

Critical Moments in Cognitive Behavioural Therapy:

A Study of Discursive Expertise

Andrew Beckwith

BMBS FRANZCP

School of Medicine

Discipline of Psychiatry

The University of Adelaide

Submitted in fulfilment of the Requirements for

the Degree of Doctor of Philosophy

April 2014

Table of Contents

Abstract	vii
Statement	viii
Acknowledgments	ix
Chapter 1 Introduction.....	1
1.1 Introduction and Aims	1
1.2 An Overview of the Published and Submitted Papers	5
1.2.1 Paper One (Chapter 4): The Negotiation of the Problem Statement in CBT	5
1.2.2 Paper Two (Chapter 5): Homework Setting in CBT: A Study of Interactional Strategies.....	6
1.2.3 Paper Three (Chapter 6): Termination in CBT: A Study of Interactional Strategies.....	7
1.3 Arrangement of the Thesis.....	8
2.1 Overview.....	10
2.2 Introduction.....	11
2.3 Psychotherapy and the Evolution of CBT.....	13
2.4 The History of CBT	19
2.4.1 The Development of Behavioural Therapy.....	20
2.4.2 The ‘Cognitive Revolution’ and the Development of Cognitive Behavioural Therapy	24
2.4.3 The Third Wave	26
2.5 The Form of Therapy that is Studied in this Thesis	27
2.6 Limitations of the CBT Literature in Addressing the Interaction between Client and Therapist.....	28
2.7 Psychotherapy Process and Outcomes Research	30

2.8	The Adoption of Research Methods from other Disciplines into Psychotherapy Research	36
2.9	Discourse Analysis, Conversation Analysis and Psychotherapy Research	38
2.9.1	Discourse Analysis.....	39
2.9.2	Discourse-Analytic Research into Psychotherapy	42
2.9.3	Conversation Analysis and Psychotherapy	51
2.9.4	Conversation Analytic Research into Psychotherapy	54
2.10	Theme-orientated Discourse Analysis	59
2.10.1	Crucial Sites	60
2.11	Expertise and Interactional Competence.....	61
2.12	Practical Relevance	63
Chapter 3	Method	66
3.1	Theme-oriented Discourse Analysis — An overview	66
3.2	The Application of Theme-orientated Discourse Analysis in this Thesis ..	68
3.2.1	Context, Including the Treatment Model of CBT.....	68
3.2.2	Generalisability and a ‘Typical Case’ Design	72
3.2.3	Focal Themes	72
3.2.4	Main Analytic Themes.....	73
3.3	The Data.....	76
3.3.1	The Setting.....	76
3.3.2	The Data.....	77
3.3.3	Recording and Transcription.....	78
3.3.4	Ethics.....	79
Chapter 4	The negotiation of the problem statement in Cognitive Behavioural Therapy.....	81
	Bionotes	82
	Abstract	83

1	Introduction: Psychotherapy and Cognitive Behavioural Therapy	84
2	The problem statement as a crucial site	85
3	Discourse analysis, Conversation analysis and the Definition of a Client's Problem in Psychotherapy	86
4	Data and Method	88
4.1	The Setting	88
4.2	The Data	89
4.3	Method of Analysis	89
5	Analysis	90
5.1	Overview of the two sessions	90
5.2	Eliciting the client's problem (Session 1, Phase 2)	91
5.3	Explaining the model	94
5.4	Articulating the problem statement	96
6	Conclusion	100
	Appendix: Transcription conventions	102
	Notes	103
	References	104
Chapter 5 Homework Setting in Cognitive Behavioural Therapy: A Study of Interactional Strategies		
	Bionotes	109
	Abstract	110
1	Introduction	111
2	Homework and Psychotherapy	111
3	Discourse Analysis and Psychotherapy	113
4	Method	114
4.1	The Data and Setting	114
4.2	Method of Analysis	114

5	Results and Discussion.....	116
5.1	Homework Introduction.....	117
5.2	Setting a Homework Task.....	119
5.3	Review of Homework.....	122
6	Conclusion	125
	Appendix: Transcription Conventions	127
	References	128
Chapter 6	Termination in Cognitive Behavioural Therapy: A Study of Interactional Strategies	135
	Bionotes	136
	Abstract	137
1	Introduction.....	138
2	Method and Data.....	141
2.1	Setting and Subjects.....	141
2.2	The Data.....	141
2.3	Method of Analysis.....	141
3	The Analysis	142
3.1	Relapse Prevention.....	143
3.2	Assessment of Response to Therapy.....	149
4.	Conclusion	154
	Appendix: Transcription conventions	155
	References	156
Chapter 7	Conclusion	160
7.1	Introduction.....	160
7.2	Overview	160
7.3	Overview of the Papers	161
7.4	General Conclusions	163

7.4.1	Politeness and the Need to Save Face.....	163
7.4.2	Complexity of Discursive Strategies and Therapist Expertise	164
7.4.3	The ‘Two Masters Problem’	165
7.5	Implications for Clinical Practice and the Potential Practical Relevance.	166
7.5.1	Therapists Reflecting on Their Own Clinical Practice	166
7.5.2	Training of Therapists.....	167
7.5.3	Contribution to the Literature on Healthcare Interactions and Theme- Orientated Discourse Analysis.....	168
7.6	Limitations of this Research	169
7.7	Further Studies	171
7.8	Conclusion	173
Appendix 1	1 st Interview.....	174
Appendix 2	The Initial Assessment	175
Appendix 3	Case Specific Measures.....	183
Appendix 4	Identifying & Challenging Negative Thoughts.....	189
Appendix 5	Paper 1.....	190
Appendix 6	Consent Form and Subject Information Sheets.....	200
References	208

Abstract

This thesis investigates how the underlying treatment model of cognitive behavioural therapy (CBT) is put into practice in the interaction between the therapist and client in the clinical setting through an analysis of the language used. The findings from three papers represent a detailed analysis of the therapist–client dyads using theme-orientated discourse analysis (Roberts & Sarangi, 2005; Sarangi, 2010). A form of psychotherapy that evolved from the separate but related traditions of behavioural therapy and cognitive therapy, CBT is a major form of psychotherapy recommended by a number of professional bodies and evidence-based treatment protocols for the treatment of a range of psychiatric disorders. There is a wealth of quantitative research attesting to the efficacy of CBT through randomised controlled trials; however, little is understood about how the treatment model of CBT, that is, the underlying theory and related techniques that inform the therapy, is put into practice in everyday clinical settings. In this thesis three crucial aspects of the treatment model are investigated. They are: negotiating the problem statement, homework-setting and termination (ending) of therapy. The analysis makes use of Candlin's concept of crucial sites and critical moments (Candlin, 2000) to focus on relevant parts of the transcript for further analysis. Theme-orientated DA is used as the method of analysis as it is specifically designed for health-related interactions and to connect professional concerns to the discourse analysis. In this case it enables connections to be drawn between aspects of the treatment model of CBT and discursive processes employed by the participants.

Statement

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree.

I give consent to this copy of my thesis when deposited in the University Library, being made available for loan and photocopying, subject to the provisions of the Copyright Act 1968, unless permission has been granted by the University to restrict access for a period of time.

The author acknowledges that copyright of published works contained within this thesis resides with the copyright holder(s) of those works.

I also give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library catalogue and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

Andrew Beckwith

29/ 04/2014

Acknowledgments

I would like to acknowledge the support of my family, especially my wife and two children who were born during the period of time I was undertaking this research.

I would also like to acknowledge the staff and clients of the service from which the data was gathered for this thesis.

I would like to pay tribute to Prof Robert Barrett, my original supervisor, who died tragically but whose belief and support was instrumental to early stages of this project.

I wish to acknowledge the support of my primary supervisor Dr Jonathan Crichton who took over Prof Barrett's role and whose assistance was invaluable in enabling me to undertake this program of research.

Acknowledgement of editor

This thesis was edited by Ms Miranda Roccisano following the University of Adelaide Guidelines. Her input was restricted to the Australian Standards of Editing Practice standards for 'Language and Illustrations' (Standard D) and 'Completeness and Consistency' (Standard E). Ms Roccisano has Bachelor of Arts (hons) from the 1970s majoring in psychology and linguistics but has not studied clinical psychology or discourse analysis.

Chapter 1 Introduction

1.1 Introduction and Aims

The aim of the program of research from which the three papers in this thesis are drawn is to investigate how the underlying treatment model of cognitive behavioural therapy (CBT) is put into practice in the interaction between the therapist and client¹ in the clinical setting, through an analysis of the language used. This is undertaken through a detailed discourse analysis (DA) of treatment of 10 clients by four therapists, of which the results from two therapist–client dyads are reported in this thesis. This study is qualitative in design and provides a focused analysis of a small number of subjects. By investigating in detail the interaction between client and therapist, this study aims to explore how therapists put into practice the treatment model of CBT through the language they use, and in so doing investigates the expertise of the therapists. The term ‘treatment model of CBT’ refers to the underlying theory and the techniques and textbook treatment protocols derived from it, which are used to treat clients. Although the analysis employs linguistic tools, namely, DA (Roberts & Sarangi, 2005; Sarangi, 2010), the focus of this research is ultimately clinical in nature, as it aims to better understand the processes by which CBT is put into practice in the clinical setting. CBT is a form of psychotherapy that has risen to prominence in the past few decades because of the large number of outcomes studies attesting to its efficacy (American Psychiatric Association, 2006; Andrews, Oakley-Browne, Castle, Judd, & Baillie, 2003; Nathan & Gorman, 2007; Roth & Fonagy, 2005). Although textbooks illustrate how to deliver CBT through idealised cases in the form of brief transcripts of vignettes (Leahy & Holland, 2000; Wright, Basco, & Thase, 2006), less is known about how CBT is practised in routine clinical settings. In particular, little is known about how the treatment model of CBT is put into

¹ I use the term ‘client’ throughout this thesis as this is the term used by the service from which the data was collected. However, some psychotherapists and services use the term ‘patient’ and I have used this term when discussing findings from the literature where the original authors have used the this term.

practice through the language used by the therapists and clients. It is the aim of this thesis to investigate the part played by discourse in CBT.

Having evolved from cognitive and behavioural traditions, CBT is a highly structured form of psychotherapy. There are generic treatment protocols for various mental disorders and illnesses. It is routine to measure outcome through the use of questionnaires and the assessment of progress towards predefined goals negotiated with the client. It is common for CBT treatment protocols to specify the tasks to be completed in each session, which is the case for the form of CBT studied in this thesis.

The research reported in the thesis involved the collection of data from the therapy of 10 clients, who were treated by one of four therapists. The therapy sessions were video-recorded and subsequently transcribed for further analysis. The clients were chosen in sequential order; each was the next available client who agreed to participate in the study. This produced a large amount of data, only a proportion of which was used in the three papers that compose this thesis. The clients were all recruited from the same treatment service, which is a dedicated service for treating clients with anxiety disorders, using CBT.

It is important to note that there are a number of different forms of therapy referred to as CBT (Dobson, 2010), which share a similar tradition but place different emphasis on behavioural and cognitive strategies. The treatment service from which this data was obtained uses a particular model of CBT that evolved from a form of behavioural therapy developed at the Maudsley Hospital in the UK by Professor Isaac Marks (1986). This treatment service has a master's course associated with it and all of the therapists have completed this course. This has the effect of providing a degree of standardisation for the CBT model used in the treatment of the service's clients; however, in routine clinical practice and in this thesis, strategies to check for model fidelity (as often used in randomised controlled trials of psychotherapy) are not used. As a consequence, the individual therapists are able to adapt and interpret the treatment model as they see fit. It is this expertise in applying the treatment model to individual clients that is the subject of this thesis. An important part of the methodological approach in this thesis is to study therapy as it is undertaken in routine clinical practice.

On one level this program of research represents a collaboration between a psychiatrist (the PhD candidate) who has trained in CBT and a linguist. However, the linguist's role was limited to that of a PhD supervisor and the DA and the thesis are the work of the psychiatrist. The aim of this thesis evolved from my training as a psychiatrist and learning how to implement the theoretical approach to CBT in day-to-day clinical practice. This question of what language-associated skills were used by experienced therapists and their clients to put CBT into practice solidified in my current role as a director of training for psychiatry. In this role I train junior doctors to become psychiatrists and observe trainees learning clinical skills, including the delivery of CBT. Prior to commencing this study I had worked in the service from which the data for this thesis was obtained. During the period of this study I continued to be involved in a limited way in the master's program to train therapists, by delivering a workshop. The aim of this thesis thus evolved from clinical and other professional concerns, rather than from primarily linguistic questions, hence the DA is fundamentally linked to addressing professional rather than linguistic concerns and makes use of Roberts and Sarangi's (1999a) notion of 'practical relevance'. However, my perspective differs from that of Roberts and Sarangi in that I am a professional making use of a DA approach, rather than a DA researcher collaborating with a professional group.

The form of DA used in this program of research was chosen for its clinical focus. Theme-orientated DA was developed for medical and other health-related encounters (Roberts & Sarangi, 2005; Sarangi, 2010) and involves the analysis of relevant texts, such as those derived from professional interactions, (e.g. therapy sessions, clinical meetings and doctor-patient consultations), as well as written documents. In the case of this thesis, the transcriptions of video-recorded CBT sessions formed the texts used in the analysis. In theme-orientated DA, discourse analytic methods are used to address focal themes. Focal themes are themes of relevance to the healthcare professionals. Analytic themes are then brought to bear to understand the discourse processes underlying these focal themes. The analytic themes are drawn from the broader discourse of analytic, social linguistic and sociology literature, including the conversation analytic literature.

In selecting the focal themes for this program of research I have made particular use of Candlin's concept of a 'crucial site' (Candlin, 2000), in which there is potential for 'critical moments'. What crucial sites have in common is a concentration of risks for one or more of the participants. Candlin describes the critical moments in the interaction as those sections where the 'communicative competence of the participants is at a premium'. I have focused on focal themes that emerge at crucial sites. These focal themes represent important therapeutic aims or tasks in the CBT treatment model. As such, they are sites at which discursive strategies are likely to be evident and are also relevant to how the CBT treatment model is implemented in the clinical setting.

The emphasis on crucial sites reflects a central assumption of this thesis that part of the therapist's professional skill is the ability to use language to achieve professional aims. As Sarangi and Candlin (2011, p.38) put it when referring to professional interactions, 'such interactions and their management go to the heart of what the respective professions regard as "being a lawyer", or "being a doctor" '. There is a growing understanding that language use in the professions is critical and that the professionals' own theoretical understandings of their use of language is limited (Peräkylä & Vehvilainen, 2003). Thus, by studying the detailed language used by the therapists during CBT, I am investigating the therapists' expertise in putting the treatment model into practice. The therapist must balance the requirements of the generic model of CBT with the needs of a particular patient. The moments in the therapy where this occurs are those where the communication and discursive skills of the therapists are at a premium and therefore exemplify the notion of crucial sites (Candlin, 2000). The clinical practice of suitably qualified and competent therapists was observed, focusing on these moments to ascertain how they put their expertise into practice in therapy sessions.

This research is arguably part of the broader tradition of process-outcomes research in psychotherapy. 'Process research' has concerned itself with processes within therapy, although the term 'process-outcomes research' is preferred by some authors as it is difficult to distinguish between research based purely on the outcomes of therapy and research into the internal mechanisms of therapy (Orlinsky, Ronnestad, & Willutzki, 2004). A number of factors within therapy

have implications for the outcome of therapy. Process-outcomes research is characterised by numerous methodologies and approaches that have related terminology, which has led to difficulties comparing results from different studies. Process-outcomes research is also ‘insider research’, in that it is largely generated by clinicians seeking to answer clinical questions, sometimes using theories generated from the model of therapy under study. Traditional process-outcomes research is generally quantitative in nature and does not provide the fine-grained analysis of language use in therapy; hence these methods were not suitable for the research question underlying this thesis. Because of some of these perceived limitations in process-outcomes research, there has been a call to use other approaches that have previously been used to study interaction in other settings (Lutz & Hill, 2009). Discourse analysis with its tradition of studying various forms of professional and other interactions, is used in this thesis in an attempt to further understand the language processes involved in CBT. However, discourse-analytic and related researchers have been accused of not paying sufficient attention to professional concerns or perspectives (Crichton, 2010; Roberts & Sarangi, 1999b). There have been increasing moves to address this concern from within the DA literature (Candlin & Sarangi, 2004; Crichton, 2010; Roberts & Sarangi, 1999b; Sarangi & Candlin, 2011), along with the application of DA data to professional problems and concerns (Roberts & Sarangi, 2003; Roberts, Sarangi, Southgate, Wakeford, & Wass, 2000). It is because of the need to address professional concerns and because it was developed to link professional concerns with the DA, that theme-orientated DA was selected as the method of analysis for this thesis.

1.2 An Overview of the Published and Submitted Papers

1.2.1 Paper One (Chapter 4): The Negotiation of the Problem Statement in CBT

Paper one, published in *Communication & Medicine* (Beckwith & Crichton, 2010), provides the detailed analysis of the first two sessions from the therapy of one client. It investigates a key component of CBT, namely, converting a client’s undifferentiated problem(s) into one that is amenable to therapy. The focal theme

was negotiation of the problem statement. The different forms of CBT achieve this in slightly different ways; however, this form uses a formal problem statement. The problem statement is a sentence that describes the client's problem in CBT-related terms and understandings. Not only does this sentence formally state the problem, but it also rates the client's perception of how difficult the problem is to overcome on a scale from 0 to 8, with 8 representing the highest level of difficulty. Because the problem statement is central to this form of therapy, I concluded that it is a crucial site and thus one where discursive strategies are potentially important in implementing the CBT model. The central finding of this study was that formulation, a process first identified in the conversation-analytic literature, is an important strategy used by the therapist to develop the problem statement. This finding is consistent with previous literature addressing similar issues in psychotherapy (Antaki, Barnes, & Leudar, 2004, 2005; Buttny, 1996; Davis, 1986; Hak & de Boer, 1996). However, I also identified a number of other discursive strategies used by both the therapist and client in this process, including face-saving strategies such as hedging (Brown & Levinson, 1987), contrast structures (Srikant Sarangi & Clarke, 2002b), asking technical questions (Hak & de Boer, 1996) and the use of reported speech (Holt, 1996). Appendix 5 contains a copy of the paper from Communication & Medicine.

1.2.2 Paper Two (Chapter 5): Homework Setting in CBT: A Study of Interactional Strategies

The second paper focuses on homework tasks, an essential part of CBT through the analysis of text from one therapist–client dyad. The focal theme of the analysis in this paper is homework. Homework tasks are not unique to CBT but are a defining characteristic of this form of therapy (Beck, Rush, Shaw, & Emery, 1979; Kazantzis, Deane, Ronan, & L'Abate, 2004). Homework tasks refer to 'between session activities that are targeted toward achieving therapy goals' (Deane, Glaser, Oades, & Kazantzis, 2005). This is a critical moment in the therapy in which the model of CBT is being put into practice, hence its relevance as a focal theme in our research. I focus on how the therapist introduces the concept of homework, how she sets up the first homework task and how she

reviews this at the beginning of the subsequent session. Politeness strategies (Brown & Levinson, 1987) are prominent in the analysis, along with the use of frames (Goffman, 1974) and constructed dialogue (Tannen, 2007). In particular we investigate the strategic use of shifts between the ‘personal frame’ and the ‘institutional frame’. ‘Personal frame’ refers to aspects of the text that discuss the therapy performed by the client, or what he must actually do, whereas ‘institutional frame’ refers to those aspects of the text that are centred around the model of therapy and the therapy protocols used by the service. How the therapist moves between these two frames to accomplish the task of establishing and encouraging the client to undertake homework tasks is highlighted in the analysis. This paper has been submitted to the journal *Communication & Medicine*.

1.2.3 Paper Three (Chapter 6): Termination in CBT: A Study of Interactional Strategies

The third and final paper in this thesis investigates the ending or terminating of therapy through the analysis of the final two sessions of one client. The focal theme of termination of therapy is further subdivided into two key tasks (1) relapse prevention and (2) assessment of progress during therapy. An important part of any therapy is how the therapy is ended. This is particularly true for short-term therapies such as CBT. A crucial part of the ending of therapy is assessing when the client is ready for therapy to cease. This is linked to the problem statement and other measures of outcome, such as questionnaires. Another important aspect of the CBT model in the termination of therapy is relapse prevention, in which the client learns strategies to put into place if the problem returns. As with the other two papers, face-saving and politeness strategies are prominent, along with constructed dialogue and intertextuality. In using constructed dialogue the therapist appears to quote the client as if the client were using CBT-related language, but in reality the quotation is generated purely by the therapist. How this strategy is used in the therapy session is explored. Intertextuality is also evident in the text. Both participants, but particularly the client, utilise previous discourse from the therapy to create new meaning more in keeping with the CBT approach. This paper has been submitted to the journal *Communication & Medicine*.

These three papers cover crucial parts of the CBT model: defining the problem, homework tasks and termination of therapy. They form part of a broader research project aimed at investigating a number of the features of the CBT model and how they are put into practice in the language used by therapists. Although the features of the model explored in this thesis are important to the practice of CBT, many other aspects of the model are not covered. The ability of the therapist to use language to implement CBT in routine therapy sessions is an important part of his or her expertise. For that reason, this thesis uses DA, an analytic approach derived from linguistics, to attempt to further understand the professional techniques that therapists use in CBT sessions. The focus of this thesis is on professional rather than purely linguistic concerns.

1.3 Arrangement of the Thesis

Chapter 2 is a contextual statement in which the rationale for the research agenda, of which the three papers form a part, is outlined in an expanded format. First, I provide an overview of the history of CBT and discuss its place in the history of psychotherapy more broadly, placing emphasis on its rise to prominence in modern psychiatric practice and the broader field of mental health care. This is followed by a discussion of traditional psychotherapy research and its limitations in addressing the aims of this thesis. I then present the rationale for selecting DA as the method of analysis for this thesis, along with an overview of the literature on DA, including conversation analysis (CA) and psychotherapy. The focus of this review is the relationship between the analysis and the underlying treatment model of the various forms of psychotherapy studied.

Chapter 3 sets out the method for the conduct of the study, including the method of analysis, theme-oriented DA. In particular, this chapter describes the method of data collection and analysis in greater detail than that provided in the papers.

Chapters 4 to 6 contain the three papers outlined above. They are included in the style as required by the journal to which they were submitted. As such, they make use of the journal's house reference style.

In Chapter 7, I discuss general conclusions of the thesis, in addition to or in greater detail than is provided in the three papers. I conclude the main body of the thesis with a discussion of the limitations of the research and suggestions for further research.

Chapter 2 Contextual Statement

2.1 Overview

This chapter presents the context of the three papers that form this thesis and the program of research from which these papers were drawn. It is important to note that the three papers in this thesis present preliminary findings from an ongoing project aimed at investigating how the treatment model of cognitive behavioural therapy (CBT) is put into practice through the use of language in the interaction between the therapist and client in the clinical setting. Within this agenda, an aim of the papers is to raise awareness among discourse analysts and psychotherapy practitioners of the value of such research to both disciplines. This focus of research evolved from my experiences both in learning how to apply the CBT treatment model in everyday clinical practice and in teaching CBT to others.

In this chapter, following a general introduction (Section 2.2), I present an historical overview of psychotherapy (Section 2.3). I discuss CBT's place within this history (Section 2.4) with particular reference to the model of CBT which is the subject of this thesis (Section 2.5). I discuss the limitations of our understanding of how the treatment model of CBT is put into practice through the use of language by therapists in the clinical setting (Section 2.6). I outline the various methodological approaches to address this question both from within the tradition of psychotherapy process-outcomes research (Section 2.7) and research methods adopted from other disciplines outside of psychotherapy (Section 2.8). The limitations of process-outcomes research are discussed and how importation of other approaches such as discourse analysis (DA) has been increasingly adopted to investigate psychotherapy (Section 2.8). This is followed by a review of the research into psychotherapy using DA and conversation analysis (CA) (Section 2.9). The reasons for selecting theme-orientated DA are outlined (Section 2.10) along with a discussion of interactional expertise (Section 2.11). The chapter concludes with a discussion of the practical relevance and application of DA research to the professions whose practice is the subject of the research (Section 2.11).

2.2 Introduction

The field of psychotherapy began with psychodynamic psychotherapy in the late 19th and early 20th centuries, rising to prominence in the mid-20th century (Lambert, 2013b). Cognitive behavioural therapy arose in part because of the perceived limitations of psychodynamic psychotherapy and in contrast is highly structured and time-limited. Owing to a large number of studies attesting to the efficacy of various permutations of CBT in treating psychiatric conditions, CBT is now recommended by a range of professional bodies and practised widely in mainstream mental health services (American Psychiatric Association, 2006; Andrews, Oakley-Browne, Castle, Judd, & Baillie, 2003; Nathan & Gorman, 2007; Roth & Fonagy, 2005). As a consequence, CBT is a very important part of contemporary psychiatric practice and a subject worthy of further investigation. There are multiple variations of CBT (Dobson, 2010) and in this thesis I focus on one particular form, which evolved from the purely behavioural therapy developed at the Maudsley Hospital in the UK (Marks, 1981, 1986, 1987, 2001)

Despite extensive research into CBT, little is understood about the language used by the therapists and clients in the implementation of the treatment model in the clinical setting. The literature illustrates therapeutic techniques with idealised transcripts and does not explore language use in detail (Leahy & Holland, 2000; Wright et al., 2006). Rather, the main focus of CBT research has been on its outcomes when used to treat particular psychiatric and other mental conditions (Nathan & Gorman, 2007; Roth & Fonagy, 2005)

Process-outcomes research, the traditional field of psychotherapy research that focuses on the internal workings of psychotherapy, is characterised by a wide variety of quantitative methodologies (Kiesler, 1973; Timulak, 2008). This plurality of approaches, reflecting different of understandings of how psychotherapy works has made a synthesis of findings problematic (Hill & Lambert, 2004). Despite this, process-outcomes research has made and continues to make a valuable contribution to the understanding of how psychotherapy is conducted. However, the research methods used by traditional process-outcomes research are not suitable for addressing the question of this thesis as they do not offer the fine-grained analysis of language necessary to address the research

question. Because of the perceived limitations of process-outcomes research, psychotherapy researchers are beginning to adopt research methods from other disciplines, which have been used to analyse a broad range of social interactions in settings such as the law, education and medicine (Lutz & Hill, 2009; McLeod, 2001). These are generally qualitative in nature and include such methodologies as grounded theory and DA. There is a growing literature of research using DA and the related field of CA to analyse psychotherapy interactions (Avdi & Georgaca, 2007; McLeod, 2011; Peräkylä, Antaki, Vehvilainen & Leudar, 2008). This research is often undertaken by researchers who are not psychotherapists, although these approaches are gaining interest from within the field (McLeod, 2001; McLeod 2011). For the method of analysis in this paper I elected to use a form of DA referred to as theme-orientated DA (Roberts & Sarangi, 2005; Sarangi, 2010), because it is specifically designed for health interactions by interlinking clinical questions or clinical concerns with discourse-analytic methods. Arguably, CA has developed a prominent position in the analysis of language in psychotherapy (Peräkylä, et al., 2008). However, limitations in how it deals with contextual information outside of the psychotherapy interactions make CA less suited for the research question that guides this thesis. Due to the large amount of data gathered for this research project (of which only a small amount is used in this thesis) I also make use of the concepts of crucial sites and critical moments, as defined by Candlin (2000), as a way of focusing on relevant aspects of the transcript.

I am in effect studying, through the therapists' and clients' use of language, the therapists' expertise (Sarangi & Candlin 2011) in putting into practice, with a client, the treatment model of CBT as expressed in textbooks and seminars. It is this expertise that is the focus of this thesis. Although it is beyond the scope of this thesis, research into how the treatment model is put into practice may aid the training of therapists through achieving a better understanding of what language strategies are used to deploy particular clinical techniques.

2.3 Psychotherapy and the Evolution of CBT

Psychotherapy, including CBT, evolved over the 20th century to become a major treatment strategy for a range of mental health problems and mental illnesses (Nathan & Gorman, 2007; Roth & Fonagy, 2005). In the sections below I outline how psychotherapy developed to the position that it now holds, with a particular focus on the development of CBT. The aim of this discussion is not to provide a comprehensive history of psychotherapy but to outline the importance of CBT in current mental health practice across a range of professions and how it fits in the broader context of psychotherapy. This serves to emphasise its importance to current clinical practice and thus the relevance of undertaking research into CBT and, as this thesis aims to do, how the CBT treatment model is put into practice in everyday clinical settings. This discussion also provides the historical context to the model of CBT studied in this thesis and how it fits with other forms of CBT.

While psychotherapy essentially began in the late 19th and early 20th centuries with the advent of psychoanalysis, it has historical roots significantly predating this, including associations with religious confession and various ancient healing rituals (Frank & Frank, 1993; Jackson, 1999; Maranhao, 1986; Shapiro & Shapiro, 1997; Wampold, 2010a). Sigmund Freud, the founder of psychoanalysis and psychodynamic psychotherapy² (Lambert, 2013b), was arguably one of the

² Psychoanalysis is the form of therapy where the client is seen several times a week for a long period, sometimes years, with the aim of altering personality functioning through an analysis of what is termed the transference. The transference is the process whereby the client projects his or her past issues onto the therapist. The client typically lies on a couch. Psychoanalysis is less frequently undertaken than it used to be. In contrast, psychodynamic psychotherapy, or psychoanalytic psychotherapy, is usually conducted once or twice weekly over a shorter duration and the client sits upright. The aim of therapy is insight and sustained change, and less emphasis is placed on interpreting the transference (Wolitzky, 2011). In modern practice the distinction between these forms of therapy is less sharply drawn and they are often used interchangeably.

most influential figures in the development of psychotherapy. Since the Second World War there has been a proliferation of varieties and forms of psychotherapy (Lambert, 2013b); however, many modern psychotherapies draw on Freud's work or see their work as developing in reaction to his ideas and the perceived limitations of psychoanalysis (Lambert, 2013b). Cognitive behavioural therapy (Beck, 1970; Beck, et al., 1979; Dobson, 2010) was one such psychotherapy which developed in the post-war period, largely in reaction to psychoanalytical therapy, but it was still influenced by psychoanalytical ideas.

As a Viennese neurologist, Sigmund Freud initially collaborated with Josef Breuer, a fellow physician, in the development of his psychoanalytic ideas (Breuer, 1955; Breuer & Freud, 1955; Gay, 2006; Meissner, 2009; Wolitzky, 2011). However, their collaboration did not continue as Breuer was concerned about the sexual nature of Freud's theories (Roith, 2008). Freud was initially inspired by Breuer's work in treating patients with hysteria, a disorder characterised by numerous anxiety-related problems and physical symptoms that are now largely thought to be of psychological origin (Gay, 2006; Meissner, 2009; Roith, 2008). Hysteria is no longer recognised as a single disorder in current psychiatric practice. A patient of Breuer's, Anna O., is famously quoted as saying that the form of therapy was 'a talking cure' (Breuer, 1955). This highlights one of the crucial aspects of psychotherapy, that it is essentially conducted through talk. The characterisation of psychotherapy as 'a talking cure' continues to the present day. The observation that psychotherapy is largely conducted through talk makes it particularly amenable to forms of research that analyse talk in interaction, such as in this thesis.

After his collaboration with Breuer, Freud continued to develop and refine his psychological theories until his death in 1939 (Gay, 2006; Jackson, 1999; Wolitzky, 2011). A full appraisal of Freudian theory is beyond the scope of this thesis. However, simply put, Freud developed a structural model of the mind. In this model thoughts are both conscious and within the awareness of the individual, and unconscious, in that the thought processes are not generally available to the individual, although thoughts that are in the unconscious mind can be brought forth into the conscious mind in certain circumstances (Meissner, 2009; Mitchell & Black, 1995). Freud further divided the mind into the id, the

ego, and the superego (Freud, 2001; Gabbard, 2010; Mitchell & Black, 1995). In the Freudian model, the id is seen as the repository for instinctual drives, such as to eat and to reproduce. The superego is where society's rules and moral values are internalised and it acts to monitor and scrutinise one's thoughts and feelings. The ego acts in an executive role by integrating a number of the mind's functions, including one's perceptual inputs and interaction with the outside world, and by modulating the functions of the id and superego (Gabbard, 2010; Meissner, 2009; Mitchell & Black, 1995). An important role of the ego is to modulate libidinal urges from the id. In the Freudian model, conflict can occur between different aspects of the mind, leading to either a healthy resolution of these issues or suppression of unresolved conflicts into the unconscious mind (Gabbard, 2010). A number of defence mechanisms are used by the mind to resolve these conflicts and Freud thought some to be more mature and functional, such as humour, and others to be immature and dysfunctional, leading to psychopathology (Meissner, 2009). Freud also developed a related theory of psychosexual development, which outlined a number of phases in childhood in which certain psychosexual developmental tasks are undertaken and failure to achieve or resolve these tasks leads to mental health problems (Meissner, 2009). It was considered that adult mental health problems often had their roots in childhood unresolved conflicts, which re-emerge or are triggered in adulthood (Gabbard, 2010). In this form of psychotherapy the therapist would attempt to uncover these issues from childhood as a way of treating adult mental health problems (Clarkin, Fonagy, & Gabbard, 2010; Gabbard, 2010).

