THE CONSTRUCTION AND USE OF BELIEF IN COGNITIVE THERAPY: A DISCURSIVE ANALYSIS.

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ABSTRACT.

This research explores how the notion of belief is constructed and used within the cognitive therapy domain. Utilising a multi-media approach, in which cognitive therapy texts were gathered from instructional books, demonstration videos, and interviews with practicing psychotherapists, the transcripts were analysed using Jonathan Potter, Derek Edwards and Margaret Wetherell's model of discourse analysis. The analytic attention was on the linguistic resources and practices therapists had available and used in constructing and deploying different notions of belief. By approaching therapists' belief talk in this way and showing the contingent, socially constructed, and rhetorical nature of their discourse use, two main constructions of belief became evident. These were of 'a belief itself' and of 'a believing person'. In addition, Davies and Harrés' positioning theory was utilised which highlighted two main subject positions; the therapist as the 'expert' and the client as the 'layperson'.

The findings tend to support the view that there are medium and therapist specific idiosyncratic aspects to belief, which are constructed and constituted in multiple repertoires and by various discursive strategies. This suggests a need for cognitive therapy to re-evaluate the notion of belief and its various uses, and highlights the benefits and pitfall of utilising a multi-media discursive approach.

ACKNOWLEDGEMENTS.

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EXCERPT ONE.

An irreligious vacationer accidentally fell over the edge of the Grand Canyon and found himself dangling precariously from a small shrub. As he hung agonizingly close to imminent death, he mustered an awesome prayer of faith and conviction. Suddenly, his cries for supernatural intervention were answered by a thunderous question from the heavens, 'Do you believe?' Startled and inspired, the dangling convert cried, 'Yes...oh, yes, I do believe!' The voice thundered back, 'Do you really believe?' 'Yes, dear God...I really, really believe!' There was a brief silence before the heavenly voice wryly responded, 'Then let go of the shrub...'.

Excerpt from Mahoney, 1974, p. 229.

INTRODUCTION.

Everybody believes! Some people assert a belief in the existence of God, whilst others say they believe in atheism or are agnostic. Some people believe themselves to be completely unlovable, whilst others believe that they are totally adorable. Most people would confirm a belief that the sun will rise again tomorrow, whilst only a few would confirm a belief in the existence of aliens. Whatever the belief or its popularity, peoples' talk of and endorsement in what they believe is a relatively commonplace phenomenon. This is because beliefs are important in facilitating the functioning of life. On a social level, our dealings with others are, to a degree, bound by the beliefs that are endorsed. Knowing what others believe aids in smooth and conventional relations by installing a sense of predictability. On an individual level, knowing what you believe in helps direct your life in the attainment and accomplishment of goals. Beliefs provide a sense of consistency that structures daily experience, and, to an extent, define who and what we are.

Given that people generally talk of and endorse certain beliefs, and that beliefs seem *prima facie* both individually and socially important, what exactly are these things people call beliefs? It was this question that set in motion this research project.

The evolution of this research project.

This initial research question, 'what are beliefs?', was originally stimulated by my curiosity in noticing different psychology lecturers mustering quite different constructions of beliefs (see Appendix A for a list of these constructions). When I asked what seemed like a simple question, 'what is a belief?', I was surprised in three distinct ways. Firstly, by the various attempts to avoid answering this question. For instance, usually after a few seconds of silence and eye wandering, respondents tended to evade the question by changing the subject altogether. Secondly, when pushed, the respondents' answers were tremendously diverse. For example, one constructed a belief as 'an idea about something', another as 'a world view or way of life', and another as 'something you hold to be true'. Lastly, I was surprised by a sense of indeterminacy in that these vague sounding and poorly described constructions also appeared to be the extent of their conceptualisations of belief. I

sensed that the respondents were unsure of their constructions, the implications of such constructions, and the particular positions that such constructions entailed. In short, after receiving their answers, I began to 'smell a rat'.

Furthering my curiosity and in order to substantiate my initial detections, I asked a larger group of 17 post-graduate psychology students and six additional psychology lectures to write down an answer to this same question; 'what is a belief?'. Reinforcing my initial hunches, these answers provided even more diversity, with almost every construction of belief being distinctly different (see Appendix B a list of these constructions). For example, a belief was also constructed as 'a perspective that you have tested on society', as 'a held value that is expressed in behaviour', and as 'an internally held systematic idea that is consistent and stable'. From this diversity of constructions I turned my attention to the psychological literature for an understanding and explanation of the notion of belief. At this early stage of this research project, and in traditional psychological research terms, I was looking for an operational definition for the construct of belief.

A paucity of literature.

Interestingly, the psychological literature had largely ignored the construct of belief. Although there was research on both the *contents* of beliefs (i.e., what people believe in; e.g., see Peterson, 1999) and *consequences* of holding certain beliefs (e.g., see Fodor, 1987; Beck, 1996), the construct of belief itself had received little analytic attention, and seemed a notion taken conceptually for granted. This appeared even more so both within the contemporary psychological literature in general (i.e., within the past 30 years), and within the cognitive therapy literature in the psychological domain.

Research in the psychological domain.

With regard to contemporary research in the wider psychological domain, it has long been acknowledged (although perhaps not widely) that belief is a construct that has been both ignored and constructed ambiguously (Mahoney, 1974; Stich, 1986). For example, in 1974 Mahoney reviewed the "scant" belief literature and

concluded that definitions and conceptions of belief "ranged widely", that "current professional connotations range from 'muddled' to 'science fiction'", and that the construct of belief currently "remains in a 'quagmire'" (1974, p. 227). In addition to its ambiguity, he further commented that psychologists have been "negligent" in "continuing to ignore" the construct, resulting in an "absence of an unambiguous definition of 'belief'" (1974, p. 228). Unfortunately, to the best of my knowledge and research skill, this challenge laid down almost 30 years ago has not been pursued anywhere within the contemporary psychological literature.

Research in the cognitive therapy domain.

With regard to research in the cognitive therapy domain, there has been no published research on the construct of belief itself. I found this discovery astounding, given that belief is central, almost bedrock, to the theory and practice of cognitive therapy. It is central because cognitive therapy practice, which is based on theory, involves talk of, and psychotherapeutic work on, an individual's beliefs. Indeed, cognitive therapists talk about beliefs all the time in both theory and practice, perhaps more so than in any other major area of psychology. For example, in Judith Beck's *Cognitive Therapy: Basics and Beyond* (1995), the words 'belief' or 'believe' appear a total of 739 times in 338 pages. With such a predominant use of the term, one would reasonably expect a firm and robust understanding or explanation somewhere within the cognitive therapy literature, or at least acknowledged from the wider psychological domain in which it resides.

However, no understanding or explanation of the construct itself has been offered from within the cognitive therapy domain. This position is predicated on my knowledge of the cognitive therapy domain and the research processes I have followed. For instance, not one of the 15 representative and predominant cognitive therapy instructional books reviewed for this research project gave an understanding or explanation of the construct of belief itself (see Appendix C for a list of the cognitive therapy books reviewed). Furthermore, not one of the predominant cognitive therapy research journals has published an article, or part thereof, on the construct of belief itself (see Appendix D for a list of the journals reviewed). In addition, this finding was further supported by informal discussions with several

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academics, highly familiar with the cognitive therapy literature, who could not recall ever reading about the construct of belief itself within this literature.

Given this dearth of literature concerning the construct of belief itself, a traditional literature review was unfeasible, as no work had previously been conducted on the construct of belief itself. However, as an alternative, and as this lack of literature necessitated a more exploratory research approach, I will outline the role beliefs purport to play in cognitive therapy theory.

Cognitive therapy theory and beliefs.

Cognitive therapy (also known as 'cognitive behaviour therapy') was developed by Aaron Beck and associates at the University of Pennsylvania in the early 1960's as a structured, short-term, present-orientated psychotherapy, directed towards solving current problems by modifying distorted thinking and behaviour (Weishaar, 1993). It is based on a model of cognitive psychology which proposes that distorted thinking is common to all psychological disturbances (Needleman, 1999; Beck, 1976). Realistic evaluation and modification of this distorted thinking produces an improvement in mood and behaviour, and enduring change results from modification of a person's unhelpful beliefs (Safran, 1998; Brewin, 1996).

Cognitive therapy utilises 'the cognitive model' (e.g., see Beck, J, 1995) to understand and conceptualise a person's psychopathology. The cognitive model proposes that in any given situation, a person's core beliefs activate intermediate beliefs, which in turn determine a person's automatic thoughts. These thoughts then have various effects on their emotions, physiology and behaviours. This can be seen in the following diagram and example:

The cognitive model.

Core belief

"I'm incompetent"

↓

Intermediate belief

"If I don't understand something

perfectly, then I am stupid"

↓

Situation	→	**Automatic thoughts**	→	**Reactions**
Reading a book		"This is too hard. I'll never		↓
		understand this"		**Emotion**
				Sadness
				↓
				Behaviour
				Closes book
				↓
				Physiology
				Heaviness in abdomen
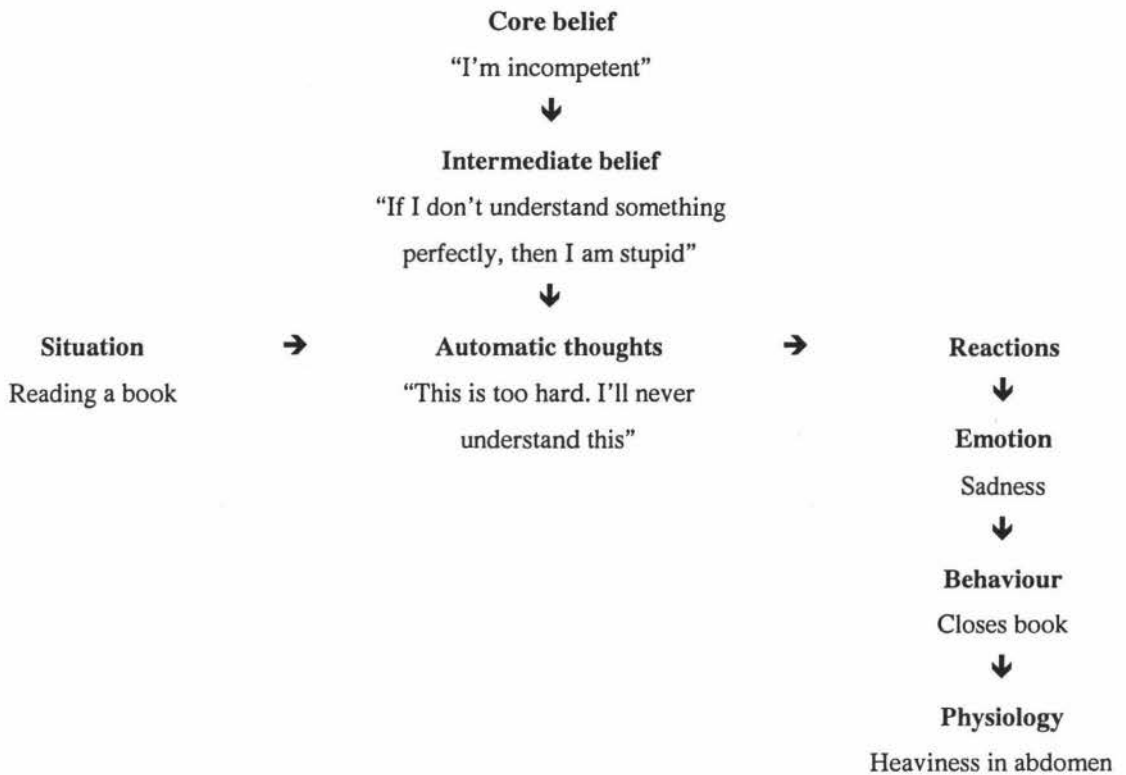
Adapted from Judith Beck (1995), *Cognitive therapy: Basics and Beyond.*

As can be discerned from this diagram, there are three 'levels of thought'; core beliefs (also sometimes called schema), intermediate beliefs (also sometimes called underlying assumptions), and automatic thoughts. Automatic thoughts are at the most basic level and are moment-to-moment, unplanned thoughts (words, images, memories) which are situation specific and repetitive. Intermediate beliefs are cross-situational beliefs or rules that guide behaviour and predominately include 'should statements' (i.e., I should do X) or conditionals (i.e., if X, then Y). Core beliefs are at a deeper level, usually developed during childhood, out of the person's awareness, and are absolutist beliefs about the self, others, and the world that guide the processing of information (i.e., I am X, others are X, the world is X).

In the course of cognitive therapy, the notion of belief filters through this model in a number of places. For instance, cognitive therapy would usually involve a number of typical processes: an assessment; a case formulation; educating the person about the working model; gaining behavioural activation; cognitive restructuring;

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modifying underlying or core beliefs; and relapse prevention. The notion of belief can play a role in this process: as the person's beliefs are assessed (e.g., 'Socratic Questioning', the 'Schema Questionnaire', or the 'Downward Arrow Technique': see Beck, J, 1995); as a cognitive case formulation is made; as the person is educated about what beliefs are; and as their particular beliefs are modified (e.g., 'Core Belief Worksheet': see Beck, J, 1995).

Why has the construct of belief been overlooked in the cognitive therapy domain?

Given that beliefs play an important and central role in cognitive therapy and that no adequate understanding or explanation of the construct itself has been offered, why has belief been conceptually taken for granted in the cognitive therapy domain? Although I can only speculate at answers to this question, I shall suggest four possible reasons.

The first possibility is the dominance of behaviourism and its renouncing of folk psychology's 'mentalistic vocabulary'. As Stephen Stich (1986) explains:

> *With Thorndike, Pavlov, Watson, and the birth of experimental learning theory, the vocabulary of folk psychology was quite self-consciously renounced. The founders of modern 'behaviouristic' psychology proposed to devise new terms and concepts to suit the purposes of their fledgling science, while renouncing the 'mentalistic' vocabulary of 'folk' psychology as prescientific mumbo jumbo* (p. 1).

For the behaviourists there were more precise ways of talking, rather than invoking folk psychological vocabulary such as unobservable beliefs. Although this 'linguistic challenge' dates back to 1930 when Watson famously ridiculed the concept of belief as "voodoo" (Watson, 1930, p. 5), the main influence of behaviourism in psychology occurred just before (i.e., the 1950's and 60's) and dominated around the same time (i.e., the 1970's) as cognitive therapy was developing. This foreground influence of behaviourism may have halted an articulation of belief developing within the emerging cognitive therapy domain.

A second possible reason is that the construct of belief has been unthinkingly borrowed from one of the many available in the philosophical domain. Philosophy is riddled with numerous different contested notions of belief (e.g., see Dennett, 1982;

Dancy, 1994). This is largely unsurprising as in the philosophical domain, belief is one of the three central tenants of epistemology, which itself is considered one of the cornerstones of philosophy. For example, most contemporary formulations of knowledge in the epistemological domain involve tripartite accounts of knowledge as 'justified true beliefs'. Here an account of knowledge needs to say something about how beliefs are justified, how beliefs are distinguished as true, and what exactly beliefs are. This proposed philosophical influence is further substantiated by the fact that philosophy has influenced many other aspects of cognitive therapy's development. For example, the popular technique of 'Socratic Questioning' in cognitive therapy can be traced to Plato's dialogue 'The Meno' (Guthrie, 1956).

A third possible reason is that the construct of belief has originated from one of the many early and ambiguous constructions available from the early psychological domain, particularly the social psychology arena. However, these constructions tend to be rather vague. For example, the social psychologists Jones and Gerard (1967) define a belief as:

An assertion about the nature of objects in a cognitive category that is more than definitional. Since both objects and attributes fall in cognitive categories, a belief may be said to express the relations between two cognitive categories when neither defines the other (p. 707).

As another example, Rokeach and Rothman (1965) define a belief as:

A unique combination of two stimuli, each having their separate meanings...the unique configuration consists of two components: a subject (S), capable of being characterized in many ways, and a characterization (C), capable of being applied to many subjects (p. 129).

The above constructions of belief, and many others like them, have been widely acknowledged as problematic and ambiguous (e.g., see Bem, 1970; McGuire, 1968; Mahoney, 1974; Stich, 1986). In addition to their ambiguity, they also seem to reflect a paradox of their own specification (i.e., being the beliefs of their definers). However, my contention is that a construction of belief may have originated from one of these earlier ambiguous conceptions available from the social psychology area.

A fourth possibility is that a conception of belief may have developed from a domain similar to cognitive therapy. For example, in Albert Ellis's 'rational emotive

therapy' (1962), therapists attempt to persuade clients that their beliefs are irrational. Although I am not familiar with Ellis's original works, a conception of belief may be available in this particular therapeutic approach which may have influenced cognitive therapy. This seems plausible given that both psychotherapies developed at roughly the same time and in roughly the same place. Other similar influences may include Donald Meichenbaum's 'cognitive-behavioural modification' (1977) and Arnold Lazarus's 'multi-modal therapy' (1976).

Speculation aside, the reason why the construct of belief itself has been conceptually taken for granted in the cognitive therapy domain remains unknown. However, these suggestions provide further context and a wider backdrop in order to assess the forthcoming analysis, as many of the flavours seen in the analysis can be discerned from these possible developmental influences.

An interest in discourse analysis.

Returning to my research endeavour, having searched and reviewed the literature, I was now trying to discern how I was going to find an answer to my initial research question; 'what is a belief?'. This was when my interest in discourse analysis developed. Essentially this interest came about by formulating the types of questions I was most curious about. These questions involved attempting to reconcile how some people talked about beliefs as if they were one thing, and how others talked about them as if they were something totally different (e.g., see Appendix A and B). How, I wondered, could people attribute such distinctly different meanings to a construct, and why were they doing so? What did they stand to gain? Evidently such questions addressing language construction and function did not lend well to a traditional psychological research approach, they did, however, lend themselves extremely well to a discursive research approach.

Reformulating the research question.

Delving into the literature on discourse analysis I soon realised that there was an incompatibility between the initial research question, 'what is a belief?', and the commitments to a discursive research approach. This incompatibility was entailed by

the question's essentialist overtones (i.e., what *is* a belief?), with an epistemology incompatible with discourse analysis and social constructionism (further discussed in the follow chapter). Thus, the research question changed from 'what *is* a belief?' or 'what *are* beliefs?' to 'how is belief constructed and used' and 'what does belief talk actually do'. I was no longer looking for 'the answer' or to map a conception of belief, but instead to gain insight into the expression of belief; how it was being constructed and used, and what it accomplished. At this stage I planned the aims for this research project.

