Therapists' experiences of the therapeutic alliance with clients with drug problems: An interpretative phenomenological analysis

By

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Thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Professional Doctorate in Counselling Psychology

February 2014

Acknowledgements

The submission of this thesis has been made possible with the assistance of a number of people to whom I am greatly indebted.

I would like to thank the therapists who gave so generously of their time to my study, thus allowing me to explore how they make sense of the alliance with clients with drug problems. I am also grateful to the organisation within which I carried out the research for providing me with the opportunity to interview their therapists.

My supervisor, Dr Jane Lawrence, deserves much praise for her guidance and availability. Your supervision provided the holding space that enabled me to make sense of the struggles on my research journey, and your clinical experience and capacity for overview have been invaluable to me.

I am particularly grateful for the relentless support given to me by my parents over the years. You are far away, but words cannot express how much I value your continued presence, encouragement and belief in me. This thesis is for you, and for those we lost along the way.

Abstract

The therapeutic alliance is fundamental for therapists who work with clients with drug problems. The alliance is central to engaging and retaining clients with drug problems in treatment and in facilitating a positive treatment outcome. Moreover, clients with drug problems may have significant difficulties in relating to others, which manifests itself in the client-therapist relationship. There is a paucity of research investigating therapists' perceptions of the alliance with clients who use drugs. Consequently, this study aimed to explore how therapists experience and understand the alliance with clients who use drugs. Six therapists were interviewed and their narratives analysed using Interpretative Phenomenological Analysis.

The data analysis generated four superordinate themes; Trapped in the system; Struggling to connect; The contradictory therapist and Resources transcending the alliance. The themes illustrate the participants' experiences of how they have little choice but to work within a treatment system they perceive as impacting upon the alliance. Moreover, most participants experience their clients as unreachable, and the results suggest that therapists may take responsibility for developing and maintaining the alliance to accommodate their clients' ambivalence. The participants further seem contradictory in their understanding of the alliance, which indicates their struggle to acknowledge the difficulties and differences in forming the alliance with their clients as opposed to with generic clients. The participants describe how clinical supervision, peer support and the use of self enable them to connect with their clients. Finally, the study demonstrates that the participants experience the alliance as heavily intertwined with unconscious processes.

The study results suggest that therapists require specific and structured support to acknowledge and manage the challenges inherent in relating to clients with drug problems, focussing particularly upon the use of self and the management of countertransference. Moreover, the study highlights the necessity of acknowledging the therapeutic alliance as inseparable from unconscious processes. Additional recommendations are made in relation to clinical practice, training and research.

Contents

Abbreviations

BPS	British Psychology Society
CBT	Cognitive behavioural therapy
DCoP	Division of Counselling Psychology
DoH	Department of Health
GP	General Practitioner
IPA	Interpretative phenomenological analysis
NHS	National Health Service
NICE	National Institute for Clinical Excellence
PHE	Public Health England

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Introduction

Several areas of existing research and theory suggest that the therapeutic alliance may be particularly pertinent for therapists who work with clients with drug problems.

Research has demonstrated a link between insecure attachment styles (Holmes, 2001; Main & Goldwyn, 1995) and the development of substance use problems (Meier, Donmall, Barrowclough, McElduff & Heller, 2005). Holmes (2001) and Gerhardt (2004) elaborate that many individuals with substance use problems may have difficulties in regulating their emotions and in forming relationships with others. To compensate, they form a relationship with a substance(s), which serves to soothe emotional distress. As such, clients with drug problems may have specific difficulties in developing and maintaining a therapeutic alliance (henceforth 'alliance') with their therapist (Schindler, Thomasius, Sack, Gemeinhart, Kustner & Eckert, 2005). In line with this, Holmes (2001), Gerhardt (2004) and Kothari, Hardy & Rowse (2010) propose that the client-therapist relationship enables clients with substance use problems to change their emotional regulation strategies and address their problems in relating to others.

Research into subjective experiences of substance use and the stigma surrounding substance use further suggests that the alliance may be particularly relevant to therapists who work with clients with drug problems. Luoma, Twohig, Waltz, Hayes, Roget, Padilla & Fisher (2007) highlight that individuals with substance use problems experience stigmatising attitudes and behaviours from others. Moreover, individuals with substance use problems may understand themselves as different from 'normal' society as a result of the stigma attributed to them by society (Watson & Parke, 2011). Furthermore, health professionals have been found to hold stigmatising opinions about individuals with substance use problems (Lovi & Barr, 2009; Peckover & Chidlaw, 2007; Skinner, Feather, Freeman & Roche, 2007 and Crome & Shaikh, 2004). Consequently, clients with drug problems may expect to encounter similar experiences in therapy, which could influence how they approach the alliance with their therapist. Hence, it could require specific skills from therapists to develop an alliance with clients who use drugs.

Additionally, the alliance seems to be linked with therapeutic outcome and treatment retention. Clients with drug problems have high drop put rates from treatment (Public Health England (PHE), 2013). Conversely, the alliance is pivotal in engaging and retaining clients in treatment (Corrigan & Bogner, 2007; Simpson, 2004). Indeed, Meier, Barrowclough & Donmall (2005) found the alliance to be a significant predictor of engagement and retention in drug treatment as well as early treatment improvement.

Finally, research into therapist and client ratings of the alliance in drug treatment demonstrates that therapist ratings of the alliance differ from client ratings of the alliance (Meier & Donmall, 2006; Tryon, Blackwell & Hammel, 2007). This indicates that therapists' experiences of the alliance are not yet fully understood, and it seems therapists have different frames of reference to their clients from which they evaluate the alliance. Moreover, the alliance is influenced by therapist characteristics (Meier et al., 2005). As such, exploring how therapists perceive the alliance could help to increase our knowledge of the alliance with clients who use drugs.

My interest in the alliance with clients with drug problems originates from my previous employment in substance use. I worked for nine years as a substance misuse worker across various substance use services. During my work, I noticed the challenges in developing and maintaining an alliance with my clients. For instance, my clients were frequently ambivalent about changing their drug use, and it seemed they often struggled to adjust to the boundaries of treatment. Moreover, my clients' early life experiences and interpersonal difficulties led them to approach the alliance in ways that made it difficult for me to connect with them. The challenges in forming the alliance with my clients were often exacerbated by service and governmental policies that, for example, dictated treatment length. Despite struggling to relate to my clients, I soon became aware how significant the alliance was. It seemed the alliance, however fragile, became the bond that held us together through the ups and downs of their treatment. Eventually, some clients came to appreciate the stability that our alliance provided, and I found it fulfilling to experience this with them.

The exploration of therapists' experiences of the alliance with clients who use drugs is pertinent to counselling psychologists. The Department of Health (DOH) (2007) reports a

high occurrence of mental health problems amongst clients in drug services in the United Kingdom. Hence, psychological services have been deemed significant in helping clients to address their drug use and psychological problems (Pilling, Hesketh & Mitcheson, 2010; DOH, 2007). Given this increased inclusion of psychology in drug treatment, it seems therapeutic work with clients who use drugs is ever more relevant to counselling psychologists.

The alliance in the field of substance use remains relatively unexplored (Mee-Lee, McLellan & Miller, 2010; Clark, 2009; Orford, 2008). Moreover, there appears to be a dearth of research exploring how therapists, as opposed to general health professionals, perceive the alliance with clients with drug problems. It further seems a paucity of research exists that investigates the resources that therapists draw upon in developing and maintaining an alliance with clients who use drugs (Kothari et al., 2010). Expanding our knowledge of therapists' experiences of the alliance with clients with drug problems will inform clinical practice for counselling psychologists and other related professionals. Moreover, it will lead to recommendations being made in relation to service development, professional development and training for counselling psychologists and other professionals.

Chapter 1: Literature Review

1.1   A note to the reader

The therapeutic alliance is known in literature and research as the 'working alliance', 'helping alliance' or the 'alliance' (Horvath & Bedi, 2002). This thesis refers to the 'therapeutic alliance' or 'alliance', unless specific terminology is used in referenced literature or research (Castonguay, Constantino & Holtforth, 2006).

At stated, there is a paucity of research investigating therapists' experiences of the alliance with clients with drug problems. Therefore, this thesis draws upon related research concerning the 'therapeutic relationship' and 'substance use' which encompasses both the alliance and drug use. Alliance and drug use specific research and literature is referred to explicitly when available.

1.2   Introduction

This review of literature provides a brief history of the therapeutic alliance, including its link with therapeutic outcome, its measurements and the debate surrounding its definition. The definition informing the current study will be outlined, as will the rationale for grounding the study in alliance as opposed to therapeutic relationship theory.

The literature review further demonstrates how the alliance is pertinent for therapists who work with clients with drug problems. This argument is based upon outcome and retention research, research into client and therapist ratings of the alliance, attachment theory (Gerhardt, 2004; Bowlby, 1988) and research concerning stigma and substance use (Lovi & Barr, 2009). Subsequently, the review outlines research relevant to the study of therapists' subjective experiences of the alliance with clients with drug problems. The review also highlights gaps in research and literature that warrant further exploration, thus giving rise to the study's research questions. Finally, the review outlines the relevance of the current study to counselling psychology.

1.3   The therapeutic alliance

1.3.1   Therapeutic alliance history and definitions

The terminologies 'the alliance' and 'the therapeutic relationship' are commonly and erroneously used interchangeably (Horvath, 2001). In fact, the alliance is part of a range of effective factors within the therapeutic relationship. Hence, the therapeutic relationship is the overarching, total client-therapist relationship of which the alliance forms part (Norcross 2010; Castonguay et al., 2006; Horvath & Bedi, 2002; Lambert & Barley, 2002).

As yet, a universally agreed upon definition of the alliance does not exist. The concept of the alliance originates from psychoanalysis and Freud's (1912) exploration of the positive transference relationship between therapist and client (Wampold, 2010). Influenced by these psychoanalytic ideas, Greenson (1967, cited in Horvath, 2001, p. 365) later coined the term 'working alliance'. He proposed that the working alliance consists of the relatively non-neurotic rapport between client and therapist, although suggested that this rapport remains somewhat impacted upon by transference and countertransference. As such, Greenson's definition of the alliance contains elements of unconscious processes. Greenson further posited that the working alliance involves collaboration and partnership between therapist and client (Messer & Wolitzky, 2010).

In 1979, Bordin expanded the working alliance as a pan-theoretical concept. Bordin presented the alliance as an ingredient of all therapies regardless of therapeutic orientation, thus avoiding the use of concepts specific to dynamic therapies. Bordin defined the alliance as the purposive and collaborative therapeutic work between therapist and client. This includes the agreement on the goals of therapy, the agreement on the tasks by which the goals of therapy are met and the development of the affective bond between client and therapist. These three components of the alliance influence one another. Agreement on the goals and tasks of therapy refers to client and therapist having a common understanding about the focus and process of therapy. The affective bond involves the trust, liking, caring and attachment that develop between client and therapist. This bond is required to be sufficiently strong for client and therapist to undertake the tasks of therapy (Bordin, 1979).

Bordin (1979) suggested that the strength of the alliance is central to the effectiveness of therapy, and further emphasised three means by which the alliance is established and maintained. The alliance is negotiated at the beginning of therapy and is renegotiated throughout therapy. Moreover, depending on theoretical orientation, different therapies involve negotiations about different goals and tasks of therapy. Finally, he proposed that ruptures in the alliance necessitate repairing for therapy to be successful.

Later, Horvath & Bedi (2002) expanded Bordin's (1979) conceptualisation of the alliance, thus defining the alliance as, 'the quality and strength of the collaborative relationship between client and therapist in therapy' (p. 41). It includes the affective bond between client and therapist and the consensus about and commitment to the goals and tasks of therapy. Horvath & Bedi state that the alliance, 'is the conscious and purposeful aspect of the relation between therapist and client: It is conscious in the sense that the quality of the alliance is within ready grasp of the participants' (p. 41). Whilst introducing a conscious aspect to the concept of the alliance, Horvath & Bedi (2002) acknowledge the impact of clients' relational history and disposition upon the alliance. This, they suggest, 'may be tacit or outside of mindful awareness at any specific time' (Horvath & Bedi, 2002, p. 41) as opposed to being a fully unconscious process. Indeed, fully unconscious processes are viewed by Horvath & Bedi to form part of the total therapeutic relationship, not the alliance.

Safran & Muran (2003) propose a broadened, although still therapeutic modality neutral, conceptualisation of the alliance. They also base their conceptualisation on Bordin's definition of the alliance, but further ground their conceptualisation in interpersonal and relational thinking. As such, they suggest that the alliance consists of the agreement on the goals and tasks of therapy and the affective quality of the bond between client and therapist. Moreover, they suggest that therapeutic change is generated by clients' experience of a constructive relational encounter with their therapist. They further view the development and resolving of difficulties in the alliance as being at the heart of therapeutic change. Additionally, they view the negotiation of the goals and tasks of therapy as central to therapy and propose that the, 'process of negotiation both establishes the necessary conditions for change to take place and is an intrinsic part of the change process' (p. 15).

Safran & Muran (2003) posit that, 'Some aspects of the alliance may involve conscious, rational deliberation, but other aspects are unconscious and affectively based' (p. 13). Indeed, Safran & Muran specifically state that the negotiation between client and therapist about the tasks and goals of therapy take place on both conscious and unconscious levels. As such, they depart from Bordin's (1979) and Horvath & Bedi's (2002) conceptualisations of the alliance as a largely conscious endeavour by recognising the existence of unconscious processes in the alliance.

1.3.2 Therapeutic alliance measures

Fuelled by interest in the link between the alliance and therapeutic outcome, various scales have been developed to measure the efficacy of the alliance. Four scales are most commonly used in research: the Penn Helping Alliance scales (Lurborsky, Barber, Siqueland, Johnson, Najavits, Frank & Daley, 1996); the Working Alliance Inventory (Horvath & Greenberg, 1989); the Vanderbilt Therapeutic Alliance Rating Scale (Shelef & Diamond, 2008) and the California Toronto scales (Horvath & Bedi, 2002; Gaston 1991). Grounded somewhat in psychodynamic thinking, the Penn Helping Alliance scales investigate the alliance as, '1) a warm, supportive, accepting relationship followed by 2) a sense of collaboration, participation and sharing in therapeutic responsibilities by the client' (Horvath & Bedi, 2002, p. 39). The most recent version of the Penn Helping Alliance scales is the revised Helping Alliance Questionnaire (Lurborsky, Barber, Siqueland, Johnson, Najavits, Frank & Daley, 1996). The Working Alliance Inventory specifically captures Bordin's (1979) conceptualisation of the alliance. The original Working Alliance Inventory has been revised to include a short form (Hatcher & Gillaspy, 2006). The revised Vanderbilt Therapeutic Alliance Scale is grounded in psychodynamic thinking, and its short version aims to investigate Bordin's definition of the alliance, the client's contribution to the alliance as well as the therapist-client interaction's contribution to the alliance (Shelef & Diamond, 2008). Finally, the most recent version of the California Toronto scales is the California Psychotherapy Alliance Scales (Gaston, 1991). This scale measures the alliance according to four dimensions: patient commitment, patient working capacity, therapist understanding and involvement and working strategy consensus.

As is evident from this brief outline, the scales differ in their emphasis on and assessment of the various features of the alliance (Horvath & Bedi, 2002). What they have in common, however, is the way in which they measure purely conscious aspects of the encounter between client and therapist. As such, they are grounded in the conceptualisations of the alliance that consider the alliance the conscious and rational aspect of therapy. Indeed, they seem inconsistent with Safran & Muran's (2003) definition of the alliance as intertwined with unconscious processes, suggesting a discrepancy between the theoretical debates and understandings of the alliance and its measurements.

1.3.3   Common factors, the alliance and outcome

Regardless of the debate surrounding its definition and measurement, the alliance is a much researched concept. As such, the alliance constitutes one of the common factors in therapy (Norcross, 2010). Common factors refer to aspects of the therapeutic encounter that are common to all types of therapies (Lambert & Barley, 2002). Contrarily, specific factors are those aspects of therapy that are specific to theoretical orientation (Wampold, 2010). Lambert & Barley (2002) conclude that 30% of therapeutic outcome is due to common factors, whilst specificity of therapy and techniques contribute 15% to therapeutic outcome, leading Mee-Lee et al. (2010) to conclude that, 'method does not matter' (p. 399). Thus, the alliance forms part of a group of common factors that have considerable impact on therapeutic success (Wampold, 2010).

Indeed, the alliance has been investigated, using the aforementioned alliance measures, across modes of therapy (Gibbons et al., 2009; Rector, Zuroff & Segal, 1999) and from therapist, client and observer perspectives (Horvath & Symonds, 1991). This body of research has highlighted the alliance as a significant predictor of therapeutic outcome, regardless of therapeutic orientation, client presenting problem and length of therapy (Holtforth & Constanguay, 2005; Martin, Garske & Davis, 2000; Horvath & Symonds, 1991). Hence, the alliance is one of the major components of therapy leading to successful outcome (Wampold, 2010).

1.3.4   Alliance ruptures

An area of research relevant to the study of the alliance is that of alliance ruptures (Safran & Muran, 2003). Grounding their research in Bordin's (1979) conceptualisation of the alliance, Safran, Muran, Samstag & Stevens (2002) defined an alliance rupture as, 'a tension or breakdown in the collaborative relationship between patient and therapist' (p. 236). Alliance ruptures involve disagreements about the tasks and goals of therapy as well as strains in the affective bond. Ruptures in the alliance are common and require repairing to avoid stalling of therapeutic change and disengagement from therapy (Katzow & Safran, 2007; Safran et al., 2002; Safran, Samstag, Muran & Stevens, 2001).

1.3.5   Theory of the alliance underpinning the current study

The theory informing this study is Safran & Muran's (2003) conceptualisation of the alliance. This was chosen, partly, because it captures Bordin's robust definition of the alliance. Moreover, it remains applicable across therapeutic modalities, as opposed to Greenson's (1967, cited in Messer & Wolitzky, 2010, p. 99) psychodynamically orientated definition. This heightens the relevance of the current study to a wide range of theoretical models and disciplines. Finally, Safran & Muran's (2003) conceptualisation moves beyond Bordin's (1979) and Horvath & Bedi's (2002) definitions by acknowledging unconscious processes in alliance. In this manner, Safran & Muran's (2003) definition is consistent with both contemporary research (e.g. Thorberg & Lyvers, 2006) and the researcher's own clinical experience of the way in which the alliance develops in therapy.

1.3.6   'Therapeutic alliance' or 'therapeutic relationship'?

Definitions of the therapeutic relationship vary widely between theoretical models. For example, a humanistic approach views the therapeutic relationship as consisting of the core conditions of empathy, congruence and unconditional positive regard (Rogers, 1957). Conversely, Gelso & Carter's (1994) psychodynamic perspective proposes that the therapeutic relationship consists of three components; a working alliance, a transference configuration and a real relationship. From a cognitive behavioural perspective the therapeutic relationship is defined as the core conditions (Rogers, 1957) and a collaborative alliance (Wills, 2008; Sanders & Wills, 2005).

It was with these inconsistencies and theory specific definitions in mind that the researcher chose for the current study to be informed by Safran & Muran's (2003) theory neutral definition of the alliance as opposed to the therapeutic relationship. Although not as broad a concept as the therapeutic relationship, the alliance is, as noted, a concept relevant to a wide range of theoretical models. As such, anchoring the study in the alliance heightens the applicability of the study's findings to a broader range of clinicians, clinical practices and therapies.

1.3.7 Summary of The therapeutic alliance

Despite the debate surrounding its definition, the alliance has consistently been demonstrated to be predictive of therapeutic outcome. Safran & Muran's (2003) conceptualisation of the alliance was chosen to inform this study. It captures Bordin's robust and well researched definition of the alliance. Moreover, it acknowledges the significance of unconscious processes to the alliance. Furthermore, their definition remains applicable across theoretical models and disciplines, thereby increasing the clinical relevance of the study.

1.4 The significance of the alliance for therapists who work with clients with drug problems

Several areas of research, literature and theory indicate that the alliance is fundamental for therapists who work with clients with drug problems. Attachment theory (Bowlby, 1988), stigma related research and retention and outcome research suggest that therapists may encounter specific challenges and may therefore require specific skills in developing an alliance with clients who use drugs. Moreover, the alliance is impacted upon by therapists' characteristics and it seems there are aspects of therapists' understandings of the alliance with clients who use drugs that remain unclear.

1.4.1 Attachment theory, substance use and the alliance

The significance of investigating therapists' experiences of the alliance with clients who use drugs is demonstrated in attachment theory (Bowlby, 1988) and research.

Holmes (2001) proposes that substance use is an attempt by the individual to establish a secure base that functions to soothe anxiety. 'Secure base' refers to the caregiver to whom a child turns for soothing when feeling distressed (Gomez, 1997). On the basis of this childhood secure base experience, humans develop a mental representation of a secure base. Adults rely upon this mental representation to regulate their emotional states. Attachment theory further proposes that our early attachment experience leads us to form internal working models, which are representations of the self in relation to others (Holmes, 2001; Ma, 2006). Individuals with insecure attachment styles are likely to have internal working models that can impact unhelpfully on their interpersonal relationships (Gomez, 1997).

Holmes (2001) suggests that many individuals with drug problems may have insecure attachment styles, and therefore unhelpful internal working models. Consequently, they may lack a secure base in their external relationships as well as a mental representation of a secure base. To compensate, they form a relationship with a substance(s), which serves as a secure base to regulate emotional distress.

Drawing on attachment theory (Bowlby, 1988), Gerhardt (2004) adopts a systemic approach to understanding emotional development. She suggests that the failure of a caregiver to soothe their child's emotions results in failure to adequately regulate their child's cortisol response. Subsequently, the child can develop a hypersensitive cortisol response and can also become unable to constructively regulate their cortisol response.

Gerhardt (2004) suggests that individuals with substance use problems are likely to be unable to soothe their own emotions, i.e. to regulate their cortisol response, and may have difficulties in seeking comfort in relationships. As such, substance use is an attempt by the individual to regulate distressing emotions.

In line with this, research has demonstrated an association between insecure attachment styles (Main & Goldwyn, 1995) and development of substance use problems (Schindler, Thomasius, Sack, Gemeinhardt & Kustner, 2007; Thorberg & Lyvers, 2006; Caspers, Cadoret, Langbehn, Yucuis & Troutman, 2005; Schindler et al., 2005). Schindler et al. (2005) argue

that this renders the alliance for individuals with substance use problems particularly important as they may have difficulties in establishing an alliance with their therapist. Indeed, Meier et al. (2005) concluded that securely attached individuals with drug problems on a rehabilitation programme formed better alliances with their counsellors than insecurely attached individuals.

Holmes (2001) and Gerhardt (2004) emphasise that attachment styles, internal working models and emotional regulation strategies manifest in the therapeutic relationship and the alliance. Conversely, the client-therapist relationship can serve as a secure base from which clients with drug problems can make changes to their unhelpful emotional regulation strategies and ways of relating to others.

As such, attachment theory and research (Holmes, 2001; Bowlby 1988) and the systemic approach adopted by Gerhardt (2004) indicate that the alliance may be particularly important for therapists working with individuals with drug problems. Clients with drug problems may have difficulties in using their therapist, a human being, as opposed to a drug, an inanimate object, for affect regulation. When entering therapy, clients also face the prospect of severing the relationship with their secure base, i.e. their substance of choice. This may lead to substantial anxiety and ambivalence, thus impacting on their ability to establish an alliance with their therapist. Furthermore, it is possible that many clients with drug problems have internal working models that could impact unhelpfully on the alliance with their therapist (Holmes, 2001). Similarly, they may have difficulties in regulating their emotions, which could render the alliance fragile (Gerhardt, 2004). Therefore, therapists may face particular difficulties in connecting with clients who use drugs, and may find themselves competing with drugs to become a secure base (Holmes, 2001). This emphasises the significance of the alliance for therapists who work with clients who use drugs. Moreover, it highlights the relevance of exploring therapists' experiences of the alliance with clients who use drugs.

1.4.2   Stigma and substance use

Research into subjective experiences of substance use and the stigma surrounding substance use further suggests that the alliance may be pertinent for therapists who work with individuals with drug problems.

Goffmann (1963) proposed that stigma is constructed by society. He defined stigma as a degrading attitude of society which discredits individuals who have certain attributes that do not conform to the norms of society.

In a survey of the general population, Crisp, Gelder, Rix, Meltzer & Rowlands (2000) concluded that individuals with substance use problems were perceived as unpredictable and dangerous. Moreover, substance use problems were viewed as self-inflicted conditions. Additionally, health professionals have been found to hold stigmatising opinions about individuals with substance use problems (Lovi & Barr, 2009; Peckover & Chidlaw, 2007; Skinner et al., 2007; Crome & Shaikh, 2004). Similarly, Luoma et al. (2007) found that individuals with substance use problems experience stigmatising attitudes and behaviours from others. For example, most participants in Luoma et al.'s study had encountered interpersonal rejection because of their substance use. Furthermore, Tsogia, Copello & Orford (2001) highlighted in a review of literature that fear of being stigmatised acted as a barrier for individuals entering substance use treatment. The fear was associated with an expected stigmatisation from society as a consequence of receiving treatment.