In his clinical work Freud treated a number of patients with mental conditions that were characterised by anxiety symptoms (Plakun, 2009). In the nomenclature of the day these conditions were termed neuroses. The cornerstone of Freud's theoretical understanding of these patients' problems was that their neuroses developed from repressed conflicts between instinctual drives and external reality as outlined above (Plakun, 2009). Freud's treatment for these patients comprised therapy sessions in which the therapist would use a number of techniques to try to access unconscious thoughts (Gabbard, 2010). For example, the patient would 'free-associate' and discuss his or her dreams, a technique to access unconscious thought processes and bring up unresolved conflicts that would be played out in

the discussions during therapy (Karasu & Karasu, 2009). Therapy of this nature was unstructured and could involve the patient being seen several times a week for a number of years. A number of other theorists added to Freud's ideas and various subtypes of psychodynamic therapy have developed (Mitchell & Black, 1995). Theoretical development of this type of therapy continues and variations on psychodynamic psychotherapy are practised in the modern era, however, traditional Freudian therapy is unlikely to be encountered now (Mitchell & Black, 1995; Wolitzky, 2011). Key criticisms of Freud's theories centred on the fact that there was very little evidence for his model of the mind and childhood development. Some have argued that a number of Freud's ideas are difficult to assess using scientific methods and they were thus inherently unscientific (Eysenck, 2004; Skinner, 1961). Although a number of patients have benefited from psychodynamic psychotherapy (Barber, Muran, McCarthy, & Keefe, 2013), concerns were also raised about the long-term nature of treatment and the slow progress that a number of patients made. It was these issues that inspired the founders of other forms of psychotherapy, including CBT, in reaction to both the Freudian psychological theories and the resultant clinical approach (Barber, et al., 2013). As I will outline below, CBT emphasises structured sessions and measurement of outcome, both as part of how the therapy is conducted and also in the use of randomised controlled trials to test the efficacy of the treatment. The founders of behaviourism and behavioural therapy, early precursors of CBT, were so concerned that internal mental processes could not be measured that they focused their attentions on observable behaviour only (Skinner, 1938, 1957; Watson, 1913). As I discuss later in the thesis, the highly structured nature of CBT is a major influence on the way therapy is conducted. The brief nature of CBT (approximately ten one-hour sessions) means that one can more readily video record a complete treatment of a particular client.

The discussion so far has emphasised the role of Freudian psychotherapy and its contrast to CBT. However, there are a large number of psychotherapies, leading one author to somewhat playfully comment, 'I am inclined to predict that sometime in the next century there will be one form of psychotherapy for every adult in the Western World' (Garfield, 1987). Certainly, the number of recognised psychotherapies is estimated to be in the hundreds (Lambert, 2013b). Although

there may be competition between different professional groups over who should deliver psychotherapy, competition between the different models of psychotherapy is considered by Hubble, Duncan and Miller (1999) to be even more ferocious. Views about what is appropriate in therapy can be quite different; therapeutic techniques from one type of therapy can be considered inappropriate by proponents of another. Although there is academic interest in debates between particular schools of psychotherapy, there are also implications for the funding of therapy by governments and private health insurance companies. Funders and service providers have to make decisions about which forms of psychotherapy to support. The practitioners of CBT have been particularly effective at assessing their therapy using scientific approaches and they have amassed a large number of studies that attest to its efficacy for a range of psychiatric conditions (American Psychiatric Association, 2006; Andrews, et al., 2003; Butler, Chapman, Forman, & Beck, 2006; Nathan & Gorman, 2007; Roth & Fonagy, 2005). This has led to CBT being recognised by professional organisations as an ‘evidence-based treatment’ and in turn has led to its recommendation in treatment protocols developed by such professional organisations as the Royal Australian and New Zealand College of Psychiatrists (RANZCP) (Andrews, et.al., 2003; Ellis, Hickie, & Smith, 2003), the American Psychiatric Association (2006) and similar organisations in the UK (McIntosh et al., 2004). As a consequence, CBT is funded by public health organisations and insurance companies where other psychotherapies may not be. For example, in Australia clinical psychologists are now funded by Medicare, the taxpayer-funded health insurance scheme, to up to 10 sessions of CBT a year for a given client (Australian Government, 2013). The funding is explicitly for CBT and related approaches (along with two others forms of therapy in specific circumstances), but not other forms of psychotherapy, such as psychodynamic psychotherapy. What this discussion highlights is the importance of CBT to clinical practice in modern mental health and, by inference, the practice of CBT is a worthy topic for further research.

It is important to note that the field of psychotherapy is not a static one. Because of CBT’s success in attracting funding and achieving recognition in treatment protocols through the use of randomised controlled trials, other forms of psychotherapy have adapted their approach to counter CBT. A form of therapy

called interpersonal psychotherapy (IPT) (Frank & Levenson, 2010; Mufson, Dorta, Moreau, & Weissman, 2011; Weissman, Markowitz, & Klerman, 2000) has been investigated in a number of randomised controlled trials that attest to its efficacy in the treatment of depression (Brakemeier & Frase, 2012; Donker et al., 2013; de Mello, de Jesus Mari, Bacaltchuk, Verdeli, & Neugebauer, 2005; Elkin et al., 1989; Mufson, Weissman, Moreau, & Garfinkel, 1999; Schramm, et al., 2007; van Hees, Rotter, Ellermann, & Evers, 2013) and bulimia (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000; Fairburn, Jones, Peveler, Hope, & O'Connor, 1993; Wilson, Wilfley, Agras & Bryson, 2010). As with CBT, IPT is also recommended in treatment protocols and is considered an evidence-based treatment, although it is less widely practised (Nathan & Gorman, 2007; Roth & Fonagy, 2005). In addition, mentalisation-based treatment (Allen & Fonagy, 2006; Bateman & Fonagy, 2004b, 2006, 2011) has been shown in randomised controlled trials to be effective for people suffering from a borderline personality disorder (Bales, et al., 2012; Bateman & Fonagy, 1999, 2004a, 2009; Jorgensen, et al., 2013). These therapies are of interest as they are related to psychodynamic psychotherapy. Thus, although CBT is a prominent feature of current mental health treatment, other forms of psychotherapy may very well prove to be equally as efficacious in the future and a broader range of psychotherapies may become recommended in treatment protocols. Despite this, CBT continues to be a prominent form of psychotherapy and many studies investigating its use and adapting it to treat a broader range of mental health problems continue to be published (Silverberg et al., 2013; Touyz et al., 2013; van Beek et al., 2013).

Commonly, psychotherapy is undertaken between one therapist and one patient or client in a room. However, psychotherapy can also be conducted in groups (Bieling, McCabe, & Antony, 2009; Yalom & Leszcz, 2005), which can be formed from strangers who meet to work through issues with the therapist, or from family members who are treated by one or more therapists (Ackerman, 1966; Minuchin, 1974; Rasheed, Rasheed, & Marley, 2010). On occasion, therapy can be conducted with another therapist watching through a one-way mirror and communicating his or her advice to the therapist in the room via telephone (Rasheed, et al., 2010). Initially psychotherapy, especially psychodynamic psychotherapy, was undertaken by medical practitioners (Cautin, 2011; Jackson,

1999). However, many professions have staked a claim in this area, with the vast majority of practitioners of the various forms of psychotherapy currently being non-medical (Cautin, 2011; DeLeon, Kenkel, Garcia-Shelton, & VandenBos, 2011). This came about in the post-Second World War era as health services tried to deliver psychotherapeutic services to a larger number of people (Cautin, 2011). There is, at times, competition between the different professions over who is best placed to deliver psychotherapy and to treat mental health problems generally (DeLeon, et al., 2011; Hubble, et al., 1999). The therapists who are the subject of this thesis are mostly behavioural nurse therapists who have undertaken master's-level training in CBT, along with a social worker who has undertaken the same master's program. This is typical of the increasing diversity of professionals who are conducting CBT, although psychologists predominate (DeLeon, et al., 2011). Whereas a number of psychiatrists were involved in the early development of CBT (Beck, 1967; Beck, 1970; Beck, et al., 1979; Marks, 1981; Wolpe, 1958), it has largely become the domain of psychology (DeLeon, et al., 2011). However, some psychiatrists continue to practise it, along with social workers, general practitioners (family physicians) and councillors (DeLeon, et al., 2011). One of the effects of CBT's growing popularity is that people from other disciplines value this form of therapy and are willing to undertake training to deliver it.

2.4 The History of CBT

What follows in the section below is a discussion of how CBT developed historically and came to prominence in the mental health field. It also places into context the variant of CBT which is the subject of this thesis. The discussion is not intended to be an exhaustive account of the history of CBT, but an overview.

Cognitive behaviour therapy developed out of the independent traditions of behavioural psychology and therapy, which began in the early decades of the 20th century, and cognitive psychology and therapy, which evolved after the Second World War (Cautin, 2011; Hawton, Salkovskis, Kirk, & Clark, 1989a).

Behavioural therapy and cognitive therapy were initially separate schools of therapy, although they have merged to form cognitive behavioural therapy, of which there are a number of different forms and schools (Dobson, 2010). Models

vary in the degree to which they favour behavioural or cognitive theory and techniques. There is debate within the field as to which techniques are appropriate or more efficacious.

In the following subsections I outline a brief history of behaviour therapy and then cognitive therapy, followed by a discussion of how they merged.

2.4.1 The Development of Behavioural Therapy

Behavioural therapy developed as a consequence of the application of learning theory to the understanding of the development of mental disorders and their treatment. In particular, the ideas of classical and operant conditioning were very influential. Pavlov, a Russian physician and physiologist, is credited with the development of classical conditioning (Hawton, et al., 1989a). Pavlov's ideas came from research on dogs and ultimately he received a Nobel Prize for his work in 1904. Simply put, the concept of classical conditioning is learning by association. Agras and Wilson (1995) express it as follows:

[L]earning occurs when an initially neutral stimulus, the conditioned stimulus (CS), is paired with the stimulus that naturally elicits a response, the unconditioned stimulus (US). The response elicited by the US is the unconditioned response (UR). After repeated and contiguous pairing of the two stimuli, the CS elicits the UR, which is then called the conditioned response (CR).
(p. 301)

The development of operant conditioning is usually attributed to the American scientist Edward L. Thorndike (Agras & Wilson, 1995). Thorndike did not coin the term 'operant conditioning', but he referred to his observation as 'the law of effect'. Hawton et al. (1989a) express his concept as:

... behaviour which is followed by satisfying consequences would tend to be repeated and behaviour which is followed by unpleasant consequences will occur less frequently. (p. 2)

Simply expressed, this is learning by consequence.

The next major figure in the history of operant conditioning and the person whose name is often associated most strongly with the concept is the psychologist B.F. Skinner (Skinner, 1938; Vargas, 2001), who is credited with extending the concept developed by Thorndike. Skinner defined reinforcing factors as those which follow a behaviour and lead to an increase in that behaviour (Skinner, 1938). These reinforcing factors may not be simply pleasurable. Skinner divided operant conditioning into positive and negative reinforcement. Positive reinforcement, which is essentially the same as Thorndike's idea, is where behaviour is reinforced by a positive consequence. Negative reinforcement is when a behaviour increases because an anticipated adverse outcome does not occur (Hawton, et al., 1989a; Skinner, 1938).

Up until the Second World War there were a few notable examples of these principles being applied to mental illness and its treatment. John D. Watson and Rosalie Rayner, American psychologists, applied the principles of classical conditioning to an 11-month-old baby referred to as 'little Albert' (Watson & Rayner, 1920). They were able to demonstrate that a loud noise that evoked a fear response could be paired with a previously neutral stimulus, a white rat. This led to the white rat eliciting in little Albert a fear response that generalised to other white and fluffy things (Watson & Rayner, 1920). Such an experiment would be generally considered unethical today. They had prepared a protocol to treat little Albert along behavioural lines, but apparently he was withdrawn from the study before the protocol could be put into effect. Mary Jones (1924), a student of Watson's, successfully applied classical conditioning principles to treat problem behaviours in children residing in a children's home.

The development of behavioural therapy in the 1950s and 1960s can be divided into three major schools or categories:

1. Wolpe and his concept of reciprocal inhibition, which he developed in South Africa and later in the United States
2. The Maudsley Hospital and the Institute of Psychiatry, under the direction of Hans Eysenck in the United Kingdom
3. B.F. Skinner and applied operant conditioning in the US.

Joseph Wolpe (1958) and his work on behavioural therapy is widely mentioned in the accounts of the history of behavioural therapy (Hawton, et al., 1989a; Jackson, 1999; Kazdin, 1978; O'Donohue, Henderson, Hayes, Fisher, & Hayes, 2001; Stanley & Beidel, 2009). Wolpe developed the concept of reciprocal inhibition (Kazdin, 1978; Hawton, et al., 1989a; Wolpe, 1958), which led him to develop a treatment for anxiety disorders. According to his protocol the patient was taught to relax using a standardised relaxation procedure (Stanley & Beidel, 2009; Wolpe, 1958). The patient would then progressively relax while imagining a given feared situation, with the view that this would lead to a reduction in anxiety when the patient is next exposed to the feared situation. That is, the patient would become desensitised to the feared situation. Examples of feared situations included public speaking, exams, heights and being in close proximity to spiders. Since most patients with anxiety disorders experience a number of feared situations, it was necessary to work out which situation to desensitise to first. The feared situations were listed in a hierarchy, and the patient moved progressively from the situation that elicited the least amount of anxiety to that which provoked the most. This became known as systematic desensitisation. A characteristic of this technique was that its efficacy was able to be empirically evaluated and it was shown to be effective (Paul, 1969).

The Maudsley Hospital, which later merged with the London University's Institute of Psychiatry, remains a centre of CBT. Hans Eysenck, who was professor of psychology at the Institute, guided research into behavioural therapy although he himself was not a clinician (Hawton, et al., 1989a). Hans Eysenck was very critical of the lack of scientific rigour in conventional psychotherapy and psychiatry (Eysenck, 1952, 2004). He famously criticised psychoanalysis in a 1952 paper for the lack of scientific evidence as to its efficacy (Eysenck, 1952). This helped establish behavioural therapy in opposition to psychoanalysis, as behavioural therapy emphasised scientific research in its development. It should be noted that psychoanalytical psychotherapy was the dominant form of psychotherapy in Britain and the US at that time. Interestingly, in the 1940s, Eysenck was influenced by an analyst who had developed a treatment of 'graduated tasks', which had many of the qualities of exposure that we now

associate with behavioural therapy. However, this analyst, Alexander Herzberg, used psychodynamic theory to explain the success of his therapy (Kazdin, 1978).

At the Maudsley Hospital and associated Institute of Psychiatry, Stanley (Jack) Rachman, a South African psychologist, brought Wolpe's systematic desensitisation treatment to England, where it was further refined on the basis of experimental and clinical data (Hawton, et al., 1989a; Rachman, 2009). Two psychiatrists worked closely with the psychologists in the development of clinical treatment protocols. They were Michael Gelder and Isaac Marks, who, along with Rachman, refined behavioural therapy techniques (Hawton, et al., 1989a). In his 1987 book *Fears, phobias, and rituals: Panic, anxiety, and their disorders*, Marks summarised the state of research into the pathology and treatment of anxiety disorders. He concluded that graded, prolonged, repeated *in vivo* exposure is the behavioural treatment of choice for anxiety disorders. Marks was also involved in establishing a program to train psychiatric nurses to deliver behavioural psychotherapy, which was the term he used to describe his form of behavioural therapy (Marks, Hallam, Connolly, & Philpott, 1977). This training program was the inspiration for the master's course that was undertaken by the therapist studied in this thesis. The model of therapy developed by Professor Marks is also the progenitor for the therapy that is the subject of my research. The history of the development of behavioural therapy in the UK is characterised by a number of different disciplines contributing to research and clinical practice (Rachman, 2009). For this reason, the therapists in my research are mostly psychiatric nurses who have undertaken special training in CBT, rather than clinical psychologists. However, in keeping with this British tradition of multidisciplinary behavioural therapy, the service also employs psychiatrists, psychologists, social workers and psychiatric registrars.

Another major school of early behavioural therapy was that based on B.F. Skinner's operant conditioning (Hawton, et al., 1989a; Rachman, 2009). This form of behavioural therapy (also called behavioural modification) is considered to be the American form of behavioural therapy (Breuer, 1955). Amongst others, Skinner applied the principles of operant conditioning to a number of clinical problems. In contrast to the South African and English groups, who focused on people with anxiety disorders, Skinner and his colleagues concentrated their

efforts on treating people with psychotic illnesses and intellectual disability (Rachman, 2009). Out of this research effort came programs such as token economies, which used systems of reward to enhance socially appropriate behaviours amongst institutionalised people (Ayllon, 1963). A common example of this form of behavioural therapy cited in the literature is the token economy developed by Ayllon and Azrin (1968). Operant conditioning has also been applied widely in many other fields outside of psychiatry and clinical psychology, such as education and marketing. A characteristic of this form of behavioural therapy is that it was led predominantly by psychology. The principle of operant conditioning is used in modern forms of CBT, including the model that is studied in this thesis (Marks, 1981, 1987). In particular, a common CBT technique to treat depression is encouraging the client to increase the use of rewarding behaviours (Kanter, Busch, & Rusch, 2009).

What links the schools of behavioural therapy is a focus on behaviour without making reference to cognitive processes (Rachman, 2009). Measurement of progress throughout therapy is systematic; the goals of therapy are clearly defined so that their attainment can be measured. The form of CBT studied in this thesis has strong roots in the behavioural therapy tradition developed at the Maudsley Hospital in the UK and shares many of its characteristics, such as clearly defined goals. However, the therapists have also incorporated aspects of cognitive therapy into their clinical practice. What follows is an overview of the history of cognitive therapy and how it was amalgamated with behavioural therapy to form CBT.

2.4.2 The ‘Cognitive Revolution’ and the Development of Cognitive Behavioural Therapy

Towards the end of the 1960s academic psychology became increasingly dissatisfied with behavioural explanations for learning. This led to increasing interest in the role of cognition in learning theory and as an explanation for human behaviour. An example of such work is Albert Bandura’s *The principles of behaviour modification* (1969), which included cognition as a major factor in his social learning theory. Craighead, Craighead, and Iliardi (1995) list three separate but related trends that led to the ‘cognitive revolution’ in psychology.

1. Increasing dissatisfaction with the stimulus-response learning model advocated by behaviourists, which had effectively excluded cognition
2. Computers as an analogue for human thought: a powerful metaphor for a cognitive approach
3. The development of alternative learning theories that incorporate cognition, such as that of Albert Bandura.

At the same time as these advances in theory were occurring, cognitive therapy began to develop. It evolved from dissatisfaction with psychoanalytical therapy in much the same way that behavioural therapy had done. The psychiatrist, Aaron T. Beck, is often credited as the founder of cognitive therapy (1967; Beck, et al., 1979; Hollon & DiGiuseppe, 2011). Beck, however, acknowledges the influence of the ideas of Albert Ellis, a psychologist, who developed rational emotive therapy (later known as rational emotive behaviour therapy or REBT) (Dobson, 2010). In collaboration with others, Beck developed cognitive therapy in the context of developing a psychotherapeutic treatment for major depression (Beck, et al., 1979). Beck had trained as an analyst, and then become dissatisfied with the slow progress that patients made using this treatment. He also conducted original research, testing hypotheses generated by the Freudian-inspired model of depression (Hollon & DiGiuseppe, 2011; Rachman, 2009). He noted that a number of predictions from the psychodynamic model of depression were not borne out in his research with depressed patients. He credits this with his inspiration for developing cognitive therapy. Cognitive therapy emphasised cognitions but it was also brief and emphasised scientific rigour, characteristics it shares with behavioural therapy. It was, however, seen as quite separate from behavioural therapy (Hollon & DiGiuseppe, 2011). A key concept of cognitive therapy is that our thoughts have a controlling influence on our emotions and behaviour (Wright, et al., 2006). The model proposed by Beck centred on the observation that mental disorders are related to distortions in thinking and that applying logic and reason to one's thoughts in a process similar to scientific enquiry can lead to the development of a more balanced way of thinking and thus relieve suffering. The therapy involves processes of identifying the distorted thoughts and then challenging them. One of the techniques utilised to find the negative thoughts is 'collaborative empiricism', in which the therapist takes an

investigative stance with the client to identify the distorted thinking and the client is taught how to investigate these thoughts to ascertain if the distorted thinking has any logical basis (Beck, et al., 1979). Thoughts are challenged through various other exercises, for example the therapist asks the client to conduct experiments, modelled on scientific experiments, where hypotheses are made and tested empirically. Although the model of therapy studied in this thesis was derived from a behavioural approach, the therapists make use of cognitive strategies in their therapy.

It was this combination of the development of learning theories that involved cognition, and the development of cognitive therapy, which had a great influence on behavioural therapy. Behavioural therapists were receptive to new approaches because there were proving to be limitations within behavioural therapy itself. Dobson (2010) refers to the difficulties of applying the behavioural techniques to phenomena such as the obsessions in obsessive-compulsive disorder, which are by definition cognitive in nature. Although behavioural therapy had proven to be efficacious for a number of psychiatric disorders and other mental health problems, not all people with these disorders responded to behavioural therapy. This led behavioural therapists to explore cognitive techniques that could be added to behavioural therapy. This resulted in the development of cognitive behavioural therapy, which is by far the most common term used to describe this form of therapy and is the term used by the therapists in this thesis to describe their approach.

2.4.3 The Third Wave

In more recent times a ‘third wave’ of CBT has developed, which centres on the adoption of mindfulness-based techniques from meditation and Buddhist theory (Crane, 2008; Fishman, Rego, & Muller, 2011; Segal, Williams, & Teasdale, 2012). Characteristically, mindfulness-based CBT has been argued for on the basis of randomised trials that attest to its efficacy in the treatment and prevention of depression (Teasdale et al., 2000). The associated techniques include learning to become an observer of one’s own thoughts and learning to be aware of, but not engage with, negative thoughts. This involves ‘acceptance’: the client learns to accept the negative thought but does not try to counter it or resist it, just lets it

pass from his or her mind (Crane, 2008; Segal, et al., 2012). This is undertaken by teaching the client to meditate and by applying this to treating their mental condition (Crane, 2008; Segal, et al., 2012). The therapists who are studied in this thesis make use of mindfulness techniques, although they do not profess to practise mindfulness-based CBT as such.

The history of CBT is clearly not a static one (Dobson, 2010). Therapists undertake ongoing education and training through which they will be exposed to new ideas and research findings. As a result, the therapy model evolves over time. Therapists themselves may also be involved in research or work in units where research is undertaken, and so play a direct role in adding to the CBT literature. However, a key theme permeating the CBT tradition is empiricism. This is reflected in therapy techniques in which clients are asked to define and measure aspects of their problem. This empiricism was initially focused on behaviour, although eventually it was applied to thought processes. It has been argued that as the ideas from therapy are incorporated into everyday understandings and discourse, therapy needs to reinvent itself (McLeod, 2001), hence the evolution of the models of therapy, including the one that is the subject of this thesis.

2.5 The Form of Therapy that is Studied in this Thesis

As stated previously, the form of CBT studied in this thesis evolved from a purely behavioural approach developed at the Maudsley Hospital by Professor Isaac Marks and his colleagues (Marks, 1981, 1986, 1987, 2001; Marks, et al., 1977), which they called behavioural psychotherapy. Marks developed his approach in response to perceived shortcomings in psychodynamic psychotherapy and from his research into both behavioural therapy techniques and the behavioural science underlying anxiety-related disorders (Marks, 1987). An important focus for Marks was the delivery of cost-effective evidence-based treatment to patients with anxiety disorders. To facilitate this he developed a program to train psychiatric nurses to deliver behavioural therapy (Marks, et al., 1977). This model of CBT was important to the service from which the data was obtained for this thesis. Initially, when the service was established in the early 1990s, the primary model was behavioural psychotherapy as practised at the Maudsley Hospital; however,

with time the therapists have adopted cognitive and now mindfulness-based strategies, although the basic structure and approach is still largely influenced by Marks's approach. The therapy that is delivered in the service is now referred to as CBT and not behavioural psychotherapy.

The service does not have one particular textbook or collection of protocols that governs all treatment. However, the treatment model used by the service studied in this thesis is in part contained within Marks' original textbooks (1981, 1986, 1987, 2001; Marks, et al., 1977) and also comprises treatment protocols outlining how various mental disorders are treated. These protocols are expressed in the material used to train therapists, such as course materials that were developed for brief CBT courses and material for a master's program, which includes lecture notes and articles. (See Chapter 3 for a more detailed discussion of the treatment model.) I was also able to draw upon my prior experience working in the service as a senior psychiatric registrar and being supervised in treating clients with CBT, along with more recent experience lecturing in the master's program used to train therapists to understand the model of therapy that is used. However, as discussed, the treatment model is not static and there is ongoing change, such as the introduction of more cognitive strategies and the more recent use of mindfulness techniques. Ultimately, the focus of this thesis is CBT as practised by the therapists. There is potentially some individual variation and, unlike in a randomised control trial, therapists are not monitored to ensure they adhere strictly to a prescribed protocol. However, a feature of the following papers is how the treatment protocols play a major role in the structure of the sessions. What this thesis explores is how this model of therapy is enacted by the therapists and clients in the sessions of therapy and the language they use to achieve this. Further details about specific aspects of the treatment model are contained within the three papers that form Chapters 4, 5 and 6 of this thesis.

2.6 Limitations of the CBT Literature in Addressing the Interaction between Client and Therapist

As stated previously, the aim of this thesis is to investigate how the underlying treatment model of CBT is put into practice in the interaction between the

therapist and client in the clinical setting through an analysis of the language used. This issue is largely unaddressed in the CBT literature. Training manuals are characterised by clear descriptions of the structure of therapy and techniques. A number of protocols have been developed using various models of CBT to treat a range of psychiatric conditions as well as other mental health problems (Antony & Swinson, 1998; J. S. Beck, 2011; Cooper et al., 2000; Greenberger & Padeskey, 1995; Hickling & Blanchard, 2006; Leahy & Holland, 2000; Wells, 1997; Williams, 2001; Williams, 2003; Young, 1999). These consist of systematic outlines of the therapy with, in many instances, descriptions of what is to be undertaken in each session with a typical patient suffering from the given psychiatric condition. Idealised transcripts and audiovisual recordings showing how therapy is to be conducted are also commonly used to train therapists (Wright et al., 2006). Textbooks may contain ‘examples’ of therapists at work delivering a given technique, consisting of transcripts either constructed for the purposes of teaching or selected from recorded sessions (Leahy & Holland, 2000; Wright et al., 2006). Recordings of the therapy conducted by acknowledged experts in the field are readily available, as are live demonstrations of therapy at professional events such as conferences and workshops. Because of the nature of the work, many of these videos and demonstrations are manufactured for training purposes using actors (often trainee therapists) to portray the client (Wright et al., 2006). This is not always the case, as some clients volunteer to appear in training videos, especially if access to the videos is restricted. The major concern is confidentiality. The highly private nature of psychotherapy, including CBT, makes it difficult to use ‘real’ clients, especially in more widely available educational material. In training courses such as the master’s course linked with the service in this study, trainee therapists will often record their sessions with clients. Subsequently the recordings are reviewed with their supervisors to provide feedback on the trainees’ technique. Video recordings of sessions by trainee therapists are also used to assess trainees’ progress. Structured questionnaires are sometimes used to assess these recordings, for example Beck et al.’s *Competency checklist for cognitive therapists* (Beck, et al., 1979, p. 404) and Blackburn et al.’s Revised Cognitive Therapy Scale (CTS-R) (Blackburn et al., 2001). It is quite clear that CBT therapists place a lot of importance on how the therapy is conducted and on teaching trainee therapists to conduct therapy

correctly; however, what is lacking in these training resources and assessments is a detailed discussion of discourse processes used in the deployment of the CBT treatment model. That is the focus of this thesis.

2.7 Psychotherapy Process and Outcomes Research

This thesis focuses on what occurs during therapy sessions in the interaction between therapist and client. Psychotherapy research has a long tradition of addressing this particular aspect of psychotherapy through the application of research methodologies collectively called process research (Greenberg & Pinsof, 1986; Kiesler, 1973; Lepper & Riding, 2006; Timulak, 2008). I argue in the following discussion that although traditional process research has been very useful in understanding some of the factors that are occurring during psychotherapy sessions, there are a number of limitations to this type of research and I have had to look to other methodologies to more directly address the research question. I outline the traditional distinction between process research and outcomes research. I then discuss the more recent concept of process outcome research which, in the view of some authors (Lepper & Riding, 2006), has come to replace the term process research. Whereas this thesis makes use of DA as its main analytical methodology and I present this as distinct from traditional process research methodology, a number of authors now include methodologies such as DA under the rubric of process or process-outcomes research (Lepper & Riding, 2006; Orlinsky, et al., 2004; Timulak, 2008). Process research has always been a collection of different methodologies and, as I shall discuss, this has led to some criticism of the field.

As stated above, traditionally, psychotherapy research has been divided into outcomes-based research and process research (Timulak, 2008, p. 5). In its purest form outcomes-based research concerns itself with whether the psychotherapy is successful or not. This is usually achieved through controlled trials comparing the clinical outcome of a particular form of therapy with another therapy or with patients on a waiting list for treatment. This contrasts with process research, which focuses on the processes within psychotherapy and has not usually concerned itself with outcomes. According to Lepper and Riding (2006) this

distinction has become less clearly defined. Most modern research combines elements of both. For example, Lepper and Riding (2006) point out that when comparing the outcome of two forms of therapy, emphasis is placed on the different processes occurring within each form of therapy as the researchers monitor the psychotherapy being undertaken to ensure that it adheres to the model of therapy being tested. Researchers may also compare similar therapies that differ only in the presence or absence of techniques, allowing conclusions to be drawn about the contribution of certain processes and techniques to the outcome of therapy. This has led some authors to use the term process outcomes research (Orlinsky, et al., 2004; Timulak, 2008) rather than process research.

Considerable research effort has been undertaken into investigating the outcome of therapy, with increasing numbers of studies comparing one therapy with another (Lambert, 2013a). There is a large body of evidence indicating that psychotherapy is effective for a range of psychiatric conditions (Butler, et al., 2006; Cooper, 2008; Nathan & Gorman, 2007; Roth & Fonagy, 2005). Whereas a large number of these studies investigate various forms of CBT, a limited but growing number of studies show positive outcomes for other forms of psychotherapy (Bateman & Fonagy, 1999, 2009; Korner, Gerull, Meares, & Stevenson, 2006; Russell Meares, Stevenson, & Comerford, 1999; Town, Abbass, & Hardy, 2011). In the studies that compared one form of psychotherapy with another the overall result is that no one model has a clear advantage (Wampold, 2010b; Lambert, 2013a). However, it is important to emphasise that there are relatively few studies to date and it is possible that one form of therapy may emerge as more successful than another or that certain forms of psychotherapy may be better suited to a particular mental health problem. As discussed previously in Section 2.4, the fact that CBT has been studied more frequently and shown to be effective, has led to this form of psychotherapy being recommended in evidence-based treatment protocols for various mental health problems developed by professional bodies such as the Royal Australian and New Zealand College of Psychiatrists (RANZCP) (Andrews, et al., 2003; Ellis, 2004; Ellis, et al., 2003), the American Psychiatric Association (2006) in the US and the National Institute for Health and Clinical Excellence (McIntosh, et al., 2004; NICE, 2009) in the UK. Based on the outcomes research and professional

recommendations, CBT has risen to prominence in therapeutic services and with health-funding schemes (Australian Government, 2013); thus, outcomes-based research is very important for the status and acceptance of a given form of psychotherapy, particularly to third-party funders. Outcomes research has tended to dominate the CBT literature. This thesis does not focus on the outcome of therapy as such. I have taken a popular and well-researched therapy (in terms of its efficacy) and focused on how it is put into practice in the clinical setting. It is because of this importance to clinical services that CBT is the focus of this thesis.

