. Approximately half the transcribed data was transcribed by the myself, and half by the external transcriber.

Transcription was guided by a simplified version of the 'Jefferson Lite' method suggested by Potter and Hepburn (2005) (shown in Table 7). The method I used is comprehensive in recording overlaps, turn taking and intonation in speech, but time efficient by not recording times of pauses. Potter and Hepburn (2005) note that this method is sufficient for DP, capturing what is required whilst reducing the lengthy process of traditional Jeffersonian transcription practices (summarised concisely by Jefferson, 2004).

2.5.1 Transcription conventions

Table 7: Table showing transcription conventions used for analysis

(.) Short Pause
(…) Long Pause
[Used at the end of one speaker's speak and [Used in front of the next speakers speak to indicate an overlap in speech
(laugh) Information on non-linguistic features
[???] A section of text which was inaudible
Text Added emphasis in speech

It was decided that the visual data provided on the DVDs would not be included on the transcripts, so in essence, the DVDs were used only for audio dataduring the transcription process. This was decided because the DVD only provided visual data for the therapist as the client was not in view. If one were to

attend to the rich visual data provided on the therapist, but not the client, this would introduce unnecessary bias and assumptions based on the information that was and was not available to the researcher.[4]

2.6 Analysis

I initially read over the session transcripts with no attempt to formally code or analyse them. This allowed me to get a feel for the sessions and the general themes that may come across on initial impression. These initial thoughts and feelings were logged in a reflective diary that was kept throughout the research process. After I had familiarised myself with the transcripts, the transcripts were coded, with all sections of text corresponding to the research questions highlighted. Care was taken at this stage to look for sections with implicit relevance to the question in addition to those with a more obvious relevance. Firstly, I coded individual interactions for both adherence to the manual and apparent responsiveness to the client. In order to assign these codes, adherence was measured by comparing therapist speech to the techniques and philosophies that were prescribed in the treatment manuals. To achieve this, I familiarised myself with the treatment manuals and used my own clinical knowledge with regards to the implementation of these features. As the features from the manuals were not operationalized to facilitate coding; there was a degree of subjectivity in the measurement of adherence. This is acknowledged in the discussion section. The level of responsiveness to the client was measured through using my own clinical judgement scaffolded by a list of criteria to help inform my judgements. These criteria were:

- How the client reacts to the therapist discourse e.g. whether they engage with it, escalate what they are saying etc.
- My personal feelings towards the therapist's intervention e.g. annoyed, pleased, surprised
- My personal feelings towards the client as a result of the therapist's intervention e.g. contented, sympathetic
- Identification of other clear EBP interventions (that I am aware of) that are not prescribed by the manual.

Though these criteria were used to scaffold my decision with regards to how responsive the therapist was to the client; the judgements made were subjective and

[4] Of course bias can never be fully eliminated because whilst the DVD visual data was not used for transcription and formal stages of analysis, the visual data was viewed by the researcher whilst watching the sessions in their entirety. This introduces an element of bias by providing partial visual context to the researcher.

relied largely on my fallible clinical knowledge. This is discussed further in the discussion chapter.

With regards to the third research aim of examining how therapists negotiate difficult experiences within the practices of therapy; I also coded the transcripts for all of the interactions which related to difficult experiences; either for the client, the therapist, or both. This included both interactions which were difficult in the moment during therapy and the reporting of difficult experiences that happened outside of therapy. In order to analyse the transcripts with regards to the first research aim of examining taken for granted assumptions that are enacted by therapists; no coding for particular interactions was made as all interactions through the session transcripts were seen to be relevant.

The relevant sections were analysed in relation to the research question using discursive psychology principles. Initially the text was studied for the identification of discourses and interpretative repertoires that were drawn upon by the therapists. These terms have more similarities than differences (Edley, 2001), though there is a subtle distinction between the two. Edley (2001) clarified this difference by stating that 'discourse' is used to describe constructs of wide structures such as medicine, or feminism; whereas 'IR' refers to smaller idiosyncratic discursive constructs. Potter and Wetherell (1987) note that an IR is "a register of terms and metaphors drawn upon to characterise and evaluate actions and events."(p138).

Throughout the process of analysis, an emphasis was put on discourse as a subjective construction of reality. Therapists took multiple roles and positions through the discourse that they used, and their discourses drawn upon served multiple functions. Care was taken to consider the multiplicity of the discourse, though it is acknowledged that my analysis of the discourses is only one way to interpret these meanings.

Once discourses and IRs were identified, the analysis focussed on the action orientation (Potter & Wetherell, 1987) of these. Analysis extended to context and the function of the IRs and discourses that were drawn on, the exploration of the rhetorical devices that were used which enacted the IRs, and the subject positions that were promoted as a result of their use. The figure overleaf shows the list of questions I asked myself during analysis which were guided by the principles of DP.

Figure 1: Figure showing key questions informing analysis

Focus of Analysis (Informed by Potter & Wetherell, 1987; Edwards & Potter, 1992; Willig, 2008; Davies & Harre, 1990; Billig, Condor, Edwards, Gane, Middleton, & Radley, 1988)

- What interpretative repertoires/discourses are being drawn upon?
- What is the context in which this interpretative repertoire is being used?
- How are these interpretative repertoires being enacted?
- What ideological dilemmas are being played out through the use of conflicting interpretative repertoires?
- What is the action that is being performed? To what end is this discourse being used?
- What is being constructed by the use of this discourse?
- How does the speaker position self and other by using the discourse?
- What discursive strategies are being used? E.g. disclaiming
- What is the function of using these strategies? Both internal and external to speaker. What subject position does it construct both for talker and receiver?
- What effect does the discourse have on the person receiving it? How do they respond?

Once all the above questions were asked of all the transcripts individually, key similarities and differences were drawn together across the transcripts. Themes were identified which appeared across the transcripts with reference to each research question. Extracts were grouped into these themes to enable a more detailed analysis. During the final stages of the initial analysis these extracts were then resituated within the original sessions in order to contextualise the observations drawn from the analysis.

Once the initial analysis of the sessions was complete, this was discussed with the supervisors of the project as a quality assurance measure. As mentioned above, the analysis conducted in this project is based on a particular informed reading of the data by the primary researcher; other interpretations may be just as valid. Therefore, the corroboration of the analysis was not intended to ensure that the data was interpreted in the 'right' way, but instead that the data were interpreted in a thorough and coherent way and told a valid story as a result.

During the process of writing up the analysis, sections of transcripts were selected to demonstrate the discursive features which were commonly identified under each theme. Pseudonyms were given to all the participants who were referred to in the write up. In order to anonymise the transcripts, regional dialogues and local references were removed from the text. Within the write-up, the context was given for

each excerpt, with extended transcripts in order to prevent reductionism. This also allowed for the client responses to therapist discourses to be incorporated into the discussion of the extracts.

2.7 Quality Assurance

In order to make a legitimate contribution to our understanding of therapist discourse as this study intends, I considered a number of quality assurance criteria to ensure I was adhering to principles of good practice. Regarding qualitative research more generally, Elliott, Rennie and Fischer (1999) noted that it is important that it is explained where the sample comes from, that the analysis is grounded using examples to demonstrate the points that are made, and that the analysis is coherent and resonates with the reader. They also note the importance of the researcher taking ownership of their own perspective on the analysis they undertake and the effect this has on any conclusions which are drawn. This is echoed by Leuder and Antaki (1996, p.24) with regards more specifically to DP informed approaches. They note that the reflexivity is integral to the process whereby the researcher must be aware of and report the influence that they have on the analysis. They also note that as all discourse is used in context, it is important that the context from which the discourse being discussed has come from is conveyed. Therefore when quotes are used they are both "de-situated and re-contextualised as evidence". This serves to ensure that ones' own influence is accounted for, and preserving the context of the discourse, protecting against over interpretation of the data. The importance of the consideration of these issues is echoed in an opinion paper by Antaki, Billig, Edwards and Potter (2003) who noted a number of traps that researchers using DP can fall into, which lead to inadequate analysis of their data. These include: summarising the text without adding any new understanding, over-using quotations and allowing them to 'speak for themselves', merely spotting rhetorical devices and not explaining the significance of them in the text, taking sides when analysing the data leading to a biased representation, and overgeneralising the findings in a way that DP does not intend to.

2.7.1 Researcher reflexivity

Researcher reflexivity is an imperative part of the process of qualitative research and DP (Elliott, Rennie, & Fischer, 1999; Leuder & Antaki, 1996). I incorporated this into the process of research, writing my reflections throughout the project in a reflective diary. This diary was used to inform the analysis, both by incorporating ideas of how the data might be interpreted, and by noting potential pitfalls that I felt there was danger of succumbing to. In this section I show some of the

reflections that occurred during the stages of analysis. Further reflections on the research as a whole, and the implications of these on the findings are placed in the discussion chapter.

During the analysis I paid particular attention to what my interpretation of the text was. In doing so I considered why I chose to see the text in a certain way, and whether there were other ways I could interpret it. An example of this is when I felt that as a clinician I would have done something differently to the therapist. At such a point I purposefully re-analysed the text to minimise the potential for my personal views to bias the analysis. I also discussed the analysis of these particular sections with my research supervisors who offered their own interpretation as a challenge to or confirmation of the way I had interpreted it. This prevented me from falling into the trap of under-analysis by taking sides (Antaki, Billig, Edwards, & Potter, 2003).

At other times, I found myself making assumptions about why the therapist was using a particular discourse, or even feeling angry at them for having 'chosen' to speak in a particular way. Potter, Edwards and Wetherell (1993) note that when using DP principles we must be "agnostic with respect to issues of "planning" or "real motive"" (p387). By returning this principle, I was able to see that I had no way of knowing why the therapist had used a specific discourse, or whether they had actively 'chosen' to use that discourse. Therefore, at such times I noted my strong feelings in order to locate what triggered them and to be able to move back to appropriate analysis of the text by looking at the function of the discourse.

Chapter 3. Analysis

In this section pen portraits are given to show an outline of the key features of the process of therapeutic interactions between each therapeutic dyad. Interpretative repertoires that therapists drew upon during the course of therapy are then explored. These repertoires are then explored further with regards to the discursive practices that are used to facilitate behavioural change. These repertoires are discussed with consideration to adherence to the treatment manual and clinical skills used in responding appropriately to the clients' needs. Finally the discursive practices that therapists used in response to clients' emotive expression are explored.

3.1 The Therapy Sessions

SBNT 1: Donna and Craig

Craig described how he was currently alcohol free and was struggling with his cravings for alcohol. He stated that he was depressed and found it difficult to get motivated to do anything. The client seemed concerned about his depression. Donna did not address the depression other than to note the anti-depressants he was taking. Donna was keen for Craig to become more active in order to help cope with his cravings. In the first three sessions she offered several suggestions, and tried to argue and convince Craig that taking action was the only way to remain substance free. Craig did not respond to this approach, and reiterated that his mood was worrying him significantly. In the fourth and final session, Craig was brighter in mood, and responded more positively to the therapist action planning approach to recovery.

SBNT 2: Sandra and Tom

The therapy lasted for four sessions, though only three recordings were available. Tom's partner, Steven, attended the third session. Tom presented as well educated and was employed in a highly skilled field. Tom was drinking every evening and working to reduce the amount he was consuming. Sandra worked closely with the treatment manual, introducing different topics to be discussed in each session, whilst Tom sometimes brought other topics which he wanted to discuss. Tom (and Steven in session 2) took an active role in the sessions, bringing conversations round to what he felt was useful to talk about. Sandra made several attempts to direct the therapy, taking the focus back to topics prescribed by the manual. The relationship between Tom and Steven was fractious at times, and Sandra attempted to manage this within the joint session, and made reference to this in other sessions.

SBNT 3: Sally and Polly

The therapist, Sally, was a female nurse in her forties and the service user, Polly, was a female in her forties. The therapy was SBNT and lasted for 3 sessions. Polly was drinking dependently in the first session, and this escalated over the course of therapy. Polly's sister, Gwen, attended the second session, and showed concern and support for Polly. The third session was an 'emergency session' which took place after Polly relapsed in her drinking. This session was arranged prior to admission, a few days later, at an inpatient unit for an alcohol detox. Polly described a difficult life involving domestic abuse from several partners, including her current partner. She reported several incidents of serious self-harm and attempted suicide. Sally gave space to Polly to explain the difficulties she was experiencing and discuss how she felt. At times, Sally supported Polly to manage her situation, and at other times she was more active in taking responsibility for managing it.

MET 1: Jenny and Peter

Peter was drinking heavily during the course of the sessions, asserting that he wanted to stop, but wanting one last binge for his approaching birthday. Jenny was motivational in the language she used with Peter in the first session, and her talk was responsive to his needs, though she did not have a warm tone. Furthermore, there was not a strong positive therapeutic relationship between them. In the second session, Peter was under the influence of alcohol and made a sexual comment towards Jenny. In the third session, he was critical of the sessions. In both these sessions, Jenny showed frustration with Peter and her talk was less responsive to his needs. Towards the end of the sessions, Peter stated that he wanted a medical detox rather than the therapy he had been offered.

MET 2: Nick and Gregory

Gregory was retired, and was drinking every evening. He was not drinking a large amount, although felt it was enough to seek help as his drinking was causing complications to his existing health conditions. Nick and Gregory had a good therapeutic alliance throughout the sessions. Initially, Gregory questioned the information that Nick was giving as part of the manualised therapy. Nick responded openly and non-defensively to this. Throughout the sessions, Nick worked motivationally with Gregory and there was sense of ease and irreverence between them. By the end of the sessions, Gregory had become alcohol free, and was pleased with the progress he had made.

MET 3: Jon and Colin

Colin had been alcohol free for two months when he attended therapy, though he was drinking heavily when he was initially assessed prior to this. During the sessions, Jon and Colin had a good rapport. As Colin had already been alcohol free for some time, and appeared to be coping well, the focus of the conversations was on the future, and maintaining these gains. The sessions were upbeat and they developed a familiar relationship with one another.

3.2 Interpretative repertoires

This section of the analysis discusses the interpretative repertoires (IRs) that therapists drew upon in the sessions with regards to what mechanisms promote client behaviour change[5]. These IRs are:

- Therapist's actions are responsible for enabling change
- Clients are responsible for changing their own behaviour
- Therapeutic alliance is required for change

All six therapists drew upon all the IRs at some point during the sections of sessions that were transcribed and analysed.

Below, each IR is introduced and outlined with reference to its origins within the treatment manuals and examples from the data set. It is important to note that the IRs are not simply enacted but are drawn upon in different ways according to which treatment the therapist is using. The use of each IR is also influenced by the client's needs and therapist's agenda alongside any other extraneous factors. In the second section, the rhetorical devices and discursive practices that therapists used to enact IRs are shown in context.

3.2.1 Therapist's actions are responsible for enabling change

In all of the sessions, almost by default, the therapist assumed at least some responsibility for a change in the client's drinking. If the therapist were to take no responsibility, this may call into question what they are contributing to the client's situation that would be any different than if they were not accessing any therapy. The IR that the 'therapist's actions are responsible for enabling change' appears in all of the therapist-client dyads analysed by this research study. However, the amount of responsibility that therapists took for change varied across the therapists in different situations, as does the way that it is drawn upon. This is demonstrated through the

[5] This section focusses only on how therapists construct client behaviour change, with reference only to feelings and emotions when this emerges as an issue within this construct. How therapists manage the expression of feelings is discussed later in the analysis (section 3.5).

use of differing discursive practices detailed in the second section of this analysis. For example, this IR can be drawn upon both with a paternalistic function to act on behalf of the client or in a more forceful manner as a reaction to client resistance.

This IR is fundamental to the theoretical mechanisms of SBNT. The treatment manual for SBNT encourages therapists to set the agenda for the sessions, offer advice when appropriate, act as an active agent of change, and be a 'team leader' of the social network. This is in contrast to the MET manual which encourages therapists to take responsibility for using appropriate speech in order to promote the client's motivation and personal responsibility.

In the below extract, Sandra (Therapist) is having an exchange with Tom (Client), and his partner, Steve, in which she constructs herself as actively responsible for Tom's behaviours. Tom's original goal was to drink a limited amount of alcohol within specific times. During the discussion prior to this extract, Tom stated that he wanted to continue the reduced intake, but that the prescribed time limits were not practical. Through enacting this change in goal at home, rather than discussing it first, this had resulted in arguments between Tom and Steven. Within this extract Steven constructed the issues they were having in their relationship as due to a lack of communication.

SBNT 2 Session 2

1 *Steven: if he has said "look I know", like I say if he had said "look I know it's early but I'm going to*
2 *go out, I won't drink any more than normal" then maybe yeah I could have accepted that*

3 *Sandra: I think that that, you know for me, what seems to have been useful about this is, is that*
4 *you're talking about what's going on each of [you*

5 *Steven: [lacking communication*

6 *Sandra: yeah exa[ctly*

7 *Steven: [it's a lack of communication*

8 *Sandra: and that's what, that's what this session is about and if you find this session useful we can*
9 *repeat it later on, you know, there are eight sessions, each with a different focus erm and*
10 *we've got some core focuses which we have to do like, communication, coping, relapse*
11 *management plan, but there are other ones which are selective and if there's nothing in*
12 *there you fancy then you think well that was really useful, we can go over that again*

13 *Tom: yeah*

14 *Sandra: I've marked on here then that you, that we're going to be more flexible in the timing in*
15 *the times, so that that's erm, but also I don't want that to mean that you don't*
16 *communicate about that*

17 *Tom: no no, I appreciate that*

Following the explanation that Steven gave constructing Tom as not communicating his intentions with regards to how much he was going to drink and when, Sandra responds in line 8 by reiterating that the manualised treatment allows

for further discussion about communication if they feel this would be useful. By doing this, she offers choice to the client, but also constructs the therapy, and indirectly herself, as a useful facilitator of improving communication. She then goes on to state in lines 14-16 that whilst acknowledging Tom will be more flexible in the timing of his drinking, that this does not negate the need to communicate what he is doing. In doing so, she draws upon the discourse that her actions are responsible for change. By reiterating the need to communicate following the affirmation of his revised drinking goals, she constructs herself as an active agent who has to manage the possible effect that this may have on his communication.

3.2.2 Clients are responsible for changing their own behaviour

All therapists drew upon the IR that clients are responsible for changing their own behaviour at some point during the course of the sessions. The treatment manual for MET focuses on the necessity for the therapist to facilitate client discourses (and thus assumed internal processes) to move towards personal responsibility and motivation to change, which then fosters responsibility for the client to make positive choices and take actions outside the session. In contrast, the SBNT manual encourages therapists to lead clients within the sessions in order to promote their ability to take responsibility to change outside the sessions. Both these approaches promote the IR of the client being responsible for changing their behaviour, but using different mechanisms, and to varying degrees. Arguably MET places more emphasis on a client taking responsibility through empowering them to make choices, whereas SBNT constructs the therapist as taking responsibility to facilitate clients to take responsibility.

In the following extract, Jon (Therapist), emphasises one of the decisions that Colin (Client) has already taken regarding medication as a determination to make changes.

MET 3 Session 1

1 *Colin:* *Erm back in December I went and saw erm there's [?] I saw another fella, another doctor*
2 *and I said I need help and he said "that's no problem, I can arrange that", and he was the*
3 *one who put me on to Louise and it's all snuggle from there. She comes out to me to make*
4 *the arrangements, I then saw her and discuss about the detox and everything else and*
5 *she said "do you want to give up?, [???] or the lot?" and I said "the lot" and it went from*
6 *there. She explained to me about the different pills. With my past medical history she said,*
7 *she advised me to go on the weaker ones*

8 *Jon:* *Campral*

9 *Colin:* *yeah. and I insisted that I went on antabuse*

10 *Jon:* *so you were determined*

11 *Colin:* *yeah. because erm she said "you can't really go on that because you've had heart attacks,*
12 *well a heart attack, you've had a stroke, you've had angina attack erm ruptured ulcers,*
13 *so it's advisable you don't go on it." And I said "well I insist"*

14 *Jon:* *You were absolutely determined*

15 *Colin:* *yeah. and so she went and got advice from her governors, her powers that be and I*
16 *started on them and I haven't looked back they're tremendous.*

Jon responded to Colin's description of choosing the stronger medication by stating "so you were determined" (line 10), and reiterated this message on line 14 when Colin continued to explain his decision. By constructing Colin as determined in making this decision, Jon made a link between Colin's motivation and action as well as affirming the decision he made. This has the function of constructing Colin as able to make changes independently therefore empowering him to continue to do so.