In line with this, qualitative research into experiences of substance use suggests that individuals with substance use problems may perceive themselves as different from what they deem 'normal' society (Shinebourne & Smith, 2011; Watson & Parke, 2011). For example, participants in one study relayed how addiction, 'disables me from functioning in normal society' (Larkin & Griffiths, 2002, p. 305) whilst another stated, 'My probation officer says to me "you are normal." I said "I'm not." Coz I'm a drug addict' (Watson & Parke, 2011, p. 113). Moreover, Boserman (2009) concluded that participants in her study relayed, 'a sense of being different from the rest of the society' (p. 443), and Watson & Parke (2011) described how, 'some [participants] deemed themselves as deviating from normality' (p. 113). It is somewhat unclear how the participants in these studies defined themselves as

different from normal society. However, the studies demonstrate how individuals with substance use problems may adopt the stigma that is constructed and attributed to them by society, thus experiencing themselves as different from the norm (Watson & Parke, 2011).

With these findings in mind, it is possible that clients with drug problems enter therapy with an understanding of themselves as different to normal society and may expect to meet stigmatising attitudes from their therapist. Moreover, they may fear other people's reactions, should they decide to undertake therapy. Consequently, they could be ambivalent about entering therapy and possibly mistrust their therapist (Luoma et al., 2007). As such, it could require extra sensitivity and specific skills from therapists to establish the alliance. Moreover, therapists' ability to provide a relationship experience that does not correspond to their clients' expectations of being stigmatised could constitute a life changing experience for their clients. Again, this demonstrates the significance of the alliance for therapists who work with clients who use drugs, and renders the study of therapists' experiences of the alliance further relevant.

1.4.3 The alliance and outcome and retention in drug treatment

Research on the alliance and treatment outcome has found that the alliance plays a significant role in drug treatment and counselling (Orford, 2008). Mee-Lee et al. (2010) conclude that common factors, including the therapeutic relationship and the alliance, are superior in predicting therapeutic outcome above theoretical orientation and therapeutic techniques. The importance of the alliance in predicting outcome in drug treatment has been replicated in research by Crits-Cristoph et al. (2009).

Research further indicates that the alliance influences retention and therefore therapeutic outcome in drug treatment (PHE, 2013; King & Canada, 2004; Mee-Lee et al., 2010). Individuals with drug problems have high dropout rates from treatment (PHE, 2013; Mee-Lee et al. 2010). Indeed, the presence of substance use problems in clinical populations predicts unplanned endings (Saxon, Ricketts & Heywood, 2010). Conversely, retention in treatment predicts positive therapeutic outcome (Corrigan & Bogner, 2007; Simpson, 2004). Meier, Donmall, McElduff, Barrowclough & Heller (2006) found that individuals with weak alliances are more likely to drop out of drug treatment than those with stronger alliances.

This mirrors findings by Petry & Bickel (1999), Simpson (2004), Cournoyer et al. (2007) and Barber et al. (2001) who established the alliance as a predictor of retention in treatment. Similarly, qualitative studies involving professionals' perspectives of the therapeutic relationship suggest that the therapeutic relationship is implicated in retaining clients in treatment (Woolhouse et al., 2011; Kothari et al., 2010). As such, Meier et al. (2005) found in a review of literature that the alliance is a significant predictor of both engagement and retention in drug treatment as well as early treatment improvement. These findings suggest that therapists who work with individuals with drug problems may require specific skills to develop an alliance to retain clients in therapy and to obtain positive therapeutic outcomes. This highlights the importance of increasing and expanding our knowledge of how therapists understand the alliance with clients with drug problems.

1.4.4   Client and counsellor ratings of the alliance

Alliance research in drug treatment has further focussed upon client and counsellor ratings of the alliance. Meier & Donmall (2006) found client and counsellor ratings of the alliance only to be weakly correlated. Moreover, the correlation between ratings grew weaker across therapy. Tryon et al. (2007) found that clients rated the alliance higher than therapists. Hence, it appears that counsellors have different frames of reference from which they evaluate and perceive the alliance to their clients. As such, it seems there is something yet to be understood about therapists' experiences of the alliance. This emphasises the need for further exploration of the alliance as it is experienced by therapists who work with clients with drug problems.

1.4.5   Therapist factors

Meier et al. (2005) suggest that the alliance is impacted upon by therapist characteristics. Counsellors who have a history of using drugs, more experienced counsellors and male counsellors received higher alliance ratings from their clients than less experienced counsellors, female counsellors and those who have not used drugs. Similarly, Bethea, Acosta & Haller (2008) report a good alliance to be associated with clients' perceptions of their therapist as collaborative, empathic and respectful. In line with this, Cournoyer et al. (2007) found that clients' perceptions of their therapist as understanding and involved were significant predictors of retention in counselling. Knowledge about the impact of therapist

factors on the alliance can help to facilitate interventions, which can, in turn, improve the alliance and thus therapeutic outcome (Meier et al., 2005). This highlights the value of research that aims to deepen our knowledge of the factors that therapists understand to help and hinder the alliance.

1.4.6 Summary of The significance of the alliance for therapists who work with clients with drug problems

The alliance seems pivotal for therapists in engaging and retaining clients in therapy (Corrigan & Bogner, 2007; Simpson, 2004). Moreover, the alliance is impacted upon by therapists' characteristics (Meier et al., 2005), and yet therapists' understandings of the alliance have not been fully explored (Tryon et al., 2007; Meier & Donmall, 2006). In addition, attachment theory (Holmes, 2001; Bowlby, 1988), the systemic approach adopted by Gerhardt (2004), stigma research (Luoma et al., 2007) and research into subjective experiences of substance use (Shinebourne & Smith, 2011) indicate that therapists may encounter specific challenges and may therefore require specific skills in developing an alliance with clients with drug problems.

1.5 Is quantitative research adequate in exploring the alliance?

The majority of the existing alliance research in substance use reviewed so far is grounded in positivist/postpositivist epistemologies and employs quantitative methodologies (Clark, 2009; Orford, 2008). Positivist/postpositivist research on the alliance has significantly increased our knowledge of the central role of the alliance in drug treatment. However, it can be argued that using quantitative measures results in researcher defined beliefs about the alliance being imposed upon participants (Orford, 2008; Langdridge, 2007). Consequently, aspects of clients'/therapists' experiences of the alliance and meanings attributed to these remain unexplored (Creswell, 2009). Conversely, qualitative research is suitable for exploring therapy processes and human experience in depth. Thus, qualitative research can increase our understanding of the meanings that therapists attach to their experiences of the alliance (Orford, 2009; Morrow, 2007). Indeed, the gaps in research outlined in this literature review, and the failure of quantitative research to shed further light upon these gaps, demonstrate the appropriateness of applying a qualitative

methodology to explore therapists' experiences of the alliance with clients with drug problems.

1.6   Subjective experiences of the alliance in substance use

Existing qualitative research exploring subjective experiences in substance use focuses predominantly on **clients', psychologists' or health professionals' general experiences of therapy or treatment**, within which the therapeutic relationship is deemed significant. As such, there is a paucity of research exploring **therapists' experiences of the alliance specifically**. This section briefly outlines clients' perceptions of drug treatment and the therapeutic relationship. This is followed by a review and critique of research relevant to the study of therapists' experiences of the alliance with clients who use drugs. Gaps in research and the significance of the alliance for therapists will be commented upon throughout.

1.6.1   Clients' subjective perceptions of treatment

Research demonstrates that clients with substance use problems view the relationship with their counsellor or treatment staff (henceforth 'staff') as central to their treatment experience (Edwards & Loeb, 2011; Godlaski, Butler, Heron, Debord & Cauvin, 2009; Redko, Rapp, Elms, Snyder & Carlson, 2007). Clients value being met with empathy, understanding, respect and a non-judgemental approach. Furthermore, clients emphasise a collaborative approach as important to their treatment experience (Edwards & Loeb, 2011; Redko et al., 2007), and highlight trust in their counsellor/staff as indicative of a good therapeutic relationship and alliance (Nordfjaern, Rundmo & Hole, 2010; Godlaski et al., 2009; Redko et al., 2007; Bacchus et al., 1999). Indeed, clients deem a relationship based upon trust a new relational experience compared to their usual interpersonal relationships (Lovejoy et al., 1995). As such, clients' relationship with their counsellors/staff is essential in meeting treatment goals (Banazadeh, Kheradmand & Abedi, 2009) and facilitating engagement in treatment (Lovejoy et al., 1995). Moreover, the relationship enables both general therapeutic change (Edwards & Loeb, 2011; Lovejoy et al., 1995) and changes in clients' interpersonal relationships (Redko et al., 2007).

Conversely, clients view mistrust in their counsellor/staff and feeling misunderstood and judged as detrimental to their treatment experience and to achieving therapeutic change. Furthermore, these negative therapeutic relationship experiences impact on drop out from treatment (Edwards & Loeb, 2011; Nordfjaern et al., 2010; Banazadeh et al., 2009; Lovejoy et al., 1995).

These findings further demonstrate the significance of the alliance for therapists who work with clients who use drugs. For example, it seems therapists may require specific skills in facilitating an empathic, non-judgemental and collaborative space to retain clients in therapy. This seems significant given the difficulties inherent in retaining clients with drug problems in treatment (PHE, 2013). Moreover, therapists' ability to create trust in the alliance seems paramount. Indeed, the alliance may provide a new relationship template for clients. This is important in light of the interpersonal problems that clients with drug problems may experience (Holmes, 2001; Gerhardt, 2004).

1.6.2 Psychologists' experiences of working with clients who use substances

Kothari et al. (2010) investigated clinical psychologists' experiences of working therapeutically with clients with substance use problems. Specifically, they explored what clinical psychologists found helpful and hindering in their clinical work. The therapeutic relationship was deemed essential in facilitating the psychologists' clinical work.

Kothari et al. (2010) found that the psychologists perceived their ability to establish good therapeutic relationships as central to engaging clients in therapy and obtaining good therapeutic outcomes. The psychologists emphasised the importance of the relationship involving collaboration and flexibility, for example around discharge and use of therapeutic interventions. They further reflected that a good therapeutic relationship served as a safe, positive relationship template that clients often lacked in their interpersonal relationships. Moreover, they viewed the therapeutic relationship as a platform that enables clients to resolve their internal working models. This mirrors clients' perceptions of the therapeutic relationship, and further corresponds to existing attachment research and Holmes' (2001) and Gerhardt's (2004) views on substance use. Moreover, the findings are consistent with research implicating the alliance in treatment outcome and retention.

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Additional findings from Kothari et al.'s study demonstrate the psychologists' need to find hope in their work and understanding the meanings of their clients' substance use. The psychologists further spoke of the responsibility held in relation to risk management and the subsequent fear this elicited for them. They also revealed a need for possessing tolerance, such as demonstrating emotional resilience and managing disappointment. Conversely, lacking hope and dealing with disappointment and lack of success hindered their therapeutic practice.

Whilst Kothari et al. (2010) explored what clinical psychologists found hindering within their work, the study reports merely two clear examples to this effect; lacking hope and dealing with disappointment and lack of success. The remainder of the findings appear to outline aspects of the psychologists' clinical work that aided their therapeutic practice in developing. This indicates a need for capturing the experiences that therapists perceive to hinder the alliance in developing when working with individuals with drug problems.

Kothari et al.'s study contributes immensely to our understanding of the significance of the client-therapist relationship in substance use. However, their study is subject to certain limitations. The study lacks an account of IPA's philosophical underpinnings of phenomenology and hermeneutics (Husserl, 1967; Gadamer, 1960/1995, cited in Dahlberg, 2006, p. 94). Moreover, the researchers fail to make their research questions explicit, rendering the focus of the research somewhat unclear. This is exacerbated by the misleading title 'The therapeutic relationship between therapists and substance-using clients'. In reality, the research aimed to, 'explore the experiences of therapists, specifically clinical psychologists, working with substance-using clients' (p. 259), within which the therapeutic relationship was deemed significant. Finally, the main theoretical anchor of the research is 'the therapeutic relationship'. However, the study fails to define the therapeutic relationship, thus jeopardising the theoretical rigour of the research. These epistemological, methodological and theoretical shortcomings cast doubt on the rigour and therefore the credibility of the study (Yardley, 2000).

1.6.3 Professionals' experiences of working with clients who use substance

The remainder of existing qualitative research involving the alliance in substance use concerns health professionals', not therapists', understandings of the therapeutic relationship or their general experiences of working with clients with substance use problems. This body of research indicates the importance of the client-therapist relationship in substance use.

Research suggests that health professionals who work with clients who use substances consider a good therapeutic relationship to consist of being present and available to clients, conveying understanding and compassion, gaining clients' confidence and facilitating a trusting environment (Woolhouse et al., 2011; Hoxmark & Wynn, 2010). This, in turn, is viewed as central to engaging clients in treatment (Woolhouse et al., 2011). Health professionals further emphasise the importance of providing safety and stability through the therapeutic relationship (Hoxmark & Wynn, 2010). This includes being reliable and predictable to clients, whilst providing a stable and consistent space (Woolhouse et al., 2011). Finally, the relationship is seen as central to treatment by offering clients a new relational experience (Hoxmark & Wynn, 2010).

Conversely, Roche, Guray & Saunders (1991) explored general practitioners' (GPs') experiences of working with patients with substance use problems. Only a small subset of the GPs perceived themselves as having a role in the management of substance use. A smaller subset worked to establish an alliance with their patients. Many GPs immediately referred their patients to specialist services and most displayed discriminatory attitudes towards their patients. As such, this study differs from the previously reviewed studies. Not only did participants display overt discrimination towards individuals with drug problems, most rejected entering a relationship with them at all. These findings resonate with research on stigma, indicating that clients with drug problems may encounter stigmatising attitudes from health professionals. As stated, this could impact on their ability to form an alliance in therapy.

1.6.4 Critique of research exploring professionals' experiences of working with clients who use substances

The studies concerning health professionals' experiences of working with clients who use substances are subject to significant epistemological and methodological difficulties. Both Woolhouse et al. (2011) and Hoxmark & Wynn (2010) employ a phenomenological methodology. Whilst Hoxmark & Wynn cite Giorgi (1997), Woolhouse et al. do not specify their data analysis. Moreover, both studies lack epistemological acknowledgement and an outline of the phenomenological position as well as bracketing and reflexivity (Husserl, 1967). This makes it difficult to ascertain whether the researchers closely described participants' experiences as required by a phenomenological approach. Moreover, the lack of epistemological recognition questions the philosophical framework of the studies and therefore the credibility of the findings (Morrow, 2007).

Similarly, Roche et al. (1991) do not make their epistemological assumption known (Morrow, 2007). It is therefore difficult to ascertain the philosophical lens from which the investigation should be evaluated (Nielsen, 2007). Moreover, the study appears to utilise an unspecified form of thematic analysis. Thus, it is unclear whether the researchers intended to identify themes on latent or semantic levels, which makes it difficult to evaluate the themes generated from their data analyses (Braun & Clarke, 2006).

These epistemological and methodological shortcomings and inconsistencies raise doubts about the rigor with which the studies have been carried out and compromise the credibility of the findings (Creswell, 2009).

1.6.5 Qualitative concerns

A specific shortcoming of the studies investigating psychologists' and health professionals' experiences of working with clients who use substances concerns the failure to embrace the values of qualitative research.

Firstly, some researchers seem to evaluate their studies against positivist criteria. Kothari et al. (2010) and Hoxmark & Wynn (2010) highlight that their small sample sizes do not allow for generalisability of findings. As such, the researchers apologise for lacking the

large sample sizes and wide applicability of positivist/postpositivist research (Ponterotto, 2005). This is inherently at odds with the aim of qualitative research, which is concerned with generating in depth and rich data that allows for theoretical transferability (Smith, Flowers & Larkin, 2009; Ponterotto, 2005).

Moreover, Kothari et al. (2010) present individuals with substance use difficulties in a negative light to build an argument for their research. The researchers invite the reader to consider the adverse impact of substance use upon the individual and those around them. In this manner, individuals who use substances are portrayed as problematic, and research is proposed to be necessary to prevent further damage from being inflicted to the individual and others.

Additionally, several studies utilise pathologising language to describe individuals with substance use problems, e.g. 'substance-using clients' (Kothari et al., 2010, p. 257), 'substance abuse patients' (Hoxmark & Wynn, 2010, p. 189), 'opiate users' (Roche et al., 1991, p. 263), 'drug-using women' (Woolhouse et al., 2011, p. 48). This type of language constructs the individual in terms of their substance use, thus painting a picture of an individual whose entire being is defined by substance use and who lacks significant qualities and worth.

The pathologising and problematising of individuals with substance use problems are at odds with qualitative inquiry. Qualitative research values the relationship between researcher and participant/topic of inquiry (Morrow, 2007) and aims to be sensitive towards the participant/topic of inquiry. Moreover, qualitative research aims to employ language that is respectful of participants (Yardley, 2000). The failure to do so disturbs the power balance between researcher and participant/topic of inquiry that qualitative research works so hard to erode (Morrow, 2007; 2005).

1.6.6 Summary of Subjective experiences of the alliance in substance use

Research indicates that the alliance is central to engaging and retaining clients in treatment and facilitating therapeutic change (Gerhardt, 2004; Holmes, 2001). Moreover, it appears the client-therapist relationship holds particular significance by providing a new relational

experience for clients who use substances (Holmes, 2001). It further seems that facilitating a stable and safe space characterised by trust may be essential for alliance building with clients who use drugs. The study by Roche et al. (1991) corroborates findings that individuals with substance use problems may frequently be subjected to stigmatisation from health professionals.

Gaps in literature and research emphasise areas in need of exploration. It appears there is a paucity of research exploring therapists', as opposed to health professionals', understandings of the alliance with clients with drug problems. Closer exploration of aspects of therapy that therapists experience to hinder the alliance also appears warranted. Moreover, it seems a need exists for methodologically and epistemologically rigorous qualitative research that embraces the value of qualitative inquiry in generating in depth and rich knowledge about the alliance in drug treatment (Morrow, 2007, 2005; Yardley, 2000).

1.7   Therapists' resources

As we have seen, therapists may encounter particular difficulties in relating to clients who use drugs (Gerhardt, 2004; Schindler et al., 2005). Hence, it is likely that therapists rely upon specific sources of support to develop and maintain the alliance with their clients. This area of literature and research appears scarce, thus indicating the need for expanding our knowledge of the particular resources that therapists may incorporate into their clinical work.

Kothari et al. (2010) report that 'finding hope', understanding the 'core meanings' of clients' substance use, managing 'fear and responsibility' and possessing 'tolerance' were crucial for psychologists when working therapeutically with clients who use substances. Here, it seems the psychologists spoke of resources located within themselves, which they developed and drew upon in their practice. Kothari et al. (2010) do not report the use of additional sources of support, such as clinical supervision or the use of self.

1.7.1 Clinical supervision

General psychotherapy research suggests that therapists incorporate clinical supervision into their clinical work. Clinical supervision aims to develop therapists' skills, knowledge and awareness, whilst simultaneously protecting the wellbeing of the client and enhancing the quality of the therapeutic relationship (Vallence, 2005). Wheeler & Richards (2011) concluded that supervision facilitates therapists' self-awareness, which subsequently impacts on therapists' understanding and management of transference and countertransference. Moreover, supervision allows therapists to develop technical skills and skills in developing and maintaining therapeutic relationships. Furthermore, supervision ensures that therapists' own emotions and difficulties do not impact upon their client work. Angus & Kagan (2007) suggest that the supervisory relationship allows therapists to gain knowledge about building effective relationships with clients. This links with the idea that supervisors act as a secure base for therapists, thus constituting a forum for soothing, guidance and protection (Gunn & Pistole, 2012).

Qualitative research extends these finding. Vallence (2005) found that supervision enables therapists to develop greater self awareness by exploring the dynamic between client and therapist. Furthermore, supervision facilitates therapists' professional development, identity and ethical practice, whilst providing a forum for skills development. Additionally, working with parallel processes in the supervisory relationship (Tracey, Bludworth & Glidden-Tracey, 2012) enhances therapists' understanding of their clients and focuses their client work (Vallence, 2005; Wells, Trad & Alves, 2003). Supervision has also been found to encourage therapists' reflective practice, which in turn facilitates effective engagement in their therapeutic practice (Johnston & Milne, 2012; Crocket et al., 2009). These findings highlight that supervision enables therapists to establish effective alliances with their clients and manage difficulties in their clinical work. Given the potential challenges in developing an alliance with clients who use drugs, it seems likely that clinical supervision may be particularly pertinent for therapists who work with clients with drug problems.

1.7.2 Use of self

Looking again towards general psychotherapy research, research illustrates that many therapists use their inner experience to facilitate their clinical work (Karamanolaki, 2008).

The encounter between therapist and client takes place in an inherently intersubjective space (Zachrisson, 2009). As such, therapists may rely upon their emotional and behavioural responses to make sense of their clients' emotions and interpersonal difficulties (Zachrisson, 2009). Within psychodynamic literature this is referred to as countertransference (Winnicott, 1949). Incorporating the use of countertransference in clinical work requires therapists to be aware of the feelings and responses that belong to themselves and those that may be elicited in them by their clients (Heimann, 1950). This enables therapists to develop insight into their clients' patterns of relatedness and prevents the acting out of the countertransference. Indeed, management of countertransference has been found to promote a positive therapeutic outcome (Hayes, Gelso & Hummel, 2011). In this manner, therapists may draw upon the 'use of self' and their inner experience in developing and maintaining effective alliances with their clients. Given the potential difficulties in relating to clients with drug problems (Holmes, 2001; Gerhard, 2004), it is possible that therapists may make particular use of the self when developing an alliance with their clients.

1.7.3   Summary of Therapists' resources

A paucity of research exists that explores the resources that therapists draw upon to develop and maintain the alliance with clients who use drugs. Findings from psychotherapy research suggests that clinical supervision and the use of self may be sources of support that therapists can helpfully draw upon when relating to clients with drug problems.

1.8   Summary of literature review

This review of literature outlined the debate surrounding the definition of the alliance and proposed how Safran & Muran's (2003) conceptualisation of the alliance informs the current study. The review further outlined how the current measures of the alliance do not seem to reflect the sophistication and complexity of the theoretical debates and understandings of the alliance.

Additionally, the review demonstrated the relevance of exploring therapists' experiences of the alliance with clients with drug problems. The alliance seems pivotal for therapists in engaging and retaining clients in therapy and achieving good therapeutic outcomes

(Woolhouse et al., 2011; Kothari et al., 2010; Corrigan & Bogner, 2007; Meier et al., 2005; Simpson, 2004). Moreover, it appears there are aspects of therapists' understandings of the alliance that remain unclear (Tryon et al., 2007; Meier & Donmall, 2006). It further seems that providing a stable and safe space characterised by trust is essential for developing the alliance with clients who use drugs (Hoxmark & Wynn, 2010). Additionally, clients with drug problems may have difficulties in relating to their therapist (e.g. Gerhardt, 2004; Holmes, 2001). Psychotherapy research suggests that clinical supervision and the use of self are sources of support that therapists can use in developing the alliance with clients with drug problems (Karamanolaki, 2008; Vallence, 2005).

Moreover, the review highlighted that there is a paucity of research exploring therapists' understandings of the alliance with clients with drug problems. Further exploration of aspects of therapy that therapists experience to hinder the alliance also appears appropriate. Moreover, it seems a paucity of research exists that explores the resources that therapists' draw upon to develop and maintain the alliance with clients who use drugs. It seems methodologically and epistemologically rigorous qualitative research could help to expand our knowledge of therapists' experiences of the alliance with clients with drug problems (Morrow, 2007).

1.9   Research questions

Based upon the above listed gaps in research and literature, this study is exploratory in nature and makes no testable predictions. Instead, in line with the qualitative research paradigm, the following open-ended research questions were investigated:

How do therapists experience and understand the therapeutic alliance with clients who have drug problems?

What do therapists perceive to impact upon establishing and maintaining the alliance with clients who have drug problems?

What might support therapists to engage in effective alliances with clients who have drug problems?

1.10 Relevance to counselling psychology

The co-morbidity of mental health problems and substance misuse in the United Kingdom has been found to be highly prevalent across mental health teams and in GP surgeries (Frisher, Collins, Millson, Crome & Croft, 2004; Weaver et al., 2003). Indeed, Kessler (2004) reported that primary mental health problems predict the development of substance use problems. Similarly, the DOH (2007) reported a high incidence of mental health problems amongst clients in drug services. As such, psychological interventions play an increasingly important role within drug treatment and have been deemed crucial in enabling individuals to change their drug use and associated psychological difficulties (Pilling et al., 2010; DOH, 2007). In line with this, a document entitled 'Psychosocial Interventions for Drug Misuse' (Pilling et al., 2010) was commissioned by the National Treatment Agency (now PHE) from the British Psychological Society (BPS). The document provides National Institute for Clinical Excellence (NICE) guidance to drug treatment services on implementing evidence-based interventions for drug use and co-morbid mental health problems.

Accordingly, drug treatment services in the United Kingdom offer various types of psychological therapies. These therapies fall into two broad categories; those that aim to enable clients to change their drug use, and those that aim to alleviate underlying co-existing mental health difficulties. The latter type of interventions, delivered by psychologists or specialist therapists, include evidence-based psychological therapies, such as cognitive behavioural therapy (CBT) for depression and anxiety disorders (DOH, 2007; NICE, 2007; Wanigaratne, Davis, Pryce & Brotchie, 2005). These interventions target underlying mental health problems and provide a crucial platform from which individuals can change their substance use (Wanigaratne et al., 2005).

