

Volume I

Research Component

**A DISCOURSE ANALYSIS OF CLIENT AND PRACTITIONER TALK
DURING MOTIVATIONAL INTERVIEWING SESSIONS**

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Summary

This ClinPsyD thesis is presented in two volumes. Volume I contains the research component, made up of two papers (a literature review and an empirical paper) reporting on the use of language within motivational interviewing (MI). An executive summary of these papers is also included within this volume. Volume II, the clinical component, consists of 5 clinical practice reports (CPRs) conducted across 4 placements within the 3 year duration of doctoral training in clinical psychology.

Volume I

The literature review reports upon the degree to which the evidence on language use within MI, as it stands, contributes to our understanding of mechanisms of client change. Thirty articles were identified, and appraisal of this evidence suggested that language may possibly serve as a mechanism of change to some extent. However, the conclusions that can be drawn from this small number of studies are limited given some of the methodological factors and biases that may affect their findings. There was also much emphasis on the coding and quantification of 'categories' of language, but little detail regarding how this was manifested within the dialogue, emphasising a need for more qualitative studies.

The empirical paper reports upon a discourse analytic study of language use in MI. By looking at verbal constructions of alcohol, the structure and function of language when talking about change, and an analysis of subject positions, the data were considered in relation to relative power within the interaction and subjectivity. The findings suggest that clients and therapists constructed alcohol as either a destroyer or facilitator, drawing upon discourses of differing degrees of power, which impacted upon the availability of subject positions of agency and expertise in relation to alcohol. There was also a diversity of function within categories of client and practitioner speech. The findings of this study provide an opportunity for practitioners to reflect upon the effect of their

actions and relative power when using MI in clinical practice, as well as offering a different perspective on language use in comparison to those asserted in the current literature.

Volume II

Volume II begins with CPR 1, which presents two formulations of 'Sanjay', a gentleman presenting at a CMHT with an anxiety disorder. Following the background information to Sanjay's referral, the assessment data are presented. This is followed by Sanjay's difficulties being formulated from two different psychological models (cognitive-behavioural and psychodynamic), and concludes with some reflections regarding the strengths and weaknesses associated with the assessment and formulation processes.

CPR 2 is a case study of 'Angela', a lady who presented to a physical health setting with chronic pain. The assessment data are used to formulate Anita's difficulties, using a cognitive-behavioural model of clinical perfectionism combined with a cognitive behavioural model of chronic pain. From this an intervention was designed and applied. The evaluation of the intervention and reflections upon the process are presented.

CPR3 consists of an evaluation of a locally enhanced healthcare service for people with learning disabilities in one small inner city GP practice. The aim of the evaluation was to establish how well the service specifications of the LES were being met by this practice, and what the clinical outcomes from the delivery of this service were. The methods used in the evaluation are described, and the results presented. The report concludes with a list of recommendations for the community learning disabilities team to further enhance service delivery within this practice.

CPR 4 reports a multiple single case experimental design with 'Jodie', an eight year old girl, who presented to CAMHS with sleeping problems. Background information on the referral, assessment and formulation of Jodie's presentation are described. An intervention was designed, aimed at increasing Jodie's number of hours sleep per night and reducing the number of times she left her bed during the night. These were subjected to statistical testing. The results are reported, and reflections are presented at the end of the report.

Finally, CPR 5 was an orally presented CPR, and thus the abstract only is included here (though a copy of the presentation slides can be found in appendix 5 for reference). This presentation described a case study with 'Emma', a lady who was admitted to a general hospital ward for rehabilitation from a hypoxic brain injury. She obtained this injury following an overdose of methadone, while receiving inpatient detox and rehabilitation from substance use. Ward staff had made continued referrals to psychiatric liaison (where I was based), concerned about Emma's emotional state and potential psychotic episodes. They also found many of her behaviours challenging. Investigation into Emma's past revealed a long history of trauma and abusive relationships. The formulation of this information led to an intervention to increase compassion among ward staff working with Emma, in the hope that this would assist in her rehabilitation, as well as finding her a placement more appropriate for her needs. The report ends with reflections upon the experience of working with Emma and the staff caring for her.

Dedication

I dedicate this thesis to my wonderful, inspiring friend and colleague, Lyn Williams.

Lyn has been a great friend to me over the years. She has been a key support to me throughout my clinical psychology training, allowing me to stay in her house Sunday-Thursday for the duration of the doctorate while working 110 miles from home.

My conversations with Lyn about dialogue, social constructionism and motivational interviewing over the years have in their own way inspired the work I have undertaken within this thesis, and motivated me to bring some of the ideas I had into fruition.

Many thanks, Lyn. I am eternally grateful for your kindness, wisdom and support. I am honoured to have you as a friend.

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Massive thanks to my mum, Jennifer Lane, for allowing me to use her little office (when I visited her and Dad at their lovely bungalow on the Costa-del-Essex). Thanks also to my cat, Kiwi, who spent hours on end purring next to me while I was working and who probably doesn't know or indeed care how comforting this was to me. Finally, I express heartfelt gratitude to my husband, Dr. Graham Feeney, for his kindness and understanding throughout the past three years. I would particularly like to thank him for giving me the time and space I needed to complete my research and clinical practice reports, when the time we have had together over this period has been so very sparse.

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Literature Review

The Use of Language within Motivational Interviewing: A review of the literature from 2001-2011

Abstract

In recent times, there has been an increased interest within the motivational interviewing (MI) field regarding the nature of client and practitioner language, and the potential for language to serve as a mechanism of change. The current review aimed to examine the existing literature in order to appraise the degree to which the evidence, as it stands, contributes to our understanding of the mechanisms of change within MI. Thirty articles were identified, which focussed on client language, practitioner language, practitioner and client language, or client and 'significant other' language. Findings suggest that language may serve as a mechanism of change to some degree, but the conclusions that can be drawn from this small number of studies is limited given some of the methodological factors and biases that may affect their findings. Future research in this area would benefit from more rigorous study design, and more qualitative approaches.

1.0 Introduction

Motivational Interviewing (MI) is an approach to facilitating change through a process of exploring and resolving client ambivalence to make changes. MI has recently been defined as 'a collaborative, person-centred form of guiding to elicit and strengthen motivation for change' (Miller & Rollnick, 2009). MI practice utilises many of the communication skills associated with client centred counselling approaches (Rogers, 1959), such as open (rather than closed) questions, simple reflections (statements replicating the content of what the client has said), complex reflections (statements indicating the meaning behind what the client has said), affirmations (statements of genuine appreciation for effort and personal qualities the client has) and summaries of what the client has said. The underlying 'spirit' of MI, which refers to the practitioner's 'way of being' with a client is also consistent with the Rogerian approach. The first component of spirit focuses on 'collaboration', and refers to the practitioner working in partnership with the client in an egalitarian way, rather than adopting an expert stance. The second component, 'evocation' refers to drawing motivation out of the client, rather than imposing it via advice giving or education. The third component focuses on the importance of 'respecting client autonomy' to make choices, which includes acceptance that the client has the right to decide not to make changes.

However, there are also cognitive and behavioural elements of MI practice that distinguish it from client-centred counselling (Miller & Rollnick, 2002). For example, the practitioner adheres to the principles of MI, which are to roll with (rather than confront) client resistance to change, to develop a discrepancy between the client's values and their behaviours and to support the client's self-efficacy about changing, while expressing empathy for the client (Miller & Rollnick, 2002).

There is also an emphasis upon practitioner and client language use. This relates to a central hypothesis about how MI works. It is asserted that while ambivalence is being explored, the more

that a client's language involves statements in favour of change, or 'change talk' (CT), the more likely the client is to make their target change. Following the same logic, the more they produce statements in favour of retaining the status quo, or 'counter-change talk' (CCT), the less likely a client is to make changes. The practitioner's role is therefore to strategically evoke CT from the client, while adhering to the spirit and principles of MI and engaging with the client's experience. It has recently been theorised that it is this strategic elicitation of and response to client CT, within the context of an empathic, humanistic approach, that is responsible for client behaviour change outcomes following MI interventions (Miller & Rose, 2009).

This assumption appears to relate closely to 'speech act' theories of language, which suggest the way in which language is constructed within a particular context impacts upon its semantic function, and thus on its social impact (Austin, 1976; Searle, 1969). Additionally, self-perception theory assumes that individuals infer their attitudes about their self from observations of their own behaviour and the arguments they make to account for their actions (Bem, 1972). It could also be argued that responding to specific types of speech in this way is consistent with the principles of positive reinforcement present in operant conditioning (Skinner, 1953).

It is important to note that MI is an approach that developed out of clinical practice, rather than from the clinical application of theoretical concepts (Miller, 1983). However, the practice of MI appears to link with several social psychological theories of human behaviour. Firstly, the spirit component of respect for client autonomy and the principle of rolling with resistance are closely aligned with the assumptions underlying reactance theory (Brehm, 1966). Reactance theory asserts that when attempts are made to restrict or prevent an individual's perceived behavioural freedom, a threat response is activated and the individual will thus increase their efforts to maintain their perceived behavioural freedom. Secondly, the principle of supporting self-efficacy has links with social

cognitive theory (Bandura, 1977), which claims that behaviour change is more likely to occur in those who perceive their success in a given task as achievable. Thirdly, the principle of developing a discrepancy between personal values and behaviour appears to relate closely to cognitive dissonance theory (Festinger, 1957). This theory claims that holding conflicting beliefs about one's self leads to discomfort. It is asserted that individuals have a motivational drive to reduce such conflicting beliefs (by altering existing beliefs, adding new beliefs to create a consistent belief system, or by reducing the importance of any one of the conflicting beliefs).

Recent reviews of randomised controlled trials of MI interventions have shown that this clinical approach is effective in assisting clients to make changes to behaviours including drug and alcohol use (Burke, Arkowitz, & Mencola, 2003; Hettema, Steele, & Miller, 2005; Smedslund et al., 2011; Vasilaki, Hosier, & Cox, 2006) and other health related behaviours (Heckman, Eggleston, & Hofmann, 2010; Rubak, Sandbaek, Lauritzen, & Christensen, 2005). However, some studies seem to conclude that MI interventions are effective, but no more effective than other interventions (Project Match Research Group, 1997; UKATT Research Team, 2005). MI is one of the NICE recommended psychosocial treatment approaches indicated within drug and alcohol misuse settings (NICE, 2007, 2010, 2011).

The strong emphasis on the role that language plays in MI has implications for what is understood to be fidelity to the approach (Dunn, Deroo, & Rivara, 2001; Lai, Cahill, Qin, & Tang, 2010). As a result, the number of studies investigating the role that language plays specifically in MI has steadily increased in the past 10 years. A number of coding instruments have been developed to better understand the skills used by the practitioner (Lane et al., 2005; Madson & Campbell, 2006; Madson, Campbell, Barrett, Brondino, & Melchert, 2005; Moyers, Martin, Manuel, Hendrickson, & Miller, 2005) and to code the impact of kinds of practitioner/client talk (Moyers, Martin, Catley, Harris, &

Ahluwalia, 2003; Moyers & Martin, 2006) upon client outcomes. Studies of 'mechanisms of change' (which are variables that intervene chronologically between assignment to an intervention and the clinical outcome) have also become important in understanding specific therapeutic tasks within MI that may impact upon client outcomes (Apodaca & Longabaugh, 2009). Given the hypotheses underlying MI, it could therefore be argued that language use within MI may be a mechanism of change in and of itself.

The underlying assumptions about practitioner and client language use within MI seem to be highly important in how it is conceptualized, taught, learned and practiced. To this end, the current systematic review aimed to critically evaluate the existing studies of language use in MI, with a view to providing answers to the question, 'How have studies about the use of language in MI contributed to our understanding of the mechanisms of client change?'

2.0 Method

The search terms used in the current literature search can be found in Table 1. The search strategy was run on 1st January 2012, using the databases Psycinfo, Medline, Pre-Medline, Psycarticles, Embase, and HMIC.

Table 1: Search terms used in literature search
"motivational interview\$" or "motivational enhancement\$" or "behav\$ change counsel\$" [limit year: 2001-2011] AND "language\$" or "talk" or "discourse" or "discursive" or "convers\$" or "dialog\$" or "interact\$" or "speak\$" or "spoke\$" or "speech\$" or "linguist\$" [limit year: 2001-2011]

2.1 Inclusion and exclusion criteria

A study was included in the review if:

- It attempted to describe how language had been used in MI
- It reported an original, empirical piece of research

Studies were excluded if:

- It was not explicit that MI was the intervention used
- Language was studied only in the context of assessing skill level from pre- to post training in MI
- Language was assessed as part of a wider study, but was not itself one of the variables under investigation
- The article was a review, discussion paper, or re-reported findings from an earlier article
- MI 'fidelity' or 'competency' in general, rather than a more detailed study of the language use, was the focus of the article

- The study was not published in a peer reviewed journal

2.2 Process

The literature search process is summarised in Figure 1 below for reference. The initial database search resulted in 238 potential articles, and the abstracts for these articles were read. One hundred and ninety seven articles were rejected as they failed to meet the entry criteria on relevance, or because they had not been published in peer reviewed journals. Therefore, 41 full publications were retrieved for review.

Additionally, a handsearch of the bibliography listed on the website of the motivational interviewing network of trainers (MINT) was conducted (at www.motivationalinterviewing.org), which resulted in four additional articles. An email to the MINT listserve, was sent to seek out any additional publications that may have been relevant (including any that were in press), which resulted in one further article. Likewise, an email was sent to individuals in the field who were known to have conducted research within this field, and this resulted in a further five articles. In total, 51 full publications were retrieved for review.

On reading these 51 articles, a further 20 were rejected due to not meeting the inclusion criteria (four were review papers, in two papers the intervention not clear, two were position/discussion papers, one was not published in a peer reviewed journal, three papers reported language only in terms of assessing pre-post training outcome, four did not address or provide enough information about language use in MI, four reported language use only in terms of 'fidelity' to or 'competency' in MI as part of another study, one was a meeting abstract), leaving a total of 30 papers included in the final review.

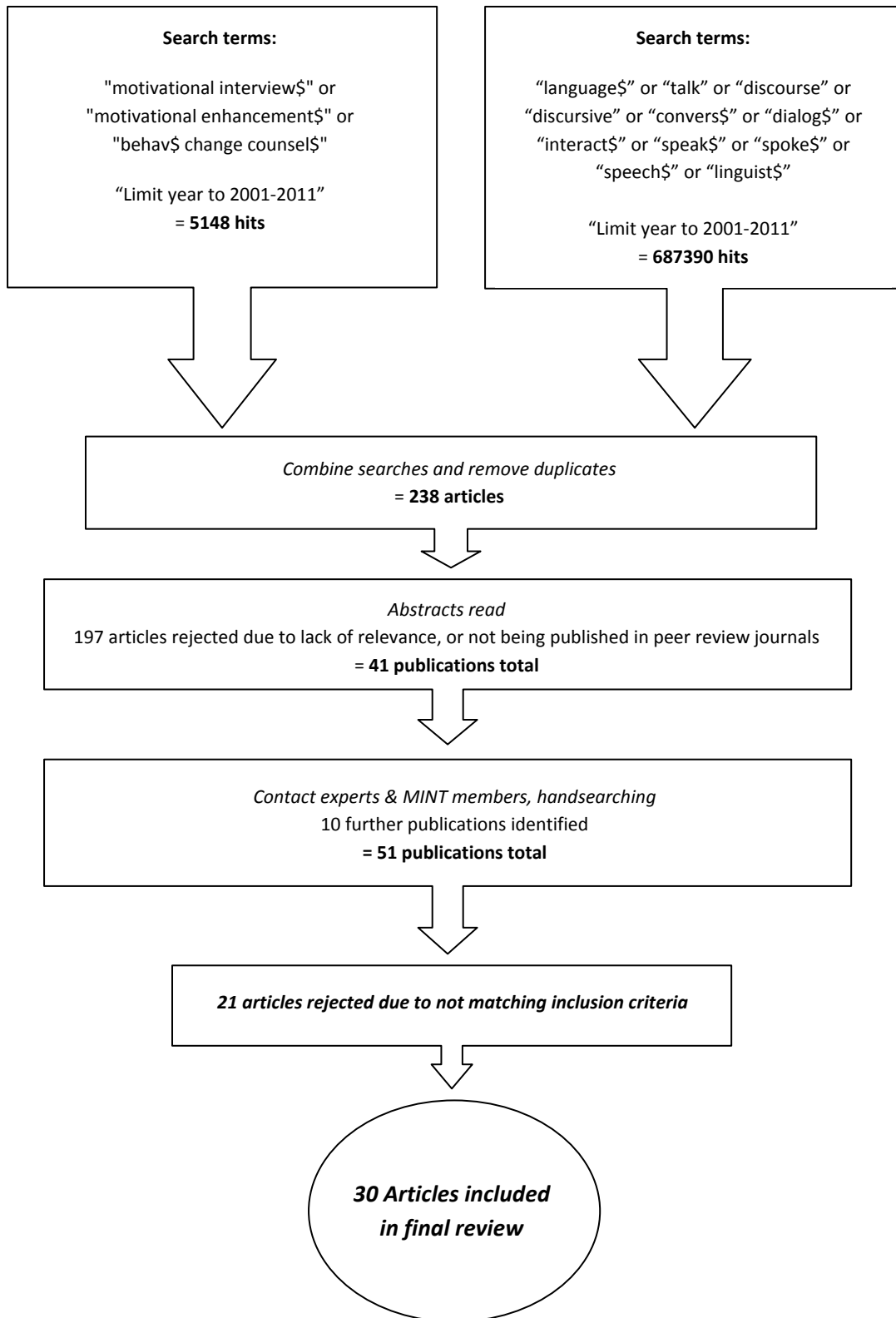


Figure 1: The Literature Search Process

2.3 Critical appraisal process

The 30 articles were read and the studies evaluated in line with the questions in Table 2.

Table 2: Questions systematically applied in the critical appraisal of articles included in the review

- | |
|--|
| <ol style="list-style-type: none">1. Research question/Study aim<ol style="list-style-type: none">a. Was the study design appropriate to the research question asked?2. Selection and retention<ol style="list-style-type: none">a. How were the study participants/data for the study selected?b. How were they allocated to groups? (if applicable)c. If data were collected across time, was data from participants who were lost to follow-up still included?3. Methods<ol style="list-style-type: none">a. Were the methods used appropriate to the study design and research question?b. Were the theoretical assumptions underlying any analysis methods met? If not were adequate controls applied?c. Were any confounding factors (including demographic variables and therapist effects) controlled for in quantitative studies?d. How much scope was there for measurement error in the findings? (via random or systematic errors in data collection)4. Generalisability and significance<ol style="list-style-type: none">a. How generalisable were the findings of the study beyond the population studied?b. What was the magnitude of the findings? (for example effect sizes, coefficient values, degree of clinical significance)c. What was the duration of the effect? |
|--|

3.0 Results

The current review highlighted studies of language that were either focussed upon the language of the client, the practitioner, or both parties within MI. A brief overview of the population, sample size, measures and analyses within the studies included can be found in Tables 4-7, located at the end of each subsection.

Within the studies selected for inclusion, several have included standardised instruments as a means to understanding language use in MI. A brief description of the instruments used in these studies and their psychometric properties can be found below in Table 3. Some studies also used differing terminology to describe 'change talk' (CT) and 'counter-change talk' (CCT), which has occurred as a result of changes in the conceptualisation and nomenclature of these behaviours within the MI field within the specified 10 year time period. For the purposes of the current review, these have been standardised throughout to CT and CCT accordingly.

Table 3: Standardised instruments used within the reviewed articles		
Instrument	Description	Reliability
Motivational Interviewing Skill Code (MISC) (Miller, 2000) (W. R. Miller, Moyers, Ernst, & Amrhein, 2008) (Miller, Moyers, Manuel, Christopher, & Amrhein, 2008)	<p>Most recent version (2.1) includes global ratings (on 7-point Likert scales) of practitioner acceptance, empathy and spirit, and client self-exploration. Also includes behaviour counts of practitioner MI consistent and MI inconsistent behaviours, and client CT and CCT.</p> <p>Previous version (1.0) included global ratings (on 7-point Likert scales) of practitioner acceptance, egalitarianism, empathy, genuineness, warmth, and spirit, and client affect, co-operation, disclosure, and engagement, and client/practitioner collaboration and benefit. Also coded CCT as 'resist change-talk'.</p>	<p>Intraclass Correlation Coefficients (ICCs) for MISC 1.0 reported to range from 0.25 to 0.79.</p> <p>No validation paper published for MISC 2.0 and 2.1, but studies included in the current review report ICCs ranging from 0.4 to 0.8.</p>
Motivational Interviewing Treatment Integrity (MITI) (Moyers, Martin, Manuel, & Ernst, 2007; Moyers, Martin, Manuel, Hendrickson, & Miller, 2005; Moyers, Martin, Manuel, & Miller, 2005)	Most recent version (3.0) includes global ratings (on 7-point Likert scales) of practitioner evocation, collaboration, autonomy/support, direction and empathy, and counts of practitioner MI consistent and MI inconsistent behaviours.	ICCs reported to range from 0.5 to 0.9 (with most at 0.6 and above), and good sensitivity from pre to post training assessment.
Independent Tape Rater Scale (ITRS) (Martino, Ball, Nich, Frankforter, & Carroll, 2008)	30 items (on 7-point Likert scales) of therapeutic strategies consistent with MI. Items on 'fundamental' (e.g. open questions, reflections, affirmations) and 'advanced' (e.g. assessing motivation, developing discrepancy).	ICCs range from 0.55 to 0.99, with most above 0.7.
Sequential Code for Process Exchanges (SCOPE) (Moyers & Martin, 2006)	Codes 30 practitioner and 16 client behaviours in sequence, derived from the MISC 2.0.	Kappa scores reported to range from 0.56 to 0.80

3.1 Studies of client language

Ten studies investigated the use of client language during MI exclusively. The first study explored the relationship between client talk within an MI session and the proportion of days abstinent from substance use in 84 participants (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). They used a qualitative coding frame to identify client CT within the categories of desire, ability, reason, need, readiness and commitment in relation to changing or not changing current substance use. These were numerically rated on a scale from -5 (extremely committed to no change) to +5 (extremely committed to change). Participants were grouped according to their average proportion of days abstinent through the 3 to 12 month follow-up period (into 'maintainers', 'changers' 'strugglers' and 'discrepant'). 'Maintainers' and 'changers' demonstrated a significantly higher strength of verbal commitment to change, in comparison to 'strugglers' and 'discrepant'. Proportion of days abstinent at follow-up was predicted by the strength of commitment language at the 7th and 10th deciles of the session. Commitment language was predicted by client expression of desire, ability, reasons and need for change.

These findings were somewhat supported by another study of using MI with pathological gambling behaviours in 40 participants (Hodgins, Ching, & McEwen, 2009), where behaviour change at 12 month follow-up was predicted by the overall strength of commitment expressed by the clients in the MI sessions. In an analysis of 19 x 10-session group MI sessions with adolescents (Engle, Macgowan, Wagner, & Amrhein, 2010), group commitment language towards the middle and end of the session and peer response to commitment language were found to be negatively associated with substance use post-intervention 12-month follow-up.