Aims of the research project.

Theoretical aim.

From the initial assumptions, that the notion of belief is important, ambiguous and has not been explained in the cognitive therapy literature, using the research approach of discourse analysis the theoretical aim was to gain clarification of the notion of belief and how it was being used. In other words, *the focus was on exploring how cognitive therapists constructed and used the notion of belief in the cognitive therapy domain.* The assumption employed was that beliefs were constituted in the discourse that cognitive therapists used; their cognitive therapy cultural narratives, language and practices. By analysing this discourse, a picture of how beliefs were constructed and what they accomplished would emerge.

Practical aim.

In line with the theory behind the research approach adopted, the practical aim was to find an area of social life that would benefit from clarification of the notion of belief and its uses. From a range of possibilities in social life considered in which belief is employed, including the areas of legal testimony, religious practices, memory, marketing and politics, the area chosen was the cognitive therapy domain.

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Rationale for the aims.

Why the cognitive therapy domain?

Gaining a clearer understanding of belief and its uses had much to contribute to both cognitive therapy theory and practice, and was chosen for a combination of practical and theoretical reasons. Firstly, as mentioned previously, beliefs are central in cognitive therapy. This is because cognitive therapy involves psychotherapeutic work on an individual's beliefs, and because belief is frequently mentioned across the whole of the cognitive therapy domain. This centrality and predominance of the use of belief lent well for its investigation in this area.

Secondly, cognitive therapy is now the dominant form of psychotherapy in New Zealand (Kazantzis & Dean, 1998) and in most western countries (Persons et al., 2001; Beck, 1991; Bergin & Garfield, 1994). For example, in New Zealand a recent survey found that 77 percent of practicing clinical psychologists use cognitive therapy as their main psychotherapeutic approach (Kazantzis & Dean, 1998). This dominance and popularity made cognitive therapy an important therapy to study, given that service providers have both an ethical and legal obligation to ensure that an optimal quality of service is available and provided.

Thirdly, this research had the potential to enhance cognitive therapy practice efficacy. Even though cognitive therapy is *generally* regarded as the most efficacious form of psychological treatment for a large variety of disorders (Beck, 1991; Persons et al., 2001), there is still considerable room to improve its effectiveness. For example, Bergin and Garfield (1994) report that cognitive therapy generally has success rates around 67 percent. Gaining clarification on the notion of belief and its uses was one area where cognitive therapy had the potential to improve its treatment efficacy. For instance, Mahoney (1974) commented that, the "analysis of belief could hardly be overemphasised in terms of its relevance for and potential impact upon future cognitive-clinical developments" (p. 227). In practice, if therapists improved their knowledge of belief and what it can accomplish, this may lead to better clinical practice and outcomes.

Fourthly, with regard to cognitive therapy theory, constructions of belief and how it is used in the cognitive therapy domain would be clarified, which may be of

benefit to cognitive therapy's theory development. This clarification of belief has the potential to make various aspects of cognitive therapy theory more potent and understandable. For example, the relationship between a belief and a thought (i.e., the belief in thought content) would be clarified. Moreover, this research may also provide a platform for further research on other psychological notions utilised within cognitive therapy which remain unclear (e.g., thoughts).

As these four points briefly illustrate, there were many practical and theoretical reasons why cognitive therapy seemed a suitable and appropriate area for investigating the construct and use of belief.

Why use discourse analysis?

A discursive research approach was chosen for a combination of theoretical reasons. Firstly, as mentioned above, discourse analysis seemed an appropriate research approach given my particular curiosities and the types of questions that I was asking (i.e., questions addressing language construction and function).

Secondly, although there has generally been little research on the theoretical aspects of cognitive therapy, compared to its practical aspects (i.e., its effectiveness), as far as I am aware there has been no research on the theoretical aspects of cognitive therapy that has utilised any kind of 'qualitative' research framework. Once again, searches of the predominant cognitive therapy books, journals and discussions with leading cognitive therapy academics supported this conclusion. Instead, research on cognitive therapy theory is dominated by the traditional quantitative research paradigm. By approaching an element of cognitive therapy theory from a distinctly different and relatively new research perspective, new insights and ways of understanding belief in the cognitive therapy domain may open up. This has been the case with other social phenomena in previous discursive studies, such as the notions of 'fatherhood' and 'eating disorders' (see Wiggins et al., 2001; Edley & Wetherell, 1999). In other words, a discursive analysis offered the potential of opening up new understandings and avenues with regards to cognitive therapy's theoretical development that perhaps would not have been possible utilising a more traditional quantitative approach.

Thirdly, a discursive approach would adequately meet this research project's objectives. Whereas it would have been difficult using a more traditional

psychological research approach, the exploratory nature discourse analysis allows could address the above objectives by exploring how cognitive therapists constructed and used the notion of belief in the cognitive therapy domain. Based on previous exploratory discursive analysis (e.g., Billig, 1997; Harper, 1996; Horton-Salway, 2001), I thought I could gain a better understanding and clarification of how cognitive therapists construct and use beliefs.

Fourthly, discourse analysis is a relatively new research approach and there are opportunities to add to its development as a research approach. Thus, this research has the potential to contribute to the growing research methodology literature on discourse analysis. For example, I have utilised a novel and rare multi-media research design (outlined in chapter three), gathering texts from three distinctly different media. This type of research is scarce in the discourse analysis literature. A discourse analytic study utilising a multi-media design, such as this particular combination of media, has yet to have been attempted, and valuable methodological lessons and analytical insights have been gained from such an approach.

As these four points briefly illustrate, there were a variety of reasons why discourse analysis seemed a suitable and appropriate research approach for this project.

Summary.

Having sketched what I considered the problem, its development, reformulation, my aims, rationales, and the benefits of the research project, I will now briefly outline a conceptual map which indicates the general direction of the path I will follow.

In the next chapter I outline in more depth the particular discursive approach adopted and explain my grounds for adopting this approach. In the third chapter I describe and explain the specific methodological elements and processes involved in this research, and outline the novel and uncommon multi-media research design. This involves outlining how the research was undertaken and why it was carried out in such a fashion. Chapter four is a bridging chapter in which I provide a snapshot of the analysis and comment on how theoretically and practically the analysis was conducted. In chapter five I discuss the first of the two constructions discerned, 'the

belief itself', and highlight the repertoires that were utilised in mobilising this construction. Chapter six discusses the second of these constructions, 'the believing person', and also highlights the repertoires that were utilised with this particular construction. In chapter seven, two frequently adopted subject positions, the 'expert' and the 'layperson', are outlined, and I cover a selection of the discursive strategies used to enable and support these positions. Lastly, in the discussion, I discuss some of the left-over tensions within and between the constructions, briefly reflect on the multi-media research approach, re-assess the research goals, and comment on possible future research directions.

DISCOURSE ANALYSIS.

Introduction.

In this chapter I outline in more detail the discursive approach adopted. I begin with some initial clarifying comments about discourse analysis in general, including its focus and aims. Having done so, I outline and demarcate the particular type of discourse analysis utilised, and give a rational for such an approach. I conclude by briefly outlining the notion of a 'subject position' developed by Davies and Harré (1990) which is utilised in the analysis.

Discourse analysis.

Background.

Discourse analysis is a relatively new and increasingly popular research approach within the social sciences (Burr, 1999; Chimombo & Roseberry, 1998; Gee, 1999). Although only emerging around the 1970's, and still currently evolving, its growing popularity is largely due to an increasing scepticism and discontent with the narrowness of psychology, as well as a growing awareness of the theoretical foundations of the traditional empiricist paradigm in the social sciences (Smith et al., 1995; Potter & Wetherell, 1987; Woolgar, 1996).

This discontent with the traditional research approach has been thoroughly covered in the broader 'qualitative' and narrower discursive literature, particularly over the last decade, in both theoretical articles (e.g., Potter, 1996; Henwood, 1996), books (e.g., Edwards, 1997; Potter & Wetherell, 1987), and as preludes in practical examples of discursive analysis (e.g., Radtke & Mens-Verhulst, 2001; Seymour-Smith et al., 2002). Given the scope of this coverage, I see no need for the general arguments in favour of discourse analysis as an approach to research to be rehashed here. Instead, it is more fruitful to sidestep these aspects and explain the essential elements of discourse analysis as an approach.

The varieties of discourse analysis.

The term 'discourse analysis' is an umbrella term which covers a variety of actual research practices and perspectives, with quite different aims, philosophical underpinnings, and theoretical backgrounds (Burr, 1999; Potter, 1996). These practices and perspectives are not always in harmony with one another (Coyle, 1995; Potter & Wetherell, 1985) and often use their own specialist language (Richardson, 1996), frequently inconsistently (Crotty, 1998). This variety of approaches, disharmony, specialist language and inconsistency of language use often leads to some confusion as to what the term 'discourse analysis' actually means.

Even though discourse analysis is still a relatively modern and evolving research approach, there are already many different "species" of discourse analysis (Potter & Wetherell, 1987, p. 7); a "bewildering variety of approaches" (Parker, 1999, p. 2). These different approaches vary in terms of what they are looking for in a piece of text, and the specific ways by which the analyses are carried out (Potter & Wetherell, 1987). As Gill (1996) notes, "the kinds of questions a discursive researcher asks are not self-evident as the same text can be interrogated in a whole range of different ways by different discourse analysts depending on their particular discursive stance" (p. 144). For example, different frameworks for studying texts include Potter and Wetherell's (1987) 'ten stages in the analysis of discourse', Billig's (1988) 'implicit theme' method, Hollway's (1989) 'intuitive feel' approach, and Parker's '20 step guide to conducting discourse analysis' accompanied by his 'seven criteria for identifying discourses' (1992). All of these approaches vary in some important practical or theoretical element. For instance, the philosophical underpinnings entailed by the epistemological realism of Parker's version of discourse analysis (1992; 1999), with its reified objectification of discourses and emphasis on the 'bigger picture', are quite different to the emphasis and epistemology of Potter and Wetherell's (1987) version.

However, the varieties of discursive approaches also have their commonalities, albeit in only the broadest of terms. For instance, many discursive researchers maintain that a discursive approach is chiefly characterised by a sensitivity to language (e.g., Parker, 1999; Chimombo & Roseberry, 1998; Fairclough, 1990; Henwood & Pidgeon, 1992). Before I turn to a discussion of some of these commonalities, I will firstly clarify what is meant by the term 'discourse'.

Definitions of 'discourse'.

As with the definitions of 'discourse analysis', the term 'discourse' has also been variably defined, depending on the theorist's particular ontological and epistemological commitments. For example, Parker (1992) reifies discourse and defines it as "a system of statements which constructs an object" (p. 5). Similarly Foucault (1972) emphasises the constructive nature of discourse and defines it as "practices that systematically form the objects of which they speak" (p. 49). Potter and Wetherell (1987) take a different tack and broadly define discourse as "in its most open sense...to cover all forms of spoken interaction, formal and informal, and written texts of all kinds" (p. 7). Coyle (1995) narrowly defines discourse as "sets of linguistic material that have a degree of coherence in their content and organisation and which perform constructive functions in broadly defined social contexts" (p. 245).

For the purposes of this research project, I am utilising Potter and Wetherell's (1987) broad definition of discourse which refers to the wider symbolic domain. This incorporates, for example, naturally occurring conversations, interview material or written texts (Gill, 1996).

The focus of discourse analysis.

As an approach to research, discourse analysis takes discourse itself as the focus of research interest (Gee, 1999; Smith et al., 1995; Potter & Wetherell, 1987). One difference between a discursive approach and the traditional empiricist approach is that discourse analysts are interested in the content and organisation of talk and texts themselves, rather than seeing talk and texts as a pathway to getting at some other reality that is assumed to lie behind or beyond the discourse (Gill, 1996; Potter & Wetherell, 1987; Parker, 1999). Instead, the research interest is with the actual detail of the passages of discourse, with what is said and written, and with the resources that are drawn upon to enable that talk and text (Potter & Wetherell, 1987). As Edwards and Potter (1992) explain, "what we want to do as discourse analysts is study the flavour and texture of language and the way discourse and talk are constitutive of social life and work as crucial practices or functioning elements in social action in their own right" (p. 4).

This focus on, and primacy of, discourse itself is a common feature of the various discursive approaches. They all share a rejection of the idea that talk and text is a neutral means of reflecting or describing the world, and instead maintain that talk and text play a central importance in constructing social life (Gill, 1996; Burr, 1995; Gergen, 1985; Shotter, 1994). This shifts the research approach away from the experimental paradigm and into a post-positivist paradigm interested in the workings of language (Smith et al., 1995; Gergen, 1994).

The aims of discourse analysis.

Under a discursive approach, the aims of social enquiry are substantially different as compared to the traditional empiricist approach in psychology. Under the empiricist approach, the assumptions and practices are focused on internal psychic structures and processes, with the aim being to 'uncover' the 'truth' about such structures and processes (Burr, 1995; Gergen, 1999). However, discourse analysis, at a broad level, aims to gain "a better understanding of social life and social interaction" (Potter & Wetherell, 1987, p. 7). At a more specific level, "the goal becomes a pragmatic and political one, a search not for truth but for any usefulness that the researcher's 'reading' of a phenomenon might have in bringing about change for those who need it" (Burr, 1995, p. 162). In other words, the research is evaluated not in regards to its truth or potential truthfulness, but on the understandings produced and their actual usefulness. The aim then is to highlight plausible and helpful ways of seeing and understanding certain phenomena, rather than to highlight 'one true way' of understanding or seeing certain phenomena.

The discursive approach of Potter, Edwards and Wetherell.

The particular type of discourse analysis adopted for this research project can best be described as a loose combination and conglomeration of that promulgated by three main, and similarly orientated, theorists: Jonathan Potter, Derek Edwards, and Margaret Wetherell. The main works of these theorists that have been drawn upon and utilised for this research project include: Wetherell (1999), Edwards (1997), Potter (1996), Potter and Wetherell (1995), Edwards and Potter (1992), Wetherell

and Potter (1988), and Potter and Wetherell (1987). However, the main force of my approach comes from Potter and Wetherell's explanation and examples of discourse analysis in their 1987 book, *Discourse and Social Psychology: Beyond Attitudes and Behaviour*.

The origins of these discursive approaches are variously acknowledged to be developed from linguistic philosophy, rhetoric, ethnomethodology, conversation analysis, speech act theory, semiology, literary theory, post-structuralism, and developments in sociology (Potter & Wetherell, 1985, 1987; Wetherell, 1999; Edwards & Potter, 1992). Additionally, social constructionism, or at least what are considered the main tenets of a social constructionist position, also seems to underlie these theorists particular type of discursive analysis (e.g., see Harper, 1996).

An outline of Potter, Edwards and Wetherell's discursive approach.

Under this discursive approach, the researcher explores the variability and consistency within and across the talk or text, investigates how the talk or text was constructed, and examines the functions and consequences the talk or text serves. By analysing accounts in this way, the assumptions and underpinning social aspects of the talk or text are made explicit (Potter & Wetherell, 1987).

On a broader level, this approach outlines two overarching and interconnected components, and three key elements which identify these components. The two overarching components are the discursive *practices* people perform with their talk or texts, and the discursive *resources* people draw on in performing those practices with their talk or texts (Potter & Wetherell, 1987). This latter component, the discursive resources people draw on, Potter and Wetherell phrase an 'interpretative repertoire' (Potter & Wetherell, 1987, 1995; Wetherell & Potter, 1988).

The three key elements that help highlight these two overarching components are examining the talk or text for its function, noticing the variation in the talk or text, and exploring the talk or text to see how it is constructed (Potter et al., 1990; Potter & Wetherell, 1987). Thus, the key tasks for this type of discursive analysis involve exploring an account's construction, investigating its variation, and identifying the functions being performed by the accounts.

Before explaining these three key elements in more depth, I shall explain the notion of an 'interpretative repertoire', as this concept plays an important role in the forthcoming analysis.

Interpretative repertoires.

Potter and Wetherell's (1987) concept of an 'interpretative repertoire' is concerned with determining the full range of accounting resources people use when constructing their accounts. More precisely, interpretative repertoires are defined as "systematically related sets of terms that are often used with stylistic and grammatical coherence, and often organised around one or more central metaphors or vivid images" (Potter, 1996, p. 88).

Interpretative repertoires operate at a broadly semantically-based level and are the available resources for making evaluations, constructing factual versions and performing particular actions (Potter & Wetherell, 1995). A common way of explaining an interpretative repertoire is as a linguistic tool-kit available to speakers in their construction of accounts (Burr, 1999); the 'building-blocks' used for manufacturing accounts (Potter & Wetherell, 1987). For instance, analogous to the repertoire of camera shots available to a film director (e.g., fade out, slide shot, wipe,) in which different shots can be selectively drawn upon from their 'tool kit', reworked and put together in different ways, with particular types of shots selected to fit most effectively with particular contexts and settings, linguistic terms can also be selected and put together in different ways for different purposes, depending on the context of the person's talk or text. Thus, people have a selection of talk or text available, and the assembly of an account involves a selection from a number of different possibilities from the pre-existing resources available.

The primary analytic aim of using the notion of an interpretative repertoire is to clarify the linguistic *resources* people use to perform various functions with talk or text. As Potter and Wetherell (1995) explain, "interpretative repertoires are pre-eminently a way of understanding the content of discourse and how that content is organised" (p. 89). Interpretative repertoires emerge and are abstracted from the talk or text as the researcher looks for many different examples of "concrete, contextualized performances of language" (Burr, 1999, p. 187). In searching the talk or text for interpretative repertoires, the questions a researcher asks include:

- What linguistic resources are people drawing on or bringing to their social interactions?

- What similar language is being mobilised?

- What broadly discernable clusters of terms and descriptions are evident?

- What vivid images are apparent and what particular expressions are used around those images?

The difference between an 'interpretative repertoire' and a 'discourse' is that a discourse has a broader scope compared to an interpretative repertoire. For instance, Potter and Wetherell (1987) define a discourse as "in its most open sense...to cover all forms of spoken interaction, formal and informal, and written texts of all kinds" (p. 7), whereas an interpretative repertoire refers to more specific and narrower elements within discourse by referring to "systematically related sets of terms" (Potter, 1996, p. 88). Although the term 'discourse' remains the standard term applied to the subject matter of discourse analysis (Coyle, 1995), I have chosen to focus more specifically on interpretative repertoires in this research project.

Variation.