Another form of outcomes research has concerned itself with factors that are common to the different forms of psychotherapy. This line of enquiry has been generated by the conclusions drawn from a number of meta-analyses that no one particular form of psychotherapy has yet been shown to be superior to another (Lambert, 2013a; Wampold, 2010b). Again, as discussed above, there is debate in this field (Lambert, 2013a). In an attempt to explain why a range of psychotherapies are successful, this form of research investigates various processes occurring within the therapies that may be common to them. An example of one of these common factors in psychotherapy is the quality of the relationship between the therapist and the client, which has been linked to outcome in various forms of therapy, even those forms in which the therapeutic relationship is not considered to be the mediator of change (Horvath, Del Re, Flückiger, & Symonds, 2011). Although research into common factors is generally quantitative in nature, qualitative methods (Chenail & Maione, 1999) have also been used.. Common factors within therapy are not necessarily part of the model of psychotherapy used. This interest in the common factors within psychotherapy has renewed interest in research that explores the processes within psychotherapy (Hubble, et al., 1999; Lepper & Riding, 2006, p.14). Although this thesis does not focus on the common factors of psychotherapy as they are generally understood, it is concerned with the processes within CBT and, in particular, the discourse processes by which the CBT treatment model is put into practice. Like research into common factors, this thesis focuses on processes within therapy that may not be identified as part of the CBT treatment model. The therapists may not be aware that they are using these language strategies even though they may be an important part of how they deliver therapy. It is also

possible that some of the language processes identified would be evident in other forms of psychotherapy, but this is not addressed in this thesis.

According to Lepper and Riding (2006), the evidence for the efficacy of psychotherapy has also increased interest in studying the processes that contribute to the outcome, and this increases the importance of process research. Many varied approaches to studying the process of psychotherapy have been undertaken since the 1930s. Traditionally they have involved quantitative methods, which have been applied to therapist notes from therapy sessions, transcribed recordings of therapy sessions and questionnaires filled in by clients and therapists.

According to Hill and Lambert (2004), the theoretical underpinnings that may inform the process research also vary, employing often competing understandings of how psychotherapy works. Researchers may employ psychoanalytical/psychodynamic, behavioural or humanistic understandings. An example of this is the research instrument called 'the Psychodynamic Intervention Rating Scale' (PIRS) (Cooper & Bond, 1992). This measures psychodynamic interventions in therapy and is dependent upon a psychodynamic understanding of psychotherapy. In a recent study (Banon et al., 2013), the PIRS was applied to sessions of CBT and these results were compared with results obtained from a similar study in which the PIRS was applied to psychodynamic psychotherapy sessions. Not surprisingly, it was concluded that this questionnaire did not adequately describe some of the interventions that occurred in CBT but fully explained the interventions that occurred in the sessions of psychodynamic psychotherapy. This study highlights the problems of using questionnaires derived from one form of therapy to analyse another. Whereas other researchers follow an atheoretical approach in which no particular psychotherapy theory is followed (i.e. they are not beholden to an understanding of psychotherapy based on a particular school of psychotherapy), clearly other theories inform their analysis. Given the complexity of the area, relatively few works have attempted to classify and summarise psychotherapy process research. In the 1970s Kiesler (1973) summarised the various methods used to date, as did Greenberg and Pinsof (1986) in the 1980s. The different methodologies described in these works represent competing theories of how psychotherapy works and are characterised by an array of terminology. Several of the methods outlined relate to ways of classifying

transcripts of therapy for the presence of predetermined processes, or the use of a rating scale to rate certain qualities in the therapy. Some of these qualities may relate to the model of therapy under investigation (e.g. the frequency with which a therapeutic technique is deployed) or some other more generic feature of therapy (e.g. the quality of the relationship between the therapist and patient). A number of other process-research techniques involve giving questionnaires to patients or therapists outside of the therapy to investigate the psychotherapy process indirectly. What these studies have in common is that they are generated by therapists who are usually from the disciplines of psychology and psychiatry and who, until recently, have taken a quantitative research approach. A number of these approaches continue to be refined and practised today, providing ongoing insights into the process of psychotherapy (Ablon & Jones, 1999; Lambert, 2013c; Lepper & Mergenthaler, 2008). Similarly, in the introduction to their overview of CA and psychotherapy, Peräkylä et.al. (2008) concluded that process research provides useful insights into what is occurring during psychotherapy. However, they argue that a weakness of this group of methods is that they are not ‘sensitive to the process through which the patient and the therapist together, and moment by moment create their psychotherapeutic session’ (2008, p.12). They conclude that analytic methods such as CA provide this detail of analysis. In this thesis I have adopted DA rather than traditional process-research methods, as the research question requires a detailed analysis of the language used in the psychotherapy sessions.

Process research into CBT has been largely quantitative in nature and has focused on those processes that may contribute to outcome. As discussed above in reference to common factors in psychotherapy, the correlation between therapeutic alliance (how well the client and therapist relate to one another) and the outcome of therapy has been studied in both CBT and other forms of psychotherapy using questionnaires (Horvath, et al., 2011). In their recent meta-analysis, Horvath et.al. (2011) concluded that a positive therapeutic alliance is correlated with outcome in psychotherapy, including in CBT. They also concluded that this finding is not dependent on the way the therapeutic alliance was measured or whether it is assessed by the client, therapist or an independent observer. However, the significance of this correlation is questionable — does a

positive therapeutic alliance lead to a better outcome or does a better outcome result in a positive therapeutic alliance? (Feeley, DeRubeis, & Gelfand, 1999) Another focus of process research in CBT has been measures of the therapist's adherence to the treatment model and competence in administering it (Webb, Auerbach, & Derubeis, 2012; Webb, DeRubeis, & Barber, 2010). These studies have produced mixed results, indicating that strict adherence to the treatment model and ratings of competence are not consistently correlated with a positive outcome. The use of questionnaires and other quantitative methodologies is not able to address the particular research question of this thesis, which is about how the treatment model of CBT is put into practice in the language used in therapy sessions. This is another reason I make use in this thesis of methodologies beyond the standard quantitative methodologies commonly used in CBT process research; that is, to enable a more detailed analysis of the language used.

According to Lutz and Hill (2009), increasing concerns from within the psychotherapy profession about the limitations of quantitative research methodologies has led to the use of qualitative research methods from other disciplines. Quantitative methods, by definition, are about the measurement of phenomena and this limits the type of research questions that can be asked. To highlight this point Lutz and Hill (2009, p.371) quote Kiesler (1973), who summarised the debate as 'If you can't count it, it doesn't count; if you can count it, that ain't it'; that is, those things which can be measured quantitatively are not that important to therapists in understanding the process of psychotherapy. However, this view is not universal as, for example, Pachankis and Goldfried (2007, p.766) 'caution process researchers not to drift too far from examining objective, quantifiable units'. The research question posed in this thesis, namely, to investigate how the underlying treatment model of CBT is put into practice in the interaction between the therapist and client in the clinical setting through an analysis of the language used, is better addressed using a research method which outlines the detail of the interaction between therapists and clients. This is more easily achieved using a qualitative approach. Thus, this thesis is part of the previously mentioned trend of adopting qualitative research methods to study psychotherapy. I have used a form of DA, a qualitative research methodology

imported from the social sciences, to investigate the processes occurring within sessions of CBT, as the research is difficult to address using qualitative methods.

2.8 The Adoption of Research Methods from other Disciplines into Psychotherapy Research

A feature of more recent process research is the adoption of research methods from other disciplines, such as from the social sciences. This has been a feature of psychotherapy process research for some time. In 1973, for example, Kiesler (p.17) acknowledged the contribution from other fields of research, in particular content analysis. However, the expansion of research into the use of language in everyday settings, along with the development of qualitative research methodologies, has been reflected in psychotherapy process research. McLeod (2001, 2011) summarises a number of the qualitative research methodologies used in psychotherapy research. These include grounded theory, phenomenology, ethnography and approaches that focus on the analysis of discourse, such as CA, DA and narrative approaches. Emerging from outside of psychotherapy research and theory, these methodologies offer a fresh perspective on the psychotherapy process. Having been used predominantly to analyse social phenomena, there is a wealth of data from other social situations, which may be applied to psychotherapy research (Lewis, 1995; McLeod, 2001). Whilst he mostly discusses the use of qualitative research methodologies to examine the processes within psychotherapy sessions, McLeod also discusses the use of qualitative methods to help address questions related to the outcome of therapy (2001). This thesis is part of this tradition of importing qualitative methodologies to better understand processes within psychotherapy.

In their overview of process research, Lepper and Riding (2006), concluded that it is unhelpful to make the distinction between qualitative and quantitative research methodologies in process research. They classify the many approaches to the analysis of psychotherapy transcripts into those that use coding methods and those that use discourse methods. The coding methods described by Lepper and Riding are similar to or are derived from methods described in Kiesler (1973) and Greenberg & Pinsof (1986), whereas the discourse methods, according to Lepper

and Riding (2006), are by and large methods imported into psychotherapy process research, such as CA, DA and grounded theory³. They argue that the rise in prominence of studies attesting to the significance of the therapeutic alliance to the outcome of therapy indicates the need to research the therapeutic interaction between the client and the therapist. They state that:

given the importance of the therapy relationship in the therapeutic outcome, and the established influences on this of client and therapist factors and interactional context itself, there are strong arguments for the focus on the therapeutic discourse. (p.20)

This thesis has as its primary focus the analysis of transcripts of naturally occurring therapy sessions. Using Lepper and Riding's classification (2006), the research makes use of a discourse a method, namely, theme-orientated DA.

By contrast, in their book summarising the conversation analytic research into psychotherapy, Peräkylä et al. (2008) describe CA as a separate tradition that complements psychotherapy process-research. Arguably, whether or not a researcher who is studying psychotherapy considers the discourse traditions such

³ Whilst Lepper and Ridding (2006) categorise research methods such as DA, CA and grounded theory as "discourse methods" it is important to note that they are methods with different theoretical underpinnings. Discourse analysis has its origins in linguistics and the study of text whereas CA has its origins in sociology and the work of Sacks (1995). As Duranti and Goodwin (1992 p.191) put it "Conversation Analysis differs from most other fields that take talk as their primary subject matter in that it uses as its point of departure not linguistics but rather a deep interest in elementary properties of social action." Grounded theory is an approach developed by sociologists Glaser and Strauss (1967) to the generation of theory by the analysis of data i.e. the theory is grounded in the data. Everything relevant to the subject of the study is considered data and subject to a process of coding. Although a popular form of research methodology in health, it is generally not considered a form of DA.

as CA to be part of process research may depend on his or her background. That is, a discourse analyst from the social sciences who is conducting research in this area may not consider him or herself to be part of the process research tradition; however, a psychotherapist wishing to further explore the field of psychotherapy through DA may well consider the research to be part of the broader tradition of process research. In this thesis I take the perspective of a clinician and CBT practitioner who wishes to understand the practice of psychotherapy, in particular CBT, and I have chosen an approach from outside of traditional psychotherapy research methods to achieve this. Hence, I would argue that this thesis contributes to the literature on process research, albeit using a non-traditional, qualitative approach. In this sense I am in accordance with Hill and Lambert (2004) who, in their summary of process research methods, include qualitative approaches (including DA and CA) as part of process research.

Ultimately the choice of methodology in psychotherapy process research reflects the research question or the area of research interest that the researcher wishes to pursue. A given research methodology is often better suited to a particular type of research question. Discourse-analytic and related approaches are underpinned by different philosophical understandings of reality than those used in science and quantitative methodologies; discourse-analytic methods treat reality as being constructed through language, rather than language reflecting reality (McLeod, 2011, p.167). As such, discourse-analytic methodologies are suited to asking questions about how the social world is constructed through the use of language, and how social practices such as psychotherapy or medical interactions are undertaken by the participants. Because the focus of this thesis is on how the CBT treatment model is put into practice in the interaction between the therapist and client in the clinical setting, through an analysis of the language used, this research question lends itself to the use of DA as the method of analysis.

2.9 Discourse Analysis, Conversation Analysis and Psychotherapy Research

To date, the psychotherapy literature summarising the various forms of process research reveals only limited perspectives on DA (Lambert, 2013c). The models

of analysis put forward as in McLeod (2001, 2011, 2013) are centred around DA as generally practised in social psychology and CA, which some authors would not consider a form of DA (Billig, 1999; Schegloff, 1999). Similarly, the main discourse-analytic approaches reviewed by Lepper and Riding (2006) are CA and narrative analysis. These books, written for a psychotherapy research audience, do not convey the diversity of the discourse-analytic and related research methodologies and approaches. Although it is beyond the scope of this thesis to comprehensively review the field of DA, some understanding of the breadth of the field is useful. What follows is a brief overview of DA and a discussion of some of the major research findings from the DA of psychotherapy. Similarly, an overview of CA is presented and the major findings from research using CA to study psychotherapy are discussed. Although the literature reviews contained within the three research papers that comprise this thesis cover some of the same material, the following section expands upon those discussions and places the papers into the context of the previous research in more detail. The following sections also present, in more detail than in the three papers, the argument for using a particular form of DA as the method of analysis for this thesis; that is, for using theme-orientated DA rather than CA or other forms of DA.

2.9.1 Discourse Analysis

Discourse analysis as a research methodology is difficult to define as a number of methodologies have used this term and there is debate about its definition.

(Fairclough, 2003, 2010; Gee, 2011; Gee & Handford, 2012; Jaworski & Coupland, 2006; Johnstone, 2008; Phillips & Jorgensen, 2002; Schiffrin, 1994; Schiffrin, Tannen, & Hamilton, 2001; Wetherell, Taylor, & Yates, 2001; Wodak & Meyer, 2009). However, the various forms of DA examine language in its context and share a social constructivist perspective (Phillips & Hardy, 2002). It is generally considered to be a qualitative research methodology, although quantitative approaches are not excluded (Edwards & Potter, 1992, p. 27).

Discourse analysis draws its ideas from many disciplines including linguistics, sociology, anthropology, philosophy (Jaworski & Coupland, 2006; Roberts & Sarangi, 2005; Schiffrin, 1994; Schiffrin, et al., 2001). It has also been adopted by a variety of other disciplines (Johnstone, 2008), for example, social psychology

(Hepburn & Wiggins, 2007; Potter & Wetherell, 1987), communication and artificial intelligence, with the result that the theory and methods of DA have been extended (Schiffrin, 1994, p.5, 2001). Discourse analysis research is undertaken by or in collaboration with people from a variety of fields including linguistics, social research (sociology, social psychology, etc.), education and health (Gee & Handford, 2012). With this plurality of backgrounds there have arisen a number of different forms of DA, such as systemic functional linguistics (SFL), pragmatics, critical DA, narrative analysis, and other less circumscribed approaches (Gee & Handford, 2012). Because DA enables a microanalysis of texts, including verbal communication and written texts (Gee & Handford, 2012; Phillips & Hardy, 2002; Phillips & Jorgensen, 2002; Schiffrin, 1994; Schiffrin, et al., 2001; Wetherell, et al., 2001), it is beginning to prove to be a useful approach to the analysis of the process of psychotherapy (Avdi & Georgaca, 2007; McLeod, 2013), the focus of this thesis.

Although the focus of this thesis is on the study of psychotherapy, DA has been applied to a wide variety of professional situations, including other healthcare settings. This literature is extensive, however, examples include education (Crichton, 2010; Mercer, 1995), social work (Hall, Sarangi, & Slembrouck, 2009; Hall, Slembrouck, & Sarangi, 2006), the law (Bhatia, Candlin, & Engberg, 2008), and related fields such as commercial arbitration (Bhatia, Candlin, & Gotti, 2012). Many aspects of health care have been investigated using DA including doctor–patient interaction (Ainsworth-Vaughn, 1998; Hamilton, 2004; Mishler, 1984; Nelson & Hamilton, 2007), psychiatric practice (Barrett, 1988; Fine, 2006; Galletly & Crichton, 2011), genetic counselling (Brookes-Howell, 2006; Sarangi & Clarke, 2002a;), nursing (S. Candlin, 2002, 2011) and adverse drug interactions (Hamilton & Bartell, 2011).

McLeod (2001) criticises discourse-analytic research and CA, as it is undertaken mainly by social scientists and other non-clinicians. Although he acknowledges the usefulness of the outsider researcher perspective commenting on psychotherapy, he is concerned that a non-therapist researcher may not address the concerns of therapists. Interestingly, this criticism is absent in the latest edition of the same work (McLeod, 2011), perhaps reflecting an increase in the use of discourse-analytic methods by clinicians in their own research in the

intervening decade between the two editions. McLeod (2001, 2011) highlighted the potential advantages of discourse-analytic research; he believed that it challenged the therapist to look at his or her clinical practice in different and perhaps thought-provoking ways. He also highlighted the potential of bringing in findings from discourse-analytic studies of other social situations and applying them to the therapy setting. In his view, ultimately, discourse-analytic research will be judged by therapists for the pragmatic value of its findings.

The application of findings from discourse-analytic research to psychotherapy and its usefulness to those who are the subjects of the research raises questions about who the consumers of the research are, and these can be the participants themselves, professional bodies and other institutions or academics. The focus of this thesis is the professional concern of how the treatment model of CBT is put into practice in the clinical setting. However, the other participant in psychotherapy is, of course, the client or patient. The rise in the consumer movement has led to consumers of services wishing to become informed about the services they are accessing. Given that discourse-analytic research draws attention to potentially hidden power relationships within therapy, it may highlight ethical issues. An example of this is Ainsworth-Vaughn's (1998) work on the power relationships within doctor–patient encounters, in which she highlights the patient's claims to power within the professional relationship and how medical practitioners address this. Discourse analysis has the ability to bring to the foreground a range of other hidden issues that may be important in the conduct of social activities, including in psychotherapy. An example of this is the use of politeness and face-saving strategies (Brown & Levinson, 1987) which is highlighted in the analysis contained within this thesis. Revealing the historical development of a social practice such as psychotherapy is also an important part of some forms of DA. Although McLeod (2001) welcomes the ability of DA to reveal hidden aspects of psychotherapy such as power relationships he notes that professionals may find this uncomfortable and confronting. Findings such as these may help consumers better understand the practice of psychotherapy they are about to engage in, as well as help psychotherapists review their practice critically.

In a review of discourse-analytic studies of psychotherapy based largely on social psychology approaches to DA, Avdi and Georgaca (2007) divided the literature into essentially two types of studies according to their stance toward psychotherapy. In their view some studies were accepting of the therapeutic principles and some were critical. Clearly this is a continuum on which studies may be placed. Those studies that were thought to be less critical focused on building a bridge ‘between the macro-level of therapeutic description and the micro-level of linguistic phenomena’. The studies contained in that review largely explored family therapy, narrative therapy and psychoanalytical psychotherapy. These are less structured forms of therapy than CBT. A number of what were thought to be less critical studies showed changes in the client’s construction of subjectivity as a process within therapy, whether that be changes in self-reflection on the part of the client, negotiation of self-agency or changes in the attribution of blame. Other studies, which focused on the therapist’s role, were thought to be largely descriptive of the language used and therapy. Finally, Avdi and Georgaca examined a small number of more (in their view) critical studies that focused on the power relationships in therapy and on the role of wider discourses in shaping psychotherapy. Using Avdi’s and Georgaca’s approach to subdividing the literature, this thesis focuses on ‘building connections between macro-level of therapeutic description and micro-level of linguistic phenomena’, that is, it aims to explore how the treatment model is put into practice through the language used. However, it is arguably limiting to divide the literature in the way described. As the authors themselves say, studies can also have elements of both a critical and a descriptive approach.

2.9.2 Discourse-Analytic Research into Psychotherapy

Discourse-analytic research into psychotherapy, like discourse-analytic literature more broadly, incorporates a range of methodologies and approaches. What follows is a discussion of some of the important discourse-analytic studies into psychotherapy, with a focus on the relationship between the language analysis and the underlying treatment model used by the therapists. The studies vary in the extent to which they interact with the therapists’ models and understanding of what they are engaged in. Few if any discourse-analytic studies specifically

investigate CBT and in some studies the type of psychotherapy is not specified. It should be noted that some of the studies are reported in books and it is beyond the scope of this discussion to summarise all of the findings of those studies.

In a seminal study, linguist William Labov and clinician (social worker) David Fanshel (Labov and Fanshel 1977) applied a form of DA which they termed ‘comprehensive discourse analysis’ to 15 minutes of a session of psychodynamic psychotherapy. The patient was a 19-year-old ‘girl’, Rhoda, with a history of anorexia nervosa and she described problematic interactions with her aunt and mother. The therapist was a female social worker who was thought of as highly skilled by her colleagues. Although the section of therapy analysed was brief, the authors note that in the long term, the therapy was judged successful as the patient returned to normal weight, married and had children ‘in a home of her own’ (Labov & Fanshel, 1977, p.347). Labov and Fanshel’s study is very detailed and difficult to do justice to in this review; however, their comprehensive DA makes a distinction between ‘what is said’ and ‘what is done’ in the conversational behaviour of participants (p.71). They refer to these as ‘two planes of conversational behaviour’. The ‘what is said’ plane refers to the text and paralinguistic cues, and implicit in this is reference to other texts and propositions. The ‘what is done’ plane refers to a multilayered complex of speech acts that are connected through a series of ‘sequencing rules’. They identify several speech acts, organised under four headings: meta-linguistic, representations, requests and challenges (p.61). The two planes of speech are connected by discourse rules for interpretation and production (p.71). Labov and Fanshel identified a number of ‘rules of discourse’, which were developed in studies prior to their study of psychotherapy. The text is divided into five ‘thematic episodes’ to which they apply their method of analysis, with the aim of answering the question, ‘What is the therapist trying to do in this conversational encounter? On the other hand, what is the patient doing or not doing that the therapist must be aware of?’ (p.28). In the final two chapters they bring the analysis together as a whole and also comment on application of the method to other instances of conversation.

From the perspective of psychotherapy, Labov and Fanshel’s 1977 study highlights the complex language used by the therapist and patient. They show

how the participants do what they do in therapy, through language. Although not a primary focus of the study, they report on how the therapist is influenced by a model of therapy but they also demonstrate some of the discourse processes that are used to enact this model. For example, the concept of repression of distressing psychological states is an important aspect of this model of therapy and the researchers describe how the patient uses a number of 'mitigating devices' to enact this resistance in her speech. She is able to modify her anger by the use of humour and casual speech.

Unfortunately, this study had a limited impact on psychotherapy until more recently, when qualitative methodologies, including DA, began to be taken up by psychotherapists. The complex nature of the analysis, which uses terms and language unfamiliar to psychotherapists, may have contributed to this. It would appear that Labov and Fanshel's study has had a greater impact on interaction research than on psychotherapy research (Peräkylä, et al., 2008, p. 9).

In a study self-described as complementary to Labov and Fanshel's work, Ferrara (1994) undertook the DA of 48 hours of audio recordings of psychotherapy described by the therapists as eclectic. The therapists were psychologists, trainee psychologists and a social worker. Ferrara describes how psychotherapy discourse differs from regular discourse. Her main findings centre on the role of repetition and retelling in psychotherapy. She also discusses dream-telling. A major theme of her work is that repetition and contiguity are used by the participants for 'strategic social purposes' and that discourse is jointly constructed by the participants as the therapist and client take up aspects of each other's speech. However, the relevant models of psychotherapy are not drawn upon in the analysis.

In a further study inspired by Labov and Fanshel (1977), Lewis (1995), a psychiatrist, undertook a DA of one of his own sessions of supportive psychotherapy, which followed a psychodynamic model. The patient was a 25-year-old single white woman whom he subsequently treated for six months for depression and mixed personality disorder. Supportive psychotherapy makes use of psychoanalytic concepts and techniques, but the focus of treatment is supporting the patient by boosting their defences and taking a more direct

approach, rather than by leading the patient to develop a full insight into the underlying repressed conflicts. It is a less structured and directive form of psychotherapy than CBT. Lewis's analysis follows the work of Debra Tannen (1989) and in particular, her work on conversation styles (Tannen, 1984). His key finding was that the therapist (himself) and the patient used different conversation styles and that he was intuitively adapting his style to meet hers. He noted that he was adjusting his enthusiasm level and making use of pacing, overlap and persistence in his speech. He also found that he made use of personal anecdotes as well as offering sympathetic, rather than problem-solving responses. As well, he used a considerable amount of indirect speech as a politeness strategy to increase rapport, which is a feature of the analysis in this thesis. Although he comments that 'the psychotherapeutic literature has been virtually silent on the translation of therapeutic goals to specific conversation strategies' he makes no strong links between the underlying treatment model of the therapy used and his DA. He does, however, identify language strategies of which he had been unaware prior to the analysis, which he states enhances his therapeutic approach in subsequent sessions.

Wodak (1996) undertook a study in group psychotherapy within a Viennese crisis centre, which is summarised in her book *Disorders of discourse*, although the original research occurred in the 1970s and analysis of this data set had been reported previously (Wodak, 1981, 1986). She studied a less structured form of psychotherapy than CBT, based on psychodynamic approaches. Her research combined a DA of recorded sessions of the group therapy with quantitative methods and an ethnographic approach. She integrated her DA with a psychodynamic understanding of the group process. In the 1996 report she illustrated her method with one particular patient within the group. She applied a classification system related to the narrative structures used by the participants to the issue of 'problem presentation in group therapy' and linked changes in progress with changes in the uses of narrative structure. She was able to show that, as the narrative structures the patient used to describe her problem changed, so did the therapist's understanding of the patient's improvement. From the perspective of the therapist's model, the key issue for the patient was her relationship with the authority figure of her father. Learning to deal with the

power relationship with the therapist finally enabled her to deal with this core issue and hence she improved. Wodak's description provides rich detail of the language as well as the psychodynamic processes, and is supplemented by clarification with the therapist. It also illustrates the issue of outcome versus process research; whilst much focus is given to the process of therapy through the analysis of language, there is at the same time a focus on the outcome of therapy and corresponding language changes. Wodak seeks to integrate the model used by the therapist, psychodynamic theory, with linguistic understanding. However, Wodak's study does not undertake a detailed analysis of the therapist's approach; instead, she focuses on the language of the patients within the group. It must be remembered, though, that in group therapy the therapist's involvement and the therapeutic change is also mediated by other patients. Although she does describe some of the interaction between the patients within the group, her techniques of using narrative classification do not necessarily illuminate the fine detail of this interaction.

Joanna Pawelczyk (2011) outlined her discourse-analytic research into psychotherapy in her book *Talk as therapy: Psychotherapy in a linguistic perspective*. Her data came from 65 hours of an eclectic form of psychotherapy called relationship-focused integrative psychotherapy. Two residential workshops, each with 25 clients, were conducted by one therapist. Individual therapy was given to each client. The clients were themselves therapists or councillors and the workshops were conducted over 10 days. The author was an observer and resided with the participants for the 10 days of the workshop. The therapy sessions each lasted approximately one hour and were witnessed by the rest of the group, including Pawelczyk. Relationship-focused integrative psychotherapy is a somewhat atypical form of psychotherapy, although Pawelczyk observed that the individual sessions within each workshop had parallels with therapy conducted elsewhere. She described her approach as a 'broadly conceived discourse analysis' (p.45) that adopted relevant analytic techniques from various sources, including pragmatics and CA. Although the form of psychotherapy studied is less structured than CBT, Pawelczyk focused on a number of features that the therapist considered to be significant to this model of therapy. In particular, she focused on the language structures underlying the

technique, referred to as ‘the transparency of meaning’, self-disclosure in the psychotherapy, communication of emotion, and strategies used to provide emotional support to the client. Pawelczyk worked with the therapist and incorporated his understanding of what he was doing into her analysis. She indicated that she was aware of the need to be relevant to practitioners of psychotherapy as well as to linguists. There are a number of parallels between Pawelczyk’s study and this thesis. The form of DA is similar, as it draws on a range of analytic tools from other disciplines. There is also a focus on therapeutic techniques and relevance to the professionals being studied.

Systemic functional grammar (SFG) (Halliday & Matthiessen, 2004) has also been applied to the analysis of psychotherapy. Garbutt (1997) undertook a research project in which he explored the ‘forms and functions of reporting’ in a model of psychotherapy, self-oriented psychotherapy. This is a form of psychodynamic psychotherapy based on the work of Heinz Kohut (1971) and has been adapted and extended by Russell Meares in what is now referred to as the ‘conversation model’ (Meares, 2004) for the treatment of clients with borderline personality disorder (Gunderson & Links, 2008). There is growing evidence for the efficacy of this model of therapy, based on cohort control rather than randomised controlled trials (Korner, et al., 2006; Meares, et al., 1999). Garbutt’s study (Garbutt, 1997) is rich in clinical detail and some links are drawn with the underlying model of therapy; however, the primary focus of his research is an investigation of reporting, rather than a clinical focus. Muntigl and Horvath (2005), building upon earlier work (Muntigl, 2004), use system functional linguistics (SFL) methods of analysis to investigate the therapeutic processes within narrative couples therapy. Their aim is to address the limitations of traditional psychotherapy research in answering the question ‘How does psychotherapy facilitate client change?’ (Muntigl & Horvath, 2005, p.213). Their work represents a collaboration between a discourse analyst (Muntigl) and a psychotherapist (Horvath), and they link the linguistic analysis to the underlying narrative processes of change as described in narrative therapy theory. It is this link between the underlying treatment model and discursive processes that this thesis aims to investigate, although this thesis focuses on tasks or techniques

dictated by the treatment model rather than the underlying theories about how change occurs.

The studies described above are drawn largely from the linguistics literature. However, a number of discourse-analytic studies into psychotherapy using a form of DA pioneered by Potter and Wetherell (1987) have been reported in the social psychology literature (Avdi & Georgaca, 2007). For example, Madill and Barkham (1997) performed a DA of ‘one successful case of brief psychodynamic–interpersonal therapy’. The authors found that a resolution of the client’s problems came about when she resolved the issue of placing her mother into care. Their DA highlighted the concept of subject position, which is ‘drawn from perspectives viewing subjectivity and identity as linguistic constructions’ (p. 232). The authors identify the subject positions adopted by the client: ‘the dutiful daughter’ in earlier sessions, and in later sessions ‘the bad mother’ and ‘the damaged child’. The client’s dilemma in part arose from her positioning as the dutiful daughter and the tension between ‘the damaged child’ and ‘the bad mother’. The resolution occurred by working through the implications arising from the client’s her description of the problem and the therapist providing her with a ‘morally defensible account’ of her action of placing her mother in a nursing home. By suggesting it was morally defensible for the client to place her mother in care, the therapist helped resolve issues related to the client’s positioning as a dutiful daughter. The results of this study were thought to be consistent with those of a previous study (Field, Barkham, Shapiro, & Stiles, 1994) using the same transcripts but the data was analysed using a form of process research in which the text was coded using a predetermined system for assessing changes in a client’s cognitive representation of a problematic experience (the assimilation model) (Stiles et al., 1990). The cultural meanings of the client’s problem were also highlighted, the cultural issue being ‘women’s role as carers’, in this case of her elderly mother, and the therapist’s suggestion of the more ‘masculine role’ of individualism to the client.

On one level a therapist may criticise Madill and Barkham’s (1997) work, as the main finding is self-evident and would be similar to what a therapist would conclude about the data without the need to resort to DA. However, what this study illustrates is a methodology that is firmly grounded in the text of the therapy

session and arguably makes no reference to underlying cognitive processes. Madill and Barkham employed a methodology that is independent of those theories of psychotherapeutic change which are based on the underlying models of psychotherapy. The potential advantage of using an outside approach to analysing therapy is that it can confirm findings from research that used methods derived from within psychotherapy (in this case, the assimilation model) (Stiles, et al., 1990). Madill and Barkham's study validates the use of DA to analyse psychotherapy and raises the possibility of applying it to other forms of psychotherapy, where it may provide further insights. However, little reference is made to the model of therapy underlying the interaction and how it may have influenced the therapist's actions. Rather, the authors have focused on uncovering the discursive process displayed in the transcripts, through which change is hypothesised to have occurred. Madill and Barkham's study, whilst focusing on the processes occurring in therapy, is also interested in outcome, and attempts to link the observed process to reasons for the therapy's success. In effect, the DA is done in parallel to another form of analysis that is derived from psychotherapy and, whilst this is useful, it does not address the issue that is the focus of this thesis, namely, how the model of therapy is put into practice in the language use of the therapists.

More recent studies involving the social psychology tradition of DA have incorporated aspects of CA. In an example of clinician-led research, Kurri and Wahlström (2007) undertake a DA of the initial three sessions of psychotherapy. The authors are psychologists/psychotherapists, but they do not indicate the nature of the psychotherapy under investigation. This appears to be a deliberate strategy, as a stated aim of the research was to focus exclusively on what was said, not to invoke theories related to the internal workings of the mind to explain what was happening. Their method of analysis was based upon discursive psychology and CA. Their analysis explored formulation or reformulation (Heritage & Watson, 1979) of agentless talk, i.e. 'displaying oneself as not being the driving force of one's own action' (Kurri and Wahlström 2007, p. 316). They described how the therapist had to juggle the need to protect the client's 'face' (Brown & Levinson, 1987) but still move the therapy forward. They conclude that the therapist achieved this by varying the 'footing' (Goffman, 1979) of their

reformulations. Once again, this lack of focus on the underlying treatment model of therapy is at odds with the approach taken in this thesis. However, face and politeness theory is a theme that is echoed in the analysis presented in this thesis. Formulation or reformulation is an important concept from CA and is discussed further in Section 2.9.4 Conversation-analytic Research into Psychotherapy. It is a concept that has been shown to be important in the analysis of psychotherapy and which is also used in the analysis in this thesis.