However, other studies of client language using this coding framework seem to suggest alternative outcomes with regards to commitment language. In one study with 54 homeless adolescents (Baer

et al., 2008), statements of desire/ability against change were predictive of decreases in proportion of days abstinent at 1 and 3 month follow-up, whereas reasons for change were predictive of reduced amounts of substance use per day at 1 month follow-up. However, there was no association between commitment language and substance use. Similarly, a study by Perry and Butterworth (2011) indicated that degree of client commitment strength showed no associations with physical activity rates in 19 women who had participated in a 12-week walking programme (Perry & Butterworth, 2011), though it significantly correlated with the participants' stage of change. In another study with cannabis users, client CT and strength of commitment from 61 MI sessions were coded (Walker, Stephens, Rowland, & Roffman, 2011). Expressions of desire and reasons for change significantly predicted the overall degree of cannabis use during the 34 month follow-up period, but commitment language showed no association with participants' clinical outcome at follow-up. Indeed, the findings of the Hodgins, Ching & McEwen (2009) study differed from the Amrhein, Miller, Yahne, Palmer & Fulcher (2003) study in that outcomes were not associated with the degree of commitment being expressed in the later stages of the MI session. Equally, the expression of the desire, reason and need for change was not predictive of the degree of commitment language produced, though ability and readiness were (Hodgins, Ching, & McEwen, 2009).

Other studies have utilised other methods of analysing language use. One such study (Bertholet, Faouzi, Gmel, Gaume, & Daeppen, 2010) coded MI based brief alcohol interventions (BAI) with 97 hazardous drinkers who presented at a hospital emergency department within another study (J. B. Daeppen et al., 2007). They quantified the numbers of participant utterances that oriented towards change, away from change, or neither for or against change, using the MI Skill Code (MISC) (Moyers, Martin, Catley, Harris, & Ahluwalia, 2003). The majority of participants' utterances did not alter in change orientation greatly during the 15-20 minute BAI (the probability of staying within the same orientation during the intervention was 80-88%). However, there was a 15% probability of transition

from 'away from change' to 'towards change', and an 11% probability of moving from 'towards change' to 'away from change'. Those who produced utterances 'towards change' near the end of the BAI were significantly more likely to have reduced their alcohol intake at 12-month follow-up. Another study that used the MISC (Moyers et al., 2007) found that proportion of days abstinent was best predicted at follow-up when proportion of days abstinent at baseline, CT and CCT were added to a hierarchical regression model. CCT was a significant predictor of proportion of days abstinent as was proportion of days abstinent at baseline, but CT was not. The number of drinks per drinking day was best predicted when CT and CCT were added to the model, with both CT and CCT being significant independent predictors of outcome. The interaction between CT and CCT showed no effect on follow-up proportion of days abstinent or drinks per drinking day, and baseline drinks per drinking day was not predictive of follow-up drinks per drinking day.

Another study looked at the effects of reading back an individual's CT and CCT statements (produced by 10 study participants during an MI session regarding alcohol use) upon their neural response (Feldstein Ewing, Filbey, Sabbineni, Chandler, & Hutchison, 2011). Using functional Magnetic Resonance Imaging (fMRI), they found statistically significant indications of a neural response within several areas of the brain associated with reward following presentations of CCT, but no such areas activated following presentations of CT.

It has been striking that to this point, all studies have focussed upon linking the use of language and behavioural outcomes. However, one study focused upon the use of two varieties of Spanish pronoun used by speakers in the New York State area of the USA: 'Uno' (translating as 'one', which is an indefinite and generic reference to the self) and 'Yo' (translating as 'I', which is a direct, first person reference to the self) (Flores-Ferran, 2009). As part of a wider study of corpus data from 12 individuals, the author investigated the alternation between these two pronouns within MI sessions

(it is not stated in the paper how many participants were in the data from the MI corpus). Results indicated that 'Uno' was used less in oral narratives than in MI sessions, and that there was a slight decrease in the use of 'Uno' in the second MI session in comparison to the first. To that end, it was suggested that 'Uno' may serve a specific discursive function within MI sessions that was not present in the data from other contexts.

3.1.1 Appraisal of studies of client language

The studies above demonstrated a number of strengths in relation to their findings. Firstly, with regards to the theorised relationship between CT, CCT and client behaviour change, there were a number of statistically significant relationships between client language and behaviour change outcome in the short term. These relationships were in the expected direction in line with theory, and are supported by linguistic theories of verbal commitment. In most studies, the samples were large enough to conduct statistical tests and were appropriate to the research questions asked.

However, there were also a number of limitations. The size of statistically significant coefficients between client language and outcomes was relatively modest, and the follow-up periods relatively short (12 months post intervention or less). Although sample sizes were sufficient for statistical analysis, they were small in regards of generalisability (particularly as participants within them were predominantly white, male and resident within the USA). One study involved just 10 participants (Feldstein Ewing, Filbey, Sabbineni, Chandler, & Hutchison, 2011), making the observed neural responses difficult to interpret. One study reported a potentially inappropriate use of statistics, and failed to report the statistic in full (Flores-Ferran, 2009). None of the studies in this part of the current review have been adjusted for clustering at the level of the practitioner.

Two studies reported ICCs of lower than 0.7 (Baer et al., 2008; Bertholet, Faouzi, Gmel, Gaume, & Daeppen, 2010), being interpreted as less than 'good' in terms of reliability (Cicchetti, 1994), and they merged distinct CT categories together in order to obtain suitable numbers for statistical analysis, which may have compromised the validity of the findings. Some studies from interventions consisting of multiple MI sessions used data from one session only (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003; Engle, Macgowan, Wagner, & Amrhein, 2010; Perry & Butterworth, 2011; Walker, Stephens, Rowland, & Roffman, 2011; Moyers et al., 2007). Additionally, most studies relied on self-reported client outcomes, with just three studies seeking additional objective measures (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003; Baer et al., 2008; Walker, Stephens, Rowland, & Roffman, 2011). Selection bias was also a possibility given that all but two studies (Feldstein Ewing, Filbey, Sabbineni, Chandler, & Hutchison, 2011; Flores-Ferran, 2009) have excluded participants lost to follow-up, and one study was conducted within an opportunistic setting (Bertholet, Faouzi, Gmel, Gaume, & Daeppen, 2010).

It is also notable that one study has been influential in how subsequent studies and coding instruments have categorised and measured client language (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). However, this study used a deductive, rather than inductive, approach in coding client language, and did not code all client language. Additionally, they allocated client groups for comparison based on drinking outcome, which violates the assumption of random allocation made by statistical tests, increasing the likelihood of regression to the mean effects and type 1 error. Although there were no observed demographic differences between these groups, there was great potential for confounding factors influencing the findings from this study, which may impact upon the later studies.

Overall, it seems possible that client CT may be a mechanism of change within MI within the contexts of these individual studies. Should this be the case, these studies suggest the magnitude of this relationship is likely to be small. There also appears to be some inconsistency in the findings of what kinds of client CT may be most important. These findings should also be interpreted with caution, as the methodological limitations associated with this small number of studies indicate that no firm conclusions can be drawn, and there is much scope for confirmation bias within these findings. Additionally, the direction of influence between language and change remains unclear from these studies (for example, does client language use lead to a change outcome, or do other associated change variables lead clients to use language in particular ways).

Table 4: Summary of Studies of Client Language

Study	Behaviour Studied	Sample Size	Data Source	Measures	Main Analyses	Main Limitations
Amrhein et al. (2003)	Substance Use	n = 84	Data from intervention arm of another study	<ul style="list-style-type: none"> Self-reported substance use at baseline, 3, 6, 9 & 12 month follow-up: 90D Questionnaire Coding of change and commitment language and numerical rating of commitment strength -5 to +5 	<ul style="list-style-type: none"> ANOVA: Between group differences in change language and commitment strength at each decile of the MI session Logistic and multiple regression: Predictive ability of client language categories upon substance use at 3-12 month follow-up 	<ul style="list-style-type: none"> Potential selection bias Potential allocation bias Potential retention bias Assumptions underlying analysis methods not met No controls for some confounders/therapist effects Findings difficult to generalise beyond study population Low magnitude of effect/relationship Indication of duration of effect limited by follow-up period
Baer et al. (2008)	Substance Use	n = 54	Data from intervention arm of another study	<ul style="list-style-type: none"> Self reported substance use in past 30 days at 1- & 3 month follow-up: Timeline Follow Back Interview (adapted) Urine tests at 3 month follow-up from 76% of sample MISC v 1.0 client global scores for affect, cooperation & disclosure, plus 1 additional global item on 'task orientation' Categories of preparatory language (desire and ability categories merged) and commitment language 	<ul style="list-style-type: none"> Multiple regression: Predictive ability of client language upon client substance use at 1 & 3 month follow up 	<ul style="list-style-type: none"> Potential selection bias Potential retention bias Assumptions underlying analysis methods not met Findings difficult to generalise beyond study population Low magnitude of effect/relationship Indication of duration of effect limited by follow-up period

Hodgins et al. (2009)	Gambling	n = 40	Data from intervention arm of another study	<ul style="list-style-type: none"> • Self-reported gambling behaviour at 3, 6, 9 & 12 month follow up: Timeline Follow Back Interview • Collateral interviews at 3, 6, 9 & 12 month follow-up: 68% of participants • GASS at baseline, 3, 6, 9 & 12 month follow-up. • MISC v 2.0, amended for gambling • Numerical rating of strength of expression -2 to +2 	<ul style="list-style-type: none"> • Binary logistic regression: Predictive ability of baseline days gambling, US Dollars lost, GASS score, mean positive commitment strength & mean negative commitment strength upon gambling outcome • Multiple regression: Preparatory language categories & mean commitment language strength 	<ul style="list-style-type: none"> • Potential selection bias • Potential retention bias • No controls for some confounders/therapist effects • Findings difficult to generalise beyond study population • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period
Flores-Ferrán (2009)	Not stated	N = 12	2 existing corpuses of narratives (including 1 of MI sessions)	<ul style="list-style-type: none"> • Occurrences of Spanish pronouns referring to the self 'uno' and 'yo' • Clause type, semantic clause type, semantic verb type, verb tense, discourse type • Speaker origin, age and gender 	<ul style="list-style-type: none"> • Frequencies: Distribution of 'uno' and 'yo' within different categories of Spanish speakers • Chi-Square: semantic clause type and discourse type 	<ul style="list-style-type: none"> • Inappropriate use of some analytic procedures • Assumptions underlying analysis methods not met • Findings difficult to generalise beyond study population • Indication of duration of effect limited by follow-up period
Bertholet et al. (2010)	Alcohol Use	n = 97	Data from intervention arm of another study	<ul style="list-style-type: none"> • MISC v 2.0 • AUDIT • Alcohol consumption: Self-reported weekly drinking at baseline and 12 month follow-up 	<ul style="list-style-type: none"> • Correlations: Transition probabilities between change orientation utterances • Bivariate regression: Initial change orientation, total orientation towards change, total orientation away from change, total non-determined orientation, final change orientation, 12 month weekly alcohol consumption • Multiple regression: Predictive ability of first and last state change orientations & number of statements towards & away from change upon weekly alcohol consumption at 12 months 	<ul style="list-style-type: none"> • Potential selection bias • Potential retention bias • No controls for some confounders/therapist effects • Potential measurement error • Findings difficult to generalise beyond study population • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period

Walker et al. (2011)	Cannabis Use	n = 61	Secondary analysis of an existing data set	<ul style="list-style-type: none"> • CLACS: Coding of change and commitment language and numerical rating of commitment strength -5 to +5 • PDA and SOCRATES at baseline, 4, 16 & 34 months 	<ul style="list-style-type: none"> • Multiple regression: Predictive ability of baseline marijuana use & client language categories upon marijuana use at follow up 	<ul style="list-style-type: none"> • Potential selection bias • Potential retention bias • No controls for some confounders/therapist effects • Potential measurement error • Findings difficult to generalise beyond study population • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period
Perry & Butterworth (2011)	Physical Activity	N = 19	Data from the intervention arm of another study	<ul style="list-style-type: none"> • Self-report amount of hours physical activity • ESOC • Rating of commitment strength (1-5) 	<ul style="list-style-type: none"> • Correlations: Associations between ESOC score, level of physical activity & commitment strength 	<ul style="list-style-type: none"> • Potential retention bias • No controls for some confounders/therapist effects • Potential measurement error • Findings difficult to generalise beyond study population • Indication of duration of effect limited by follow-up period
Feldstein Ewing et al. (2011)	Alcohol Use	N = 10	Component of a larger study	<ul style="list-style-type: none"> • Drinking level SCID, ADS, AUDIT • fMRI images when presented with CT and CCT • fMRI images when presented with alcohol cues following CT and CCT 	<ul style="list-style-type: none"> • Mixed effects analysis using FLAME to identify significant differences in brain area activation 	<ul style="list-style-type: none"> • Potential selection bias • Potential measurement error • Findings difficult to generalise beyond study population • Indication of duration of effect limited by follow-up period
Moyers et al. (2007)	Alcohol Use	n = 45	Data across 3 therapy conditions of another study	<ul style="list-style-type: none"> • MISC 1.0 • Mean monthly self reported PDA and DDD across follow-up period (9-15 months) 	<ul style="list-style-type: none"> • Hierarchical Multiple Regression: Predictive ability of baseline PDA & DDD, CT & CCT, & CT/CCT interaction upon PDA & DDD at follow-up. 	<ul style="list-style-type: none"> • Potential selection bias • Potential retention bias • No controls for some confounders/therapist effects • Potential measurement error • Findings difficult to generalise beyond study population • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period

Engle et al. (2011)	Substance Use	n = 19 (groups)	Data from the intervention arm of another study	<ul style="list-style-type: none"> • Mean DUSI-R score for the group • Strength of group commitment language -5 to +5 • Rating of group peer response -5 to +5 • MITI scores for empathy 	<ul style="list-style-type: none"> • Correlations: Associations between group leader empathy, group peer response & group commitment strength 	<ul style="list-style-type: none"> • Potential selection bias • Potential allocation bias • Potential retention bias • Assumptions underlying analysis methods not met • No controls for some confounders/therapist effects • Potential measurement error • Findings difficult to generalise beyond study population • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period
<p>Acronyms: MISC = Motivational Interviewing Skill Code, GASS = Gambling Abstinence Self Efficacy Scale, AUDIT = Alcohol Use Disorders Identification Test, CLACS = Client Language and Coding Scale, PDA = Proportion Days Abstinent, SOCRATES = Stages of Change Readiness and Treatment Eagerness Scale, ESOC = Exercise Stage of Change Measure, SCID = Structured Clinical Interview for DSM IV Disorders, ADS = Alcohol Dependence Scale, CT = Change Talk, CCT = Counter-Change Talk, DUSI-R = Drug Use Screening Inventory Revised, MITI = Motivational Interviewing Treatment Integrity Scale</p>						

3.2 Studies of practitioner language

Seven studies focused upon the language used by the practitioner within MI.

Two studies in this area have focussed on adolescent substance use populations. One study investigated MI as an approach of engaging 54 young people with substance use treatment (Smith, Hall, Jang, & Arndt, 2009). There was a statistically significant interaction between the client's perception of substance as a problem and numbers of MI consistent language behaviours, meaning that those adolescents with low problem perception were more likely to engage with treatment when practitioners used more MI consistent language. The other study investigated whether MI consistent language behaviours were directly linked to cannabis cessation (McCambridge, Day, Bonnita, & Strang, 2011) in 75 young people. Global ratings of MI spirit and the use of complex reflections were independently predictive of cannabis cessation in participants at 3-month follow-up.

Another study investigated the role of informal discussions on drinking outcomes within MET and counselling-as-usual sessions for substance use, in addition to client attendance at sessions (Martino, Ball, Nich, Frankforter, & Carroll, 2009). Seven hundred and thirty six sessions were rated for intervention adherence and informal discussions. Eighty eight percent of practitioners incorporated informal discussion, which tended to involve sharing personal information or common experiences with the client. This happened significantly less in the MET condition. Informal discussion was negatively associated with number of MI consistent language behaviours and the degree of within-session client change, but showed no association with client attendance and substance use outcomes.

Two studies have looked at practitioner language within the HIV field. One study explicitly linked adherence to antiretroviral medication with MI consistent language behaviours in 47 participants

who received an MI session as part of a treatment plan (Thrasher et al., 2006). Adherence rates were positively associated with a greater ratio of reflections to questions and affirmations, and negatively associated with the use of closed questions. Similarly, another study of condom use in HIV positive older adults (Lovejoy et al., 2011) found that higher scores of MI spirit, reflection to question ratios and complex reflections at 3 month follow-up decreased the odds of unprotected sex. This was also found at 6 month follow-up, with higher numbers of open questions and MI consistent language behaviours also decreasing these odds.

Two studies have been conducted with university students. One study investigated the link between MI adherence by peer counsellors and drinking outcomes in 67 participants (Tollison et al., 2008). There was a negative relationship between the number of closed questions and readiness to change post intervention, whereas the number of open questions was positively related to this. There was also a positive association between simple reflections and 3-month drinking levels, and a negative association between complex reflections and 3-month drinking levels. Within another study of relationship violence among university students (Woodin, Sotskova, & O'Leary, 2011), a greater ratio of reflections to questions was predictive of reductions in aggression in both male and female students. Analyses also suggested a greater percentage of open questions predicted a greater reduction in aggressive episodes for women.

3.2.1 Appraisal of studies of practitioner language

Similar to studies of client language, the findings of these studies seemed to offer some support for theories of practitioner use of language in MI. The relationships between practitioner language and client outcome were in the expected direction. Strengths associated with these studies include adequate numbers of participants for statistical analyses and appropriate use of tests. Standardised, validated measures enable comparison across as well as within studies. One study also included

elements of MI which are common to another therapeutic modality for comparison, and investigated elements of the interaction that may not have been captured in other studies (Martino, Ball, Nich, Frankforter, & Carroll, 2009).

However, generalisability from most of these studies remains an issue, given the relatively small samples and the demographics of the populations (predominantly white and male), with all studies conducted with English speakers, and six out of seven studies conducted in USA. However, there was some diversity in terms of the behavioural outcome studied, and the age of participants. Four of the seven studies reported client outcomes based entirely on self report, though one study did attempt to control for this by administering a bogus saliva test (McCambridge, Day, Bonnita, & Strang, 2011).

All studies excluded clients who were lost to follow-up from analyses, and just 2 studies adjusted for clustering at the level of the practitioner (Martino, Ball, Nich, Frankforter, & Carroll, 2009; McCambridge, Day, Bonnita, & Strang, 2011). One study used the last self-report follow-up point as the final outcome for those clients, despite there being three follow-up points over nine months, and attrition rates at 9 months being 60% (Woodin, Sotskova, & O'Leary, 2011), raising questions regarding the interpretation of the findings. Follow-up points for all studies occurred at 12 months or less, limiting inferences regarding longer term outcomes.

There were also limitations in terms of ecological validity. In the study of informal discussions within MI, practitioner disclosure of their own substance use was omitted from the analysis, preventing analyses in relation to this language variable (Martino, Ball, Nich, Frankforter, & Carroll, 2009). The discussion of one study highlighted the potential of results being a reflection of practitioners finding it easier to incorporate specific linguistic behaviours with clients who were more likely to change at follow-up (McCambridge, Day, Bonnita, & Strang, 2011). Another study suggested that medication

adherence was not the primary concern of some clients, which in turn questions how valid the reported outcomes may have been (Thrasher et al., 2006).

All seven studies reviewed used recognised validated measures of practitioner language, or published data on its reliability within the article. However, it was striking that practitioner language was quantified in terms of its structure, but little detail was given regarding the content of what was said, and several discrete language variables were merged, which often enhanced coding reliability but may have compromised validity. Additionally, the modest coefficients between practitioner language in relation to client outcomes indicate relatively small relationships in some studies (Martino, Ball, Nich, Frankforter, & Carroll, 2009; Smith, Hall, Jang, & Arndt, 2009; Tollison et al., 2008; Woodin, Sotskova, & O’Leary, 2011).

Overall, it is a possibility that practitioner language may also serve as a mechanism of change within the studies reviewed. However, the relationship between MI consistent behaviours and client outcomes appears to be modest, and there seem to be different suggestions as to which kinds of linguistic behaviours may be most efficient. However, reducing practitioner behaviours to summary variables, and describing their structure rather than their content, limits the conclusions that can be drawn regarding what it is about these behaviours that may make them effective in MI. Similar to studies of client language, the direction of associations between practitioner language and client outcomes remains uncertain. Again, bearing in mind the methodological limitations of these studies, these findings should be interpreted with caution. There are also a small number of studies in this area, making firm conclusions difficult to draw.

Table 5: Summary of Studies of Practitioner Language

Study	Behaviour Studied	Sample Size	Data Source	Measures	Main Analyses	Main Limitations
Martino et al. (2009)	Substance Use	n = 60	Data from CAU and MET arms of another study	<ul style="list-style-type: none"> • ITRS • Clinician and Supervisor Survey • HAQ-II • Qualitative thematic codes of informal discussions 	<ul style="list-style-type: none"> • Correlations: Association between counsellor/process/client outcomes & informal discussion frequency • ANOVA: Differences in informal discussion frequency between groups according to treatment group, orientation and recovery status. 	<ul style="list-style-type: none"> • Potential retention bias • Potential measurement error • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period
McCambridge et al. (2011)	Cannabis Use	n = 75	Data from the intervention arm of another study	<ul style="list-style-type: none"> • MITI • Bogus saliva collection • Self-reported cannabis use at 3 months and 6 months 	<ul style="list-style-type: none"> • Multi-level modelling: Predictive ability of MITI variables upon cannabis cessation at 3 months and 6 months 	<ul style="list-style-type: none"> • Potential retention bias • No controls for some confounders/therapist effects • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period
Smith et al. (2008)	Substance Use	n = 54	Data from the intervention arm of another study	<ul style="list-style-type: none"> • Ratings of linguistic topics/categories on 12 point Likert scales • GAIN-I item on degree to which substance use is a problem 	<ul style="list-style-type: none"> • Logistic regression: Predictive ability of therapist scores on the Likert scales upon client entry to treatment for substance use 	<ul style="list-style-type: none"> • Potential allocation bias • Potential retention bias • No controls for some confounders/therapist effects • Findings difficult to generalise beyond study population • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period

Thrasher et al. (2006)	Antiretroviral Adherence	n = 47	Data from the intervention arm of another study	<ul style="list-style-type: none"> • MISC 1.0 • Medication adherence at 4 and 12 weeks: electronic pill bottle cap monitor, pill count at the end of the study, patient self report 	<ul style="list-style-type: none"> • Correlations: Association between antiretroviral adherence and practitioner linguistic behaviours 	<ul style="list-style-type: none"> • Potential retention bias • Assumptions underlying analysis methods not met • No controls for some confounders/therapist effects • Potential measurement error • Findings difficult to generalise beyond study population • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period
Tollison et al. (2006)	Alcohol Use	n = 67	Data from the intervention arm of another study	<ul style="list-style-type: none"> • MITI 2.0 • Daily Drinking Questionnaire at 3 months • Readiness to Change Scale 2 weeks post intervention 	<ul style="list-style-type: none"> • Multiple regression: Predictive ability of closed & open questions upon level of contemplation to change & drinks per week at follow-up. Predictive ability of simple & complex reflections upon level of contemplation to change & drinks per week at follow-up. 	<ul style="list-style-type: none"> • Potential retention bias • No controls for some confounders/therapist effects • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period
Woodin et al. (2011)	Partner Aggression	n = 25 (couples)	Data from the intervention arm of another study	<ul style="list-style-type: none"> • MITI 2.0 • CTS2: Change in score from baseline to final follow-up 	<ul style="list-style-type: none"> • Hierarchical linear modelling: Predictive ability of practitioner linguistic behaviours upon number of aggressive incidents in preceding 3 months 	<ul style="list-style-type: none"> • Potential retention bias • No controls for some confounders/therapist effects • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period

Lovejoy et al. (2011)	Condom Use	n = 77	Data from the intervention arm of another study	<ul style="list-style-type: none"> • MITI 3.1.1 • Self-reported condom use over previous 3 months (at 3 and 6 month follow-up) • Response to question regarding stage of change in relation to condom use 	<ul style="list-style-type: none"> • Generalised estimating equations: Longitudinal odds ratios of condom use across time in relation to scores on MITI variables 	<ul style="list-style-type: none"> • Potential retention bias • No controls for some confounders/therapist effects • Potential measurement error • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period
HAQ-II = Helping Alliance Questionnaire, ITRS = Independent Tape Rating Scale, MISC = MI Skill Code, ASI = Addiction Severity Index, SUC = Substance Use Calendar (based on the Timeline Follow-Back Interview), MET (motivational enhancement therapy), GAIN-I = Global Appraisal of Individual Needs – Intake, CTS2= Revised Conflict Tactics Scale						

3.3 Studies of client and practitioner language

Twelve studies of language use in MI have looked at language from both the practitioner and the client.

