

**Problem Construction in Initial Sessions of Psychotherapy:
A Meta-Synthesis of Existing Literature and a Critical Discourse Analysis**

Alex D. Young

**Submitted for the award of
Doctor of Clinical Psychology**

Clinical Psychology Unit

University of Sheffield

October 2016

This page is intentionally blank

Declaration

This thesis has been submitted for the award of Doctorate in Clinical Psychology at the University of Sheffield. It has not been submitted for any other qualification or to any other academic institution.

Structure and Word Count

Literature review without references	7,924
Research report without references	13,441
References and appendices	5,567
Total word count without references and appendices	21,365
Total word count including: Title page for whole thesis, declaration, acknowledgements, structure and word count, abstract for both parts of thesis, list of contents, references and appendices	27,583

Abstract

This thesis consists of a literature review and a research study. The review used a meta-synthesis to integrate the findings of existing literature on problem construction in initial sessions of psychotherapy. Five main themes were constructed from the studies reviewed: Problems are defined by therapists, Therapists employ rhetorical strategies, Therapists' use of power and clients' resistance, Problems are structured and ordered through language, and Problems exist in socio-historical context. A new explanatory model for problem construction in psychotherapy was proposed. Therapists' problem schemas that were shaped by socio-historical factors and rhetorical strategies involved in realising these schemas were central to the process of problem construction. Epistemological differences in research methodologies generated difficulties in the synthesis of existing research.

For the research study, a critical discourse analysis was used to analyse therapist-client problem construction in first sessions of therapy in a trial comparing two psychotherapies for depression. Four stages of analysis were conducted, with the following findings: (1) discursive constructs included how problems were experienced and made sense of; (2) rhetorical strategies were used to pursue agendas by both clients and therapists; (3) subject positions were interactive and could be contradictory for both therapists and clients, they were generally more problem focused for clients and powerful for therapists; (4) therapists and clients reproduced normative discourses from institutions and ideologies shaping their subjectivity. Methodological limitations and recommendations for practice were outlined.

Acknowledgements

I would like to express my gratitude to my research supervisors, Professor Gillian Hardy and Dr Anthony Williams for their encouragement, guidance and invaluable input throughout planning, conducting and writing up this thesis. I would also like to thank Dr Harriet Cameron and Ben Wright for taking their time to listen and discuss ideas and for their help with analysis and comments on drafts. Further thanks to my friends and family who looked at drafts and supported me throughout my work on this thesis. Lastly, thanks to my partner and best friend Gemma for her loving care and for being there through the good times and the bad.

List of Contents

Access to Thesis Form.....	ii
Declaration.....	v
Structure and Word Count.....	vi
Abstract.....	vii
Acknowledgements.....	viii

Part One: Problem Construction in Initial Sessions of Psychotherapy:

A Meta-synthetic Review

Abstract.....	12
Introduction.....	13
Method.....	15
Findings.....	26
Discussion.....	43
References.....	48

Appendices

Appendix A: QualSyst Quality Checklist and Manual	53
Appendix B: A worked example to illustrate the procedure of transforming data into the themes and overarching themes presented in the findings.	57

Part Two: A Critical Discourse Analysis of Therapist-Client Problem

Construction in Psychotherapy

Abstract.....	60
Introduction.....	61
Method.....	64

Results.....	72
Discussion.....	105
References.....	111

List of Contents (Continued)

Appendices

Appendix A: Notes on Transcription.....	118
Appendix B: Transcriber Confidentiality Agreement.....	119
Appendix C: Problem Construction Thematic Map.....	121
Appendix D: Extract From Coded Transcript.....	122
Appendix E: Reflexivity on Analysis.....	123
Appendix F: Ethics and Governance Documents.....	125
Appendix G: Participant Information Sheet and Consent Form.....	136

Part One: Literature Review

Problem Construction in Initial Sessions of Psychotherapy:

A Meta-Synthetic Review

Abstract

Aim. This literature review aimed to evaluate qualitative research into the processes by which problems are constructed by therapists and clients in initial sessions of psychotherapy.

Method. Databases were searched for relevant studies, which were then reviewed for quality and their findings summarised in a data extraction table. The findings of the studies were then discussed, interpreted and combined through a process of meta-synthesis.

Findings. Five overarching themes were constructed from the studies reviewed. These were: Problems are defined by therapists, Therapists employ rhetorical strategies, Therapists' use of power and clients' resistance, Problems are structured and ordered through language, and Problems exist in socio-historical context. From these themes an explanatory model for the process of problem construction in psychotherapy was proposed. This highlighted the influence of therapists' problem-schemas, which are shaped by socio-historic factors and the rhetorical strategies therapists use.

Discussion. The limitations of the search strategy for finding appropriate papers and the tensions arising from combining studies with different research methodologies were discussed.

Practitioner Point.

The explanatory model could be used to enhance reflexivity during the supervision and training of therapists.

Research Point.

Future research should look into therapists' awareness and use of problem schemas in initial sessions of psychotherapy and include reports of analyst's reflexivity processes.

Introduction

This review aimed to complete a meta-synthesis of qualitative research into problem construction by therapists and clients in initial sessions of psychotherapy. The practice of psychotherapy involves specialised talk focused on problems and ways to understand or solve these problems that is guided by a therapist (Labov & Fanshel, 1977). In order to find the most helpful understanding or solution for a person's difficulties, problems need to be identified and clarified to form a shared understanding between therapist and client. Existing research shows that this is not simply a process of a client coming into therapy and telling their difficulties to a therapist (e.g. Davis, 1984). Client accounts are shaped and altered to create problems that are amenable to therapy (Hak & de Boer, 1996).

Although there are no systematic reviews of problem construction in initial sessions of psychotherapy, Avdi and Georgaca (2007) provide a critical review of discourse analytic studies of therapy. In this review they highlight the role that therapists play in the transformation of client's meanings in psychotherapy. Discourse analysis can be used to examine therapy talk at a macro level; in terms of wider social and historical discourses that this talk draws upon. For example, discourse analysis has shown how therapy practices can promote certain normative ideas about personhood and healthy functioning (Guilfoyle, 2002). Other methods, including grounded theory (Glaser, & Strauss, 1967), have been used to identify rhetorical processes at work in the practice of defining problems for therapy (e.g. Jankowski & Ivey, 2001).

There is also a body of conversation analytic research on initial sessions of therapy that analyses linguistic structures used by therapists and clients to talk about problems (e.g. Antaki, Barnes & Leudar, 2004; Hak & de Boer, 1996).

This analysis constitutes a micro level of examination focused on interactional processes such as turn taking in conversation. A number of analyses of therapy show therapists using various techniques to alter problem accounts in certain ways, for instance by using a process of 'formulating' (summarising and subtly transforming) a client's talk, to make their problems amenable to change (e.g. Antaki, Barnes & Leudar, 2004; Hak & de Boer, 1996). The differing micro and macro focuses of conversation analysis and discourse analysis could be conceived of as too distinct to allow a comparison of findings across approaches (Parker, 1997). However, elements of conversation analysis and discourse analysis have been combined successfully in discursive analysis to understand the interplay of linguistic structures and associated wider discourses (Willig, 2008). To understand how the micro and macro levels of discursive analysis of problem talk in therapy might fit together it would be beneficial to review this body of research and attempt to integrate the findings.

Many phenomena relevant to mental health and distress are usefully studied using qualitative research methods. Traditional forms of systematic review that often focus exclusively on quantitative research have been criticised for not incorporating diverse forms of evidence found in qualitative research (Dixon-Woods, Agarwal, Jones, Young & Sutton, 2005). Excluding qualitative research could lead to important findings being omitted from the recognised evidence base (Finfgeld, 2003). There are a growing number of methods being described for reviewing qualitative research and combining the collective results (Dixon-Woods, et al., 2005). One method that attempts to review research in a related area and combine the findings is meta-synthesis. Meta-synthesis aims to develop novel conceptual or theoretical understandings of a research area.

Aims of review

- To review qualitative research on problem construction in psychotherapy
- To assess the quality of this research
- To critically examine the qualitative research methodologies used to analyse problem constructions
- To integrate these findings into a meta-synthesis of existing qualitative research on problem construction in psychotherapy

Method

Search Strategy

A search for literature reviews concerning problem construction in psychotherapy using a range of synonyms for the main search terms returned no results. The Cochrane database and Google Scholar were also checked for existing reviews of problem construction in psychotherapy with no relevant results being found.

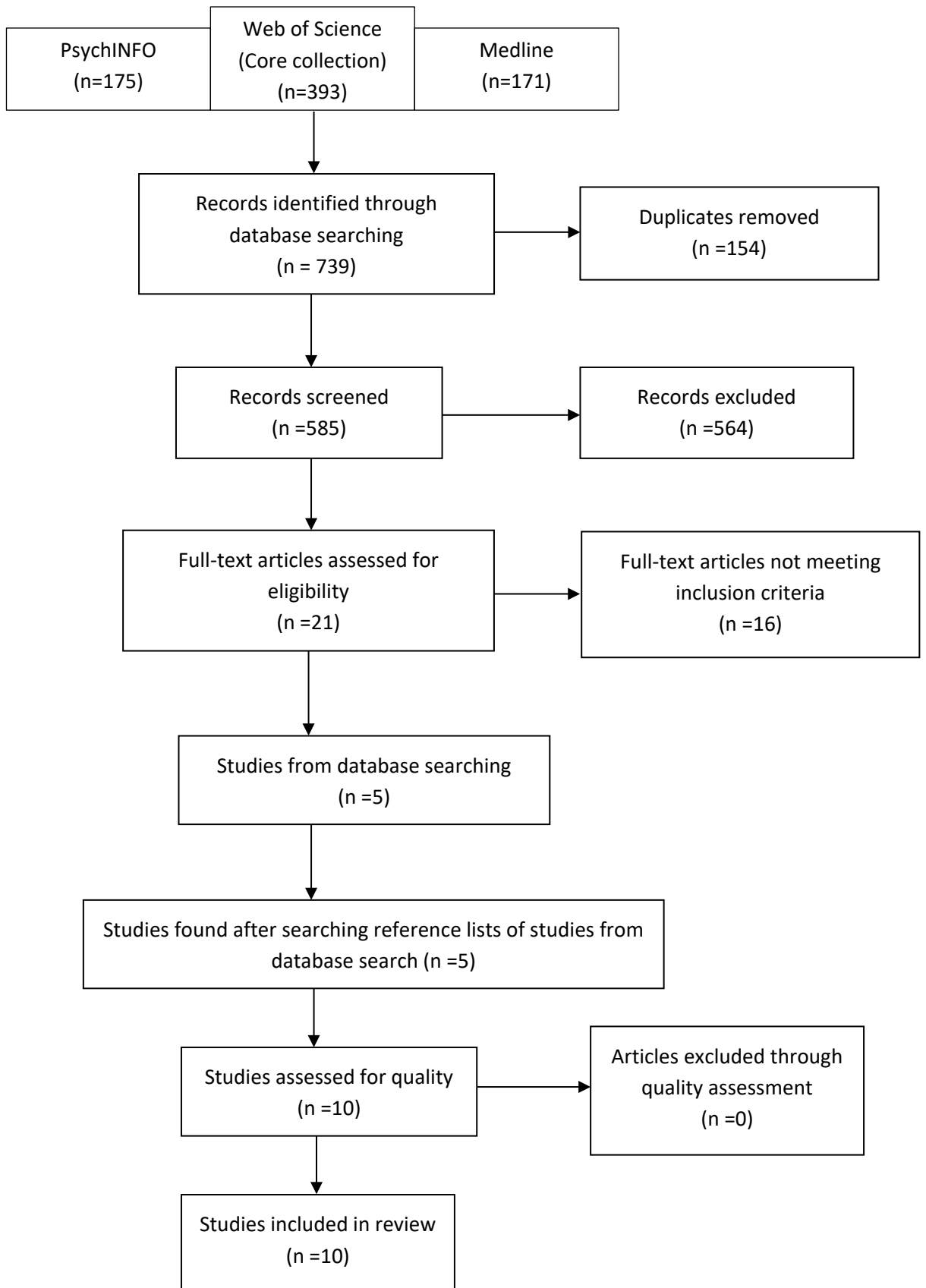
In January 2016, PsychINFO, Medline and Web of Science (core collection) were searched for articles with the keywords '*therap* AND problem OR formulation (in the title) AND first OR initial' (in the whole article) with no date restriction (see figure 1. for search strategy). Seven hundred and thirty nine results were returned with 585 remaining after duplicates were removed. The abstracts of the remaining results were checked and 564 records were excluded. Articles were excluded if they did not meet the inclusion criteria (see list below). The remaining 21 full-text articles were checked using the same inclusion criteria, leaving five results remaining from the database searches. The reference lists of the full text articles were hand checked for relevant articles and five additional papers were found. The ten articles found through

searches and reference checks were then assessed for quality using the 'QualSyst' tool (Kmet, Lee, & Cook, 2004).

Inclusion Criteria

- Qualitative studies
- Studies that analyse a psychological therapy intervention
- Studies that include first sessions of therapy in their analysis
- English language articles

Figure 1. Search Strategy



Quality

The quality of a meta-synthesis depends upon the quality of the papers reviewed (Korhonen, Hakulinen-Viitanen, Jylha & Holopainen, 2012). It is important therefore to review the quality of studies found during searches in order to both exclude any of low quality and to inform the process of synthesis (Jones, 2004). The 'QualSyst' checklist for quality review of research was developed as two checklists for reviewing both quantitative and qualitative research (Kmet, Lee, & Cook, 2004). For the purposes of the review reported here the qualitative checklist was used (a copy of the checklist and manual are included in Appendix A). The authors of QualSyst drew on existing qualitative review guidelines in the construction of their checklist (Mays & Pope, 2000; Popey, Rogers & Williams, 1998). The checklist is easy to use and gives an overall score that provides a basis for comparison of studies.

The quality of the papers reviewed ranged from 0.65-0.9, with a possible range of 0-1. Quality ratings and limitations of the studies are reported in table 1. The authors of the checklist recommend that studies below 0.75 should be considered for exclusion. However, this would exclude all of the conversational analytic papers and the limitations in the reports of these studies may be due to the methodology as suggested below. They have been retained in the review but the limitations of these studies should be taken into account. The quality of studies will be referred to throughout the review but there are some general factors relating to quality that are worthy of note.

Few papers regardless of methodology reported their verification and reflexivity processes. These are key processes for maintaining the consistency and transparency of qualitative research. Verification procedures were only reported adequately in two studies (Madill & Barkham, 1997; Patrika & Tseliou,

2015). One study (Buttny & Jensen, 1995) reported reflexivity adequately, assessing the impact of their own characteristics on the analysis, with one other reporting in a partial way (Jankowski & Ivey, 2001). It may be that reflexivity was not reported due to the limited word counts of journal articles. However, it would be beneficial for studies to include some basic indication of reflexivity when describing their methodologies.

The conversation analytic papers have lower quality ratings (range 0.65-0.7) than the discourse analytic papers (range 0.75-0.9), with the only grounded theory paper scoring 0.85. In addition to the limited discussion of verification procedures and reflexivity, the conversation analytic studies' sampling strategies and data collection methods are also less well described. It may be that the conversation analytic studies' micro-analysis of the text accompanied by large extracts from transcripts is considered to justify its inclusion for analysis and provide the opportunity for verification of the findings by the reader. However, conversation analytic studies might benefit from reporting on their data collection processes.

Meta-synthesis

Meta-synthesis is a process of combining existing qualitative research to develop novel conceptual or theoretical understandings of a research area (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004). The aim is to say something about a body of research that is greater than the sum of its parts (Sandelowski, 2006). Qualitative meta-synthesis in this way can contribute to the evidence base in health care research and advance theory and practice. The term meta-synthesis is used to describe a variety of methods for synthesising qualitative research. A useful clarifying distinction has been made

between integrative and interpretive types of meta-synthesis (Noblit & Hare, 1988).

Integrative synthesis is primarily a descriptive process of summarising and combining data from multiple primary studies (Dixon-Woods, et al., 2005). Integrative synthesis defines concepts early on in the review process to facilitate focused summaries of the empirical data in a particular area. Quantitative reviews such as meta-analyses can be described as integrative in this way. Integrative synthesis is sometimes referred to as aggregative synthesis or meta-aggregation (Korhonen, Hakulinen-Viitanen, Jylha, & Holopainen, 2012).

Interpretive synthesis attempts to use the findings of multiple studies to develop concepts and theories that explain the collective findings of the research reviewed. Interpretive synthesis is an iterative process driven by the findings that are constructed through the review process, attempting to avoid pre-specification of concepts (Dixon-Woods, et al., 2005). Accordingly, new frameworks or models not specified in the reviewed primary literature may be developed to provide new explanations or meanings from the combined studies. As models not defined in primary studies are developed, this process should be tentative and grounded in the findings described in the original studies.

Meta-synthesis was used in this review as a method of reviewing the research relating to problem construction in initial sessions of psychotherapy. Searches of relevant databases found only qualitative studies relating to this research question. Critiques of traditional forms of systematic review have highlighted the limitations of review methods that do not adequately include qualitative research (Dixon-Woods, et al., 2005). Qualitative research has a distinctive and complementary contribution to make to psychotherapy research

(Dixon-Woods, Fitzpatrick & Roberts, 2001). For instance, it can provide valuable explanations of process issues in therapy (Korhonen et al., 2012). If qualitative research is not adequately reviewed the findings will not be included in the evidence base and important contributions will be lost.

The meta-synthesis used in this review was interpretive rather than integrative. This is because the intention was to create an initial theoretical perspective on problem construction in psychotherapy. It was also intended to direct future research into this area and because the importance of discourse in shaping the focus of clients' therapies was recognised. The meta-synthesis presented here follows conventions outlined in reviews and discussion papers on meta-synthesis (e.g. Downe, 2008; Walsh & Downe, 2004). These draw on the analytic strategy for meta-ethnography outlined by Noblit and Hare (1988).

The procedure by which studies were reviewed and data were converted into findings was as follows:

1. Following the search process, papers were reviewed for quality as discussed previously. This process provided an opportunity for familiarisation with the papers.
2. Initial summaries were made of aims and findings as well as details of research methodology in a data extraction table. Data extraction affords a visual overview of similarities and differences in various study characteristics.
3. Studies were re-read and the processes of problem construction were highlighted and initial sub themes were applied to extracts of the data. The data from which the themes were derived were the authors' interpretations of their original data.

4. The initial sub themes from all the studies were then compared and contrasted to identify similarities and differences to determine how they are related.
5. Overarching themes were identified across papers that explained related findings (Dixon et al., 2004). The written account of the synthesis process is organised in this review by these resulting overarching themes.
6. At the point of overarching theme development the importance of highlighting any contradictory findings from primary studies has been emphasised (Walsh & Downe, 2004). They are described in the written descriptions of the themes.
7. Drawing on the overarching themes an exploratory interpretive model was developed to explain these collective findings.

A worked example illustrating how the data was extracted and transformed into the findings is presented in appendix B. At the final stage of tentative model development reflexivity is particularly important. Reflexivity will be described following the presentation of the findings. The data extraction table with summaries of findings, quality ratings and limitations is now presented.

Table 1.
Characteristics and Quality Ratings of Studies

Authors	Number of participants	Method of Analysis	Therapeutic Approach	Aims	Summary of Findings	Quality Score (0-1)	Limitations of Studies
Antaki, C., Barnes, R. & Leudar, I. (2004) UK	1 therapist-client dyad	Conversation Analysis	CBT	To analyse an example of a client proposing a problem for consideration in therapy	The analysis illustrates that there can be a mismatch between how a client sees their problem and a therapist's formulation of their problem.	0.7	Verification procedure not reported. Reflexivity not reported
Buttny, R. (1996) USA	1 therapist with a couple and a family of five	Conversation Analysis	Family therapy	To investigate the phenomena of therapists providing alternative descriptions of problems	The therapist uses conversational strategies to reframe the client's problems in psychological terms. This is conceptualised as a process of persuasion. The process utilises two main devices, telling the client about themselves and using a third turn to evaluate, correct or confirm responses from the client.	0.7	Sampling strategy and data collection methods partially described. Verification procedure not reported. Reflexivity not reported
Davis, K. (1984) Netherlands	1 therapist-client dyad	Conversation Analysis (appears to be conversation analysis although it is not directly specified)	Psychotherapy	To demonstrate the process of a therapist individualising a client's problems.	Using the rhetorical strategy of 'formulation' the therapist converts the client's complaints into a problem amenable to therapy. This involved a three part process: definition, documentation and organisation, which the client attempts to resist. The author gives a feminist critique of the therapy.	0.7	Method of analysis unclear. Verification procedure not reported. Reflexivity not reported
Hak, T. & de Boer, F. (1996) Netherlands	3 clinician-patient dyads	Conversation Analysis	Counselling	To describe the function of the formulation-decision pair in diagnostic interviewing.	Professional definitions of patients' problems can be constructed by formulating patient's talk. The main interactional device for this is the formulation-decision pair.	0.65	Limited description of study design and sampling strategy. Verification procedure and reflexivity not reported

Table 1 (Continued)

Authors	Number of participants	Method of Analysis	Therapeutic Approach	Aims	Summary of Findings	Quality Score (0-1)	Limitations of Studies
Jankowski, P. J. & Ivey, D. C. (2001) USA	10 therapist-client groups (families and couples)	Grounded Theory	Family therapy	To describe the processes by which problem definition occurs in family therapy	Two meta-problem definition processes are described 1. Clinicians keep definitions internal to themselves 2. Therapists incorporate internal problem definitions into conversations with clients.	0.85	Verification procedure not reported. Limited account of reflexivity.
Beckwith & Crichton (2010) Australia	1 therapist-client dyad	Theme-Oriented Discourse Analysis	CBT	To analyse how problem statements are negotiated with a specific focus on CBT	The authors describe how problems are made amenable to therapy. Formulations are used to progressively convert client's language into CBT terms.	0.8	Verification procedure not reported. Reflexivity not reported
Buttny, R. & Jensen, A. D. (1995). USA	1 therapist with couple	Discourse Analysis	Family therapy	To analyse discourse of problems and responses to problems in family therapy	The structure of problem talk is highlighted. Problems are shown to be organised hierarchically. The use of rhetorical strategies (e.g. excusing and justifying) are also described.	0.75	Limited information regarding study design, sampling strategy and data collection methods. Verification procedure not reported.
Guilfoyle, M. (2002). South Africa	1 therapist with family	Discourse Analysis (discursive psychology)	Family therapy	To demonstrate that therapy favours individualised accounts of the person	Therapists use rhetorical techniques such as reification and ironization to favour individualised accounts of the person and promote the self-contained individual as an ideal.	0.75	Limited information regarding sampling strategy. Verification procedure not reported. Reflexivity not reported

Table 1 (continued)

Authors	Number of participants	Design/Method of Analysis	Therapeutic Approach	Aims	Summary of Findings	Quality Score (0-1)	Limitations of Studies
Madill, A., & Barkham, M. (1997) UK	1 therapist-client dyad	Discourse Analysis	Psychodynamic interpersonal psychotherapy	To demonstrate the merits of a discourse analytic approach for process research. To analyse how therapeutic change was achieved	The study discusses how subject positions (e.g. 'dutiful daughter') that are taken up are related to the client's problems. These are primarily specified by the client. Subject positions are situated in the wider context of available discourses about womanhood and being a daughter.	0.9	Reflexivity not reported
Patrika, P., & Tseliou, E. (2015) Greece	4 therapists with 6 families	Discourse Analysis	Family therapy	To present discourse analysis of initial family therapy sessions to analyse family response to therapists systemically neutral agendas	Families interpret the discursive moves of family therapists attempting to introduce a systemic perspective as attributing blame.	0.9	Reflexivity not reported

Findings

The papers reviewed here had a number of different analytic research methodologies. Of the ten studies reviewed four used conversation analysis (Antaki, Barnes, & Leudar, 2004; Buttny, 1996; Davis, 1984; Hak & de Boer, 1996) one grounded theory (Jankowski & Ivey, 2001) and five discourse analysis (Beckwith & Crichton, 2010; Buttny & Jensen, 1995; Guilfoyle, 2002; Madill & Barkham, 1997; Patrika & Tseliou, 2015). These methodologies can be characterised as lying along an epistemological spectrum. On one end lies realism, the view that there are knowable truths that we can discover through investigation. On the other lies relativism, the perspective that there are no absolute truths but what we can know is subjective and context dependant. Relativism acknowledges the importance of meaning to individuals perspectives on knowledge. Between these points one can place the position of critical realism (Parker, 1999). This epistemological position acknowledges that the material world exists but asserts that our knowledge of it is constructed through social processes.