Partanen, Wahlström and Holm (2006) used analytic tools derived from DA and CA in a study of group therapy conversations for intimately violent men. The main finding was that the therapist used inconsistencies in the client's talk to challenge the client's use of loss of self-control as an excuse for violence. This is clearly an important therapeutic strategy used by the therapists, although clear links were not made to the model of therapy being used. Suoninen and Wahlström (2010) analyse sessions of Milan-school family therapy conducted in the late 1980s. This approach involves multiple therapists working with a family. The method of analysis draws on 'social psychological discourse analysis, conversation analysis and social constructionism' and they explore the interactional positions within the family therapy conversation. In particular, they explore how the father's construction of his identity changes with the different interactional positions taken by the therapists. The analysis is rich in detail of the interaction between the participants. Although there is some discussion about the model of therapy, once again it is not the focus of analysis.

In another example of clinician-led research, Crowe and Luty (2005), a mental health nurse and a psychiatrist respectively, undertook a DA of 14 one-hour sessions of interpersonal psychotherapy (IPT). An evidence-based psychotherapy, IPT (Weissman, et al., 2000) has been shown to be effective in treating patients with major depression. As a consequence it is recommended in protocols for the treatment of major depression, along with CBT. Crowe and Luty used a form of DA based on Fairclough's (1995) critical DA. Although not a fine-grained form of DA, their analysis provides a rich description of a client's progress through therapy and the changes that occur in the client's description of her relationship with others. Crow and Luty also highlight some of what they identified as techniques used by the therapist, which included exploring communication

patterns, seeking information, exploring beliefs, exploring affective responses and exploring alternative subject positions. There were not, however, strong links drawn between the underlying treatment model of IPT and the results of the DA.

Although a number of the studies discussed above engage with the treatment model of the therapy studied to some degree, the implementation of the model and associated therapeutic techniques was neither the starting point of the analysis nor the main focus of the research, as is the case in this thesis. In addition, those studies used a range of forms of DA methods, but none of them addressed research questions comparable to the one asked in this thesis. I used none of these forms of DA, turning instead to theme-orientated DA, a method that is focused directly on professional concerns.

2.9.3 Conversation Analysis and Psychotherapy

Conversation analysis, a form of verbal language analysis, is based on the work of sociologist Harvey Sacks (1995). It has come to prominence in the analysis of a range of professional settings, including health care, where doctor–patient interaction has received considerable attention from CA researchers (Heritage & Maynard, 2006). It has made and continues to make a significant contribution to the understanding of psychotherapy (Peräkylä, et al., 2008) and, arguably, has become one of the dominant forms of discourse-analytic methodologies used in the study of psychotherapy. A number of these studies are reviewed in the following section. In the DA I undertake in this thesis I draw upon relevant findings from the CA literature. However, I did not make use of CA as the primary method of analysis because of its potential limitations, notwithstanding some CA researchers' attempts to address the perceived limitations of the methodology (Antaki, 2011).

In its purest form, CA does not concern itself with the context of the recorded interactions other than when it is referred to in the text. Pawelczyk (2011, p.25) states that CA in psychotherapy research 'does not draw on the therapist's insights, dictates or recommendations that can be found in psychotherapeutic literature; rather it bases its research on the growing literature on how conversation works.' Traditional CA may address the professional's perspective if

it is expressed in the text, although the researcher may not recognise it in the text. Some CA researchers (e.g. Buttny, 1996), explicitly state that they do not use the perspective of the therapist or, by inference, an understanding of the treatment model used by the therapist. By contrast, this thesis starts from the treatment model espoused by the therapists, making the perspective of the therapy literature and the resultant understanding of the treatment model of CBT a focus of this program of research.

There has been awareness within the CA research community about the limitations of pure CA research and attempts have been made to address them in research conducted into professional discourse. Cicourel (1992) has raised concerns about limiting the analysis to the information that is within the text. He illustrated this by discussing an example of the analysis of medical interactions in ward rounds, and showed how extra ethnographic information altered one's interpretation of the transcript of the ward rounds. More recently, Antaki (2011) criticised what he termed 'canonical' CA and suggested the need for ethnographic background information to supplement the analysis, although he points out that this has long been a feature of some strands of CA research. In an attempt to address this criticism of CA's privileging the text, Peräkylä and Vehvilainen (2003) (prominent CA researchers in the field of psychotherapy) have suggested that conversation analysts should interact with what they call the "stocks of interactional knowledge" of the professions under study. That is, professionals such as doctors and psychotherapists already have an understanding of what they are doing in each session and the conversation analysts should interact in some way with this understanding. Peräkylä and Vehvilainen classify the literature of research into social interaction on the basis of three possible positions it adopts on the 'stocks of interactional knowledge' (SIK). They classify research as follows:

1. using the SIK as its point of departure, typically 'insider research'. Much of the CBT research into the process of psychotherapy falls into this category
2. focusing on the structures and practices of interaction, making little reference to the practitioners' SIK. This type of research uses models of interaction from areas such as linguistics to study psychotherapy but does not engage with or utilise the therapist's own models of understanding.

3. Peräkylä and Vehvilainen (2003) propose a third type of approach, in the interaction research ‘seeks a dialogue with SIKs’ (p. 730) by one of the following types of interaction:
 - i. CA falsifies and corrects assumptions that are part of the SIK.
 - ii. CA provides a more detailed picture of practices that are described in a SIK.
 - iii. CA adds a new dimension to the understanding of practices described by a SIK.
 - iv. CA expands the description of practices provided by a SIK and suggests some of the missing links between the SIK and the interactional practices.

Although Peräkylä and Vehvilainen (2003) focus on CA, this model could be applied to DA. It could be argued that the research focus of this thesis is the fourth category of the third research type in the list above, with the SIK being the treatment model of CBT. However, when defining SIK, the authors appear to be referring to such things as communications skills used by professionals to guide how they conduct their interactions with clients or patients. The treatment model of CBT is not easily conceptualised as a ‘SIK’, making it difficult to use this approach to CA for this thesis. The model of DA used in this thesis, theme-orientated DA, enables the professional concern, in this case the CBT treatment model, to be tracked throughout the text and connected with the interactional practices. Because this thesis focuses on how the treatment model of CBT is put into practice in the clinical setting, it is necessary to have an understanding of the treatment models of CBT before beginning the analysis of data, and to use this understanding to guide the analysis. Arguably, it might have been possible to use CA in this thesis; however, even with the greater engagement with the therapist’s perspective provided in the models above, CA still gives primacy to the text, excluding other information from consideration. This makes the CA method less suited to the particular research question at the heart of this thesis.

2.9.4 Conversation Analytic Research into Psychotherapy

There are a number of key CA studies of psychotherapy. Of particular interest is the relationship of the analysis to the underlying treatment model of the therapy being studied.

One of the characteristics of the CA literature is a limited focus on the underlying model of therapy. There are, however, exceptions to this. An example of where research engages with the model of therapy under study is the work of Gale (1991; Gale & Newfield, 1992). McLeod (2001, 2011), a psychotherapy and counselling researcher, identified this study as one of the more accessible CA studies of psychotherapy for practising psychotherapists. Gale's study was initially published as a book, *Conversation analysis of therapeutic discourse: The pursuit of a therapeutic agenda* (1991) and its salient findings were subsequently published in a journal (Gale & Newfield, 1992). Gale presents the results from a CA of one 45-minute session of solution-orientated therapy conducted by a recognised exponent of this therapy, William O'Hanlon. The clients in this session were a married couple undergoing therapy for relationship problems. Solution-orientated therapy derives from the tradition of family therapy and is based on the view that language is an interactive and constructive process (Gale, 1991). This was thought by Gale to be more consistent with the method of analysis used by him in this study than cognitive approaches. Gale's study yielded nine categories of therapist procedures or classes of rhetorical devices, in which the therapist:

1. Pursues the response over many turns
2. Clarifies unclear references
3. Modifies his assertion until he receives the response he is seeking
4. Poses questions or possible problems and answers these questions
5. Ignores the recipient's misunderstanding or rejection and continues as if his assertions were accepted
6. Overlaps his talk with the husband's or wife's talk in order to get a turn
7. (Re)formulates
8. Offers a candidate answer

9. Uses humour to change a topic from a problematic one to a solution theme.

Of these, Gale described the last five as having been largely previously described by the solution-orientated therapy therapists themselves in their own literature (Gale, 1991), albeit with some differences. Apart from confirming that these theorised processes do occur in actual therapy, Gale elaborates on the conversational behaviour of these processes through a more detailed description of the language used in therapy. Gale's study more explicitly addresses the underlying model of therapy whilst also highlighting 'therapist procedures' that were thought not to be part of the model of psychotherapy under investigation. In another example Peräkylä (1995), in a study of AIDS counselling, undertook the CA of video recordings of 32 sessions of family systems therapy with clients living with HIV/AIDS. The study and its findings are too broad to summarise here; however, the author attempts to engage with the underlying model of therapy by exploring the therapeutic technique of 'live open supervision' and investigating how it is deployed in practice. He also described how live open supervision had functions in the interaction that were not described in the therapy literature. What these two studies show is that CA can engage with the underlying psychotherapeutic treatment model to explain some of the phenomena seen in the data; however, they do not start from the point of view of understanding how the treatment model is put into practice, which is the focus of this thesis.

Peräkylä (2004a, 2005), a professor of sociology and a trained psychoanalyst, and his colleague Vehvilainen (2003) have written about the psychoanalytic technique 'interpretation' from the point of view of CA. These are an important series of papers as their CA is focused on a psychotherapeutic technique. Vehvilainen (2003) shows how the therapist and client co-construct the series of turns, which lead to an interpretation in a process she refers to as the 'interactive trajectory'. Peräkylä (2004a) describes the process of arriving at an interpretation in psychoanalysis, whereby the analyst draws connections between the domains of

childhood, current everyday life and the analyst–analysand⁴ relationship. A successful interpretation is achieved when the client is persuaded of the validity of the therapist’s interpretation. According to Peräkylä, the delivery of a successful interpretation by the therapist is facilitated by two processors:

- lexical choice, in which the therapist selects appropriate words that connect the three different domains
- topic-sequencing, in which the therapist ‘builds a case’ for the interpretation over a number of turns.

In a subsequent study Peräkylä (2005) explores the client’s various responses to interpretations. He divides them into three types and discusses their significance to psychodynamic theory. The significance of these papers is that, like this thesis, the focus is on a therapeutic technique, in this case interpretation. Relevant sections of the transcript are selected for further analysis based on the presence or absence of discourse related to interpretation. In this way, clear links are drawn between the CA and the therapeutic technique. Peräkylä’s training as an analyst has enabled him to combine the perspective and knowledge of a professional therapist with those of a conversation analyst.

Examples of CA’s contribution to the understanding of psychotherapy where the therapists’ perspective is largely not addressed include Richard Buttny (1996) in his paper ‘Client’s and therapist’s joint construction of the client’s problem’. He examined two sessions of psychotherapy undertaken by a psychiatrist who had trained in family therapy and identified his perspective as a ‘combination of the interactional and constructivist views’ (p. 128). The paper focused on ‘reframing’, a psychotherapeutic technique whereby the therapist produces an alternative understanding of the client’s problem to help the client resolve his psychological issue. Buttny identified that the therapist employed formulation, amongst other conversational strategies; however, he explicitly stated that the therapist’s perspective was not used in his study but that he focused on the interaction

⁴ ‘Analysand’ is a term used in psychoanalysis and is equivalent to the term ‘client’.

between the client and the therapist. Reframing is a technique specific to certain forms of psychotherapy. On one level, Buttny has engaged with the therapist's understanding of what he is doing (i.e. reframing), and investigates in interactional terms how this reframing is occurring; however, this is the extent of his engagement with the therapist's understanding of what he does. Buttny concluded that reframing is a consequence of various forms of conversational control by the therapist, along with other attempts to engage the client in considering and addressing the reformulation given.

In a study of group CBT with sex offenders, MacMartin & Le Baron (2006) examined both the verbal and visible behaviour of the therapists and the clients in videotapes of therapy sessions. They investigated the concepts of 'multiple involvements', referring to Goffman's (1963) concept of involvement in social activity as a 'concerted behavioural achievement – not merely a psychological state' (as cited in MacMartin & Le Baron, 2006, p. 43). They define multiple involvements as 'people participating in more than one activity while engaging in interaction with others' (p. 42). The authors concluded that 'a therapist's suspension and resumption of paperwork is an interactional resource when she corrects an offender's resistance to feedback' (p. 41). However, the perspective of the therapist and the link to how she understands and enacts the particular model of therapy are again unavailable.

One of the more significant findings from the CA studies of psychotherapy is the role of formulation in psychotherapy. A number of previous CA studies of psychotherapy have focused on the role of formulation (Heritage and Watson, 1979) and what Hak and de Boar (1996) refer to as the formulation-decision device in the co-construction of a client's problems. It is important to distinguish between the concept of formulation as used in discourse research and formulation as used in psychotherapy. The latter concept a commonly used technical term used in various forms of psychotherapy to express a statement that summarises the client's problem in terms consistent with the therapy model used and is not related as such to the CA concept. Garfinkel and Sacks (1970, p.350) identified formulation:

as an occasion to describe that conversation, or explain it, or characterise it, or explicate, or translate, or summarise, or furnish the gist of it, [...]. A member may use some part of the conversation as an occasion to formulate the conversation.

This observation was further refined by Heritage and Watson (1979), who make a distinction between 'gist' formulation and 'upshot' formulations. The former concept is exemplified by the interviewer or therapist showing his or her understanding of what the client says by summarising it for the client. The latter concept is exemplified by drawing out the implications of what the client has said. Kathy Davis (1986) reported her observation of an initial therapy interview conducted by a clinical psychologist. She found that the process of converting a client's everyday troubles into something amenable to therapy occurred using formulations; the therapist selected an issue from the client's conversation and constructed it as the problem to be worked on. She also showed how the client resisted this, but she did not link this back to the therapist's understanding of what he was doing. Antaki et al. (2005), in a study of CBT and humanist therapy, described how the therapist uses formulations to direct the client towards the therapist's requirements in respect to 'therapeutic interpretation'. However, what these studies do not do is foreground the role of the particular model of therapy and how it informs the therapist's expertise in shaping the production and interpretation of language in therapy sessions.

Hak and de Boer (1996) compared recorded interactions from medical, psychiatric and psychotherapy interviews focusing on the different use of formulation in each setting. Hak and Boer referred to these three interview types as interrogatory, exploratory and collaborative, respectively. From their analysis of the data they concluded that medical (interrogatory) interviews were characterised by a relative absence of formulation or, if formulation was used, it had a limited role in clarification of a preceding utterance. (More recently, this finding of the relative absence of formulation in medical interviews has been questioned (Gafarange & Britten, 2004).) The authors concluded from their analysis of an initial psychotherapy (collaborative) interview that the main process whereby a therapist translated a 'patient's troubles into a professional

problem definition' was formulation. This way of using formulation was absent from the medical and psychiatric interviews.

Conversation analysis has provided useful insights into psychotherapy, although, as expressed in the professional literature, there are concerns about the limitations of CA research in incorporating the perspective of the psychotherapists. Although there is a growing movement within CA research to incorporate the perspectives of the professionals (such as psychotherapists) whose work is being investigated, traditionally it is not a central feature of the method (Antaki, 2011), and I have not used CA in this thesis. Because this thesis aims to address an issue of clinical interest, namely, how the treatment model of CBT is put into practice in the clinical setting, I have selected a model of DA that has the core aim of linking professional concerns with the analysis. I have, however, made use of some of the findings from CA studies in my analysis.

2.10 Theme-orientated Discourse Analysis

The method of analysis that I employ in the three papers that make up this thesis is theme-oriented DA. It was developed to link the DA to professional concerns and was developed primarily for the study of health interactions. To my knowledge, until the first paper presented in this thesis was published, this method had not been used to analyse psychotherapy, although it had been used in the related field of genetic counselling (Brookes-Howell, 2006; Sarangi & Clarke, 2002a, 2002b). Other examples of the application of theme-orientated DA include school nurses, health-related counselling about the weight issues of obese or overweight pupils (Magnusson, Hulthén, & Kjellgren, 2009) and a psychiatric interview with a person suffering from schizophrenia (Galletly & Crichton, 2011). The processes of theme-oriented DA are outlined in more detail in the method section of this thesis. In essence, this approach involves selecting focal themes in the text which are of professional concern and apply various analytic themes mainly drawn from linguistics and sociology including CA.

2.10.1 Crucial Sites

In addressing the aim of the thesis I was faced with the challenge of identifying which aspects of the data to analyse, as recordings of psychotherapy sessions generate large amounts of data. The approach taken was to employ Candlin's concept of crucial sites and critical moments. Candlin (2000) argues that within interaction there are crucial sites made up of critical moments where discursive skills are at a premium. He defines crucial sites as:

those contexts of communication, in part defined physically, in part by topic, in part by participation, in part by perception, which participants in healthcare, as users and providers, identify as especially salient.

What crucial sites have in common is a concentration of risks for the participants. The critical moments in the interaction are those sections of the interaction where the 'communicative competence of the participants is at a premium' (Candlin, 2000 p. 10). The three papers in this thesis reflect three crucial sites within CBT, in that they each represent important components of the therapy. The selection of the crucial sites within the text of the papers is justified with reference to the CBT literature. Within these crucial sites we have selected critical moments from the text for further analysis. The use of crucial sites reflects the aim of the thesis, which is to investigate how the underlying treatment model for CBT is put into practice in the interaction between the therapist and client in the clinical setting through an analysis of the language used. Using specific aspects of the CBT model as crucial sites in the text and then selecting critical moments within these crucial sites for further analysis enables a large amount of data to be managed.

The first paper investigates the crucial site, 'the problem statement', which is the conversion of the client's problem into one more amenable to therapy. Clearly this is very important to the therapy, as the problem statement forms a major part of the shaping of the subsequent therapy. The second paper investigates another crucial site, homework tasks, which are a fundamental strategy in CBT. The third paper investigates the termination of the therapy, also a crucial site and an important part of the model of CBT. Although it is not exclusive to CBT, termination of therapy is explicitly addressed in aspects of the CBT model. It is

important to note that this thesis presents initial findings from an ongoing program of research in which other aspects of the CBT model will be investigated. There are many other potential aspects of the CBT model studied which could be conceived of as crucial sights, such as challenging one's cognitions or exposure tasks. These are addressed in the papers in passing, but further research is required to explore these issues in detail.

As a professional undertaking discourse-analytic research rather than a discourse-analytic researcher investigating professional practice, I faced a different set of issues from that of the 'analyst's paradox' described by Sarangi (2002, 2007). The analyst's paradox is the challenge discourse analysts face in incorporating their views with those of the participants. He argues for an alignment of perspectives rather than exclusively privileging the participant's or analyst's perspective (Sarangi, 2002). Whilst Sarangi discusses participants becoming discourse analysts in their own right through the process of alignment, he does not directly address the issues for professionals who are undertaking a DA within their area of professional practice and expertise without being the subject of the research. Having a professional understanding of CBT assisted in identifying crucial sites and critical moments in the CBT sessions; however, selecting the appropriate analytic themes required me to become familiar with a literature outside of my professional area of practice. One might paraphrase Sarangi and call this the 'professional's paradox', although choosing what focal and analytic themes to bring together in a way which accords with one's own professional knowledge might be better characterised as a dilemma.

2.11 Expertise and Interactional Competence

The three research papers that comprise this thesis investigate what is arguably an important aspect of the expertise of the therapist, namely, discursive competence. As Sarangi and Candlin (2011) stated when referring to professional discourse and interactions, 'such interactions and their management go to the heart of what the respective professions regard as "being a lawyer", or "being a doctor" ' (p. 38). The roles of doctor, lawyer, nurse, psychotherapist and psychologist are enacted through the use of language. These professions all recognise the

importance of communication skills in their practice. Thus, this research into how the therapists put the CBT therapy model into practice is in effect a study of their expertise as therapists. Within the field of psychotherapy the ability to communicate with clients and develop a good rapport is seen to be an essential part of therapy (Orlinsky, et al., 2004). Although CBT places considerable emphasis on therapeutic technique, communications skills are also considered to be fundamental. Beck et al. (1979), in their landmark book *Cognitive therapy of depression*, included a checklist to assess the competency of cognitive therapists. Whereas a number of key items on the checklist refer to the application of the techniques dictated by the CBT model, there are also items to assess such factors as 'genuineness', 'warmth', 'accurate empathy', 'professional manner' and 'rapport'. Professional manner is assessed by rating the therapist's tone of voice and control of the session. Similarly, rapport is assessed by determining whether or not, amongst other things, the 'flow of verbal interchanges was smooth'. More recent textbooks instructing therapists in CBT (Ledley, Marx, & Heimberg, 2010; Wright, et al., 2006) refer to developing a good rapport through good communication skills with clients as an essential part of therapy. This thesis does not focus on these aspects of communication, which are from the field of psychotherapy itself. Instead, it focuses on a more detailed analysis of discursive strategies underlying the deployment of therapeutic techniques by the therapist.

There is a growing literature concerning the definition of expertise and the discursive processes underlying or defining this expertise (S. Candlin, 2002; Candlin & Candlin, 2002; Nguyen, 2006). It is beyond the scope of this discussion to cover this area in detail. However, similar to this thesis, some previous studies have focused on experts in their field, investigating what discursive strategies they have used to carry out their professional role. For example, discursive skill and professional expertise has been explored in the nursing profession (S. Candlin, 2002). It was shown that the experienced nurse employed a number of discursive strategies that expand the professional encounter to take on some aspects of a social encounter, whereas the inexperienced nurse was more restrained. Similarly, Nguyen (2006) showed how, as a pharmacy intern gained more experience, he was able to use more interactional strategies to link his technical knowledge to the lay understandings

and experience of the patient. Unlike these studies, this thesis does not aim to investigate the difference between novice and expert discourse. However, in common with these studies, the assumption is made that an experienced professional employed by an institution is by definition considered to be an expert in his or her field.

Other authors (Peräkylä, 2002; Sarangi & Clarke, 2002b) have focused on the related issue of how doctors and patients construct expertise; that is, how the issue of the doctor as an expert professional is dealt with in the interaction between the patient and the doctor. Peräkylä (2002) investigated how patients related to the expertise of the doctor when the patient was given a diagnosis by the doctor, and the effect on the patient's agency. Sarangi and Clarke (2002b) described how, in a genetic counselling session undertaken by a medical specialist in genetics, the specialist defined what was and was not his or her area of expertise. Unlike these studies, this thesis does not primarily focus on how the therapist defines or constructs himself or herself as an expert in the therapy sessions. Instead the focus is on how expertly delivered CBT is constructed in the process of the therapy sessions. That is, by taking the treatment model as the starting point, this thesis focuses on how the therapists, who are experts in their field, put into practice the CBT treatment model and in so doing highlights an aspect of their expertise, that is, their discursive competence.

2.12 Practical Relevance

Within the discourse-analytic literature there are concerns about making the findings of research practically relevant to the professions under study (Roberts & Sarangi, 1999a, 1999b). This goes beyond incorporating the professional perspective in the analysis and involves answering professional questions with the view to enhancing professional practice. To that end, there is a growing literature on the practical relevance and application of the findings of discourse-analytic and similar studies of interaction to professional practice (Carroll, Iedema & Kerridge, 2008; Hamilton, Gordon, Nelson, & Kerbleski, 2006; Iedema, et al., 2009; Iedema, Long, Forsyth, & Lee, 2006; Jones & Sin, 2004; Nelson & Hamilton, 2007; Roberts, et al., 2000; Roberts & Sarangi, 1999a, 2003; Sin,

Jones, & Petocz, 2007; Shaw & Bailey, 2009). The motivation for selecting the research question that is at the core of this thesis was to better understand how CBT is put into practice in the clinical setting by highlighting the discursive expertise of therapists undertaking this task. It is through the fine-grained analysis offered by DA that I am able to explore this level of linguistic expertise. Once this expertise is better understood and characterised through further research, the aim is to potentially use these findings to contribute to the education of trainee therapists. I have not explored the potential educational or other applications of my findings in this thesis. However, there are examples of discourse-analytic findings being taken up by the professions under study and being incorporated into professional practice. Roberts et al. (2000) undertook a consultancy with the Royal College of General Practitioners (RCGP) to investigate why doctors with an overseas background had a lower pass rate in the oral exams (viva). They undertook a DA of video-recorded exams. They were able to highlight a number of problems related to the use of language that impaired the performance of the exam candidates. One example of such a problem was language misunderstandings. These were ultimately corrected but because the exam was time-limited, candidates lost valuable time. These findings were then used to educate examiners about language concerns (Roberts & Sarangi, 2003). Through the use of 'video reflexive-ethnography', healthcare interactions in various hospital settings such as an emergency department and intensive care units were video recorded, analysed and shown to participants in reflexive sessions to encourage them to become aware of previously hidden issues (Carroll, et al., 2008; Iedema, et al., 2009). This led to changes in clinical practice (Iedema, et al., 2009). Nelson and Hamilton (2007) investigated the communication between physicians and patients with chronic obstructive pulmonary disease and made recommendations about how communication might be improved. Hamilton et al. (2006) undertook similar work, studying the interaction between patients with hepatitis C and their healthcare providers, leading to suggestions about how to improve communication between the participants. Similarly, in the area of accounting, findings of linguistic research have been used to develop communication training for accountancy students in universities (Jones & Sin, 2003; 2004), with outcome data attesting to the efficacy of these programs

(Sin, et al., 2007). In the conclusion (Chapter 7), I discuss how the findings of this thesis may be practically relevant.

Chapter 3 Method

This chapter outlines the research methodology used in this thesis in greater detail than that which is contained within the three papers. The three papers for this thesis were drawn from a larger research program and this method section discusses both the overall project and the three papers. In Section 3.1 I provide an overview of the theme-orientated discourse analysis (DA) approach and in Section 3.2 I describe the application of theme-orientated DA in this thesis. This includes an overview of the treatment model of CBT studied as well as the selections of focal and analytic themes. I also discuss the use of a ‘typical case’ design and issues of generalisability of the results. Although the recording method, transcription and ethical considerations are briefly described in the three papers, they are expanded upon in Section 3.3.

The three papers presented in this thesis form part of an ongoing research project which has to date collected the corpus of data explored in this chapter. As part of this agenda, further analysis of the collected data will be undertaken.

3.1 Theme-oriented Discourse Analysis — An overview

As outlined in Chapter 2, the method of analysis used in this thesis is based on theme-orientated DA (Roberts & Sarangi, 2005; Sarangi, 2010). The reasons for selecting this form of DA are outlined in Chapter 2 and I shall not revisit them in detail here. Theme-orientated DA is a form of DA initially developed to investigate how language is used to construct health-related professional practice. It is important to note that theme-orientated DA is not a rigidly prescriptive methodology but is designed to be a flexible approach to analysis and can be used to analyse both written and verbal texts. In this thesis the focus is on naturally occurring verbal interactions between therapists and clients.

In theme-oriented DA, the researcher first obtains an overview of the institution or setting in which the research is to occur. This may take the form of an ethnographic study. This information is then used to identify appropriate interactions or other sources of data to analyse. In the case of this thesis I selected therapy sessions between the client and therapist to record and analyse. Roberts

and Sarangi (2005) divide the process of analysis that follows into four stages. In the first stage the researcher repeatedly listens to or views (as in this thesis) the recordings. This has the effect of immersing the researcher in the data and enables the researcher to divide the data into phases. These phases reflect the content of the speech or other linguistic characteristics and aids in focusing and selecting transcripts for further, more detailed analysis. In the second stage the recordings are transcribed for analysis, the method of transcription depending on the detail of analysis to be undertaken. In the third stage the researcher reads the text as a whole, where possible gaining input from the participants. In the fourth and final stage the researcher repeatedly re-reads the text, informed by sociolinguistic, sociological and other related concepts and literature.

In the analysis, relevant sections of the text are selected on the basis of ‘focal themes’. Focal themes reflect professional interest or concerns and are used to select relevant areas of the text for detailed analysis. Focal themes might include broader issues such as ‘normality’ or ‘responsibility’ or can be more focused on professional techniques such as ‘delivery of a diagnosis’, or patient behaviour such as ‘symptom presentation’ (Sarangi, 2010). Analytic themes, drawn from a variety of sources including linguistics, sociology, anthropology, conversation analysis (CA) and related disciplines, are utilised to analyse these focal themes. A number of suggestions for potential analytic themes are made by Roberts and Sarangi (2005) and Sarangi (2010) and include interactive frames and footing (Goffman, 1974, 1979), contextualising cues and inferences (Gumperz, 1982) and politeness and face-work (Brown & Levinson, 1987). Sarangi (2010) lists other devices such as contrast, constructed dialogue, repetition, lists, metaphor, analogy, extreme case formulation, character and event work. These lists were not intended to be exhaustive and are meant as guides. This form of DA enables professional concerns to be the focus of the research through the use of focal themes and it enables links to be drawn between areas of professional interest and the linguistic analysis. The focus of this thesis is primarily clinical, in that it is to investigate how the underlying treatment model of CBT is put into practice in the interaction between the therapist and client, in the clinical setting, through an analysis of the language used. As a clinician my aim was to use DA to address

clinical concerns. Theme-orientated DA was chosen because it places these concerns at the forefront of the research.

Theme-orientated DA, as used in this thesis, takes a pragmatic approach to identifying and linking language strategies to professional practice through the use of focal themes. In contrast to more traditional text focused forms of DA, it focuses on what people do with language to enact their professional practice i.e. discourse as a form of expertise. More traditional approaches to DA have focused on the analysis of text without linking this in any principled way to professional practice. This thesis does not focus on the analytical themes and how they are constructed per se but on how the analytic themes are able to explain how the therapeutic model of CBT is put into practice. The focus is not, for example, on the role of politeness (an analytic theme) in CBT and how politeness is linguistically achieved but rather on how tasks from the underlying model of CBT (focal theme) are achieved and, if relevant, how politeness strategies underpin these professional tasks. Sarangi's own view has orientated towards what might be viewed as pragmatics in a linguistic sense; theme-orientated DA itself takes a pragmatic approach in a lay sense to its data and analysis and more broadly this resonates with the philosophical tradition of pragmatism (Bacon, 2012).

3.2 The Application of Theme-orientated Discourse Analysis in this Thesis

3.2.1 Context, Including the Treatment Model of CBT

An important initial step in theme-oriented DA is gaining an understanding of the context of the healthcare setting that is the subject of research. This may take the form of a formal ethnographic study, which is used to guide the selection of interactions and other texts to be analysed further. As Sarangi (2010, p.413) states when discussing the use of DA in analysing professional practice in health care settings, 'discourse analysts must acquire adequate knowledge and experience via "thick participation" in the specific site being investigated as a condition of practising discourse analysis'. In outlining the method, Roberts and Sarangi (2005) wrote from the position of the discourse-analytic researcher investigating a

healthcare setting about which the researcher may have little knowledge. However, in this thesis I am a health care professional who has imported a discourse-analytic approach to research clinical practice in a service in which I have worked and which uses a model of CBT in which I received training. For a number of years prior to the period of this study, I worked in the service that is the subject of this research. Prior to and during the period of the study I delivered a regular workshop as part of the master's course that is used to educate the therapists. In my present employment I continue to train junior psychiatric registrars in the model of CBT that is studied in this thesis through direct supervision of their clinical work and I also attend conferences and in-service training related to CBT. It is in these ways that, as the investigator in the project being reported, I developed an understanding both of the service that is the subject of this study, and of CBT more broadly. As defined by Candlin and Crichton (2011), my position as researcher is 'within' the profession; I can be seen as belonging to the group of discourse researchers which is 'regarded as both professionally engaged as researchers in DA and those researchers and/or practitioners in the particular professions and organisations within which they conduct their discourse based research' (Candlin & Crichton, 2011, p.2).

The treatment model used by the service that is the subject of this study is contained within the various textbooks written by Isaac Marks. He developed the form of behavioural therapy that forms the basis of the CBT model used in the service (Marks 1981, 1986, 1987, 2001; Marks, et al., 1977). This information was supplemented with literature produced by the service for its training courses. It is important to note that the treatment model of CBT studied in this thesis is not codified to the level seen in a randomised, controlled trial of CBT. Although there are broad protocols or guides for treating various conditions, therapists have the freedom to adapt these protocols as they see fit. It is exactly this expertise in applying and adapting the treatment model to fit with a given client that is the focus of this thesis. Thus, whilst a formal ethnographic study of the service was not undertaken, I believe I had adequate knowledge of the service through 'thick participation' (Sarangi, 2010) in the research site and CBT more generally.