One ABAB experimental design with 47 university students aimed to establish the degree to which clinicians play a role in eliciting client CT within MI (Glynn & Moyers, 2010). Practitioners were trained to elicit CT or ask functional analysis consistent questions at alternate points during an intervention for alcohol use. Clients produced significantly more CT in the CT elicitation condition.

One study attempted to look at practitioner and client language use in terms of within session therapeutic processes (Magill, Apodaca, Barnett, & Monti, 2010). Within a sample of 291 clients presenting at a hospital emergency department, practitioner MI consistent behaviours and client CT positively predicted written change plan completion, whereas client CCT negatively predicted its completion. These findings did not appear to be associated with client readiness to change. This supports the findings of Catley and colleagues, who analysed 89 initial MI sessions for smoking cessation with African American smokers (Catley et al., 2006). Practitioner MI consistent language behaviours correlated positively with client production of CT. Similarly, findings from a cluster RCT of single MI sessions with 16-20 year olds using cannabis (Strang & McCambridge, 2004) suggest that client CT was predictive of reductions $\geq 50\%$ or complete cessation of cannabis use at 3-month follow-up. However the strongest predictor of outcome was discussion of changing cannabis use.

Four studies analysed the interaction between practitioner and patient language within an MI based BAI within a Swiss hospital emergency department, using data from the intervention arm of a RCT (J. B. Daeppen et al., 2007). The first showed that within a sample of 97 patients, those who stated that they intended to change their drinking expressed more CT during the BAI than those who did not, but

these results were mostly independent of practitioner linguistic behaviours (J. B Daeppen, Bertholet, Gmel, & Gaume, 2007). A further follow-up study of the same 97 participants' drinking outcomes 12 months later (Gaume, Gmel, & Daeppen, 2008a) suggested that patients expressing their ability to change their drinking predicted a decrease in weekly alcohol consumption at 12 months. Although there were significant differences in individual practitioner linguistic behaviours, these were not predictive of 12-month drinking outcomes. However, when these behaviours were collapsed into total MI consistent and total MI inconsistent categories, they were found to be positively predictive of the client drinking outcomes, with practitioners using more MI inconsistent language being more effective in facilitating change with clients who expressed more ability to change (Gaume, Gmel, Faouzi, & Daeppen, 2009). Sequential analysis of this data was conducted to further investigate the relationship between practitioner behaviours and patient CT (Gaume, Gmel, Faouzi, & Daeppen, 2008b). Practitioner MI consistent behaviours were significantly more likely to be followed by client CT, and this was significantly more likely to result in further exploration of CT. MI inconsistent behaviours were significantly more likely to be followed by client talk not related to alcohol use and significantly less likely to be followed by client CT. Equally, practitioners were more likely to exhibit MI consistent behaviours following discussions exploring change with a client than when following client talk not related to alcohol use.

Another study of MI sessions for alcohol use (Vader, Walters, Houck, & Field, 2010) analysed client and practitioner language in two kinds of MI sessions with university students (one that included a personalised feedback on alcohol use, and one that did not) with the MISC 2.0. Within the feedback condition, MI consistent practitioner language was positively associated with the amount of client CT. Clients in the feedback group also produced less CCT in comparison to those who received MI without feedback. Client CT was negatively associated with drinking outcomes at 3 month follow-up, while CCT was positively associated.

Some studies have focused on trying to establish causal mechanisms between practitioner and client verbal behaviours and drinking outcomes. An initial study looked at the relationship between practitioner interpersonal skills on client involvement and language (Moyers, Miller, & Hendrickson, 2005). Structural equation modelling analyses were conducted on 103 recordings of MI sessions scored by the MISC 1.0 at 4-month follow-up post training. Practitioner interpersonal skills were positively associated with the degree of client involvement, and this association was enhanced by practitioner MI inconsistent language (which was contrary to the hypothesis that these behaviours would result in less client involvement).

A further study aimed to capture the transition probabilities between practitioner and client talk during MI sessions (Moyers & Martin, 2006; Moyers et al., 2007). A sample of 38 sessions (MI, CBT and 12 step) taken from another study (Project Match Research Group, 1997) was coded by the SCOPE, and transition probabilities were calculated. Client CT was likely to follow MI consistent and 'other' practitioner behaviours, with transitional probabilities of 17% and 15% respectively. CCT was most likely to follow MI inconsistent (8%). Clients appeared to remain on the topic of the target behaviour and were significantly less likely to transition to neutral topics after expressing CT and CCT (8%-21%). Following further refinement of the SCOPE, analyses of 63 initial MET sessions from this data source (Moyers, Martin, Houck, Christopher, & Tonigan, 2009) found that MI consistent behaviour was predictive of client CT and MI inconsistent behaviour was predictive of counter change-talk. CT was also positively predictive of the number of drinks per week. Calculation of transition probabilities also indicated that practitioner reflections of client CT and questioning the negative side of the client's drinking increased the probability of client CT by 49%, and that client CT significantly increased the probability of practitioner reflections of client CT by 17%. Mediation analyses were also conducted between MI consistent behaviours, CT and drinks per week. The

results suggested that CT mediates between MI consistent behaviours and drinks per week, explaining 30% of the variance.

3.3.1 Appraisal of studies of client and practitioner language

It is interesting that many of the reviewed studies have attempted to try to understand more closely the relationship between client and practitioner language, and most attempted to link this to client behavioural outcome. One study (Glynn & Moyers, 2010) attempted to look at differences in client language within a study designed for this purpose, rather than conducting post hoc analyses upon non-randomised participants. In common with the studies discussed previously, all studies conducted appropriate statistical analyses on adequate sample sizes. Another notable strength was that where measures were used, the ICCs reported were mostly greater than 0.6, indicating 'good' levels of reliability (Cicchetti, 1994). Four out of the 12 studies took into account clustering at the level of the practitioner within their analyses (Glynn & Moyers, 2010; Magill, Apodaca, Barnett, & Monti, 2010; Strang & McCambridge, 2004; Vader, Walters, Houck, & Field, 2010). In terms of populations studied, these articles appear to be more diverse in terms of participant demographics, including a study within a predominantly female African American population (Catley et al., 2006), a predominantly female population (Vader, Walters, Houck, & Field, 2010), a black UK population (Strang & McCambridge, 2004), and two studies containing similar numbers of male and female participants (Glynn & Moyers, 2010; Strang & McCambridge, 2004). One study also coded CT as a variable and MI language behaviours within other interventions (Moyers & Martin, 2006).

However, although adequate for statistical analysis, the ability to generalise beyond the studies in these samples is difficult, as they contained relatively small numbers of participants, with all but two studies (J. B Daeppen, Bertholet, Gmel, & Gaume, 2007; Magill, Apodaca, Barnett, & Monti, 2010) consisting of less than 100 participants. Seven of the 12 studies were conducted in the USA, four in

Switzerland (French speaking), and one in the UK, limiting the cross-cultural and linguistic generalisability of the findings. Most client behavioural outcomes were followed up at time periods of 12 months or less, and most studies did not account for clustering at practitioner level.

It is also notable that four studies (J. B. Daeppen, Bertholet, Gmel, & Gaume, 2007; Gaume, Gmel, & Daeppen, 2008a; Gaume, Gmel, Faouzi, & Daeppen, 2008b, 2009) used identical data from one study (J. B. Daeppen et al., 2007) in their analyses. The authors did not state that they had adjusted for multiple comparisons within their analyses to that end. Additionally, given that these data were drawn from opportunistic settings (as was another study (Magill, Apodaca, Barnett, & Monti, 2010)), the potential for selection bias was increased. This was also a possibility in one study that relied upon tapes supplied by practitioners for assessment following training (Moyers, Miller, & Hendrickson, 2005).

There were also some limitations associated from some of the measures used. The SCOPE was still under development in one study (Moyers & Martin, 2006) and changes were later made to it (Moyers, Martin, Houck, Christopher, & Tonigan, 2009). Some studies coded a 20 minute segment, rather than the full MI session (Catley et al., 2006; Moyers, Miller, & Hendrickson, 2005). Some studies showed low ICCs on their measurement instruments (particularly the MISC), and either eliminated those variables from the analyses or merged variables, increasing the possibility of measurement error (Catley et al., 2006; Gaume, Gmel, Faouzi, & Daeppen, 2008b; Glynn & Moyers, 2010; Magill, Apodaca, Barnett, & Monti, 2010; Moyers & Martin, 2006; Moyers, Martin, Houck, Christopher, & Tonigan, 2009). For those studies that reported client behavioural outcomes following MI, all of these data were obtained via client self-report with no objective measures reported. Again, there is also a lack of information regarding the content and meaning of utterances.

Overall, it appears that the interaction between client and practitioner language may contribute to mechanisms of change, but the exact nature of this remains unclear. Studies of within session processes seem to suggest that practitioner MI consistent behaviours may be associated with client CT, and MI inconsistent behaviours with client CCT or other kinds of speech. Additionally, CT appears to be associated with behaviour change and CCT with no behaviour change at short-term follow-up within the populations studied. However, two studies suggest that there may also be a role for MI inconsistent within certain conditions. It also seems that when change is discussed within a session, it is more likely to remain a topic through the session than other topics and vice versa. The strength of these relationships however, appears to be modest. There were also a number of methodological issues that suggest that caution should be exercised when interpreting the findings of these results, and it cannot be said with certainty that it was language leading to change, or factors associated with change leading the certain kinds of language production from both parties. Given the relatively small number of studies in this area and the variability in findings, it is difficult to draw firm conclusions from this evidence thus far.

Table 6: Summary of Studies of Client and Practitioner Language

Study	Behaviour Studied	Sample Size	Data Source	Measures	Main Analyses	Main Limitations
Catley et al. (2006)	Nicotine Use	n=86	Data from the control and intervention arms of another study	<ul style="list-style-type: none"> • MISC 1.0 	<ul style="list-style-type: none"> • Correlation: Associations between practitioner language behaviours upon client language behaviours 	<ul style="list-style-type: none"> • Assumptions underlying analysis methods not met • Potential measurement error • Findings difficult to generalise beyond study population
Daepfen et al. (2007)	Alcohol Use	n = 367	Data from the intervention arm of another study	<ul style="list-style-type: none"> • MISC 2.0 • Client statement of readiness (or not) to decrease drinking • Weekly drinking levels and heavy drinking episodes at 12 month follow-up • AUDIT at 12 month follow-up 	<ul style="list-style-type: none"> • Wilcoxon Signed Rank: Differences between those who expressed readiness to decrease and those who did not, in terms of practitioner language behaviours 	<ul style="list-style-type: none"> • Potential selection bias • Potential retention bias • Assumptions underlying analysis methods not met • No controls for some confounders/therapist effects • Potential measurement error • Findings difficult to generalise beyond study population • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period
Gaume et al. (2008a)	Alcohol Use	n = 97	Data from the intervention arm of another study	<ul style="list-style-type: none"> • MICO & MIIN practitioner language behaviours, and CT, CCT and neutral client language behaviours (as quantified from categories of language by the MISC 2.0) 	<ul style="list-style-type: none"> • Odds ratios of transitions: Client to practitioner language behaviours, practitioner to patient language behaviours, practitioner to practitioner language behaviours, patient to patient language behaviours 	<ul style="list-style-type: none"> • Potential selection bias • Potential retention bias • Assumptions underlying analysis methods not met • No controls for some confounders/therapist effects • Potential measurement error • Findings difficult to generalise beyond study population • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period

Gaume et al. (2008b)	Alcohol Use	n=97	Data from the intervention arm of another study	<ul style="list-style-type: none"> • MISC 2.0 • Changes to weekly drinking levels and episodes of heavy drinking at 12 month follow-up 	<ul style="list-style-type: none"> • Correlations: Associations between practitioner and patient language behaviours and drinking outcomes at 12 months • Multiple linear regression: Predictive ability of practitioner and patient language behaviours upon drinking outcomes at 12 months, when controlling for age, sex and alcohol use severity 	<ul style="list-style-type: none"> • Potential selection bias • Potential retention bias • Assumptions underlying analysis methods not met • No controls for some confounders/therapist effects • Potential measurement error • Findings difficult to generalise beyond study population • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period
Gaume et al. (2009)	Alcohol Use	n = 97	Data from the MI arm of another study	<ul style="list-style-type: none"> • MISC version 2.0 • Change in self-reported mean weekly alcohol consumption from baseline to 12 month follow-up • AUDIT at 12 month follow-up 	<ul style="list-style-type: none"> • Multi-level modelling: Predictive ability of patient language expressing ability to change & mean practitioner MI linguistic behaviours upon weekly drinking outcomes at 12-month follow-up 	<ul style="list-style-type: none"> • Potential selection bias • Potential retention bias • Assumptions underlying analysis methods not met • No controls for some confounders/therapist effects • Potential measurement error • Findings difficult to generalise beyond study population • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period
Glyn & Moyers (2010)	Alcohol Use	N = 47	Experimental Design (ABAB)	<ul style="list-style-type: none"> • MISC 1.1 	<ul style="list-style-type: none"> • Paired t-test: Condition • Three-way repeated measures ANOVA: <ul style="list-style-type: none"> ○ Within subjects: condition & time ○ Between subjects: clinician 	<ul style="list-style-type: none"> • Potential selection bias • Potential measurement error • Findings difficult to generalise beyond study population
Magill et al. (2010)	Alcohol Use	N = 291	Data from another study of two types of MI intervention	<ul style="list-style-type: none"> • MISC 2.0 • AUDIT score • Contemplation Ladder • Within session change plan completion 	<ul style="list-style-type: none"> • Hierarchical logistic regression: Predictive ability of practitioner and client language categories (across 8 session deciles) upon completion of a change plan (within session deciles 9-10) • Stepped logistic regression: Predictive ability of MI consistent, CT & CCT upon 	<ul style="list-style-type: none"> • Potential selection bias • Potential measurement error • Findings difficult to generalise beyond study population

					change plan completion.	
Moyers et al. (2005)	Various	n = 103	Data from an MI training study	<ul style="list-style-type: none"> • MISC 1.0 	<ul style="list-style-type: none"> • Structural equation modelling: Associations between 'client involvement' and MI consistent/MI inconsistent practitioner language behaviours. Associations between 'clinician interpersonal skill' and 'client involvement'. Interactions between MI consistent/MI inconsistent practitioner language behaviours, 'clinician interpersonal skill' and 'client involvement'. 	<ul style="list-style-type: none"> • Potential selection bias • No controls for some confounders/therapist effects • Potential measurement error • Findings difficult to generalise beyond study population • Low magnitude of effect/relationship
Moyers et al. (2006)	Alcohol Use	n = 38	Data from the MI arm of another study	<ul style="list-style-type: none"> • SCOPE 	<ul style="list-style-type: none"> • Correlations: Transition probabilities between different categories of client and practitioner language (MI consistent, MI inconsistent, CT, CCT, F/A, 'other') 	<ul style="list-style-type: none"> • No controls for some confounders/therapist effects • Potential measurement error • Findings difficult to generalise beyond study population • Low magnitude of effect/relationship
Moyers et al. (2009)	Alcohol Use	n = 63	Data from the MI arm of another study	<ul style="list-style-type: none"> • SCOPE • DW at weeks 1-5 	<ul style="list-style-type: none"> • Correlations: Transition probabilities between client and practitioner language categories • Linear regression: Predictive ability of client language categories upon practitioner language categories • Multilevel modelling: Predictive ability of client speech upon client DW. Predictive ability of practitioner MI consistent language upon client DW. • Mediation analysis: Between practitioner language, client language and client drinking outcome 	<ul style="list-style-type: none"> • No controls for some confounders/therapist effects • Assumptions underlying analysis methods not met • Potential measurement error • Findings difficult to generalise beyond study population • Low magnitude of effect/relationship • Indication of duration of effect limited by follow-up period
Strang & McCambridge (2004)	Cannabis Use	n = 105	Data from the MI arm of another study	<ul style="list-style-type: none"> • Practitioner ratings of quantity of client self-motivational statements • Reduction of 50% or more in cannabis use at 3 month follow-up 	<ul style="list-style-type: none"> • Logistic regression: Predictive ability of environmental factors, topics of discussion, discussion of changing cannabis use & practitioner ratings are predictive of cannabis use at 3 months. 	<ul style="list-style-type: none"> • Potential measurement error • Findings difficult to generalise beyond study population • Indication of duration of effect limited by follow-up period

Vader et al. (2010)	Alcohol Use	n = 143	Data from the MIO & MIF arms of another study	<ul style="list-style-type: none"> • Composite Drinking Score (comprised of DW, BAC, protective behaviours) • MISC 2.1 	<ul style="list-style-type: none"> • Linear regression: Association between practitioner and client language • t-tests/mann-whitney U: comparisons between MIO and MIF in practitioner and client language categories • Multi-level modelling: Relationship between client language and client drinking outcome • Mediation analysis: Between practitioner language, client language and client drinking outcome 	<ul style="list-style-type: none"> • Potential selection bias • Potential measurement error • Findings difficult to generalise beyond study population • Indication of duration of effect limited by follow-up period
MISC = MI Skill Code, AUDIT = Alcohol Use Disorders Identification Test, SCOPE = Sequential Code for Observing Process Exchanges, PDA = Proportion Days Abstinent, DDD = Drinks per Drinking Day, MICO = MI consistent, MIIN = MI inconsistent, CT = change talk, CCT = counter-change talk, MIO = MI only, MIF = MI Feedback, BAC = Blood Alcohol Concentration						

3.4 Other studies

One study has looked at the language of significant others (SOs) within MET sessions, upon the language in session and drinking outcomes of 27 clients within another study (Manuel, Houck, & Moyers, in press). Language was coded using the MISO (MI with Significant Others) coding measure and MISC 2.1. There were significant associations between specific kinds of SO language and specific types of client CT. SO 'encouragement/support' was associated with 'client ability to change', SO 'advice giving' with client 'steps towards change' and 'other talk towards change', SO 'CT' and client 'desire to change' and SO 'CCT' with client 'need to change'. Additionally, SO 'giving information about self' was negatively associated with client 'commitment' and 'steps towards change'. SO CCT was predictive of drinks per drinking day when controlling for baseline drinking levels.

3.4.1 Appraisal of other studies

In line with the limitations of other studies in the current review, it is difficult to generalise these findings given the small sample size used, and the fact that the study from which data was drawn was not set up to test hypotheses regarding the impact of SO language upon client outcomes. Practitioner effects were also not controlled for. It is also the case that SOs were not given a particular role to play within the original study; they were simply just invited to be there (Project Match Research Group, 1997), which may also impact how language was used. It is also notable that the SO language categories as measured by the MISO, although incorporating some ideas from marital interaction research, is predominantly measuring language categories measured by client/practitioner instruments and influenced by another study (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003), rather than looking at SO language in its own right.

As this was the first study of its kind (Manuel, Houck, & Moyers, in press), it is difficult to draw any firm conclusions from these findings in isolation, though the language of SOs within MI sessions is an under-researched area and deserves further consideration.

Table 6: Summary of Other Studies						
Study	Behaviour Studied	Sample Size	Data Source	Measures	Main Analyses	Main Limitations
Manuel et al. (in press)	Alcohol Use	N = 27	Data from the MI arm of another study	<ul style="list-style-type: none"> • MISO • MISC 2.1 • DDD 	<ul style="list-style-type: none"> • Correlations, hierarchical regression: SO talk, Client CT & CCT categories 	<ul style="list-style-type: none"> • Assumptions underlying analysis methods not met • Potential measurement error • Findings difficult to generalise beyond study population
MISO = MI with Significant Others, MISC = MI Skill Code , DDD = Drinks per Drinking Day, SO = Significant Other, CT = change talk, CCT = counter-change talk						

4.0 Discussion

The purpose of the current review was to establish how studies about language use within MI have contributed to our understandings of the mechanisms of change.

Considering the evidence thus far, it seems that, consistent with the model of how MI works, the language that clients produce during MI, and the way practitioner uses language in MI may have some bearing on within session processes and client outcomes in the short term. However, this has been predominantly found in North American, white male populations, and in most cases, secondary analyses from datasets not created to test hypotheses about language use upon outcomes. Although these studies have often used regression analyses, the way that samples are constituted, selected and tested limits the wider conclusions of predictive validity that can be drawn from them. Further cross-cultural validation of instruments and more diversity in populations is also greatly needed in order to generalise findings. Additionally, in most studies the target behaviour change was predominantly substance use (alcohol, nicotine, illicit drugs), and just three studies looking at health behaviours (Lovejoy et al., 2011; Perry & Butterworth, 2011; Thrasher et al., 2006). As one of these three studies showed no impact of client commitment language upon outcomes, further research is clearly needed in this area. Additionally, the possibility of factors associated with client change leading to increased instances of practitioner language cannot be ruled out at this stage.

It appears that one early study has heavily influenced the way that client language is conceptualised and measured in the studies throughout this review (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). Similarly, both client and practitioner language are being investigated by created and specific measures designed to measure them in line with theorised mechanisms for change. In line with this, it is particularly striking that 17 of the 30 studies included researchers associated with 1 of 3 research groups, and 3 of the 4 measures used within the studies reviewed were designed and created by 1 of

those research groups. This is not to say that the work of these groups and associated measures are in any way invalid, but they should be considered in line with the biases and limitations that tend to accompany first and second generation research studies. Our current understanding of language as a mechanism of change within MI is therefore predominantly limited to providing evidence for the theory of how MI should work. It appears that just one study reviewed looked at language in a different way to this (Flores-Ferran, 2009). It remains that there may or may not be other processes occurring that have not yet been investigated, and it cannot be said with certainty that findings to date may have been affected by bias or measurement error.

There are also a number of important strengths associated with the research conducted into language use in MI to date. For example, the study by Glynn & Moyers (2010) is the first to manipulate practitioner language under experimental conditions, which in turn enhances the assumptions that can be made regarding the impact of therapist language. Future studies could also benefit from experimental designs, to reduce the risk of confounding factors accounting for behavioural outcomes in secondary analyses of data not collected for this purpose. The Baer et al. (2008) study is one of few studies which attempt to code talk from multiple sessions and link this to behavioural outcomes, rather than choosing one session or extract from a multi-session intervention from which to make these assumptions. Future studies should bear in mind the limitations of the inferences that can be made regarding behavioural outcome if only part of the intervention has been analysed. It is also noteworthy that some more recent studies have adjusted their analyses for clustering effects at the level of the therapist (Magill, Apodaca, Barnett, & Monti, 2010; Martino, Ball, Nich, Frankforter, & Carroll, 2009; McCambridge, Day, Bonnita, & Strang, 2011; Vader, Walters, Houck, & Field, 2010), which is important in ruling out some of the unidentified confounding factors associated with the interventionist. Future studies should also consider undertaking this in their analyses of practitioner and client language. Additionally, two studies have attempted to conduct

analyses of language that is not focussed exclusively around therapist MI consistent language or client CT and CCT (Flores-Ferran, 2009; Martino, Ball, Nich, Frankforter, & Carroll, 2009). This has the advantage of beginning to understand other potential linguistic mechanisms of change within MI that have not yet been hypothesised, and is therefore a line of enquiry that would be beneficial to continue to pursue in future studies.