Given the co-morbidity of mental health problems and drug use, plus the increased inclusion of psychology in drug treatment, it is likely that counselling psychologists during their careers will encounter clients who have drug problems. These encounters may take place in drug services or in generic psychology services. Consequently, exploring how therapists experience and understand the alliance with clients who use drugs could inform clinical practice for counselling psychologists. Moreover, investigating the resources that

therapists draw upon to develop alliances with their clients could inform training and professional development avenues for counselling psychologists.

Furthermore, counselling psychologists acknowledge the way in which marginalisation and discrimination affect the individual. As such, counselling psychologists commit to anti-discriminatory practices, work towards empowering the individual and, 'seek to relate to the whole person with the problem, regardless of the way in which he or she may be perceived by wider society' (Division of Counselling Psychology (DCoP), 2013). The literature review demonstrated the stigmatisation that individuals with drug problems are subjected to. As such, counselling psychologists are strongly placed to undertake clinical work with individuals with drug problems. Counselling psychologists are also ideally positioned to promote equal opportunities for individuals with drug problems, for example at service provision level. As such, the finding from this study can influence the way in which counselling psychologists provide therapy to and advocate for a marginalised client group.

Finally, the alliance is a popular topic of research within counselling psychology (Kivlighan & Shaughnessy, 2000). The BPS DCoP notes that counselling psychology, 'continues to develop models of practice and research which marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship' (DCoP, 2013). Moreover, with its roots in Humanism (Rogers, 1957), counselling psychology centralises the helping relationship, and therefore the alliance, in its ethos, research and clinical practice (Burton & Davey, 2003; Strawbridge & Woolfe, 2003). It follows that counselling psychology emphasises therapists' self awareness and use of self as core aspects of the therapeutic encounter (Strawbridge & Woolfe, 2003). As such, this study explores concepts that lie at the heart of what it means to be a counselling psychologist.

Chapter 2: Methodology

This chapter outlines the study's epistemological position, hermeneutic-phenomenology, and the study's methodological framework, interpretative phenomenological analysis (IPA) (Smith et al., 2009). The chapter demonstrates how IPA grounded in hermeneutic-phenomenology enables the exploration of therapists' experiences and understandings of the alliance with clients with drug problems. The chapter further describes the procedures utilised in the study and, finally, outlines the study's ethical and credibility issues in line with IPA and the qualitative research paradigm.

2.1 Epistemological position

Epistemology is a branch of philosophy concerned with knowledge and how reality is known (Morrow, 2007). Counselling psychology research was until recently dominated by quantitative methods anchored in positivist and postpositivist epistemologies (Ponterotto, 2005). Positivism is concerned with verifying existing theories, and assumes that measurement and observation of behaviour, senses and language provide access to an objective reality. Postpositivism proposes a modified stance by acknowledging the impossibility of accessing objective reality. Nonetheless, it assumes that scientists can *approach* this unknown quality through the process of falsifying existing theories (Creswell, 2009). Thus, positivist and postpositivist research generate testable hypotheses and aim to observe and predict phenomena. Their research questions, therefore, are closed and inquire about causal relations (Creswell, 2009).

2.1.1 Qualitative inquiry

Sceptical of the suitability of quantitative positivist/postpositivist research in capturing the complexity of human experience, counselling psychology increasingly recognises the potential of qualitative research in obtaining in depth understandings of human experience (Morrow, 2007).

The current study is qualitative in nature. Qualitative research is concerned with describing and understanding human phenomena and experience in depth and aims to explore human

sense making processes. As such, it is ideal for investigating the processes of therapy (Morrow, 2007; Ponterotto, 2005). Qualitative research is exploratory, employs open ended research questions and relies upon language to access human experience (Langdridge, 2007). This enables qualitative research to capture the meanings of participants' experiences that cannot easily be accessed via questionnaires or observations (Morrow, 2007). Qualitative research is typically employed to investigate previously unexplored phenomena or to add in depth knowledge to phenomena that are not well understood (Creswell, 2009).

Qualitative research is particularly relevant to the current study as it explores the alliance, a process within the therapeutic encounter. Moreover, the literature review identified that positivist/postpositivist research has struggled to tap into the specific features of the alliance in substance use (Orford, 2008), and has failed to illuminate the salient aspects of the alliance for therapists who work with clients with drug problems (Meier & Donmall, 2006; Meier et al., 2005). The ability of qualitative research to generate in depth and detailed understandings of therapists' experiences of the alliance with clients who use drugs thus renders a qualitative approach further relevant to the current study (Orford, 2008). Indeed, Clark (2009) and Orford (2008) advocate a shift in the epistemological assumptions of substance use research to obtain in depth accounts of subjective perceptions of treatment.

2.1.2   Phenomenology

Nielsen (2007) highlights the importance of qualitative researchers making their epistemological stance explicit to achieve coherence in the research process.
The proposed research is anchored in the hermeneutic-phenomenological epistemology, thereby bridging the phenomenological and hermeneutic positions. The phenomenological position, developed by Husserl (1967), posits that language provides access to subjective reality. Phenomenology is concerned with how humans make sense of and assign meaning to their world (Bryman, 2008). According to phenomenology, knowledge is derived from human experience (Becker, 1992) and phenomenologists attempt to capture the essence of experience by bracketing previous knowledge about phenomena (Husserl, 1967). Heidegger

(1927/1962, cited in Ashworth, 2006, p. 24) recognised the impossibility of bracketing and suggested that knowledge is derived from interpretation. He rejected the notion that language provides direct access to phenomena, and instead proposed that humans exist in context of their world and are therefore intrinsically engaged with, assign meaning to and interpret their world. Thus, Heidegger assumed an interpretative stance to knowledge production, thereby introducing hermeneutics in phenomenology.

2.1.3   Hermeneutics

According to the hermeneutic epistemology, knowledge is obtained via interpretation. Hermeneutics is concerned with subjective experience and the interpretation of meaning, and posits that interpretation is influenced by the researcher's and participant's context, e.g. history, culture, language (Schleiermacher (1768-1834, cited in Bauman, 2010, p. 17). Gadamer (1960/1995, cited in Dahlberg, 2006, p. 94) proposed that the researcher/participant is always influenced by their preconceptions of phenomena. Thus, when assuming a hermeneutic position, the researcher's/participant's context and preconceptions are viewed as intrinsic to knowledge production (Bauman, 2010). Moreover, knowledge is sought by placing the researcher's subjectivity in a *dialogue* with that of participants' (Gadamer, 1960/1995, cited in Dahlberg, 2006, p. 92).

The hermeneutic-phenomenological position was chosen as an anchor for the current study for several reasons. The study's research questions are concerned with exploring therapists' subjective understandings and experiences of the alliance. Moreover, the study strives to closely describe their experiences of the alliance (Husserl, 1931), although recognises that this process depends on the interpretative stance of participants and the researcher (Heidegger, 1962, cited in Becker, 1992, p. 13). Indeed, the hermeneutic turn is particularly appropriate for the study as it considers the researcher's preconceptions of substance use an asset to knowledge production (Bauman, 2010).

2.1.4   Limitations of hermeneutic-phenomenology

Hermeneutic-phenomenology can be questioned due to the conflict between phenomenology's concern with describing participants' experiences (Husserl, 1967) and the

hermeneutic claim that interpretation generates knowledge (Heidegger, 1927/1962, cited in Ashworth, 2006, p. 24). However, the epistemologies can appear limited when considered separately. The focus on interpretation when adhering to the hermeneutic position can lose participants' subjective experiences through interpretation (Bauman, 2010). Similarly, the bracketing inherent in assuming a purely phenomenological position seems implausible (Koch, 1995), and the resulting essence of experience lacks the richness that interpretation provides (Bauman, 2010). Undoubtedly, the combination of phenomenology and hermeneutics is tension laden and dilemmatic. However, it provides a space that allows for closely accessing human experience, whilst interpretation adds depth and meaning to understanding experience (Pringle, Drummond & McLafferty, 2011).

2.2   Methodology

2.2.1 Interpretative phenomenological analysis

The study's methodology is interpretative phenomenological analysis (IPA) (Smith et al., 2009) and was chosen as it is consistent with the study's epistemological position. IPA employs a phenomenological strategy of inquiry and aims to closely describe and produce in depth accounts of participants' subjective, lived experiences and sense-making processes (Langdridge, 2007; Smith, 2004). Moreover, due to its hermeneutic influences, IPA moves beyond describing participants' experiences to the interpretation of participants' accounts. IPA embraces researcher subjectivity and recognises researchers' preconceptions as inherently embedded in knowledge production (Langdridge, 2007). Hence, IPA acknowledges the interpretative endeavour by both researcher and participant, thus creating a double hermeneutic whereby the researcher interprets participants' interpretations of their experiences (Langdridge, 2007; Smith, 2004). IPA is also strongly (and increasingly) idiographic. This refers to studying the particular, both in relation to studying individual cases carefully before moving onto the next, and in studying particular phenomena in depth (Smith et al., 2009).

IPA grounded in hermeneutic-phenomenology was chosen as the study's methodology for the purpose of generating in-depth insights into the alliance as experienced by therapists

who work with clients with drug problems (Langdridge, 2007). Furthermore, IPA acknowledges the researcher's preconceptions of the alliance with clients who use drugs (Smith et al., 2009). Additionally, the study's research questions are concerned with experiences of a significant phenomenon, the alliance, in line with IPA research (Smith et al., 2009). Indeed, the alliance that develops in the human encounter between therapists and clients with drug problems may be particularly meaningful, as described in the literature review.

2.2.2   Limitations of IPA

IPA's reliance upon language to access participants' experiences can be regarded as a limitation. Firstly, it is assumed that participants can reflect upon and articulate the richness of their experiences. This could be challenging for some participants. However, the current study's participants are therapists who engage in reflective practices, for example in supervision. Thus, they may be versed in reflecting upon and describing the meaning of their experiences. Secondly, IPA posits that participants' use of language describes their experience (Langdridge, 2007). A constructionist approach (see p. 122) advocates that the use of language construes reality. Thus, the words used by participants to describe experience construct a particular version of their experience, not the actual experience itself. Moreover, language can be viewed as *shaping* how participants experience and describe phenomena as opposed to merely *providing access* to participants' experiences. As such, IPA can be criticised for not engaging sufficiently with the role of language (Willig, 2008).

2.3 Reflexivity

Reflexivity is the process whereby the researcher reflects upon the impact of their subject position on the research (Williams & Morrow, 2009; Langdridge, 2007; Morrow, 2007). Making explicit one's reflexivity denotes the credibility of qualitative research and demonstrates the researcher's attempt to stay close to participants' experiences despite their preconceptions. Moreover, reflexivity allows the reader to identify the impact of the researcher's position on the study findings (Langdridge, 2007; Morrow, 2007).

2.3.1 The researcher's subjectivity

My interest in the alliance with individuals with drug problems originates from my previous employment in substance use. My job roles were as a substance misuse worker and I do not have experience of providing therapy to clients with substance use problems.

As noted in the Introduction, my work in substance use highlighted the challenges involved in developing and maintaining an alliance with clients who use drugs. Similarly, I discovered how important the alliance was to both my clients and I. Consequently, I developed a keen interest in the significance of the alliance in drug treatment.

During my training as a counselling psychologist, I became further interested in the alliance and its theory. I am particularly drawn to the central position of the alliance over and above specificity of therapy as this confirms my clinical experiences in substance use. Coupled with my interest in therapeutic work with clients with drug problems, this encouraged me to explore how therapists experience the alliance with clients who use drugs.

From working with individuals with drug problems, I hold ideas about the alliance with this particular client group. I also hold ideas about what helps and hinders the alliance and the resources that impact upon the alliance. For example, in my own work, I often found it challenging to connect with my clients, whilst they frequently rebelled against the boundaries of treatment. Moreover, I found it difficult to tolerate my clients' relapses that tested the alliance by leaving both my clients and I dispirited. Overall, it seemed the alliance was fragile and prone to rupturing. I also recall that supervision enabled me to persevere with developing the alliance. I further recall the joy I felt when my clients started to change their drug use. I was continuously astounded at how individuals with such difficult early experiences slowly found the strength to relate to me differently.

Undoubtedly, my preconceptions shaped the research process. For example, it is implied in the study's research questions that therapists require specific resources to develop alliances with clients who use drugs, as I did. Moreover, my pre-existing knowledge led me to interpret particular themes in the participants' accounts. I have included a section on

reflexivity later in the thesis (p. 97) in which I elaborate upon the impact of my subjectivity on the data analysis.

2.4 Sampling and recruitment

2.4.1 Sampling

The study employs purposive sampling to ensure that participants can relay the particular experience under study (Langdridge, 2007). Due to IPA's idiographic approach, the sample size is small, allowing for detailed, in depth engagement with individual participants' accounts. Furthermore, the sample is as homogenous as possible to allow for rich data to be obtained from participants' shared experiences. As such, the participants represent certain perspectives within a particular group of therapists, thus allowing for theoretical transferability of the study findings (Smith et al., 2009; Langdridge, 2007).

The research involved interviewing six volunteers, male and female therapists who have at least six months current or previous experience of working with clients with drug problems. The study did not discriminate between participants' gender, age, theoretical orientation or qualification. However, therapeutic work with clients with dual diagnosis and children was not considered for the study. This was to ensure homogeneity of the participants in terms of experiences that could influence their understandings of the alliance.

2.4.2 Issues of homogeneity

This study assumes two pillars of homogeneity: **therapists** who have at least **six months experience of working with individuals with drug problems**. IPA recognises that complete homogeneity is a relative phenomenon and that practicalities in recruiting and relevance to the research topic should be acknowledged (Smith et al., 2009).

The decision to include therapists/counsellors/psychologists of varying qualifications and theoretical orientations was made for practical reasons. Due to the diverse nature of therapists in drug services, it was beyond the scope of this study to recruit therapists of a more homogenous nature. It could be argued that failure to do so compromises the

participants' homogeneity. However, the study retains an acceptable level of homogeneity by assuming its two pillars, as outlined above. Additionally, the diversity of the participating therapists reflects the diversity of therapists in drug services. Thus, the study offers increased relevance to real life clinical practice.

Whilst IPA is concerned with homogeneity, it is also interested in subjective variations in the data. Indeed, the analysis of variations adds richness and breadth to the study's findings (Smith et al., 2009). The researcher identified first commonalities then variations across the data sets. Variations that became apparent as a result of the participants' diversity were contextualised in the findings (Langdridge, 2007).

2.4.3   Recruitment

Participants were recruited from within one non-statutory health care organisation. The researcher contacted the organisation by telephone to enquire about accessing volunteers. The researcher subsequently sent, via email (Appendix 1), a written invitation and information about the study (Appendix 2), the interview schedule (Appendix 3) and the ethics approval from the University of East London Research Ethics Committee (Appendix 4) to a Consultant Psychologist. The Consultant Psychologist sent therapists in the organisation written information about the study (Appendix 5), including a leaflet summarising the study (Appendix 6) and a consent form (Appendix 7). For ethical and confidentiality purposes, the participants were given the option of contacting me directly or contacting me via the Consultant Psychologist or his research colleague to arrange an interview. The Consultant Psychologist and his research colleague requested to be informed of the names of the participating therapists. This was to identify other suitable participants should the contacted therapists decline to take part. Participants were explicitly informed of this verbally and via email (Appendix 8), and all agreed to take part under these circumstances.

I met four participants in a private room in their workplace. I met two participants in their homes. For precaution, I called a designated person pre and post interviewing these two participants.

2.5   Data collection

2.5.1   Semi-structured interview

The research utilised semi-structured interviews to obtain rich accounts of participants' experiences (Smith et al., 2009). The semi-structured interview was chosen as the topic of investigation was known in advance, and because the structure of the questions ensures to capture maximum information about these topics (Langdridge, 2007; Smith, 2004; McLeod, 2003). The open-ended and non-directive interview questions were developed by the researcher (Appendix 3) and were pilot tested on two of the six participants. It was not necessary to adjust the questions following the pilots (Langdridge, 2007).

2.5.2   Procedure and participant profile

Prior to the interview, participants were required to sign a consent form, detailing information on confidentiality, anonymity and right to withdraw from the study (Appendix 7). Additionally, participants were verbally informed of the purpose and nature of the research and what was expected of them, including assurance of confidentiality and anonymity and right to withdraw. Demographic details of participants (age, gender, qualification, theoretical orientation, type of employment, length of experience of working with clients with drug problems and length of time since working with clients with drug problems) were obtained at the start of the interview (Appendix 3).

Table 1. outlines the profile of the participants. Two participants were male, four were female. Their experiences of working with clients with drug problems ranged from two to twenty years. One participant described their theoretical orientation as CBT, one as existentialist, one as eclectic and three as integrative. The participants worked across community substance use services, psychological therapies services and in private practice. They ranged in age from 27 to 58.

Name (pseudonym)	Age	Gender	Qualification	Theoretical Orientation	Current Employment	Length of experience of working with clients with drug problems
Melissa	58	Female	Trainee Counselling Psychologist/High Intensity Therapist	Cognitive behavioural therapy	Psychological Therapies Service	Approximately six years
Joe	36	Male	Advanced Diploma in Humanistic Counselling	Existentialism	Private practice and substance use service	Approximately six years
Alex	45	Male	Counselling Psychologist	Eclectic	Private practice and substance use service	Approximately 20 years
Lisa	27	Female	Trainee Counselling Psychologist	Integrative	Substance use service	Approximately two years
Nadine	42	Female	Diploma in Integrative Counselling	Integrative	Substance use service	Approximately two and a half years
Emilia	43	Female	Counselling Psychologist	Integrative	Substance use service	Approximately six-seven years

Table 1. Participant Profile

Interviews were recorded using a digital recorder with the participants' permission. The researcher also made written notes during and after the interview (Willig, 2008). Interviews lasted approximately 60 minutes, after which participants were offered debriefing. The researcher monitored signs of distress in the participants and would have terminated the interviews at signs of emotional disquiet. Details of external support agencies would have been provided had participants become upset (Appendix 9). Moreover, the researcher would have ensured that participants had existing sources of support available. None of the participants required such sources of support (Smith et al., 2009).

To adhere to principles of confidentiality and anonymity (Langdridge, 2007) participants' interview schedules (including demographic details) and consent forms were pre-marked with individually matching ID numbers. Participants' consent forms were stored in a locked storage compartment separate from the demographic details. Audio recordings and transcripts from each interview were marked with an ID number which linked them to the corresponding interview schedule and consent form. Data from the interview schedule, audio recordings, transcripts of interviews and the dissertation write up were stored

electronically and password protected. Any identifying details were removed from the working transcripts to ensure participants' anonymity.

2.6   Data analysis

In line with IPA's hermeneutic-phenomenological underpinnings, focus was initially directed towards closely describing participants' experiences. The analysis further included an interpretative aspect to add depth to our understanding of participants' experiences (Larkin, Watts & Clifton, 2006). The researcher engaged in reflexivity about how their preconceptions may impact upon the analysis by keeping a research journal (Yardley, 2000) (Appendix 10). The themes derived from the data analysis represent the researcher's subjective interpretation of the therapists' experiences and understandings of the alliance (Langdridge, 2007). There are many others ways of interpreting the data, and it is possible that different results could be produced from the same narratives.

Participant interviews were transcribed verbatim. Wide margins were left on each side of the transcript for writing comments (Appendix 11 on CD). IPA requires the analysis of cases one by one in line with its idiographic commitment. Thus, IPA involves the reading and re-reading of the transcript produced from one individual case. This was followed by making exploratory, descriptive, linguistic and conceptual comments in the left column of the transcript. Subsequently, themes from these comments were identified and noted in the right column (Appendix 12). Connections across emergent themes within the transcript were established and labelled, followed by a graphic presentation of the superordinate themes and subthemes in a table (Appendix 13). The researcher then moved onto the next case, following the same procedure for the remainder of cases (Smith et al., 2009). Following this, patterns of themes across cases were identified and presented in a master table (Appendix 14), including quotes (Appendix 15). This process was iterative and cyclical whereby the researcher continuously returned to the data to ensure that the themes captured the meaning of participants' experiences and that interpretations were grounded in the data (Langdridge, 2007).

2.7   Ethical considerations

The study obtained ethics approval from the University of East London Research Ethics Committee (Appendix 4) and followed the BPS' Code of Ethics and Conduct (2009).
As an IPA write up includes quotations from participants to evidence grounding of themes in participants' accounts (Morrow, 2005), the research obtained informed consent for this purpose specifically (Appendix 7). Moreover, the researcher was mindful of the power balance between researcher and participants; the phenomenological and idiographic influences of IPA ensure that individual perspectives are valued and retained in the study findings (Smith, 2004). Furthermore, the researcher considered how the participants may benefit from taking part in the research. By sharing their specialist knowledge of the alliance the participants contributed to a body of knowledge that will inform their clinical practice. Moreover, the study findings can lead to recommendations being made to improve the resources available to the participants in their clinical work (Yardley, 2000).

2.8   Quality and credibility

The quality of qualitative research is concerned with what is variously known as trustworthiness, rigor or credibility (Morrow, 2005). In the following, the term 'credibility' is used to denote how quality is ensured in the current research. Credibility depends to a large extent upon the epistemological underpinnings of the research (Morrow, 2007). This study provides consistency and coherence across the research process by adhering to the hermeneutic-phenomenology epistemology (Bryman, 2008) and the IPA framework (Smith et al., 2009). This ensures that credibility is achieved in providing a fit between the epistemological and methodological underpinnings of the research. Moreover, it provides a clear stance from which the research can be evaluated (Yardley, 2000). Credibility is further ensured by the researcher engaging in reflexivity throughout the research process by keeping a journal and making their reflective processes explicit (Morrow, 2005). Furthermore, transparency and coherence are achieved by clearly outlining the research process and leaving a paper trail (Smith et al., 2009). The homogeneity of the participant sample and the idiographic engagement with each participant's account is consistent with IPA research and therefore lends further credibility to the study. Finally, the included

verbatim extracts from participants' narratives evidence grounding of findings and arguments in these accounts in line with IPA research (Langdridge, 2007).

2.9   Summary of methodology

This chapter considered how qualitative inquiry, the epistemological position of hermeneutic-phenomenology and IPA (Smith, 2004) facilitate the in depth exploration of therapists' experiences of the alliance with clients with drug problems. The study's procedure and data analysis were outlined, as was the researcher's reflexivity. Finally, issues pertaining to ethics and credibility within the qualitative research paradigm and IPA were presented to evidence the quality of the research.

Chapter 3: Results

3.1   Overview

This chapter presents four superordinate themes derived from the interpretative phenomenological analysis (Smith et al., 2009) of six therapists' narratives in relation to their experiences and understandings of the alliance with clients with drug problems. The themes are as follows:

1. Trapped in the system
2. Struggling to connect
3. The contradictory therapist
4. Resources transcending the alliance

In the following, the four themes and their subthemes will be outlined. The themes indicate the commonalities across the therapists' accounts, although variations in the accounts will also be highlighted. Verbatim extracts from the therapists' accounts will be presented to evidence grounding of the themes in their accounts (Smith et al., 2009).

3.2   Introduction to the themes

The four superordinate themes outline how six therapists make sense of the alliance with clients with drug problems. The superordinate themes are distinct but linked in that together they provide a rich insight into the contextual and relational tensions that the therapists and their clients struggle with. As such, the therapists describe the alliance as impacted upon by an organisational and governmental treatment system in which both client and therapist become trapped. Moreover, the therapists appear to struggle to connect with their clients, partly as a result of the treatment system, and ultimately assume responsibility for the alliance to avoid disconnection from their clients. Additionally, the therapists' narratives contain numerous contradictions. These contradictions seem indicative of unacknowledged tensions that the therapists experience about the alliance. As such, the contradictions may suggest that the therapists find it difficult to acknowledge that there are parts of the alliance they cannot make sense of. Moreover, the therapists seem to

struggle to acknowledge that the alliance with their clients is different to the alliance with generic clients, and that this alliance can be inherently difficult to develop and maintain. Finally, the therapists recount the resources that enable them to develop and maintain the alliance with their clients.

3.3   Theme 1: Trapped in the system

This superordinate theme illustrates the therapists' experiences of the alliance with their clients as situated within a wider organisational and governmental treatment system. It contains four subthemes:

The trapped therapist
The trapped client
Hopelessness
Navigating the system

Some of the therapists describe how the alliance with their clients is embedded in a treatment system that significantly restricts the alliance. The treatment system seems to impact significantly upon several aspects of the alliance, including the collaborative and purposive work of therapy, the negotiation of the tasks and goals of therapy as well as the development of the bond between client and therapist. The therapists relay how both therapist and client become trapped in the system and experience little choice and freedom. Consequently, the therapists describe feeling dissatisfied and hopeless, leading them to make specific attempts to navigate the system to strengthen the alliance with their clients.

3.3.1   The trapped therapist

This subtheme demonstrates how some therapists understand the alliance with their clients to be situated within a treatment system. They describe how different aspects of the system prevent them from forming a meaningful alliance with their clients, and recognise that their clients' needs are sometimes not met. They view themselves as trapped in the system with little room for manoeuvre and express dissatisfaction with this. The following statement

from Joe captures the dissatisfaction. Joe speaks about having to comply with service policies to engage clients by contacting them when they fail to attend therapy.

