An Interpretative Phenomenological Analysis of the experience of therapists working with clients with substance misuse disorders.

By
Beverley Marais

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City University Declaration

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Section A: Preface

PREFACE

The central theme of this thesis concerns the value of the therapeutic relationship, accompanied by an exploration of 'what works' with client groups seemingly more resistant and ambivalent to treatment. By ambivalent, I refer clients in the 'precontemplation' and 'contemplation' stages of change (DiClemente, 2003). Whilst it is acknowledged that these are not linear positions, they are circular in that change is dependent on the client as well as therapeutic relationship which may offer the framework for necessary changes to occur. This aims to raise the profile of the significant role of counselling psychologists and other healthcare professionals in eliciting and building therapeutic relationships with individuals who are, at times, compromised in this regard. It links together different aspects of my journey as I have developed and embodied my role as a counselling psychologist within the fields of addictions and eating disorders. Both of these areas have been traditionally dominated by clinical psychologists and therapeutic models of working have been structured accordingly. I recall, many years ago, being identified as the first counselling psychologist to form part of a large NHS addiction service in London, dominated by a team of clinical psychologists. Needless to say I was viewed with a certain amount of suspicion, and then later with relief, in that what I had to offer was not necessarily perceived as particularly different. It did make me aware, however, of the difference in positioning myself as a practitioner-scientist, which compliments the pursuit of evidence-based practice, whilst also remaining consistent with the philosophical foundations of counselling psychology.

Across my training journey and indeed, my experience in working as a counselling psychologist, developing a therapeutic relationship with clients has always been at the forefront. I began my career working in a forensic psychiatric unit (whilst in training), which consisted of patients presenting with medium to severe mental illness. I was part of the substance misuse team at this hospital. It was during this time that I first became interested in the function of substances for the individual and the powerful role they played in the therapeutic dyad.

Following completion of my training, I then worked within a drug and alcohol addiction service in the NHS, involving both inpatient and outpatient services. Whilst working within the outpatient services, I became aware of the high drop-out rate with these clients and the fragility of the working alliance in this field. I became mindful of the individuals' early developmental experiences which might have contributed to the ability to maintain a therapeutic relationship over time, as well as the challenges this represented for the therapist. My experiences with these clients further encouraged my interest in exploring the relationship between addictive processes and adult attachment styles.

Finally, I added the further speciality of working within an eating disorder outpatient NHS service. Interestingly, I found that within this clinical group, the dropout rates were lower, however, the challenge to build an effective therapeutic relationship remained. Again, I became intrigued by the function of the eating disorder for the individuals and the resistance to change within the therapeutic dyad. Whilst at this service, I became the coordinator for their online therapy service for bulimia sufferers. This provided me with some insight into an additional therapeutic medium with which to connect with the individual and motivated me to explore further ways in which this could be enhanced.

During the latter period, I also began working privately. Essentially, my private work provided me with increased breadth and depth in applying my framework to the therapeutic practice. I found that this gradually evolved into a two-phased model of practice whereby I would firstly work therapeutically at the symptomatic level and secondly, on the underlying cause. My interests in the significance of early developmental experiences on the presenting problems individuals brought to therapy, could be explored in increased complexity. My NHS experiences, on the other hand, assisted me in positioning myself within the empirical world of targeted, short-term and evidence-based clinical procedures.

Introduction to the Thesis

As a researcher, practitioner and reviewer, the three major sections of this thesis reflect my personal areas of interest which involve drug and alcohol addiction and the impact of the therapeutic relationship; working with resistance and ambivalence; and the medium of online therapy in increasing clients' access to psychological therapies. At this point, I shall briefly introduce how differently resistance is understood in various psychotherapeutic models.

The concept of resistance has its origin in Freudian psychoanalysis. Within that framework, it is referred to as evolving out of repressed anxiety-provoking memories and insights of the client. Thus, the 'main seat' of anxiety is viewed as within the client as opposed to the therapist or the therapeutic relationship (Wolman, 1986). One important aspect of resistance from a psychodynamic view is that it is necessary in the therapeutic process as it reflects the clients' inner conflicts.

Beutler, Moleiro and Talebi (2001) introduce different theories of resistance. In general they describe patient resistance as "imped[ing] the achievement of therapeutic goals" (Beutler et al., 2001, p. 132). In social psychology, Brehm and Brehm (2013) introduced a term called 'psychological reactance' which can be understood as a more extreme form of resistance. In contrast to the psychodynamic model of resistance, 'psychological reactance' is viewed as a more 'normal' response displayed to protect the sense of personal freedom, and not to mask unconscious desires and urges (Beutler et al., 2001).

From the viewpoint of social influence theory, resistance is not something protective but is rather perceived as "an internal conflict between the patient's desire to accept the therapist's influence and the patients' reluctance to do so because of the perceived illegitimacy of the therapist's influence" (Beutler et al., 2001, p.131).

A final viewpoint to introduce is resistance understood within behavioural and cognitive models. Alford and Lantka (2000) understand resistance as being "a problem with task avoidance rather than a relational problem" (Cautilli et al., 2005, p.151). Here the focus is set on the task and not the relationship between therapist and client. In summary, each theoretical model has a different view of resistance.

Throughout the three major sections of this thesis, themes surrounding the therapeutic relationship, the role of attachment and working with clients who are ambivalent toward change, play a central role. In more detail, the research section includes an introduction to the therapeutic relationship with regards attachment theory and substance misuse. It also explores clients' resistance and ambivalence toward change, through the use of the therapeutic relationship.

This is followed by the case study which focuses on a client whose father was an alcoholic, suffering from low self esteem. The client was experienced as ambivalent towards change whilst also appearing to resist some therapeutic interventions. While the research section focuses on the experiences of other therapists with their clients, in the case study, I describe my own experiences and thus offer a view of the therapeutic alliance including that of managing resistance, from another perspective. In the case study, attachment theory is used to explore the emergence of the clients' problems from a developmental perspective, as well as the ways in which she attaches within the therapeutic relationship.

The literature review section includes aspects of resistance, attachment and the development of a therapeutic relationship online. The field referred to here is that of eating disorders and this client group is also susceptible to resistance and ambivalence around change.

Essentially, these themes (drug and alcohol addiction and the impact of the therapeutic relationship; working with resistance and ambivalence; and the medium of online therapy in increasing clients' access to psychological tools for

change), link together by paving the way to an enquiry into 'what works' and 'what could work better' in the quest as a counselling psychologist, into helping clients change unhelpful modes of being in the world, whilst navigating healthier and more successful outcomes. With this in mind, I shall briefly outline the aims and objectives of each of the three major sections that form part of this portfolio in some detail.

Section B: The Research

The first section comprises the research component and is proportionally the largest part of this portfolio. It embodies my journey into making sense of and formulating an understanding of the therapeutic relationship within the context of individuals with substance misuse disorders. It does this by exploring the experiences of therapists working with clients suffering from substance misuse disorders. A secondary aim, based on the therapists' experiences of their clients, is to explore whether attachment theory provides explanatory value for the common factors involved in therapeutic change.

The research was conducted using semi-structured interview data and was analysed using qualitative methodology, namely, Interpretative Phenomenological Analysis (IPA). The analysis is discussed with reference to the empirical literature, and reflections as well as implications for counselling psychology are considered and acknowledged.

Section C: Professional Practice

This section contains a client case study that focuses on the therapeutic work with a young, female client presenting with low self esteem. This client did not suffer from substance misuse or eating disorders, however, her father was an alcoholic and her sister suffered from anorexia. Therapeutic work focussed on her self esteem and took place within the context of my private practice. I chose this particular clinical case because it is representative of my overarching theme and enquiry involving the therapeutic relationship. Indeed, my learning within

this piece of work paralleled by development as a counselling psychologist, in navigating, perhaps clumsily at times, the nature of the therapeutic dyad with a client who appeared ambivalent around change and considerably resistant to therapeutic intervention. Attachment theory was used to explore the nature of her attachment within the therapeutic relationship. Due to therapy taking place within my private practice, longer term work was negotiated with the client and I was able to use a psychodynamic psychotherapeutic model. Verbatim excerpts from the therapy sessions were interspersed throughout this piece of work, in order to provide an opportunity to reflect on interventions, whilst also offering the reader a 'snapshot' of the therapeutic process.

Section D: Critical Literature Review

The final section of the thesis contains the critical literature review. The topic chosen explores the viability of a different therapeutic medium in making contact with a field of sufferers known to be resistant to change. The review explores the literature around current online therapies in the treatment of eating disorders and the feasibility of these treatment options in the future. The therapeutic relationship, role of attachment and resistance to change is noted within the review. This interest stemmed from a period of work within an eating disorders service wherein I coordinated an online programme for people suffering from eating disorders. This gave me the opportunity to experience first hand the challenges and rewards of developing therapeutic relationships online. Evidence-based CBT programmes transfer easily to online services due the structured nature of the treatment that is often modulised. Inevitably this modality continues to present challenges to both therapists and clients alike, however, more importantly, it affords both parties increased access and flexibility in approach.

Conclusions

The content of the three sections within this portfolio embodies my personal journey as a counselling psychologist, contextualised by the areas within which I

have worked. All three of these areas consist of therapeutic work with clients who are on some level ambivalent about change or resistant to therapeutic input. As a consequence, I have reflected on the use of the therapeutic relationship as a vehicle for change. As I contemplate the choices I have made, both within my career as well as the themes chosen for this thesis, I am mindful of the secure base I feel my training provided me, such that the very process of compiling this thesis has served to strengthen and inspire me to continue to explore and enquire as to 'what works', during the next part of my journey.

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Glossary of Keywords

Attachment Theory – The model of attachment theory refers to the way in which early developmental relationships impact current relationships. Attachment styles are mediated by the security of attachment and involve differing levels of exploration, reflexivity and relational competence.

Common Factors – The common factors are also referred to as 'non-specific' factors and refer to the elements of psychotherapy that are frequently present in different psychotherapeutic treatments and therefore, are not limited to any particular type of psychotherapy.

Substance Misuse Disorder – The term substance misuse disorder refers to individuals who are physically or psychologically dependent on the use of drugs and/or alcohol.

Therapeutic Relationship – This is also referred to as the therapeutic or working alliance and describes the professional, interpersonal and interactional relationship between the therapist and client.

Section B: Doctoral Research

An interpretative phenomenological analysis of the experience of therapists working with clients with substance misuse disorders.

An Interpretative Phenomenological Analysis of the experience of therapists working with clients with substance misuse disorders.

ABSTRACT

Aim This research explores the therapeutic contact with clients with substance misuse disorders as experienced by therapists and whether attachment theory can provide explanatory value for the common factors of therapeutic change.

Methods Ten therapists (psychologists, counselors and psychotherapists) of whom three worked in Private Practice and seven worked for addiction agencies, were interviewed. Interviews were tape-recorded, transcribed in full and analysed using IPA. Assertions of attachment theory were compared with the themes that were extracted from the analysed interviews.

Results and Discussion The assertions of attachment theory were found either explicitly or implicitly to correlate with the main themes highlighted in the data and especially matched the seeking of a secure base provision. Many therapists appeared to use a model of attachment theory as means of making sense of the therapeutic relationship with substance users.

Similar relational difficulties were found to apply to clients that were viewed by therapists as 'working well' and to those 'not working well'.

The clients seen as gaining positive outcomes were viewed as being more able to establish and make use of the therapeutic relationship and accordingly, therapists viewed themselves as impacting those clients positively. The qualities of the therapist were seen to impact this process and these were subject to change depending on the qualities of the client.

Clients appear to have a greater capacity for exploring their external worlds than their internal worlds. The clients' ability to explore their internal worlds, as well as difficulties with narrative competence as experienced by their therapists, appear to correlate with their level of psychological-mindedness.

Empathy was used as a tool by therapists to engage their clients whilst promoting a sense of understanding of the clients' process. Ruptures within the therapeutic relationship were viewed as an opportunity to facilitate their clients' learning about relationships through the use of the therapeutic relationship.

Conclusions This research supports the view that the qualities of the therapeutic alliance in psychotherapy is of most importance to the outcome. Findings of this research suggest the usefulness of applying a model of attachment theory to this population. They also increase our understanding of the significance of the therapeutic relationship at the level of engagement in therapy.

Keywords

Attachment Theory - Common Factors - Substance Misuse - Therapeutic Relationship

INTRODUCTION

One of the main problems with working with substance misusers is that of developing an effective therapeutic relationship. People with addiction problems tend to be compromised by their ability to form meaningful relationships and this impacts directly onto the therapeutic frame. Psychodynamically, addiction might be viewed as a disorder in self-regulation, as individuals dependent on substance misuse are unable to regulate their emotions, self-care, self-esteem and relationships (Khantzian,1999).

As a result, some individuals use substances to self-medicate in order to overcome their struggles linked to deficiencies in self-regulation (Khantzian, 2012). In this regard, Khanzian (2013) describes the premise of the so-called self-medicaiton hypothesis, "[n]amely, drug-dependent individuals resort to, and become dependent on, these agents because they relieve human psychological suffering and not because they are seeking pleasure" (Khantzian, 2013, p.668). In more detail, Khantzian (2012) states that drug use is an attempt to self-correct the aforementioned difficulties by enhancing or even containing emotions, by generally affecting the connection with others and by influencing self-esteem and sense of self. Moreover, it is the ability or inability of self-care that eventually has an impact on the experimentation with and the dependency on drugs(Khantzian,2012).

Substance misuse as a disorder of attachment

Flores (2004) extends this theory by viewing substance misuse as essentially a disorder of attachment. He views the individual's relationship with drugs as informed by the relational principles in attachment theory. Here, substance misuse generally begins as a means to help individuals manage interpersonal relationships. It is viewed as a misguided attempt at self repair as the individual's use of the drug is experienced as providing a variant of a secure base, particularly when experiencing increased anxiety or threat. Individuals

who have difficulty establishing emotionally regulating attachments are seen to be more inclined to substitute drugs and alcohol for their deficiencies in intimacy. Gradually, their already impaired capacity for attachment deteriorates, and they become unable to control their substance use (Flores, 2004).

The concept of *intimacy* is an important one in psychotherapy and is deep-seated in attachment theory. As cited in Fisher (2012), in 1965 Webster defines *intimate* as "belonging to or characterizing one-s deepest nature [...] marked by very close association, contact or familiarity [...] marked by warm friendship developing through long association [...] or of a very private and personal nature."(as cited in Fisher, 2012, p. 347).

The importance of interpersonal relationship in the concept of intimacy becomes more apparent when taking Sullivan's (1953) definition into account: "Intimacy is that kind of situation involving two people which permits validation of all components of personal worth." (Sullivan, 1953, p.246). Sullivan's (1953) explanation also involves collaboration and the necessary adjustment of a person's behaviour to the needs of the other.

Attachment theory and relationships

Attachment theory posits that a child's early bonds with their caregivers essentially shape their behaviour and relationships with others (Bowlby, 1998). Bowlby (1998) termed the attachment behavioural system, which is a motivational system intended to regulate the child's proximity to a significant caregiver or attachment figure. Should the attachment figure be in close proximity, the child would feel secure and open to explore their environment. Should the attachment figure not be present, the child would feel insecure and experience and exhibit distress in their behaviour. These early relationships therefore resulted in an individual becoming either securely or insecurely attached (Bowlby, 1988). Ainsworth (1979) expanded on this theory by empirically demonstrating and developing concepts allowing for individual differences which consisted of secure, anxious-resistant and avoidant attachment patterns. Researchers increasingly explored adult relationships based on the implications of attachment theory (see eg. Bartholomew, 1993;

Collins & Feeney, 2000). While secure attachment is considered ideal, researchers currently no longer measure attachment styles in terms of specific categories, rather they conceptualize individual attachment differences along dimensional scales. The first categories were identified by Ainsworth and Bell (1970). They divided attachment into three different styles: insecure avoidant (type A), secure (type B), and insecure ambivalent/resistant (type C.) A fourth attachment style, the 'disorganized' one, was added 20 years later by Main and Solomon (1990). The more recent conceptualisation of attachment styles refers to dimensions rather than categories and mainly focuses on a two-dimensional model that uses avoidance and anxiety as the main axes (see Shaver and Fraley, 2004).

One of the most important implications of attachment theory is that the attachment behavioural system originating in infancy, continues to influence cognition, affect and behaviours in adults (Bowlby, 1988).

Attachment theory holds the position that individuals cannot regulate their affective states alone (Lewis et al. 2000). Therefore, substance misusers might only develop the capacity for healthy affect regulation in a relationship once they abandon their unhealthy attachment styles, otherwise they will seemingly remain vulnerable to drug use. For those experiencing drug dependence, attachment to their substance is extremely powerful. Likewise, they might be seen as requiring an equally powerful 'substitute' in order to establish a different way of being. Attachment theory is further discussed in the literature review part that follows below.

Attachment theory and therapeutic relationships

Additionally, research evidence on the therapeutic alliance indicates that non-specific variables are very important to outcome and the quality of the therapeutic alliance is viewed as a potent predictor of outcome (Lambert & Barley, 2001; Martin et al., 2000). Therefore, it may be assumed that the quality of the therapeutic relationship would need to be remarkably good in order to achieve positive outcome measures. Attachment theory might offer a set of

explanatory ideas that focuses precisely on those variables necessary to establish a good working alliance with a client. This can be regarded as analogous to a situation in which a mother provides an infant with a secure base. According to attachment theory, once the client is in a secure base provision, then attachment behaviour systems deactivate (Bowlby, 1988). In this way, the client is then free to explore and is more available for therapeutic work. Therefore, for substance misusers, if the healing aspects are applied in the therapeutic alliance, this is even more important. It will provide them with a way of experiencing intimacy in a relationship within a safe environment. Once therapy proceeds on this basis, the range of the client's Internal Working Models (Bowlby, 1988) becomes open to new and revised adaptations that are able to internalize and utilise the positively experienced alliance. This will increase the client's capacity to draw on new and improved relational templates, whilst also revising those already in existence, including the relationship with his or her drug(s) of choice (Weegman & Cohen, 2002).

Before going into more detail with attachment theory and related therapies in the field of addition, the most prominent therapy models in the treatment of substance misuse is presented.

Cognitive Behavioural Therapy, Twelve-Step Facilitation Therapy, and other influential Psychosocial Models

Two dominant Psychosocial models in the field of addiction are the cognitive behavioural (CBT) approaches, such as Relapse Prevention and Twelve-step facilitation Therapy. The CBT model explores the meaning of the behaviour for the individual and how this benefits them in positive way. Likewise, should the individual wish to reduce or become abstinent, the negative implications of the behaviour would be explored. Together client and therapist would build a formulation using a functional analysis of current patterns of substance use, the problems associated with this and their motivation for seeking treatment. A developmental history would also be undertaken as well as a shared understanding of how the client had adapted their behaviour over time. The therapeutic goals would be on changing the problematic behaviour, identifying

and challenging negative automatic thoughts associated with the behaviour, and tolerating uncomfortable feeling states. Due to the structured nature of CBT treatment, it lends itself well to research. To this end, many randomised control trials have provided support for CBT treatment for addictions and it is recommended by the NICE guidelines should clients suffer from comorbid conditions such as depression and anxiety (e.g. Carroll et al., 2008; Baker et al., 2010).

The Twelve-step facilitation program which was originally proposed by Alcoholics Anonymous (AA) aims to provide the individual with a set of spiritual principles to assist them on their journey to recovery. Meetings are group-based and individuals have a sponsor to actively guide them in the use of these tools to cope with necessary lifestyle changes and problematic behaviours.

According to Khantzian (2014), even though AA is officially not considered a therapy and is atheoretical, twelve-step programs clearly show therapeutic effects. They support group members in becoming aware of, clarifying, and expressing their thoughts and feelings, which are believed to be crucial parts of an effective therapy. Khantzian (2014) elaborates on "how important 12-step programs are in stimulating the transition from the self-absorbing nature of addictive illness to meaningful connections to other in the recovery process. For some it is the connection to the fellowship; for others it is the importance of connecting to a Higher Power, in whatever form that takes; and yet for many it involves a spiritual awakening and search for sources of comfort and meaning in places other than the ones that were found in drug and alcohol solutions" (Khantzian, 2014, p.226). One further interesting aspect of twelve-step facilitation programs and AA is that these interventions also address the narcissistic element, be it cause or effect, of alcohol dependent people who are encouraged to reflect on this part of their personality (Khantzian, 2014).

In order to preserve anonymity, few studies (e.g. Wells et al. 1994), have been conducted in this approach however, Twelve-step models continue to grow as a

result of personal accounts of recovery among its members (see e.g. Khantzian, 2014).

Further influential psychosocial models include Motivational Enhancement Therapy and Relapse Prevention. One popular method that is part of Motivational Enhancement Therapies is Motivational Interviewing (MI). According to Khantzian (Weegman, 2006), it includes "techniques which promote a non-judgemental interviewing approach" and "MI respects that psychological change is a process and not an event" (Weegman, 2006, p.28).

MI, which comes form a client-centred approach is aimed at eliciting motivation change in a client, thereby relying on concepts of motivational psychology. Motivational change is sought to be evoked in a rapid manner and works by mobilizing the client's inner resource by means of strengthening their autonomy and motivation (Ryan, 2010, Miller, 1995). In clinical settings, the application of Motivational Enhancement Therapy produced promising results in the treatment of mild to moderate alcohol dependence (Sellman et al., 2001) and in the field of eating disorders (Feld et al., 2001).

This might be a good point to introduce the concept of resistance. How resistance in the context of psychotherapy is understood and addressed strongly depends on the theory the therapist pertains to. Originally rooted in psychoanalysis and within that framework, resistance refers to repressed anxieties in the client that ultimately lead to resistant behaviour. Thus, in this context, resistance is placed nearly exclusively within the client. Broadly speaking, resistance might describe any behaviour exhibited by clients that obstruct the therapeutic process (Bischoff & Tracey, 1995).

One further concept that is strongly linked to resistance is that of threat in psychotherapy. This is a prevalent phenomenon particularly in the context of addiction. Accordingly, the client sees the therapist as a threat to alter the bond with or to take away his or her drug of choice (Weegman & Cohen, 2002). The role of the therapist within this relationship is important in this regard. Butler et al.

(1996) suggests that client-centred approaches where therapists and clients are both considered experts and where emphasis is placed on "the expression of […][clients'] ideas, concerns and expectations", is a potential solution (Butler, Rollnick, & Stott, 1996, p.138). This is considered to be especially useful in the treatment of clients with high resistance to change such as those with substance misuse disorders (Butler et al. 1996).

Relapse Prevention (RP) is based on social learning theory and includes behavioural as well as cognitive intervention techniques (Marlatt & Goerge, 1984). Originally, RP has been developed for the treatment of addictions with the goal of anticipating breakdowns and relapses and to successfully avoid them while maintaining previously achieved behavioural change. Marlatt and George (1984) identify three major reasons for relapse: negative emotional states, interpersonal conflict, and social pressure. The RP training thus has the goal to equip the client with skills needed to cope with situations that involve these three major reasons, amongst others, and thus to prevent him or her from falling back into old habits (Marlatt & George, 1984). RP was found to be effective in the treatment of various substance dependencies such as alcohol, cannabis, cocaine as well as in the treatment of other clinical conditions like depressions and bipolar disorder (see Marlatt & Donovan, 2005).

Attachment theory and the current study

Various theorists have identified the relationship between the client and therapist as a major therapeutic force (Greenson, 1967; Langs, 1973; Menninger & Holtzman, 1973; Duncan et al., 2010). Many efficacy studies indicate that more research needs to be done on the components of a helping relationship (Strupp, 1974; Seligman, 1995; Bohart, 2009; Cooper and McLeod, 2011). Moreover, while it is accepted that substance misusers experience difficult in establishing a therapeutic relationship, there is a lack of research investigating ways to improve the quality of the therapeutic relationship in order to facilitate a more positive outcome.

In what follows and before I introduce the present research in more detail, I will provide a brief insight into the reasons why I undertook the present research. It was fundamentally derived from a specific case study research carried out as part of a Master of Science at Metanoia Institute in 2005. The case study had focused on my therapeutic work with a client who had experienced a substance misuse disorder. The client appeared to epitomize the relational deficits present in many substance misusers. He displayed both verbal and emotional ambivalence towards letting go substance misuse. By ambivalence, I refer to part of him being invested in the rewards of the drugs, that is, his substance use helped him increase his levels of self esteem, regulate his emotions and manage the relationships in his life. This is contrasted with his recognition that maintaining his substance use might eventually lead to his mental health and ultimately, his life, deteriorating further. He had starkly presented his sense of loss and grief regarding his lack of drugs. I learnt about how precious his drug was to him as a means of survival, and I also discovered the usefulness of viewing his drug dependence as his need to attach. For this reason I found that I had to establish a very different way of working with and understanding him. Each person has a different relationship with his or her drug(s) of choice depending on each individual's history and developmental milestones. Through collaboration with the client, the research relationship was processed. This paved the way for further exploration into the therapeutic tools contributing to the establishment of safe and meaningful relational contact within the therapeutic relationship.

Data collection consisted of detailed notes taken after each session with the client, including supervision material, over a period of two years. In an attempt to build an in-depth picture of this case, archival records, documents and ward file notes were also examined. The data had been analysed in a manner similar to that of the 'Data Analysis Spiral' (Cresswell, 1998). Thereby the data was initially collected in the form of texts (therapist-client and supervision notes). These were then organised into a file detailing the developing therapeutic relationship between the client and myself over time. Following the management of the material, specific clinical vignettes were sampled according

to those that most impacted and challenged me into understanding the client's plight in a different light. These pieces of research were reflected on, questioned, explored and described further during the process of supervision. Through this process, several themes emerged, centering not only on the client's strong attachment to his substances of misuse but also on our difficultly to establish a satisfactory therapeutic relationship together. During the process of making sense of and attaching meaning, themes emerged that were then categorized into the six assertions that mirrored the fundamental domains of attachment theory. These themes were listed as:

i) The establishment of a secure base
ii) The ability to explore
iii) The regulation of affect
iv) The experience of loss
v) The hierarchy of Internal Working Models
vi) The access to narrative competence

As a result and in consultation with my research supervisor, I decided to investigate this further. Various motifs from this previous case study can also be found in the present research. The first of such motifs is that of the discussed client suffering from a substance misuse disorder. The client displayed typical symptoms such as difficulties to relate and fear of loss, that, within the past project, I described within the framework of attachment theory. Attachment theory, the second reoccurring motif, was intriguing to me and inspired me to investigate further how it can be usefully applied to the understanding of substance misuse disorders. As previously mentioned, in this past research I also focussed on the therapeutic relationship that developed with the client. As a third important theme, it is this relationship that I decided to explore in depth, this time from another, more observant point of view.

The present research explores the experiences of various therapists working in the field of addiction, as opposed to my analysing my own relationship with a client as in the previous research. Furthermore, it explores whether the

assertions of attachment theory are a useful lens for viewing the qualities of this relationship. Thus, the central themes of the current research (i.e. substance misuse, attachment theory and the therapeutic relationship) were all inspired by this case study, hence paving the way for the present research.

In keeping with a phenomenological approach and in order to research the above themes, the aim is to closely capture their related experiences within the therapists' specific contexts. Through this process, phenomenological analysis then attempts to discover, investigate and understand the psychological meaning of the aforementioned 'phenomenon'. In order to analyse the descriptive data, the database necessarily consists of retrospective descriptions derived from the therapists' therapeutic experiences with their clients, thereby creating the setting to research psychological meaning. This supports congruence among the raw data obtained, methodological analysis and sought outcomes (Smith, 2003a). In order to assist with a fresh piece of research and afford openness to the experiences being examined, it is also necessary to bracket knowledge gained from the previous research during the methodological analysis. By bracketing occurrences of the same phenomenon, different aspects of the phenomenon are open to be noted. An attitude of scientific phenomenological reduction is an additionally preferred methodological aid in that the therapists' experiences noted are perceived as 'presences' and no claim is made that this is indeed objective reality (Smith, 2003a).

REVIEW OF THE LITERATURE

To illustrate the shift from clinician to researcher a comprehensive literature review is included that details much of the background and thereby creates a platform from which to explore the data analysis and results in greater depth within a contained framework.

This qualitative study is initially being presented in three main strands. Firstly, I present research evidence supporting the view that relational factors are an

important component in therapy and are positively related to outcome. Secondly, I illustrate the robust and empirical position of attachment theory in providing the explanatory power indicative of these non-specific factors crucial to positive therapeutic outcome. Thirdly, addiction-specific literature containing alternative models of addiction with reference to outcome are reviewed. Following these three main strands, the research methodology, data analysis and results are described. I shall then discuss any relevance to the six assertions mirroring the domains of attachment theory as well as the implications of this model in practice.

1. Literature relating to the Therapeutic Alliance

Luborsky, Singer, & Luborsky (1975) analysed data on the efficacy of psychotherapy from 25 years of research and concluded that psychotherapy generally produces change in a large proportion clients. This conclusion was supported by other researchers (Meltzoff & Kornreich, 1970; Glass, 1977 as cited in Harvey & Parks, 1982). Even under reasonably controlled conditions, however, it has been impossible to prove that one technique is evidently superior to another (Luborsky et al., 1975; Strupp & Hadley, 1979 as cited in Harvey & Parks, 1982).). Luborsky (1975) stated that it was probable that there were particular ingredients commonly associated with all therapies were the main influencers of outcome. One example suggested that a therapist who was empathic, supportive and warm might produce a powerful impact on the outcome of a treatment in any treatment modality (Luborsky, 1975). The common and potent explanatory factor in all psychotherapeutic treatments is the helping relationship with the therapist (Rosenzweig, 1936; Frank, 1971; Strupp,1974 as cited in Luborsky et al, 1975; Grencavage & Norcross, 1990). Evidence suggests that specific ingredients (e.g. treatment manuals and techniques) account for very little of the variance in outcome, whereas common factors such as client characteristics, therapist qualities, change processes treatment structures, and relational dynamics (Grencavange & Norcross, 1990) are mainly responsible for psychotherapeutic benefits (Rosenzweig, 1936; Goldfried, 1980; Castonguay, 1993). The therapeutic relationship is the most

consistent common factor in psychotherapeutic literature (Grencavange & Norcross, 1990; Wolfe & Goldfried, 1988). Horvath & Symonds (1991) conducted the first meta-analysis to investigate the alliance-outcome relationship and found a robust correlation between the therapist-client alliance and the outcomes that are produced by therapy. Moreover, studies by Gullo et al. (2012) and Fluckiger et al. (2012) have cemented the importance of the therapeutic relationship as a significant predictor of outcome.

In order to situate this in current practice, the NICE (National Institute for Health and Clinical Excellence) guidelines are the most influential guidelines which inform psychological treatment. Whilst consistent findings implicate the therapeutic relationship as significant in engendering positive therapeutic outcome, the NICE guidelines place emphasis on the therapeutic models as the predictor of positive outcome. NICE use randomised control trials (RCTs) as their basis for compiling a compendium of approved evidence. Thus, evidence-based practice here constitutes those techniques that can be most easily measured, controlled and manualised for treatment. These consist of lists of models and techniques that are associated with different types of diagnoses and symptoms. The rationale being that the use of these models and techniques are most likely to result in symptom reduction and better treatment outcomes. In the meta-analysis conducted by Wampold (2001) and Miller, Duncan and Hubble (1997), however, it has been consistently illustrated that it is not the therapeutic techniques or models of therapy that produce positive or negative outcomes. The research shows that "13% of the variability in outcomes is due to psychotherapy" and that "at least 70% of the psychotherapeutic effects are general effects" (Wampold, 2001, p.207). The general effects referred to include the client's readiness to change and the therapeutic relationship. The specific effects referred to are those techniques employed by the therapist, and these "account for at most 8% of the variance" (Wampold, 2001, p.207). Thus, they are listed as the least relevant factor in accounting for outcomes. Given the results of meta-analyses (such as Wampold, 2001 and Miller et al., 1997) and studies (e.g. by Gullo et al., 2012, and Fluckinger et al., 2012), the question of whether RCTs and perhaps NICE attending to the wrong thing seems reasonable to pose.

2. Literature relating to Attachment Theory

Based on the evidence, a good client-therapist relationship is more productive and a better predictor of success than adhering to any specific treatment methodology (Martin et al., 2000). Defining the relational factors that comprise a good client-therapist relationship, however, is difficult as all relationships are complex.

Attachment theory has a particular value in that the client might experience enhanced self-efficacy when able to enjoy a secure base provided by therapy. The support from therapy's alliance creates for the client a greater potential for positive behaviour change. According to Reading (Weegman & Cohen, 2002), attachment theory infers that experiences such as these allow the re-working of Internal Working Models. This is due to more emphasis being placed on the interpersonal space created by therapist and client within the relationship. This precedes the potential for internalisation (as cited in Weegman & Cohen, 2002).

Very few studies contradict the assumptions (detailed below) made by attachment theory, and so the theory maintains universal validity. Accordingly, Van Ijzendoorn and Sagi (1999) tested the principal propositions of attachment theory and summarized what constitutes its core hypothesis under four main headings: 1. The Universality Hypothesis, 2. The Normativity Hypothesis, 3. The Sensitivity Hypothesis and 4. The Competence Hypothesis (Van Ijzendoorn & Sagi, 1999).

1. The Universality Hypothesis describes the idea that all infants become attached to one or more significant care-giver(s). The caregiver can be parental or nonparental.
2. In the Normativity Hypothesis it is claimed that the majority of infants become securely attached. However, there are a considerable number of insecurely attached children and this varies in relation to different factors. Due to the fact that it appears easier for securely attached children to settle normally as

opposed to insecurely attached ones, a secure form of attachment can be considered to be normative, thus leading to the term 'Normative Hypothesis'.

3. The concept that a secure attachment is dependent on sensitive and responsive child-rearing practices is detailed in the Sensitivity Hypothesis. The authors further state that various studies show a clear relationship between sensitive child-rearing and attachment security (Van Ijzendoorn & Sagi, 2008).

4. The Competence Hypothesis states that those with different attachment styles also possess different competencies in affect regulation and cognitive abilities. This can be in the form of non-presence of aggression, a more sustainable relationship with peers and or the emergence of cognitive abilities (Van Ijzendoorn & Sagi, 2008).

The implications of these four hypotheses might underpin most, if not all modes of psychotherapeutic practice whilst also situating attachment theory in an empirically robust position.

Holmes (2014) adds three more hypotheses to the ones by Ijzendoorn and Sagi (1999):

1. The Continuity Hypothesis states that attachment patterns evolving during childhood have a big influence on adult life, including relationship patterns.
2. The Mentalization Hypothesis implies that there is a strong connection between secure attachment and the ability to reflect on states of mind.
3. The Narrative Competence Hypothesis describes the idea that secure attachment styles from childhood are reflected in the way people talk about their past and prior relationships.

Using these seven hypotheses, Holmes (2014) then infers six attachment domains: "secure base, exploration and play, protest and assertiveness, loss, internal working models, and reflective capacity" (Holmes, 2014,p.7).

In order to appreciate the salient aspects of attachment theory as a body of knowledge, I shall briefly comment on the non-specific relational factors (also referred to as common factors) that are based on empirical findings.

The Common Factors

Lambert (1992) proposed four therapeutic factors directly beneficial to clients' treatment outcome. These are described as:

1) extratherapeutic - relating to the clients' strengths, their environment and other supportive elements outside the therapeutic frame. Lambert estimated that this would account for 40% of positive outcome variance in therapy.

2) common / relationship factors - referring to all the relational variables in all therapies irrespective of the therapeutic models employed. Lambert estimated that this would account for 30% of outcome variance in therapy.

3) expectancy or placebo - referring to the credibility of procedures and rationale and the extent to which both the therapist and client believe in this. Lambert's estimation of outcome variance here was 15%.

4) model / technical factors - which consist of beliefs and methodology directly related to specific models of treatment. Again Lambert estimated that the outcome variance would be 15%.

Building on Lambert's (1992) work, Duncan et al. (2010) expanded on his theory by further exploring these 'non-specific factors', in an attempt to ascertain the major ingredients in therapy accountable for change. They found that 87% of change in therapy can be attributed to the client and extratherapeutic factors. This then concludes that only 13% of change in therapy can be attributed to the treatment as a specific model or technique. Furthermore, Duncan et al. (2010) proposed approaching these common factors as dependent on one another, fluctuating and dynamic and as moving toward being less aligned with specific percentages and pie chart categorization.

3. Literature relating to Substance Misuse

So how is this relevant to those with substance misuse disorders and what is different about this population? There are few studies in the area of addiction research dealing with improving the therapeutic alliance. What has been established is that a good working alliance early on in treatment will have a positive effect on treatment outcome (Luborsky et al., 1983). It has also been

found that it is the quality of the alliance and not the specific treatment modality or technique that determines successful outcome (Luborsky, 1985; McLellan et al., 1988). There are, however, substance misuse studies that have used alliance measures to predict outcome in psychotherapy. These studies conclude that those patients able to form a positive relationship with their therapist also show improvement in psychotherapy (Gerstley et al., 1989). The length of time in treatment also has an effect on outcome. Studies by the Drug Abuse Reporting Programme (DARP) and the Treatment Outcome Prospective Study (TOPS) indicate that relatively long treatment periods have a positive effect on outcome.

Meier et al. (2005) examined whether a prediction could be made regarding the early therapeutic alliance in the treatment of substance misuse. They found that the clients more likely to develop positive alliances were those who were better motivated, had some degree of social support and who had a secure attachment style. It is my experience of working within the filed of substance misuse that the majority of clients tend to not have a secure attachment style, which is often illustrated through their lack of engagement in the therapeutic process. In this regard it is important to be aware that there is a cause-consequence debate about whether such insecurity derives from the addiction and the associated lifestyle or if the insecurity is there beforehand. That there is a correlation between insecure attachment styles and substance dependence has been shown by various studies (eg. Borhani, 2013, Davidson & Ireland, 2009). Correspondingly, Flores (2004) argues that insecure attachment can be both, cause and consequence of substance misusing behaviours. Thus, insecure attachment can predispose individuals to be more vulnerable to substance use as a means to cope with negative feelings such as anxiety, but can also follow from substance misuse, as an unhealthy attachment style towards the drug of choice. (Flores, 2004). Khantzian (1987a) vies substance misuse as related to psychosocial needs which can take the form of self-medication in resonse to emotional and psychic deficits. In addition, he also views substance misuse as a consequence of dependent drug use which reinforce these associations, while in some cases, it could take the form of a both. (Khantzian, 1987a). In other words, “with serious dependency, the likelihood of the latter makes it

difficult to distinguish causes and consequences of addiction, like separating the 'dancer from the dance'" (Weegman and Khantzian, 2011).

Two of the largest studies on substance misuse, Project MATCH (1997) and Mesa Grande (1998 and revised in 2000, see Miller & Wilbourne, 2007), both conclude that psychological treatments do work and have an impact on alcohol drinking outcomes. Both studies also suggest that the quality of the therapeutic relationship is more significant to successful outcome than the models and techniques of each theoretical intervention.

Over time, substance misuse treatment has gravitated toward brief treatment interventions in the community as opposed to long term and intensive residential and rehabilitation treatment (Roth & Fonagy, 1996).
The NICE guidelines on formal psychosocial interventions for drug misuse recommend contingency management to assist engagement with services for those receiving methadone maintenance treatment and for those who primarily misuse stimulants. They also recommend behavioural couples therapy for those who are in close contact with non-drug-misusing partners. Cognitive behavioural therapy (CBT) or Psychodynamic therapy is an option for those with co-morbid depression and anxiety disorders. However, these choices are specifically for those misusing cannabis or stimulants and for those abstinent or stabilised on opioid maintenance treatment. The National Treatment Agency for Substance Misuse (NTA) provides a framework and toolkit for implementing NICE-recommended treatment interventions.