The research thus far has been primarily quantitative in nature, and has sought to establish which kinds of linguistic behaviours may be inter-related, and how they might be related to outcome. This provides some idea of 'what' some of the linguistic mechanisms of change may be, but gives limited insight into 'how' they may be. The way that data are currently measured in these studies currently provide little scope for assessing that this is the intention of the speakers, and what the functions and effects of their language use during MI may be (Potter & Wetherell, 1987). There are also utterances that have been coded as 'other' within these studies. Some studies of other therapeutic approaches have utilised qualitative methodologies such as discourse analysis, narrative analysis and conversation analysis to investigate language use (Harper & Thompson, 2012). These kinds of methodologies could offer much to understanding how language may or may not operate as a mechanism of change within MI. It has been noted however, that the failure to adopt a critical stance within these methods has resulted in them not being used to their full potential in therapeutic contexts (Avdi & Georgaca, 2007), so future studies utilising these methodologies would benefit from taking this into consideration.

Finally, one limitation that should be considered in relation to the current review concerns the mode by which studies were systematically compared. The systematic comparison of studies was made using questions generated by the author, based on several years of research experience, to evaluate the appropriateness of the methodology and the inferences that could be made from the findings.

However, the alternative approach of using of a validated rating scale may have been a useful addition in so far as articles could be graded via a numerical rating of study quality. This would have enabled the quality of the studies to be compared in a more explicit way, potentially making this easier for the reader to draw their own conclusions about study quality.

5.0 Conclusion

In conclusion, the studies reviewed have contributed to our understanding of the mechanisms of change to some extent. It seems that client CT and CCT may have some bearing on short term behavioural outcomes (particularly within substance use contexts). The degree to which a practitioner uses MI consistent behaviours also seems to be important, though there may also be some kind of a role for MI inconsistent behaviours in facilitating client change.

The limitations of the relatively small number of studies thus far however, make concrete conclusions about these findings difficult to draw. There is potential for bias and error within these studies, which are generally quantitative in nature. The findings, although promising, should be interpreted with caution. Future quantitative studies should aim to involve more diverse populations and incorporate more controls for confounding variables. Conducting experimental studies of these actual variables and controlling for practitioner effects in the analyses may be of benefit in this respect. What also remains unclear is the finer detail of *how* these behaviours are conducted, and what other kinds of processes may impact upon client change that are not stated by the hypotheses behind how the approach may work. One study provides some limited insight into this (Flores-Ferran, 2009). Qualitative research could provide more insight as to how language is actually used in practice within MI sessions, rather than limiting this to the quantification of behaviours considered significant.

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Empirical Paper:

A discourse analysis of client and practitioner talk during motivational interviewing sessions

Abstract

Despite many studies of language use in motivational interviewing, the vast majority have based this upon the quantitative coding of practitioner and client linguistic behaviours in order to relate these to client change outcomes. The current study aimed to investigate how clients and practitioners co-constructed the process of change using discourse analysis. Ten MI sessions for alcohol use were analysed in terms of how alcohol was verbally constructed, the functions and effects of rhetorical strategies employed and subject positions. Power and subjectivity were considered alongside these strands of analysis. The findings suggest that clients and therapists constructed alcohol as either a destroyer or facilitator, drawing upon discourses of differing degrees of power, which impacted upon the availability of client positions of agency and expertise in relation to alcohol. There was also a diversity of function within categories of client and practitioner speech. These findings have implications for clinical practice, in terms of moving beyond the recognition of 'types of client talk' and responding with an 'MI consistent' verbal behaviour, and moving towards reinvigorating the spirit of MI in relation to clinical outcome.

1.0 Introduction

Nationally and internationally, substance use continues to be a highly debated topic, with social, health and political implications. In 2005, 10.5% of the population of England and Wales had used illicit drugs, and 181,390 adults were receiving structured treatment for substance misuse (The NHS Information Centre, 2007). In 2007, 24% of adults in England were classified as hazardous drinkers, with 9% of men and 4% of women being alcohol dependent (The NHS Information Centre, 2009). Around a quarter of the UK population are smokers (The NHS Information Centre, 2008).

Several evidence-based pharmacological and talking therapies aim to help individuals change substance use by implementing harm reduction or abstinence. Evidence-based talking therapies for substance use include: cognitive-behaviour therapy (Morgenstern & Longabaugh, 2000); social behaviour and network therapy (UKATT Research Team, 2005); 12-step facilitation therapy (Ferri, Amato, & Davoli, 2009); and behavioural couples therapy (O'Farrell & Fals-Stewart, 2000).

One additional evidence based talking therapy is Motivational Interviewing (MI), an approach recently described as 'a collaborative, person-centred form of guiding to elicit and strengthen motivation for change' (Miller & Rollnick, 2009). MI draws upon interpersonal skills associated with client centred counselling approaches (Rogers, 1959), such as open (rather than closed) questions, simple reflections (statements replicating the content of what the client has said), complex reflections (statements indicating the meaning behind what the client has said), affirmations (statements of genuine appreciation for effort and personal qualities the client has) and summaries of what the client has said. The 'spirit' of MI, or a practitioner's 'way of being' with a client is also consistent with the Rogerian approach, and is made up of three components. The first component, 'collaboration', refers to the practitioner working in partnership with the client in an egalitarian way, rather than adopting an expert stance. The second, 'evocation', refers to drawing motivation out of

the client, rather than attempting to impose it upon them. The third component focuses on the importance of 'respecting client autonomy' to make choices, which includes acceptance that the client has the right to decide not to make changes.

In addition to its humanistic elements, there are also cognitive and behavioural elements of MI practice that distinguish it from client-centred counselling (Miller & Rollnick, 2002). For example, the practitioner adheres to the 'principles' of MI, which are to roll with (rather than confront) client resistance to change, to develop a discrepancy between the client's values and their behaviours, to support the client's self-efficacy about changing, while expressing empathy for the client (Miller & Rollnick, 2002).

MI has shown good potential in facilitating client behaviour change outcomes in a variety of settings (Burke, Arkowitz, & Mencola, 2003; Dunn, Deroo, & Rivara, 2001; Heckman, Egleston, & Hofmann, 2010; Hettema, Steele, & Miller, 2005; Lai, Cahill, Qin, & Tang, 2010; Rubak, Sandbaek, Lauritzen, & Christensen, 2005; Smedslund et al., 2011; Vasilaki, Hosier, & Cox, 2006). Although MI itself was an approach that grew out of clinical practice, a number of psychological and linguistic theories have been drawn upon in an attempt to understand why MI based approaches may appear to be related to some successful client outcomes, including speech act theory (Austin, 1976; Searle, 1969), operant conditioning (Skinner, 1953), self-perception theory (Bem, 1967), cognitive dissonance (Festinger, 1957), social cognitive theory (Bandura, 1977) and reactance theory (Brehm, 1966).

It is widely believed that within MI, positive outcomes result from the degree to which clients talk is oriented towards change ('change talk'), rather than talk oriented away from change ('counter-change talk'). The practitioner is seen as having a key role in this process by strategically eliciting and reflecting client change-talk within the discussion, while concurrently adhering closely to the spirit

and principles of MI. Several studies of practitioner and client talk have therefore been conducted. A recent review of these studies highlighted the primarily quantitative nature of existing research to that end, and emphasised the need for more qualitative studies of how language is used within MI (Lane, 2012). This need was further underlined by a recent conference paper (Allison, 2009) regarding talk within MI sessions that is relevant to the target behaviour. The author asserted that this talk may be serving some interactional function, but its function was unclear, as it was not codeable as change or counter-change talk. This possibly reflects the current research climate within MI, whereby kinds of talk are coded and quantified to provide evidence for 'outcomes', rather than thinking more broadly about interactional processes.

Thus, language within MI has predominantly been reduced to a coded type of talk removing much of the intricacies of what has been said, negotiated and achieved by practitioners and clients. This has implications for clinical practice, as other processes which may be important within MI have not been highlighted. It seems that presently, there is a gap within the literature that looks at interactional processes in more detail, rather than coding 'types of language behaviours'.

1.1 Discursive psychology & discourse analysis

An alternative position from which to conceptualise language use in MI is a discursive psychological position. Within discursive psychology, language is understood to be a form of social action in its own right (Potter & Wetherell, 1987). Rather than language being coded into distinctive categories, the assumption is that things are said as a means of, and in the course of, doing things in a socially meaningful world. When viewing language from this perspective, it makes sense that perhaps different questions about how language is used within MI can be asked. It is likely that within MI sessions, there are interactional processes occurring beyond those that have been coded thus far, as little attention has been drawn to the speakers' intent or social effect of their dialogue.

One methodological approach that examines processes of interaction is discourse analysis (Wetherell, Taylor, & Yates, 2001). The fundamental principle is social constructionist, asserting that the way in which language is used constructs social reality, resulting in variable social effects, distinguishing it from psycholinguistic approaches, which focus upon the cognitive processes underlying language production (Garman, 1990).

There are two different forms of discourse analysis. One is derived from post-structuralist theory and is often termed 'Foucauldian discourse analysis' (Harper, 2012). Discourse analysis from this approach focuses on the ways in which 'discourses' (ideas within a given culture) construct and maintain certain versions of objects and reality. Researchers using this form of discourse analysis adopt a 'relativist view' epistemologically, asserting that there are no objective grounds on which fact can be established. The alternative form of discourse analysis is derived from the fields of linguistics, semiology, sociology, psychology, ethnomethodology and conversation analysis, and is the form associated with discursive psychology (Harper, 2012). Discourse analysis from this perspective primarily focuses upon how language is used to negotiate meaning, identity, reality and accountability within various social settings. Researchers using a discursive psychological approach to discourse analysis adopt a 'critical realist view' epistemologically, in turn acknowledging underlying structures of fact but see these as mediated by social processes. However, there are some generic features common to both approaches, including how phenomena constructed through talk, how interpersonal goals are achieved, and the social effects that result from this (Georgaca & Avdi, 2012).

1.2 Discourse analysis, therapy and alcohol use

To date, one study has undertaken analysis of talk specifically in relation to the strength of verbal commitments made within MI, resulting in behaviour codes that were quantified and linked to outcomes (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003), but this analysis did not focus how meaning was created and negotiated through the interaction. However, discourse analysis has been applied to other therapeutic interactions. The majority of studies have undertaken analyses of family therapy, couples therapy and psychoanalysis (Avdi & Georgaca, 2007), possibly as the epistemological underpinnings of systemic therapies are social constructionist. However, one study to date has also applied discourse analysis to cognitive-behaviour therapy (Messari & Hallam, 2003).

A recent review of discourse analytic studies of therapeutic interactions (Avdi & Georgaca, 2007) highlighted that one major strength of this set of methods is the potential for to stimulate reflection and reflexivity on practice via a focus on variability in the construction of meaning, on the theoretical assumptions and techniques underpinning practice, and the effects produced thereof. It was therefore decided that a discourse analysis of MI would be beneficial both in terms of widening the theoretical understanding of the process, and in generating awareness of clinical practice. The current study was undertaken with a view to answering the following research question:

How do practitioners and clients co-construct the process of change within MI sessions?

2.0 Method

As has been highlighted (Dunn, Deroo, & Rivara, 2001; Medical Research Council, 2000), the standard and quality of complex interventions (like MI) delivered during research trials has until recently been questionable. For this reason, the secondary analysis of an existing dataset, which had been checked for MI intervention quality and standards, was utilised.

2.1 Data

The UK Alcohol Treatment Trial (UKATT) was a pragmatic, multicentre randomised controlled trial comparing Motivational Enhancement Therapy (MET) (a three session MI intervention incorporating a personalised feedback component on alcohol use) and Social Behaviour and Network Therapy (UKATT Research Team, 2001). Details regarding the structure of MET sessions can be viewed in Appendix 2G. Seven hundred and forty two clients with alcohol problems were recruited between 1999 and 2001, from seven specialist addiction treatment sites based across three UK cities (Leeds, Birmingham and Cardiff). They were randomly allocated to either one of two intervention groups (three 50 minute MET sessions, eight 50 minute SBNT sessions over an eight to 12 week period), or a wait list control group. Results indicated that both interventions significantly reduced alcohol use and alcohol related problems in comparison to wait-list controls at 12-month follow-up, and these two interventions did not differ significantly in outcome from each other (UKATT Research Team, 2005).

The therapy sessions in UKATT were video recorded as part of the trial for supervision and fidelity purposes. When consenting to participation, participants indicated whether or not this data could be retained for further studies. Those who opted out from this had their data destroyed at the end of

the study. Thus, recordings sampled for the current study have been selected from those who agreed for their data to be used in additional studies.

2.2 Sampling

The video recordings within the UKATT study had been coded for MI quality using the UKATT Process Rating Scale (Tober et al., 2008) as part of that study. This instrument seeks to establish how well different aspects of the intervention were delivered (intervention quality), and how much it was implemented (intervention frequency) during the session, scoring a minimum of zero and a maximum of four across 11 specific items. A copy of the instrument, with the MET items highlighted, can be found in Appendix 2B. The UKATT Process Rating Scale Scores were stored in a secure electronic database along with the unique identification numbers for the recordings.

A sample pool was created from these ratings. Recordings were included into the sample pool providing they had a minimum score of 2.5 overall for intervention quality (MET was delivered at least 'reasonably well') and 1.75 for intervention frequency (MET was delivered at least 'somewhat' during the session). This resulted in a sample pool of 38 MET sessions. As discourse analysis is an intensive process that aims to look at interaction in great detail, a small sample of 10 MI sessions were selected for analysis. These sessions were purposively selected to ensure a diversity of client gender, session number and session length within the sample. A copy of the sampling pool can be found in Appendix 2C. The final sample consisted of 10 individual therapists and 10 clients. The breakdown of the final sample selected for the current study can be viewed in Table 1 below.

Table 1: Breakdown of sample						
Transcript number	MET Session Number	Therapist	Client	MET Frequency	MET Quantity	Session Duration (mins)
01-0888-1663	1	T1 (female)	C1 (female)	1.91	2.86	63
03-0017-1085	2	T2 (male)	C2 (male)	1.82	2.2	59
04-0054-1344	2	T3 (female)	C3 (male)	2.09	2.89	44
04-0122-1759	2	T4 (female)	C4 (male)	1.8	3.0	49
08-0404-1338	3	T5 (female)	C5 (female)	1.91	3.44	36
08-0777-1739	1	T6 (male)	C6 (female)	2.0	3.0	60
08-0381-1308	1	T7 (male)	C7 (male)	2.18	2.89	44
08-0649-1589	2	T8 (male)	C8 (male)	1.91	3.5	60
08-0603-1549	3	T9 (male)	C9 (male)	1.91	2.71	34
08-0530-1471	1	T10 (female)	C10 (male)	2.18	3.38	51

2.3 Procedure

The audio data from the sampled sessions was copied from the videos into digital audio files (no visual data was used, just audio data). The data from these audio files was then transcribed verbatim by the author of the current study. Names, places and other information that could identify clients, therapists or services were anonymised at the point of transcription, by replacing them with a description in square brackets (such as [Name of Client], [Name of Town], [Name of Friend]). Speakers on the transcript were coded using either a letter C (indicating client speech) or a letter T (indicating therapist speech), along with a single digit number to differentiate which client or therapist was speaking as indicated in Table 1. These identifiers were listed alongside their respective transcript numbers for reference.

Extracts of data selected for detailed linguistic analysis were transcribed using the Jefferson system (Jefferson, 2004). A copy of the transcription conventions can be found in Appendix 2D. The analysis

was conducted using the framework described by Georgaca and Avdi (2012), whereby the data is analysed on five levels.

Level one of the analysis concerned the **construction of verbal objects through talk, and the discourses from which they draw**. MI is an approach that is meant to facilitate change by developing a discrepancy between the person's behaviour and their wider values, and the dataset used involved MI sessions with individuals regarding alcohol consumption. For this reason, the object under study within this analysis was alcohol.

Level two focuses upon the **function and effects of the language used, the rhetorical strategies employed** and the ways of talking about alcohol in the ways outlined at level one. This provides information regarding the interpersonal functions served by the use of language. As MI is a therapeutic approach to behaviour change, within the current study, the discursive aspect of the analysis focussed on discussions about changing drinking.

Level three involves the analysis of **subject positions used within the dialogue, with regards to their function and effects**, and the relation of this to the analyses conducted at levels one and two. Specifically, this highlights how individuals are addressed or referred to within the interaction, who is doing the talking, and on whose behalf they speak. The current study focused on how both clients and therapists positioned their selves and each other within MI.

Level four analyses the degree to which the discourses maintain or challenge dominant institutions and practices, and thus the **power relations** within the discourse. Within the current study, this involved a critique of the effects of dominant discourses upon how 'alcohol' was constructed, how

'change' was linguistically negotiated, and how subject positions were taken up by the practitioner and client within the session.

Level five of the analysis concentrates upon '**subjectivity**' (what it means to be a person located within the discourses identified within the analysis) and thus how an individual may think, feel and experience his or her self. This was discussed in relation to the analyses of levels one to four within the current study.

Within the current study, Avdi & Georgaca's framework was followed with a particular emphasis on the first three levels forming distinct 'steps' of analysis. Power and subjectivity were integrated into these three levels of analysis, particularly in relation to subject positions. The transcripts were read initially by the author of the current study, and notes pertaining to each of the five levels were made. They were then re-read several times in more detail, in accordance with each level of the analytic framework, and notes were made on the transcripts. More in depth notes and associated data extracts to this end were recorded in memos and tables (see Appendix 2E for examples of this). This enabled the explication of the similarities and diversity within the data. Overarching themes were applied to the data to group similar occurrences of discursive actions, with particular attention remaining upon the linguistic diversity within these themes. Hypotheses were then generated regarding the effects of these constructions.

2.4 Ethical Approval

Participants in the original UKATT trial were given the option to allow their session recordings to be used in future studies as part of the consent process. The data for participants who chose to opt out from this had been destroyed at the end of the UKATT trial. Therefore, the sample from which

consultations were selected for the current study was made up only from those participants who had provided consent for their data to be used in future research studies.

The proposal for the current study was submitted to the National Research Ethics Service (NRES) for ethical approval. This was granted by the committee in March 2011 (see Appendix 2H).

3.0 Analysis

3.1 Constructions of alcohol

Alcohol was constructed by clients and therapists as either a destroyer or facilitator. The points at which this occurred within the transcripts are summarised in Table A1 in Appendix 2F.

3.1.1 *Alcohol as a destroyer*

Alcohol was constructed as a 'destroyer', a cause of 'harm' or 'damage' that presented 'hazard' or 'risk' in three main ways. Firstly, all clients constructed alcohol as a destroyer of the body and health:

C10: Yeah. Right, and I think this was best time for me to try and do summat about it, because if I don't I aren't gonna reach 50... They, haven't said that, the doctor, but the way, if I keep going on now...yeah, another ten years and I won't be alive, you know what I mean? And I'll just kill me self.

Most therapists also produced independent constructions of this nature, particularly during the feedback component of initial MET sessions:

T7: To put that into a bit more perspective, in a non drinker, so somebody perhaps somebody... who doesn't drink a lot, getting a blood alcohol concentration of about three hundred would be enough to render them unconscious and for them to get up to a blood alcohol concentration of a thousand okay? For them to get up to a blood alcohol concentration of over a thousand...[it] could be a lethal amount of alcohol... You know somebody who wasn't used to drinking, could die from that amount of alcohol.

T2: If you have up to 14 units a week... then uh the likelihood of developing any health problems because of drinking is very, very low, yeah? So you are drinking on a weekly basis roughly 70 units, which is about five times and a half more than the recommended units per week.

In these examples, both clients and therapists drew predominantly upon medical discourse. Medical discourse is characterised by the identification of specific, diagnosable physical problems within an individual, having a 'proven' cause and prognosis. Such claims are based on 'objective', scientific findings, associating them with power, and making them difficult to refute. Utilising this discourse enables clients and therapists to present a strong rationale for reducing or quitting drinking. Within

the first extract above, the client stated that he is not in a position to speak with authority about his prognosis, but the claims made within medical discourse are strong enough for him to speak on behalf of the medical profession with a disclaimer of his expertise. However, as therapists assume the role of a 'professional' offering 'treatment', they are able to speak from the position of the medical profession without such a disclaimer. This also reflects the relative differences in power between the two parties.

Some clients also constructed alcohol as a destroyer of relationships:

- C7: well the main thing that concerns me about my drinking is losing my family .. well there's four kids, a girlfriend... when I came last week to see you... me and the girlfriend had fallen out. Had a really big bust up. Our eldest lad, he were still up and he was crying cos he didn't want me to go... as a result of my drinking I'm hurting them... I got kicked out... not last Friday... the Friday before
- C6: I don't want [my children] to grow up like me, like I've always seen my dad drink... Always seen my dad drink and get drunk, and I've seen you know like everything, arguments and ... [I] see that now, which I didn't before.
- C8: Well my wife don't like this drinking. She don't drink... And I seem to get a bit silly really like. And I shouldn't say the cruel things that I say to her... I never hit my wife... I can guarantee that... But I can insult her, very, very badly... Because when I'm in a drink and eh she'll say something to us like I'll tell her to 'Oscar'... and things like that, you know... I'm not going to say the proper words to you

Therapists' constructions of this nature again tended to occur during the feedback component of the initial MET session:

- T1: Okay. So the next uh test is problem related to drinking profile, yeah? It's uh testing what sort of problems did you have um in the last six months uh because of your drinking, yeah?... Problems um physical problems, psychological problems, financial problems, you know? Relationship problems and everything else. So as you can see here, uh in about three categories you're marked quite above average... friends and um alcohol related problem others for is 18 which is in a high category and this is the general score and it's showing how uh your result is compared to others who are receiving um help from us.

Some clients utilised the discourse of dysfunction in their constructions of alcohol as a destroyer of relationships. 'Dysfunction' is originally a sociological term associated with actions that have a

negative impact upon social groups and society (Merton, 1957), with dysfunctional relationships being associated with the toleration of conflict, misbehaviour and abuse within relationships to the point where it becomes 'normal' (Stoop & Masteller, 1991). Dysfunction is frequently used within politics and the mass media to attribute blame for 'social problems' (Blair, 2011). For example, in the extracts above, these clients made accounts of behaviour commensurate with what would be expected within dysfunctional family relationships, particularly in terms of physical and verbal abuse towards other family members, which is constructed as hurtful, distressing and damaging to those who are party to it, and tolerated in so far as this behaviour has not resulted in the dissolution of these relationships. All three clients above attribute these actions to having been under the influence of alcohol, and thus holding alcohol accountable for dysfunction. Most therapists, however, drew upon the discourses of science and statistics. Scientific discourse is characterised by its 'objective' approach to establishing 'measurable facts'. Statistical discourse specifically seeks to support or challenge scientific fact by substantiating these numerical 'averages'. From this, inferences regarding causes, problems and successes can be made. For example, in the above extract the therapist constructed 'relationship problems' via a numerical value that has been quantified and is measurable by questionnaire, and compared the client's score to what is considered to be an 'average' numerical value among individuals seeking help for drinking problems, making it difficult for the client to debate the severity of her problem in relationships. Utilising this kind of discourse enables therapists to position themselves as possessing 'scientific knowledge of the facts', and in a position to comment on the degree to which the client's alcohol use is problematic.

Finally, drinking was constructed by most clients as a destroyer of achievement and living life:

- C5: If I want to live life as I'm going on then there won't be no alcohol in my life I won't touch alcohol.. now this is my time to do what they've been doing... I just want to [settle] down and it me that's got to do it. It's me that's got to get this job to get that house, so . that's really what my next three years are cos I've got to do that... My life won't travel like that [with alcohol], which is obvious cos it didn't when it was in my life.