Noticing and identifying the variation in accounts involves searching for systematic patterning in the talk or text. This includes looking for both variability *and* consistency in the material. Variability refers to the differences in either the content or forms of accounts, whereas consistency refers to the identification of recurrent patterns or features shared by or across accounts (Potter & Wetherell, 1987).

With variability, the assumption is that peoples' accounts, their motives, and the reasons for their actions are variable as social life produces many conflicts; people set up one version of events and then, as the communication situation changes, alter this version (Potter & Wetherell, 1987). Thus, variation within or across accounts is expected as people perform different actions with their talk or text in different contexts.

Searching for and noticing variability in discourse is important because people use different resources, different repertoires, for different purposes, thus highlighting

different functions. Hence, the variability within and across accounts helps mark both the interpretative repertoires and function orientation of the talk and texts.

With consistency, the assumption is that people are drawing on a limited number of compatible resources or interpretative repertoires. If the same resources are being used by a person or different people, this indicates the presence of a certain phenomena. Consistency in discourse is important because it demonstrates that the researcher has found some genuine phenomena through the regular pattern of language use and has not biased or distorted the results (Potter & Wetherell, 1987).

The process by which the researcher attunes to the talk or texts' variation and consistency is by asking a series of questions in relation to its organisation, which include:

- What different meanings are at work in the talk or text?
- How is the talk or text organised?
- What regularity or consistency is apparent in the talk or text?
- What inconsistent patterns are evident in the talk or texts?

In answering these questions the analyst is looking for consistencies, inconsistencies and contradictions that suggest similar or different versions of the social world are being formed. Patterns of variation and consistency help the researcher map out the interpretative repertoires that the participants are drawing on and deploying in different portions of their talk or text (Potter & Wetherell, 1995).

Construction.

Exploring the talk or text to see how it is constructed is concerned with how people use language. More precisely, it is concerned with how they put language together to construct a particular account. With each account, the talk or texts that people use are manufactured out of pre-existing resources; or different interpretative repertoires. Any phenomena can be described in a number of different ways and any particular description that is chosen will depend upon the orientation of the person (Gill, 1996). Different people may construct meaning in different ways, even in

relation to the same phenomenon (Willig, 1999). Thus, we deal with the social world in terms of constructions, chosen from different linguistic repertoires.

The process by which the researcher attunes to the talk or texts' construction is by asking a series of questions in relation to its construction, which include:

- How are the participants' accounts constructed?
- How are the meanings that are portrayed in the talk or text constructed?
- How has the talk or text been constructed so that it makes sense to listeners or readers?

In answering these questions the analyst is looking for different repertoires that participants are drawing upon to construct a particular phenomenon or to perform different functions with their language. Thus, the discursive researcher asks about the talk and texts' construction in relation to its function and the interpretative repertoires that are employed (Potter & Wetherell, 1987).

Function.

Function is concerned with the discursive practices people perform; "their language use, what is achieved by that use, and the nature of the interpretative resources that allow that achievement" (Wetherell & Potter, 1988, p. 34). By examining the talk or text for its function, the analyst is concerned with how people perform social acts through their use of language. In this sense, language use is a social practice as people use language in order to do certain things. For instance, people blame, excuse, justify, accuse and present themselves in certain ways. The aim is to identify the functions, actions or activities of the talk and texts and to explore how they are performed (Gill, 1996).

In exploring for function, the researcher forms hypotheses about the talk and texts' functions and effects, and then checks these hypotheses by searching for linguistic evidence that supports them. The hypothesized functions should also provide an explanation for the pattern evident in the talk or text. Thus, the researcher is aiming to discover a regular pattern of accounting that is designed for a specific goal; the accounting serves a function in the sense that the language is used to do things, to accomplish specific actions. For example, much of peoples' talk is

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involved in establishing one version of the world in the face of competing versions. Politicians are attempting to win people over, advertisers to motivate a purchase. The function of the language of both the advertiser and the politician is to establish their version of the world, the best product or policy, which will hopefully lead to a certain course of action. Hence looking at the function of discourse involves looking for the techniques by which people manage to justify themselves and their versions of the world through their talk or texts.

The process by which the researcher attunes to the functions of the talk or texts is by asking a series of questions in relation to its function, which in turn helps derive possible hypotheses. These questions include:

- What social functions does the organisation of the talk or text have?
- What are the functions and consequences of different types of constructions?
- What is the linguistic evidence to support these hypothesized functions?
- What are these contradictory or consistent systems of meaning actually doing?
- What does the language actually do in the social world?
- How is the talk or text fulfilling these functions?

In answering these questions, the researcher formulates tentative hypotheses regarding the possible functions of the talk or texts and checks these against the available accounts. As an additional strategy that can aid the identification of the functional orientation of the talk or text, the analyst can also look at what precedes and follows a segment of talk or text as this might give a clue to its function (Coyle, 1995). In other words, in seeking to identify discursive functions, a useful starting point is the broader discursive context.

Interlude: The importance of context and culture.

On a broad level, any discursive analysis is simultaneously involved in analysing discourse *and* in analysing the interpretative context and culture in which that discourse is produced. As Gill (1996) eloquently notes, "we are continuously

orientating to the interpretative context in which we find ourselves and constructing our discourse in order to fit that context" (p. 142). Parker (1999) further elaborates this point nicely:

> *Words and phrases do not come ready packaged with a specific delimited meaning that a researcher can be sure to know as if they were fixed and self-contained. Rather, it is the interweaving of words and phrases in different contexts that gives them their sense, and when we attempt to grasp patterns in a text we always have to carry out that exercise against a cultural backdrop* (p. 2).

Being aware of the contextual concerns and cultural backdrop to which the talk or text alludes is not just important, but essential to a high-quality discursive analysis. This is because the researcher needs to know what the talk or text is referring to in order to produce a reading and carry out an analysis (Macnaghten, 1993). Context and cultural awareness includes our knowledge of groups, social, political and cultural trends, and is thus necessary and essential for an excellent discursive analysis.

Summary: Interpretative repertoires, variation, construction, function, culture and context.

To summarise the preceding overview, the discursive approach of Potter, Edwards and Wetherell involves two overarching and interconnected components and three key elements for identifying these two components. The two broad components are the discursive *practices* people perform and the discursive *resources* people draw on in performing those practices. The three key elements that help highlight these two components are examining the talk and text for function, noticing the variation and consistency in the talk and text, and exploring the talk and text to see how it is constructed. In addition, the variation, consistency and construction employed in the talk or text help clarify the interpretative repertoires (i.e., resources), whilst the wider context and cultural backdrop helps clarify the discursive functions (i.e., practices).

Why I chose this particular discursive approach.

This particular discursive approach, as compared to other common discursive approaches (e.g., Parker, 1992; Billig, 1988; Hollway, 1989; Willig, 1999; Fairclough, 1990), was chosen for a number of reasons. The first was that this conglomeration of theorists provided a scaffolding so similar that I found it unfeasible to make minor distinctions between their understandings in the actual *practice* of discourse analysis. Thus, it was more pragmatically feasible to utilise this conglomeration.

Secondly, the scaffolding and broad theoretical framework of the adopted approach provided a decent sense of stability, understanding and direction, which I considered an important feature as a beginning discursive researcher. Although I am not completely familiar with many of the intricacies of the other types of discursive approaches available, I felt I knew and sufficiently understood this particular approach in order to competently use it as a research approach.

Lastly, as Gill (1996) explains, "doing discourse analysis involves you in the interrogation of your own assumptions and the ways in which you make sense of things" (p.145). The assumptions and 'ways of making sense' entailed by Potter, Edwards and Wetherell's particular approach seemed to 'click' with my philosophical views and values. By choosing this form of discourse analysis I realised that I was buying into a whole series of choices, perspectives and epistemological commitments, and these seemed more aligned and acceptable with my philosophical views and values than with my understandings of any of the other approaches available.

Positioning theory.

In addition to the discursive approach adopted, I have also utilised Davies and Harré's (1990) 'positioning theory'. According to positioning theory, a 'subject position' is created when people in interaction use language to negotiate positions for themselves. As Burr (1999) explains:

Discourses provide us with conceptual repertoires with which we can represent ourselves and others. They provide us with ways of describing a

person... Each discourse provides a limited number of 'slots' for people...
These are the subject positions that are available for people to occupy when
they draw on this discourse. Every discourse has within it a number of
subject positions... (p. 141).

The subject positions that are taken up by people are achieved by individuals negotiating different and shifting identities and accounts which reflect the contingencies of their accounting situation (Wetherell, 1999). Many different kinds of subject positions are actualised from moment-to-moment, and these may be offered, accepted, claimed or resisted by the individuals (Davies & Harré, 1999). Subject positions emerge and are identified by focusing on the discourses manifestation between individuals and by noticing the effects that these discourses have (Langenhove & Harré, 1999). Thus, the use of discourse creates subject positions, and the positions available are contingent on the individuals understanding of the discourse.

Davies and Harré (1990) acknowledge that people are both products of discourse, and producers of discourse. They are products in the social constructionist sense in that their identities "come to be produced by socially and culturally available discourse" (p. 140). They are producers in the individualistic sense in that within the cultural and social discourses available, individuals in interactions manipulate discourse to position themselves as they "manoeuvre in the prevailing discourses" (p. 141). Thus, the use of discourse in social interaction has the function of creating different subject positions, and positioning refers to this process of negotiated identity or account construction (Langenhove & Harré, 1999).

In addition, the positions available within discourses bring with them a 'structure of rights' (Davies & Harré, 1990). This entails that each subject position not only provides a sense of "who we are" (Burr, 1999, p. 145), but also the possibilities for and limitations on action within a particular discourse (Davies & Harré, 1990). Thus, different constructions of an interaction can offer different subject positions, which entail different rights, obligations and possibilities for action. Hence, subject positions have implications for power relations as they constrain and shape what an individual can do. In other words, each individual is exposed to an interaction of different discourses, each with its own possible subject positions, structure of rights, obligations and possibilities for action, and each carrying different power implications.

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Having outlined 'discourse analysis', the particular discursive approach adopted, my grounds for choosing such an approach, and provided a brief explanation of 'positioning theory', I will now describe and give a rationale for the methodological and process elements that were involved in this research project.

METHODOLOGY.

Introduction.

In this chapter I outline the orderly pathway that this research project undertook. I accomplish this by explaining the multi-media design utilised, including the order of the approach taken, considerations in choosing the material for analysis and the particular procedures that were followed in conducting this research. This involves detailing the three different textual media utilised, the particular surrounding issues that each distinct media entailed, explaining when and how they were used, and giving a justification for their inclusion.

The prevailing intention of this chapter is to reveal the practicalities and particularities of conducting this type of discursive analysis with these particular media. In doing so I lay out the process engaged in for scrutiny and defend that process as a legitimate and fruitful form of social inquiry.

The multi-media approach.

The multi-media approach of this research involved obtaining three distinctly different types of talk and text from within the cognitive therapy domain. These consisted of two cognitive therapy instructional books, two cognitive therapy demonstration videos, and two interviews with practicing cognitive therapists. The main reason and principle benefit for using this multi-media approach was that it allowed the capturing of the widest possible variation in accounts, in different types of materials, across the domain of interest. As Potter and Wetherell (1987) explain:

> *By collecting documents from many sources, recording interactions, and then combining this with more directive interviewing, it is possible to build up a much fuller idea of the way participant's linguistic practices are organized compared to one source of data alone* (p. 162).

Theoretically and practically this translated into a better understanding of how the notion of belief was being used and constructed within and across the cognitive therapy domain. If, for example, I had only collected material from instructional books, I may have missed the rich and dissimilar understandings that were available

in the demonstration videos or interviews. In short, the analytic potency would have been diminished if the construct of belief was used or constructed in certain ways in the cognitive therapy domain by one medium and in a different ways in this domain by other media. However, by strategically employing a multi-media approach from the outset I was able to gain a much wider exploratory scope of the discursive resources and practices available for constructing and using belief. Thus, I have reduced such a potency concern and enhanced the exploratory effectiveness of the research.

A second benefit was that this approach allowed the interweaving of analytic questions that only an approach of this kind could have allowed. For example, a question such as, 'do practicing cognitive therapists talk about beliefs in a way consistent with the way the cognitive therapy literature talks about beliefs, or is their talk constrained by that literature?'. Such a question, which highlights the interactional effects of the different media, would not have been possible without such a multi-media design. These interactional questions provided fruitful insights into how the media interacted, how the therapists utilised different media when using and constructing belief, and how they positioned themselves by the use of these particular media.

Which media to utilise?

Having decided on using a multi-media approach from the outset, there was the question of which particular media to utilise. There were many media available in the cognitive therapy domain in which belief was utilised. These included cognitive therapy instructional books, internet material, demonstration videos, interviews, e-mail discussions, 'chat room' material (e.g., support groups), cognitive therapy sessions, and conference proceedings or papers. From these media, instructional books, demonstration videos, and interviews with practicing cognitive therapists were chosen for a number of reasons.

Firstly, in specifying the scope as the cognitive therapy domain, these particular media provided a wide coverage of aspects relevant to cognitive therapy that included therapists' 'belief talk'. In contrast, other media, such as 'chat room' discussions or conference proceedings, may not have covered or alluded to belief, or may have been dominated by non-therapists.

Secondly, there was easy access to these three media, whereas some of the other media would have been less practical. For example, utilising cognitive therapy sessions would have been both time consuming (e.g., organising the logistics of gathering the material) and involved additional ethical and therapeutic concerns (e.g., therapeutic sensitivity, additional confidentiality, gaining permission).

Thirdly, only three of the possible media were chosen as I considered that these would provide an adequate and representative sample of talk and text within the cognitive therapy domain. The number was also limited by the nature of the research project being a one year project and myself being a beginning discursive researcher.

Fourthly, the three media chosen provided an advantageous combination of media, ranging on a continuum from 'fixed' to 'interactive' material. At one end were the books which remained fixed in the sense that they were unalterable and refined (i.e., edited). Towards the middle of this continuum were the videos which also remained fixed in the sense that they were unalterable, however interactive in the sense that the discourse produced was unscripted and unrefined (i.e., unedited). At the other end of this continuum were the interviews with the therapist which were interactive in the sense that they were both alterable and unrefined.

Which media to approach first?

Having decided on the particular media to utilise, there was the question of which particular media to approach first. More specifically, in which order should the material be gathered, and what might be the effects of the differing orders? For example, should I interview therapists first, second or last? The order chosen was to firstly collect material from the instructional books, secondly demonstration videos, and lastly interviews with cognitive therapists. There were a number of reasons why this particular order was chosen.

Firstly, there appeared less methodological risk in approaching fixed material (i.e., books and videos) than in approaching interactive material (i.e., interviews). By beginning with the fixed material, if a procedural error or important conceptual misunderstanding occurred, it would have been relatively easy to begin again afresh. However, this would not have been the case with the interactive texts. A number of discursive commentators have noted that the more practice a researcher has at

actually undertaking discourse analysis, the greater the potential for a higher quality (i.e., more insightful, more illuminating) analysis to be produced (e.g., Coyle, 1995; Edwards, 1997; Fairclough, 1990; Silverman, 2001). The fixed books and videos allowed unlimited opportunity for unrestricted practice, unlike the interviews, and having the opportunity to practice also facilitated my confidence in proceeding as a beginning discursive researcher.

Secondly, once I had decided to obtain the interview material last, I had to decide whether to approach the books or videos first. The instructional books were chosen as I pragmatically had instant access to these, whereas I had to wait for permission to gain access to the demonstration videos. I also considered the analysis would be more straight-forward with the books, as in the videos there is more "going on" (Russell, 1999, p. 94) in that particular medium; another important consideration for a beginning researcher.

Considerations in obtaining the texts.

Cognitive therapy instructional books.

Having chosen to begin gathering information from cognitive therapy instructional books, the pertinent questions were which books and how many? Two books were chosen out of a possible 15 considered for this research project (see Appendix C for a list of those reviewed). These were Judith Beck's *Cognitive therapy: Basics and Beyond* (1995), and Aaron Beck, John Rush, Brian Shaw and Gary Emery's *Cognitive therapy of depression* (1979).

With regard to the choice of books, there were three factors taken into consideration. Firstly, I wanted to analyse literature that would be most representative of the cognitive therapy domain, and that most cognitive therapists would have read. The assumption employed here was that these books and how they used and constructed belief would, to some degree, influence how therapists themselves used and constructed belief. The process I followed was to informally consult with senior practicing cognitive therapists and academics at Massey University and the Waitamata Health Cognitive Therapy Centre who specialised in cognitive therapy. All identified these two books as among the most commonly used and predominant cognitive therapy instructional books.

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Secondly, the term 'cognitive therapy' can be applied to a variety of slightly different approaches (e.g., Clark & Fairburn, 1997), and I wanted to narrow my focus to the cognitive therapy developed and refined by Aaron Beck. This was because he is continually acknowledged as the field's creator, leader and prime innovator (Salkovskis, 1996; Weishaar, 1993). While both books chosen emphasise the same conceptual and practical content (the cognitive therapy of Aaron Beck), they are however from two different discursive sources.

Thirdly, I wanted to explore the temporal development of belief in cognitive therapy. To accomplish this, I had to sample both an early and contemporary book, as this would highlight any possible adaptations to the notion of belief over time. For instance, as a general observation of the 15 books reviewed, it seemed apparent that the older the book, the less reference to belief, and the newer the book, the more reference to belief. As a specific example, *Cognitive therapy of depression* (1979) mentions 'belief' or 'believe' a total of 372 times in 425 pages, compared to *Cognitive therapy: Basics and Beyond* (1995) which mentions 'belief' or 'believe' a total of 739 times in 338 pages; an increase from 0.87 instances per page in 1979 up to 2.18 instances per page in 1995. This insight, that the notion of belief is becoming more predominant and popular as the cognitive therapy field has evolved, would not have been possible had I chosen two contemporary books.

I chose to analyse two books as both books were of considerable length (338 and 425 pages), necessitating considerable reading time. A discursive analysis involves a close reading and inspection of the material, and reading more books of this size *this closely* was unfeasible. I was also aware of the numerous warnings in the discursive literature of "ending up with a mountain of unstructured data to sift through" (Coyle, 1995, p. 247). I considered two books the amount practically manageable. I also found that once the 'belief talk' from the two books was transcribed, an ample amount of material for analysis emerged. There seemed no reason for gathering more material of this type, as larger samples of text would have added to the analytic task and may not have added significantly to the analytic outcome.

Cognitive therapy demonstration videos.