In contrast to the above example illustrating how the IR that clients are responsible for changing their behaviour can serve the function of empowering the client to do so, this IR can also be drawn upon in order to construct the client as 'at fault' for not having changed their behaviour. In the below extract, Jenny (Therapist) responds to a disclosure from Peter (Client), in their last session, that he had increased his drinking since they last met one month before.

MET 1 Session 3

1 *Jenny:* *So this is our last session Peter.*

2 *Peter:* *Yeh*

3 *Jenny:* *What I was going to do was talk a little bit about what you first came to us with, which*
4 *was at the end of November last year, and you know, go back through all the worries*
5 *that you had about your drinking then, and then look at the plan that you made about*
6 *what you wanted to do about it, and then ask you how you got on. Does that sound ok?*

7 *Peter:* *I haven't done nothing.*

8 *Jenny:* *You haven't done anything?*

9 *Peter:* *No*

10 *Jenny:* *So things are much the same.*

11 *Peter:* *Well if anything I'm drinking more.*

12 *Jenny:* *Right, right. Ok well I'm going to go through that again anyway and then we will talk*
13 *about what has happened since. Ok? Right, when you first came we gave you all that*
14 *feedback on your drinking, all that information on how much you were drinking, your*
15 *tolerance, and how it had affected you. Erm, and one things that you said was that*
16 *although you're drinking made you feel less anxious in the short term you thought that*
17 *probably in the long term it had made you feel generally much more anxious, and it was*
18 *also quite isolating for you. You were going into pubs that you saw as the most empty*
19 *ones and drinking on your own. Yeh?*

20 *Peter:* *uhuh*

21 *Jenny:* *Erm, you, you were thinking that something was going to happen with your health about*
22 *your drinking although you weren't, you thought well it's going to be in the future and it*
23 *was difficult to tell how worried you were about your health and drinking. Erm, but I*
24 *think the main thing was that you erm, with your work, you'd already had a written*
25 *warning and that was because of your drinking, (mm) erm, and also if you were going to*

26 *be made redundant and get a pay off if you like, if you didn't stop drinking, that the*
27 *chances are that money would all go onto drinking. And that some really severe*
28 *consequences didn't it. You could see that you had an awful lot to lose if that happened. Is*
29 *that a fair summary?*

30 *Peter:* *uhuh*

31 *Jenny:* *So you thought that you wanted to stop drinking completely. Erm, when I saw you about*
32 *a week after that first time. Erm, and there were lots of different things that you talked*
33 *about that you wanted to do. You talked about taking up Tai Chi, erm, and Buddhist*
34 *meditation, and you also talked about going on a pilgrimage, I think it was to Sai was it?*
35 *(uhum) yeh. Erm, volunteering with the NSC, the NS, the animal, yeh, sorry I don't, I can't*
36 *remember what it's called. And doing other things like reading and so on. And that that*
37 *you felt, you felt that you had an awful lot to offer. Erm, maybe even counselling, that*
38 *sort of thing, there's an awful lot of things that you could do but drinking would actually*
39 *stop you from doing that. Erm, and you said that you know at the time that you were sick*
40 *of feeling ill because of drinking erm, and you didn't want to spend your redundancy*
41 *money, and you thought that there were goals that you could really achieve that you*
42 *could really get on with and be a lot happier, if you weren't drinking. Yeh?*

43 *Peter:* *uhuh*

44 *Jenny:* *What actually <u>has</u> happened in the last couple of months Peter?*

45 *Peter:* *I managed to buy a Buddha. But that's the nearest things I've done to*

Jenny explains at the beginning of the session that she intends to summarise what had been previously discussed, and then explore how Peter had progressed since. Peter immediately states that he has not made any progress, and has in fact been drinking more, before Jenny is able to review previous discussions. After Peter makes this disclosure, Jenny continues to summarise Peters concerns about drinking (lines 12-29), and his plans to address his drinking (lines 31-42). By continuing to offer this summary immediately following his disclosure, Jenny emphasises all the plans that he had failed to enact and in doing, constructed Peter as not having done what he stated he would do last time they met, indicating that he was responsible for this opposing decision. By summarising, it is not necessarily apparent that she is reiterating his failings, as she could be adhering to the manual and the signpost that she gave that she would summarise, without consideration that this might be interpreted as blaming. However, the tone of the question on line 44 suggests that Jenny is constructing Peter as not having done what he expressed he would. By emphasising the word "has" when asking what has happened she implies a judgement that not much has happened when it should have. By drawing upon the IR that he was responsible for making changes she is able to construct him as to blame, and absolve her responsibility.

3.2.3 Both client and therapist in collaboration are responsible for change

The IR that both client and therapist in collaboration are responsible for was drawn upon by all therapists in their discourses to varying degrees. Both the MET and the SBNT manuals construct collaboration as an essential therapeutic ingredient, although there are key differences in regards to the priority to which it is given. In MET, collaboration is a fundamental philosophy and contributes to the mechanism of change in itself, whereas in SBNT it is acknowledged as a useful, though the content of the therapy is prioritised. This IR was drawn upon in a number of ways. At times, the collaboration between therapist and client was clear through the open discussion of ideas towards a common goal. At other times collaboration was enabled by more subtle mechanisms, for example the therapist positioning themselves through talk as "one-down" (Watzlawick, Weakland, & Fisch, 1974) in order to allow the client to occupy the "one-up" position to even out the inherent power imbalance. The discursive mechanisms that underpin this IR are discussed further in section 3.3.5, as 'being collaborative' was categorised as a key discursive practice in its own right.

An example of this is shown below whereby the therapist, Nick, responds to the client, Gregory, asking whether he should complete some extra homework (i.e., a drinking diary). To put this in context, Nick had previously suggested this, but Gregory had not done so.

MET 2 Session 1

1 *Nick: Right, so in this moment, the thing you want to do is to not drink.*
2 *Gregory: Yeh, I think that's going to be the only way of doing it. (right) And how I go to get there*
3 *is completely another question entirely.*
4 *Nick: Yeh, I mean that's, that's the thing. I mean one thing is knowing what you want to do,*
5 *and the next bit is knowing how to do it.*
6 *Gregory: I've still got that double sided edge (yeh) in me, that goes no you don't. Yes you do, no*
7 *you don't, yes you do [laughs].*
8 *Nick: yeh, yeh, I mean that bit about knowing how you can go about doing that. I mean, that's*
9 *something we can certainly look at together (yeh) and maybe give some thought in time*
10 *for us to meet next time.*
11 *Gregory: Would you like me to keep an actual drinking diary for you and me? (yeh) So you know,*
12 *the next time I come, I can actually say how many units I've really had.*
13 *Nick: mm I mean, do you feel like that would be useful for you?*
14 *Gregory: Erm, (.) I think it would be useful as a direction. (right) And I think it would be useful as*
15 *an exercise (yeh,) So that each time I have a drink of a night, if I have one, on a night, the*
16 *ideal would be zero unit (yeh), but it would just be great to say that 4 units instead of 8.*
17 *(yeh) And for that point of view if I'm seeing 9 units or if I see 16 units then I think 'well*

18 *hang on' (mm) you know. And that's a verbal way of doing it (yeh) But it's visual also*
19 *(yeh, yeh). A visual way of seeing.*
20 *Nick:* *Why not go for it, I mean try that, try doing the drink diary, see what benefits, you know,*
21 *what effect it has on you doing that.*

In the above extract, Nick makes it clear in line 13 that Gregory should only complete the drinking diary if he feels it is personally useful for him. By stating this, Nick rejects the opportunity to take an expert position, and instead frames the decision as the clients' to do what he feels best. This is concurrent with the philosophy of MET, whereby one must be motivated to do something for oneself or it will not be done and is respectful of Gregory's agency within the sessions. Also on line 9, Nick says that how to be alcohol free is something "we can certainly look at together." This also demonstrates collaboration between therapist and client to work towards a common goal Following Gregory's statement that he is keen to complete the diary (lines 14-19), Nick then says "*Why not go for it" (line 20)* using more familiar language and conveying that he supports this decision, but that he has no expectation that he must do it. In doing so, Nick allowed Gregory to own the idea of completing the diary as he raised it as an idea on this occasion, without displacing the ownership back onto himself having been the one who originally introduced the idea.

3.3 Discursive Practices

This section of the analysis discusses the discursive practices used by therapists to negotiate through the therapeutic sessions by linking back to the IRs that are drawn upon. The therapists' discursive practices were analysed for the action orientations they performed and the subsequent subject positioning that these practices constructed for the client and the therapist. The discursive practices are discussed in detail below.

These were:

- Being paternalistic
- Being critical
- Lecturing
- Persuading
- Being collaborative
- Being familiar
- Constructing self as a powerful expert
- Acting as benevolent expert

Whilst categorising these practices for ease of discussion; different therapists in different contexts drew upon similar discursive practices to different ends. In many

cases, there is considerable overlap between categories. For each category there are many examples from the data that could be used to represent the discursive practices used. To illustrate each category, examples which demonstrate the practices identified are illustrated.

Table 8: Table showing the discursive practices identified in each therapeutic dyad

	Being paternalistic	Being critical	Persuading	Lecturing	Constructing self as a powerful expert	Being familiar	Being collaborative	Acting as benevolent expert
SBNT 1	●	○	○	○	○	●	●	●
SBNT 2	●	●	●	○	○	●	●	●
SBNT 3	○	●	●	●	●	-	●	○
MET 1	-	○	●	●	●	●	○	-
MET 2	●	-	-	●	-	○	○	●
MET 3	●	-	-	-	●	○	○	●

● Present in extracts analysed ○ Predominant in extracts analysed

- Not present in extracts analysed

As illustrated in the above table, the majority of discursive practices appeared at least once in each dyad. To differentiate, the predominant practices for each dyad is displayed.

3.3.1 Being paternalistic

Five of the six therapists used paternalistic discourses at some point during the process of therapy. Paternalistic discourses involved taking charge of the talk in the session, and directing the topics in a way that the therapist felt would be best for the client. When therapists used a paternalistic discourse, they drew upon the IR that therapist actions were responsible for enabling change.

In the below extract, Sally (Therapist), along with Polly's sister, Gwen, suggests to Polly (Client) that she could transfer to another GP practice.

SBNT 3 Session

1 *Gwen:* *I just think it's because she just can't, cos she(.) she's never been able to get on*
2 *with her doctors*

3 *Polly:* *I just can't talk to them, I don't even like going to them, I'll stop myself from*
4 *going if I've gotta go.*

5 *Sally: Is there another GP practice close to you that you could change to?*

6 *Polly: Well it took me how long to get that one?*

7 *Gwen: I have told her to try mine because he's a very very good doctor*

8 *Sally: Is he?*

9 *Gwen: He's an excellent doctor and he would take her on his list*

10 *Sally: It's worth considering*

11 *Polly: I might try that one, because I really don't get on with my doctors*

12 *Sally: but for your sake and your health's sake you need to do something. Yeah,*
13 *because you've said you've managed to stop yourself, umm, but you do need*
14 *some kind of…*

Instead of telling Polly that she feels this is what she could do, she uses an "advice giving interrogative" (Butler, Potter, Danby, Emmison, & Hepburn, 2010) by asking "Is there another GP practice close to you that you could change to?". By doing this, she is offering advice, whilst avoiding placing herself in a position of power. By asking Polly about the logistics of another nearby practice she positions Polly as the expert in determining whether the advice is applicable to her. Sally then promotes the Gwen's position as knowledgeable by asking a follow-up question "is he?" to elicit more information about an alternative GP that Gwen has suggested. Following Gwen's statement on line 9 recommending her GP, Sally endorses the statement using her category entitlement (Sacks, 1974) by stating "It's worth considering" allying herself with Gwen to convince Polly to change GP. At the end of the extract, Sally positions herself as more of an expert to tell Polly more directly that she needs to do something. In doing this, she makes an emotive plea to Polly which emphasises to her Sally's perceived seriousness of the situation. She makes a 'show concession' (Antaki & Wetherell, 1999) (lines 12-14) whereby she initially proposes that Polly needs to take action "*but for your sake and your health's sake you need to do something".* Sally then concedes that Polly has been able to stop herself, "*Yeah, because you've said you've managed to stop yourself".* This demonstrates that she acknowledges this, which then adds emphasis to the reassertion that despite this, she still feels that the Polly needs to enlist additional support *"umm, but you do need some kind of…"* This was characterised as adherent to the SBNT manual as Sally was actively supporting Polly in recruiting people to her network who would be supportive of the changes she is trying to make. Sally and Polly had demonstrated a strong therapeutic alliance throughout the sessions, whereby Sally was supportive and responsive to Polly. Therefore in this instance, this example of paternalistic discourse was characterised as responsive to the client as, Sally was drawing upon the trust they had within the alliance to support Polly in making a decision. If the context of this interaction was not built upon already having a strong therapeutic alliance, it may have been characterised as less responsive,

and more critical; as a didactic statement such as "*but for your sake and your health's sake you need to do something"* (line 12) could be constructed very differently if it were not said within such a supportive context.

The following extract is from the third session of Polly's SBNT therapy with Sally. Polly is talking to Sally after disclosing a recent serious incident of self-harm.

SBNT 3 Session 3

1 2 3 4	*Polly:*	*I dunno. (...) I know I'm scared of myself. (yeh((.) And I'm scared of me really. I'm scared of what I can do. (Mhhm)(...) And I can't stop it. Sometimes when I know what I'm doing, and I try and stop it, I can't. I've even got the electric knife (...)*
5	*Sally:*	*And what stopped you?*
6 7 8 9	*Polly:*	*Sally. (...) I don't have the electric knife in the house, He's broke it up and throw it away. (...) I just {???} It would be quicker. (.) Then I'll sit down and I'll say why do you want to hurt yourself? (.) I can't answer it, coz I don't know. (...) I know I don't want to die.*
10	*Sally:*	*You know that?*
11	*Polly:*	*But I know it's going to happen if I don't stop.*
12 13	*Sally:*	*That's the danger, yeh (...) And I think, the best thing we can do is get you in as soon as we can. (.) yep?*
14	*Polly:*	*yeh*
15	*Sally:*	*But we also need to look at what help you have long term*

Initially, Sally asks what might be considered a risk management question by enquiring what stopped Polly from hurting herself (line 5). Through asking this question, Sally is also presenting to Polly the idea that she had personal control by making the decision to and being able to stop herself. When Polly replies (line 6), she does not accept that she has personal control, and explains that her partner has destroyed the knife she was to use and that she does not know why she wants to harm herself. Here, Polly positions herself in a helpless role, despite, on this occasion, Sally's question positioning her in an empowered role. By going on to state she does not want to die, she shows that though she feels helpless, she does have a willingness to survive. By Polly constructing herself as helpless yet willing to be helped, she invites Sally to help her. Sally responds to this plea by stating *"And I think, the best thing we can do is get you in as soon as we can. (.) yep?"* (lines 12-13). Although Polly's wish to be admitted had been discussed earlier in the session, Sally reframes the discussion as evidence that she and the treatment team have made the right decision to admit her. By doing this, Sally constructs herself and the team as decision makers who are taking care of Polly. This reinforces the helpless role that Sally has placed herself in as it suggests that she will be taken care of as she is unable to do so herself. For reasons similar to the ones

given for the extract above between Sally and Polly, this paternalistic discourse was categorised as both responsive and adherent. However, though the discourse was characterised as responsive to the client, it did place Polly into the role of the 'helpee' which is non-collaborative (Parker, 1999); and there were alternative discourses Sally could have used which would have been more empowering for Polly.

These two examples of paternalism discourse are similar in that the therapist is positioning herself in a 'saviour' role which fits alongside the 'victim role' in which the client is positioned. This dynamic is reciprocal, as by positioning herself in the 'saviour' role, she invites the client to fulfil the 'victim' role. One function of the discourse is to help the client to do what she already wants to (help herself become alcohol free) but feels she cannot.

In contrast, the following extract shows Donna (Therapist) drawing upon paternalistic discourses to move Craig (Client) forward in the way that she feels is best for him. By attempting to move Craig forward in this way, she positions herself in the role of knowing what is best whilst Craig is positioned in a role whereby he does not appear to know what is best for him and needs to be told (passivity). This extract was categorised as adherent to the SBNT manual as it involved Donna taking the lead in attempting to help Craig take action to move forward. However, because the direction that Donna was trying to lead Craig was not co-constructed or responsive to the issues that Craig was prioritising at the time (his low mood) it was categorised as not responsive to the client.

SBNT 1 Session 1

1 *Donna: so that you're not going to go out and spend it in the pub. And that's worked up*
2 *to now?*

3 *Craig: yeah*

4 *Donna: but maybe we need to look at how you cope with it in the longer term. Because I*
5 *guess a year from now you're not going to want your mum to have your money,*
6 *erm even though that's been very effective up till now.*

7 *Craig: Hmm*

8 *Donna: other things we need to look at are the way that you spend your time, because it*
9 *sounds at the moment like without alcohol there's not a lot going on for you.*

10 *Craig: No.*

Craig has expressed throughout the session that overcoming his problems with low mood is a priority, whereas Donna stresses the need to think about activities to occupy his time. The suggestions that Donna makes to Craig are not made in consultation with him, and appear to be unlinked to his priorities. However, in lines 4

and 8 Donna uses "we" which constructs her suggestions as more collaborative than they actually are.

As noted, by using a paternalistic discourse, Donna imparts to Craig what she feels are his priorities for treatment (i.e., activity planning). By choosing to construe those decisions as made to Craig without consulting with him, it is likely that these are drawn from her repertoires and the SBNT manual only, and not in reaction to those expressed by Craig. For example, Donna uses a widely available discourse of Western society, 'individualism' (e.g. Triandis, 1990), and constructs Craig as an adult who should want to have control over his own money in order to justify her rationale for suggesting alternative strategies (lines 4-6), rather than Craig stating that he wants this for himself. She does preface this as an assumption by saying "I guess", though as she has constructed it as a value judgement this leaves little room for Craig to disagree without fearing judgement.

Donna also draws upon the discourse that alcohol causes social isolation (e.g., Crosnoe, Benner, & Schneider, 2012) as a rationale for suggesting plans for activity to promote recovery. By voicing this discourse, she attends to the IR that not all potential topics are relevant to change and neglects or, perhaps, discredits the competing available discourse Craig endorses; that low mood promotes and is maintained by social isolation (e.g. House, 2001). This, therefore, reduces the likelihood of Craig discussing the impact of his low mood on his activity levels, which is something that he had previously indicated as a significant concern to him.

3.3.2 Being critical

Another discursive practice that was observed in four of the six therapy dyads was the therapists "being critical". The below extract demonstrates how Jenny (Therapist) uses this discourse when Peter (Client) arrived at his final session under the influence of alcohol.

MET 1 Session 3

1 *Jenny:* *What have you actually done to try and change your drinking Peter?*

2 *Peter:* *Just drunk more. (.) You know, because I just sor. er, I don't know what I were*
3 *expecting. It's just that it's depressed me if anything you know.*

4 *Jenny:* *mm ok, Coz when I saw you last time, you seemed, you know, pretty confident*
5 *that you could actually change your drinking, and you had lots of really good*
6 *ideas of the things that you could do to help that. Have you actually done any of*
7 *those things?*

8 *Peter:* *Nothing.*

9 *Jenny:* *Why is that?*

10 11 12	*Peter:*	*Because {???} I'm a very negative person, I've just, I don't know, I've just got no goals in life really. I mean I have, I have got goals if you know what I mean, but I've got no motivation, put it that way.*
13 14 15	*Jenny:*	*mmm, but you've told me a lot of things about, you know, you did have a lot to offer, and that sounded like you did have quite a bit of motivation that you could do other things, that you liked to achieve other things.*
16	*Peter:*	*Yeh well I suppose we delude ourselves at times. You know.*

In the extract, Jenny asks Peter on two occasions what he has "actually done" (lines 1 & 6). This use of the word "actually" conveys a sense of frustration in the therapist talk, and implies a value judgement that he should have done something, or something more or greater than he has, with a presupposition that he has not done what was expected of him. In asking this question, Jenny was not adherent to the MET manual nor was she responsive to the client.