- T5: Right. So you can see that you can only achieve those things if you continue to stay away from alcohol completely
- C5: Right now how I feel is, I've got too much in my life for a glass of a glass of wine
- C10: If I didn't drink? I think I'd be, we'd be doing a lot more activities. That's one thing, you know like going home, instead of just crashing out, getting on with things... I mean, I used to do all sorts. I used to get home from work, I'd be doing bathroom, cause I used to do plumbing you see, with me brother, I still do it now and then um, but I started fitting a bathroom, I haven't finished it yet, and that were about three year ago... I've got a lot of things I could be getting on with, yeah, a lot of things, but the time, like you get home, you have an hour, you have a couple of cans.
- C3: Yeah, I think some of my ambition's come back... which is one of the first things that went [when I was drinking]. I mean I like my job, but I'm not content to stay there... and I think if I can stop [drinking] then my chances of going on to join the Police or go to another company will be increased. Also I can sort of do more activity that I want to do, you know, find new things that I would like to do um but, you know, whether that sort of thing happens or not it's something that I can focus up to and make myself better.
- T3: Yeah and it sounds like your sense of yourself kind of moving out there is certainly more awakened

Some clients drew on the discourse of capitalism when constructing alcohol in this way. One feature of capitalistic discourse is that it promotes the production and consumption of 'objects', emphasising the role of the individual as an agent in this process. It is often associated with psychological constructs such as intrinsic motivation and reward (Friedman, 1962; Kalkberg, 2002), as well as achievement, freedom and success (Friedman, 1962). In the extracts above, all three clients spoke of striving for or achieving an 'output' of some kind in their daily life (such as a house, a job, or a finished 'product'), and requires action on their part for it to be acquired. While alcohol is present, it seems that these 'objects' cannot be acquired, and the motivation to undertake these efforts is diminished. Clients used this discourse to attribute the responsibility for their lack of motivation and achievement to alcohol, rather than to their own agency. All therapists amplified clients' accounts, rather than producing independent constructions. For example, in the extracts above, therapist T5 co-constructed achievement as conditional upon abstaining from alcohol, while the therapist T3 constructed the motivation to 'move out there' as being resurrected by the non-consumption of

alcohol. Amplifying clients' accounts in this way enabled therapists to remain consistent with constructions that alcohol is a destroyer, while promoting client agency to make changes.

3.1.2 Alcohol as a facilitator

In direct conflict with being a destroyer, drinking was also constructed as a 'facilitator' that enabled clients to achieve positive ends.

Firstly, drinking was presented by most clients as a facilitator of social functioning, as in the following examples:

- C10: Whereas, all right, I know that everybody likes to go out for a pint and stuff like that, fair enough, you know what I mean? People deserve it when they've been working all week just to go out and, but I can't do that because I know if I go out and I just won't stop... And then say in a couple of years time I've stopped me drinking then I can either revert back to where I can go out for a social drink...
- C9: I've got all me drinking friends there and they've been...they support me with people trying to break into me flat and that and talk me through it... And that's about all really. There's not really 'owt else good about [drinking].
- C3: You know, it's just on my mind and also uh just things like, don't know, Christmas and... it's got to a point where I think, my impression of people is sometimes they know you don't drink. Firstly, I want to know why you're not drinking and then they'll say, "Well...", they'll all be drinking ...they'll think that I'm sort of anti-drink or I'm sort of casting aspersions on them sort of.

In doing this, most clients drew upon discourses of social norms and expectations. There are times when within British culture, it is accepted and expected that an individual will drink alcohol, such as special occasions (like in the third example), or as in the first example, a reward for exerting effort, with the 'after work drink' with friends being a recognised social activity (Beaven, 2005; Harnett, Thom, Herring, & Kelly, 2000). Failure to drink alcohol in these situations can be perceived as unusual (Smith, Abbey, & Scott, 1993), requiring justification and potentially resulting in perceived social pressure. Additionally, as in the second extract, drinking was constructed by clients in terms of

fostering and maintaining normal social friendships, which could be lost through abstaining from or changing drinking (Orford, 2008a). Therapists did not independently construct drinking like this, but built upon client constructions. As in the example below, when therapists accompanied client constructions with negative consequences, this enabled them to construct alcohol as problematic despite positive consequences that were facilitated by it:

T7: When somebody actually asks you to come for a drink you find it very difficult to say no, but when you do go for a drink, it sounds as if it turns into much more than just one very quickly.

Alcohol was also constructed by some clients as a facilitator of wellbeing, by drawing upon discourses of healing:

C7: Basically, it just makes me forget . I forget my troubles that I find hard to cope with. I just drink and... just forget about everything... like bad memories and that.

Similar to ‘treatments’ within medical discourse, alcohol becomes an alleviator of pain, problems and a promoter of sleep within the data. Clients can utilise this discourse to provide a justifiable rationale for continuing drinking, or to account for their drinking thus far. There is also the potential to challenge medical and scientific discourses advocating for change, because alcohol within this discourse ‘makes bad things feel better rather than worse’. Therapists did not construct alcohol as a facilitator independently, but did build upon clients’ constructions:

C3: It’s the feeling...the initial feeling of wellbeing that I miss and for that there wouldn’t be a substitute, you know, there’d be other things that will take my mind off things and will make me feel better and everything um but it’s that feeling of wellbeing after the first few drinks.
T3: Yeah and you’ll miss that
C3: Yeah I will miss that. I’m worried about that.
T3: And what will happen after that initial wellbeing feeling?

This example illustrates how therapists can lead clients to deconstruct alcohol as a facilitator of wellbeing, and open up the opportunity to challenge the discourse of healing by encouraging the client to reconstruct alcohol as a problem. Therapist T3 achieved this by indirectly referring back to previous constructions of alcohol as destructive in her question. She invited the client to construct the outcome of drinking beyond the benefit, thus constructing the wellbeing facilitated by alcohol as temporary and ineffective in the longer term.

Finally, alcohol was also constructed as a facilitator of control in some instances:

- C1: Mmm today like my son would be at nursery full time, I'll have my daughter at home and try and get all my jobs done during the day and then, as I say, I pick my son up and then that's it, I can, you know, have a drink sort of thing. It's just got into a habit and, as I've said to you before, my husband ((doesn't like me drinking)) vodka... so I'm not allowed to drink vodka in the house. I'm allowed...let me drink vodka in the house, or drink it from quarter past three, so I sneakily have to try and drink it before he comes home.
- T1: Ah, so you're going behind his back somehow because he doesn't allow you having vodka in the house

This client drew upon the discourse of secrecy and deception, which enabled her to maintain control over the actions restricted by her husband, in line with theories such as psychological reactance (Brehm, 1966). This has the effect of constructing alcohol as enabling of agency. Therapists did not independently construct alcohol as a facilitator in this way, but like in the example above, used such client constructions to account for the secrecy and rationale for drinking.

3.1.3 Summary

Therapist and client constructions of alcohol as a destroyer provide a rationale for change, by drawing upon powerful discourses that are difficult to dispute, and promote client agency. Therapists only constructed alcohol as a destroyer, and used their language to indirectly challenge the degree to which alcohol was facilitative, directing and limiting the positions available for client

constructions of alcohol. However, clients were able to achieve these constructions, by drawing upon other discourses and opening up their own subject positions. The examples above illustrate how clients' and therapists' talk in MET is negotiating the contradictions and ambivalence apparent when alcohol is constructed by clients as both a destructor and a facilitator, which are in themselves, opposing constructions. This process is discussed further in the next section.

3.2 Discursive analysis of client change talk

Change talk, or client expressions indicating desire, ability, reason, need and commitment to change (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003), is theorised to be one of the key mechanisms of client change outcomes within MI. This was therefore analysed in more detail within the current study. Change talk appeared in many different places throughout the transcripts, with clients speaking in favour of change in the future, at the present, and in the past. Within the second and final MET sessions, this seemed particularly apparent in relation to clients' perceived indicators of change as being successful, often facilitated by therapists' questions (such as 'How would you know your plan was working?' 'What differences would you notice as a result of making this change?' 'You said you would know your plan was working because... how is that?'). In MET 1 sessions, change talk often occurred when alcohol was being constructed as a destroyer by clients and therapists.

Within the scope of the current paper, it was not possible to conduct discursive analysis of every instance of change talk within the data, due to length and time restrictions. For this reason, discursive analysis was conducted upon one extract that featured client change talk, as it would typically be manifested within a session regarding alcohol use. This extract was of particular interest as the client change talk seemed to appear despite aspects of the therapist's practice being inconsistent with MI at points.

The extract comes from an initial MET session between a male therapist (T7) and a male client (C7). This extract was selected due to its position within the MET 1 session. At this point, clients have usually received their personalised feedback in relation to their drinking, and to that end a more focussed discussion around behaviour change typically begins. This in turn made it particularly relevant to the central research question which concerns how change is co-constructed between therapists and clients. This extract was also selected as an example of how a therapist may employ principles and skills indicative of MI but may at times not adhere closely to the spirit (and thus, how this may play out in the discourse between them). Additionally, it contained several examples of client change talk, providing opportunities to deduce some possible functions of change talk.

The extract follows the process of the client receiving personal feedback on his drinking, and which led to the client accounting for minimising harm from his drinking, and stating his drinking was a problem. It precedes the closing of session 1.

1 T7: right (.) it sounds as if you've got kind of mixed feelings about your drinking (.) i: in in some respects you
2 (.) you're really u:m (.) you're so concerned about the kind of state that you get yourself into that you
3 actually (.) take steps [to to reduce]=
4 C7: [to mind the]
5 T7: =that risk (.)
6 C7: mmmm (.) what (.) what I'd prefer to do is like (.) u:m (.) be able to just go out and have a social drink
7 T7: right
8 C7: I'd say like once a week or maybe once a fortnight (.) out social drink with like (.) friends
9 T7: mmmm (.) I wonder how realistic that is
10 C7: well I started to do with friends down (.) and I like I had like a social I had a sociable drink in the bottom
11 (.) I wouldn't say it were sociable no cos I were in the bottom of the garden heh
12 T7: right
13 C7: but (.) one of (.) one of my mates came down for a beer (.) have a beer with me (.) sat at the bottom of
14 the garden with me for a bit (.) and basically (.)
15 T7: right
16 C7: we sat just down and had a chat (.)
17 T7: right (.) can I just ask you how long you've been (.) how long you have been drinking in this kind of way
18 [name of client]
19 C7: heavily? heh u:m (.) since I was (.) about (.) nineteen (.)
20 T7: right (.) and how old are you now?
21 C7: twenty-seven at the end of this year
22 T7: right (.) so you've had about eight years (.) of drinking in this kind of way (.) right (.) and what you're
23 thinking of is you're thinking that you perhaps need to cut down? (.) and you're thinking perhaps of (.)
24 just drinking socially (.) yeah?
25 C7: yeah
26 T7: I wonder whether I might just (.) um (.) explain a little bit to you about (.) u:m (.) ((sniff)) (.) how other
27 people have (.) um (.) have managed with trying to do that when they've had a history of drinking as (.)
28 as as long as you have
29 C7: mmm mmm
30 T7: would that be okay?
31 C7: yeah
32 T7: its (.) it's actually often proved to be very difficult for people um (.) to (.) cut their cut their drinking
33 down in that way when they've had u:m (.) a history of problems with drinking for as long as you say
34 you have [and that's eight years]
35 C7: [mmmm]
36 T7: and also when they've been as dependent on alcohol (.) as you have been (.) definitely find it difficult
37 to drink in a [controlled way]=
38 [mmmm]
39 T7: =can you
40 C7: I've (.) I have done (.) the way (.) I look at it (.) is (.) I stopped before (.) for a month (.) and (.) if I can stop
41 for a month I should be able to control how much I drink
42 T7: right (.) so you think you if if you you could stop [for a month]=
43 C7: [mmm]
44 T7: =right (.) you think you should be able to control it
45 C7: yeah (0.5) I know it's gonna be ha:rd
46 T7: right (.) so you think you should be able to control it but you think that will be difficult
47 C7: yeah (.) but I've just gotta (.) what I've gotta think about is (.) if I drink (.) if I do drink really heavily (.)
48 what's gonna happen heh
49 T7: right (.) so you're aware that if you did decide to drink socially (.) you would need to keep your drinking
50 right [down]=
51 C7: [mmm]
52 T7: =and (.) you'd have to be very aware of (.) of the risks of your drinking by going back up [again and]=
53 C7: [mmmm (.) mmmm]

54 T7: =you think that will probably be quite difficult to do [but it's so (.) it's]=
55 C7: [yeah but I know I]
56 T7: =so difficult at the moment to think of (.) of managing without alcohol that that you're prepared to
57 take that risk
58 C7: and I know the reason why I drink heavily (.) and I've taken steps (.) to um (.) to stop that (.) to stop me
59 from drinking heavily
60 T7: you've taken steps to stop you from drinking heavily
61 C7: yeah
62 T7: oh right (0.5) tell me a little bit about that

At lines 1-5, the therapist presents 'the dilemma' of drinking. He uses the pronoun 'you' and the verb 'have', locating the dilemma within the client. 'Mixed feelings' accounts for a perceived inconsistency in how the client has spoken about his drinking. The therapist uses the client's 'concern' about the 'state he gets himself into' as an explanation for his implementation of risk reduction strategies. This constructs the client's drinking as problematic and harmful, locates the problem within the client, and justifies this construction of drinking as a destroyer by highlighting the client's actions to attempt to limit such destruction. This in turn limits the positions that can be taken up against changing. It also 'sets the scene' for discussion of change as beneficial.

In lines 6-8, the client takes up a position in response to the dilemma. He signals he would 'prefer to' drink differently by engaging in 'social drink once a week or once a fortnight with friends'. Through this utterance, he is attributing the 'problem' not to alcohol itself, but to the way he has been drinking it. He draws on the discourse of social norms and expectations to achieve this, constructing alcohol as a facilitator of a normal social life, with the use of 'just', minimising any destruction that may be associated with this use of alcohol. This justifies the proposed drinking as legitimate.

Following this at line 9, the therapist states 'I wonder how realistic that is'. 'I wonder' suggests that the therapist does not know the potential outcome, and 'how realistic that is' creates an element of uncertainty regarding the success of the client's preference. Use of the word 'wonder' locates this uncertainty within the therapist. The effect of this is that it challenges the change proposal by the client. Despite the declarative form of this utterance, the function appears to be an indirect directive, a request for the client to either change his position or justify it.

This is borne out at lines 10-16, where the client draws upon the discourse of normal social relations, and constructs alcohol as a facilitator of relaxation and enjoyment with friends. This enables him to

account for the apparent conflict at line 11, caused by the isolated 'unsociable' location which would open up a position to construct alcohol as a destroyer rather than a facilitator. The function of the client's utterance is to present his idea as feasible, by justifying this with evidence of past success.

The therapist requests permission to question the client at lines 17-20, by uttering 'can I just ask you'. This is an example of a locutionary act (Austin, 1976), implying through lexical selection that the client can choose whether or not to answer. However, the illocutionary force (the meaning of the utterance) is for the client to answer the question, which he does at lines 19 and 21. The therapist states the client's position at line 22, in order to justify his next move at line 26-28. Again he 'wonders' if he 'might just explain'. The use of a modal verb here has similarities to expressions of politeness through respecting a person's freedom of action and imposition or 'negative face' (Brown & Levinson, 1987; Goffman, 1967), and positions the therapist as respectful of the client to that end. However, the fact that the therapist is hoping to 'explain' about other peoples' experiences of the client's preferred change, indicates that he is preparing to challenge the client's position on this change. He asks the client whether it would 'be okay' to share this information at line 30, implying that the client can say 'no', but the illocutionary act of this utterance not really allowing space for this.

The therapist then constructs this explanation by talking about the experiences of 'other people', with a similar demographic implementing the client's plan, positioning the client's idea in relation to 'the average'. 'Other people' is general, rather than specific, creating the impression that this represents a majority, rather than a minority, experience. The therapist's challenge is made at line 32-39, where he constructs 'cutting down' and 'controlled drinking' as 'difficult'. Using statistical discourse provides justification for the therapist's challenge and places him within a position of power in relation to the client, given the power associated with this discourse. The experience is

difficult to contest given that this has been 'often proved' and is 'definitely' difficult (in contrast to the uncertainty expressed earlier in the extract), and because of where the client is positioned in relation to 'other similar people' within this discourse, indirectly constructing exceptions to the rule as possible but unlikely. In effect, this makes the therapist appear objective and rational in his account of the difficulties, as he is simply 'stating the norm'. He also speaks from a position of expertise in relation to this knowledge, given the power of his professional role. This provides justification for the presentation of this evidence, and provides an invitation for the client to change his position.

The client, however, does not accept this invitation, responding at lines 40-41 by re-asserting his position on social drinking. He counter-challenges the therapist's evidence by stating that he 'has done', controlled drinking. He states 'the way I look at it is', creating a separate version of the therapist's evidence (located within the client) which disputes it. He justifies his position on the therapist's evidence by providing counter evidence of his one-month abstinence, which required control. This constructs his preferred change as a feasible one. He cohesively links to the therapist's account by talking about his ability to 'control' his drinking, rather than drinking socially, creating the impression that he is leading logically on from the therapist's evidence. He also maintains a degree of uncertainty in the success of his plan through the use of 'should', possibly because his position of power within the 'objective' discourse of statistics makes certainty more difficult from his position. He draws on scientific discourse in terms of cause and effect to justify his position on drinking socially. The therapist then reiterates the client's position on controlled drinking at line 42-44, locating this within the client via the use of the phrase 'you think', as well as reconstructing the client's use of 'should' as an expression of his uncertainty of success at this change.

The client then states that he knows it will be 'hard' at line 45 in order to justify his resistance to the position opened up by the therapist, by explaining he has already given this 'difficulty' consideration. The therapist then reconstructs the client's difficulty at line 46, indicating that the client believes that change will be difficult, and thus indirectly asserting that the client will not be successful. The client accounts for his acceptance of this difficulty at lines 47-48 by accounting for the perceived difficulties of cutting down drinking as being mediated by the perceived consequences of drinking heavily.

In keeping with the client's knowledge of controlled drinking and acceptance of the difficulty, the therapist then positions the client as possessing relevant expert knowledge by stating that 'you're aware that' at line 49. He uses this client-expert position to state the conditions that would need to be fulfilled if the client's proposed change was to be successful. This creates the impression of a shared knowledge and coherent agenda between the two parties. However, the therapist is indirectly imparting the therapist's position upon the client, limiting the opportunity for the client to dispute this. The therapist then accounts for the client not accepting the offer to change his position as the client being 'unable' to envisage managing without alcohol at lines 54-57. This also accounts for the client falling outside of the 'rule of averages'.

The client then continues to position himself within the expert role, stating his knowledge of his drinking, and actions he has taken to change it (lines 58-60). This account makes the client appear rational and in control of his drinking, and consistent in his claim that his goal is a feasible one. However, this conflicts with his earlier account of needing to change, by suggesting that he has already changed. It is likely given this, that this is an attempt to present his competence in relation to his proposed change. At line 62, the therapist acknowledges the client's existing changes, and invites him to explain more. As the client has successfully challenged the therapist's position on the

client's proposed change, the function of this utterance is possibly to seek evidence to strengthen his own original position or counter it.

3.2.1 Summary

Within this extract, change is negotiated between the client and therapist who have differing discursive agendas and use their discursive resources to attempt to maintain consistency between accounts. The therapist's agenda is to encourage the client to change his position on drinking, while the client's agenda is to present his idea as viable, despite the power differential not being in his favour at that point in the interaction. The overall function of the client's change talk therefore goes beyond expressing inner cognitive and affective processes in favour of change. Within his dialogue, although his utterances could be coded as change talk, he is advocating for a particular course of action, constructing this course of action as feasible, challenging the therapist's position, and resisting the subject positions opened up for him by the therapist. Subject positions are analysed more closely in the next section.

3.3 Subject positions

In response to how alcohol is constructed by therapists and clients, and how changing drinking is negotiated through interaction, therapists and clients can create and take up subject positions during that dialogue. Within the sample, key positions regarding agency and expertise were opened up, taken up and resisted. The occurrences of these positions within the transcripts are summarised in Table A2 in appendix 2F.

3.3.1 Agency

Agency refers to the ability of an individual to act within a given social structure (Hollway, 2007).

Within the initial MET sessions, all therapists stated their position at the outset:

- T1: Before we really get into the session I want to ensure you that um I'm not going to push you to change your mind or to do anything that is uncomfortable. Everything that uh is happening uh you will decide yes what you want to do about it or don't you need anything, yeah?
- C1: Mmm.
- T1: So what we are doing here is just to discuss about your- your...about what's going on in your uh life around your drinking and just to see if you can or if you want to do something about it. So it's just your decision and you are in charge, okay?
- C1: Okay, yeah.

Within this extract, the therapist has positioned the client as the agent of change and their self as a person with no influence upon the client's drinking. This places the responsibility and accountability for drinking with the client, and absolves the therapist of these demands. This provides the client with the relative power associated with agency in relation to change, and removes this from the therapist completely, positioning them as powerless in this respect.

The position of client as agent was frequently opened up by all therapists. This was often taken up by clients, as in the following extract:

- T3: Yeah and the down side is just the bit about the cravings and sort of, "How am I going to cope?"
- C3: Yeah, yeah that's the down side.
- T3: Yeah and when that down side comes, it sort of flashes through or however it appears to you
- C3: Yeah, yeah.
- T3: What do you say to yourself? What do you...? What do you do? How do you minimise that?
- C3: I don't know. I'm not sure um
- T3: How are you coping with it at the moment?
- C3: Well I always think, "Well it's been 18 days. That's the best I've managed."
- T3: In how long?
- C3: Well since...I mean um well the last six weeks or so, you know, um you know, so there's that to sort of keep me going. There's also...I mean maybe...I don't know if this is right or not, but the fact that I've been off the drink for a while makes me think a bit more clearly and I can sort of, not necessarily rationalise things, but I can argue better with myself for uh for not going to the off licence.
- T3: Yeah so it's kind of brought back your kind of powers of decision making

The therapist seeks a response from the client about his role in minimising difficulty, thus positioning him as the agent. Although this is not initially taken up, the therapist reconstructs her question, focusing on his present agency, providing evidence for his agency from his current actions to account

for improvements in decision making. She is not making suggestions about how the client could cope with these difficulties, therefore placing responsibility and accountability for change with the client, but indirectly retains the professional power to manage the discourse in this way.

Another way in which all therapists consistently fostered client agency throughout the data was by speaking as, or on behalf of, the client:

- T4: So it sounds as if although it hasn't been easy
C4: No.
T4: You have developed some ways of dealing with the situations
C4: Some of it, yeah
T4: Where you feel that you, you want to drink
C4: Yeah.
T4: Um, you're, you're still getting up while watching TV programmes but you're getting something else to drink rather than alcohol.
C4: Mmmm.
T4: You've spent time with this friend working on cars and so on and he's somebody that you, you have not drunk with in the past.
C4: Mmmm.
T4: And getting very absorbed in something like doing your car work has helped as well.
C4: Yeah.

In MI, there is a strategic focus on using 'reflections' and 'summaries' of the client's talk, particularly when it is related to change (Miller & Rollnick, 2002). Within this extract, the therapist constructs a narrative from the client's accounts of change. This increases the difficulty for the client to dispute their agency, as it would make their own account appear irrational and inconsistent.

However, positions of agency were not always taken up by clients. One way in which this was resisted is via the presentation of alcohol as a destroyer and thus, an inhibitor of agency:

- C5: Yeah, how can anybody know what to do with their life when they're in that state... it's very, very true, how can, you know, when you're like that, what you want to do. You've no chance of knowing.

This positions the client as physically unable to take up the position of agent when they are under the influence of alcohol, and thus powerless, being neither responsible nor accountable for the lack of changes made.