As with the instructional books, once again the pertinent questions were which videos to analyse and how many? Two demonstration videos were chosen from a possible 21 accessible. These were *Cognitive Therapy for Panic Disorder: A Client Session* conducted by Christine Padesky (1993), and *A Demonstration of Cognitive Therapy* conducted by Aaron Beck (1995).

With regard to the choice of videos to analyse, there were two factors taken into consideration. Firstly, cognitive therapy demonstration videos are not as freely available as are cognitive therapy books. Consequently, I was limited to only those videos that I had access to through Massey University and the Waitamata Health Cognitive Therapy Centre.

Secondly, the aim was to select videos that portrayed a realistic use of cognitive therapy with a client *in situ* (i.e., unscripted cognitive therapy). Both of these videos met this requirement by demonstrating cognitive therapy with a volunteer client, in a workshop style format. This realism was important as I wanted as naturalistic a demonstration of cognitive therapy in practice as possible.

With regard to the decision to analyse two demonstration videos, this decision was influenced by two factors. Firstly, each video was just under an hour in length and gave a sufficient amount of belief talk that was representative of cognitive therapy in practice.

Secondly, using two videos with different demonstrators gave access to two different styles of cognitive therapy, as although both therapists were practicing the cognitive therapy theory of Aaron Beck, the two therapists differed in their individual styles and in the subject content they demonstrated.

Practicing cognitive therapists.

Similarly the pertinent questions were also which cognitive therapists to interview and how many? With regard to which cognitive therapists to interview, the participants were practicing clinical psychologists in the Auckland area who held a post-graduate diploma in clinical psychology. The reason for selecting these types of therapists were that after consulting with Massey University staff who specialised in cognitive therapy, it was thought that there were three distinctly different types of

practicing cognitive therapists. Firstly, there were practicing cognitive therapists who were also academics, highly familiar with the cognitive therapy literature. The assumption here was that their familiarity with the literature would influence to a greater degree the way they talked about belief. Secondly, there were practicing cognitive therapists who had had formal training in cognitive therapy, such as clinical psychologists who held a post-graduate diploma in cognitive therapy or clinical psychology. And lastly there were practicing therapists who used cognitive therapy as their main psychotherapeutic intervention, yet did not have more formal training in cognitive therapy.

As the three groups of therapists' levels of knowledge of cognitive therapy varied in amounts, by way of middle ground I targeted the second group. The criteria to participate in the study were that they, in their own opinion, currently practiced cognitive therapy as their main psychotherapeutic approach. The length of time practicing as a cognitive therapist, their training, and background reading were also considered relevant and enquired into; the assumption here being that these elements would considerably influence the way they talked about beliefs. In this regard, both therapists had been practicing for eight years, had obtained a post-graduate diploma in clinical psychology as their highest qualification, and had read "20 plus" books on cognitive therapy, including the two utilised in this research. However, both also mentioned that they had not read any books "recently".

With regard to how many cognitive therapists to interview, I thought that samples of talk from two therapists would produce a large enough number of linguistic patterns to study in order to discern the variety of discursive forms that were utilised in constructing and using notions of belief. This was largely because at this stage in the research process, I only wanted to tap specific areas and patterns of interest.

Text collection, transcription and coding.

Cognitive therapy instructional books.

Text collection and transcription.

After the initial readings of each book, every instance of 'belief' or 'believe' was highlighted. Each instance, along with its surrounding context (i.e., belief talk), was then extracted and transcribed word-for-word into a computer file. These transcriptions were organised by both context number and page number. For example, if the word 'belief' or 'believe' was used more than once in a sentence or in the immediately following sentences, this accounted for one context. For example:

24)   *This process led to Sally consolidating a negative core belief about herself. Sally's negative beliefs were not rock solid, however...* p. 20.

In this example, the number 24 indicates that this is the 24th instance of a separate context of 'belief' or 'believe' in the book, and that this occurred on page 20. This system was devised to allow easy accessing of the material for further analytic investigation when needed. The judging of particular contexts was a subjective process, and my guide was to include any relevant material to the mentioning of 'belief' or 'believe'; for example, further explanations, examples, or analogies. I was also conscious of warnings in the discursive literature that certain aspects of the texts may become more apparent during the analysis and coding process (e.g., Potter & Wetherell, 1987; Parker, 1992), so I lent on the side of inclusion rather than exclusion of context. In some instances this amounted to copying out almost complete pages of the books. However, going through this process of transcription was helpful in that it forced a closer reading of the text; a point various discourse analysts comment on (Potter & Wetherell, 1987; Parker, 1992; Willig, 1999; Silverman, 2001). Once the transcriptions were complete and checked for accuracy, the process of coding began.

<u>Coding.</u>

The coding of the material followed on from the transcription and was a preliminary process to the analysis stage (Potter & Wetherell, 1987). The goal of coding was not to find results, but rather a pragmatic goal of squeezing a large body of relevant discourse into manageable chunks in preparation for more intensive study (Potter & Wetherell, 1985).

From the transcribed computer files, all instances of 'belief' or 'believe' were placed or duplicated into one or two coding categories; 'the belief itself' and or 'the believing person'. After reading the transcribed material a number of times, these categories were used as cognitive therapists seemed to be repetitively mobilising two main and distinct constructions around the notion of 'belief' in the texts. Although guidance from the discursive literature on the process of coding itself seemed extremely scant, in practice I found it helpful to read each line of the transcripts and ask, 'what kind of picture of belief is being portrayed here?' and 'is a picture of a belief itself or a believing person being portrayed in this segment of the transcript?' If it was, I then placed or duplicated each segment into one or two of the two categories.

Similar to the process of transcription, the process of coding was also completed as inclusively as possible. All instances that seemed only vaguely relevant were included in their relevant categories, and in many instances, both categories. Once this process was compete, I was left with two discrete piles of text in two files, each representing belief talk in one particular category of interest.

Cognitive therapy demonstration videos.

<u>Text collection and transcription.</u>

After completing the transcription, coding and preliminary analyses of the two books (described in the next chapter), I turned my attention to the demonstration videos. In contrast to the books, in which word-for-word transcription was relatively easy, the verbal and visual presentation of discourse is much more complicated because of an abundance of unedited 'mess' (Holstein and Gubrium, 1995). For this reason, the form of transcription notation adopted was similar to that predominately

used and recommended by Potter and Wetherell (1987), and is acknowledged as a reduced version of the transcription system developed by Gail Jefferson (1985) for conversational analysis. Although in this type of analysis "the spoken is always reduced to the written" (Parker, 1999), this more comprehensive transcription system (outlined in full in Appendix E) emphasises different features of interaction which include, for example, speech errors, pauses, gross changes of volume and emphasis. It is these features which played an important role for the participants as they made sense of an interaction (Potter & Wetherell, 1985), and in my case also aided in determining the subject positions of the discourse users.

After the initial viewings of each video, each video was audio taped, and each instance and context of 'belief' or 'believe' highlighted by a time stamp. Each context instance of 'belief' or 'believe' was then extracted from the audio tape and transcribed into a computer file. Analogous to the transcriptions used for the books, these transcriptions were organised by time stamp. For example:

14.11) *Therapist: ...rate how much you believe now, (1.2) that you were having a heart attack, on a ZERO to one hundred percent scale, how much do you think you were having a heart attack that night?*

In this example, 14.11 indicates that this dialogue began 14 minutes and 11 seconds into the video. There are three main points of difference between the transcriptions from the books to that used with the videos. Firstly, with the video material, additional contextual elements such as body position, hand signals and facial expressions have also been taken into account. In other words, the non-linguistic textual features that aided in the communication were also included. Here my goal was to obtain a transformation from the visual media to the written transcription that permitted a faithful rendition and interpretation of the discourse used, including how it was used and the surrounding context, without doing "violence to the text as we stop its flow and present a snapshot" (Parker, 1999, p. 8).

Secondly, I wanted to reproduce passages at a level of transcription that allowed readers to make their own evaluations about what was happening in the videos and this necessitated a more comprehensive transcription system than that used for the instructional books.

Thirdly, the transcription notation utilised helped highlight the performance elements of the talk and text. For instance, in the above example, the underlining highlights the speaker's added emphasis.

Coding.

Once the video material had been transcribed, re-checked for accuracy, and read a number of times, the coding into computer files followed the identical procedure outlined above for the instructional books. After viewing and transcribing the videos, the coding categories utilised were the same as those used with the books (i.e., 'the belief itself' and 'the believing person'), as no further or different categories seemed appropriate. Once this process was compete, I also had two discrete piles of text in two files, each representing belief talk in one particular category of interest.

Interviews.

Text collection.

Once I had completed the transcription, coding and preliminary analysis of the videos (described in the next chapter), I began interviewing the cognitive therapists. Interviews have been extensively used by discourse analysts and consequently my approach was guided by numerous examples of research that has utilised interviews to gather texts (e.g., Auburn, Lea & Drake, 1996; Billig, 1988; Edley & Wetherell, 1999; Harper, 1996; Horton-Salway, 2001), and many helpful articles and chapters with methodological insights regarding interviewing (e.g., Breakwell, 1995; Silverman, 2001). Interviews in particular allowed the opportunity to explore a range of themes and interpretative repertoires that participants had available, as well as the uses to which those repertoires were put (Silverman, 2001). In other words, interviews allowed the 'fleshing out' of the way belief was being worked up.

The interview data was collected in one-to-one interviews at the participant's place of work. This process began with an internet search for clinical psychologists in the Auckland area. I then e-mailed a number of listed clinical psychologists informing them of the purpose of the study (see Appendix F for the study

information sheet), outlining the requirements to participate, and requesting participation. The first two therapists that volunteered were phoned, upon which I explained the extent of commitment required and arranged a time for the interview at their convenience.

Prior to each interview commencing, and in accordance with contemporary research practice, two copies of the consent form (see Appendix G) were signed and permission was obtained for the interview to be audio taped. Participants were informed that the tapes would be transcribed and destroyed within 48 hours, and that any identifying characteristics would be edited out during the transcription process to ensure confidentiality.

The interviews began by inquiring about general information concerning the therapist; background, training, and experience. The purpose of this was to increase rapport, encourage an informal atmosphere, relax the interviewee, and gain a fuller context for their discourse use. I then moved onto a set of guiding topics and themes that were organised around 15 questions (see Appendix H). These questions targeted both specific areas developed from the preliminary analysis of the books and videos, and also allowed exploration of new areas by probing interesting and unique 'belief talk', as well as what I though might be important questions related to the notion of belief in cognitive therapy. Nonetheless, the idea was to avoid the questions influencing the therapists' constructions to a large degree, and to locate their belief talk within the institution of cognitive therapy by allowing the discourses and repertoires to be addressed in different contexts.

Although all questions were covered, meaning that the same topic areas were covered by both participants, not all questions were asked as the participants answered some of the questions in response to others. This flexible format entailed a relatively open-ended, semi-structured and informal interview. This particular format and content was chosen because it served to orient the therapists towards specific cultural ideals and resources used for constructing belief, and because it was also the approach recommended by Potter and Wetherell (1987).

The interviews lasted 27 and 29 minutes, and at the conclusion of the interviews, any further questions regarding the study were answered. Both therapists mentioned that the interview process had been a beneficial experience and admitted challenging their own assumptions about the notion of belief and how they used it.

Although being a qualified applied ethicist (PGDipAppEth) and previous member of a university ethics committee, ethical review from the Massey University Human Ethics Committee was also obtained. However, it was not anticipated that the study would cause any harm to the participants, or raise any important or unusual ethical concerns.

Transcription and coding.

At the conclusion of each interview, each tape was transcribed immediately. The transcription and coding methods, and procedures utilised, followed those used for the transcription and coding of the demonstration videos, including the use of visual notes. Likewise, the same two coding categories seemed appropriate and were used; 'the belief itself' and 'the believing person'. Once this process was compete, I had two discrete piles of text in two files, each representing belief talk in one particular category.

Having outlined the pathway that this research project undertook, including its multi-media design and the particular procedures that were followed, next I go on to outline further considerations regarding how the process of analysis was conducted and provide an overview of the analysis.

ANALYSIS.

Introduction.

The purpose of this bridging chapter is to link together certain aspects of the three previous chapters with the analysis that follows and in doing so make that analysis more comprehensible to the reader. To achieve this objective, I firstly outline further theoretical and methodological considerations regarding how the process of analysis itself was conducted, and secondly present a concise overview of the analysis as a conceptual guide.

An outline of how the analysis was conducted.

Sequential overview of the analysis process.

Once the information from the books had been collected, transcribed, checked, and coded into the two relevant categories, a preliminary analysis on the transcripts was conducted. Using the discursive approach outlined in the second chapter, the analysis followed ten stages for each media. With regard to the book transcripts, my first aim was to search each of the two coding category files for instances of variability within each separate account (1), and then between accounts (2). Following this, I searched for consistent features within each account (3), and then shared by the accounts (4). Next, I looked at how each account was constructing the notion of belief (5), and how these constructions were the same or different (6). Then I concerned myself with the functions and implications of each account (7), and between accounts (8). Lastly, I investigated the specific interpretative repertoires (9) and wider discursive context (10). This ten stage sequence of examining the transcripts was repeated with the videos and the interview material.

I found by trial and error (while practicing on other similar material) that this order imparted the most coherence and analytical sense. I had, as Parker comments, gone through a "process of arriving at an appropriate method... (in order) to be true to the text" (Parker, 1999, p. 2).

Applying discourse analysis to the research project: From theory to practice.

Theory.

In theory I was exploring the discourses and repertoires to which the therapists orientated in giving an account of belief and how they negotiated among the subject positions and cultural resources available. The underlying assumption was that cognitive therapists are both producers and products of discourse. They are producers in the sense that they are engaged in actively constructing beliefs. They are products in the sense that they draw on ways of making sense that are widely available as part of the cognitive therapy culture. Thus, if the meaning of belief is discursively constituted, a therapist's account of belief will be constituted as a function of the various linguistic resources available to them, and they will draw on these to accomplish certain actions and notions of belief.

Practice.

In practice, to enact this theory and to accomplish this ten stage analysis for each media, I transposed the questions associated with the discursive approach adopted (i.e., see pages 26-29), as well as a few of my own, into questions more relevant and applicable to the notion of belief in the cognitive therapy domain. These were the specific questions that were asked of the transcripts that guided and aided the analysis. These included:

Variation questions.

Variability.
- In what ways are cognitive therapists' accounts of belief variable in the transcripts?
- Are beliefs formulated as different kinds of objects in the transcripts?
- Are there different kinds of presentations of belief in the transcripts?
- How is the belief talk of cognitive therapists organised?

- What are the particular patterns in the transcripts in terms of its variability?
- Does the notion of belief have different meanings in the transcripts?

Consistency.

- In what ways are cognitive therapists' accounts of belief consistent in the transcripts?
- What regularity or particular pattern is apparent in the transcripts portraying belief?
- Does the notion of belief have similar meanings in the transcripts?

Construction questions.

- How do cognitive therapists put discourse together to construct notions of belief?
- How are the variable and consistent meanings of belief that are portrayed in the transcripts constructed?
- How are particular types of belief achieved in the transcripts?
- How has the talk or text about a particular notion of belief been constructed so that it makes sense and seems solid and unproblematic?
- What linguistic resources are drawn on in constructing belief in the transcripts?

Function questions.

- What are the functions and consequences of different constructions of belief in the transcripts?
- What is the linguistic evidence to support these hypothesized functions for belief?
- How is the account of belief in the transcripts made persuasive?
- What are the functions and consequences of cognitive therapists' variable accounts of belief in the transcripts?

- What are the functions and consequences of cognitive therapists' consistent accounts of belief in the transcripts?
- What is the talk of belief actually doing in the world?
- What interactional business is being attended to in the talk and text on belief?
- What is the function of using the construct of belief?

Interpretative repertoire questions.

- What discursive resources are therapists drawing on or bringing to their social interactions?
- What similar linguistic phenomena are being mobilised?
- What broadly discernable clusters of terms and descriptions are apparent in the transcripts?
- What 'family resemblance' (i.e., in the Wittgensteinian sense: Wittgenstein, 1958) is there in the talk or text?

Context questions.

- What is the context in which the discourse is taking place?
- What cultural notions are at play in or support the talk or text?
- What is the talk or text referring to?

These guiding questions were designed for two purposes. Firstly, to assist in exploring both the functional and constructive ways beliefs were talked about and worked up, as well as the consequences that these practices had for the construction of belief. These questions allowed a search for themes and sets of statements which talked about or represented beliefs in similar ways, for metaphors that brought with them particular images of belief, and for words which seemed loaded with meaning.

The second purpose was to avoid the empiricist temptation of interpreting the talk and text as an indicator of 'underlying beliefs', and using those beliefs to then interpret the talk and text. Consequently, these questions helped evade this anti-

realist tendency and inherent cognitive reductionism, and instead highlighted the way that belief was being played out in the social interactions.

Applying positioning theory to the research project: From theory to practice.

With regard to positioning theory, I was interested in the ways cognitive therapists utilised different discursive strategies and repertoires to position themselves and their clients, and the various effects the positioning had for the therapeutic process. In order to determine the various positioning that was happening in the interactions, I focused on the way therapists used particular strategies to present and describe themselves and others, as well as the 'structure of rights' entailed by the positions. For the purposes of this research project, I have chosen to focus on the two main positions discerned.

The reflexive and holistic nature of the analysis.

The nature of the research process I have undertaken can be conceived of as mutually reflexive and holistic. It is reflexive in the sense that the analysis of one medium affected the analysis of the next: the analysis of the books then affected the coding and analysis of the videos, which in turn affected the obtainment, coding and analysis of the interviews. This analytic reflexivity enabled the analysis of the construction and use of belief to be continually refined, and also allowed for the probing and following of interesting insights. This sequential design and continual refinement should not be interpreted as an attempt to get at any essentialist notion of belief, but rather to ensure that the 'discursive field' of cognitive therapists' talk and texts had been adequately covered.

The research process can also be considered holistic in the sense that the reflexive analysis entailed a 'bigger picture' of how beliefs were constructed and used through the three different media, across the whole of the cognitive therapy domain. In other words, the different media combined to make a whole, and paint a holistic picture of how beliefs were constructed and used.

Reflexivity.

Being a reflexive researcher entails outlining in more detail both my perspective and role as the researcher. This entails acknowledging that what I bring to this research in the way of my background, assumptions and preconceived notions of how belief is used impacts on the research. This is because everything from my interpretation of the transcripts, to my selection of the material, to the questions that I ask of these, will inevitably be influenced to some degree by my perspective. As Burr points out, "the questions we come to ask about that world, our theories and hypothesis, must also of necessity arise from the assumptions that are embedded in our perspective" (1995, p. 160). Thus, as the researcher, I have to acknowledge that my involvement in the research process is influential on the outcomes of the research.