The Department of Health's (2007) UK guidelines on clinical management of drug misuse and dependence identify the therapeutic alliance as one of the key principles within psychosocial interventions and cite some of Roth and Pilling's (2007) key competencies in this regard. These competencies include skills such as "the ability to engage a patient appropriately while demonstrating satisfactory levels of warmth, the ability to build trust, and to be able to adopt a personal style that is consist with and meshes with that of the patient, an ability to adjust the nature of the invention according to the capacities of the patient, [and] an

ability to deal with difficult emotions, understand and work with a patient's emotional context including patient motivation" (Department of Health, 2007,p.36).

The current treatment approaches in substance misuse as identified by the Department of Health, in line with the NICE guidelines, are Behavioural Therapy (cue exposure treatment, community reinforcement approach, contingency management, cognitive therapy, cognitive behavioural therapy, relapse prevention, motivational interviewing, motivational enhancement therapy), Twelve-step facilitation approaches and other approaches that include counselling, group therapy and the involvement of marital and family therapy built into the context of substance misuse (Ajayi, 2008).

The NTA (2004) provided a research and practice briefing for treatment providers and commissioners on engaging and retaining clients in drug treatment. This was specifically focussed on methadone maintenance treatment. They cite the English National Treatment Outcomes Research Study (NTORS), and it indicated low retention in treatment and high dropout rates. Similar findings emerged from the US Drug Abuse Treatment Outcome Studies (DATOS), implying that US services also varied in their ability to retain clients. The DATOS studies also indicated that the biggest influence on outcome concerned the relationship between the treatment provider and the client. A similar finding was made by a study of buprenorphine detoxification and maintenance where the 'therapeutic alliance' between keyworker and client was found to have more influence on treatment completion than factors such as dose or addiction severity, especially for individuals with severe psychiatric problems (Petry, 1999).

Roth and Fonagy (1996) created a critical review of psychotherapy research and found that in the area of substance misuse, RCT trials involved one primary drug of abuse at a time in order to enhance internal validity. External validity could, however, be enhanced by researching polydrug users, and these are representative of clinical settings. The researchers also noted that frequent co-

morbidity with other Axis I and II disorders bears an additional challenge when investigating outcomes (Roth & Fonagy, 1996). In addition, treatments often include a range of procedures, and as a result, cost efficiency might vary across service organisations and delivery.

In the case of alcohol treatment, evidence-based psychological approaches, often in conjunction with other procedures, consist of social skills training, relapse prevention, cue exposure, coping skills training, contingency management and motivational interviewing. Community reinforcement approaches tend to show evidence of efficacy in the shorter term (Meyers et al., 2011). Formal psychological therapies (e.g. CBT and Psychodynamic) appear beneficial only in conjunction with other treatments and procedures as do Twelve-step facilitation programmes (Morgenstern & Longabaugh, 2000).

For the treatments of stimulants, such as cocaine, evidence suggests that CBT-based relapse prevention and Twelve-step facilitation programmes are beneficial (Maude-Griffin et al., 1998). With regard to opiate treatment, psychological interventions are less well researched. Research in this context focuses on treatment programmes that include methadone maintenance or opiate reduction. Outside of this framework it is therefore possible to predict who would respond better to which treatment. Poorer outcomes are, however, associated with more severe drug use, poor treatment compliance and maintaining social drug-use networks (Smyth el al, 2005, Veilleux et al, 2010, Drummond & Perryman, 2007). Treatment programmes usually include a methadone maintenance or opiate reduction, and it is in this context that they are researched.

So to what degree do clients experiencing problematic substance misuse require an approach that is different from those who do not have difficulties with addiction? As substance misusers experience difficulty in establishing a therapeutic alliance, they often require greater demands of the therapists' skills (Luborsky, 1985; McLellan et al., 1988). Thus, a model that is beneficial in terms of increasing therapists' relational skills might appear more relevant to this

population. In how far the present research adds clarification to that question and what the specific research goals and aims are is elaborated in the following section.

RESEARCH AIMS

One major weakness of past research and studies in the field of addiction is their lack of accountability for the therapist-client relational factor. This makes it impossible to assess in what way the therapist is able to effect change in relation to the client. A major part of this type of research - where therapist variables are eliminated due to standardized measures and without the evaluation of relational dynamics – bears some inheritent difficulties. More specifically, it makes it difficult to establish what exactly can be learned from these clinicians in order to adapt our practice and promote successful treatment outcomes for those with substance misuse disorders.

With regard to research providing the evidence basis for treatment, treatment trials tend to focus on clients with one primary substance of abuse. Many clients in clinical practice, however, are often polydrug users. Furthermore, clinical trials often exclude individuals with co-morbidity or medical problems (Humphreys & Weisner, 2000). That research is not too close to 'real life' settings in order to meet standard scientific requirements such as homogeneity of the research sample and the elimination of factors that could potentially confound results is a common problem in science. Thus, a research need is highlighted whereby RCTs identify participants more representative of those entering treatment. In that way findings can be generalized to larger client groups, and thereby inform clinical practice.

Because substance misusers experience difficulty in establishing a therapeutic alliance, they often present both professional and personal challenges to the therapist. Research evidence illustrates that those clients with a greater severity of disturbance make additional and more complex demands of the therapists' skills (Luborsky, 1985; McKellan et al., 1988).

Therefore, by focussing on a challenging client group, such as those with substance misuse problems, my primary aim is to investigate the experience of therapists working with substance misusing clients. My secondary aim is to explore whether attachment theory can provide explanatory value for the common factors of therapeutic change, based on the therapists' experiences of their clients.

METHODOLOGY

Rationale for adopting a Qualitative Approach

This research follows a qualitative route. It is a methodological approach exploring the nature of therapeutic contact as experienced by therapists working with clients who misuse substances. Due to the fact that this question explores a given experience (i.e. a phenomenon) and how the participants, in this case the therapists, make sense of this phenomenon, my enquiry will take the form of an Interpretative Phenomenological Analysis (IPA) research design. This qualitative approach to the data gathering process allows for a flexible and detailed exploration that, in this case, has semi-structured interviews. The IPA approach will provide the researcher as well as the reader with an insight in the experience of the participant and give room for interpretation and meaning making.

My rationale for approaching this project using IPA as research methodology developed out of a practice-based evidence framework referring directly to my work with substance misusers, as opposed to the traditional evidence-based practice. This is consistent with a practitioner-scientist approach (McLeod, 1999). The very nature of the question "how to establish a relationship…" with another human being, including the dynamics of attachment issues and the position of the therapist in relation to that, point toward a qualitative route.

This work is located within a non-positivist paradigm which means that the 'truth' depends on the view of the observer and is not independent of him or her, as a positivist approach would state (Aliyu et al., 2014). It is grounded on a

sound methodological basis, making for a humanistically-based approach and is relevant to the field of counselling psychology.

The phenomenological basis of enquiry propagates the attitude of reflection on experience. This reflexive attitude involves disengaging from activity and engaging instead, with the experience of the activity. Husserl (Smith et al., 2009) referred to this in terms of the individuals' increasing awareness of their own experience of a phenomenon, in as much depth, breadth and precision as possible (Smith et al, 2009). According to Husserl, the goal is then to get "the essential qualities of that experience" which "would transcend the particular circumstances of their appearance, and might then illuminate a given experience for others too" (Smith et al., 2009, p.12).

In order to engage the reader in a comprehensive analysis of the experience of therapists working with substance-misusing clients, the IPA design was viewed as most appropriate. This is because it attempts to explore the personal experiences of therapists engaged in work with this client group as well as the individual perceptions of the ways in which they work. Thus the research is phenomenological as it asks about the nature of the individuals' experience with particular phenomena. Furthermore, the use of a qualitative approach engenders an integration of theory and practice, encouraging an investigation into a model of working with clients that could provide realistic and meaningful outcomes within the context that is described.

To introduce the theoretical rationale for using the IPA approach for this study, I shall briefly explain why alternative qualitative approaches were not deemed appropriate. With content analysis, the researcher sets out with a pre-conceived list of categories or themes; however, with IPA themes will be elicited from the data analysis. Discourse analysis is another approach that was ruled out as it concentrates on cultural and linguistic factors that influence ways of thinking, speaking and acting on a given topic (Schiffrin et al., 2008). Narrative analysis explores how people use narrative to make sense of or construct meaning in their experiences and therefore this was not as useful for the study design

(Riessman, 2005). According to the literature (Smith, 2003), grounded theory is closest to IPA methodology. There are, however, there are some important differences. IPA focuses specifically on how people make sense of their experiences, whereas grounded theory can focus on any of the psychological content within the qualitative data. Both approaches are bottom-up, inductive approaches. The analysis stage of IPA, however, is more interpretative and less emergent than grounded theory would allow. Methodologically, grounded theory approaches tend to generate very detailed and formulaic recipes for engaging in grounded theory designs. IPA, on the other hand, codes data descriptively and experientially at first, then moves toward the development of themes, which then allows for more interpretative, contextual accounts (Smith & Osborn, 2008).

In addition to the main research question (the experience of therapists working with clients with substance misuse disorders), I have included a secondary, theory-driven research question (explore whether attachment theory can provide explanatory value for the common factors of therapeutic change, based on the therapists' experiences of their clients) that, in parts, refer more specifically to attachment theory. According to IPA, this type of question is secondary as it can only be meaningfully addressed at the interpretative stage of analysis. In this way, existing theories and models could be evaluated using the data gained from the phenomenological account originally established (Smith, et al., 1997).

Validity

Validity in qualitative research poses challenges different from those in quantitative research, and there are now a variety of methods to establishing data quality for the foremost. Yardley (2000) offers three broad principles with which to assess the quality of qualitative research and posits that these may be addressed in different ways. One of the first principles offered by Yardley is referred to as 'sensitivity to context' (Yardley, 2000). In this way, researchers are able to illustrate an awareness of the existing literature which is substantive

and related to the topic of investigation or theoretical which fortify the research method itself. In this case, the current phenomenological study uses much of the introduction to outline the rationale for a phenomenological approach and also illustrates an awareness of the major concepts of this approach. The discussion section of the study supports this by linking the findings to the psychological literature from the substantive area.

Yardley's (2000) second principle refers to commitment, rigour, transparency and coherence. In order to assess commitment, the degree of engagement would need to be demonstrated, and this can be done by either the researcher having extensive experience of a particular approach, or by having extensive knowledge of the substantive field under investigation. With reference to this study, the researcher possesses extensive knowledge of the substantive fields of substance misuse, with work experience of 9 years in this specialised area, thus satisfying the principle of commitment. Indeed, the methodology section indicates some of the extensive immersion in the data collected as transcripts were re-read, themes were identified and data was coded. Rigour then refers to how meticulous and thorough the methodological approach and analysis was in practice. This could be assessed, for example, by the appropriateness of the sample of participants with reference to the research question. In this sense, the participants selected met the criteria specified by the researcher in order to most accurately gain answers to the phenomenological question posed. The analysis then explored their responses by engaging with their experiences of the context under observation. Transparency and coherence refers to the clarity in the way the research process is outlined and recorded in the study. Throughout the methodology, transparency in this research is enhanced by conscientiously describing how participants were selected, how the interview schedule was constructed, how the interviews were conducted and the stages used in the analysis. In turn, the coherency of the argument and discussion in the analysis section can be evaluated by the reader. Coherence might also be noted in the type of research being carried out and the methodological approach used; that is, the ways in which this research understood and adhered to the principles underlying the interpretative phenomenological approach.

Yardley's (2000) third principle refers to impact and importance, which assesses whether a study is useful, important or can make a difference. In the introduction, the researcher introduced the rationale for this study, and within the discussion section, discusses the value of the question at hand and the implications it might have for future treatment with this client group. In addition, the reader is invited to question the ways in which this research might contribute to the existing work in this field.

Maxwell (1992) provides an overview of validity and proposes that it constitutes the following types: descriptive, interpretive and theoretical validity as well as generalisability.

Descriptive validity refers to the accuracy of the data and needs to reflect exactly what the participants say. This usually consists of the initial stage of the research that is reflective of data gathering. In that sense the transcription of the data needs to include all features of the participants' speech, such as their pitch and particular words they emphasize (Maxwell, 1992). In this regard, it is comparable to the concept of credibility used by Glaser and Strauss (1967) who emphasise the need for details in descriptions so that the reader feels enabled to make judgements about the data themselves.

Maxwell (1992) upheld that in order for an account to be considered valid, the perspectives of the participants need to be respected, and he referred to this as 'interpretive' validity. He describes this in terms of how well the researcher captures the meaning of what the participant says and does during the data gathering process or interview. The researcher's data, therefore, would need to reflect and support any interpretation made.

Theoretical validity is referred to as more abstract in that it goes beyond the concrete and descriptive and focuses more on the way the researcher constructs and develops the research. The researcher in this case does not only need to highlight a pattern and propose a theory but needs to gather data that in the end might support a theory. This entails that the research is sensitive and flexible,

thus adaptable to the situation, and links with Glaser and Strauss's (1967) proposition that methodology is 'data driven' or emergent.

Descriptive, interpretative and theoretical validity can all be assessed using participant validation and the independent audit. The independent audit involves the researcher allowing another researcher or individual access to all the data in the research report. The involvement of an additional interpreter in checking the researcher's initial coding was incorporated in order to "check that the annotations have some validity in relation to the text being examined and the approach being employed" (Smith et al., 2009, p.184). Smith et al. (2009) further elaborates by stating, "Thus we see the independent audit in the same way as Yardley's criteria. It is a flexible creature offering a range of opportunities to help the IPA researcher demonstrate the validity of their work" (Smith et al., 2009, p.184). Yin (1989) proposes that a research report is filed in such a way as to provide the independent observer the process of data gathering leading to the initial findings and then the final report. In this study, the evidence was submitted to the independent auditor in the form of the initial research notes related to the research question, the research proposal, interview schedules for therapists, audio recordings, verbatim transcripts, tables of themes and coding, the draft and the final version of the report. Thus, the task of the independent researcher is not necessarily to reach a consensus or emerge with a singular 'truth' but to focus on how systematically and transparently this research report has been constructed. In this way, the independent audit is also synonymous with Yardley's (2000) criteria by allowing the researcher to flexibly demonstrate and commit to validity in research.

These types of validation ensure that the researcher is using the data to ground the emerging theories and can also to provide discussion around areas of disagreement. Morse (1994), however, suggests that it is not possible for a researcher not present at interview to code transcript data independently, as according to him, they do not have access to all the non-verbal cues privy to the researcher, such as facial expression or eye contact.

Despite Morse's (1994) criticism, participant validation and the independent audit have been used for the purpose of this research. Thus, there is the possibility that areas of discussion or disagreement might occur that would then require my discernment as researcher that is supported by directly experienced knowledge gained from the interactions during the interviews. This can be achieved by recording any areas that caused disagreement or debate and then making explicit the reasons for continuing that line of enquiry.

The notion of 'generalisibility' is viewed very differently in qualitative and quantitative research. A possible explanation for this difference might be that researchers within these methodologies investigate very different types of situations and phenomena. Qualitative research, for example, concerns itself with the meanings and experiences of the person or culture as a whole, whereas quantitative research investigates measurable categories that can be applied to all participants or similar situations. Maxwell (1992) and Auerbach and Silverstein (2003) suggested that qualitative research can have two levels of generalisability, referred to as the internal level and external level. Walsh (2003) refers to generalisability using a term more aligned with qualitative methodology and that is 'transferability'. The internal or situation-specific level of transferability refers to how the concepts and theories could be applicable in other similar situations. The external or abstract level of transferability relates to how these concepts and patterns could be more widely applied (Walsh, 2003). Within this research, the situation-specificity in terms of clinical practice and type of clients being treated would mean that internal transferability could find theories derived from the study being applied across similar outpatient clinical settings. The holistic process, however, of engaging therapeutically with clients might be more generally applicable to other areas of the health service where engagement is crucial.

Reliability

With regard to quantitative methodology, reliability comprises achieving replicable findings when repeating the experiment. This type of rigour is directly

associated with quantitative methodologies. Using qualitative methodology, reliability is alternatively associated with the theoretical validity of the findings as well as the dependability of the data. In this way, different researchers are able to produce similar interpretations of the data and repeated examinations of the data can replicate observations. Reliability is met in the present qualitative study by the aforementioned coding and categorizing. In addition, this analysis was supported by two independent coders as well as by the fact that individual participants controlled for accurate interpretation of their words into the sets of codes and categories.

Transparency

Transparency is another area of importance with regard to issues of rigour within research. Auerbach and Silverstein (2003) suggest that everything about the research has to be explicit, from sampling to interview schedules, methodology and coding. In this way, the reader is then able to make sense of the process of the research, which includes the way the researcher gathered data and reached consequent findings. It should be noted that even though the reader has access to the single steps of how the researcher arrived at the findings, they might disagree with the interpretations.

The Reflexive Researcher

As a reflexive researcher, it is important for me to acknowledge that what I bring to the research study does influence my process of research as well as analysis of the data. Strauss and Corbin (1998) proposed the idea that no researcher is able to investigate a research study as a blank slate. As a result, prior knowledge of the clinical practice, treatment, as well as the client group, impacts the way the researcher conducts the interviews and obtains the data. Thus, for Strauss and Corbin (1998), the relationship between the researcher and the researched was a key component in eliciting and managing the research data and findings. A significant position, therefore, is the idea that knowledge is co-constructed through the relationship between researcher and participant, whereby the

researcher reacts to information imparted by the participant, thereby co-creating the subsequent dialogues.

In the case of the current research, I have worked therapeutically in clinical community settings within the area of substance misuse for several years. This experience has provided me with a unique insight into some of the issues involved in engaging this client group in treatment. I have also benefited from a substantial amount of informal data that assisted the process of arriving at a research question, establishing an interview schedule and then guiding me in toward appropriate participants. Being somewhat immersed in the subject matter at hand has also provided me with information on areas of concern, developmental needs of services and the types of research studies that might be helpful. It has allowed me to tailor interview questions in a relevant and contextually grounded manner. Strauss and Corbin (1998) state that at the extreme end valuable insights from participants can be ignored should the researcher become too immersed in their own agenda and not open to participant's emerging data. McEvoy (2001) proposes the idea of the etic researcher—someone who is informed but an objective outsider. Within this research, whilst I work within the field of substance misuse, I do not work with the clients that are spoken about in this study. I also do not work with therapists sampled for this study. As a result of my working within this clinical field, I do not, however, view myself as an objective outsider. Instead, I believe there are both advantages and disadvantages in researching the client population you work with.

Narayan (1993) states that "there will inevitably be certain facets of self that join us with the people we study, other facets that emphasise our difference" (Narayan, 1993, p.680). In this way, I am required to be mindful of some the experiences of the participants that I can relate to while also being aligned to the 'practitioner-scientist' approach and the philosophy of IPA, whereby I am able to bracket my perspective enough in order to truly listen and hear the perspectives of the participants. I would also have the increased awareness that I am in a

unique position insomuch as I am able to use my own experiences as a navigational tool in order to explore the experiences of others.

Ethical Considerations

In keeping with being a reflexive researcher, there are also a number of ethical considerations to consider. For those participants working within a substance misuse agency, I contacted the staff members involved in the management of research and ethics were contacted and the Ethical Approval Form (*see Appendix A*) submitted. The procedures outlined have therefore been subject to rigorous ethical checks and appraised by their committees to ensure their ethical soundness. Upon their approval, relevant participants who had agreed to take part in the research have been contacted via email.

I have considered the ethical implications of 'interference / intrusion' within the therapist-client relationship by raising questions with specific reference to the therapeutic relationship. To this effect, the type of questions I asked in the interview schedule offers minimal 'interference' and also none of these are to the detriment of the therapeutic relationship but instead, the opposite, in that the possibility of heightened awareness might increase the effectiveness of treatment (UK Alcohol Treatment Trial Research Team, 2005). Thus, while the interview questions might highlight success and failings in relationships, this research is of sound basis and the minimal risks are outweighed by the potentially positive input as well as acquiring the knowledge, albeit on an exploratory level, of what therapists believe works well (or not) concerning the therapeutic relationship with this challenging client group.

Written consent was obtained from all participants before participation in the study (*see Appendix D)*. Within my duties as a researcher, I also have a responsibility to ensure that no harm comes to any participant as a result of taking part in the research. It is therefore of note that the very nature of qualitative research involves the participants openly talking about aspects of their work, lives and relationships that might open up for the participant areas of

previously unacknowledged or unprocessed difficulties. Although such risks of harm in this sense are minimal, given the length of training and experience of participants, it is nevertheless to be acknowledged that through the very process of asking questions, areas of consciousness might come into awareness that might leave the participant with a sense of inability to cope. (Duncombe & Jessop, 2002).

In the interests of confidentiality, all transcripts will remain unpublished and any published material will maintain the anonymity of the participants in the study. In keeping with the Division of Counselling Psychology's Professional Practice Guidelines (2005), participants were provided with full information about the nature of the research. Following the interview, participants were debriefed and an information sheet was given to them providing an outline of the study (*see Appendix F*). In addition, they were also provided with my contact details should they have any questions or concerns about the research at a later date. The participants were also provided with contact details for the researcher's supervisor should they require further support. Furthermore, they were advised that they may wish to contact their individual supervisors about the research should they have been in any way adversely impacted by this.

The ethical considerations have also been managed by offering clear and concise information to the participants on the nature of the research and the participants' rights to withdraw participation at any time without incurring any penalty. Confidentiality and anonymity would be maintained by removing all identifying information from the transcript, keeping all recordings, transcripts and data securely in a locked cabinet or in a password-protected computer file. Thus, by offering the participants access to debriefing following the interview in addition to the access to my supervisor and prompting them to use theirs, the chances of causing them harm in light of opening up and not being able to process certain issues is minimised (*Appendix F*).

Research Method and Design

Having covered the philosophical and analytic paradigms as well as issues relating to ethics and rigour in research, it is now appropriate to describe the design of the research.

i) Sampling and Participants:

Traditionally, a small sample size is consistent with the principles of the IPA approach and so for this reason 10 participants were selected. This is considered a sufficient number of cases to provide and develop meaningful detailed accounts of individual experiences. The reason for the small sample size is that detailed case-by-case analysis of individual transcripts is time consuming and the aim of the study is to extract the perceptions, experiences and understandings of this particular group rather than make general claims (Smith & Osborn, 2008).

The study sample was taken from a selection of psychotherapists, counsellors and psychologists working in private practice and in substance misuse agencies. The practitioners were required to have a minimum of Diploma level in counselling. The sample consisted of 10 practitioners who work with clients involved in substance misuse. The selection process involved emailing a large amount of random British Association for Counselling a d Psychotherapy (BACP), British Psychological Society (BPS) and United Kingdom Council for Psychotherapy (UKCP) accredited practitioners and inviting them to participate in this study. Of those who agreed, participants were selected on the basis of meeting the inclusion criteria for the purpose of this study which consisted of:

1. practitioners working psychotherapeutically with substance-misusing clients
2. practitioners with a minimum of 3 years' experience who work in community settings, as opposed to inpatient settings
3. practitioners working in the non-statutory sector

4. practitioners working in CBT or Psychodynamic Models of therapy as recommended by the NICE guidelines
5. those engaged in long-term work with clients (6 months or longer)

My rationale for this latter requirement was that although a lot of short-term therapeutic intervention is successful, in order to explore the quality of the client-therapist relationship in detail over time, long-term work was viewed as more effective for the purpose of this study.

Of these therapists, five were asked to view the questionnaire with a client in mind whom they believed was working well in therapy. The remaining five therapists were asked to answer the questionnaire bearing in mind a client of theirs who they believed was not working well or was experiencing difficulty with the therapeutic encounter. My rationale for this was in order to compare and investigate the quality of the alliance linked to treatment outcome.
Exclusion criteria included working with clients with complex mental health needs, such as Community Mental Health Teams (CMHTs) and inpatient settings and those who worked with clients with neurological disorders.

All the participants in the study were female. This was chosen to increase homogeneity of the sample. In keeping with this methodological approach, each of the 10 participants selected was homogenous and well-matched for comparisons by criteria identified above. This fits well with the fact that IPA is useful for making comparisons along one dimension within a study (Smith, et al. 2009) and for this reason, a homogenous sample is more significant when analysing outcomes.

ii) Procedure:

A list of interview questions was devised against a background of six assertions of Attachment Theory *(*Holmes, 2001*)* in an attempt to build an in-depth picture that might establish a relationship between an applied model of attachment theory and its relevance to the quality of therapeutic contact with substance

misusers. It also allowed me the opportunity to explore the quality of the relational factors within the therapeutic relationship, as seen by the therapists, and their significance to treatment outcome within the area of substance misuse (*see Appendix E*).

The questions were drawn up on the basis of attempting to capture each participant's experience of the therapeutic relationship with their substance-misusing clients. In the following, a short account of the six assertions of attachment theory along with a description of corresponding questions is given:

1. The establishment of a secure base is essential to positive treatment outcome.

These questions attempt to explore the therapist's role security and the ways in which the therapeutic relationship and working alliance becomes established.

2. Creating the capacity to explore is essential for positive treatment outcome.

These questions attempt to explore the flexibility of both therapist and client in the relationship and what factors contribute to this.

3. The use of empathic attunement to facilitate the experience of loss of the addicted substance is a crucial contributor to positive treatment outcome.

These questions attempt to explore the therapist's use of empathy as well as the model used for understanding the client's use.

4. The regulation of affect is an essential component of the therapeutic relationship in promoting positive treatment outcome.

These questions attempt to explore the therapist's response to client's emotions and their framework of understanding.

5. The revision of internal working models is a necessary component in creating positive treatment outcome.

These questions attempt to explore the ways in which therapists work with their clients' relational patterns.

6. Creating the capacity for narrative competence is a fundamental component of positive treatment outcome.

These questions attempt to explore the therapist's experience of the client's reflexive functions as well as the client's competence in making use of the therapeutic relationship.

Appendix E identifies the questions for the researcher within the attachment framework described above. The participants will not view the questions as set out in Appendix E in order to prevent bias.

A. Procedures used with Participants

Each therapist was interviewed with a set of questions relating to the topic of research. Each was also required to contextualise these questions with reference to their client (either working well or not working well).

The criteria for 'working well' referred to: attending weekly sessions; ability to engage within the therapeutic relationship; interest in altering their substance use and working toward this effect.

The criteria for those 'not working well' referred to: inconsistent attendance at sessions; exhibiting difficulty engaging within the therapeutic relationship and avoidance / difficulty with working toward goals around their substance use.

B. Materials

A digital recorder and a tape recorder were used in the interviews. All the participants were aware that their tapes might be transcribed by someone other than myself and that they might also be heard by my Research Supervisor.

C. Recruitment

Purposive sampling (Silverman, 2001) was adopted to obtain a selection of participants who met the processes under research. Participants were recruited by emailing them directly via the British Association for Counselling and

Psychotherapy (BACP), British Psychological Society (BPS) and United Kingdom Council for Psychotherapy (UKCP) websites. Upon contact with the researcher, they were provided with further information about the research being undertaken.

Once practitioners agreed to participate and they had been deemed eligible for participation, they were emailed with the set of interview questions (*see Appendix C*) to be explored during interview and informed of the facts of confidentiality and the nature of the semi-structured interview. They were also emailed an information sheet (*see Appendix B1. and B2.*), detailing requirements of them in the interview and that the interview would be recorded. This was based around Smith el al.'s (2009) terms differentiating between 'hot' and 'cold' cognition. 'Hot' cognition refers to accessing the participants' on-the-moment pre-reflective experiences, whereas 'cold' cognition is based on how people make sense of their experiences, given time to reflect. The participants in this research study were therefore requested to read through the questions beforehand in order to reflect on their answers in advance and thus provide rich data that could then be analysed. The questions sent to them in advance were neutral in tone, with no implicit judgements and were open-ended, thus creating space for other narratives that have not been predicted to emerge.

Once consent was given via email, the practicalities of the time and venue arrangements for the interview were made at the participants' convenience. All interviews were carried out at the participants' places of work.

D. Interviews

Pilot Interview

In order to rest the design of the interview a pilot interview has been conducted. The intention was to use Interpretative Phenomenological Analysis that does not strictly require any testing of a predetermined hypothesis (Smith and Osborn, 2003). Unless major restructuring of the research method or design was

required, the data would validly be incorporated into the rest of the main study because the qualitative approach by nature is intended to be a flexible and detailed exploration.

The interview design was piloted on one female psychologist who was recruited by word of mouth and who met the eligible criteria. This was in order to clarify whether the interview questions asked elicited the information being sought for the research study as well as to gauge the necessary time constraints involved in the interview process. Following the pilot interview it was found that some of the original interview questions in Appendix C could be removed as questions in their own right as they served better as prompts. Thus, the interview questions were reduced in order to allow more focus for the participant and also to elicit a more freely flowing interview between participant and researcher. As a result of this and in consultation with my research supervisor, I revised the questions (*see Appendix C*)

The participant was asked about her experience of the interview and reported a positive response. The questions were found by both participant and researcher to be appropriate for the purposes of the study, and the results were based on the researcher's subjective perception of the semi-structured interview and whether the questions seemed to elicit data pertinent to the research question. The interview procedure and all other ethical and methodological considerations were identical to that of the main study.

These were also discussed with the researcher's supervisor. Interviewing occurred in a place of each participant's choosing, and at the mutual convenience of participant and interviewer. As a result of this and in consultation with my research supervisor, I revised the questions (*see Appendix C*).

Participant Interviews

The interviews lasted between 45 minutes and 1 hour and were recorded on a small digital recording device. The process of the interview was explained in

advance and any remaining questions were answered. Prior to the start of the interview, participants were provided with a demographic questionnaire (*Appendix G*) in order to report on any salient differences that might emerge from the data. Participants were then requested to sign a consent form (*Appendix D)*, which included permission to tape record the interview. Participants were also advised to request a break in the interview at any point and were reminded that they could opt out of the interview at any stage.

A semi-structured and flexible interview schedule was used to guide the interview process (*Appendix C*). This allowed the participant and researcher to engage in a less formal dialogue that provided the freedom and flexibility to explore novel and unexpected issues where they arose (Smith & Osborn, 2003). Whilst participants were encouraged to contribute openly, they were also aware that it was their choice to answer or not to answer questions if they felt unwilling or uncomfortable. Whereas the researcher expressed interest in the topic undertaken, no attempts were made that conveyed any expectation of outcome.

Following the interview, the participants were provided with the opportunity to debrief about their experiences of the interview, and this lasted between 10 and 20 minutes. They were provided with a debriefing information sheet (*Appendix F*) that included the contact details for both the researcher and researcher's supervisor. In addition, participants were reminded of their right to withdraw their interview material at any stage before the completion of the research. The interviews were then transcribed and analysed consecutively.

A reflective diary was used throughout the research study to comment on any processes and reflections that emerged for the researcher.

Situating the Sample

The final sample consisted of 10 female participants and reflected the experiences of therapists with at least 3 years' experience working with individuals who misuse substances. Participants were recruited from London

and Kent. The participants' characteristics as reported on their demographic questionnaire are presented in table 1 below.

Initials	Gender	Age	Models of Therapy	Years of experience	Accreditations	Ethnicity
G. D.	Female	48	CBT	19	BABCP, HCP reg. Applied Psychologist	White
S. P.	Female	37	CBT	8	HCP reg. Applied Psychologist	White
A.G.	Female	36	CBT	10	HCP reg. Applied Psychologist	White
F.S.	Female	42	Psychodynamic	14	HCP reg. Applied Psychologist	White
W.K.	Female	34	Psychodynamic	4	BACP	White
S.L.	Female	36	Psychodynamic	4	BACP	White
G.H.	Female	43	Psychodynamic	16	BACP, HPC reg. Applied Psychologist	White
L.P.	Female	50	CBT	22	BACP, BABCP	White
J.C.	Female	49	CBT	27	BACP, HPC reg. Applied Psychologist	White
J.P.	Female	38	Psychodynamic	7	BACP	White

Reflections on Interview Process

It was attempted to use neutral rather than value-laden or leading questions and questions were designed to exhibit an open questioning style. Despite this, I

found that with some participants a few prompts were necessary in order to truly engage their thoughts within the interviewing process. The questions followed a logical sequence ending with the participant reflecting on their impact on their client. In reality all the interviews became a gradually evolving process for the researcher, as I found that I became more confident in addressing the balance between encouraging exploration and maintaining focus as the interviews progressed.

Using the semi-structured interview technique, I saw my role as a facilitator and guide through the questions. There was a questionnaire sheet for both participant and researcher (*Appendix C* for participant and *Appendix E* for researcher). I initially attempted to follow the order of questions on the form. However, I found that participants sometimes provided answers for other questions in their feedback. This means that the interview process was actively modified according to the answers of participants. Moreover, as researcher, I found that a flexible and adaptive style was necessary in order to continue engaging participants. First, all the participants were interviewed and subsequently the data analysis was performed.

As the interviews progressed, I became aware that I was developing and refining my interview techniques as my confidence grew as researcher. I also found that I used my role to assist in clarifying the participants' responses in various areas and interestingly, at times, found some incongruities and inconsistencies with their answers in different sections (see examples and annotated text below).

While I think I gave the participants enough time to answer the questions, there were certain answers given that upon reflection, I would have like to have followed up. The follow-up questions were of open nature, grounded in the spirit of curiosity, and with reference to the participant's personal experiences.

Another interesting find in the process of interviewing participants was that I did not receive rich data from all the therapists. The dynamic of interviewer-interviewee might have brought about some projections either conscious or

unconscious whereby the participant was experienced by myself as defensive in relating their modes of practice. With reflection they might have experienced the interview process as similar to an assessment or examination. The status of the researcher within a professional-to-professional interview might also have impacted this process. Another possibility relates to the impact of the client on the therapist. The participant might have been reflecting on a client which might have engendered the creation of a parallel process between researcher and participant. A more thorough awareness of these possibilities, an increased effort on the behalf of researcher to create the core conditions of Carl Rogers (1957, 1959), as well as more preparation of some participants about the research process might have eliminated this from occurring.

E. Transcriptions

The IPA methodology requires a verbatim transcribing process. To this end, all interviews were transcribed and included notes where relevant nonverbal communications, such as pauses and laughter, took place. Listening to the audio tapes also afforded me the opportunity to reflect on interview technique and ways this could have been improved should there be further opportunity.

F. Validity

In order to incorporate validity into the research design, I used the technique of Member Validation. Member validation has been proposed by Lincoln and Guba (1985) as "the most crucial technique for establishing credibility" (Lincoln & Guba, 1985, p.314). This procedure involved that participants read my results section and give feedback as to how well it accurately represented what they had said. This is considered a strong version of member validation (Seale, C. 1999). In the results section I have commented on their findings. In addition, I have also included the aforementioned independent audit, that are also commented on in the results section.

iii) Analytical Strategy

The IPA methodology requires in the first instance the verbatim transcription of the, in this case, ten tapes. The manuscripts were then read in order to search for anything that was interesting or significant to my chosen focus in terms of how the participants attempted to make sense of their experiences. The stages below outline the process involved whereby I immersed myself in the data by reading and re-reading in order to actively explore and engage with the analysis.

Stage 1.

Following the transcription, I read through all the manuscripts looking for anything that was interesting or significant to my chosen focus with regard to the participants' responses. I used the left-hand margin in order to annotate this first stage of analysis. This was my initial process of looking for themes. The example of the text below demonstrates my methodological approach to my thematic collection of themes. This initial level of analysis is exploratory by design and stays close to the participant's explicit meaning (Smith et al. 2009). Table 2. below consists of the first transcript used in analysis.

	Int. Okay. So, what is your experience of working with your client?
Variable comfort with client *Client managing therapist* *Cautious regarding client's history* *Mixed feelings* *Supervision* *Fears narcissistic flip* *Very careful with client* *Confidence – knowledgeable about diagnosis* *Difficult case; complex client* *Competence* *Experience relating to client* *Confidence*	Pt. It varies. I have a particularly complicated and complex client who I sometimes feel as though he is managing me, rather than me managing him. Also, he has an obsessive relationship with somebody, and he's attacked that person. I sometimes wonder whether I'm going to be part of an obsessive relationship as well. So I have mixed feelings about it, and have brought it up in supervision a couple of times [coughs]. I did… [pauses] I didn't feel fear, but I am aware that he is a tricky customer, and could be quite [siren in the background], could be quite hostile. At the moment I am wonderful and it could be followed by that narcissistic flip in which I become the bad guy. So I am very careful with him, very careful... let me think about this... ...The client has a multi faceted addictive process, a major addiction to cocaine, alcohol, and violent sex, and an obsessive relationship. So, there are four interconnecting addictive processes, alcohol, cocaine, possibly other drugs. I can't remember whether poppers or not, and sex and this sort of relationship...yet I feel competent in working with him. Int. And you don't feel overwhelmed? Pt. No. I mean, I've been working in addiction for a long time, and I am a psychosexual therapist and work with obsessive relationships and sexual compulsivity, and I have been involved in all this since about 1988. So I don't feel overwhelmed. I feel that he is… I feel I'm probably better at it than most people he would get, given his

Admiration for client *Likes client despite feeling apprehensive at times* *Empathy* *Need awareness of ruptures occurring to attend to it.* *Attend at earliest opportunity.* *Ruptures crucial to establishment of therapeutic relationship.* *Client's process began before therapy* *AA chip and staying drug-free for 3 months*	particular combination. Int. And to what extent do you feel emotionally impacted by your client? Pt. Yes, well, he has a wonderful way with words, and he knows it... Int. You mentioned earlier that he might have some hostile feelings towards you, and that doesn't make you apprehensive? Pt. Yes, it does make me apprehensive, but I still like him. He is suffering hugely. Int. Can you tell me about how you manage ruptures in the therapeutic relationship? Pt. Yes ... I am aware of them. Well, I'm aware of them when I'm aware of them [laughs]. It's possible I suppose that there could be ruptures without being aware, but I attend to them at the earliest appropriate opportunity trying to explore them and seek to repair the rupture, because in my experience, the therapeutic relationship is not properly established until there has been a rupture repaired. Well, that's probably too strong a statement. Often the strongest therapeutic relationships are based on repaired ruptures. Int. What has been the effect of treatment since your client began therapy? Pt. Well, I think he was improving before he began therapy. He certainly… he got his three months chip. You know what that means? Int. Three month…? Pt. Chip. In AA you get a chip, it's a medallion for sobriety, and you can

Client has physical illness too *Client's amount of distress* *Client became abstinent after engaging in therapy.* *Therapist establishing what's possible and what's not regarding therapy and client's drug use.* *Therapist only works with clients that are abstinent or low use.* *Clients need to know this – empowers them to make choices.*	pick up a one day chip or a one week chip or a month chip, and 90 days is quite a key one. He's got his 90 day chip in cocaine and a 90 day chip in AA. So he's had three months free. He's also got prostate cancer at the moment, and has been having radiotherapy, and I think he's done extraordinarily well, given the threats to his life, which the cancer presents, and given the fact that he's in so much distress, I think he's done very well. Int. So you say he was in the process of changing even before? Pt. Well, when he first came to me he was still acting up, cocaine, sex and alcohol. I think I said to him that we really couldn't do anything until he got the cocaine and alcohol sorted, because there's no point in trying to work on sexual relationship if he's drunk drinking or drugging. I think it was at that point that he decided to engage once again in sobriety. Int. So the way you practice, you need someone to be abstinent? Pt Well, I think to do anything serious around sex and relationships while people are mood altered by drugs and alcohol, it doesn't make any sense, because you are dealing with a person who is mood altered. So I won't actually work with someone who is… well, I work with someone who is continuing to use, but I won't work with someone who is using so excessively that you can't do any work, if you see what I mean? I mean, if someone is high all the time, there's no point, you can't do therapy, in my view.