When Peter noted that he did not find therapy to be what he was expecting, Jenny summarised the positive comments he had made in the last session. This serves to construct him as previously motivated (lines 4-7), and therefore something that had changed since then. By constructing this change in motivation since her last contact with him Jenny places responsibility on Peter for the lack of change in his drinking behaviour and absolves herself as his therapist. Also, by reflecting his expressed intentions to change in order to contrast with his current behaviour she uses a technique from the MET manual called 'developing discrepancy' aimed at creating cognitive dissonance for the client. This can therefore be characterised as adherent, though not responsive to the client, as due to the context of the initial question on line 1 asking what he had "actually done" she created a framework whereby the use of the technique came across as critical rather than curious.

Taken from the same session, the below extract demonstrates Jenny constructing Peter as 'resistant' during an exchange about the possibility of trying a medication to help him with his alcohol use. This is within the third and final treatment session within the context of Peter's drinking having escalated over the period of therapy sessions.

MET 1 Session 3

1	*Jenny:*	*There's also a sort of medication called antabuse. Have you heard of that?*
2 3	*Peter:*	*I've heard of it. That's been around for years. (uhuh) I want something to help my mind, not to make me sick.*
4	*Jenny:*	*(.) Right.*
5 6	*Peter:*	*I mean, is it. If you're on that stuff, I mean. If I wanted a drink, I'd just stop taking it.*
7	*Jenny:*	*And you've, you've had it before?*

8 *Peter: I've never had it before, no.*

9 *Jenny: But you don't th, you don't really want to try that?*

The construction of Peter as 'resistant' occurs when Jenny suggests a specific medication indicated to help with alcohol cravings. When Peter states that he does not want to take it, she asks a closed question to confirm that he had tried the medication before. By asking *"And you've, you've had it before?"* (line 7) she indicates that she expects that he should have tried it before in order to rightfully state that he does not want to take it. By asking this question, Peter is constructed as resistant, as when he says he has not taken the medication he does not conform to the common sense discourse of "don't knock it 'till you've tried it." In this extract, Peter has a fair idea of the biological mechanisms of change behind the medication, and so by Jenny going on to summarise that he does not want to try it she continues to construct Peter as resistant to trying interventions that might help him, rather than as an informed consumer who is exercising his rights to choose other treatment options. As noted above, Jenny suggests the medication following Peter not changing his drinking behaviour following the previous therapy sessions. By constructing Peter as resistant to this second line intervention, it could be implicit that that this is therefore a character trait of Peter and therefore he is also to blame for not responding to the first line treatment i.e. the MET.

In both of these extracts the therapist constructs the client as having made decisions which are worthy of criticism rather than directly criticising them or their actions. In contrast, in the extract below, Donna (Therapist) is openly critical of Craig's lifestyle. At this point in the session, Craig has offered several valid reasons for his social isolation, in particular his low mood. Previously in the session, Donna has suggested that increasing his activity will help Craig cope with his alcohol cravings.

SBNT 1 Session 1

1 *Donna: But it is something that's quite difficult to do on your own. Because it sounds like*
2 *at the moment, you know, your days quite lonely, boring.*

3 *Craig: Yeah I suppose.*

4 *Donna: Do you have any friends that don't drink?*

5 *Craig: No. they're all drinkers.*

6 *Donna: Yeah. But you're staying in the house a lot of the time?*

In the above extract, Donna is openly critical of Craig's life by stating that his days are "lonely, boring" (line 2). In the context of her previous attempts to encourage him to do increased his activity, she appears to escalate her attempts as instead of attempting to persuade him to change, she is using a discourse that is critical of his status quo. By doing so, she constructs Craig's life as impoverished to promote change.

According to the SBNT manual, this interaction could be seen as adherent, as Donna is exploring the status quo in order to promote change. However, the critical tone of this extract shows that it is not fostered upon being responsive to the needs of the client, but in response to a perceived failure of the intervention.

3.3.3 Lecturing

Another discursive practice of therapists was the use of a 'lecturing' style during the sessions. This practice was identified at least once in five of the six therapy dyads. At times this lecturing style emerged simply through value laden questions or comments. For example, in the extract below, Sally begins eliciting from Polly how she can work towards having access to her grandchildren in a collaborative and supportive manner. She then goes on to tell Polly that she has to earn their trust (lines 11-13); first of all phrased as a closed question which Polly is pressured into answering yes to, and then as a concrete statement uttered by Sally.

SBNT 3 Session 3

1 Polly: I'd like to see the grandkids (mm). I'd like to be able to have them for a night.
2 Sally: So what's it going to take for that to happen do you think?
3 Polly: I need to go back into hospital. And <u>really</u> trying this time.
4 Sally: And how will it be different this time to how it's been before?
5 Polly: Coz, I'll need to try this time. Coz, or I won't be here. I know in myself I won't
6 (mmm) (.) And I don't want, I want to see me grandkids grow up (mm) I want
7 to be able to walk out with my boy, to be able to take them to the park and
8 things like that, I want to be trusted. To walk with them on my own.
9 Sally: Can you see that that trust is going to have to be rebuilt?
10 Polly: uhuh
11 Sally: You're gonna have to <u>earn</u> that trust.

The use of the lecturing style in the above extract is adherent to the principles of the SBNT manual, though it is not categorised as responsive to the client. The concept of repairing trust appears to be an important one to be addressed, though it would be more responsive if it has been elicited through open socratic questioning rather than a leading question followed by a direct statement.

Similarly, Donna lectures Craig based on her apparent perception that he needs to change his social isolation.

SBNT 1 Session 2

1 *Donna: Hm. So you avoid places where there's lots of people?*
2 *Craig: yeah, because I just get wound up all the time. (.) maybe its me who's weird, but*
3 *I always think of ???? that way because they just annoy me. (…)*

4 5 6 7	*Donna:*	*but I guess something's going to need to change isn't it. You're going to need to start going out again at some point, you're going to need to start talking to people. (.) so how do you think you could go about at least starting to talk to people?*
8 9 10	*Craig:*	*at the moment I don't know. Think at the moment, all I can think about at the moment is to stop my drinking, which I'm doing alright to now and then getting prison out of the way. Because beyond prison I just can't see anything ????*
11 12	*Donna:*	*you're doing really well with your drinking, you know you've stopped you've gone a month really. Was it the twenty-fifth of December?*
13	*Craig:*	*about the twenty-fifth I think it was yeah*
14	*Donna:*	*right. Well it's the twenty-fourth of January today.*
15	*Craig:*	*twenty-fourth is it?*
16	*Donna:*	*yeah.*
17	*Craig:*	*not done too bad then*
18 19 20	*Donna:*	*you've done very well with that. And now that you've decided, you've made a decision to go on the antabuse, um, which is a really positive decision I think, because that's something that's going to help you to stay off the drink.*
21	*Craig:*	*Mm*
22 23 24 25 26 27 28	*Donna:*	*but there's more to tackling your drink problem than just stopping drinking, which obviously why you're coming here. Um, as I said to you last time there were lots of different things that we needed to look at and one of those is communication and how you talk to people. Because it's quite common, um, with someone who's been drinking heavily to rely on the alcohol to give them confidence, to give them courage um and the ability to talk to people, because you can probably talk to anyone when you've had a few drinks.*
29	*Craig:*	*oh Mr Confidence when I've got a few drinks down me.*
30 31 32 33	*Donna:*	*Yeah, yeah. But now that you've not got that drink (.) you can't spend the rest of your life not talking to people. Because then you'll start to miss the drink, because you're looking for something else that's going to give you that confidence.*

Donna lectures Craig by using value statements such as "*but I guess something's going to need to change isn't it.*" (line 4)and leading questions such as "*so how do you think you could go about at least starting to talk to people?* ". However, in addition to using these rhetorics, Donna uses a 'show concession' (Antaki & Wetherell, 1999) whereby she proposes her argument using a 'lecturing' tone (lines 4-7), concedes the progress that Craig has made thus far (lines 11-21), and then reasserts her argument (lines 22-33). By conceding the progress that he has made thus far, she shows that she has acknowledged it which adds power to her argument, as she suggests that her argument stands despite the progress he has already made. This interaction was characterised as adherent but not responsive, as she is attending to the principles of the SBNT manual, but not attending to the clients feelings or opinions regarding this.

3.3.4 Persuading

Several of the therapists appeared to attempt to try to persuade the clients to do certain actions or think in certain ways in order to help them address their drinking. In the extract below, Donna is attempting to persuade Craig to be more sociable, which is something that he has strongly stated that he does not want to do.

SBNT 1 Session 2

1 2 3 4	*Donna:*	*Right. Well I'm certainly not going to encourage you to go along to acting or dancing classes to give you confidence, I think there's a lot of other things that you can do. But learning to talk to people is probably one of the most fundamental things you will need to learn.*
5	*Craig:*	*Mm*
6 7	*Donna:*	*and it might feel a bit false for a while, but it's an important skill. Cos it's something you're always gonna to need to do (.)*
8 9	*Craig:*	*it's weird though, when I go for jobs, when I've been for interviews it doesn't bother me, no problem at all*
10	*Donna:*	*so you can talk then?*
11 12	*Craig:*	*yeah, but it's all false. I can act false, but I just don't see why I should. I don't like false people.*
13 14	*Donna:*	*Maybe it just feels false because it's different and it's new and it's not something you're used to doing.*
15	*Craig:*	*Mm*
16 17 18 19	*Donna:*	*If you felt a bit more comfortable with it, it might not feel false (…) but sometimes you can pretend to be confident for a while, and then gradually you find out that you're getting more confident just by being in those situations and then it's not false anymore.*
20	*Craig:*	*I'll have to try that one eventually*

Donna has made clear throughout the session prior to this extract that she feels being more sociable is integral to Craig's recovery. The client has expressed that he is not interested in becoming more sociable as he just wants to stop drinking, and is not currently feeling sociable due to being low in mood. On line 6, Donna attempts to align herself with Craig's point of view by saying "it may feel a bit false." This is not a clear agreement as she is using a 'contingent repertoire' (Gilbert & Mulkay, 1984) which constructs the 'falseness' as something that he feels rather than something that is factually there, which therefore makes it appear to be less objectively true.

However, by using a 'show consensus' (lines 6-7) and showing some level of agreement with his objections she then gives herself the power to rebut them by going on to tell him to do it anyway (Antaki & Wetherell, 1999). When Craig does not respond to this, Donna then offers an explanation of why it may feel false, in order to state what he can do to make it feel less false (lines 13-14). This continues to minimise Craig's experience as incorrect or misguided. Craig's response to her persuasion that

he will "have to try that one eventually" (line 20) gives an indication that he is telling her what she wants to hear so that she will stop pursuing it, rather than he has been successfully persuaded to do as she says.

As Donna is promoting Craig's engagement with a wider social network for support, which is a fundamental aspect of SBNT this extract is considered adherent; though because she does not empathically explore the rationale for Craig's resistance and instead attempts to change his mind; it is not considered to be responsive to the client's need.

In the same therapy dyad, another technique of persuasion is used by Donna in an attempt to move Craig forward. The below extract illustrates Donna using what Craig has previously said in order to add weight to the point that she is trying to make. She uses a priming structure which builds, leading Craig to agree with the point she is trying to make.

SBNT 1 Session 1

1 2	*Donna:*	*Right, ok. You said willpower. now the thing about willpower is it can desert you at any moment can't it, I'm sure you've found that out in the past.*
3	*Craig:*	*It can do*
4 5	*Donna:*	*I think just simply relying on willpower, erm, it doesn't usually work. And it sounds like you desperately need to stay off the drink before you go in.*
6	*Craig:*	*Definitely*
7 8 9	*Donna:*	*Yeah. And that's why I think even though its difficult it's going to be important to be doing other things. Because they're the things that might keep you off the drink.*
10 11	*Craig:*	*(...) I'll have to think about that, like I say wait for these tablets to kick in a bit more*

First, Donna presents the concept of willpower as his own, and asks Craig to note times where it has failed him (lines 1-2). Once Craig has agreed with this, Donna suggests that consequently willpower is insufficient, reminding him of the commitment he gave to being alcohol free (lines 4-5). Once Craig has agreed to this, Donna notes that to live up to this commitment that he stated he had, he must do the things she says (lines 7-9). This is presented in a similar way to a logical consequence whereby if the first two assertions are sound, then as the third is based on those, then that will be sound also. However, in this extract, the first two assertions are based on what Craig has said, and the third is what she thinks he needs to do. This third statement does not follow the pattern of a logical consequence, even though it is set up to mimic it rhetorically. Using this format, whereby she gets Craig to agree with every step along the way, it therefore makes it much harder for Craig to disagree with the end conclusion. In this case, Craig does not accept the end conclusion by stating after a

pause "*(...) I'll have to think about that*" (line 10) and so the rhetorical device Donna uses for the function of persuading is unsuccessful. For the same reasons given for the extract directly preceding this one, this extract was considered to be adherent to SBNT, but not responsive to the client.

3.3.5 Being collaborative

The discursive practice of 'being collaborative' featured in all of the therapy dyads. Perhaps influenced by the nature of the two distinct therapies that were being delivered, true collaboration was more frequent in MET sessions than SBNT sessions. This is likely to be because the MET philosophy is characterised by the assumption that collaboration with the client is an integral vehicle for change whereas less focus is given to such dynamics in SBNT whereby the therapist is the active agent of change using their position to educate and initiate behaviour change. Collaboration was typically shown when the therapist and client assumed equal subject positions, and co-constructed the conversational focus.

Collaborative discourses were present in all six of the dyads, and were relatively common when conversation was flowing freely with few obstacles between client and therapist. I have used three examples to demonstrate collaboration within the therapy sessions, which all come from the same MET therapy dyad. I have selected these to illustrate this discursive practice as they all occur in contexts where the therapist could have easily used a different approach to negotiate what is being discussed. All of the below extracts are characterised as both adherent to the MET manual and responsive to the client.

In the following extract Gregory (Client) asks Nick (Therapist) whether he needs to know about his medical history.

MET 2 Session 1

1 *Gregory: Yeh I'm actually waiting to have a triple bypass operation on my heart. (right).*
2 *Erm, (.) the reason, I don't know if you know anything about my history at all?*

3 *Nick: Not, no nothing really so*

4 *Gregory: Ok, I don't know if you actually need to know nothing about the history or not?*

5 *Nick: Not unless you feel, you [know, it's]*

6 *Gregory: [well, no.] When I say a 4 pack it isn't a lot, it is if you*
7 *are on certain tablets. (right) So therefore if you are on warfarin for instance.*
8 *Warfarin, but it thins the blood down (right). And alcohol can accelerate this as*
9 *you know. Maybe you don't*

10 *Nick: No, yeh (both laugh)*

When Gregory asked how much Nick needed to know, he responded by stating that he only needs to know the information that Gregory wanted him to know. This

served to minimise the inherent power imbalance (Boyd, 1996) within the therapeutic relationship, positioning the client, as having the power to decide what he wishes to disclose. However, when Gregory asks Nick whether he has knowledge of the medication he takes, he says "*No, yeh".* This is interpreted as Nick stating that he does not know in response to Gregory saying "*I don't know if you know*", and affirming that he indeed does not know in response to Gregory's utterance "*Maybe you don't*".

In the following extract, Gregory explains that he is unsure what the benefit is of looking at the statistics regarding his alcohol unit consumption, which is part of the MET manualised therapy. When faced with this, Nick "rolls with resistance" (Miller & Rollnick, 2002) in the style of motivational interviewing.

MET 2 Session 1

1 *Gregory: Ok well I'll probably say that er, with that in mind, that I'm not quite an*
2 *alcoholic, maybe I've got a drink problem (right) erm, and I think that's where*
3 *I'll probably come from from that. (yeh) off the top of my head if you know what*
4 *I mean (yeh, yeh). Just thinking about it.*

5 *Nick: Yeh, So looking at the quantity that you drink you feel that suggesting to*
6 *yourself that you feel you've got a drink problem. (mm) Right, yeh. (…) yeh (…) I*
7 *mean, are there any concerns about that, you know, in terms of?*

8 *Gregory: I think the concerns around that are the fact that without knowing those*
9 *statistics anyway, I knew that the the intake of the units or such was far too high,*
10 *and I don't really know how. I mean I knew that the units were too high anyway,*
11 *so by us sitting here discussing the units, it's just referring what I already knew*
12 *anyway, which is to changing. (right, yeh). So I suppose I'm saying, well, I*
13 *understand that, I understand that my drinking units are far too high. I also*
14 *understand that I'm a high drinker, if you look at it from the statistics (yeh, yeh)*
15 *So, I mean, with that in mind I'm probably going to try and bring it down.*

16 *Nick: Right yeh, so it sounds like then in that sense that information isn't really new to*
17 *you because you were kind of aware of what your units were, what you were*
18 *drinking.*

19 *Gregory: Well, it's also not not very erm relevant (right). Because I already knew that.*
20 *(right) And if like I was talking to somebody a couple of weeks ago about*
21 *different things, and they said who would you like in your family, well not just*
22 *your family but whoever, to be a support to you. Erm, and I said, my wife Julie,*
23 *and you know she's a positive helpful person, and then I said, but hang on, I've*
24 *already heard everything about this from whoever, and I haven't listened so*
25 *what is going to make me listen now? (right) And knowing those statistics I'm*
26 *just wondering what that has got to do with me? Erm, altering my way of*
27 *thinking?*

28 *Nick: Right. How does that, I suppose what's the relevance, what's the point of it? Yeh?*

29 *Gregory: yeh (laughs) Yeh, if it's going to be tied down in statistics, and I'm thinking*

30 *Nick: yeh, yeh yeh, I mean the purpose of it is, many people aren't, I mean yourself, as*
31 *you've said, you're aware of units and you've been counting in units, and you're*
32 *quite aware of the discrepancy between say the recommended guidelines and*
33 *your own units. I mean I suppose the purpose of this is is for many people aren't*
34 *actually aware of the units they are drinking, erm, but you know, in terms of*

35 *yourself, you're aware of that, and feeling well it's something you're wanting to*
36 *do. To work on, to reduce the number of units that you are drinking and perhaps*
37 *to make a change in your drinking. (yeh).*

As illustrated, rather than becoming defensive when the usefulness of the approach is challenged, Nick acknowledges Gregory's perspective and frames it as positive by using implicit flattery suggesting that Gregory has an awareness of the levels of his drinking that some people do not have (lines 30-36). In line 27 Nick uses 'active voicing' (Wooffitt, 1992) by repeating back and validating Gregory's perspective using words as if they were quotes from him. By stating *"what's the relevance, what's the point of it? Yeh?",* Nick demonstrated that he has heard Gregory's concerns without colluding with them as he is acknowledging them as coming from Gregory and not himself. By doing this Nick is able to validate Gregory's concerns within the therapy without confirming them to be true. This then allows Nick to explain how therapy can be useful despite these concerns, which Gregory is then able to engage with as his concerns had previously been acknowledged..

In this third example, Gregory states that he has felt that therapy has been useful. Instead of merely agreeing that attending therapy has helped Gregory, Nick reflects back at several points the progress that Gregory has made for himself independently. Affirmations and reflections are typical acknowledgements of progress when delivering MI based interventions (Miller & Rollnick, 1991, 2001) and are detailed as integral techniques within the MET treatment manual used in the UKATT trial. This avoids Nick placing himself in an expert position to offer praise to acknowledge the progress made.