The researcher's perspective.

Being a 26 year old, white, middle class, male with seven years of university education and a background in philosophy has inevitably influenced this research project. In this sense, I agree with Jones and Gerard (1967) who express that "the biologist, the philosopher, and the psychologist all probe the nature of man, but their perspectives, and hence their vocabularies for dealing with man, differ" (p. 157). For instance, the conceptual schemes and language offered in philosophy are very different to those in the psychological domain, entailing various different uses and conceptions of belief, and my background in these different discourses has impacted on my conceived notions of belief and its uses.

Preliminary notions of belief.

Before I started this research project, I did not have a firm understanding of the notion of belief or how it was used, but rather a collection of casually conceived notions. The first of these was that belief was a dichotomous notion; either a person believed something or they did not. It was not until I encountered the cognitive therapy literature that I found the portrayal of belief as a continuous notion.

Subsequent reading has also highlighted the possibility of a combination of these, for example, Mahoney (1974) comments:

> *Is the belief gradually shaped in the direction of therapeutic improvement, or is dichotomous 'revelation' a more appropriate metaphor? When the depressed perfectionist alters his assumptive standards and self-evaluations, does it occur gradually or overnight? My noncommittal hunch is that both of these phenomena occur in most therapeutic modifications of belief. Conversations with colleagues and my own clinical experiences over the past few years have offered ample documentation of all-or-none belief change. As a matter of fact, a phenomenon which might be called the 'cognitive click' seems to appear very frequently in a variety of clinical applications* (p. 240).

The second of my notions was that beliefs were largely controlling mechanisms; beliefs assist understanding, decision making and direct behaviour. In other words, if an individual believes something, this stance results in either action or inaction in line with the content of their belief. Whatever the action or inaction, the individual takes a *stance* against or for something. These were essentially the limits of my preconceived notions and I shall comment more on them in the discussion.

The constructed nature of the analysis.

My analytic comments and the way I have chosen to present the following three chapters and subsequent discussion chapter are themselves constructions. The way I have used language to portray therapists' constructions and uses of belief, and the positions they adopt, is no less constructed, occasioned or action orientated than that of the language that the therapists have used. Likewise, what I have chosen not to analyse or discuss, what could be considered 'leftover' in the material, is also part of my construction.

The focus of the analysis.

Although the English language provides us with various resources and different opportunities to talk about belief in different ways, my focus is looking at therapists' ways of talking within the cognitive therapy domain; their resources and the functions of their particular selections of talk. In other words, the focus is with

what belief is actually doing in that domain. In this regard, I concentrate on how the constructions of 'the belief itself' and the 'believing person' are accomplished by various ends. This type of analysis is very different from focusing on the semantics of the talk *per se*, which would indubitably portray quite a different picture.

Presentation of the analysis.

The style of presenting the analysis goes from quite detailed and small to a broader and bigger picture. The aim of presenting the analysis in this way was to draw attention to the talk and what was happening in the talk, and then to step back from this and draw some larger conclusions. Another way to conceive of this is that I was firstly concerned with presenting the discursive resources drawn upon, then with the discursive practices performed with their talk or texts, and lastly with what I thought this means or entailed.

Although in unravelling how the talk and texts work, it was not possible to present all instances that supported particular repertoires or strategies, I nonetheless present selected examples of talk and text. My overriding intention here was to walk the reader through what I thought was happening in the material; "to 'point' to the data and make visible the moments when things happen" (Wetherell, 1998). As Potter (1996) notes, "perhaps the most important and distinctive feature in the validation of discourse analysis is the presentation of rich and extended materials in a way that allows the readers of discourse studies to evaluate their adequacy" (p. 139).

The extracts chosen are selective examples only, come from a wide selection of the talk available, and attempt to furnish the evidence necessary to justify the subsequent interpretations. As the analysis has a large scope, only a few examples were chosen. The selection of these examples were random as to avoid bias and the making of an extreme case for my interpretations. If at any stage the reader seems concerned, or would like to view more or fuller extracts, a copy of the six transcripts in their original format is available for reviewing in the CD-ROM inside the front cover.

An overview of the analysis.

The analysis is organised into three main chapters, as well as further analytic comments that are provided in the discussion. The first of these chapters focuses on the construction of 'the belief itself', including the repertoires that were drawn upon and their various functions. These include an objectification, malleability and scientific repertoire. The second of these chapters focuses on 'the believing person', and also includes the repertoires that were drawn upon and their various functions. These include a medical, defective and changeable repertoire. In simpler terms, these two chapters provide a picture of therapists' constructions of, firstly, 'a belief' that could, secondly, be possessed by 'a believing person', and once possessed had varying consequence for that person. Another way of interpreting this link is that, although it is arguable as to whether 'beliefs' are derivative or enabled by 'believing', the notion of belief plays an object role in the first of these chapters and an agentive role in the second.

The last of the main analytic chapters focuses on the two main and most frequently adopted subject positions; the therapist as an 'expert' and the client as a 'layperson'. Here I outline three of the most common discursive strategies and a moral repertoire that were used to enable and support this particular positioning. These strategies included the way therapists imparted knowledge, made extreme cases, and concealed information from their clients. These strategies were tied to practices which supported and maintained positions of power and dominance for the therapists. Additionally, in the discussion I cover some further tensions that were detected within and between the constructions of 'the belief itself' and 'the believing person'.

Having outlined a number of considerations regarding the process of analysis and presented a brief overview of the analysis, in the following chapter I outline and discuss in more detail the construction of 'the belief itself', and the repertoires that assembled and supported this construction.

THE BELIEF ITSELF.

Introduction.

Cognitive therapists seemed to mobilise two distinct constructions in their 'belief talk'; firstly a 'belief' was a discrete object ('the belief itself'), which could secondly be possessed or held by an individual ('the believing person'). In this chapter I outline and discuss the first of these constructions; 'the belief itself'.

Presentation notations.

Transcribed material is presented with an identification marker at the end of each relevant segment. For example, the marker (V-AB-40:59) below:

Therapist: ...bridging the gap between the intellectual knowledge, and the actual experience, the change in belief... (V-AB-40:59)

This marker indicates that that this extract was from a video (V), conducted by Aaron Beck (AB), and occurred 40 minutes and 59 seconds (40:59) into the video demonstration. The bold text highlights my added emphasis. Below are the identification markers for the six different sources of material utilised:

Example.	Material.	Author.	Reference guide.
(B-JB-235)	Book	Judith Beck	Context number, 235.
(B-AB-27)	Book	Aaron Beck	Context number, 27.
(V-CP-12:34)	Video	Christine Padesky	Time stamp, 12: 34.
(V-AB-34:21)	Video	Aaron Beck	Time stamp, 34: 21.
(I-ONE-13:33)	Interview	Anonymous	Time stamp, 13: 33.
(I-TWO-25:55)	Interview	Anonymous	Time stamp, 25: 55.

Overview.

In this construction of 'the belief itself', therapists constructed a belief as a discrete, malleable and legitimate object. They accomplished this by drawing on a number of interconnecting and supporting repertoires, which included an

objectification repertoire, a malleable repertoire and a scientific repertoire. The objectification repertoire was drawn on to work up a belief as a discrete and separate object. The malleable repertoire was drawn on to make belief a mouldable and changeable object. The scientific repertoire was drawn on to then legitimise the status of the belief itself. These repertoires combined to portray a picture of beliefs as discrete, malleable and legitimate objects from which the therapist could utilise to effect therapeutic improvement in their clients.

An objectification repertoire.

The first aspect of 'the belief itself' that will be discussed involved depicting beliefs as discrete objects. This talk, which seemed emphasised towards the beginning of the transcripts, drew a boundary around the notion of belief. This individuation talk can be discerned in the following extracts:

> *"do what is expected of you, otherwise you'll screw things up".* **This belief** *then led her to approach her problem in the old way by acting on what...* (B-AB-53)

> *Therapist: ...to kind of change* **this belief** **(points to whiteboard),**... (V-AB-21:49)

> *Therapist: ...so the heaviness in the chest went with* (the belief of) *suffocating, (.5)* **which belief** *did the <u>breathing fast</u> go with?* (V-CP-14:06)

> *Therapist: ...when they, they get* **that <u>belief</u>,** *that it <u>won't happen</u> until you get...* (V-CP-42:09)

> *...has started the process of modifying it* **(her core belief),** *via...* (B-JB-235)

> *...the belief itself becomes somewhat more attenuated.* (B-JB-194)

Here the belief was individualised so that the therapist could work with 'it', enabling the theoretical objective of belief change for therapeutic improvement. This individuation was also apparent not just in what was said, but also in how it was said. For example, in one of the video demonstrations the therapist commented:

> *Therapist: So if we were going to rate, (1.0) your belief, (.5) "I'm gone'a die",...* (V-CP-14:06)

Here each pause, or "yawning chasm in the fast flow of conversation" (Potter & Wetherell, 1987, p. 85), served to emphasis that the client's belief was a discrete and separate object. Similarly, this distinguishing element was also evident in the interview material:

> *Interviewer: Ok, how do you talk about beliefs with your clients? I mean how do you introduce them?*
> *Participant: Arr (1.0), I basically discuss how, **BELIEFS,** are generated throughout their lives, particularly when they're young, um, and the sorts of experiences that can shape certain **beliefs**, and then <u>link</u> them in with their thinking patterns, and their behaviours.* (I-ONE-1:02)

In this instance, the increase in voice and change in tone also served to emphasise that beliefs were discrete and separate objects. Supporting this individuation, beliefs were talked of as being of a certain 'kind', which fell into a specific 'category', and were part of a 'set' which interconnected with a larger belief 'system':

> *Therapist: Ar, hu, so:: (1.0) the **<u>kind</u>** of belief that you have is...* (V-AB-21:31)

> (the therapist)...*mentally hypothesizes from **which category** of core belief ("helplessness" or "unlovability") specific automatic thoughts appear to have arisen.* (B-JB-204)

> *Therapist: ...you currently have a **set of beliefs** that...* (B-JB-153)

> *Although common themes can be found in the **belief systems** of depressed patients each patient has a unique **set** of personal **rules** (i.e., intermediate beliefs).* (B-AB-129)

> *Another clue to the patient's **belief system** is his frequent use of particular kinds of words.* (B-AB-137)

This taxonomic talk made a belief a discrete and separate object by drawing a boundary around the notion, and served a number of particular functions for the therapists. The first was that the foundations of the person's problem (i.e., their beliefs) were labelled and categorised. This perspective lessened ownership of the problem, provided the client with distance from their problem, and thus bestowed partial therapeutic relief. For example, in both demonstration videos, after the clients had outlined their problems and the therapists began to talk of their problems in an

individualising way, both clients seemed reinvigorated and more optimistic. One client sat forward on her chair and the other client started to make more eye contact with the therapist. Both then adapted to and embraced this individualising way of talking. This technique is in line with research which suggests that clients are relieved by receiving a label (or 'handle') for their problems (e.g., see Fodor, 1987).

A second function was that the client was furnished with a sense of confidence in their therapist and the therapeutic process they were undertaking. By the therapist individualising a belief and conveying that it is an object, of a certain 'kind' which fits into a 'category' and is part of a 'set' and larger 'system', an assisting framework was alluded to. In some cases this framework was alluded to directly:

> *Therapist: Okay, what I would like to do <u>right now,</u> is we're going to back up over this and I want to, <u>show you,</u> (1.0) a model for understanding a panic attack.* (V-CP-14:06)

This framework allowed the therapist to assess, measure, and manipulate a client's beliefs in order to provide therapeutic relief. By alluding to this framework, and by the client's subsequent realisation that the therapist had access to and knowledge of this framework, confidence and faith in the therapist and therapy process were fostered and strengthened.

In addition to the confidence cultivated, credibility was drawn by the type of framework that was conveyed, as many other highly creditable professions use a similar framework. For example, doctors use a similar effective and successful framework in their diagnosis of patients. If a patient was diagnosed with a virus, it would be described as fitting into a certain 'kind' or 'category' of illness (i.e., infection), of a certain 'system' (i.e., part of a human; cells), which has effects (i.e., disease), for which there is a known remedy (i.e., anti-biotics). In no instance did the clients seem to question the therapists' framework, and thus credibility came through in their acceptance of this framework.

Summary of the objectification repertoire.

In this repertoire therapists worked up and depicted beliefs as discrete objects. More specifically, this was achieved by an individualising talk of 'this belief', 'that belief', 'the belief itself', as well as of a certain 'kind' of belief which belonged to a

specific 'category', which was part of a 'set' and larger 'system'. This talk drew a boundary around the notion of belief so that the therapist could work with 'it' and enable the theoretical objective of belief change. The main functions this repertoire served for the therapists included labelling the problem in order to provide therapeutic relief, and obtaining confidence and credibility in the therapist and therapeutic process through the acknowledgement of a reputable working framework.

A malleability repertoire.

The second aspect of 'the belief itself' that will be discussed involved portraying beliefs as malleable and modifiable objects. This was a very strong and dominant representation throughout the various transcripts. This is perhaps unsurprising given that modification of unhelpful beliefs is one of the most important goals of cognitive therapy (Safran, 1998). This depiction of beliefs as malleable was in contrast to their portrayal as fixed and stable. Here beliefs were objects that were 'fixed', 'strong', 'rigid', 'maintained' and part of a 'closed system'. This talk can be discerned in the following extracts:

> ...a problem that is too tightly tied to a very **strong**, very **rigid** belief. (B-JB-291)

> Therapist: ...<u>Now</u> I want to point out one other thing to you and the group here watching, that you have a, a <u>**strong: belief**</u> that you were going to pass out, (.4) when we... (V-CP-42:09)

> However, by engaging his interests in exploring the validity of his **fixed notions**, we can unlock this **closed system.** (B-AB-111)

> In this way he **maintains** the belief... (B-JB-20)

> ...the beliefs **maintenance** through the years. (B-JB-204)

This depiction as fixed and stable occurred towards the beginning of the transcripts and usually portrayed the current state of their client's beliefs. Contrasting against this stability depiction, beliefs were constructed as malleable and modifiable objects by the therapists. This involved talk of 'modifying', 'altering' or 'changing' the beliefs themselves:

*Since the patient's beliefs cannot readily accommodate the anomaly, they become more accessible to **modification**.* (B-AB-111)

*In order to decide which strategies to use to **modify a given belief**, the therapist clearly formulates to himself a more adaptive belief.* (B-JB-164)

*Many beliefs do require some **modification** before the patient is willing to change behaviorally. However, frequently only some belief **modification**, not complete **belief change**, is needed.* (B-JB-194)

*...to learn to identify and **alter** the dysfunctional beliefs which predispose him to distort his experiences.* (B-AB-6)

*Participant: Once they have started to **alter** the relevant beliefs...* (I-ONE-5:07)

*Therapist: ...bridging the gap between the intellectual: knowledge, and the actual <u>experience</u>, **the change in <u>belief</u>** Judy said, ...the <u>beliefs</u> change in=the=heat=of <u>emotions</u>, you need the emotion, to **melt the dysfunctional beliefs**...* (V-AB-40:59)

These extracts allude to the belief itself being modified or changing so that it becomes a different entity. Supporting this more direct reference to the malleability of beliefs, therapists also corroborated this construction by frequently highlighting the temporality of beliefs. These references functioned to reinforce both the possibility and normalcy of the belief's themselves changing. Here beliefs were portrayed as being either 'old' or 'new', suggesting and reinforcing temporal change:

*For example, Figure 10.5 lists Sally's **current** beliefs and the **new** beliefs the therapist has in mind. Although constructing a **new** belief is a collaborative process, the therapist nevertheless mentally formulates a range of more reasonable beliefs so he can appropriately choose strategies to change the **old** belief.* (B-JB-164)

***Old belief:** if I don't get an A, it means I don't have what it takes to be a success (90% - strength of belief). Intervention. Outcome: (80% rerating strength of belief). **New belief.** X 80%.* (B-JB-58)

*Therapist: The third thing is the assignment I already gave, arr, when he goes out and actually <u>experiences</u> the emotion, then in the heat of the emotion, can help to change the belief, provided that there's a **new** belief to insert in there, and so the **new** belief would be, 'I=am=a=man, I'm=a=good=parent, I=can=really=do=things', so that's the:: homework assignment.* (V-AB-40:59)

In addition to this enactment of theory in the texts, an interesting discovery was the particular way therapists orchestrated their discourse to construct a more malleable form of belief, paving the way for the beliefs themselves to change. In this regard, a frequent pattern of discourse organisation in the transcripts referred to belief and then subsequently referred to a more malleable concept associated with, or instead of, the belief. These concepts included shifting the use of belief to an 'idea', a 'notion' or an 'understanding'. This pattern of organisation can be seen in the following extracts:

> *Their most central or core **beliefs** are **understandings** that are so fundamental and deep that they often do not articulate them, even to themselves. These **ideas** are regarded by the person as...* (B-JB-20)

> *Therapist: Okay, so we've identified some of your **beliefs**: 'It's terrible to do a mediocre job'...Where do you think you learned these **ideas**?* (B-JB-153)

> *The therapist can then ask whether the patient has changed any of his **beliefs** in the past – **ideas** that teachers, parents, or childhood friends may have told him, for example...* (B-AB-198)

> *However, he* (the therapist) *labels it* (a core belief) *an **'idea'** (implying it is not necessarily a truth) and marks it as a future topic.* (B-JB-212)

> *It does not occur to him to question **these beliefs**. Even when they are questioned by the therapist, they appear reasonable to him. However, by engaging his interests in exploring the validity of his fixed **notions**, we can unlock this closed system.* (B-AB-111)

This semantic shift which portrayed beliefs in less stable and more malleable terms, assisted in the process of portraying beliefs themselves as changeable. By associating a belief with the concepts of an 'idea', a 'notion', and an 'understanding', this association functioned to break beliefs down into a more malleable form. This was because these particular concepts can be easily changed or modified, as they are not certain or known, but are instead only regarded or considered by an individual. By associating belief with these concepts, if a person was able to easily change their ideas, understandings or notions, they should also be able to change their beliefs because the objects themselves are malleable. This is also the case in cognitive therapy theory where 'intermediate beliefs' are also commonly referred to as 'underlying assumptions'; the term 'assumption' also highlighting a more malleable concept.

Summary of the malleability repertoire.