Although the relevant aspects of the treatment model of CBT are discussed in the papers (Chapters 4, 5 and 6), an overview is included here to aid in the

understanding of the CBT treatment model as a whole. Appendix 1 contains copies of course materials used to train mental health professionals in the model of CBT used by the service, with reference to treating a client with an anxiety disorder. This largely outlines the behavioural model of CBT used by the service and which still forms the basis of its clinical practice, although cognitive and mindfulness strategies now also form part of routine clinical practice. The first page of Appendix 1 provides a brief list of tasks to be undertaken in each session of treatment and is a guide for therapists. This document presents information in a list format that requires elaboration. In the first session the therapist takes a history of the presenting problem and develops an understanding of the problem in CBT terms. This is achieved by performing a ‘behavioural analysis’ of the problem, in which the therapist obtains details about physical symptoms (autonomic symptoms such as fast heart rate and sweating), behaviour, the thoughts associated with the problem (cognitions), and the impact or disability the problem causes. The long-term pattern of the problem is also obtained from the client, including its duration, severity and fluctuations over time. It is during this phase that the therapist gains an understanding of whether or not the client is suitable for treatment using the CBT model offered by the service. The therapist takes a brief history of past treatments and issues, such as whether or not the client has a drug or alcohol problem or other major psychiatric problem such as a mood disorder. The treatment model is then explained, along with what is expected of the client during treatment. The client is then offered educational materials. The example given here in this pro forma is *Living with fear: Understanding and coping with anxiety* (Marks, 2001), a book for clients about anxiety disorders and how to treat them using CBT. If needed, there is also a discussion about using other family members to help with therapy (as co-therapists). Appropriate psychiatric questionnaires are given to the client to fill out before the next session.

Following the description of the first interview is the description of a second interview (or session). In this session the therapist takes a full psychiatric history, exploring the person’s background, development or upbringing and life experience, in order to develop an understanding of where the client’s problem fits with their life situation, referred to as a formulation in this setting. This is

done to uncover any potential problems with the client undertaking CBT, such as major relationship problems, or financial or work-related problems. The other major task of this session is to develop the problem statement and long-term goals of the therapy, which are broken down into weekly targets (see Appendix 2, which is discussed below). During the second session the therapist addresses the issue of homework tasks along with the need to record homework, and the frequency of homework that will be required. This document refers to the homework task as ‘exposure’, a task of desensitising oneself to triggers for anxiety. The third interview or session and subsequent session is then outlined. At the beginning of this session, the therapist reviews the client’s homework from the previous session and looks for problems with the homework, including such things as avoidances. This document is focused on one form of a task to treat anxiety symptoms, exposure. One of the problems with this type of task is that the client may seek reassurances from other people, which interferes with the exposure tasks; for example a client has significant anxiety problems and continually visits their general practitioner for reassurance that they do not have a major medical illness such as cardiac disease. This can prevent them from overcoming the anxiety problem and it is an essential part of their treatment that this reassurance-seeking is curtailed. At this point there is a discussion about the possibility of relapse (e.g. worsening anxiety symptoms), as the client begins to work on the problem, and this needs to be addressed by the therapist. This document also includes a reminder that significant input is needed from the therapist and that the therapist needs to have good interpersonal skills to support and encourage a client to continue treatment. Finally, ‘relapse prevention’ is mentioned in the second session, although this plays a greater role later in therapy.

Appendix 2 contains a detailed outline of ‘The Initial Assessment’ which discusses the first session in greater detail. Once again, it takes a largely behavioural approach to anxiety disorders. It illustrates the highly structured nature of CBT as practised in the service under study. Appendix 3 contains two documents. The first, ‘Case Specific Measures’, outlines such things as the problem statement, targets (all goals), and descriptions of how to evaluate therapy using case-specific measures and psychiatric questionnaires. The second

document, 'Problems and Targets', is the form used by therapists to rate the problem statement and targets in an ongoing way. Appendix 4 is a copy of the form used by clients to record and challenge their cognitions.

3.2.2 Generalisability and a 'Typical Case' Design

Theme-orientated DA is qualitative in nature and leads to a detailed description of the text under study, in this case, the transcript of therapeutic sessions. This thesis employs single case studies presented in three separate papers and follows a 'typical case' design (McLeod, 2010, p.36). There is a long tradition of single case studies in psychotherapy (Kazdin, 2010), beginning with the pioneering work of Freud (Breuer & Freud, 1955) and Watson (Watson & Rayner, 1920). McLeod (2011) expresses the view that detailed case studies offer clinically rich descriptions of psychotherapy and are a counter to large randomised controlled trials. The results obtained from theme-orientated DA are not statistically significant and caution must be taken in drawing general conclusions from this and other DA studies (McLeod, 2010). However, in focusing on a small number of clients and therapists this thesis aims to give a detailed description of the interaction between the therapist and client. The clients and therapists are typical of the service and in that sense represent typical cases (McLeod, 2010). The transcripts from which the analysis is drawn are provided in the papers (Chapters 4, 5 and 6), allowing the readers to review the findings for themselves. The detailed description of the therapeutic interaction contained within the papers enables the reader to decide whether or not the findings apply to their own clinical work (Whitley, 2005). As discussed in the Chapter 2, quantitative methodologies would have difficulty providing this level of detailed analysis and addressing the aim of this program of research.

3.2.3 Focal Themes

It is the long-term intention to explore a number of focal themes reflecting different aspects of the CBT treatment model in this research program. However, for the purposes of this thesis focal themes have been selected for each of the three papers, reflecting aspects of the CBT model which are critical to the therapeutic process. Each of the papers contains a more detailed discussion of the

relevant focal theme, incorporating a discussion of its place within the overall model of treatment. In the first paper (Chapter 4), the focal theme is ‘negotiation of the problem statement’, as this involves the conversion of a client’s problems into one more amenable to the CBT approach. In the second paper (Chapter 5), the focal theme is ‘homework’, a very important strategy used in CBT. Although it is not unique to CBT, it is a prominent feature of most models of CBT and critical to the model investigated. In the final paper (Chapter 6), the focal theme ‘termination of therapy’ is investigated. Once again, this is not unique to CBT, but in CBT there are important aspects of how termination is handled that are dictated by the treatment model. In this paper, the focal theme is divided into two components:

- ‘Relapse prevention
- ‘Assessment of the client’s improvement over the course of therapy.

The focal themes for the three papers were selected because they reflect important, critical parts of CBT whose omission would compromise therapy or leave it incomplete. It is important that all trainee therapists master the three focal themes. They are in effect crucial sites (Candlin, 2000) in the therapy, from which critical moments (Candlin, 2000) have been selected for detailed analysis. The focal themes were used to select relevant parts of the text (crucial sites) and within these sections of text, critical moments are identified for more detailed analysis.

3.2.4 Main Analytic Themes

The main analytic themes that emerged from the analysis in the three papers are formulation (Heritage & Watson, 1979), face-work and politeness strategies (Brown & Levinson, 1987), reported speech (Tannen 2007), constructed dialogue (Tannen 2007), intertextuality (Fairclough 1992) and frames (Goffman, 1974). Formulation was discussed previously in Chapter 2. It is beyond the scope of this thesis to discuss these concepts in detail; however, some elaboration beyond that which is contained in the papers (Chapters 4 to 6) is warranted. It is important that the researcher does not approach the text looking for these focal themes but

allows them to emerge during the analytic process, which includes repeated rereading of the text.

In adopting face-work and politeness strategies as an analytical theme, I have drawn upon Brown and Levinson's (1987) seminal work in the area, in which they developed what they termed universal principles of language use concerning politeness and the need to save face. Their findings were based on studies of three unrelated languages — English, Tamil and Tzeltal — and was initially published in 1978 and republished in 1987 with a critical introduction. Their study developed from the work of Goffman (1967) and his concept of face. Face is defined as the public self-image that every member wants to claim for himself or herself: 'Face is something that is emotionally invested, and that can be lost, maintained, or enhanced, and must be constantly attended to in interaction.' (Brown & Levinson, 1987, p.61). Face has two components, negative and positive. Negative face is the 'basic claim to territories, personal preserves, rights to non-distraction i.e. to freedom of action and freedom from imposition' (p.61). Positive face is the 'positive consistent self image or "personality" (crucially including the desire that this self image be appreciated and approved of) claimed by interactions' (p.61). More simply put, negative face is the desire of a person to be able to do what they would like without being imposed upon by others and positive face is the desire to be appreciated and admired by at least some other members of society. Those acts which intrinsically threaten face (positive or negative) are referred to as 'face threatening acts'. Brown and Levinson describe a number of language strategies related to politeness, which participants use to avoid or redress the face-threatening act. It is these language strategies that are identified in the text of the therapy sessions and form part of the analysis in this thesis. Brown and Levinson's model has been criticised on the basis of its claims to universality (Wardhaugh, 2010) and because it does not sufficiently distinguish between commonsense and theoretical understandings of politeness (Vilki, 2006). Although these are important concerns, this thesis focuses more on the language strategies used by English-speaking therapists and clients than on a detailed analysis of theories about face and politeness. The analytic theme of politeness and face-saving strategies was a feature of all three papers and forms an important part of the analysis.

Two related analytic themes that emerged from the data were reported speech and constructed dialogue (Tannen 2007). In the former, the speaker repeats another's words uttered previously. This can take the form of a direct quote and is usually prefaced by 'you said' or 'he/she said'. This is often referred to as direct reported speech. Alternatively the speaker may paraphrase what has been stated previously, for example 'James said he would take the bus'. This is often referred to as indirect reported speech, in which the paraphrasing occurs in the current speaker's voice. However, Tannen (2007, p.102) argues that this distinction is not always clear-cut and that in practice it can be difficult to classify an example of reported speech as either direct or indirect. For this reason, the analysis undertaken in this thesis does not make use of the distinction between direct and indirect reported speech. Tannen describes another form of what appears to be reported speech, but the material, reported as if it is speech, was never uttered by another speaker. She distinguishes this from the concepts of reported speech by referring to it as 'constructed dialogue'. Tannen (p.112) makes the point that all forms of reported speech are constructed to a degree, even if they are apparently verbatim quotes, but the term 'constructed dialogue' refers to apparent quotes in which there is no original utterance. The use of constructed dialogue as a rhetorical device is explored in the analysis presented in this thesis.

The analytic theme of 'intertextuality' used in the analysis of the data presented for this thesis draws upon Fairclough's (1992) account of intertextuality. Fairclough, in turn, had built upon the work of Kristeva (1986) and her development of Bakhtin's (1986) ideas. Intertextuality in this instance refers to 'how texts contained within themselves evidence of the histories of other texts' (Candlin & Maley, 1997, p. 203). Crichton (2010, p.30) describes Fairclough's account of intertextuality as 'emphasis...[ing] the ways that texts draw on earlier texts and are in turn drawn upon in later texts.' Fairclough (1992) distinguished between manifest intertextuality (direct quotes in the text) and the form of intertextuality he calls interdiscursivity (dealing with the more abstract relationship between discourses). In this thesis the term 'intertextuality' rather than 'interdiscursivity' is retained, but intertextuality is taken to encompass a more abstract connection between texts and not merely direct quotes from previous texts.

Another important analytic theme used in this thesis is Goffman's (1974) notion of 'frames' and 'frame shift'. The second paper (Chapter 5 of this thesis) briefly outlines this analytic theme, but it warrants further elaboration. Buchbinder (2008) succinctly defines frames as 'a set of principles by which we define, categorise and interpret social action'. The analysis in Chapter 5 makes use of the play or switch between what are defined as personal and institutional frames. In this thesis, 'institutional frame' is defined as the therapy model and protocols of the service in which the therapy occurred, and 'personal frame' refers to the aspects of therapy that pertain directly to the clients, including what they are asked to do by the therapists as part of their treatment. Sarangi and Roberts (1999) have made the distinction between professional and institutional frames by separating the professional practice from institutional concerns and issues to explore the tension and interplay between these two issues. In the treatment service from which the data for this thesis was obtained, the treatment model of CBT is part of the institutional approach to managing the clients. The master's course associated with the service provides a broad overview of mental health and CBT, but focuses on the particular model of CBT used by the service. It is because of this that the treatment model was incorporated within the concept of the 'institutional frame'.

3.3 The Data

3.3.1 The Setting

The data from this study were drawn from a service which specialises in the treatment of clients with anxiety disorders. The main therapeutic intervention for clients is cognitive and behavioural therapy. Clients are referred to other services for medication-based management of their conditions, if required. The service does not offer psychopharmacological interventions as part of its treatment protocol, but neither is it set up in opposition to such interventions. Clients may be prescribed psychiatric medication via another healthcare provider, such as their general practitioner, concurrently with undergoing CBT through the service. The model of CBT offered has been described previously in Chapter 2. Essentially, it is a form of CBT that has evolved from the behavioural therapy or behavioural

psychotherapy developed by Isaac Marks (1986) at the Maudsley Hospital in the UK. Over time, the model has been updated with cognitive and, more recently, mindfulness-based interventions. At its core, the model of CBT offered by the service follows the basic session-by-session structure outlined by Marks (1986). The service is attached to a university department of psychiatry that offers a master's program teaching health professionals how to undertake CBT. Therapists are trained within the service and supervised by the in-house existing therapists. Most of the therapists working in the service have completed the master's course. They are mainly psychiatric nurses, but social workers, general practitioners and psychiatrists have undertaken the master's course and may also work for the service.

3.3.2 The Data

The data comprises video-recorded sessions of CBT conducted in the service, as described previously. The therapy was conducted by four therapists and involved the treatment of 10 clients. The four therapists in this study were all fully qualified and experienced, and have undertaken the master's course associated with the service. Three of the therapists were psychiatric nurses and one was a social worker. The treatment of 10 clients was recorded. In normal practice, each client has approximately 10 sessions of treatment although there is considerable variability depending on clinical need. The clients had various psychiatric diagnoses and the data collected represents their complete treatment at the service. The treatment of the clients is considered complete in that none is receiving ongoing treatment from the service, other than potential 'booster sessions'. After completing a course of therapy clients are offered booster sessions in the 12 months after their treatment sessions on an as-needed basis. This particular form of CBT offers these booster sessions routinely at scheduled intervals of one, three and six months if needed. Booster sessions do not form part of this study. Only the data from two clients are reported in this thesis which for convenience I have labelled as client 1 and 2. A total of 58 sessions were recorded.

3.3.3 Recording and Transcription

The sessions were recorded using standard definition digital video recorders utilising mini-DV cassettes. The cameras were positioned in such way that they were immediately behind the client, either to the left or right. Thus, the therapist's face is identifiable in the videos but the face of the client cannot be seen. The reason for this was twofold: to help preserve the anonymity of the client; and to position the camera closer to the therapist and client so that the audio recording would be of a higher quality. The microphone available on the video recorder was used to record sound as it was thought that an external microphone would be more intrusive and potentially more difficult for the therapist to set up at each therapy session. Despite some concerns that this would not be of high enough quality the cameras were close enough to the participants to obtain good quality audio recordings. The cameras were mounted on tripods and operated by the therapists in an attempt to minimise disruption in the room that a camera operator would provide, and to minimise observer's and participant's paradoxes (Sarangi, 2002, 2007). The rooms used to conduct the therapy for this thesis were the standard therapy rooms used by the therapists.

The sessions were transcribed verbatim by a confidential transcription service with whom there was a confidentiality agreement. In the verbatim transcription the client was referred to as 'C' and the therapist as 'T'. After relevant sections of the transcript were identified they were further transcribed using a version of Gail Jefferson's transcription method (Jefferson, 1989, 2004) outlined by ten Have (2007). ten Have summarises the transcription conventions as practised in the majority of contemporary CA research, although he avoids some of the subtleties described by Jefferson. Although Jeffersonian transcription was developed for CA it is now used in DA and other related fields. Because the method of analysis was discourse, not CA, the additional refinement generated by a strict adherence to Jeffersonian transcription method was not required. Names and other personal details have been changed to maintain anonymity. The following table outlines where the extract from the 3 papers are located in the transcripts of the sessions.

Table 3.1 Outlines where the extracts are located in the transcript.

	Extract	Client Number	Session No.	Start Line	Finish Line
Paper 1	Extract 1	1	1	124	140
	Extract 2	1	1	760	778
	Extract 3	1	2	429	444
	Extract 4	1	2	523	542
Paper 2	Extract 1	2	1	1769	1785
	Extract 2	2	2	1355	1383
	Extract 3	2	3	72	90
Paper 3	Extract 1	2	10	338	360
	Extract 2	2	11	296	316
	Extract 3	2	11	763	801

3.3.4 Ethics

This study was approved by both the University of Adelaide’s Human Research Ethics Committee (HREC) and the research ethics committee of the institution in which the study was conducted. Therapists and clients all consented to the study. Confidentiality is clearly paramount in any clinical study; however, in this study using recordings of clients describing very personal events from their lives, there is potential to identify people. To address this issue, in the papers de-identification went beyond removing a client and therapist’s name. Significant identifying information, such as place of employment, was altered to preserve anonymity. These alterations were deemed not to alter the analysis. All data are stored securely in a locked facility. See Appendix 6 for copies of the consent form and subject information sheets.

Statement of Authorship

Title of Paper	The negotiation of the problem statement in Cognitive Behavioural Therapy
Publication Status	<input checked="" type="radio"/> Published, <input type="radio"/> Accepted for Publication, <input type="radio"/> Submitted for Publication, <input type="radio"/> Publication style
Publication Details	Communication and Medicine Volume 7(1) 2010, 23-32

Author Contributions

By signing the Statement of Authorship, each author certifies that their stated contribution to the publication is accurate and that permission is granted for the publication to be included in the candidate's thesis.

Name of Principal Author (Candidate)	Dr Andrew Beckwith		
Contribution to the Paper	I collected the data. I undertook the analysis of the data and I wrote the text of the paper.		
Signature		Date	27/7/2013

Name of Co-Author	Dr Jonathan Crichton		
Contribution to the Paper	I provided guidance, supervision and editing.		
Signature		Date	23/7/2013

Name of Co-Author	N/A		
Contribution to the Paper			
Signature		Date	

Name of Co-Author	N/A		
Contribution to the Paper			
Signature		Date	

Chapter 4 The negotiation of the problem statement in Cognitive Behavioural Therapy

Title: The negotiation of the problem statement in Cognitive Behavioural Therapy

Short Title: Negotiation of the problem statement

Dr Andrew Beckwith
Discipline of Psychiatry
The University of Adelaide
North Tce.
Adelaide
South Australia 5005

Phone:61-8-82225141
Fax:61-8-82222865
andrew.beckwith@health.sa.gov.au

Word Count: 6993

Character count: 43,241

Bionotes

- (1) Dr Andrew Beckwith BMBS FRANZCP is a Director of Psychiatric Training and a HIV/Hepatitis C liaison psychiatrist. His research interests include the role of language in psychotherapy. He is a clinical lecturer and PhD student in the Discipline of Psychiatry, The University of Adelaide. Address for correspondence: Discipline of Psychiatry, The University of Adelaide North Tce., Adelaide SA 5005, Australia.

Email: andrew.beckwith@health.sa.gov.au

- (2) Dr Jonathan Crichton PhD is a Lecturer in Applied Linguistics and Research Fellow in the Research Centre for Languages and Cultures, University of South Australia. His research focuses on the role of language in interactions in health and educational settings. He has recently authored the Discourse of Commercialisation and co-edited Discourses of Deficit with Palgrave Macmillan. Address for correspondence: Research Centre for Languages and Cultures, University of South Australia, St Bernards Rd, Magill, SA 5072, Australia.

Email: jonathan.crichton@unisa.edu.au

Beckwith, A.R. & Crichton, J. (2010) The negotiation of the problem statement in cognitive behavioural therapy.

Communication and Medicine, v. 7(1), pp. 23-32

NOTE:

This publication is included on pages 83-106 in the print copy
of the thesis held in the University of Adelaide Library.

Statement of Authorship

Title of Paper	Homework Setting in Cognitive Behavioural Therapy: A Study of Interactional Strategies
Publication Status	<input type="radio"/> Published, <input type="radio"/> Accepted for Publication, <input checked="" type="radio"/> Submitted for Publication, <input type="radio"/> Publication style
Publication Details	Submitted to Communication and Medicine

Author Contributions

By signing the Statement of Authorship, each author certifies that their stated contribution to the publication is accurate and that permission is granted for the publication to be included in the candidate's thesis.

Name of Principal Author (Candidate)	Dr Andrew Beckwith		
Contribution to the Paper	I collected the data. I undertook the analysis of the data and I wrote the text of the paper.		
Signature		Date	27/7/2013

Name of Co-Author	Dr Jonathan Crichton		
Contribution to the Paper	I provided guidance, supervision and editing.		
Signature		Date	23/7/2013

Name of Co-Author	N/A		
Contribution to the Paper			
Signature		Date	

Name of Co-Author	N/A		
Contribution to the Paper			
Signature		Date	

Chapter 5 Homework Setting in Cognitive Behavioural Therapy: A Study of Interactional Strategies

Author (1): Dr Andrew Beckwith

Affiliation: The University of Adelaide

Full Address: Discipline of Psychiatry

North Tce

Adelaide

South Australia 5005

Phone: 61-8-82225141

Fax: 61-8-82222865

andrew.beckwith@health.sa.gov.au

Author (2): Dr Jonathan Crichton

Affiliation: University of South Australia

Full Address: Research Centre for Languages and Cultures,

St Bernards Rd,

Magill,

South Australia 5072

Phone: 61-8-83024491

Fax: 61-8-83024396

jonathan.crichton@unisa.edu.au

Title: Homework setting in cognitive behavioural therapy: A study of interactional strategies.

Short Title: Homework setting in cognitive behavioural therapy

Word Count: 7164

Character count (with spaces): 44225

Bionotes

- (1) Dr Andrew Beckwith BMBS FRANZCP is a Director of Psychiatric Training and a HIV/Hepatitis C liaison psychiatrist. His research interests include the role of language in psychotherapy. He is a clinical lecturer and PhD student in the Discipline of Psychiatry, The University of Adelaide.

Address for correspondence: Discipline of Psychiatry, The University of Adelaide North Tce, Adelaide SA 5005, Australia.

Email: andrew.beckwith@health.sa.gov.au

- (2) Dr Jonathan Crichton PhD is a Lecturer in Applied Linguistics and Research Fellow in the Research Centre for Languages and Cultures, University of South Australia. His research focuses on the role of language in interactions in health and educational settings.

Address for correspondence: Research Centre for Languages and Cultures, University of South Australia, St Bernards Rd, Magill, SA 5072, Australia.

Email: jonathan.crichton@unisa.edu.au

Beckwith, A.R. & Crichton, J. (2013) Homework setting in cognitive behavioural therapy: a study of interactional strategies.

Communication and Medicine, (in press)

NOTE:

This publication is included on pages 110-133 in the print copy of the thesis held in the University of Adelaide Library.

Statement of Authorship

Title of Paper	Termination in Cognitive Behavioural Therapy: A Study of Interactional Strategies
Publication Status	<input type="radio"/> Published, <input type="radio"/> Accepted for Publication, <input checked="" type="radio"/> Submitted for Publication, <input type="radio"/> Publication style
Publication Details	Submitted to Communication and Medicine

Author Contributions

By signing the Statement of Authorship, each author certifies that their stated contribution to the publication is accurate and that permission is granted for the publication to be included in the candidate's thesis.

Name of Principal Author (Candidate)	Dr Andrew Beckwith		
Contribution to the Paper	I collected the data. I undertook the analysis of the data and I wrote the text of the paper.		
Signature		Date	27/7/2013

Name of Co-Author	Dr Jonathan Crichton		
Contribution to the Paper	I provided guidance, supervision and editing.		
Signature		Date	23/7/2013

Name of Co-Author	N/A		
Contribution to the Paper			
Signature		Date	

Name of Co-Author	N/A		
Contribution to the Paper			
Signature		Date	

Chapter 6 Termination in Cognitive Behavioural Therapy: A Study of Interactional Strategies

Author (1): Dr Andrew Beckwith

Affiliation: The University of Adelaide

Full Address: Discipline of Psychiatry

North Tce

Adelaide

South Australia 5005

Phone: 61-8-82225141

Fax: 61-8-82222865

andrew.beckwith@health.sa.gov.au

Author (2): Dr Jonathan Crichton

Affiliation: University of South Australia

Full Address: Research Centre for Languages and Cultures

St Bernards Rd

Magill

South Australia 5072.

Phone: 61-8-83024491

Fax: 61-8-83024396

jonathan.crichton@unisa.edu.au

Title: Termination in cognitive behavioural therapy: A study of interactional strategies.

Short Title: Termination in cognitive behavioural therapy

Word Count: 7118

Character count (with spaces): 43602

Bionotes

- (1) Dr Andrew Beckwith BMBS FRANZCP is a Director of Psychiatric Training and a HIV/Hepatitis C liaison psychiatrist. His research interests include the role of language in psychotherapy. He is a clinical lecturer and PhD student in the Discipline of Psychiatry, The University of Adelaide.

Address for correspondence: Discipline of Psychiatry, The University of Adelaide North Tce., Adelaide SA 5005, Australia.

Email: andrew.beckwith@health.sa.gov.au

- (2) Dr Jonathan Crichton PhD is a Lecturer in Applied Linguistics and Research Fellow in the Research Centre for Languages and Cultures, University of South Australia. His research focuses on the role of language in interactions in health and educational settings.

Address for correspondence: Research Centre for Languages and Cultures, University of South Australia, St Bernards Rd, Magill, SA 5072, Australia.

Email: jonathan.crichton@unisa.edu.au

Beckwith, A.R. & Crichton, J. (2013) Termination in cognitive behavioural therapy: a study of interactional strategies.

Communication and Medicine, (in press)

NOTE:

This publication is included on pages 137-159 in the print copy of the thesis held in the University of Adelaide Library.

Chapter 7 Conclusion

7.1 Introduction

The following conclusion draws together the findings of the papers and discusses them in the broader context of cognitive behavioural therapy (CBT) and clinical practice. The findings of the three papers are summarised and discussed below, and the potential clinical implications related to the findings are discussed with particular reference to the notion of ‘practical relevance’. It is important to emphasise that the results from the research presented in this thesis are preliminary findings from a small number of subjects and that caution must be exercised in drawing any general conclusions for clinical practice. The limitations of this thesis that go beyond those already noted in the papers are discussed below with reference to potential future studies.

7.2 Overview

The aim of the program of research from which this thesis is drawn is to investigate how the underlying treatment model of CBT is put into practice in the interaction between the therapist and client in the clinical setting through an analysis of the language used. This thesis represents initial steps towards addressing this aim. By analysing ‘real world’ therapy sessions, that is, therapy sessions that would have taken place if this program of research did not occur, I have investigated how two therapists and two clients use discursive strategies to undertake CBT. In doing so focus has been placed on what Candlin (2000) has called ‘crucial sites’, meaning emphasis has been placed on aspects of the CBT treatment model where discursive strategies are likely to be at a premium for the client’s treatment. The crucial sites represent focal themes that are crucial to the model of CBT, where therapy would be compromised if the therapeutic tasks dictated by the model were not carried out. In particular, analysis has been conducted on:

- how the client’s problem is converted into one that is more amenable to therapy

- the undertaking of homework tasks
- termination (discharge) from therapy.

Although these are important to the implementation of the model of CBT, clearly there are many other aspects of the CBT model that were not investigated as part of this thesis. The method of analysis in this thesis was theme-orientated discourse analysis, a form of discourse analysis (DA) that was specifically developed to analyse health-related interactions and texts. As discussed in Chapter 2, this method was chosen because it enabled connections to be drawn between aspects of the CBT treatment model that are of professional interest and underlying discursive strategies previously identified in the DA and other related literature.

The small number of clients and therapists investigated permitted a detailed analysis of the complex interactional strategies used to implement the CBT treatment model. Those discursive strategies included the consideration and use of formulation, face-saving (politeness), intertextuality, technical questions, reported speech, contrast structures, constructed dialogue, pronoun shifts and frames. The analysis revealed the use of not one simple discursive strategy to implement a particular CBT technique, but a complex interplay of discursive strategies, reflecting the therapist's expertise (Sarangi & Candlin, 2011). The therapists had to employ a range of discursive strategies, often in combination, to achieve their aim. For example, Paper 1 (Chapter 4) confirmed the reports of many other papers in this field, that formulation is an important part of converting the client's problem into one that is more amenable to CBT. However, Paper 1 also reports the use of a number of other strategies as well.

7.3 Overview of the Papers

Each paper focused on one client–therapist dyad.

Paper 1 (Chapter 4). The Negotiation of the Problem Statement

The first paper addressed the issue of converting a client's problem into one that is more amenable to CBT. The focal theme in this paper was the negotiation of

the problem statement, a sentence stating the client's problems in CBT terms. Other forms of CBT differ slightly in the way they express the client's problem, although the task is common to them all. Although formulation was found to be an important analytic theme, a number of other analytic themes were also evident, including face-saving strategies such as hedging (Brown & Levinson, 1987), reported speech (Holt, 1996), contrast structures (Sarangi & Clarke, 2002b) and asking technical questions (Hak & de Boer, 1996). The finding that formulation was an important process in converting a client's problem into one more amenable to therapy was consistent with previous literature across a range of forms of psychotherapy (Antaki, et al., 2004, 2005; Buttny, 1996; Davis, 1986; Hak & de Boer, 1996). What this paper demonstrated was the complexity of the process and presence of multiple analytic themes.

Paper 2 (Chapter 5). Homework-setting in Cognitive Behavioural Therapy: A Study of Interactional Strategies

In the second paper the focus was on the therapeutic technique known as homework. As stated in the paper, homework refers to 'between session activities that are targeted toward achieving therapy goals' (Deane, et al., 2005). Homework is a crucial technique in this form of CBT and, while not exclusive to CBT, it is a prominent technique in CBT approaches in general. In this paper the predominant analytical themes were the issue of face and related politeness strategies, as well as the use of frames. The analysis showed that the therapist moved strategically between a personal frame and an institutional frame.

Paper 3 (Chapter 6). Termination in Cognitive Behavioural Therapy: A Study of Interactional Strategies

The third paper focused on the ending of therapy, often referred to as termination. Termination is an important issue in all forms of therapy. Given that CBT is a time-limited, brief form of psychotherapy, termination issues have to be addressed in a timely way. A key component of termination is the assessment of the client's progress to determine when therapy should end. While this seems self-evident, the measurement of the client's progress throughout therapy and assessment of the client's response is an important part of the CBT therapy model. Another important component of termination, and a particular aspect of

the CBT model, is relapse prevention. The client is trained in both identifying a relapse and ongoing therapeutic strategies that he or she can use even when no longer in therapy. Once again, key analytic themes were face and face-saving strategies, which were prominent even when the client had apparently done well in therapy. Intertextuality was identified as an important discursive strategy underpinning the therapeutic task of relapse prevention. The therapist drew upon and textualised previous understandings and conversations to help construct and put into place preventative strategies that foreshadowed potential future therapeutic interaction.

7.4 General Conclusions

Whilst the major findings of the three papers have been summarised above, overarching general conclusions can be drawn from the papers as a whole, which have a bearing on the broader program of research anticipated by these papers.

7.4.1 Politeness and the Need to Save Face

Face-saving and politeness strategies were a prominent feature of the transcripts contained within the papers. These strategies were used by the therapists throughout therapy, including the later sessions. Indeed, in the third paper, when it was clear the client had responded well to therapy, the therapist still made use of face-saving strategies, although it is difficult to draw general conclusions from this observation. The nature of the politeness strategies used included hedging, indirect speech and, at times, constructed dialogue. In considering why these strategies are so prominent, it is important to bear in mind that psychotherapy of any type, including CBT, it is potentially a very stressful and confronting process. The client is asked to discuss distressing, personal and potentially embarrassing information with a relative stranger and any resulting stress may be exacerbated by the client's mental condition. In choosing to have psychotherapy the client would reasonably be expected to be aware that they would discuss such topics, but the client risks losing face. One of the key skills of any therapist is to develop a therapeutic alliance with the client (Beck, et al., 1979; Ledley, et al., 2010; Roth & Fonagy, 2005; Wright, et al., 2006). It is arguable that protecting the client's 'face' is an important part of this aspect of CBT. If the therapist is impolite and

tactless, then for many clients (but not necessarily all) the therapeutic alliance would be impaired and the client may drop out of therapy. Of course, this is a hypothesis that would need to be explored in further research. Based on the evidence presented in the three papers, it appears that face-saving strategies are not only necessary for the task at hand, such as introducing homework or ending therapy, but they may underpin a sound therapeutic alliance that enables the client to undertake the difficult process of CBT itself. Further research would be needed to clarify this issue.

7.4.2 Complexity of Discursive Strategies and Therapist Expertise

One of the significant observations from the three papers as a whole is the complexity of discursive strategies employed by the therapists and the clients in CBT. This highlights an aspect of the therapist's expertise. Discursive ability is part of the expertise of professionals (Sarangi & Candlin, 2011), including therapists, and by describing in some detail the discursive strategies used by the three CBT therapists, the three papers have highlighted the sophistication of approach employed by these therapists. Discourse analysis can potentially identify mechanisms and processes of which the participants may be unaware. Whilst skills such as building a therapeutic alliance with the client are acknowledged by CBT therapists, the full discursive complexity of the interaction between client and therapist is not fully discussed in the broader CBT literature. Arguably, what this thesis achieves is to highlight discursive strategies that are routinely and strategically employed by the therapist (and the client), and in so doing foreground the therapists' expertise in implementing the particular model of therapy at moments that are critical to the therapeutic process.