MET 2 session 2

1 *Gregory: and it's nice to be clear headed. So from that point of view I've really benefitted*
2 *from coming here*

3 *Nick: yeah*

4 *Gregory: erm from the point of view that when I first walked in I was thinking "I don't*
5 *wanna be here, I shouldn't be here, I'm only having four a night" erm but*
6 *without any pressure without any sort of bribery if you like or any sort of arm*
7 *up the back job, a nice simple approach has maybe just changed a little bit of*
8 *what I was like before, erm and I think it's maybe made me a bit of a better*
9 *person*

10 *Nick: right*

11 *Gregory: funny*

12 *Nick: yeah yeah,*

13 *Gregory: to the poetry, it's your fault (laughs) I'm setting (?) by the (?)*

14 *Nick: I mean it sounds like one of the ways that this has worked for you Gregory in*
15 *that you've made the choice yourself and it's you that's in control and it's your*

16 *decision and that's how you prefer it to be rather than feeling you've got an arm*
17 *up your*

18 *Gregory: yeah*

19 *Nick: yeah. that's what kind of works for you is making that choice yourself*

20 *Gregory: that's right*

21 *Nick: you know, I'm an adult, I can make this decision, and you have made it yourself*
22 *and you've been weighing it up for yourself, yeah*

23 *Gregory: yeah. and like I said there isn't any sort of. I don't make any rules about it*
24 *because once I start making rules then that, rules are there to be broken, do you*
25 *know what I'm trying to say.*

On line 14, after Gregory attributes brighter mood constructed through his newfound interest in poetry to Nick, Nick responds by rejecting this attribution. Instead Nick reiterates the choices that Gregory has made himself that has precipitated this change. Also, in line 19, Nick paraphrases the progress that Gregory has made by using 'constructed discourse' (Tannen, 1986) "I'm an adult, I can make this decision." By doing this, Nick has emphasised Gregory's value of making his decisions independently by quoting his understanding of his thoughts as if he had said them verbatim. If Nick had said "you're an adult, you can make this decision", this would have placed a value judgement on Gregory and rather than an assessment of what he was saying.

The commonality across these three extracts is that Nick and Gregory's negotiation of progress is done jointly through collaboration. At times, collaboration was enabled by Nick taking a "one-down" position (Watzlawick, Weakland, & Fisch, 1974) allowing Gregory to take a "one-up" position. For example, by denying the impact that he has as a therapist on change, in order to allow Gregory to assume responsibility for the progress he has made. Though this may not be what the lay person would describe as equal collaboration, in the context of psychotherapy where the therapist has an inherent category entitlement (Sacks, 1974), by the therapist enabling the client to take charge, the power imbalance is diminished and the opportunity for a collaborative exchange is increased.

3.3.6 Using Humour

In five of the six therapy dyads the therapists used humour during the sessions, though the function of this humour diverged immensely. Two distinct examples of how humour was used by therapists are explored below.

In the following example, humour is used with the function of acknowledging client progress in an egalitarian manner. This use of humour has a secondary outcome of contributing to the therapeutic alliance. By using humour in the below extract

meeting these functions; Jon is being both adherent to the MET manual and responsive to the client.

MET 3 Session 3

1	*Jon:*	*Erm, financially you were saying what about seventy pounds a week?*
2	*Colin:*	*Ooh Christ, at least*
3 4	*Jon:*	*yep. And you've said that your better half is trying to [???] to spend most of that money, but er*
5 6	*Colin:*	*oh yeah, (?) Matalan, went in for a pair of slacks and she ended up buying three pairs of shoes and a white top (laughs)*
7	*Jon:*	*oh dear (laughs)*

Jon (Therapist) repeats a discourse that Colin (Client) had spoken about earlier in the session (lines 3-4). Colin had been jokingly moaning about his wife spending all of his money, which appeared to be an informal and defended way of expressing that now he was alcohol free and was enjoying spending time with his wife, and that they had more money. Jon chose to repeat this in a light-hearted way, demonstrating the positive changes to Colin's life and staying close to his experience. By doing this, Jon confirmed that Colin was experiencing a 'normal' life by colluding with a common sense discourse that a day-to-day minor worry for men is that women spend all the money. By calling his wife his 'better half' he ensured that he is summarising this in a playful way. In this example the use of humour by Jon (and Colin previously) allowed them to discuss how Colin's life had changed so dramatically, from having poor relationships and no money to the opposite without having to acknowledge this explicitly. Past research has indicated that humour is widely used to help people discuss 'taboo subjects' (Emerson, 1969). By expressing the shift in this way, Jon and Colin were able to share an understanding without having to become too intimate by sharing all the details. Additionally, by using humour at the expense of Colin's wife, Jon was able to reinforce the therapeutic relationship by bringing them together as an 'ingroup' (men) at the expense of the 'outgroup' (women; namely Colin's wife) (Meyer, 2000).

In contrast to the example above of humour use, the following example shows the therapist using humour in an attempt to rebuild an alliance after a therapeutic rupture. Prior to the extract below, the client, Peter and therapist, Jenny, had not achieved a comfortable therapeutic relationship. Peter had arrived for the sessions under the influence of alcohol, and had told her that he wanted to have sex with Jenny, which had ruptured the relationship further. Lines 1-31 are shown in order to show this disclosure to contextualise of the use of humour.

MET 1 Session 2

1	*Jenny:*	*Right, ok, what do you want to do right now?*
2 3	*Peter:*	*Right now, I'll tell you what I'm doing, what I'm off to do when I leave here. I'm off to the pub for a pint of Guinness.*
4	*Jenny:*	*Right.*
5 6 7 8	*Peter:*	*Then er, (.) a few more. I can't have too many coz I'm working tomorrow. But erm, (.) er, (.) How can I put it. I've lost things I wanted to do (mm) Things that never happened, so (.) I'm thinking something now I shouldn't say (.) I'd like to have sex with you.*
9	*Jenny:*	*Well, I'm [not here to talk about that Peter.*
10	*Peter:*	*[I know, I know, I know, but that's what goes through your head.*
11	*Jenny:*	*Well*
12	*Peter:*	*I know.*
13	*Jenny:*	*Not an appropriate thing to be bringing up Peter.*
14 15 16	*Peter:*	*I know it isn't but that's, what you're saying is, what's this, what's that. Erm (.) The (...) I don't know you see, I've never had many goals in life. (mm) And I suppose that's a danger where alcohol is took over. It's easy (mm) to fill the void.*
17 18	*Jenny:*	*(.) Yep, so what things are going to need to change Peter, to help fill that void for you, do you think?*
19	*Peter:*	*Er.*
20 21 22 23 24 25	*Jenny:*	*You, you've told me about past times when you've given up and you've been really successful at doing that. (mm) But the problem has been that you you've felt bored, you've felt lonely, you've felt that there hasn't been enough for you to do in that time. But you've mentioned that you've got quite a few ideas of what you might do, so that you do have a change of focus and you are occupied for yourself.*
26 27	*Peter:*	*I just have to, sort of as I say I've got a few ideas. I'll just have to try to put them into fruition.*
28	*Jenny:*	*Well, what, what are your ideas. Shall we sort of list them down?*
29	*Peter:*	*err, stopping drinking I suppose is the first one.*
30	*Jenny:*	*Yep*
31	*Peter:*	*Er, taking tai chi.*
32	*Jenny:*	*Yeh, where would you do that?*
33	*Peter:*	*Local centre, they do it.*
34	*Jenny:*	*Oh do they? Is that near you.*
35	*Peter:*	*It's not far, I live up (local area), so it's what half, 20 minutes' walk.*
36	*Jenny:*	*Yeh,*
37	*Peter:*	*Buddhist meditation.*
38	*Jenny:*	*Is that, where can you do that?*
39	*Peter:*	*I think that 'local leisure centre' does it as well.*
40 41	*Jenny:*	*Yeh? You must excuse my spelling, I don't know if I can spell Tai Chi, but I'm sure you'll see what I mean.*

42 *Peter:* *It means basically taking the, your breathing, your taking, the Tai is the breath,*
43 *you're taking it in, and (uhuh) and you get the energy, (right) or the chi, you*
44 *know you're taking it in and you're getting your energy from basically the*
45 *oxygen or whatever. (ummhumm) But you take it down and instead of, is take it*
46 *into your stomach. That's the centre of everything, your stomach (uhumm).*

47 *Jenny:* *Ok, so it's not Tai as in Thailand*

48 *Peter:* *No, no*

49 *Jenny:* *Ok {laughs} I've put an H in it. Ok so, Tai Chi, Buddhist Medication, meditation.*

On line 40 Jenny uses subtle self-deprecating humour, by pointing out that she has made a spelling mistake, serving the function of attempting to repair the alliance rupture. The use of self-deprecating humour is commonly understood to aid in allying oneself with others (Chapel, 1978) by showing that she is fallible and therefore something they have in common. It is also possible that the humour in this situation was used to diffuse the anxiety she felt (Shurcliff, 1968), or that after him making a sexual comment towards her, she used the humour to demonstrate that she was still willing to have a connection with him. For this reason this section was classified as responsive to the client. It was hard to categorise as either adherent or non-adherent; as though it did not directly draw upon any principles of MET, neither did it draw upon any competing principles. Therefore, as it appeared to be an attempt to repair the rupture in the alliance (which is noted as important in MET) it was considered as adherent.

3.3.7 Acting as benevolent expert

This section explores the discursive practices used when therapists embrace the inherent power they have in order to attempt to benefit the client in some way. The examples presented are explored with regards to how power or expert status is used with the apparent outcome of being beneficial to the client. However, I have made no value judgement as to whether the active use of power was actually beneficial or not to the client.

In the following extract, Sally uses her inherent power as a therapist in an attempt to help absolve Polly of the guilt she is feeling about her son being abused at boarding school.

SBNT 3 Session 3

1 *Polly:* *Like I say she's a manageress (in national company), she is doing brilliant, but I*
2 *could have messed her life up too, [if I'd*

3 *Sally:* *[But you didn't mess their life up, or their*
4 *lives up Polly*

5 *Polly:* *I did*

6 7 8 9	*Sally:*	*Yeh, but that guy, that guy that abused them messed their lives up, not you. (.) You left their dad because he was beating you up, (.) you didn't create that, that happened to you. You did the best thing that you could do by getting away from it.*
10 11	*Polly:*	*I feel as though if I hadn't sent {son} there, and we hadn't seen this teacher, then maybe {son] and {son} would be better kids.*
12	*Sally:*	*Well you don't know that do you?*
13 14	*Polly:*	*But he was really ah being naughty, he was stealing. (exactly) He was being violent. (exactly) He was only <u>seven.</u>*
15	*Sally:*	*And you were <u>advised</u> to do that. That was the best thing for him.*
16	*Polly:*	*They said it would be the best thing for him.*
17	*Sally:*	*Yeh, exactly, and you took the advice, which you know*
18	*Polly:*	*It didn't [work*
19 20 21 22 23 24	*Sally:*	*[Which anybody would have done. (.) The thing is you've only got to read the papers today, the newspapers haven't you? How many parents are in the same boat as you? Kids went off to boarding schools or whatever, and they went to what they, parents thought were the best schools available and the kids have ended up being abused. (.) It's not your fault for sending him there.*

Sally uses Polly's name (line 4) to connect with her on a more intimate level to try to covey her message more explicitly. Sally uses repetition (lines 6-8) to get her point across that Polly was not responsible for the problems her children faced. When Polly does not accept Sally's rebuttal of her guilt, Sally makes a statement that indicates that Polly's explanation is not based on fact (line 11). Sally makes this statement in the form of a question in an attempt to elicit a particular response (Quirk, Chaplin, Lelliot, & Seale, 2012). By asking this question, Sally positions Polly as irrational by not accepting her alternative explanation. Sally then goes on to make a 'consensus formulation' (Potter & Edwards, 1990) (lines 18-22). By framing Polly's experience as what "anybody would have done", Sally both attempts to persuade her that she did nothing wrong, and that she is not alone in this experience.

In the below extract, Sally 'categorises' Ray's behaviour as abuse in order to construct his behaviour as unacceptable in a way that is hard for Polly to refute (Edwards, 1991). Sally is using "empiricist repertoire" (Gilbert and Mulkay, 1984) to demonstrate that this categorisation as an objective fact, by using the words "it is" and noting that it emerges directly from the evidence Polly has given rather than admitting any personal thinking or feeling that lead her to a conclusion to categorise.

SBNT 3 Session 3

1 2	*Sally:*	*From what you what you've said. How you've described the way, some of the things Ray says, it it is mental (.) abuse really, and verbal abuse*

Within the context of both of the above extracts containing themes of abuse (which is objectively unacceptable) it appears that Sally's use of category entitlement to validate her opinion is responsive to the needs of the client. As this also served the function of facilitating discussion regarding strengthening Polly's social network it was categorised as both adherent and responsive.

In the following extract, Nick gives his opinion on Gregory's progress. Nick has placed himself in an expert position to pass this on to Gregory.

MET 2 Session 3

1 *Gregory: But yeah life is a lot better, it's a struggle, not because of the not drinking but*
2 *you know trying to balance the business against the health against the*
3 *operation, about this and I've just thought sod it, let's just take life as it is and go*
4 *with it you know. And err, I seen a couple of guys standin outside the pub*
5 *yesterday when I was driving past and I thought "I know mate, it looks bloody*
6 *lovely" but I can't, I'll have my glass of water, and it really doesn't bother*
7 *me. ???? thought I fancy a pint I'd have loved it, not now. Erm, and I know you've*
8 *probably had people sit here and say they don't drink over the years, maybe not*
9 *I don't know, but I really feel good about it.*

10 *Nick: yeah, I know I can see that, yeah I can see it's changed you. And you have, I mean*
11 *that's the thing about what you've said and I do think that's why you've got,*
12 *you've reaped the benefits because you have been honest and you have worked*
13 *at it. And what I've appreciated as well is you haven't just sat there and when*
14 *I've said something, you haven't just gone "yeah, yeah you're right", you've*
15 *actually worked with it, so there's been occasions when you've said well I'm not*
16 *sure about that, lets work with it, and you have worked with it and that's, I think*
17 *that's been good in terms of us working together and that's one of the things*
18 *that's helped because you have thought about things. Yeah, you've thought*
19 *things through and worked out.*

Nick uses his inherent category entitlement (Sacks, 1974) as a therapist to endorse the progress that Gregory has made due to his own volition as an expert in his own life. This may seem like a contradiction, as Nick uses his own power with the function of attempting to empower Gregory. This is also interesting in contrast with the example on page 75 which is also focussed on acknowledging progress, whereby Nick collaborates with Gregory and deconstructs his own power in order to empower Gregory. This extract shows Nick being responsive to the client by validating or even complimenting Gregory's progress. This however, not adherent to the MET manual which advocates the use of 'affirmation' though eliciting the client's own comments on their progress, rather than offering one's own opinion as it is seen as extrinsic and therefore irrelevant to the clients personal motivation.

3.3.8 Constructing oneself as powerful expert

In addition to constructing their inherent power in a benevolent fashion, five of the six therapists constructed themselves as experts with the function of preserving

their status in the face of situations which challenged this. None of the extracts in this section demonstrated responsiveness to the client, as the function instead appeared to be therapist self-preservation. As the focus of the conversation was not on client progress, but instead constructing therapist status, none of the extracts displayed skills or topics which were adherent to either treatment manual.

In the extract below Donna constructs 'category entitlement' (Sacks 1974) by stating that she would keep him on the medication he is currently using (lines 12-13).

SBNT 1 Session 4

1 2 3 4	*Donna:*	*So I thought today we'd look at, you know, we've touched on it before, about how, staying off the alcohol. Umm and making sure that you don't relapse, because I know that at the moment you feel very strongly about that. Are you still taking the disulfarim?*
5	*Craig:*	*yeah, I need some more though*
6	*Donna:*	*right, ok. Well I'll sort that out for you.*
7 8	*Craig:*	*I was supposed to ask my doctor last time I think, but had too much on my mind at the time*
9 10	*Donna:*	*yeah, you had a lot on your mind, ok. But you've been taking the disulfarim anyway*
11	*Craig:*	*yeah*
12 13	*Donna:*	*yeah. No problems with those? (.) No, good ok. Well I think the best thing would be to keep you on those at the moment because they do seem to be helping.*

Donna implies that she has made the decision to keep Craig on the medication after evaluating that they are useful to him. This is despite Craig having already stated that he wanted to continue taking them, and despite that it would actually be a medical doctor who would continue prescribing rather than her. In the context of the struggles that Donna has had in attempting to convince Craig to take her advice, it is possible that Donna constructed herself as in control of the decision making with regards to medication to ensure she came across as competent both to Craig and for her own self-esteem.

Perhaps, for a similar function, Jenny constructs herself as an expert in determining whether Peter needed a detox programme. To place the below extract in context, Peter explicitly stated that he had not found therapy useful, and that he had wanted a detox.

MET 1 Session 3

1 2 3 4 5	*Jenny:*	*hmmm Yeh, Coz I think, you know, if I can give you my sort of opinion, I mean well we can look at organising a detox for you. Er, it hasn't been apparent up until now that you've actually needed a detox, coz not everybody does. (mmm) But I guess, what what we really need to look at is, it's not just a case of giving you a few tablets for a few days and that will sort everything out, or at least that's generally not the case. What we need to*

6 *look at, are the reasons why we've thought about plans, different activities, different*
7 *ideas, is to look at a more long term solution. Really, or or a much more permanent*
8 *change in your drinking, just rather than a few days, where you're taking tablets. Does*
9 *that make sense?*

In order to get her point across, on line 1, Jenny initially asks if she can give her opinion before giving it. She phrases it as rhetorical question and does not give Peter time to agree or disagree. However, by asking this, and Peter not saying no, she has opened herself a space to give an opinion without being criticised for giving it. She then goes on to concede that a detox is possible although states that it was not apparent that Peter had needed a detox (lines 1-3). By stating "it hasn't been apparent" she uses an empiricist repertoire (Gilbert & Mulkay, 1984) in describing this as fact. Also by using her category entitlement (Sacks 1984) she portrays her opinion that it has not been apparent as fact, when it is possible that it was objectively apparent and she did not identify this. Jenny goes on to minimise the usefulness of the detox that Peter has requested (lines 3-5) re-emphasising the approach that she had been advocating until this point.

In the following extract Sandra portrays herself through her discourse as an integral agent in the process of accessing medication. Until the point that this extract was taken from, Sandra had been placed on the back-foot several times by Tom and his partner, Steven, who were both well-educated and eloquent. In this extract, Tom is asking about a possible medical intervention for his drinking. It emerges that Tom, as a biomedical scientist, knows more about this intervention than the therapist. After Tom appears to be the more knowledgeable in the conversation (lines 42-43), Sandra notes that if the GP needs to consult with her then he can. By noting this, she is able to position herself once again as a useful and potentially necessary influence in the pursuit of medical intervention.

SBNT 2 Session 2

1 *Tom: because I did mean to ask you about, because you gave me some details on*
2 *Campral*

3 *Sandra: yes*

4 *Steven: What's that?*

5 *Sandra: that's erm, that's something that can help people with their cravings, it's erm a*
6 *drug that can help*

7 *Steven: can I take it {????}*

8 *Sandra: it's erm*

9 *Tom: because I think perhaps I'd, you know, if it's possible I'd quite like to try that*

10 *Sandra: right, that works for, and that works much more effectively if you're not*
11 *drinking. So it might be an idea to speak with your GP*

12 *Tom: ok*

13 *Sandra: yeah, take it in and speak to your GP about that or I can talk with your GP if you*
14 *know. Go along to the GP see what his response is and if there is a difficulty then*

15 *Tom: because I did read in the leaflet that it helps to prevent people relapsing but it*
16 *also helps people when they are drinking to drink much less*

17 *Sandra: Mm, mm it err. What it does is it helps you with the environmental cues that can*
18 *be around and the cravings really and it's not*

19 *Tom: I know how it works cos I looked it up*

20 *Sandra: you've already looked it up, yeah. doesn't it tell you all that in the leaflets I gave*
21 *you?*

22 *Tom: yeah, but also there's much more information on the internet*

23 *Steven: being a scientist*

24 *Tom: because I'm a biochemist*

25 *Steven: you find that if I get any tablets or drugs from the doctor it's the BNF comes out*
26 *and the internet {???} to see what you can do with these tablets and what you*
27 *can't do*

28 *Sandra: ok, so it's not broken down in the liver at all, well you can explain obviously to*
29 *Steven*

30 *Tom: No it isn't, it acts on the CNS*

31 *Sandra: yeah, so there are some leaflets, have you still got the leaflets, yeah. So you can*
32 *look through those.*

33 *Steven: I understand a bit about the ???? because I did some nurse training, so I*
34 *understand a bit*

35 *Sandra: Erm ok, well if you're…*

36 *Tom: it's a longer term therapy isn't it*

37 *Sandra: it's a year, yeah*

38 *Tom: you take it for about a year because it corrects imbalances in neurotransmission,*
39 *neurotransmitters in the brain.*

40 *Sandra: yeah, they recommend you take it for a year*

41 *Tom: yeah*

42 *Sandra: so, as I say speak to your GP about that then and if he needs to meet up with me*
43 *at all then you know that that's ok.*

3.4 Negotiating troubled feelings

In addition to exploring how therapists negotiate behavioural change, I was interested in how they negotiated the clients' troubled feelings within therapy. Jefferson and Lee (1992) noted from a discourse analytic study that service users only take advice if they feel that prior to advice being given, their "troubles telling" have been heard and acknowledged. They stated that if therapists failed to attend to emotional reciprocity prior to attempting to encourage behaviour change, it was less likely that this would be successful. Being open to and exploring a client's experiences

as well as facilitating the client's emotional expression was associated with improved therapeutic alliance and superior outcomes (Ackerman & Hilsenroth, 2001). Therefore, appropriate negotiation of troubled feelings is an integral part of any therapy, though not necessarily a key aspect of technique based treatment manuals.