Conversation analysis explores the interaction between speakers in detail, analysing linguistic processes such as blaming and turn taking in conversation (Sacks, Schegloff, & Jefferson 1974). It is on the realist end of the spectrum, holding assumptions that analysis of processes in talk gives us knowledge of what is going on in the talk. It can provide a useful detailed micro analysis of what speakers are doing with their talk. Grounded theory can take up different epistemological positions with a more realist type and a more relativist type (social constructionist grounded theory). The grounded theory study reviewed here is of the more relativist type. The five discourse analytic studies are situated on the relativist side of the epistemological spectrum of

studies reviewed. Although the discourse analytic studies share some common features, there are a variety of methodologies subsumed under the umbrella of discourse analysis. From discursive psychology which is closer to conversation analysis and is primarily concerned with discursive practices and how they are used to negotiate localised meaning to Foucauldian discourse analysis, a social constructionist approach. Foucauldian discourse analysis draws on the genealogical work of Foucault (e.g. Foucault, 2001). Genealogy examines how discourses (ways of talking about a particular phenomenon) are located in a specific historical context. It is concerned with tracing the historical and social factors that influence or constrain local, 'here and now' constructions. Beckwith and Crichton (2010) use theme-oriented discourse analysis (Roberts & Sarangi, 2005) which is closer to conversation analysis on the realist end of the spectrum. Buttny and Jenson (1995) and Guilfoyle (2002) draw from the discursive psychology tradition. The other two discourse analytic studies are more constructionist in their approach discussing subjectivity, meaning and truth as being constructed in the particular therapy conversations analysed (Madill & Barkham 1997; Patrika & Tseliou, 2015). These provide an analysis of historical, social and cultural discourses at a macro level, enabling a view of the talk in it's wider social context. Combining studies using methodologies based on different epistemological positions is complex. However, attempting a meta-synthesis is valuable because it draws together disparate knowledges about the process of problem construction in intial sessions of therapy. Looking at different aspects of these processes can tell us something about how the whole process of problem construction might connect.

A number of different therapeutic approaches were used by therapists in the studies reviewed. They involve therapists working with individuals, couples and families. Five studies are of family therapy sessions, two discuss CBT, one counselling, one analyses an unspecified form of psychotherapy and one analyses a case of psychodynamic interpersonal psychotherapy. Implications for different models of therapy will be discussed under the analytic themes of this review. The fact that different models of therapy are analysed in these studies adds to the complexity of the analysis. However, the diversity of perspectives on problem construction that emerge creates an opportunity to say something general about common features of problem construction in psychotherapy.

Themes

Studies are discussed under themes drawn from the close reading and data extraction process. Examples are given from all relevant papers that have generated the themes and any contradictory findings are outlined. An outline of the themes and their emergence in the papers reviewed is given in table 2.

Table 2.

Problem Construction Themes

1. Problems are defined by therapists

- Therapists use meta processes to withhold or share their definitions of problems with clients (Jankowski & Ivey, 2001)
- Therapists translate a patient's troubles into professional definitions of problems (Hak & de Boer, 1996)
- The therapist universalises a client's problem account (Antaki, Barnes, & Leudar, 2004)
- The therapist selects certain aspects of a client's account for focus and elaboration (Davis, 1984)

2. Therapists employ rhetorical strategies

- Therapists use formulation, a summarising of what has been previously said by an interlocutor to subtly transform it (Davis, 1984; Hak & de Boer, 1996)
- The therapist uses focused technical questions particular to CBT alongside formulation (Beckwith & Crichton, 2010)
- Therapists use techniques such as circular questioning to attempt to introduce a systemic perspective on troubles (Patrika & Tseliou, 2015)
- Therapists use 'third turn evaluations' to confirm agreement with their accounts of a client's problems or correct disagreement (Buttny, 1996)
- The rhetorical strategies of reification and ironization are used to promote the concept of the self-contained individual who is responsible for their behaviour as an ideal (Guilfoyle, 2002)

3. Therapists' use of power and clients' resistance

- Clients' problems are decontextualized (Davis, 1984)
- The therapist's formulations are resisted by client as having missed the point (Antaki, Barnes & Leudar, 2004)
- The therapist introduces a relational perspective and the family resists (Patrika & Tseliou, 2015)

4. Problems are structured and ordered through language

- Problems are organised hierarchically (Buttny & Jensen, 1995)
- Subject positions are maintained by discourses (Madill & Barkham, 1997)

5. Problems exist in socio-historical context

- The subject position of dutiful daughter draws on discourses of gender roles and family obligations (Madill & Barkham, 1997)
- The therapist individualises problems reducing their social significance consistent with western ideas of the individual as autonomous and responsible (Davis, 1984)
- Therapists promote self-containment and favour autonomy through their use of language, reproducing individualised accounts of the person (Guilfoyle, 2002).
- Conflicts between a therapist's institutional agenda and a client's wish to explain their problems fully are highlighted (Antaki, Barnes & Leudar, 2004)

1. Problems are defined by therapists. A number of studies show that the emerging definition of the problem in therapy is shaped primarily by the therapist. Jankowski and Ivey (2001) describe two key processes whereby therapists define clients' problems. These are conceptualised in their paper as meta-processes. The first process involves therapists withholding problem definitions whilst the second involves therapists' problem definitions being shared with clients by being incorporated in the therapeutic conversation. Jankowski and Ivey (2001) conceptualise the problem construction or definition as primarily concerned with the therapist rather than a co-construction. This is observable in the meta-processes described where the therapists make the decision to withhold or share their problem definition. This grounded theory study used visual observations of therapy sessions and analysis of the therapy talk as well as interviews with therapists. The interviews with the therapists may have contributed to the therapist centric view of problem construction. However, other studies reviewed support this theme. In their analysis of a psychotherapy interview the patient's troubles are seen as being translated by the therapist into the professional's definition of the problem.

In this extract, first, the interviewer formulates the gist of the patient's utterance (C1) by paraphrasing it as "not able to draw a line somewhere" and elicits a decision (in C2). Subsequently, after the patient's confirmation (in P2/P3), he formulates the professional upshot of the patient's talk (in C4): "you are subassertive". (Hak & de Boer, 1996, p. 93).

A similar process is described by Antaki, Barnes, and Leudar (2004) where a therapist attempts to turn the idiosyncratic telling of a client's problems into a universal understanding of a problem through the process of analogy.

Davis (1984) describes the therapist leading the process of problem definition by selecting particular preferred aspects of a client's whole account. These selected aspects are focused on and elaborated through direct questioning and the therapist's formulations.

Madill and Barkham's (1997) account differs in focusing to a greater extent on the client's own description of her difficulties and how this description implies the causes of her depression. Although client versions of problems are brought into the therapy in the other studies mentioned they are described as primarily being defined or redefined by the therapists. It may be that the model of therapy used may have an impact on who is leading the definition of problems. Madill and Barkham state that psychodynamic-interpersonal therapy assumes that problems are due to difficulties with clients' significant relationships. In the session analysed the client gives an interpersonal account of her difficulties. The therapist is shown to accept and work with the account the client brings possibly because it fits the model of therapy being used.

2. Therapists employ rhetorical strategies. The majority of the studies reviewed describe particular ways of talking or rhetorical strategies that are used by therapists to bring about certain aims in therapy. These rhetorical strategies are seen as purposeful and employed to pursue the rhetorical agendas of the speakers (Billig, 1990). A key process across studies is that of formulation¹, where a member of a conversation will describe, explain or summarise the conversation for the other. This is seen as a key device for therapists in transforming or altering clients' accounts of their problems (Davis, 1984; Hak & de Boer, 1996). The formulation is often achieved by paraphrasing

¹ Formulation as described here is a linguistic term distinct from the use of the word formulation as a process of coming to understand problems and direct therapeutic interventions as used in clinical psychology and other disciplines.

a client's account to maintain some original features whilst recasting it to introduce new material. Beckwith and Crichton (2010) describe the process of a client's problems being converted into CBT terms. The CBT therapist utilises formulation as a rhetorical strategy as outlined in other studies but also employs focused technical questions particular to CBT to implement the CBT model.

By only offering the choice of these two symptoms for what is a non-specific statement by the client the therapist has once again steered the client's problem to one of an anxiety problem and as such more amenable to CBT. (Beckwith & Crichton, 2010, p. 28).

Beckwith and Crichton (2010) describe this process of fitting the client's problems into a CBT frame as expertise. Their analysis differs from the other studies more descriptive analysis in that they make positive value judgements about the rhetorical strategies being used. In the family therapy described by Patrika and Tseliou (2015), therapists use techniques such as circular questioning to attempt to introduce a systemic perspective on troubles. This is consistent with the systemic theoretical stance of family therapy. However, in this case the families interpret the discursive moves of family therapists as attributing blame. The authors suggest that discourse analysis is useful for family therapists in enhancing reflexivity about their discursive practices, for example by highlighting how therapists and family members can become trapped in unhelpful discourses, such as those that place blame for problems in one part of a system.

Rhetorical strategies are conceptualised as being used to persuade clients that their problems are best seen in a different way. Guilfoyle (2002) describes the use of reification and ironization as strategies to privilege certain interpretations of problems. I use reification here to mean the process of

prioritising certain accounts by constructing them as true and objective or more important than another account. Ironization is the devaluation or minimisation of account's importance or truth. Guilfoyle (2002) argues that these strategies are used to promote the idea that people are responsible for their behaviour. Buttny (1996) discusses a three part process used by therapists to pursue a rhetorical agenda. Therapists tell the client something about themselves e.g. 'what might be going on for you is this...'. The client then responds in some way, for example by confirming, challenging or correcting the therapist's suggestion. The therapist is then seen to employ 'third turn evaluations', which are used to correct or confirm agreement with their original ascription about the client. These third turns form an evaluation of how the client has responded to the initial turn of the therapist.

The therapist can take the clients' utterances as displaying understanding or assessment of what the therapist has just said. As such, these client responses provide a valuable interactional resource in that the therapist can, in turn, move to correct, assess, or elaborate on the clients' alignment with the therapeutic position (Buttny, 1996, p. 140).

These strategies appeared to be used purposefully to achieve therapeutic aims. Some analyses of these processes question what is happening to clients' own versions of their difficulties (e.g. Antaki, Barnes, & Leudar, 2004).

3. Therapists' use of power and clients' resistance. Davis (1984) provides a feminist critique of the conversion of a client's problems that are related to social and situational factors into an individual problem that is amenable to therapy. The client believes that losing her role through staying at home following getting a degree is part of her problem. The therapist locates

her problem in a lack of confidence. The female client is shown to resist early formulations by the male therapist, by pointing out instances where the therapist's version of the problem did not apply. Through repeated use of strategies such as 'documentation of new perspectives', where evidence is given for the therapist's account, the client agrees to the therapist's conceptualisation of her difficulties. Antaki, Barnes and Leudar (2004) describe a 'battle' between the therapist and the client over what the problem is. They describe a back-and-forth process of formulation by the therapist and resistance by the client who treats the therapist's formulations as having missed the point.

She competitively overlaps the therapist's further elaboration with a version of the recurrent theme: 'I just find I can't stand too near him'. This is not quite the canonical 'I can't stand looking him in the eye' which was the client's original complaint, but is clearly a version of it, and very different from a positive appreciation of the therapists elaborate analogy. It disaffiliates from the therapist's gloss, and by implication from the therapist's move to next business. It reasserts what the therapist can't dispute or 'formulate away': the client's own felt experience. (Antiki, Barnes & Leudar, 2004, p. 136).

In their analysis of a family therapy session, Patrika and Tseliou (2015) describe a family's resistance to the moves of a therapist to introduce a relational perspective on the family's problems. For example, the father of the family responds with an overt denial: 'The problem is not mine (.) the problem starts from herself' (Patrika & Tseliou, 2015, p13).

Although Beckwith and Crichton (2010) describe the therapist using formulation to 'shepherd' a client's language converting it to model preferred language they do not conceptualise this process in the same way as the other

three studies mentioned here. They talk about the 'expertise of the therapist in aligning the requirements of the CBT model with the needs of a particular client' (Beckwith & Crichton, 2010, p30). During an extract where the therapist is outlining a draft problem statement the client makes utterances such as 'yeah but' and 'yeah I guess, I guess that's alright'. These statements could be conceptualised as the therapist having not quite captured the clients' meaning and Beckwith and Crichton (2010) in their analysis acknowledge that the problem statement is 'confronting' but do not problematise this process in the way other analyses have. Instead they see the rhetorical strategies used to shape the client's account and persuade them of a different perspective as expertise. The difference in analysis may have resulted from the choice of analytic method. Theme-oriented discourse analysis is directed towards a focal theme that is pre-determined, in this case how a problem statement is negotiated in CBT. This creates an analysis that is descriptive of the rhetorical processes occurring in the talk but that is less concerned with the context in which these processes occur.

4. Problems are structured and ordered through language. Some studies describe problem accounts being organised and structured through language. Buttny and Jensen (1995) discuss the structure of problem talk arguing that it has an underlying hierarchical structure.

The underlying logic of the wife's initial presentation of the problem is represented by a hierarchical ordering of levels of meaning. The superordinate level is the main problem, husband is leaving. The subordinate levels are: consequences (she does not want to share with him) and no solution (glossed as problem solution-obstacle). (Buttny & Jensen, 1995, p. 29-30).

They propose that problem constructions are organised in a hierarchical framework such that higher order or overall problems are supported by lower order problem talk. The higher order superordinate meanings provide a frame or context for subordinate meanings to be understood. Rhetorical strategies as discussed previously are directed at the higher order structure thus maintaining a global coherence to the problem construction. The turn by turn sequencing of talk is aimed at supporting this global coherence, providing evidence for it and therefore constructing the overall problem.

Buttny and Jensen's (1995) chapter is the only one to explicitly discuss a hierarchical organization of problem construction. However, other studies could be described in this way. Madill and Barkham (1997) discuss the way discourses construct subject positions creating a sort of hierarchy, where reference is made to the higher order structure of subject positions such as the dutiful daughter to maintain global coherence of an account of the client's difficulties. This type of structural analysis provides a top down approach to understanding the construction of problems that can complement a bottom up micro analysis of the text.

5. Problems exist in sociohistorical context. In several papers problems are related to historical events and to social factors. These relationships are made by drawing on discourses from outside the therapy room such as from families or society. Madill and Barkham (1997) analyse the interactional processes that develop the subject positioning of clients. In their study the client positions herself as being a 'dutiful daughter'. They argue that the analysis of subject positions can highlight the identities clients and therapists use and explain the problems clients bring to therapy. In discussing subject positions they highlight the socio-historic nature of problem construction.

In therapy clients are drawing on available discourses from their contexts (e.g. their family, the media etc.). The role of dutiful daughter draws on societal expectations of mother-daughter relationships, situated in discourses of female subjectivity, for instance, discourses positioning women as having the duty to care for family members. They also discuss the subject positions' relationship to cultural discourses of guilt.

Davis (1984) also discusses wider societal discourses arguing that therapy individualises problems reducing their social significance consistent with western ideas of the individual as autonomous and responsible. Guilfoyle (2002) argues that therapists through their use of language promote certain notions of the person. Therapy is seen to promote self-containment and autonomous action as an ideal. The therapist discussing a boy's anger introduces a language of agency, "The therapist again introduces a language of agency in this excerpt. Lionel's temper is constructed as 'designed' for some purpose to suit Lionel's aims" (Guilfoyle, 2002, p. 307).

Guilfoyle (2002) points out that ironically this notion of the self-contained individual is co-constructed in dialogue between pairs of groups of people. Antaki, Barnes, & Leudar (2004) discuss the conflict between the therapist's institutional agenda of making a list of problems for consideration in therapy and the client's wish to explain her situation fully and be understood from her perspective.

A number of related themes about problem construction have been drawn from the body of studies reviewed here. The first theme highlights that although therapists and clients both talk about problems, they are primarily defined by therapists. The second theme outlines a number of rhetorical strategies used by therapists to shape clients' problem accounts. In the third

theme, the therapists' use of power in defining problems and the clients' relationship to this use of power is explored. The fourth, a less prominent theme, looks at the way language is structured to construct problems. The fifth and final theme looks at problem constructions in therapy in the context of broader cultural, social and historical discourses. As discussed previously, there are tensions in bringing together research from different epistemological positions that use different methodologies. However, these different focuses can provide insights into different parts of an overall process. Taken together these parts can be organised into an overall explanatory account of the process of problem construction in psychotherapy.

The Therapeutic Schema Model of Problem Construction in Psychotherapy

Problem construction appears to be derived from client's accounts of their difficulties but be predominantly driven by a therapist's schema and shaped using rhetorical strategies and techniques (see figure 3). Here I take schema to mean, a plan or overall strategy that the therapist has for conceptualising client's difficulties. This schema is influenced by a number of socio-historic factors such as the training a therapist has had, the society, culture and sub-cultures they live in or the institution they work for. Examples of these socio-historic factors are outlined in theme five. This mental organising structure is considered to be active but will not always be in conscious awareness. A therapist is unlikely to be thinking, 'I work for the NHS so will conceptualise the client's problems this way', although their institutional context will frame their way of interpreting problems. The problem-schema of the therapist appears to have a strong influence on the process of problem construction. This is evident in the theme that emerged of problems being

defined by therapists, and the findings of the use of power and resistance regarding the way problems are constructed. The schema is influenced by theoretical perspectives held by the therapists in each instance. A family therapist may pursue a systemic perspective, a CBT therapist a cognitive one or a psychodynamic interpersonal therapist an inter-relational one. This is perhaps not surprising but the influence of these perspectives may have a powerful effect on the way problems are co-constructed in sessions. As mentioned above the sociohistorical context is important.

The client brings their account of their difficulties into this pre-existing context. This account is central to the content of the construction. However, the problem construction that is formed by the end of the session is dependent on other factors, including the powerful influences of societal norms and the powerful position of the therapist in the therapeutic encounter. In initial sessions therapists rely on category entitlement, where they are politically, culturally and scientifically sanctioned to evaluate what clients bring to therapy because of their status (Edwards & Potter, 1992). From the literature reviewed here the problem constructions appear to be shaped according to the schema of the therapist using a variety of rhetorical strategies. There appears to be a feedback process where the client responds to these strategies by correcting, complying or resisting the accounts offered. What results is a problem construction created discursively in the context of the other discourses available to the therapist and client. It is not clear how much of this process is deliberate or conscious and of course this will vary depending on the contingent circumstances in each therapy. Implications for this model of understanding problem construction will be discussed further below.