Stage 2

Some of the comments made in the left-hand margin are intended to summarize and paraphrase the participant's responses. Following this process, I then documented initial themes that emerged from that which encapsulated the essential qualities of what was found in the text were documented. These were annotated in the right-hand margin. The aim was to establish connections between themes that could be transferred across the different participants while still retaining the individual quality of what was specifically expressed. The challenge during this phase of the data analysis was to remain theory-free while moving themes toward abstraction. This process of analysis allowed me to respect the convergences and divergences of the data as well as assist the practice in recognizing potential similarities and differences of the participants' responses. An example using the same transcript can be seen in the transcript below, labeled as Table 3.

Int. Okay. So, what is your experience of working with your client?	
Pt. It varies. I have a particularly complicated and complex client who I sometimes feel as though he is managing me, rather than me managing him. Also, he has an obsessive relationship with somebody, and he's attacked that person. I sometimes wonder whether I'm going to be part of an obsessive relationship as well. So I have mixed feelings about it, and have brought it up in supervision a couple of times [coughs]. I did… [pauses] I didn't feel fear, but I am aware that he is a tricky customer, and could be quite [siren in the background], could be quite hostile. At the moment I am wonderful and it could be followed by that narcissistic flip in which I become the bad guy. So I am very careful with him, very careful... let me think about this...	*Client's relational patterns* *Anxiety as she refers to client's relational patterns.*
...The client has a multi faceted addictive process, a major addiction to cocaine, alcohol, and violent sex, and an obsessive relationship. So, there are four interconnecting addictive processes, alcohol, cocaine, possibly other drugs. I can't remember whether poppers or not, and sex and this sort of relationship...yet I feel competent working with him.	*Supports her narrative by saying how difficult client is.* *Authority, field knowledge, confidence and ability.*
Int. And you don't feel overwhelmed?	*Refers to client's relational patterns first and then refers to self. Questions herself …*
Pt. No. I mean, I've been working in addiction for a long time, and I am a psychosexual therapist and work with obsessive relationships and sexual compulsivity, and I have been involved in all this since about 1988. So I don't feel overwhelmed. I feel that he is… I feel I'm probably better at it than most people he would get, given his	*Relevant experience*

particular combination. Int. And to what extent do you feel emotionally impacted by your client? Pt. Yes, well, he has a wonderful way with words, and he knows it... Int. You mentioned earlier that he might have some hostile feelings towards you, and that doesn't make you apprehensive? Pt. Yes, it does make me apprehensive, but I still like him. He is suffering hugely. Int. Can you tell me about how you manage ruptures in the therapeutic relationship? Pt. Yes ... I am aware of them. Well, I'm aware of them when I'm aware of them [laughs]. It's possible I suppose that there could be ruptures without being aware, but I attend to them at the earliest appropriate opportunity trying to explore them and seek to repair the rupture, because in my experience, the therapeutic relationship is not properly established until there has been a rupture repaired. Well, that's probably too strong a statement. Often the strongest therapeutic relationships are based on repaired ruptures. Int. What has been the effect of treatment since your client began therapy? Pt. Well, I think he was improving before he began therapy. He certainly… he got his three months chip. You know what that means? Int. Three month…? Pt. Chip. In AA you get a chip, it's a medallion for sobriety, and you can	*Confidence in abilities.* *Empathic regarding client's process.* *Yes but… managing tensions within the relationship. Client can make therapist apprehensive but she still likes him. 'I'm competent, experienced and I like him'…therapist making sense of her experience.* *'I'm aware…' …defines herself as competent.* *Repairing ruptures are crucial to the establishment of the therapeutic relationship.* *Ruptures as the basis of the therapeutic relationship.* *The strength of clients – clients have strength as well. Refers to this theme directly when asked about success because client has something in himself that works for him.* *Therapist might locate therapy in one of client's strengths.* *Two representations of client:* 1. *difficult, complex client* 2. *suffering too much/ having*

pick up a one day chip or a one week chip or a month chip, and 90 days is quite a key one. He's got his 90 day chip in cocaine and a 90 day chip in AA. So he's had three months free. He's also got prostate cancer at the moment, and has been having radiotherapy, and I think he's done extraordinarily well, given the threats to his life, which the cancer presents, and given the fact that he's in so much distress, I think he's done very well.	*strengths* *Two representations of therapist:* *1. anxious* *2. competent* *She focuses on both herself and client. Value placed on engagement in process.*
Int. So you say he was in the process of changing even before?	*So client perhaps not as 'good' as mentioned earlier.*
Pt. Well, when he first came to me he was still acting up, cocaine, sex and alcohol. I think I said to him that we really couldn't do anything until he got the cocaine and alcohol sorted, because there's no point in trying to work on sexual relationship if he's drunk drinking or drugging. I think it was at that point that he decided to engage once again in sobriety.	*Refers to specifics of relational setting.* *Refers to client's interest in this.* *Refers to client's competence.* *Therapist facilitated change in client.*
Int. So the way you practice, you need someone to be abstinent?	
Pt Well, I think to do anything serious around sex and relationships while people are mood altered by drugs and alcohol, it doesn't make any sense, because you are dealing with a person who is mood altered. So I won't actually work with someone who is… well, I work with someone who is continuing to use, but I won't work with someone who is using so excessively that you can't do any work, if you see what I mean? I mean, if someone is high all the time, there's no point, you can't do therapy, in my view.	*Theme is abstinence. Therapist uses abstinence as an indication of well-being.* *Rules and boundaries of therapeutic relationship. Therapist talks about his practice.* *Requires client's acceptance of rules of service.*

Stage 3

The emerging themes were listed chronologically, based on the order in which they came up in the transcript. The next stage involved connecting these to provide a more analytical and theoretical ordering to them by way of making sense of emerging themes. Some themes are presented in clusters that also included sub-themes. The first transcript that consisted of a client 'working well' was annotated along this process. This was then put aside while the same data analysis was conducted on a second transcript that consisted of a client 'not working well'. The themes from these initial transcripts were then used to help orient the subsequent analysis. Tables 4. and 5. below indicate the comprehensive list of the potential emerging themes taken from all the transcripts.

With regard to coding, a '+' meant that this theme occurred either explicitly or implicitly in other transcripts. A '[2, or 3, etc.]' records the number of the transcripts the theme was found in, so as to differentiate each transcript and also to be able to access these narratives easily. A ' * ' next to a number means that this theme has been expressed implicitly by that participant within the text. For example, the emerging theme of 'therapist reflecting on self' was named explicitly by four out the five responds in Table 1. but was also implicit in the material of the fifth respondent.

During this process of data analysis, I became aware that some of the emerging themes lay within the overall meaning of the interactive interview, rather than in merely different styles of response and use of language. Through this I began to acknowledge the personal process involved in the use of this methodology and the way that each stage of the analysis became an interpretative process. Thus I came to understand the importance and meaning underlying the participants' responses and how they might support or otherwise the underlying themes that were emerging. I also tried to capture the intentional meaning in participants' responses, which could easily be missed if the questions were only asked in one way. The reason for this design was to allow for or attempt to eliminate misinterpretation that the researcher considers more likely in a reflective style

of interview. It is also this researcher's style of checking back on her own understanding of the participant (Casement, 1985). Furthermore, it allows for more space for reflective thought in the participant when the question is posed from a slightly different or even an opposite perspective.

To an observer this 'intentional meaning' might not have been obvious from parts of the text, but in the context of the researcher's experience of the whole interview and the resultant transcript, it was apparent whether they concurred or differed from an emergent theme.

At this stage the clusters of themes were divided under six different headings. At times care had to be taken to ensure that the meaning of the theme did not change if it occurred at different or unexpected points of the text. For example, the theme of 'anxiety' occurred during various stages of the text. However, these are clustered together because their occurrence was always in the context of the impact of the client onto the therapist. At this point, these headings were not definitive and were refined at a later stage under super-ordinate themes. The themes (highlighted) at this stage of the analysis were the following:

- **Therapist Qualities** – which consisted of the sub-themes of 'therapist in relation to self', 'therapist in relation to client' and 'flexibility'
- **The Therapeutic Relationship** – which consisted of the sub-themes of 'establishing the working alliance' and 'drug and alcohol use'
- **Working with the Client's Internal and External Worlds** – which consisted of the sub-themes, 'internal world' and 'external world'
- **Empathy** – which consisted of the sub-themes of 'therapist's use of self', 'therapist's use of theory', 'impact of client on therapist' and 'therapist's expectations of client'
- **Therapist's Resources** – which consisted of the sub-themes, 'management' and 'supervision'
- **The Client** – which consisted of the sub-themes, 'narrative competence', 'impact of therapist on client' and 'outcome'

Table 4. below illustrates the clustering of themes for clients 'doing well'.

Table 5. illustrates the clustering of themes for clients 'not doing well'. It is of note that while this research design involved the comparison of two groups, the researcher was also focused on trying to understand the experiences of the participants as individuals as well as the whole.

Table 4. illustrates the clustering of themes for clients 'doing well'

Therapist Qualities
Sub-themes

1. Therapist in Relation to Self
- Therapist refers to her relating patterns
- Reflects on self +1; [5]+1; [4]+1; [1]+1; [2]*
- Focuses on herself as therapist and the therapeutic rel.
- Therapist making sense of her experience
- Therapist questions herself – anxiety re competence dealing with client+1; [4]+1;[2]*
- Questions self; trust in self as therapist [2]+1;
- Power of therapist – authority 'I make an impact on people' –
- Therapist's self disclosure – specific for specific client
- Therapist's personal history +1;
- Field knowledge; relevant experience +1; [2] +1
- Age – appears knowledgeable to clients
- Confidence in ability +1; [6]+1; [2] +1 therapist's lack of confidence in ability – views client as unstable
- Therapist's competence+1; [2] +1
- Therapists refers and is aware of her strength & weaknesses – personal characteristics +1; [2] +1
- Therapist not blaming clients – reflects on own process +1; [1]+1

2. Therapist in Relation to Client
- Therapist's role/function with client [4]+1; [5]+1
- Client needs to know that therapist can cope [3]
- Therapist's comfort with client increases over time [2]+1; [4]+1; [6] +1; [3]+1; also competence & skills [5]+1
- Therapist's transference +1; awareness of projected emotions [4]+1; [6]+1
- Therapist's awareness of what client can tolerate [3]
- Two representations of therapist: 1. anxious
  2. competent

3. Flexibility

- Flexibility of therapist +1; [2]+1 needs wide repertoire of skills; [4]+1; [5]+1 creative
- Adapts relationally +1; [3]+1 client sets pace; [5]+1; [4]+1;[4]+1 how much client can tolerate
- Therapist views her change relationally as linked with client change [2]
- Time restriction limits flexibility [3]+1; [4]+1

The Therapeutic Relationship
Sub-themes:

1. Establishing the Working Alliance

- Therapist focuses on self and on client +1
- Requirements of therapist/ boundaries of therapist/client's acceptance of this
- Managing tensions in relationship
- Ruptures crucial to establishment of therapeutic relationship +1; [5]+1
- Therapist anticipates and explores ruptures with client +1; [4]+1
- Therapist explores how her own attendance/lack of elicits ruptures
- Therapist views ruptures as client 'being drunk' [4]
- Ruptures seen as in attendance of client & therapist
- Refers to self & client as 'we'; not only the client or only the therapist +1; [5]+1 views relationship as co-created
- Therapist defines therapeutic relationship as re-enactment of past relational issues +1; [4]+1; [4]+1
- Therapist brings into awareness the impact of the therapeutic relationship on client & therapist +1
- Names client processes outside the room & the potential re-enactment of this process in the room+1; [5]+1
- Knowledge about client's relational patterns increases sense of safety in relationship for therapist [2] +1
- Views clients as having poor relational skills [2]
- Gives rationale therapist's interventions dependent on client's abilities, readiness, needs, wants, fears [2]+
- Therapist's interventions depended on what the client could tolerate and also what the therapist could tolerate[2] +1; [4]+1
- Client obeyed rules +1
- Client's psychological mindedness +1; [6]+1 and self-awareness
- The strength of clients +1
- Client's competence
- Two representations of client: 1. difficult/complex client
  2. suffering client who has strengths
- Therapists relationship with client & other agencies – managing tensions [2]

1. Drug & Alcohol Use

- Abstinence – therapist uses abstinence as indication of well-being +1; [5]+1
- Process of change began before beginning therapy
- Value placed on engagement in process, above this – drug/alcohol use
- Therapist uses reduction as measure of success [3]+1; [4]+1

Working with Client's Internal and External Worlds
Sub-themes:

1. Internal world

- Psychological mindedness referring to working with something behind the screen
- Therapist view is that some clients have this, some don't
- Client's psychological mindedness takes time – can only explore inner world when client ready [2] +1; [1] +1; [3]+1; [4]+1; [3]+1; [1]+1 need for trust; [4]+1 and when drug use addressed/stabilized
- Therapist's sense of danger with working with client's inner world how client might cope with this [3]+1; [3]+1
- Therapist challenges client's negative thoughts/relational patterns – client not responsive [2]+1; [3]+1 client not able to make links – explore relational patterns

1. External World

- Very important in addiction treatment +1; [4]+1; [5]+1; [6]+1 most of the work – impacts on internal; [3]+1 it's what brings clients into therapy
- Looking at present events/current situation +1; [2] +1
- Challenges risky behaviours +1; [3] +1; [4]+1; [5]+1; [6]+1; [3]+1 too unsafe to challenge
- Clients respond better to this [2]
- External world is more practical [3] +1 – managing tasks, experiences, relationships; [4]+1; [1]+1 easier than the internal; [2]+1reward systems, activity planning
- Therapist works with present, here & now material [6]+1; [2]+1 external world needs building up to replace subs. use
- Looks at examples of positive elements/aspects of current situation

Empathy
Sub-themes:

1. Therapist's use of Self

- Function of therapist's empathy for client = client is active agent in this as well
- Depends on client
- Focus on subjective experience of client for meaning on client's own subjectivity in terms of meaning making = making sense of therapist, therapy and relationship +1; [3]+1; [4]+1; [1]+1; [4]+1

- therapist views role as reparative +1; [2] +1 nurturing, soothing; [3]+1 empathic
- Therapist refers to own past
- Therapist's use of body language
- Instrumental use of therapist himself in relation to client
- Therapist's distress in relation to client's difficult emotions: note taking; naming these in session

2. Therapist's use of Theory

- Views client's relationship with substance use as complex [3]
- Explores this with client including client's resistance [3]
- Therapist uses elements of attachment theory to understand client [3]+1; [5]+1
- Use of metaphors to describe [4]+1; [5]+1
- Views alcohol use as client not engaging with self outside of therapy [4]
- Therapists' reflection promotes her understanding to client [6]+1
- Therapist normalizes +1; [2] +1 promotes acceptance
- Identifies and educates +1; [2] +1 reflecting back to client; helps client make sense of their world; [4]+1 and links past with present; [5]+1; [4]+1
- Therapist explores meaning [3]+1; [5]+1; [3]+1
- Therapist as witness [2] +1; [3]+1; [5]+1; [6]+1
- Function of addiction – numbs emotions +1; self-medication [2] +1; [4]+1 addiction linked interdependently to emotions; [6]+1; [3]+1; [4]+1
- Client's distress in relation to difficult emotions +1
- Therapist's view of relinquishing of substance a loss +1; [4]+1
- Need to be grieved +1; [2] +1 prepares for loss; [4]+1
- Empathy+1; [2] +1 nurtures; [6]+1
- Function of addiction – to avoid processing / dealing with loss
- Function of addiction – compensation for loss [3]; [2]+1

3. Impact of Client on Therapist

- Satisfaction re progress +1; [3]+1 feels rewarded; [4]+1
- Anxiety re client +1; [1]+1; [3]+1; [2] +1 re complex client – dual diagnosis; [3] +1 anxiety around exploring client's inner world & coping with client's responses; [5]+1; [4]+1 around ending; [2]+1; [3]+1; [4]+1
- Views client as complex +1; [2]+1; [3]+1; [4]+1 and challenging
- Apprehensive regarding client's presentation at times [4]+1; [3]+1
- Therapist reflects on client's impact on others [2]+1; challenging relationship for client & therapist [3]+1; [6]+1
- Conflicts of therapist [2]+1; [3]+1 therapist has to manage conflicts – therapist has to bring something outside (social services) into the session
- Therapist wants to rescue client [2]+1; [4]+1
- Privileged position of therapist
- Sacred
- Therapist experiencing humility as being part of client's process

- ‘Punch-drunk’ – intense feeling – strong impact of client’s progress on therapist
- Also depends on personal history of therapist +1; [4]+1; [5]+1
- Therapist’s fear of client – danger – feeling threatened +1; anxiety & fears around client’s response to interventions [2] +1; [2]+1; fears client’s anger [3]+1
- Fear of things getting out of control, difficult, dangerous
- Subjective experience of threat on part of therapist
- Depends on personal history of client
- Therapist impacted by client – concern for client +1; [5]+1
- Therapist feels ‘observed’ by client [3]
- Therapist feels ‘warmth’ for client [3]
- Therapist experiences client as ‘a lot of work’ [3]+1; [4] +1 hard work; [1]+1; [2]+1
- Therapist views client as sabotaging their work together [3]
- Therapist experiences client as managing her sometimes +1; Therapist experiences client as controlling sessions & therapy by using his/her emotions [3] +1
- Therapist experiences pressure around not making a mistake with client [3]

<u>Therapist’s expectations of client</u>

- Therapist feels frustrated at not impacting client in way she’d like [3]+1; [1] +1; [2]+1
- Therapist describes her expectations of client that interfere with what stage the client is at [3]+1; [4]+1; [5]+1
- Therapist’s expectations of self & what’s possible [4] and her frustrations around this; [2]+1
- Therapist frustrated with client’s need to use substances [3]+1; [4]+1; [5]+1 expects lapses [6]+1 and normalizes
- Lack of expectations keeps therapist ‘on her toes’ [5]

<u>Therapist’s Resources</u>
<u>Sub-themes:</u>

1. <u>Management</u>

- Managing is taking notes
- Taking notes an attempt to cope with anxiety elicited from relationship with client
- Therapist manages herself first [2] – engages with psychological & physical space
- Control and safety – refers to own resources for controlling situation rather than relying on someone else
- Sense of control over situation linked with how much therapist likes client [2]

2. <u>Supervision</u>

- Supervision helps manage therapist & therapist's management of client +1; [2] +1; [4]+1; [5]+1; [6]+1; [3]+1; [4]+1
- Multiple resources on part of therapist
- Challenges of the relationship
- Helps re-establish empathy [4]+1

The Client
Sub-themes:

1. Narrative Competence
- Client gives detailed account of life story, in 'victim' state [2]+1; [5]+1
- Therapist experiences client as 'dumping' on her [2]+1; [5]+1Therapist's interventions dependent on client [2]; [4]+1
- Facilitates client's sense of self efficacy [2]
- Dependent on client's history [2]
- Dependent on client's trust in therapist [4]
- Therapist's role in this [4]
- Therapist experiences client as withholding in regard to part of her life [3]+1
- Therapist models curiosity – client responsive [6]
- Therapist names client's process around difficulties in narrating life story [6]
- Therapist makes process comments to help client re-engage [6]

2. Impact of Therapist on Client
- Unsure
- Aware that therapist might be idealized +1; [4]+1; [5]+1
- Aware that client might believe that she has little skill/ability because he wants immediate change [5]+1
- Therapist views client as dependent on her nurturing style [5] – client lapses when she's away; client relies on therapist for everything
- Therapist actively elicits client feedback as to whether her words are received or listened to [2]
- Client 'watches' to see whether her words are received, listened to and remembered by therapist [3]
- Promotes narrative continuity between sessions for client and for herself [2]
- Views client's consistent engagement as client being impacted positively by therapist [3]+1
- Measures impact by client's altered coping strategies [4]
- Dependent on what client can internalize [4]+1; [2]+1; [5] +1 client doesn't internalize therapist outside of therapy

3. Outcome
- Uncomfortable predicting outcome +1; [4]+1; [4]+1
- Ambivalence regarding outcome [5]
- Hope for present

- Therapist focuses on the negative – unclear on 'doing well' +1; Believes therapy would work well if long term but unlikely [3] +1
- Psychological mindedness does not refer to outcome
- Views consistent contact important for positive outcome [2]+1; [3] +1; [4] +1 as well as client's accountability around this
- Views client taking responsibilities in life outside room & self-efficacy as measure of improvement [2] +1; [4]+1 and how present client can be for family; [5]+1 periods of abstinence
- Therapist views success in terms of client's engagement, responsiveness, trust in therapist [3]+1; [4]+1; [5]+1; i.e. success inside the room as measure of improvement

Table 5. illustrates the clustering of themes for clients 'not doing well'

Therapist Qualities
Sub-themes

4. Therapist in Relation to Self

- Reflects on self +1; [5]+1; [4]+1; [1]+1
- Therapist questions self – anxiety re competence dealing with client+1; [4]+1
- Questions self; [1]+1 therapist critical of self; [2]+1 getting it right
- Therapist's personal history +1; [1]+ therapist's feelings about drug use interfered with her empathy; [4]+1
- Confidence in ability +1; [6]+1; [2] +1 therapist's lack of confidence in ability – views client as unstable; [3]+1 lack of confidence; [4]*; [6]*
- Therapist's competence+1; [2] +1; [4]+1 and confidence in model used
- Therapist refers and is aware of her strength & weaknesses – personal characteristics +1; [2] +1; [1]+1; [3]+1 and limitations
- Therapist not blaming clients – reflects on own process +1; [1]+1

5. Therapist in Relation to Client

- Therapist's role/function with client [4]+1; [5]+1; [1]+1; [3]+1 transitional role
- Therapist's comfort with client increases over time [2]+1; [4]+1; [6] +1; [3]+1; also competence & skills [5]+1; [1]+1 therapist felt incompetent & not confident; [3]+1; therapist uncomfortable with client [1]+1; [4]+1
- Therapist's conflicts: [2]+1; [3]*; [5]*
  1. looks forward to sessions 2. a lot of work to prepare
- Therapist switches between feeling: [1]
  1. colluding 2. client being seen
- Therapist's transference +1; awareness of projected emotions [4]+1; [6]+1; [3]+1 therapist not always aware
- Therapist's needs to feel safe in relationship with client [4]+1; [1]+1;[2]+2 therapist doesn't completely trust client; [4]+1

6. Flexibility

- Flexibility of therapist +1; [2]+1 needs wide repertoire of skills; [4]+1; [5]+1 creative; [1]+1 over-adapting to each other
- Adapts relationally +1; [3]+1 client sets pace; [5]+1; [4]+1;[4]+1 how much client can tolerate; [3]+1; [1]+1 therapist & client working at different paces – pace therapist-led
- Inflexibility of client – client wanted CBT [2]
- Therapist feels restricted in work with client [1] +1; [2]+1

The Therapeutic Relationship
Sub-themes:

1. Establishing the Working Alliance

- Use of therapeutic relationship to expand current relational skills [4]+1
- Use of therapeutic relationship dependent on how much clients can use it/tolerate it [4]
- No working alliance till after 2 years [1]; establishing working alliance the most challenging [1] ; [2]+1; [3]+1; [4]+1 client disengaging
- Trust created relationship [1]; both therapist & client in parallel processes [1];
- Also reflects on client's relationship with her [1] – client feeling exposed in 1:1/therapist's avoidance
- Therapist's self-awareness – avoidance of ruptures or confrontations [1]+1; [3]+1– impacts robustness of therapist's interventions – too unsafe
- Therapist active, client passive [2]+1; [6]*
- Therapist views ruptures s client's ambivalence [2]
- Ruptures seen as in attendance of client & therapist; [2]+1; [4]+1 encourages client to attend to therapeutic relationship
- Refers to self & client as 'we'; not only the client or only the therapist +1; [5]+1 views relationship as co-created; [1]+1 and parallel processes
- Therapist defines therapeutic relationship as re-enactment of past relational issues +1; [4]+1; [4]+1
- Therapist brings into awareness the impact of the therapeutic relationship on client & therapist +1; [1]+1 through transference & countertransference – therapist explores relationship with self and with client
- Therapist views substance use as major relationship in client's life [2]
- Gives rationale therapist's interventions dependent on client's abilities, readiness, needs, wants, fears [2]+; [3]+1 timing of interventions important; [4]+1
- Client obeyed rules +1; client uncooperative [2]+1; client's lack of honesty [4]+1
- The strength of clients +1; [2]+1 – therapist can challenge

2. Drug & Alcohol Use

- Therapist uses drug use to help establish therapeutic relationship [4]
- Awareness of both therapist & client of whole person, holding client's ambivalence [1]+1; [4]+1
- Therapist's belief – increased awareness equals more control [1]

Working with Client's Internal and External Worlds
Sub-themes:

2. Internal world

- Client's psychological mindedness takes time – can only explore inner world when client ready [2] +1; [1] +1; [3]+1; [4]+1; [3]+1; [1]+1 need for trust; [4]+1 and when drug use addressed/stabilized
- Therapist's sense of danger with working with client's inner world and how client might cope with this [3]+1; [3]+1; [4]*; [2]*
- Therapist challenges client's negative thoughts/relational patterns – client not responsive [2]+1; [3]+1 client not able to make links – explore relational patterns

2. External World

- Very important in addiction treatment +1; [4]+1; [5]+1; [6]+1 most of the work impacts on internal; [3]+1 it's what brings clients into therapy
- Challenges risky behaviours +1; [3] +1; [4]+1; [5]+1; [6]+1; [3]+1 too unsafe to challenge
- External world is more practical [3] +1 – managing tasks, experiences, relationships; [4]+1; [1]+1 easier than the internal; [2]+1reward systems, activity planning
- Therapist works with present, here & now material [6]+1; [2]+1 external world needs building up to replace substance use

Empathy
Sub-themes:

4. Therapist's use of Self

- Focus on subjective experience of client for meaning on client's own subjectivity in terms of meaning making = making sense of therapist, therapy and relationship +1; [3]+1; [4]+1; [1]+1; [4]+1; [2]*
- Therapist views role as reparative +1; [2] +1 nurturing, soothing; [3]+1 empathic; [3]+1 empathizes with client's inability to empathize with self
- Therapist experiences self as: (conflicts) [1]
  1. colluding 2. empathic

5. Therapist's use of Theory

- Therapist uses elements of attachment theory to understand client [3]+1; [5]+1; Function of addiction: client emotionally attached to it [2] +1; [4]+1
- Therapists' reflection promotes her understanding of client [6]+1; [3]+1 non-judgemental; [4]+1 and empathy; [2]*; [5]*; [6]*; [3]*
- Habituation; ritualistic, institutionalized = behaviourist [2]

- Identifies and educates +1; [2] +1 reflecting back to client; helps client make sense of their world; [4]+1 and links past with present; [5]+1; [4]+1
- Therapist explores meaning [3]+1; [5]+1; [3]+1; [2]*
- Function of addiction - [4]+1 addiction linked interdependently to emotions; [6]+1; [3]+1; [4]+1
- [1]+1 Client experiences feelings as dangerous and need to be blocked out; [2]+1 client avoidant of emotions
- Therapist's view of relinquishing of substance a loss +1; [4]+1; [1]+1; [2]+1; [3]+1 loss of relationship; [4]+ loss of attachment figures
- Need to be grieved +1; [2] +1 prepares for loss; [4]+1; loss linked with bereavements [2]+1
- Function of addiction – compensation for loss [3]; [2]+1

6. Impact of Client on Therapist

- Anxiety re client +1; [1]+1; [3]+1; [2] +1 re complex client – dual diagnosis; [3] +1 anxiety around exploring client's inner world & coping with client's responses; [5]+1; [4]+1 around ending; [2]+1; [3]+1; [4]+1
- Therapist doesn't feel emotionally impacted by client [2]+1; [4]+1 ambivalent feelings toward client
- Views client as complex +1; [2]+1; [3]+1; [4]+1 and challenging; [1]+1; [3]+1 and difficult
- Views client as fragile [4]+1; [2]*
- Takes time to be impacted by client [4]+1; [2]*; [3]*
- Apprehensive regarding client's presentation at times [4]+1; [3]+1
- Challenging relationship for client & therapist [3]+1; [6]+1; [4]+1 feels angry
- Anxiety & fears around client's response to interventions [2] +1; [2]+1; fears client's anger [3]+1; [5]*
- Therapist experiences client as 'a lot of work' [3]+1; [4] +1 hard work; [1]+1; [2]+1
- Therapist experiences client as controlling sessions & therapy, using their emotions [3] +1; [2]+1 and therapist feels impotent – power & control – sub theme?; [4]+1 client disengaging, therapist has no control 'don't know what's going on'
- Therapist experiences sense of hopelessness [1]+1; client's world view is hopelessness; [3]+1 despair
- Choice of therapist – client not chosen by her; given to her [3]

Therapist's expectations of client

- Therapist feels frustrated at not impacting client in way she'd like [3]+1; [1] +1; [2]+1
- [1]+1 pacing
- Therapist's expectations of self & what's possible [4] and her frustrations around this; [2]+1
- Therapist wanted to explore internal world & client didn't [1]
- Therapist and client at different pace [1]+1; [2]*; [3]*
- Therapist critical of her own motives/expectations of client [1]
- Therapist invested in getting client better [1]

- Therapist has limited expectations of client and of self [3]

Therapist's Resources
Sub-themes:

3. Management
- Managing is taking notes[1]+1;[2]*

4. Supervision
- Supervision helps manage therapist & therapist's management of client +1; [2] +1; [4]+1; [5]+1; [6]+1; [3]+1; [4]+1
- [3]+1; [4]+1 personal therapy; [4]+1 colleagues

The Client
Sub-themes:

4. Narrative Competence
- Therapist experiences client as 'dumping' on her [2]+1; [5]+1; [4]+1 these clients don't tend to engage
- [3]+1 client feels safer exploring past than present
- Explores past relational patterns [4]+1
- Client experiences difficulty narrating life story [1]+1;[2]+1

5. Impact of Therapist on Client
- Therapist doesn't think she's impacted client [2]+1; [3]+1 doesn't think client feels understood by her
- [4]+1 Inconsistent engagement views lack of positive impact on client
- Client experiences pressure from therapist to learn from experiences, emotions, etc. [1];[3]*
- Client engages more with self than with therapist [2]+1;[3]+1 client doesn't engage with self[4]*
- Client doesn't engage with self in room, engages outside and brings it back
- Dependent on what client can internalize [4]+1; [2]+1; [1]+1 client would bring it back in completely different form; [2]+1; [3]+1

6. Outcome
- Uncomfortable predicting outcome +1; [4]+1; [4]+1
- Client's increased awareness might result in lapse [2]
- Client not ready for change [4]
- Hope for present [1]+1; [5]+1; [3]*
- Therapist's limitations [2]+1; client not improved [3]+1
- Therapist views success in terms of client's engagement, responsiveness, trust in therapist [3]+1; [4]+1; [5]+1; [2]+1 more exploration

Stage 4

At this point in the data analysis it was decided to amalgamate the data collected from both 'clients doing well' and 'clients not doing well', thereby presenting the clusters under more super-ordinate themes. This was as a result of my sustained engagement with the texts as well as the detailed process involving its interpretation. During this process, those themes that involved an affirmative response from five or more of the participants were taken as a 'significant' theme. In keeping with the iterative process of the analysis, earlier transcripts were reviewed in light of the sub-ordinate themes as they emerged and these instances were included in the ongoing analysis (see Smith & Osborn, 2008). An example of a participant's responses identified representing the themes is illustrated in Table 6 in below. It also became apparent that some themes had a bearing on others as they emerged in the study. For example, the questions around 'loss' and 'regulation of affect' occurred in both areas, and likewise, questions around 'the revision of internal working models' also impacted the responses relating to questions around 'narrative competence' as well as 'the establishment of the secure base'. Table 6. below illustrates the super-ordinate themes for the group as demonstrated by one transcript.

Table 6. Super-ordinate / Master themes for the Group as illustrated by one transcript.

Coding of themes is as follows: 1.28 = page 1, line 28; + = explicit in text; * = implicit in text.

Even though a specific page and line number has been recorded here for this example, it is also to be noted that these themes might have occurred a number of times through a participant's transcript.

	Transcript 1.
1. Therapist Qualities	
Competence, confidence and skills	1.28 +; *
Personal history	5.12 +
Relevant experience	2.4 +

- Self-awareness 2.18 +; *
- Reflective on self and client's process 6.23 +
- Role and function 4.2 +
- Conflicts with self, client and others 6.4 *
- Awareness of projected emotions 2.18 +
- Flexibility 4.3 +
- External restrictions of work
- Client restrictions around work 5.6 *

2. The Therapeutic Relationship

- Establishing the working alliance 3.14 +
- Use of therapeutic relationship 10.5 +
- Managing ruptures 2.19 +
- Client's engagement 10.19 *
- Co-created relationship 3.16 *
- Trust in self, client and process 2.7 *
- Client relational patterns 8.32 +
- Timing of interventions 4.2 *
- Client's competence 6.3 *
- Relationship between therapist, client and others
- Client's drug or alcohol use 3.6 +

3. Capacity for Exploration

- Client's internal world 4.9 +
- Client's external world 4.22 +
- Client's responsiveness 4.23 +

4. Empathy

- Therapist's use of self 5.20 +
- Therapist's conflicts regarding role of empathy 5.18 +
- Therapist's use of theory to promote understanding 5.15 *
- Use of metaphors
- Function of addiction 7.28 +
- Therapist as witness to client's emotions 8.11 *
- Client's difficulties regarding emotions 7.29 *
- Client's experience with loss 6.29 +

5. Impact of Client on Therapist

- Therapist's anxieties, apprehensions and fears 7.20 *
- Complexities and challenges of client 1.21 +
- Conflicts of therapist
- Therapist's need for control in relationship 1.10 *

- Therapist impacted by client's emotions 5.33 +
- Therapist's expectations of client 7.19 *
- Therapist's expectations of self
- Therapist's management of self and client 6.7 +
- Uneasiness in predicting outcome 3.23 +
- Measures of success 2.30 *

6. Client's Narrative Competence

- Client's disclosure of life story 9.23 *
- Therapist's experience of this 9.33 *
- Client's sense of self efficacy 10.14 *
- Therapist's subsequent interventions 10.17 +
- Client's ability to reflect on life 10.14 *

7. Impact of Therapist on Client

- Therapist's awareness of impact 5.28 +
- Therapist's views of client 11.2 *
- Therapist's measures of their impact 11.1 *
- Client engagement 3.21 *

Table 7. below illustrates the super-ordinate themes that represent the final phase of the data analysis process.

Table 7. Master List of Themes

1. Therapist Qualities

- Competence, confidence and skills
- Personal history
- Relevant experience
- Self-awareness
- Reflective on self and client's process
- Role and function
- Conflicts with self, client and others
- Awareness of projected emotions
- Flexibility
- External restrictions of work
- Client restrictions around work

2. The Therapeutic Relationship

- Establishing the working alliance

- Use of therapeutic relationship
- Managing ruptures
- Client's engagement
- Co-created relationship
- Trust in self, client and process
- Client relational patterns
- Timing of interventions
- Client's competence
- Relationship between therapist, client and others
- Client's drug or alcohol use

3. <u>The Capacity for Exploration</u>

- Client's internal world
- Client's external world
- Client's responsiveness

4. <u>Empathy</u>

- Therapist's use of self
- Therapist's conflicts regarding role of empathy
- Therapist's use of theory to promote understanding
- Use of metaphors
- Function of addiction
- Therapist as witness to client's emotions
- Client's difficulties regarding emotions
- Client's experience with loss

5. <u>Impact of Client on Therapist</u>

- Therapist's anxieties, apprehensions and fears
- Complexities and challenges of client
- Conflicts of therapist
- Therapist's need for control in relationship
- Therapist impacted by client's emotions
- Therapist's expectations of client
- Therapist's expectations of self
- Therapist's management of self and client
- Uneasiness in predicting outcome
- Measures of success

6. <u>Client's Narrative Competence</u>

- Client's disclosure of life story
- Therapist's experience of this
- Client's sense of self efficacy

- Therapist's subsequent interventions

7. Impact of Therapist on Client

- Therapist's awareness of impact
- Therapist's views of client
- Therapist's measures of their impact
- Client engagement

RESULTS AND DISCUSSION

Details of Themes Identified

The main emergent themes lie under seven interrelated clusters consisting of the following: therapist qualities, impact of client on therapist, capacity for exploration, client's narrative competence, empathy, the therapeutic relationship and the impact of the therapist on the client. For the purpose of transparency consistent with IPA research methodology, I present the themes elicited supported by verbatim extracts from participants. I also discuss their links to the literature as well as any relevance to the six assertions identified through Attachment Theory.

1. Therapist Qualities

Qualities such as competence, confidence and therapeutic skills were identified by all therapists. This was associated with their levels of self-awareness, relevant experience as well as personal history. All therapists identified a flexible approach or style as crucial when working with this client group. I have used the therapists' initials in order to differentiate the transcripts.

Examples from the text that represent the themes found:

i) Clients doing well

G.H.'s account captured the 'therapist qualities' identified earlier. She identifies this client group as complex and supports her narrative by stating how difficult

her client is. During this extract she expands on her abilities as therapist by referring to both her own and her client's relational patterns.

Int. Okay. So what is your experience of working with your client?

G.H. It varies. I have a particularly complicated and complex client who I sometimes feel as though he is managing me, rather than me managing him. Also, he has an obsessive relationship with somebody, and he's attacked that person. I sometimes wonder whether I'm going to be part of an obsessive relationship as well. So I have mixed feelings about it, and have brought it up in supervision a couple of times [coughs]. I did… [pauses] I didn't feel fear, but I am aware that he is a tricky customer and could be quite [siren in the background], could be quite hostile. At the moment I am wonderful and it could be followed by that narcissistic flip in which I become the bad guy. So I am very careful with him, very careful....The client has a multi-faceted addictive process, a major addiction to cocaine, alcohol and violent sex, and an obsessive relationship. So, there are four interconnecting addictive processes, alcohol, cocaine, possibly other drugs. I can't remember whether poppers or not, and sex and this sort of relationship...yet I feel competent working with him.

Int. And you don't feel overwhelmed?

G.H. No. I mean, I've been working in addiction for a long time, and I am a psychosexual therapist and work with obsessive relationships and sexual compulsivity, and I have been involved in all this since about 1988. So I don't feel overwhelmed. I feel that he is… I feel I'm probably better at it than most people he would get, given his particular combination.

ii) <u>Clients not doing well</u>

W.K's account of her qualities as a therapist is greatly impacted by her experience of her client. She talks about experiencing herself as incompetent in

relationship with her client and reflects on her relationship with self. She also reveals that this has changed over time.

Int. Can you tell me about your experience of working with your client?

W.K. The particular client I'm talking about, for the first year I did not feel comfortable with her. I think we are both over-adapted, both her and me, so she was trying to adapt to my style and I was trying to adapt to her style, and I think we missed each other very much so in about the first year. We didn't really bond or get down to it. In the second and third year we formed an alliance. We got through that difficulty and we talked it out, we worked it out, we got there, and then we did get on well. She was in therapy with me for four years, but the first year was really hard.

Int. What do you think changed?

W.K. I think talking about the difficulties I felt with her, but I needed a certain amount of trust before I was able to even do that, so that's why it took about a year of working weekly. I didn't think I had the skills to work with her but I did in the end. I don't think it was a very neat therapy. It felt a bit clumsy, it felt full of mistakes, and at times I would have said I hadn't got the necessary skills to help her. I got stuck a lot with her, but in the end, we got there.

Int. Again, what changed with you being different?

W.K. I think she might have learnt to trust me at last, and I might have learnt to trust me as well, in that process.