 "I mean there's also policies that you have to comply with that aren't aren't what I what I would do given the free rein that I have in private practice" (Joe: 168-171).

The words 'free rein' and 'have to comply with' denote Joe's experience of being trapped in a system in which he cannot make his own choices. Joe pitches the freedom in private practice against restrictive service policies, thus viewing his freedom in the service as seriously compromised. He outlines how he must follow procedures that are detrimental to the alliance because they place him in a position of chasing his clients when they show limited willingness to relate to him, thus undermining the collaborative aspect of the alliance.

Melissa reflects upon a different part of the system. She speaks about finding it difficult to merely provide short term therapy to clients with personality issues.

"I mean, all of this [personality issues] is entirely possible to work with but, you know, a lot of the time it doesn't get addressed unless somebody is in inpatient care [...] in shorter term therapy it's very difficult to work with that" (Melissa: 212-220).
"So, it's better to see you and have some level of therapeutic alliance with somebody than nothing" (Melissa: 251-254).

Unable to refer her clients to secondary care, Melissa describes how the system prevents her from working with clients in a way that is congruent with their needs. Specifically, her second quote suggests that the relationship experience she is able to offer her clients is inadequate. Both quotes denote a sense of being trapped – she is stuck working with client presentations that belong in secondary care. Moreover, she knows the alliance is inadequate, but she sees no options but to offer it. Thus, Melissa appears to have little choice but to operate within the system to her best ability.

Similarly, Alex understands the alliance with his clients as being influenced by organisational requirements. He reflects upon the tension between meeting clients' needs and organisational needs.

"...it is really significant when the client is the driver of where they are going and whether due to financial pressures, in a tax system or whatever and you have to reach as many people as possible, as quickly as possible...we prioritise, erm, us at least partially driving the change.. It's a difficult balance" (Alex: 141-165).

Alex' statement 'it's a difficult balance' indicates the tension between meeting his clients' needs and meeting the needs of the organisational system. He acknowledges that it is significant for the alliance when the client is in control of change, but has to work within an organisation that dictates therapeutic goals. Thus, Alex' desire for allowing the client to be the 'driver' of change is compromised when he meets organisational requirements. Again, he appears stuck in a system that impacts on the alliance but must function within it.

3.3.2   The trapped client

This subtheme outlines how the majority of the therapists understand their clients to be equally trapped in the system. The theme highlights, firstly, how some clients are forced to attend therapy to address their drug use. As such, the treatment system determines the goal of therapy, which the therapists describe as detrimental to the alliance.

Joe and Alex reflect upon working with clients who are involved with the criminal justice system. In this manner, clients can be given court orders to attend therapy as part of their sentencing conditions.

"..their autonomy to a I an extent has been taken away from them and you either attend [name of organisation] or they go back to prison. That's the kind of choices they're given" (Joe: 88-93).

"..clients were experiencing this as if, erm, they did not really have a choice" (Alex: 190-192).

Similarly, Nadine describes how some of her clients attend therapy because they are coerced by other services. This situation arises when other services withhold treatment until clients have addressed their drug use.

"...they feel they have to come, but they don't want to come because of some other service saying, "Well, we can't help unless you go" (Nadine: 812-815).

Both Joe and Alex make use of the word 'choice' and Nadine alludes to the lack of choice that some clients have in coming to therapy. Their statements indicate the lack of agency that these clients have about attending therapy and changing their drug use. Thus, the therapists perceive their clients as being trapped in a treatment system, where, because of their drug use, they experience a lack of freedom. Moreover, it seems the therapists are in a position of having to work with clients who are unable or unwilling to bond with them.

Melissa further reflects upon her frustration with secondary care NHS services that refuse to see her clients, leaving them situated in primary care with unmet needs.

"Well, you know, refer upwards to a CMHT, you are joking! Not only if there is substance misuse present will they say "Oh, kick them out to a specialist service", erm, "It's drug induced psychosis" or whatever their excuse of the week is [...] if you refer anybody to a CMHT they've got to be actively immediately suicidal or frothing at the mouth or threatening to kill strangers..." (Melissa: 237-246).

Melissa's statement demonstrates how her clients are trapped in a treatment system that refuses to meet their psychological needs. She views her clients' drug use as preventing them from receiving appropriate care, and her use of language 'you are joking', 'excuse of the week' and 'frothing at the mouth' clearly demonstrates her anger and frustration with this.

3.3.3 Hopelessness

Melissa, Joe and Alex seem to express hopelessness as a result of viewing themselves and their clients as situated in an organisational and governmental system that determines the

approach to treatment, thereby restricting client and therapist choice and the development of the alliance. In the following quotes, the therapists reflect upon merely being able to offer short term therapy to their clients.

"...all you might be able to achieve is, well, you know, this is this is my script about, you know, how the world is going to treat me but it but but it doesn't generalise. Erm, it's just well Melissa didn't do that but everybody else will still so you haven't really made a dent in in that part of their view of things" (Melissa 221-229).

"...so immediately it's not the drug that's the problem, they're being used to manage feelings extending from the rape. So you work with that, but then a trauma counsellor on according to the NHS guidelines won't be sent in to work with that client, it will be a drug and alcohol counsellor, but a drug and alcohol counsellor has got 12 sessions and can't work with (Interviewer: "With the actual trauma, yeah") with the trauma" (Joe: 314-325).

"...it feels something significant when they're ready for it, rather than for, we have a referral [sighs], they have 8-12 sessions to get, you know, change or even 16 sessions to change if they're lucky" (Alex: 121-127).

Melissa's use of the phrase 'haven't really made a dent' indicates her hopelessness about being unable to provide some of her clients with the in depth alliance they require to experience therapeutic change. Similarly, Joe's statement reflects hopelessness about his inability to work with the underlying trauma that leads clients to use drugs. Finally, Alex' sigh and phrase 'if they're lucky' highlight the despairing nature of being unable to fully meet his clients' needs. It is as if the therapists are aware that their therapeutic work with some clients is, to some extent, futile due to organisational and governmental constraints. This, in turn, leaves them feeling hopeless.

3.3.4   Navigating the system

In response to their dissatisfaction with the way the treatment system traps both therapist and client, the therapists seem to have devised ways of operating within the system,

sometimes even bypassing the system. Melissa speaks of sidestepping the required use of CBT in her service.

"She wants supportive listening [as opposed to CBT] and maybe that's what you have to do that day" (Melissa: 120-121).

Melissa recognises that the use of prescriptive CBT can be unhelpful and instead offers supportive listening. This, she finds, helps to strengthen the alliance with her clients. In this manner, she bypasses the way in which service requirements dictate the tasks of therapy and instead creates a way of working that fosters the alliance with her clients.

Joe conveys how the organisation he works for prevented him from undertaking a course in EMDR (eye movement desensitization and reprocessing). He believed the course would enable him to address the trauma underlying his clients' drug use. The organisation considered this to be outside his remit as a drug and alcohol counsellor. Frustrated with this restriction, he found a way around it.

"So I did it anyway, I paid for it [EMDR course] myself and I did it anyway and that's really helped my practice because then I can actually deal with what's going on" (Joe: 355-359).

As Melissa, Joe gets around the system, 'I did it anyway', to attempt to strengthen the alliance with his clients.

Alex reflects upon his previous work in the criminal justice system where he encountered clients who were given little choice to attend therapy. He managed by making use of a therapeutic technique popular within substance use treatment, Motivational Interviewing (Miller & Rollnik, 2013).

"...Okay, I can still engage in a motivational interviewing intervention to support the people who are ready to make some changes to make those changes" (Alex: 224-228).

The word 'still' signifies how Alex found a way of existing within the system. This, in turn, enabled him to connect with his clients.

Also recounting how she works with clients who have been forced to attend therapy, Nadine describes how she attends to clients' ambivalence:

"...the moment you pick up on it [ambivalence about therapy] in the first session, you just have to keep revisiting every session as you get them to make that decision" (Nadine: 833-839).

In this manner, Nadine has devised a way of attending to the alliance with her clients despite both of them being trapped in a system that hinders the development of the alliance.

3.3.5   Summary of Theme 1: Trapped in the system

This theme outlined some of the therapists' understanding of the alliance as influenced by an organisational and governmental system. The therapists view themselves and (some of) their clients as trapped in a treatment system where both experience little choice and freedom. The treatment system seems to dictate and impact upon the collaborative development of the goals and tasks of therapy, as well as the bond between client and therapist. The system further appears to fail to meet clients' needs for a fulfilling alliance experience. The therapists express dissatisfaction with this and seem to feel hopeless about developing a meaningful alliance with their clients. As a consequence of their dissatisfaction, the therapists develop ways of navigating the system. These ways of navigating the system indicate a level of resourcefulness implemented by the therapists to strengthen the alliance with their clients.

3.4   Theme 2: Struggling to connect

This superordinate theme highlights how the therapists struggle to connect with some of their clients. As a result, the therapists seem to assume responsibility for developing and maintaining the alliance. In trying to understand this struggle and their response, some

therapists tend to name the system as a cause, so linking with the previous theme Trapped in the system. The theme consists of two subthemes:

The unreachable client

Taking responsibility to avoid disconnection

The therapists relay how some of their clients are in different ways absent from the alliance, i.e. despite their physical presence in the counselling room, some clients are mentally unable to engage in the alliance. This elicits strong feelings for the therapists, such as desperation, powerlessness, frustration and uncertainty. To avoid disconnection from their clients, the therapists take responsibility for developing and maintaining the alliance. Thus, the therapists question themselves, change themselves, seem very careful not to upset their clients and stretch the therapeutic boundaries.

3.4.1   The unreachable client

This subtheme describes the therapists' experiences of their clients' ambivalence about engaging in therapy and changing their drug use. Consequently, the therapists seem to understand and experience some of their clients as 'missing' from the alliance. Moreover, the therapists view their clients' mistrust towards the therapists as a barrier to forming the alliance. It appears some of the therapists understand part of their clients' ambivalence and mistrust to be caused by the treatment system. Ultimately, all therapists seem to experience their clients as out of their reach.

Joe reflects upon working with clients who attend therapy as part of their court orders.

"...an outside force is pushing them to have a relationship with me that they may not even want..." (Joe: 118-121).
"Well, usually you're met with hostility. Erm, hos I'd say hostility or, erm, belligerence, erm, and and so, you know, a person might turn up because they have to turn up, but what they do is completely different" (Joe: 146-151).

His use of language 'outside force' demonstrates the power he attributes to the system that enforces the orders. His statements denote how his clients physically attend therapy but may be mentally and emotionally unavailable to him. It seems Joe attempts to bond with his clients, whilst his clients are unable or unwilling to relate to him, leaving him instead to manage their hostility.

Melissa further provides an example of working with a client who had been coerced into attending therapy.

*"You see that was another element to it, though, he didn't... he **actually** said to me, "I don't have a problem with my drinking other people have a problem with my drinking" but his mother had sort of hogtied him and brought him along so he didn't want to be there so that was an added element of why this was probably never going to be successful" (Melissa: 1127-1134).*

Here, Melissa tried to relate to a client who did not perceive himself as having a substance use problem and so did not want to form an alliance with her. She recognises this as futile for therapeutic change. Her emphasis on the word 'actually' indicates her disbelief and annoyance at her client's statement that he is present in the room but does not wish to be.

Similarly, Alex reflects that some of his clients have significant interpersonal difficulties due to their early and current life experiences. This leads them to approach relationships cautiously.

"...when someone comes close to them [...] even any notion of closeness means that simply they withdraw further..." (Alex: 724-725).

This statement demonstrates how Alex attempts to bond with his clients. However, they respond by pulling away, unable to let him in. Thus, he struggles to form an alliance with them and recognises that this is a slower process than with clients who do not have the same level of interpersonal problems.

Lisa, Nadine and Emilia all relay how some clients are generally ambivalent about wishing to change their drug use. Again, this seems to affect the development of the alliance, particularly the bond and the collaborative aspect of the alliance.

Lisa reflects:

"...and there is a line between the two of you and, erm, and you aren't sitting side-by-side in a way..." (Lisa: 176-178).
"I think there was a mixture of emotions for me to be honest because I think that, erm, I felt quite desperate and I think at some at one point and I because I could see that he wasn't doing well and and I could see that, you know, it was impacting on so many other things in his life and I wanted to help him [...] and there was a bit of frustration as well I think, erm, where I thought oh well, you know, what am I going to be able to do it if, if erm, if you're not going to work with me because I can only do so much and there has to be the two-way relationship..." (Lisa: 367-385).

Lisa's poignant metaphor 'there is a line between the two of you' represents the disconnection she feels from her clients. She attempts to develop a collaborative alliance with her clients, but their ambivalence about changing their drug use is wedged between them. The language used in her second statement 'there has to be the two-way relationship' suggests that Lisa experienced her client as missing from the alliance. The statement also highlights contradictory emotions. Lisa feels frustrated that she was the only one doing the work. She switches from talking *about* the client *to* the client, suggesting that her frustration remains unresolved. Simultaneously, her desperation about not being allowed to help is evident, indicating a position of powerlessness.

Nadine further speaks of encountering clients who attend therapy under the influence of drugs.

"Because if the client can't be present, who are you really working with?" (Nadine: 879-880).
"...they want to to engage in the work, and they'll come, may even be on time, but the using will get in the way because you'll very rarely see the real them" (Nadine: 917-920).

Nadine's statements highlight that, although physically present in the room, her clients are unavailable to her when under the influence of drugs, to the point of their persona being obscured. In her first statement, Nadine poses this as a question, suggesting an ongoing uncertainty about not knowing who she is in the room with.

Similarly, Emilia describes having to decide whether to terminate sessions when clients attend under the influence.

"Erm, it puts pressure on the therapist to come up with different skills or try and engage, or, or make a bigger effort, I guess [...] you have to make a decision whether they're in a state where there where there can be interaction. Erm, and if that's the case, then, you know, you struggle to make the alliance work the best way you can" (Emilia: 15-25).

Emilia experiences this decision as challenging given her choice of language 'pressure' and 'struggle'. It seems it is often questionable whether Emilia and her clients can form an alliance at all. Even if it is possible to form an alliance, Emilia's words 'the best you can' suggest that she finds this alliance far from satisfactory. Again, her clients' drug use appears to leave her clients unavailable for her to connect with.

In addition, the majority of the therapists view their clients as mistrustful. The mistrust places the therapists in a position of attempting to bond with clients who avoid relationships. This reinforces the therapists' understanding of their clients as difficult to reach.

Joe, Lisa and Nadine describe how their clients' experiences with external agencies in the treatment system and the media fuel mistrust in the relationship.

"...you can say that nothing goes back to social services until you're blue in the face but people have people who are in that situation fear everybody, not just you, so why should you be any different? [...] it [social services] breeds mistrust into the relationship because is the person telling you the truth or are they telling you a load of stuff that is juicy..?" (Joe: 591-607).

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Joe's choice of language 'until you're blue in the face' shows how he struggles to enable his clients to trust him, to no avail. His question 'so why should you be any different?' demonstrates how his clients' mistrust in their interpersonal relationships transcends the alliance. Joe poses a second question 'is the person telling you the truth?', suggesting that he himself becomes mistrustful of his clients, and that his mistrust is an ongoing difficulty.

Lisa and Nadine emphasise:

"...sometimes I think you can pick it up from from a person almost straight away the minute they walk through the door [...] they have a lot of suspicions towards you and they they don't trust you to begin with" (Lisa: 714-723).

"It's, "Okay, you seem okay, you're talking to me respectfully. But it's your job, isn't it? You get paid to do that." That's the attitude they come with" (Nadine: 427-439).
"Whatever it takes to break that wall down, I'll use it" (Nadine: 479-480).

Lisa' statement describes how she responds to an unconscious process by picking up her clients' mistrust derived from their interaction with other services and professionals in the treatment system. Similarly, Nadine reflects that her clients are mistrustful due to the stigmatising picture the media portrays of people who use drugs. Nadine's use of the metaphor 'break down that wall' paints a picture of Nadine and her clients on different sides of a 'trust' barrier that must be demolished to reach her clients.

Melissa highlights how her clients' early experiences can impact upon the trust they place in their therapist.

Because I know it's [development of the alliance] going to maybe take longer [...] because you have to break through that paranoia and very possible assumptions about things..." (Melissa: 1252-1256).

Melissa experiences many of her clients as wary about forming an alliance due to their early life experiences and subsequent interpersonal difficulties. Her use of the words 'break

through' again suggests that mistrust is a barrier that separates client and therapist and makes it difficult for Melissa to connect with her clients.

Emilia adds:

"...most clients that I've worked with, erm, somewhere in their developmental stage, the trust has been broken, erm, so erm, it's very hard to really confide or trust anybody else [...] you have to work very hard at, erm, building some trust in order for them to be motivated to change, I guess. So yeah, trust is important. Erm, but it doesn't come first. It probably comes last [Emilia laughs]. (Interviewer: So it's something that develops...) And some of them, because because we're doing short term work, err, you know, people will not trust 100%. Or if they do, they do it with their adult aspect, they don't do it with a child's or infantile needs" (Emilia: 825-846).

Emilia states that she finds it challenging to build trust with her clients. Her quote 'people will not trust 100%' further indicates that trust will never be fully achieved in the alliance. Thus, it seems there is always part of the client, perhaps their unconscious 'infantile' self, that she is unable to reach. It is difficult to make sense of Emilia's short laugh. It is possible that the laugh demonstrates the irony of developing alliances that lack the pre-requisite trust for the bond between client and therapist to form.

3.4.2   Summary of The unreachable client

This subtheme outlined how all the therapists experience some of their clients as absent from the alliance despite their physical presence in the counselling room. Some clients are ambivalent about changing their drug use and attending therapy, whilst others are mistrustful of relationships. This appears to impact upon several aspects of the alliance, particularly the bond and the collaborative negotiation of the goals of therapy. Consequently, the therapists struggle to connect with clients who are somewhat unavailable to them. This is experienced both consciously in what their clients say and unconsciously in their clients' non-verbal responses. It seems the therapists experience a metaphorical barrier in the alliance that keeps their clients out of reach.

3.4.3 Taking responsibility to avoid disconnection

In response to their difficulties with reaching and connecting with their clients, the majority of the therapists assume responsibility for developing and maintaining the alliance. This manifests itself in several ways; questioning themselves, changing themselves, being careful not to unsettle their clients and stretching the boundaries of therapy. By taking responsibility, the therapists seem to attempt to avoid disconnection from their clients. The therapists seem largely unaware of this process.

Thus, Melissa speaks about doubting her abilities as a therapist in response to clients' relapses.

"...I was disappointed, yeah, because maybe I wasn't doing so good at it. Maybe I wasn't doing my job with her, maybe I wasn't hitting on the right things, hitting on the right notes, you know, maybe there was a problem [...] or am I doing something wrong, even, you know, as a therapist" (Melissa: 1177-1190).

Melissa's statement highlights how she attributed her client's relapse to a failure on her behalf. Her disappointment is obvious. Her words 'problem' and 'wrong' suggest that she thought herself problematic, even harmful to the client. Later, she uses the word 'angst' *(1210)* to describe how she felt, thereby emphasising the level of anxiety generated by questioning her abilities.

Reflecting on working with a client whom she suspected had relapsed, Lisa echoes Melissa's sense of responsibility.

"...and I wanted to help him and, erm, and, you know, not being able to get that information out of him almost or, you know, not being able to provide him with that environment where he he would feel safe enough to talk to me about it..." (Lisa: 372-377).
"...it's almost like [you] started looking at yourself, like what am I not doing right here?" (Interviewer: 392-394).

"... yeah, you start doubting yourself and you start to think that it's your responsibility to do it [enable client to change their drug use] whereas, you know, it's as much your responsibility as it is the client's responsibility" (Lisa: 395-398).

Lisa's words 'not being able to provide him with that environment' and 'not being able to get that information out of him' denote how she thought it was her fault that her client was unwilling to disclose his relapse. This made her feel both desperate and frustrated *(378-380)*. Prompted by me, Lisa acknowledges that she doubted herself and took unnecessary responsibility for the alliance whilst realising that this responsibility also belonged to the client. As such, it appears she was able to examine her countertransference, thus recognising how she assumed responsibility for the alliance.

As the other participants do not describe this level of self doubt, it is possible that both Melissa and Lisa were influenced by their status as trainee therapists. Thus, they may have attributed their clients' relapse to a perceived lack of therapeutic skills. However, it seems further plausible that their self doubt serves to maintain the alliance. If they were not to question themselves, they would have to question their clients' motivation and the possibility of therapeutic success. Moreover, they may have felt overwhelmed by their disappointment and frustration with their clients. Both these positions could serve to alienate them from their clients, thus resulting in a threat to the alliance.

Similarly, Emilia reflects upon her internal struggle around enforcing the boundaries of therapy when clients attend sessions under the influence of drugs. Earlier in the interview, Emilia described her internal struggle as finding the balance between maintaining the boundaries of therapy versus rejecting her clients when doing so. Emilia goes on to explain that her clients appreciate that she allows them to stay in the session for a while even though they are under the influence.

"So in in fact, erm, my internal struggle has nothing to do with how they've seen me [...] And yet you're thinking [sharp intake of breath] (Interviewer: I felt bad) I I I felt bad for doing what I've done to you, you know. And and maintaining a boundary, erm...so that that's good to to hear afterwards" (Emilia: 422-434).

Emilia's use of the word 'struggle' to describe her internal process, her sharp intake of breath and feeling 'bad' indicates how challenging she experiences the boundary enforcing process. Her language 'what I've done to you' suggests that she views her actions as harmful. Also implicit in the statement is that she seemingly questions if she has rejected her clients until they reassure her otherwise. It seems her clients push the therapeutic boundaries, whilst Emilia takes responsibility for this by questioning herself. Again, it is possible that Emilia's self doubt serves to maintain the alliance. Should she cease to question herself, she may be left in a position of questioning her clients' commitment to therapy and the possibility of therapeutic success. Both of these positions could threaten the alliance. As such, self blame may seem a preferable, albeit unconscious, choice as opposed to blaming her clients.

Another way in which most of the therapists assume responsibility for the alliance is by attempting to connect with their clients by stretching the therapeutic boundaries. As such, they call clients when they fail to engage, change the therapy setting, self disclose and treat therapy like a friendly chat. It seems the therapists believe they may lose their clients should they enforce boundaries that are considered standard for a generic client group.

Nadine describes how she changes the therapy room to facilitate her clients' disclosure.

"...we need to go into some stuff which is going to be quite deep. I will then change the room [...] because when we're in that room [...] we're at this pace, this distance. And sometimes I lean forward. So we can bring drinks in, so it's more like an intimate chat [...] Because where I'm going, without them realising, it's going to be quite tender. So if I soften it all, including the atmosphere and the environment, it will help them to open up..." (Nadine: 1021-1037).

It appears Nadine believes she must change the therapy setting to connect with her clients. She perceives a need to bring herself physically closer to her clients, treat therapy like a friendly chat and create an informal environment to facilitate the alliance, thus pushing the boundaries of therapy. Her actions denote how she assumes responsibility for connecting with her clients. This is emphasised by her statement 'Because where **I'm** going, **without**

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them realising' whereby she appears to take control of alliance without the actual involvement of her client.

In the following examples, Melissa, Lisa and Emilia recount how it strengthens the alliance to call clients when they fail to attend therapy.

"...the policy of the service is discharge, DNA, out, but I've always managed to side step that and I phone people up and I try to, you know, find out what's going on, find out what's happened, you know" (Melissa: 360-363).

"...a lot of the time what we do here if they miss a session we'll call them up and ask if they, you know, if they can attend the next session" (Lisa: 1200-1202).

"...they've been met with somebody who is willing to be there, session after session, whether they turn up or don't turn up, you know, the space is there, makes the phone call to see why they haven't turned up and blah blah blah, you know, and brings them back in..." (Emilia: 866-872).

Melissa's use of the word 'out' indicates how she views the service DNA (did not attend) policy as discarding her clients. She describes how she goes against service policy to re-connect with her clients. Lisa echoes the same need for contacting clients to re-engage them, although for her this action follows service policies. Also following service policies, Emilia outlines that being available for and contacting clients help her clients to develop trust. Emilia's use of language 'brings them back in' indicates that her clients' return to therapy is facilitated by her, not her clients. By contacting their clients, Melissa, Lisa and Emilia engage in practices that for a generic client group would be considered stretching the boundaries of therapy. In doing so, they seem to take responsibility for the alliance and for avoiding disconnection from their clients.

Joe also reflects upon contacting his clients when they fail to attend. Contrary to Melissa, Lisa and Emilia, he deems this detrimental to the alliance, but must follow service policy.

"That impacts the relationship in that you're chasing the client which you wouldn't do in normal therapy. And you're sudden I've even had one supervisor describe it as mothering the client [...] why would you do that?" (Joe: 186-194).

Joe's use of 'chasing' and 'mothering' and his question 'why would you do that?' indicate that he views contacting clients as taking unnecessary responsibility. He contrasts this with his experiences of 'normal' therapy outside his service, suggesting that he considers contacting clients as abnormal and pushing the boundaries of therapy. It is possible that his insight is generated from his private practice where he is not influenced by a treatment system that forces him to follow certain service policies.