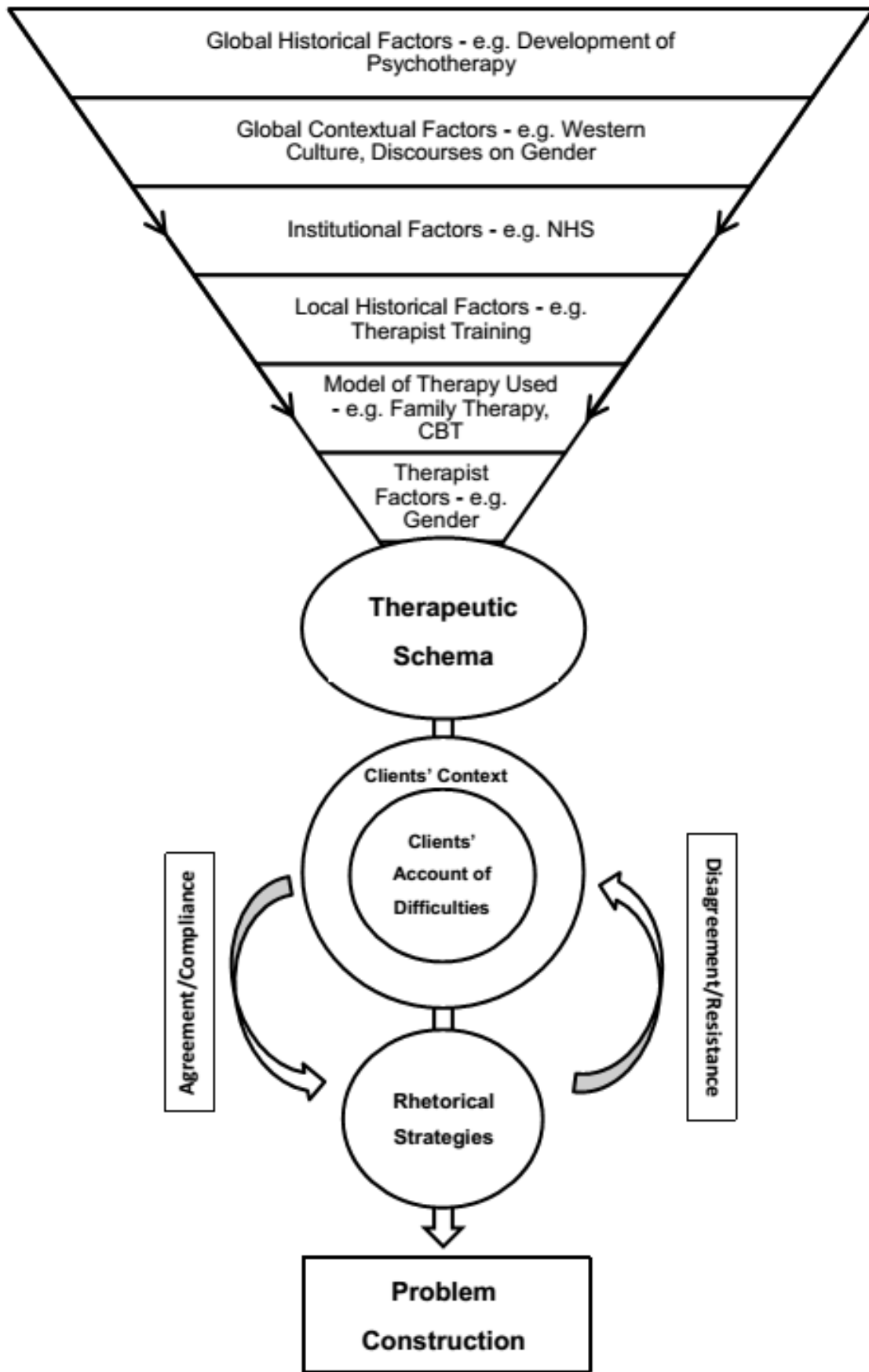
Reflexivity on Literature Review

Reflexivity is important, particularly relating to qualitative research, as it is recognised that the subjectivity of the researcher will affect how they make sense of findings (Mruck & Breuer, 2003). I have experience of conducting discourse analysis so understand this methodology better than conversation analysis and grounded theory. This will have created a more discourse analytic frame for interpreting the findings of the body of studies. The themes were discussed with a researcher who is aware of the differences between the approaches in an attempt to create distance from the studies and themes that were constructed from them. I conducted further reading into rhetorical strategies discussed in conversation analysis to understand these processes when they were described in conversation analytic studies. I am also a therapist so interpreted the findings of these studies from a position of having experienced the kind of situations outlined in the research. This creates the potential for skipping over material because of its familiarity or aligning with or being critical of the therapists because of my views on how therapy ought to be conducted. My views, for example, that therapy should be pursued in collaboration with clients.

Reflexivity can also be usefully applied to reasons for focusing on particular research questions and methods (Ortlipp, 2008). I was interested in looking at problem construction in therapy because of my experiences as a therapist attempting to help people make sense of their distress. I was interested in bringing a critical reflexivity to the processes by which the linguistic construction of problems is arrived at in therapy in the context of the mental health institutions these therapy sessions are taking place in and the wider society the therapist and client inhabit. I was also interested in the implications

of institutional power and social discourses around mental health and therapy and their effects on the process of problem construction. When reading the studies reviewed here I had reactions to the papers that are illustrative of my position in relation to the findings. Kathy Davis' (1984) feminist analysis is strongly critical of the rhetorical strategies use by the therapist to influence the problem telling's of the client and therefore the problem construction that is made by the therapist-client dyad. I found myself thinking that at times she was inferring motives of the therapist from extracts that could be interpreted in a more neutral way; although the analysis is detailed and grounded in numerous extracts from the session. Conversely Beckwith and Crichton (2010) conduct their analysis in a much more descriptive way and appear to gloss over instances where the therapist appears to ignore utterances by the client that do not fit with the therapists preferred direction. Reflecting on these reactions, my position lies somewhere between these two points of interpretation. My position is one of thinking that psychotherapy can be a helpful process for people but that therapists ought to be aware and reflexive of the discursive influence they have and how this can reproduce dominant discourses about ways of being.

Figure 3. Therapeutic schema model of problem construction



Discussion

This review aimed to analyse and synthesise research into problem construction in initial sessions of psychotherapy. By examining overarching themes across the studies reviewed, a tentative explanatory model has been proposed. A benefit of conducting a meta-synthesis is the bringing together of different findings to say something bigger than the sum of its parts about a topic. This meta-synthesis has attempted to integrate the more fine-grained micro analysis of text that gives detailed understanding of rhetorical strategies used in problem construction with macro analysis that places the therapy interaction in socio-historic context. This strategy of combining different levels of analysis risks glossing over the nuance of some of the fine-grained micro analysis of the text. Trying to acknowledge distal social and historical influences on therapy also carries the potential for missing the subtleties of discourse in use. Acknowledging the influence of culture could be misconstrued as blaming the individual therapists for being influenced this way. However, the effects are likely to be unacknowledged in day-to-day practice even when reflected upon in supervision or training. What clients and therapists say is inevitably influenced by power and interests that have their origins in distal regions that can remain unacknowledged (Smail, 2005).

The therapeutic schema model of problem construction posits that a number of socio-historic factors contribute to a therapist's approach to problems. The organising structure behind this approach to problems has been called the problem-schema. The therapist brings this schema to bear on client's difficulties in initial therapy sessions. The client talks about their difficulties and the therapist uses various rhetorical strategies to organise the clients' difficulties according to their problem schema. The clients then agree with, comply,

disagree with or resist the account being formulated and problem constructions are co-created.

In the papers reviewed the use of rhetorical strategies to pursue therapeutic agendas is conceptualised in different ways. Some studies analyse this process more descriptively, taking a neutral stance on the effects of these strategies. Others have problematised some of the effects of the use of rhetorical strategies. They conceptualise this process as being part of psychological therapy reproducing a dominant discourse of individuality (Rose, 1998). The therapist schema model of problem construction proposed here intends to be descriptive and therefore compatible with different interpretations. The model does, however, highlight the prominence of the therapist's problem-schema for problem construction. This review did not intend to focus on therapists over clients. In fact my expectations were that more studies would discuss the co-constructive nature of discourse. The greater attention on therapists in the themes and resulting model is due to the overall emphasis across the reviewed papers on what therapists are doing with their talk.

Limitations

This review had a number of limitations from the initial search for papers to the proposal of a new explanatory model. It was difficult to identify the appropriate papers in the search strategy. By adding more search terms and a range of synonyms many more results were returned but this did not appear to return more relevant papers. This difficulty when searching for qualitative papers has been highlighted elsewhere (Downe, 2008). Alternative checklists such as the Critical Appraisal Skills Program (2015), which provide an assessment framework for qualitative research, could have been used to assess the quality of the papers in this review. However, QualSyst was selected

as it provides an overall quality score, enabling a comparison between studies across a range of study designs (Kmet, Lee, & Cook, 2004).

As stated previously there are challenges to combining studies with different research methods (e.g. conversation analysis and discourse analysis) and different therapeutic models. In carrying out this review the epistemological tensions between research methodologies created difficulties in the writing of the review as language is considered to perform different functions depending upon the assumptions made about its use. Overall because of my social constructionist standpoint, a perspective on language as constructive was taken. However, I also attempted to discuss papers using the terms used within these papers and the naming of the themes and subthemes draws closely on the language used in the studies reviewed. This created a new epistemological tension between the studies and the review.

Relating to reflexivity discussed previously and here in the limitations it is important to consider the potential implications of the interests of the researcher on the choice of topic and the position of the researcher on the findings of the review (Ortlipp, 2008). An interpretive synthesis is subjective and will have been influenced by the position of the reviewer as a therapist, as a white man and as someone interested in the effects of institutional power and discourses around mental health. Considering this position I may have been more attentive to the use of power by therapists than that of clients. Although, this focus is also likely to have been influenced by the fact that the papers are often focused on the rhetorical processes used by therapists and I was analysing their interpretations of extracts presented rather than re-analysing their original data. It was important therefore to use systematic search processes and review techniques,

including quotations from the studies to demonstrate transparency and to seek guidance through supervision to enhance the reflexive process.

Implications

The findings of this review suggest that it is important for therapists to examine their schemas and be aware of the effect these schemas may have on their understanding of clients' accounts. In settings such as the NHS, western conceptions of the person are difficult to avoid. However an awareness of the discourses that are re-told in certain settings might mitigate the concerns raised in some of the papers (e.g. Guilfoyle, 2002) about therapy being reduced to a technology for the reproduction of a particular way of being.

As the therapists' problem-schemas have been shown to be influential in problem construction with the potential to decontextualize client meanings the findings suggest it may be beneficial to use supervision to consider the process of problem construction. Supervision is a space that allows reflexivity on the processes in therapy (Scaife, 2009). The therapeutic schema model can help with the reflexive process. In supervision therapists could reflect on their personal therapeutic schemas and the reasons for these, for example the preferred model of therapy or their personal characteristics. In training there is scope for collective process analysis of recordings or transcripts. Analysis of recorded sessions is widely recommended for technical analysis and to check adherence to models of therapy. However, recordings could be analysed with this model in mind to promote reflection on the problem construction schemas and rhetorical strategies that are operating. Cases where the therapist may have missed the point of a client's telling of their difficulties may be improved by checking out with the client whether an interpretation is accurate (Antaki, Barnes & Leudar, 2004), although arguably part of the therapy process is

working out and negotiating a shared understanding of problems, where 'getting it wrong' is acceptable.

Future research might fruitfully combine micro and macro discursive analysis of first sessions of therapy in order to examine the usefulness of the model for understanding problem construction. Careful consideration of clients' rhetorical strategies and contribution to problem construction may allow new insights into the process of problem construction. Research into therapist experiences of the process of problem construction may give valuable insight into therapists' awareness of processes, such as rhetorical strategies. Researchers might want to interview therapists about their problem-schemas. Based on the quality appraisal of the studies in this review, studies should report verification procedures and reflexivity of accounts in their dissemination of findings.

References

- Antaki, C., Barnes, R., & Leudar, I. (2004). Trouble in agreeing on a client's problem in a cognitive - behavioural therapy session, *Rivista di Psicolinguistica Applicata*, 4, 127–138. <http://digital.casalini.it/17240646>
- Avdi, E., & Georgaca, E. (2007). Discourse analysis and psychotherapy: A critical review. *European Journal of Psychotherapy and Counselling*, 9, 157-176. doi: 10.1080/13642530701363445
- Beckwith, A., & Crichton, J. (2010). The negotiation of the problem statement in cognitive behavioural therapy. *Communication & Medicine*, 7, 23–32. doi: 10.1558/cam.v7i1.23
- Billig, M. (1990). Rhetoric of social psychology. In I. Parker & J. Shotter (Eds.), *Deconstructing Social Psychology*. London: Routledge
- Buttny, R. & Jensen, A. D. (1995). Telling problems in an initial family therapy session: The hierarchical organization of problem-talk. In G. Morris & R. Chenail (eds). *The talk of the clinic: Explorations in the analysis of medical and therapeutic discourse*. (pp. 19-47). Hillsdale, NJ, England: Lawrence Erlbaum Associates
- Buttny, R. (1996). Clients' and therapist's joint construction of the clients' problems. *Research on Language and Social Interaction*, 29, 125-153. doi: 10.1207/s15327973rlsi2902_2
- Critical Appraisal Skills Programme (CASP). (2015). *Critical Appraisal Skills Programme (CASP)*. [online] Available at: <http://www.casp-uk.net/#!/casp-tools-checklists/c18f8> [Accessed 08 Aug. 2016].
- Davis, K. (1984). The process of problem (re)formulation in psychotherapy. *Sociology of Health & Illness*, 8, 44–74. doi:10.1111/1467-9566.ep11346469

- Dixon-Woods, M., Agarwal, S., Jones, D., Young, B. & Sutton, A. (2005).
Synthesising qualitative and quantitative evidence: A review of possible
methods. *Journal of Health Services Research & Policy*, *10*, 45-53. doi:
10.1258/1355819052801804
- Downe, S. (2008). Metasynthesis: a guide to knitting smoke. *Evidence Based
Midwifery*, *6*, 4-8.
- Edwards, D. & Potter, J. (1992). *Discursive psychology*. London: Sage.
- Fingfeld, D. L. (2003). Metasynthesis: The state of the art-so far. *Qualitative
Health Research*, *13*, 893-904. doi: 10.1177/1049732303253462
- Foucault, M. (2001). *Madness and Civilisation*. London, UK: Routledge
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory:
Strategies for qualitative research*. Chicago, IL: Aldine Publishing
Company.
- Guilfoyle, M. (2002). Rhetorical processes in therapy: the bias for self-
containment. *Journal of Family Therapy*, *24*, 298-316. doi: 10.1111/1467-
6427.00218
- Hak, T., & de Boer, F. (1996). Formulations in first encounters. *Journal of
Pragmatics*, *25*, 83–99. doi: 10.1016/0378-2166(94)00076-7
- Jankowski, P. & Ivey, D. (2001). Problem definition in marital and family
therapy: A qualitative study. *Contemporary family therapy*, *23*, 419-439.
doi: 10.1023/a:1013001012043
- Jones, M. L. (2004). Application of systematic review methods to qualitative
research: practical issues. *Journal of Advanced Nursing*, *48*, 271–87.
doi:10.1111/j.1365-2648.2004.03196.x

- Kmet, L., Lee, R., & Cook L. (2004). Standard quality assessment criteria for evaluating primary research papers from a variety of fields. Alberta, Canada: Alberta Heritage Foundation for Medical Research.
- Korhonen, A., Hakulinen-Viitanen, T., Jylha, V., & Holopainen, A. (2012). Meta-synthesis and evidence-based health care: a method for systematic review. *Scandinavian Journal of Caring Sciences*, 27, 1027-1034. doi: 10.1111/scs.12003
- Labov. W., & Fanshel, D. (1977). *Therapeutic discourse: Psychotherapy as conversation*. New York, NY: Academic Press
- Madill, A., & Barkham, M. (1997). Discourse Analysis of a Theme in One Successful Case of Brief Psychodynamic-Interpersonal Psychotherapy. *Journal of Counselling Psychology*, 44, 232-244. doi: 10.1037/0022-0167.44.2.232
- Mays, N., & Pope, C. (2000) Quality in qualitative health research. In: N. Mays & C. Pope (Eds.), *Qualitative research in health care* (2nd ed.), (p.82-102). London, UK: BMJ Books
- Mruck, K., & Breuer, F. (2003). Subjectivity and reflexivity in qualitative research – a new FQS issue. *Historical Social Research*, 28, 189-212.
- Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Newbury Park, CA: Sage.
- Parker, I. (1997). Discursive Psychology. In D.R. Fox & I. Prillentsky (Eds.), *Critical Psychology: An Introduction* (p.338 – 356). London, UK: Sage.
- Parker, I (1999). Against relativism in psychology, on balance. *History of the Human Sciences*, 12, 61-78. doi:10.1177/09526959922120496

- Patrika, P., & Tseliou, E. (2015) Blame, responsibility and systemic neutrality: A discourse analysis methodology to the study of family therapy problem talk. *Journal of Family Therapy*, 1-23. doi: 10.1111/1467-6427.12076
- Popay, R., Rogers, A., & Williams, G (1998). Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research*, 8, 341-51.
doi:10.1177/104973239800800305
- Roberts, C. & Sarangi, S. (2005). Theme-oriented discourse analysis of medical encounters. *Medical Education*, 39, 632-640. doi: 10.1111/j.1365-2929.2005.02171.x
- Rose, N. (1998). *Inventing Our Selves: Psychology, Power and Personhood*. Cambridge, UK: Cambridge University Press
- Sacks, H, Schegloff, E. A., & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking for conversation. *Language*, 50, 696-735.
doi:10.2307/412243
- Sandelowski, M. (2006). 'Meta-jeopardy': the crisis of representation in qualitative metasynthesis. *Nursing Outlook*, 54, 10-16. doi: 10.1016/j.outlook.2005.05.004
- Scaife, J. (Ed.). (2009). *Supervision in clinical practice: A practitioners guide* (2nd ed.). Hove, UK: Routledge.
- Smail, D. (2005). *Power, interest and psychology: Elements of a social materialist understanding of distress*. Ross-on-Wye, UK: PCCS Books
- Thorne, S., Jensen, L., Kearney, M.H., Noblit, G. & Sandelowski, M. (2004). Qualitative metasynthesis: Reflections on methodological orientation and ideological agenda. *Qualitative Health Research*, 14, 1342-1365. doi: 10.1177/1049732304269888

Walsh, D., & Downe, S. (2004). Meta-synthesis method for qualitative research: a literature review. *Journal of Advanced Nursing*, 50, 204-211. doi: 10.1111/j.1365-2648.2005.03380.x

Willig, C. (2008). *Introducing qualitative research in psychology: adventures in theory and method* (2nd ed.). Maidenhead, UK: Open University Press.

Appendix A – QualSyst Quality Checklist and Manual

Table 2. Checklist for assessing the quality of qualitative studies

Criteria	YES (2)	PARTIAL (1)	NO (0)
1 Question / objective sufficiently described?			
2 Study design evident and appropriate?			
3 Context for the study clear?			
4 Connection to a theoretical framework / wider body of knowledge?			
5 Sampling strategy described, relevant and justified?			
6 Data collection methods clearly described and systematic?			
7 Data analysis clearly described and systematic?			
8 Use of verification procedure(s) to establish credibility?			
9 Conclusions supported by the results?			
10 Reflexivity of the account?			

The original checklists and scoring manuals were developed following a review of various quality assessment documents and discussion by the authors of the elements considered central to internal study validity. Ten quantitative and ten qualitative studies were then randomly selected and independently scored by two reviewers. For the quantitative studies, 14 items (Table 1) were scored depending on the degree to which the specific criteria were met ("yes" = 2, "partial" = 1, "no" = 0). Items not applicable to a particular study design were marked "n/a" and were excluded from the calculation of the summary score. A summary score was calculated for each paper by summing the total score obtained across relevant items and dividing by the total possible score (i.e.: $28 - (\text{number of "n/a"} \times 2)$). Scores for the qualitative studies were calculated in a similar fashion, based on the scoring of ten items (Table 2). Assigning "n/a" was not permitted for any of the items, and the summary score for each paper was calculated by summing the total score obtained across the ten items and dividing by 20 (the total possible score).

Appendix B: Manual for Quality Scoring of Qualitative Studies

Definitions and Instructions for Quality Assessment Scoring

How to calculate the summary score

- **Total sum** = (number of "yes" * 2) + (number of "partials" * 1)
- **Total possible sum** = 20
- **Summary score**: total sum / total possible sum

Quality assessment

1. *Question / objective clearly described?*

Yes: Research question or objective is clear by the end of the research process (if not at the outset).

Partial: Research question or objective is vaguely/incompletely reported.

No: Question or objective is not reported, or is incomprehensible.

2. *Design evident and appropriate to answer study question?*

(If the study question is not clearly identified, infer appropriateness from results/conclusions.)

Yes: Design is easily identified and is appropriate to address the study question.

Partial: Design is not clearly identified, but gross inappropriateness is not evident; or design is easily identified but a different method would have been more appropriate.

No: Design used is not appropriate to the study question (e.g. a causal hypothesis is tested using qualitative methods); or design cannot be identified.

3. *Context for the study is clear?*

Yes: The context/setting is adequately described, permitting the reader to relate the findings to other settings.

Partial: The context/setting is partially described.

No: The context/setting is not described.

4. *Connection to a theoretical framework / wider body of knowledge?*
 - Yes:** The theoretical framework/wider body of knowledge informing the study and the methods used is sufficiently described and justified.
 - Partial:** The theoretical framework/wider body of knowledge is not well described or justified; link to the study methods is not clear.
 - No:** Theoretical framework/wider body of knowledge is not discussed.
5. *Sampling strategy described, relevant and justified?*
 - Yes:** The sampling strategy is clearly described and justified. The sample includes the full range of relevant, possible cases/settings (i.e., more than simple convenience sampling), permitting conceptual (rather than statistical) generalizations.
 - Partial:** The sampling strategy is not completely described, or is not fully justified. Or the sample does not include the full range of relevant, possible cases/settings (i.e., includes a convenience sample only).
 - No:** Sampling strategy is not described.
6. *Data collection methods clearly described and systematic?*
 - Yes:** The data collection procedures are systematic, and clearly described, permitting an "audit trail" such that the procedures could be replicated.
 - Partial:** Data collection procedures are not clearly described; difficult to determine if systematic or replicable.
 - No:** Data collection procedures are not described.
7. *Data analysis clearly described, complete and systematic?*
 - Yes:** Systematic analytic methods are clearly described, permitting an "audit trail" such that the procedures could be replicated. The iteration between the data and the explanations for the data (i.e., the theory) is clear – it is apparent how early, simple classifications evolved into more sophisticated coding structures which then evolved into clearly defined concepts/explanations for the data). Sufficient data is provided to allow the reader to judge whether the interpretation offered is adequately supported by the data.
 - Partial:** Analytic methods are not fully described. Or the iterative link between data and theory is not clear.
 - No:** The analytic methods are not described. Or it is not apparent that a link to theory informs the analysis.

8. *Use of verification procedure(s) to establish credibility of the study?*

Yes: One or more verification procedures were used to help establish credibility/trustworthiness of the study (e.g., prolonged engagement in the field, triangulation, peer review or debriefing, negative case analysis, member checks, external audits/inter-rater reliability, "batch" analysis).

No: Verification procedure(s) not evident.

9. *Conclusions supported by the results?*

Yes: Sufficient original evidence supports the conclusions. A link to theory informs any claims of generalizability.

Partial: The conclusions are only partly supported by the data. Or claims of generalizability are not supported.

No: The conclusions are not supported by the data. Or conclusions are absent.