Negotiating feelings was managed in a number of different ways, some of which appeared to be useful for the clients, and some of which were less so. More useful strategies employed including reflecting back the feeling, and responding with self and compassion. Less useful strategies included avoidance of discussing feelings by diverting the topic of conversation, attempting to resolve the troubled feelings, or putting a positive spin on the feeling. These different strategies are all discussed in more detail below.

3.4.1 Acknowledging troubled feelings

In this section, I discuss some of the strategies used to acknowledge troubled feelings that clients disclose during sessions. All of the therapists acknowledged their clients' troubled feelings at some point during the sessions, though at times this was a minimal acknowledgement in order to move the conversation forward (Antaki & Jahoda, 2010), or to make a rebuttal (Antaki & Wetherell, 1999). These types of acknowledgements which served ulterior functions are not discussed in this section directly, though an example of this is shown in the second example on p.88 where Jon makes a 'show concession' initially (Antaki & Wetherell, 1999), which is not well received, before going on to offer a more robust acknowledgement. Instead, the acknowledgements that are primarily discussed in this section are those which serve the function of allowing the client to know that they are being heard and their experiences are validated. These acknowledgements were present in some of the therapist-client dyads more frequently than in others. They occurred more in the sessions where the client was constructed as making progress, and there was a stronger therapeutic alliance. The reasons for this are likely to be reciprocal, though when considering how a therapist's discourse constructs the therapeutic relationship and client progress, when a therapist acknowledged the client's distress for the purposes of relationship building and validating rather than merely as a function to promote behaviour change, a stronger therapeutic alliance is more inherent.

Reflecting back

Several of the therapists negotiated feelings by reflecting them back to the client. This served the function of allowing the client to feel that what they were saying was heard and understood. In the following example, Gregory had previously

disclosed that he felt disgusted with himself for having driven whilst under the influence.

MET 2 Session 3

1 *Gregory: To sort have say "oh you shouldn't do that again", it was just the fact that I had had that*
2 *drink and I was behind that wheel and I thought this is absolutely crazy, it shouldn't*
3 *happen. And I'm afraid a lot of drink drivers probably will not respond to any sort of*
4 *education or advertising till they sit down and think [I*

5 *Nick: [yeah, yeah*

6 *Gregory: and that's the only thing I think that would turn it round (client sounds tearful)*

7 *Nick: Yeah, yeah, and I hear what you're saying, it's not like you consciously thought about I'm*
8 *having a drink and a few sort of thing. It was more like you hadn't realised, it was that*
9 *sudden realisation that actually it's like putting the drink before my safety and my family*

10 *Gregory: my life*

11 *Nick: before your life*

12 *Gregory: anyone's life*

After Gregory became tearful (line 6), Nick responded by summarising the realisation that Gregory had described. By doing this, Nick neither attempted to 'save' Gregory by trying to make him feel better about having driven under the influence, nor did he make judgements about how serious it was to do this. Instead, he reflected the experience that Gregory reported, allowing him to feel that his distress was understood and was tolerable.

In the following extract, Colin disclosed feeling glad that he is now alcohol free and expressed a sense of regret that he had not achieved this sooner.

MET 3 session 1

1 *Jon: how did you feel about it?*

2 *Colin: great. I feel like a different person altogether. Erm I'm a damn sight happier, laugh and*
3 *joke I don't get depressions that I had before, I don't get the urge. erm I just love to[???]*
4 *it's marvellous. Like I say I just wish that I had the information that I could have gone to*
5 *these, to this years ago*

6 *Jon: So this transformation this vast improvement in your life, you're just kicking yourself a*
7 *little bit that you didn't get the opportunity earlier?*

8 *Colin: Yeah. Yeah I mean I was drinking fairly early, from the age of fifteen*

9 *Jon: Mmm*

10 *Colin: and all through my adult life. Always been a heavy drinker, if I'd have done this twenty*
11 *years ago, Christ, who knows where I'd be*

12 *Jon: and I suppose that's where, I mean clearly that's sort of very relevant in one way erm and*
13 *years of drinking must add to that frustration that I could have done this years ago but I*
14 *suppose partly to keep us focussed on now and the future and because we've only got*
15 *three sessions erm I suppose that's one of the reasons not to dwell on the past but to*
16 *focus on the future*

17 *Colin: [quiet] yeah*

18 *Jon: but I can, you know hear what you're saying and that must be, how old are you now*

19 *Colin: Pardon*

20 *Jon: how old are you now?*

21 *Colin: erm, sixty-three now*

22 *Jon: (.) So something like forty-eight years of regular reasonably heavy to very heavy drinking.*
23 *So no wonder you think back and think this could have happened earlier.*

Initially, Jon reflects back a simple summary of what Colin said about being happy with his achievement yet regretted that he had not achieved this sooner (lines 5-6). When Colin continues to talk about how he regrets all the years he has been drinking, Jon uses a 'show concession' (Antaki & Wetherell, 1999) on lines 11-14, in an attempt to acknowledge the regret and urge Colin to positively focus upon the future. However, on line 18 Jon then goes on to re-acknowledge Colin's regret by clarifying his age and the length of time he has been drinking in order to more closely acknowledge in line 22. This reacknowledgement appeared to be an attempted repair of the 'show concession' as the client did not respond positively to it. Also, doing this enabled Jon to construct Colin's regret as a logical conclusion that anyone would come to, thus showing that he understood how he was feeling which was both adherent to the manual and responsive to the client.

Responding with compassion by using the 'self'

Another way that therapists respond to feelings or emotive topics that were expressed within the sessions by their client was to disclose their own feelings. In this example Polly is talking about some recent serious self-harm.

SBNT 3 Session 3

1 *P: When, when I done my arm, that was my worse one I ever done. And, he come up to the*
2 *room the next day and he says, come on lets clean it up and put a bandage on it. He says then we'll*
3 *go out. I says you don't want to see this Chris. Oh it can't be as bad as when you've done it before. I*
4 *says, you don't want to see this. And when I took me arm out from under the blanket, he says I*
5 *can't touch that. You'll have to go to hospital (.)*

6 *S: [quiet] oh god Polly(...)*

Sally responds to Polly's explanation of the aftermath of her self-harm, and the emerging narrative of how serious it was by making an expression of commiseration (line 6). She uses a soft tone of voice in showing her personal reaction, most likely of sadness, to acknowledge how awful the situation was. By using Polly's name directly, Sally reaches out to Polly on a more personal level. In doing so, and allowing her sadness as a reaction to the reported situation to be seen Polly, Sally shows that she is 'coming alongside' (Beuken, 2002) Polly by sharing the emotive pain.

3.4.2 Avoidance of troubled feelings

In this section I discuss the discursive strategies used by therapists to avoid discussing troubled feelings. These strategies were present only in some of the therapist-client dyads. The dyads that they were present in were the ones that tended to feel more 'stuck' in terms of progress with the client and those without a solid therapeutic relationship. The avoidance of feelings was also more concurrent with therapists who used more 'critical', 'lecturing' and 'persuading' discourses; in particularly Donna and Craig, Jenny and Peter, and to a lesser extent Sandra and Tom. The observed presence of 'stuckness' and poorer therapeutic alliance were constructed by both therapist and client in their discourse. Therefore no effort is made to conclude whether therapist avoidance of feelings was an initiator to these contexts, or whether the avoidance was in response to these concepts. As all discourse is both constructive and constructed in nature (Edwards & Potter, 1991) it is likely that both of these explanations are true to some extent.

Diverting the topic of conversation

One of the ways that therapists managed feelings that they perceived as uncomfortable for themselves or the client, or not useful to discuss in the context of behavioural change, was to divert the topic of the conversation. This diversion was used as a vehicle to circumnavigate the topic directly and to move the conversation forward.

In the following extract, Sandra draws the session to a close. During the session, Tom had disclosed that since the previous session he had been made redundant and had a serious legal allegation made against him by a family member. In addition to this Tom spoke about the relationship difficulties he was having with his partner.

SBNT 2 session 4

1 *Sandra: ok, well look thanks for coming today and er all these difficult circumstances you've been*
2 *under and for ringing and cancelling your other appointment because I wouldn't have*
3 *thought it would be your top priority on your mind so*
4 *Tom: mmm*
5 *Sandra: so I appreciate that, I'm sorry that you've been through these difficulties*
6 *Tom: hopefully I'll be coming out the other side*
7 *Sandra: yeah yeah. Ok well thanks for today then, we'll close because I know you're struggling*
8 *with your throat and your hay fever*
9 *Tom: I am a bit yeah*

This session lasted 25 minutes, noticeably shorter than the other sessions. When drawing the session to a close, Sandra acknowledges the "difficult circumstances" that Tom has spoken about both by thanking him for cancelling a

previous appointment (lines 1-3) and by saying she is sorry that he has had to experience them (line 5). In lines 7 and 8, she then states that the reason for finishing the session early was due to his throat and hay fever. By offering this explanation, Sandra eliminates the other "difficult circumstances" that Tom has disclosed as a reason to end the session. By doing this, Sandra offers a satisfactory justification for ending the session which is palatable to Tom and herself. By discounting his personal difficulties as the reason, she constructs herself as responsive to the Tom's physical needs. This prevents her from coming across as uncomfortable or unable to use the time to discuss Tom's drinking in the context of these difficulties.

To place the following extract in context, Peter arrived at the session under the influence of alcohol and stated that he had made no changes to his drinking since the last session. He states that the process of therapy with Jenny has *"just depressed me"* (line 5).

MET 1 Session 3

1 *Jenny:* *mm mm, Have you, have you done anything to cut down the amount that you're*
2 *drinking?*

3 *Peter:* *No.*

4 *Jenny:* *Why is that?*

5 *Peter:* *It's, I don't know. As I say this course, this, this has just depressed me.*

6 *Jenny:* *In what way, why is that]*

7 *Peter:* *: [I suppose I just expected more out of, you know. (.) It sort of*
8 *dragged on (mm) When I've, when I've been here before I've come here maybe once or*
9 *twice. They've sort of give me the Librium and that's it.*

10 *Jenny:* *And that's what you expected and wanted again?*

11 *Peter:* *Well I were hoping for sommat else actually but, you know, but erm, I've like some drugs*
12 *or medication. When it said this trial, I didn't realise it was, sort of therapy, I didn't*
13 *realise what sort it was. I would, I spose I just expected something else.*

14 *Jenny:* *uhum. Ok, ok, what I'll do Peter is I expect, Who's your GP? (looks in file)*

15 *Peter:* *Dr X*

16 *Jenny:* *Dr X?*

17 *Peter:* *Well no, actually no, he is the le, the what do you call it, (.) the head of the practice. It's Dr,*
18 *ohh what is called, Dr, Dr, Dr,*

19 *Jenny:* *Y?*

20 *Peter:* *Y. That's it*

21 *Jenny:* *Riverview health centre. Ok. Is to allocate you a new keyworker, erm, because I can only*
22 *see you for this sort of therapy.*

When Peter states that therapy has depressed him (line 4) and states that it was not what he was expecting (lines 10-12), Jenny responds by stating she will organise a new key-worker to provide him with the alternative care that he is

requesting (line 20). This is a pragmatic way of dealing with the situation which is responsive to the Peter's needs. However, before explaining this, Jenny asks who his GP is and looks into his file (line 14). The function of doing this first is that Jenny diffuses the conversation and takes charge by eliciting information from Peter, instead of exploring the complaint that Peter has, or acknowledging his disappointment.

Attempting to resolve the feeling

Another strategy that therapists used to avoid discussing troubled feelings was attempting to resolve the feelings. One might expect this to be a useful strategy in therapy in order to help the client feel better; however, it can be dismissive if it is not appropriately timed as an intervention. The research suggests that clients respond positively to feeling heard and validated with regards to their difficulties (e.g. Linehan 1997) and that this is an important step to recovery in itself before attempts are made to resolve them.

In the below extract, Donna is continuing a conversation about the importance of Craig raising his levels of activity. Craig expresses that he doesn't feel able to do any more activities at this time due to his low mood. Donna responds by trying to troubleshoot his low mood in a pragmatic fashion.

SBNT 1 Session 1

1 *Donna: Hmm. So knowing that, what can you do with that time?*

2 *Craig: I don't know at the moment, because I'm waiting for these tablets to start working*
3 *properly, you know what I mean*

4 *Donna: your anti-depressants*

5 *Craig: Yeah. Cos at the moment really, I've got absolutely no interest in anything at all. Might be*
6 *different in a couple of weeks when these start working, I don't know. Just know at the*
7 *moment. all I'll do when I leave here is I'll go home and watch tv.*

8 *Donna: right*

9 *Craig: I've just got no interest*

10 *Donna: do you go out with Paul at all?*

11 *Craig: No. I just go up and see him or talk to him on the phone*

12 *Donna: (.) do you think it might be helpful to go out? Somewhere that doesn't involve drinking.*

13 *Craig: I don't know. Like where?*

14 *Donna: I don't know, I don't know what you. Like you said you enjoyed sport*

15 *Craig: I couldn't even bother going to a gym at the moment, want to get my head together a bit.*
16 *Now that I've (?) and all that stuff*

17 *Donna: doesn't appeal to you?*

18 *Craig: not at all.*

19 *Donna: do you watch any sport?*

Craig indirectly reminds Donna that he is low in mood by stating that he is waiting for his antidepressants to work. He follows up this by stating that he has "absolutely no interest in anything at all" (line 5) which is a common experience for people who are struggling with low mood. At this point, Donna offers a "minimal receipt" (Antaki & Jahoda, 2010) by stating "right" (line 8). The lack of sufficient acknowledgement of Craig's disclosure prompts him to repeat that "I've got no interest at all." By repeating himself, Craig is noting that this is a significant difficulty for him and that he wants acknowledgement. Rather than acknowledge his hardship, Donna goes on to ask several questions about how Craig can occupy his time (lines 10, 12, 14, 19). By asking these questions, Donna avoids discussion about how it feels to be low in mood, instead drawing upon a discourse that he will feel better if he keeps busy, which, if successful, would negate the need for her to discuss the negative feelings that he is experiencing. In this extract, this discourse was not shared by Craig, which is possibly because no acknowledgement of his difficult feelings was offered before advice was given (Jefferson & Lee, 1992).

Similarly, in the following extract (taken from the same session), instead of acknowledging how Craig may be feeling about his situation, Donna attempts to change the reality of the situation.

SBNT 1 Session 1

1 *Craig:* *yeah, well I can't plan anything, I'm waiting just to go to prison at the moment*

2 *Donna:* *But there's a possibility at least that you might not go to prison*

3 *Craig:* *I don't think so, I think I'll go me*

4 *Donna:* *right. Have you been told that?*

By stating that he might not go to prison (line 2) and asking for a reliable evidence in order to be convinced of that he would go to prison (line 4), Donna avoids acknowledging that Craig may be going to prison and thus closes down the potential for discussing his feelings and worries about this.

Putting a positive 'spin' on the troubled feelings

Another way that therapists negotiated feelings was to reframe them as something more positive or put a positive spin on them. This has been discussed as a form of avoidance, as in the instances it was observed, the function was to avoid talking about negative feelings. By attempting to help the client see the feelings in a more positive way, the therapist negated the need to discuss how distressing they were for the client.

The following extract is taken from a conversation whereby Peter is talking about his past drinking, and how he has considered suicide, and how he feels he is slowly killing himself by drinking. To put this extract in context, Peter is under the influence of alcohol in the session, has not yet made any attempts to change his drinking, and has made an inappropriate sexual comment towards Jenny previously within the session. Prior to this extract, Jenny has expressed her frustration with Peter by adopting a more confrontational approach than she had previously.

MET 1 session 2

1 *Peter: I mean, as I say I got to 50. I didn't think I'd get to 50 (right). I've neglected myself (uhuh),*
2 *er physically, mentally. I started give up years ago. (right) Erm, I've asked God to take my*
3 *life. I mean after all the drinking, is a form of suicide. (hmm, well). It's a slow, painful*
4 *form of suicide. It's not like jumping out of a window or hanging yourself. It's, you, you're*
5 *feeling dejected, you're feeling lonely, you're feeling poorly every day of your life. And it's*
6 *as I say, you're committing suicide. But er, coz basically, I ain't got the guts to do it*
7 *outright you know (mm) I've thought about it, but because of me Catholic upbringing*
8 *(mm) and fear of going to hell.*

9 *Jenny: mmm So life's going to be a lot happier for you, a lot more fulfilled for you.*

10 *Peter: Hopefully, hopefully.*

11 *Jenny: That's the idea, yeh*

12 *Peter: Yeh,*

13 *Jenny: Great*

After Peter has spoken about how he has thought about suicide, and feels that he is killing himself with his alcohol use, Jenny offers a positive reframe by stating *"So life's going to be a lot happier for you, a lot more fulfilled for you" (*line 8). By attending to how Peter will feel better in the future if he stops drinking, she is avoiding acknowledging how Peter is currently feeling. The reframe also has the function of moving the conversation towards the benefits of change, though this is at the expense of acknowledging Peter's feelings which is an important aspect of developing and maintaining the therapeutic alliance.

In the following extract Donna and Craig are exploring being alcohol free and his cravings to use alcohol. Craig notes several times that he feels he is struggling, and Donna takes responsibility for the direction of the conversation by prioritising his actions over his feelings despite his objections to this.

SBNT 1 session 1

1 *Craig: I can talk to anyone really, but like I say if my minds set on a drink.*

2 *Donna: But so far you've not had a drink*

3 *Craig: No, but it's been bloody hard though*

4 *Donna: But you've not given into that, and I think that's really good. Because it sounds like the*
5 *last few days cravings have been very very strong.*

6 *Craig: Definitely*

7 *Donna: But you've not given into that.*

8 *Craig: Yeh, but I've been bloody close*

9 *Donna: There's a big difference between wanting to and doing it*

10 *Craig: It's just that how I feel at the moment I'm not sure I could keep going that much longer at*
11 *the moment.*

12 *Donna: ok*

13 *Craig: I'm being honest.*

14 *Donna: What sort of situations make your cravings worse?*

Craig constructs remaining alcohol free as a struggle, implying that he requires acknowledgement of how hard it is and support with that struggle (lines 1 & 3). In contrast, Donna constructs remaining alcohol free as an achievement (line 2) and adds to this by constructing it as a more impressive achievement due to it being a struggle (lines 4-5). By stating that it is good to cope with cravings, Donna shuts down Craig's attempts to open up a conversation about how hard it is for him. Both Donna and Craig use the word "but" (lines 7 and 8) indicating that they disagree with each other's construction of remaining alcohol free whilst experiencing cravings. It is clear that Craig does not find this positive reframe useful as in lines 10-11 he uses a discourse of desperation as a plea to Donna to acknowledge how hard it is for him. When Craig states that "*I'm being honest*" (line 13), he is expressing that he feels he is not being rewarded for his honesty by his concerns being validated, as he is putting himself in an emotionally vulnerable position. At this point, Donna does indirectly acknowledge his struggle by asking a practical based question about his cravings (line 14), in order to begin problem solving. By asking this question, she is able to attend to Craig's plea for help with his cravings whilst still avoiding speaking about how the struggle feels for him.

3.5 Brief summary of analysis

The interpretative repertoires (IRs) that therapists draw upon using were examined, and the discursive practices that used to promote client change were identified. The IRs identified were:

- Therapist actions are responsible for enabling for change
- Clients are responsible for changing their own behaviour
- A therapeutic alliance is required for change.