Some clients also drew upon competing discourses to resist positions of situational agency:

T8: Ah okay. You feel under a lot of pressure to go for a drink with
C8: That's right, yeah.
T8: Okay that's, that's really difficult to, to, to do.
C8: Yeah.
T8: Okay I, I wonder how you could, could, could get around that. What do you think?
C8: So, well I have tried everything, you know
T8: Tell me some of the things you've tried.
C8: Eh I've told them to 'Oscar'
T8: Right.
C8: eh the hard words like
T8: Yeah.
C8: you know. "I ain't going out"
T8: And, and, and
C8: "I'm staying in tonight".
T8: What happens when, when you said that to them?
C8: Well they just looked at us and said, "Don't be silly, come on, let's go", you know.
T8: Okay and what, and then what happened?
C8: Well we just go for a pint then
T8: Right.
C8: and that's it.
T8: Okay, well what else have you tried?
C8: Eh I've tried, you know, dodging them if I can. If I see them in ((shop name)) I've tried to go in the opposite way
T8: Right.
C8: but I always seem to bump into them, at one end, you know.
T8: Right.
C8: So, I've tried everything like that.
T8: Okay.
C8: So that's it.
T8: Right.
C8: But eh I'd just like to turn round and say, "Look, I'm on medication mate, I can't drink and that's it".
T8: Right so if, when you were on the medication is that what you used to say to them?
C8: Yeah.
T8: Right and, and then what happened.
C8: I just walked away then.
T8: Right.

Within this extract, the therapist persists with trying to position the client as the agent of change.

This is resisted by the client who draws upon the discourse of social expectation. He positions

himself as unable to refuse drinking alcohol within this social group. However, by obtaining medication (which was not possible for this client) he would be able to draw upon the more powerful discourse of medicine within his social group. This would provide a viable rationale for not drinking, and provide him with the power to retain his agency to abstain within that social context. This indirectly positioned his agency as conditional upon receiving medication, retaining no responsibility or accountability for the outcome without it due to his lack of power in that context.

Some clients also attempted to renounce agency itself with regards to changing drinking:

- C1: But it's like, you know, I still, as I say, like I can't, as I say, a quarter wasn't enough. You know what I mean?
So
T1: But you managed that.
C1: I managed, but I mean, you know, I find it hard sort of thing. I just wish somebody would have a magic wand.
T1: That's, you know, not really the reality, you know, that is the magic wand, let's go and take the problem away from you. It's just how determined you are to making it happen, yeah? And it sounds like you have all the reasons to keep going, yeah and to make this change and even when it's hard yesterday you found the resources and, you know, the alternatives to stuck to whatever you decide to do, yeah?
C1: Yeah.
T1: So how do you want to do it the next time? It is quite important, you know, because got to give you some sense of direction.
C1: Yeah I'm planning my...um I was going...because my partner stopped working Monday and I was going...you know, I've got those tablets sort of thing, either tonight or tomorrow night not have a drink and take one of those tablets, complete taking the tablets for about three nights, you know what I mean?

The therapist constructs the concept of a 'magic wand' as 'not the reality', constructs the client as possessing agency already, and then positions her as the decision maker in the interaction. It should be noted that the therapist is able to make these constructions due to her relative power in the interaction. No 'magic wand' closes down the availability of this position, meaning the client needs to take up another. In this case, she takes up the position made available to her by the therapist, assuming some power in relation to her actions, but again the responsibility and accountability which go with that.

However, some clients retained the option of creating another position with regard to agency. In the following extract, this client has drawn upon the discourse of medicine to challenge the effectiveness of three sessions of MET to 'cure' his 'drink problem':

- C2: Yeah. You seriously found this did you?
T2: Definitely three times, two or three times, so. And we've had two
C2: So you uh gotta out on your own again have you
T2: Yeah. That's the definition of it. Talking treatment. And where does that leave you?
C2: So who's gonna help me, after three sessions, to go to the big wide world and uh unquote (laughs) and I'll be out there and some sort of something for forty five you know uh, twenty years ummm
T2: It's a. It's a good question. I mean it
C2: I mean you say three fifty minute sessions like you know, that to me, I wouldn't think that was ummm, a lot of it could come down like for your efforts

The therapist initially positions himself as an expert, drawing upon the discourse of science (thus possessing relative power), and attempts to open up a position of agency for the client. However, the client's explicit reference to the therapist's 'efforts' positions the therapist as the agent of change. The client also questions the scientific evidence as 'unfeasible', challenging the therapist's expertise and ability as the agent.

3.3.2 Expertise

Another frequently occurring subject position was that of expert. All clients and therapists positioned each other and themselves in expert roles in relation to drinking.

Despite having positioned themselves as non experts, therapists did move into an expert position when providing personalised feedback, particularly in MET 1 sessions:

- T10: Well, it's very difficult to say, it's not an exact science and it's very hard to say oh well alcohol's caused this particular problem... But certainly, I mean, you've been telling me that alcohol stops you eating, it makes you very tired. You're more vulnerable when you're in that state, and so, you know, it's difficult to, for me to say, oh well, yeah it's because of that, but it's likely that the drinking hasn't helped at all. You know, and thinking about how drinking's, drinking affects all the internal organs, it affects everything, and so I think as I said, the thing to take from this would be drinking to these levels and the tolerance that you have, you could damage yourself and you wouldn't know, and that's a very dangerous position to be in.

- C10: I see, yeah.
 T10: Does that make sense?
 C10: It does, yeah.
 T10: Yeah? What does that mean to you?
 C10: It's like I said, well, that I think that's one of the biggest reasons why I've got to stop the drinking, but it's got to be a stop and not try to cut me down, because I think I may already have done the damage, because if I've already done the damage, if I slow the drinking down, it's not going to get any better.

This therapist draws upon the discourse of medicine, positioning herself as possessing specialist knowledge or expertise in alcohol as a destroyer, and in her professional role possessing the power and authority to do so. She provides consistency in alcohol as destructive by speaking on behalf of the client in relation to his physical difficulties and medical discourse, providing some power to the disempowered party within this part of the interaction. This limits the positions available to the client to challenge the information, which could be argued to either empower them towards agency, or disempower them to resist agency. However, the therapist opens up a position of information analyst to the client. This is taken up, and enables him to create a position for himself in relation to alcohol, thus assuming more power within the dialogue.

Within the feedback, the client is also positioned by the therapist in relation to other people in wider society, as follows:

- T7: [People] who are drinking between eleven and twenty one units a week. There's twenty six percent of the population drink more than them.
 C7: mmmm
 T7: Yeah? um, and you're in the very very high category there drinking four hundred and seventy six units, well you can see there that there's just a dash. And what that actually means, doesn't actually mean that there's nobody who's drinking more than you, but it means that it's a lot less than five percent
 C7: Yeah
 T7: Yeah? So in other words if we had a hundred people in the room, that we just chose at random from the general population, yeah?
 C7: Yeah
 T7: There would probably be less than five of them that were drinking as much or more than you
 C7: ((exhale of breath)) Surprised
 T7: You're surprised
 C7: I am.
 T7: Right. That's not what you were expecting
 C7: No. ((exhale)) At best I thought like. I know I were drinking more than more than what I should have been doing.

The utilisation of statistical discourse limits the power of the client to negotiate his position in relation to others. However, the therapist uses his power to open up a position for him in relation to the impact of the feedback, enabling the client to construct alcohol as either destructive or facilitatory.

Additionally, some therapists opened up positions of expertise for clients within scientific discourse, enabling them to dispute the 'evidence', as in the following example:

- T6: ((pause)) What about that one there? I'll just take you back to that one there. That says two, and I'm wondering - and that's a sort of low level of problems, whereas - does that make sense to you with the account that you've been given?
- C6: I'd say, um, above average because it's hard.
- T6: Right.
- C6: It is hard, we do you know fall out quite a lot and it's hard for me to ...
- T6: I see, right. So looking at this again, you'd say well actually you'd expect the score to be somewhere about there? Right., okay, okay. All right. And let's just run down - I mean the, the score of one there, do you want to revise that, or do you think that's where it ought to be?
- C6: I think that's where it ought to be.
- T6: Okay. Police, zero.
- C6: Stay there, yeah.
- T6: Right, friends zero. Okay. Children zero.
- C6: ((pause)) Um I'd say above average because I you know I'm stressed, I get stressed out all the time with everything you know.
- T6: Oh right, you'd say that is above average as well.
- C6: Yeah, I would.
- T6: Right, okay. What makes you - what makes you say well that ought to be above average, tell me.

The client is positioned as their own expert in what their own scores mean, enabling them to position their selves within their own measurements and providing opportunities to modify results. This in itself challenges the discourse of science by incorporating subjectivity. It also opens up the opportunity for the client to construct alcohol as personally problematic and to take up a position of associated agency and power in relation to it.

3.3.3 Summary

Therapists speaking in the position of or on behalf of clients are able to maintain consistency with clients' discursive constructions of alcohol as a destroyer, building the rationale for change and reducing the client's ability to resist agency. However, clients are also able to draw upon alternative uses of discourses and constructions of alcohol as facilitatory. This challenges the assumption of agency being located within them, and has the effect of constructing agency as conditional or manifested within others.

Therapists are able to assume positions of expertise while providing feedback due to the power associated with their role and drawing from discourses that assert fact and objectivity. However, therapists appear to 'share expertise' and power with clients, enabling them to construct an interpretation of the 'facts'. This enables them to construct alcohol as a destroyer or facilitator, and to take up or resist positions of agency for change.

4.0 Discussion and Concluding Remarks

The current study was the first applying a discursive psychological approach to understand the interactive processes operating within MI. The aim was to establish how practitioners and clients co-construct the process of change. This involved a choice of methodology that could enable an understanding of the forms, functions and effects of language use within MI in comparison to existing studies, which have predominantly reduced this to focusing upon assigning codes to 'types' of speech.

4.1 Main findings

The main findings from the current study suggest that practitioners and clients draw upon a number of discursive resources to co-construct the process of change.

Firstly, while therapists constructed alcohol only as a destroyer, clients drew upon discourses to construct alcohol as a destroyer and a facilitator. Within MET sessions, the opposing nature of these constructions was negotiated between clients and therapists. The findings from one quantitative study (Moyers, Martin, Houck, Christopher, & Tonigan, 2009) suggested a potential causal relationship between therapists questioning the negative aspects of the behaviour and client change talk. The findings from the current study go some way to providing an explanation for this. The discourses drawn upon to construct alcohol as a destroyer were powerful discourses, which were difficult to challenge given their objective, factual nature. This in turn limited the subject positions available to clients to be taken up against them, potentially opening more positions of agency for change and increasing the likelihood of acceptance of such a position by clients.

Secondly, the discursive analysis of an extract of client change talk revealed that change talk itself incorporates much diversity in its function. Change talk in the relatively short extract on pages 71-72

was used to propose action, to rationalise previous accounts, to challenge alternative perspectives, and to resist agency within this particular interaction, rather than its function being an expression of intent or commitment to change as has been previously suggested (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). Indeed, it is likely that analysis of additional extracts in future studies would reveal functions additional to those listed above. Additionally, it was clear that at points where therapists appeared to offer client choice in an MI consistent way (for example, asking permission to share information), the illocutionary act did not permit real choice on the behalf of the client. Research on the use of language within MI to date has thus far focussed upon assigning codes to 'kinds' of client and practitioner talk (Lane, 2012). However, this appears to be a measure of its semantic form, rather than its pragmatic function. The findings from the current study demonstrated that providing a behavioural label to client and practitioner talk does not adequately reflect what the speakers are trying to achieve from a particular linguistic act. Diversity in the function of client and practitioner talk could also account for the findings of another study that found MI inconsistent behaviours enhanced the degree of client involvement within a session (Moyers, Miller, & Hendrickson, 2005).

Thirdly, by speaking from the position of the client, therapists were able to maintain consistency with clients' discursive constructions of alcohol as a destroyer across the session, and subtly undermined constructions of alcohol as a facilitator, building the rationale for change and reducing the client's ability to resist agency. This is somewhat contrary to what is suggested regarding some uses of linguistic behaviours such as 'reflections', 'affirmations' and 'summaries', which are presented as expressions of 'empathy' with the client that demonstrate 'understanding the client's experience', but is commensurate with the principle of developing discrepancy between values and behaviour (Miller & Rollnick, 2002).

The findings from the current study suggest that in MI, using linguistic behaviours, where the therapist speaks from the position of the client, means that the therapist is able to reconstruct client experience. This is often achieved using the client's words in that process while creating a subtle difference in meaning, which limits the degree to which clients are able to resist the associated subject positions opened up by that process. This of course has implications for the degree of freedom the client has to dispute the positions opened. Several studies from social constructionist perspectives on therapy suggest that it is opening up possibilities for flexibility in linguistic repertoires and the deconstruction of the dominant discourse that result in successful clinical outcomes (Avdi, 2005; McNamee & Gergen, 1992; Sluzki, 1992). Contrary to this, it seems that in MI, it is the closing down of flexibility between discourses in the construction of alcohol that may be an important mechanism of change. This corresponds with other studies that have suggested that the closing down of client narratives may be beneficial when they are disorganised or confusing. Such narratives could potentially prevent co-construction of meaning due to lack of understanding between the parties in the interaction, and may also prevent moving forward (Avdi, 2005; Dimaggio & Semerari, 2001; Lysaker, Lancaster, & Lysaker, 2003; Stiles, 1999). This would make sense, given that in the current analysis, clients had conflicting constructions of alcohol, and therapists maintained consistency in accounts by acknowledging client constructions of alcohol as a facilitator, but then using linguistic resources to undermine this, constructing alcohol as a destroyer.

Fourthly, it should also be noted that in MI, it is considered to be the emphasis upon client autonomy and choice that decrease resistance or discord within the interaction, and as such, therapists are encouraged to support and encourage client autonomy (Miller & Rollnick, 2002). This is in line with the findings of the current study with regards to therapists opening up of positions of agency and expertise for clients within the interaction. Yet, within the current study, clients often appeared to resist positions of agency that were opened up, often drawing upon constructions of alcohol as a

facilitator with the effect of challenging the assumption of agency being located within them, and at times constructing agency for change as conditional or manifested within others. This seems counter-intuitive to theories such as reactance (Brehm, 1966) or self-perception (Bem, 1967) associated with an MI approach, while consistent with the transtheoretical model (Prochaska & DiClemente, 1986), and self-efficacy theory (Bandura, 1977). However, it should also be acknowledged that with a greater degree of agency comes increased perceived power, and 'with great power comes great responsibility' (Voltaire, Beuchot, & Miger, 1832). If clients take up positions of agency, this in turn means that they become responsible and accountable for their actions, which is on the one hand empowering of the client, but on the other hand, acceptance of responsibility could be experienced as disempowering by clients as it in itself violates autonomy through perceived obligation. It also places the responsibility for change within the individual, rather than within the social structures that surround them (Orford, 2008b).

Overall, the findings within the current study suggest that clients and therapists co-construct the process of change through constructions of alcohol as either a destroyer or facilitator, drawing upon discourses of differing degrees of power. This impacts the availability of subject positions of agency and expertise in relation to alcohol. The current study also highlighted a diversity of function within categories of client and practitioner speech that aim to achieve diverse ends within the interaction.

4.2 Study limitations and recommendations for future research

The findings of the current study have demonstrated that although client and practitioner speech have historically been coded into 'categories of talk' based on their structure, as has been measured by several validated coding instruments, this does not necessarily capture the interpersonal function of those utterances. Therefore, future research into language use within MI could benefit from a focus on explicating the different discursive functions of utterances within MI sessions. This could in

turn provide an opportunity for instruments coding the function of utterances to be developed for further quantitative analyses.

More generally, the richness of a qualitative approach to language analysis alongside quantitative analyses could further understanding of how client outcomes are facilitated via MI practice. It could also provide insight into what might constitute 'therapist effects' on an interpersonal level with regards to client outcomes.

Additionally, the current study has also highlighted a tension between the empowerment and disempowerment of clients, specifically in terms of being offered positions of agency, the closing down of inconsistencies in constructions of alcohol, and therapist reconstructions of client utterances (for example, through the use of 'reflections' in the dialogue). Future studies would benefit from critically appraising the effects and implications of these processes within MI contexts for clients and therapists alike, with due consideration given to the positive and negative ethical implications of an MI approach to facilitating change.

There are several limitations associated with the current study. Firstly, as this was the first study of its kind within the MI field, the decision was taken to conduct a broad analysis across 10 independent MI sessions. Additionally, this work was undertaken in order to fulfil part of an academic qualification, with associated time and word space restrictions. This directly impacted upon the degree of discursive analysis that could be undertaken as part of this project. Future studies would benefit from undertaking more detailed analysis of fewer numbers of transcripts, in order to gain a deeper understanding of the functions and effects of linguistic constructions, and to widen this to talk beyond change talk. Additionally, undertaking more in depth analysis upon smaller numbers of

sessions would enable investigations of the discursive agendas of practitioners and clients across entire sessions, to see how these may impact upon the session as a whole.

Secondly, the data sample was constructed from recordings made in a particular era, within a particular social group within society, within a specific research study providing treatment for alcohol use, potentially limiting the diversity within this study. Future studies of using this methodological approach may wish to consider different applications of MI, such as in healthcare or school settings.

As the current study consisted of a sample of just 10 sessions, generalisation from the findings is difficult. However, the findings presented may stimulate new ideas that could be tested by quantitative studies, or assist in the interpretation of quantitative findings.

Finally, the current study chose to focus on the construction of one specific verbal object (alcohol) in detail, rather than a range of different verbal objects that appeared within the data. While this had the advantage of looking at a verbal object that was central to all interactions within the sample, it means that other verbal objects that may be highly relevant to the relational process of change within some MI sessions (such as parenthood or selfhood for example) were not discussed. Therefore, their relationship to discourses, language use, subject positions, power and subjectivity were not explored. Future studies may benefit from explicating the kinds of verbal objects that are constructed within MI, to attempt to understand how these kinds of constructions in and of themselves may impact upon the discussions regarding change in MI contexts.

4.3 Reflexivity

Factors that may have biased the interpretations of the researcher include her position as a female in her mid 30s living in the UK. Her profession as psychologist with experience of working within

mental health and physical health settings would also subject her to the discourses associated with those settings. She has 11 years experience of working with MI in research, training and practice contexts, with MI informing much of her clinical work. She also has her own understanding and experiences of what alcohol is, and what makes using it 'problematic'.

4.4 Practice Implications

In recent times, there has been an increased emphasis on the strategic elicitation and reflection of client change talk through MI, bolstered by an increase in attempts to measure practitioner and client language and correlate this with outcomes. Although MI spirit continues to be stressed as essential to the MI process within the training and practice sectors, there has been less focus upon how this is actually enacted on the part of the practitioner within the research arena, with no such focus on how spirit itself is manifested within talk.

The current study has demonstrated that therapists' linguistic constructions can have a direct impact upon the kinds of subject positions available for clients to take up or resist within MI sessions, and that there are gains and losses for clients associated with this. Additionally, the findings of the discursive analysis suggest that if the spirit of MI is lacking within an interaction, utterances that could be coded as client 'change talk' may not be an expression of client desire, ability, reason, need or commitment to change. These findings therefore have implications for clinical practice, in terms of moving beyond the recognition of 'types of client talk' and responding with 'MI consistent' verbal behaviours. It is perhaps appropriate based on the findings of the current study to begin moving towards reinvigorating the spirit of MI in relation to clinical outcomes. The functions and effects of practitioner utterances should not be assumed to simply correspond with the categorical labels given to them (such as 'affirmation', 'reflection' or 'question').

Practitioners should also continually evaluate their own motives and aspirations for using particular utterances through the process of supervision, as a means to reflecting on the degree to which they are consistent with the spirit of MI. It is also important for them to think critically about the positive and negative ethical implications of the relative power they assume through the language they employ with clients, regardless of how MI consistent this is coded to be.

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Executive Summary:

A discourse analysis of client and practitioner talk during motivational interviewing sessions

A discourse analysis of client and practitioner talk during motivational interviewing sessions:

A Research Study Conducted in Partial Fulfilment of the Requirements of the

Doctorate in Clinical Psychology at the University of Birmingham

Executive Summary

Background

Within the UK and around the world, drug and alcohol misuse continues to be a highly debated topic, with social, health and political implications. There are a number of physical and talking therapies available which aim to help individuals make changes to their alcohol and drug use.

One of the evidence based talking therapies available is Motivational Interviewing (MI), which aims to assist individuals to make changes to their drug or alcohol use by exploring and resolving their uncertainty about making those changes. MI has been most recently defined as ‘a collaborative, person-centred form of guiding to elicit and strengthen motivation for change’ (Miller & Rollnick, 2009: 137). A great degree of emphasis is placed on working collaboratively and non-judgementally with a client during therapy, and eliciting ‘change talk’ from the client. Change talk refers to the expressed desires, abilities, reasons and needs to make changes. It is hypothesised that the focus on change talk is what makes MI effective.

Most of the studies looking at language thus far have studied language by creating categories of language that could be quantified and statistically tested. These were influenced by existing assumptions about how MI works (Miller & Rollnick, 2002). There is currently little qualitative research investigating how language is used within MI sessions outside of these existing hypotheses. To that end, it is possible that there are patterns of language occurring within MI that we are not

aware of, which may also impact on client outcomes. This in effect can impact on how MI is practiced and how it is taught to practitioners.

Literature Review

Thirty existing articles about language use in MI were identified from a literature search. The findings in these articles were appraised to establish how much it contributes to our understanding of how MI helps clients to make changes. The results from these studies suggest that how language is used may directly impact upon whether or not clients make changes following MI, we cannot be entirely certain of this. There are not many studies of language use in MI, and ways that many of the studies were conducted may have biased their results. Future research in this area would benefit from more rigorous study design, and more qualitative approaches to research to better understand these relationships.

Research Study

As the literature review highlighted the need for more qualitative studies of language use in MI, a research study was conducted using discourse analysis. The current study used a method called 'discourse analysis' to look in detail at how clients and therapists used language within MI and what they achieved from using language in that way.

The findings suggest that both clients talked about alcohol as being destructive and facilitative, whereas therapists only spoke about alcohol as being destructive and discretely challenged the facilitative role of alcohol. This makes it more difficult for clients to continue to talk about alcohol as facilitative and leads them towards talking about it as destructive, which places the therapist in a powerful position. Therapists also used their language to encourage clients to take an active role in

changing their drinking, though some clients found ways to resist this through their use of language. It was also found that within the 'change talk' category used in previous studies, the language within this category was used to achieve many different social actions, which raises questions as to whether the previous codes used in quantitative studies may be too simplistic.

The findings of the current study provide an opportunity for practitioners to think more deeply about the effect of their language when conducting MI, and upon the relative power that they have in their role as therapist to shape client language in this way. It also adds to the existing literature on language use in MI by adding some detail of how language was used, rather than what language was used.

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Appendix 1: Literature Review

**Appendix 1A: Journal formatting requirements:
Clinical Psychology Review**

(Pages removed due to copyright requirements)

Appendix 2: Empirical Paper

**Appendix 2A: Journal Formatting Requirements:
Addiction Research and Theory**

(Pages removed due to copyright requirements)

Appendix 2B: UKATT Process Rating Scale

TALLY SHEET

1) Others present in the session:

Were there any other people present in this session?

0 = No

1 = Yes

7 = Don' t know

Was more than one other person present?

0 = No

1 = Yes

7 = Don' t know

If so, did this person or these people take an active part in what was going on?