In this repertoire therapists organised their discourse to work up and depict beliefs as malleable objects that enabled the theoretical and practical objective of belief change. This was in contrast to an initial depiction of beliefs as fixed and stable objects. More specifically, this malleable repertoire was achieved by talking of beliefs as 'modifiable', 'alterable' and 'changing', by being 'old' and 'new', and by subsequently referring to more malleable concepts instead of belief; such as an 'idea', a 'notion' or an 'understanding'. The main function this repertoire served for the therapists was to break down the stability of the notion to allow for belief change, and thus therapeutic improvement.

A scientific repertoire.

A third aspect of 'the belief itself' that will be discussed involved legitimising and giving a status to a belief as an object. This was achieved by therapists expressing a scientific account of the process engaged in for a belief to be legitimate. Here beliefs came to be 'accurate' by being 'formulated' into 'hypotheses' which were 'evaluated' and 'examined' by standard 'procedures'. Beliefs were 'supported' by 'evidence' and 'data' which 'proved' the beliefs when 'tested'. This scientific process can be seen in the following extracts:

> *We formulate the patient's dysfunctional idea and beliefs about himself, his experiences, and his future into hypothesis and then...* (B-AB-9)

> *The therapist helps the patient to search for (and reframe) evidence that seemed to support the core belief from an early age and also to uncover evidence that contradicted it.* (B-JB-235)

> *Examine your interpretation of situations to determine whether you are distorting evidence to support a negative core belief and / or if you are ignoring or discounting evidence to the contrary to this core belief.* (B-JB-307)

> *Therapist: ...we'd try to evaluate, and help you <u>test out</u> all of the different thoughts that you had that supports the 'heart attack' hypothesis...* (V-CP-47:59)

*The therapist asks the patient to provide **evidence** (usually from recent experience) for and against each assumption and belief.* (B-AB-31)

*...refines his **hypothesis** about the core belief as the patient provides additional **data** about current and childhood situations...* (B-JB-204)

*Once the reason for the belief is discovered, the therapist can apply standard **procedures**, for example, seek **evidence** and **data** to **prove** or **disprove** the belief.* (B-AB-196)

*Therapist: ...in fact I want you to:, I want you to:, kind of arr, <u>rock</u> back and forth, on you feet, and you feel really, I'd like you to <u>sway</u> and **test out** this belief, that you are going to pass out. You still feeling kind of light headed?* (V-CP-26:36)

This scientific process of gathering 'evidence' and 'data' which 'supports' the belief, and 'evaluating', 'examining' and 'testing' it, then led to a judgment about the 'accuracy' of the belief. This accuracy notion in turn gave the belief a legitimate status. This accuracy judgement can be discerned in the following extracts:

*(a person's)...interactions with the world and other people lead to certain understandings or learnings, their beliefs, which may vary in their **accuracy** and functionality. What is of particular significance to the cognitive therapist is that beliefs that are dysfunctional can be unlearned and new beliefs that are **more reality based** and functional can be developed and learned through therapy. Taking this to the extreme, a client who holds a belief without any evidence maintains the belief even though it is **inaccurate** and dysfunctional.* (B-JB-20)

*Therapist: ...this belief is not a **correct belief**,...* (V-AB-21:49)

*...cognitive therapy teaches the person how to change **unrealistic beliefs** that are making him uncomfortable and unhappy.* (B-AB-206)

Therapist: ...but what does that tell you about some of the <u>beliefs</u> that you had when you're anxious, (.5) in terms of their <u>reality:</u>, because you pretty strongly thought you might pass out. (V-CP-43:03)

*...prior to the exploration of dysfunctional thoughts and **erroneous** beliefs.* (B-AB-28)

Although it is generally acknowledged in theory that the therapist is to "evaluate beliefs through the systematic accumulation of evidence" (Gluhoski, 1994, p. 597), the warranting effects entailed by such a scientific justification process are not known or so obvious. The main function this scientific process provided was

credibility for the therapeutic process from which the therapist worked. For example, by drawing on scientific notions to increase the object status of belief, these notions worked in a similar way to a doctor's scientific search for evidence in a patient's medical exam to support their diagnosis or prognosis. In such a case, the evidence works to support and hold together the doctors diagnosis or prognosis, as well as to give it a legitimate status. Analogously, here the therapist's hypothesised and formulated beliefs were supported and legitimated by a similar scientific and evidence based approach. The effect of portraying this scientific process through their talk was that the legitimacy of the belief itself as a discrete and malleable object was substantiated. The belief itself was given a higher and more valid perceived status by the client, which in turn increased their confidence in therapy and aided in the therapeutic and belief change process.

Summary of the scientific repertoire.

In this repertoire therapists used a scientific account and notions to depict beliefs as legitimate objects. More specifically, this involved talk of beliefs being 'formulated' into 'hypotheses', which were 'evaluated' and 'examined' by standard 'procedures'. This involved beliefs being 'supported' by 'evidence' and 'data' which 'proved' the beliefs when 'tested'. This led to a judgment about the beliefs 'accuracy'. It was the scientific process that led up to this accuracy notion that in turn gave the belief a legitimate status. The main functions this repertoire served for the therapists included providing credibility to the therapeutic process from which the therapist worked, increasing the client's confidence in therapy, and aiding the belief change process by establishing the legitimacy of beliefs.

Chapter summary.

In this chapter I have highlighted how therapists constructed a belief as a discrete, malleable and legitimate object. This was achieved by drawing on a number of repertoires, which included an objectification repertoire which worked up a belief as a discrete and separate object, a malleable repertoire which made a belief modifiable and changeable, and a scientific repertoire which legitimised and gave a

high status to a belief. These ways of talking about beliefs served various functions. Foremost amongst these were the enabling of the theoretical objective of belief change, providing therapeutic relief by labelling the problem, instilling confidence in the client, and giving credibility to the therapy process and therapist. In the next chapter I outline and discuss the second of the two constructions discerned; 'the believing person'.

THE BELIEVING PERSON.

Introduction.

The second of the two constructions that cognitive therapists mobilised in their 'belief talk' was that of a believing person; a person holding or possessing a belief. In this chapter I outline and discuss in more detail this construction that emerged from the transcripts.

Overview.

In this construction of 'the believing person', the therapists portrayed the person holding a particular belief as a defective, yet changeable, patient. They accomplished this by drawing on a number of interconnecting and supporting repertoires, which included a medical repertoire, a defective repertoire and a changeable repertoire. The medical repertoire was drawn on to work up the believing person as a patient. In conjunction with the medical repertoire, the defective repertoire was drawn on to depict the patient as flawed or damaged. The changeable repertoire was drawn on to suggest the necessity of the patient changing the beliefs they held. These ways of talking combined to sketch a picture of the believing person as a defective, yet changeable, patient.

A medical repertoire.

The first aspect of 'the believing person' that will be discussed involved the use of various medical notions, terminology and images to depict the believing person as a patient. This repertoire was a very strong, consistent, and unified feature throughout all of the transcripts. Moreover, it also seemed a broad and overarching repertoire in the sense that it did not solely apply to 'belief talk' or constructions of 'the believing person', but contextually covered and interwove with just about all aspects of the cognitive therapists' talk. For example, although not directly related to 'belief talk', therapists frequently utilised the medical notion of a 'symptom' to describe their client's troubles:

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Therapist: Right, that was very, that was the most <u>powerful</u> symptom. (V-AB-14:06)

Therapist: Ok. What, (1.0) were there any of these other symptoms related to,... (V-CP-14:06)

Participant: once you've got a good grasp on their particular symptoms, you can... (I-TWO-3:43)

The most evident use of this medical repertoire was the extensive direct referencing of the client as a 'patient'. For example, in a random survey of 10 pages of *Cognitive therapy: Basics and Beyond* (1995), the word 'patient' appeared a total of 154 times. In contrast, other possible more neutral descriptive terms such as 'client', 'person', 'individual', 'consumer', 'customer', 'subject' or any other referential term did not appear once in the selected pages. This direct representation of the believing person as a patient is demonstrated in the following extracts:

*What stratigies has the **patient** used throughout life to cope with these negative beliefs?* (B-JB-50)

*(the therapist) begins to evaluate and modify the core belief with the **patient**; assists the **patient** in specifying a new, more adaptive core belief; specifies the core belief (to himself) using the same techniques he used to identify the **patient's** intermediate beliefs.* (B-JB-204)

*Judy Beck: Now, one, one <u>first</u> step to help the **patient** start to integrate, what he's thinking...* (V-AB-39:41)

*By tracking the **patient's** everyday experiences as a testing ground for checking his various beliefs about himself,...* (B-AB-4)

Supporting this more direct referencing of the believing person as a patient, therapists organised their discourse to assist this depiction in a number of medicalised ways. These included utilising the notions of their clients being 'examined', receiving a 'prognosis' and obtaining 'treatment' from the therapists.

With regard to being examined, a particular part of the patient (i.e., their beliefs) was examined by the therapists. This happened in a similar fashion to the way a doctor examines their patient for an illness. With the therapists, the examination process involved the person's beliefs being 'identified' or 'hypothesised', and then 'evaluated', 'tested' and 'monitored'; all elements of a

medical examination and diagnostic process. This can be discerned in the following extracts:

> *Therapist: Okay, so we've **identified** some of your beliefs...* (B-JB-153)

> *...presents his **hypothesis** about the core belief(s) to the patient, asking for confirmation or disconfirmation; refines his **hypothesis** about the core belief....* (B-JB-204)

> *...the therapist uses the same kinds of questions to **examine** Sally's belief that he used in evaluating her automatic thoughts. Even when he identifies a general belief, he helps her **evaluate it** in the context of specific situations.* (B-JB-168)

> *(Section title) Historical **tests** of the core belief.* (B-JB-235)

> *Often it is useful for patients to **examine** the advantages and disadvantages of continuing to hold a given belief.* (B-JB-158)

> *...the patient has been **monitoring** the operation of her core belief in the present and...* (B-JB-235)

From the examination of the person's beliefs, the therapists then made a prognosis based on their examination. This was achieved by talking about 'good and bad news', 'improvement', and 'getting better'; all elements of a medical prognosis. This can be discerned in the following extracts:

> *Therapist: Well, the **bad news** is that you currently have a set of beliefs which aren't bringing you much satisfaction, right? The **good news** is that since you learned this current set of beliefs, you can unlearn them and learn others...* (B-JB-153)

> *...enduring **improvement** results from modification of the patient's underlying dysfunctional beliefs.* (B-JB-1)

> *The therapist can explain that many depressed people believe they cannot change or **get better**.* (B-AB-197)

Following on from the notion of 'prognosis' was the portrayal of the patient obtaining 'treatment' from the therapist for their beliefs. Here the patient improves and gets better provided they follow the therapist's 'treatment'. This can be discerned in the following extracts:

*...and that he believes that cognitive therapy is the appropriate **treatment** for her...* (B-JB-52)

*The latter part of **treatment** focused on helping her to change this belief.* (B-AB-146)

*Participant: ...when you're **treating** certain people...* (I-TWO-12:41)

These three medical notions of being 'examined', receiving a 'prognosis' and obtaining 'treatment' interconnected to support the more direct reference of the person as a 'patient'.

Summary of the medical repertoire.

In this repertoire therapists used various medical notions, terminology and images to depict the believing person as a patient. More specifically, this medical repertoire was achieved by direct reference to the client as a 'patient', and reinforced by the medical notions of being 'examined', receiving a 'prognosis' and obtaining 'treatment'. The function of this talk was to lay the groundwork for, and interconnect with, the following 'defective' repertoire.

A defective repertoire.

The second aspect of 'the believing person' that will be discussed involved depicting the patient as 'defective', with a diminished status. This was a strong and dominant representation throughout the various transcripts, and as it contained various medical elements, built on the depiction of the client as a patient. By 'defective' I mean the client was portrayed as flawed or damaged, with a diminished status and thus in need of change. There were three distinct facets to this defective depiction, which included portraying the patient as being 'ignorant' of their beliefs and in need of 'education', having to 'cope' with their 'painful' beliefs, and lastly being in a 'dysfunctional' state as a result of their beliefs.

In the first facet, the believing person was portrayed as ignorant of the beliefs they held and in need of education about their beliefs. Here the patient's beliefs were to be 'identified', 'articulated' and made known by the therapist. This can be seen in the following extracts:

*What we would do is try to **identify** any <u>beliefs</u> that were <u>interfering</u>, with, arr, the credibility of the alternative but more <u>benign</u> explanation...* (V-CP-49:45)

*Novice cognitive therapists often jump from one intermediate belief to another instead of **identifying** the most central beliefs and doing sustained work on them.* (JB-B-114)

*...they often **do not articulate them** (core beliefs), even to themselves.* (B-JB-20)

*The therapist has to remember that assumptions (i.e., intermediate beliefs), for the most part, are not **articulated** by the patient without considerable introspection.* (B-AB-134)

Interconnecting with the medical repertoire, this ignorance seemed analogous to a doctor's patient being ignorant about their specific illness when they first seek medical treatment. Here the process of a doctor linking symptoms to known causes and categories of pathogens or illness, and educating their patient about their particular illness, was similar to the therapist educating their patient about their particular beliefs and how their symptoms were linked to their beliefs. As the belief ignorance was not bliss, therapists revamped and patched up this ignorance by 'educating' and 'teaching' their patients about the beliefs they held, which they in turn 'learned':

(the therapist) *Educates the patient about core beliefs in general and about her specific core beliefs;...* (B-JB-204)

*The therapist can tell the patient that cognitive therapy **teaches** the person how to change unrealistic beliefs...* (B-AB-206)

*Therapist: ...the second thing would be to do a <u>role-play</u>, (.4) right in here, so that again we can get the <u>emotions up</u> which would then facilitate **learning**.* (V-AB-40:59)

The second facet of this defective construction involved the patient being portrayed as 'coping' with their 'painful' beliefs. This coping talk can be seen in the following extracts:

*How has she **coped** with her dysfunctional beliefs?* (B-JB-17)

Therapist: The key to belief work is, getting them to realise that they are able to <u>cope</u>, regardless of the outcome. So you're looking to focus on <u>process</u>, rather

than outcome, and by doing that you're exposing the, truthfulness about things. In a sense, whether they can cope or not. (I-ONE-5:12)

What strategies has the patient used throughout life to cope with these negative beliefs? (B-AB-50)

Which behaviors helped her cope with the belief? (B-JB-120)

Alternatively, the therapist could have described the person as handling, managing, grappling or dealing with their beliefs. However, the notion coping entailed and portrayed an extra effort; an effort beyond that required if one was handling or dealing with the possession of a certain belief. Instead the activity of coping was represented analogously to the way a doctor's patient copes with their illness, and implied a diminished capacity.

Closely tied with the notion of coping was the associated notion that the beliefs that the patients were coping with had 'painful' effects and consequences:

How did the patient cope with the painful core belief? (B-JB-122)

...examples of strategies that patients develop to cope with painful core beliefs. (B-JB-131)

He also tends to avoid discussing issues that activate a painful core belief early in therapy before... (B-AB-291)

The notion of pain, like coping, is also a concept highly associated with a medical context. This is because the generally perceived role of the medial profession is to relieve pain. However, the impression of a person in pain also conjured up a 'damaged' image in the context in which it was used.

The last facet of this construction directly portrayed the patient as 'dysfunctional', as a result of their painful beliefs. This representation was in contrast to a portrayal of an ideal person as functional. In other words, on the one hand a person's beliefs could 'function adaptively' giving them a 'normal and healthy' status, and on the other hand the beliefs could be 'dysfunctional' giving them a 'flawed and unhealthy' status. This dysfunctional aspect can be seen in the following extracts:

They need to organise their experience in a coherent way in order to function adaptively. Their interactions with the world and other people lead to certain understandings or learnings, their beliefs, which may vary in their

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*accuracy and functionality. What is of particular significance to the cognitive therapist is that beliefs that are **dysfunctional** can be unlearned and new beliefs that are more reality based and **functional** can be developed and learned through therapy.* (B-JB-24)

*...he maintains the belief even though it is inaccurate and **dysfunctional.*** (B-JB-20)

*Therapist: ...you need the emotion, to melt the **dysfunctional** beliefs,...* (V-AB-40:59)

*It is generally useful to attempt to elicit these **dysfunctional** beliefs even though the therapist may actually feel warmth and concern for the patient.* (B-AB-222)

Here the patient's dysfunctional beliefs worked analogously to the way that 'disease' functions to give a doctor's patient the status of 'ill' or 'sick'. Because the belief made the patient dysfunctional or had dysfunctional consequences, the patient was constructed as 'flawed', 'damaged' or 'unhealthy', and attained a dysfunctional patient status. From here, the role of the therapist was to advance the patient from having 'painful' and 'dysfunctional' beliefs, which entailed a 'defective status', to obtaining more functional beliefs, which would furnish a normal and healthy status.

In all, the patients were depicted as incapacitated, passive, in need of help, and having a lesser degree of responsibility for their health. For example, therapists frequently mentioned the patient's need for help:

*Therapist: Now one of the things that **might help you** to...* (V-AB-21:49)

...that he (the therapist) *believes **he can help her** and that she can learn to **help herself**.* (JB-B-52)

*Participant: Long term, um, **help** really comes from restructuring beliefs, whereas short term **help** comes from, you know, **helping** with thoughts and behaviours.* (I-ONE-5:23)

The main function this repertoire provided for the therapists was to reduce the status of the believing person, enabling the enactment of therapeutic improvement.

Summary of the defective repertoire.

In this repertoire, therapists built on the medical depiction of the client as a patient, and used various defective notions to depict the patient as defective, with a diminished status, and in need of change. More specifically, this was achieved by portraying the believing person as being 'ignorant' of the beliefs they held and in need of 'education', having to 'cope' with their 'painful' beliefs, and lastly being in a 'dysfunctional' state as a result of their beliefs. The main function this repertoire served was to reduce the status of the patient, thus enabling the enactment and necessity of change for therapeutic improvement.

A changeability repertoire.

The third aspect of 'the believing person' that will be discussed involved portraying the defective patient themselves as changeable. Here various changeability notions were used to depict the believing person as possible of changing, necessitating a change, and having changed. In contrast to the malleability repertoire of 'the belief itself' construction where the beliefs themselves changed, here it was the person that changed in relation to the beliefs.