What was also observed, at least for the two clients and therapists studied, was that multiple discursive strategies were used in different combinations to achieve a particular therapeutic strategy. Although it is difficult to draw general conclusions about CBT from the small sample size (see discussion of limitations in Section 7.6 below), these three papers highlight the multiple-discursive – strategic nature of CBT, in which the discursive resources of the therapist are deployed in different configurations at different stages to guide the trajectory of the therapy, and it is arguable that this reflects the more general practice of CBT

and other forms of psychotherapy. Illustrations from the papers include, in the first paper (Chapter 4), the therapist's use of the conversation analysis (CA) device of formulation, which had been identified in previous studies, but was here clearly seen to operate in combination with a number of other strategies. Similarly, undertaking homework in CBT and terminating therapy were not achieved by use of a single discursive strategy. In the case of homework, it is unlikely that any particular therapeutic strategy will be solely linked to a particular discursive strategy. However, future studies are required to investigate this issue before drawing more general conclusions.

7.4.3 The 'Two Masters Problem'

Each paper focused on an important therapeutic task in the CBT treatment model. The analysis described how therapists were able to use discursive strategies to implement these therapeutic techniques in interaction with the client. An issue identified primarily in Paper 1 (Chapter 4), although it applies across the other papers, is the 'two masters problem'. In the analysis it became apparent that the therapists had to balance the needs of the generic treatment model of CBT with its prescriptive structure, with the needs, vulnerabilities and perceptions of the particular client. In effect, the therapist has to be a broker between the model and the client. The stakes here could not be higher because unless this 'balancing' can be done in a way that leads to the client taking up the model for herself, the therapy will not be enacted. To put the treatment model of CBT into practice clinically, the therapists had to address this 'two masters problem' by discursively adapting the treatment model to the clients' specific needs. It was the therapists' ability to realise their clinical expertise through their discursive expertise that enabled them to address this problem. From a clinical perspective this was an important finding (albeit only a preliminary finding at this stage), as it highlighted therapeutic skills that are traditionally not discussed in the CBT literature, and how DA and related methodologies can be used to uncover the expertise of professionals such as psychotherapists.

7.5 Implications for Clinical Practice and the Potential Practical Relevance

In discussing the practical relevance (Roberts & Sarangi, 1999a) of this thesis it is to be remembered that the focus of this thesis has been on the discursive strategies used by the therapist and client to put the CBT treatment model into practice.

Whereas the focus is on clinical practice, with the site of study the naturally occurring therapy session, the clinical implications of this program of research are not explicitly studied.

The following section discusses potential clinical implications of this thesis, but ultimately further study is required to address this issue. As discussed in Section 7.6 below, because of the small sample size of this thesis it is necessary to be cautious about generalising the results and deriving broader clinical implications. However, as discussed in the Chapter 3, the study of a small number of sessions has enabled a more detailed analysis of the language use than could easily be achieved with a large number of subjects. The cases represent typical cases as identified by the therapists. Given the detail of the description, mental health professionals can decide for themselves whether or not the cases relate to their own professional practice.

7.5.1 Therapists Reflecting on Their Own Clinical Practice

Viewing recordings of their own or others' sessions of therapy, in conjunction with consideration of these and future findings, may enable the therapists to reflect upon their own clinical practice. In light of this understanding and a greater awareness of the discourse processes they are using in their clinical work, therapists are placed in a better position to refine their practices. I have taken some preliminary steps towards this by presenting my findings to the therapists and students in the service that was the subject of this research, in one of their regular education seminars. Examples of areas of clinical practice where language analysis has been used to inform the health practitioners' communication include a spinal pressure area clinic (Iedema, et al., 2006), an intensive care unit and an emergency department (Carroll, et al., 2008; Iedema, et al., 2009). This involved a process of 'video reflexive-ethnography' (Iedema, et al., 2006), in which suitable interactions were video-recorded, analysed and edited. A DVD was then produced

and shown to the healthcare practitioners in reflexive sessions. The aim was to bring to attention previously hidden issues that led to changes in clinical practice (Iedema, et al., 2009). Similarly, therapists from other services may be encouraged to be reflexive about their own clinical practice through an awareness of the DA of CBT practised by other therapists and viewing the recordings. A case in point is my own clinical practice, in which I have become more aware of discursive strategies that I use and of which previously I was unaware.

7.5.2 Training of Therapists

One further potential application of the findings of this thesis is in the field of training mental health professionals to become CBT therapists. For example, making trainee therapists aware of politeness strategies used by expert therapists may help the novice therapist become more rapidly proficient in this aspect of therapy. A common problem with trainee therapists is that they can be too ‘wooden’, focusing overly on the CBT techniques themselves rather than on how they are put into practice with a given client. Therapists typically learn how to put into practice CBT techniques through their own clinical experience, by watching other therapists at work and in receiving feedback from supervisors. By making explicit some of the discourse processes involved in delivering CBT, theme-based DA may allow for discursive strategies to be taught in a more formal way, instead of being informally assimilated by the therapist in training. Therapist training could incorporate descriptions of politeness strategies used by experienced therapists to deliver CBT. It is this ability of DA to draw one’s attention to previously hidden discourse processes in the therapy that makes it a potentially valuable tool in training therapists.

The service from which the data was collected for this thesis also trains new therapists in the service’s model of CBT. The therapists who were involved in the study also participate in the training of new therapists, which involves showing trainee therapists video recordings of therapy conducted within the service. Whilst concerns about the ability to generalise the findings of this study have been raised, the video recordings could provide the therapists with specific information about their own style of therapy, increasing the visibility of their own use of discursive strategies and providing a more nuanced grounding in the variation of

styles than is currently possible, which they could in turn convey to the trainees. Rather than simply show a recording of themselves delivering therapy, the therapists could use the DA findings to describe in greater detail what they are doing, and how and why they are doing it. Providing a model to describe and explain in greater detail what they are viewing may help novice therapists learn more from a given video recording. Extrapolation to other training facilities may also be possible. A therapist who is training student therapists could potentially use a personalised DA of their own therapy as an example in their teaching.

In discussing how the findings of this thesis might be used in training, one must be cautious not to overstate the implications, as there are limitations to this research. (See Section 7.6 of this chapter for a discussion of these limitations in more detail.) As explained this thesis is a preliminary step only in establishing a research agenda that can contribute more broadly to CBT practice. The findings from this study would need to be replicated and expanded to enable broader conclusions to be drawn. One way of further investigating the training implications of this thesis would be to develop training packages based on the research findings and implement them in a way that can be systematically evaluated to compare the impact of these new training packages with the usual approach to training.

7.5.3 Contribution to the Literature on Healthcare Interactions and Theme-Orientated Discourse Analysis

This thesis and the research agenda for which it argues contributes not only to the psychotherapy DA literature but also to the growing literature on health professional interactions in general. It also adds to the growing literature using theme-orientated DA as its primary analytic approach. Although this approach has been applied to health-related interactions related to psychotherapy such as genetic counselling (Brookes-Howell, 2006; Sarangi & Clarke, 2002a, 2002b), school nurses' counselling of obese/overweight pupils (Magnusson, et al., 2009) and a psychiatric interview (Galletly & Crichton, 2011), it appears that this thesis reports its first application to psychotherapy. Following on from the research presented here, future research may apply this form of DA to other forms of psychotherapy. Theme-orientated DA uses analytic themes derived from the

broader sociological and social linguistics literature. The analytic themes or tools used are not unique to this thesis and I have attempted to build upon previous research into interactions, including in psychotherapy, which have explored these analytic themes. For example, from the CA literature (Heritage & Watson, 1979) formulation has been used to aid in understanding the conversion of a client's problems into one that is more amenable to CBT. This had been shown in other settings (including psychotherapy) to be a prominent linguistic mechanism (Antaki, 2008; Antaki, et al., 2005; Davis, 1986; Hak & de Boer, 1996). Findings in DA and CA generally cannot be statistically combined, but as each study is undertaken it contributes to the broader understanding of professional interaction. For example, the finding of this thesis that formulation is important in converting a client's problem into one that is more amenable to therapy, adds weight to the view that this is a widely used strategy in psychotherapy. Future studies may further explore the role of intertextuality and face-work in psychotherapy, in turn building on the analysis presented here. In this way, this thesis adds to this literature as it builds upon and extends previous research in this area.

7.6 Limitations of this Research

Limitations of this program of research are touched on in the three papers (Chapters 4, 5 and 6) but some of the limitations warrant further expansion. The thesis shares methodological issues common to other studies using DA. There were a limited number of subjects in this thesis: only two clients and two therapists were utilised in the three papers. Both the small sample size and the focus on one particular model of CBT invite caution about generalising the findings to all forms of CBT. However, given the prescriptive nature of the model of CBT and the common need for therapists to implement treatment that is tailored to a particular client, the findings of the study provide evidence of discursive expertise required by CBT practitioners. The subjects in this study, both the therapists and the clients, were selected on the basis of their willingness to participate in the study and they represented 'typical cases' (McLeod, 2010). Not all of the therapists involved in the service agreed to participate, nor did all of the clients who were approached. It is possible that there is something different about those therapists and clients who did not participate that was not captured in

this research, although it is hard to see how such variability would have affected the findings around the implementation of discursive expertise, given the nature of the therapy and its associated model. After discussion with the therapists and from my own clinical experience, the clients were considered typical of those seen in the service. Whereas the specific findings of the papers may have limited generalisability, this type of detailed research may form the basis for future research. The same method of analysis could be used for other clients from my data set, or in other settings to be further elaborated upon. Moreover, the detailed nature of the analysis, including the contextual information, would enable psychotherapists to decide whether or not the findings were applicable to their own practice (Whitley, 2005).

One criticism of this type of research is that it takes a ‘snapshot’ of what is a long-term process (Peräkylä, 2004b). In the case of this thesis, not only was there a focus on a small number of clients but, in addition, only sections of sessions of the treatment were analysed. This raises the possibility that other information from sessions not used in the papers may impact on the analysis. To address this, prior to choosing the particular sessions, all therapy sessions for a given client were reviewed and transcribed as part of the data analysis. It was only after a full assessment with reference to the focal themes that sections of the text were selected for more detailed analysis.

The aim of DA is to investigate the meaning of discourse structures, which is fundamentally an interpretive process. A degree of subjectivity is required on the part of the researcher and, as discussed in Chapter 3, the analysis is grounded in a ‘thick participation’ (Sarangi, 2010) in the research site and CBT more generally through my training and clinical practice in CBT. This helps minimise what Sarangi refers to the ‘analyst’s paradox’ (Sarangi, 2002; Sarangi, 2007) in that the analysis of the text is undertaken with contextual understanding about the service and CBT model, its practice and training. The issue for me as a professional in CBT undertaking DA of CBT was to obtain an understanding of the DA and associated linguistic and sociological literature to inform my analysis, an issue which could be termed, after Sarangi, a ‘professional’s paradox’. The analysis I undertook was also reviewed by a supervisor (a non-clinician), who brought the perspective of an outsider to CBT. He was able to question my assumptions and

at times encouraged the pursuit of a broader perspective. The transcripts, from which the conclusions are drawn, are provided in the papers so that the reader can review the data and analysis. Paper 1 (Chapter 4) has been peer-reviewed and published, and Papers 2 and 3 are in the process of being peer-reviewed.

Presenting the data in the form of published and submitted papers had both benefits and shortcomings. Each paper provided a discrete focus that assisted in clarifying and containing the analysis. However, the nature of DA and the very large amounts of data that were collected made it difficult to show the richness of the social interaction within the word limit of an academic journal. In particular, the therapy sessions are all interconnected to some degree and, as stated, by focusing on a snapshot from a particular session, the current thesis is unable to fully capture the evolution of the therapy session by session. Having been able to view all of the recorded sessions, it was evident to me that the therapists skilfully built upon previous sessions while anticipating and foreshadowing the possible trajectory of future sessions. Whilst this was touched upon through the analytic device of intertextuality in the third paper, there is potential to explore this issue further.

7.7 Further Studies

As foreshadowed in Chapters 2 and 3 this thesis represents the initial findings from a larger program of research. As a result, this thesis focused on a small number of subjects, two clients and two therapists, in establishing a research agenda that will be further developed. The corpus as a whole comprised data from 10 client/therapist dyads composed of 4 therapists and 10 clients. The aim is to use the data collected for further analysis, both to investigate other therapeutic techniques used within CBT and to explore differences between the different therapists and clients. In this way it is intended to further explore the expertise of the therapists in putting into practice the treatment model of CBT or, as it was referred to as in Chapter 4, addressing the ‘two masters problem’. Future potential focal themes include the use of a particular form of homework called an ‘exposure task’, whereby clients are asked to expose themselves to the feared situation and to stay in the feared situation until their anxiety lessens and the

client habituates. Another important therapeutic strategy in CBT is challenging negative automatic thoughts, the distorted thinking patterns believed to underpin a number of mental health problems (Beck, 2011; Beck, et al., 1979; Burns, 1999a, 1999b; Clark, Beck, & Alford, 1999; Hawton, et al., 1989b; Leahy, 2003; Leahy & Holland, 2000; Wright, et al., 2006). Of the numerous possible directions for further research, another is to explore the interconnectedness of the therapy sessions and expand upon the issues of intertextuality in CBT by following a particular focal theme across multiple sessions.

Whilst an important goal is to understand of how the underlying treatment model of CBT is put into practice in the interaction between the therapist and client in the clinical setting through the discourse used, this understanding could also be used to report back to therapists in a way that may be helpful for their practices. As described above, a model for such an approach is the work undertaken by Iedema and his colleagues in reporting back interactional data to the participants in a range of healthcare settings, which has influenced their practice (Carroll, et al., 2008; Iedema, et al., 2006; Iedema, et al., 2009). In a similar way, information from this program of research could be presented to therapists and its impact (or not) on clinical practice assessed. I have taken preliminary steps towards this by presented my findings as part of the regular education program for the CBT therapists from the service which is the subject of this thesis, and I have incorporated discursive findings in my supervision of psychiatric registrars.

The three papers (Chapters 4, 5 and 6) explore the issue of face and threats to face in sessions of CBT. The findings could be taken further by investigating the issue of face and politeness within other forms of CBT, as well as other forms of psychotherapy and mental health-related interactions. As stated in Chapter 2, an important area of research in psychotherapy is to investigate the common aspects of all forms of psychotherapy. This approach is inspired by the research findings that when one compares different forms of psychotherapy to one another, the usual result is that both are effective (Wampold, 2010b). One approach to this issue would be to compare discursive strategies used by therapists from different disciplines. It may be that a feature of psychotherapy in general is the use of a number of different discursive strategies to achieve similar goals within the therapy. Alternatively, particular models of psychotherapy may make use of a

different set of discursive strategies. Future research employing theme-orientated DA may help in addressing these issues and in informing practice and training.

7.8 Conclusion

In conclusion, this thesis has broadened my understanding of the role of discursive strategies in implementing the treatment model of CBT in practice clinically. This thesis represents the preliminary findings of an ongoing study which, as I have indicated above, has impacted on my clinical practice through a greater understanding of the discursive strategies used in CBT and clinical interactions more broadly. My aim in undertaking this research was essentially a clinical one in that I wanted to better understand how the treatment model of CBT, as expressed in textbooks and treatment protocols, is put into practice in real-world therapy sessions. This thesis presents a beginning of this process and one which I aim to build upon. Also, by undertaking this study, I hope to have added in a small way to the growing body of theme-orientated DA literature as well as to the DA literature into psychotherapy more broadly.

Appendix 1 1st Interview

(reprinted with permission)

1ST INTERVIEW - (ASSESSMENT - SCREENING)

Behavioural Analysis : duration of disorder, severity, fluctuations

Autonomic

Behaviour

Cognitions

Disability

Previous Treatments

Alcohol/drugs

Depression

Decide on suitability of current problem for treatment.

Explanation of the Model and Treatment (self)

"Living with Fear"

Co-therapist/spouse

Questionnaires

2ND INTERVIEW

Full psychiatric history including formulation

Problems and targets, scales, graphs and questionnaires

Daily homework tasks - weekly tasks - daily homework record sheet

Frequency of exposure

TREATMENTS BASED ON:

Live exposure

Response prevention

Habit reversal

3RD INTERVIEW AND REVIEW SESSIONS

Look at homework sheets - correlation of outcome with anxiety levels

Look for avoidances

Discuss relapses

Interpersonal skills of the therapist

No reassurance (family, GP, etc)

Relapse prevention

Appendix 2 The Initial Assessment

(reprinted with permission)

The Initial Assessment.

AIMS AND OBJECTIVES.

This assessment serves several purposes:

1. To gather information about the clients problem and its impact on their lives and the lives of those around them.
2. To deliver the rationale for the treatment to the client and give an informed account of possible difficulties and chances of success.
3. To educate the client about the treatment environment and resources available.
4. To determine whether behavioural psychotherapy is a suitable treatment for the clients particular problem.
5. To allow the client to make an informed decision about whether they wish to enter treatment.
6. To discuss future options if the treatment is not suitable.

THE INTERVIEW.

This should consist of the following stages (times given are approximate and for an average interview, more difficult problems take longer to assess). **Ensure you have everything you need before going into the interview:**

1. INTRODUCTION AND ORIENTATION. (3 mins)

Items included in this are:

Name and role of interviewer and any other staff present, and an explanation of why they are there i.e. teaching, research etc..

Purpose of the interview i.e. to gather information, assess treatment suitability, explain treatment and allow an informed decision to be given.

Explanation of environment, if necessary, pointing out any distractions e.g. note taking, cameras, noise etc..

Length of the interview to prevent overrunning or over inclusive conversations and to help focus the interview.

Agenda to structure the interview.

2. PROBLEM ASSESSMENT (30 mins)

At this initial stage of the interview you must presume that:

- a. the client is being honest.
- b. the client is responsive (partnership).
- c. the client tries to cope.

The interview should follow a structured pattern and questions should allow the interviewer to focus in onto finer details. The first question should be open, allowing the client to start. However, it is useful to limit the area to which you want to attend. For instance, the two questions below may get very different answers:

A. "Could you tell me in your own words what you feel your problem is?"

B. "Could you tell me in your own words what you feel your problem is, at the present time?"

Question A is too open, allowing the client to discuss any aspect of their problem past or present. The response to this type of question may be:

"Well it started in 1958 when I had just married for the second time and I was out of work and I had a fear of socialising, but that cleared up."

We still do not know what the details of the problem are.

Question B tells the client that we wish to know about the problem, but only as it is affecting them now. A typical response may be:

"Well I keep having to wash my hands whenever I touch anything."

This gives us the current behaviour and we can now focus in on this and gain more details by asking more specific questions. This funnelling of questions could take the following form:

- "What situations do you find you have to wash in?"
- "Why do you need to wash, what do you fear?"
- "How often do you have to wash after being there?"
- "How long does each wash take?"
- "What does each wash comprise of?"
- "Do you use soap or disinfectant?"

Each layer of the funnel asks for more and more specific information. Clients may start to wander off the point and if this happens excessively should be interrupted, given an explanation as to why they were interrupted and that the information is not needed at present

and asked further questions. Repeated wandering needs repeated interruptions as general chit-chat will not help the problem assessment. However, where possible let the client flow and allow them to offer information that is relevant.

The interviewer will need to take notes as unobtrusively as possible, and should use **clear, concise, single questions** as multiple questions can confuse clients. The full interview schedule with the types of question needed are in appendix A.

Time should be given at the end for the client to add any information they feel is significant and has not been dealt with, and they should be allowed to ask a limited number of their own questions.

Apart from the interview, interviewers should be aware of information from referrers, other agencies, relatives, and from observations made during the interview.

3. *ASSESSING SUITABILITY*, (15 mins)

The following criteria should be considered:

1. The presence of organic pathology that contra-indicate treatment e.g. dementia, physical disability or poor physical health.

2. The use of anxiolytics may mask the effects of anxiety and reduce a clients ability to habituate to anxiety. Clients taking over 21 units of alcohol/week or over 5mg diazepam (or other benzodiazepine equivalent) should reduce to these levels before starting treatment. Illicit drug use is also a contra-indicator.

3. Motivation of the client is important. Have they sought referral or been forced into it. Do they see themselves as their own therapist or do they feel therapy should be done to them. Have they had past therapy? What were their response to it? If it did not work, why not? Why are they coming here at this time? Do they understand the rationale, and can they accept and believe in the treatment method. All these things need to be taken into account.

4. Acute psychotic symptoms, and the loss of contact with reality associated with it, means that clients cannot adhere regularly to a programme. Clients with psychosis that is maintained on medication, or **are** not acutely psychotic, may still be considered.

5. Depression may cause a lack of motivation, and the clients safety is paramount when considering admission to treatment. Can they maintain their own safe environment? If depression is present, providing it is not severe, there is no reason why a client cannot be considered for treatment and antidepressant medication is not a contra-indication.

6. Other issues such as travelling to and from treatment sessions also need consideration, can they function with other people within a hospital environment.

4. TREATMENT RATIONALE. (10-15 mins)

The client needs to know that once fears are acquired they are maintained by the fact that they avoided. Human behaviour tends to seek out rewards and avoid punishment. Once a behaviour is rewarded it will be repeated (operant conditioning). In the case of fears and phobias the symptoms of anxiety are obviously aversive to the person, so in order to stop these they avoid or escape from the feared object or stimulus. They are then rewarded by the disappearance of the anxiety symptoms. Thus when they next encounter the same or a similar feared situation they avoid, as they have learned that by not exposing to it or escaping they do not get anxiety. As the avoidance continues the person becomes unable to test reality to find out whether they could cope with that anxiety or whether it would reduce of its own accord.

We know, from research, that were a person with a fear or phobia to expose to their feared stimulus, they would, given time, habituate to it i.e. their anxiety would reduce. However, this is a difficult thing for clients to do. For this reason the client needs to have a clear picture of what is required and why it is required before they enter treatment.

Explanation of the treatment rationale is extremely important. As health care professionals we have an obligation to provide clients with information about their treatment and personal health. We have access to a great deal of information, much of it derived from research, which can lead to improvement of health. Since this particular form of treatment requires little therapist input to be effective it seems logical to provide the client with the information needed to treat themselves. There are important points to remember about treatment rationale:

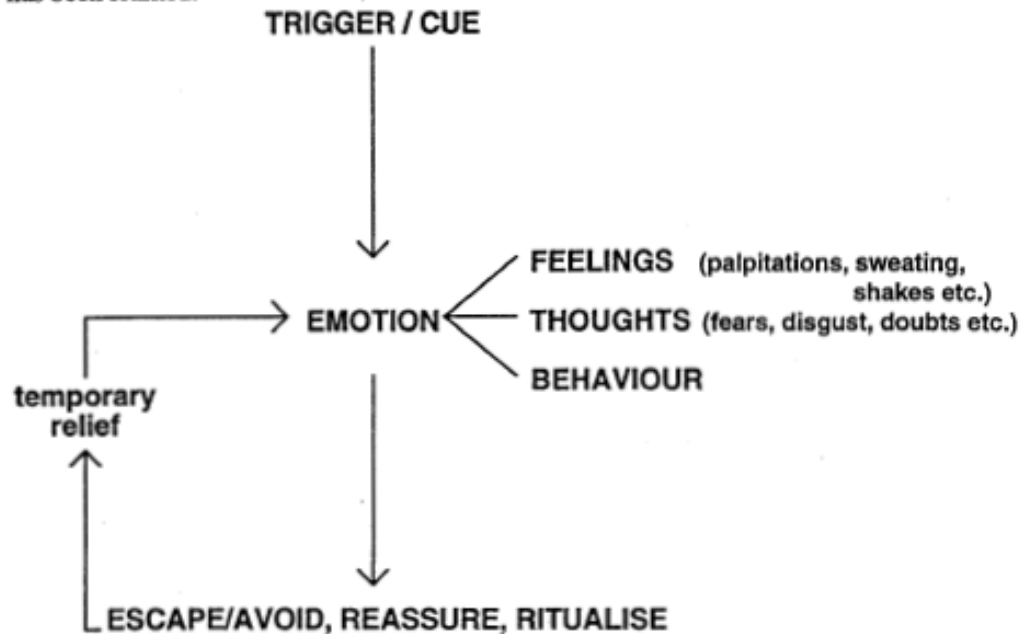
1. The explanation should be clear, concise and understandable. Informed consent can then be gained and clients will understand why they are asked to comply with an occasionally distressing treatment.
2. It should contain explanations of what is presently happening to the client and what they can do about changing this e.g. explain the nature and origin of anxiety symptoms. This can begin to challenge unrealistic fears e.g. "I'm going to have a heart attack".

Using examples of habituation may be helpful to the client, such as everyday anxieties e.g. interviews, or specific case examples that you have come across.

The client should be told that anxiety is made of many components including:

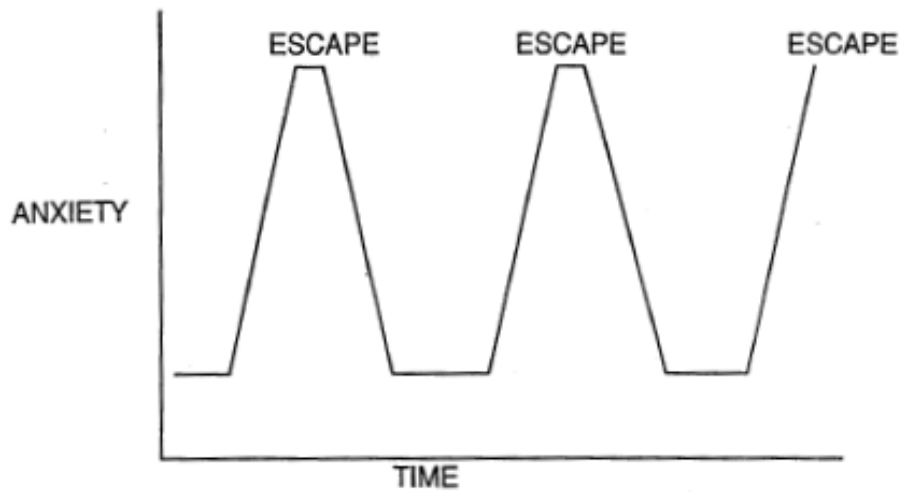
- BEHAVIOUR - what they do when anxious.
- FEELINGS - what they feel when anxious.
- THOUGHTS - what they think when anxious.

By using these three components, a demonstration of what happens in feared situations can be given to the client. Important aspects peculiar to the individual can then be filled in under the categories by the client. This diagram can then be kept by the client in order to reinforce what has been learned.



The diagram can be adapted depending on the clients description of their problem e.g. thoughts may be the trigger in OCD or may set off some phobic avoidances. It should be emphasised that it is the escape/avoidance behaviour in this circle that maintains the problem and is the most important to work on.

Once the client is aware of what is happening to them they need to be made aware of what can be done about it. To lead into this it is useful to demonstrate how the client's anxiety levels fluctuate with their present behaviour, whilst referring back to the three systems diagram.



It can be pointed out that this behaviour was originated as a response to fear and that new, less handicapping, behaviours can be learned.

It is important when explaining self-exposure principles to make the explanation clear and concise. Time spent, at this stage of treatment, on ensuring that the client is sure of, and fully understands, the rationale is time well spent. This will enable them to solve any problems that may arise during treatment without the need for therapist input e.g. homework task too hard, therefore adjust it themselves so as not to waste a weeks practice time.

Having demonstrated what happens with their present behaviour, we need to demonstrate what would happen if they were to remain in the feared situation i.e. exposure. We need to introduce the fact that self-exposure needs to be prolonged (1-2hrs) to allow the anxiety to reduce naturally, and this has been shown to be true by extensive research.



It is useful for the client to see the patterns of anxiety for habituation and escape. They can then keep the graph as a reminder that anxiety will reduce given time.

We have introduced the idea of prolonged self-exposure. Now we must explain how it will be graded. This can be done by using a hierarchy system of fears. The client ranks feared situations in order from most to least feared. They then go about tackling these in order starting with the least feared. In this systematic way the tasks gradually get harder and harder as the client gets more confident and starts to avoid less. In some instances it is difficult to grade exposure e.g. OCD, but where possible it is advisable to build a client's confidence before moving to harder tasks.

It should be made clear to the client that self-exposure needs to be practised on a regular, frequent and repeated basis. This practice should be done in the form of daily homework. The old adage of "practice makes perfect" is very true in this case. Homework should be prolonged, regularly practised and repeated frequently (at least 1 hr per day).

5. INFORMATION GIVING. (5-10 mins)

It should be pointed out at this stage that it is the clients responsibility to tackle what is, after all, their problem. There are no magic cures administered by the therapist. The harder they work, the greater their chances of improvement. The therapist is there to assist, support, and advise the client whilst they go about changing their behaviour. Treatment will make demands on their time and they should consider it as the priority in their life (chances of success diminish if treatment takes the back seat). This is a reasonable request considering the short duration of treatment.

Clients should also be made aware of the chances of success should they complete a reasonable trial of treatment. Many studies give efficacy figures for behavioural treatments with varying disorders, and these can be quoted if necessary. However, it should be made clear that this is not a guarantee of success, but they have as good a chance as anyone else.

Sometimes the ward environment or travelling may be a problem, or sharing toilet and bathing facilities. Clients should be shown the environment and something of the routine adopted there should be told.

In summary the client should gain the following things from the treatment rationale :

1. explanation of present problem.
2. information about what needs to be done to overcome it.
3. information about how the techniques will be carried out i.e. prolonged, repeated, graded self-exposure with homework.
4. information about possible treatment difficulties, chances of success (where available).
5. information about the environment in which treatment will take place.

The therapist should ask if the client has any further questions, and these should be answered before checking that the client has understood what has been said. This can be done by asking them to explain the treatment back to you.

6. CLIENTS CONSENT TO TREATMENT.

Armed with this information the client is then able to make an informed judgement of whether they can make the commitment to work at their problem using behavioural methods. Their consent to treatment should be gained before proceeding any further.

7. ANY OTHER ISSUES.

Any other issues should be dealt with at the end i.e. expenses, date of admission, contingency homeworks etc..

Most assessments should take about 1-1½ hours even for more difficult cases. Initially you may take up to 2-2½ hours, but with training and supervision this time should soon decrease.

Appendix 3 Case Specific Measures

(reprinted with permission)

CASE SPECIFIC MEASURES

(a) Problem Statements

Problem definition is an essential step in any problem-orientated approach including the nursing process (Tiernay, 1984). Explicit definitions are much easier to measure than woolly ones. It is better to write a problem down in a simple but comprehensive way that is immediately understandable, than to miss bits out or to leave things open to misinterpretation. This is a lot easier said than done. One way to structure problem statements is to base them on the behavioural analysis that formed part of our assessment. An example is given below.

'Anxiety when leaving the house for fear of panicking, leading me to avoid pubs, clubs, shops and other crowded places and thus restricting my daily life'.

Planning and evaluating therapy

The components of this statement are:

- 1 The problem - anxiety
- 2 The feared consequence - fear of panicking
- 3 The antecedent - when leaving the house
- 4 The behaviour - avoiding pubs, clubs and shops
- 5 The consequence - restriction of daily life

A problem statement is thus very exact and precise. Not only is the problem - anxiety - stated, but also made concrete are the exact nature of the client's fears, the context of his fears, the behavioural manifestation of his fears and the effects of fear on the person's life.

The important part of any problem statement is no doubt the first bit, eg 'compulsive urges to binge eat' or 'inability to achieve erection,' etc, but problem statements are most useful if we can put them into context as above. Two problem statements of this nature are usually enough to accurately describe a client's difficulties.

Problems are also best stated in the client's own words. We should always avoid putting words in the client's mouth, defining problems is no different. It can be quite a useful exercise to ask a client to say, in one short sentence, what their problem is. This can then be developed with the client until agreement is reached.

(b) Targets

Targets (or goals) are specific activities that clients currently find difficult and wish they were able to do were it not for their problems.

Targets are:

- identified from problem statements
- precise
- stated positively
- client centred
- realistic
- measurable

Targets decided on at assessment are long term aims and not the same as weekly treatment goals. The best targets are those derived from the problem statements and thus immediately relevant to the client's situation. They need to be precise in their description of what is to be achieved, ie.

- *What* behaviour is to be demonstrated
- *The conditions* under which the behaviour is to be performed, eg alone or accompanied, where, etc
- *Frequency, duration*, etc, to evaluate the behaviour.

An example of a target that is derived from our previous problem statement might be:

Shopping alone, at a busy time, for one hour, twice a week in the local supermarket.