10. *Reflexivity of the account?*

Yes: The researcher explicitly assessed the likely impact of their own personal characteristics (such as age, sex and professional status) and the methods used on the data obtained.

Partial: Possible sources of influence on the data obtained were mentioned, but the likely impact of the influence or influences was not discussed.

No: There is no evidence of reflexivity in the study report.

Appendix B - A worked example to illustrate the procedure of transforming data into the themes and overarching themes presented in the findings.

Themes	Subthemes	Example Data (Author's Interpretations)	Papers
Problems Defined by Therapists	Problem definition meta Processes	The first meta-process that emerged from coding of the data was a process in which the clinicians' definitions remained internal. In contrast, the second meta-process created during the coding of the data involved clinicians making overt their internal problem definitions' (Jankowski & Ivey, 2001)	Jankowski & Ivey (2001)
	Professional definition	This last instance, in which a relationship is articulated between the patient's talk ("not daring to say no", which takes up the patient's "I can't say no") and the professional problem formulation, is an example of how a professional definition of a patient's problem can be constructed', (Hak & de Boer, 1996)	Hak & de Boer (1996), Jankowski & Ivey (2001)
	Universalsising analogy	The moral or gist of the story is that anyone (including mentally healthy people) who had been made to do something they did not initially like would end up hating it (Antiki, Barnes & Leudar, 2004)	Antiki, Barnes & Leudar (2004)
	Therapist chooses focus	This formulation serves to introduce this aspect of the client's behaviour as a new topic for conversation. Ultimately, it will become a full-fledged therapy problem' (Davis, 1984)	Davis, (1984)

Therapists Employ Rhetorical Strategies	Formulation	In each extract, a formulation is provided which, among other things, is marking significant gist' (Davis, 1984)	Davis (1984), Hak & de Boer (1996)
	Focused Technical Questions	'by only offering the choice of these two symptoms for what is a non-specific statement by the client the therapist has once again steered the client's problem to one of an anxiety problem and as such more amenable to CBT' (Beckwith & Crichton, 2010)	Antiki, Barnes & Leudar (2004), Beckwith & Crichton (2010)
	Circular Questioning	'In this extract the therapist's attempt to introduce a relational perspective by means of circular questioning seems to be understood by the mother as if allocating blame and responsibility to family members.' (Patrika & Tseliou, 2015)	Patrika & Tseliou (2015)
	Third Turn Evaluations	'The therapist can take the clients' utterances as displaying understanding or assessment of what the therapist has just said. As such, these client responses provide a valuable interactional resource in that the therapist can, in turn, move to correct, assess, or elaborate on the clients' alignment with the therapeutic position.' (Buttny, 1996)	Buttny (1996)
	Reification and Ironization	'The ironization of the medication discourse, and the rejection of the passive position it suggested for Lionel, allows for the reification of an agency discourse, which then becomes the 'real' reason for Lionel's change.' (Guilfoyle, 2002)	Guilfoyle (2002)

Part Two: Research Report

A Critical Discourse Analysis of Therapist-Client Problem Construction in Psychotherapy

Abstract

Objective. This study aimed to investigate the co-construction of problems by clients and therapists in first sessions of psychotherapy in IAPT services

Design. A qualitative design was employed to analyse six first session therapy transcripts for clients receiving Cognitive Behaviour Therapy (three) or Counselling for Depression (three).

Method. Critical discourse analysis was used, involving four stages: Discursive Constructs, Rhetorical strategies, Subject Positioning and Institutions, Practices, Ideology and Subjectivity

Results. Distressing feelings and dysfunctional thoughts were prominent problem constructions across the sessions analysed. Problem construction was influenced by practices such as completing questionnaires that are required in IAPT services. Discourses of social norms were also prominent in the construction of problems. These include ideas around what it is to be normal or what people should do with their lives. These social norms or 'rules for living' impacted upon people's identities.

Discussion. The connection between normative discourses and problems that are constructed in psychotherapy highlights the need for therapist reflexivity on their theoretical approach, and societal norms that both they and the client may reproduce in sessions.

Practitioner Points: Supervision and training should be used to enhance reflexivity about the effects of institutional practices and social norms on therapists' and clients' discourses and problem constructions.

Introduction

Psychotherapy is a practice involving conversations focused on people's problems and their understanding or resolution (Labov & Fanshel, 1977). Previous research on problem formation in therapy has often focused on therapists' rhetorical strategies (e.g. Guilfoyle, 2002; Hak & de Boer, 1996). Research highlighted that when clients tell their problems to therapists, therapists reframe them as problems amenable to therapy (e.g. Madill & Barkham, 1997). In a conversation analysis of family therapy, Buttny (1996) shows how certain rhetorical devices are used to 'correct' clients' understandings of their problems. Davis (1984) discusses how social context can be disregarded in formulation processes, situating problems in individuals. The problem discourses that clients and therapists use raise implications about the origins and maintenance of their problems and the way these problems are related to in particular therapeutic contexts.

Institutional contexts in which problems are constructed in psychotherapy are important, as they may influence the discourses that therapists and clients use and reproduce (Proctor, 2002). The most common way that people get psychological help in the UK is through Improving Access to Psychological Therapies (IAPT). IAPT is an NHS service created to offer talking therapies to a greater number of people with depression and anxiety instead of, or alongside, medication, often the only form of 'treatment' available to them (Healthcare Commission, 2007). In the UK, psychological services emphasise tailoring brief interventions for specific diagnostic groups. Diagnostic categories form the basis of psychological service provision because current evidence is based on large scale randomised controlled trials appraised by the National Institute for Health and Clinical Excellence (NICE) that follow diagnostic models such as

those outlined in Diagnostic and Statistical Manual of Mental Disorders Five (DSM-5; American Psychiatric Association, 2013). This emphasis is particularly strong in IAPT (Clark, 2011).

These social, institutional, national and service level contexts have implications for clients' therapy. Therapists are required to follow NICE guidelines and routinely use outcome measures providing an existing framework for conceptualising problems, e.g. the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) that measures severity of depression according to Diagnostic and Statistical Manual of Mental Disorders Four (DSM-IV) criteria. Clients also have limited choice over factors such as the model of therapy they receive or the number of sessions they can access in NHS services.

Studies have reported on IAPT effectiveness (Department of Health, 2012; Parry et al., 2011) with more people returning to full time work and over 50% of patients considered as having recovered using the most stringent criteria in demonstration sites. However, there has been little published process research or studies of client experiences of IAPT services. Research tends to be based on focus groups or semi-structured interviews, analysing NHS worker or client attitudes thematically (e.g. Jones, Bale, & Morera, 2013; Rethink, 2011). Using Framework Analysis and Interpretative Phenomenological Analysis, the evaluation by Parry et al. (2011) found that some patients found contact with general practitioners (GPs) and IAPT services useful in identifying problems and goals. However, some service users found initial sessions that focused on outcome measures and paperwork, lacked a sense of care and could be off-putting.

A study was conducted into primary care practitioners' attitudes toward NICE guidance on depression (Mitchell, Dwyer, Hagan, & Mathers, 2011). It was viewed positively as helping to structure assessment and direct intervention but its impact was perceived as compromised by limited resources in routine practice. Standardised screening and assessment questions such as those in the PHQ-9 were perceived as unlikely to improve quality of care, with some primary care practitioners seeing its use as a 'tick box exercise', unable to capture diversity in clients' experience and interfering with the flow and holistic focus of patient centred consultation. To date there are no qualitative studies of in-therapy talk in IAPT services. Given issues regarding the use of structured assessments and outcome measures, and concerns with limited choice and information around referral and intervention, an in-depth analysis of how problems are discussed in first sessions of therapy within IAPT would be beneficial.

Two key interventions for depression in IAPT services are Cognitive Behaviour Therapy (CBT) and Counselling for Depression (CfD). Both are NICE recommended and have been shown to help people with depression in trials. As they have different underlying philosophies they might contribute to problems being constructed in different ways. During initial therapy sessions clients will typically say why they have sought therapy. This is a process of telling problems and offering accounts of how they have occurred. A key question that then emerges is how therapists and clients agree which problems to work on and how this is managed within their relationship.

Although there are a growing number of conversation analyses of therapy, the actual interaction between therapists and clients in clinical settings has barely been examined using discourse analysis (Georgaca, 2012). So,

although the mechanics of therapist and client interactions are examined, the wider social context in which they occur has been neglected. This study will explore the co-construction of problems by clients and therapists in first sessions of psychotherapy through analysing their problem talk in detail. Discourse analysis enables analysis of the impact of wider social factors, including institutions and ideologies, on the problem constructions made by clients and therapists (Avdi, 2012).

This research aimed to investigate therapists' and clients' co-construction of presenting problems within the context of an IAPT service and wider social discourses regarding psychological problems. IAPT is the most common form of therapy available to people in the UK, so provides a useful site for analysing how problems are constructed in therapy. However, the higher focus on capturing outcomes and emphasis on delivery of manualised forms of therapy creates a particular context for this analysis that is likely to influence problem construction. The central research question of this study is: How are problems constructed by therapists and clients in the first session of psychotherapy in IAPT services?

Method

A qualitative design was used with critical discourse analysis as the methodology using stages of analysis drawn from Georgaca and Avdi (2012). These stages incorporate tools of discursive psychology and Foucauldian discourse analysis (Willig, 2013). Audio data was gathered from psychotherapy sessions recorded as part of the 'Pragmatic, Randomised Controlled Trial assessing the non-Inferiority of Counselling and its Effectiveness for Depression' (PRaCTICED; Saxon et al., in preparation).

PRaCTICED Trial

PRaCTICED is a research trial comparing CfD and CBT as interventions for depression in an IAPT service. It is being carried out in Sheffield's IAPT service in routine practice with people who have a diagnosis of depression. Clients are randomly assigned to CBT or CfD. It is designed as a non-inferiority trial as it is hypothesised that CfD outcomes will not be significantly inferior to CBT outcomes.

Epistemological Position

Where relevant, I have used the personal pronoun 'I' to refer to myself as the speaker or writer rather than the impersonal 3rd person 'researcher'. This is because I wish to highlight my part in co-constructing the discourse in my analysis. This use of 'I' is consistent with my methodology explained below.

The discourse analysis used was social constructionist. Social constructionism is the theory that reality does not exist independently of its construction through social practices and systems of meaning (Burr, 2007). What people experience, including perception and feeling is mediated by culture, history and language (Willig, 2013). It entails a broadly relativist epistemology. Relativism is the view that there are no absolute truths but that what we can know is subjective and context dependent. Relativism has provided a useful framework for deconstructing truth claims made about dominant discourses, including those from psychology that privilege certain ways of being (Burman, 1994).

However, taken in a strong form, relativism's privileging of individual perspectives or subjectivity can limit claims to shared knowledge and social practices (Parker, 1999). This in turn limits possibilities for understanding the material world beyond individual perception and limits social action. Critical

realists acknowledge that the material world exists but assert that our knowledge of it is constructed through social processes which, being structural and maintained by institutions and their practices, are relatively enduring (Parker, 1999). This research adopts a critical realist epistemology as it intends to comment on the material conditions and institutional practices that influence people's constructions of problems (Bhaskar, 1989). This epistemology influences the methodological approach used to analyse the therapist-client talk about problems.

Methodology

Discourse analysis is an approach for studying discourses drawing on social constructionism. It is a close study of language in use, which sees language use as functional. It also allows an analysis of wider social discourses present in institutions, such as the NHS, in which the data is occurring. In the field of discourse analysis, a range of types of analysis are used. Three different types of discourse analysis are outlined below. Distinctions are made between the approaches to explain why critical discourse analysis was chosen as the method for answering the research questions from the epistemological position of critical realism. The types of analysis discussed here are: discursive psychology, Foucauldian discourse analysis and critical discourse analysis.

Discursive psychology examines how psychological concepts such as feelings and beliefs come to be constructed in talk. It focuses mainly upon the functions of language in interaction. Here discursive psychology is concerned with the specifics of interaction such as turn-taking, persuasion, or accusation and how speakers manage issues of stake and interest (Willig, 2013).

Foucauldian discourse analysis draws on the genealogical work of Foucault (e.g. Foucault, 2001). Genealogy is concerned with tracing historical

and social factors that influence or constrain local, 'here and now' constructions. By looking at how discourses change over time it examines the availability of certain ways of talking within particular cultures and contexts that are influenced by the systems of belief or ideologies of that time.

Critical discourse analysis focuses on the institutional and professional contexts in which constructions and discourses are used whilst exploring the interactional processes in talk. It draws on Foucauldian analysis of institutions and ideology and discursive psychology's analysis of language in use.

Consistent with a critical realist epistemology this study will employ a critical discourse analysis as it allows the examination of broader discourses present in institutions and society as they are reflected in the discourses of the therapist and client, whilst also recognising their locally produced, context-bound constructions.

Participants

Participants were from both arms of the PRaCTICED trial. The clients were referred by GPs to Sheffield's IAPT service, and then screened by psychological wellbeing practitioners (PWP's). All participants were willing to take part in the trial and gave written consent. Participants were over 18 and met the International Classification of Diseases, Tenth Edition (World Health Organisation, 1992) criteria for a diagnosis of moderate to severe depression; both requirements of inclusion in the trial. The client's age, gender, ethnicity and employment status are given along with the gender of the therapist and their model of therapy in table 1. The therapists delivering CfD were accredited counsellors fully trained in CfD. The CBT therapists were BABCP approved, and used a Beckian CBT model.

Table 1.

Demographic Information

Client	Age	Gender	Employment Status	Ethnicity	Therapy Model	Therapist Gender
Client 1	60	M	Employed	White British	CfD	F
Client 2	27	F	Not Employed	White British	CBT	M
Client 3	24	F	Employed	White British	CfD	M
Client 4	45	M	Not Employed	White British	CBT	F
Client 5	51	F	Employed	White British	CBT	F
Client 6	57	M	Employed	White British	CfD	F

Sampling

The sample consisted of six clients, three from each arm of the trial. All transcripts analysed are from the first session of therapy. There are no standards for the designated numbers of participants for discourse analysis (Willig, 2013). Analysis is a labour intensive process and the selection of an amount of data is determined by having enough material to conduct a detailed analysis. Three hours from each model of therapy were selected in this case to provide enough data for potential differences to be analysed between models of therapy (CBT and CfD) and to allow for a variety of problem constructions across different therapist-client dyads. The data selected for analysis were the first audio data available from the first three therapists in each arm of the trial. Different therapists were used to give as much diversity and breadth as possible in the small sample size in order to give a range of problem constructions.

Analysis Process

Audio data from therapy sessions was transcribed in accordance with clinical psychology unit guidelines by approved transcribers (see appendix A for details of transcription notation). Audio files were given to the transcribers on an encrypted memory stick and they signed a confidentiality agreement (see appendix B). Transcripts were checked for continuity. Initial coding of problem constructions in the data took place and extracts relating to my research questions were then selected for analysis in more depth. Analysis drew on analytic tools of discursive psychology described by Willig (2013) and used stages outlined there and in Georgaca and Avdi (2012) as a framework. The stages I used are adapted from these sources to focus particularly on dialogical processes involved in therapy. They were conducted sequentially.

Stages of Analysis

1. Discursive Constructs. The first stage of analysis identified instances of the use of problem talk, including all references to depression and related concepts both implicit and explicit. Instances of problem talk are the 'discursive objects' under study (Willig, 2013). They were coded in the transcripts with time points noted. Problem constructions were collected on thematic maps for each transcript in order to easily identify and compare the range of problem constructions. A further thematic map was created with the problem constructions that were most prominent and common across sessions. A copy of this thematic map is included in appendix C. Maps were used as the basis of the write up of findings.

2. Rhetorical strategies. The second stage involved looking at the discursive objects in the context of the surrounding talk. Rhetorical analysis has been emphasised as a useful means of analysing the interactive processes

through which therapeutic aims such as change, meaning making and insight are constructed (Guilfoyle, 2002). Rhetorical strategies can be used knowingly (explicitly) or unconsciously (implicitly) but particularly, when explicit, can be conceptualised as argumentative in structure, supporting one position whilst criticising or denying another (Billig, 1990). An analysis of their use can highlight the agendas of the therapists and clients in this research. Instances of use of rhetorical strategies were coded in the transcripts.

3. Subject Positioning. Discursive constructs and rhetorical strategies create a number of possible positions in the interaction that are available to the therapist and client (Davies & Harre, 1990). Analysing these subject positions allows us to explore participants' subjectivity. These positions have implications in terms of issues such as power or credibility for participants as they allow certain actions and restrict others. Davies and Harre (1990) distinguish the concept of position, which is changeable depending on context and the concept of role, which they conceptualise as more fixed. Positioning can also be either interactive when one person is positioned by another or reflexive, when someone positions themselves.

4. Institutions, Practices, Ideology and Subjectivity. The fourth (macro) stage of analysis explored how ideological contexts influenced factors such as discourse choice and subject positioning. It examined the ways in which discourses, were influenced by and involved in maintaining, institutional practices. This stage recognises that conversation occurs in relation to a history of conversations that have already occurred and that the interaction of the therapist and client is shaped by their institutionally defined positions (Avdi, 2012).

Quality Control

Drawing from discussions of quality criteria for discourse analysis (e.g. Georgaca & Avdi 2012) the following principles and procedures were utilised:

- (1) Analysis is grounded in extracts from the transcripts. An example of a section from a coded transcript is included in appendix D.
- (2) The research process is described to provide transparency.
- (3) Consistency in the analysis of extracts with the whole transcript was sought through re-listening to the data following each analytic stage.
- (4) The analysis was discussed throughout the process by discussing drafts with supervisors and a discourse analyst.
- (5) Reflexivity about my role in the research process and its implications were recorded in a reflexive journal.
- (6) The usefulness of the study for theory and practice is considered in the discussion.

Reflexivity

Reflexivity is a process of self-reflection where effects of characteristics of the researcher such as gender, race and age on analysis are considered (Haynes, 2012). I used supervision as a reflective space in which assumptions were discussed and reflexivity was heightened. Reflective journals can facilitate the process of critical self-reflection and provide a record of changes in thinking throughout the research process (Ortlipp, 2008). I recorded reflections on the data, the research process and assumptions I had about these elements of the research. This helped me alongside supervision to be aware of over interpreting the data, instead leaving space for the reader to draw conclusions from the data and analysis. The diary also helped me to reflect on my emotional reactions to

the therapists and clients. Some examples of my reflections on analysis are included in appendix E.

Ethical Considerations

My study fitted within the ethical approval already gained for the PRaCTICED trial. Governance approval was sought through the University of Sheffield and granted. See appendix F for a copy of ethical approval and governance documents. The participant information sheet and consent form is included in appendix G. Lengthy extracts were avoided and the names of people, places and other identifying features were removed. Another key ethical consideration in this trial concerned the management of data to preserve confidentiality and anonymity.

Data Security and Management

All data (electronic, paper, and recorded media) were stored securely in accordance with the Data Protection Act (1998) regulations and NHS guidance on management of personal data in research databases.

Service User Involvement

Discourse analysis is interpretive in nature and assumes that processes such as positioning are not necessarily conscious. It has been argued that service user involvement in participant validation is inappropriate as participants could not validate something of which they might not be conscious (Coyle, 2000). It was decided not to include service users in the analysis of findings. However, details of the findings will be fed back to service user groups.

Results

Results of the analysis are presented in two sections. The first presents the micro analysis of problem constructions in the interaction. The second broadens the analysis to include the wider social context constituting a macro

analysis of discourses in the text. The first section contains three stages of analysis: Constructions of problems by therapists and clients, rhetorical strategies participants use to pursue their agendas and how these discourses and strategies entail certain subject positions. In the second section institutions, practices, ideologies and subjectivity are explored.

Micro-Analysis

Analysis Stage 1 – Problem Constructions. Problems are constructed in a variety of ways in the therapy sessions analysed. These can be grouped under common themes outlined in Table 1. Examples are given and their location within the systems of meaning or discourses available to the participants is briefly discussed before being elaborated in later analysis.

Table 1.

Discursive Constructs by Theme

Problem Constructions	Example
Distressing feelings as the problem	<i>Mood up or down</i> – 1.10, Transcript 2 <i>Being Angry</i> – 1.188, Transcript 5 <i>'Scared shitless'</i> – 1.45-1.48, Transcript 1 <i>Worry every day</i> – 1.4, Transcript 6
Dysfunctional thoughts as the problem	<i>Can't think straight</i> – 1.18, Transcript 1 <i>Brain overthinking</i> – 1.60, Transcript 2
The problem as having an unspoken history	<i>'Things' in the past</i> – 1.52, Transcript 3 <i>'Abuse' at the start</i> – 1.38-1.40, Transcript 4
The problem as having parts	<i>One part sorted</i> – 1.9, Transcript 2 <i>Not one problem</i> - 1.35-1.37, Transcript 4
The problem as unnamed	<i>'Things'</i> – 1.8-1.9, Transcript 2
The problem as measurable	<i>Captured by a form</i> – 1.128, Transcript 3
The problem as a diagnosis	<i>Diagnostic</i> – 1.19, Transcript 4 <i>Didn't realise I had Depression</i> – 1.32, Transcript 5
The problem as an 'unhealthy' lifestyle	<i>Alcohol & smoking</i> – 1.82-1.87, Transcript 2
The problem as not meeting social expectations	<i>Useless</i> – 1.20, Transcript 1 <i>A Burden</i> – 1.27, Transcript 2 <i>Caring too much</i> - 1.107, Transcript 6
The problem as loss	<i>Deaths, breakup</i> – 1.25.2, Transcript 1

Distressing feelings as the problem. Distressing feelings are frequently constructed as being the problem in all sessions. In the following extract the client refers to mood being down, a common occurrence in discourses around depression (Lawler, 2012).

Therapist – ...so when you say things are a lot better, does that mean that your mood's better, you're feeling a bit better in yourself?

Client – ... *My mood is better (mm) and even my dad said that yesterday but I still have days where I'm like (sure) really down.* 1.10, Transcript 2

Here mood and feelings are constructed as being changeable, being able to move up and down. Directional metaphors are commonly used to describe mood (Killick, 2014). The construction of anger as the problem here occurs through the client's description of their aggressive behaviour.

Client - *I flipped, I got hold of him and I wanted to – I swore at him, I put my coat on, I threw the hoover at him, I wanted to strangle him with the hoover pipe.* 1.188, Transcript 5

Elsewhere other feelings are constructed; here the client and therapist use slightly differing constructions relating to fear.