0 = No

1 = Yes

8 = Not applicable

Site Id:

Location Id:

Therapist Id:

Client Id:

Date:

Session Length:

Session ID:

SESSION MANAGEMENT

2) Maintaining Structure:

Frequency:

Quality:

3) Agenda Setting:

Frequency:

Quality:

4) Explanation of Philosophy of Treatment or Treatment Session:

Frequency:

Quality:

5) Reviewing Inter - Session Change:

Frequency:

Quality:

6) Consistency of Problem Focus:

Frequency:

Quality:

7) End of Session Summary:

Frequency:

Quality:

SPECIFIC TASKS

8) Homework:

Frequency:

Quality:

9) Drinking - Feedback/Negative Consequences:

Frequency:

Quality:

10) Alternative Activities to Drinking:

Frequency:

Quality:

11) Eliciting Client Concerns about Drinking:

Frequency:

Quality:

12) Social Support for Change - General:

Frequency:

Quality:

13) Eliciting Self-efficacy for Change:

Frequency:

Quality:

14) Involvement of Others in Behaviour Change:

Frequency:

Quality:

15) Commitment to Drinking Goal:

Frequency:

Quality:

16) Identify Sources of Support for Change:

Frequency:

Quality:

17) Ambivalence:

Frequency:

Quality:

18) Creating Conflict:

Frequency:

Quality:

19) Eliciting Commitment to Change Drinking:

Frequency:

Quality:

20) Eliciting Optimism for Change:

Frequency:

Quality:

THERAPIST STYLE

21) Therapist as Task Oriented:

Frequency:

Quality:

22) Therapist as Active Agent for Change:

Frequency:

Quality:

23) Reflective Listening:

Frequency:

Quality:

24) Collaboration:

Frequency:

Quality:

25) Interpersonal Focus:

Frequency:

Quality:

26) Exploration of Feelings:

Frequency:

Quality:

27) Empathy:

Frequency:

Quality:

28) Session Content:

Please tick appropriate box for the following:

Content/Activity	Yes	No
Feedback of test results		
Change plan worksheet		
Action plan		
Communication skills		
Coping skills		
Social support		
Relapse prevention plan		
Alcohol Education		
Increasing Pleasurable Activities		
Employment		
Giving Advice		

Additional Comments: Please tick appropriate box for the following:

<u>Tape quality:</u>	Sound	Picture
Very poor
Poor
Good
Very good

Please answer yes or no to the following questions, unless other notes are needed:

Client:

Did the client leave the treatment session temporarily?

Did the client leave the treatment session prematurely?

Did the client have any children with them that caused any problems within the session?

Did the client have any family crisis that they mentioned?

Was the client distressed/crying/upset at any stage of the treatment session?

Was there a clear beginning to the session?

Was there a clear end to the session?

Other Information:

Were there other disturbances?

If so were they:

Phone ringing
Fire alarm
Someone entering the room
Someone leaving the room
Background / Outside noise
Other (please specify)

Appendix 2C: Sampling Pool

ID	Sex	Condition	METQ	METF	Length	Session no.	Sampled
01-0838-1619	Male	MET	3.83	1.91	60	1	Bad Audio
08-0623-1564	Male	MET	3.57	1.91	57	1	
08-0649-1589	Male*	MET	3.5	1.91	60	2	Yes
08-0404-1338	Female	MET	3.44	1.91	36	3	Yes
08-0530-1471	Male	MET	3.38	2.18	51	1	Yes
04-0116-1726	Male	MET	3.38	1.82	59	2	Faulty
08-0733-1693	Male	MET	3.33	1.82	49	1	
08-0805-1770	Female	MET	3.29	2	70	1	Missing
04-0113-1707	Male	MET	3.2	2.09	44	1	
08-0406-1328	Male	MET	3.13	1.82	30	1	
08-0254-1181	Male	MET	3	2	48	1	Yes
08-0777-1739	Female	MET	3	2	60	1	
08-0256-1183	Male	MET	3	1.82	50	1	
08-0638-1580	Male	MET	3	1.82	50	1	Yes
04-PS	Male*	MET	3	1.8	49	2	
08-0381-1308	Male	MET	2.89	2.18	52	1	
04-0054-1344	Male	MET	2.89	2.09	44	2	Yes
04-0045-1295	Male	MET	2.89	2	47	1	Yes
08-0029-1035	Male	MET	2.89	1.91	70	1	
01-0888-1663	Female	MET	2.86	1.91	62	1	
09-0048-1327	Male	MET	2.75	1.91	45	3	Yes
08-0543-1494	Male	MET	2.75	1.82	45	1	
08-0297-1227	Female	MET	2.71	1.91	48	1	
08-0603-1549	Male	MET	2.71	1.91	34	3	Yes
08-0257-1188	Male	MET	2.71	1.82	50	1	
08-0566-1520	Male	MET	2.67	1.82	41	1	
02-0124-1490	Male	MET	2.63	1.91	65	1	Missing
08-0511-1437	Male	MET	2.63	1.91	52	1	
08-0170-1139	Male	MET	2.56	1.91	33	3	
08-0305-1218	Female	MET	2.5	2	50	1	Missing
08-0018-1016	Male	MET	2.44	2.18	55	1	
02-0295-1508	Male	MET	2.22	2.09	43	1	
05-0017-1001	Male	MET	2.22	1.91	52	1	Yes
03-0017-1085	Male	MET	2.2	1.82	59	2	
08-0635-1575	Male	MET	2.13	1.91	55		Faulty
02-0192-1281	Male	MET	2.11	2	64	1	Missing
04-0094-1573	Female	MET	2.11	1.82	51	1	
02-0087-1210	Male	MET	1.44	2.09	88	1	

Appendix 2D: Transcription Conventions

The Jefferson Transcription System

The transcription system uses standard punctuation marks (comma, stop, question mark); however, in the system they mark intonation rather than syntax. Arrows are used for more extreme intonational contours and should be used sparingly. The system marks noticeable emphasis, volume shifts, and so on. A generally loud speaker should not be rendered in capitals throughout.

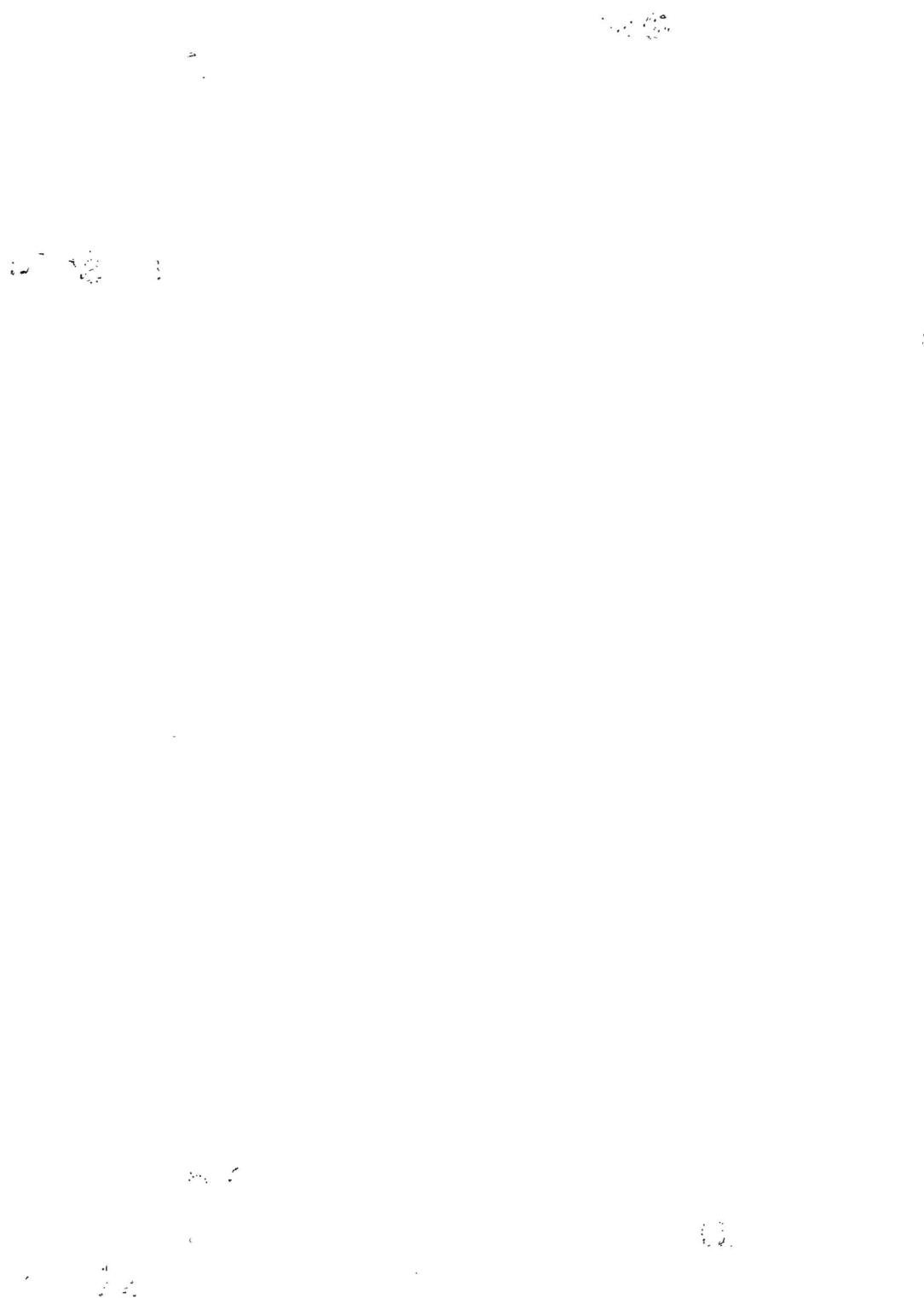
[] Square brackets mark the start and end of overlapping speech. They are aligned to mark the precise position of overlap as in the example below.

↑ ↓	Vertical arrows precede marked pitch movement, over and above normal rhythms of speech. They are used for notable changes in pitch beyond those represented by stops, commas and question marks.
→	Side arrows are used to draw attention to features of talk that are relevant to the current analysis.
Under <u>l</u> ining	indicates emphasis; the extent of underlining within individual words locates emphasis and also indicates how heavy it is.
CAPITALS	mark speech that is hearably louder than surrounding speech. This is beyond the increase in volume that comes as a by product of emphasis.
°↑ I know it, °	‘degree’ signs enclose hearably quieter speech.
that’s r*ight.	Asterisks precede a ‘squeaky’ vocal delivery.
(0.4)	Numbers in round brackets measure pauses in seconds (in this case, 4 tenths of a second). If they are not part of a particular speaker’s talk they should be on a new line. If in doubt use a new line.
(.)	A micropause, hearable but too short to measure.
((stoccato))	Additional comments from the transcriber, e.g. about features of context or delivery.
she wa::nted	Colons show degrees of elongation of the prior sound; the more colons, the more elongation.
hhh	Aspiration (out-breaths); proportionally as for colons.
.hhh	Inspiration (in-breaths); proportionally as for colons.
Yeh,	‘Continuation’ marker, speaker has not finished; marked by fall-rise or weak rising intonation, as when delivering a list.

y'know?	Question marks signal stronger, 'questioning' intonation, irrespective of grammar.
Yeh.	Full stops mark falling, stopping intonation ('final contour'), irrespective of grammar, and not necessarily followed by a pause.
bu-u-	hyphens mark a cut-off of the preceding sound.
>he said<	'greater than' and 'lesser than' signs enclose speeded-up talk. Occasionally they are used the other way round for slower talk.
solid.= =We had	'Equals' signs mark the immediate 'latching' of successive talk, whether of one or more speakers, with no interval.
heh heh	Voiced laughter. Can have other symbols added, such as underlinings, pitch movement, extra aspiration, etc.
sto(h)p i(h)t	Laughter within speech is signalled by h's in round brackets.

For more detail on this scheme see Jefferson (2004).

Appendix 2E: Examples of the data analysis process



Example of initial reading and coding of transcripts

Page 23 of 36

Client justification - why he must be given meds

Therapist: Agency to change also meds.

828 T: Okay I, I wonder how you could, could, could get around that. What do you think?

829 C: So, well I have tried everything, you know, I've tried--

830 T: Tell me some of the things you've tried.

831 C: Eh I've told them to 'Oscar'...

832 T: Right.

833 C: ...eh the hard words like...

834 T: Yeah.

835 C: ...you know. "I ain't going out"...

836 T: And, and, and...

837 C: ..."I'm staying in tonight".

838 T: ...what happens when, when you said that to them?

839 C: Well they just looked at us and said, "Don't be silly, come on, let's go", you know.

840 T: Okay and what, and then what happened?

841 C: Well we just go for a pint then...

842 T: Right.

843 C: ...and that's it.

844 T: Okay, well what else have you tried?

845 C: Eh I've tried, you know, dodging them if I can. If I see them in ((shop name)) I've tried to go in the opposite way...

846 T: Right.

847 C: ...but I always seem to bump into them, at one end, you know.

848 T: Right.

849 C: So, I've tried everything like that.

850 T: Okay.

851 C: So that's it.

852 T: Right.

853 C: But eh I'd just like to turn round and say, "Look, I'm on medication mate, I can't drink and that's it".

854 T: Right so if, when you were on the medication is that what you used to say to them?

855 C: Yeah.

856 T: Right and, and then what happened.

857 C: I just walked away then.

858 T: Right.

859 C: You know.

860 T: So--

861 C: I was in the pub on Wednesday, right, I go to the over 60s...

Impact of social acceptance of client upon agency in drinking alcohol

Construct self as helpers Not as helpers Function: Enhance agency.

Challenges: Therapists' construction

If he doesn't go with them he'll be seen as silly.

Social acceptance of friends

Part of normal daily life

alcohol - central part of friendship activities

Powerless in social group to resist alcohol

Justifying: Why he should be given antabuse

this is acceptable power of being told by someone in authority 'you will die' or 'you can't drink'

building argument for meds

Relative power of medical vs. social discourse.

Challenging

Links with medical discourse

Example of extracting data into theme tables to explore how alcohol was constructed

Alcohol				
<i>"Alcohol as a problem soother"</i>				
ID	Session	Sex	Client	Therapist
08-0530-1471	1	Male Client Female Therapist	<ul style="list-style-type: none"> Lines 38 and 54: Not eating makes him unwell, not drinking Lines 95-139: Problems with partner responsible for drinking, and memories of these problems responsible for drinking Line 208-213: Doesn't drink when away on holiday as no problems Line 230-265: Getting away from daily life on holiday— don't need to drink then Lines 307-312: 'It just takes everything away' 	<ul style="list-style-type: none"> Lines 140-150: Difficult times lead to client drinking at higher levels Lines 307-312: 'Any benefits to drinking?' 'It blocks them out'
08-0831-1308	1	Male Client Male Therapist	<ul style="list-style-type: none"> Lines 50-53: Drinking helps client 'forget bad memories' and 'troubles' and 'everything' 'that I find hard to cope with' Line 62-63: Drinking helps client to 'relax' Lines 64-66: Drinking helps client to 'sleep better' 	<ul style="list-style-type: none"> Lines 48-49: Can you tell me some of the things you like about drinking? Lines 52 & 59: So drinking helps you to forget. Line 61-65: What else do you like about it. Sleep better. What else? Line 67-68: Drinking helps to forget problems, relax and sleep better. Line 106-107: 'The things you like about drinking is it helps you to forget your problems helps you to relax and you feel it helps you sleep better.'
04-0054-1344	2	Male Client Female Therapist	<ul style="list-style-type: none"> Lines 37-40: Drinking helps him to sleep, he has trouble sleeping now he is abstaining from it Lines 165-167: Drinking is a 'safety net' for when his mood goes down Lines 170-173: Not drinking prevents him from 	<ul style="list-style-type: none"> Line 180-181: The client will miss this initial feeling of wellbeing Line 201-207: Client seems to have a greater understanding of his drinking – that it alters the client's consciousness when he feels the need to

			<p>'escaping' [problems? worries?]</p> <ul style="list-style-type: none"> • Lines 175-179: Drinking gives an initial feeling of wellbeing • Line 211: Hopefully won't need to escape now he's seeing a counsellor • Lines 218-228: Drinking helps him mask his concerns which are about 'big things' that cannot be resolved, rather than 'little things' that can be resolved • Line 232: Drinking is probably one of the 'big things' 	<p>escape</p> <ul style="list-style-type: none"> • Lines 207-210: Will the client still need to escape now he's seeing a counsellor? • Line 229-231: Is drinking a big thing or a little thing?
08-0404-1338	3	<p>Female Client</p> <p>Female Therapist</p>	<ul style="list-style-type: none"> • Line 635-642: uh wh . to be honest if the only thing tha that I know . I could find with doing what I've done . in a way . but there's always gonna be that . that I know I could but only if anything really really bad happened , but I know that that I could . that's only tha . that. it's always at the back of my mind but I know that I really really won't heh heh, but there's always . it's there ain't it • Line 644: but I wouldn't cos I'd think no: I wouldn't want to do it wouldn't • Line 648: I know would nn . nn. it was always • Line 650: yeah . yeah . yeah . definitely • 	<ul style="list-style-type: none"> • Line 633-634: is there anything in the future you can envisage making life difficult or making it . about . about alcohol • Line 643: okay . so . I guess you're thinking that if something really awful happened • Line 645 - 647: you wouldn't want to tempt fate by being over confident like you said but at the same time • Line 649: you feel very afraid that you're going to
08-0603-1549	3	<p>Male Client</p> <p>Male Therapist</p>	<ul style="list-style-type: none"> • Lines 102-107: Err...well, someone tried to break into me flat a few week ago and I just went back on the drink. I were doing well. I got it down to four or five pints a day and...and it just started again. I got depressed and...err...when someone tried to break into me flat it just sent me down. • Line 153: It helps me to forget 	<ul style="list-style-type: none"> • Line 108: Right, so there've been some difficulties • Line 154: so drinking again's helped you to forget • Line 645-648: If you're not worrying about things you're not needing to blank things out with alcohol as you mentioned earlier

"Alcohol as a physical toxin"				
ID	Session	Sex	Client	Therapist
08-0530-1471	1	Male Client Female Therapist	<p>Initially indirectly, becomes more direct as interaction progresses</p> <ul style="list-style-type: none"> Line 36-80: It leads to you not eating, which is what makes you feel ill, tired and unmotivated, but you can maintain good health even if you aren't eating Line 97: Liver began to show damage due to drinking use Lines 122-130: He can still function next day after drinking, and hangovers are not so bad as they do not give him headaches but he is tired. Lines 157-167: Predicts death by the age of 50 if he does not stop drinking Lines 187-203: Health will deteriorate if drinking continues. Evidence of this through recent hospitalisation for pneumonia, would be dependent on family for care Lines 422-424: Over consumption of alcohol responsible for weight gain Lines 434-464: Makes him feel sick, but something he does when he starts to feel better Lines 468-468: Others would think he was unwell if he <i>didn't</i> drink Lines 471-478: Told wife he stopped drinking as doctor told him there were problems with his liver Lines 501-588: The client has done damage to his body by drinking, it 'just hit him' and resulted in him getting pneumonia. Lines 814-858: Drinking will lead to poor health 	<p>Tries directly initially, has to backtrack, then able to directly attribute</p> <ul style="list-style-type: none"> Line 39-42: Drinking leads to you neglecting yourself Line 70-76: Drinking makes you tired Line 148-50: Drinking makes you tired, groggy and not eating Lines 157-167: Client believes drinking will lead to death directly as a result of alcohol Lines 195-203: Future drinking would be attributed to illness, and this illness would cause strain at home Lines 422-424: Over consumption of alcohol responsible for inactivity, which may be responsible for weight gain Lines 501-588: Having increased tolerance to alcohol means that alcohol can do more physical damage to the body without the client feeling the effects, and the client's risk of damage is high due to having high tolerance. May be indirectly responsible for pneumonia. Stopping drinking will reduce tolerance and will improve health to that end. Lines 603-611: Client is above average in terms of health problems experienced in comparison to others with drinking problems. Lines 859-930: Damage to the liver – alcohol is impure and the liver has to filter this out. Tests show that damage is occurring to his liver as his test show he is out of the 'normal range' for damage to the liver. If he continues the damage will get worse.

			<p>and will lead him to be a dependent person, unable to provide for his family</p> <ul style="list-style-type: none"> Lines 859-930: Continuing drinking will result in further damage to his liver 	
08-0831-1308	1	<p>Male Client</p> <p>Male Therapist</p>	<ul style="list-style-type: none"> Line 232-234: BAC is 'just numbers' 'as far as I can gather right now, it's not doing me any harm' Line 250: It can give you epileptic fits Line 448-450: Client not surprised liver function tests are normal as he feels well Line 473: If client continues to drink in the same way the test results will probably 'go through the roof' 	<ul style="list-style-type: none"> Line 203-227: Client's blood alcohol concentration would be enough to kill some people Line 235-241: 'It's not doing you any harm' asks permission to explain why it may be harmful Line 249-352: 'You know alcohol can cause you harm'. People can have fits when withdrawing. Higher BAC = higher tolerance = alcohol more able to do more physical damage to the body Line 369: In terms of physical problems, this client has scored below average Line 439-444: Liver function tests are in the normal range. Line 451-474: Doesn't mean no damage has been caused, and damage will be probably caused if he continues to drink in the same way.
04-0054-1344	2	<p>Male Client</p> <p>Female Therapist</p>	<ul style="list-style-type: none"> Lines 37-55: Still waking up feeling groggy. Not enough sleep since abstaining – alcohol helps him to sleep – perhaps alcohol is not responsible for him feeling groggy in the mornings. Lines 119-127: Noticed how bad he felt in the morning following drinking the night before, following a short period of abstinence on a previous occasion Line 243-246: Feeling better from not drinking is not just for the next few weeks but for as long as he doesn't have a drink, and he does not want to start drinking again 	<ul style="list-style-type: none"> Line 9: Last session blood tests were in a normal remit – client relieved about that Lines 41-43: This is normal for people who are giving up alcohol. Sleep will increase if abstinence continues Lines 247-260: How would your health be if you continued to drink? You might be in increasing pain and turn yellow but that's a long way down the line though these things have a habit of catching up with you

			<ul style="list-style-type: none"> Lines 247-260: Don't know specific nature of the damage but he could become seriously ill if he continues to drink 	
04-PS	2	Male Client Female Therapist	<ul style="list-style-type: none"> Line 152: Haven't woken up feeling quite so rough Line 157-158: First days are horrible I suppose withdrawing, and even after that, you do notice the physical benefits straightaway Line 337-338: If I don't go into work with a headache or feeling rough then the day will start better and you know, I won't spend the first two hours in the morning... Line 415-420: If I'm healthy I'll be more enthusiastic about work... [feeling ill] pulls you down a couple of notches, well this pulls me down a couple of notches most days. Line 815-817: There are no other issues really. My health is important, my health affects my work, and working is important as well. Line 727-737: Oh gosh, first time I came into this building I'd been sick in the park on the way here. I suppose I don't feel that (unwell) right now (it's nice sitting in the park this morning) 	<ul style="list-style-type: none"> Line 13-14: You were also telling me you had concerns about your health line 153-156: So you're waking up in the morning feeling better in yourself Line 339-340: So it sounds as if you're going more energetic and more focussed
08-0404-1338	3	Female Client Female Therapist	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> Line 47-52: I think the other thing that was quite a shock to you was that the hospital had told you that if you carried on drinking you'd have two years to live, and that was a huge shock to you. Line 114-117: You wanted...to get your health back
08-0404-1338	3	Female Client Female	<ul style="list-style-type: none"> Line 325-331: well I don't think I'd be long to go to be honest I really don't . well it were obvious . it's just I I know I was ill . I knew I was ill but thinking back I never knew owt . in fact looking back I 	<ul style="list-style-type: none"> Line 324: Can you imagine how things would have been if you'd have not stopped drinking? Line 740-741: the last test that we had was the