All of the above identified IRs had some theoretical base in at least one of the treatment manuals, and were also used according to the therapist's own personal repertoires whether based on clinical judgement or more individual influences. These

IRs were enacted through several identified discursive practices which were: being paternalistic, being critical, persuading, lecturing, using humour, being collaborative, acting as benevolent expert and constructing oneself as a powerful expert.

Throughout the discussion of these discursive practices, the therapists' implementation of a treatment manual with reference to adherence and responsivity, was addressed. This was achieved by linking the discursive practices with the manual content and with other functions for the client or therapist. A range of balance between adherence and responsivity was found across the analysis, and observations were made regarding the context and effects of these differing approaches.

Finally, the discursive practices used to negotiate difficult feelings were examined. This analysis generated several practices under two broad themes: acknowledgement, and avoidance. Discursive practices used to acknowledge feelings were: reflecting back, and responding with compassion by using the 'self'. Discursive practices used which avoided a client's feelings were: diverting the topic of conversation away from feelings, attempting to resolve the feelings of the client, and putting a positive 'spin' on a client's feelings.

Chapter 4. Discussion

The analysis in this study was primarily interested in how therapists working in services for alcohol addiction use discourse in manualised therapy sessions. In order to address this question, three particular aims were identified which are shown below in order to help situate the discussion

- To identify the taken for granted assumptions drawn upon by therapists and how these are enacted in the practise of therapy
- To examine the practice of the therapists with reference to both adherence to the manual, and clinical judgement.
- To examine how therapists negotiate difficult experiences within the practices of therapy.

The analysis which relates to each of these research aims is discussed below in relation to the existing literature. The limitations of this research study are then discussed, followed by a discussion of the clinical and research implications of this study and recommendations for future practice.

4.1 Findings in relation to existing literature

4.1.1 Fidelity to the treatment Manuals

Previous research has suggested significant differences in different therapists' treatment outcomes when using treatment manuals in research trials (Luborsky, Mclellan, Diguer, Woody, & Seligman, 1997; Longabaugh, Donovan, Karno, McCrady, Morgenstern, & Tonigan, 2005). The majority of the literature regarding therapist effects in psychotherapy (See Blow, Sprenkle, & Davis, 2007 and Ackerman & Hilsenroth, 2003 for literature reviews) have been quantitative in nature and matched to outcome. In contrast, this research study intended to be an in-depth qualitative exploration of therapist discourse to illuminate findings from the previous literature, and to highlight possible directions for further research in this area.

Based on a review of the previous literature, table 9 was generated to illustrate the differing ways that therapists negotiate the use of treatment manuals. Each of the four cells from the table is discussed with regards to the analysis of the data from this research study.

Table 9: Table showing ways therapists negotiate the use of treatment manuals through talk[6]

	Using skills and techniques prescribed by the manual	Not using skills and techniques prescribed by the manual
Attending to therapeutic processes using clinical judgement	**1. Fidelity to the manual** (assumed to be of benefit to client[7])	**2. Supplanting the manual** (which may or may not be of benefit to client)
Not attending to therapeutic processes using clinical judgement	**3. Adherence to the manual (but not fidelity)** (unlikely to be of benefit to the client)	**4. Lack of adherence to the manual and of responsivity to the client** (which is not of benefit to client)

1. Fidelity to the manual

The first cell illustrates occasions where interventions used by therapists adhered to what was prescribed by the manual, and were also responsive to client need. The pairing of both adherence and responsiveness is described in the literature as 'fidelity' (e.g. Leichsenring, Salzer, Hilsenroth, Leibing, Leweke & Rabung, 2011; Schoenwald, Garland, Chapman, Frazier, Sheidor, & Southam Gerow, 2011; Forgatch, Patterson & DeGarmo, 2005). Manual fidelity was observed in the analysis particularly through 'being collaborative' and 'using benevolent power'. An example of this is demonstrated on p.76 when Nick (therapist) responded to Gregory's (client) initial resistance to engage with the process of being fed-back statistics on the effects of his drinking. Nick responded by being non-defensive and exploring the meaning the feedback had, or indeed did not have, for him. This shows fidelity to the manual as the therapist was both responsive to the client, and actively working with his motivation as prescribed by the treatment manual. This mode of delivery can be described as ideal, as adherence ensures evidence based interventions are implemented, whilst the

[6] This table was used to structure the analysis of how therapists negotiated the use of treatment manual within therapy sessions. The four different conceptualisations were used to characterise individual discursive instances rather than entire sessions .

[7]According to the tenets of the evidence based practice movement, it is assumed that if an evidence based treatment is delivered with fidelity, that it is of benefit to the client. As discussed in the introductory chapter this is not necessarily true.

therapist ensures they are responsive to the client, and importance of the therapeutic alliance is acknowledged (Davidson & Scott, 2009)[8].

2. Supplanting the manual

The second cell is 'supplanting the manual'. This occurred when therapists attended to clients using methods other than those prescribed by the manual. Deviation from the manual categorised in this conceptualisation, refers only to deviations that are in response to client need. When this occurred in sessions, it is categorised as non-adherence, though this approach has the potential to be useful to a client as therapists were responsively attending to a client's needs (Jones, Cumming & Horowitz, 1988; Castonguay, Schut, Constantino, & Halperin, 1999). Two examples of supplanting the manual are shown on p.82 when Sally responded to Polly's disclosures of abuse towards herself and her son. Instead of problem solving, she uses her category entitlement (Sacks, 1974) to reinforce that the abuse was not Polly's fault and to acknowledge the emotional pain that Polly was feeling. Gresham *et al.* (2000) noted that such deviations are useful only when there is a meaningful rationale for doing so, which benefits the client.

3. Adherence to the manual (but not fidelity)

The third cell is one of adherence to the manual but not in terms of manual fidelity. Therapist discourse is categorised as such when the skills and techniques used are prescribed by the treatment manual, but are unresponsive to the client or therapeutic relationship. This was observed in the analysis at times when therapists were 'being critical' or 'lecturing' towards clients. Commonly within SBNT sessions, when therapists attempted to move a client forward, and drawing on these discursive practices, they were adhering to the manual by using techniques such as setting the agenda, actively attempting to engage network members, and offering advice and feedback; however, they were not attending to the therapeutic relationship or collaboratively addressing client resistance to the topic. For example, on p.92, Donna (therapist) suggested several times that Craig should focus on activity planning, despite his resistance to this due to having a greater concern for his low mood. Also, within this example, not only did Donna use topics that were adherent but not responsive, she also used a tone of voice which was not compassionate to Craig's

[8] Though this is conceptualised as the ideal implementation of manualised treatment, this is based on the fallible assumption that the evidence based treatment being implemented is both effective and appropriate. Problems with the construction of evidence based practice were discussed in the introduction chapter and is discussed later in this chapter. If we accept that the evidence based treatment is not always the best treatment for an individual client, it may be that the second cell whereby the therapist is responsive but non-adherent can at times be superior to treatment fidelity.

concerns. It has been noted in the literature that the delivery of techniques can be received positively or negatively depending upon its delivery e.g. warm or cold tone of voice (Strupp & Anderson, 1997)

Also, at times, a therapeutic technique may have been delivered in an objectively appropriate way according to the treatment manual, but delivered at an inappropriate time, or as an inappropriate response to a particular event (e.g. Spektor, 2007; Castonguay, Schut, Constantino, & Halperin, 1999). Within this data set, particularly when 'difficult' concepts were discussed, when there was strict manual adherence, this was at the expense of attending to the therapeutic relationship. This was similar to the findings of Castonguay, Goldfried, Wiser, Raue, and Hayes (1996).

This highlights the need for treatment fidelity in contrast to merely adherence, whereby the manual is used alongside clinical judgement rather than as a replacement for it. In the light of evidence suggesting that the therapeutic relationship is a key predictor of outcome, (e.g., Wampold, 2001) it is important that therapists attend to this through responsiveness to client needs when implementing techniques prescribed by the treatment manual. Frequency data of the number of events typified by adherence without responsivity cannot be presented due to the nature of selection of material for analysis being inherently subjective with a leaning towards selecting verbal exchanges that were 'interesting'[9]. For this reason, an over-representation of exchanges which fit this category (adherence to the manual (but not fidelity)) were selected for transcription and analysis. Nonetheless, a significant number of exchanges that were adherent without fidelity were present within the sessions as a whole, and thus this require further thought when considering treatment implementation in clinical practice. Clinical recommendations for addressing the delivery of manuals in adherent but not responsive manner are discussed further later in this chapter.

4. Lack of adherence to the manual and responsivity to the client

The final cell is lack of adherence and lack of responsiveness to client's needs. This occurs when the therapist is attending to processes other than the therapeutic relationship and client needs. For example, this may occur when therapists are anxious or unsure how to respond. This was an uncommon feature in the sessions analysed, where most interactions fitted into the other three categories. When this did occur in the analysis it was mostly associated with therapists managing their power or professional identity within the therapeutic dyad, using the discursive practice of constructing oneself as a powerful expert. An example of this was shown on p.84 when Jenny explained to Peter the reasons why she felt that he had not presented as needing

[9] See p.49 for description of process of selecting 'interesting' verbal exchanges

a medical detoxification, following him stating that this was an expectation he had of therapy that she did not fulfil. Alternatively, the therapist deviated from the focus of the therapy to respond to their own personal needs, rather than those of the client. This is unlikely to be useful for the client as it does not utilise the intended change mechanisms prescribed by the manual, nor does it contribute to a positive therapeutic alliance.

4.1.2 Contrasting the MET and SBNT Treatments

Amongst the sessions as a whole, it can be noted that there was a higher frequency of 'adherence without fidelity' amongst SBNT sessions than MET sessions. It is possible that being adherent **and** responsive is a more natural occurrence for therapists delivering MET than the SBNT due to the treatment philosophies. One of the tenets of MET is to work with client motivation and resistance responsively and collaboratively, and so in doing so (and thus being adherent) one is also responsive to the client. In contrast, the techniques prescribed by SBNT (Copello, Orford, Hodgson & Tober, 2009) are not necessarily synonymous with responsiveness to the client as the therapist is constructed as a a "task oriented team leader" (p.22) who promotes the development of a client's support network with no particular prescriptive reference to how this should be done in a responsive manner. Therefore, the SBNT manual requires the therapist to take personal responsibility for attention to be paid to responsivity in addition to the techniques prescribed as they are not automatically linked in the manual aside from acknowledging more generally that therapists should have "counselling and communication skills" (p.30). This highlights the need for consideration of the format of treatment manuals in order to facilitate therapist responsivity in addition to adherence. This is discussed further in the clinical considerations later in this chapter.

4.1.3 Promoting change through the use of Interpretative Repertoires

The majority of therapists drew upon multiple IRs with regards to the process of change at different points within the sessions and to different ends. The use of these IRs in relation to existing literature and in the context of clinical practice, is discussed.

Therapist's actions are responsible for enabling change

This IR that therapists are responsible for change was enacted through discourses which constructed the therapist as the 'helper' and the client as the 'helpee' (Parker, 1999). This is similar to the therapist enacting an 'I'm ok, you're not ok' role as described by transactional analyst Berne (1964). This was enacted through the

discursive practices of 'being paternalistic' and 'using benevolent power.'[10] When this IR was utilised by therapists, the client was often constructed as in a position of requiring help. It is likely that this was a reciprocal role, whereby the client's apparent and perceived helplessness was constructed in a context in which the therapist assumed responsibility, placing the client in a helpless role. This interaction is akin to the traditional medical model of mental illness (Laing, 1971), which is pervasive in the majority of current psychotherapy practice and medical systems (Kaye, 1999).

By taking responsibility for facilitating the client's progress in therapy, the therapist constructs him/herself as powerful through expert, informational, and possibly referent power (French & Raven, 1959). As might be expected, as the therapist assumes a more powerful role, the client is positioned in a comparatively less powerful role. Kaye (1999, p.24) describes this process of inducing change in a client as "re-visioning", whereby therapists use their expert knowledge to find a solution for a client's issue. Actively drawing upon this IR can be useful in therapy. For example, Karno, Beutler and Harwood (2002) identified that clients who had low scores for reactance and defensiveness benefitted from when therapists were more directive, however they also identified the converse for clients with elevated scores in reactance. When clients refuse to be placed in the less powerful role, this can lead the therapist to become uncomfortable and a power struggle to ensue.

Within the sessions, there were times when this IR was used by therapists to allow them to take care of clients when they presented in a vulnerable position; either due to their own behaviour, or problems in their social context and close relationships. Being directive in the face of client personal risk, or being categorical about abuse towards the client is a necessary and ethical action. If therapists were to avoid using their category entitlement when expressing their opinion in these situations, they would inadvertently be condoning or colluding with situations which could have negative consequences for a client's wellbeing. In other situations, when clients were in a vulnerable position which was less objectively unacceptable (e.g., a client reporting feeling low in mood) by being directive to 'save' the client, therapists denied clients the opportunity to explore and address issues these independently (or at least collaboratively), thus reducing their self-efficacy. This is categorised as acting as 'the rescuer' by Karpman (1968) in which the therapist acts in a way that places the client in the 'victim' role. In summary, this suggests that therapists need to pay keen attention to when it may be necessary to be directive, versus non-directive, within the

[10] Other directive practices such as 'lecturing' and 'being critical', which might at first glance seem to fit here, were not considered to be drawn from the IR that therapists are responsible as they served the function of shifting responsibility onto the client. These are discussed later in the discussion alongside the IR that clients are responsible for changing their own behaviour.

therapeutic dyad. At times it may be appropriate for therapists to scaffold an individual to solve their own difficulties through an awareness of such paradigms as Vygotsky's 'Zone of Proximal Development' (Vygotsky, 1978); and at other times it may be appropriate to be more active in mitigating immediate concerns (e.g., risk) when the client may have insufficient resources upon which to act appropriately or safely. This remains a dilemma for any clinician, but should be an active and informed decision which is responsive to client need.

Clients are responsible for changing their own behaviour

Some of the discursive practices used by therapists, in particular persuasion, being critical, and lecturing, suggested that therapists were drawing upon their power as a therapist to induce client change. Many of the interactions typified by these practices could be categorised as the therapist taking a 'persecutor role' (Karpman, 1968). Through the use of these practices, therapists use their category entitlement as a therapist (Sacks, 1974) to impart knowledge or instruction to clients with the assumption that it should be followed to improve their clients' personal situation. This is similar to what Berne (1964, p.127).) described in his book 'Games People play' as the game of "I'm only trying to help you" By playing this 'game', professionals construct clients as "ungrateful and disappointing" which absolves professionals of guilt should the client not get better. By telling the client what they 'should' be doing, therapists are able to construct that they have 'done what they can' and can shift the responsibility onto the client regarding whether they choose to heed their instruction or not. If clients do not readily accept therapeutic advice they are constructed as unfulfilling the obligations expected of them due to the 'Sick Role' they have been positioned in by society and services (Parsons, 1951). By using discursive practices akin to this 'game', therapists can achieve the aim of 'holding their side of the bargain' without particular investment in whether the client does the same.

DeVaris (1994) offered one reason why therapists, at times, are drawn into power struggles, noting that when they feel ineffective, unchecked countertransference can influence therapists to use their power destructively within the therapeutic encounter. This is more likely to occur when clients do not adhere to the expectations of what therapists consider they 'should' be doing or saying, and thus not constructing themselves as the "good patient" (Katz, 2000). This then positions therapists as unable to help a client, which can lead therapists to feel helpless, disempowered, or that their competence is being challenged. In the analysis, this occurred particularly when the negotiation of troubled feelings occurred, and when clients constructed themselves as distressed and unable to overcome this distress. At

this point it appeared that some therapists also felt unable to mobilise any change in the face of such distress, leading them to become pejorative or avoidant of the issues the client was expressing. An example of this (p.92) was when Craig (client) presented as low in mood and expressed a need to address this in order to progress, however Donna (therapist) focused upon her own agenda dismissing Craig's concerns, which he then did not engage with. This led to Donna appearing to become frustrated, and focussing more on her own intervention, constructing herself as the expert in order to construct Craig's unwillingness to agree with her intervention as resistant. To overcome this, DeVaris (1994), drawing on psychodynamic and feminist theory, recommended that therapists should resolve their personal issues with powerlessness or helplessness so to prevent them from 'playing out' their unresolved personal issues with power within the therapeutic relationship. This has implications for clinicians providing psychotherapy, including the more manualised treatments, especially in the light of evidence suggesting that a positive therapeutic alliance has a major influence on outcome (e.g. Wampold, 2001).

Both client and therapist in collaboration are responsible for change

Therapists who drew upon this IR used collaborative discourses that constructed responsibility for change as shared. When this IR was used, therapists used discursive practices that demonstrated they were working together with the client to achieve change. In doing so, therapists facilitated client change though partnership and the cumulative power of sharing of client and therapist resources rather than through enforcing or stating expectations of change. This was demonstrated both within SBNT and MET sessions.

In sharing responsibility for change with the client, the therapist attended to the inherent power imbalance between client and therapist in an effort to make it more balanced. Therapists who drew upon this IR used collaborative discourses, prioritising client's own views and supporting them with this using their own expertise. An example of this is shown on p73 whereby Nick (therapist) responds to Gregory (client) asking how much he needs to know about his operation by telling him that he can know what he feels is appropriate to tell him. This approach was made popular by Rogers (1989) who in his writings about 'Client centred therapy' noted that the client should be trusted in their expertise of their own lives and experiences, whilst the therapist takes a role in facilitating the process of therapy rather than directing it. When this IR was drawn upon, the exchanges between therapist and client appear to flow well. When this IR was used, the therapist takes appropriate responsibility for their own influence whilst respecting the agency of the client. This approach facilitates

a process where both parties are invested in change fairly equally thus preventing issues of blaming or shirking responsibility.

4.1.4 Critical evaluation of Manualised treatments as evidence based treatments

Both SBNT and MET are evidence based treatments. MET has a strong evidence base (e.g., Burke, Arkowitz, & Menchola, 2003; Rubak, Sandboek, Lauritzen, & Christensen, 2005; Jensen, Cushing, Aylward, Craig, Sorell, &. Steele, 2011), and SBNT is a relatively new treatment with an emerging evidence base which appears promising (e.g. UKATT, 2005). However, because treatments are evidence based does not necessarily mean they are the most effective of all the available treatments. Due to the empiricist philosophy that underpins evidence based practice, the research that is currently accepted as evidenced tends to derived from systematic reviews of randomised controlled trials (RCTs) (Hjorland, 2011). As RCTs are large scale and require substantial funding they tend to be focussed on more established treatments, whereas much of the research into promising emerging treatments, or mechanisms and theories that underpin treatments is on a smaller scale and therefore is not considered when evidence based treatment policies are created (Hjorland, 2011; Marks, 2002; Dixon-Woods, Fitzpatrik, & Roberts, 2001; Rycroft-Malone, Seers, Titchen, Kitson, Harvey, & McCormack, 2004). This results in a skew in what research is acknowledged as 'evidence' which limits what can then be considered an evidence based treatment. An example of this is given by Holmes (2002) who proposes that the popular assumption that CBT has the strongest evidence base of all psychotherapies is due to the fact that more large scale studies and systematic reviews have taken place than for other available therapies, and not that CBT has been shown to produce superior outcomes. In a review of the literature promoting evidence based practice, Marks (2002) identified that only 2.2% of the sample reviewed qualitative data, and less than 1% utilised such data to inform decisions. Marks (2002), among others (e.g. Dixon-Woods, Fitzpatrik, & Roberts, 2001; Hjorland, 2011; Cohen, Stavin & Hersh, 2004) recommended a paradigm shift in what is considered worthy research to inform evidence based practice, and note an ethical need to attend to research methods that allow consideration of treatments that do not attract major funding, and facilitate the investigation of mechanisms and theories which underpin treatments. Without the consideration of such research, one can only conclude whether a therapy works or not, not how it works, nor whether it is there may be another therapy that can work better.