Client - ... *he's not going to nursery he's in the army (.) and with all the best will in the world and all the (.) negative thoughts that go through my mind and every time I switch the news on I'm like oh no (...)*

Therapist - *You're frightened*

Client - *Scared shitless (.) sorry*

Therapist - *No you, like I said you can use (.) whatever language, that's how it feels you're scared shitless.* 1.45-1.48, Transcript 1

The therapist here interprets the client's thoughts about his son coming to harm in the army as him experiencing fear. The client takes up this construction but alters it and emphasises it by using a more extreme construction. The therapist reinforces the feeling discourse repeating his words back to him. In session six the problem is constructed as both anxiety and worry.

Well, in terms of anxiety, I didn't sleep – last week I was worrying about this. I know it's not anything to do with you really, but if it – you know, it's

something new, just something different, - I worry every day 1.4,

Transcript 6

The worry is connected to feelings of anxiety but also has a cognitive component as it concerns worries about the session.

Dysfunctional Thoughts as the Problem. 'Faulty' thinking processes are constructed as being the problem. In session one the client says that they are unable to think straight.

Client - ... *there's nothing to sort (.) when I think of it (.) but there is plenty going on upstairs where I can't think s-straight.* 1.18, Transcript 1

The client is suggesting that the problem is not something that needs solutions but rather a problem with their thinking processes. Client two uses a similar construction but externalises it to her brain.

Client - ... *your brain decides that even though you want to go to sleep, your brain don't want to (yeah). So it's like you just constantly think of like stuff that's happened, like from a couple of weeks before to like what's happened that day and stuff like that (aha). It's like your brain just starts thinking and over-thinking...* 1.60, Transcript 2

The problem as having an unspoken history. Problems are described as having a history or being caused by past events throughout transcripts. These descriptions of past events construct a narrative or story for problems. Effects of the past are mentioned explicitly here but details are left out.

Client - ... *I have things in the past that both my mother and grandparents don't know about which is why I've kind of taken it more seriously, because stuff that's happened in the past and various bits and pieces, I think has led to where I am now...* 1.52, Transcript 3

Elsewhere clients refer to specific events that have led to problems.

Client - ... *I was walking to my grandma's at six or seven years old, ermm, going up to [Place] (.) and I got pulled off the street and sexually abused (.) erm*

Therapist - *Goodness, that must've been horrible*

Client - *I've (.) not told anybody about that apart from the previous woman I saw... 1.38-1.40, Transcript 4*

In both these extracts past events are referred to as having not been spoken about.

The problem as having parts. Therapists and clients refer to problems as having parts or being multiple. The following extract from transcript two illustrates problems being talked about as explicitly having parts.

Client – ... *the main part of the problem was like the place that I was working at (ahum, yeah) but I've actually recently got a new job (oh right) so (well done). That's one part of the problem sorted. 1.9, Transcript 2*

Below in transcript four the therapist introduces the problem as a single entity and the client challenges this, introducing the view that there is more than one problem.

Therapist – “...*So is it OK then if I get you to tell me what you think the problem is and what, you know, what brought you to your doctor, what, what is the problem with your life? (.) and, we sort of spend til about half past giving you the chance to just tell me what the problem is. (.) Is that OK?”*

Client – “*You make it sound like there's one specific problem”*

Therapist – “*OK, yeah, (I don't) there might be more than one... 1.35-1.37, Transcript 4*

The problem as unnamed. There are instances where the problem is unnamed, referred to implicitly using words like 'it' or 'things' or referring to 'the situation'. As unnamed the problem here is constructed implicitly.

Therapist – ... *So, perhaps if we just started with you telling me how things are for you at the moment.*

Client – *At the moment they're a lot better than what they was (ok that's good to hear). 'cause like the main part of the problem was like the place that I was working...* 1.8-1.9, Transcript 2

Here the therapist asks 'how things are' for the client. A thing is an object or entity that cannot be specifically designated or precisely described. However, the client appears to pick up on 'things' as being related to problems as she describes them as being better than they were and then goes on to refer to 'problems' making the 'things as problems' explicit.

The problem as measurable. There are a number of problem constructions related to problems being able to be measured and categorised. The therapist in session three is discussing items on the PHQ9 and problems are constructed there as being able to be categorised.

Therapist - ...*there's kind of 4 categories in it and I guess most people who are depressed don't score zero, and might score one; when I see them they're probably score a 2 or a 3 ...* 1.128, Transcript 3

The PHQ9 has symptom items, which are used by the therapists to discuss problems.

Therapist - ... *'have little interest in doing things in the last 2 weeks', that's true nearly every day, more than*

Client - *Um, I'd say probably about more than half...* 1.114-1.115, Transcript 3

All constructions of problems as measurable were introduced by therapists. The use of these measures is a feature of first sessions in IAPT services and they are shown here to influence the problem discourse.

The problem as a diagnosis. Problems are also referred to in diagnostic terms such as anxiety or depression.

Therapist - ... *So a doctor has to decide that you've got anxiety or depression...* 1.19, Transcript 4

The therapist invokes a *medical discourse* through talking about doctors deciding on diagnostic terms that define problems for clients. In session five the client constructs depression as something that a person has or doesn't have.

Client - *Not really, I just – I didn't realise that I had depression, because nobody's ever said that.* 1.32, Transcript 5

The problem as an 'unhealthy' lifestyle. Problems are discussed as being related to lifestyle. Certain practices such as smoking, drinking alcohol or taking illegal drugs are problematised, usually by therapists.

Therapist - *Right (.) Ok, erm, but you don't, you don't have much caffeine (no). (..) Ok, um, just in terms of sort of other lifestyle factors- how about alcohol, do you drink much?*

Client - *No, (.) drinking just don't interest me.*

Therapist - *Does that mean you don't drink at all or-*

Client - *Well I do like if it's like a family party or (yeah but-) but I think the last time I had a drink was like the beginning of August.*

Therapist - *Ok, so very occasional (yeah) (.) How about smoking?*
1.82-1.86, Transcript 2

The problem as not meeting social expectations. Clients across accounts refer to being a burden on others, being useless and not having a job.

These constructions refer to not meeting social expectations. They relate to ideas about what people 'should' be able to do. Here the client compares himself to a past functioning self that was a rock for others and casts himself as currently useless.

Client – ... *I have been a rock for a lot of people and at the moment I don't think I () (voice shakes).Er (.) I don't, I don't think I'm use, I just think I'm absolutely useless at the moment.* 1.20, Transcript 1

Elsewhere the client constructs the problem as having lost his role in life, which involved being useful for other people. Another construction that relates to discourses of independence is being a burden on others.

Client – *Yeah and I, I don't know I just felt really lonely (mm) and like I was just burdening people with like (right) what I was going through and stuff like that.* 1.27, Transcript 2

Caring too much about what other people think is another problem construction centred on social expectations.

Client - *I care, but sometimes I think I care too much about what other people think – my, my existence or the way I feel about myself is based on how other people think, not on how I think.* 1.107, Transcript 6

The problem as loss. This construction only features explicitly in session one but it is a prominent theme throughout. Here it is about losing people, but in the same session, loss of role and '*losing his marbles*' are other themes of loss.

Client - ...*you lose your father you lose your mother you lose your sister (..) (sniff) you lose your wife (.) and then er obviously the kids are grown up as you bring them up to do and (sniff) and you lose them.* 1.25.2, Transcript 1

Summary. The first two problem constructions relate to the phenomenology of the problem, how they are experienced by the client. The other problem constructions are more descriptive and are ways of understanding the problem. Problems are made sense of by talking about them having a past, having parts or being measurable/diagnostic.

Analysis Stage 2 – Rhetorical Strategies. Identifying rhetorical strategies enables us to look in detail at what the two participants in the therapy interaction are doing with their talk. Rhetorical strategies are outlined in Table 2 and are discussed in more detail following the table.

Table 2.

Rhetorical Strategies by Type

Rhetorical Strategies	Example
Naturalisation	<i>Just find it hard to sleep</i> – 1.58, Transcript 2 <i>It just happens</i> - 1.154, Transcript 5
Rationalisation	<i>What stops you sleeping?</i> - 1.59, Transcript 2
Extreme Case Formulation	<i>She's like <u>really</u> annoyed</i> – 1.35, Transcript 2
Ironization	<i>You have a partner though</i> – 1.91, Transcript 4 <i>But you're acknowledging</i> - 1.57, Transcript 6
Attribution	<i>The past has led to where I am now</i> – 1.52, Transcript 3
Externalising	<i>My Gremlin says 'fuck off'</i> – 1.70, Transcript 3
Blaming	<i>She brought them people into our house</i> – 1.172, Transcript 3
Justification	<i>But I'm not a stoner</i> – 1.166, Transcript 4
Formulation	<i>So all of it is strange</i> – 1.15, Transcript 1 <i>You're not good enough</i> 1.65, Transcript 6
Disclaiming	<i>Not saying for one minute</i> – 1.71, Transcript 1

Naturalisation and Rationalisation. Naturalisation is a process whereby some thing or state of affairs is constructed as naturally occurring or

having always been the case 'just the way it is' (Vaara & Tiernari, 2002).

Rationalisation is the process of offering a reasonable explanation for something. These two processes are discussed together because they occur together in interactions and can be competing explanations for a phenomenon, as seen here in a discussion on sleep.

Client – Um, I don't know, it's just like (.) I find it hard to get to sleep (mm) but then once I'm asleep I'm constantly waking up (mm). So it's like by the time I get up in a morning it's like I haven't slept at all.

Therapist - Ok so you're still really tired (yeah) (.) And when you're trying to get to sleep (aha) what is it that's stopping you, do you think?

1.58, Transcript 2

Here the client says they don't know why they find it difficult to sleep they just do. The word 'just' is often used to naturalise something i.e. 'it just happens'. The therapist then asks a question that implies that there is a reason for the client not sleeping. This is a challenge to the idea that she 'just can't sleep'. In session five the client uses naturalisation to explain her anger, explicitly saying she can't give an explanation.

Client - it's like they just flick a switch, and I can't do anything about it. But then I'm the most patient person in the world with – oh, I just can't explain it. It's just – it just – it just happens. 1.154, Transcript 5

It is important to think about what rhetorical strategies are being used for. Saying things 'just happen' may be a way for a client to avoid thinking about possible reasons for a state of affairs. Therapists have a stake in things having explanations because if things 'just are' then they are hard to change.

Extreme Case Formulation. These are extreme examples or absolute statements about something e.g. brand new, every time (Pomerantz, 1986).

They are often hyperbolic and emphasised in speech. The client here is explaining why she thinks her sister does not want her to be around her house.

Client - ...*when I go round there like she's fine to begin with (um) and then it looks like she's like really annoyed about something (ok). And it's like I'll ask her what's up and she just constantly says that there's nothing wrong (mm) but you could clearly see that there is.* 1.35, Transcript 2

The client says really annoyed, constantly says, nothing wrong and could clearly see. These extreme case formulations are used here to add emphasis to her point and to exclude other possible explanations.

Ironization, is a process of devaluing an account, to minimise its importance or question its veracity. Here the client says they do not speak to doctors, friends or family. They are claiming that there is no one to talk to about their problems. The therapist's response serves to partially undermine this claim.

Client - ... *I haven't got any friends, I don't do friends. (.) I haven't got any family either.*

Therapist - *You have a partner though, I think I noticed? (yeah) Good strong relationship with your partner? (yeah yeah)...* 1.91-1.92,

Transcript 4

The therapist draws on knowledge of the client's partner to suggest that there is at least one person he talks to. This is a tentative move involving a hedge; 'I think I noticed?', which is then followed up with a question about the strength of this relationship inviting agreement to support the suggestion that there are people he talks to. Ironization here is used as a response to the extreme case formulations of the client. The therapist uses ironization in session six to undermine self-deprecation used by the client.

Therapist - *But you're acknowledging that you had success.* 1.57,

Transcript 6

Attribution, is the process of attributing traits or causes to things observed (Harper, 1996). Here the client attributes her current difficulties to events that have happened in the past.

Client - *... stuff that's happened in the past and various bits and pieces, I think has led to where I am now...* 1.52, Transcript 3

Externalising, is the process of attributing something to causes outside of the self or outside of one's control. It is a form of attribution. Here a client externalises her Tourette's.

Client - *...Um, I – my ex-girlfriend used to call it my gremlin, because it's not – it's not me that says 'fuck off' or 'chicken', it's the gremlin inside my head that pushes the buttons...* 1.70, Transcript 3

Externalising has the effect of disowning the behaviour and may be a way of avoiding shame. It is noted that the client later talks about her embarrassment and shame relating to not having control over what she says (1.70, Transcript 3).

Blaming. Blaming is used to suggest that someone or something is responsible for a state of affairs (Patrika & Tseliou, 2015). The client previously talked about being sexually abused. Here she explicitly blames her mother for these events happening.

Client - *It's like I've openly admitted to my Mum that in a way I did blame her for it happening, (mm) like it was her fault (yeah). Like the way I see it, she brought them people into our house...* 1.172, Transcript 3

The client reinforces her statement that she blames her mum by saying 'it was her fault' and then gives a reason as way of further explaining why she blames her mother.

Justification. Justification is a process of providing an acceptable reason or explanation for something. This often occurs when a person feels they have or may be criticised in some way.

Client - *I sometimes use cannabis, yeah (OK) (.) to help me get to sleep.*

(.) It does work, it does relax me... 1.166, Transcript 4

Here the client has several features to their justification. Firstly they say 'sometimes', as a minimisation. They then give a reason, 'to help me get to sleep', which can be conceived of as healthy and appropriate. They follow this with asserting that 'it does work'.

Formulation. Formulation is the process of describing, explaining or summarising the conversation for the other speaker in an interaction. It is a common feature used by therapists in therapy interactions (Hak & de Boer, 1996). It is used as a sense making tool, and a way of checking out whether the therapist has understood what is being said.

Client - *Strange, very strange (.) but erm (.) I suppose I suffer from er (.) (sniff) that male symptom, you know, can sort it ourselves (right) and I think it's been like that for a long time (.) and just recently over the last (...) [intake of breath] six to twelve months, especially the last six months (.) I've er not understood me self (.) it's just foreign so I dunno what else to say about that*

Therapist - *So all of its strange, you feel strange to yourself, coming here is strange. 1.14-1.15, Transcript 1*

The client goes on to agree with this formulation (1.16, Transcript 1).

In the extract below rather than answer the client's question the therapist provides a formulation summarising what the client has been saying. The client subsequently confirms this interpretation given by the therapists' formulation.

Client - *It's not been good enough, has it?*

Therapist - *The 'not good enough', 'you're not good enough compared to the situation*

Client - *no matter what I do I can't enjoy it – because I'm never good enough.* 1.64-1.65, Transcript 6

Disclaiming. Disclaiming is a process where speakers will deny a potential implication of something they have said or are about to say. Here the client has been talking about his decision making process about whether to work away from home and the potential effects of this on his relationship with his ex-wife.

Client - *and so on that premise having had having just had a little baby girl (.) she said well let's have a go and we did (..) and then it all ended up rubbish (.) I'm not saying for one minute it was the work because loads of people do it but whatever way...* 1.71, Transcript 1

After suggesting that 'everything ending up rubbish' followed the decision to work away he disclaims '*I'm not saying for one minute it was the work*'. It may be that this denial of the impact of working away is to protect himself from blame for problems with his relationship.

Summary. Rhetorical strategies are employed to construct problems in particular ways. For example attribution is used to construct problems as having a past. They are also used to make sense of problems. The analysis of pairs of rhetorical strategies highlights the interactive dynamics of this sense making. There are self-other strategies such as the naturalisation-rationalisation and

extreme case formulation-ironization pairs. Rhetorical strategies are also used to make sense of self-self conflicts around problems as in the case of disclaiming.

Analysis Stage 3 - Subject Positions. At this substage of my analysis, I changed focus to the ways problem discourses allow or do not allow certain subject positions (Davies & Harré, 1990). Here I will order the analysis of subject positions by transcript. This is to concentrate on the way therapists and clients position themselves in relation to each other in order to highlight the interactive nature of subject positioning.

Transcript one subject positions. In session one the CfD therapist positions herself reflexively as being a holder of an open space.

Therapist - *this is a place where you, you can feel that you can talk about whatever you need to talk about in whatever terms you need to talk about it.* 1.26, Transcript 1

This is an interesting reflexive positioning because it is a construction of a space being open rather than her being a neutral person. An exception to the position of 'open space holder' is when the therapist is speaking as someone whose interest is recognising emotions.

Therapist - ... *any interventions I might make are about, about thinking about the emotions, what's going on emotionally, what are the connections in your emotions.* 1.108, Transcript 1

This position is held tentatively by the therapist, as a possibility consistent with the position of openness. The client in transcript one holds a greater number of subject positions, most of which are reflexive. These subject positions are sometimes contradictory and highlight tensions in his constructions. He uses

the past tense for most of his reflexive positioning. Here the client positions himself as being previously dependable.

Client - ... *I have been a rock for a lot of people and at the moment I don't think I () (voice shakes).Er (.) I don't, I don't think I'm use, I just think I'm absolutely useless at the moment.* 1.20, Transcript 1

Related to his being dependable are the subject positions of being competent and responsible. The subject position of being competent is constructed through talk of working hard and doing well.

Client - ... *I used to work away a lot (.) that's what I did (.) I worked for a big American company (.) done very well (.) I worked hard...* 1.71, Transcript 1

Here the position of being responsible is taken up.

Client - *Yeah I, I, I'm, I've bil, I've always, I've had a I-I've had responsibility from very very young and I've always had the ability (.) say give me twenty four hours and I'll sort it...* 1.16, Transcript 1

Elsewhere the position of being responsible is associated with his family and children (1.69, Transcript 1). The following extract illustrates a number of subject positions held by client one. The three positions of being a cry baby, being in touch with emotions and being in control of emotions are to some degree in tension with each other. The therapist touches on this tension in her observation.

Client - *I dunno (sigh) sound like a cry baby, people have gone through more (.) I don't know*

Therapist - *So there, there's (client sighs) you can talk about it up to a point but then some, something stops you, something I shouldn't be doing this be I shouldn't be talking like this*

Client - *it sounds so crap don't it, it sounds so (.) sounds so cry baby (..) that's why I can't (.) I'm not, I am not erm (...) I've never been a male chauvinist (.) I'm always been in touch with my own feelings (...) I always had erm (.) the ability up until now (.) to keep my emotions in check when everybody else was falling apart. 1.35-1.37, Transcript 1*

The client here is struggling with contradictory subject positions. These relate to different ways he feels he is expected to be; at the same time in touch with and in control of emotions, neither of which should involve being a cry-baby.

Transcript two subject positions. In transcript two the therapist positions themselves explicitly as being a CBT therapist.

Therapist - *... so my name's [Therapist Name], (aha) I'm a Cognitive Behavioural Therapist... 1.1, Transcript 2*

Later the therapist positions themselves as being knowledgeable about CBT and in a position to be able to explain it to the client.

Therapist - *...So shall I explain a bit about CBT (aha) and what that would involve yeah? (aha) so um, I mean have you read er anything about CBT or know anything about- 1.198, Transcript 2*

By positioning themselves explicitly as a therapist they recruit their 'therapist category entitlement' (Edwards & Potter, 1992). This entails that therapists are politically and culturally allowed to ask questions and evaluate the answers. They use this entitlement positioning themselves as being a problem investigator.

Therapist - ...*So we've got about an hour today (yep) and that's really a chance for me to find out how things are for you at the moment; talk a bit about how your problems have developed...* 1.2, Transcript 2

As the therapist positions themselves this way they position the client interactively as being an information giver or story teller. This position assumes that they are knowable. The client here takes up this position.

Therapist - ... *perhaps if we just started with you telling me how things are for you at the moment.*

Client - *At the moment they're a lot better than what they was...* 1.8-1.9, Transcript 2

Later in the session when the client is filling in the PHQ9 the therapist positions themselves as being an expert in relation to the task.

Therapist - ...*If there's anything you're not sure about, just ask me...* 1.53, Transcript 2

Positions taken up by the therapist in transcript two are positions of power where they have authority. The client's subject positions are relatively powerless. A position taken up several times by the client in transcript two is being a burden.

Client - *I just felt really lonely (mm) and like I was just burdening people with like (right) what I was going through...* 1.27, Transcript 2

The client also positions themselves as being depressed, through talking about a friend that is 'also depressed'. The therapist interactively reinforces this positioning for the client.

Client - ... *she's um been told by her doctor as well that she's depressed (ok). So it's a case of like, we try and cheer each other up.*

Therapist - *Yeah ok (.) so she's also feeling depressed as well...* 1.45-1.46, Transcript 2

The subject position of being normal is adopted by the client in transcript two. However, this position relates to the past, which is presented as a contrast to the other positions taken up by the client.

Client - *The rest of it was fine (ok) (.) I was a normal kid...* 1.181, Transcript 2

Transcript three subject positions. In a similar way to the therapist in transcript two the CfD therapist in transcript three positions themselves explicitly as being a counsellor (1.9, Transcript 3). Shortly after this the therapist positions themselves as being experienced.

Therapist - *... I've worked as a counsellor for about, um, I've worked as a counsellor for about 15 years...* 1.13, Transcript 3

The impact of this statement is perhaps heightened given a client who is aged 24. By referring to the amount of people they see, the therapist reinforces their position of being experienced.

Therapist - *...I meet lots of people who are depressed, and so very often in depression, people will say things to me like...* 1.33, Transcript 3

This position of being an experienced counsellor is further strengthened by referring to his qualification and time spent training.

Therapist - *...To get my very basic qualification in counselling, I had to sit in your place, [Name of Client], for 40 hours...* 1.33, Transcript 3

The time spent setting up their position as being an experienced counsellor may have a variety of functions. For example he may be trying to position himself as competent to engender hope in the client or as a result of anxiety about his competence. The therapist also positions himself as being non-judgmental.

Therapist - ... *to do all that with someone who can, in counselling, number one, won't judge them...* 1.33, Transcript 3

This position is created in the third person, which may be a way of universalising the claim to give it credence. As was seen in the client subject positions in transcript one there is tension in the subject positions of the therapist here. The therapist wants to be non-judgemental but has explained that there are certain cases, such as when terrorism is mentioned (1.23, Transcript 3) that he has to bring a judgemental gaze to bear and report this to the police.