Another way in which some of the therapists take responsibility for avoiding disconnection from their clients is by being careful not to unsettle them. Thus, Melissa, Emilia and Nadine paint a picture of walking on egg shells around their clients in an attempt to develop and maintain the alliance.

Melissa's first statement below describes her response to a client's explanation about not attending therapy. Her second statement outlines her reaction to suspecting that a client has relapsed.

"Now his explanation was very convoluting and contained a lot of holes, but I was still gonna leave it..." (Melissa: 368-371).
"...sort of three or so months into therapy I knew she's relapsed and, erm, but I didn't say anything because I thought let's see if she tells me" (Melissa: 140-143).

Melissa's extracts demonstrate how she knows there is something significant about the alliance that her clients are not telling her. However, she purposely chooses not to address it. This may be a form of avoiding a conflict and a subsequent rupture in the alliance.

Nadine reflects on attempting to make her clients feel safe by being carefully selecting therapy rooms.

"So all those sorts of things I take into account, is to what would make them feel unsafe in the early stages of the work. So I have to be really mindful of what room I use and how long for. If I have to use this room, then I do apologise" (Nadine: 1063-1069).

Nadine goes out of her way to develop the alliance by preventing her clients from feeling unsafe. Her language 'all sorts of things' and 'really mindful' indicate the amount of situations she holds in mind to facilitate her clients' safety. Her words 'then I do apologise' reinforces how she attempts to avoid an adverse reaction from her clients by apologising for something which is beyond her control.

The below quotes from Emilia relate to her previously discussed struggle with finding a balance between enforcing therapeutic boundaries and rejecting her clients when they attend therapy under the influence of drugs (p. 64).

"...but you do get the reassurance that you have been, as they said, human. And you've listened to them rather than reject" (Emilia: 448-451).
"So there is stigma in society about who these people are. Erm, and I guess that's what I mean, erm, because we haven't differentiated and haven't said, "Oh, your drug, or you're under drugs influence right now, and get lost, come back another time" (Emilia: 491-499).

In her first quote, Emilia speaks consciously about her fear of rejecting her clients. Her word 'human' denotes that to enforce therapeutic boundaries could in some circumstances be inhuman. In her second quote, Emilia pitches herself and her service against 'society' who she understands to reject her clients. This further demonstrates Emilia's anxiety about being rejecting. Thus, Emilia describes a situation in which her clients push the boundaries of therapy, although she takes responsibility for this by feeling anxious and being careful about how she responds.

Finally, all the therapists seem to change aspects of themselves to connect with their clients. This includes changing their fundamental expectations of therapy, altering their behaviours or overcoming their emotional reactions. Again, this may represent how they assume responsibility for the alliance with their clients.

Melissa and Emilia describe how they have addressed their emotional responses to their clients.

"I I really just started to think he's... he's [short laugh] so narcissistic I don't like him, erm, and I didn't like him, erm but, you know, I thought well okay, but you know, I think I can overcome this" (Melissa: 1058-1062).

"...I have a, you know, instinctual repulsion towards somebody who smells that badly. So it's about conquering that and again seeing the person rather than the problem" (Emilia: 667-672).

Melissa speaks about disliking a client because of his behaviour towards herself and other women. Her short laugh seems to indicate her disbelief of how narcissistic he was. They way in which she switches from present to past tense further suggests that her dislike of him remains unresolved. However, the word 'overcome' indicates that she expects herself to surmount her dislike because it obstructs the alliance. Similarly, Emilia's use of 'instinctual repulsion' denotes the intensity of her reaction towards her client, something which is beyond her control. Emilia demands of herself to 'conquer' her repulsion, giving the impression of entering into battle against her repulsion because it damages the alliance.

Joe and Lisa reflect upon learning to change their expectations of therapy, which they believe has facilitated the alliance.

"...changing yourself. Changing what you expect to achieve, so when a client sits down and says, "Oh, I'm using so much of whatever" and then you say, "Right, oh okay, erm, then what would you like to achieve?" "Well I want to be clean" and then you've got 12 weeks to achieve that [...] how useful is that goal of being clean if they require much longer term work? It's not..." (Joe: 864-877).

"...to be less outcome focussed, to be a bit more flexible, erm, and you know, and hold that flexibility in mind because, yeah, things happen and you just can't control them..." (Lisa: 1182-1186).

Joe specifically states that he has to change himself and his expectations of what constitute useful therapeutic goals when working with certain clients. It seems his clients struggle to change because short term therapy falls short of addressing their needs, leaving Joe to change instead. Similarly, Lisa has to manage her expectations about the level of change her clients can achieve. She also has to embrace the unpredictability of therapy and let go of attempting to control events in therapy. It seems Lisa has to change fundamental parts of herself to develop the alliance with her clients.

Finally, Nadine and Alex both describe how they alter their behaviours to connect with their clients.

"...just don't use certain buzzwords that will make them, you know, feel nervous or whatever. Tone of voice. Body language, the way I sit. (Nadine: 990-992).

"I need to be able to find some common ground to connect with them" (Alex: 570-571).
"From dress, from interest, from the way of speaking. Err, from it could be ethnicity, it could be, erm, sexual orientation, it could be gender. Anything, really, location, anything that...it's almost like a bridge or a hook for something to connect" (Alex: 576-582).
"Really I try matching as much as possible" (Alex: 740).

Nadine lists a number of behaviours she has to change to avoid unsettling her clients and to facilitate the alliance. Alex speaks about attempting to connect with his clients by 'matching' them, which includes altering himself in a range of ways. The word 'bridge' paints a picture of Alex and his clients as separated whilst Alex attempts to reach them by changing himself. His use of the word 'hook' indicates his need to catch his clients before they slip away. The array of things that Alex and Nadine believe they must or can change about themselves to connect with their clients suggest the amount of responsibility they both assume for the alliance.

3.4.4   Summary of Theme 2: Struggling to connect

This theme illustrated how the therapists struggle to connect and bond with some of their clients. The theme further illustrates the challenges involved for the therapists in

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establishing useful goals and collaboration in therapy. They perceive their clients as somewhat unavailable to them due to their ambivalence about being in therapy and mistrust about relating to others. The therapists seem to understand their clients' ambivalence and mistrust to arise, partly, from the nature of the treatment system, thus linking Trapped in the system and Struggling to connect. In response to their struggle to connect with their clients, the therapists assume responsibility for the alliance, thus demonstrating their desire to remain connected with their clients. This manifests in the therapists questioning themselves, changing themselves, stretching the boundaries of therapy and being careful not to unsettle their clients. In doing so, the therapists seek to avoid disconnecting from their clients. The therapists appear largely unaware of the way in which they take responsibility for the alliance, indicating how they respond to unconscious processes when relating to their clients.

3.5   Theme 3: The contradictory therapist

This superordinate theme outlines how the therapists seem to contradict themselves when describing their experiences and understandings of the alliance with their clients. The theme consists of two subthemes:

> I understand...or do I?
> It's not that different or difficult...or is it?

The therapists claim they have a level of understanding about their clients that others do not posses. Moreover, the therapists describe how the alliance with their clients is not that different compared to the alliance with generic clients, nor is it particularly difficult. However, their narratives reveal several contradictions to these statements. These contradictions seem outside the therapists' awareness. The researcher's interpretation of the meaning of the contradictions identified how the therapists seem to struggle to acknowledge that there are aspects of the alliance they do not understand. Moreover, they seem to struggle over whether the alliance with their clients is different to the alliance with generic clients, and whether it is sometimes inherently difficult.

3.5.1 I understand...or do I?

The majority of the therapists describe how they view their clients as human beings. They relay how it strengthens the alliance to attend to the person and their emotional problems as opposed to focussing solely on their drug use. The therapists state they are different from others whom they deem to be somewhat ignorant of their clients. In this manner, the therapists perceive themselves to possess a level of understanding of their clients that others do not have. However, a closer, interpretative analysis of their narratives reveals an apparent struggle to make sense of the alliance with their clients. This could indicate that the therapists find it difficult to acknowledge that there are aspects of the alliance with their clients that are hard to comprehend.

Melissa, Lisa, Nadine and Emilia emphasise the importance of seeing the human being behind the drug use.

"...so there are those signals that they are drug users, for example. I think if you go past that you still see a human being with with a lot of history of trauma and abuse, PTSD, you know. So I guess, erm, it's going past that facade and and just seeing the real person with real needs and problems and struggles" (Emilia: 515-524).

"...it's, you know, really seeing that person as an individual and also seeing them as a person..." (Melissa: 579-581).
"You can see that I'm still a human being maybe" (Melissa: 604-605).

"...what I try and do is always attend to the person first and then whatever else comes up [...] by attending to them rather than their drug use it can be quite helpful for them to actually find out who they are and what they feel and what they want..." (Lisa: 619-639).

"It's not about where you're coming from, it's not about the labels, it's just about you as a person" (Nadine: 211-214).

Emilia's use of 'facade' represents the therapists' view that their clients' drug use is a front that obscures the person and their needs. The therapists utilise the words 'human being'

and 'person' to describe who they find when they look beyond their clients' facade. It is as if the therapists perceive drug use to render the person somewhat unreal. This is reinforced by Emilia's language that there is a 'real person' and 'real needs' behind the drug use. The therapists view their ability to attend to whoever they find behind the drug use as strengthening the alliance.

Similarly, Joe reflects upon the function of drug use:

"So there there's always an underlying issue as to why someone's using drugs, drug taking in and of itself is symptomatic, it's not it's not the cause of problems, it's a symptom [of unresolved emotions]" (Joe: 17-21).

Here, Joe reveals his understanding that drug use is a consequence of an underlying emotional problem. Joe's statement reinforces the importance of looking beyond his clients' drug use to understand the person's emotional needs and to facilitate the alliance.

Some of the therapists describe how they are different from others, such as professionals, the treatment system or society, whom they perceive to lack understanding about individuals with drug problems. It seems the therapists believe they have a level of understanding about individuals with drug problems as human beings and the function of their drug use that others do not have. This, in turn, helps the alliance to develop.

As such, Melissa and Lisa differentiate themselves from other people in their clients' lives.

"...A lot of clients have had a lot of experience with therapists, erm, or professionals who, erm, have never known anybody who used drugs, have no idea why they'd do such a thing and no understanding of the extreme intensity of emotion [...] that they feel pushed, erh, to go out and use again" (Melissa: 453-461).
"...because she didn't actually in March feel that she could tell me that she'd relapsed [...] because when she relapses the important people in her life get very, very angry at her" (Melissa: 153-161).

Melissa reveals that other professionals in the treatment system lack basic understanding about the function of drug use. Moreover, people in her clients' interpersonal relationships fail to understand the nature of relapse. Implicit in these statements is Melissa's view of herself as different to other people in her clients' world.

Lisa elaborates on Melissa's point by reflecting that her clients often encounter impatience and irritation from other professionals. Later, she emphasises the importance of attending to her clients' emotional life.

"...I think what they experience is quite a lot of irritation and [...] impatience that, you know, "Why is it taking you so long? Why why can't you just give it up and why can't you just move on so I can tick you off my list and and put you in the pile of people that I've cured..." (Lisa: 683-690).

"...and I think it [attending to clients' feelings] shows your own curiosity and your own sort of understanding of the fact that they could be feeling differently that day, that things might be coming up for them that, erm, you know, that you're trying to to understand what what they are going through and I think that that certainly helps, erm, the alliance because, you know, they feel like you you actually want to want to be there for them rather than, erm, be maybe one of those people that just, you know, that will frown upon them..." (Lisa: 596-607).

Lisa's language in her first extract 'put you in the pile of people' denotes her perception that other professionals treat her clients as numbers or objects rather than people. In her second quote, Lisa distinguishes herself further from other professionals by stating that she is 'there for' her clients rather than 'frown upon' them. Moreover, she views herself as different to others by emphasising that she understands about her clients' emotions, thus implying that others do not fully comprehend her clients' emotional life.

Nadine describes a client's relationship with the NHS treatment system.

"If you mention anything to do with the NHS the NHS he will run a mile. But he will come here, committed, and, you know, faithful in in the work [...] with him, it was a case of finding

that one person he could trust, who he can open up with, who was there for him in the main..." (Nadine: 194-210).

Nadine pitches both her service and later herself against the NHS whom she views in its entirety as detrimental to her client. Her language 'run a mile' emphasises that the NHS is so bad for her client that he must escape from it. Nadine distinguishes herself from the NHS by describing herself as 'the one person he could trust' and 'who was there for him'.

Similarly, Emilia reflects upon the stigma that her clients experience from society in general.

"So there's stigma in the society about who these people are. Erm, and I guess that's what I mean, erm, because we haven't differentiated..." (Emilia: 491-495).
"For us it's different, and I think that's that's what they see" (Emilia: 474-475).

Emilia's language 'there's stigma in society about **who these people are**' denotes that she perceives society to lack understanding about her clients. Her use of 'we' as opposed to 'I' suggests that she speaks for her entire service, not merely herself. Her words 'we haven't differentiated' and 'For us it's different' demonstrate how she separates herself and her service from the ignorance that characterises the rest of society.

Despite the therapists' perception of themselves as understanding of their clients and holding a level of understanding that others do not posses, it seems the therapists struggle to fully make sense of the alliance. This is demonstrated by the contradictions in their narratives. The following outlines a selection of these contradictory statements.

In her first extract below, Melissa reflects that her clients know that she understands ('I get it') the issues that affect individuals with drug problems, such as the nature of relapse. Her understanding, she states, helps the alliance to develop.

"...most of my clients kind of get the impression pretty quickly that I get it" (Melissa: 136-137).

Later, Melissa speaks about a client who dropped out of therapy when she reinforced a therapeutic boundary by querying why the client failed to attend a session.

"Although if that had been private practice I still would have wanted to discuss, "Why you DNAd?", you know, "What what's going on here, what's this really about?" and all that and I think that might have that potentially that could have set him off as well maybe. Erm, I don't know, I'll never know now..." (Melissa: 430-436).

Here, Melissa oscillates between past and present tense. Moreover, she changes from talking about her client to her client, and wonders in the moment 'I'll never know now'. This indicates an ongoing struggle to make sense of why her client dropped out. In this manner, her statement that she 'gets it' is contradicted by her continued struggle to understand what happened between her and her client.

Alex reflects upon the impact of therapeutic models upon the alliance. He describes the significance of providing long term therapy to clients who use drugs. He believes this allows them to take control of changing their drug use, which is helpful for the alliance.

"...where I had really long contracts and open ended contracts we may have addressed different areas, and then I may have knocked on their psychological door and said by the way I think this [substance use] is an issue [...] Erm, but it feels something significant when they're ready for it" (Alex: 111-123).

Later, Alex highlights how a therapeutic model, the Cycle of Change (Prochaska & DiClemente, 1983) is helpful in enabling clients to change their drug use.

" I think the cycle of change seems really significant [...] This is quite a different model because it's quite a brief model model, rather than the other model that we described, the much longer term therapy. Where.. I can see.. No, the longer term therapy I don't think time is wasted simply because someone waits for the client to move to another place" (Alex: 230-241).

Alex recognises that the Cycle of Change is a short term model, which contradicts his first statement. His hesitative 'Where.. I can see.. No, the longer term therapy I don't think time is wasted' suggests that he is further unsure about initially highlighting longer term therapy as significant. Again, these contradictions suggest that it may be difficult for Alex to make sense of the alliance, and also indicate his ambivalence about how best to form an alliance with his clients.

Lisa describes the way in which drug use affects her clients' emotions and thus the alliance. As such, she finds it difficult to connect with her clients when they are under the influence. She relays her knowledge that many clients use drugs to escape their emotions.

"...*a lot of the time they do actually use drugs because they want to block some of their emotions out" (Lisa: 62-64).*

However, Lisa later reflects that her clients use substances to access and express their emotions.

"... *I think a lot of people do use drugs and alcohol because they that's, erm, that's one way for them to get in touch with their emotions and to, erm, to help offload them..." (Lisa: 1022-1025).*

The apparent contradictions in Lisa's understanding of how her clients' drug use impacts upon their emotions and the alliance are clear. This could, again, suggest that she perhaps struggles to fully understand how her clients' relationship with their drug use manifests in the alliance.

Nadine describes several times in her narrative how she encourages her clients to take responsibility for their therapy. In the extract below, she explains how she attempts to battle her clients' poor motivation and reliance on others for help. She does this by being explicit about the effort they have to invest in therapy and stating that she will not do the work for them.

"You've got to do it by yourself, I'm not going to hold your hand for you. You know, no counsellor will hold your hand because that's not going to be helpful for you" (Nadine: 721-725).

Nadine later describes how using a specific therapeutic intervention resulted in an intense negative emotional reaction for a client. She elaborates upon her own response to seeing her client in an emotionally 'dangerous place' *(Nadine: 1167)*.

"I've got to bring him back down, make him feel safe and secure [...] So my 10-minute grace period in between clients, I just thought, if I need to run over to bring him into that safe place before discharging him, I'm just going to have to run over and just go straight back to that client. And that's what I had to do" (Nadine: 1144-1155).

Nadine's use of language 'I've got to' and 'I had to' plus the way in which she stretched the therapeutic boundaries denote how she assumed responsibility for her client's safety. Thus, her quest to enable her clients to take responsibility is pitched against her tendency to do so for them. This indicates her difficulty in fully understanding what goes on between her and her clients.

Finally, prior to the quotation below, Emilia reflects upon the stigma that her clients are subjected to by society. I subsequently query how this stigma impacts on the alliance. In response, Emilia describes that she does not like to differentiate between clients who are highly functioning (and experience less social exclusion) and those from a more deprived background. Rather, this is a distinction that society makes:

"So that's...but that's...that's a differentiation that I would like not to make very obvious, but it is obvious out there in society" (Emilia: 544-547).

Emilia then elaborates upon the difference between highly functioning clients and those from a deprived background, stating that the former tend to hide their drug use:

"I think people who hide it, erm, have a much more, erm, first of all they can be more resistant" (Emilia: 580-582).

Here, Emilia describes how she experiences highly functioning clients as more resistant, thus demonstrating a significant difference between the two types of clients. Thus, Emilia initially minimises the need to differentiate, describing it instead as belonging to the stigmatising attitudes of society. However, she then identifies a difference that clearly affects her experience of the alliance. These contradictions suggest that Emilia, like the other therapists, may struggle to make sense of how the alliance with her clients is established and maintained.

3.5.2 Summary of I understand...or do I?

Most of the therapists state that they understand the human being behind their clients' drug use. Moreover, they understand the function of their clients' drug use. Additionally, they claim that many others do not have this level of understanding. Yet, their narratives contain numerous contradictions to these claims. The content of the contradictions vary from therapist to therapist, but demonstrate how, unbeknownst to themselves, the therapists might struggle with making sense of particular aspects of the alliance and unconsciously respond in inconsistent ways. Indeed, it appears there are tensions in establishing and developing the alliance that are difficult for the therapists to hold in mind.

3.5.3 It's not that difficult or different...or is it?

The therapists state that the alliance with clients with drug problems is not that different compared to the alliance with generic clients, nor is it particularly difficult. However, the therapists then relay aspects of the alliance that are specific to drug use and describe aspects of the alliance that seem difficult to both tolerate and work with. All the therapists appear unaware of these contradictions. It seems the therapists may struggle to acknowledge that the alliance with their clients is different to that with generic clients and that it is, at times, inherently difficult. The following outlines a selection of the therapists' contradictory statements.

The majority of the therapists describe how the alliance with clients who use drugs is not that different from the alliance with generic clients. As such, Melissa identifies substance use as an added dimension to generic client presentations.

"...if you start from the premise that acknowledging this added dimension of substance misuse, but the premise that, you know, this is a person just like la the depression client that you saw yesterday, erm, because this person is coming because they're depressed too, erm, then it's really very easy to apply all the skills you use seeing any other client to this situation. So.. there are a few adjustments here or there..." (Melissa: 1559-1569).

Melissa's language 'just like a depression client', 'it's really very easy' and 'there are a few adjustments' demonstrate how she views working with clients with drug problems as merely slightly different to working with generic clients.

However, throughout her interview, Melissa reflects upon several experiences that seem contradictory to this statement. For example, Melissa describes how serious trauma is more prevalent in clients who use drugs than in generic clients. She believes that clients' disclosure of serious trauma can make or break the alliance. In this sense, disclosure can bring her and her clients together. Conversely, her clients can regret disclosing and subsequently disconnect from her.

"More likely to encounter really, really horrible trauma, erm, like, you know, being sodomised by your boyfriend. Erm…yeah, yeah, I would say that" (Melissa: 84-87).

Moreover, she recounts how a client's choice not to disclose their relapse provided information about the strength of their alliance. When speaking about this, she reveals her emotional reaction to the client's relapse.

"Erm, although I…you know, again I felt empathy about this and I felt…I felt disappointed, you know, "Gosh, I thought we were getting somewhere," you know, "Oh man!" (Melissa: 741-744).

Melissa's language 'really, really horrible trauma' emphasises the severity of trauma that she encounters in her clients. She further reflects upon feeling disappointed and disheartened ('I thought we were getting somewhere') when recounting her client's relapse. Thus, Melissa outlines emotionally laden events that are very specific to working with clients with drug problems. Therefore, her experiences of the alliance with clients with drug problems appear more than slightly different to the alliance with generic clients.

Similarly, Joe initially emphasises that the treatment system, in which clients are sometimes forced into counselling, is the only aspect that distinguishes the alliance with clients who use drugs from the alliance with generic clients.

"Is there anything that makes it [the alliance] different? Erm.. I s'pose not, really, err, I think the difference is the organisational context..." (Joe: 49-52).

Later, Joe reflects how congruence and immediacy are necessary in forming the alliance. He provides an example of how he sometimes raises with clients that their drug use is killing them. He states that naming the impact of his clients' drug use on their health can facilitate the alliance.

"... and I said, "Is that...so is this where you want the relationship [with his client's children] to end because if you carry on using the way you are you are gonna die..." (Joe: 514-518).

Thus, Joe highlights a situation that is specific to the alliance with clients who use drugs; in working with the client group it is necessary to manage and address the possibility that clients can kill themselves. This is contradictory to his initial statement that the treatment context is the only difference with the alliance with clients who use drugs.

In our interchange below, Alex states that the alliance with clients who use drugs does not differ significantly from the alliance with other client populations.

"So something that makes this client group special, almost, is you were saying the knowledge, you need to have a level of knowledge of of substance, you have to have an

awareness of the attitudes surrounding it. Erm, anything else that you can think of?"
(Interviewer: 341-347).

"Not really. I think there'd have been, other things would apply also with other clients..."
(Alex: 349-350).

Later, he describes how risky ways of administering drugs and the use of certain risky drugs impact on the alliance. He believes that the engagement in risk behaviours denotes a presence of internal and external deprivation and therefore links with his clients' capabilities (resources) to relate to him.

"Yes, definitely, the way of administering the drugs. Because again it's linked to resource, and even and the kind of drug, because I think it's often linked to...external and internal resources" (Alex: 657-663).
"Erm, and the same applies with even with the types of drug drugs because they may be drugs that they are more risky than others" (Alex: 671-674).

In this manner, Alex highlights issues affecting the alliance that are specific to clients with drug problems. This is in contrast to his initial statement that his experiences of the alliance are not terribly different from other client populations.

Emilia reflects that clients with drug problems belong to a category of complex clients:

"I guess, erm..I guess they can be placed into the category, or or or clients with drug use can be placed into the category of more complex clients [...] but I think if you are [sighs] leaning on alcohol or drugs [...] it's much more complicated, it feels" (Emilia: 273-315).

As such, she makes a distinction between her clients and less complex client presentations. Whilst speaking, she further acknowledges that her clients are more complicated than generally complex clients due to their substance use. Her sigh could indicate the difficulty she experiences with making this distinction, given her next comment, again relating to the complexity of her clients and its impact on the alliance:

"Yeah, so it's harder, but on the same lines, I guess, for anybody else that you see" (Emilia: 317-319).

Initially, Emilia's statement 'so it's harder' is congruent with her first quote. However, in the latter part of her statement she reverts to equalling the alliance with clients with drug problems to other complex clients. Thus, she oscillates between different perspectives that contradict each other but does not seem aware of this.

Lisa is the only therapist who explicitly states that the alliance with clients with drug problems is inherently different to generic clients. Below, she outlines her first encounter with the client group.

"...I didn't really put them in a separate box to my other clients [...] and I think that that I did perhaps generalise it a little bit too much at the very beginning because I thought that, you know, erm, my clients that do use drugs aren't going to be that much different to my other clients and I think what I found in the end was that they do differ a little bit, or they can anyway" (Lisa: 11-26).

Lisa's metaphor 'separate box' denotes her perception that clients with drug problems are different. Despite her statement to this effect, she seems to downplay the difference by adding 'a little bit'. Indeed, Lisa later describes several experiences that suggest the alliance differs significantly. For example, she reflects below that therapy with clients who use drugs is unpredictable due to her clients' exaggerated emotions.

"But I think, erm, particularly with clients that that do use drugs or or have had in the past there is that.. it's.. it's almost like their, erm, their emotions are sort of blown out of proportion a little bit" (Lisa: 442-446).
"... for a practitioner that's especially that's just starting doing that work it can be a little bit frightening sometimes and can be a little bit sort of, "Oh", you know, "What should I do about now" [short laugh] and "How do I how do I approach that, how do I work with it?"..." (Lisa: 487-493).