To accomplish such a relationship change between the person and the belief, therapists utilised a number of different notions, including the person 'learning' and 'developing' different beliefs, which were then 'activated', 'operated' or 'arose'. These notions highlighted the transforming relationship between the belief itself and the person who held or possessed the belief. This can be seen in the following portions of transcript:

> *...since you **learned** this current set of beliefs, you can **unlearn** them and **learn** others...* (B-JB-153)

> *...beliefs that are dysfunctional can be **unlearned** and new beliefs...can be **developed** and **learned** through therapy.* (B-JB-24)

> *Alternatively, depression may be triggered by a physical abnormality or disease that **activates** a person's latent belief that he is destined for a life of suffering.* (B-AB-18)

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*This belief may **operate** only when he is in a depressed state or it may be **activated** much of the time. When this core belief is **activated**,...* (B-JB-20)

*...guides the patient in monitoring the **operation** of the core belief in the present.* (B-JB-204)

*The **operation** of the "shoulds" (i.e., intermediate beliefs) was readily apparent in the behaviour of another patient who believed...* (B-AB-152)

*How do the core beliefs and intermediate beliefs **arise?*** (B-JB-24)

This way of talking emphasised that it was the person's relationship to the beliefs that changed and not the beliefs themselves. For instance, when a belief was 'learned' or 'developed', this belief was 'taken on board' or 'possessed' by the person as it was. When the belief was 'activated' or 'arose', the person's relationship with this belief changed as it became more predominant or apparent to them. In both cases the person's relationship with the belief had changed, rather than the belief itself changing in any content or form.

Supporting this relationship change were various temporal notions that further suggested that the person, rather than the belief, had or was changing. This can be discerned in the following extracts:

*Therapist: Okay:, and **how much right now**, sitting=here=with=me=today, do you believe that you were dying that night?*
Client: Zero again.
*Therapist: Okay. Okay. Now I, I want to ask you another question. How much **did you believe that night**, how much did **you believe then**, (1.2) that you were suffocating.* (V-CP-14:06)

Therapist: Okay. (1.0) Now what do you notice between, (.3) these two <u>lists</u>, your beliefs <u>now</u> and the beliefs <u>then</u>. (V-AB-14:06)

*Therapist: ...we'd have people go home, and when they are all <u>alone</u>, hyperventilate to test out, cause that will <u>REALLY test out</u> the <u>confidence</u> in their <u>beliefs</u>, so as **their <u>beliefs</u> begin to shift and they begin to <u>believe</u>** that its not dangerous, we then have them do these inductions by themselves,...* (V-CP-50:46)

*Therapist: What were the: (.3) <u>sensations:</u>, that, **led you to <u>believe</u>** that you were suffocating?* (V-AB-10:21)

These temporal notions relating to different states were also reinforced by the clients themselves:

Client: I think that was just part of my reaction to <u>believing that</u>, (.4) that I was, (.3) critically ill. (V-CP-14:06)

Once the appropriate relationship change had occurred between the person and the belief, the ways of talking shifted to segment this change and stabilise the person and the belief that was taken on board. It was now appropriate for the patients to be described as possessing or 'holding' certain beliefs. This can be seen in the following extracts:

*When an individual **holds** an important belief, he usually has some subjective feeling about it.* (B-AB-23)

*...are still continuing to **hold** a given belief.* (B-JB-158)

*...but it's an extremely deeply **held** <u>belief</u>, is that, every time that he starts to feel that way,...* (V-AB-39:41)

Here, holding a belief implied that both the person and the object were in a relatively stable relationship, either pre or post relationship change. Thus, there appeared to be a progression ranging from stable to fluid to stable in which the notion of the believing person was constructed; in some instances the relationship was stable and in others it was changing. In other words, through the use of various indirect notions, a believing person was constructed as stable, moved through a fluid phase, and then returned and segmented a stable position. The main function of this talk was to open the client up to the possibility of changing their relationship with certain beliefs, and to assist with this relationship change. Both of these aspects enabled therapeutic improvement.

Summary of the changeability repertoire.

In this repertoire, therapists used various changeability notions to depict the patient as needing or having changed. More specifically, this changeability repertoire was achieved by portraying the patient as 'learning' and 'developing' different beliefs, which were then 'activated', 'operated' or 'arose'. This was supported by temporal notions of change and the portrayal of the believing person as both stable and fluid. These notions highlighted the transforming relationship between the patient and the belief itself, where it was the patient's relationship to the belief that

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was changing and not the belief itself. The main function this repertoire served was to open up the possibility for, and necessity of, changing, and thus enact and allow for therapeutic enhancement.

Chapter summary.

In this chapter I have highlighted how therapists constructed 'the believing person' as a defective, yet changeable, patient. This was achieved by drawing on a number of repertoires, which included a medical repertoire that depicted the believing person as a patient, a defective repertoire that depicted the patient as flawed and damaged, and a changeable repertoire that portrayed the patient as needing or having changed. These ways of talking about the believing person served various functions. Foremost amongst these were to reduce the status of the patient, open up the possibility for and necessity of changing, and allow for and enable the enactment of therapeutic improvement.

SUBJECT POSITIONS.

Introduction.

The constructions of 'the belief itself' and 'the believing person' were aided by two frequently mobilised and distinct subject positions. These involved the therapists positioning themselves as 'experts' and their clients as 'laypeople'. Although this positioning was achieved by therapists selectively drawing on repertoires associated with the constructions of 'the belief itself' and 'the believing person', in this chapter I focus on one additional repertoire and three discursive strategies that therapists used, in order to emphasise how these positions were attained. Essentially, all of these repertoires and strategies interwove to provide a powerful cumulative warranting effect that established the positions of 'expert' and 'layperson'. These positions, and the 'structure of rights' they entailed and enabled, equally supported, aided and endorsed 'the belief itself' and 'the believing person' constructions.

Caveat emptor: Two points.

Firstly, the subject positions adopted were particularly hard to discern given the different types of media and interactional formats utilised. For example, the identities negotiated seemed slightly different when therapists were conversing with other therapists (such as in the instructional books), as compared to conversing with clients (such as in the video demonstrations). Compounding this element, and as would be expected, the subject positions adopted also varied as therapists' talk changed as a function of their particular contexts and what they were trying to achieve in particular instances.

Secondly, I have chosen to focus on and present the two most frequently adopted subject positions ('expert' and 'layperson') discerned in the texts, as these were most relevant to 'the belief itself' and 'the believing person' constructions. However, in addition to these, both the therapist and client also adopted a number of other subject positions. These included the therapists adopting a 'friend' position in which they befriended their clients, and a 'nursing' position in which they cared for their clients. Clients also adopted a 'teachers favourite' position in which they sought

special treatment and attention from their therapist, and a 'hopelessness' position in which they resisted their therapist. Nonetheless, these positions are not covered in this chapter.

Positioning overview.

When therapists were conversing with other therapists or clients, they frequently adopted and became enmeshed in the subject position of an 'expert'. From this position, the therapists warranted all the rights, responsibilities, standards, reputations, and entailments usually given to or assumed by an expert. In more practical terms, adopting this position provided therapeutic credibility, validated their accounts of belief, and established various 'medical powers' relevant to the therapeutic and belief change process.

From this 'expert' position, therapists frequently positioned their clients, and their clients adopted (although I do not cover this aspect), the opposite subject position of 'layperson'. In this position, the clients were passive, sub-optimal and deficient of knowledge and skill, entailing a somewhat diminished status. In more practical terms, the client was afforded lesser rights to make decisions, have input into and control over the therapy process, and afforded less ability to use and converse in relevant psychological terminology.

Utilised positioning strategies.

Imparting knowledge.

The first discursive strategy that will be discussed involved therapists highlighting their privileged knowledge through the use of an educative role, in order to warrant an expert status. Here therapists constructed themselves as "gatekeepers to a restricted and exclusive realm of knowledge" (Langenhove & Harré, 1999, p. 27) which they then imparted to their clients in an educative fashion. A selection of the ways therapists assumed this educative role can be discerned in the following extracts:

*Therapist: ...this belief, which **I think you might realise,** (.4) is not a correct belief, ...you probably realised that...* (V-AB-21:49)

*Therapist: ...and what I want to <u>ask you</u> is, to <u>look</u> at these two lists and see what you see as the connection between these two lists, **you've already kind of <u>said it</u>, but I would just like you to say it again...** (V-CP-14:06)*

*Therapist: Okay, and um, when, **have you being paying attention** focusing on your sensations while you've been writing?*
Client: No. (V-CP-33:19)

Therapist: Okay, why=don't=you <u>write that down,</u> that (.4) when I'm paying attention to other things and when I'm not focusing on sensations, (.9) they can go down. (client writes down information) (V-CP-33:19)

This educative role was also reinforced with a number of distinctive phrasings that strengthened both their knowledge and status:

*Therapist: **So the <u>bottom line</u> was,** that you <u>believed</u> that...* (V-AB-19:55)

*Therapist: Ok, **SO,** let=me=get=this=straight. So you had a series of sensations, and these thoughts, and **let me just point out now** which sensations went with which thoughts,...* (V-CP-14:06)

*Therapist: Ok, **SO, here we have now then** a list of <u>sensations</u> which you experienced,...* (V-CP-14:06)

This educative role served to persuade the client, strengthen their faith in the therapist and therapy process, and to give credibility to the therapeutic framework. This put the therapists in a largely paternalistic and authoritative position, assuming a rather beneficent and non-maleficent role, which established their expert status.

However, this educative role did not always entail beneficial consequences. For example, there were no instances where the clients asked for clarification or questioned the therapists. In contrast, there were countless instances where the therapists asked for clarification or questioned their clients, for example:

Therapist: You feel much better now, okay, now I want to ask you, (.3) <u>how do you explain that?</u> A few minutes ago you were having these very intense uncomfortable sensations now you feel better!
Client: I guess when I am writing I now feeling less anxious. (V-CP-33:19)

Here the direct questioning resulted in the client becoming less sure of herself, in contrast to previous dialogue. Nonetheless, despite the occasional detrimental effect, the educative role warranted the therapists' expert status.

Going to extremes.

A second discursive strategy involved the regular use of 'extreme case formulations' (Pomerantz, 1986). Extreme case formulations involve taking a position being advocated to its extreme in order to help make that position more persuasive (Coyle, 1995; Gergen, 1989). In the therapists case, this included the use of terms such as 'always', 'never', 'nobody', 'really', 'extremely' and 'everyone'. Examples of the use of these terms can be seen in the following extracts:

> *Judy Beck: ...but it's an **extremely deeply** held <u>belief</u>, is that, every time that he starts to feel that way, to feel <u>worthless</u>...* (V-AB-39:41)

> *Therapist: NOW at this particular time, (.5) do you **really** <u>believe</u> that at this time in your life, (.4) you're **just** a push=over and weakling, like you were when you were a kid, are you a mammas' baby or not?* (V-AB-36:29)

> *Participant: I **always** get them to look at their beliefs...* (I-TWO-17:22)

The function of this terminology was to make the positions the therapists were advocating more convincing. This increased the strength of their accounts, ensured that their versions prevailed, and in turn helped warrant their 'expert' status. However, at times it seemed that some of these formulations pushed the "horizon of the intelligible" (Wetherell, 1999, p. 268). For example, this was demonstrated by the client's body language, such as raising eyebrows and squinting, and posed a direct threat to the therapist's expert status.

Concealment.

A third discursive strategy involved therapists concealing their own beliefs in order to reinforce their expert status. In this case, what was not said turned out to be just as important as what was said. Throughout the transcripts therapists never revealed or acknowledged what they themselves believed, even when directly questioned, for example:

Client: Is that, kind'a, what you believe?
Therapist: What's important is that you... (V-AB-43:11)

To reveal or acknowledge would have potentially jeopardised their positions as experts, as it would have allowed the possibility and opportunity for criticism, and thus the weakening of their status. This absence was particularly noticeable as in this relationship, perhaps more so than in any other professional relationship, the client would have benefitted from direct modelling and learning about more pleasurable and functional beliefs. Instead, however, therapists seemed to portray themselves as perfect, almost omnipotent.

A moral repertoire.

The use of a moral repertoire involved the therapists drawing on and using moral terminology and notions in their interactions with their clients while in the expert subject position. In contrast to the other repertoires, this was a very subtle and less dominant repertoire. In this repertoire therapists constructed moral notions of both belief and of persons. With regard to beliefs, there was the 'right kind of beliefs' for the client to hold. This element can be discerned in the following extracts:

*Therapist: ...they just don't know what's really **bad** about the beliefs they've got.* (I-TWO-7:11)

*Therapist: ...there are **better beliefs** than these, (1.0) these beliefs just aren't **right** for them.* (V-AB-12:12)

*Client: Well what=I=want=to **believe** is like that it's like something like about them. But what I fell:: inside is that it's something about me,...* (V-AB-21:49)

With regards to persons, and as a consequence of having the 'right kind of beliefs', there was a striving to be a 'good' or an 'ideal' person. This can be discerned in the following extracts:

*Therapist: Well, it's not really what you **would want** to believe. That's not gone'a get you to where you **need to be.*** (V-CP-44:02)

*...this more functional belief would be **good** for her.* (B-AB-82)

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*Therapist: So you believe pretty strongly that **you should** do things yourself
[rule] and that...* (B-JB-155)

Although the vast majority of moral references were about or directed towards the clients, and indeed this repertoire only operated between therapist-client interaction, the implicit implication seemed to be that therapists had obtained or knew of 'the better life', and could thus qualify as 'ethicists'. By drawing on this normative and prescriptive way of talking, therapist worked up and positioned themselves as 'experts'.

The function of the strategies and repertoire.

As a whole, the use of these discursive strategies and this repertoire strongly put the power of the relationship in the hands of the therapist; even though cognitive therapy is supposedly a collaborative process and relationship (Persons et al., 2001). For example, once established, the expert position granted therapists a paternalistic 'licence to confuse' their patients. Similar to the way doctors regularly converse in medical concepts and terminology beyond the level of comprehension of their patients, in which the patient usually acknowledges and accepts, although does not understand, the terminology or concepts, therapists conversed in concepts and terminology beyond the level of comprehension of their patients. This subtle paternalism evident in a doctor's non-explanation of complex medical terminology could also be seen in aspects of the therapists discourse, for example:

*...the tightening of your **intercostal muscles** lead to a fear of not being able
to breathe* (V-AB-24:39).

However, this 'structure of rights' (Davies & Harré, 1990) entailed by the two positions also seemed equally agreeable to both parties. The regular uptake of both of these positions in actuality laid much of the foundation for the therapeutic process and subscribed the possibilities for and limitations on various actions. Hence, these subject positions had considerable implications for the power relations between the therapist and client, as they constrained and shaped to a large degree what was possible in their relationship.

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For the client, there seemed a number of advantages to adopting such a position. Foremost amongst these were the offset of responsibility onto the therapist to care for the client, and positioning themselves in a more malleable position from which to allow therapeutic and belief change. For the therapist, there also seemed a number of advantages to adopting the expert position. Foremost amongst these were the instilment of certain powers and responsibilities to act in a beneficent and non-maleficent way, and the clarifying of boundaries surrounding what was and could be expected.

DISCUSSION.

Introduction.

This final chapter traverses a number of distinctly different issues and topics. In this sense, it is somewhat piecemeal and fragmented. However, it is also necessary, as there remain a number of interesting aspects of this research project as yet discussed. These include conversing some of the left over tensions within and between the two constructions, reflecting on the multi-media approach, outlining some of the methodological weaknesses, assessing the research goals, and commenting on possible future research directions.

The tensions within and between the two constructions.

Given the two constructions, as well as the positions, repertoires and strategies that enabled and supported these constructions, there remained a number of interesting unresolved tensions detected in the transcripts.

What changed?

Perhaps the most evident tension was between talk which mobilised a change in the belief itself as opposed to talk which mobilised a change in the person. In some instances the talk was around changing the beliefs themselves:

*...and once the patient realises this, the **belief itself becomes...** (B-JB-177)*

Whereas in other instances it was around changing the person by changing their relationship with certain beliefs:

*What is of particular significance to the cognitive therapist is that beliefs that are dysfunctional can be **unlearned** and new beliefs that are more reality based and functional can be **developed** and **learned** through therapy.* (B-JB-24)

Both of these elements came through at times, almost interchangeably, in the same sections of talk. As a reader of these transcripts I was quite often confused as to

what exactly the therapists' talk was endeavouring to change; change the belief or change the person? This produced a clear tension between the different objectives of change.

This discovery was unanticipated and constitutes one of the most interesting aspects of this study. This is because the ramification of such a tension throws considerable doubt onto the whole belief change process in cognitive therapy. The evident implication is that cognitive therapy needs to make clearer the distinction between changing a belief and changing a person's relationship to a belief, and perhaps more importantly, which of these (if not both!) the therapist should be trying to accomplish. Although perhaps the former was favoured in the texts, a recent research study (Teasdale et al., 2001) suggests the latter type of talk may be more beneficial. For example, in this study they concluded that, "interventions that focus on changing patients' relationship to their dysfunctional thoughts and feelings, rather than attempting to modify thought content or belief, would be more useful" (p. 355).

How are the beliefs changing?

A second evident tension was that between talk which mobilised different ways of changing beliefs. From the therapists' talk there seemed three distinct ways; deactivating them, modifying their structure and content, or constructing more adaptive beliefs to neutralise and replace the dysfunctional beliefs. Examples of the three different strategies included:

Deactivation.

*...beliefs **become less salient** – or even disappear.* (B-AB-48)

Modification.

*...frequently only some belief **modification**, not complete **belief change**, is needed.* (B-JB-194)

Constructing new beliefs.

...transfers some of the cathexis from the 'helpless' or 'unlovable' belief to a more adequate, 'likeable' belief. (B-AB-52)

However, neither the therapists talk, nor cognitive therapy theory, suggests guidelines as to which particular approach is appropriate. At times, some of the talk indicated various combinations of strategies, for example:

*To reach this degree of belief, the patient, with the help of the therapist, has to **challenge his old** maladaptive beliefs actively **and** act on **new adaptive beliefs**.* (B-AB-206)

Given research which suggests that people are confirming rather than disconfirming (Rokeach & Rothman, 1965; Mahoney, 1974), this meaning that client's are more responsive to evidence which supports beliefs rather than to evidence which disconfirms them, constructionist talk (in the above sense) may be a more fruitful path.

Talks' influence on change.

A third evident tension involved the therapists drawing on the medical and scientific repertoires. In doing so, they drew on the associated attributes of 'certainty' and 'stability' which were, at times, in stark contrast to the portrayal of beliefs as fluid and non-ridged objects. Thus, this talk restricted and hindered the belief change process. In other words, by the very nature of the repertoires drawn on, the therapists' talk lent towards a stable notion of belief, whereas talk which lent towards a fluid and non-ridged notion of belief might have been more therapeutically efficacious in various contexts.