The client in transcript three is positioned by the therapist as being anxious.

Therapist - ... *if I was going to see the doctor, because I was anxious, because you are, by definition...* 1.104, Transcript 3

Using the language '*by definition*' to position the client as anxious makes it difficult to resist for the client. The client does not respond directly to this position but later positions themselves as shy (1.36, Transcript 3). Relatedly, the client in transcript three positions themselves as being hidden by a mask.

Client - ... *underneath being all silly with them and being me, I'm very – they know me basically and everyone else gets – you know when you put a mask, like a confidence mask on...* 1.36, Transcript 3

People who are close get to know the real client who is shy but everyone else gets a mask. Many of the positions of the client in transcript three are problem focused. The client positions themselves as having been a cocaine addict.

Client - ... *I became a bit of a coke addict... [if] there was coke in this room, I'd rip the room apart until I found it...* 1.38, Transcript 3

Later in the session the client positions herself as being different.

Client - ... *it makes me me, how I um, (.) I like to be – I like to be different? Yes, I do, I like to be different. I don't like to be weird, but I like to be different.* 1.89, Transcript 3

This is a 'different' that is set apart from 'weird'. Here the client takes up the subject position of being a failure, as she hasn't achieved anything in her life.

Client - ...*I haven't achieved anything in my life, 24 I should be doing better than I'm doing now, for want of a better term, Ha.* 1.129, Transcript 3

This 'should be doing better' is a normative standard that the client may have picked up from cultural discourses about achievement.

Transcript four subject positions. In transcript four the CBT therapist positions herself as being a professional who works for the health care system.

Therapist - ...*a doctor has to decide that you've got anxiety or depression (.) and then I'm always working on their behalf...* 1.19, Transcript 4

The implications for this position may be of responsibility. The therapist is later positioned by the client as being in charge and themselves as being done to.

Client - ...*I'm gonna get what you give me sort of thing.* 1.32, Transcript 4

The client emphasises their position of not knowing and having no expectations by stating that they have not had therapy before.

Client - *I've had no sort of therapy whatsoever.* 1.28, Transcript 4

Related to previous reflexive positioning of being done to, the client describes being a guinea pig when GPs tried different medications.

Client - ...*I told him I felt like a guinea pig...* 1.56, Transcript 4

The subject positions taken up by the client in transcript four continue to relate to being ignored and marginalised.

Client - ...*this seems to happen all the way through my life, I seem to be invisible with people...* 1.202, Transcript 4

As well as being ignored the client describes being isolated.

Client - ...*I haven't got any friends, I don't do friends. (.) I haven't got any family either.* 1.90, Transcript 4

Some of these positions may have their origin in a subject position of being unsure that he is loved that is taken up through a childhood story.

Client - ...*I remember seeing a counsellor at secondary school erm (.) and he mentioned does your mum love you and I went (.) I don't know. And I remember when mum got an appointment into school cos he wanted to see her and the only time that my mum has ever told me that she loved me was when she was stood next to him and she put her hand on my head and went 'of course I love you [Name of Client]'* 1.188, Transcript 4

Transcript five subject positions. The Therapist positions the client as a gentle nurturing person in contrast to the client's descriptions of anger and aggression illustrated in stage 1 of the analysis.

Therapist - *And like you say, though, you're patient in other areas*

Client - *Oh, god, yes. When it comes to animals, anything, I've got all the time*

Therapist - *like, you're quite a gentle, nurturing person?*

Client - *My kids, at work, I'll do anything, anything for them, yes.* 1.157-1.160, Transcript 5

The client then confirms this positioning by agreeing with the therapist.

The Therapist positions herself explicitly as having expertise. This is different to other transcripts because she also positions the client as having expertise and them needing to work as a team.

Therapist – *we need to be working as a team, (ok) you've got the expertise on you and your entire life; I've got the expertise on CBT, there's no point both of us existing without each other, we've got to kind of pair them up* 1.81, Transcript 5

The therapist appears to be trying to establish a collaborative relationship between her and the client through these reflexive and interactive subject positions.

Transcript six subject positions. In transcript six the therapist uses very little talk relating to themselves. When she does refer to herself she describes herself in the third person.

Therapist - ... *realistically be uncertain about the person you're going to be meeting...* 1.5, Transcript 6

The client's reflexive positioning is negative and self-deprecating. He positions himself as not good enough.

Client - *no matter what I do I can't enjoy it – because I'm never good enough.* 1.66, Transcript 6

Shortly after this he describes himself as difficult and trouble, and refers to being positioned this way by others.

Client - *I realise now was how my mum felt and how my dad felt, and I was difficult. I was trouble – that's kind of like being articulated in the last couple of years.* 1.68, Transcript 6

Summary. Generally, therapist subject positions are more agentic and powerful than client subject positions, which are more problem focused. The

problem focused and powerless subject positions are often reflexive. As subject positions held by the clients are problem focused it makes them part of the problem, shaping their subjectivity. There are contradictory subject positions for both clients and therapists.

Macro Analysis

In this section my analysis turns towards the macro level, considering how institutions and practices are maintained by discourses. I also consider how discourses relate to ideology, how they construct systems of belief and how these ideologies influence people's subjectivity.

Institutions and Practices. I use the word institution here to mean an organisation with a professional or social purpose. Practices are customary, habitual or expected procedures or ways of doing things. The institutions have connected practices arising from formal policy and procedure and informal habits and customs.

NHS institution. The NHS is a prominent institution in these transcripts as the therapy is taking place in NHS premises, with therapists employed by the NHS.

Therapist - ... *I need to just touch base with the legal stuff to do with any talking therapies and my professional body and the NHS says I've got to do that anyway...* 1.13, Transcript 3

The therapist also refers to their professional body as an institution and the practice they are obliged to follow involving '*legal stuff*'.

Information held about clients. Within the institution of the NHS the practice of holding information about clients is constructed in sessions.

Therapist - ... *about 8 years ago [NHS Trust], invested in a computer system ... so it means that your notes are the most secure they've ever been because of that system...* 1.31, Transcript 3

The holding of information allows the therapist to know something about the client before they have actually met the therapist.

Therapist - ... *so I've had a quick look at your notes and I've seen you've seen er, [Name of professional] fairly recently (yeah) yeah so I've got er, a very brief idea of how things are for you at the moment...* 1.4, Transcript 2

The practice of government institutions holding information about people has been linked to wide ranging surveillance in western societies (Foucault, 1985). Knowledge of this surveillance may have subtle effects on people's subjectivity.

Cancellation Policy. Within the larger institution of the NHS sits IAPT. IAPT has a number of policies and practices governing it, which are explicitly referred to.

Therapist - ... *you do need to know there's a strong cancellations policy in IAPT now...* 1.27, Transcript 4

The therapist presumably wants to inform the client, so they are not discharged if they miss future sessions. This also has the effect of acting as an implicit threat of therapy being withdrawn.

Forms. Within IAPT there is a practice of using structured outcome measurements. These are introduced in the first session and have an influence on problem construction as seen in stage one of the analysis. These are often referred to as 'forms' in the therapy sessions.

Therapist - ... *I've got a short form that I'd be grateful if you'd fill out just to give us an idea where you're starting off with anxiety and depression.*

1.3, Transcript 4

The therapist constructs the forms as providing information about anxiety and depression, influencing how the problem is constructed. In the same transcript the client questions this practice as not being able to account for his actual experiences.

Client - *Do you know what really annoys me about these scores, (.) it says over the past two weeks, they always say over the past two weeks. What if I hadn't been out the house for two weeks? Therefore I haven't been anxious...* 1.78, Transcript 4

The use of the PHQ 9 in IAPT is standard in first session assessments. The therapist here normalises the use of the measure and universalises scoring some points on the scale. She then constructs it as giving information about mood.

Therapist - *Well, that's why – you know I said this score is 10 or above, that's because everybody scores a little bit on this one, but this does indicate that you are sort of – you've got a problem with your mood at times.* 1.149, Transcript 5

Normative lifestyle. Therapists ask questions about people's lifestyles, which often contain implicit and explicit judgements about what are good or bad choices.

Therapist ... *do you eat sort of cooked, proper meals or? (yeah) right ok, and fruit and veg, do you have fruit and veg? (yeah). It sounds like you've got a reasonably healthy diet (yeah) you're not eating takeaways*

all the time? (no). Ok and how about um exercise, or physical activity, do you do any sport or exercise? 1.98, Transcript 2

Words such as 'proper' contain moral judgements about peoples eating habits. Intervening in clients 'unhealthy' lifestyles is part of a cultural project where professionals transform the lives of clients. As part of a health service, psychotherapy is involved in the reproduction of certain ways of being in society (Rose, 1998).

Family as institution. Institutions are typically large organisations. The use of the word to describe a family is atypical.

Client - ... I moved up here forty years ago for one reason and one reason only to marry my wife (sniff) and we became over many many years an institution and we had two lovely kids... 1.41, Transcript 1

However, its use by this client is consistent with his description of his childhood family, which was governed by certain practices.

Client - ...I come from a really nice Lon-cockney rhymish family (..) who had (.) simple (.) rules and simple ways of conducting yourself and (..) looking after each other and that meant or fell to me... 1.57, Transcript 1

Rules this client has to live by have implications for his subjectivity and is implicated in his distress, born of conflicts between different subject positions that he occupies.

College. The client has talked about working in a college with disadvantaged children. Unnamed 'higher ups' in the college are referred to as being uncaring about the children he looked after and only interested in money.

Therapist - There's a sense of sadness – the powers that be – did they know -

Client - *Yes, that's what I mean, it was like a conspiracy – part of it, part of it was – how do you sleep at night when you're taking this money from the government for – having – trying to educate and then give them the worst possible and in every possible way to get rid of them, to – but they're happy to take the money. Now, if you have that conversation with somebody – it's pretty bad, really, They don't want to hear that.* 1.61-1.62, Transcript 6

The effects of the institution and its practices on the clients mental health are hinted at by the therapist talking about a sense of sadness.

Ideology and Subjectivity. When therapists and clients construct problems, use rhetorical strategies and take up subject positions they do this within discourses from historical systems of ideas and ideals in their social and cultural contexts. These systems of ideas or ideologies create norms for living, which exert a normative pressure upon people's subjective identities.

Normality. Participants draw upon and re-construct a discourse of normality in the psychotherapy sessions. Here a client is talking about how he is no longer able to act normally.

Client - *... there is plenty going on upstairs where I can't think s-straight (sniff) can't act normally, what I would call normal...* 1.18, Transcript 1

The client in transcript two talks about being a normal kid.

Therapist - *... you've had kind of these horrendous things happen to you but how was, how was the rest of your childhood?*

Client - *The rest of it was fine (ok) (.) I was a normal kid –laughs.*

Therapist - *Right, ok –laughs (..) So when you say it was fine, I mean were you a happy child (yeah) Did you have friends?*

Client - *Yeah I had school friends and stuff like that.*

1.180-1.183, Transcript 2

The normality constructed above is different to the abuse, which is implicitly not normal. In this way the client is not reduced to the effects of the abuse. The normality is backed up with examples such as having school friends. The client in transcript three defines herself against an implicit conception of normality and likes to be different.

Client - ...*it makes me me, how I am, (.) I like to be – I like to be different? Yes, I do, I like to be different. I don't like to be weird, but I like to be different.* 1.89, Transcript 3

The client is trying to find her own subjectivity but stepping aside from normality is dangerous and isolating, so she does not want to be positioned as weird. The difficulty for the client here is that one person's different is another person's weird. 'Different' is an almost impossible place to securely inhabit. Ideologies exert a normative pressure, seen in clients' statements about what they are supposed to do. There are external sources of normative pressure, such as the questions about lifestyle by therapists but this is often internal, via a self-policing according to rules and norms people feel they should follow.

Gender Roles. Specific roles for men and woman are constructed across transcripts. The client in transcript one talks about providing for his family, which relates to his subject position of being responsible. He then genders this role.

Client - ...*I worked (..) and provided and done everything a bloke should do...* 1.35, Transcript 1

As well as fulfilling his role in doing '*everything a bloke should do*', he has also had to take on additional responsibilities.

Client - ... *she was just going through that early sort of teenage years and (sniff) (..) women's stuff (..) that dad had to cope with...* 1.43,

Transcript 1

Elsewhere gender roles are less explicit but arguably present. The client here discusses her housework and appears to be limited in action by this role as once this is done there is nothing left to do. The client's statements draw on discourses about women that have historically focused on their domesticity (Westkott, 1986).

Client - ...*if I'm in the house on my own I just like, do the house work and then once that's done, it's like I'm just sat there thinking well, what can I do now (ok) so, and then that's when I start feeling down and stuff 'cause (ok) everything's been done (yeah) and there's nothing else to do* 1.51,

Transcript 2

Gender roles that are defined by dominant discourses about what men and women should do influence client's subjectivity (Burman, 1992).

Self-contained individual. The client here does not want to bother other people with her problems.

Client - ... *I feel like I'm putting my problems onto everybody else (mm) (..) And it's like, I think to myself like I'm 27 and I should be able to deal with it myself* 1.108, Transcript 2

In constructing themselves as being a burden the client here is relating to the discourse of the healthy individual being autonomous: not relying on others (Rose, 1998). The construction of being a burden on others is consistent with an individualised view of the self, based on western values (Sampson, 1993). The client in transcript four also talks about attempting to sort things out himself.

Client - *I'm not stupid and I try and sort my own head out but (right)*
(background voices) it's (.) I dunno, it's just, it's not happening 1.180,
Transcript 4

Discourses favouring self-containment create a dilemma for people seeking help from others as they are supposed to solve problems themselves whilst accepting help in solving problems.

Work. Discourses around work in the transcripts are often related to status.

Therapist - ... *so you've gone up in the world [both laugh] were you work, were you working in [clothes shop] (yeah) before, yeah, ok.*

Client - *But they didn't treat their staff very good, so.*

Therapist - *Right ok, so you've managed to find a new job, so that's good...* 1.18-1.20, Transcript 2

Finding a new job in a more prestigious clothes shop is positively evaluated by the therapist.

The Dream. The client in transcript one talks about a dream he had with his ex-wife when they were first together.

Client - ... *we had a dream (.) like the young couples did in them days I'm talking the seventies mid-seventies (.) we'd like a nice big, bigger house (.) we'd like (.) a car (.) we'd like (.) two weeks in the sunshine (.) but the thing about it was (.) we had what really really mattered we had each other (.) I thought (.) and as the stuff got more (.) and the stuff got more (.) and more (.) we got less and less and less...* 1.113, Transcript 1

The dream constructed is one of western materialism. The construction of a dream here invokes the discourse of the 'American dream' (McGinnis, 2009) of neoliberal capitalism, involving striving for property ownership and consumption.

Summary. This final stage of the analysis has highlighted discourses that establish context for these therapy conversations. These discourses from institutions and ideologies shape the practices therapists and clients engage in and the subjectivities available to them. Some of the problems constructed are borne of frustrated attempts to navigate a path through norms that the clients and therapists are aware of from their society and culture.

Summary of Findings

Stage one of the analysis highlighted different ways in which problems can be constructed in psychotherapy. Influenced by structured outcome measures used within IAPT services, problems were constructed using medical discourses of diagnosis and symptoms. Clients and therapists also constructed distressing feelings and dysfunctional thoughts as problems. Other key constructions centred on making sense of problems through trying to understand their origins in past events or their relationship to normative discourses from family and society. There were no consistent differences in problem construction between CBT and CfD.

Stage two identified rhetorical strategies used by therapists and clients to pursue agendas that involved making sense of problems. There were differences in the rhetorical strategies most commonly used by the therapists in each model, although these differences were not absolute. The CBT therapists used rationalisation more often, trying to find reasons for things happening. The CfD therapists used formulation more often to try to explore meaning for clients. When self-other strategies were used by therapists they were often employed to correct problematic sense making by the client or reinforce appropriate sense making.

Stage three highlighted the interactive nature of subject positioning in therapy, where therapists and clients positioned each other. Therapists and clients held contradictory subject positions at times. The contradictions appear to arise because of competing norms and practices, such as the demands of the NHS to report on terrorism or promote healthy lifestyles and the theoretical requirement for being non-judgemental in CfD.

Stage four highlighted how institutions such as the NHS and IAPT and their related practices influenced discourse. Ideological ideas about normality and personhood were constructed and reproduced by therapists and clients. For example clients talked about what they should have achieved in life and referred to 'rules for living' that they identify in discourses about family and gender roles. References were made to the practices associated with CBT and CfD as models of therapy. As highlighted in stage one of the analysis this did not appear to consistently influence the problem constructions. Thus institutional and ideological discourses might be seen to have a greater influence on problem construction than therapy type.

Discussion

This study analysed the co-construction of problems by therapists and clients within an IAPT service. As one might expect in the NHS, there were constructions around diagnostic categories of depression and anxiety as well as feelings and thoughts. This is consistent with depression being conceptualised as a clinical problem (Greenberg, 2010). Problems were also constructed through implicit discussion of social expectations. Lewis (1995) previously highlighted a range of discourses around depression that clients use to make sense of their experiences. The findings of this study develop those of Lewis

(1995) by discussing broader societal discourses beyond the immediate social circumstances of clients and by analysing therapy talk rather than interviews.

A number of rhetorical strategies were used to construct problems that were consistent with networks of available meaning. The findings differed from much previous work focusing on strategies used by therapists to pursue therapeutic agendas (e.g. Beckwith & Crichton, 2010). These studies could suggest that clients are merely passive recipients of therapists' techniques. This study found that rhetorical strategies used by both the therapists and clients were often used to make sense of problems in the context of social norms. These norms appeared to be difficult to navigate for the participants and contributed to contradictory subject positions.

Analysis of subject positions found that clients took up relatively powerless and problem focused subject positions. Burman (1992) highlights the effect of power differentials on limiting available positions. The conflict in subject positions appears to be related to a struggle to negotiate normative 'rules for living' derived from social, institutional and ideological discourses. This study examined the function of norms embedded within ideological and institutional discourses in the problems constructed in therapy sessions, linking the micro analysis of language with a macro understanding of the context of this language.

The reproduction of normative discourses in therapy creates conflicts for both therapists and clients. For example, the clients describe a pressure to have 'better' jobs than they have and feel inadequate because of their lack of progress. Low status given to people on low incomes has been linked to feelings of shame (Mills, Zavaleta, & Samuel, 2014). Failure to meet perceived social status norms has also been linked to problems with identity and social

exclusion (Croghan, Griffin, Hunter, & Pheonix, 2006). A meta-analysis found associations between shame and depression (Kim, Thibodeau, & Jorgensen, 2011). These normative discourses can be traced to ideologies in modern western culture, which contain ideas about personhood and individuality (Rose, 1998). Individuals are considered to be solely responsible for themselves and through their hard work be able to achieve in education and employment (Smail, 2001).

Discourses of normality and the self-contained individual who is responsible for themselves were present in the discourses highlighted through analysis in this study. These appeared to be most frequently expressed by clients rather than therapists and reflect discourses in society. However, the effect of the institutional and ideological discourses on both client and therapist constructions of problems appear to be powerful. Focusing on the effects of power from institutions and ideology enables us to go beyond a unidirectional analysis of power as something purely done by one person to another that is emphasised in previous work on problem construction (e.g. Davis, 1984).

Implications

The findings of this study have implications for the practice of psychotherapy. Paying attention to the language used in therapy interactions can help to heighten practitioners' sensitivity to the discourses clients use to make meaning in their lives and the effects of the practices introduced by the institutional context of the therapy. The connection between powerful norms and the problems that are constructed highlights the need for therapist reflexivity on their theoretical approach, and societal norms that both they and the client may reproduce in sessions. This reflexivity would entail an awareness of rhetorical strategies and subject positions. For example, a rationalising strategy and an

expert subject position may place clients in an answer giving, responsive and relatively powerless position, limiting their repertoire of subject positions and capacity to change. It is also important to consider the effects of powerful normative forces on both the therapist and the client and how their interaction is shaped by these normative forces. An awareness of them in research and practice may enable new conversations to be had that recognise the ways they shape people's subjectivity and script their lives.

As there are few studies that have analysed actual therapy transcripts, this study has added to a small but growing body of discourse analytic process research (Avdi & Georgaca, 2007). There are also implications for future research. Studies could usefully investigate therapists' and clients' perspectives on normative discourses through interviews about their experiences of these norms and how they perceive them affecting their distress.

Limitations

The interpretive nature of critical discourse analysis means that the findings are only one interpretation and there are many others that could have been made. However, this subjectivity is an acknowledged part of discursive research as the epistemological standpoint rejects the notion of one true understanding of the text. There is a parallel process in my attempts to make meaning within my historical context as there is for the clients and therapists in theirs. They try to make sense of problems in the context of what they 'know', for example: 'people should achieve', or 'blokes should provide'. I have tried to make sense of the findings within my own previous knowledge of therapy practices and ideas about concepts such as gender from my previous study. This creates an unavoidably personal co-constructed analysis. However, I have attempted to illustrate coherence in my analysis through grounding it in extracts

from the transcripts. I also aimed to offer transparency with regard to analysis by following a series of defined analytic stages.

In analysing the way social and historical discourses impact upon discourses used in therapy, analysts can risk assuming that these discourses entirely define the specific beliefs, experiences or behaviour of therapists and clients. This has been called 'discourse determinism' and limits the capacity for change or recognition of alternatives to normative discourses (Henriques et al., 1998). To avoid this determinism, it is important to recognise the agency people have whilst understanding the parameters in which people operate.

In this analysis I combined a macro analysis that focused on broader discourses present in institutions and society whilst also analysing locally produced, context-bound constructions. Parker (1997) questions whether these approaches to discourse can be used together. In attempting to combine the two there is a risk of not attending to either level adequately. The limitations of space in the presentation of the findings created an inevitable compromise in how much attention could be afforded to each set of discourses. However, the benefits of seeing how rhetorical strategies were used and how these related to subject positionings and broader discourses outweigh the potential limitations of a multi-level analysis.