Therapist Qualities and relationship to Literature:

Research indicates that the quality of the therapist is crucial to successful outcome of therapy. Within this research (Wampold, 2001), therapist's competence is defined by outcome, that is, more competent therapists produce better outcomes than less competent therapists. Within my research, therapist's competence appeared more to relate to the intersubjective experience between client and therapist. Skills, abilities, techniques and personal qualities that work well with a variety of other client groups perhaps work less well within the field of addiction. Competence in relationship is what is most deficient within this client group and might be exposed and projected to a much greater extent within their therapeutic encounter.

In my research I found that therapists' views of their competence might reflect their level of self-awareness of client processes, and their role within this. In an account by S.L., she describes an awareness of her limitations as a therapist as well as the limitations of her client's process.

Int. Okay, so do you mean that you trusted that you had the skills you needed to help your client?

S.L. No, because my view is that this client is borderline and there was a set of sessions, not this time but last time, when he was actively suicidal and as often is the case in Mental Health there was a…game of ping-pong between Mental Health and us (Addiction Agency). This is again … and that was very frustrating for him, for me, and it was very hard not to get sucked in. And actually, I think I did actually get sucked into that and lost sight of what I was doing because that seemed to be the primary problem, and because it wasn't really catered for by the mental health team, which I believe was the right place, it was really hard not to rescue that client in the counselling. So with a background he, if you like, and a realisation that I don't have the skills to do that type of work because that's not really part of the training. I have awareness, but not geared up to do that because of the way we work…

Interestingly, this transcript came from a 'client doing well', indicating that the relationship between competence and outcome might not exist in such a clear-cut manner as implied by Wampold (2001). All therapists interviewed including S.L., G.H. and W.K. describe this client group as complex. This perception directly infers that necessary qualities would need to be present within the therapist in order to engage and sustain this client group within treatment. The next theme takes this further as it differentiates the person of the therapist by introducing the qualities of the client that might impact.

2. Impact of Client on Therapist

All of the participants either explicitly or implicitly revealed that their clients impacted them in a powerful manner. They described this client group as complex and challenging that, in turn, highlighted their anxieties, apprehensions and fears. Here S.P. describes her apprehension toward a particular 'not working well' client.

Int. So, what is your experience of working with your client?

S.P. Well, I think I've been reasonably comfortable working with him. I guess there's a bit of anxiety before the session on my part. I kind of think if he doesn't turn up, then it doesn't matter too much. I'm not terribly looking forward to the experience. So, I have a kind of mixed feeling. If he does turn up, it's okay, it's good, but if he doesn't, I'm not devastated.

As a result of the emotional impact these clients have on therapists, a sense of control over what may or may not be acted out in the room appears to be in constant awareness. This can be seen in G.H's segment below where she expresses some of her fears in relation to her client that also alluded to her personal history. She then describes how she manages this.

Int. Can you tell me your experience of difficult emotions projected onto you by your client?

G.H. That's the most difficult bit, and I haven't had much of it. That's the bit that frightens me, when I am projected as the perpetrator. I haven't had it in therapeutic life. I have had it in another life, and it was horrendous. It was really very unpleasant. My way of managing it is first of all talk about the particular client about whom I've been speaking tonight, I started last week to say to him you've talked about how you flipped from being very committed to this guy that you are obsessed by, and then you attack him, and then I say, could that happen here? I meant in the therapy room, and he didn't even get the point. He went back to the partner. So, I raised that because one of the ways in which I would seek to deal with it is to deal with it before it happens, and also try and keep good notes.

G.H. also alludes to the level of psychological-mindedness of her client and how this might affect an intervention concerning the immediacy of the therapeutic relationship. Therapists also highlighted the importance of support for them. Multiple resources on the part of the therapist were considered valuable in this regard. Supervision was seen as a process whereby the therapist was assisted, and that assistance enhanced the therapist's management of the client. In response to the question above, J.C. discloses how her awareness of the client's impact is raised.

J.C. Well, I'm very fortunate in that… I think very often at first I'm not aware- I think I don't always recognise those but a little later I will because then I'll find that there are things that I'm experienced in…and I know that these are not directly related to me or… I actually am able to separate out some of that stuff myself but I have twice a week therapy. So, I'm able to take an awful lot to that. So, I would then process it and look at it in supervision and so on. So, I'm quite fortunate in that I have a good support system.

Another central theme here was the expectations of the therapists of their clients. The nature of working with substance-misusing individuals is that they come into therapy with goals around abstinence or reduction. Therapists might

be experiencing pressure within themselves to support these goals. W.K. describes her awareness of this, with hindsight, in the extract below.

Int. What is your experience of your client's disappointment, excitement, rage, etc.?

W.K. If say, she had a relapse, and she's really upset and she'd been beating herself up about it, I kind of liked to slow that right down and see what was really going on, and try and get in touch with the rebel part and then use sort of like okay, so what weren't we listening to here, what do we need to listen to. So I'd be, you know, concerned about the disappointment, but I was so fast and keen to use it as an opportunity for learning, that sometimes I might have gone too far. So I can see where I sort of went wrong with her. I was going… she seemed like a speedy person, and she was in some areas, but she wasn't in this.

Int. Yeah, so it sounds like the pacing…

W.K. My pacing wasn't right. I was always going a bit too fast.

Impact of Client on Therapist and relationship to Attachment Theory

The impact of an (at times) chaotic client group can create feelings of despair, hopelessness, fear and apprehension in the person of the therapist. Attachment theory lends itself well to a parallel process whereby the therapist's capacity to regulate his or her own affect and to self soothe when confronted with difficult emotions and counter-transferences is vital to the establishment of secure base provision. Essentially, the therapist requires a secure base to work from. By this I refer to that which would provide the therapist with a sense of physical and emotional security, such as basic needs around supervision, training, salary, safety, etc. and also further needs relating to his or her therapeutic commitment such as confidence, experience, personal therapy and role security. In this way the impact of the client on the therapist appears related to therapists' qualities.

Therapist Qualities and relationship to Attachment Theory

The therapist's role security is an important factor here as these clients in particular tend to respond defensively to the very thought of relinquishing their drug use. A therapist who is role-secure would be more able to respond through the use of empathic attunement and understanding, as opposed to reacting in a defensive or anxious manner. In addition, role security is also extended to the therapeutic model employed. The model of attachment theory makes personal as well as empirical sense to me and is congruent with my value system. Therapists working with individuals who are dependent on illicit substances are already subject to a pre-transference prior to establishing a therapeutic relationship. They are already identified as the persons threatening the client's addictional bond. Attachment theory provides a useful method of understanding these dynamic transferential representations in that it assists in understanding how difficult is might be for an individual to let go of a substance whilst also finding the experience of the substance rewarding in many ways. The therapist may then become viewed as a threat to their attachment to their addictional bond (Weegman and Cohen, 2002).

Thus, in applying the attachment model to this population, the secure base provision of the therapist also needs to be addressed. This includes that which denotes a sense of security when working within this environment. Apart from basic needs such as salary, there is also training coupled with supervisory or therapeutic support both inside and outside of the treatment setting. The support of colleagues as well as the relative stability of personal relationships might allow for a more present relational quality and ensure that interventions are approached with the best interests of the client at heart. Personal therapy might facilitate the therapist by ensuring that his or her inner world and external reality are comprehensively attended to in order to assist in his or her task as a reliable attachment figure. In this way, the processing and enactment of the therapist's own attachment issues or anxieties do not interfere with the therapeutic encounter.

3. Capacity for Exploration

The clients' capacity for exploration may also be referred to as client qualities. This centred on the therapists' views of their clients' capacity to explore their internal and external worlds. Internal world referred to the client's psychological mindedness, which referred to their ability to think, reflect and make sense of their material, however, this is also dependent on relationship. The external world referred to the client's external reality, current events and the practicalities of their lives. All of the therapists viewed the exploration of their external world as very important in addiction treatment. Not all therapists worked with their clients' internal world and there was no significant difference between those 'working well' and 'not working well'. It appeared that this was due to the clients' level of substance use as well as their readiness and capacity to explore their inner world. Below, G.H. describes well what the majority of participants have reported: a flexible approach and style of working is practically mandatory with this client group. She also highlighted the difficulty experienced by the therapist when working with clients with varying levels of psychological mindedness.

Int. What is your sense of 'freedom of movement' when working with your client?

G.H. I'm willing to move around modalities. I am willing to be client led in the sense that if I think a client wants teaching I teach, and I think they want [coughs] or need a more structured approach, I let it be as client led as… I try to work with transference. Some of the people I see, that's not appropriate. They really want an educational programme. So I have been trying to make it as… tried to respond as best I can to what I think is most needed and wanted by the client. Some clients don't have an inner world. They are completely oblivious to it, and then it's quite difficult. Are you speaking about clients in general, or about my particular client?

Int. Yes, can you talk about your clients?

G.H. I'm thinking about some clients I work with... have an immediate awareness of their inner world, and can take positions within it and understand it and make connections. Others it's very difficult to try to get them to that point. I am working with a man who had three affairs simultaneously, until they all met up at a restaurant. He managed this for about six months or something, and we have been trying to explore why. He's not given to kind of psychological mindedness, and so part of the task has been to use every mechanism I can to help him illuminate for himself what was going on behind what was going on.

All of the participants appear to have a shared perception that working with a client's inner or internal world depends largely on their psychological mindedness. G.H. explains further the meaning of external exploration and why it is particularly important in the field of addiction. Therapists report that clients respond more readily to this type of intervention.

G.H. Well, I take very detailed history. I take a three hour history with them.

Int. Yes, I remember you said.

G.H. So I know quite a lot about the history of the person. I look at things like not just… I mean, I will go into working life, hobbies, why does my… why did this particular client choose to drive racing cars, what is that about? Is that about escape, is that about getting out of here as quick as you can, is that about control, because it takes perfect control to drive a racing car. So we sort of explore all that kind of stuff [coughs], but not only looking at the environment of the person as it is, but with addiction in particular, the task is not just to take away the substance as it's being used addictively, or the process. The task is to help people, facilitate people, activities, events and ways of being, which fill the hole that's been left by the addiction. Addiction is designed to anaesthetise inner distress. If you take away the addiction, all you are left with is an inner distress. So the task as a therapist is to move further than that, to help people mend and undertake processes which actually mend the inner disturbance. I call that what I would describe helping

clients have a good life, so relationships, physical fitness, healthcare, self-care, all those kinds of things.

Capacity for Exploration in relation to Attachment Theory

Bowlby (1988) viewed the therapist's role as "analogous to that of a mother who provides her child with a secure base from which to explore the world". The attachment model emphasises the importance of experience over time above that of insight. This is because it views the therapeutic experience as producing change in the client relationally. Here sessions might incorporate 'role-plays', building on the skills already held and learning to compensate for those lacked. Studies revealed that clients generally build a bond to their therapist and see them as attachment figures (see Obegi, 2008). Thus, in addition to Bowlby's (1988) maternal view of the therapists' role, there are several other ways of seeing it. The therapist can also be viewed as tutor or teacher, or a spiritual guide who uses a wider wisdom, all these roles being attachment figures of one kind or the other. Attachment-based therapy places great importance on enhancing the client's capacity to appreciate the interpersonal significance of his/her behaviours. This might be viewed as synonymous to working with a client's external world as illustrated by the participants earlier.

Attachment theory explains that secure attachment liberates (Flores, 2004). Securely attached children take more risks in exploring and also enjoying their environment. This would infer that securely attached clients also take more risks in disclosing and exploring their inner worlds and has indeed received support by various studies (see Mikulincer and Shaver, 2010). However, it has to be noted that, the exploration of one's inner world is closely related to Psychological mindedness. Therefore an interdependency of the clients' capacity to explore their inner world and their level of psychological mindedness appear connected.

There is an indication that a client's psychological mindedness and his or her capacity for exploration of inner worlds can increase over time. S.L., below,

reveals how her 'working well' client, re-admitted to the Addiction Agency on a number of occasions, demonstrated an increased ability to relate to himself over time. This might also have been affected by her belief that her skills in working with this client increased over time.

Int. What is your sense of 'freedom of movement' when working with your client?

S.L. With him I probably do (have a freedom of movement) because last time I felt boxed in again… but that was because of what was going on for him. And also... that feeling of being a bit deskilled or not having the skills necessary…Less so now.... He does respond eventually to working at a deeper level... you know, eventually there was… there were so many smokescreens that we would push through and… but I think, if I think of clients similar to him as well I do believe that if they're able to come back (to therapy) and if they do come back, eventually you see that being able to happen.

There is also an inference that this particular client group might require longer treatment or extended therapy in order for a secure base to be established between therapist and client. Whilst I believe that the client's ability to explore his or her inner world and physical reality represents on some level an acknowledgment that there is a secure therapeutic relationship with the therapist, the results of this study indicate that many therapists experience their clients as encountering difficulty with exploration. It certainly appears that these clients are more available to experimenting with and acting on their external world. As mentioned above, there is a strong link between internal world exploration and the level of psychological mindedness, meaning that each of these constructs can facilitate the other. However, many drug therapies are so focussed on change that the client's internal worlds and the ways in which he or she manifests relationally with the therapist tend to be disregarded, thus dismissing a rich source of clinical material. Ultimately the client's internal drama, often the embodiment of his or her deficits in relationship, might not be explored. For members of this difficult client group, solace and escape from their painful internal worlds is found in attachment to a drug that is essentially a

substitute for and avoidance of relationship with others. Through the therapist establishing secure base provision, the client becomes free to explore.

Weegman and Cohen (2002) provide an interesting view on the relationship between client, drug and therapist. They propose a three-way negotiation in the form of a triangular diagram. It conveys that the ally between the client and the therapist, or the client and the drug, can be weaker or stronger at any given point in time. This three-way negotiation also expresses itself through the fact that help, provided by the therapist, can be a threat to the relationship with the drug, and a stronger relationship with the drug might damage the one with the therapist (Weegman & Cohen, 2002).

Attachment theory offers the opportunity to help manage the anxieties and fears triggered in interpersonal relationships by creating and facilitating a gradual detachment from the addictive object. Using this approach, perhaps continual assessment throughout the therapeutic relationship for psychological mindedness might be necessary in order to co-create an opportunity for further exploration.

4. Client's Narrative Competence

Clients' narration of their life story was experienced in different ways by therapists. Whilst some clients were able to articulate their stories in great detail, they were in certain cases experienced by their therapists as 'dumping' on them. Some therapists experienced some clients as having difficulty narrating their life stories. Therapists' interventions were dependent on their clients in this regard, the level of trust within the therapeutic relationship and also the history of the client. Participant S.L. (working well) expresses her frustration with a client's narrative competence below.

Int. Okay. And what is your experience of the way in which your client discloses details of their life to you?

S.L. If I go back to the previous client I discussed earlier on, none at all whatsoever. In fact, that's what I would call a smokescreen very often because, you know, all the experiences, details, and everything without the kind of perception of what is my...or their rather... responsibility or what... It's very much like a victim state that initially presented… So it's got easy to just tell his story, but not actually to be aware of, you know, what they can change themselves.

S.L. elaborates further by exposing her beliefs around clients' narrative competence. Here she implies that healthy relational contact before the onset of substance use might have a positive effect on a client's narrative competence.

S.L. But I think it very much depends on the client and I think if the client has had a fairly functioning family around and maybe if they've worked as well before they start using (drugs), they seem to understand that more easily and whereas a client who's not had any of that and started using very young will really struggle I think to appreciate that.

Another participant, L.P. (not working well) shares her experience of her client's difficulty in telling her life story.

Int. And what is your experience of the way in which your client discloses details of their life to you?

L.P. I think, yeah... I think there's quite a lot there that she probably doesn't think is that relevant and, on a psychological level, I might think it is really. [laughs] But because she has a kind of shutdown on her emotional or internal world really, it's sometimes quite difficult for her to express this. You know, it's a bit of a process at the moment and I'm not quite sure in the time that we have how far we'll get. There's a lot there.

Int. So something that's there that you're kind of hoping to follow through?

L.P. I would hope so, certainly her, you know, her inability to sort of talk about internal, her internal world or express that very well. She's very... when I see her she's very much the same every time. She's very… usually a bit down, quite low. She never really changes from that and, as I said, the very interesting thing was her diary. When she did diaries she said, oh, I don't think I've done this very well, and produced probably the best, [laughs] the most comprehensive diaries I've ever seen any client ever do. But the column about feelings for the most part was completely blank, so that's a really good clue to me about her. She just said... I just really couldn't think about what that was. But that's one of our trials of exploration. Also, the other… It sort of kind of goes into integrating the internal world, the feeling world, and also the practical stuff. You know, what she can practically do to keep...maybe challenge her moods somewhat.

Client's Narrative Competence and relationship to Literature and Attachment Theory

The psychotherapeutic process is a practice based on the dialogue between the client and the therapist. The narrative of the client forms the basic material upon which the therapy exists, as it provides increasing evidence as to the individual's developmental history and internal world. "Just as literary narrative can be 'deconstructed' into a dialogue between writer and reader, so, as therapy unfolds, a shared narrative is forged to which both patient and therapist contribute, the former mainly through his works and affect, the latter by his responsiveness and attunement" (Holmes, 1996, p.54).

Research evidence (Shapiro, 1995) on common factors in psychotherapy indicates that "all effective therapies offer patients a rationale, or story, within which their difficulties can be located and helped to make sense, and that this in itself produces an enhanced sense of mastery" (Holmes, 1996, p.17). From an attachment perspective, the use of the Adult Attachment Interview (AAI) provides an intersubjective method of story-telling through which meaning and understanding can be digested, assimilated and accommodated within the therapeutic relationship. In addition, therapeutic narratives can be approached

with an attachment focus through the use and management of attachment classification styles or categories. These attachment classification categories offer an important system from which to assess and understand how clients experience themselves and others relationally. It provides important information as to how inner experiences and memories are organized; the various ways that separation, loss and reunion are developmentally managed; the unique process of individuation; and the regulation of emotions (Cassidy & Shaver, 1999). A therapist employing attachment theory seeks to understand the function of the regulatory methodologies in direct accordance with the particular attachment classification, thus allowing them access to the intricate psychodynamics of clients' representational models (Cassidy & Shaver, 1999). The work of Mary Main (1991) on attachment narratives also suggests that client narratives are based both on historical truths as well as retrospective constructions. Furthermore, these reconstructions are prejudiced by defensive processes, with not remembered details of childhood events potentially pointing to repressed painful emotions (Holmes, 1996).

The work of Main (1994) on attachment styles was extended by that of Fonagy and colleagues (1994) who found that a strong relationship existed between an individual's attachment style and their ability to think about themselves in relation to another. They referred to this as the reflexive self function (RSF). It reveals an individual's capacity for knowledge about oneself, insight and inner speech. Research evidence indicates that the capacity for RSF can only develop within a relationship providing secure attachment provision, reflecting "an important principle of development and emotional health: one cannot know oneself until one feels understood and known by another" (Flores, 2004, p.200).

Depending on the clients' attachment organization, very different challenges to the treatment process and to the establishment and maintenance of a therapeutic relationship are posed. G.H. describes below how she helps facilitate a client's 'narrative incompetence' when the client experiences difficulty in talking about his emotions.

G.H. I think I manage in two ways. One is that I sometimes make the point if that's how you feel, that's how you feel, and is it okay how it feels. Secondly, because I work with a lot with men, part of the task is to help them identify what their feelings are, and will often ask people what are you feeling. They usually tell me what they are thinking or what their partner is feeling. I will often intervene on feelings and make the point that a feeling is just a feeling. It's not necessarily reality. It's a body chemical state, and will suggest ways in which they can manage feelings without using the addictive process.

Within the attachment framework, the therapist responds to the client's disjointed internal world by providing a coherent explanation for the client's difficulties, thereby creating a shared narrative that is containing while also engendering a sense of continuity.

Relatedly, narrative therapy is being applied in the treatment of addictions. According to White and Epstein (1990), problems arise when the narratives of peoples' lives do not match their experienced lives (White & Epston, 1990). Therefore, the therapist takes the stance of a reporter and asks the client questions, comparable to an interview, that are aimed to facilitate the process of externalizing a problem for the client. In that way, the therapists help to deconstruct a narrative about a problem and reconstruct it in a more helpful way, thereby potentially also reshaping identity (Brown & August-Scott, 2006). Especially in the field of substance abuse, narrative therapy has gained a lot of attention and the work of Diamond (2002), shows how the use of this style of therapy can be helpful for the achievement of sobriety. Flores (2004) points out that a narrative has not only intrapsychic, but also interpersonal meaning. He states that on top of simply giving a representation of an even in a specific order, a client can also make use of a narrative to impress or test the therapist. Coming back to the shared narrative, this contributes to the formation of a secure base relationship whereby the client can begin to explore even further.

According to Holmes (1996), this shared narrative consists of the input the client gives in form of words and affect, and the input the therapist provides in form of

attunement and responsiveness. The client can go into not only a unique history but also that of the therapeutic relationship (Bowlby, 1988). For those individuals experiencing substance misuse disorders, access to narrative competence provides insight not only to the ways that substance misuse exacerbates difficulties in life in general, but also the ways that relational difficulties with attachment contribute to substance misuse (Flores, 2004). It has, however, to be noted that especially those clients suffering from substance misuse might exhibit 'alexithymia', that is the inability to express their emotions with words (Speranza et al., 2004) and accordingly a high prevalence rate of alexithymia in patients with alcohol dependence was found (Thorberg et al., 2009). Alexithymia also includes the recognition, the processing and expression of emotions. Khantzian (2012) suggests that therapists with these clients need to "be prepared to actively elicit, label and put into words for their patient the feelings that seem elusive or confusing" (Khantzian, 2012, p.277). Moreover, if a clients states he does not know how he feels, this should not be interpreted as a denial but rather as an inability to express and put in words what he feels. This issue of alexithymia is also linked to mentalization. According to Allen (2001), "Mentalizing requires attention and takes mental effort; it's a form of mindfulness, that is, being mindful of what others are thinking and feeling as well as being mindful of your own thoughts and feelings. Thus mentalizing is similar to empathy. But mentalizing goes beyond empathizing because it also includes awareness of your own state of mind – empathizing with yourself " (Allen et al., 2008, p.311).

As mentalizing exhibits a strong link to self-awareness, the building up and maintaining of meaningful relationships, as well as self-regulation, it is highly important for mental health (Allen et al., 2003). In sum, these are things the therapist has to consider when working with clients – be that clients suffering from substance misuse or of any other condition. Alexithymia or deficiencies in mentalization might complicate therapy, but will, if taken into consideration, help the client develop a better connection with their emotions.

5. Empathy

The results indicated that therapists used empathy in a variety of forms and functions. However, its purpose appeared to be that of conveying a sense of understanding on the part of the therapist of the client's experience of substance use and loss thereof. This can be seen in W.K.'s (not working well) experience below.

Int. Can you describe in what way you convey to your client your understanding of their relationship with substances of misuse?

W.K. Okay. What we did for this was the part she brought into therapy was the part that wanted to stop. The part she was less willing to bring to therapy is the part that wanted to go on, and that part, I was always in a bit of a hurry to get to meet, the rebel part, or whatever you want to call it. I was wanting to explore what's good about it, because if you say everything is bad and then they act on it, you are working out of awareness. So I was keen to get into awareness this rebel part of her that wanted to use, but she seemed to think this was dangerous territory. She seemed to think we should keep it locked up, and I was thinking the more you keep it locked up, the more you are going to act on it rather than be aware of it. Be aware of it and you'll have a bit more control. So this was a bit of a tussle and a bustle, but we got there eventually. And then, when I got her almost to befriend, you know, befriend this rebel part and think of other ways of appeasing it so it didn't have to act out, we almost started to make progress. But this was part of exploring the inner world bit, and she was so reluctant to go there. It wasn't a good achievement. I was in too much of a hurry and she was slow, so it was a very clumsy therapy really. But that's how we worked with it, sort of like, you know, the part that wants to stop and the part that doesn't want to stop, and getting to know the part that didn't want to stop was the work, and integrating that into the whole, rather than keeping it outside, was the work…

A short while later in the transcript she reveals her conflicts as a therapist with regard to the role of empathy and how this impacted her.

Int. In what way would you say you empathised?

W.K. Well, it was a prop to her (drugs), and she felt she would disappear without it, and I could empathise with the feelings of disappearing, not being important, low self-esteem, that she felt this magic potion gave her. But I think I was sort of frightened of colluding with it a bit, and I might not have given it my all, as it were. I could empathise with the low self-esteem, but I found it difficult to fully engage with entering into the understanding that the substance was a help. I could empathise with the idea that substance would help, but I made the distinction in a way so clearly that it probably irritated her a lot.

The therapist's instrumental use of self in relation to client was another theme in the use of empathy. In the segment below, G.H. (working well) illustrates this through the use of her body language and also through self-disclosure.

Int. Can you describe in what way you convey to your client your understanding of their relationship with substances of misuse?

G.H. Well, I sometimes disclose that I'm an addict in recovery myself. I don't always do that. It depends really partly on what I think, how I estimate the client. But sometimes I will make it clear to the client that my starting point is not just theoretical. I know about addiction, I am an addict, I am in recovery. I've been in recovery 18 years. In addiction recovery, self-disclosure is much more common than in other psycho therapeutic traditions. Sometimes I will disclose without disclosing. I use we, rather than I, and talk about the pain of withdrawal which we feel. I'll use that and I'll kind of slip back and forth, which suggests that I've been there, seen it and done it. I mean, I'll try to use sympathetic eye contact, but I am aware that certainly in the early stages of working with addicts in recovery, they are so full of self-loathing that they hear compassion as… well, they don't hear compassion, even if you said it. So, I am less clear on that question.

By focusing on the subjective experience of empathy for the client, G.H. further explores what this means for the client thereby making sense of therapist, therapy and client in relationship.

Int. So you empathise with your clients' experience....

G.H. Yes, I do, but I also check out what it means for them, because being nice to some of these people is not experienced as nice. It's experienced as manipulative or is experienced as false, because their inter-persecuting voice is so powerful that if you say something, if I say something nice to them, they think she's just paid to say that, or if they have been manipulated by a mother or a father who said nice things to them to get them to do things. So I always check out what their... how they respond hearing empathetic statements, and some of them welcome them, and others, it causes them to get immensely uneasy, and then you try to explore why that is.

Int. And how do you view your clients' abstinence or reduction in substance misuse, or attempts at these?

G.H. Well, it is a loss. It's a loss of an old friend, and I will sometimes specifically say it is a loss that will need to be grieved. It's worked very well for a time anyway. We don't use addictive substances or processes because they aren't pleasurable.

Empathy and its relation to Literature and Attachment Theory

Research investigating the strength of the therapeutic alliance (Strupp, 1999) indicates that empathy is an important tool with reference to successful treatment outcome. Strupp (1999) further elaborated on the definition of empathy stating that it was not only about being able to listen to what was being expressed but also to what was not being expressed. Research also indicates that the personal characteristics of the client as well as the client's interpersonal skills are a significant determinant in successful treatment outcome (Cartwright et al., 1996). The effectiveness of the therapeutic relationship in facilitating

beneficial change is, however, also dependent on the therapist's personal characteristics and skill in contributing to and managing relational dynamics, particularly with reference to those clients inept in this area (Flores, 2004). These clients, especially those who misuse substances, are particularly challenging in this respect and require the therapist to maintain a creative and flexible stance so as to match their relational needs as well as the changing requirements of the therapeutic alliance in a satisfactory manner (Meier et al, 2005).

Research on infant-caregiver attachment styles indicate that affect-regulation is a fundamental component of the parent-child relationship in determining the individual's secure or insecure attachment pattern (Flores, 2004). "Mothers who can regulate their infant's excitement, rage, disappointment, and so on, and enable the infant to integrate emotion into the developing self, serve an important organizing function for the child" (Flores, 2004, p.149). Thus, the implication for clinical practice is that emotional attunement and affective regulation are fundamental components of successful therapy as it assists the individual in developing a sense of self within an interpersonal context. This is especially crucial when the attachment bond is threatened, with reference to both the relationship with an individual and with the relationship to a drug.
According to Weegman and Khantzian (2011), "[t]he therapist's empathic attunement to the disorganization and chaos resulting from addiction is often a first and necessary step in recovering" (Weegman & Khantzian, 2011, p.176). Thus, viewing a client's substance use as having an adaptive function could assist in facilitating therapists' empathic attunement toward a client's distress, thereby contributing to the strength of the therapeutic relationship, which contributes to positive treatmentoutcome.

Attachment theory posits that affect regulation is only possible through external support and that "we all are emotional regulators of each other" (Flores, 2004, p.8). In keeping with an attachment model of addiction, Khantzian's (2001) self-medication hypothesis highlights the adaptive function of the use of substances (as opposed to human beings) in regulating affect.

Implications for Practice

By viewing clients' drug use as an attempt at self-repair or relief of pain, a more positive and empathic clinical approach is engendered. When accurately attuned, the therapist is able to gain a deep understanding of the client's immediate experience. The drug can be experienced by the client as providing a version of a secure base during those times when he had anxiety or required internal support. Similarly, an infant would seek out his or her mother in times of emotional distress in order for her to provide assurance, comfort and support. S.L. (working well) describes her model of empathic attunement and the ways that she conveys this to her client.

S.L. I think it's depending on what they... what their experiences are and what they tell me, and it's just a reflection of that really. I'm not too sure… I think it's such an individual thing and you know, you can find some general tendencies… It's usually about looking for nurturing, a soothing thing, and self-medication. I think they're usually quite… In my experience they're quite quick at understanding that and making a lot of sense out of that.

Given the high drop-out rates for these clients in particular (e.g. 33-46% for cocaine misusers in CBT, as reported in Mann, 2004), the therapist's capacity to promote empathic understanding of the clients' strong attachment bond to their drug of choice is crucial to engaging and retaining them in treatment. Empathy for the client's adaptive strivings, however, is not enough, as the therapist also has to bear witness to the client's desire for change and the ambivalence that this involves. In addition, the client might manifest an ambivalent transference toward the therapist, viewing them as both antagonist (who is taking the drug away) and collaborator (who is helping him change). The therapist needs to promote a sense of collaboration. Here the personal qualities of the therapist come to the fore. A therapist who is role-secure is less likely to act on potential counter-transferential feelings or adhere to reassuring yet constraining clinical ideologies. Rather they would be more willing to acknowledge, address and

process their client's conflictual dilemma within the therapeutic frame (Holmes, 2009).

Research on the training of psychotherapists by Alan Cartwright (no date given) expresses this view well. He states that: "General clinical theories are important because they provide the therapist with a view of the client and thus makes the therapist more secure. Unfortunately they can also restrict the therapist's view of the client making them appear lacking in understanding and ultimately uncommitted. The advantage of formal theories is that they can provide the trainee with security though that very security might make it more difficult for them to relate appropriately to the client."

The excitement and striking effects of not only the ritual of obtaining but also in taking the drug is in stark contrast to the boredom and emptiness many substance misusers feel without the drug. Such painful affective states tend to emphasize their present distress, reducing them to focussing on how to relieve their discomfort, without allowing them the peace of mind to explore how this had come out. These client character-logical deficits can be so overwhelming that they threaten to surpass any form of relational intervention on the part of the therapist. It is for this very reason that the therapist needs to engage the client with a sense of energy, vigour, interest and curiosity in order to activate these feelings within the client themselves, modelling that this experience is possible without the use of alternative substances. By this I do not mean that the client's needs be immediately or consistently gratified but that a level of optimum frustration and gratification is established in order for their dependency and nurturing needs to be met whilst they learn to process and regulate their affect through the use of the therapeutic relationship.

5. The Therapeutic Relationship

Establishing and maintaining the working alliance appeared to be a theme amongst all participants, irrespective of those 'clients working well' and those 'not working well'. The client's ability to make use of the therapeutic

relationship often determined the ways that therapists were able to utilize their skills and time appropriate interventions. The segment below reveals how S.P. (not working well) describes her use of the therapeutic relationship in order to assist her client in expanding his relational skills. This appears to be a client-led intervention directed by client's levels of psychological mindedness.

Int. What is your experience of the use of the therapeutic relationship with your client in therapy?

S.P. I think it's important to use what is done in our relationship and how that could be repeated outside of the... the therapy. So, I very much use that relationship between us.

Int. And does your client respond to this?

S.P. I think some do and some don't. It's all… You know, it all depends on their psychological-mindedness and ability to… relate. So, it all depends on... on... on... on the client... really.

Int. Yeah. And how much they can tolerate.

S.P. How much they can tolerate, how much they, they're aware of.

S.P. explains further about her exploration of ruptures within the therapeutic relationship. Ruptures in the therapeutic relationship have different meanings amongst the therapists. They include the client's disengagement, client's substance use and client's misinterpretations of therapeutic interventions.

Int. Can you tell me about how you manage ruptures in the therapeutic relationship?

S.P. What do you mean by ruptures?

Int. Anything that's not working well between the two of you...

S.P. Yeah. I mean, he... his attendance before with me was reasonably okay. I think it was down to one (DNA – did not attend) out of about eight or nine (sessions) but since we've moved to M (different location), his attendance has been really erratic and bad and I'm wondering, you know, if that's because of the move to M* now, which he didn't before. So, yes, we did talk about it but I feel that he's disengaging at the moment in that I haven't been able to see him for about two or three weeks. So, I'm not sure what's going on…*

Int. Okay.

S.P. But, yeah, generally I would try to address it with him.

S.P. also described her confusion with regard to her client's lack of attendance above as well as her lack of control around this. Whilst therapeutic interventions are dependent on how much clients can tolerate, they're also dependent on how much therapists can tolerate, as can be seen below in a segment by another participant, W.K. This would also link in with 'therapist qualities' and 'client impact on therapist' because the person of the therapist is triggered here in relationship with another.

Int. I mean, I know you've just mentioned that there were difficulties, but can you tell me about how you manage ruptures in the therapeutic relationship?

W.K. Not as quickly as I should do. You know, I'm a bit avoidant... I tend to think they'll go away, and of course they don't, but I do eventually, yes [chuckles].

Int. And in what way?

W.K. I talk about my counter-transference, I talk about what's going on for me, and I'll ask her what's going on for her. I just unpick stuff like what did you think I

meant when I said… and oh, you meant it like that, and in fact my intention is this. You know, just sort of really slow unpicking.

G.H. below places a strong emphasis on the reparative aspects of the therapeutic relationship with reference to ruptures in the alliance. All participants viewed that attendance to ruptures in relationship were important, however, the ways these were managed were dependent on the qualities of the therapist as can be seen by W.K. above and by G.H. below.

G.H. I am aware of them. Well, I'm aware of them when I'm aware of them [laughs]. It's possible I suppose that there could be ruptures without being aware, but I attend to them at the earliest appropriate opportunity trying to explore them and seek to repair the rupture, because in my experience, the therapeutic relationship is not properly established until there has been a rupture repaired. Well, that's probably too strong a statement. Often the strongest therapeutic relationships are based on repaired ruptures.

The Therapeutic Relationship in relation to Literature

Strupp (1998) indicated in his Vanderbilt research studies that by far the largest contributor to premature dropout rates and unsuccessful treatment outcomes was the management of the therapeutic alliance. This is especially so in the case of those with substance misuse disorders, whose fragile sense of self in relationship can feel defeated as a result of empathic failures (Thorberg & Lyvers, 2006). Ruptures within the therapeutic relationship provide an opportunity for facilitating clients' learning about relationships and how they can be repaired without the need to anaesthetize through substance use. Because the capacity to establish a therapeutic alliance is not in the sole control of the therapist given that this is an interpersonal process, it is essential to understand the contribution of both therapist and client to the quality of the alliance. Within this co-created relationship, it appears from my research that how and whether clients can make use of the therapeutic relationship in the way

intended by the therapist might contribute to increased engagement. Thus, client qualities are important here.

The Therapeutic Relationship in relation to Attachment Theory

"Attachment theory holds the position that as long as the substance abuser continues to use substances, the establishment of a working therapy alliance will be difficult to establish or maintain. The prevailing reinforcing effects of chemical use are just too powerful and compelling, overriding anything the therapist might have to offer" Flores (2004, p.24). This is made even more difficult when clients see no need for relinquishing substance misuse. The reason for intervening at this stage is to encourage the client to contemplate the possibility of alternative options in terms of getting needs met, as opposed to substance misuse being the only means familiar to them. Therefore, before therapy can even begin, a pre-transference has already been established. By pre-transference I refer to the client's transference in relationship to the therapist before they have even met. The client views the therapist as the person who is going to take his or her drug away and often resents the therapist for this. This is often the case with those clients referred to Addiction Agencies against their will, and this interpersonal dynamic around creating and setting boundaries is also represented in the data. "Missed appointments, deceit, and various other modes of defensiveness can be usefully apprehended as deriving from the patient's attempt to negotiate the relationship with a figure who simultaneously represents both a trusted ally in the pursuit of change and a despised, potential threat to the homeostasis bond with the drug of choice" (Weegman & Cohen, 2002, p.27). Relatedly, S.P. below explores her difficulty in trusting her relationship with her client.

Int. What has been the effect of treatment since your client began therapy?

S.P. It's very difficult in this work because you get bits of information (from different modalities within the Agency). Now, I would have said, yes, I did believe

he was doing reasonably well but then I heard some information about him which now makes me question it, something that he told the doctor when he came to see the doctor here. So, it's... it's really difficult. So it's not really, well, it's not really pure in the sense that, you know, because you get information outside of the session... What else can you do … especially when the client's working well in the session?

Int. Yeah. But just based on your experience with the client you would have thought he was doing well…

S.P. I would have thought so but I question that with the information I've now got and the fact that he hasn't attended his last couple of sessions. But before that, yes, I would have thought that he was doing reasonably okay.

Int. Okay. What would be a positive development with this client in therapy?

S.P. I think it's about timing and I think it's about his drug use. I...I think that my client's very ambivalent about his drug use. He is very young. When I say very young, I mean he's in his early 20s, 20/21, I think, he is. He's got a long history of drug use already, although he's only 21. The family all uses, you know, his mother, his brother and his sister. There's such an ingrained drug use that I don't know if it's the right time for him. I mean, really, the very point of the therapy is to look at his drug use. So, I guess, on the therapy side of things part of it was monitoring his use and top up his methadone script but the other part of it is looking at his use of relationships, particularly his relationship with heroin. So, a positive development? I don't know... So, perhaps he needs to come back here when he's a bit older and things have changed a bit for him.

Below, G.H. describes the rules and boundaries of her practice with regard to clients still misusing substances while in therapy. She reveals that she requires a client's acceptance of these boundaries by referring to the specifics of the relational setting, while also encouraging her client's interest in this. Here a

client quality is also highlighted – the strength of clients. Therapy might also be located in one of a client's strengths.

Int. So you say he was in the process of changing even before?

G.H. Well, when he first came to me he was still acting up, cocaine, sex and alcohol. I think I said to him that we really couldn't do anything until he got the cocaine and alcohol sorted, because there's no point in trying to work on sexual relationship if he's drunk, drinking or drugging. I think it was at that point that he decided to engage once again in sobriety.

Int. So the way you practice, you need someone to be abstinent?

G.H. Well, I think to do anything serious around sex and relationships while people are mood altered by drugs and alcohol, it doesn't make any sense, because you are dealing with a person who is mood altered. So I won't actually work with someone who is… well, I work with someone who is continuing to use, but I won't work with someone who is using so excessively that you can't do any work, if you see what I mean? I mean, if someone is high all the time, there's no point, you can't do therapy, in my view.

6. Impact of Therapist on Client

This super-ordinate theme presented significant differences in responses between therapists with clients 'working well' and those with clients 'not working well'. Therapists with clients 'working well' largely viewed their impact on clients as positive. They measured this by their clients' altered coping strategies as well as their levels of dependence on them as therapists. Those with clients 'not working well' were largely unsure about their impact on their clients, their views ranging from a lack of positive impact to no impact at all. These therapists also measured their clients' responses by their level of dependence on them, which took the form of inconsistent engagement.