		Therapist	<p>don't know how I did some of the things that I did . I real I really pushed myself . don't know how I did the things that I did sometimes even though with dah. ee. I . you'd go to work and I'd be uh being really really physically . uh poorly and I'd think I'll be alright I'll be alright soon I've had to walk to work to get me . to it'll be alright you've gotta do it you've gotta do it . but sometimes I don't know how I did it . I really don't . but it's alright now . heh heh heh</p> <ul style="list-style-type: none"> • Line 759: is it? • Line 763: you know I can't believe it • Line 766: fantastic yeah • Line 770: I can't believe it's done it that fast though • Line 	<p>second of june . a:nd . you:r . ((rustles papers)) have you had your results from the second of june</p> <ul style="list-style-type: none"> • Line 743: well do you want me to give them to you • Line 745: your gamma gt on the seventh of April which is the warning one u:m . which does fluctuate quite a lot . normal range is between seven and thirty two yours wa:s two thousand six hundred and twelve . on the second of June a hundred and eighty four . mmmm got a way to go but your ALT which is sort of long term sort of any issues. lang term yeah damage there is . it was . well the normal range is between five and thirty five it was eighty one . and it is now . thirty seven • Line 760: aha . you're delighted • Line 764: so that's fantastic • Line 767: isn't it just . it's it's. I guess it's just good to see • Line 771-773: I mean that's. two thousand six hundred and twelve down to a hundred and eighty four . ((rustles paper)) a:nd . eighty one. down to thirty seven • Line 779-785: ok . so . your . health has objectively improved dramatically, and subjectively you're feeling an awful lot better, you're feeling energetic, you're feeling , ok
08-0603-1549	3	Male Client Male Therapist	<ul style="list-style-type: none"> • Line 161-166: I'm ((losing?)) me sleep again and me appetite's gone back down. • Line 200-201: Erm...well, going back the way I were before and me nerve--, me...me health getting worse – worse than I were – and I don't want that. • Line 286-287: When I was...when I cut down the last...just before Christmas I felt a lot better, a lot healthier, more fitter and I started cleaning me flat 	<ul style="list-style-type: none"> • Line 161-166: So your appetites got worse again. That was one of your big concerns. • Line 181-184: You made some very good points that even though you've not been drinking for a long time, already your diet's suffered... and your sleep's suffered...erm... Tell me about your diet? • Line 202: So your health overall • Line 306-325: And you described before about not

			<p>more.</p> <ul style="list-style-type: none"> Line 311-325: Yeah, that's been happening quite a lot... Really bad... Yeah. I'm getting stomach cramp again. It was a lot easier...erm... I weren't getting...I weren't getting...err...pains as much as I were...as I am now and I weren't as sick as I...as I am... Yeah, a lot better. 	<p>only not eating but feeling sick and trying to be sick but there was nothing there. But has that been happening?... Right, and what does that feel like?... Really bad?... So...so you're retching and straining?... Right. What was it like when you'd cut down on your drinking and you were eating better? Okay. So things are clearly much...erm...much <u>better</u> when you'd cut down?</p> <ul style="list-style-type: none">
08-0649-0589	2	<p>Male Therapist</p> <p>Male Client</p>	<ul style="list-style-type: none"> Line 364-369: I'm on my heart medication and things like that... you know because I had two massive heart attacks. So. And that's another thing it's given us. Line 590-: Yeah well she'd, the nurse told us that I'd eh, what you call it? I've done something to my, my kidneys and my liver or whatever... 	<ul style="list-style-type: none"> Line 584-: Right. I mean I think from what you were, you know, from what we were talking about last time we met and looking at some of the results that we got, I think that even without medication if you go back to drinking again then I'm absolutely certain that that will shorten your life. .. Even without medication... I think your liver has been badly damaged by your drinking... and you've also, on top of that, you've got heart problems... and drinking is likely to make those much worse... It's likely to have- -... Line 1126-1127: But if you drink, whether or not you're on Antabuse, with the state of your health as it is, it could kill you anyway.

Example of developing overarching themes in the construction of alcohol

Memo – verbal constructions of alcohol

5th April 2012

Theme consolidation:

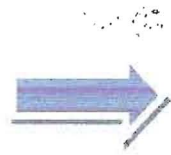
Alcohol as a problem soother

Alcohol as a fosterer of relationships

Alcohol as a normal part of social life/occasions

Alcohol as a mood modifier

Alcohol as personal control



Alcohol as 'facilitator'

Alcohol as a physical toxin

Alcohol as a destroyer of relationships

Alcohol as the antithesis of agency

Alcohol as a destroyer of living life



Alcohol as 'destroyer'

Example of developing overarching themes for construction of alcohol

Example of data analysis memo

Memo: 6th April 2012 10:30am

Transcript number: 08-0649-1589

- Discursive Agenda of Client: To obtain Antabuse?
 - *Begins by constructing alcohol as a destroyer:* Emotional impact, low self worth, impact on wife [Justifies why he wants to stop drinking]
 - Constructs self as lacking agency in being able to stop drinking: May as well be dead, he is unable to control himself around alcohol, unable to assert agency when within the structure of his friendship groups, has to drink with friends UNLESS there is a good reason (medical structure higher power than friendship group structure) – *alcohol as facilitatory to maintaining those relationships unless a more powerful discourse prevents this.* Cannot stop drinking by himself, needs some help with it.
 - Constructs past changes as attributable to Antabuse rather than his own agency. Constructs success of future change upon whether or not he can justify to his friends reasons for not drinking. Antabuse would do this, general bad health would not (masculinity – drinking is about being a man, showing strength, there would have to be a dire consequence to make not agreeing to drink with friends justifiable, as this is a 'normal' thing to do – risks being stripped of masculinity and seen as not normal). Alcohol as a facilitator of social friendships, alcohol as a destroyer of
 - Challenges medical rationale for not prescribing Antabuse. Tries to obtain a compromise of making it look as if he's been prescribed antabuse when he hasn't.
 - Discusses several different changes, but effectiveness of these are dependent on being able to prove to his friends that he will die if he has one drink, returning to the subject of Antabuse when the opportunity arises within the dialogue.
- Positioning by client
 - Positions friends as accountable for his drinking the day before following a period of abstinence. Positions friends as superior.
 - Positions therapist as the 'gatekeeper' of the Antabuse, and as the 'helper' and the 'expert'
 - Positions self as having some agency in making changes: Can do so, but is influenced by the dominance of medical and friendship discourses.
 - Takes up position as a person who does not want to drink, but has little agency under most conditions to choose not to.
- Discursive Agenda of the Therapist: Challenge the perceived lack of agency to change, to encourage the client to make changes and to come up with a 'plan' to that effect.
 - Emphasises past successes as evidence of agency
 - Asks about alternative ideas and thoughts the client has – 'what could you do?' 'What might be a way around that?'
 - Notes how difficulties have been overcome – how successes have occurred despite failures
- Positioning by therapist

- Positions self as 'not the decision maker', and the client as the expert and decision maker
- Positions client as agent of change
- Takes up the position of expert at points
- Speaks often from the position of the client

Appendix 2F: Occurrences of alcohol constructions and subject positions

Table A1: Occurrences of alcohol constructions within the data

Transcript number	MET Session	Alcohol construction	Location within transcript (line numbers)
08-0530-1471	1	Destroyer	36-97, 148-167, 187-203, 275-277, 318-341, 422-424, 462-478, 501-588, 603-620, 859-930
		Facilitator	22-31, 38-54, 82-177, 208-229, 307-312, 409-468, 501, 763-785, 859-130
08-0831-1308	1	Destroyer	72-81, 107-111, 203-352, 385-387, 439-474, 511-622, 727-776
		Facilitator	50-70, 106-107, 620-680, 710-720
04-0054-1344	2	Destroyer	9, 37-55, 119-127, 243-260
		Facilitator	35-40, 130-180, 210-235, 285-300, 540-600
04-0122-1759	2	Destroyer	13-18, 153-158, 337-340, 415-420, 727-737, 815-817
		Facilitator	166-177, 211-227, 469-519
08-0404-1338	3	Destroyer	47-52, 114-117, 325-331, 319-451, 740-785
		Facilitator	510-550, 630-650
08-0603-1549	3	Destroyer	82-87, 161-202, 250-274, 286-287, 306-373, 423-430, 466-474
		Facilitator	75-76, 124-132, 148-158, 232-242, 450-460, 500-505, 598-610, 755-761
08-0649-0589	2	Destroyer	53-57, 71-119, 122-159, 222-306, 318-336, 415-419, 584-630, 1063-1077, 1126-1127
		Facilitator	11-42, 161-173, 806-979, 1000-1114
08-0777-1739	1	Destroyer	105-335, 380-687, 734-787, 805-851, 895-933, 958-969
		Facilitator	60-100, 855-865, 980-1001
01-0888-1663	1	Destroyer	30-50, 71-79, 167-223, 245-267, 282-289, 324-329, 371-379, 447-455, 467-472, 521-547, 563-602, 608-676, 693-783
		Facilitator	60-111, 141-148, 159-166, 295-303, 314-323, 534-542, 664-671, 799-802
03-0017-1085	2	Destroyer	19-33, 129-170, 239-241, 275-336, 356-408, 512-568
		Facilitator	1-18, 45-47, 79-84, 480-511

Table A2: Occurrences of subject positions within the data

Transcript number	MET Session	Subject Position	Location within transcript (line numbers)
08-0530-1471	1	Agency	6-19, 169-185, 385-392, 433-464, 574-592, 750-763
		Expertise	157-167, 183-203, 393-977
08-0831-1308	1	Agency	23-35, 494-521, 555-607, 623-631, 663-680, 793-807
		Expertise	117-494, 645-660, 665-680
04-0054-1344	2	Agency	3-40, 72-75, 85-102, 111-181, 229-246, 247-262, 315-334, 359-372, 387-406, 415-587, 595-613, 614-638
		Expertise	41-70, 103-110, 182-211, 259-287, 315-358, 373-599
04-0122-1759	2	Agency	2-83, 101-120, 175-203, 237-291, 359-365, 469-535, 550-567, 607-635, 777-910
		Expertise	86-96, 107-148, 165-178, 287-358, 411-417, 648-671, 700-716, 738-776
08-0404-1338	3	Agency	27-218, 238-253, 284-338, 347-354, 376-381, 407-461, 506-558, 601-611, 626-650, 656-731, 856-878, 887-890
		Expertise	740-778
08-0603-1549	3	Agency	5-26, 40-145, 409-700,
		Expertise	326-436, 701-733
08-0649-1589	2	Agency	7-65, 81-106, 145-197, 317-454, 512-519, 550-583, 664-763, 795-1298
		Expertise	230-316, 441-600, 764-806, 881-897, 908-914, 922-941, 991-1018, 1034-1047, 1126-1143
08-0777-1739	1	Agency	27-37, 248-259, 971-1021
		Expertise	15-38, 351-970
01-0888-1663	1	Agency	17-26, 30-330, 751-880
		Expertise	331-750, 855-858
03-0017-1085	2	Agency	33-128, 180-225, 460-533, 572-573, 599-613, 617-652
		Expertise	226-241, 272-454, 460-571, 574-600, 609-613

Appendix 2G: Extract from the MET manual: Session structure

The Structure of MET Sessions

The preceding sections outline the basic flow of MET from Phase 1 through Phase 3. This section addresses issues involved in planning and conducting the four specific sessions.

The Initial Session

Preparation for the First Session

Before treatment begins, clients are given an extensive battery of assessment instruments; the results are used as the basis for personal feedback in the first session. Appendix A discusses the instruments used in Project MATCH and various alternatives.

When you contact clients to make your first appointment, stress the importance of bringing along to this session their spouse or, if unmarried, someone else to whom they are close and who could be supportive. Typically, this would be a family member or a close friend. The critical criteria are that the SO is considered to be an "important person" to the client and that the SO ordinarily spends a significant amount of time with the client. Those designated as significant others are asked to participate in assessment and also to attend two (and only two) treatment sessions. If no such person is initially identified, explore further during the first session whether an SO can be designated. The intended support person is contacted either by the client or by the therapist (whichever is desired by the client) and invited to participate in the client's treatment. Again, the initial invitation should be for one visit only, to allow flexibility regarding a second session.

Also explain that the client must come to this session sober, that a breath test will be administered, and that any significant alcohol in the breath will require rescheduling. All MET sessions are preceded by a breath alcohol test to ensure sobriety. The client's blood alcohol concentration must be no higher than .05 (50 mg%) in order to proceed. Otherwise, the session must be rescheduled.

Presenting the Rationale and Limits of Treatment

The MET approach may be surprising for some clients, who come with an expectation of being led step by step through an intensive process of therapist-directed change (Edwards and Orford 1977). For this reason, you must be prepared to give a clear and persuasive explanation of the rationale for this approach. The timing of this rationale is a matter for your own judgment. It may not be necessary at the outset of MET. At least *some* structuring of what to expect, however, should be given to the client at the beginning of the first session. Here is an example of what you might say:

Before we begin, let me just explain a little about how we will be working together. You have already spent time completing the tests that we need, and we appreciate the effort you put into that process. We'll make good use of the information from those tests today. This is the first of four sessions that we will be spending together, during which we'll take a close look together at your situation. I hope that you'll find these four sessions interesting and helpful.

I should also explain right up front that I'm not going to be changing you. I hope that I can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing, *you* will be the one who does it. Nobody can tell you what to do; nobody can make you change. I'll be giving you a lot of information about yourself and maybe some advice, but what you do with all of that after our four sessions together is completely up to you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is *you*. How does that sound to you?

Many clients will find this a very comfortable and compatible approach. Some, in fact, will express relief, having feared being castigated or coerced. Other clients or their significant others, however, may be uneasy with this approach and may need additional explanation and assurance. Here are several lines of followup discussion in such cases:

- Even with very extensive kinds of treatment, it is still the person who, in the end, decides what happens. *You* will determine what happens with your drinking.
- Longer and shorter treatment programs don't seem to produce different results. People in longer or more intensive programs don't do any better, overall, than those getting good consultation like this. Again, no one can "do it to you." In fact, many people change their drinking or quit smoking without any formal treatment at all.

- You are not alone. We will be keeping in touch with you to see how you are doing. If at followup visits, you still need more help, this can be arranged.
- You can call if you need to. I'm available here by telephone.
- I understand your worries, and it's perfectly understandable that you would be unsure at this point. Let's just get started, and we'll see where we are after we've had a chance to work together.

After this introduction, start with a brief structuring of the first session and, if applicable, the SO's role in this process (refer to the section on "Involving a Significant Other"). Tell the client (and SO) that you will be giving them feedback from the assessment instruments they completed, but first you want to understand better how they see the client's situation. Then proceed with strategies for "Eliciting Self-Motivational Statements." Use reflection ("Listening With Empathy") as your primary response during this early phase. Other strategies described under "Affirming the Client," "Handling Resistance," and "Reframing" are also quite appropriate here. (The "Motivational Interviewing" videotape by Dr. Miller demonstrates this early phase of MET.)

When you sense that you have elicited the major themes of concern from the client (and SO), offer a summary statement (see "Summarizing"). If this seems acceptable to the client (and SO), indicate that the next step is for you to provide feedback from the client's initial assessment. Give the client a copy of the Personal Feedback Report and review it step by step (see "Presenting Personal Feedback"). Again, you should use reflection, affirmation, reframing, and procedures for handling resistance, as described earlier. You might not complete this feedback process in the first session. If not, explain that you will continue the feedback in your next session, and *take back the client's copy of the PFR* for use in your second session, indicating that you will give it back to keep after you have completed reviewing the feedback next week.

If you do complete the feedback process, ask for the client's (and SO's) overall response. One possible query would be:

- I've given you quite a bit of information here, and at this point, I wonder what you make of all this and what you're thinking.

Both the feedback and this query will often elicit self-motivational statements that can be reflected and used as a bridge to the next phase of MET.

After obtaining the client's (and SO's) responses to the feedback, offer one more summary, including both the concerns raised in the first "eliciting" process and the information provided during the feedback (see "Summarizing"). This is the transition point to the second phase of MET: consolidating commitment to change. (Again, you will not usually get this far in the first session, and this process is continued in subsequent sessions.)

Using cues from the client and SO (see "Recognizing Change Readiness"), begin eliciting thoughts, ideas, and plans for what might be done to address the problem (see "Discussing a Plan"). During this phase, also use procedures outlined under "Communicating Free Choice" and "Information and Advice." Specifically elicit from the client (and SO) what are perceived to be the possible benefits of action and the likely negative consequences of inaction (see "Consequences of Action"). These can be written down in the form of a balance sheet (reasons to continue as before versus reasons to change) and given to the client. The standard commendation of abstinence is to be included during this phase at an appropriate time. If a high-severity client (range 3 or 4 in table 2) appears to be headed toward a moderation goal, this is also the time to employ the abstinence advice procedure outlined in "Emphasizing Abstinence." The basic client-centered stance of reflection, questioning, affirming, reframing, and dealing with resistance indirectly is to be maintained throughout this and all MET sessions.

This phase proceeds toward the confirmation of a plan for change, and you should seek to obtain whatever commitment you can in this regard (see "Asking for Commitment"). It can be helpful to write down the client's goals and planned steps for change on the Change Plan Worksheet. If appropriate, this plan can be signed by the client (and SO). Be careful, however, not to press prematurely for a commitment. If a plan is signed before commitment is firm, a client may drop out of treatment rather than renege on the agreement.

Ending the First Session

Always end the first session by summarizing what has transpired. The content of this summary will depend upon how far you have proceeded. In some cases, progress will be slow, and you may spend most of the first session presenting feedback and dealing with concerns or resistance. In other cases, the client will be well along toward determination, and you may be into Phase 2 (strengthening commitment) strategies by the end of the first session. The speed with which this session proceeds will depend upon the client's current stage of change. Where possible, it is desirable to elicit some client self-motivational statements about change within the first session and to take some steps toward discussing a plan for change (even if tentative and incomplete). Also discuss what the client will do and what changes will be made (if any) between the first and second sessions. Do not hesitate

to move toward commitment to change in the first session if this seems appropriate. On the other hand, do not feel pressed to do so. Premature commitment is ephemeral, and pressuring clients toward change before they are ready will evoke resistance and undermine the MET process.

At the end of the first session, always provide the client with a copy of *Alcohol and You* (Miller 1991) or other suitable reading material. If feedback has been completed, also give the client the Personal Feedback Report and a copy of "Understanding Your Personal Feedback Report."

The Followup Note

After the first session, prepare a handwritten note to be mailed to the client. This is *not* to be a form letter, but rather a personalized message in your own handwriting. (If your handwriting is illegible, make other arrangements, but the note should be handwritten, not typed.)

Several personalized elements can be included in this note:

- A "joining message" ("I was glad to see you" or "I felt happy for you and your wife after we spoke today")
- Affirmations of the client (and SO)
- A reflection of the seriousness of the problem
- A brief summary of highlights of the first session, especially self-motivational statements that emerged
- A statement of optimism and hope
- A reminder of the next session

Here is an example of what such a note might say:

Dear Mr. Robertson:

This is just a note to say that I'm glad you came in today. I agree with you that there are some serious concerns for you to deal with, and I appreciate how openly you are exploring them. You are already seeing some ways in which you might make a healthy change, and your wife seems very caring and willing to help. I think that together you will be able to find a way through these problems. I look forward to seeing you again on Tuesday the 24th at 2:00.

Keep a copy of the note for your records.

Followthrough Sessions

The Second Session

The second session is scheduled 1 to 2 weeks after session 1 and should begin with a brief summary of what transpired during the first session. Then proceed with the MET process, picking up where you left off. Continue with the client's personal feedback from assessment if this was not completed during the first session, and give the client the PFR and a copy of "Understanding Your Personal Feedback Report" (see appendix A) to take home. Proceed toward Phase 2 strategies and commitment to change if this was not completed in the first session. If a firm commitment was obtained in the first session, then proceed with followthrough procedures.

At the end of the second session, in all cases, offer a closing summary of the client's reasons for concern, the main themes of the feedback, and the plan that has been negotiated (see "Recapitulation"). This is the closing of the second session. If no commitment to change has been made, indicate that you will see how the client is doing at the followup in 4 weeks and will continue the discussion at that point. In any event, remind the client of the third session at week 6. When a spouse or SO has been involved in the first two sessions, thank the SO for participating in those sessions and explain that the next two sessions will be with the client alone. If the SO was not involved in both of the initial sessions, he or she may return for the third session. (The SO's involvement is not to exceed two sessions.)

Sessions 3 and 4

Sessions 3 and 4 are to be scheduled for weeks 6 and 12, respectively. They are important as "booster" sessions to reinforce the motivational processes begun in the initial sessions. As before, the therapist does not offer skill training or prescribe a specific course of action. Rather, the same motivational principles are applied throughout MET. Specific use is made in each session of the followthrough strategies outlined earlier: (1) reviewing progress, (2) renewing motivation, and (3) redoing commitment. Sessions 3 and 4 do *not* include the SO, unless the SO has not already attended two sessions.

Because several weeks normally lapse between sessions 2 and 3 and between sessions 3 and 4, you should send the client a handwritten note or telephone the client a few days before the scheduled appointment. This serves as a reminder and also expresses continued active interest in your client.

Begin each session with a discussion of what has transpired since the last session and a review of what has been accomplished in previous sessions. Complete each session with a summary of where the client is at present, eliciting the client's perceptions of what steps should be

taken next. The prior plan for change can be reviewed, revised, and (if previously written down) rewritten.

During these sessions, be careful not to assume that ambivalence has been resolved and that commitment is firm. It is safer to assume that the client is still ambivalent and to continue using the motivation-building strategies of Phase 1 as well as the commitment-strengthening strategies of Phase 2.

There should be a clear sense of continuity of care. The four sessions of MET should be presented as progressive consultations and as continuous with the research protocol's schedule of followup sessions. The initial sessions build motivation and strengthen commitment, and subsequent sessions serve as periodic checkups of progress toward change.

It can be helpful during sessions 3 and 4 to discuss specific situations that have occurred since the last session. Two kinds of situations can be explored:

- Situations in which the client drank
- Situations in which the client did not drink

Drinking Situations

If the client drank since the last session, discuss how it occurred. Remember to remain empathic and to avoid a judgmental tone or stance. Consistent with the MET style, do not prescribe coping strategies for the client. Rather, use this discussion to renew motivation, eliciting from the client further self-motivational statements by asking for the clients thoughts, feelings, reactions, and realizations. Key questions can be used to renew commitment (e.g., "So what does this mean for the future?" "I wonder what you will need to do differently next time?")

Nondrinking Situations

Clients may also find it helpful and rewarding to review situations in which they might have drunk previously or in which they were tempted to drink but did not do so. Reinforce self-efficacy by asking clients to clarify what they did to cope successfully in these situations. Praise clients for small steps, little successes, even minor progress.

Termination

Formal termination should be acknowledged and discussed at the end of the fourth session. This is generally accomplished by a final recapitulation of the client's situation and progress through the MET sessions. Your final summary should include these elements:

- Review the most important factors motivating the client for change, and reconfirm these self-motivational themes.
- Summarize the commitments and changes that have been made thus far.
- Affirm and reinforce the client for commitments and changes that have been made.
- Explore additional areas for change that the client wants to accomplish in the future.
- Elicit self-motivational statements for the maintenance of change and for further changes.
- Support client self-efficacy, emphasizing the client's ability to change.
- Deal with any special problems that are evident (see below).
- Remind the client of continuing followup sessions, emphasizing that these are an important part of the overall program and can be helpful in maintaining change.

Review, in session 4, the major points that have come up in the prior three sessions. It may be useful to ask clients about the worst things that could happen if they went back to drinking as before. Help clients look to the immediate future, to anticipate upcoming events or potential obstacles to continued sobriety.

Appendix 2H: Letter of ethical approval

Removed to protect confidentiality