Lisa's three questions and her use of language 'frightened' demonstrate the feeling of fear, uncertainty and helplessness that the alliance with her clients can generate, or certainly did generate when she first embarked on the work. Her frequent use of 'little bit' seems to clash with the nature and severity of her emotional responses. It appears she experiences her clients as different to generic clients, but somehow needs to minimise the extent of the difference by adding 'little bit' to her claims.

In addition to emphasising that the alliance is not that different from generic clients, some therapists relay how developing the alliance with their clients is fairly straightforward. Again, their narratives contain several contradictions to this.

In his first quote below, Joe responds to my question about his experiences of forming an alliance with clients who use drugs by stating that he finds it easy to develop this alliance.

"...it's generally quite easy to to form a an alliance with someone using drugs..." (Joe: 10-12).

However, during his interview Joe relays experiences that seem very challenging. For instance, he recounts how his clients' dishonesty hinders the alliance. In the example below, Joe links his clients' dishonesty with their fear that he reports to social services, particularly regarding Safeguarding Children.

"I think when people lie that hinders but I think people generally lie out of fear" (Joe: 574-576).

As such, Joe describes how the alliance may be obstructed by his clients lying to him. Moreover, Joe introduces the notion of 'fear' into the alliance, creating a picture of a relationship based on fear and dishonesty. This contradicts his initial statement of finding it easy to form an alliance with his clients.

Similarly, Alex describes that he does not find it challenging to develop an alliance with his clients. He links this with his ability to view addiction as a broad concept that applies to many aspects of life, not just substance use.

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"So for me creating the alliance is not a difficulty…" (Alex: 26-27).

Later, Alex describes how his clients' psychological damage can impact on the alliance because if affects their capacity to make therapeutic changes and to relate to him.

"If clients are so damaged, through their upbringing, or at or through other deprivation in the present social deprivation that it just.. that makes it really, really hard to form the alliance" (Alex: 534-539).

Here, Alex explicitly states that it can be extremely challenging to form the alliance, 'really, really hard', which is in stark contrast to his initial claim that he does not experience difficulties in creating the alliance.

Nadine does not explicitly state that she finds it easy to form the alliance with her clients. However, she frequently describes knowing how to intervene when she encounters challenges. Moreover, she reports that her clients respond in a desired manner to her interventions. This gives the impression that although she does experience difficulties, these are successfully solved. For example, she recounts how she manages some clients' reluctance to cease using drugs and the subsequent necessity to terminate therapy:

"And, you know, when I give that to them, then they'll think about it, then they'll say, "Yeah, you're right. I'm ready to talk but I'm not ready to do give up the drug yet"" (Nadine: 855-859).

However, Nadine recounts numerous experiences that seem very challenging. For example, Nadine explains that her clients struggle to trust her due to their interpersonal experiences and experiences with other services, such as social services and the criminal justice system.

"So for me, yeah...I have to work really hard on the trust" (Nadine: 516-517).

Here, Nadine reveals that her clients enter the alliance with little capability to trust her. Consequently, she has to 'work really hard' to facilitate trust. This paints a different picture than her overt portrayal of having an easy solution to the challenges she encounters.

3.5.4   Summary of Theme 3: The contradictory therapist

This theme outlined how the therapists seem to contradict themselves in relation to their experiences and understandings of the alliance with clients with drug problems. Some therapists state that they understand their clients as human beings and see the person behind the drug use. Moreover, they view themselves as different to others who do not have the same level of understanding of their clients. Furthermore, they describe how the alliance is not that different compared to the alliance with generic clients, nor is it particularly difficult. However, their narratives contain several contradictions to these claims of which the therapists seem unaware. As such, it seems the therapists may struggle with aspects of the alliance they do not comprehend and seem not to hold these tensions in mind. Moreover, the data suggests that it may be difficult for them to acknowledge that being in a relationship with their clients can be very challenging and that the alliance is specified by their clients' drug use.

3.6   Theme 4: Resources transcending the alliance

This superordinate theme outlines the resources that the therapists draw upon in developing and maintaining the alliance with their clients. The theme contains three subthemes.

Clinical supervision

Peer support

Use of self

The therapists highlight how supervision, peer support and the use of self support them in their clinical work. As such, supervision and peer support play a key role in helping the therapists to develop the alliance with their clients. The therapists further make use of their

own emotional responses, i.e. their countertransference, and attend to the unconscious processes in the alliance in order to strengthen the alliance with their clients.

3.6.1 Clinical supervision

The therapists emphasise that supervision is essential in approaching the alliance with their clients. Supervision provides a reflective space in which the therapists, for example, examine challenges in the alliance and gain awareness of their emotional responses to their clients. Moreover, in examining their own emotional responses, supervision becomes a forum that facilitates the therapists' wellbeing by, for instance, helping them to cease taking unnecessary responsibility for the difficulties experienced in the alliance. As such, the supervisory alliance provides the knowledge and skills required to develop the alliance with clients whom the therapists otherwise struggle to connect with. Moreover, the supervisory alliance provides a space that facilitates the therapists' wellbeing in response to the challenges they encounter in their clinical work.

The supervisory alliance further seems to constitute a forum from which the therapists seek support and comfort, as opposed to being in a position of providing support and comfort to their clients. Moreover, supervision is a forum in which the therapists allow themselves to be vulnerable. This is mediated by the trust and sense of safety that seems to exist between supervisor and supervisee. As such, the supervisory alliance differs from the therapists' experiences of the therapeutic alliance which lacks trust and safety. Additionally, the therapists seem to experience a strong connection with their supervisor, which again differs from the therapists' struggle in connecting with their clients. Thus, it seems the supervisory alliance is characterised by a stability and connectedness that the fragile therapeutic alliance lacks.

Melissa reflects upon her supervisor:

"...I've had the same counselling psychology clinical supervisor and I tell you what if it wasn't for him I wouldn't be standing. Erm, you know, he's he's wonderful (Mm), erm, and so and, you know, I feel I can discuss anything, erm, including the fact that I didn't like this guy" (Melissa: 1343-1349).

"...So, erm, it's not that they have taught me how to have a therapeutic alliance, it's that we've looked at very, very specific situations and the question is "Could I have done anything differently?" Erm, and sometimes the answer is no and sometimes it's maybe slightly or a bit somewhat..." (Melissa: 1413-1420).

Melissa's language 'if it wasn't for him then I wouldn't be standing' suggests that she would falter under the challenges of her clinical work without her supervisor. It paints a picture of Melissa being metaphorically held up by her supervisor. Her use of 'wonderful' further denotes how important he is to her. It appears Melissa values supervision because she feels safe to be vulnerable and honest about the challenges she encounters with her clients. Melissa does not believe that supervision has taught her the fundamentals of having an alliance. However, she describes how supervision enables her to examine specific events, which subsequently influences her future clinical work. From her statements, it seems Melissa understands supervision to have a dual role; she perceives supervision to impact on the alliance with her clients whilst at the same time supporting her own wellbeing.

Alex echoes Melissa's description of supervision:

"Definitely, supervision, a key aspect" (Alex: 1009).
"So therefore having a space and supervision where I explored my own feelings, erm, and thoughts, erm, my own anxieties. And then having released and shared some of that and.. I think there is something significant about.. sharing with someone else [...] Because I can hear also someone else's perspective from it which gives, you know, a rebalancing in terms of what might be proactive, what might be a reactive kind of transference..." (Alex: 1034-1047).

Alex uses 'key aspect' to describe the central role supervision plays in the alliance with his clients. He continues by emphasising that supervision allows him to release and explore his feelings. It seems supervision is a space where he feels comfortable to share his difficult feelings. Moreover, supervision allows him to reach an equilibrium, 'rebalancing', in terms of his understanding of his emotional responses to his clients. Like Melissa, Alex therefore

appears to understand supervision as simultaneously influencing the alliance with his clients and supporting him emotionally by understanding the unconscious aspects of the alliance.

Similarly, Nadine describes how supervision helps her to develop the alliance with her clients.

"Oh my lovely supervisor! Yeah, it's great. Erm, the group is great because if I've got a problem, or if I feel… Sometimes I feel, gosh, I'm a bit of a a hard-nut. I'm a… I'm a tough-love type of mummy! [laughs] So I tend to go in there and he'll be like, "Okay then, erm, are you maternal to this one?" [laughs] (Nadine: 1336-1342).
I see them sometimes, and I don't even realise that's how I see them, he brings that to my awareness" (Nadine: 1367-1370).

Nadine's expression 'Oh, my lovely supervisor!' demonstrates how strongly she feels about her supervisor and further denotes the significance of supervision to her. Nadine reflects how group supervision and particularly her supervisor highlight when she feels maternal towards her clients, thus encouraging her awareness of unconscious processes in the alliance that are not obvious to her. Supervision also appears to confirm Nadine's fears of being too firm, 'a hard-nut', with her clients. Nadine's laughs signify how her tendency to be maternal has, as she later states, become a running joke between her and her supervisor. This suggests that the supervisory alliance has developed to the extent where Nadine can comfortably and safely discuss her emotional responses.

Lisa reflects on her use of group supervision to understand her feelings in response to a client's anger.

"...and that's when supervision was great because, you know, it's.. I I think I think to begin with I was almost I almost thought that it was my fault, that there was something wrong with me as a therapist, that I couldn't bracket it out [...] it helped with with kind of realising that no, it's not about me..." (Lisa: 1301-1310).

Lisa's language 'great' denotes how she values supervision, and it seems supervision also holds a dual role for Lisa. Expressing her self doubt in supervision enabled her to cease questioning herself and instead relinquish responsibility for her client's behaviour, 'no, it's not about me'. As such, supervision facilitates her understanding of her emotional responses, i.e. her countertransference, to her client's behaviour and supports her wellbeing. Lisa later states that relinquishing responsibility helped her to develop empathy for her client. Furthermore, she gained insight into how his anger manifested in the relationship. In this manner, supervision also facilitated the alliance with her client.

Emilia describes how she used supervision following a client's angry outburst.

"But I hold this feeling that's, erm, although I was very scared in the moment, he wasn't directing that anger at me. He just wanted me to see and feel how he gets, erm. So I I I think that's why I needed to see my supervisor, is it just me completely colluding with the client and not realising that, you know, he can actually act on that anger, or or the feelings were real?" (Emilia: 1029-1039).

Here, Emilia's supervision enabled her to explore her countertransference of fear and doubt, whilst providing certainty that her analysis of her client's anger was plausible. Again, it seems Emilia views supervision as a safe space in which is it okay to struggle and feel uncertain. Emilia's language '**needed** to see my supervisor' suggests the necessity for her to use supervision to process her feelings and achieve clarity. Emilia later reflects that this helped her because:

"...supervision helped me manage my own feelings first of all, and and support the client as well, I guess" (Emilia: 1068-1071).

Emilia is not clear how supervision enabled her to support her client. However, she states that her client apologised after the incident: *"Well, I was never going to [become violent], I was just trying to tell you how angry I was" (Emilia: 1042-1044).* This, she explains, confirmed her hypothesis that her client had wanted her to see his anger. As such, it is

possible that managing her own feelings in supervision provided the mental capacity necessary for Emilia to gain insight into her clients' problem with anger.

Finally, Joe reflects on his supervision experience.

"Supervision I use a hell of a lot" (Joe: 807).

"Erm, I guess when you get stuck, erm, you know, erm, or you're looking for a way in, erm, that's that's when it's useful (Joe: 828-831).

"So it's useful for things that you don't come across, it's also useful for processing your own stuff, what goes on in your life so that it doesn't impact on the therapeutic relationship" (Joe: 851-856).

Joe's phrase 'a hell of a lot' emphasises the extent to which he uses supervision to develop and maintain the alliance with his clients. He describes how supervision allows him to become unstuck and 'find a way in', i.e. connect with his clients. He further outlines how supervision helps him to manage the unknown and to examine the impact of his personal issues on the alliance. It seems Joe, like the others therapists, views supervision as a reflective space in which he also feels safe to explore his emotional wellbeing.

3.6.2 Peer support

Two therapists, Lisa and Emilia, emphasise the importance of peer support in developing and maintaining the alliance with their clients. Peer support is evident only in Lisa and Emilia's narratives. However, it was decided to include the subtheme due to its significance to Lisa and Emilia. Lisa deems peer support helpful as it provides a forum for drawing upon the experience of her colleagues to gain skills in facilitating the alliance. Emilia emphasises the importance of peer support in exploring her difficult feelings, which subsequently improves her emotional wellbeing. For Emilia, there is an 'ad hoc and less formal than supervision' quality about peer support, something which she can draw upon immediately after a difficult client session. It further seems peer support differs from supervision in that peer support concerns the conscious and practical/technical aspects of the alliance, whereas supervision also attends to unconscious processes in the alliance.

Lisa reflects upon the peer support group that she participates in.

"...peer support [...] has been excellent because, you know, they've all, erm, a lot of the people that have worked here before me, they've worked here for a number of months or years and they've all had an experience of of that and they were able to tell me, you know, that's kind of that's how you you can approach that that's what you can say that, you know, that's that's what you can do, that's what you maybe we shouldn't really be doing..." (Lisa: 1224-1234).

Lisa utilises the work 'excellent' to describe her experience of peer support, thus demonstrating the importance of peer support. She highlights how she draws upon the experience of her colleagues for guidance when she encounters challenging or uncertain situations. Lisa subsequently implements these learning experiences in her clinical work, which helps to strengthen the alliance with her clients. As such, peer support provides a forum for learning specific skills in developing the alliance with her clients.

Similarly, Emilia describes how she views her colleagues as important in facilitating her emotional wellbeing.

"...when you come out of the room, and you are in a certain state, it's kind of, like, therapeutic to be with your colleagues and have a space like you saw, you know, where we're at. And, erm, sometimes talk about how you feel. Erm, and allow a space to kind of come back to your own state of, err, you know, wellbeing..." (Emilia: 906-914).

Emilia's description of being with her colleagues as 'therapeutic' denotes how she views them as important to her psychological wellbeing. Emilia's language 'when you come out of the room' suggests that peer support constitutes an immediate and less formal source of support than supervision. Emilia uses her peers to process how she feels about difficult cases. Her language '**allow** a space' suggests that she makes a conscious effort to create the room to reflect upon her feelings. Her words 'come back to your own state of wellbeing' demonstrates that being with difficult clients can unsettle her. Conversely, being with her

colleagues and processing her feelings enables her to return to a state of equilibrium within herself.

3.6.3 Use of self

Finally, the therapists describe how they make use of the self and their understanding of unconscious processes to connect with their clients and to develop the alliance. The therapists draw upon their own emotional responses, i.e. their countertransference, to, for example, understand how their clients feel, to develop insight into their clients' interpersonal relationships and to address process in the relationship. As such, the use of self allows the therapists to connect with clients whom they generally struggle to build an alliance with.

As described earlier (p. 69), Melissa struggled with not liking a client due to his behaviour towards herself and other women.

"And so even after the fact, you know, something that struck me was nobody likes him. That must be an awful way to live, to have nobody much like you..." (Melissa: 1084-1087).

Her statement demonstrates how she utilised her dislike of her client to gain insight into his interpersonal relationships, i.e. that not many people like him. Moreover, her words 'that must be an awful way to live' suggest that she further used her dislike to find empathy for her client's feelings about not being liked. In doing so, Melissa was able to continue working with her client until he dropped out of therapy.

Alex and Lisa reflect upon using their countertransference feelings to indicate how their clients feel. Speaking about his response to risk management, Alex states:

"...I'm less empathic or less acute, so cannot heal as well. I cannot, I mix more, my anxiety with what they're presenting" (Alex: 948-951).
"...sometimes I'm able to conceptualise it under the construct of, erm, projective identification, so I may be feeling things that they are disowning, so, you know, I'm feeling their anxiety when the situation is quite anxiety provoking" (Alex: 953-959).

In his first extract, Alex says that his own anxiety when managing risk can obstruct the alliance as he can experience a lack of empathy and confusion about the origin of his anxiety. Alex subsequently explores his anxiety and recognises that it may belong to his clients. Thus, listening to his anxiety indicates how his clients feel about their risk issue. Moreover, it appears that identifying his felt anxiety as belonging to his client, i.e. identifying his countertransference, could help to decrease his experience of feeling anxious. This could, in turn, increase his capacity for responding empathically.

Lisa highlights how she utilises her emotional responses in a number of ways.

"...if you did pay attention to how you're feeling then, you know, it can give you all sorts of clues as to how people respond to that person outside of the room [...] if you think that they they are looking at you and and they are seeing you as someone similar to, erm, I don't know, one of their family members or friends, then it it's a huge clue as to how to work with them, err, when it comes to that relationship [...] they won't say how they feel or they will try and hide it a little bit [...] if you can let yourself sort of feel what [...] is lingering in the room sort of thing then it can give you a lot of clues as to what they're feeling [...] it does help the alliance hugely actually, erm, because it makes it more real..." (Lisa: 1352-1375).

Lisa states that paying attention to her countertransference provides insight into how others respond to her clients and information about how to work with clients' interpersonal relationships. Furthermore, it gives her access to her clients' otherwise inaccessible feelings. Her words 'it makes it more real' suggest that she experiences the alliance as somewhat stunted when her clients' feelings are missing. As such, using her emotional responses brings therapy and the alliance to life and seems to allow her to connect with her clients. Her language '**let** yourself feel' denotes that making use of her feelings requires effort, something which she has to be open to and prepared to do.

Similarly, Joe reflects:

"...I think, erm, congruence and immediacy in the therapeutic relationship are key, because, erm, if you feel something, erm, and you share it with the client and it's useful to the client

you can move you forwards, but it can also move you together, so it can also draw you

together" (Joe: 933-940).

Joe's use of the word 'key' signifies that sharing his feelings with his clients holds a central role in his clinical work. Joe understands the use of his emotional responses to be helpful in propelling therapy forward, almost as if sharing his feelings unlocks ('key') and moves therapy onwards. Moreover, he perceives sharing his feelings as something that enables him to connect with his clients as evident from his language 'move you together, draw you together'.

Emilia reflects upon sharing her feelings with a client in response to his aggressive behaviour.

"So finding a way of saying, "Well, I'm scared sitting here with you." So, erm, obviously not exactly saying it like that, but saying more or less that and. And, erm, widening widening it out to saying, "I wonder if other people out there reject you because they're scared as well?" *(Emilia: 769-776).*

Emilia shares her countertransference with her client to encourage him to consider the possibility that others reject him because of his aggression. Emilia's words 'find a way of saying' and 'obviously not exactly saying it like that' demonstrate that it can be challenging to delivery her feelings to her clients in sensitive manner. It seems there is a risk of the alliance rupturing when Emilia shares her feelings with her clients. Therefore, Emilia considers carefully how to present them.

Finally, Nadine provides an example of working in a family setting with a client and his mother. Nadine reflects on the double edged outcome of sharing her frustration with and setting a boundary for her client.

"And he hasn't been back since. His mum's been coming, but he hasn't been back. And and she said, "His use has gone off the scales", so.. But it's a case of taking that frustration to supervision not really knowing the way it was, and then, erm, my supervisor being able to

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just pinpoint exactly what role I was actually playing, without me realising [...] but since working with his mother, erm, I've realised that it empowered her, because it gave her an example of how to deal with his behaviour" (Nadine: 1526-1555).

Nadine recognises how supervision helped her to make sense of her frustration and understand how her client elicited certain unconscious responses in her. Nadine seems to have some unresolved feelings about her client leaving therapy, as indicated by her sentence trailing off, 'so...'. She highlights that enforcing a boundary and sharing her frustration with her client unexpectedly provided his mother with an example of how to enforce boundaries. As such, Nadine's use of self helped to strengthen the alliance with her client's mother. However, Nadine experienced a rupture in the alliance with her client, thus indicating that there remains a risk of disconnection in the alliance when making use of the self.

3.6.4   Summary of Theme 4: Resources transcending the alliance

This theme outlined the resources the therapists experience as significant in developing and maintaining the alliance with their clients.

Group and individual supervision provides a reflective space that enables the therapists to, for example, examine their countertransference and develop skills in managing the alliance with their clients. Moreover, supervision supports the therapists' emotional wellbeing. It seems supervision provides an experience for the therapists in which they are in a position of seeking support and comfort, as opposed to providing support and comfort to their clients. The supervisory alliance seems inherently different to the therapeutic alliance in that it is characterised by a sense of trust, safety and connection between supervisor and supervisee. Ultimately, the data suggests that supervision enables the therapists to connect with otherwise difficult to connect with clients, whilst supporting them emotionally with the challenges they encounter in their clinical work.

Peer support allows Lisa to gain skills in developing the alliance with her clients. For Emilia, peer support serves an ad hoc platform that enables her to process her feelings, thus

supporting her wellbeing. As such, it seems the alliance with peers influences the therapeutic alliance and can support therapists' emotional wellbeing.

Finally, the data illustrates how the therapists make use of their countertransference to develop the alliance. This serves a multitude of functions, such as providing access to their clients' feelings, allowing insight into their clients' interpersonal relationships and addressing process in the relationship. It appears the use of self can rupture the alliance and must be delivered sensitively, as reflected upon and experienced by some of the therapists. However, the use of self ultimately seems to enable the therapists to connect with their clients. This seems significant given the potential for disconnection that the therapists may experience from their clients.

3.7   Reflexivity

In the following, I reflect on the impact of my subjectivity upon the data analysis. Firstly, the relationship between the participants, the organisation and I will be reflected upon. This will be followed by an outline of my relationship with the participants. Finally, I consider how my personal experience has influenced the data analysis.

3.7.1   Researcher - participant - organisation relationship

In exchange for accessing therapists from within the participating organisation, I agreed to give the organisation access to the results section of the thesis. Moreover, the organisation requested permission to inform relevant third parties that they participated in the research. A particular challenge I experienced in the research process arose as a consequence of this and must be discussed.

During the data analysis, it became apparent that the therapists' narratives contain a number of contradictions suggestive of their struggle with developing an alliance with their clients (Theme 3). Initially, I was apprehensive about including this discovery in the thesis. I was concerned about placing the therapists in an unfavourable light when presenting the results to the organisation. Moreover, I felt indebted to the therapists and the organisation for participating in the research and did not want to appear ungrateful by saying negative

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things about the therapists. As such, I was torn between wishing to demonstrate the discrepancies in the therapists' accounts and wanting to say only positive things about the therapists.

Initially, this impacted upon the data analysis. My first drafts were descriptive and lacked interpretative depth. Furthermore, I neglected to present the major ways in which the therapists struggle to make sense of the alliance. Guided by supervision, I was able to process my anxiety. This allowed me to assume a more critical and interpretative stance, thus producing the results as they feature in this thesis.

Interestingly, my anxiety appears parallel to the therapists' experiences with their clients. The therapists seem careful not to upset their clients and walk on egg shells for fear of disconnecting from their clients (Theme 2). Similarly, I felt unable to communicate aspects of my findings due to feeling anxious about upsetting the therapists and the organisation. Moreover, the therapists speak of being trapped in the system which impacts on the alliance with their clients (Theme 1). I too felt trapped in their organisational system, unable to communicate my discoveries for fear of seeming ungrateful. Ultimately, these parallel processes and my feelings of anxiety and frustration helped to guide my interpretation of the therapists' experiences of the alliance with their clients.

3.7.2   Researcher – participant relationship

It is equally important to consider how my interaction with the therapists impacted upon the data and its analysis. My interview questions allude to my position that the alliance with clients who use drugs is different to the alliance with generic clients. My questions also suggest that the alliance may be difficult and that therapists need support to develop and maintain the alliance. Therefore, it is likely that my questions challenged the therapists' position that the alliance is 'not that difficult and not that different' (Theme 3). Paradoxically, this could have increased their desire to communicate this position. As such, my very interview questions may have rendered the therapists' understanding of the alliance as 'not that difficult, nor that different' so evident in their narratives.

Similarly, the therapists describe how they have a level of understanding about clients who use drugs that many others do not posses (Theme 3). Had the therapists openly acknowledged the alliance as hard and specific, as my interview questions suggest, they may have perceived themselves as similar to others who do not understand (Theme 3). Again, this may have increased the therapists' need to adhere to the position that the alliance is not particularly difficult and not that different, thereby making the position so obvious in their narratives.

An interesting parallel process concerning my relationship with the therapists that deserves reflection was my difficulty in making sense of the therapists' narratives. I found it incredibly challenging to understand how they understood the alliance with their clients. When relaying my initial findings to my research supervisor, my supervisor also struggled to make sense of my presentation. This enabled us to identify the numerous contradictions in the therapists' narratives (Theme 3). Again, this parallel process and my feeling of confusion shaped my interpretation of how the therapists struggle to make sense of the alliance with their clients.

3.7.3   Impact of my personal experience on the data analysis

It is equally important to reflect upon the impact of my own work in substance use on the data analysis. Due to my experience of struggling to develop and maintain an alliance with clients who use drugs, I recall being surprised by the therapists' insistence that the alliance with clients who use drugs is fairly similar to that with generic clients and that it is not particularly challenging. This is so contrary to my own experiences that their statements were very noticeable to me. This, in turn, later enabled me to identify the contradictions (Theme 3) in the therapists' accounts. Had I been inexperienced in the field of substance use, the contradictions may have gone unnoticed and an important aspect of the alliance with clients who use drugs may have remained unexplored (see also Appendix 10).