S.L. (working well) describes her measure for ascertaining her client's improvement during therapy below. She also alludes to her improvement as a therapist in working with this client.

S.L. Yes, I think he's taking more responsibilities for his actions because he used to focus on everyone else he could blame. He's starting now to challenge himself. He's near enough ready to go into rehab. He's never done that before, and probably as a mirroring of my change he's a lot more committed. So…yeah...

W.K. (not working well) asserts below that both therapist and client were impacted by each other. She expresses her frustration at not impacting her client in the way that she would like.

Int. And do you think your client felt understood by you?

W.K. Some of the time not, but I think I impacted on her and she impacted on me in such a way that in the end we did have a mutual understanding. During... you know, there were sometimes I would have said an emphatic no to that question. It was a real struggle. The whole relationship was quite a struggle.

Whilst these are the therapists' perceptions of their impact on their clients, it is acknowledged that the accuracy of this would have been enhanced by their actual client feedback. Although there appears to be a distinct difference between those 'working well' and 'not working well', clients might be impacted to a greater or lesser extent within both.

Evaluating the Research

Member Validation

Participants initially appeared preoccupied with recognising themselves in the transcripts, their use of language and how they had come across. Some reported that their clients were working better than they had previously described and

that perhaps they had been feeling more critical on the days of the interview. All participants reported that their data had been accurately recorded and that they agreed with the results and findings.

The Independent Audit

By way of controlling the subjectivity of the research findings, the independent audit was administered by a PhD psychology research student, specialising in IPA research methodology at Birkbeck College, London. Her findings were that the sequence of events in the final report was recorded logically in stages. Moreover, she stated that the report was a plausible and credible one with reference to the data collected.

Reflections on Ethical Considerations

Feedback from participants included that they found the research questions interesting as they helped them raising awareness about their therapeutic processes with their clients. Participants further reported that they did not experience interference within the therapist-client relationship nor any consequential distress associated with participating in the research.

Analysis and Discussion: Main Findings and their Implications

This study set out to explore the experiences of therapists working with clients with substance misuse disorders and whether an applied model of attachment theory could provide explanatory value for the common factors of therapeutic change. The data analysis and results revealed a number of findings that in the context of this research were significant. As indicated earlier, I have chosen to consider anything as a theme of significance where it had been indicated by six or more of the participants. These have been clustered under seven super-ordinate themes and are discussed separately and with reference to the literature below.

1. Therapist Qualities and relationship to Literature and Attachment Theory

Research studies indicate that the person of the therapist is crucial to a successful outcome of therapy (Lambert & Barley, 2001, Smith, 2003b). Duncan (2015) goes as far as to say that after the client, the therapist plays the most crucial role in outcome. Many researchers, including Wampold (2001), report that therapist's competence is defined by outcome, that is, more competent therapists produce better outcomes than less competent therapists. Within my research, however, therapist's competence appeared more to relate to the intersubjective experience between client and therapist. Skills, abilities, techniques and personal qualities that work well with a variety of other client groups perhaps work less well within the field of addiction. It is competence in relationships that appears to be what is most deficient within this client group. This might be exposed and projected to a much greater extent within their therapeutic encounter, and in that way lead to the result of the current project, which points towards a strong relationship between therapists' competence and intersubjective experience between client and therapist.

The research data also indicates that therapists' views of their competence might reflect their level of self-awareness of client processes, and their role within this, which might relate to Fonagy et al.'s (1994) theory of reflexive self function (RSF). Therapists had, in this respect, described an awareness of both their limitations and those of their clients. As mentioned earlier, RSF is associated with the knowledge about oneself and insight. It also includes the experiencing and regulating of emotions (Pajulo et al., 2006). High levels of RSF were found to exhibit a strong relationship with positive working alliances (Fonagy et al., 1994) and parents with high RSF values tend to have more securely attached children (Pajulo et al., 2006). In the framework of addiction, it was found that substance-abusing mothers exhibit low RSF levels towards their children (Pajulo et al., 2006) and thus one can hypothesise that substance-misusing clients exhibit low RSF levels towards people that are close to them. With regards to therapists, RSF

levels might play an important role in the treatment of addictions. A therapist with high RSF levels might be very good in reflecting their own abilities and may better understand their client's actions and thoughts. Relatedly, high levels of empathy, which might be based on RSF levels, in therapists have been linked to lower drop-out and relapse rates and better therapeutic alliances (Moyers & Miller, 2013). While RSF appears to play an important role in therapy and attachment, concepts relating to role security also bear attention.

Research examining the relationship between role security, role competence and role legitimacy found that workers with more knowledge, experience, self-esteem and better support systems, displayed higher role legitimacy and adequacy. In addition, they showed greater therapeutic commitment. As a consequence, changes in these role requirements might successfully result in more pronounced clinical effects (Cartwright, 1980; Anderson, 1985; Clement 1987; Bush and Williams 1988; as cited in Cartwright et al., 1996).

Again this research is indicative of the potency of therapist factors and their effect on positive treatment outcome. Role insecurity is likely to occur when a therapist's self-esteem is threatened in direct relation to a client perceived as difficult. By this I refer to a therapist experiencing a client's problems as overwhelming, and believing that the work is beyond his or her remit. My view of role security is that it is synonymous with the therapist's secure base. Thereby I address my support system that would include aspects providing me with a sense of security. These might include adequate supervision, training, salary, job clarity, boundaries, expectations, belief in the therapeutic model, knowing which clients I am able to work with and being aware of my limitations. Knowledge, experience, and acquired skills are also found to contribute to being role secure. In addition, therapists experiencing an affinity with people experiencing these difficulties, would have an increased sense of role security. Attachment theory lends itself well to this parallel process whereby both the therapist and client seek out secure base provision. This is required to enable both to explore their internal and external worlds to a larger extent (Flores, 2004).

2. Impact of Client on Therapist

Impact of Client on Therapist and relationship to Attachment Theory

The data indicates that the impact of an occasionally disorganised client group could create feelings of despair, hopelessness, fear and apprehension in the person of the therapist, thus eliciting powerful counter-transferential feelings. In addition, the therapist's subjective experience of the client might provide a unique opportunity for understanding the client's relational frame from an experiential perspective. Attachment theory lends itself well to a parallel process whereby the therapist's capacity to regulate his or her own affect and to self soothe when confronted with difficult emotions and countertransferences, is vital to the establishment of secure base provision (Flores, 2004). Essentially, the therapist requires a secure base to work from. This refers to anything that provides the therapist with a sense of physical and emotional security, such as basic needs around supervision, training, salary and safety, and also further needs relating to the therapeutic commitment, such as confidence, experience, personal therapy and role security. In this way the impact of the client on the therapist appears related to therapists' qualities.

The support of colleagues as well as the relative stability of personal relationships might allow for a more present relational quality and ensure that interventions are approached with the best interests of the client at heart. As the data indicated, personal therapy might facilitate the therapist by ensuring that both the inner world and external reality are comprehensively attended to in order to assist in the task as a reliable attachment figure. In this way, the processing and enactment of the therapist's own attachment issues or anxieties do not interfere with the therapeutic encounter.

3. Capacity for Exploration and relationship to Attachment Theory

Bowlby (1988) viewed the therapist's role as "analogous to that of a mother who provides her child with a secure base from which to explore the world" (Bowlby,

1988, p.40). The attachment model emphasises the importance of experience over time above that of insight (Flores, 2004). This is because it views the therapeutic experience as producing change in the client relationally. Here sessions might incorporate 'role-plays', building on the skills already held and learning to compensate for those lacked. Attachment-based therapy places great importance on enhancing the client's capacity to appreciate the interpersonal significance of his or her behaviours (Bowlby, 1988). This might be viewed as synonymous to working with a client's external world as illustrated by the results of the data. Furthermore, attachment theory places more emphasis on the ability to utilise current relational provision and less emphasis on the need to work through archaic relational positions. Additionally, once the empirical findings on non-specific relational factors in therapy (both generic and substance misuse – specific) are taken into account, attachment theory can be viewed as the very model that helps us to appreciate why it is that these factors are so potent in effect.

Attachment theory explains that secure attachment liberates (Flores, 2004). This infers that securely attached children take more risks in exploring and also enjoying their environment. This then postulates that securely attached clients might take more risks in disclosing and exploring their inner worlds. My research results appear to indicate that a client's capacity to explore their inner world is largely dependent on their level of psychological mindedness. This makes sense considering the close relationship and interdependency between the two concepts.

The data potentially implies that a client's psychological mindedness and capacity for exploration of the client's inner worlds can increase over time. This might highlight the importance of the therapist's ability to match the client's changing requirements of the alliance. This is supported by empirical findings that indicate that these client factors are open to change during the process of psychotherapy (Garfield, 1994, Mallickrodt et al., 1995).

There is an inference within the data that this particular client group might require longer treatment or extended therapy in order for a strong alliance or secure base to be established between therapist and client. Whilst I believe that the client's ability to explore their inner world and indeed their physical reality represents on some level an acknowledgment that he or she exists in a secure therapeutic relationship, the results of this study indicate that many therapists experience their clients as encountering difficulty with exploration. It appears that these clients are more available to experimenting with and acting on their external world. It appears also that for any internal world exploration, clients would need to demonstrate a level of psychological mindedness, however, this is not a linear development, rather more circular. However, many drug therapies are so focussed on change that the client's internal worlds and the way in which this manifests relationally with the therapist tend to be disregarded, thus dismissing a rich source of clinical material. Ultimately the client's internal drama, often the embodiment of deficits in relationship, might not be explored. For members of this difficult client group, solace and escape from their painful internal worlds is found in attachment to a drug that is essentially a substitute for and avoidance of relationship with others. Through the therapist establishing secure base provision, the client becomes free to explore. Attachment theory offers the opportunity to help manage the anxieties and fears triggered in interpersonal relationships by creating and facilitating a gradual detachment from the addictive object (Flores, 2004). Using this approach, perhaps creative and continual assessment throughout the therapeutic relationship for psychological mindedness is necessary in order to co-create an opportunity for further exploration as this too is dependent on the relationship with the client. It is also more helpful to view the internal an external worlds on a continuum, similar to that of insecure and secure attachment.

4. Client's Narrative Competence and relationship to Literature and Attachment Theory

The data suggests that many therapists experience their clients as having difficulty in communicating their life stories. Those clients who were articulate

in presentation, on the other hand, appeared to be experienced by many therapists as non-reflective, possibly masking some relational difficulties. The psychotherapeutic process is a practice, based on the dialogue between the client and the therapist. The narrative of the client forms the basic material upon which the therapy exists, as it provides increasing evidence as to the individual's developmental history and internal world. "Just as literary narrative can be 'deconstructed' into a dialogue between writer and reader, so, as therapy unfolds, a shared narrative is forged to which both patient and therapist contribute, the former mainly through his words and affects, the latter by his responsiveness and attunement" (Holmes, 1996, p.54).

Research by Shapiro (1995) on common factors in psychotherapy indicate that "all effective therapies offer patients a rationale, or story, within which their difficulties can be located and helped to make sense, and that this in itself produces an enhanced sense of mastery" (Holmes, 1996, p.17). Attachment research points out that that securely attached children tend to disclose their narratives coherently, whereas those with insecure attachment styles tend to demonstrate greater difficulty with narrative competence (Cassidy & Shaver, 1999). This implicates that the quality of a client's narrative competence could be an important determinant in successful therapeutic outcome in the field of addictions, due to positive correlation with secure attachment. In this regard, Holmes (1996) points out that discontinuities in the narrative or the story a client provides, might correspond to disruptures in their past and unremembered details of an event might point to repressed emotions.

5. Empathy and its relationship to Literature and Attachment Theory

The data reveals that all therapists, in various forms, attempted to empathize with their client's substance use. By exploring the meanings of the effects of the drugs for their individual clients, therapists were able to identify and clarify their clients' ambivalence around relinquishing their use. The majority of the therapists appeared to view their clients' drug use as attempts at self-repair or pain-relieving in nature. This tends to engender a positive and empathic clinical

approach. When accurately attuned, therapists are able to gain a deeper understanding of their client's immediate experience.

With reference to Attachment Theory, the drug can be experienced by the client as providing a version of a secure base during those times when anxiety is experienced or internal support required. Given the high dropout rates for these clients in particular (Mann, 2004), I believe that the therapist's capacity to promote empathic understanding of the client's strong attachment bond to his or her drug of choice is crucial to engaging and retaining them in treatment. Empathy for the client's adaptive strivings, however, is not enough, as the therapist also has to bear witness to the client's desire for change and the ambivalence that this involves. In addition, the client might manifest an ambivalent transference toward the therapist, viewing them as both antagonist (who is taking the drug away) and collaborator (who is helping them change). The therapist needs to promote a sense of collaboration. Here the personal qualities of the therapist come to the fore yet again. A therapist who is role-secure is less likely to act on potential counter-transferential feelings or adhere to reassuring yet constraining clinical ideologies. Rather they would be more willing to acknowledge, address and process their client's conflictual dilemma within the therapeutic frame.

Dozier, Cue and Barnett (1994) express this view well and state that "the security of case managers appears particularly important in their ability to respond therapeutically to the individual needs of clients. Case managers who are more secure seem able to attend and respond to clients' underlying needs, whereas case managers who are more insecure respond to the most obvious presentation of needs" (Dozier et al., 1994, p.198).

6. The Therapeutic Relationship and its relationship to Literature and Attachment Theory

Strupp (1998) indicated in his Vanderbilt research studies that by far the largest contributor to premature dropout rates and unsuccessful treatment outcomes

was the management of the therapeutic alliance. The data in this study indicates that all therapists respond to ruptures within the therapeutic relationship at various times within the process of therapy. They tend to view ruptures within the therapeutic relationship as providing an opportunity to facilitate their clients' learning about relationships and how they can be repaired, without the need to anaesthetize through substance use (Strupp, 1998). I believe that this is especially important in the case of this client group, as they tend to have a fragile sense of self in relationship and experience defeat as a result of empathic failures. As the data indicates, the capacity to establish a therapeutic alliance is not in the sole control of the therapist, however, much of the counselling literature tends to focus on how the therapist contributes to this intersubjective experience.

Orlinsky et al. (1994) noted that the primary determinant of outcome depends on the quality of the client's interaction with the therapist. Relatedly, several studies cited in Garfield (1994) emphasize the importance of client involvement in his or her therapy as a major variance in outcome. How the client 'uses' the therapist (actively or not) appears to be more important than the treatment methodologies. Is the client actively able to use the therapist? If not, what does this imply? According to attachment theory, this indicates that the client has an insecure attachment style and is unable to or resistant to attach to the therapist in a secure way. According to Holmes (2001), insecurely attached clients fear, as well as need their base, thus their therapist, and alternate between approach and avoidance, being unable to actively 'make use' of the therapist to attain therapeutic change. This is what an attachment-based therapy would work with – the quality of the therapist-client interaction. Within this co-created relationship, these research findings reflect the importance given to the client qualities that underlie and promote change. An applied model of attachment theory focusing on these qualities and in particular, those of psychological mindedness, could be a focus of further research.

More recent research has focussed on eliciting some of the internal client factors contributing to therapeutic change such as client participation in therapy

(Orlinsky et al., 2004), client agency (Mackrill, 2009), motivation (Zuroff et al., 2007) and hope (Snyder, 2002). Duncan and Miller (2000) view the clients as having the resources to affect change and achieve their therapeutic and life goals. Attachment theory in this sense can be regarded as the vehicle through which a client can learn to use the therapist to achieve his or her goals. Another appropriate model this relates to is Rogers' (1959) humanistic client centred therapy. This approach states that it is the client who is responsible for a positive change in life as opposed to the therapist, thus supporting Duncan and Miller's (2000) view of the client as being able to affect change. Moreover, according to Rogers (1959), the client starts the therapy in an incongruent state and the task of the therapist is to change that situation. The fact that this kind of therapy focuses on the subjective view of the world of the client, gave it the name client-centred therapy. Cooper and McLeod (2011) have a similar notion and also claim that it is the client who makes therapy work. Duncan (2015) also supports this belief, giving the client most importance in the therapeutic outcome, stating that only "after the client, the therapist is the most potent aspect of change in therapy" (Duncan, 2015, p.458).

Attachment theory offers a conceptualization of human relatedness in which it is asserted that early relational experiences with others become internalized and that these develop into templates that dictate the passage of future relationships (Weegman & Cohen, 2002). I see ruptures within the therapeutic relationship as linking directly with the revision of Internal Working Models (IWM) as applied through the use of Attachment Theory. This implies that the transference relationship becomes one in which maladaptive aspects of the client's relationship (insecure patterns of attachment) with the therapist can be identified and worked through. The data also suggested that this may be dependent on "how much the client can tolerate". This might imply that whenever transference analysis becomes indicated at different points in the therapeutic encounter, the capacity for further exploratory work may compromised by the clients' ability to make use of the therapeutic relationship. Leibert et al. (2011) suggests that the therapeutic relationship is even more important for those clients with lower social support. This is often the case with

clients referred to Substance Misuse agencies. As a result of substance dependence, there is also an inevitability of a certain amount of relationship breakdowns (Flores, 2004). Counselling psychologists, therefore, with training inherently more focussed on the therapeutic relationship may be assumed to be in a better position to influence client factors. Mallinckdrodt's (1996) research into clients' social competencies concluded that the therapeutic relationship can improve the clients' social resources in conjunction with symptom relief. Inherent in the data is also the notion that therapists' own Internal Working Models may be subject to revision as a result of experiences within a relationship, including those with clients.

7. Impact of Therapist on Client

According to the data, those clients who were 'working well' were viewed as being positively impacted by their therapists, whereas those who were 'not working well' were viewed as having being impacted either negatively or not at all by their therapists. Research indicates that therapists and clients appear to appraise the relationship differently. Studies suggest that clients rate the therapeutic relationship more positively than observers and therapists do (Gurman, 1977; Orlinsky & Howard, 1986; Lambert, et al., 1978; Patterson, 1984). Thus, therapists might be unaware of or hold only a modest position on the enormous impact they might be having on their clients' relational worlds.

The present analysis has, however, fallen short of responding to requests such as those of Townend and Braithwaite (2002) who have argued for the inclusion of clients' perspectives in psychological research. Given the powerful impact of the client on the therapist as discussed earlier with regard to the data results, it might follow that clients could be impacted in ways other than those already imagined by therapists. As there is a lack of knowledge with this regards to these potential influences, further research focusing on these possibilities would be desirable.

Within this research study, I have become mindful of the language directed to the therapists advising them on contextualising their clients into 'working well' and 'not working well' in therapy. The criteria for clients 'working well' referred to the weekly attendance of sessions, engagement in therapeutic relationship and interest in and working towards a change in substance use pattern. 'Not working well' clients were characterized as exhibiting the opposite behavioural patterns in above described respects.

My rationale for this was in order to compare and investigate the quality of the alliance linked to treatment outcome. Upon reflection, this now appears almost simplistic. None of the therapists appeared to use abstinence as an indication of well-being. Four out of the five therapists with criteria for 'wellness' did not provide any evidence of their clients doing well other than the very basic categorical requirements for this research. One possibility here is that therapists might have presented clients who impacted them emotionally rather than those 'working well'. Another possibility might be that therapists who practice within a time-limited framework view their work with the clients as limited and therefore view their function as transitory; that is, they move them to their next 'bus stop' along their destination.

Implications of the Research

The accumulation of these findings suggests several important implications for therapists working with clients that are difficult to engage in therapeutic treatment. In the following, five major ones are described. This is succeeded by further implications including the role of expectations and suggestions for more effective treatment strategies.

First, differences in therapists' skill with regard to 'therapist qualities' tend to accommodate large variances in outcome. Luborsky et al. (1985) discovered that therapists were relatively consistent in that some continually had positive outcomes, whilst others negative. This in itself is open to any number of interpretations as it could be due to particular therapist's skills or to common

factors such as empathy or goal consensus. As a lot of emphasis is put on treatment outcome, and there is not enough research in this area to inform any conclusive results, further studies that investigate this phenomenon in more detail would add much explanatory value.

Second, research findings (Binder, 1999) also suggest that the way in which a therapist manages negative processes in therapy can contribute largely to treatment outcome. In these cases and in accordance with a model of attachment, when therapists attend to the therapeutic alliance, adapt and adjust their responses to ruptures when they occur, the alliance becomes stronger. Whilst attachment theory provides for the type of position the therapist has to take in order to make room for the client to engage in dissent, the client's capacity to engage therapeutically also requires consideration. Bowlby (1988) believed that an attachment figure with an ability to empathically attune to and accept dissent without reprisal or extreme anxiety formed the foundations of a secure attachment. Therefore, this research encourages the view that a therapists' ability to manage a clients' hostility or rage without responding anxiously or defensively, is more likely to attain a more positive treatment outcome, despite continuing difficulties in relationship.

Third, there is an important ancillary consideration here: are some people just more charismatic? The Canterbury study by Cartwright et al. (1996) showed that negative factors were more potent predictors of non-engagement than positive factors were predictive of successful engagement. There is the possibility that certain therapists have a particular potential to offer highly effective alliance possibilities. Thus the generalised positive correlation between alliance and treatment outcome needs further examination. Furthermore, in support of Cartwright et al.'s (1996) argument, perhaps training could focus on preparing therapists to be more role secure when working relationally with clients. This might also promote the therapists' capacity for reflexive self function, and high levels of RSF are associated with a positive working alliance (Fonagy et al., 1994). A model of attachment theory could facilitate this process by creating a therapy and therapist reflecting the needs of the client while

actively promoting a positive therapeutic alliance. This also encourages positive treatment outcome. Thus, this might have implications for future training and supervision.

Fourth, therapists in this study at times described their clients' impact on them in terms of fear and anxiety. It is possible that therapists' attachment styles might be triggered in response to clients' insecure attachment styles. Multiple sources of support as identified by the respondents, including peer supervision, might be helpful in this regard.

Fifth, therapists might also experience unrealistic expectations both of and from their clients as a result of their clients' goals around drug or alcohol cessation. This process might be enacted in the transference that can result in both therapist and client experiencing a sense of inadequacy. Perhaps a greater awareness of this process might provide for a more realistic contract around what is possible or not within the time agreed. Because the nature of what these clients bring involves issues around dependency, awareness of what is possible during a finite time together with their therapists might provide more accurate expectations as well as an increased possibility of a successful outcome.

Research on the role and impact of the therapists' expectancies on therapy outcome are found to be significant (Duncan et al., 2004). Therapists who believe in their ability to facilitate change as well as in their clients' ability to effect change are viewed as having better outcomes (Ryan et al., 2010). This ability is considered imperative with regard to the theory of hope in that it encourages the clients to reach the processes of agency and pathway thinking. Indeed, early research literature on social learning theory (Bandura, 1969) provides evidence on the way in which clients model the behaviour and thinking of their therapists.

Some individuals might not have had their own hopes and expectancies nurtured in early relationships, and so they might benefit from an applied model of attachment theory. This is because attachment theory encourages a positive,

optimistic approach fostering hope that focuses not only on the client's weaknesses but on the promotion of their strengths. Attachment theory places more emphasis on the ability to utilise current relational provision and less emphasis on the need to work through past relational positions (Bowlby, 1988).

The respondents' emphasis on the ways that the client's psychological mindedness impacts treatment bears relevance to treatment outcome. Perhaps awareness of this during the assessment process, as well continuing assessment throughout therapy, might allow for tailoring of treatment more appropriate to the clients' capacity for engagement. Attendance to this can also impact and reduce client disengagement rates. Whether or not therapists should dramatically alter their style of working to accommodate clients' styles of relating is another matter of debate, however, an applied model of attachment within the therapeutic encounter might enhance these client factors by setting the stage and encouraging these change processes to emerge.

Within the attachment framework, the therapist responds to the client's disjointed internal world by providing a coherent explanation for the client's difficulties, thereby creating a shared narrative that is containing while also engendering a sense of continuity. This contributes to the formation of a secure base relationship whereby the client can begin to explore even further both his or her unique story as well as the therapeutic relationship (Bowlby,1988). For those individuals experiencing substance misuse disorders, access to narrative competence provides insight not only to the ways in which substance misuse exacerbated difficulties in life, but also to the ways in which their relational difficulties with attachment contributed to their substance misuse (Flores, 2004).

In the interest of providing information about alternative therapeutic models used within the substance misuse field in relation to outcome, Roth and Fonagy (1996) describe program outcomes as disappointing and refer to the high relapse rates in this regard. Here again there are client factors, such as the initial response to treatment as well as the willingness to engage in treatment, that are

indicative of positive outcome. Furthermore, better outcomes appear to be associated with interventions that focus directly on modifying drug-related behaviours as well as when high levels of social support are offered.

As best practice, formal psychological interventions are offered in conjunction with treatment programmes or as a primary treatment on its own. Interestingly, Roth and Fonagy (1996) hypothesized that psychological interventions might be of more use at a later stage in treatment when the client is less dependent on substances of misuse as he or she might be more able to focus on psychological issues. While I believe that this can be the case for some individuals with more complex and severe comorbidity, a blanket approach might disregard those individuals requiring psychological support in order to make changes to their substance use. This begs a further question: is it ethical to work with clients who are coerced or resistant to psychological therapy? For those practitioners working in the NHS or Substance Misuse Agencies it might perhaps not be a subject of choice, but more of meeting the needs of service provision. This further calls for the therapeutic skills therapists need in order to tolerate the negative transference engendered by this client group. For those in private practice, it might be a subjective decision based on individual trainings, philosophy of practice, as well as the personal qualities of the therapist contributing to the therapeutic relationship.

As mentioned earlier, psychological therapies within the NHS are based on the NICE guidelines that recommend particular treatment models for specific diagnoses. CBT therapies tend to dominate the therapeutic models recommended (Department of Health, 2011), whereas Lewis (2012) observes that this overlooks the outcome equivalence research. Wampold (2001) refers to this as the 'dodo bird effect' that acknowledges that clients have benefited from different therapeutic models. I believe, therefore, that it might appear somewhat simplistic to limit clients' access to only one particular model. Overall, I hope that my research encourages the debate surrounding a more relational approach to helping people as opposed to the models of reductionism within this field. Within this approach there is also an acknowledgement that the

therapeutic and human relationship is paramount and interventions need to reflect this. A broader societal question may present with 'what kind of treatment do we want to offer? What kind of society do we want?' In this way, broader contexts can be challenged in which different paradigms can be explored.

Reflections

As a reflexive practitioner and reflective researcher, I have become aware of my use of language in the description of the sample throughout my research process. Therapists were asked to respond to questions in the context of a client whom they thought was 'working well in therapy' versus a client who was 'not working well in therapy'. This description might carry an implicit blame of the client and an alternative might have been a 'therapist who was not working well' rather than a client. Furthermore, this conceptualisation could have influenced the analysis by moulding the therapists' perceptions of what was going well or not with their clients. Thus, both therapist and client qualities contribute to the interpersonal process of relationship building.

I have also had further thoughts about the way in which I had adapted the IPA approach and how this might have had implications for my results. By having a predetermined list of interview questions sent to participants, even though these were more respondent-led in the actual interviews, I have become aware that I might have potentially limited their coverage to that of my agenda rather than theirs. This could have resulted in limiting the respondents' possibilities of revealing what they might have considered to be highly relevant and important as their full thoughts did not come through. In my methodology section, I had commented on my experience of some participants as somewhat defensive in relating their modes of practice and have since become aware that this might also have been a result of their experiencing my agenda as different to theirs during this intersubjective process. Thus, whilst I had adapted the IPA approach in order to generate material that directly focused on attachment processes and issues, it is possible that I could have impeded the generation of novel responses

from participants. On reflection, I could have incorporated more open-ended questions, allowing the participants to expand further on their experiences with their clients. It is important in IPA to maintain a flexible stance and in this way, by creating more open-ended research questions, I could have allowed for increased flexibility and breadth in the participants' responses, which may then have informed my research accordingly.

Adaptation of the IPA approach

The secondary aim of the research enquired whether attachment theory provided explanatory value for the common factors within the therapeutic relationship. This question influenced and guided the research. In this research, semi-structured interviews were based on the six assertions of attachment theory. In this way, attachment theory provided the framework for these interviews and the participants shared their experiences of this. Thus, by choosing to use these interview questions (Appendix C), I impacted the information provided by participants. While Smith and Osborne (2008) state that "[t]here is no attempt to test a predetermined hypothesis of the research; rather, the aim is to explore, flexibly and in detail, an area of concern" (p.55), this does not entail that it is forbidden to have a pre-existing theoretic framework as a base to explore from. Several researchers who make use of IPA do have a theoretical framework they base their research and results on (for more details see Brocki& Waerden, 2006, p.92). As Brocki and Waerden (2006) state, "it seems unlikely that researchers could embark upon a project without having at least some awareness of the current literature and issues surrounding the area" (p.92).

I have also reflected on my process of interviewing participants. This had involved interviewing all of the participants initially, and then analysing all the data at a later date. With hindsight, I now have a raised awareness of how useful it potentially is to interview and analyse in parallel because in this way the analysis is open to change as the research process becomes more dynamic. This can slightly alter the questions and focus during the subsequent series of interviews for more beneficial data gathering. Smith et al. (2009) elaborate that

in using IPA methodology, more experienced researchers in this specific technique would become more creative over time in their use of the principles of IPA, using their "steps to analysis" simply as a guideline.

I have reflected on my attempts at homogeneity through the use of an all female sample. As a result of conducting this research, I have come to realize that an all female sample does not effectively reduce the variables. Thus, since this is the first time that I was applying the IPA methodology to research, I am aware that my technique will develop over time and I see these insights regarding potential improvements as valuable pieces of knowledge for future work.

I am aware that the identified themes are interpreted meanings perceived either implicitly or explicitly. In the final analysis it is clear that the themes draw on the raw data but are also an amalgamation of explicitly stated comments by the participants and the inferences the researcher has made of these interviews and transcripts with reference to attachment theory. Thus the clusters of themes are valuable at this stage only as indicators that raise questions that future research can scrutinize more specifically. For this future research it is conceivable that quantitative methodology as well as a larger sample size will be used.

Limitations of the research

This study is subject to methodological limitations that need to be taken into account. The sample population was small and while this is consistent with an IPA approach (Smith & Osborn, 2008), it could be that a larger sample size might increase diversity of participants' responses while also expand on some of the interesting themes elicited. While the sample of participants were all female in the interests of homogeneity, male participants could have elicited gender differences with regard to their therapeutic approach and experiences of these clients. Furthermore, the fact that the participants of my sample were all female did not effectively reduce the variables. The clients spoken about in the study were addicted to more than one substance. While this was representative of real-world clinics, the study may have benefited from exploring the experiences

of clients using either a single substance or those of a specific type. This might in part increase the homogeneity of the sample.

There are limited case study methodological studies in the research literature which explores the individual therapeutic relationship with those with substance misuse disorders. A case study methodology with this client group might demonstrate better the types of interventions helpful while also increasing both therapist and clients' understanding of the vulnerabilities of addiction.

It would also be interesting to view the experiences of therapists who specialised in only a psychodynamic or a CBT treatment model. This has the potential to provide indepth insights into the nature of different treatment models and the therapeutic benefits of the client-therapist interactions that exist in each.

The schematic representation that emerged from this research is partial and still emerging. For example, the analysis paid little attention toward individual differences and cultural influences, although they are bound to also play a mediating role within the client-therapist relationship and their experience of each other. The findings of this study therefore remain open to further developments in future research. One of these areas could involve researching well-trained psychodynamic therapists effectively applying an attachment theory framework with substance-misusing clients, exploring both their and clients' experiences within the therapeutic relationship. This may help demonstrate a rich understanding of the benefits and challenges of this approach.

The study was additionally limited in the way the questions were framed for the participants. More open-ended questions might have resulted in different themes emerging during the data analysis.

Conclusions and Applications to Counselling Psychology

This study explored the experience of therapists working with substance misusing clients. In addition, based on the experiences of the therapists, this research investigated whether attachment theory can be used to provide explanatory value for relational factors accounting for therapeutic change, The chosen group of substance-misusing subjects symbolises the difficulty in developing attachment relationships with others. The results from this qualitative piece of research indicate that the six assertions of attachment theory were found, either explicitly or implicitly, to correlate with the main themes highlighted in the data.

Many therapists also appeared to use a model of attachment theory as means of making sense of the therapeutic relationship with substance users. Whether clients were viewed by therapists as 'working well' or 'not working well' in treatment, similar relational difficulties were found to apply. Those clients seen as gaining positive outcome were those viewed as more able to establish and make use of the therapeutic relationship. Accordingly, therapists viewed themselves as impacting these clients positively. The qualities of the therapist were seen to impact this process and these were subject to change depending of the qualities of the client.

This research supports the view of the importance of therapist factors on treatment outcome. For counselling psychologists working in this field, it would appear imperative that they receive adequate clinical support tailored to the their relational needs. This, in turn, would compliment their views of their levels of competence, thus promoting role security. Given that the qualities of the therapist play a significant role in treatment outcome, particularly within ambivalent client populations such as substance misusers, it is in the interests of the NHS or alternative institutions to invest in their therapists, by offering the necessary trainings aimed at increasing their robustness.

This particular client group appears to impact in the therapists in a powerful manner. The way in which therapists respond to this impact relate to the qualities of the therapist. Clients appear to have a greater capacity for exploring their external worlds than their internal worlds. It appeared that the clients' ability to explore their internal worlds might correlate with their level of psychological-mindedness. Therapists view many of their clients as experiencing difficulties with narrative competence, and this might also relate to their levels of psychological-mindedness. Empathy was used as a tool by therapists in engaging clients whilst promoting their sense of understanding of the clients' process. Ruptures within the therapeutic relationship were experienced by therapists as providing an opportunity to facilitate their clients' learning about relationships, through the use of the therapeutic relationship. Counselling psychologists, therefore, with training inherently more focussed on the therapeutic relationship may be assumed to be in a better position to influence client factors.

Given that the therapeutic relationship constitutes the most consistent common factor affecting the outcome of therapy, I would like this research to contribute to positioning the therapeutic relationship in the forefront, within psychological therapies in the field of addiction. Currently, treatment models are largely CBT led and whilst this is of evidence-based value, I would like to encourage an enquiry into alternative models that may not be as easily evidenced as CBT. Counselling psychologists historically hold the therapeutic relationship in high regard and it is indeed a central tenet of our training (Division of Counselling Psychology: Professional Practice Guidelines, 2005). Furthermore, health care professions are bringing the focus of building therapeutic relationships to the foreground, and for this reason, it is perhaps imperative for counselling psychologists to present a more robust position with regard to both clinical practice and future research.

An important part of counselling psychology training consists of the trainee engaging in personal therapy. The capacity for reflection is considered a strength of Counselling Psychologists, and Holmes (2001) regards this reflexive

capacity as strengthening the attachment relationship with the therapist. "In fact, to be a counselling psychologist of whichever kind, perhaps the things we have in common are our difference, capacity to reflect on experience and difference in moment, as well as the ability to hold it together as a coherent whole. Flexibility allows for a strengthening of the secure base rather than a fracturing which could be a risk if we hold too rigidly to what we always been." (Jordan, cited in Holmes, 2001). Having a strong but flexible secure base might be preferable to the therapist aligning themselves with an uncompromising therapeutic stance or structure. It is hoped that this research could highlight some of the difficulties as well as possibilities in working with this challenging client group and inform clinical practice.

So what are the implications of an applied model of Attachment Theory for counselling psychologists working in the field of substance misuse? If one accepts the substantial body of support for the importance of the qualities of the alliance in psychotherapy outcome research and seeks to use attachment theory as an explanatory model, it would appear that relational factors are potent predictors of successful treatment outcome. Given the high disengagement rates of this client group, alliance factors can be viewed as even more significant in therapeutic work within the field of addiction. The findings of this research suggest that the usefulness of applying a model of attachment theory to this population informs our understanding of the significance of the therapeutic relationship at the level of engagement in therapy. It also helps in understanding the process during retention in therapy and in relapse prevention.

Whilst I have drawn on Flores' (2004) view of addiction as an attachment disorder, our opinions differ in an important point. This might be due to Flores (2004) being greatly influenced in the American context. Flores (2004) is wedded to the Twelve-step/AA model, which in my understanding is based on the premise that addicted individuals can only successfully begin therapeutic work once they become abstinent from their substances of misuse. For Flores (2004), fellowship groups, such as AA, play an important role for psychotherapy and he links them closely. According to Prochaska & Diclemente's (1994) Stages

of Change model, this is synonymous with the Action Stage of Change. Unfortunately, this rules out a large proportion of substance misusers on the Pre-Contemplation and Contemplation stages who, often at the severe end of the spectrum, are left unsupported due to their 'inactive' stage of change. It may be that this is where a model of attachment theory comes to the fore in that it creates the capacity for an alternative way of being in relation to another. In this way, holding an attachment framework can be enormously effective in these early stages, thus promoting entry into the Action stage of change and where possible, working with clients in conjunction to their attending fellowship groups.

An individual's relationship with a drug can be related to those relationships we all have with significant others. Thus, they may turn to a drug or substance as opposed to their partner to help meet their needs. There are elements of security but there are also elements of need, therefore, an illusion of security. The ruptures in our relationships could give rise to more primitive, defensive ways of being in the world, and in the language of addiction, this would indicate a lapse or relapse. Weegman and Khantzian (2011) propose the term "psychic envelopment" as opposed to addiction. They describe this as "a process whereby a treasured activity, preoccupation and value slowly infiltrates other, ordinary activities and motives, to the point that one's whole being is coloured and charged by its presence. With envelopment, drug use subserves more and more aspects of personal functioning" (Weegman and Khantzian, p. 169, 2011). This in turn, might result in denial of the problem or resistance to making changes which, consequently, might negatively impact the therapeutic relationship. Attachment theory concerns itself with the relationship of one human being with another (Flores, 2004). When applied to psychotherapy, its emphasis is on working through alliance ruptures, dependency issues and matters of security – all the very business of the substance misuser. It is for this reason that an applied model of attachment theory engages well with the relational factors so relevant to this particular client group. The use of this framework may encourage therapists to empathise with their clients' conflicts, thus enhancing the possibilities of a successful treatment outcome. Attachment theory,

therefore, can enhance the therapists' and clients' ability to locate their symptoms within an interpersonal context (Weegman & Cohen, 2002).

Thus, while no theory provides complete explanation of the common factors, holding an attachment framework is helpful in understanding and exploring relational factors within the therapeutic relationship.

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APPENDICES

Appendix A: Ethical Approval Form

Ethics Release Form for Psychology Research Projects

All students planning to undertake research in the Department of Psychology for degree or other purposes are required to complete this Ethics Release Form and to submit it to their supervisor prior to commencing the investigation. Please note the following:

- An understanding of ethical considerations is central to planning and conducting research.
- The published Code of Ethics of the British Psychological Society (1997) Code of Conduct, Ethical Principles and Guidelines. BPS. Leicester and American Psychological Society (1992) Ethical Principles of Psychologists and Code of Conduct. American Psychologist, 47, no 12, 1597-1611 should be referred to when planning your research.
- Approval to carry out research does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.