Interestingly, supporting this view, a growing number of clinicians have openly acknowledged the unhelpful medical and scientific influences in cognitive therapy, and have taken proactive steps to alleviate such an influence. For example, a recent paper by Dvorak (2002) redesigned some of the popular cognitive therapy tools (e.g., thought record, core belief worksheet) to 'combat' their scientific and medical 'slant'. In their original formats, clients commented that they appeared 'cold', 'mechanical', 'clinical' and 'medical', which was deemed to hinder therapeutic progress.

Ownership of change.

A fourth evident tension concerned where the locus of change originated from. The therapists talked as if therapeutic enhancement came from themselves, rather than from the client's volition:

> *The therapist seeks in a variety of ways to **produce cognitive change** – change in the patients thinking and belief system – in order to bring about enduring emotional and behavioral change* (B-JB-2).

However, when confronted, clients resisted this talk, claiming ownership for their own efforts to change:

> *Client: Well, I think **I**'ve really made **good progress**...* (V-AB-50:23).

This was a surprising tension given the claimed collaborative nature of cognitive therapy. The implication is that therapeutic efficacy may be enhanced by therapists emphasising the focus of change on the client, rather than themselves. For example, Garfield (1988) comments, "when individuals are allowed to examine and evaluate the rationality and coherence of their own beliefs, resulting cognitive changes are often more dramatic and enduring than when a didactic strategy is applied" (p. 78). In other words, belief change may be more straightforward and have more effect when client directed, rather than therapist mediated, and could easily be reinforced by shifting the focus of the talk.

Reflections on the multi-media approach.

A number of interesting methodological discoveries have emerged from utilising this particular multi-media approach. Firstly, the repertoires and strategies identified in the transcripts were, to a large degree, text dependent. As Burr (1995) explains:

> *The discourses or repertoires that are identified in a piece of text will, to some extent at least, depend upon what kind of text is being analyzed (interview transcript, textbook, transcript of conversation, newspaper article and so on)* (p. 182).

This text dependency in the different textual forms was evident in a number of ways, for example:

- 'Extreme case formulations' were not as prevalent in the cognitive therapy books (perhaps because of the editing process), however were a distinctive feature of the video demonstrations and interview material.

- Some repertoires and strategies came through stronger in certain media than in others. For instance, a medical repertoire was stronger, and seemed more easily expressed, in the instructional books than it was in the other two media.

- Instances of belief varied greatly between media. For example, belief was frequently mentioned in the instructional books, however it was rarely mentioned in the video demonstrations. This raised a number of interesting questions; for instance, 'given the rise in popularity of belief in the books, why has this not transferred into practice?' or 'Why aren't practicing therapists enabled by this literature?'.

- 'Patient talk' was reserved for conversing with other therapists, as this talk was never directly to the client themselves. For instance, in the video demonstrations the therapists did not use the term 'patient' once during the demonstrations, however, once the demonstrations were completed, the term 'patient' was regularly used when reflecting on the demonstration. This same pattern was also evident in the therapy demonstration segments within in the books where 'patient' was regularly used before and after such segments, however never in the actual segments themselves.

These four selected examples highlight only some of many interesting discoveries that emerged from such a multi-media approach.

The researchers' wish list.

Albert Einstein famously said, "if we knew what we were doing, it wouldn't be called research, would it?". Thus, as this was my first foray at using a discursive

research approach, there were many oversights, unexpectancies, and things that I would do differently if I had the opportunity:

- Account for and allow synonyms of 'belief' or 'believe' when collecting the materials. This is perhaps the major methodological weakness, as I have only extracted, transcribed and used 'belief' or 'believe'. Other synonyms, especially 'schema' (i.e., core beliefs) and 'underlying assumptions' (i.e., intermediate beliefs) should have been included.

- Sought more advice, and carried out more practice, coding the material. This is because I found this stage extremely challenging and have reservations about the adequacy of the coding produced.

- I would include a sample of actual beliefs to be analysed, (e.g., "I am a bad father") and conceptualisations of belief (similar to those in Appendix A and B). This avenue would have produced a number of interesting findings, verified my preconceived notions, and allowed further interesting questions. For example, does belief or believing predominately relate to a person (e.g., I am a bad father) or a person's actions (e.g., I can't do that)?

- Put more initial effort into mapping the boundaries of the particular repertoires, including their similarities and differences, as well as the discursive strategies utilised. Until towards the end of this project, I found it particularly difficult to make clear and consistent judgments concerning the repertoires' boundaries, and particular strategies used.

- Focused on, and included more of, the clients' discourse, as the vast majority of the discourse was from the therapist, given the media chosen. This shift in emphasis would have provided further insights into the therapeutic relationship. For example, only therapists described their patients as 'coping', rather than the clients themselves.

Research goals.

This research project embarked with a number of clearly defined aims and objectives (i.e., see pages 15-18). These have been fulfilled in various ways. From a holistic point of view, my insights and comments provide a better understanding of how belief is constructed in the various interactions within the cognitive therapy domain. My illumination and reading of these texts provides a useful and helpful means of understanding some of the ways of how belief is deployed and put to work in that domain. However, at a more pragmatic level, my goal was to make this research useful in "bringing about change for those who need it" (Burr, 1995, p. 162). I wanted the various understandings and insights produced to be useful to both practicing cognitive therapists, and to cognitive therapy theorists.

With regard to practicing cognitive therapists, these aspects have started to be actualised and achieved. For instance, the therapists interviewed were largely unaware of the power of their use of belief. Both therapists mentioned that through the interview process, they had challenged their own assumptions about the notion of belief and how they used it. This was also the case when selections of these findings were presented at the New Zealand Psychological Society annual conference (August 2002), as various participants additionally revealed that they had also had their assumptions about belief challenged.

With regard to cognitive therapy theorists, the scope of this understanding, with all its various nuances and patterns, has made a contribution to the cognitive therapy domain, and various important aspects of social action and interaction within that domain. Although not an initial goal, perhaps a major worth of this research comes not from insights into the notion of belief or its various uses, but rather the insights into the therapeutic and belief change process, with all its entailed power relations. I suspect the repertoires, strategies, and positioning would be very similar in any other area of cognitive therapy (i.e., other than focusing on the notion of belief).

Future research.

I would speculate that the picture belief portrays in the cognitive therapy domain would bear little resemblance to how belief is constructed in a variety of other domains; such as legal testimony, religious practices, memory, marketing and politics. This is largely because of the therapeutic emphasis and relationship entailed in cognitive therapy. Thus, replication in one or more of these other domains might provide further insight into the notion of belief and how they are used.

In addition, as this year has unfolded and my learning of discourse analysis has increased, it became apparent that an analysis of these texts utilising Parker's (1992, 1998) variety of discourse analysis would portray and highlight many additional fertile insights. For instance, there seemed many different objects constructed, and such a focus on a 'bigger picture' and discourse in his sense, rather than at the finer level I have chosen, would be helpful to further understand belief and its role within the cognitive therapy domain.

Summary statement.

From my initial curiosity in noticing different psychology lecture's constructing quite different conceptions of belief, I have travelled a rather lengthy, and albeit disjointed, journey to get to this position. At the end of this journey, I very much concur with Potter, in that "learning to do discourse analysis is very much a craft skill like riding a bike or sexing a chicken" (1996, p. 140). I concur because the former is usually painful and the latter is usually unpleasant, and elements of both were evident at times.

Nonetheless, when I embarked on this journey, it was with the hope that my investigation would have a similar effect as that which I gain by finding the right adjustment on my telescope lens; the notions of belief and its use in the cognitive therapy domain should come into focus rather than remain somewhat blurry, its boundaries and possibilities should become crisper and clearer, its various usefulness should be further discernible, and there should be a principled coherence to the entire picture portrayed.

Although my particular focus and adjustment has changed, in line with the research methodology adopted I hope others will share in this crisper picture, and perhaps more importantly, learn themselves how to adjust their own lens in regards to belief in the cognitive therapy domain.

Closing thought.

Carl Jung (1933) once remarked:

The very fact that a general problem has gripped and assimilated the whole of a person is a guarantee that the speaker has really experienced it, and perhaps gained something from his suffering. He will then reflect the problem for us in his personal life and thereby show us a truth (p. 14).

I can easily agree with Jung, as the notion of belief has 'gripped' and 'assimilated' the whole of my person throughout this research project. However, the discursive struggles I have undergone have enabled and resulted in a richer in-depth experience, which will indubitably benefit my future practice and research.

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APPENDIX A: PSYCHOLOGY LECTURES' CONSTRUCTIONS OF BELIEF.

1) A belief is an idea about something.

2) A belief is a world view or way of life.

3) A belief is something you hold to be true.

4) A belief is a view based on knowledge and experience.

5) A belief is a value that guides your behaviour.

APPENDIX B: POST-GRADUATE PSYCHOLOGY STUDENTS AND LECTURES' CONSTRUCTIONS OF BELIEF.

1) A belief is a manifestation of thought that relates to ones idea about how something is constructed.

2) A belief is a strongly held attitude towards something or somebody – difficult to change.

3) A belief is something you hold near and dear. A perspective that you have 'tested' on society and come to believe is fact / reality.

4) A belief is some tenant considered to be true / applicable in some circumstances / frameworks.

5) A belief is a conviction.

6) A belief is a set of priorities or aspects or 'rules' that we abide and assists us in our approach to different life events.

7) A belief is a piece of string that holds up our existential trousers or skirts. It is often socially constructed, and seldom purely cognitive or intellectual in its nature and function.

8) A belief is an individual and / or collective understanding of something – socially constructed.

9) A belief is an idea about something that is continually changing, based on the relationships and social interactions you have with others.

10) A belief is a psychologist's misunderstanding of how people function – a social construction.

11) A belief is a held value that is expressed in behaviour.

12) A belief is an idea held by a person that is constructed through experience and discourse.

13) A belief is a proposition you adhere to, which you feel is inherently correct. It may, or may not, be based on evidence. Sometimes it will not be abandoned, even in the face of contradictory evidence.

14) A belief is an internally held systematic idea that is consistent and stable.

15) A belief is personal knowledge derived from personal experience and social interactions.

16) A belief is a cognitive construct that captures a version of reality.

17) A belief is a viewpoint of the way things are.

18) A belief is an internal model that may or may not guide your cognitions / behaviour.

19) A belief is what you think and feel is real to you.

20) A belief is an intended guide that determines your daily attitude to the environment and people.

21) A belief is from human perception and something you see as a fact.

22) A belief is a view based on knowledge and experience.

23) A belief is a conscious or unconscious judgment about something.

APPENDIX C: REVIEWED COGNITIVE THERAPY INSTRUCTIONAL BOOKS.

1) Beck, A. T., & Greenberg, R. L. (1973). *Coping with depression*. New York: Institute of rational living.

2) Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: John Wiley & Sons.

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4) Blackburn, I-M., & Davidson, K. (1995). *Cognitive therapy for depression and anxiety*. Oxford: Blackwell Sciences.

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6) Clark, D. M., & Fairburn, C. G. (1997). *Science and practice of cognitive behaviour therapy*. Oxford: Oxford University Press.

7) Dattilio, F. M., & Freeman, A. (1994). *Cognitive-behavioural strategies in crisis intervention*. New York: Guildford Press.

8) Greenberger, D., & Padesky, C. A. (1995). *Mind over mood: Change how you feel by changing the way you think*. New York: Guildford Press.

9) Hawton, K., Salkovskis, P. M., Kirk, J., & Clark, D. M. (1989). *Cognitive behaviour therapy for psychiatric problems: A practical guide*. Oxford: Oxford University Press.

10) Needleman, L. D. (1999). *Cognitive case conceptualisation: A guidebook for practitioners*. New York: Lawrence Erlbaum Associates.

11) Persons, J. B. (1989). *Cognitive therapy in practice: A case formulation approach*. New York: Norton.

12) Persons, J. B., Davidson, J., & Tompkins, M. A. (2001). *Essential components of cognitive-behavior therapy for depression*. Washington, DC: American Psychological Association.

13) Safran, J., & Segal, Z. (1996). *Interpersonal process in cognitive therapy*. New Jersey: Jason Aronson.

14) Safran, J. (1998). *Widening the scope of cognitive therapy: The therapeutic relationship, emotion and the process of change*. New Jersey: Jason Aronson.

15) Wells, A. (1997). *Cognitive therapy of anxiety disorders: A practice manual and conceptual guide*. Chichester: John Wiley & Sons.

APPENDIX D: REVIEWED COGNITIVE THERAPY RESEARCH JOURNALS.

1) Cognitive Therapy and Research.

2) Journal of Consulting and Clinical Psychology.

3) Journal of Counselling and Clinical Psychology.

4) Journal of Cognitive Psychotherapy: An International Quarterly.

5) Clinical Psychology and Psychotherapy.

6) Psychotherapy.

7) British Journal of Clinical Psychology.

8) Theory and Psychology.

9) International Cognitive Therapy Newsletter.

Appendix E: Transcription notations.

1) An equal's sign at the end of a speaker's utterance and at the start of the next utterance indicates the absence of a discernable gap:

   Therapist: Anyway Brian=
   Client: =Okay, okay.

2) Numbers in brackets indicate pauses estimated to the nearest tenth of a second. A full stop in brackets indicates a pause which is noticeable but too short to measure:

   A: I went (3.6) a lot further (.) than I intended.

3) One or more colons indicate an extension of the preceding sound:

   Client: Yea::h, I see::

4) Underlining indicates that words are uttered with added emphasis. Words in capitals are uttered louder than the surrounding talk:

   Therapist: It's not right, not right AT ALL.

5) Round brackets indicate there is doubt about the materials accuracy. Un-italicised materials within round brackets are context signifiers.

   Therapist: (the doctor) *he (couldn't tell you) that...*

6) Three dots indicate that some material not consider relevant has been omitted

   Therapist: Jill believed she would be there. However,...

The above transcription notation was adapted from Potter and Wetherell (1987), and O'Connell and Kowal (1995).

APPENDIX F: STUDY INFORMATION SHEET.

Psychology Department

Massey University

Information Sheet

<u>The social construction of belief in cognitive therapy: A discursive analysis.</u>

You are cordially invited to take part in a study of 'beliefs' and how they are constructed and used by cognitive therapists. The aim of this study is to learn about the concept of belief itself, and its application and applicability within the cognitive therapy domain.

If you choose to participate in this study you will be interviewed for approximately 25 to 30 minutes about the concept of belief and its use in cognitive therapy. The interview will be held at your convenience, and it is not anticipated that there will be any harmful effects or discomfort resulting from this interview.

The results of this study will be used for a Masters Thesis, disseminated amongst the cognitive therapy community (i.e., seminars, conferences) and may be published, but only in a form that ensures that you cannot be identified, assuring strict confidentiality. Please note that taking part in this study is voluntary and you can withdraw at any stage.

If you would like any further information, or would like to participate, please either ring or e-mail, Aaron Jarden, █████████████████████████ ████ as I would very much appreciate your participation.

If you have any additional queries or concerns, you can also contact my supervisor, Professor Andy Lock, Department of Psychology, Massey University, Palmerston North, (06) 350 5799 ext 2040.

This project has been approved by the Massey University Human Ethics Committee, 2002.

APPENDIX G: STUDY CONSENT FORM.

Consent Form.

I have read and I understand the information sheet for volunteers participating in this study. The nature and purpose of this study has been explained to me. I have had the opportunity to discuss and ask questions about this study and I am happy with the answers given to me.

I understand that I have the right to know what will happen to the data from this study and I have the right to request information about the outcome of the study. I understand that my participation in this study and the information I provide is confidential and that no material that could identify me will be used in reports on this study.

I understand that taking part in this study is voluntary and that I can withdraw at any stage.

I _____ (full name) herby agree to take part in this study.

Signature:_____

       Date:_____

I am available to answer any questions about this study: Aaron Jarden, ████████ ████████████████ However, if you have any additional queries or concerns, you can also contact my supervisor, Professor Andy Lock, Department of Psychology, Massey University, Palmerston North, (06) 350 5799 ext 2040.

This project has been approved by the Massey University Human Ethics Committee, 2002.

Appendix H: Interview question list.

1) If I say the word 'belief', what immediately springs to mind?

2) How do you talk about beliefs with your clients? How do you introduce beliefs to them? Is it generally the therapist who starts to talk about beliefs or is it the client?

3) Do you think your clients or other therapists talk about beliefs differently to how you talk about them? Do you think you ever have different understandings? Are there any different terms for 'belief'?

4) When you or a client talk about beliefs, is there anything else that is highly associated with belief? I mean are their any particular features that always go with belief? For example, behaviour, truth, reason.

5) Can you give me some examples of things either you believe in or things your clients believe in? Why do you or they believe that?

6) If a client said to you "I believe I am totally incompetent", what do you take out of a statement such as this?

7) Now I have a few questions looking at the comparison between a belief and some other notions. What do you think the difference between a thought and a belief is? What is the difference between saying something to yourself and believing it?

8) Is the notion of truth related to the notion of belief, and if so how?

9) Is the notion of ethics related to the notion of belief, and if so how?

10) What is the difference between a value and a belief?

11) Given all that cognitive therapy has to offer, how useful do you think the concept of belief is?

12) If a belief hypothetically turned into a person, can you describe that person?

13) If an eight year old asked you 'what are beliefs and why do we have them', how would you answer their question?

14) Just to finish off, when I say the word 'belief', what immediately springs to mind now?

15) Is there anything that you would like to add about belief that I haven't asked about?

EXCERPT TWO.

Participant: One of my former clients, a women who had um, was cooking Christmas ham, a young women, the new wife. And so she, put the ham, and she remembered that when her mother cooked the ham, the first thing she did was cut off, the end of it, cut off about six inches of the end of the ham. So she did that and prepared it for the oven and it was great. And then the daughter came in, five years old and said, mummy why did you do that, why did you cut the end off, and she said, oh I don't know, it's what my mother used to do. So she rang the mother and said, and said, oh mum why did you cut the end off the ham, why is it that you cut it off, you've always cut it off, why did you do that, and she said, oh I don't know my mother always did it. So they rang the grandmother to find out why and the grandmother said, well it wouldn't fit in the oven. (laughing) I use that quite often in therapy, you know, when I'm challenging someone's belief, of 'why do you believe that', and that's a good illustration that we become conditioned to believing things, (3.0) it was a family tradition you see.

Excerpt from Interview Two, 2002.