It has been noted that in everyday practice, the utilisation of evidence based practice has been promoted as a replacement for clinical judgement when instead it should aid clinician decision making alongside clinical judgement (Marks, 2002; Dixon-Woods, Fitzpatrik, & Roberts, 2001; Tonelli, 1999; Hjorland, 2011). This argument is

clearly illuminated by Rycroft-Malone, Seers, Titchen, Kitson, Harvey, and McCormack (2004, p81) who stated with regards to nursing practice that *"the practice of effective nursing, which is mediated through the contact and relationship between individual practitioner and patient, can only be achieved by using several sources of evidence…namely research, clinical experience, patient experience, and information from local context."* They noted that both the scientific and the intuitive are necessary for effective patient-centred care.

When considering how evidence based practice tends to be informed by large scale quantitative efficacy research it becomes apparent that research and theory incorporating social constructionist principles are ignored within this domain. For example, small scale research indicating the positive influence of service user involvement on outcomes (e.g. Thornicroft & Tansella, 2005), or the developments in the deconstruction of psychotherapy (e.g. Parker, 1999; Kaye, 1996) becomes incompatible with the evidence based practice agenda due to competing ideologies. Both the therapies included in this research study have clear explanations of the assumed mechanisms of change which underpin them. When considering MET, there is a growing amount of research investigating these mechanisms (See Apodaca & Longabaugh, 2009). As SBNT is a relatively new treatment, the understanding of the mechanisms of change is largely limited to the initial propositions given by developers (Copello, Orford, Hodgeson & Tober, 2009). However, this research is dwarfed by large scale efficacy studies focussed on ascertaining what treatments should be used, rather than how they should be used. When considering how clients are essentially consumers expecting the best possible care, it appears counterintuitive that as professionals we would accept that a treatment has a strong evidence base, and be satisfied with this as 'good enough'. This research study highlights great variability in how both of the two evidence based treatments are delivered. Throughout the analysis many discursive practices are discussed, some of which appear to have been well received by clients and some less so. Therefore, more research is required investigating the subtleties of how these treatments are delivered, the mechanisms of change that underpin them, and client views on their utility.

4.1.5 Attending to feelings within treatment

Within the analysis of this study, therapists responded to clients' expression of emotion in a variety of ways. These responses were categorised as either acknowledging or avoiding.. Existing literature suggests that facilitation of client affect is associated with better therapeutic outcomes (e.g., Diener, Hilsenroth & Weinberger, 2007) and that models which explain how the appropriate acknowledgement of client emotion are beneficial (e.g. Bion, 1962; Winnicott, 1971). Whether the therapist

responded in a manner that acknowledged or avoided affect appeared to depend on a number of factors related to the reciprocal interaction between therapists and clients. These factors are considered below, with links to existing literature and current therapeutic practice.

With regards to factors associated primarily with the therapist, a useful concept to consider the responses of therapists is that of countertransference (Freud, 1910), initially derived from psychoanalytic theory. Hayes, McCracken, McClanahan, Hill, Harpe and Carozzoni (1998) explained how countertransference can influence the therapeutic relationship through shaping therapist behaviour:

> *"The clinician's use of the self as a therapeutic instrument can be influenced greatly by countertransference. On the one hand, countertransference may cause therapists to act defensively in accordance with their own needs, perceive clients in distorted fashion, and exhibit poor clinical judgment. On the other hand, the insight that may be gleaned from countertransference can deepen therapists' awareness of relationship dynamics and provide valuable information about the course of treatment" (p.468)*

Prasko and colleagues (2010) reviewed the literature with regards to attending to transference and countertransference issues in CBT. They recommended that therapists should be aware of the emotional responses that the client brings to the therapeutic relationship, and should neither encourage nor ignore them, but acknowledge them. They also recommend that therapists should attend to their own countertransferential issues by developing an awareness of the source of their emotional reactions that occur within themselves and within the therapeutic relationship to utilise these within the therapeutic encounter, or to mitigate their impact.

Some therapists who tended to engage in more 'critical' and 'lecturing' discursive practices, also tended to avoid the acknowledgement of client emotions. One way of interpreting this potential link is to consider the attention that they pay to the countertranferential feelings they have towards clients within the sessions. It is possible that they feel threatened, hopeless, or even angry when clients experience difficulty, which leads them to respond in a way that could be categorised as less empathic. In contrast, therapists who tended to be more collaborative and use benevolent power during sessions tended to acknowledge the difficult emotions clients presented with, indicating that they were possibly more comfortable in 'holding' (Winnicott, 1971) client concerns, and prioritising client needs rather than attending to their own unchecked countertransferential feelings.

Remaining with the concept of countertransference, the client's presentation appeared to affect how therapists responded, whereby when clients were less engaged

in combination with more severe problems, or failing to make objective progress, therapists responded in a more avoidant way. This was shown when Jenny was more avoidant in response to Peter's disclosure of having felt suicidal in the past (p.94), in the context of him not changing his drinking behaviour during the course of therapy. Donna was also avoidant of Craig's disclosure of low mood in the context of him being resistant to her suggestions of activity planning to address his drinking (p.92). Using the concept of countertransference to explain this is, in part, supported by Bethea, Acosta and Haller (2008) who compared session by session working alliance ratings of opiate addicted clients and their therapists. They reported that clients' ratings rose session by session regardless of outcome, whereas therapist ratings only increased if the client was making progress; particularly when sessions were focused on behavioural change. Whilst no causal attributions can be made with regards to the therapist's alliance ratings, it can be concluded that therapists feel differently about the therapeutic relationship if their clients are making less progress than they perhaps expect. This could affect their feelings towards the client, or the therapy, which could in turn affect the way they respond to the client during sessions.

One understanding of the function of this for therapists was to protect themselves from disappointment or blame if a client's situation did not improve. Another alternative explanation could be because they found the situation too overwhelming to respond in a more acknowledging way. Samaniego (2010), noted from a systemic perspective, that when clients present in a way that therapists find challenging, they often respond more confidently on a cognitive rather than emotional level. The lack of validating client feelings could simply be because they do not like the client and thus are unmotivated to respond empathically, or actively choose not to. This is supported by the findings of Wolff and Hayes (2009) who reported that therapists who rated their emotional reactions to clients as more negative were rated by clients as being less empathic, and had a weaker therapeutic alliance.

When considering the implications of the analysis for therapeutic practice, one must consider the acknowledgement of affect (e.g. Fosha, 2001), or corrective emotional experience (Alexander and French, 1946; Hartman & Zimberoff, 2004; Bridges, 2006) not only as a proven mechanisms of change but also as an integral aspect of developing and maintaining a good therapeutic alliance (e.g. Baird et al. 2007). With the knowledge that the therapeutic alliance is positively related to clinical outcome (Wampold, 2001) this leads to the conclusion that acknowledging feelings is an important aspect of psychotherapy. Also, in the analysis it was observed that clients responded better when therapists acknowledged client emotions, for example, in the extract on p88, when Jon initially attempted to move past the emotions Colin

expressed with regards to years lost to drinking, Colin did not engage, but then when Jon repaired by acknowledging the loss, Colin re-engaged with the conversation. Therefore we must consider that it is likely that clients prefer this approach. As ultimately the client is the consumer, and with the acknowledgement that service user informed care is ethical and necessary (Thornicraft & Tansella, 2005), if it is evident that clients find it important for their feelings to be acknowledged, then it is important that thought is given to this process.

4.1.6 Therapist use of self

The therapeutic use of self by therapists is defined as the "planned use of his or her personality, insights, perceptions, and judgments as part of the therapeutic process" (Punwar & Peloquin, 2000, p. 285). Edwards and Bess (1998, p.89) explained the need for therapeutic use of self "to loosen the rigors of anonymity and neutrality in service of genuine relating." They noted that in addition to knowledge and technique, therapists should also have a knowledge of themselves, and how they can influence therapy. As an advocate for the therapeutic use of self, Wosket (2002) noted that in allowing oneself as a therapist to use the "self" appropriately within the therapeutic relationship, the therapist can minimise power imbalances and enhance the relationship to one that is truly genuine. Wosket (2002, p.1) advocates therapist use of self as the key to "express their full therapeutic capacity." The therapeutic use of self in order to respond in an emotive exchange was observed in the analysis only on one occasion. Within the analysis, this use of self was clearly observed in Sally's response to Polly when she disclosed some serious self-harm (p.89).

In addition to therapist use of self to address emotions, therapists also used their self in the facilitation of behavioural change. This was done by owning their own responsibility for client behavioural change, rather than applying a series of techniques then leaving the rest up to the client. This was achieved by therapists accepting responsibility for their role in helping clients to augment or maintain their motivation, rather than offering their input and then leaving it to the client to choose whether to listen based on their level of personal motivation. The discursive practice of collaboration outlined in this research study shows how by co-constructing motivation and plans for behavioural change, the therapist works with the client to achieve mutual aims. Revisiting transactional analysis theory, therapists construct a discourse of 'I'm ok, you're ok' (Berne, 1964). Through collaborative discourse, the therapist has not achieved their aim in the therapeutic interaction unless the client has also achieved theirs. Therefore, this is a more risky attitude for therapists to take, in terms of preserving their sense of self and competence. To come alongside a client and

experience their successes and failures as one's own, therapists must have confidence both in their own ability, and their client's ability to achieve change.

4.2 Limitations of the research

4.2.1 Methodological issues

The context of data sampling from a research study

Acknowledging discourse as situated in the context in which it is spoken is core to the principles of Discursive Psychology (Potter & Wetherell, 1986; Edwards & Potter, 1991). Therefore, it is important to consider the wider context in which the data were produced. The session recordings were taken from a research trial (UKATT, 2005) which was conducted to compare the efficacy of two separate treatments. The use of manuals was, in part, to standardise the methods that therapists used, which is a common feature of psychotherapy research more generally (Bergin, 1997), and so treatment adherence was expected and monitored by researchers. Therefore, with therapists aware of this, they may have attempted to maintain more integrity to the treatment than if they were in general clinical practice. It could be possible that this process reduced the impact of therapist effects or common factors (Chambless, 1996; Lambert & Okiishi, 1997; Westen, 2002). It is also possible that instead of reducing therapist effects, the fact that therapists were part of a trial may have simply changed the therapist effects. By being aware that they were part of a trial, they may have chosen (consciously or unconsciously) to do things differently than they would normally. As mentioned above, the most likely choice in this context would be to attempt to be more manual adherent; however, we cannot assume that this simply made therapists more adherent with no other effects. This could have prevented them from using skills that they would usually use which actually made them less adherent (and incongruent), or reduced their competence or quality of the intervention thus affecting the treatment fidelity. I cannot assume the mechanisms or effects that occur as a result of delivering therapy as part of a research trial compared within general clinical practice. Therefore, all that can be done is to acknowledge this potential bias, and consider it in the analysis and recommendations.

Sampling from extant data

A sizable amount of time has elapsed between since the UKATT data was collected (UKATT research group, 2005). Since the original data were collected, there has been a shift in the political and economic climate which is likely to have affected the wider context within which alcohol treatment is provided. However, both the SBNT

and MET treatments that were used in the trial are widely used in today's clinical practice, so it is likely that a re-analysis of this data can still add to our understanding of alcohol addiction psychosocial treatment. Furthermore, the micro-level of analysis that was used in this research study focussed initially on the context of the treatment between the therapist and client, which is likely to share more similarities than differences with similar treatments that occur currently.

There are certain issues associated with the data not having been collected by the primary researcher which include a lack of control over the rigour of data collection. However, the original research was conducted by reputable researchers, renowned in the field of alcohol addictions, and was published in high profile journals (e.g., 'British Medical Journal' and 'Alcohol and Addiction': UKATT, 2001, 2005). The methods used in the original UKATT trial are clearly explained in these publications. Therefore, it is taken that appropriate procedures for data collection were followed.

There were practical issues associated with the analysis of extant data, in particular a lack of control over what data may be missing. There was a significant number of sessions on the database for potential selection which were not recorded for technical reasons. There is no evidence to believe that these sessions were qualitatively different to those recorded. Therefore, this is unlikely to have skewed the data sample. Despite some sessions not being recorded, there were enough session recordings that were present for the sample to be taken from. Furthermore, some clients and/or therapists did not give consent for their data to be used for secondary analysis. This had the potential to significantly affect the characteristics of the sample. For example, if therapists felt unhappy with their performance they may have withdrawn their data. This limitation was considered when planning the research, and it was concluded that though it was not ideal, it was a reality when investigating naturalistic data, as people have the right to prevent their data from being analysed in this way. Though it may affect the characteristics of the sample, it is likely to be more diverse than a design whereby therapists were recruited by opting in to participate (e.g., an opportunity sample) to produce data for this research, and is more varied and valid than recruiting therapists for research interviews. The Discursive Psychology (DP) method is interested in the discourses that are present in everyday naturalistic situations without attempting to make generalizable theories about these situations.

Sampling

This study could possibly have benefitted from a larger sample size, which was not possible due to time restrictions. Though the aims of the study were not to find 'truths' that can be generalised, the sample contained so much variability that having

more therapist-client dyads may have shown the key findings more clearly, or identified further discourses not present in this sample. Although one could conclude that a greater sample than was used may have benefited the validity of the findings of this research, there is the argument that despite only a sample size of six dyads, this research study focused upon many small events and individual exchanges within the therapeutic encounters for each dyad.

The choice to sample from two distinct therapies offered a wider range of discursive encounters, and offered two distinct therapeutic contexts from which these encounters were set. It was decided that both SBNT and MET therapies would be studied as they have very different styles of delivery and are founded on contrasting key therapeutic assumptions; both equally as relevant and interesting. However, the choice to sample from both therapies muddied the waters of analysis and made drawing consistent conclusions from the data more difficult. Also, the decision to sample extracts from across sessions rather than whole sessions carried both costs and benefits for analysis. The decision was made as a pragmatic compromise to allow the inclusion of all sessions in the sample within the timeframe given for the research. Sampling extracts across all sessions for each dyad allowed for the whole process of each therapy to be examined, and the narrative of the process to be included in the context of the analysis. Also, much of the omitted sections of transcripts contained discussions which were of less analytic value such as arranging session times and organising medication. However, by selecting only sections of each session to transcribe in an inherently subjective manner, an additional bias was introduced to the data. This could have been overcome by a different compromise of selecting a smaller number of client-therapist dyads to analyse, but using all sessions in their entirety. However, this would introduce other sampling limitations such as reducing the variety of interactions.

4.2.2 Analytic issues

Pragmatic focus of analysis

As noted by Advi & Georgaca (2007) within the field of discourse analysis of psychotherapy, there are a range of stances taken. They note that some studies focus on highlighting therapeutic processes at the expense of exploring links between discourses and wider social processes; whilst others focus on deconstructing psychotherapy but are criticised for lacking clinical utility to the individual practitioner. This study focussed on how therapists use discourse in the implementation of manualised therapy. In taking this stance, the analysis focussed on

micro-processes of talk within the therapy both directly linked to the manual, and those which the therapist uses which are over and above those prescribed by the treatment manual. It is hoped that in highlighting how therapists use manuals, the study can increase therapist reflexivity in helping them to become more aware of the effect that the discourses they choose have on the therapeutic process. However, in prioritising this facet of analysis, the social constructionist focus on the link between discursive processes of therapy and the wider social context was partially neglected. Further research suggestions that address this issue are discussed later in section 4.4.2.

Transcription

Pirjo (2008) noted that transcripts should be a transparent representation of the recording that is transcribed and should be comprehensive enough to allow readers to make their own judgements. For the purposes of this study, an adapted version of the "Jefferson Lite" guidelines (Potter & Hepburn, 2005) for transcription was used. This allowed some aspects of nonverbal communication to be recorded (e.g. turn-taking, intonation, and the presence of pauses). This method was chosen over the comprehensive Jefferson technique (Jefferson, 1988, 2004) partially due to the time constraints of this research, and partially because, although it sacrifices some of the finer details of talk, it improves the readability of the transcript. If time permitted, the use of a more detailed transcription notation encompassing the more subtle intonation of talk could have added rich information to the analysis, and potentially allowed readers to more easily evaluate the arguments presented in the analysis. For example, in the MET 1 sessions with Jenny and Peter, the words of the therapist were often adherent to the principles of MI and encouraging in nature, though her intonation seemed, at times, harsh or uninterested. The transcription notation used in this research did not allow for this to be presented within the extracts presented, so readers are compelled to take my word when I describe the context and subtleties of the talk.

As noted in the method section (p. 49-50), though the data was in the form of DVD data, the audio only was used for transcription purposes. This was decided because the visual data only showed the therapist and not the client, and so attending to the visual data may produce unbalanced insight into the body language of the therapist and not the client. However, as DVD data was viewed by the researcher when selecting extracts to transcribe, the visual data was used at this stage to inform sampling, and the knowledge of this viewing would be incorporated into the analysis even if it was not a specific focus of the analysis.

Researcher Reflexivity

It is important to note that the analysis presented in this study is based on my reading and interpretation informed by discursive psychology theory. There are many other informed interpretations that could also have been applied to this data. In addition to this it is acknowledged that both my selection of data to transcribe, and my choice of exchanges to focus on from the transcribed data, contributed to the shape of the story that I located within the data. This does not make the findings of this study invalid, but instead means that there are other valid interpretations that are not included in this study. I have justified my analysis of the data through linking it with relevant literature, transparently demonstrating my interpretations, and ensuring that I only draw conclusions that I am entitled to make (i.e. commenting on the functions of talk rather than the speaker's rationales or motivations for talk). Another way I validated my analysis, was to be clear about my own assumptions and biases that could affect the way I interpreted the data. In the introduction and method chapters of this study I have outlined some of my reflections and positions with regards to the research itself as per recommendations for qualitative research (Elliott, Rennie, & Fischer, 1999; Leuder & Antaki, 1996).

Throughout the process of watching the recordings, transcribing and analysing, I used a reflective diary and supervision to help identify my thoughts and assumptions about the data. As a clinician, I noticed aspects of therapist talk or clinical contexts that were similar or different to mine, and so reflected on how I was interpreting this. Often, when this occurred, I would initially draw conclusions based from my own experiences on the reasons that talk was used, which is not the purpose of discursive psychology (and likely to be inaccurate) and so would guide myself back to analysing the talk in the context. It was insufficient to simply not make a note of these assumptions, as these assumptions could have affected how I would analyse the talk. Therefore once I had become aware of a potential assumption I reflected on this further in order to understand where they may have come from, and the impact they may have on my analysis. This involved discussing these with my research supervisors, both for alternative points of view in the early stages of investigation, and as a quality assurance checks during latter stages of the analysis.

During this research I experienced a range of emotions, most notably sadness for the position of the client, frustration and anger at the therapist, dislike or like for either party and awe at the way that clients and therapists coped with particular therapeutic situations or external events. As a clinician, I work using a systemic framework, which I believe lends itself well to the use of Discursive Psychology as a method as both ideologies acknowledge all actions as situated within their context.

However, this made me aware of my judgemental bias that I tend to identify more with clients than with therapists especially if they do not formulate with clients in a systemic way. This leads me to become compassionate towards clients due to their situations or contexts, but not always afford the same compassion towards professionals, instead locating their actions as more static, internal or dichotomously good or bad. By refocusing upon the discursive psychology framework that guided this research, I attempted to overcome this by paying attention to the context that both parties created, were placed in, and participated in, rather than just formulating this for clients. This was particularly important for this study as the primary focus was on therapist discourse.

4.3 Implications for clinical practice

This section focusses on the clinical utility of the analysis from this study. It is noted that a discursive psychology approach was taken to analyse the data, which is grounded in constructionist approaches, attending only to dialogue, not internal states. Therefore there is a tension between the principles of the analytic technique and making recommendations that are useful to clinicians and other interested parties. However, Auletta (2012, p. 177) noted that the intra-psychic and inter-subjective perspectives of psychotherapy interactions need to be acknowledged as "equally meaningful" in contributing to our understanding of the dialogical processes at work. Auletta balanced the importance of looking beyond the assumption that language is a direct manifestation of the inner self by looking at the functions of talk in context with the importance of looking at the personal positions that a person brings to an interaction. It is noted that whilst talk is a performed action which positions others, each turn in a conversation is not solely predicted by the previous talker; the responder has a choice of discursive options that they can draw upon. This is demonstrated with the analogy of a chess game, noting that each move influences or limits the options of moves that the subsequent player takes, but it does not predict exactly which move they make as this is still down to personal choice. Therefore with regards to making clinically useful conclusions, it is important to acknowledge the intra-psychic processes that therapists can attend to in order to influence the discursive processes that occur during alcohol therapy.