Please answer all of the following questions:

1.	Has a research proposal been completed and submitted to the supervisor?	Yes	x	No	
2.	Will the research involve either or both of the following:				
	2.1 A survey of human subjects/participants	Yes	x	No	
	2.2 An intervention with a cohort of human subjects/ participants, and/or an evaluation of outcome of an intervention?	Yes	x	No	
3.	Is there any risk of physical or psychological harm to participants (in either a control or experimental group)?	Yes		No	x
4.	Will all participants receive an information sheet describing the aims, procedure and possible risks involved, in easily understood language? (Attach a copy of the participants information sheet)	Yes	x	No	
5.	Will any person's treatment or care be in any way prejudiced if	Yes		No	x

they choose not to participate in the study? | | |

6.	Will all participants be required to sign a consent form, stating that they understand the purpose of the study and possible risks i.e. will informed consent be given?	Yes	x	No	
7.	Can participants freely withdraw from the study at any stage without risk of harm or prejudice?	Yes	x	No	
8.	Will the study involve working with or studying minors (i.e. <16 years)?	Yes		No	x
	If yes, will signed parental consent be obtained?	Yes		No	
9.	Are any questions or procedures likely to be considered in any way offensive or indecent?	Yes		No	x
10.	Will all necessary steps be taken to protect the privacy of participants and the need for anonymity?	Yes	x	No	
	Is there provision for the safe-keeping of video/audio recordings of participants?	Yes	x	No	
11.	If applicable, is there provision for de-briefing participants after the intervention or study?	Yes	x	No	
12.	If any psychometric instruments are to be employed, will their use be controlled and supervised by a qualified psychologist?	Yes	x	No	

If you have placed an X in any of the double boxes further information below: [X], please provide

Participants will be invited to take part in a research study. I am exploring the dynamics of the therapeutic relationship, specifically with regards to which factors influence outcome in the treatment of individuals engaged in substance misuse.
Should participants agree to take part, I shall meet with them and ask them a set of questions relating to the topic described above. The questions are guideline questions and I would ask that they spend a little time thinking about their responses to the questions beforehand. Before they answer the questions, I would request that they put them into a certain context. They would be asked to:
1. Think about them in reference to one client with whom you currently work

2. Choose a client which they believe is either doing well or not doing well. The criteria for wellness shall be referred to as: attending weekly sessions, ability to engage within the therapeutic relationship, interested in altering their substance use and working towards this effect. The criteria for not doing well shall be referred to as: inconsistent attendance at weekly sessions, exhibiting difficulty engaging within the relationship and avoidance / difficulty with working towards goals around their substance use.
3. I shall ask them the set of questions with reference to their client that is either doing well or not doing well.
4. The interview will take approx. 45 mins-1 hour
5. All interviews will be taped but will only be heard by myself, a transcriber and possibly my research supervisor
6. With any printed material I shall endeavour in every reasonable way to keep their identity anonymous

I do not believe that there are any disadvantages or risks in taking part in this research, other than possibly achieving a heightened sense of awareness of the therapeutic relationship.
They will be given a copy of the information sheet and asked to sign a consent form.

Student's Name: Beverley Marais

Degree Programme: DPsych Top up

Title of Research Project: Does an Applied Model of Attachment Theory, with its focus on the Therapeutic Relationship, make more apparent the common factors attributed to the alliance-outcome relationship? An Interpretative Phenomenological Analysis of the experience of therapists working with clients with substance misuse disorders.

Supervisor: Susan Van Scoyoc
Signature of Student: .....B. Marais.....
Signature of Supervisor: .....
Signature of a 2nd Psychology Department member:.....
Date: .....
Any further comments:

Please attach a copy of the participant's information sheet and return this form to:
Room W310, Department of Psychology, City University, Northampton Square, London,
EC1V OHB

Appendix B1: Information Sheet for Therapists (clients doing well)

Beverley Marais
City University

Research:
Exploring the quality of the relational factors within the therapeutic relationship and their significance to treatment outcome within the area of substance misuse.

Invitation Paragraph:
You are being invited to take part in a research study. Before you decide to agree, it is important for you to understand why the research is being done and what it will involve. Your participation in this research is entirely voluntary. If you decide to take part, you may withdraw at any time without having to provide an explanation. Please take your time to read the following information carefully and should you require more information or clarity, feel free to ask me.

What is the Purpose of the Research:
I am exploring the dynamics of the therapeutic relationship, specifically with regards to which factors influence outcome in the treatment of individuals engaged in substance misuse.

What will happen if I agree to take Part?
I shall meet with you and ask you a set of questions relating to the topic described above. The questions are just guideline questions and I would ask that spend a little time thinking about your responses to the questions beforehand. The more reflective and willing you are to share, the richer the interview material. Before you answer the questions, I would like you to put them into a certain context:

1. Think about them in reference to one client with whom you currently work
2. Choose a client which you believe is doing well. The criteria for wellness shall be
   referred to as: attending weekly sessions, ability to engage within the therapeutic
   relationship, interested in altering their substance use and working towards this effect
3. I shall ask you the set of questions with reference to your client that is doing well
4. This interview will take approx. 45 mins to an hour
5. All interviews are taped but will only be heard by myself, a transcriber and possibly my research supervisor
6. With any printed material I will endeavour in every reasonable way to keep your identity anonymous

The material you share with me will be entirely confidential.

What are the Possible Disadvantages and Risks of Agreeing to take Part:
I do not believe that there are any disadvantages or risks in taking part in this research, other than possibly achieving a heightened sense of awareness of the therapeutic relationship.

Consent:
You will be given a copy of the information sheet and asked to sign a consent form.

Who is Reviewing the Study:
All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. City University has reviewed and approved this proposal.

Thank you for taking the time to read this information sheet.

APPENDIX B2: INFORMATION SHEET: (Therapists)

Beverley Marais
City University

Research:
Exploring the quality of the relational factors within the therapeutic relationship and their significance to treatment outcome within the area of substance misuse.

Invitation Paragraph:
You are being invited to take part in a research study. Before you decide to agree, it is important for you to understand why the research is being done and what it will involve. Your participation in this research is entirely voluntary. If you decide to take part, you may withdraw at any time without having to provide an explanation. Please take your time to read the following information carefully and should you require more information or clarity, feel free to ask me.

What is the Purpose of the Research:
I am exploring the dynamics of the therapeutic relationship, specifically with regards to which factors influence outcome in the treatment of individuals engaged in substance misuse.

What will happen if I agree to take Part?
I shall meet with you and ask you a set of questions relating to the topic described above. The questions are just guideline questions and I would ask that spend a little time thinking about your responses to the questions beforehand. The more reflective and willing you are to share, the richer the interview material. Before you answer the questions, I would like you to put them into a certain context:

1. Think about them in reference to one client with whom you currently work
2. Choose a client which you believe is not doing well. The criteria for not doing well shall be referred to as: inconsistent attendance at weekly sessions, exhibiting difficulty engaging within the relationship and avoidance / difficulty with working towards goals around their substance use
3. I shall ask you the set of questions with reference to your client that is not doing well
4. This interview will take approx. 45 mins to an hour
5. All interviews are taped but will only be heard by myself, a transcriber and possibly my research supervisor
6. With any printed material I will endeavour in every reasonable way to keep your identity anonymous

The material you share with me will be entirely confidential.

What are the Possible Disadvantages and Risks of Agreeing to take Part:
I do not believe that there are any disadvantages or risks in taking part in this research, other than possibly achieving a heightened sense of awareness of the therapeutic relationship.

Consent:
You will be given a copy of the information sheet and asked to sign a consent form.

Who is Reviewing the Study:
All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. City University has reviewed and approved this proposal.

Thank you for taking the time to read this information sheet.

APPENDIX C: INTERVIEW QUESTIONS

Psychotherapist / Counsellor / Psychologist:
Taped Interview: 45 mins.- 1 hour

1. How comfortable do you feel working with your client?
2. Do you feel that you have the necessary skills to help this client?
3. Do you like your client?
4. How do you attend to / manage ruptures in the therapeutic relationship?
5. Do you think your client has improved since beginning therapy?
5. Do you think therapy with this client will work well?
6. Do you sense that you have 'freedom of movement' when working with your client? i.e. not feeling confined / restrained
7. Are you open to exploring your client's inner world?
8. Is your client responsive to this?
9. Are you open to exploring your client's external world?
10. Is your client responsive to this?
11. In what way do you convey to the client your understanding of the client's association / relationship with substances of misuse?
12. Do you occasionally feel emotionally impacted (positively or negatively) when working with your client?
13. Do you empathise with your client's experiences of abstaining / reducing substance use? In what way?
14. Do you feel that your words are received / listened to in the client's mind?
15. Do you view their reduction / abstinence or attempts at these as relating to experiences of loss?
16. How do you respond to your client's disappointment, excitement, rage, etc?
17. Do you view your client's relationship / association with or engagement in substances of misuse as relating either directly or indirectly to their emotional states?

18. In what way do you manage this and what effect does your 'management' have on the client?

19. How do you manage difficult emotions projected onto you by the client?

20. Does therapy with your client include the consideration / exploration of early patterns of relational styles?

21. Do you adapt your relational style to meet the needs of your client?

22. Do you challenge your client's relational style / perceptions of relationships?

23. Do you find that your client experiences difficulty / or not, in telling their 'life story' / disclosing details of their life to you?

24. Do you assist them?

25. Do you use the therapeutic relationship to reflect on your immediate relationship with your client in therapy?

26. Does your client engage with themselves?

27. Do you think your client feels understood by you?

APPENDIX D: WRITTEN INFORMED CONSENT

City University

I have understood the details of the research as explained to me by the researcher, and confirm that I have consented to my material being used in the study.

I understand that my consent is entirely voluntary and that my material used in the research will not be identifiable. I have the right to withdraw my permission to use my material at any time and without any obligation to explain my reasons for doing so.

I further understand that the material will be used for an in depth analysis and my subsequently be published, and I provide consent that this might occur.

Print Name: .....

Signature: .....

APPENDIX E: SIX ASSERTIONS

Researcher's Questions based on the 6 Domains of Attachment Theory

Psychotherapist/Psychologist/Counsellor
Taped Interview: 45 mins – 1 hour

I) The Establishment of a Secure Base is Essential to Positive Treatment Outcome

(test secure base with self & others)

1. *How comfortable to you feel working with your client?*
2. *Do you feel that you have the necessary skills to help this client?*
3. *Do you like your client? (Prompt: do you look forward to/dread/apprehensive regarding sessions with your client?)*
4. *Do you attend to ruptures in your relationship? In what way? (Prompt: do you manage ruptures in your relationship?)*
5. *Do you think your client has improved since beginning therapy? (Prompt: what do you think has changed?)*
6. *Do you think therapy with this client will work well? (Prompt: how can you tell?)*

II) Creating the Capacity to Explore is Essential for Positive Treatment Outcome

1. *Do you sense that you have a 'freedom of movement' when working with your client? Ie. Not feeling 'boxed in' or constricted*
2. *Are you open to exploring your client's inner world? And is your client responsive to this?*
3. *Are you open to exploring your client's external world? And is your client responsive to this? (Prompt: do you encourage your client to have fun/experiment/interact with their environment (safely)/engage in pleasant activities out of /and within therapy?)*

III) The Use of Empathic Attunement to Facilitate the Experience of Loss of the Addicted Substance is a Important Contributor to Postive Treatment Outcome

1. *In what way do you convey to the client your understanding of the client's association with/relationship to substances of misuse?*

2. *Do you occasionally feel emotionally impacted (positively or negatively) when working with your client? (Prompt: how do you manage this?)*

3. *Do you empathise with your client's experience of abstaining/reducing substance use? In what way? (Prompt: do you assist the client in managing the loss of their substance of misuse? In what way?)*

4. *Do you view your client's abstinence/reduction of substances of misuse or attempts at these as related to experiences of loss?*

5. *Do you feel that your words are received/listened to in the client's mind?*

IV) <u>The Regulation of Affect is an Essential Component of the Therapeutic Relationship in Promoting Positive Treatment Outcome</u>

1. *How do you respond to your client's disappointment, excitement, rage, etc?*

2. *Do you view your client's relationship/association with or engagement in substances of misuse as relating either directly or indirectly to their emotional states? In what way do you manage this? What effect do you believe this has on your client?*

3. *How do you manage difficult emotions projected onto you by the client?*

V) <u>The Revision of Internal Working Models is a Necessary Component in Creating Positive Treatment Outcome</u>

1. *Does therapy with your client include the consideration /exploration of early patterns of relational styles? (Prompt: do you focus on adapting/changing unhelpful relational patterns?)*

2. *Do you adapt your relational style to meet the needs of your client? (Prompt: in what way?)*

3. *Do you challenge your client's relational style/perceptions of relationships? (Prompt: in what way?)*

VI) Creating the Capacity for Narrative Competence is a Fundamental Component of Positive Treatment Outcome

1. *Do you find that your client experiences difficult/or not, in telling their 'life story'/ disclosing details of their life to you? Do you assist them? (Prompt: in what way do you assist them? Eg. Do you look for themes, use pictures, music, etc which give a picture of their difficulties?)*

2. *Do you use the therapeutic relationship to reflect on your immediate relationship with your client in therapy? (Prompt: do you find this helpful? Does your client respond to this? How?)*

3. *Does your client engage with themselves?*

4. *Do you think your client feels understood by you?*

APPENDIX F: DEBRIEF FOR PARTICIPANTS

Information Sheet providing outline of research study

Research Title:
Does an applied model of Attachment Theory, with its focus on the therapeutic relationship, make more apparent the common factors attributed to the alliance-outcome relationship? An Interpretative Phenomenological Analysis of the experience of therapists working with clients with substance misuse disorders.

Research Aims:
The research attempts to explore therapists' views of the qualities of their therapeutic relationships with substance misusing clients and whether an applied model of attachment theory, that is, it's assertions, is a useful lens for viewing this relationship.

A major downfall of previous research studies is their lack of accountability for the therapist-client relational factor. This makes it difficult to assess in what way the therapist was able to effect change in relation to the client. Substance misusers present challenges to therapists in terms of establishing therapeutic alliances.

By focussing on this challenging client group, this research aims to investigate therapist-client relational factors accounting for therapeutic change; the therapeutic skills deemed helpful in this regard; and whether attachment theory assists in providing explanatory value of this.

The methodology used is IPA. Following transcription and data analysis, results will be discussed as well as their relevance with regards the assertions of attachment theory. A list of interview questions had been devised along the 6 assertions of attachment theory. These questions are designed to explore the following:

1. The establishment of a secure base is essential to positive treatment outcome.
2. Creating the capacity to explore is essential for positive treatment outcome.
3. The use of empathic attunement as contributor to positive treatment outcome.
4. The regulation of affect is essential in positive treatment outcome.
5. The revision of internal working models is necessary for positive treatment outcome.
6. Creating the capacity for narrative competence is fundamental to positive treatment outcome.

Basis for current enquiry:

- Difficulties in engaging and retaining substance misusers in treatment.
- Flores (2004) Addiction is an attachment disorder. Attachment theory focuses on those variables necessary to establish a good working alliance with a client.
- 70% of the psychotherapeutic effects are general effects (Wampold, 2001)

- Can these psychotherapeutic effects be explained through the application of attachment theory?

Current Treatment Guidelines:
The Department of Health (2007) and National Treatment Agency for Substance Misuse (2004) in line with NICE guidelines recommend:
- Behavioural therapy
- Psychodynamic therapy
- 12-Step approaches
- other (group, counselling, marital/ family therapy)

Participation in research:
Approximately 10 therapists will have been interviewed with a set of questions relating to the topic of research. 5 Therapists will have been asked to view the questionnaire with client in mind whom they believed was working well in therapy. The remaining 5 therapists will have been asked to view the questionnaire with client in mind whom they believed was not working well in therapy. This is in order to compare and investigate the quality of the alliance linked to treatment outcome.

Implications for Counselling Psychology:
- To contribute to psychological therapies in the field of addiction.
- Current practice is largely CBT lead and this is of evidence-based value.
- To encourage enquiry to alternative models which may not be as easily experienced as CBT.
- To highlight difficulties as well as possibilities in working with this challenging client group, and thus, inform clinical practice.

Contact:
These are my contact details should you have any questions or concerns about the research:
Beverley Marais 07949243275
These are the contact details for my research supervisor should you require further information or support:
Susan van Scoyoc 0207 1830892
You may wish to contact your supervisor about the research should you feel you may have been adversely impacted by this.

Thank you again for your time.

APPENDIX G: DEMOGRAPHIC QUESTIONNAIRE

- Initials:
- Gender:
- Age:
- Model of Therapy:
- Number of years' experience:
- Accreditations:
- Ethnicity:

Section C: Professional Practice
Advanced Client Study:

An Integrative Psychotherapeutic Model applied to a young adult with Low Self Esteem

Section C: Professional Practice
Advanced Client Study:

A Psychodynamic Psychotherapeutic Model applied to a young adult with Low Self Esteem

Introduction

I have chosen this client case study because it incorporates my different areas of clinical practice and theoretical frameworks. The client has been seen in my private practice where I am able to work creatively and use a psychodynamic model to work through presenting issues in longer term therapy.

Many studies indicate that relationship factors are potent predictors of successful treatment outcome (see Grencavange & Norcross, 1990, Wolfe & Goldfired, 1988, Martin et al., 2000). Accordingly, meta-analyses (Wampold,2001, Miller, Duncan, & Hubble, 1997) showed that it is not the therapeutic techniques or models of therapy that produce positive or negative outcomes. Instead, the research indicates that "13% of the variability in outcomes is due to psychotherapy" and that "at least 70% of the psychotherapeutic effects are general effects" (Wampold, 2001, p.207).

This case study demonstrates an emphasis on developing the therapeutic relationship and the difficulties that arise when a client is resistant to change and perceives the therapeutic relationship as threatening. I have chosen this client case study because it incorporates my different areas of clinical practice and theoretical frameworks.

As can be seen in the following, the client over time develops trust in this process, my interventions and indeed, herself, in relationship.

All identities throughout this case study have been changed to protect the anonymity of the client.

Summary of Theoretical Framework

Psychodynamic Framework

This case study incorporates the use of a psychodynamic framework in order to contextualise and frame interventions. The focus within this case study has been set on the psychodynamic theoretic models of Kohut (1971), Winnicot (1965)

Kohut's (1971) self psychology purports that low self esteem results form the faulty interaction between the child and their selfobjects, resulting in a disturbance in the normal development of the self. With the term 'selfobjects', Kohut (1971) refers to the significant others that "are experienced as nonautonomous components of the self" (Banai, Mikulincer, & Shaver, 2005, p.227). and as "that dimension of our experience of another person that relates to this person's shoring up of our self" (Kohut, 2009, p.49). The tow selfobjects identified as crucial within this model is the mirroring selfobject and the idealised selfobject. The need for mirroring translates to a need for admiration and valuation (Banai et al., 2005) and in addition acts as a form of feedback. As a consequence, the unmirrored self develops if mirroring needs in childhood were not satisfied.

In adult life this might lead to an exaggerated need of being mirrored and is, according to Kohut (1987) a primary source for the development of narcissism. Another term for this phenomenon is the 'reverse selfobject experience'. In the case of a moth-child relationship, this translates to a situation where the child acts more as the selfobject for the mother than the mother acts as selfobject for the child. Since in early childhood this requirement for fulfilment of the own selfobject needs are very strong, heightened vulnerability to reverse selfobject experiences occurs particulary during this phase (Lee, 1988). As a consequence, children with lacking selfobjects are more likely to suffer from traumas. In the case of absent parental care, children often rely on siblings and use them as selfobjects (Lee, 1988). Relatedly, pathological grandiosity, which can be defined as seeing oneself better than anyone else, i.e. an exaggerated feeling of superiority, might develop; from absent mirroring and intense reverse selfobject experiences. This pathological

grandiosity manifests itself in an excessive need for admiration and attention, a deficiency in empathy and controlling behaviours amongst others. Interestingly, people with disproportionate reverse selfobject experiences ten to become resistant in terms of psychotherapy in their adult lives, which is elaborated further upon in a later paragraph (Lee, 1988).

With regards to self esteem and the self, Winnicott (1965) developed a theory that is characterized by two kinds of self. He offers the view that a false self develops when the true self is denied in order to comply with demands of the primary caregiver. Winnicott (1965) describes the occurrence of this dissociation between true and false self in healthy people as well as in a pathological form. In the latter case, the false self can service as the seat of intellectual processes and "a dissociation between mind and psyche-soma" can develop (Winnicot, 1965, p.134). Moreover, the false self can act as a defence mechanism. As an example, he introduces the case of a child that might not want to eat. In order to comply with its caregiver who wants it to eat, it will eventually consume food, probably copying other people's behaviour, and in that way hiding its real self "and becom[ing] deprived of living experience" (Winnicott, 1965, p. 102). Winnicott (1965) adds that only the real self can be analysed in therapy. Thus, if a client exhibits a pathological false self, the therapist firstly has to access the client's inner environment. As a result, the client becomes dependent and falls in the role of an infant so that the therapist can start the work of the analysis (Winnicott, 1965).

Stern (1985) refines this further by specifying various types of parental responses that contribute to the development of a child's false self. He refers to these responses as different forms of attunements. In his book 'The Interperosnal World of the Infant: A View from Psychoanalysis and Developmental Psychology', Stern (1965) starts with describing non-attunement which is characterized by a lack of intersubjective relatedness. As an example, Stern (1985) introduces the case of a young mother with a schizophrenic condition who was attentive to her baby, yet not attuned to it at all. While taking care of her baby and being extremely protective, the mother did not respond to

any expression by the baby that usually would lead to some form of interaction. Thus, she only attended to external conditions while dismissing her baby (Stern, 1985). As a result, and if the caregiver situation would not change, the child might develop a feeling of aloneness, and an "ego-syntonic, acceptable, chronic isolation oat the level of intersubjective relatedness" (Stern, 1985, p.207).

Another form of attunement, selective attunement, is described by Stern (1985) as "permit[ting] the parents to convey to the infant what is shareable, that is, which subjective experiences are within and which are beyond the pale of mutual consideration and acceptance" (Stern, 1985, p. 208). Thus, parents "create a template for the infant's shareable personal experience" (Stern, 1985, p. 209) and in that way, also a false self.

A third form of attunement is that of misattunement. Stern (1985) states the difficulty of recognizing misattunements as "they fall somewhere between communing (well-matching) attunement and a maternal comment (that is, an affectively nonmatching response)" (Stern, 1985, p.211). Misattunements are being used to influence and form a child's behaviour. Stern (1985) hypothesizes that successful misattunements lead ot the creation of a place in the child's experience gets entered and subsequently changed by the caregivers misattuning response. At the extreme, misattunements can result in the 'theft' of the child's own experience thus eventually becoming the start of the lies and secrets at later stages in childhood (Stern, 1985).

The role of attachment

Bowlby's (1969) attachment theory posits that a secure base or attachment style between the child and caregiver is necessary to develop a healthy sense of self esteem.

Regarding the importance of a secure base in the development of self esteem, attachment theory can be used to facilitate learning on how to be close and

intimate while also managing a certain separation. A secure base and a self regulating other are substantial parts in this.

Attachment theory offers a set of explanatory ideas that focus precisely on those variables necessary to establish a good working alliance with a client. This can be regarded as analogous to a situation in which a mother provides an infant with a secure base. According to attachment theory, once the client is in a secure base provision, attachment behaviour systems deactivate (Bowlby, 1988). In this way, the client is then free to explore and is more available for therapeutic work.

In addition, the therapist's subjective experience of the client might provide a unique opportunity for understanding the client's relational frame from an experiential perspective. Attachment theory lends itself well to a parallel process whereby the therapist's capacity to regulate his or her own affect and to self soothe when confronted with difficult emotions and countertransferences, is vital to the establishment of secure base provision (Flores, 2004). Essentially, the therapist requires a secure base to work from. This refers to anything that proves the therapist with a sense of physical and emotional security, such as basic needs around supervision, training, salary, and safety, and also further needs relating to the therapeutic commitment, such as confidence, experience, personal therapy and role security. In this way, the impact of the client on the therapist appears related to therapists' qualities.

While attachment theory offers important explanations and information regarding the theoretical framework of the present case study, resistance plays a crucial role and is expanded on in what follows.

Resistance in Psychotherapy

Resistance has been defined from a number of perspectives in psychotherapy. Psychodynamic definitions have their roots in Freudian theory and usually place resistance within the client. These definitions view resistance in the context of the client repressing their anxiety-provoking memories and insights. More

broadly, resistance can also be viewed as any behaviour on the part of the client that either explicitly or implicitly opposes the therapist or the therapeutic process (Bischoff & Tracey, 1995). Messer (2002) goes as far as to "view resistance as the way in which clients present themselves in therapy" (Messer, 2002. P.158), thus in his definition the opposing aspect is missing. In more detail, he says that resistance "is a way of avoiding and yet expressing unacceptable drives, feelings, fantasies and behaviour patterns"(Messer, 2002, p.158).

Messer (2002) makes an interesting point, suggesting to see resistance in clients as something to work with rather than to work against. Clients that struggle to recognize their emotions likely develop negative feelings such as anxiety in the process of admitting them to themselves or to the therapist. This is one common form of resistance in therapy (Messer, 2002). Furthermore, resistance in disclosing feelings to the therapist is a second function of resistance (Messer, 2002). Other forms are "the opportunity for clients to demonstrate self-sufficiency and self-efficacy" (Messer, 2002, p.159), the unwillingness to change the behaviour outside of therapy and "a function of failure of empathy on the part of the therapist" (Messer, 2002,p.160).

In addition to exhibiting resistance in therapy, experiencing the therapeutic relationship as threatening also poses a challenge. Frequently, these perceptions of being threatened occur in a setting with client with addictions: "Missed appointments, deceit and various other modes of defensiveness can be usefully apprehended as deriving from the patient's attempt to negotiate the relationship with a figure who simultaneously represents both a trusted ally in the pursuit of change and a despised, potential threat to the homeostasis bond with the drug of choice" (Weegman & Cohen, 2002, 27).

It has to be noted that not only in a setting of addiction, but also within therapeutic encounters, therapy can be perceived as being threatening. Patterson (2000) draws a relationship between resistance and threat by stating that "resistance is a defense; defense is a response to threat" (Patterson, 2000,

p.186). Patterson (2000) further claims that it is often the intervention per se, interpretations that are part of the therapy, evaluation, and attempts to persuade patients in form of argumentation as, for example, occur in cognitive therapy, that are being perceived as being threatening. Importantly, Rogers (2006) states that "resistance to counseling and to the counselor is not an inevitable part of psychotherapy, nor a desirable part, but it grows primarily of out poor techniques of handling the client's expression of his problems and feelings…out of unwise attempts on the part of the counselor to short-cut the therapeutic process by bringing into discussion emotionalized attitudes which the client is not yet ready to face" (Rogers, 2006, p.151).

In my clinical practice, a main theme is that of relationship factors as potent predictors of successful treatment outcome. My challenge in this case has focused on how to develop a therapeutic relationship when the client is either resistant and, or perceives the relationship as threatening. A good approach for the therapist to support the client in the overcoming of these problems is to show empathy (Messer, 2002), to empathize with difficult situations the client experiences or has experienced in the past. The therapist is then seen as an ally and not as an opponent.

In the following case study, I start with the presentation of the client which is followed by a description of the therapeutic process and a case formulation. Furthermore, one section of the case study is used to thoroughly discuss and critique my rationale for the approaches I have used.

The Client

Context of Referral

The service that this client was seen in was my private practice in London. Within my private practice I specialise in working with individuals suffering from eating disorders as well as addiction. In addition, I also work with a variety of other conditions such as depression, anxiety, and general psychotherapeutic concerns. Clients are either self-referred, or referred via a general practitioner (GP) or psychiatrist and the work would involve either short or long term

therapy which is contracted either at the beginning or during the therapeutic encounter. The initial meeting involves an assessment process and following this a treatment plan is identified in collaboration with the client. During the initial session, confidentiality is discussed and the client becomes aware that this would only be broken in cases of risk to self or other. Within these cases, if confidentiality were to be broken, a prior discussion would take place with the client. Where the client would want information to be shared with others, such as their GP or psychiatrist, consent is agreed at the outset.

These client sessions were recorded on a voice recorder in order to reflect on therapeutic practice. Confidentiality was explained to the client and a consent form was signed. Moreover, where appropriate the body of the report contains brief transcripts to highlight the therapeutic process.

The client in this case study I shall refer to as Lisa. She is twenty-seven years old and is an identical twin. Lisa was referred to my practice through her GP. She was in good physical health. Her GP had prescribed anti-depressants because Lisa had described to her how depressed she felt, however, she did not believe in taking these. Lisa viewed her presenting problem as low self esteem. She had just ended a relationship with her ex-boyfriend. While in this relationship, she had become increasingly aware of her low self esteem.

At the time of the referral, Lisa presented as a very young-looking twenty-seven year old. Despite her tall height and fashionable appearance which could give the impression of confidence, she sat the entire time with her feet pointing inwards, leaning forward over hunched shoulders, with her arms crossed over her knees. Physically, she was thin but not frail. She made reference to thinness being encouraged in her family, however, she was not defensive about the subject. During the assessment, I noted that Lisa's eating patterns did not meet the criteria for an eating disorder as outlined by the 4th edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) (American Psychiatric Association, 1994). Lisa spoke very quickly and this was something she was aware of.

She attributed this to believing that people would not be interested in what she had to say.

Background History

Lisa was single at the time, however, did engage in fleeting relationships. She had rarely been without a boyfriend since the age of 17. Lisa disclosed that she felt insecure without having someone there for her and has tended to begin a new relationship before ending a current one. Lisa stated that she normally ended the relationships because she became bored or felt that the chemistry had gone. The longest relationship she had experienced was for three years. Her most recent relationship lasted for eighteen months and they had been living together before their relationship ended approximately nine months ago. Lisa now lived in a rented flat-share.

Lisa's parents lived approximately two hours away from London and she visited them regularly. She described her parents as showing little emotion, displaying minimal affection towards her and her twin during her childhood. She described her grandparents as emotionally undemonstrative. When Lisa was 14, her father's behaviour changed towards her and her sister in that he barely spoke to them. She attributes this to him not wanting them to grow up. Lisa found out at the age of 18 that her father was an alcoholic. She had until then presumed that his alcohol use was "normal". As an adult, her relationship with him was very strained. Lisa found this very painful and was upset that her father seemed to have a reasonable relationship with her sister.

Lisa's mother worked late when she was growing up and both her and her sister would make their own dinner from about age 10. She described her mother as constantly being absorbed by "television soaps" and always too tired to hear about their day. Lisa felt that as twins, they were put on display, constantly told to behave well in front of others and were praised and rewarded for this. No matter what difficulties were experienced in the home, the family always had to project the image of a perfect nuclear family.

Lisa learnt from her mother how to skip a meal before going out for a special occasion in order to look her best. Lisa's sister spent years getting professional help for anorexia and bulimia and Lisa recognised her own tendency to skip meals on occasion. By this she referred to not having lunch or dinner if she was feeling particularly low and not feeling comfortable with her body. This would happen approximately two to three times a month. Whilst being aware that she was thin, Lisa did not regard herself at the time as having any eating-related issues. Lisa described her mother as lacking in self esteem and as someone who always tried to please people. She described having had to grow up on her own in that she did not really rely on her parents for support. Lisa stated that as a twin, they were always seen as one person. Whilst they had very different personalities, she found that she always adapted to or compensated for her twin. She describes their relationship with one another as ambivalent and competitive. Her twin sister had recently moved to Australia with her boyfriend and planned to remain there for one year.

Lisa worked for a major television company in the field of documentaries. She described herself as putting "110%" into her work and wanted to be successful. Work was the one area where she felt in high self esteem.

On reflection, with regards to the impact of the environment Lisa was raised in, it is useful to draw upon the literature on adult children of alcoholics. Brown (1988) employs on developmental and systemic perspectives by viewing the alcoholic family as organised around the dominant needs of the parents. She specifies these needs as the alcoholic's need for alcohol and the non-alcoholic's need to control the alcoholic. Both parents are viewed as being overwhelmed with their own anxiety on a regular basis and therefore, are either unavailable or only marginally available and attentive to the needs of the child.

It is recognised that alcoholism in the family is often denied and instead, focus set "on other things as the 'real problem'" (Brown & Abbott, 2005, p.48). Children are sometimes made responsible for their parents drinking behaviour (e.g. by having low grades in school). Thus, Brown and Abbott (2005) state, the

children of alcoholics often experience feelings of loneliness, abandonment and emptiness and further that the perception of shame and fear might lead to distortions of the self. As children do have little choice but to adapt to their parental environment, it is highly like that they develop a defensive mechanism that is not based on self-development (Brown & Abbott, 2005).

Moreover, studies found a link between alcohol abusing parents and their children's psychopathology in so far as to higher prevalence of depression, anxiety, relationship problems amongst others (Brown & Abbott, 2005).

In the case of Lisa, her needs appear to have been secondary to those of her parents. She described her father as withdrawing from her and this might have been his coping strategy for maintaining his emotional equilibrium. Her mother, alternatively, appeared to engage in mindless activities, perhaps as her way of managing her own anxieties within this environment. Spiegel (1953) reports on the concept of masking or concealing alcoholism within the family in order to support and defend parental equilibrium. This is relevant to Lisa's experience as she was unaware that her father was an alcoholic until she reached adulthood. Since being aware of her father's alcoholism, she has then been tasked with the painful process of reconstructing events and relationships within her family as they actually were, as opposed to how they appeared.

The Therapeutic Process: Part 1

Our therapeutic process was organised into three stages: i) Beginning Stage; ii) Middle Stage; and iii) Current Stage. These represent key content issues and interventions. The first stage will be introduced here because essentially this is where our relationship began.

i) The Beginning Stage: Building the therapeutic relationship

In terms of our initial contact, Lisa appeared to have limited affect in the session. She seemed to rationalise and provide explanations for her feelings in a dismissive way, as if what she thought was more important than what she felt.

She appeared intelligent, articulate, and outwardly confident, presenting as though she experienced no problems at all. At times there appeared to be tears in her eyes, however, her emotions appeared to be in conflict with what she was telling me. While relating painful information from her past and present, she often smiled and laughed in a cynical way, for example, she had recently asked her father what he liked about her. After a long pause, he had replied by saying that she was a good driver. Lisa laughed as she recalled this. I hypothesised that her cynicism could be interpreted as her repressed anger. I also experienced her as was laughing at me and negating my interventions in the process. She identified that her three best friends were male and that she did not like "girly-girls who were pink and fluffy" as all they could talk about was make up and fashion and were "unbearably unintelligent". I wondered about her impression of me at the time. She described her mother as a "feminine, girly-girl" and someone she has nothing in common with. Lisa stated that she had found men less competitive, more strong, supportive and accepting of her. She liked being adored and had some insight into how this affected her self esteem. When I asked her about how she experienced me as a female therapist, she then contradicted herself by stating that she expected a male therapist to experience her as silly and dismissive. I suspected that she may be telling me something about how she was experienced by her father and that she yearned for his approval.

Our first session together felt very 'speedy' as though there was no space to think. It felt like an interview where I would ask questions and she would provide answers, looking at me, smiling, as she waited for the next question. I was aware that clients tended to exhibit anxiety during the assessment interview, however, counter-transferentially, I experienced Lisa as hostile to any form of relational contact, with my interventions seemingly experienced by her as an attack. I sensed that she may have been testing me and that within the dynamic of the therapeutic frame we somehow came to be in competition with each other. Lewin (2004) states that in the early stages of therapy with twins, the narcissistic elements of the twinship tend to dominate the therapeutic relationship. I understood this metaphorically in terms of the narcissistic

twinship where as an external 'other' I became viewed as antagonistic and threatening. Meltzer (1967) theorized that twins come into therapy with a pre-transference which alludes to the therapists being a transference twin. Whilst theories such as Kohut's (2001) inform the 'twinship' hypothesis, it is recognised that each client and indeed, each twin is unique. At earlier stages, Kohut saw twinship as a mere archaic form of the mirror transference, whereas towards the end of his life he viewed it as an independent selfobject transference (Togashi & Kottler, 2015).

This theory of Meltzer (1976) that hypothesises a pre-transference of twins in therapy towards the therapist as a transference twin, resonated with my experience of Lisa as controlling during this early assessment session. My sense was that she had found it difficult to tolerate difference and therefore resisted therapeutic activity initially. She had begun the session by stating that she had broken up with her boyfriend who she was together with for 18 months. She asserted that she was "fine" about this because "he wasn't good for me" and then moved onto another subject. Any further probing was met with resistance and it felt very much that she needed to be in control in her relationship with me. I found it difficult to see any outward sign of vulnerability or in fact what it was she wanted from psychological treatment at all.

Lisa was very aware of the time throughout the session, which began at 6.00pm and at exactly 6.50 pm she said "right, I have to go". I immediately felt dismissed. I was aware of strong counter-transferential feelings throughout this initial session. These consisted of feeling pressured to perform, to be a brilliant therapist, to come up with all the right answers, to be quick and think on the spot. These triggered my own issues and perhaps insecurities as a psychologist, with regards to needing to solve problems and making people better.

The session passed very quickly. I was also aware of strong counter-transferential feelings immediately after the session, which consisted of feeling angry, confused, that Lisa had been disappointed with our interaction, that I was

not good enough for her, that I was in competition with her and that I had been through some sort of battle which I needed to recover from.

During the early stages of our work together, building a therapeutic alliance was most challenging. I tried to encourage Lisa to talk to me about her distressing encounters, however, I experienced her as resistant to actually acknowledging the powerful impact these encounters had on her. It felt to me as though I was 'making a fuss' about nothing. I found that this triggered my attachment style wherein I would become ambivalent around making contact within this relational space. In terms of our styles of contact much of our early sessions consisted of me feeling dismissed by her. My interventions and attempts at empathic contact were ridiculed through her cynical laughter on occasion and I felt as though she was just humouring me. This would generally result in my withdrawal of any relational engagement by focussing on the content of what she was telling me and not on her process. Through supervision I was able to address my counter-tranferential feelings towards her as well as the impact my resultant ambivalent attachment style was having on our therapeutic alliance. Experientially and in the counter-transference I found I became 'little Lisa', accessing the part of her that needed to 'produce the goods' as a child, living up to the expectations of others while struggling to survive it and avoid failure. During this parallel process, I had to learn how to own my authority in the room with her and to trust in my interventions. I noticed the discrepancy between her very mature, articulate 'performance' and the scared little girl inside. Through her cynicism and self-deprecating laughter, she was able to censor her feelings and dismiss these as childish.

Her eye would often be on the clock during the sessions and she would announce her time to leave. This further highlighted her need for control illustrating to me that the world was not a safe place and she was having difficulty trusting me in this space. Over time, the more she revealed about herself relationally, the more fragile I deemed her sense of self to be. During the early stages of therapy, I found that she was only able to relate to me in superficial manner. I felt that her narcissistic rage was directed toward me as a transference twin in the form of

some kind of sibling rivalry or competition. She was repeating her past by projecting her difficult relationship with her twin onto me. I found that I became the available object for all of the split-off and disowned parts of her self.

Sometimes, during silences, she would look up at me, waiting for me to tell her the answers in order for me to reinstate her false self. Alternatively, Lisa would try to suppress her emotions by rapidly changing the subject. Her sentences are unfinished and fragmented. During this time I used to struggle with this process and found myself busy with trying to put the pieces together on my own, instead of reflecting any of this to her. At the time, I was unaware that on a developmental level, I was experiencing a mother-infant transference, whereby the mother-figure knows the infant's signals of distress, reading their minds and making sense of their words. My counter-transference consisted of me feeling as though I should know what she meant all the time. When she thwarted relational contact I found that my attachment style would be triggered and I would step back and withdraw myself. This resulted in much of our early work together being mainly content based and this seemed to feel safe for both her and me. Lisa had already begun Cognitive Behavioural Therapy (CBT) work on herself via a self help book and had expected me to expand on this with further CBT treatment. Essentially I felt that she had expected me to fit in with her mode of relating and that she disregarded the form of therapy I was providing. Whilst I interpreted this as her insistence on sameness which was an attempt to prevent any sign of separateness, I was also aware that there are times when individuals begin a therapeutic encounter having already predetermined their mode of relating. My challenge at the time concerned how to begin building a therapeutic relationship with Lisa whilst also containing our different styles of relating. I addressed the tension between her view of CBT and the relational work that I was offering.