The components of this statement are:

- 1 The behaviour - shopping
- 2 The conditions - alone, at busy times
- 3 The frequency - twice a week
- 4 The duration - for one hour

The target is not only precise but is directly related to the client's problem, ie fear of panicking in crowded places. Targets are normally stated in terms of what the client is to do and they should be realistic and practical. They should also be things that the client would actually *want* to do if he were not handicapped by his problems. Stating targets positively, ie what is to be achieved rather than what is not to happen is essential. Clients will feel much better about progress towards an achievable target than emphasis on reducing some other behaviour.

Measuring problems and targets

Problem severity can be measured by using a 9-point category scale. This is merely a straight line on a piece of paper which has 9 points along its length. Each point represents a category. In the scales used to measure problems and targets the line is categorised according to how much the problem upsets the client and interferes with his normal activities. So point 2 indicates that the problem slightly upsets the client and sometimes interferes with his normal activities, whereas point 8 indicates that the problem very severely upsets him and continuously interferes with his normal activities. In fact the 9-point scale has become an accepted standard in the clinical measurements outlined in this book. Different circumstances require different categories along the scale but the principles remain the same. The client chooses the category that best

describes how he feels about the statement above the scale. This is then recorded on the form.

Planning and evaluating therapy

Thus, once problems have been defined, they can be measured by asking the client how much, 'This problem upsets me and/or interferes with my normal activities.' The scale used is reproduced below.

'This problem upsets me and/or interferes with my normal activities'				
0	2	4	6	8
does not	slightly/ sometimes	definitely/ often	markedly/ very often	very severely/ continuously

The client's self rating can then be recorded. It can sometimes be useful to include a 'therapist's rating' of the same problem, though this will rarely differ from the client's rating, especially at assessment. The client is usually the best judge of his problem severity.

Measurement of targets takes the same format. This allows targets to be partly achieved, rather than an all-or-nothing approach which can only emphasise failure. A similar scale is used by the emphasis here is on progress towards achievement of the targets. The client can be asked to rate his, 'progress towards achieving each target regularly and without difficulty'. The actual scale used is a percentage success rate, as follows:

'My progress towards achieving each target regularly without difficulty'					
	0	2	4	6	8
Discomfort	none	slight	definite	marked	very severe
Behaviour	complete success	75% success	50% success	25% success	no success

Again, a higher rating indicates greater difficulty with achieving the target and, if the targets are relevant, a greater problem severity.

VALIDATED QUESTIONNAIRES

(a) Work and social adjustment - a measure of handicap

One thing that is very important to know is what effect the client's problems have on his day to day existence. We have already asked about this in the assessment, but we can quantify it by using a very useful measure, the Work and Social Adjustment scale (Marks I.M., 1986). Again using our zero to 8 scale the client is asked to rate how his problem affect four key areas in his life. These are: work (earning money type of work), home management, social leisure (ie with other people) and private leisure. The full questionnaire is reproduced in Appendix A but one section is shown below.

' Because of my problems my ability to work is impaired'								
0	1	2	3	4	5	6	7	8
not at all		slightly		definitely		markedly		very severely/ I cannot work

Each area thus has a score of between 0 and 8 and we have a neat profile of the impact of the problem on the client's life. This measure, along with problems and targets is suitable for all clients regardless of their problems. In fact research has indicated that it is possible to extend this measure to many more psychiatric patients than those suitable for behavioural psychotherapy (Richards *et al.*, 1988). This is a reasonable assumption since the social adjustment scale asks for ratings of the effect of *any* problem on the person's life. Along with problem and target measurement this would give us an excellent outcome measure in quality assurance exercises.

(b) The Fear Questionnaire

The Fear Questionnaire (Marks, I.M. and Mathews, A.M., 1979) was developed by analysing the responses of over 1000 people with phobias, and reliably picks out certain types of common fears. It has been used for over 10 years now and has facilitated comparisons of the results of treatments from many different centres and research studies. A full copy of the questionnaire is reproduced in Appendix A.

The Fear Questionnaire is divided into three parts. The client completes the questionnaire himself after explanation. In the first part, the top line is left blank for the client to write in a short definition of his main feared situation or object. Following this are 15 common phobic situations and then another space for any additional fears not covered in the previous 15 items. The client rates how much he avoids these situations on a zero to 8 scale, zero being 'would not avoid' and 8 being 'always avoid'. Within the 15 items are 5 typically agoraphobic situations, 5 blood and injury fears and 5 social phobic situations. These three sub-scales are added up independently and then totalled together. This therefore gives both a total score and a breakdown of the main areas of phobic avoidance. The 'main phobia' is also rated as is any additional situations if identified.

The second part of the questionnaire measures 'dysphoria'. This is the term used to describe the mixture of anxiety and related depression found in phobias. Groups of symptoms are described eg; 'miserable and depressed', 'irritable and angry' and the client is asked to rate how troublesome these symptoms are in his daily life. The zero to 8 scale used here ranges from zero = 'hardly troublesome at all' to 8 = 'very severely troublesome'. This second section is then added together to give a total score.

The final section is a zero to 8 scale that asks the client to rate how disturbing and disabling his phobic symptoms are, and is referred to as the global phobic score. It ranges from 'no phobias present' to 'very severely disturbing and disabling'. This gives us an idea of the overall impact of the client's phobic anxiety.

The Fear Questionnaire, therefore, gives a lot of valuable information as well as being a reliable way of measuring treatment outcome. It should be used to complement the assessment and definition of a person's problems. It remains most useful, however, as an excellent outcome measure of overall phobic anxiety and can be given to all phobic clients taken into treatment.

(c) The Beck Depression Inventory (BDI)

This is a questionnaire developed by Aaron Beck (Beck *et al.*, 1961) famous for his work on the cognitive therapy of depression. In it, certain areas of depressive thoughts and feelings are identified. Each area then has a choice of statements about it, the client being asked to choose the statement for each area that best describes how they feel. The statements are ranked for each area, going from a fairly innocuous statement to a statement that is typical of very depressed thinking. Each statement has a score, the more depressive the statement, the higher the score. These individual scores are added together to get a total. An example is given below:

If depression is a prominent feature in a client's presenting problems or is hinted at in the dysphoria sub-scale of the fear questionnaire, the BDI can be given to assess mood. The BDI is

Table 6.4 Beck Depression Inventory - example

3	I feel as though I am very bad or worthless
2	I feel quite guilty
1	I feel bad or unworthy a good part of the time
0	I don't feel particularly guilty

better than the dysphoria sub-scale at evaluating mood since it is only concerned with depression. Certain scores ring alarm bells and these are detailed in Beck *et al* (1961). However, it is not necessary to give the BDI to every client, only those for whom there is a strong depressive element to their presenting problem.

PROBLEMS AND TARGETS

Patient:..... Hospital No:..... Therapist:.....

Date:.....

PROBLEMS

PROBLEM A

	Pre	Mid	Post	1m	3m	6m	12m
Self							
Therapist							

PROBLEM B

	Pre	Mid	Post	1m	3m	6m	12m
Self							
Therapist							

"This problem upsets me and/or interferes with my normal activities"

0	1	2	3	4	5	6	7	8
does not		slightly/ sometimes		definitely/ often		markedly/ very often		very severely/ continuously

TARGETS

A1

	Pre	Mid	Post	1m	3m	6m	12m
Self							
Therapist							

A2

Self							
Therapist							

B1

Self							
Therapist							

B2

Self							
Therapist							

"My progress towards achieving each target regularly without difficulty"

	0	2	4	6	8
DISCOMFORT	none/ complete	slight/ 75%	definite/ 50%	marked/ 25%	very severe/ no success
BEHAVIOUR					

Appendix 4 Identifying & Challenging Negative Thoughts

(reprinted with permission)

IDENTIFYING & CHALLENGING NEGATIVE THOUGHTS (A-B-C-D-E)						
This form builds upon your skill in identifying negative thoughts. Continue to write down the negative thoughts you have identified, and now also record how you challenged and disputed them leading to a new emotional consequence using the A-B-C-D-E model.						
Date	Situation or event (A)	Thoughts identified in response to the situation (B)	Emotional consequences (C)	Counter-thoughts that Dispute or Challenge the Negative Thoughts (D)	New Emotional consequences (E)	Comments
Example 5/10/01	Received an overdue account for council rates.	I'll never be able to catch up with my bills. It's all my fault that this happens. I'm a total loser.	Helpless Hopeless Frustrated Depressed	How can I say I'll never catch up with my bills? No, it's only partly my fault. Being unable to pay one bill doesn't make me a loser.	More optimistic Confident Relaxed Less depressed	This happens often, but I can try to manage each situation as they arise.

Appendix 5 Paper 1

Beckwith, A.R. & Crichton, J. (2010) The negotiation of the problem statement in cognitive behavioural therapy.

Communication and Medicine, v. 7(1), pp. 23-32

NOTE:

This publication is included on pages 190-199 in the print copy of the thesis held in the University of Adelaide Library.

Appendix 6 Consent Form and Subject Information Sheets

THE UNIVERSITY OF ADELAIDE HUMAN RESEARCH ETHICS COMMITTEE

STANDARD CONSENT FORM FOR PEOPLE WHO ARE SUBJECTS IN A RESEARCH PROJECT

1. I,(please print
name)

consent to take part in the research project entitled:

**“The Discourse Analysis of Sessions of Cognitive and Behavioural
Therapy (CBT)”**

2. I acknowledge that I have read the attached Information Sheet titled
“The Discourse Analysis of Sessions of Cognitive and Behavioural
Therapy (CBT)”
3. I have had the project, so far as it affects me, fully explained to my
satisfaction by the research worker. My consent is given freely.
4. Although I understand that the purpose of this research project is to
improve the quality of medical care, it has also been explained that my
involvement may not be of any benefit to me.
5. I have been informed that, while information gained during the study
may be published, I will not be identified and my personal results will
not be divulged.
7. I understand that I am free to withdraw from the project at any time and
that this will not affect medical advice in the management of my health,
now or in the future.
8. I am aware that I should retain a copy of this Consent Form, when
completed, and the attached Information Sheet.
9. I agreed to my sessions of CBT being videotaped YES / NO
(please circle one)

.....
(signature)

.....
(date)

WITNESS

I have described to(*name of subject*)

the nature of the procedures to be carried out. In my opinion she/he understood the explanation.

Status in Project:

.....

Name:

.....

.....
(*signature*)

.....
(*date*)

Subject Information Sheet - Client

Project Title: The Discourse Analysis of Sessions of Cognitive and Behavioural Therapy (CBT).

Chief Investigators: Dr Andrew Beckwith – University of Adelaide
Dept of Psychiatry.

Dr Professor Robert Barrett – University of
Adelaide Dept of Psychiatry.

You are invited to take part in a study being conducted by the University of Adelaide Department of Psychiatry and the XXXXXXXXXXXX Service. This study forms part of a PhD program. We are interested in looking at how Cognitive and Behavioural Therapy (CBT) is put into practice when clinicians treat clients at the Centre for Anxiety and Related Disorders. We are particularly interested in the language used by clinician and clients during a course of therapy. We expect that this will lead to a better understanding of how CBT works. It is our hope that this will ultimately improve the quality of treatment. However, you may not directly benefit from participating in this study.

If you agree to participate you will undertake your course of CBT in the usual way. Each session will be videotaped by an unmanned camera. The tapes will then be studied carefully to look at the language processes used in the

CBT sessions. To aid in this the tapes will be transcribed by a confidential legal transcription service.

The tapes will be handled with the strictest confidence and will be kept in locked storage. Other than information on the tapes, no extra personal details will be recorded. The information on the tapes will only be used for research purposes. The results of this study may be published but you will not be identified and your personal details will not be divulged

Your involvement in this study is voluntary and you are free to withdraw from the study at any time. If you withdraw from the study and do not wish any of your video tapes to be used for research they will be destroyed. Your choice to not be involved in or withdraw from this study will not in any way affect your treatment by the XXXXXXXXXXXXXXXX service.

This study has been reviewed and approved by the University of Adelaide Human Research Ethics Committee and the XXXXXXXXXXXX Clinical Research Ethics Committee.

If you have any questions or concerns about this study please do not hesitate to ring Dr Andrew Beckwith on 82225141. I also refer you to the attached complaints form.

If you, as a participant of this research, suffer injury, compensation may, at the discretion of the researcher or sponsor of the research, be paid without litigation. However, compensation is not automatic and you may have to take legal action in order to receive payment.

This study has been reviewed by the XXXXXXXXXXXXXXXX Ethics Committee.

Should you wish to discuss the study with someone not directly involved, in particular in relation to matters concerning policies, your rights as a participant, or should you wish to make a confidential complaint, you may contact the Administrative Officer – Research, XXXXXXXXXXX, at the XXXXXXXX (8XXXXXXX).

Subject Information Sheet - Clinician

Project Title: The Discourse Analysis of Sessions of Cognitive and Behavioural Therapy (CBT).

Chief Investigators: Dr Andrew Beckwith – University of Adelaide
Dept of Psychiatry.

Professor Robert Barrett – University of
Adelaide Dept of Psychiatry.

You are invited to take part in a study being conducted by the University of Adelaide Department of Psychiatry and the XXXXXXXXXXXX Service. This study forms part of a PhD program. We are interested in looking at how Cognitive and Behavioural Therapy (CBT) is put into practice when clinicians treat clients at the XXXXXXXXXXXX Service. We are particularly interested in the language used by clinician and clients during a course of therapy. We expect that this will lead to a better understanding of how CBT works. It is our hope that this will ultimately improve the quality of treatment.

If you agree to participate you will undertake your sessions of CBT in the usual way with your clients. Each session will be videotaped by an unmanned camera. The tapes will then be studied carefully to look at the language processes used in the CBT sessions. To aid in this the tapes will be transcribed by a confidential legal transcription service.

The tapes will be handled with the strictest confidence and will be kept in locked storage. Other than information on the tapes, no extra personal details will be recorded. The information on the tapes will only be used for research purposes and will not be used to assess work performance. The results of this study may be published but you will not be identified and your personal details will not be divulged

Your involvement in this study is voluntary and you are free to withdraw from the study at any time. If you withdraw from the study and do not wish any of your video tapes to be used for research they will be destroyed. Your choice to not be involved in or withdraw from this study will not in any way affect your work the XXXXXXXXXXXXX service.

This study has been reviewed and approved by the University of Adelaide Human Research Ethics Committee and the XXXXXXXXXXXXX Clinical Research Ethics Committee.

If you have any questions or concerns about this study please do not hesitate to ring. Dr Andrew Beckwith on 82225141. I also refer you to the attached complaints form.

If you, as a participant of this research, suffer injury, compensation may, at the discretion of the researcher or sponsor of the research, be paid without litigation. However, compensation is not automatic and you may have to take legal action in order to receive payment.

This study has been reviewed by the XXXXXXXX Clinical Research Ethics Committee.

Should you wish to discuss the study with someone not directly involved, in particular in relation to matters concerning policies, your rights as a participant, or should you wish to make a confidential complaint, you may contact the Administrative Officer – Research, Ms. XXXXXXXX, at the XXXXXXXX (8XXXXXXX).

References

- Ablon, J. S., & Jones, E. E. (1999). Psychotherapy process in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, 67(1), 64–75. doi: 10.1037/0022-006x.67.1.64
- Ackerman, N. W. (1966). *Treating the troubled family*. New York: Basic Books.
- Agras, W. S., Walsh, T., Fairburn, C. G., Wilson, G. T., & Kraemer, H. C. (2000). A multicenter comparison of cognitive-behavioral therapy and interpersonal psychotherapy for bulimia nervosa. *Archives of General Psychiatry*, 57(5), 459–466.
- Agras, W. S., & Wilson, G. T. (1995). Learning theory. In H. I. Kaplan & B. J. Sadock (Eds.), *Comprehensive textbook of psychiatry, Vol. 1* (6th ed., pp. 300–310). Baltimore: Williams and Wilkins.
- Ainsworth-Vaughn, N. (1998). *Claiming power in doctor–patient talk*. Oxford: Oxford University Press.
- Allen, J. G., & Fonagy, P. (eds). (2006). *The handbook of mentalization-based treatment*. Chichester: John Wiley & Sons Ltd.
- American Psychiatric Association. (2006). *American Psychiatric Association practice guidelines for the treatment of psychiatric disorders: Compendium*. Arlington: American Psychiatric Publishing.
- Andrews, G., Oakley-Browne, M., Castle, D., Judd, F., & Baillie, A. (2003). Summary of Guideline for the treatment of panic disorder and agoraphobia. *Australasian Psychiatry*, 11(1), 29–33. doi:10.1046/j.1440-1665.2003.00529.x
- Antaki, C. (2008). Formulations in psychotherapy. In A. Peräkylä, C. Antaki, S. Vehvilainen & I. Leudar (Eds.), *Conversation analysis and psychotherapy* (pp. 26–42). Cambridge: Cambridge University Press.

- Antaki, C. (2011). Six kinds of applied conversation analysis. In C. Antaki (Ed.), *Applied conversation analysis: Intervention and change in institutional talk*. Basingstoke: Palgrave Macmillan.
- Antaki, C., Barnes, R., & Leudar, I. (2004). Trouble in agreeing on a client's problem in a cognitive behavioural therapy. *Rivista di Psicolinguistica Applicata*, 4, 127–138.
- Antaki, C., Barnes, R., & Leudar, I. (2005). Diagnostic formulations in psychotherapy. *Discourse Studies*, 7(6), 627–647.
doi:10.1177/14611445605055420
- Antony, M. M., & Swinson, R. P. (1998). *When perfect isn't good enough: Strategies for coping with perfectionism*. Oakland: New Harbinger Publications.
- Australian Government. Department of Health and Ageing. (2013). Medicare Benefits Schedule — Note M7.1 Retrieved 15/5/2013, 2013, from <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M7.1&qtype=noteID&criteria=psychology>
- Avdi, E., & Georgaca, E. (2007). Discourse analysis and psychotherapy: A critical review. *European Journal of Psychotherapy & Counselling*, 9(2), 157–176. doi: 10.1080/13642530701363445
- Ayllon, T. (1963). Intensive treatment of psychotic behaviour by stimulus satiation and food reinforcement. *Behaviour Research and Therapy*, 1(1), 53–61. doi: 10.1016/0005-7967(63)90008-1
- Ayllon, T., & Azrin, N. (1968). *The token economy*. New York: Wiley.
- Bacon, M. (2012). *Pragmatism: An introduction*. Cambridge: Polity.
- Bakhtin, M. M. (1986). *Speech genres and other late essays* (V. W. McGee, Trans.). Austin: University of Texas Press.

- Bales, D., van Beek, N., Smits, M., Willemsen, S., Busschbach, J. J., Verheul, R., et al. (2012). Treatment outcome of 18-month, day hospital mentalization-based treatment (MBT) in patients with severe borderline personality disorder in the Netherlands. *Journal of Personality Disorders*, 26(4), 568–582. doi: 10.1521/pedi.2012.26.4.568
- Bandura, A. (1969). *The principles of behavior modification*. New York: Holt, Rinehart and Winston, Inc.
- Banon, E., Perry, J. C., Semeniuk, T., Bond, M., de Roten, Y., Hersoug, A. G., & Despland, J.N. (2013). Therapist interventions using the Psychodynamic Interventions Rating Scale (PIRS) in dynamic therapy, psychoanalysis and CBT. *Psychotherapy Research*, 23(2), 121-36. doi: 10.1080/10503307.2012.745955
- Barber, J. P., Muran, C. J., McCarthy, K. S., & Keefe, J. R. (2013). Research on dynamic therapies. In M. J. Lambert (ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 443–494). Hoboken: John Wiley & Sons, Inc.
- Barrett, R. J. (1988). Clinical writing and the documentary construction of schizophrenia. *Culture, Medicine and Psychiatry*, 12(3), 265–299. doi: 10.1007/bf00051971
- Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. *American Journal of Psychiatry*, 156(10), 1563–1569.
- Bateman, A. W., & Fonagy, P. (2004a). Mentalization-based treatment of BPD. *Journal of Personality Disorders*, 18(1), 36–51. doi:10.1521/pedi.18.1.36.32772
- Bateman, A., & Fonagy, P. (2004b). *Psychotherapy for borderline personality disorder: Mentalization based treatment*. Oxford: Oxford University Press.

- Bateman, A., & Fonagy, P. (2006). *Mentalization-based treatment for borderline personality disorder: A practical guide*. Oxford: Oxford University Press.
- Bateman, A., & Fonagy, P. (2009). Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. *American Journal of Psychiatry*, 166(12), 1355–1364. doi: 10.1176/appi.ajp.2009.09040539
- Bateman, A., & Fonagy, P. (2011). *Handbook of mentalizing in mental health practice*. Arlington: American Psychiatric Publishing.
- Beck, A. T. (1967). *Depression: Causes and treatments*. Philadelphia: University of Pennsylvania Press.
- Beck, A. T. (1970). Cognitive therapy: Nature and relation to behavior therapy. *Behavior Therapy*, 1(2), 184–200. doi: 10.1016/S0005-7894(70)80030-2
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.
- Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). New York: The Guilford Press.
- Beckwith, A., & Crichton, J. (2010). The negotiation of the problem statement in cognitive behavioural therapy. *Communication and Medicine* 7 (1): 23–32. doi:10.1558/cam.v7i1.23
- Bhatia, V. K., Candlin, C. N., & Engberg, J. (Eds.). (2008). *Legal discourse across cultures and systems*. Hong Kong: Hong Kong University Press.
- Bhatia, V. K., Candlin, C. N., & Gotti, M. (Eds.). (2012). *Discourse and practice in international commercial arbitration*. Farnham: Ashgate.
- Billig, M. (1999). Conversation Analysis and the Claims of Naivety. *Discourse & Society*, 10(4), 572-576. doi: 10.1177/0957926599010004007

- Bieling, P., McCabe, R. E., & Antony, M. M. (2009). *Cognitive-behavioral therapy in groups*. New York: The Guilford Press.
- Blackburn, I. M., James, I. A., Milne, D. M., Baker, C., Standart, S. H., Garland, A., et al. (2001). The revised cognitive therapy scale (CTS-R): Psychometric properties. *Behaviour and Cognitive Psychotherapy*, 29(4), 431–446. doi:10.1017/S1352465801004040
- Brakemeier, E. L., & Frase, L. (2012). Interpersonal psychotherapy (IPT) in major depressive disorder. *European Archives of Psychiatry and Clinical Neuroscience*, 262 Suppl 2, S117–121. doi: 10.1007/s00406-012-0357-0
- Breuer, J. (1955). Fraulein Anna O. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud*. London: Hogarth press.
- Breuer, J., & Freud, S. (1955). *Studies in hysteria* (Vol. 2). London: Hogarth Press.
- Brookes-Howell, L. C. (2006). Living without labels: The interactional management of diagnostic uncertainty in the genetic counselling clinic. *Social Science and Medicine*, 63, 3080–3091. doi:10.1016/j.socscimed.2006.08.008
- Brown, P., & Levinson, S. C. (1987). *Politeness: Some universals in language usage*. Cambridge: Cambridge University Press.
- Buchbinder, M. H. (2008). 'You're still sick!' Framing, footing, and participation in children's medical play. *Discourse Studies*, 10(2), 139–159. doi: 10.1177/1461445607087018
- Burns, D. D. (1999a). *The feeling good handbook* (2nd ed.). New York: Plume.
- Burns, D. D. (1999b). *Feeling good: The new mood therapy* (2nd ed.). New York: Quill.

- Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, 26(1), 17–31. doi: 10.1016/j.cpr.2005.07.003
- Buttny, R. (1996). Clients' and therapist's joint construction of the clients' problem. *Research on Language and Social Interaction*, 29(2), 125–153. doi: 10.1207/s1532797rlsi2902_2
- Candlin, C.N. (2000). Reinventing the patient/client: New challenges to healthcare communication. Paper presented at the The Cardiff Lecture, Cardiff.
- Candlin, C.N., & Candlin, S. (2002). Discourse, expertise, and the management of risk in health care settings. *Research on Language and Social Interaction*, 35(2), 115–137. doi:10.1207/S15327973RLSI3502_1
- Candlin, C. N., & Crichton, J. (2011). Introduction. In C. N. Candlin & J. Crichton (Eds.), *Discourse of deficit* (pp. 1–22). New York: Palgrave MacMillan.
- Candlin, C. N., & Maley, Y. (1997). Intertextuality and interdiscursivity in the discourse of alternative dispute resolution. In B.-L. Gunnarsson, P. Linell & B. Nordberg (Eds.), *The construction of professional discourse* (pp. 201–222). Harlow: Addison Wesley Longman Ltd.
- Candlin, C. N., & Sarangi, S. (2004). *Making applied linguistics matter*. *The Journal of Applied Linguistics*, 1(1), 1-8. doi : 10.1558/japl.2004.1.1.
- Candlin, C.N & Sarangi, S. (Eds.) (2011), *Handbook of communication in organisations and professions*. Berlin: Walter de Gruyter.
- Candlin, S. (2002). Taking risks: An indicator of expertise? *Research on Language & Social Interaction*, 35(2), 173–193. doi: 10.1207/s15327973rlsi3502_3

- Candlin, S. (2011). Changes in professional identity: Nursing roles and practice. In C. N. Candlin & S. Sarangi (Eds.), *Handbook of communication in organisations and professions* (pp. 551–569). Berlin: Walter de Gruyter.
- Carroll, K., Iedema, R., & Kerridge, R. (2008). Reshaping ICU ward round practices using video-reflexive ethnography. *Qualitative Health Research*, 18(3), 380–390. doi: 10.1177/1049732307313430
- Cautin, R. L. (2011). A century of psychotherapy 1860–1960. In J. C. Norcross, G. R. vandenBos & D. K. Freedheim (Eds.), *History of psychotherapy: Continuity and change* (2nd ed., pp. 3–62). Washington DC: American Psychological Association.
- Chenail, R. J., & Maione, P. V. (1999). Qualitative inquiry in psychotherapy: Research on the common factors. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart & soul of change: What works in therapy* (Ch. 3). Washington, DC: American Psychological Association.
- Cicourel, A. V. (1992). The interpenetration of communicative contexts: Examples from medical encounters. In A. Duranti & G. Charles (Eds.), *Rethinking context: Language as an interactive phenomenon* (pp. 291–310). Cambridge: Cambridge University Press.
- Clark, D. A., Beck, A. T., & Alford, B. A. (1999). *Scientific foundations of cognitive theory and therapy of depression*. New York: John Wiley & Sons.
- Clarkin, J. F., Fonagy, P., & Gabbard, G. O. (2010). *Psychodynamic psychotherapy for personality disorders: A clinical handbook*. Washington DC: American Psychiatric Publishing.
- Cooper, M. (2008). Essential research findings in counselling and psychotherapy. The facts are friendly. London: Sage Publications Ltd.
- Cooper, M., Todd, G., & Wells, A. (2000). *Bulimia nervosa: A cognitive therapy programme for clients*. London: Jessica Kingsley Publishers.

- Cooper, S. H., & Bond, M. (1992). The Psychodynamic Intervention Rating Scale (PIRS). Montreal. Unpublished manuscript.
- Craighead, W. E., Craighead, L. W., & Ilardi, S. S. (1995). Behavior therapies in historical perspective. In B. Bongar & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 64–83). New York: Oxford University Press.
- Crane, R. (2008). Mindfulness-based cognitive therapy: Distinctive features. Hove: Routledge.
- Crichton, J. (2010). The discourse of commercialization: A multi-perspectived analysis: Palgrave Macmillan.
- Crowe, M., & Luty, S. (2005). Recovery from depression: A discourse analysis of interpersonal psychotherapy. *Nursing Inquiry*, 12(1), 43–50.
- Davis, K. (1986). The process of problem (re)formulation in psychotherapy. *Sociology of Health*, 8, 44–74. doi:10.1111/1467-9566.ep11346469
- de Mello, M. F., de Jesus Mari, J., Bacaltchuk, J., Verdelli, H., & Neugebauer, R. (2005). A systematic review of research findings on the efficacy of interpersonal therapy for depressive disorders. *European Archives of Psychiatry and Clinical Neuroscience*, 255(2), 75–82. doi: 10.1007/s00406-004-0542-x
- Deane, F. P., Glaser, N. M., Oades, L. G., & Kazantzis, N. (2005). Psychologists' use of homework assignments with clients who have schizophrenia. *Clinical Psychologist*, 9(1), 24–30. doi: 10.1080/13284200500048141
- DeLeon, P. H., Kenkel, M. B., Garcia-Shelton, L., & VandenBos, G. R. (2011). Psychotherapy, 1960 to the present. In J. C. Norcross, G. R. VandenBos & D. K. Freedheim (Eds.), *History of psychotherapy: Continuity and change* (pp. 39–62). Washington DC: American Psychological Association.

- Dobson, K. S. (2010). *Handbook of cognitive behavior therapies* (Third ed.). New York: The Guilford Press.
- Donker, T., Bennett, K., Bennett, A., Mackinnon, A., van Straten, A., Cuijpers, P., et al. (2013). Internet-delivered interpersonal psychotherapy versus internet-delivered cognitive behavioral therapy for adults with depressive symptoms: randomized controlled noninferiority trial. *Journal of Medical Internet Research*, 15(5), e82. doi: 10.2196/jmir.2307
- Duranti, A., & Goodwin, C. (Eds.). (1992). *Rethinking Context: Language as an interactive phenomenon*. Cambridge: Cambridge University Press.
- Edwards, D., & Potter, J. (1992). *Discursive psychology*. London: Sage.
- Elkin, I., Shea, M. T., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, J. F., et al. (1989). National Institute of Mental Health Treatment of Depression Collaborative Research Program. General effectiveness of treatments. *Archives of General Psychiatry*, 46(11), 971–982; discussion 983.
- Ellis, P. (2004). Australian and New Zealand clinical practice guidelines for the treatment of depression. *Australian and New Zealand Journal of Psychiatry*, 38(6), 389–407. doi: 10.1111/j.1440-1614.2004.01377.x
- Ellis, P. M., Hickie, I. B., & Smith, D. A. R. (2003). Summary of guideline for the treatment of depression. *Australasian Psychiatry*, 11(1), 34–38.
- Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, 16(5), 319–324.
- Eysenck, H. J. (2004). *Decline and fall of the Freudian empire*: Transaction Publishers.
- Fairburn, C. G., Jones, R., Peveler, R. C., Hope, R. A., & O'Connor, M. (1993). Psychotherapy and bulimia nervosa. Longer-term effects of interpersonal psychotherapy, behavior therapy, and cognitive behavior therapy. *Archives of General Psychiatry*, 50(6), 419–428.
- Fairclough, N. (1992). *Discourse and social change*. Cambridge: Polity press.

- Fairclough, N. (1995). *Critical discourse analysis*. London: Longman.
- Fairclough, N. (2003). *Analysing discourse: Textual analysis for social research*. London: Routledge.
- Fairclough, N. (2010). *Critical discourse analysis: The critical study of language* (2nd ed.). Harlow: Pearson Education Ltd.
- Feeley, M., DeRubeis, R. J., & Gelfand, L. A. (1999). The temporal relation of adherence and alliance to symptom change in cognitive therapy for depression. *Journal of Consulting and Clinical Psychology*, 67(4), 578–582. doi: 10.1037/0022-006x.67.4.578
- Ferrara, K. W. (1994). *Therapeutic ways with words*. Oxford: Oxford University Press.
- Field, S. D., Barkham, M., Shapiro, D. A., & Stiles, W. B. (1994). Assessment of assimilation in psychotherapy: A quantitative case study of problematic experiences with a significant other. *Journal of Counseling Psychology*, 41(3), 397–406. doi: 10.1037/0022-0167.41.3.397
- Fine, J. (2006). *Language in Psychiatry: A handbook of clinical practice*. London: Equinox.
- Fishman, D. B., Rego, S. A., & Muller, K. L. (2011). Behavioral theories of psychotherapy. In J. C. Norcross, G. R. VandenBos & D. K. Freedheim (Eds.), *History of psychotherapy: Continuity and change*. Washington DC: American Psychological Association.
- Frank, E., & Levenson, J. C. (2010). *Interpersonal psychotherapy*. Washington DC: American Psychological Association.
- Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: The Johns Hopkins Univeristy Press.
- Freud, S. (2001). *The ego and the id and other works* (Vol. 19). London: Vintage.