It is hoped that, through the analysis of therapist discourse, this study can allow other therapists to learn of some of the traps that therapists fall into when responding to the interaction and take steps towards minimising their personal risk in doing so, and likewise notice the value in more positive discourses used and endeavour to use them in practice. Whilst talk is accepted as interactional and

responsive to the situation; and no assumption is made during analysis of internal processes: recommendations suggest to how clinicians can become more aware to the discourses that they use when with clients.

4.3.1 Therapist attention to common factors

As discussed in the introduction and earlier in this chapter, much time and expense has been given to the investigation and comparison of evidence based treatments (EBT) (Chambless & Hollon, 1998) which has led to certain assumptions about what needs to be in place in order to produce an effective treatment. More recently, there has been a call to investigate 'common factors' in therapy, perhaps most notably the therapeutic alliance (Wampold, 2001) which has widened the understanding of what needs to be considered as the 'evidence base' over and above the comparison of particular treatments. This research study has highlighted the variance in the ways that therapists have implemented therapy both within and between the two different evidence based treatments. This is supported by the existing literature suggesting that the use of treatment manuals based on EBT is not EBP unless they are used in conjunction with clinical decision making and skills (e.g. Scaturo, 2001; Strupp and Anderson, 1997; Connolly Gibbons, Crits-Christoph, Levinson & Barber, 2003). In the light of literature positing that treatment manuals are an attempt to standardise care (e.g. Chambless & Ollendick, 2001), this study suggests that there is great variance in therapist factors when delivering manualised therapy, even when manuals are adhered to in their strictest sense. This variance is not just with regards to adherence to the manuals, but the idiosyncratic responses that therapists brought to their responses to individual situations. For example, within the analysis from this study discursive practices such as lecturing, being critical, and constructing oneself as powerful expert were all used, despite not being related to any of the therapeutic techniques recommended in either treatment manual. Therefore, this study reiterates the need for clinicians and service commissioners to prioritise considerations with regards to **how** EBT is being implemented rather than **which** EBT is being implemented. In order to do this, therapists are encouraged to consider the intra-psychic influences (Auletta, 2012) that influence the discourses that they use within the therapeutic dialogue. From this study, it emerged that the following factors affecting treatment delivery require particular attention:

- For therapists to have a working knowledge of their own emotional state, its effects, and how to manage it in order to attend to client need (i.e. to be aware of their own countertransference and to manage it appropriately within sessions). To consider how they can use the therapeutic use of self

within sessions for client benefit. This includes considering their own reactions to client's emotional states.

- For therapists to consider their role of power within the therapeutic dyad with regards to how they position themselves and the client. For therapists to also consider how they can be positioned by the client, and which positions can be more or less useful to take as a response to client positioning.
- For therapists to embark upon a process of thoughtful consideration when they deviate from treatment manuals; and to feel comfortable that flexible use of the manual can be useful if done so in a thoughtful way.
- For therapists to actively attend to facilitating the development and maintenance of a positive therapeutic alliance at all times; including times when they are delivering therapy in a manner that is adherent to the manual. For supervisors and researchers who monitor the use of manuals to incorporate this into the processes of therapy evaluation.

In order for these recommendations to be enacted, it is imperative that therapists receive appropriate supervision to foster an appropriate thinking space for therapists to consider how they adopt these practices with their clients. In addition to appropriate supervision, therapists' consideration of their 'internal supervisor' (Casement, 1985) can be useful. The 'internal supervisor' refers to the internalised commentary or thought process, based on what their supervisor might say, that a therapist can use in-vivo when in dialogue with the client. The use of this concept can assist therapists in their selection of discourses used to respond to the client.

4.3.1 Training considerations for therapists delivering manualised therapy

The analysis in this study supports previous research suggesting that manuals do not control for therapist factors as much as researchers might intend when utilising them to purify distinct therapies to facilitate comparisons between them. (e.g. Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Longabaugh, Donovan, Karno, McCrady, Morgenstern, & Tonigan, 2005). In the reality of clinical practice, treatment manuals are adhered to by varying degrees, and so this must be taken into account when considering the contexts and rationales in which they are used. We cannot assume that they standardise care, as even with fidelity, individual therapists bring idiosyncrasies to treatments, and without fidelity they do so even more.

Therefore, it is important that the analysis of this research study is considered within the context of service commissioning, and staff development. Concerns have been noted regarding the use of manuals by service providers to justify employing

unskilled (and thus cheaper) therapists to deliver therapy (Scaturo, 2001; Castonguay, Schut, Constantino, & Halperin, 1999; Strupp & Anderson, 1997). Considering the individual differences in this study that were shown by therapists in the use of the manuals, it is concluded that appropriate therapist skill and experience, as well as ongoing therapeutic training and development is of integral importance to the delivery of manualised treatment.

With regards to discourses used by therapists in sessions, it is only possible for them to draw upon those which have been made available to them, whether that be through their professional background, ongoing training and supervision, or societal interactions. With thought to professional training, if professional training aims to equip therapists with an arsenal of appropriate discourses and techniques to use responsively with clients, the use of treatment manuals as a substitute to in depth training is a cause of concern. Instead, appropriate and thorough training of alcohol therapists in the implementation of manualised therapies is required which must include a foundation of basic counselling skills and concepts of self awareness in order to promote responsivity to client need.

In addition to the basic counselling skills that are noted above, it is important that training for drug workers are prepared in their training to tolerate the discussion of emotional pain. In the analysis section, it was demonstrated that on several occasions therapists avoided the client's disclosures of emotions. Therefore, as the data showed less useful discursive strategies used as a response to clients' emotions (namely diverting the topic of conversation, attempting to resolve the feeling, and putting a positive spin on the feeling), one recommendation is to consider incorporating preparedness to tolerate client emotional pain in the training and ongoing development of therapists. It is accepted in SBNT and MET treatment manuals that the focus of the interventions is on alcohol use behaviours and associated behaviours, and not resolving all other personal wellbeing issues. However, though active processing of trauma and difficult emotions would not be addressed in alcohol therapy, it is important that they are acknowledged appropriately within the therapeutic context. In addition to these disclosures being visible within the data, the inevitability of these disclosures is supported by the largely accepted formulation that alcohol use can be a strategy for coping with or blocking out emotional pain (e.g. Cooper, Frone, Russell, & Mudar, 1995; Khantzian, 1997).

4.3.3 Manual design

The interpretative repertoires and discursive practices generated by the analysis highlighted the diversity of discourses used to implement treatment prescribed by the manuals. This diversity is partially demonstrated by the highlighted

differences between the four categories of therapist implementations discussed earlier in the chapter and shown in table 9. However, there is also diversity within the categories of implementation. Each of the six therapists included in this study brought their own style and techniques to the implementation of the manual within therapy. No direct attempt was made to assess the quality of the therapeutic interventions, nor label them in binary language (i.e. good, bad, useful, or not useful) as this was not related to the research aims. However, it is likely that some of the approaches used by therapists were more useful than others, for example acknowledging and validating a client's feelings showed better responses than avoiding a client's feelings.

The recommendations from this study detailed in the section above relate to how therapists use their own skills or are facilitated in doing so by policy and service provision. In addition to this, it is recommended that a consideration of these issues is incorporated into the design of treatment manuals. In doing so, therapists are given direction and guidance on how to use their clinical judgement and be responsive to their clients. Also the common factors which are known to enhance therapeutic outcomes (Wampold, 2001) are shown as a treatment priority, not an additional extra. In doing so, the therapeutic delivery will have to be responsive to the client's needs in order to be adherent rather than responsivity being an additional factor to be considered. This is an important distinction, as, if we consider treatment manuals as effective evidence based treatments, if they are not being implemented in the way that was intended, they can no longer be considered as such.

This was shown in comparison of the MET manual and SBNT manual, whereby the MET manual incorporated directions for process as well as content which facilitated responsivity and the importance of therapeutic alliance alongside adherence, whereby the SBNT manual was more technique driven. The analysis from this study indicates that the addition of directions for therapists to attend to psychotherapeutic process such as therapeutic alliance in addition to the evidence based techniques in the SBNT manual could promote more effective delivery of that particular evidence based treatment.

4.4 Implications for research

4.4.1 Therapist effects related to outcome

The aims of this study involved deconstructing therapist discourse in manualised therapy with no attempt to comment on treatment outcome. Instead the processes involved in delivering therapy were investigated with clinical recommendations made about how manual delivery can be best implemented in practice. However, though deconstruction is valuable to aiding our understanding,

another important factor to understand is the implication of such processes on client outcomes. Though a focus on outcomes is not typically associated with the social constructionist agenda, it may be necessary to enter this debate in order for the important constructionist research that is being undertaken (both in this study and growing extant research) to hold significant influence in a climate of empiricism and focus on evidence based treatment. Further research could benefit from the operationalization of some of the discursive features identified by this study and comparison with client outcome. For example, if a certain discursive practice (e.g., 'being critical') were to be operationalized this could then be compared with outcome measurements. Alternatively, further research led by service user views could be useful, for example, incorporating qualitative analysis of sessions alongside debriefing interviews with service users in order to investigate through interpretative phenomenological analysis (Larkin, Watts, & Clifton, 2006) how they experienced the discourses and actions of the therapist within the sessions.

4.4.2 Analysis of manualised treatment methods using Foucaldian Discourse Analysis (FDA) approach

It is noted that discourse analytic studies often assume a benign view of psychotherapy and use analytic techniques to narrate the discursive techniques used to facilitate change (Advi & Georgaca, 2007; Georgaca, 2012). These authors argue that this ignores the constructive nature of therapeutic interactions on clients' identities, personal wellbeing issues, and society more generally. The methodological approach of this study was informed by Discursive Psychology (e.g. Edwards & Potter, 1992; Potter & Wetherell, 1987). This constructionist approach was used to explore the actions that therapists took through their use of discourse in therapy sessions. This study goes some way in acknowledging the constructive nature of therapist talk, in how it positions clients, their difficulties, and their personal motivations. However, the main focus of this study was to elucidate the discursive strategies that therapists use when delivering manualised therapy and their immediate impact, without particular attention to the importance of these to constructing and maintaining reality in a wider socio-cultural sense. Another approach that could have been used to analyse this data was FDA (e.g. Parker, 1994). As noted in the method chapter, FDA focuses on how power relationships are constructed and maintained through discourse, and the impact that this has on wider social constructions. This would be relevant, as there is much commentary on the power dynamics in psychotherapy across a wide range of therapeutic models. For example, DeVaris (1994) noted that therapists and clients experience both power and powerlessness during the process of psychotherapy. This power, or lack of power, can be overt or covert, and constructive or destructive. The

analysis in this study opened a dialogue with reference to the influence of the power of therapists, which would benefit from further attention paid to these issues using FDA.

4.5 Conclusions

This study used Discursive Psychology principles to investigate discourses used by therapists when delivering manualised therapy for alcohol addiction. Several discursive practices were identified, some of which were adherent to the manuals (e.g. collaboration), and some of which were not (e.g. most instances of 'being critical'), some of which appeared to be responsive to the client, (e.g., using humour), and some of which did not (e.g., constructing oneself as a powerful expert). These discursive practices can be understood in the context of the treatment manuals from which they are delivered, but perhaps more significantly can also be considered alongside therapist factors such as countertransference, and training and background. The literature suggests that therapist behaviour contributing to interpersonal processes has a strong effect on therapeutic alliance (Lambert, & Barley, 2001), which is known to be a strong predictor of outcome (Wampold, 2001).

It seems that the prevailing assumption that services must provide evidenced based treatments is harboured under the illusion that these are provided in a standardised way; that it is assumed that if a therapy is proven to be efficacious in research then it will automatically be effectively delivered in practice. Koss & Shiang (1994, p.675) warn that "It is foolish to believe that the use of manuals alone will 'standardise' a therapy. The actual delivery of therapy is dependent on the contributions and interactions that take place between people." The findings of this study highlighted the subtleties and idiosyncrasies that emerge through discourse in the delivery of therapy, which suggests that the above assumption should not be made, and more consideration needs to be given to how evidence based treatments are delivered.

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6. Appendices

Appendix 1: UKATT Participant Consent Form

I agree to take part in the research comparing two forms of help for stopping or reducing drinking.

The research has been explained to me. I understand that I will be offered one of two forms of help and that I will be required to complete some further questionnaires during the therapy and to attend follow-up appointments. I also understand that, with my consent, someone (or more than one) who knows me well may be involved in meetings with the therapist.

I understand that any personal information I give in this research project will be kept strictly confidential. I understand that this information will be used only in combination with information from many other people so that I cannot be identified.

I understand that, with my consent, the member of my family or other person who knows me well whom I have suggested, may be contacted for further information of my progress after the end of the therapy. I understand that any information from this other individual will be kept strictly confidential. I also understand that any other contact names and addresses I have supplied will be used purely for establishing my whereabouts during the follow-up period and my involvement in this trial will not be revealed to them.

I agree to video recordings of my sessions being used for quality control and teaching purposes, and for future research. I understand that I will not be seen in the video but my voice will be heard on the recording. I understand that by putting a cross in the appropriate box below these tapes will be destroyed at the end of the trial.

I know that I can ask questions about the research now or at any stage, and that I can choose to withdraw from the research at any time without this affecting the quality of the help I receive.

I have been given a list of the names and telephone numbers of those responsible for this research, including the name of a manager to whom I should address any complaint or grievance that I might have.

I require that all video recordings of my session be destroyed at the end of the trial ☐

Name... Assessors Name...

Signature.. Signature...

Date...

Appendix 2: REC approval documentation

NHS
Health Research Authority
NRES Committee Yorkshire & The Humber - Sheffield
Yorkshire and the Humber REC Office
First Floor, Millside
Mill Pond Lane
Meanwood
Leeds
LS6 4RA

Telephone: 0113 30 50126
Facsimile: 0113 855 6191

21 June 2012

Ms Hannah Capon
Psychologist in Clinical Training
Leeds Teaching Hospitals NHS Trust
Institute of Health Sciences,
Charles Thackrah Building, University of Leeds,
101 Clarendon Road, Leeds
LS2 9LJ

Dear Ms Capon

Full title of study: **The function of professional identity in the delivery of manualised therapy**
REC reference number: **12/YH/0302**

Thank you for your email of 18 June 2012. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 01 June 2012. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Other: Email from Researcher		18 June 2012

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

12/YH/0302	**Please quote this number on all correspondence**

Yours sincerely

Anne Ward

Mrs Anne Ward
Committee Co-ordinator

E-mail: anne.ward7@nhs.net

Copy to: *Research Ethics and Governance Administrator,*
Mr James Hughes, Leeds and York Partnership NHS Foundation Trust

Health Research Authority

NRES Committee Yorkshire & The Humber - Sheffield
Yorkshire and the Humber REC Office
First Floor, Millside
Mill Pond Lane
Meanwood
Leeds
LS6 4RA

Telephone: 0113 3050108
Facsimile:

01 June 2012

Ms Hannah Capon
Psychologist in Clinical Training
Leeds Teaching Hospitals NHS Trust
Institute of Health Sciences,
Charles Thackrah Building, University of Leeds,
101 Clarendon Road, Leeds
LS2 9LJ

Dear Ms Capon

Study title:	**The function of professional identity in the delivery of manualised therapy**
REC reference:	**12/YH/0302**

The Proportionate Review Sub-committee of the NRES Committee Yorkshire & The Humber - Sheffield reviewed the above application on 01 June 2012.

Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

1. Members require clarification of the destruction of data pertaining to this study, rather than all data associated with the research programme (i.e. section A43 IRAS form).

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation.

Approved documents

The documents reviewed and approved were:

Document	*Version*	*Date*
Covering Letter		24 May 2012
Evidence of insurance or indemnity		24 May 2012
Investigator CV		24 May 2012
Other: CV Supervisor Carol Martin		24 May 2012
Other: CV Supervisor Shona Hunter		24 May 2012
Other: Information Letter and the Trainee Clinical Psychology Research		24 May 2012
Other: UKATT Participant Consent Form	1	24 May 2012
Other: Therapy Session Initial Checklist	1	24 May 2012
Other: Research Panel Constitution		24 May 2012
Other: Research Panel - Feedback Form		24 May 2012
Protocol	1	24 May 2012
REC application	1	23 May 2012

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

NHS
Health Research Authority

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

12/YH/0302	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Pp
Dr Basil Sharrack
Chair

Email: jade.thorpe@nhs.net

Enclosures: *List of names and professions of members who took part in the review*
"After ethical review – guidance for researchers"

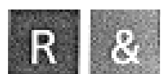
Copy to: *Research Ethics and Governance Administrator*
Mr James Hughes, Leeds and York Partnership NHS Foundation Trust

Attendance at PRS Sub-Committee of the REC meeting on 01 June 2012

Committee Members:

Name	*Profession*	*Present*	*Notes*
Dr Mary Cooke	Lecturer in Midwifery and Nursing	Yes	
Mrs Jacqui Gath	Retired Senior Systems Analyst	Yes	
Dr Basil Sharrack	Chair of REC and Consultant Neurologist	Yes	

Appendix 3: R & I approval documentation



Our Ref: 2012/370/L

Research & Innovation
North Wing, St Mary's House,
St Mary's Road
Leeds LS7 3JX

E-mail: [illegible]
Direct Line: 0113 295 2387
FAX: 0113 2954466

Ms Hannah Capon
Institute of Health Sciences
Charles Thackrah Building
101 Clarendon Road
Leeds
LS2 9LJ

5 September 2012

Dear Ms Capon,

RE Project Title: The function of professional identity in the delivery of manualised therapy
REC Reference: 12/YH/0302

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and NHS Permission has been granted on behalf of Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within **Leeds and York Partnership NHS Foundation Trust.**

The final list of documents reviewed and approved is as follows:

Document	Version	Date
Protocol	1	24 May 2012
Other: UKATT Participant Consent Form	1	24 May 2012
Other: Information Letter and the Trainee Clinical Psychology Research		24 May 2012
Other: Therapy Session Initial Checklist	1	24 May 2012
REC Approval Letter		1 June 2012 & 21 June 2012

This approval is granted subject to the following conditions:

- You must comply with the terms of your ethical approval. Failure to do this will lead to permission to carry out this project being withdrawn. If you make any substantive changes to your protocol you must inform the relevant ethics committee and us immediately.
- You must comply with the Trust's procedures on project monitoring and audit.

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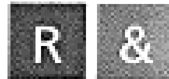

- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care[1] (RGF). Failure to do this could lead to permission to carry out this research being withdrawn.
- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines.
- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance.

For accuracy:
As this study focuses on professional communication, it is suggested that careful checking and review by academic supervisors is carried out on any written reports.

Please note that suspected misconduct or fraud should be reported, in the first instance, to local Counter Fraud Specialists for this Trust. R&I staff are also mandated to do this in line with requirements of the RGF.

Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using **Trust incident reporting procedures in the first instance and to the chief investigator**[2]. They should **also** be reported to:

- The R&I Department
- the Research Ethics Committee that gave approval for the study
- other related regulatory bodies as appropriate.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Changes to the agreed documents MUST be approved by in line with guidance from the Integrated Research Applications System (IRAS), before any changes in documents can be implemented. Details of changes and copies of revised documents, with appropriate version control, must be provided to the R&I Office. Advice on how to undertake this process can be obtained from R&I.

Projects sponsored by organisations other than the Trust are reminded of those organisations obligations as defined in the Research Governance Framework, and the requirements to inform all organisations of any non-compliance with that framework or other relevant regulations discovered during the course of the research project.

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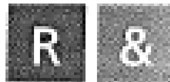
[1] Details from:
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wdel Tv

[2] SUSARS – this must be within 24 hours of the discovery of the SUSAR incident



Leeds and York Partnership NHS
NHS Foundation Trust

The research sponsor or the Chief Investigator, or the local Principal Investigator, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

The R&I office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action.

The R&I Office should be notified within the same time frame of notifying the REC and any other regulatory bodies.

Note that NHS indemnities only apply within the limitations of the protocol, and the duties undertaken therewith, by research staff with substantive or honorary research contracts with this Trust.

Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time. May I take this opportunity to wish you well with the project.

Yours sincerely

Alison Thompson
Head of Research and Innovation

Cc Dr **Shona Hunter**
Dr Carol Martin

improving health, improving lives

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