Individual autonomy is an important factor in therapy. This comes from the fact that motivation and volition from the side of the client are indispensable for long lasting changes and a positive treatment outcome (Ryan et al., 2010). Relatedly, clients often display a resistance to change and even if, on a superficial level, they

seem to show some motivation, on a deeper level they frequently act against a therapeutic change. Motivational interviewing as a technique that is applied before the actual therapy begins to foster motivation and volition in the client becomes more and more popular (Ryan et al., 2010).

The respect of autonomy has a long tradition in philosophy and basically translates to "respecting the rights of a person to think, decide and act, to the extent that such respect does not conflict with the right of others who might possibly be affected to think decide and act" (Ryan et al., 2010, p.238). In the framework of therapies, respect for autonomy includes providing the client with sufficient information about therapy types, about their rights, obtaining permission before starting a treatment and keeping confidentiality. Interestingly, it has to be noted that psychodynamic approaches might not set such a big focus on transparency and prior consent due to the fact that here, resistance is often seen as an unconscious symptom that is being treated in the course of therapy (Ryan et al., 2010). In the current case study, however, this was not the case, as the client had been fully informed about therapy techniques and prior consent had been given.

The question of autonomy is also a question of ethics and power. The client has to be informed of what the therapy will consist of, how long it takes, about fees, the clinician's expertise and alternative treatment approaches. However, when it comes to the question of whether clients should have the individual autonomy to ask for a particular therapy, as in the case of Lisa asking for CBT, it can present an ethical dilemma. Clients may not have all the expertise needed to make an informed choice. This would therefore need to be mutually explored through collaboration, trust and forming a contract in order to consider whether the treatment mode is a viable option. It is explicit and agreed, therefore power is acknowledged but not misused by the therapist.

While Lisa was ‘compliant’ and open to working in a different way verbally, in reality, very little had changed within our relational dyad other than my attempts at engaging her at a deeper level of contact and her consistent attempts at avoiding it. We regularly addressed her experience of our therapeutic work together and I found that she remained ambivalent about whether I was going to help her.

Regarding her resistance and ambivalence to change, my perception was that one part of her wanted to change, while the other part viewed change as threatening. This latter one is the part that seems to ‘speak’ louder within the therapeutic encounter.

As a result of my subjective responses to Lisa including her history and initial session content, my initial hypothesis was that she presented with a narcissistic personality style. This appeared to have been triggered by her relationship with her now ex-boyfriend with whom she was constantly left lacking in terms of being ‘doted upon’ and being ‘adored’. Feeling emotions were not allowed or role-modelled within her family and as a result these were not even in conscious awareness. Her perfectionistic traits were exhibited through her extreme judgements of herself and of others which indicated the pressure she felt around having to portray a perfect self image. Her laughter and her cynicism represented strong defences which she needed in order to survive relationally. Lisa’s relationship with her twin may have been a representation of the relationships she expected to have with women, that is, constant competition for affection and praise, fear of attack, envy and a generalized ambivalent attachment. She was never seen or acknowledged in a ‘good enough’ way unless she ‘performed’. In terms of her relationship with me there was an overwhelming lack of trust that I could in any way take care of her even in terms of watching our session time. This was a direct result of her taking care of herself from a very young age and to the extent of not even expecting support from me, where for example, she had already begun doing her own exercises around self esteem. I was given the impression that support was something she had to fight for or did not believe could exist for her.

An Outline of the Initial Contract and Initial Clinical Focus

We had agreed a three-week assessment period and upon its conclusion, Lisa was surprised that I had agreed to engage in therapy with her. She was so convinced that I would reject her that she had brought a card saying 'good-bye'. Her insecure attachment pattern had truly presented itself to me. She told me that she had expected me to tell her that her problems were not big enough. Once I was able to empathically attune to her experience of rejection, I was able to explore how, without any acknowledgement, she had carried her anxiety around potential rejection throughout the assessment sessions. She then started crying.

We agreed to meet at a set time, on a weekly basis. We also agreed to work towards a six month contract which could then be reviewed. The initial clinical focus centred around accessing what her authentic feelings and needs were and how to have these met within a non-judgemental and accepting environment, that is, the therapeutic relationship. Because Lisa felt that she had never had her own identity, part of this included an exploration of her experience of being a twin, in an attempt for her to more fully own her personality.

A Case Formulation from a Psychodynamic Perspective

I agreed with the Lisa's self diagnosis of low self esteem. Low self esteem, I believe, is inextricably linked with narcissistic injury (Miller, 2008; Kernberg, 1995; Johnson, 1994). My counter-transferential feelings following our initial conversation confirmed to me her narcissistic personality style, seen in her attempts to constantly assert her superiority over me. My counter-transferential feelings also helped me understand how she experiences others relationally, that is, constantly feeling judged and attacked and therefore explains her defensive stance. The triggering event instigating her therapy was her evaluation of self within her relationship with her boyfriend. The mirroring in this relationship was inadequate for her, exposing her underlying feelings of anxiety, depression and not feeling good enough. Previous partners have reinforced her needs for

adoration and grandiosity. Her conditions of worth dictate that she needed to be perfect in order to accommodate everyone effectively and as a consequence her feelings of anger or rage had to be repressed. The fulfilment of her legitimate narcissistic needs would be necessary in order to promote the development of healthy self esteem. I follow Kohut's (1971) view of narcissism as opposed to DSM-IV (APA, 1994) because Kohut de-pathologizes narcissism by viewing it as a developmental trauma rather than a formal presentation that needed to be frustrated. Whilst Freud (Sandler et al., 2012) de-pathologized narcissm previously, Kohut does this in a more explicit way.

In more detail, Freud describes narcissism as often being normal in the early stages with the capacity of turning into a pathology at later stages. Kohut, on the other hand, focused on clinical observation he made from his work with patients with narcissistic personality disturbances and deducted the before mentioned two types of transference, mirror transference and idealizing transference (Sandler et al., 2012). By using these two transferences to explain disturbances in the structure of the psyche, Kohut establishes distinct definitions for the evolvement of narcissism and object love (Sandler et al., 2012).

Lisa's unsatisfied narcissistic needs were repressed and therefore unconscious which resulted in her attempting gratification through alternative means. As a result of her accommodation of her parents' needs, she had identified with what Winnicott (1965) describes as a false self. In this way, she revealed only what was expected of her by others and was unable to identify her own needs and expectations. All her relationships appeared to have had hidden agendas, essentially, an attempt to inflate the false self. Her father's love was experienced only on the condition that she presented her false self. She had often described herself as having "no sense of self", indicating that her true self was undeveloped and unconscious. As in the myth of "Narcissus", her fixation with her false self not only made authentic object love unattainable, it also denied her the possibility of self love.

The contempt shown for her parents as she described them in the initial consultation was a defence against her rage and disappointment in them. She would therefore ward off her pain at not being able to idealize them while also defending herself against her narcissistic rage relating to their relational unavailability. Lisa's contempt for her twin also concealed her envy of her twin being her father's favourite as well as her twin's freedom to do as she pleased without a fear of object loss.

Underlying her narcissistic personality style was a very real fear of being abandoned. As a defence against this, she would set up relationships with male admirers while already having a partner, in order to avoid the pain of feeling rejected once a relationship had come to its 'inevitable' end. Not only would she deny her own emotions but she would disown them through intellectualization. In relation to Winnicott's (1965) theory of self, because of her intellectual inclination, her false self and body had become located in her mind, thereby creating a dissociation between her cognitions and her emotions. Winnicott (1965) describes this phenomenon as "the intellectual process becomes the seat of the false self " (Winnicott, 1965, p.134). In this way the false self serves as a measure to hide the real self and the person is exclusively using their intellect to address problems (Winnicott, 1965).

These defence mechanisms served to repress the true self, the original situation and the emotions relating to it. Because she had not internalized an affectionate and empathic self-object, she was unable to be fully aware of her emotional world. Instead, she experienced depression and despair which was a defence against the pain associated with feelings of abandonment.

As a twin, in addition to a relatively symbiotic relationship with her father, I viewed Lisa as being unable to in any way complete the separation-individuation phase (Mahler, 1975) of child development, noting how she struggled with identifying her own sense of self as an adult. Thus her level of autonomy was dependent on the proximity of a significant other and she was excessively reliant on admiration from other people. Her locus of evaluation was therefore external.

Any venture into aspects of her true self elicited guilt and 'unsafe' emotions because it involved separation from the other. Lisa's fear of separation highlighted her insecure/ambivalent attachment style, illustrating that while she yearned for intimacy she was afraid of being abandoned and also engulfed by the other. The specialness of being a part of a twin was exalted in the family. For this reason both her and her sister's separation and individuation needs had not only been neglected but also disencouraged. Lisa had managed to adapt her personality to that of her twin by way of becoming the passive partner to that of her extrovert and aggressive sister.

Having a real twin provides a unique resolution to a sense of belonging in the world as elicited by the twinship transference, however, it is also constricting. The relationship between twins affects the development of the self in a profound manner. If one considers the development of a single child who is creating its identity primarily via its relationship to its mother and subsequently, with its father, it becomes clear that this process is more complicated for a twin. Accordingly, instead of the dyad that occurs with single children, in the case of twins, this relationship becomes a triad. If also taking the father into account, the relationship becomes one that contains six pairs of and four triads, and thus is of even more complex nature (Lewin, 2004).

On the one hand, it is possible that a twinship might help in moments of maternal neglect. Oh the other hand, their rivalries and conflicts complicate their intense closeness and further add to their difficulties in establishing their individual sense of self. Relatedly, it is often found that twins exhibit difficulties in establishing clear ego boundaries and separate sense of self. Thus, the relationship within a twinship can be as much companionable as it can be of narcissistic nature (Lewin, 2004).

In the case of Lisa, the only way she could be in the world was by being symbiotically linked to an identical other, while she as well as her twin sister were 'owned' by their father (Lewin, 2004).

According to DSM-IV (APA, 1994) (as at the current time of therapy), Lisa displayed seven out of the eight criteria associated with dependent personality style. In view of this, I believed that in relationships, her dependent style fluctuated between mild and moderate levels of intensity. She feared dependency, yet also feared being alone. This was a major conflict and in order to manage this she distanced herself from her emotions. By disallowing this form of contact, she remained 'safe'. Her ambivalence around intimacy and dependence illustrated itself within the therapeutic relationship where she remained fearful of revealing deeper emotional states in order to maintain a sense of control. She adapted to me very readily through the use of her false self and I was aware as to how difficult this experience was for her within the therapeutic relationship.

Reformulation of the Initial Clinical Focus

As I became more attuned to the way I experienced her relationally in the room, which was that of dependent yet terrified of relational intimacy, I revised my initial view of her having a dependent personality style. I did not experience her as a dependent person but found that it was a component that was very much expressed in her borderline process.

During our work together, it became evident that her fear of abandonment was a more primary influence than previously experienced. The borderline fear of abandonment was stronger than the narcissistic fear of not being seen. While Lisa's borderline position afforded her a need for contact, the contact was not authentic because her narcissistic defences did not enable her to have real contact with another. A classic borderline personality style script appeared where 'a bad relationship was better than no relationship' (Johnson, 1994). This fitted in with her insecure/ambivalent attachment style where she needed contact around her to maintain a sense of security. There was a fear of separation and her sense of self identified almost completely with the other: 'I am nothing without you' (Johnson, 1994). Thus, I reformulated my initial clinical focus to that of borderline personality character with a narcissistic adaptation, as

her core was that of the borderline process: 'I hate you – please don't leave me' (Johnson, 1994). Her narcissistic adaptation seemed to be a compensatory defence.

In linking with Winnicott's (1965) theory of true self and false self, her borderline personality character was regarded as her real self and her narcissistic adaptation as her false self. Johnson (1994) further added the Symptomatic Self and I believe that this presented itself in her low self esteem and depression. These were the symptoms that compelled her to come for therapy. This formulation is illustrated in the table below.

False Self	**Symptomatic Self**
Narcissistic adaptation	Low self esteem Depression
Real Self	
Borderline process which is repressed	

Table 1. Adapted from Johnson's Three Expressions of the Self

With reference to the above formulation, Lisa's false self was no longer working effectively, resulting in her symptomatic self rising to the fore. Essentially, she engaged in psychological therapy in the hope that I would facilitate the re-establishment of her false self.

Johnson (1994) humanizes the DSM-IV (APA, 1994) personality disorders which is in harmony with my Rogerian value system (see Rogers, 1991) as a Counselling Psychologist, so I look to his character styles to further my understanding of relational and development frameworks. In his therapy model and book 'Character Styles', Stephen M. Johnson (1994) argues that people

usually have one major character styles but in addition can possess several others. The seven character styles Johnson (1994) suggests are

1. Schizoid/avoidant (The Hated Child),
2. Symbiotic withdrawal (The Abandoned Child),
3. Narcissistic (The Used Child),
4. Symbiotic character (The Owned Child),
5. Masochistic (The Defeated Child),
6. Histrionic (The Exploited Child) and
7. Obsessive-compulsive (The Disciplined Child)

In keeping with the client's symbiotic relationships, I identified Lisa as the 'abandoned child' which correlates with borderline personality style, and as the 'owned child', which correlates with narcissistic personality style. This further transmitted to her familial world where her mother was largely unavailable (thus abandoned) and her father masculinized her and her twin as he would have preferred boys (thereby owned). Within this conflictual dynamic, her father 'owned' the twins as objects to show off, and to feed his narcissistic need for sons. Their mother 'abandoned' them due to her uninvolvement, mis- attunement and emotional unavailability.

Using object relations theory, Miller (1981) describes the consequences for children whose narcissistic parents dominate their values and needs at the expense of their children. The child then becomes a narcissistic extension of the parents, resulting in a loss of self rather than autonomous development.

With regards to Johnson's (1994) theory, the owned child is linked to the symbiotic character style. This style arises in parents who need their child, do not let their child separate and often exhibit over-protection resulting in total dependence. Important things such as self-identity, self responsibility and initiative are not fostered but rather suppressed (Johnson, 1994). Thus, as a reaction to a separation attempt form the child, parents react with blocking these attempts as a result of anxiety and sometimes might even punish the child for

that. If the child, on the other hand, expresses sympathy for the parent, this behaviour is overrated (Blumenfeld, 2006).

Lisa's relationship with food was symbolic of her relationship with herself. Her mother intra-psychically undernourished herself, and inter-personally starved the girls of affection and warmth. Thus food and drink beared relational resonance. I found Stern's (1998) concept of the self-regulating other extremely applicable in this sense, given that that there was a huge impairment within her mother. The role of her mother or father as a soothing object was absent. For Lisa, food was symbolic of her relationship with her mother – she needed it functionally for nourishment in the same way that she needed her mother, however, she was also repulsed by her need and for this reason exercised control over it.

Generally, twins tend to have a good sense of self because of their unique capacity to see how they are experienced externally by viewing the impact of their 'image' on another (Lewin, 2004). Lewin states further that problems occur when they become locked into a merger transference or symbiotic entanglement. With Lisa and her twin, their main sources of mirroring were each other and in their mother's 'absence' also used each other as alternative objects. This was problematic as both twins occupied generational sameness, while neither possessed the emotional maturity to adequately process the projections of one another. Lisa and her twin appeared enmeshed in a relational dyad where any form of individuation exposed them to hypersensated states which they are unable to modulate, further increasing their sense of fear. This was the result of lack of maternal containment which in turn, promoted the development of a narcissistic system, both intra-psychically and interpersonally. A narcissistic twinship, hiding forbidden internal states such as jealousy and destructiveness, had been created which protected both twins from an awareness of the need for a parent (Lewin, 2004).

Kohut (1971) created a distinction between normal and pathological twinning processes in the transference. With normal twinship, Kohut refers to the need of

children for likeness which includes a feeling of belonging and being a human being amongst human beings. This 'normal twinning process' is necessary for children in order to develop a feeling of participation (Bishop et al., 2002). Pathological twinning processes on the other hand, are an an attempt to repair early damage or deficits in mirroring. Thus he sees it as essentially adaptive. I agree with Kohut's (1971) idea of pathological twining as endeavouring to heal the damaged self, however, in this case I believed that Lisa came into therapy in order to reinstate the twinship rather than repair her early developmental deficits.

Outline of the Anticipated Direction of the Psychological Therapy

As a twin and given her symbiotic relationships with others, I needed to be aware of transferential dynamics within the therapeutic frame. For this reason her early parental relationships needed to be explored developmentally as well as her relationship with her twin, as these established her core psychic identity. Attachment Theory addresses the impact of early significant relationships on psychological development (Bowlby, 1988). Lisa's parents' relationship with her have critically shaped her identity and levels of self worth. Her ambivalent relationship towards her twin – both wanting a twinship yet resenting it - could have played itself out in the relational dyad between us. My counter- transference feelings are important in this respect they provide a source of invaluable information with respect Lisa's early developmental relationship with her twin. The exploration of her twinship needs and transferences relationally, would gradually pave the way for her to tolerate difference and support separation, while still valuing the twinship.

The true opposite of depression is vitality (Miller, 1981) pertaining to the experience of spontaneous emotions freely and without the constraints of the other. In order to achieve this, Lisa's childhood roots needed to be explored. Thus access to Lisa's true self was only possible once the fear of the emotional world of her early childhood had been relinquished. She could only be free from depression once her self esteem was based on her own authentic needs and

feelings and not on her achievements or possession of desired and perhaps unattainable qualities. This bears resonance with Johnson's (1994) theory of the owned child who has a poor sense of self coupled with a lack of autonomy. By supporting Lisa's self-expression in the therapeutic space, I would assist her in becoming less sensitized to it, while encouraging her discovery and development of her sense of self.

Given Lisa's fragile sense of self, embodied in her fragile process both intra-psychically (internally) and inter-personally (externally), she presented as a very scared child. The work of Bowlby (1988) influenced my relational style with reference to her insecure/ ambivalent attachment style by helping me to modulate and monitor my relational style. It did this so as not to flood her with too much relational contact, and equally so in being not too distant to prevent triggering her abandonment phobia. In this way I can facilitate her learning how to be close and intimate while also managing separation. This can also take the form of me being a soothing other (Stern, 1998) to assist in affect attunement. As a self-regulating other I would also need to be both exciting and stimulating to encourage her inner child to realize self agency. By providing a secure base, I am able to contain and hold the 'child' within the therapeutic frame. Thus the work of Stern (1998) aided my attendance to developmental trauma through a containing, soothing and holding methodology. With reference to Table 1., I would have needed to explore and monitor our relational space in order to encourage her real self to come to the fore, creating a framework for dialogue with the real self.

I need to address Lisa's repressed anger/rage in a relational manner in order to assist her individuation process. The more she was able to access and express it, the more she can separate from her symbiotic ties. According to Winnicott (1965), the father is normally the 'gate-keeper' in assisting with the separation process from the mother. By supporting the integration of her thinking and feeling, I could promote that separation by being the 'gate-keeper' and opening the door to a much bigger world. This would facilitate her separation-individuation process. This resonates with Mahler's (1975) rapprochement

crisis in that Lisa was too frightened to separate and move away, creating much anxiety around becoming intimate. Johnson (1994) echoes this in his theory of the abandoned child where Lisa's pathogenic beliefs would consist of: "no one will want me because I'm so needy, hostile and desperately unhappy". Working through Lisa's resistance bearing a nurturing position, might help elicit and heighten her awareness of some of her underlying fears and needs.

Because borderline personality characters are ruled by emotions (right brain), I would need to stimulate her thinking around these emotions (left brain). For this I turn to the work of Padesky (1995) whose theory indicates that emotional wisdom can be gained through the integration of feeling and thinking. Lisa's emotional reflexes tend to consist of depression and anxiety and main defence mechanisms consist of denial, projection, rationalization and intellectualization. I did not engage in CBT initially, as I believed it would reinforce her insecure attachment style. This might increase her sense of isolation and result in her re-instituting her false self which, in turn, might reduce any meaningful emotional and relational contact. The decision to not initially engage with a CBT approach initially with Lisa presented me with an ethical dilemma for practice. I had to think about whether I focussed more on her depressive symptoms wherein the National Institute for Health and Clinical Excellence (NICE) guidelines recommend a CBT approach, or whether my therapeutic focus should be on her low self esteem, which appeared to be the underlying cause of her depression. This dilemma was something I discussed and reflected on in my clinical supervision and herein we explored how Erskine (1999) fed into my therapeutic model of working. What he distils is empathic attunement, respectful enquiry and psychological involvement. His methodology is synonymous with the interpersonal, experience-near, two-person psychology as a way of changing an individual's intra-psychic world. Whilst CBT strategies might help provide Lisa with some tools to cope with depression, I felt that her symptoms would never completely heal unless a more indepth relational approach was effectively facilitated. This was then discussed with Lisa and I presented the rationale for a more relational approach as well as the costs and benefits of a mostly CBT

approach. Whilst she agreed a relational approach was more challenging she felt that this would be of longer term benefit.

The Therapeutic Process: Part 2

ii) The Middle Stage: Reaching the Affect

During the early sessions I felt that transferentially Lisa was in a twinship relationship with me because she had expected to relate to me in the same way as with her twin sister. She relied on her false self presentation to avoid painful contact with her underlying true feelings. On a deeper level, her archaic memories of trauma and anger were triggered. These related to her ambivalent relationship with her sister where Lisa was always the one deemed 'inferior'. I found that through being an accommodating and accepting other, and not repeating the reactive responses she expected (e.g. not laughing at or with her as she hid her pain), as well as maintaining a consistent style of engagement, her need for control over me subsided and this particular transference gradually dissolved. This paved the way for a "corrective emotional experience" (Alexander, 1961) whereby, further along in the therapy, Lisa became more able to present her painful emotions to me without constantly needing to hide that part of herself away.

Interestingly, a different transference dynamic slowly appeared. Lisa began to relate to me as one of her critical parents.

T1: is it difficult to stay with feeling upset?
C1: yes…feels bad when I cry-I don't want to cry in front of you
T2: how do you imagine I am when you do?
C2: you'd think I'm silly
T3: that's quite a powerful judgement

A theme for me during this period centred around creating an awareness of her emotions with me in the room. Gradually and with much resistance on her part, I began to help her to experience her affect, identify it, own it and try to

understand it and she came to take up more space in the room. As I invited her into more process work, I sensed how challenging she found it. Another short excerpt of a session, twelve months into our working relationship together, can be found below.

T1: .when you say that you feel as though you're on the edge – teetering on the edge, what will happen if you fall?
C1: ....I'll just fall into depression
T2: .hmm and what will that be like?....can you describe what its like…when you fall into depression?
C2: .....I suppose you just want to cry all the time and things go black (client starts crying)
T3: .sounds incredibly painful, I can see how painful it is for you
C3: .and also you just become really self-centred…

While asking her to describe her depression in the above example, I became aware that her inner child was so angry that she was scared. In psychoanalytic theory depression is seen as inverted anger (Miller, 1981). I tried to deepen the process by contacting the distressed child. In this way, I become the self-regulating other (Stern, 1998) as can be seen in T3, however, this intervention was not successful as she did not internalize me an empathetic other or allow me to contain her. Here she illustrated her ambivalent attachment style. Lisa had poor self-regulatory mechanisms to deal with affective states. I tried to contain the 'child' emotionally by creating a holding environment. By attuning to the client and mirroring and reflecting back her emotional states, these reparative interventions assisted in increasing her awareness of being seen because later on in the same session she talked about her parents only seeing in her what they had wished to see. One major theme for her was not being seen as she really is and I believed that it would be healing for her to be aware that she was being seen by me.

Because of a rupture within herself and her own sense of her emotional states, Lisa used the third person in C2 and C3 as a dissociative defence mechanism in

order to disconnect from her painful affect. There was a dislocation here as she was ambivalent about her emotional state. In this way she distanced herself from her feelings which meant that she could not own them. I also saw this as a way of disconnecting herself from a relationship with me. I chose not to challenge this as she was already engaged in a painful process. Because of her ambivalent and insecure attachment style, I did not feel it appropriate to flood her with even more emotional material at that point.

I kept monitoring that I was a consistent object in order to provide repair for the troubled child. In an attempt to bracket off of the narrative and allow me to be more fully present with her, I tried to make contact with her underlying feelings which is illustrated by the following excerpt from another session:

T1: .so you'll be too much for everyone
C1: .hmm
T2: .and they'll leave you as well
C2: .yeah….(pause….she looks down to the floor)
T3: .I feel as though you're – you'd be wanting to say to yourself 'oh you need to sort this out – you need to get over yourself – you need to put on a smiley face – you need to be back to normal again as soon as possible'….and I can imagine one of your parents saying that to you…when you're being in a mood or upset…or sad…who would be saying that to you?
C3: …my dad….
T4: so you didn't even feel entitled to be angry…and sad and depressed…about what was happening to you….what was that like….for a little girl?
C4: hmm…I just didn't feel taken notice of …
T5: you had to try and soothe yourself…
C5: hmm
T6: no-one came and comforted you…no-one helped make it better…
C6: no….no they just mocked you…(she looks down to the floor)

As I tried to decipher what she was unconsciously communicating to me, I managed to elicit the central themes to her life's fears – those of abandonment,

rejection and feeling that she is too much for everyone to cope with. I also felt that Lisa was distancing herself from me by engaging in an internal self attack. Following these interventions in T1 and T2 I wondered that whether through her body language and lack of eye contact, she was showing me that she was blaming herself for being abandoned. We had on occasion addressed this in previous sessions so I felt I could recognise this as it was happening in the session. I had a solid working alliance with her at this point so I was able to challenge her there. I went on to challenge her self critical inner voice, her negative automatic thinking, and in particular, her all or nothing thinking style. Internally and intrapsychically she used to put her feelings aside and make herself invisible, and therefore this was her external experience too. In C3 she indicated to me that her dad was an internalized persecutory object.

The next segment illustrates an emergent theme in our work together, Lisa's very painful awareness of her process of individuation and separation. She speeds up early in this section and there was a change of pace, coupled with a change in emotion and emotional pace. She revealed here that her father was not a constant object. When she became a young woman she felt that he disconnected from her and there had been a huge rupture. Her perception was that he would have preferred to have had boys. Her mother was an emotionally absent object. The client (child) did not appear to have a constant object where both good and bad could be held together with some kind of object constancy. My interventions here were designed to try to help her to separate by encouraging her to express disallowed affective states, such as sadness and anger. Often during our sessions, Lisa used to begin her painful story with 'its quite funny…'. I had become aware that the adult in her was trying to entice me into what was done to the child. I was now attuned to this and listened out for the underlying pain she was trying to shut out. I experienced a strong counter-transference pull to be amused with her. She showed me that she was frightened of taking her feelings seriously. Her humour was used as a defence mechanism, specifically that of reaction formation, and her laughter was self-depreciating.

T1: so you were quite angry that you were put in that position yesterday

C1: yeah…we all make out that everything's fine but then the next minute he (her father) won't talk to me

T2: and it sounds like again you're being put in a position where you're quite powerless and helpless

C2: hmm

T3: and you're not in control…and you're not able to articulate any of that

C3: hmm…..they got loads of photos out to show Lee (her boyfriend)..he wanted to see some – kind of childhood photos of me….and it suddenly struck – we looked through quite a few actually….I found in every photo, there was kind of – either I was with my sister – or obviously we were dressed in the same clothes…or erm…just…got obviously – they were not allowed to take one – if they took a photo of Sarah, they'd have to take a photo of me straight afterwards so they were always alternated

T4: hmm

C4: which is how we were always always together…there was no…kind of…escape there at all …we were always with each other

T5: hmm…that sounds as though it was pretty painful looking at that…sounds like you couldn't see yourself

C5: even to the point I mean I know twins look really alike but I suppose just – again how we're taken on different…roles within… so every photo that we've sort of looked moody, everyone would assume that's my sister

T6: hmm

C6: and then they're really surprised when they find out that's me – it was like she was only – she was only allowed to be the moody one and I was like the angelic one

While I pick up the theme of anger in the beginning of this segment, she acknowledged this feeling, but I was aware that her anger was not in the room among us. This was also typical of our sessions where while Lisa was able to acknowledge a 'negative' emotion such as anger, she was not able to fully access it in the room with me. In this segment, Lisa provided a brief glimpse that she came second in relation to her twin. Their twinship needs such as wanting to belong and being the same in the world, had been met by each other. Here the trauma of the twinship – their own individual uniqueness – had been lost in

symbiosis, indicating a lack of a sense of self. She has not individuated and her sense of identity was enmeshed with that of her twin. The two sisters had become split: Lisa was the good, angelic one and her sister was the bad, moody one. However, there appears to be a turnaround as Lisa became the bad object because of this, that is, her sister is likened to her father and Lisa was not. Her real feeling, that is, her hidden rage, anxiety, competitiveness was disallowed and therefore repressed.

During this stage of work with Lisa, I found that through trusting my counter-transference feelings in the room with her, I could use my counter-transference to help her make contact with her emotions. An example can be seen below:

T1: hmm….it sounds like a really scary place…what are your worst fears?
C1: …erm…don't know what it is but I'm feeling a bit mental

Lisa then spoke at length about the difficulties she experienced over the previous weekend, in a superficial manner. I was able to recognise this as her 'wall of words' and intervened in the following relational manner:

T2: hmm and I'm sitting here feeling really impacted by what you said, when you said that
you feel as though you were going mental

This intervention brought her back to the here and now thereby increasing her awareness of her feelings in the moment. While she had not communicated this to me verbally, I experienced counter-transferentially, her intense fears and anxieties around feeling 'mental'. Here, projective identification was used as a form of affective communication (Casement, 1985), in that Lisa projected her unconscious need of wanting to feel contained, and then proceeds into a long dialogue in an attempt to contain herself. As I am open to the impact of her interactional behaviour, an affective communication had been achieved. I viewed her resistance as a form of self protection indicating that she was not

used to risking being emotionally honest in relationships, for fear of being rejected or abandoned, as had been her early experience. (Hycner, 1991)

iii) Current Stage: Making Relational Contact

During the middle stage of our work together I was made very aware of Lisa's process of relational contact which was consistent with her ambivalent attachment style. While the earlier stage focussed on reaching her affective states, this current stage now focused on making relational contact with each other. This was a very challenging stage for me as, given my ambivalent attachment style, I also needed to be aware of the ways in which I may prevent a contactful encounter. I have become more aware of Lisa's 'wall of words' where she speeds up her pace in a long narrative and the way that I struggle to connect with her during these times. At times I have felt defeated by Lisa's onslaught of narrative and found it difficult to be fully present with her in the room. I found that I had to address what prevented me from holding my power and authority in relationship with her and found that part of this led back to my counter-transferential feelings in my earliest encounter with her. Both of us were in a parallel process where we 'had to get it right'. The other part was about increasing my confidence as an integrative counselling psychologist whilst also revisiting earlier issues such as a fear of being 'incompetent', 'redundant' and 'ineffective'. The process of engaging with and accepting these parts have been crucial to my development as a counselling psychologist. Over time these fears have diminished and I am aware that I have become more open to a relational encounter. An example of this can be seen in an excerpt of a session below.

T1: I wonder if there's a part of you in here that holds yourself back by not bringing everything…and all of you…for whichever reason…for feeling guilty, for feeling that you might be burdening me, for feeling that you need to protect me

C1: yeah probably just emotions…I prefer looking at things at a critical level or an analytical level….rather than just talking about emotions

T2: so it's easier for you to come here and have me take care of you when you're …at a more cognitive level

C2: hmm

T3: what would be your fears about having me take care of you at an emotional level

C3: cos I don't know you (she speaks very softly…and her face goes red briefly)

(Silence)

T4: you're also telling me that you're finding it difficult to trust me…with your emotions

C4:….erm…hmm

T5: can you tell me about what you might be afraid of?

C5: ….. er…I don't know, like you say I prefer to be more cognitive…and if I was to become more emotional….I don't know…maybe part of it is because you tape sessions and like obviously…you review things and things like that…

Through working relationally, I provided Lisa with an opportunity to elicit her honest feelings about our therapeutic relationship. I felt that she was uncomfortable working relationally with me because she was unable to reinstate her false self. As a twin, she was familiar with adapting to another and does so in all her relationships, to the extent that she took her cue in terms of how to be, directly from another. She knew too little about me in order to successfully adapt to her false self, however, I was aware that she had transference feelings about me, as can be seen in C3. My counter-transferential feelings at the time were that of anger at being dismissed, while also diminishing the value of our work together. I recognised her insecure-ambivalent attachment pattern within the frame and her inability to trust any 'good' in another.

I learnt that the tools facilitating my being more relationally present with Lisa were working in the here and now, inviting her comments on the relationship between us and by naming the process as I saw it. Through this I was able to see that relational interventions were not only about meeting in the moment, but in staying there, in the present with the client. We had since re-contracted to work more in this manner, so whenever I experienced her 'wall of words', instead of trying to figure it out on my own I would name my experience of her which invited her to process it with me. I was also aware that she had not experienced a level of containment in which she has felt safe enough to express all who she

was and realised that I could offer the opportunity to facilitate a corrective emotional experience through the use of relational contact, thus creating an environment where both of us can exist, equally. Over time, Lisa became more present in the room and less afraid of experiencing her emotions with me. We agreed to end recording of the sessions and this appeared to facilitate more openness on her part. She gradually fed back that she had become less critical of herself within her work and social environments.

Outcome of Therapy and Prognosis

Lisa's self esteem had improved throughout our work together and she became more confident about working through some further underlying issues. At this point in therapy, Lisa began to talk about experiencing unbearable internal emotional states, such as anxiety, which occurred both inside and outside the therapeutic encounter. This coincided with a new relationship she had begun with a man, which had triggered all of her defences and her early anxieties had re-surfaced. During these times, she found that she became trapped in feelings of anxiety about being rejected and abandoned by her partner. In order to relieve her from this state of intra-psychic paralysis, I attended to her symptoms through the use of CBT techniques, in addition to working relationally. This was a two-phased approach whereby I assisted Lisa initially in understanding and working through her symptomatology (anxiety symptoms) and then explored and linked this with the underlying causes. I provided Lisa with some psychoeducation about anxiety using a developmental perspective. Helping her to understand some of the psychology around fearful states provided her with an increased sense of trust in the therapeutic relationship and the treatment model used. She agreed to keep a thought record of situations she found distressing and diligently recorded and identified her most powerful thoughts. She was willing to explore these at greater depth during our sessions. This process allowed her to understand the links between her thoughts, feelings, behaviours and physiological symptoms of anxiety. By helping her to learn how to challenge her negative automatic and anxiety-provoking thoughts, she gradually learnt how to self-soothe, as opposed to feeling overwhelmed, especially outside of

therapy when she felt uncontained. We explored her anxious responses and contextualised these in terms of an overestimation of disaster in the form of catastrophic thoughts such as, "he's never going to call me again and I'll be alone forever". This was accompanied by an underestimation of her ability to cope, which was linked to her low self esteem and beliefs around not being good enough. In order to engender her belief in her ability to cope, Lisa was encouraged to describe her worse case scenarios and rate the probability and possibility of these occurring. Coping strategies would then be put in place.

I believed that Lisa would benefit from longer term developmental trauma and repair work through relational contact. She needed to further establish her own boundaried identity with a more concrete sense of self and separateness, and then mourn the loss of the twinship. I viewed our therapeutic relationship becoming more honest and challenging for both of us as we explored the impact we had on one another within the therapeutic frame. Lisa agreed to continue with therapy in the longer term and currently attends on a fortnightly basis.

Concluding Remarks

This client played a significant role in my practice as a counselling psychologist using a psychodynamic psychotherapeutic approach. Overall, I viewed my learning in the context of how to establish a good enough therapeutic relationship. More specifically, I explored my challenge in terms of how to develop a therapeutic relationship when a client appears resistant to the encounter or perceives the relationship as threatening. The three stages I outlined as part of the therapeutic process with the client also mirror my developmental process as a practitioner. In this way I fully began to understand Stern's (1998) concept of the therapists' attunement to the client's process.

Accordingly, in the first stage, which was about building a therapeutic relationship, I experienced a variety of counter-transferential feelings. During the sessions these mainly revolved around a pressure to perform and to be the perfect therapist who always provides the correct responses fairly quickly. Following the sessions, I perceived counter-transferential feelings of anger,

confusion and competition. In this stage, it was most challenging to continue building the therapeutic alliance. After consultation with my supervisor, I became aware that I had to address these counter-transferential feelings as well as both her and my ambivalent attachment styles. Thus, in order to accomplish building a good enough therapeutic relationship, I learned to take the role of an accommodating and accepting other, to not give my client the expected negative answers (such as laughing with her as a response to her attempts to hide her pain) and to maintain a consistent style of engagement. As a result, I observed a decrease in her need to control and the dissolving of the general twinship transference that persisted throughout the first stage.

In the middle stage, where the goal was to reach the client's affect, our transference dynamic changed from a twinship to a critical parent one. In order to help my client experience her affect, I learned to mirror and reflect back her emotional states. This also helped her to experience being seen. Through my encouraging her to express emotions she was perhaps not allowed to express as a child, she was able to advance in her process of individual and separation. In this stage, I particularly learned that through trusting my counter-transference feelings, I could make use of them to inform and connect with my client's emotions. In this way, I became aware of her process of relational contact.

This relational contact is also the subject matter of the current stage of our therapy. In this stage, I was especially aware of my ambivalent attachment style. I learned to address what prevented me from holding my power and authority in the relationship. It became evident to me how important it is to increase my confidence as a counselling psychologist and that working with the 'here and now' helps me with being more relationally present with my client. IN that way, I was able to offer the opportunity to facilitate a corrective emotional experience through the use of relational contact.

In summary, I learnt how to match the client's energy and address the client's needs by listening to subtle changes in voice, noticing the tears in her eyes, sensing the suppression of emotions and essentially being a mirror to non-verbal self

expressions. In the process of becoming more robust I also had to honour the enormous impact the client has on the therapist within the therapeutic relationship and the power of this to effect change.

I often reflected on my psychotherapeutic approach throughout my work with this client and wondered about whether a purist CBT approach might have been more beneficial for her. Had I used a CBT model of practice from the outset, I think the client might have benefitted from acquiring a more immediate skill set and this perhaps would have supported the relational work to greater extent. With hindsight I think I might have wanted to attend to her depressive symptoms during our early work together using a CBT approach in order for her to feel more empowered and support her need to feel in control in these sessions.

Managing Resistance: What I could have done differently

Lisa initially tended to avoid working through and processing her emotions with me. I pre-assumed that the use of a psychodynamic psychotherapeutic approach was the best form of treatment. On reflection I realise that during these early stages, I could have altered my mode of relating towards cognitively-based interventions, rather than the perceived emotionally-threatening ones. This might have increased her confidence in engaging with me, thereby assisting us in building a stronger therapeutic alliance. As I viewed her as being 'undernourished' by her mother, I could have 'fed' her more with reference to containing her silences and providing some psychoeducation about her symptoms, explaining how these could be formulated. Alternatively, I could have provided a better rationale for the treatment approach I used, within a framework that she understood and therefore was containing for her.

As described in the section about resistance, Messer (2002) advocates empathizing with the client as a good approach for therapists to overcome these resistance challenges, in order for them to be perceived as an ally and not as an opponent. Furthermore, there is a trend towards the application of motivational enhancement interventions before the start of psychotherapy in order to foster

motivation and heighten willingness for change in clients (Ryan et al., 2010). Of these interventions, one popular method is motivational interviewing (MI). The rationale behind MI, which comes from a client-centred approach and was originally applied in the domain of addictions, is the enhancement of the clients' inner volition to change (Ryan et al., 2010). Some of the key concepts of MI are mentioned by Westra (2012): "empathic reflection; creating an atmosphere of discovery and experimentation; drawing on and evoking the client's ideas and resources in pursuing change; supporting client autonomy while contributing therapist ideas or expertise on change; continually being sensitive to the client's receptivity to change efforts, level of engagement, and any re-emergent ambivalence; rolling with resistance as needed to help process such fluctuations in motivation for change" (Westra, 2012, p.231-232).