- Gabbard, G. O. (2010). *Long-term psychodynamic psychotherapy: A basic text* (2nd ed.). Washington DC: American Psychiatric Publishing.
- Gafarange, J., & Britten, N. (2004). Formulation in general practice consultation. *Text*, 24(2), 147–170. doi:10.1515/text.2004.006
- Gale, J. E. (1991). *Conversation analysis of therapeutic discourse: The pursuit of a therapeutic agenda* (1st ed.), Advances in Discourse Processes, Vol. 41. Norwood: Ablex Publishing Corporation.
- Gale, J.E., & Newfield, N. (1992). A conversation analysis of a solution-focused marital therapy session. *Journal of Marital and Family Therapy*, 18(2), 153–165. doi: 10.1111/j.1752-0606.1992.tb00926.x
- Galletly, C., & Crichton, J. (2011). Accomplishments of the thought disordered person: A case study in psychiatrist–patient interaction. *Medical Hypotheses*, 77(5), 900–904. doi: <http://dx.doi.org/10.1016/j.mehy.2011.08.006>
- Garbutt, M. D. (1997). *Figure talk: Reporting speech and thought in the discourse of psychotherapy*. Doctor of Philosophy, Macquarie university, Sydney.
- Garfield, S. L. (1987). Towards a scientifically oriented eclecticism. *Scandinavian Journal of Behaviour Therapy*, 16(3), 95–109. doi: 10.1080/16506078709456250
- Garfinkel, H., & Sacks, H. (1970). On formal structures of practical actions. In J. C. McKinney & E. A. Tiryakian (Eds.), *Theoretical sociology* (pp. 337–366). New York: Appleton Century Cross Crofts.
- Gay, P. (2006). *Freud: A life for our times*. London: W. W. Norton & Company.
- Gee, J. P. (2011). An introduction to discourse analysis: Theory and method (3rd ed.). New York: Routledge.
- Gee, J. P., & Handford, M. (Eds.). (2012). *The Routledge handbook of discourse analysis*. New York: Routledge.

- Glaser, B., & Strauss, A. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine de Gruyter.
- Goffman, E. (1967). *Interaction ritual — essays on face-to-face behavior*. New York: Pantheon Books.
- Goffman, E. (1974). *Frame analysis*. Boston: University Press of New England.
- Goffman, E. (1979) . Footing. *Semiotica*, 25(1–2), 1–30. doi: 10.1515/semi.1979.25.1-2.1
- Greenberg, L. S., & Pinsof, W. M. (1986). *The psychotherapeutic process: A research handbook*. New York: The Guilford Press.
- Greenberger, D., & Padesky, C. A. (1995). *Mind over mood: Change how you feel by changing the way you think*. New York: The Guilford Press.
- Gumperz, J. J. (1982). *Discourse strategies*. Cambridge: Cambridge University Press.
- Gunderson, J. G., & Links, P. S. (2008). *Borderline personality disorder: A clinical guide* (2nd ed.). Arlington: American Psychiatric Publishing.
- Hak, T., & de Boer, F. (1996). Formulations in first encounters. *Journal of Pragmatics*, 25, 83–99. doi:10.1016/0378-2166(94)00076-7
- Hall, C., Sarangi, S., & Slembrouck, S. (2009). Speech representation and the categorization of the client in social work discourse. *Text — Interdisciplinary Journal for the Study of Discourse*, 19(4), 539–570. doi: 10.1515/text.1.1999.19.4.539
- Hall, C., Slembrouck, S., & Sarangi, S. (2006). *Language practices in social work: Categorisation and accountability in child welfare*. New York: Routledge.
- Halliday, M., & Matthiessen, C. (2004). *An introduction to functional grammar* (3rd ed.). London: Hodder Arnold.

- Hamilton, H. E. (2004). Symptoms and signs in particular: the influence of the medical concern on the shape of physician-patient talk. *Communication & Medicine*, 1(1), 59–70. doi: 10.1515/come.2004.006
- Hamilton, H. E., & Bartell, A. M. (2011). Peering inside the back box: Lay and professional reasoning surrounding patient claims of adverse drug effects. In C. N. Candlin & S. Sarangi (Eds.), *Handbook of Communication in Organisations and Professions* (pp. 143–171). Berlin: Walter de Gruyter.
- Hamilton, H. E., Gordon, C., Nelson, M., & Kerbleski, M. (2006). Physicians, nonphysician healthcare providers, and patients communicating in hepatitis C: an in-office sociolinguistic study. *Gastroenterology Nursing*, 29(5), 364–370.
- Hawton, K., Salkovskis, P., Kirk, J., & Clark, D. M. (1989a). The development and principles of cognitive-behavioural treatments. In K. Hawton, P. Salkovskis, J. Kirk & D. M. Clark (Eds.), *Cognitive behaviour therapy for psychiatric problems*. Oxford: Oxford University Press.
- Hawton, K., Salkovskis, P., Kirk, J., & Clark, D. M. (Eds.). (1989b). *Cognitive behaviour therapy for psychiatric problems*. Oxford: Oxford University Press.
- Hepburn, A., & Wiggins, S. (Eds.). (2007). *Discursive research in practice: New approaches to psychology and interaction*. Cambridge: Cambridge University Press.
- Heritage, J., & Maynard, D. W. (Eds.). (2006). *Communication in medical care: Interaction between primary care physicians and patients*. Cambridge: Cambridge University Press.
- Heritage, J., & Watson, D. (1979). Formulations as conversational objects. In G. Psathas (Ed.), *Everyday language: Studies in ethnomethodology* (pp. 123–162). New York: Irvington Publishers.

- Hickling, E. J., & Blanchard, E. B. (2006). *Overcoming the trauma of your motor vehicle accident: A cognitive-behavioral treatment program*. New York: Oxford University Press.
- Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert (Ed.), *Bergin's and Garfield's handbook of psychotherapy and behavior Change* (pp. 84–135). New York: John Wiley & Sons.
- Hollon, S. D., & DiGiuseppe, R. (2011). Cognitive theories of psychotherapy. In J. C. Norcross, G. R. VandenBos & D. K. Freedheim (Eds.), *History of psychotherapy: Continuity and change* (pp. 203–242). Washington DC: American Psychological Association.
- Holt, E. (1996). Reporting on talk: The use of direct reported speech in conversation. *Research on Language & Social Interaction*, 29(3), 219–245. doi: 10.1207/s15327973rlsi2903_2
- Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy*, 48(1), 9–16. doi: 10.1037/a0022186
- Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.). (1999). *The heart and soul of change: What works in therapy*. Washington: American Psychological Association.
- Iedema, R., Merrick, E. T., Kerridge, R., Herkes, R., Lee, B., Anscombe, M., et al. (2009). Handover—enabling learning in communication for safety (HELICS): A report on achievements at two hospital sites. *Medical Journal of Australia*, 190(11 Suppl), S133–S136.
- Iedema, R. A. M., Long, D., Forsyth, R., & Lee, B. B. (2006). Visibilising clinical work: Video ethnography in the contemporary hospital. *Health Sociology Review*, 15(2), 156–168.

- Jackson, S. (1999). *Care of the psyche: A history of psychological healing*. New Haven: Yale University Press.
- Jaworski, A., & Coupland, N. (Eds.). (2006). *The discourse reader* (2nd ed.). New York: Routledge.
- Jefferson, G. (1989). Preliminary notes on a possible metric which provides for a “standard maximum” silence of approximately one second in conversation. In D. Roger & P. Bull (Eds.), *Conversation: An interdisciplinary perspective* (pp. 166–196). Clevedon: Multilingual matters.
- Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G. Lerner (Ed.), *Conversation analysis: Studies from the first generation* (pp. 13–31). Amsterdam/Philadelphia: John Benjamins.
- Johnstone, B. (2008). *Discourse analysis* (2nd ed.). Malden: Blackwell Publishing.
- Jones, A., & Sin, S. (2003). Generic skills in accounting: Competencies for students and graduates. Sydney: Pearson Education.
- Jones, A., & Sin, S. (2004). The integration of language and content: Action research on a theory of task design. *Journal of Applied Linguistics*, 1(1), 95–100.
- Jones, M. C. (1924). The elimination of children’s fears. *Journal of Experimental Psychology*, 7(5), 382–390. doi: 10.1037/h0072283
- Jorgensen, C. R., Freund, C., Boye, R., Jordet, H., Andersen, D., & Kjolbye, M. (2013). Outcome of mentalization-based and supportive psychotherapy in patients with borderline personality disorder: a randomized trial. *Acta Psychiatrica Scandinavica*, 127(4), 305–317. doi: 10.1111/j.1600-0447.2012.01923.x
- Kanter, J. W., Busch, A. M., & Rusch, L. C. (2009). *Behavioral activation*. Hove: Routledge.

- Karasu, T. B., & Karasu, S. R. (2009). Psychoanalysis and psychoanalytic psychotherapy. In B. J. Sadock, V. A. Sadock & P. Ruiz (Eds.), *Kaplan and Sadock's comprehensive textbook of psychiatry* (9th ed., Vol. 2, pp. 2746–2774). Philadelphia: Lippincott Williams and Wilkins.
- Kazantzis, N., Deane, F. P., Ronan, K. R., & L'Abate, L. (Eds.). (2004). *Using homework assignments in cognitive behavior therapy*. London: Routledge.
- Kazdin, A. E. (1978). *History of behavior modification: Experimental foundations of contemporary research*. Baltimore: University Park Press.
- Kazdin, A. E. (2010). *Single-case research design: Methods for clinical and applied settings* (2nd ed.). New York: Oxford University Press.
- Kiesler, D. J. (1973). *The process of psychotherapy: Empirical foundations and systems of analysis*. Chicago: Aldine Publishing.
- Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders*. Chicago: University Of Chicago Press.
- Korner, A., Gerull, F., Meares, R., & Stevenson, J. (2006). Borderline personality disorder treated with the conversational model: A replication study. *Comprehensive Psychiatry*, 47(5), 406–411.
doi:10.1016/j.comppsy.2006.01.003
- Kristeva, J. (1986). Word, dialogue and novel. In T. Moi (Ed.), *The Kristeva reader* (pp. 36–61). New York: Columbia University Press.
- Kurri, K., & Wahlstrom, J. (2007). Reformulations of agentless talk in psychotherapy. *Text & Talk*, 27(3), 315–338.
doi:10.1515/TEXT.2007.013
- Labov, W., & Fanshel, D. (1977). *Therapeutic discourse : Psychotherapy as conversation*. New York: Academic Press.

- Lambert, M. J. (2013a). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 169–218). Hoboken: John Wiley & Sons, Inc.
- Lambert, M. J. (2013b). Introduction and historical overview. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 3–20). Hoboken: John Wiley & Sons, Inc.
- Lambert, M. J. (Ed.). (2013c). *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed.). Hoboken: John Wiley & Sons, Inc.
- Leahy, R. L. (2003). *Cognitive therapy techniques: A practitioner's guide*. New York: The Guilford Press.
- Leahy, R.L., & Holland, S. (2000). *Treatment plans and interventions for depression and anxiety disorders*. New York: The Guilford Press.
- Ledley, D. R., Marx, B. P., & Heimberg, R. G. (2010). *Making cognitive behavioral therapy work: Clinical process for new practitioners* (2nd ed.). New York: The Guilford Press.
- Lepper, G., & Mergenthaler, E. (2008). Observing therapeutic interaction in the “Lisa” case. *Psychotherapy Research*, 18(6), 634–644.
- Lepper, G., & Riding, N. (2006). *Researching the psychotherapy process. A practical guide to transcript-based methods*. Houndmills: Palgrave MacMillan.
- Lewis, B. (1995). Psychotherapeutic discourse analysis. *American Journal of Psychotherapy*, 49(3), 371–384.
- Lutz, W., & Hill, C. E. (2009). Quantitative and qualitative methods for psychotherapy research. *Psychotherapy Research*, 19(4–5), 369–373. doi: 10.1080/10503300902948053

- MacMartin, C., & Le Baron, C. (2006). Multiple involvements within group interaction: A video-based study of sex offender therapy. *Research on Language and Social Interaction*, 39(1), 41–80.
doi:10.1207/s15327973rlsi3901_3
- Madill, A., & Barkham, M. (1997). Discourse analysis of a theme in one successful case of brief psychodynamic-interpersonal psychotherapy. *Journal of Counselling Psychology*, 44(2), 232–244. doi: 10.1037/0022-0167.44.2.232
- Magnusson, M. B., Hulthén, L., & Kjellgren, K. I. (2009). Misunderstandings in multilingual counselling settings involving school nurses and obese/overweight pupils. *Communication and Medicine*, 6(2), 153–164.
doi: 10.1558/cam.v6i2.153
- Maranhao, T. (1986). *Therapeutic discourse and socratic dialogue: A cultural critique*. Madison: The University of Wisconsin Press.
- Marks, I. M. (1981). *Cure and care of neuroses*. Washington: American Psychiatric Press.
- Marks, I. M. (1986). *Behavioural psychotherapy: Maudsley pocket book of clinical management*. Bristol: IOP publishing Ltd.
- Marks, I. M. (1987). *Fears, phobias and rituals: Panic, anxiety and their disorders*. Oxford: Oxford University Press.
- Marks, I. M. (2001). *Living with fear: Understanding and coping with anxiety* (2nd ed.). Maidenhead: McGraw-Hill.
- Marks, I. M., Hallam, R. S., Connolly, J., & Philpott, R. (1977). *Nursing in behavioral psychotherapy: An advanced clinical role for nurses*. London: The Royal College of Nursing of the United Kingdom.

- McIntosh, A., Cohen, A., Turnbull, N., Esmonde, L., Dennis, P., Eatock, J., et al. (2004). *Clinical guidelines and evidence review for panic disorder and generalised anxiety disorder*. National Institute for Health and Clinical Excellence, 165. Retrieved from <http://www.nice.org.uk/nicemedia/pdf/cg022fullguideline.pdf>
- McLeod, J. (2001). *Qualitative research in counselling and psychotherapy*. London: Sage Publications Limited.
- McLeod, J. (2010). *Case study research in counselling and psychotherapy*. London: Sage Publications Ltd.
- McLeod, J. (2011). *Qualitative research in counselling and psychotherapy* (2nd ed.). London: Sage Publications Ltd.
- McLeod, J. (2013). Qualitative Research: Methods and contributions. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 49–84). Hoboken: John Wiley and Sons Inc.
- Meares, R. (2004). The conversational model: an outline. *American Journal of Psychotherapy*, 58(1), 51–66.
- Meares, R., Stevenson, J., & Comerford, A. (1999). Psychotherapy with borderline patients: I. A comparison between treated and untreated cohorts. *Australian and New Zealand Journal of Psychiatry*, 33(4), 467–472. doi:10.1080/j.1440-1614.1999.00594.x
- Meissner, W. W. (2009). Classical psychoanalysis. In B. J. Sadock, V. A. Sadock & P. Ruiz (Eds.), *Kaplan and Sadock's comprehensive textbook of psychiatry* (9th ed., Vol. 1, pp. 788–837). Philadelphia: Lippincott Williams and Wilkins.
- Mercer, N. (1995). *The guided construction of knowledge: Talk amongst teachers and learners*. Clevedon: Multilingual Matters.
- Minuchin, S. (1974). *Families and family therapy*. Harvard University Press.
- Mishler, E. G. (1984). *The discourse of medicine: Dialectics of medical interviews*. New Jersey: Ablex.

- Mitchell, S., & Black, M. (1995). *Freud and beyond: A history of modern psychoanalytic thought*. New York: BasicBooks.
- Mufson, L., Dorta, K. P., Moreau, D., & Weissman, M. M. (2011). *Interpersonal psychotherapy for depressed adolescents* (2nd ed.). New York: The Guilford Press.
- Mufson, L., Weissman, M. M., Moreau, D., & Garfinkel, R. (1999). Efficacy of interpersonal psychotherapy for depressed adolescents. *Archives of General Psychiatry*, 56(6), 573–579. doi: 10.1001/pubs.Arch Gen Psychiatry-ISSN-0003-990x-56-6-yoa8163
- Muntigl, P. (2004). *Narrative counselling: Social and linguistic processes of change* (Vol. 11). Amsterdam: John Benjamins Publishing Company.
- Muntigl, P., & Horvath, A. (2005). Language, psychotherapy and client change: An interdisciplinary perspective. In R. Wodak & P. Chilton (Eds.), *A new agenda in (critical) discourse analysis* (pp. 213–239). Amsterdam: John Benjamins.
- Nathan, P. E., & Gorman, J. M. (Eds.). (2007). *A guide to treatments that work* (3rd ed.). New York: Oxford University Press.
- Nelson, M., & Hamilton, H. E. (2007). Improving in-office discussion of chronic obstructive pulmonary disease: Results and recommendations from an in-office linguistic study in chronic obstructive pulmonary disease. *American Journal of Medicine*, 120(8 Suppl 1), S28–32. doi: 10.1016/j.amjmed.2007.04.010
- Nguyen, H. T. (2006). Constructing “expertness”: A novice pharmacist’s development of interactional competence in patient consultation. *Communication and Medicine*, 3(2), 147–160.
- NICE. (2009). Depression: The treatment and management of depression in adults (Update), 2013, from <http://www.nice.org.uk/CG90>

- O'Donohue, W. T., Henderson, D. A., Hayes, S. C., Fisher, J. E., & Hayes, L. J. (Eds.). (2001). *A history of the behavioral therapies: Founders' personal histories*. Reno: Context Press.
- Orlinsky, D. E., Rønnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcomes research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 307–390). New York: John Wiley & Sons.
- Pachankis, J. E., & Goldfried, M. R. (2007). On the next generation of process research. *Clinical Psychology Review*, 27(6), 760–768.
doi:10.1016/j.cpr.2007.01.009
- Partanen, T., Wahlström, J., & Holm, J. (2006). Loss of self-control as excuse in group-therapy conversations for intimately violent men. *Communication and Medicine*, 3(171–183). doi: 10.1515/CAM.2006.019
- Paul, G. L. (1969). Outcome of systematic desensitization II: Controlled investigation of individual treatment, technique variations, and current status. In C. M. Franks (Ed.), *Behavior therapy: Appraisal and status*. New York: McGraw Hill.
- Pawelczyk, J. (2011). *Talk as therapy: Psychotherapy in a linguistic perspective*. Gottingen: Walter de Gruyter.
- Peräkylä, A. (1995). *AIDS counselling: Institutional interaction and clinical practice* (1st ed. Vol. 11). Cambridge: Cambridge University Press.
- Peräkylä, A. (2002). Agency and authority: Extended responses to diagnostic statements in primary care encounters. *Research on Language & Social Interaction*, 35(2), 219–247. doi: 10.1207/s15327973rlsi3502_5
- Peräkylä, A. (2004a). Making links in psychoanalytic interpretations: A conversation analytical perspective. *Psychotherapy Research*, 14(3), 289–307. doi: 10.1093/ptr/kph026

- Peräkylä, A. (2004b). Reliability and validity in research based on naturally occurring social interactions. In D. Silverman (Ed.), *Qualitative research* (2nd ed., pp. 283–304). London: Sage.
- Peräkylä, A. (2005). Patients' responses to interpretations: A dialogue between conversation analysis and psychoanalytic theory *Communication & Medicine* (Vol. 2, pp. 163).
- Peräkylä, A., Antaki, C., Vehvilainen, S., & Leudar, I. (Eds.). (2008). *Conversation analysis and psychotherapy*. Cambridge: Cambridge University Press.
- Peräkylä, A., & Vehvilainen, S. (2003). Conversational analysis and the professional stocks of interactional knowledge. *Discourse and Society*, 14(6), 727–750. doi:10.1177/09579265030146003
- Phillips, L., & Jorgensen, M. (2002). *Discourse analysis as theory and method*. London: Sage Publications.
- Phillips, N., & Hardy, C. (2002). *Discourse analysis: Investigating processes of social construction* (Vol. 50). Thousand Oaks: Sage Publications Ltd.
- Plakun, E. M. (2009). Psychoanalytic treatment of anxiety disorders. In B. J. Sadock, S. V. A. & P. Ruiz (Eds.), *Kaplan and Sadock's comprehensive textbook of psychiatry* (9th ed., Vol. 2, pp. 2775–2780). Philadelphia: Lippincott Williams and Wilkins.
- Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour* (1st ed.). London: Sage Publications.
- Rachman, S. (2009). Psychological treatment of anxiety: The evolution of behavior therapy and cognitive behavior therapy. *Annual Review of Clinical Psychology*, 5(1), 97–119. doi:10.1146/annurev.clinpsy.032408.153635
- Rasheed, J. M., Rasheed, M. N., & Marley, J. A. (2010). *Family therapy: Models and techniques*. Thousand Oaks: SAGE Publications, Inc.

- Roberts, C., & Sarangi, S. (1999a). Hybridity in gatekeeping discourse: Issues of practical relevance for researchers. In S. Sarangi & C. Roberts (Eds.), *Talk, work and institutional order: Discourse in medical, mediation and management settings* (pp. 473–503). Germany, Berlin: Mouton de Gruyter.
- Roberts, C., & Sarangi, S. (1999b). Introduction: Revisiting different analytic frameworks. In S. Sarangi & C. Roberts (Eds.), *Talk, work and institutional order: Discourse in medical, mediation and management settings* (pp. 389–400). Berlin: Mouton de Gruyter.
- Roberts, C., & Sarangi, S. (2003). Uptake of discourse research in interprofessional settings: Reporting from medical consultancy. *Applied Linguistics*, 24(3), 338–359. doi: 10.1093/applin/24.3.338
- Roberts, C., & Sarangi, S. (2005). Theme-orientated discourse analysis of medical encounters. *Medical Education*, 39, 632–640. doi:10.1111/j.1365-2929.2005.02171.x
- Roberts, C., Sarangi, S., Southgate, L., Wakeford, R., & Wass, V. (2000). Oral examinations—equal opportunities, ethnicity, and fairness in the MRCGP. *British Medical Journal*, 320(7231), 370–375. doi:doi.org/10.1136/bmj.320.7231.370
- Roith, E. (2008). Hysteria, heredity and anti-semitism: Freud's quiet rebellion. [Article]. *Psychoanalysis & History*, 10(2), 149–168. doi: 10.3366/e1460823508000147
- Roth, A., & Fonagy, P. (2005). *What works for whom: A critical review of psychotherapy research* (2nd ed.). London: Guilford Press.
- Sacks, H. (1995). *Lectures on conversation: Volumes one and two*. Oxford: Blackwell Publishing.
- Sarangi, S. (2002). Discourse practioners as a community of interprofessional practice: Some insights from health and communication research. In C. N. Candlin (Ed.), *Research and practice in professional discourse* (pp. 95–135). Hong Kong: City University of Hong Kong Press.

- Sarangi, S. (2007). Editorial: The anatomy of interpretation: Coming to terms with the analyst's paradox in professional discourse studies. *Text & Talk — An Interdisciplinary Journal of Language, Discourse Communication Studies*, 27(5–6), 567–584. doi: 10.1515/text.2007.025
- Sarangi, S. (2010). Practising discourse analysis in healthcare settings. In I. Bourgeault, R. Dingwall & R. de Vries (Eds.), *The SAGE handbook of qualitative methods in health research* (pp. 397–416). London: SAGE Publications Ltd.
- Sarangi, S., & Candlin, C. N. (2011). Professional and organisational practice: A discourse/communication perspective. In C. N. Candlin & S. Sarangi (Eds.), *Handbook of communication in organisations and professions*. Berlin: Walter de Gruyter.
- Sarangi, S., & Clarke, A. (2002a). Constructing an account by contrast in counselling for childhood genetic testing. *Social Science & Medicine*, 54(2), 295–308. doi:10.1016/S0277-9536(01)00029-6
- Sarangi, S., & Clarke, A. (2002b). Zones of expertise and the management of uncertainty in genetics risk communication. *Research on Language and Social Interaction*, 35(2), 139–171. doi:10.1207/S15327973RLSI3502_2
- Sarangi, S., & Roberts, C. (1999). The dynamics of interactional and institutional orders in work-related settings. In S. Sarangi & C. Roberts (Eds.), *Talk, work and institutional order: Discourse in medical, mediation and management settings* (pp. 1–55). Berlin: Mouton de Gruyter.
- Schegloff, E. A. (1999). Naivete vs Sophistication or Discipline vs Self-Indulgence: A Rejoinder to Billig. *Discourse & Society*, 10(4), 577–582. doi: 10.1177/0957926599010004008
- Schiffrin, D. (1994). *Approaches to discourse* (1st ed.). Oxford: Blackwell Publishers Ltd.
- Schiffrin, D., Tannen, D., & Hamilton, H. E. (Eds.). (2001). *The handbook of discourse analysis*. Malden.

- Schramm, E., van Calker, D., Dykieriek, P., Lieb, K., Kech, S., Zobel, I., et al. (2007). An intensive treatment program of interpersonal psychotherapy plus pharmacotherapy for depressed inpatients: acute and long-term results. *American Journal of Psychiatry*, 164(5), 768–777. doi: 10.1176/appi.ajp.164.5.768
- Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2012). *Mindfulness-based cognitive therapy for depression* (2nd ed.). New York: The Guilford Press.
- Shapiro, A. K., & Shapiro, E. (1997). *The powerful placebo: From ancient priest to modern physican*. Baltimore: Johns Hopkins Univsity Press.
- Shaw, S. E., & Bailey, J. (2009). Discourse analysis: what is it and why is it relevant to family practice? *Family Practice*, 26(5), 413–419. doi: 10.1093/fampra/cmp038
- Silverberg, N. D., Hallam, B. J., Rose, A., Underwood, H., Whitfield, K., Thornton, A. E., et al. (2013). Cognitive-Behavioral Prevention of Postconcussion Syndrome in At-Risk Patients: A Pilot Randomized Controlled Trial. *Journal of Head Trauma Rehabilitation*. 28(4), 313–322 doi: 10.1097/HTR.0b013e3182915cb5
- Sin, S., Jones, A., & Petocz, P. (2007). Evaluating a method of integrating generic skills with accounting content based on a functional theory of meaning. *Accounting & Finance*, 47(1), 143–163. doi: 10.1111/j.1467-629X.2007.00201.x
- Skinner, B. F. (1938). *The behavior of organisms*. New York: Appleton-Century-Crofts.
- Skinner, B. F. (1957). *Verbal behavior*. New York: Appleton-Century-Crofts.
- Skinner, B. F. (1961). A critique of psychoanalytic concepts and theories. In B. F. Skinner (Ed.), *Cumulative record (enlarged edition)* (pp. 185–194). New York: Appleton-Century-Crofts.

- Stanley, M. A., & Beidel, D. C. (2009). Behavior Therapy. In B. J. Sadock, V. A. Sadock & P. Ruiz (Eds.), *Kaplan and Sadock's comprehensive textbook of psychiatry* (9th ed., Vol. 2, pp. 2781–2803). Philadelphia: Lippincott Williams & Wilkins.
- Stiles, W. B., Elliott, R., Llewelyn, S. P., Firth-Cozens, J. A., Margison, F. R., Shapiro, D. A., et al. (1990). Assimilation of problematic experiences by clients in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 27(3), 411–420. doi: 10.1037/0033-3204.27.3.411
- Suoninen, E., & Wahlström, J. (2010). Interactional positions and the production of identities: Negotiating fatherhood in family therapy talk. *Communication & Medicine*, 6(2). doi: 10.1558/cam.v6i2.199
- Tannen, D. (1984). *Conversational style: Analyzing talk among friends*. Westport: Ablex Publishing.
- Tannen, D. (1989). *Talking voices: Repetition, dialogue and imagery in conversational discourse* (1st ed.). Cambridge: Cambridge University Press.
- Tannen, D. (2007). *Talking voices. Repetition, dialogue, and imagery in conversational discourse* (2nd ed.). Cambridge: Cambridge University Press.
- Teasdale, J. D., Segal, Z. V., Williams, J. M. G., Ridgeway, V. A., Soulsby, J. M., & Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, 68(4), 615–623. doi: 10.1037/0022-006x.68.4.615
- ten Have, P. (2007). Appendix A: Transcription conventions. In D. Silverman (Ed.), *Doing conversation analysis: A practical guide* (2nd ed., pp. 215–216). London: Sage Publications.
- Timulak, L. (2008). *Research in psychotherapy and counselling*. London: Sage Publications Ltd.

- Touyz, S., Le Grange, D., Lacey, H., Hay, P., Smith, R., Maguire, S., Bamford, B., Pike, K.M. & Crosby, R.D. (2013). Treating severe and enduring anorexia nervosa: a randomized controlled trial. *Psychological Medicine*, available on CJ02013. doi: 10.1017/s0033291713000949
- Town, J. M., Abbass, A., & Hardy, G. (2011). Short-term psychodynamic psychotherapy for personality disorders: A critical review of randomized controlled trials. *Journal of Personality Disorders*, 25(6), 723–740. doi: 10.1521/pedi.2011.25.6.723
- van Beek, M. H., Oude Voshaar, R. C., Beek, A. M., van Zijderveld, G. A., Visser, S., Speckens, A. E., et al. (2013). A brief cognitive-behavioral intervention for treating depression and panic disorder in patients with noncardiac chest pain: A 24-week randomized controlled trial. *Depression and Anxiety*, 30(7), 670–678. doi: 10.1002/da.22106
- van Hees, M. L., Rotter, T., Ellermann, T., & Evers, S. M. (2013). The effectiveness of individual interpersonal psychotherapy as a treatment for major depressive disorder in adult outpatients: a systematic review. *BMC Psychiatry*, 13, 22. doi: 10.1186/1471-244x-13-22
- Vargas, J. S. (2001). B.F. Skinner's contribution to therapeutic change: An agency-less contingency analysis. In W. T. O'Donohue, D. A. Henderson, S. C. Hayes, J. E. Fisher & L. J. Hayes (Eds.), *A history of the behavioral therapies founders' personal histories* (pp. 59–74). Reno: Context Press.
- Vehvilainen, S. (2003). Preparing and delivering interpretations in psychoanalytic interaction. *Text*, 23(4), 573–606. doi:10.1515/text.2003.002
- Vilkki, L. (2006). Politeness, face and facework: Current issues. *SKY Journal of Linguistics*, 19(supplement), 10.
- Wampold, B. E. (2010a). *The basics of psychotherapy*. Washington DC: American Psychological Association.

- Wampold, B. E. (2010b). The research evidence for common factors models: A historically situated perspective In B. L. Duncan, S. D. Miller, B. E. Wampold & M. A. Hubble (Eds.), *The heart and soul of change* (2nd ed., pp. 49–81). Washington, DC: American Psychological Association.
- Wardhaugh, R. (2010). *An introduction to sociolinguistics* (6th ed.). Chichester: John Wiley & Sons Ltd.
- Watson, J. B. (1913). Psychology as the behaviorist views it. *Psychological Review*, 20(2), 158–177. doi: 10.1037/h0074428
- Watson, J. B., & Rayner, R. (1920). Conditioned emotional reactions. *Journal of Experimental Psychology*, 3(1), 1–14. doi: 10.1037/h0069608
- Webb, C. A., Auerbach, R. P., & Derubeis, R. J. (2012). Processes of change in CBT of adolescent depression: review and recommendations. *Journal of Clinical Child & Adolescent Psychology*, 41(5), 654–665. doi: 10.1080/15374416.2012.704842
- Webb, C. A., DeRubeis, R. J., & Barber, J. P. (2010). Therapist adherence/competence and treatment outcome: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 78(2), 200–211. doi: 10.1037/a0018912
- Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2000). *Comprehensive guide to interpersonal psychotherapy*. New York: Basic Books.
- Wells, A. (1997). *Cognitive therapy of anxiety disorders: A practice manual and conceptual guide*. Chichester: Wiley.
- Wetherell, M., Taylor, S., & Yates, S. J. (Eds.). (2001). *Discourse as data: A guide for analysis*. London: Sage Publications Ltd.
- Whitley, R. M. (2005). Qualitative research in psychiatry. *Canadian Journal of Psychiatry*, 50(2), 108–114.

- Williams, C. (2001). *Overcoming depression: A five areas approach*. London: Arnold.
- Williams, C. (2003). *Overcoming anxiety: A five areas approach*. London: Arnold.
- Wilson, G. T., Wilfley, D. E., Agras, W. S., & Bryson, S. W. (2010). Psychological treatments of binge eating disorder. *Archives of General Psychiatry*, 67(1), 94–101. doi: 10.1001/archgenpsychiatry.2009.170
- Wodak, R. (1981). How do I put my problem? Problem presentation in therapy and interview. *Text*, 1(2), 191–213.
- Wodak, R. (1986). *Language behavior in therapy groups*. Los Angeles: University of California Press.
- Wodak, R. (1996). *Disorders of discourse*. Harlow: Addison Wesley Longman Ltd.
- Wodak, R., & Meyer, M. (Eds.). (2009). *Methods of critical discourse analysis* (2nd ed.). London: Sage Publications.
- Wolitzky, D. L. (2011). Psychoanalytic theories of psychotherapy. In J. C. Norcross, G. R. VandenBos & D. K. Freedheim (Eds.), *History of psychotherapy: Continuity and change* (2nd ed., pp. 65–100). Washington DC: American Psychological Association.
- Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford: Stanford University Press.
- Wright, J. H., Basco, M. R., & Thase, M. E. (2006). *Learning cognitive behavior therapy: An illustrated guide*. Washington: American Psychiatric Publishing.
- Yalom, I. D., & Leszcz, M. (2005). *Theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.
- Young, J. (1999). *Cognitive therapy for personality disorders: A schema-focused approach* (3rd ed.). Sarasota: Professional Resource Press.