The particular context of this study as an analysis of first sessions in an IAPT service introduces certain practices that are particular to this setting. The language introduced through the use of outcome measures such as the PHQ9 and the diagnostic terms prevalent in IAPT will have influenced the discourse that was constructed by both therapist and client. These discourses would not appear in the same way in other contexts, and indeed would change over time in later sessions. However, the majority of the session and problem talk was not

focused on the use of measures and questionnaires and related to people's history or social context. Therefore, the findings are likely to have relevance to other psychotherapeutic encounters outside of this setting. Further study of other therapeutic modalities might substantiate the relevance of the findings for other therapeutic encounters.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Avdi, E. (2012). Exploring the contribution of subject positioning to studying therapy as a dialogical enterprise. *International Journal for Dialogical Science*, 6, 61-79.
http://ijds.lemoyne.edu/journal/6_1/pdf/IJDS.6.1.05.Avdi.pdf
- Avdi, E., & Georgaca, E. (2007). Discourse analysis and psychotherapy: A critical review. *European Journal of Psychotherapy and Counselling*, 9, 157-176. doi: 10.1080/13642530701363445
- Bhaskar, R. (1989). *Reclaiming Reality: A Critical Introduction to Contemporary Philosophy*. London: Verso
- Billig, M. (1990). Rhetoric of social psychology In I. Parker and J. Shotter (eds) *Deconstructing Social Psychology* (pp.47-60) New York: Routledge
- Bourdieu, P. (1991). *Language and symbolic power*. Cambridge and Massachusetts: Polity Press.
- Burman, E. (1992). Identification and power in feminist therapy: A reflexive history of a discourse analysis. *Women's Studies International Forum*, 15, 487-98. doi: 10.1016/0277-5395(92)90082-7
- Burman, E. (1994). *Deconstructing Developmental Psychology*. London: Routledge
- Burr, V. (2007). *Social Constructionism, second edition*. Hove, U.K.: Routledge.
- Buttny, R. (1996). Clients' and therapist's joint construction of the clients' problems. *Research on Language and Social Interaction*, 29, 125-153. doi: 10.1207/s15327973rlsi2902_2

- Clark, D. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry*, 23, 375-384. doi: 10.3109/09540261.2011.606803
- Coyle, A. (2000). *Discourse analysis*. In G.M. Breakwell, S. Hammond & C. Fife-Shaw (Eds.), *Research Methods in Psychology* (Second Edition). London: Sage.
- Croghan, R., Griffin, C., Hunter, J. & Phoenix, A. (2006). Style failure: Consumption, identity and social exclusion. *Journal of Youth Studies*, 9, 463-478. doi: 10.1080/13676260600914481
- Davies, B. & Harre, R. (1990). Positioning: The Discursive Production of Selves. *Journal for the Theory of Social Behaviour*, 20, 42-63.
doi:10.1111/j.1468-5914.1990.tb00174.x
- Davis, K. (1984). The process of problem (re)formulation in psychotherapy. *Sociology of Health & Illness*, 8, 44-74. doi:10.1111/1467-9566.ep11346469
- Great Britain (1998) *Data Protection Act*. London: Stationery Office.
- Department of Health. (2012). IAPT: 3 Year report; the First Million Patients.
- Edwards, D. & Potter, J. (1992). *Discursive psychology*. London: Sage.
- Fee, D. (2000). *Pathology and the postmodern: Mental illness as discourse and experience*. London, UK: Sage.
- Foucault, M. (1985). *Discipline and Punish: The Birth of the Prison*. Harmondsworth, UK: Penguin
- Foucault, M. (2001). *Madness and Civilisation*. London: Routledge
- Georgaca, E. (2012). Discourse analytic research on mental distress: A critical overview. *Journal of Mental Health*, 23, 55-61. doi: 10.3109/09638237.2012.734648

- Georgaca, E. & Avdi, E. (2012) Discourse Analysis. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 147-161) Chichester, U.K.: Wiley Blackwell.
- Gergen, K. (1999). *An Invitation to Social Construction*. London, UK: Sage.
- Greenberg, G. (2010). *Manufacturing depression: The secret history of a modern disease*. London, UK: Bloomsbury
- Guilfoyle, M. (2002). Rhetorical processes in therapy: the bias for self-containment. *Journal of Family Therapy*, 24, 298-316. doi: 10.1111/1467-6427.00218
- Hak, T., & de Boer, F. (1996). Formulations in first encounters. *Journal of Pragmatics*, 25, 83–99. doi: 10.1016/0378-2166(94)00076-7
- Harper, D. J. (1996). Accounting for poverty: From attribution to discourse. *Journal of Community & Applied Social Psychology*, 6(4), 249-265. doi: 10.1002/(sici)1099-1298(199610)6:4<249::aid-casp369>3.3.co;2-l
- Harper, D. & Moss, D. (2003). A different kind of chemistry? Reformulating 'formulation.' *Clinical Psychology*, 25, 6-10.
<http://hdl.handle.net/10552/3602>
- Haynes, K. (2012). Reflexivity in Qualitative Research. In G. Symon, & C. Cassell, (Eds.) *Qualitative Organisational Research*. (pp. 72-89) London, UK: Sage.
- Healthcare Commission (2007). *Talking about medicines: The management of medicines in trusts providing mental health services*. London: Healthcare Commission.

- Henriques, J., Hollway, W., Urwin, K., Venn, C., & Walkerdine, V. (1998). *Changing the subject: Psychology, social regulation and subjectivity* (2nd ed.). London, UK: Routledge.
- Johnstone, L. & Dallos, R. (2014). *Formulation in psychology and psychotherapy: Making sense of people's problems, second edition*. London, UK: Routledge
- Jones, E. A., Bale, H. L., & Morera, T. (2013). A qualitative study of clinician's experiences and attitudes towards telephone triage mental health assessments. *The Cognitive Behaviour Therapist*, 6. doi: 10.1017/S1754470X13000226
- Killick, S. (2014). Something is Something Else - Using metaphors in therapy *British Psychological Society continuing professional development workshop*, 01 September, Leicester, UK.
- Kim, S., Thibodeau, R., & Jorgensen, R. S. (2011). Psychological shame, guilt and depressive symptoms: A meta-analytic review. *Bulletin*, 137, 68-96. doi: 10.1037/a0021466
- Kogan, S. (1998). The politics of making meaning: discourse analysis of a 'postmodern' interview. *Journal of Family Therapy*, 20, 229-251. doi:10.1111/1467-6427.00085
- Kroenke, Spitzer, R. I. & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, 606-613. doi: 10.1046%2Fj.1525-1497.2001.016009606.x
- Labov, W., & Fanshel, D. (1977). *Therapeutic discourse: Psychotherapy as conversation*. New York: Academic Press
- Lawler, C. (2012). *From Melancholia to Prozac: A History of Depression*. New York: Oxford University Press.

- Lewis, S. (1995). A search for meaning: Making sense of depression. *Journal of Mental Health, 4*, 369-382. doi: 10.1080/09638239550037424
- Madill, A., & Barkham, M. (1997). Discourse Analysis of a Theme in One Successful Case of Brief Psychodynamic-Interpersonal Psychotherapy. *Journal of Counselling Psychology, 44*, 232-244.
- McGinnis, T.A. (2009). Seeing possible futures: Khmer youth and the discourse of the American Dream. *Anthropology & Education Quarterly, 40*, 62-81. 10.1111/j.1548-1492.2009.01028.x
- Mills, C., Zavaleta, D., & Samuel, K. (2014). Shame, humiliation and social isolation: missing dimensions of poverty and suffering analysis. *OPHI Working Paper 71*, University of Oxford.
- Mitchell, C., Dwyer, R., Hagan, T. & Mathers, N. (2011). Impact of the QOF and the NICE guideline in the diagnosis and management of depression: a qualitative study, *British Journal of General Practice, 61*, 278-289. DOI: 10.3399/bjgp11X572472
- Ortlipp, M. (2008). Keeping and using reflective journals in the qualitative research process. *The Qualitative Report, 13*, 695-705
- Parker, I. (1997). *Discursive Psychology*. In D.R. Fox & I. Prillentensky (Eds.), *Critical Psychology: An Introduction* (p.338 – 356). London: Sage.
- Parker, I (1999). Against relativism in psychology, on balance. *History of the Human Sciences, 12*, 61-78. doi:10.1177/09526959922120496
- Parry, G., Barkham, M., Brazier, J., Dent-Brown, K., Hardy, G., Kendrick, T., ... Lovell, K. (2011) An evaluation of a new service model: Improving Access to Psychological Therapies demonstration sites 2006-2009. Final report. NIHR Service Delivery and Organisation programme

- Patrika, P., & Tseliou, E. (2015) Blame, responsibility and systemic neutrality: A discourse analysis methodology to the study of family therapy problem talk. *Journal of Family Therapy*, 1-23. doi: 10.1111/1467-6427.12076
- Pomerantz, A. (1986). Extreme Case Formulations: A Way of Legitimizing Claims. *Human Studies*, 9, 219-229. doi: 10.1007/bf00148128
- Proctor, G. (2002). *The Dynamics of Power in Counselling and Psychotherapy: Ethics, Politics and Practice*. Ross-on-Wye, UK: PCCS Books
- Rethink. (2011). A user-focused evaluation of IAPT services in London. (Rethink, London) <http://www.rethink.org/resources/a/a-user-focused-evaluation-of-iapt-services-in-london>
- Rose, N. (1998). *Inventing Our Selves: Psychology, Power and Personhood*. Cambridge: Cambridge University Press
- Sampson, E. (1993). The challenge of social change for psychology: globalization and psychology's theory of the person. *American Psychologist*, 44, 914-921. doi: 10.1037/0003-066x.44.6.914
- Saxon, D., Ashley, K., Bishop-Edwards, L., Connell, J., Harrison, P., Olhson, S., ... Barkham, M. (in preparation). A pragmatic non-inferiority randomised trial of the clinical and cost-effectiveness of counselling for depression versus cognitive-behaviour therapy, for patients in primary care meeting a diagnosis of moderate or severe depression (PRaCTICED). *Trials*
- Smail, D. (2001). *The nature of un-happiness*. London, UK: Robinson.
- Vaara, E., & Tienari, J. (2002). Justification, legitimization and naturalisation of mergers and acquisitions: A critical discourse analysis of media texts. *Organization*, 9, 275-304. doi: 10.1177/1350508402009002912

- Wetherell, M. (2008). Subjectivity or psycho-discursive practices? Investigating complex intersectional identities. *Subjectivity*, 22, 73-81. doi: 10.1057/sub.2008.7
- Westkott, M. (1986). Historical and developmental roots of female dependency. *Psychotherapy*, 23, 213-220. doi: 10.1037/h0085600
- Willig, C. (2013). *Introducing qualitative research in psychology* (3rd edn). Maidenhead: Open University Press.
- World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva: World Health Organization.

Appendix A - Notes on Transcription

The table below is a key to the symbols used in transcription.

Symbol	Example	Meaning
<u>underline</u>	<u>Really</u> frustrating	Speaker emphasizes the underlined portion of the word.
?	<i>Is it?</i>	Questioning intonation.
[]	<i>[name of person]</i>	Additional information or anonymised
()	<i>(hmmm)</i>	The other speaker speaking during the main speakers turn.
(.)	<i>I don't know (.) yeah.</i>	Short pause.
(...)	<i>I am <u>not</u> erm (...) I've never</i>	Long pause
...	...	Indicates speech before or after the extract by the speaker in the same turn.

Appendix B – Transcriber Confidentiality Agreement

Transcribing Confidentiality Form & Guidance Notes

Type of project: Clinical Skills Assessment / Research thesis

Project title _____

Researcher's name _____

The recording you are transcribing has been collected as part of a research project. Recordings may contain information of a very personal nature, which should be kept confidential and not disclosed to others. Maintaining this confidentiality is of utmost importance to the University.

We would like you to agree:

1. Not to disclose any information you may hear on the recording to others.
2. If transcribing digital recordings – only to accept files provided on an encrypted memory stick .
3. To keep the tapes and/or encrypted memory stick in a secure locked place when not in use.
4. When transcribing a recording ensure it cannot be heard by other people.
5. To adhere to the Guidelines for Transcribers (appended to this document) in relation to the use of computers and encrypted digital recorders, and
6. To show your transcription only to the relevant individual who is involved in the research project.
7. If you find that anyone speaking on a recording is known to you, we would like you to stop transcription work on that recording immediately and inform the person who has commissioned the work.

Declaration

I have read the above information, as well as the Guidelines for Transcribers, and I understand that:

1. I will discuss the content of the recording only with the individual involved in the research project
2. If transcribing digital recordings – I will only accept files provided on an encrypted memory stick
3. I will keep the tapes and/or encrypted memory stick in a secure place when not in use
4. When transcribing a recording I will ensure it cannot be heard by others
5. I will treat the transcription of the recording as confidential information
6. I will adhere to the requirements detailed in the Guidelines for transcribers in relation to transcribing recordings onto a computer and transcribing digital audio files
7. If the person being interviewed on the recordings is known to me I will undertake no further transcription work on the recording

I agree to act according to the above constraints

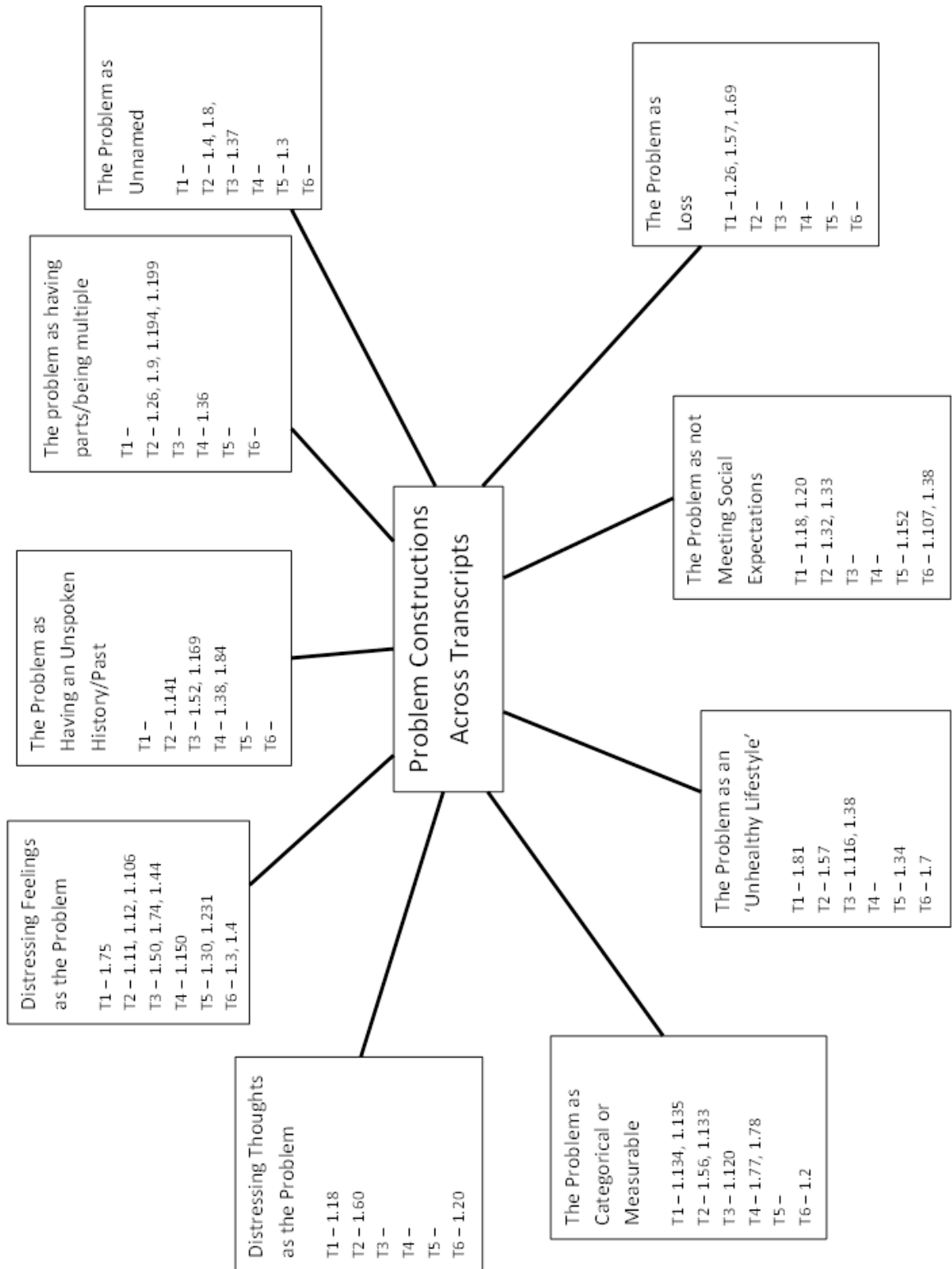
Your name _____

Signature _____

Date _____

Occasionally, the conversations on recordings can be distressing to hear. If you should find it upsetting, please stop the transcription and raise this with the researcher as soon as possible.

Appendix C – Problem Construction Thematic Map



Appendix D – Extract From Coded Transcript

02:32	<p>1.15 1.16</p> <p>Prac: So all of it's strange, you, you feel strange to yourself, coming here is strange</p> <p>C1: Yeah I, I'm, I've bil, I've always, I've had a I-I've had responsibility from a very very young age, I've always had the ability (.) so give me twenty four hours and I'll sort it (.) whatever it is with me, my family, whatever it would be (sigh) (...) and right now (.) I don't understand what sweeps me, I really don't.</p>	<p>Therapist Formulation</p> <p>Subject position – being responsible ECFs</p> <p>Not understanding self</p>
1.17	<p>Prac: OK (...) I can't sort it.</p>	
1.18	<p>C1: I can't (...) But there's nothing to sort (.) when I think of it (.) but there is plenty going on upstairs where I can't think s-straight (sniff) can't act normally, what I would call normal (.) I'm no use to sometimes me self and and others (.) I dunno how to explain it</p>	<p>Thoughts going wrong</p> <p>Normality</p> <p>Being useless</p>
03:06	<p>1.19 1.20</p> <p>Prac: (.) and we've got time, we've got time to look at it a bit more and-</p> <p>C1 (interrupts): it was my son actually er (.) suggested that I mean (.) we lived together for three years for various reasons (.) and erm in August he joined the, the army, he's in the army now, in fact he's just about to have his passing out parade (.) and erm (.) you know e-e I brought my kids up from the time that he was ten and my daughter was thirteen (.) their mum left (.) and erm he said you, you need to (.) speak to someone (.) (faint beep)</p>	<p>Position together</p>
04:18	<p>1.21</p> <p>So I mean he obviously see (.) differences in me and he see my actions (sniff) (.) different from what I've been (.) it's very hard but I mean at the end of the day I have been a rock for a lot of people and at the moment I don't think I (.) (voice shakes) Er (.) I don't, I don't think I'm use, I just think I'm absolutely useless at the moment</p> <p>Prac: And you're used to being the rock? Um (very quiet) (.)</p>	<p>Army as institution</p> <p>Partner left - loss</p> <p>Being useless</p>

Appendix E – Some Examples of Reflexivity on Analysis

Using the reflexive diary I considered how my experiences values and assumptions might influence my analysis. I have experience as a therapist and as a client receiving therapy. Before starting the analysis I considered the approach I would bring to it being as a therapist myself. I recognised practices used by therapists, such as formulating what the client has just said. There may be other therapy practices that I have not paid analytic attention to because of their familiarity to me. There are also practices, such as the use of outcome measures, which are recognisable because of their familiarity. The PHQ9 is never explicitly mentioned but I know the items on this outcome measure and recognise its use. An analyst who was not a therapist may have had a more distanced perspective on the therapy talk allowing for a clearer deconstruction of therapy practices.

Conversely as I was having personal therapy at the time of analysis I reflected on how I might analyse from the position of 'client'. I may identify strongly with the client, I might think critically of the therapist If I didn't like the way they spoke.

As I had conducted a literature review I expected therapists to be shaping encounters with rhetorical strategies as they had been prominent in literature on problem construction. I identified strategies such as rationalisation, used to find explanations for states of affairs. However, there were also many strategies used by clients. As I noticed these I was careful not to position the clients as only being powerless and being 'done to' although this was evident at times, particularly in their reflexive subject positions.

In terms of my emotional responses to the transcripts, when listening to one of the sessions I thought that the client would be difficult to work with. This

lead me to thinking about swapping their data for another transcript. Reflecting on this thought I was careful when listening to this data to follow my analytic stages closely and to be aware of judgements I might make about the people in the therapy.

Conducting this research heightened my awareness of language use in my own practice. I became more aware of times where I might reproduce normative discourses about what people should be, or how they should act. The research has enabled me to have conversations with clients about where messages they have received from their families or society might be coming from, hopefully facilitating new insights into their distress.

Appendix F – Ethics and Governance Documents



**DEPARTMENT OF PSYCHOLOGY.
CLINICAL PSYCHOLOGY UNIT.**

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training
& consultancy.

**Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK**

Telephone: 0114 2226570
Fax: 0114 2226610
Email: dclinsy@sheffield.ac.uk
Please address any correspondence to Ian Macdonald,
Research Support Officer

22nd May 2015

To: Research Governance Office

Dear Sir/Madam,

**RE: Confirmation of Scientific Approval and indemnity of
enclosed Research Project**

Project title: A Discourse Analysis of Therapist-Client Problem Construction.

Investigators: Alex Young (DClin Psy Trainee, University of Sheffield); Professor Gillian Hardy and Dr Anthony Williams (Academic Supervisors, University of Sheffield).

I write to confirm that the enclosed proposal forms part of the educational requirements for the Doctoral Clinical Psychology Qualification (DClin Psy) run by the Clinical Psychology Unit, University of Sheffield.

Three independent reviewers appointed by the Clinical Psychology Unit Research Sub-committee have scientifically reviewed it.

I can confirm that all necessary amendments have been made to the satisfaction of the reviewers, who are now happy that the proposed study is of sound scientific quality. Consequently, the University will also indemnify it and would be happy to act as research sponsor once ethical approval has been gained.

Given the above, I would remind you that the Unit already has an agreement with your office to exempt this proposal from further scientific review. However, if you require any further information, please do not hesitate to contact me.

Yours sincerely

A black rectangular box redacting the signature of Dr. Andrew Thompson.