Moreover, as stated (p. 41), I approached the data with certain ideas about how the therapists may understand the alliance with their clients. As such, I strongly relate to the therapists' understanding of the alliance as being situated within an organisational and political system. In my own work, I recall feeling frustrated with working in a restrictive

environment that seemed to disregard my clients' and my own needs for a satisfactory alliance (Theme 1). Similarly, I too struggled to connect with my clients for many of the reasons illustrated in this study. Moreover, I somewhat relate to taking responsibility for maintaining the alliance, thus recognising how unconscious processes are involved in this response (Theme 2). Finally, the therapists' accounts of the importance of their clinical supervision significantly resonate with me (Theme 4). Undoubtedly, this influenced my interpretation of the therapists' experiences and my subsequent decision to generate Themes 1, 2 and 4.

In this manner, my interaction with the participants and the organisation as well as my personal subjectivity considerably influenced the data analysis. However, the data analysis adheres to the phenomenological requirements of IPA as the therapists' contradictions, struggle with connecting with their clients, sense of being trapped and experiences of supervision were evident in the data and demonstrated in the verbatim extracts in the results section. Moreover, I ensured to explore the data sets for contradictions to my interpretations and identified themes. As such, I searched the therapists' narratives for anything to suggest that, for example, supervision was not significant to the therapists. This ensured grounding of the themes in the therapists' accounts, whilst my personal experiences added interpretative depth to the analysis (Larkin et al., 2006).

Chapter 4: Discussion

4.1   Introduction

This chapter contextualises the results of the study in relation to its research questions and relevant literature and research. The chapter commences with an overview of how the study findings correspond to the research questions. This will be followed by an in depth discussion of each theme and their relevance to the research questions. Subsequently, an outline of the study's implications for alliance theory will be presented, followed by a critical evaluation of the study. The chapter will conclude with an outline of the implications for clinical practice and future research. The use of IPA can generate unexpected findings (Smith et al., 2009). Hence, literature and research not reviewed in Chapter 1 will be incorporated when appropriate to discuss such findings.

Six therapists were interviewed about their experiences of the alliance with clients with drug problems. The study's research questions were:

How do therapists experience and understand the therapeutic alliance with clients who have drug problems?
What do therapists perceive to impact upon establishing and maintaining the alliance with clients who have drug problems?
What might support therapists to engage in effective alliances with clients who have drug problems?

IPA was utilised to analyse the therapists' narratives generated from the interviews. This analysis produced four themes that indicate how therapists experience the alliance with clients who use drugs.

4.2   Overview of the study findings

Most therapists in this study experience the alliance with clients who use drugs as situated within a treatment system that hinders the alliance in developing. The data suggests they

perceive both themselves and their clients as trapped in a system they have no choice but to comply with. Subsequently, the therapists struggle with feeling hopeless.

The therapists perceive their clients' fundamental mistrust of others and ambivalence about undertaking therapy and changing their drug use as impacting upon establishing and maintaining the alliance. Their clients' ambivalence and mistrust seem partially related to the treatment system, and further concern their clients' difficulties in relating to others. As such, client ambivalence and mistrust can be contextualised in stigma and attachment literature and research (Luoma et al., 2007; Gerhardt, 2004; Holmes, 2001; Bowlby 1988). In response to struggling to connect with their clients, the therapists appear to experience significant countertransferential responses that lead them to assume responsibility for developing the alliance. This, in turn, further hinders the alliance in developing.

Additionally, all the therapists appear contradictory in their understanding and experience of the alliance. This process seems outside their awareness. As such, the data suggests they may experience difficulties in acknowledging that there are aspects of the alliance with their clients they do not comprehend. Moreover, it seems they struggle to recognise that the alliance is different to that with generic clients. This dilemma can be contextualised in Safran & Muran's (2003) alliance rupture work, which indicates that the therapists attempt to adopt a fixed conception of the alliance. This, in turn, serves to manage their emotional discomfort in response to struggling with the alliance (Safran & Muran, 2003).

The therapists highlight clinical supervision, peer support and the use of self as sources of support that enable them to establish effective alliances with their clients. Consistent with generic psychotherapy research, supervision plays a significant role in providing the therapists with a secure base, enabling the therapists to examine and use their countertransference and facilitating their emotional wellbeing. Peer support seems concerned with the conscious and practical elements of the alliance, and is highlighted by two therapists as essential for developing skills in relation to the alliance and in supporting their emotional wellbeing. Finally, the therapists make use of the self, i.e. their countertransference, when developing the alliance. This seems to facilitate self-

understanding and relational insights that enable them to connect with otherwise difficult to connect with clients.

An interesting finding from the study concerns the way in which the therapists experience the alliance as intertwined with unconscious processes, such as their countertransference. This discovery has significant implications for the definitions and measurements of the alliance that term the alliance a conscious concept, e.g. Horvath & Bedi (2002) and Horvath & Greenberg (1983). This study demonstrates that it is necessary to recognise the alliance as inseparable from the unconscious processes in the therapeutic encounter in line with Safran & Muran's (2003) definition of the alliance (p. 13). Alternatively, the findings from the study question the usefulness of the concept of the alliance as distinct from the total client-therapist relationship on a clinical practice level (p. 116).

4.3   Trapped in the system

This theme provides insight into therapists' general understanding of the alliance with clients with drug problems. Moreover, the theme highlights factors that both hinder and help the alliance in developing. The therapists in the current study understand the alliance with clients who use drugs as nested within a treatment system that impacts upon the alliance. The therapists' experiences of the treatment system seem largely within the therapists' awareness, as opposed to the unconscious processes that appear to be involved in Themes 2 and 3.

4.3.1   Trapped therapist and client

The therapists experience themselves as having little choice but to operate within a treatment system they recognise as detrimental to the alliance. The therapists further understand their clients as trapped in the system with little choice but to comply. Indeed, the treatment system appears to be experienced by the therapists as hindering the agreement on the tasks and goals of therapy, the collaborative nature of therapy as well as the therapeutic bond (Safran & Muran, 2003). The therapists provide different examples of the parts of the system that hinder the alliance in developing. These are contextualised below.

4.3.2 Contextualising 'the system'

Therapy for individuals with drug problems is guided by the NICE guidelines (2007) (see also p. 34). It is common for services to offer approximately twelve sessions of therapy (NICE, 2009). Due to the complexity of coexisting drug use and mental health problems, some clients do not receive the therapeutic time they require to make changes, as reflected upon by Melissa (p. 54). Moreover, the type of therapy offered is often CBT and Motivational Interviewing (NICE, 2009; 2007). As such, other therapeutic interventions deemed helpful by therapists may be considered inappropriate, as Joe experiences (p. 55). Furthermore, Lisa refers to service re-engagement policies (p. 66). Again, services often operate a policy whereby therapists are required to contact clients when they fail to attend sessions. It is further common for therapists to utilise outcome measures in line with organisations' monitoring of therapeutic outcome. In the quest to 'produce' good therapeutic outcomes, therapists may experience difficulties in balancing the requirements of the organisation with their clients' needs (PHE, 2010).

In addition, generic psychological services frequently decline working with individuals who have drug problems until they receive treatment for their drug problem. Consequently, therapists in substance use services may work with clients who receive drug treatment purely to access other services. This is referred to by Nadine (p. 53).

Finally, HM Government's Drug Strategy (2010) state that individuals with drug problems who offend are required to seek treatment as an alternative to a prison sentence. Alex and Joe describe how some clients are placed on drug rehabilitation requirements to attend drug treatment (p. 52). Alex specifically reflects upon providing therapy to individuals with drug problems in prisons (NICE, 2007). Thus, therapists providing therapy to individuals with drug problems in the criminal justice system may find themselves attempting to develop an alliance with clients who have little choice but to attend therapy.

Existing research relating to therapists' or professionals' experiences of the alliance with clients with drug problems appears not to consider the impact of the treatment system upon the alliance. Neither does existing research highlight how therapists experience both themselves and their clients as stuck in the system. As such, the current study deepens our

insight into how therapists who work with clients who use drugs understand the alliance as nested within a treatment system that is detrimental to the alliance.

4.3.3   Hopelessness

Although not explicitly stated, some therapists in the study indicate feeling hopeless as a result of viewing themselves and their clients as situated in a system that restricts the alliance. The therapists seem aware that their therapeutic work with certain clients is somewhat futile and inadequate.

The therapists' hopelessness mirrors to some extent findings by Kothari et al. (2010) who report that psychologists experience 'lacking hope' in their therapeutic practice with individuals with drug problems. However, lacking hope in Kothari et al.'s study concerns psychologists' doubt about clients' ability to overcome their addiction. As such, this study's findings contextualising hopelessness in the treatment system and its impact upon the alliance appear original.

Therapists' hopelessness may impact upon their engagement in the alliance. Kothari et al. (2010) report that psychologists' hopelessness stalled therapeutic change by leaving both psychologists and clients stuck in space of feeling hopeless. Thus, it seems likely that therapists may respond to feeling hopeless by being unable to fully take part in the purposive and goal directed work of therapy. Moreover, therapists could become despondent about their clinical work and about forming an alliance and indeed a bond with their clients.

4.3.4   Navigating the system

The therapists in this study have devised ways of navigating the system, which help to develop and maintain the alliance. Joe's statement "*So I did it anyway, I paid for it [EMDR course] myself and I did it anyway and that's really helped my practice because then I can actually deal with what's going on" (Joe: 355-359)* demonstrates brilliantly the therapists' resourcefulness in creating ways of developing the alliance.

Navigating the system illustrates, on one level, how the therapists attempt to develop the alliance with their clients despite the constraints of the system. It further seems possible that navigating the system represents the therapists' attempt to retain hope that their therapeutic work is not futile. Thus, navigating the system links to the previous subtheme relating to hopelessness, and may serve to counteract the hopelessness the therapists experience when attempting to develop an alliance with some of their clients in context of the treatment system. The findings from the current study suggest that experiencing hopelessness may be a prominent challenge for therapists who work with clients with drug problems. This seems an avenue for future research.

4.4   Struggling to connect

This theme provides insight into the aspects of therapy that therapists may experience to hinder the alliance in developing when working with clients who use drugs. The therapists describe how some of their clients are absent from the alliance, which impacts upon the collaborative development of the goals of therapy as well as the therapeutic bond. Subsequently, the therapists take responsibility for the alliance, a process of which they seem unaware.

4.4.1   The unreachable client

The therapists relay how some clients are unavailable to them. The therapists deem this a consequence of their clients' ambivalence about changing their drug use and their mistrust of relationships. The therapists appear to understand some of their clients' ambivalence and mistrust to arise as a result of the treatment system. In this manner, the therapists seem to experience the treatment system as forcing some clients into an alliance they do not wish to take part in. Moreover, the therapists seem to perceive their clients' experiences with aspects of the treatment system as creating mistrust in the alliance. Thus, Struggling to connect links with Trapped in the system.

4.4.2   Ambivalence

Ambivalence can be defined as, 'the experience of more than one feeling about the same event, object or person that causes internal discomfort' (Hagedorn, 2011, p. 110).

Ambivalence about undertaking therapeutic change is common (McEvoy & Nathan, 2007), although particularly prevalent in substance use (Hagedorn, 2011). The findings from the subtheme The unreachable client extend existing literature concerning ambivalence in the alliance by demonstrating the way in which ambivalence partially exists in context of the treatment system. Moreover, the findings provide insight into the emotional impact that clients' ambivalence has on therapists, such as feelings of desperation, powerlessness, frustration and uncertainty. It seems possible that these feelings may impact upon therapists' ability to bond with their clients and hinder their full engagement in the goals and the tasks of therapy.

4.4.3 Mistrust

The finding that clients with drug problems approach their therapist with mistrust seems partly unique. Existing research suggests that trust constitutes an important part of the client-therapist relationship (Woolhouse et al., 2011; Hoxmark & Wynn, 2010; Nordfjaern et al., 2010; Godlaski et al., 2009; Redko et al., 2007; Bacchus et al., 1999). However, it appears existing research does not consider how mistrust hinders the alliance in developing by keeping clients out of therapists' reach. Additionally, existing research does not seem to explicate how mistrust of a therapist can arise as a consequence of clients' experiences more generally within the treatment system. As such, the findings from the current study increase our knowledge of how (mis)trust is poignant for therapists who work with clients with drug problems.

Additionally, clients' mistrust resonates with stigma research and research into subjective experiences of substance use. The literature review (p. 20) demonstrated that individuals with drug problems encounter stigmatising attitudes from others (Watson & Parke, 2011; Luoma et al., 2007; Lovi & Barr, 2009; Roche et al., 1991). This can lead them to become apprehensive about developing a bond with their therapist.

4.4.4 Contextualising ambivalence and mistrust in attachment theory

It is further possible to contextualise mistrust and ambivalence about therapy and changing drug use in attachment theory. As highlighted in the literature review (p. 17), individuals with substance use problems seem to have insecure attachment styles (Schindler et al.,

2007; Thorberg & Lyvers, 2006; Casper et al., 2005; Schindler et al., 2005). Hence, it is possible that their early life secure base experience has resulted in an internal working model whereby trusting others is associated with anxiety. Moreover, individuals with substance use problems may have difficulties with regulating troubling emotions (Gerhardt, 2004, Holmes, 2001). Drug use can be viewed as an individual's secure base, i.e. an emotional regulation strategy (Gerhardt, 2004; Holmes, 2001). Separating from a 'trusted' emotional regulation strategy may elicit anxiety and fear for clients. Indeed, it may elicit anxiety for clients to relate to a human being as opposed to their inanimate, known object. This could make it difficult to develop and maintain a bond with their therapist (Mikulincer, Shaver, Bar-On & Ein-Dor, 2011). As such, mistrust and ambivalence about therapy and changing drug use could link with clients' inherent difficulties in relating to others. In this manner, clients' early attachment experiences may result in fundamental problems in developing a bond with their therapist, which manifests itself in ambivalence about therapy and mistrust in their therapist.

The results of the current study in relation to trust/mistrust and ambivalence support existing research indicating that the client-therapist attachment could constitute a new relational template and emotional regulation strategy for individuals with drugs problems (Kothari et al., 2010; Gerhardt, 2004; Holmes, 2001; Lovejoy et al., 1995). Indeed, the client-therapist relationship, of which the alliance forms part, can provide clients with a relational experience that enables them to make changes to their unhelpful internal working model and ways of regulating emotions. That is, it can provide a relational experience characterised by trust, which may generalise to external relationships (Safran & Muran, 2003).

4.4.5   Taking responsibility to avoid disconnection

The majority of the therapists assume responsibility for developing and maintaining the alliance as a consequence of struggling to reach their clients. Paradoxically, 'taking responsibility' can be seen as detrimental to the alliance. This is in stark contrast to most of the therapists' understanding that (some of) the strategies they employ help to develop and maintain the alliance. The 'taking responsibility' strategies and their relation to existing research and literature are considered below.

4.4.6   Self doubt

Some of the therapists respond to being unable to reach their clients by doubting themselves. These findings are somewhat original. Kothari et al. (2010) mention briefly how some psychologists in their study feel responsible for the outcome of therapy, which leads to self doubt. Kothari et al. (2010) contextualise this in the psychologists' need to save their clients. The findings from the current study offer a different context. Seen as part of a wider picture of taking responsibility to avoid disconnection, it seems possible that self doubt serves to maintain the alliance. By doubting themselves, the therapists avoid being overwhelmed by feelings of disappointment and frustration with their clients. Moreover, they avoid questioning their clients' commitment to therapy and the possibility of therapeutic success. Indeed, self doubt shifts the therapists from emotional states that could alienate them from their clients. As such, this study extends existing knowledge of therapists' experiences of the alliance with clients who use drugs by offering a different perspective from which to consider therapists' self doubt.

4.4.7   Stretching therapeutic boundaries

The therapists in this study further assume responsibility for the alliance by stretching the therapeutic boundaries. Apart from one participant, Joe, the therapists believe these measures facilitate the development and maintenance of the alliance.

This finding is partly novel. Kothari et al. (2010) recommend that therapeutic flexibility is necessary to accommodate a challenging client group, for example around discharge following non-attendance. In this manner, flexibility is viewed as essential in engaging and maintaining clients in therapy. Conversely, the current study suggests that stretching the boundaries of therapy, or therapeutic flexibility, demonstrates the therapists' difficulty, almost desperateness, to connect with their clients. Indeed, stretching the boundaries of therapy can be viewed as counterproductive to facilitating a stable and safe environment (Woolhouse et al., 2011; Hoxmark & Wynn, 2010). As such, in their attempt to develop the alliance with difficult to connect with clients, the therapists in this study respond in ways that may potentially recreate the instability and fragile attachments in their clients' lives (Lemma, 2003). The therapists seem largely unaware of this. At times, stretching the boundaries of therapy is even required on a service level, thus further illustrating how the

treatment system impacts upon the alliance between client and therapist. It appears that maintaining therapeutic boundaries may be particularly pertinent for therapists and services who work with clients who use drugs to develop a stable, containing environment and, indeed, the alliance. This requires a rethink on a service level about the counterproductive nature of therapeutic flexibility.

4.4.8   Walking on egg shells

Some of the therapists in the current study seem careful not to upset their clients in an attempt to avoid conflict and ruptures in the alliance. These findings resonate with Safran & Muran's (2003) work on alliance ruptures. Safran & Muran highlight the importance of therapists attending to therapeutic impasses as clients may not be able to communicate these. This can, in turn, prevent alliance ruptures and enable therapeutic change. Conversely, failure to attend to impasses results in ruptures in the alliance and drop out from therapy (Safran et al., 2001). Paradoxically, the therapists in this study deem walking on egg shells a means of preserving the alliance. With Safran & Muran's theory in mind, walking on egg shells can, in fact, be perceived to hinder the alliance by leaving significant parts of therapy that rupture the alliance, such as relapse and non-attendance, unaddressed (Safran & Muran, 2003). This finding does not appear to exist elsewhere in literature and research pertaining to drug use and thus offers a unique contribution to understanding how therapists experience the alliance with clients who use drugs.

4.4.9   Changing self

Finally, some therapists in the current study change aspects of themselves to connect with their clients. Again, this finding offers a previously unknown contribution to existing alliance research in drug treatment. The therapists perceive changing themselves as helpful in developing and maintaining the alliance. However, it is as if the therapists are left having to change fundamental aspects of themselves as a consequence of their clients being unable or unwilling to change. Ultimately, this demonstrates the amount of responsibility the therapists assume for the alliance with their clients.

4.4.10 Contextualising 'taking responsibility to connect'

The therapists' tendency to take responsibility for the alliance may indicate an unhelpful reaction to their countertransference (Heimann, 1950). Assuming unnecessary responsibility for aspects of therapy is commonly discussed in general psychotherapy (Wishnie, 2005; Lemma, 2003; Maltzberger, 1999), although appears not to be documented in existing research and literature in relation to the alliance with clients who use drugs. It seems possible that the therapists in the current study assume responsibility for developing and maintaining the alliance in response to their clients' inability to do so. Wishnie (2005) and Maltzberger (1999) highlight the importance of therapists reflecting upon their countertransference, thus allowing their clients to take responsibility for their therapy and wellbeing. Indeed, taking responsibility for the alliance can be seen as disempowering clients as opposed to enabling their recovery and building the alliance. It seems worthwhile for future research to explore how therapists manage their countertransferential responses to clients who use drugs.

4.5   The contradictory therapist

This theme provides insight into therapists' general understanding and experiences of the alliance with clients who use drugs. The study findings indicate that the therapists in the current study experience unacknowledged tensions in relation to the alliance with their clients. As such, it seems the therapists struggle with making sense of certain aspects of the alliance. Moreover, the therapists may struggle to acknowledge how the alliance with clients who use drugs is different to the alliance with generic clients, and that it is sometimes very difficult.

These findings provide an original contribution to our knowledge of how therapists may experience and understand the alliance with clients with drug problems. Previous research, particularly Kothari et al. (2010), highlight that working with clients with substance use problems can be challenging. For example, the psychologists in Kothari et al.'s study speak of feeling hopeless, disappointed, frustrated, mortified and fearful, whilst managing risk, needing to be emotionally resilient and able to tolerate distress. The psychologists do not contradict themselves to this effect or minimise the impact of their statements.

4.5.1 Contextualising the contradictions

It is possible to contextualise the way in which the therapists in the current study contradict themselves in Safran & Muran's (2003) work on alliance ruptures. Safran & Muran suggest that therapists' self worth can be threatened by therapeutic impasses, which in turn leads therapists to feel discomfort and anxiety. Safran & Muran propose that therapists' sense of self worth and competency are linked with their ability to make sense of the complex and confusing difficulties that clients present with. Moreover, therapists' self worth and competency are based upon the ability to introduce order and structure to the ambiguity and meaninglessness that can characterise clients' presentations. When faced with situations that threaten self worth and competency, it can be tempting for therapists to maintain a fixed conception (understanding) of their interaction with their clients, as opposed to keeping an open mind about what is really happening in the interaction. As such, therapists can retain a fixed idea of the alliance to, for example, avoid feeling incompetent, or to avoid acknowledging their own role in the interaction with their clients. This, in turn, serves to reduce anxiety and discomfort.

The possibility exists that the therapists in the current study attempt to retain a fixed conception of the alliance with their clients. Their fixed conception consists of maintaining that they understand their clients, and that the alliance with their clients is not that difficult nor that different from generic clients. Maintaining a fixed conception may protect them from feeling incompetent when struggling to connect with their clients. Moreover, it may prevent them from, in their minds, becoming like other individuals in their clients' lives whom they deem not to understand their clients. Indeed, it is possible that admitting how they struggle to understand and relate to their clients, as well as openly acknowledging how the alliance is different to generic clients, clash with their professional identity as therapists. It is also entirely possible that retaining a fixed conception of the alliance prevents them from reflecting upon their contribution to the difficulties in the alliance, i.e. their tendency to take responsibility for the alliance (Safran & Muran, 2003).

In this manner, the therapists' fixed conception of the alliance serves to manage their anxiety and discomfort generated by developing and maintaining the alliance with their clients. It also seems that the therapists' fixed conception helps them to connect and stay

connected with their clients. For example, should the therapists acknowledge how challenging they find the alliance, it may increase their feelings of hopelessness that are already prominent as a result of being trapped in the treatment system. In fact, maintaining a rigid understanding of the alliance hinders the alliance in developing by leaving therapeutic impasses as well as countertransference reactions unaddressed (Safran & Muran, 2003). This can lead to ruptures in the alliance (Safran et al., 2001). Moreover, it can prevent the therapists from processing how they feel about the challenges inherent in the alliance, thus impacting upon their emotional wellbeing. The way in which therapists may attempt to retain a fixed conception of the alliance opens up avenues for further research.

4.6 Resources transcending the alliance

This theme provides insight into resources that therapists may draw upon to establish and maintain effective alliances with clients who use drugs. The theme links with the previous themes, as the therapists describe the resources that enable them to manage the challenges in the alliance with their clients. The therapists reflect upon the significance of clinical supervision, peer support and the use of self. In the following, these three sources of support will be discussed and contextualised in literature and research.

4.6.1 Clinical supervision

Group and individual supervision is described as a reflective space that provides the therapists with the knowledge and skills required for developing the alliance with clients who are difficult to connect with. This includes the exploration and use of the therapists' countertransference. Moreover, the supervisory alliance facilitates the therapists' wellbeing in response to the challenges in connecting with their clients.

The therapists indicate that they experience a strong bond with their supervisor. Indeed, the supervisory alliance seems to constitute a platform from which the therapists seek support and comfort. Moreover, supervision seems a space where the therapists can be vulnerable and in need of guidance as a function of the trust and safety that characterises the supervisory alliance. Thus, it seems the supervisory alliance involves a stability, trust and bond that is absent from the therapeutic alliance.

The findings from the current study are consistent with existing generic psychotherapy research suggesting that the supervisory relationship provides a secure base wherefrom therapists receive soothing, guidance and protection (Gunn & Pistole, 2012). Moreover, the findings reflect the way in which supervision has been found to facilitate therapists' self-awareness, thus enabling therapists' understanding and management of transference and countertransference. The findings further suggest that supervision helps therapists to develop technical skills in relation to the therapeutic relationship (Wheeler & Richards, 2011; Angus & Kagan, 2007; Vallence, 2005).

Whilst the impact of clinical supervision upon therapy and the alliance is well documented in general psychotherapy, it seems a paucity of research exists that documents the significance of supervision for therapists who work with clients who use drugs. As such, the findings from the current study provide an original contribution to understanding how therapists can draw upon supervision to establish effective alliances with clients who use drugs. The role of supervision seems particularly important to therapists because of the countertransferential responses they may encounter in the alliance with clients who use drugs. Indeed, supervision could helpfully increase its focus on countertransference given the unresolved countertransference reactions the therapists in the current study appear to experience. Moreover, it seems therapists may benefit from supervision as a secure base and holding environment in light of the fragile and challenging alliance they experience with their clients.

4.6.2   Peer support

Two therapists describe how peer support enables them to develop effective alliances with clients with drug problems. As such, peer support is viewed as a forum for developing skills relating to the alliance. Moreover, peer support takes an ad hoc format that enables the processing of feelings, thus facilitating the emotional capacity to engage in the alliance. This seems poignant in light of the challenges that therapists may experience in forming an alliance with clients who use drugs. Peer support appears to concern the conscious and technical skills aspects of the alliance, in contrast to supervision which also concerns the unconscious processes, e.g. countertransference, of the alliance.