Following the experience I gained from my relational work with the client in the current case study, and after having faced difficulties regarding resistance in therapy, I consider using MI as a pre-treatment option during the beginning stage of working with future clients who exhibit strong tendencies towards resistance. Indeed, it is a model of working that I generally use in my clinical work with clients in the field of addictions throughout the therapeutic encounter. Whilst motivational methods have not been generalised to the treatment of prevalent mental health problems such as anxiety and depression, it is useful to view it as an adjunct to traditional therapeutic models for use with clients resistant to and significantly ambivalent about change-based techniques for managing or alleviating symptoms.

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Section D: Critical Literal Review:

The Viability of Online Therapy for the Treatment of Eating Disorders:

A Review of the Current Literature.

The Viability of Online Therapy for the Treatment of Eating Disorders: A Review of the Current Literature.

Introduction

According to the National Association of Anorexia and Associated Disorders (ANAD), approximately 1%, or one out of every hundred, young women between the ages of ten and twenty have anorexia. Half of those will develop bulimia and, at about 4%, the numbers of bulimia sufferers are even more shocking. Furthermore, for some, "living with" an eating disorder is somewhat of a misnomer because ANAD research has shown that, in the absence of treatment, up to 20% of these individuals will die.

This critical literature review aims to evaluate the viability of online therapy for the treatment of eating disorders. Whilst dependent on many factors, the genesis of this form of therapy for this particular client group, centred on two sets of statistics: 1) the number and demographics of those suffering from anorexia nervosa, bulimia nervosa and binge eating disorder; and 2) the percentage of those populations that frequent the Internet. My interest in this area stems from my own experiences of coordinating a specific online treatment for bulimia suffers within an National Health Service (NHS) eating disorder service. Given the current government's drive to increase clients' access to psychological therapies, it makes sense to incorporate the availability and efficacy of online therapies in this regard.

With regard to the internet-specific therapy, there can be no doubt that, some time ago, we entered an electronic age, when the advent of the worldwide web made information gathering, learning and communication, all with a mere click of a mouse, an everyday occurrence. While this phenomenon affects individuals of nearly all ages, it is particularly true of what has been called the M2 generation, those between the ages of 8 and 18 (Rideout, Foehr, & Roberts, 2010). In fact, Prensky (2001) called adolescents 'digital natives' who have grown up surrounded by and making constant use of digital technology to learn

and communicate. However, it should be kept in mind that frequent use of the Internet is not limited to that young demographic. Lee Rainie (2010), reporting for the Pew Research Internet Project, noted that 74% of American adults (ages 18 and older) used the Internet on a regular or even daily basis. According to the United Kingdom's Office for National Statistics, during the first quarter of 2013, 43.5 million adults (86%) in the UK were regular Internet visitors.

The advent of various forms of online therapy represented a convergence of the above factors. This caused mental health professionals to ask whether more people could be reached with a greater degree of effectiveness through online as opposed to traditional, face-to-face therapy. Rochlen, Zack and Speyer (2004) discussed this integration of technology and psychotherapy, defining online therapy as "any type of professional therapeutic interaction that makes use of the Internet to connect qualified mental health professionals and their clients" (Rochlen et al., 2004, p. 270).

Rochlen et al. (2004) outlined some of the benefits of online therapy, among them convenience and increased access, particularly for those with limited mobility, help for those with limited options for mental health services and the avoidance of feelings of stigmatization that some clients may feel when seeking those services. Rochlen et al. (2004) also mentioned the high degree of both intimacy and honest exchange to be found in relatively anonymous, text-based self-disclosure. Another benefit is the therapist's ability to easily and quickly supply clients with information from the abundance of such material available online, rather than being limited to the printed resources from his or her clinical premises.

Despite the myriad of benefits, there are also challenges involved in online therapeutic interaction: the inability to witness non-verbal behaviours or to quickly clarify one's statements; anxiety as to the result of any delay in response times; discomfort felt by those who lack expertise in written communication; and the sometimes impossible task of swift crisis intervention in the event of the client's evidencing suicidal or homicidal intentions (Rochlen et al., 2004). As a

means of mitigating these challenges, Rochlen et al. (2004) suggested that clients be carefully screened and that therapists only work with those who will benefit from this service. Barak (1999) also discussed these challenges and he observed that care must be taken in educating young and possibly naïve Internet users, to be selective about web sources so that they receive correct information from fully qualified professionals and avoid sources that may be biased or simply outdated.

Doyle, Hopf and Franko (2011) reiterated these benefits, adding that the multimedia approach available to online clients encourages active participation while such internet-based programs can be designed to best address a variety of learning styles and needs. Further, they noted that the high degree of shame sometimes felt by those with eating disorders is greatly mitigated by the anonymity of internet interactions. This factor alone can encourage some clients to seek the treatment they so badly need and otherwise, may never have received. This idea was echoed by Kündiger, Wesemann, Verhey, and Grunwald (2010), who observed that while individuals suffering from an eating disorder, particularly anorexia nervosa, frequently lack motivation to seek the assistance that could save their lives. They believed the lack of exposure found in online counselling could make it an attractive and viable alternative to face-to-face therapy. Whilst these authors propose legitimate benefits of online therapies, an important consideration around motivation remains. Given that many online therapy programmes are largely self-directed, the efficacy may be questionable for individuals with low levels of motivation, in particular those suffering from eating disorders at the severe end of the scale.

In order to situate the reader into what the components of an online modality might entail, Ritterband et al. (2009) outlined the specific steps involved in an internet intervention program, that would effectively modify behaviours and reduce symptoms of eating disorders. Influenced by their environment, the client makes use of the website. Their adherence is affected by both the support they receive and the characteristics of that website. Through enhanced knowledge and motivation, targeted behaviours then change, thus impacting

physiology and improving symptoms. The idea is that treatment maintenance allows these gains to be retained over time. Whilst Ritterbrand et al. (2009) provide a clear outline for a successful online programme, I am mindful that these interventions clearly mirror face-to-face treatment. Literature on therapeutic outcomes posit therapeutic change within the context of a therapeutic relationship and thus, it is of interest to view 'with whom' or 'how' this relationship is organised within an online medium. Whilst many online interventions propagate effective treatment for clients suffering from eating disorders, a large proportion of adherence to treatment, as in face-too-face therapy, would be the due to client characteristics. This raises an enquiry into the nature of clients who prefer communicating online therapeutically and whether there are ways of enhancing the psychotherapeutic benefits in this regard.

The purpose of this review is to examine the premise of online therapy – what the literature reveals about the forms taken by online therapy, what works and what does not and which areas are in need of further study. The following sections will discuss the programs that are either currently available or that have been initiated and tested in the fairly recent past, as well as any shortfalls of those programs and the suggestions that have been made to address those shortfalls. This review then concludes with a summary and recommendations for counselling psychologists interested in using this modality in the treatment of clients suffering from eating disorders.

The "Student Bodies" Program

In 1998, Winzelberg et al. recognized the importance of providing university-age women with a self-directed, relatively inexpensive and easily disseminated body image program based on cognitive-behavioural therapy principles. In response, they developed a CD-ROM and an email discussion group. The program worked well, with the intervention group evidencing an increase in body satisfaction, a decreased preoccupation with weight and less frequent incidences of disordered eating behaviours. Building on that success, Winzelberg et al. (2000) revised

"Student Bodies" so that it could be available as an Internet-delivered computer-assisted health education (CAHE) program and have a greater focus on changes in women's perception of their body image. The structured, 8-week intervention initiates with a discussion of the development and the effects of eating disorders. It then progresses to include the cultural factors and media influences that determine what is considered to be beautiful, in addition to cognitive-behavioural strategies for improving body satisfaction. The software is interactive and comprises text, audio and video components as well as an online journal. Included are exercises to help change participant behaviours, mandatory and optional assignments, a requirement to post weekly messages on the message board and to respond to at least one other message.

Winzelberg et al. (2000) were cautiously optimistic about the results of the program, noting that the greatest improvements were seen in follow-up assessments made post intervention. There were problems with participant compliance, with less than 66% completing the program. Although most contributed to the discussion group, they reported only a moderate degree of social support from the group. The researchers noted that although their results were encouraging, additional research was needed to measure the long-term effects of the program and its efficacy with other populations.

Celio et al. (2000) also worked with a university-age population in a study that compared the results of the "Student Bodies" program with "Body Traps". "Body Traps" is a classroom-delivered psychoeducation intervention aimed at the reduction of body dissatisfaction and disordered eating behaviours or attitudes. To correct the compliance problems seen in Winzelberg et al.'s (2000) study, the incentive of a pass/fail grade based on program adherence was offered to participants. In addition, the program was made more user-friendly on the basis of feedback from participants.

"Body Traps" comprised a series of lectures on topics such as the media's influence on body image, physical disabilities, childhood and adolescent development, as well as readings, group discussions and a short reflection paper

discussing personal reactions and feelings. The "Student Bodies" Internet program incorporated exercises based on cognitive-behavioural therapy, information about binge eating, readings and interventions from Davis et al.'s (1989) "Road to Recovery" program. Participants were required to log into a password-protected website, complete an online progress report and receive feedback about their level of effort and improvement. They were also given readings and exercises such as observing and comparing 'real' women to those seen in fashion magazines. Journaling was mandatory and aimed at allowing participants to make note of situations that triggered negative body images and, in time, confront their dysfunctional beliefs about themselves.

This study revealed that while the "Student Bodies" program was effective in its goal of reducing body image dissatisfaction as well as attitudes and behaviours associated with eating disorders, the classroom program was not. In particular, in this iteration of "Student Bodies", participants' increased use of the electronic message board has a positive relationship with increased feelings of social support. The researchers found that this supported the idea that interaction via the Internet, supplemented by brief face-to-face contact, could be more effective than traditional therapy in improving body image and reducing the disordered attitudes and behaviours found in those with eating disorders (Celio et al., 2000). It follows that for the student population, many of whom organise their lives around online activity whilst also involved in solitary activities, online therapy provides a familiar and non-intrusive medium for addressing body-image concerns. Thus a view may be that online interventions are more normalised to the current generation of students, in search of immediate resources and easily accessible services.

Of course, concerns about body image and the emergence of eating disorders are not limited to university-age individuals. Children and younger adolescents are also at risk for such problems. Further, at that age, they can be heavily influenced by their families, whose teasing, critiques, eating patterns, and reinforcement of what has been called the 'thin body ideals' can increase or even predict the onset of bulimia symptoms (Stice et al., cited by Brown, Winzelberg, Abascal, & Taylor,

2004). That being the case, when Brown et al. (2004) evaluated the effectiveness of the "Student Bodies" program when incorporated into a high school curriculum with 152 tenth grade girls, they included 69 of their parents. As in other studies, students were provided with information concerning the risks of eating disorders, with each session focused on improving body image. Participants' attitudes and behaviours in terms of weight and shape were assessed, and documentary style audio and video, personalized feedback, self-quizzes, self-monitoring, weekly reading and writing assignments, as well as involvement in the Internet discussion group, served as the key features of the program. Parents were encouraged to log on and explore the material as well as to take part in online forums in which they could ask questions, join discussions or just interact with the other parents. An important part of the parents' program involved encouraging them to acknowledge their children's variations in weight and shape, recognize signs of unhealthy eating behaviours, determine if dieting was indeed necessary for their daughters, and develop supportive communication skills with which they could discuss weight- and shape-related issues with them (Brown et al., 2004).

Surprisingly, unlike studies that showed a considerable degree of success when utilizing the "Student Bodies" program, Brown et al. (2004) found that in the student sample, as measured by the Eating Disorder Examination – Questionnaire (EDE-Q), while improvements in both knowledge and the reduction of specific eating disordered attitudes, behaviours or symptoms were seen during the treatment phase, those results were not maintained at follow-up. The researchers posited that, by 10th grade, the degree to which negative body image and eating attitudes were ingrained and change-resistant made it necessary to utilize longer and more intensive interventions. It may also be that this group would require different or perhaps more individually tailored interventions prior to follow-up. The parents' intervention was more effective, with the intervention group evidencing significant decreases in critical attitudes toward others' weight, shape or appearance; 86% of the parents indicated that they had initiated dialogues with their daughters concerning eating disorders and related issues. However, the changes experienced by parents did not affect

their daughters' scores (Brown et al., 2004). A case of too little, too late? This research does, however, identify that there seems to be a crucial period in young girls' development of their body-image and that the "Student Bodies" program could possibly be targeted to reach younger children who have not yet solidified their attitudes and behaviours.

Using a modified version of the "Student Bodies" program, SB2-BED (binge eating disorder), Jones et al. (2008) also examined the efficacy of an internet-based weight management program aimed at reducing both binge eating and overeating and preventing weight gain in a population of high school students whose mean age was 15. Although participants had significantly lower body mass index scores when measured from baseline to follow-up assessments, and reported far fewer episodes of binge eating, their level of adherence to the program was low. While the researchers noted that there did not seem to be a relationship between adherence and outcomes, they posited that as the intervention was self-directed and, at 16 weeks, rather lengthy, both the lack of structure and duration may have contributed to the problem with adherence (Jones et al., 2008). They also addressed a question frequently raised among professionals in this field, i.e., does the increased attention to weight that is an inevitable result of a weight loss program increase the risk of eating disorders? According to their findings, Jones et al. concluded that if, as in their study, the components of eating disorder prevention programs are integrated into a weight management program, the risk of the program precipitating eating disorders is minimal and may even be reduced. This is an interesting concept because many clients report weight loss as a trigger to developing eating disorders. Should eating disorder relevant and preventative material be included in weight loss programmes, it may indeed foster healthier attitudes toward individuals' perceptions of their body-image.

With regards to this discussion of the "Student Bodies" program, it is important to note that while most of the literature has extolled its virtues, some researchers have mentioned reservations as to its use with all populations and all conditions. Zabinski et al. (2001), while conceding that the use of such

programs in general, and the Student Bodies program in particular, provides an easily and inexpensively disseminated intervention that allows for improvement in unhealthy attitudes toward weight and body shape, they may better serve as stepping stones to more traditional, long-term therapies that could be more effective, especially for individuals experiencing severe symptomology. It may be that the more traditional therapies are also accessible with an online intervention, if this is the client's preferred medium.

"Getting Better Byte by Byte"

Robinson and Serfaty (2003) have conducted several studies of the acceptability, safety and efficacy of the email delivery of therapy. The first two, conducted in 2001 and in 2003, showed that email recruitment and treatment of those diagnosed with bulimia nervosa or related disorders were both useful and effective. They cautioned, however, that while therapists' emails could convey warmth and empathy, non-verbally transmitted cues such as demeanour were lost in that medium. In addition, there was concern about the security of emails, and their research ethics committee raised some questions about the therapists' inability to intervene via email in crisis situations (Robinson & Serfaty, 2001, 2003). This indicates that specific training in the use of online therapy for therapists is particularly advantageous.

In Robinson and Serfaty's 2008 intervention, titled "Getting Better Byte by Byte," the researchers began by emailing questionnaires concerning possible eating disorders to approximately 20,000 students and staff at the University of London. There were 110 respondents and these were randomly assigned to one of three groups: receive either bulimia therapy via email (eCBT), engage in twice weekly; self-directed writing (SDW) about their problems with eating disorders and then send those responses to the assigned therapist; or be placed on a waiting list. They found that there was little difference between the eBT and SDW groups. Both reduced the number of participants meeting eating disorder criteria as established by the DSM-IV, to a degree significantly higher than seen in the group placed on the waiting list. As the majority of students and staff who

participated had never been diagnosed with bulimia nervosa, much less received treatment, Robinson and Serfaty (2008) found the study's result to be very encouraging, particularly in terms of recruiting and providing treatment to a previously undiagnosed and untreated population.

The "European SALUT" program

In 2011, Carrard et al. evaluated and reported on the results of a study that ran from 2001 to 2004 in which researchers from Switzerland, Spain, Sweden, and Germany involved in the "European SALUT" project tested their newly designed web-based, self-treatment program for bulimia nervosa (BN). Participants included 127 females with a mean age of 24.7 years who were either BN or subthreshold BN patients. The program lasted for 4 months with a 2 month follow-up (Carrard et al., 2011).

Guidance was provided via mandatory weekly email contact with a psychiatrist or psychologist who served as a 'coach.' The program comprised seven modules based on classical cognitive behavioural theory: 1) Prepare for change; 2) Observe yourself; 3) Change your behaviour; 4) Change the way you think; 5) Solve your problems; 6) Assert yourself; and 7) Prevent relapse. In each module, a fictitious student who had been diagnosed with BN ("Sarah") provided information about the exercises. Coaches had access to both diaries and exercises, which allowed them to tailor their advice to best suit each participant. As a result of the program, an average of 40% of the participants showed clinical improvement in their symptoms and 52% had fewer episodes of bingeing and self-induced vomiting, with no increase in excessive physical activity. By the end of the program, 23% were symptom-free (Carrard et al., 2011).

While, in many ways, this study showed that an online program could be a successful option for the treatment of BN, it did point to problems seen in other, similar internet treatment modalities, specifically, dropout rates and lack of participant compliance. Carrard et al. (2011) cited Wilson (1996) as noting that a tendency to drop treatment is common among eating disorder patients. With a

dropout rate of 25.2%, this was certainly shown to be true by the SALUT program. However, compliance was also a problem, with less than half of participants completing all seven of the program modules; in fact, the authors felt that rather than insisting that all participants complete all aspects of the program, a more individualized approach that addressed each patient's specific needs might be more appropriate. Dropout rates, however, may also have been related to the chronicity of patients' illness and the length of time they suffered from their eating disorder. Given that eating disorders typically develop in adolescence and the mean age of the participants in this study were 24, the intervention whether online or face-to-face, may not have occurred early enough. With this in mind, I would agree with the authors that an approach tailored to the individual might have been more effective in reducing the dropout rate, as well as compliance to treatment.

iCBT: "Overcoming Bulimia Online"

Sánchez-Ortiz et al. (2010) completed what was at that time the first research study of computer-based CBT treatment for bulimic disorders that incorporated guidance by a clinician. iCBT: "Overcoming Bulimia Online" was first developed by Williams, Aubin, Cottrell, and Harkin in 1998 and is a cognitive-behavioural interactive multimedia treatment program that combines various cognitive-behavioural, motivational and educational strategies spread over eight sessions. In the case of this study, participants also received support and encouragement via email from two therapists experienced in the treatment of eating disorders. Support from the therapists was focused on the first 3 months of the study and then tailed off during follow-up. The results for the intervention group were good, with rates of abstinence from bulimic behaviours at 25.8% at the end of iCBT and 39.1% at follow-up. In fact, over half of those who completed the 6 month assessment period no longer met diagnostic criteria for an eating disorder (Sanchez-Ortiz et al., 2010).

Sánchez-Ortiz et al. (2010) mentioned that data from the United Kingdom eating disorder charity, 'beat', indicated that 85% of patients believed that their general

practitioner understood neither their eating disorder nor ways in which they could help with that disorder. They suggested that if iCBT were offered through reputable self-help organizations such as ‘beat’, those suffering from eating disorders could bypass inadequate primary care and easily access effective treatment. The ease and speed of access would in themselves be extremely helpful, thereby improving outcomes by taking advantage of an initial motivation to change (Sanchez-Ortiz et al., 2010).

In 2011, Sánchez-Ortiz et al. undertook another study in the field of bulimia nervosa and related disorders, this time examining the determinants of patients’ decisions to undertake internet-based treatments and their experiences in and assessments of those treatments. Through semi-structured interviews and questionnaires, participants provided their reasons for choosing that form of treatment. This included dissatisfaction with previous counselling experiences, accessibility, flexibility, privacy, positive feedback about iCBT, and the belief that their ED’s lack of severity did not justify seeking medical assistance. Confidentiality and anonymity were very important (“You know that a computer isn’t gonna judge you and a computer isn’t gonna go and talk about your problems with somebody else” (Sanchez-Ortiz et al., 2011, p. 96). There were, however, some concerns expressed about accessing iCBT in a public venue. Flexibility, i.e., the ability to log in at any time, was seen as a benefit, although some interviewees noted that doing so required both self-discipline and motivation. Although some did not do so, many felt reassured by their ability to seek support through email and only one believed the process to be impersonal. Most believed that the program had provided them with useful strategies to change their eating patterns and overcome their eating disorder. When comparing iCBT and face-to-face counselling, several participants mentioned that they appreciated iCBT’s focus on what to do going forward as opposed to traditional counselling, which one said was “. . . more like going into the past” (Sanchez-ortiz et al., p. 97). It appears that iCBT’s success related to it being a minimal intervention, designed to be used with client flexibility and perhaps if it was not set up in this way, it might have failed.

Another group of researchers, Pretorius, Rowlands, Ringwood and Schmidt (2010), also examined the reactions of young participants (aged 16 to 19) to a web-based intervention. This incorporated the "Overcoming Bulimia Online" program, with electronic message boards for both participants and their parents and email support from clinicians and 'beat' staffers, all of whom were trained in the treatment of eating disorders. Many of the comments reiterated the themes of accessibility, flexibility and anonymity as factors influencing their choice of treatment, i.e., online versus traditional, face-to-face therapy. For the most part, responses were positive, with participants appreciating the email support, the freedom they felt to speak honestly about their struggles and concerns and their sense of control over their treatment. Others, however, felt that the program was not sufficiently personal and did not want to turn to a computer in times of crisis. As to motivation, although most seemed to be at least relatively motivated at the start of the program, some said that maintaining that motivation was difficult when symptom improvement seemed slow or, interestingly, when they started to feel better. However, overall, positive improvements were noted, including reductions in binge eating, purging, thoughts about shape and weight and anxiety. Some participants, even those who did not find the program in itself to be that helpful, reported that the experience served as a stepping stone to their seeking further assistance because it increased their confidence in discussing their eating disorder and, in some cases, helped them understand the extent of their problems with the disorder. Indeed, even the process of answering the researchers' questions was of benefit because it provided participants with an opportunity to reflect on both the work they had done and their progress and increased their motivation to do further work (Pretorius et al., 2010)

"ESS-KIMO"

Hötzel et al. (2014) investigated the ability of "ESS-KIMO" ('Klärendes Internetprogramm zur Steigerung der Veränderungsmotivation bei Essstörungen'), an online intervention using motivational enhancement therapy to affect changes in eating disorders. In addition to their primary hypothesis,

that such an intervention would both clarify and increase patients' motivation to make changes in their eating disorders, the researchers believed that "ESS-KMO" would also serve to significantly reduce eating disorder pathology and increase self-esteem. Unlike many other studies, Hötzel et al. (2014) regarded this online therapy as a precursor to face-to-face counselling, one that would motivate and prepare patients so that they could receive the fullest benefits from a more traditional mode of treatment. Utilizing an individualized intervention via a closed website that incorporated interactive elements and graphical presentation, participants were expected to apply each topic to their own situation and complete writing tasks related to those topics. Feedback was supplied by two of the authors.

Hötzel et al.'s (2014) conclusions revealed this to be a promising program. The researchers cited the participants as stating that their motivation to change behaviours such as dieting or refusing to gain weight had significantly increased, as did their self-esteem, while their cognitions such as the fear of becoming obese and a preoccupation with food and weight had decreased. However, there was little to no increase in their feelings of self-efficacy. In addition, the researchers reported a high rate of dropout (Hötzel et al., 2014). It is possible the authors did not consider that the high dropout rate might have been due to the online intervention being viewed by both clients and therapists as a 'precursor' to face-to-face therapy, rather than a treatment in it's own right. Furthermore, it was noted that since specific diagnoses (AN versus BN) were obtained through self-report questionnaires, it was not possible to address the differences in response to the intervention in terms of differing eating disorders. The authors observed that since the participants in this study ranged in age from 18 to 50 years, further research was needed to age-adapt interventions in such a way that older patients would feel more at ease with computer applications, a change that might provide different results (Hötzel et al., 2014).

"The Information and Online Counselling Service for AN and BN"

"The Information and Online Counselling Service for AN and BN" (www.ab-server.de) was established in Germany as the country's first specialized online program for eating disorders. In addition to providing general information, it also includes contact details for self-help groups, counselling centres and therapists, in addition to links to both national and international eating disorder websites. Visitors, including those diagnosed with eating disorders, their friends, relatives and colleagues, can gain anonymous access to free, online counselling services. In their study of the ab-server, Kündiger, Wesemann, Verhey, and Grunwald (2010) focused on describing the various user groups, determining the specifics of their questions and concerns, learning about clients' level of professional and/or therapeutic exposure prior to making contact with the website and examining family members' degree of hardship when caring for a person affected by an eating disorder.

Questions posed by online clients were particularly revealing. For example, relatives (a group to which one in four people contacting the ab-server belonged) asked whether they should or should not intervene if they knew a loved one was suffering from an eating disorder; would their saying something make the problem even worse? One person said that she believed she reinforced the behaviours by "just watching and not helping her" (Kündiger et al. 2010, p. 390). There were many enquiries as to the cause of eating disorders, e.g., could it be caused by a virus? Kündiger et al. (2010) noted that most of the written communications with the "ab-server's" counsellors served as the users' first contact with a mental health professional and observed that, this being the case, it was crucial that the online counsellors' responses be sensitive, tactful and aimed at encouraging them to seek professional help.

"ES[S]PRIT"

In addition to designing interventions to reduce symptomology, researchers have also examined the feasibility of programs that will prevent eating disorders.

To this end, Bauer, Moessner, Wolf, Haug, and Kordy (2009) conducted a study of "ES[S]PRIT", an internet-based eating disorder prevention program aimed at university students. Bauer et al. (2009) noted that entry into university is an especially stressful period for young people and that those students who are at risk may have the need for special support. Further, the development of disordered eating and full-blown eating disorders is common in this population at this time in their lives.

"ES[S]PRIT" contrasts with other interventions in that it uses a stepped-care approach and follows a strategy that coincides with participants' specific and individual needs. While most participants will not develop severe eating disorder symptoms, some might experience periods in which they require more intensive online support, face-to-face counselling or possibly even more concentrated psychotherapy. That being the case, a salient feature of this program is its ability to track participants, allowing for early identification of any deterioration or the onset of a critical period. If such problems are reported in participants' email communications, online counsellors are immediately notified and then contact the troubled student. There is also the option of counsellors making referrals to the University Counselling Centre for face-to-face therapy.

There are two ways in which chat technology is utilized: monthly, clinician-guided group chat sessions and individual sessions geared toward the discussion of more private questions. Details revealed in the latter can also prompt a referral to the counselling centre. Bauer et al. (2010) noted that this stepped approach, combined with supportive monitoring and feedback program, reflected the fact that, despite their increased risk, most participants will never develop an eating disorder and are not in need of intense interventions. This program's design, however, allows them to access more focused care on an as-needed basis. All of this allows the needs of a diverse and much broader population to be addressed. Given the pressures that universities are under in managing student mental health concerns, a preventative measure would be a highly effective resource in managing these concerns, but this would also have significant implications for funding.

The misuse of internet information

Whilst the focus thus far has been on online treatments and programmes for individuals with eating disorders, it is important to acknowledge websites that describe, encourage and endorse eating disorders.

The concern about 'Pro-eating disorder' websites is that these sites can increase the probability of eating disordered behaviours. Csipke and Horne (2007) conducted a study examining users' opinions of 'pro-eating disorder' websites. They distinguished between interactive users and 'silent browsers'. The interactive users claimed beneficial effects, such as an improved mental state from engaging with others on these sites. For these individuals, it was found that the impact of the potentially damaging content was reduced. It was found that the 'silent browsers', however, were vulnerable to the worsening of their symptoms due to the absence of the beneficial effects of emotional support.

Despite the perceived benefits found by the interactive users, the very act of engaging with others in support of their eating disorders, may result in further identifying with the eating disorder, competitiveness among one another, as well as increased resistance to change in the longer term.

Resistance to treatment programmes

Little or no motivation to change may impede individuals suffering from eating disorders from accessing both physical as well as online treatment services. Peak incidence of eating disorders in young females is in the age bracket of fifteen to nineteen years. Poor nutrition, hormonal changes and high levels of stress associated with starvation disrupt brain maturation during this time. Various clinical trials suggest that prognosis becomes worse if the illness endures beyond three years (Steinhausen, 2009). In addition, recent research in neurocognition and anorexia has indicated a link between poor set-shifting and anorexia. Thus, individuals suffering chronically from an eating disorder will be more cognitively rigid and those experiencing a first episode of anorexia. Anorexic behaviours such as restriction, the aspiration to have an emaciated body and excessive

exercise, become more rewarding over time and ultimately become habitual. (Roberts, Treasure & Tchanturia, 2010). Clinical and biological studies (see e.g. Treasure & Russell, 2011) support the idea that early intervention in order to reduce the duration of untreated eating disorders is important.

Treatment resistance in eating disorders is therefore complex and manifests differently depending on diagnosis, age and duration of illness. These features help inform the therapist about the types of resistance likely to be encountered as well as possible interventions that may help overcome barriers to treatment. The role and quality of resistance will vary depending on the individual.

There are numerous different definitions of resistance in psychotherapy. Freud gave rise to a psychodynamic framework of resistance in which the client is the 'main seat' of resistance. In this context it is assumed that the client represses their anxiety-provoking memories and insights. In a more general sense, one can view resistance as any behaviour exhibited by clients that opposes the therapeutic process or the therapist themself in either an explicit or an implicit way (Bischoff & Tracey, 1995). These resistant behaviours can occur in face-to-face, as well as in online therapy settings. In the latter case this can, for example, be manifested in not gong online, visiting other websites and talking to other people while using the online therapy, or not paying for the service amongst others (Scharff, 2012). These mentioned expressions of resistance in an online therapy framework might correspond to "anxieties [that] block the flow of associations" (Scharff, 2012, p.23) that are often experienced in face-to-face therapies.

Motivational Interviewing (MI) is one method to foster motivation for change in clients and is gaining more popularity. MI has originally been applied in the context of addictions, comes from a client-centred approach, and has the enhancement of the clients' inner volition to change (Ryan et al., 2010) as a rationale. Westra (2012) mentions some of the key concepts of MI which are "empathic reflection; creating an atmosphere of discovery and experimentation; drawing on and evoking the client's ideas and resources in pursing change;

supporting client autonomy while contributing therapist ideas or expertise on change; continually being sensitive to the client's receptivity to change efforts, level of engagement, fluctuations in motivation for change" (Westra, 2012, p. 231-232). Accordingly, by strengthening clients' autonomy and motivation, MI is being used to facilitate change.

Its efficacy in the treatment of eating disorders in the form of brief interventions, either as a stand-alone or as a pretreatment method, has been reported by several studies (Dunn, 2003, Mhurchu, Margetts, & Speller, 1998, Feld et al., 2001) and it is highly conceivable to also use this technique in an online therapy setting. Thus, further research involving the effectiveness of online therapy in eliciting motivation to change, would be valuable within this area.

In sum, the fact that many perceive the internet as a safe, secure place, might help with overcoming resistance and the building of a therapeutic relationship. Behaviours such as honesty and self-disclosure are likely to be fostered in such an environment while shame and anxiety might occur to a lesser extent, thus facilitating the development of intimacy (Amichai-Hamburger, 2014). As resistance plays an important role in the development of a therapeutic relationship, and as the quality of this relationship is considered to be crucial for treatment outcome, more detail with regards to the therapeutic alliance in online therapies will be presented in what follows.

The Therapeutic Relationship in Online Therapies

Research showed that the therapeutic alliance is the largest contributor to premature dropout rates and adverse treatment outcomes (Strupp, 1998). Accordingly, in the framework of eating disorders, it was found that the first impressions of the therapeutic alliance are significantly predictive of treatment outcome in a sample of hospitalized anorexic (AN) patients (Sly et all, 2013). By experiencing ruptures in this therapeutic relationship, clients get the opportunity to learn about relationships in general and especially about how they can be repaired. Due to this being an interpersonal process, the

development of a therapeutic relationship does not solely lie within the therapist, but instead, both therapist and client contribute to the establishment of a working alliance. In this regard, the strongest link has been found between clients' views of the therapeutic relationship and treatment outcomes (Cook & Doyle, 2002).

In an online setting, an important question that arises in this regard is whether it is possible to develop a stable therapeutic alliance if therapist and client are geographically separated. This question becomes particularly intriguing given that in the classical sense, nonverbal cues are consider to be crucial for the establishment of a strong therapeutic alliance (Cook & Doyle, 2002). Interestingly, Cook and Doyle (2002) cite several studies that found that strong and deep relatioships can be formed on a pure online basis (see e.g. Walther & Burgoon, 1992, McKenna, 1998). It is hypothesised that "[a]nonymity, or perceived anonymity, may foster intimacy by increasing the amount of personal, self-disclosure in friendships on the internet, where the fear of rejection that may prevent disclosure in face-to-face relationships does not exist. In short, people are often more frank when they feel anonymous, as many do over the internet, and this leads indirectly to greater intimacy" (Cook & Doyle, 2002, p.97). In their study where they compared a representative sample of participants frequenting face-to-face therapy with a group of participants using online therapy, Cook and Doyle (2002) found that online therapy participants experienced a "collaborative, bonding relationship with therapists" (Cook & Doyle, 2002, p. 102) and that the working alliance in this group was as strong as the one in the representative face-to-face therapy relationship (Cook & Doyle, 2002).

Thus, it can be assumed that in online settings, strong therapeutic alliances can be formed. As, in this regard, attachment styles matter, their role in online therapies will be elaborated on in the subsequent section.

Attachment in Online Therapies

The factors that are necessary to form a healthy therapeutic relationship can be explored form the viewpoint of attachment theory that lends itself well by containing useful explanatory ideas for this matter. Broadly speaking, attachment behaviour systems deactivate once a client is in a secure base provision (Bowlby, 1988). This enables the client to be more open to exploration and thus facilitates therapeutic work. IN more details, the first categories identifiy by Ainsworth and Bella (1970), were insecure avoidant (type A), secure (type B), and insecure ambivalent/resistant (type C), with type B considered the ideal. Twenty years later, Main and Solomon (1990) added a fourth attachment style, the 'disorganised' style.

Further research began to apply this framework and explored adult relationships based on attachment theory (see e.g. Bartholomew, 1993; Collins & Feeney, 2000). Meanwhile, the conceptualisation of attachment patterns has changed and researchers make use of different dimensional scales to assess differences in attachment, therapy mainly focussing a tow-dimensional model that has avoidance an anxiety on its main axes (see Shaver and Fraley, 2004). One of the key implications of attachment theory is that affect, behaviours and cognition in adults are being influenced by attachment behavioural systems that originate in infancy (Bowlby, 1988).

With regard to eating disorders in general, primarily insecure attachment styles have been found to be prevalent in patients suffering from eating disorders (Wallour, 2004). In more detail, the majority of patients suffering from anorexia are assumed to display "dismissing and unresolved adult attachment" (Salcuni, 2015, p. 53), thereby exhibiting avoidant and fearful personalities. The prevalent attachment style in especially anorexic patients is an "unresolved" (for loss and abundance) one which grounds in disorganisation and is assumed to go back to "dysregulations of co-adaptive processes […] in attachment –caregiving relationships […]" (Salcuni, 2015, p.53). This assumed avoidant and disorganised attachment in anorexic patients might reflect their restrictive

relationship with food, which is inherently avoidant. High levels of attachment anxiety have mainly been linked to eating disorders such as bulimia nervosa or binge eating and were found to increase the risk for more severe forms of eating disorders and negative treatment outcomes (Wallour, 2014).

Given that it seems possible to develop a strong therapeutic alliance in an online setting (Cook & Doyle, 2002), it is highly conceivable that the development of a healthy attachment between therapist and client is possible too within an online setting. Unfortunately, to date, there is a lack of research in this regard. Thus, studies examining the viability of online therapies in the field of eating disorders with special regard to attachment relationships, are desirable.

Conclusions and future research

The literature findings make it clear that the use of internet-based therapies to reduce the effects of, or even prevent eating disorders is not only increasingly widespread but can also be highly effective. Today, a movement that began in the late 1990's continues to grow and to serve a broader and more diverse population with increasingly sophisticated online applications of both traditional and new therapeutic strategies, aimed at combatting the ravages of eating disorders.

This, of course, is not to say that sufficient progress has been made and additional research is not necessary, a point made by numerous researchers in this field. Pretorius et al. (2010) observed that while web-based interventions show great potential in increasing accessibility to treatment, all components of those interventions may not be useful to all populations of eating disorder clients and that further research is needed to differentiate which of them and of what intensity is most appropriate and for whom.

In their discussion of their study of the "Student Bodies" program, Low et al. (2006) observed that while they found the program to be successful, small sample size and the homogeneity of their participants may have, at least to a

degree, compromised their findings. Sample size should be a concern, with much of the research cited above involving relatively few participants, given the large and diverse population of those suffering from eating disorders.

The needs of males with eating disorders have not been thoroughly addressed, nor have those of older individuals; the efficacy of these interventions with those populations must be examined and any necessary changes to existing online interventions must be made.

Concerns would need to be addressed about the feasibility of working with anorexic clients online who also require physical clinically-based interventions, such as regular weighing and blood tests. A system of liaison between services would need to be developed with a particular party ensuring clinical responsibility. Peak incidences of eating disorders in young females are typically in the age bracket of 15-19. From this age of onset there is high risk of disrupting physical, social, emotional and educational development. While young people tend to shy away from conventional health services, shame and ambivalence also play a role. Through the use of individually tailored and perhaps 'creative-types' of interventions, online therapy may prove effective in preventing some of the barriers to early treatment for young people, whilst also reducing the amount of time adults need to wait before entering face-to-face treatment.

Curiously, the very growth of technology itself may be an impediment to web-based therapy; Paxton, McLean, Gollings, Faulkner and Wertheim (2007) expressed concern about the constant evolution of such technology as some older participants, who may not be familiar or comfortable with a chat room environment, or those with fluctuating internet service may find completion of online programs problematic. Apart from mechanics, the quality of online therapy (and therapists) is also of concern. Alleman (2002) noted the care that must be taken to avoid unqualified or unprincipled practitioners. He points to the need for trained, accredited counsellors to ensure that clients' access to their online services is easy and convenient and that therapy itself is non-invasive,

non-threatening and effective. With regard therapist characteristics, therapists would need to have an openness and a willingness for these approaches to work. To this end, it is not the programs that do the work but how they are supported. In terms of the choice between online or face-to-face support, this is not necessarily about which medium is better, but more about which medium the client prefers. It appears that a key message here is for clients to be able to use a service with a certain amount of flexibility and for it to be time and age appropriate.

Finally, for counselling psychologists interested in working with this client group through the use of the online medium, it is recommended that in addition to the clinical speciality needed to work therapeutically, training specific to online therapy also take place, in order to support and build increased self efficacy in the therapist. It is feasible to conclude that the medium of online therapy will not diminish, but rather that demand will continue to increase over time. It is therefore imperative that online training be incorporated into counselling psychology training programmes in order to generate informed, competent and confident counselling psychologists paving the way forward in the digital era.

To conclude, it is useful to note that early in this therapeutic revolution, Barak (1999) observed that that "[p]sychology, on the threshold of a new millennium, is driving on a superhighway that is taking the world to an unknown destination" (Barak, 1999, p. 241). Through the work of researchers and practitioners toward the development of effective, feasible interventions, the treatment of eating disorders is well-advanced on that journey.

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