Dr. Andrew Thompson
Director of Research Training

Cc. Alex Young; Professor Gillian Hardy; Dr Anthony Williams



The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK

Telephone: 0114 22 26650
Fax: 0114 22 26610
Email: ian.macdonald@sheffield.ac.uk

30th June 2015
Alex Young
Trainee Clinical Psychologist
Department of Psychology
Western Bank

Project title: A Discourse Analysis of Therapist-Client Problem Construction

6 digit URMS number: 144771

Dear Alex Young,

LETTER TO CONFIRM THAT THE UNIVERSITY OF SHEFFIELD IS THE PROJECT'S RESEARCH GOVERNANCE SPONSOR

The University has reviewed the following documents:

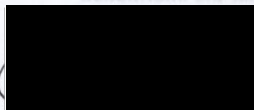
1. A University approved URMS costing record;
2. Confirmation of independent scientific approval;
3. Confirmation of independent ethics approval.

All the above documents are in place. Therefore, the University now **confirms** that it is the project's research governance sponsor and, as research governance sponsor, **authorises** the project to commence any non-NHS research activities. Please note that NHS R&D approval will be required before the commencement of any activities which do involve the NHS.

You are expected to deliver the research project in accordance with the University's policies and procedures, which includes the University's Good Research & Innovation Practices Policy: www.shef.ac.uk/ris/other/gov-ethics/grippolicy, Ethics Policy: www.sheffield.ac.uk/ris/other/gov-ethics/ethicspolicy and Data Protection Policies: www.shef.ac.uk/cics/records

Your Supervisor, with your support and input, is responsible for monitoring the project on an ongoing basis. Your Head of Department is responsible for independently monitoring the project as appropriate. The project may be audited during or after its lifetime by the University. Monitoring responsibilities are listed in Annex 1.

Yours sincerely



Dr Andrew Thompson
Director of Research Training, Clinical Psychology Unit

Cc: Professor Gillian Hardy (supervisor);
Dr Anthony Williams (supervisor);
Professor Paul Overton (Head of Department).



Health Research Authority

NRES Committee Yorkshire & The Humber - South Yorkshire

North East REC Centre
Unit 002, TEDCO Business Centre
Rolling Mill Road
Jarrow
Tyne and Wear
NE32 3DT

Telephone: 0191 428 3561

27 March 2014

Professor Michael Barkham
Director, Centre for Psychological Services Research
University of Sheffield
Dept of Psychology
University of Sheffield
Western Bank
SHEFFIELD
S10 2TN

Dear Professor Barkham

Study title: **A pragmatic non-inferiority randomised controlled trial of the clinical and cost-effectiveness of counselling for depression versus cognitive-behaviour therapy, for clients in primary care meeting a diagnosis of moderate or severe depression: The PRaCTICED Trial**

REC reference: **14/YH/0001**

IRAS project ID: **130352**

Thank you for your letter of 25 March 2014. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 04 February 2014

Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Interview Schedules/Topic Guides	Interview Topic Guide / Version 2.0	25 March 2014
Participant Consent Form: Main Consent Form	Version 2.0	25 March 2014

Approved documents

The final list of approved documentation for the study is therefore as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter	Michael Barkham	11 December 2013
Evidence of insurance or indemnity	The University of Sheffield	13 November 2013
GP/Consultant Information Sheets	Information Sheet for GP, V1.0	20 November 2013
GP/Consultant Information Sheets	GP Notification, V1.0	20 November 2013
GP/Consultant Information Sheets	GP Risk Letter, V1.0	20 November 2013
Interview Schedules/Topic Guides	Brief Exit Interview, V1.0	20 November 2013
Interview Schedules/Topic Guides	Interview Topic Guide / Version 2.0	25 March 2014
Investigator CV	Michael Barkham	16 November 2013
Letter of invitation to participant	Patient Information from PWP, V1.0	20 November 2013
Other: CV - Student Research Supervisor	Gillian E. Hardy	16 November 2013
Other: Student CV	Caroline Dunsmuir-White	16 November 2013
Other: Student CV	Kim Campbell	16 November 2013
Other: Letter from Funder	BACP Research Foundation	19 November 2013
Other: Adverse Events Reporting - Study Specific Procedure	V1.0	20 November 2013
Other: Risk Protocol - Research Interviews	V1.0	20 November 2013
Other: Risk Form for Suicide and Self Harm	V1.0	20 November 2013
Other: Risk Form for Risks Not Including Suicide and Self Harm	V1.0	20 November 2013
Participant Consent Form: Consent to Contact	V1.0	20 November 2013
Participant Consent Form: Consent to Interview	V1.0	20 November 2013
Participant Consent Form: Main Consent Form	Version 2.0	25 March 2014
Participant Information Sheet: PIS Main Trial	V1.0	20 November 2013
Participant Information Sheet: Patient Information for Assessment	V1.0	20 November 2013
Protocol	V1.0	20 November 2013
Questionnaire: Treatment Preference		
Questionnaire: Therapy Expectation Form		
Questionnaire: CIS-R		
Questionnaire: BDI-II		
Questionnaire: PHQ-9		
Questionnaire: GAD-7		
Questionnaire: EQ-5D		
Questionnaire: Wellbeing-VAS		
Questionnaire: CORE-OM		
Questionnaire: Work and Social Adjustment Scale		
Questionnaire: CD-RISC		

A Research Ethics Committee established by the Health Research Authority

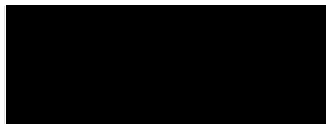
Questionnaire: MINI Diagnostic - Sections I&J		
Questionnaire: CSSRI-EU		
Questionnaire: Client Satisfaction		
REC application	IRAS V3.5	21 November 2013
Referees or other scientific critique report	Peer Review 1	
Referees or other scientific critique report	Peer Review 2	
Referees or other scientific critique report	Peer Review 3	
Summary/Synopsis	Flowchart Recruitment, V1.0	20 November 2013
Summary/Synopsis	Consort, Wave 1, V1.0	20 November 2013
Summary/Synopsis	Consort: Wave 2, V1.0	20 November 2013
Summary/Synopsis	SOP Recruitment	20 November 2013
Summary/Synopsis	SOP Patient Treatment, V1.0	20 November 2013

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

14/YH/0001

Please quote this number on all correspondence

Yours sincerely



Kerry Dunbar
REC Assistant

E-mail: nrescommittee.yorkandhumber-southyorks@nhs.net

Copy to: *Mr David Saxon, University of Sheffield*
Mr Nicolas Bell, Sheffield Health & Social Care NHS Foundation Trust



Health Research Authority

NRES Committee Yorkshire & the Humber - South Yorkshire

North East REC Centre
Unit 002, TEDCO Business Centre
Rolling Mill Road
Jarrow
Tyne and Wear
NE32 3DT

Telephone: 0191 428 3566

Facsimile: 0191 428 3432

04 February 2014

Professor Michael Barkham
Director, Centre for Psychological Services Research
Department of Psychology
University of Sheffield
Western Bank
SHEFFIELD
S10 2TN

Dear Professor Barkham

Study title: **A pragmatic non-inferiority randomised controlled trial of the clinical and cost-effectiveness of counselling for depression versus cognitive-behaviour therapy, for clients in primary care meeting a diagnosis of moderate or severe depression: The PRaCTICED Trial**

REC reference: **14/YH/0001**

IRAS project ID: **130352**

The Research Ethics Committee reviewed the above application at the meeting held on the 30 January 2014. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Mrs Joan Brown, nrescommittee.yorkandhumber-southyorks@nhs.net.

Ethical opinion

It was queried whether you were applying for approval of the whole RCT as well as what the students would be doing and you confirmed that ethical approval was being sought for the whole trial.

It was observed that the only issue with the application was that there was no indication of the topics that would be discussed with the people who dropped out of the study. It was explained that this was a work in progress and would be submitted to the REC once it had been finalised.

It was observed there was a minor clarification required in the consent form.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, **subject to the conditions specified below.**

Ethical review of research sites

NHS Sites

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

Conditions of the favourable opinion

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

- 1. Submit a revised Consent Form as follows: Amend Point 5 to read "I understand that data collected during the study may be looked at by individuals from the study team or individuals from regulatory authorities or the NHS Trust where it is relevant to my taking part in this study. I give permission for these individuals to have access to my records"**
- 2. Submit a copy of the interview schedule that will be used for people who drop out of the study once it has been finalised for information only. There is no need for the schedule to be approved by the REC.**

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

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

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

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

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

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

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

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

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

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter	Michael Barkham	11 December 2013
Evidence of insurance or indemnity	The University of Sheffield	13 November 2013
GP/Consultant Information Sheets	Information Sheet for GP, V1.0	20 November 2013
GP/Consultant Information Sheets	GP Notification, V1.0	20 November 2013
GP/Consultant Information Sheets	GP Risk Letter, V1.0	20 November 2013
Interview Schedules/Topic Guides	Interview Topic Guide, V1.0	20 November 2013
Interview Schedules/Topic Guides	Brief Exit Interview, V1.0	20 November 2013
Investigator CV	Michael Barkham	16 November 2013
Letter of invitation to participant	Patient Information from PWP, V1.0	20 November 2013
Other: CV - Student Research Supervisor	Gillian E. Hardy	16 November 2013
Other: Student CV	Caroline Dunsmuir-White	16 November 2013
Other: Student CV	Kim Campbell	16 November 2013
Other: Letter from Funder	BACP Research Foundation	19 November 2013
Other: Adverse Events Reporting - Study Specific Procedure	V1.0	20 November 2013
Other: Risk Protocol - Research Interviews	V1.0	20 November 2013
Other: Risk Form for Suicide and Self Harm	V1.0	20 November 2013
Other: Risk Form for Risks Not Including Suicide and Self Harm	V1.0	20 November 2013

Participant Consent Form: Main Consent Form	V1.0	20 November 2013
Participant Consent Form: Consent to Contact	V1.0	20 November 2013
Participant Consent Form: Consent to Interview	V1.0	20 November 2013
Participant Information Sheet: PIS Main Trial	V1.0	20 November 2013
Participant Information Sheet: Patient Information for Assessment	V1.0	20 November 2013
Protocol	V1.0	20 November 2013
Questionnaire: Treatment Preference		
Questionnaire: Therapy Expectation Form		
Questionnaire: CIS-R		
Questionnaire: BDI-II		
Questionnaire: PHQ-9		
Questionnaire: GAD-7		
Questionnaire: EQ-5D		
Questionnaire: Wellbeing-VAS		
Questionnaire: CORE-OM		
Questionnaire: Work and Social Adjustment Scale		
Questionnaire: CD-RISC		
Questionnaire: MINI Diagnostic - Sections I&J		
Questionnaire: CSSRI-EU		
Questionnaire: Client Satisfaction		
REC application	IRAS V3.5	21 November 2013
Referees or other scientific critique report	Peer Review 1	
Referees or other scientific critique report	Peer Review 2	
Referees or other scientific critique report	Peer Review 3	
Summary/Synopsis	Flowchart Recruitment, V1.0	20 November 2013
Summary/Synopsis	Consort, Wave 1, V1.0	20 November 2013
Summary/Synopsis	Consort: Wave 2, V1.0	20 November 2013
Summary/Synopsis	SOP Recruitment	20 November 2013
Summary/Synopsis	SOP Patient Treatment, V1.0	20 November 2013

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

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

After ethical review

Reporting requirements

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

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

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

Feedback

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

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

14/YH/0001

Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

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

Yours sincerely



**pp Ms Jo Abbott
Chair**

Email: nrescommittee.london-camdenandislington@nhs.net

*Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments
"After ethical review – guidance for researchers" SL-AR-2*

*Copy to: Mr David Saxon, University of Sheffield
Mr Nicolas Bell, Sheffield Health & Social Care NHS Foundation Trust*

NRES Committee Yorkshire & the Humber - South Yorkshire

Attendance at Committee meeting on 30 January 2014

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Ms Jo Abbott (Chair)	Consultant in Public Health	Yes	
Dr Ahmed H Abdelhafiz	Consultant Physician, Elderly Medicine	Yes	
Dr Peter Allmark	Principal Nursing Lecturer	No	
Reverend Joan Ashton	Co-ordinator of Chaplaincy Services	Yes	
Ms Helen Barlow	Knowledge Service Manager	Yes	
Professor Nigel Beail	Consultant Clinical Psychologist & Professor of Psychology	Yes	
Mr Ian Cawthorne	Chief Pharmacist	No	
Ms Susan Hampshaw	Head of Research, Evaluation and Innovation	Yes	
Mr Neil Marsden	Police Staff	Yes	
Dr Duane Mellor	Lecturer in Dietetics	No	
Mrs Andrea Porritt	Community Specialist Practitioner/District Nurse	Yes	
Mrs Carole Taylor	Deputy Chief Pharmacist	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Ms Joan Brown	REC Manager



Information about the research

PRaCTICED Study

A randomised trial comparing the effectiveness of cognitive behavior therapy and counselling for depression

Thank you very much for agreeing to be contacted about the above research study. This information sheet explains the purpose of the study and what will happen if you take part. Please contact us if anything is not clear and talk to others about the study if you wish. You will have a further opportunity to discuss the study with researchers before consenting to full involvement.

What is the purpose of the study?

Depression is a common problem that affects many people and can sometimes be hard to manage. Experts recommend that people with depression receive a ‘talking treatment’ and/or medication. Your GP may have prescribed some medication for you but this is not always enough on its own. This is where talking therapies can be very helpful.

There are different forms of talking treatments. Our research is trying to find out whether there is a difference between two particular approaches in the treatment of depression: Cognitive Behaviour Therapy (CBT) or Counselling for Depression (CfD).

- Counselling for Depression (CfD) aims to address depression by providing the opportunity for clients to talk about underlying feelings. The therapist and client work together to make personal sense of these feelings.
- Cognitive Behaviour Therapy (CBT) looks at how we think about a situation and how this affects the way we act. The therapist and client work together in changing the client’s behaviours, or their thinking patterns, or both of these.

The Sheffield IAPT service delivers both these treatments in its routine service. The purpose of this trial will be to see if there are differences between these two treatments and whether some people are more suited to one form of treatment rather than the other. The study will also tell us what it is about the treatments that people like or dislike so that we can improve them for other people.

Both treatments will be for a minimum of 8 sessions and will normally be for up to 16 sessions but can be up to 20 sessions. Taking part in the study does not mean that you cannot receive treatment later from the Sheffield service.

Do I have to take part?

It is your decision to take part. If you do agree, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. Leaving the study will not affect the standard of care you receive. However, it is always helpful to understand why someone leaves treatment, in order to try and improve services. We will not try to change your decision.

What will happen to me if I am willing to take part?

About 3 weeks prior to your therapy starting, a researcher will contact you by your chosen method, to invite you to a one-off assessment interview. This will be based at a location as convenient to you as possible. The invitation to this meeting will include a one-day bus pass in case there is a need to use a bus to attend the meeting. We have done this so that no one is out of pocket for attending this one-off meeting.

At the meeting, you can ask any questions you might have about the study. The researcher will ask you a number of questions that will help to see whether the trial is appropriate. If it is, then you will be informed which treatment you will receive. You stand an equal chance of receiving either treatment. You will then be asked to complete some forms.

You do not have to take part unless you feel completely happy with the study.

What are the treatments?

The treatments are Counselling for Depression (CfD) and Cognitive Behaviour Therapy (CBT) and were briefly described earlier.

Both treatments are psychological therapies that have been recommended by NICE (National Institute Clinical Excellence) for the treatment of depression.

What if I have a very strong preference and don't want to receive one of the treatments?

People may have a preference for one treatment over the other. This is understandable. However, if you have a very strong preference, such that, you would be unwilling to receive one of the treatments if you were given it, then please talk to the assessor. If after talking with them you feel the same, then the assessor will ensure that you are referred back to the normal service without losing your place on the waiting list.

How is it decided who gets which treatment?

Sometimes it is not always clear which is the best way of treating patients. To find out, we need to compare different treatments. We allocate people to one of two treatments then compare the results to see if one treatment works better for some people while another works better for others.

To try to make sure patients in each treatment are similar to start with, each patient is allocated a treatment by chance. You will have an equal chance of receiving either cognitive behaviour therapy or counselling for depression.

What else will be involved if I take part?

It is standard practice in this service for the sessions to be audiotaped. This is to enable the person you will be seeing to have regular supervision on their work, this is required by the service to ensure we offer the best service.

For the research, a small number of recordings will be listened to by a researcher in order to check the quality of the talking therapy people are receiving. If they do listen to a tape, it will be under strict confidentiality agreements. Some other tapes will also be used as part of the research in order to increase the understanding about how these talking therapies help people who are experiencing depression.

At six months and 12 months after the meeting with the researcher, we will send you a set of questions to see how you are feeling. These will be similar to those forms completed at the start. The actual research study will take 3 years to complete, but you will only be involved for 12 months.

We will ask patients for permission to contact them by their preferred choice (standard mail, email, phone) if they decide to end treatment. This is for us, as researchers, to understand why this has happened. It is not to try to change your decision. However, if you do not wish to take part at that time, then we will respect that decision.

We will also like to conduct some interviews with some people when they complete their treatment. We will not be interviewing everyone but we need your permission to approach you if you are selected. We will only ask about 1 in 10 patients. You do not have to agree to this and saying 'No' will not affect your involvement in the trial or any treatment in the future.

If you are interested in taking part in the separate interview study, we will provide you with more information before you make the decision.

What are the possible disadvantages and risks of taking part?

Both treatments are used in the routine service, so we are not introducing a new treatment. There are no known side effects of either treatment. We are trying to find out a bit more about what works best for particular people, so we have no reason to believe that any one is being disadvantaged. If you had a strong preference for one treatment, then you will have declared that and the trial would not be appropriate for you.

At any point during the study you can leave without having to give a reason why.

Will I receive any payment for taking part?

We will provide a free one-day bus pass to attend the initial assessment (regardless of whether you have to use it or not). We will also enclose a £10 shopping voucher with the questionnaires at 6-months and 12-months. These will be sent to you regardless of whether you complete the forms or not. However, we hope that this will off set the time spent on completing the forms and very much hope you do.

What happens if new information becomes available during the course of the study?

Sometimes during a study, new information becomes available about the treatment being studied. If this happens, the research team will tell you and discuss whether you want to continue in the study. If you decide to stop taking part in the study your usual care will continue. If you decide to continue in the study you may be asked to sign an updated consent form. If we think you should withdraw from the study, we will explain the reasons and arrange for your care to continue.

What happens when the study stops?

Very occasionally a study is stopped early. If this happens, the reasons will be explained to you and arrangements made for your ongoing care.

What if there is a problem?

If you have a concern about any aspect of this study you should ask to speak to the researcher (Lindsey Bishop-Edwards tel: 07710 388985) or the chief investigator, Michael Barkham (tel: 0114 222 0817) who will do their best to answer your questions.

If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact the University Research Practice and Governance Co-ordinator Richard Hudson by email to r.j.hudson@sheffield.ac.uk

What will happen to information about me collected during the study?

All information will be held securely and in strict confidence. Only authorised people working on the study will have access to your information and this is kept securely. Where possible, a unique study ID number will be allocated to replace any identifier and only authorised researchers that need to contact you will have access to your personal contact details.

We will destroy all personal details 5 years after the end of the study.

We keep the health information we collect about you separate from your personal details. We will use the information we collect to look at how best to help people with depression. We will keep it 20 years and then destroy it securely.

Involvement of your GP

We will tell your GP that you are taking part in the study. No other results will be given to your GP.

If we are worried that you are having thoughts about harming yourself, we may need to discuss these with your GP. We will, of course, discuss this with you.

What will happen to the results of the study?

When the study is completed, the results will be published in a scientific journal so that health care professionals can see the results. Your identity and personal details will be kept confidential and no named information about you will be published in any reports.

Who is organising and funding the study?

This study is organised by the University of Sheffield. The funder is the British Association of Counselling and Psychotherapy (BACP) Research Foundation.

Who has reviewed the study?

This study has been reviewed by an independent group of people, called the Research Ethics Committee, to protect your safety, rights, well-being and dignity. The study has been given a favourable opinion by NRES Committee Yorkshire & The Humber - South Yorkshire Ethics committee.

Who is the study co-ordinator?

The study co-ordinator can be contacted by telephone on: (07710 388985). Alternatively, you can write to the researcher at:

PRaCTICED

ScHARR

Regent's Court, 30 Regent's Street

Sheffield, S1 4DA

Email: practiced@sheffield.ac.uk

Thank you for taking time to read this information sheet



PRaCTICED Study

Research participant consent form

If you are interested in taking part in the PRaCTICED study, please read through the points below and note any queries you may have. When you attend the assessment with a member of the research team, they will talk you through the points and answer any questions you may have about the study. Only then will you be asked to complete this form.

Please **INITIAL** box

- 1 I confirm that I have read and understand the information sheet dated 20.11.13 (version 1) for the above study. I have had the opportunity to consider the information, ask questions about the study and understand why this research is being done
- 2 I understand that I may not be eligible to take part in the study
- 3 I agree to complete the relevant questionnaires at 3, 6 and 12 months after entering the study
- 4 I agree to my GP being informed of my participation in the study and of any health concerns the study team may become aware of during my participation
- 5 I understand that data collected during the study – as with all data collected within routine NHS service delivery – may be looked at by individuals from the study team or individuals from regulatory authorities or the NHS Trust where it is relevant to my taking part in this study. I give permission for these individuals to have access to my records
- 6 I understand that, as part of normal practice, my sessions will be audio-recorded for the purposes of supervision
- 7 I understand that some of these audio-recordings may be listened to by researchers either with the purpose of ensuring that the treatments are being delivered appropriately or to enable a better understanding of these treatments
- 8 I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected

9 I understand that I may be approached to take part in an additional interview as part of the study, and that I will be given further information and another consent form

10 I agree to take part in the above study

Name of patient (BLOCK CAPITALS)

Date

Signature

Name of person taking consent

Date

Signature



PRACTICED Study

Research participant consent form

If you wish to take part in the PRACTICED study, **please place your initials in each of the boxes below, sign and date this form and return it to us in the pre-paid envelope provided.**

Please **INITIAL** box

- 1 I confirm that I have read and understand the information sheet dated (version ..) for the above study. I have had the opportunity to consider the information, ask questions about the study and understand why this research is being done
- 2 I agree to an interview with a member of the study team. This will either be face-to-face or by phone and I will be able to choose which one suits me better.
- 3 I agree to my interview being recorded for the purposes of the research
- 4 I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected

Name of patient (BLOCK CAPITALS) Date Signature

Name of person taking consent Date Signature

FOR COMPLETION BY RESEARCHER ONLY **PARTICIPANT ID:**

--	--	--	--	--