The role of peer support in developing alliances with clients who use drugs has not been described elsewhere in literature or research. It appears there is also a paucity of research investigating peer support in relation to the alliance in general psychotherapy. A search of literature revealed somewhat related research; school psychologists deem peer support groups important in enhancing their professional growth and development (Zinz & Murphy, 1996). Moreover, mental health nurses describe how support from peers in the form of collegial support and formal support groups is essential, for example in processing critical incidents (Cleary, Horsfall, O'Hara-Arons & Hunt, 2012). Finally, Babin, Palazzolo & Rivera (2012) recommend that domestic violence advocates explore and share their experiences of their work to avoid burn out. These findings, combined with the findings from the current study, suggest that support provided by peers can transcend the alliance by helping therapists to develop skills relating to the alliance. Moreover, it can enhance therapists' wellbeing when working with clients who use drugs, thus increasing their capacity to engage in the alliance with their clients. As such, peer support has the potential to constitute an important forum for therapists in establishing the alliance. Indeed, the role of peer support in working with clients who use drugs seems to warrant further investigation.

4.6.3   Use of self

This subtheme demonstrates how therapists may draw upon their emotional responses to their clients, i.e. their countertransference (Heimann, 1950), to establish the alliance. The use of self helps the therapists to connect with clients whom they otherwise experience a disconnection from.

Therapists' use of self to develop the alliance with clients with drug problems seems not to be documented in depth elsewhere in literature or research. As such, the current study increases our knowledge of the resources that therapists can helpfully draw upon in relation to the alliance with clients with drug problems. Kothari et al. (2010) report briefly that psychologists in their study recognise how their hopelessness indicates their clients' hopelessness. Aside from this, the therapists' use of self can be contextualised in general psychotherapy literature and research. The findings from this study relate to research demonstrating how therapists use their emotional and behavioural responses to understand their clients' emotions and interpersonal difficulties (Zachrisson, 2009; Hayes et al., 2011). It

seems awareness and use of countertransference may be particularly fundamental when developing the alliance with clients who use drugs, given the pronounced countertransferential responses the therapists in the current study experience.

4.7   Unconscious processes and alliance theory

This study has demonstrated that therapists seem to understand the alliance with clients who use drugs as heavily intertwined with unconscious processes. Indeed, the therapists' countertransference forms a significant aspect of their experiences of the alliance. It can be argued that this has implications for the conceptualisations of the alliance that define the alliance as the conscious and rational part of therapy, e.g. Horvath & Bedi (2002). Horvath & Bedi recognise that, 'the alliance may be impacted upon by prior relational history or disposition at several different levels and, though conscious, may be tacit or outside mindful awareness at any specific time' (p. 41). However, they specifically state that transference and countertransference, although aspects of the therapeutic relationship, are not part of the alliance.

It seems the relational experiences that have emerged in the current study, the therapists' countertransference and their lack of awareness of how they contradict themselves are largely unknown to the therapists as opposed to merely 'outside their awareness'. As such, this study demonstrates the necessity of acknowledging the conceptualisation of the alliance as intertwined with unconscious processes. Indeed, the findings are consistent with Safran & Muran's (2003) definition of the alliance which underpins the current study. As described in the literature review (p. 13), Safran & Muran specifically state that the alliance cannot and should not be separated from the unconscious processes that occur between client and therapist in the therapeutic encounter.

Furthermore, the findings from the current study have important implications for the way in which the alliance is measured by alliance scales (p. 14). As stated, alliance scales do not measure unconscious processes. Rather, they concern the rational and conscious aspect of the client-therapist encounter. Thus, this study's findings demonstrate not only the discrepancy between the theoretical conceptualisation of the alliance and the measurement

of the alliance (p. 15). They also demonstrate the discrepancy between therapists' subjective experiences and understandings of the alliance and the measurement of the alliance. Indeed, this study suggests that therapists' understanding of the alliance is inherently subjective and may therefore be difficult to quantify and measure.

An alternative explanation exists for the finding that the alliance seems enmeshed with unconscious processes; if we align ourselves with the definitions of the alliance that term the alliance a conscious and rational concept, e.g. Horvath & Bedi (2002), it can be argued that the interviewed therapists do not seem to understand the 'conscious' alliance as distinct from the therapeutic relationship (which, according to Horvath & Bedi, contains the unconscious processes). Rather, the alliance may be experienced by the therapists as inseparable from the total client-therapist relationship. This, then, begs the question whether the concept of the alliance is relevant to actual clinical practice. As such, the alliance may appear useful in an empirical sense, whilst translating poorly as a discreet concept into practice because is it viewed and experienced by therapists as part of the total client-therapist relationship. This could cast doubt upon the clinical usefulness of the concept of the alliance.

It seems research is warranted to explore how the alliance is experienced by therapists in relation to the unconscious processes in the therapeutic encounter. Moreover, it seems worthwhile for future research to investigate how therapists understand the alliance to relate to clinical practice. Additionally, it appears that if attempts are to be made to measure the alliance, then alliance scales may benefit from including items relating to unconscious processes in therapy. This could inform alliance theory, research, clinical practice as well as training.

4.8   Critique of the research

The current study provides an original contribution to our knowledge of how therapists experience and understand the alliance with clients with drug problems. The following outlines the limitations of the study.

4.8.1 Participants

It is plausible that the therapists may have had an invested interest in participating in the study. The researcher noticed particular therapists' desire to express dissatisfaction with the treatment system. Whilst it is apparent that the treatment system impacts upon the alliance, some participants may have utilised the interviews to voice how, in their view, the treatment system restricts the alliance. As such, they may have focussed upon getting their message across, thus preventing other experiences from being reflected upon.

Moreover, it is entire possible that the therapists wished to promote the plight of a marginalised and stigmatised client group (Theme 3), thus giving rise to the contradictions in their narratives. In this manner, the therapists may have attempted to reduce the stigma surrounding individuals with drug problems by maintaining that they understand their clients, that they hold an understanding of their clients that others do not possess and that the alliance is not that difficult nor that different to generic clients. Additionally, the therapists may have wished to communicate to the researcher their competence in working with their clients. As such, the researcher's interpretations of the meaning of the therapists' contradictions, i.e. that they maintain a fixed conception of the alliance, could be questioned.

Finally, it may have impacted upon the data that the organisation's Consultant Psychologist knew the identity of the therapists. Although the therapists were entirely aware of this, it is plausible that it prevented the therapists from explicitly voicing that they struggle to make sense of the alliance. As such, they may have stated that they understand their clients and that the alliance is not that different and not that difficult to portray their competence in working with their clients. Again, this could have generated the contradictions in their narratives, as opposed to signifying that they hold a fixed and unconscious conception of the alliance.

4.8.2 Data analysis

A further limitation of the study concerns the researcher's subjective and emerged role in analysing the data. Due to the researcher's background in working with clients who use drugs, it is possible that the researcher chose to probe and interpret certain aspects of the

therapists' narratives. This may have left parts of the therapists' experiences of the alliance unexplored. However, the hermeneutic influences of IPA (Smith, 2004) acknowledge that the researcher's subject position and preconceptions impact upon and aid the data analysis. Indeed, the researcher's subject position may have enabled the interpretation of findings that would otherwise have remained unnoticed, as reflected upon earlier (p. 99).

Additionally, it can be argued that Theme 1 – Trapped in the system could be incorporated into Theme 2 – Struggling to connect. Undoubtedly, the system impacts upon the therapists' connection with their clients, and there is definite cross over between the subthemes The trapped therapist/The trapped client with The unreachable client. Additionally, the therapists' navigation of the system could be viewed as Taking responsibility to avoid disconnection and stretching the boundaries of therapy. However, the researcher separated the two themes to highlight the impact of the system upon the alliance, and to emphasise the alliance as contextualised by events external to the therapy room. This may have been somewhat 'lost' if incorporated into one theme. Moreover, it seems the therapists' ways of navigating the system constitute a conscious response to being trapped and feeling hopeless, as opposed to an unconscious countertransferential attempt to connect with clients who are absent from the alliance. Indeed, the therapists seem to struggle more with the unconscious processes in the alliance than the conscious experience of being trapped in the system, thus further separating the two themes.

4.8.3   Credibility

Triangulation is frequently highlighted as a means of increasing credibility in qualitative research. This study relies solely on therapists' accounts, which could question the adequacy of the data (Morrow, 2005). However, Yardley (2000) comments that triangulation should be considered according the study's epistemological position. As this study aims to explore therapists' subjective experiences, a thorough investigation of individual accounts is sufficient in achieving credibility in the research, and it makes little sense to include perspectives from other sources.

4.9 Implications for clinical practice and research

4.9.1 Clinical practice and training implications

This study provides a significant and unique contribution to understanding how therapists experience the alliance with clients with drug problems. The findings from the study suggest that it is pertinent for service providers to acknowledge how therapists can struggle to develop and maintain an alliance with clients with drug problems in the current treatment system. It appears therapists may require structured support, such as clinical supervision, in managing the challenges they encounter in relation to the alliance in this manner. Indeed, therapists will benefit from supervisory guidance on exploring the hopelessness and difficulties in connecting with clients that may arise as a result of the treatment system.

It is further important for therapists who work with clients with drug problems to gain specific skills in working with ambivalence. This could, in turn, help therapists to connect with their clients. Knowledge of and training in attachment theory and the idea of drug use as a secure base and emotional regulation strategy will be helpful in this respect (Gerhardt, 2004; Holmes, 2001). Moreover, Prochaska & DiClemente (1983) developed the Transtheoretical Model of Change which specifically incorporates ambivalence. Additionally, Motivational Interviewing (Miller & Rollnick, 2002) is often used in substance use to encourage clients to shift from ambivalence towards initiating change. These two models provide good foundations in working with ambivalence.

Similarly, therapists will benefit from being aware of the difficulties that clients with drug problems may have in developing trust in the alliance. Again, it seems knowledge of attachment theory and the concept of providing a new relational experience (Holmes, 2001; Bowlby, 1988) may be helpful. Furthermore, Safran & Muran's (2003) alliance rupture work provide good guidance on addressing mistrust in the alliance, which can subsequently strengthen the bond between client and therapist.

It is essential for therapists to engage in reflective practice to explore and make use of their countertransference when working with clients who use drugs, particularly in relation to

struggling to connect with their clients and taking unnecessary responsibility for the alliance. Clinical supervision appears to provide a forum in which therapists can safely do so. This could avoid the acting out of unhelpful countertransference whilst benefitting therapists' emotional wellbeing. Indeed, reflecting upon countertransference could facilitate the alliance by allowing therapist and client to work through alliance ruptures and therapeutic impasses (Safran & Muran, 2003). Specifically, it seems crucial for both therapists and service providers to maintain therapeutic boundaries when providing therapy to clients with drug problems to create a safe and stable environment. This includes reconsidering service policies, such as contacting clients when they fail to attend, which ultimately disempower clients and hinder the alliance in developing.

Additionally, supervision may allow therapists to explore their difficulties in acknowledging how they struggle to make sense of the alliance with clients who use drugs. It further seems supervision can play a significant role in helping therapists to maintain their emotional wellbeing. Supervisors should be aware that therapists could attempt to retain a fixed conception of the alliance to cope with the difficulties in relating to their clients. Supervisors will further benefit from providing a safe, stable and trusting environment in which therapists can allow themselves to struggle and be vulnerable.

Finally, peer support, on collegial support and formal group levels, has the potential to constitute an important forum of support for therapists, both in developing skills concerning the alliance and in maintaining therapists' wellbeing. As such, service providers may wish to consider encouraging and providing the space for the formation of groups in which therapists can draw upon the support and knowledge of each other.

4.9.2   Research implications

The findings from the study highlight areas in need of exploration in relation to therapists' understanding of the alliance with clients who use drugs. It seems feelings of hopelessness may be a significant challenge for therapists who work with this particular client group. A qualitative inquiry could generate in depth knowledge of how therapists experience and manage hopelessness, whilst investigating how hopelessness impacts upon therapists' relationship with their clients.

The therapists in the current study experience pronounced countertransferential reactions, particularly in response to struggling to connect with their clients. It seems worthwhile for future research to investigate how therapists recognise, respond to and manage their countertransference when providing therapy to clients who use drugs. Indeed, this could facilitate the alliance, therapeutic outcome and therapists' emotional wellbeing. Again, it seems a qualitative investigation is well placed to explore this inherently subjective encounter between client and therapist (Morrow, 2007).

Furthermore, the therapists in the current study retain a fixed conception of the alliance in response to struggling to make sense of the alliance. Earlier, the researcher speculated about the purpose that the fixed conception may serve for therapists (p. 112). It would be interesting to explore this further as it constitutes a pronounced part of the therapists' experiences of the alliance with their clients. It seems a constructionist approach may be particularly suited in this respect. Constructionism assumes that the use of language construes reality (Ponterotto, 2005). Constructionist research is concerned with language creating knowledge and language itself is therefore of primary interest (Bryman, 2008). In this manner, constructionism emphasises the interaction between individuals (Schwandt, 2007) and, indeed, the interaction between participants and researcher. Thus, constructionist research could investigate in depth how participants potentially contradict themselves. Moreover, constructionist research could explore how participants may wish to communicate to others that they do not struggle in relation to developing the alliance with their clients.

The role of peer support for therapists who work with clients who use drugs seems to warrant further investigation. Indeed, peer support may constitute a significant source of support alongside clinical supervision. Future research could investigate how therapists make use of peer support. Moreover, research could explore how therapists understand peer support to impact upon clinical practice.

Conclusions

This research aimed to increase our knowledge of how therapists experience and understand the alliance with clients with drug problems. Specifically, it explored what therapists perceive to impact upon establishing and maintaining the alliance with clients who have drug problems. Moreover, it investigated what supports therapists to engage in effective alliances with clients with drug problems. The use of IPA enabled the in depth exploration of the way in which therapists make sense of their experiences of the alliance with clients who use drugs.

The analysis generated four themes: Trapped in the system; Struggling to connect; The contradictory therapist and Resources transcending the alliance. Some findings are consistent with existing literature and research, although predominantly general psychotherapy as opposed to substance use specific literature and research. Many findings appear unique, particularly those relating to therapists' experiences of being trapped in the treatment system, their struggle to connect with their clients, their pronounced countertransference responses and the way in which they hold a fixed conception of the alliance. Similarly, the resources that therapists perceive to influence the alliance with clients who use drugs seem to constitute an original contribution to alliance research and literature in drug treatment. Finally, the findings from the study have important implications for the definition, conceptualisation and measurement of the alliance, highlighting the necessity to acknowledge and measure the alliance as intertwined with unconscious processes.

As such, this study informs clinical practice and training for services, therapists and other professionals who provide therapy to clients with drug problems. Moreover, the study generates avenues for further research, both in relation to clinical practice with clients who use drugs and the conceptualisation of the alliance. Given the increased inclusion of psychology in drug treatment and the relevance of the alliance concept to counselling psychology, the study thus provides a significant contribution to counselling psychology research and practice.

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Appendix 1: Email to Consultant Psychologist

Dear XXXX

I hope you are well and thank you very much for your continued interest in my research program.

The aim of my study is to explore therapists' experiences of the therapeutic alliance with clients with drug problems. I'm particularly interested in the factors that therapists perceive to impact on the development of the alliance. Moreover, I'm interested in exploring the resources that therapists draw on to develop and maintain effective alliances with their clients.

Again, the overall aim of my research is to inform clinical practice for therapists and organisations who provide therapeutic services to individuals with drug problems.

I'm hoping to interview any type of therapist/counsellor, i.e. level of qualification or theoretical orientation is irrelevant. The only criteria is that they have at least 6 months experience of working therapeutically (i.e. not keyworking) with clients with drug problems. This can be both current or past experience, although work with children and clients with a dual diagnosis cannot be included.

I have attached the invitation letter that I'm required to send to you in which full details of the study are outlined.

I have also attached the interview schedule, as well as the new ethics approval.

I hope you find my study of interest to your organisation. Please do not hesitate to contact me should you require any further information.

Best Wishes,

Henrike

Appendix 2: Written invitation and information about the study

<div align="right">

University of East London
Stratford Campus
Water Lane
London
E15 4LZ

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<div align="right">

Saturday 9th of February 2013

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███████ █████████████████████████████████

Dear ████

I hereby send you an invitation for your service and therapists to participate in the below described research programme.

The research programme has achieved ethics approval from the University of East London Research Ethics Committee.

If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact the Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

The details of the Investigator of the research programme is as follows:

<div align="center">

Henrike Andersson
Professional Doctorate in Counselling Psychology
University of East London
Stratford Campus
Water Lane
London
E15 4LZ
Contact number: 07817516944
E-mail: henrikeandersson@gmail.com

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Project Title

The title of the research programme is: Therapists' experiences of the therapeutic alliance with clients with drug problems: An interpretative phenomenological analysis

Project Description

This project attempts to understand how therapists experience the therapeutic alliance with clients with drug problems. Focus will be directed at the factors in therapy that therapists understand to impact upon the development of the alliance. The project also investigates the resources that therapists draw upon in developing and maintaining alliances with clients who use drugs.

Research has demonstrated that the therapeutic alliance is a consistent predictor of therapeutic outcome regardless of therapeutic orientation. Furthermore, the therapeutic alliance is associated with engagement and retention in treatment as well as early treatment improvement for individuals with drug problems. From a therapist perspective, a strong therapeutic alliance has been found to be essential in clinical practice. However, research has called for further investigations in this area to expand our understanding of the features of the alliance in drug treatment, particularly from the views of therapists. It is hoped that carrying out a qualitative piece of research will meet this need, thereby informing clinical practice for therapists providing therapy to clients with drug problems.

Participants will be required to attend an interview, which will be conducted by the researcher. The interview will last approximately 60 minutes, and will be recorded using a digital audio recorder.

Participants will be asked to complete a consent form prior to the interview. Demographic details will be obtained as part of the interview schedule. Participants will be asked to answer a set of questions in relation to their experience of developing and maintaining the alliance with clients with drug problems. Participants will also be encouraged to reflect upon the support sources they draw upon to assist them in developing effective alliances with clients with drug problems. These interviews will be recorded and transcribed. Anonymised extracts of the transcripts will be included in the write up of the project.

The discomfort that participants may experience by taking part in the study is expected to be minimal, if at all present. However, there is a small possibility that participants may become emotionally upset during the interview process. Should participants become upset during the interview, they will be given the opportunity to terminate the interview.

All participants will be given an opportunity for debriefing after the interview. If necessary, they will be given details of relevant local support services to manage emotional upset. Moreover, the researcher will ensure that participants have existing sources of support with whom to discuss their emotional upset, such as clinical supervision or personal therapist.

Confidentiality of the Data

The signed consent forms will be stored in a locked storage facility separate from demographic details. Aliases will be used in place of any identifiable data throughout the process of the project. Written material will be stored on a computer and will be password protected so that no third parties will have access to these.

All data will be disposed of when the research has been published in a peer reviewed publication. This will be done by permanently deleting computer files and shredding paperwork. In addition, audio recordings will be permanently deleted. The researcher's supervisor and examiners will have access to all details of the study. Data and conclusions drawn from the study will be owned by the researcher and University of East London, and the findings will be reported in a doctoral dissertation, with the aim of publication in a peer reviewed publication.

Should the researcher become aware of imminent harm to yourself or others, the research is required to discuss this with their research supervisor after which appropriate action have to be taken in order to prevent harm or risk from occurring.

Location

It is hoped that the research can be carried out in your service, during day time or evening hours, depending on the requirements of your service and therapists.

Disclaimer

Your service is not obliged to take part in this study, participation is entirely voluntary. Your service is free to withdraw from the study up until one month after participant interviews were conducted. Should your service choose to withdraw from the programme it may do so without disadvantage to itself and without any obligation to give a reason.

I hope that you decide to take part in the research programme. I will contact you shortly to ascertain whether you would like to take part in the study and to answer any questions that you may have.

Please do not hesitate to contact me on the above stated contact details should you require any further information about the research programme.

Kind Regards,

Henrike Andersson
Trainee on the Professional Doctorate in Counselling Psychology Programme
University of East London

Appendix 3: Interview schedule

Interview Schedule

Date of Interview
Participant ID
Demographic details
      Age: Gender:
      Type of employment:
      Qualification:
      Theoretical Orientation:
      Length of experience of working with clients with drug problems:
      Length of time since working with clients with drug problems:

Part A. Contextual Mapping: Experience of therapeutic alliance

Question: **What has been your experience of forming an alliance with clients who use drugs?**

Prompt 1: What have you noticed about developing an alliance with clients who use drugs?
Prompt 2: What are the most significant aspects of developing an alliance with client who use drugs?
Prompts 3: How might this differ from other kinds of therapeutic alliances, in your experience?

Part B. Development of therapeutic alliance

Question: **What helps the alliance to develop?** This could be something that you or your client did or said during sessions or outside sessions, or something external to therapy.

Prompt 1: What stands out for you as aiding the alliance in developing? Can you give an example?
Prompt 2: How did this aid the alliance in developing?

Question: **What hinders the alliance in developing?** This could be something that you or your client did or said during sessions or outside sessions, or something external to therapy.

Prompt 1: What stands out for you as getting in the way of the alliance developing? Can you give an example?
Prompt 2: How does this get in the way of the alliance developing?

Part C. Challenges in establishing a Therapeutic Alliance

Question: **How do you manage the challenges that you encounter when developing an alliance with clients who use drugs?**
Prompt 1: How do you attend to the difficulties that you experience when developing an alliance with your clients?

Question: **What kind of resources do you draw upon in helping you to establish and maintain an alliance with clients who use drugs?**
Prompt 1: What role does supervision play in helping you to manage?
Prompt 2: Personal therapy?
Prompt 3: How do you use yourself and your own responses when developing an alliance with clients with drug problems?

Appendix 4: Ethics approval from University of East London Research Ethics Committee

SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of
East London
www.uel.ac.uk

School of Psychology

Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966   fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk   web: www.uel.ac.uk/psychology

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UK

INVESTOR IN PEOPLE   The Government Standard

The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853

Appendix 5: Written information about the study

<u>University of East London</u>
Stratford Campus
Water Lane
London
E15 4LZ

University Research Ethics Committee
If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact the Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

The Principal Investigator(s)
Henrike Andersson
Professional Doctorate in Counselling Psychology
University of East London
Stratford Campus
Water Lane
London
E15 4LZ

Contact number: 07817516944
E-mail: henrikeandersson@gmail.com

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study. The research programme has achieved ethics approval from the University of East London Research Ethics Committee.

Project Title

Therapists' experiences of the therapeutic alliance with clients with drug problems: An interpretative phenomenological analysis

Project Description

This project attempts to understand how therapists experience the therapeutic alliance with clients with drug problems. Focus will be directed at the factors in therapy that therapists understand to impact upon the development of the alliance. The project also investigates the resources that therapists draw upon in developing and maintaining alliances with clients who use drugs.

Research has demonstrated that the therapeutic alliance is a consistent predictor of therapeutic outcome regardless of therapeutic orientation. Furthermore, the therapeutic alliance is associated with engagement and retention in treatment as well as early treatment improvement for individuals with drug problems. From a therapist perspective, a strong therapeutic alliance has been found to be essential in clinical practice. However, research has called for further investigations in this area to expand our understanding of the features of the alliance in drug treatment, particularly from the views of therapists. It is hoped that carrying out a qualitative piece of research will meet this need, thereby informing clinical practice for therapists providing therapy to clients with drug problems.

Participating in this study will involve attending a one to one interview with me, the researcher. The interview will last approximately 60 minutes, and will be recorded using a digital audio recorder. As part of the interview, you will be asked some questions about your age, gender, qualification, theoretical orientation, type of employment, length of experience of working with clients with drug problems and length of time since working with clients with drug problems.

During the interview, you will be asked some open-ended questions in relation to your experience of developing and maintaining the alliance with clients with drug problems. You will also be encouraged to reflect upon the support sources you draw upon to assist you in developing effective alliances with clients with drug problems. These interviews will be recorded and transcribed. Small sections of the transcripts will be included in the write up of the project to give examples from a body of data generated by the group of people interviewed as part of this study. All private information will be removed so that your identity cannot be recognised at any point.

The discomfort that may be experienced by taking part in the study is expected to be minimal, if at all present. However, there is a small possibility that you may become emotionally upset during the interview process. Should you become upset during the interview, you will be given the opportunity to terminate the interview.

You will be given an opportunity for debriefing after the interview. If necessary, you will be given details of relevant local support services and options for receiving support from existing sources of support, such as supervision, will be explored.

Confidentiality of the Data

The signed consent form will be stored in a locked storage facility separate from the details taken about your age, gender, qualification, theoretical orientation, type of employment, length of experience of working with clients with drug problems and length of time since working with clients with drug problems. Aliases will be used in place of any identifiable data throughout the process of the project, including the interview transcripts. Your anonymity is fully guaranteed. Electronic material will be stored on a computer and will be password protected so that no third parties will have access to these.

All data will be disposed of when the research has been published in a peer reviewed publication. This will be done by deleting computer files and shredding paperwork. In addition, audio recordings will be deleted.

The researcher's supervisor and examiners will have access to all details of the study. Data and conclusions drawn from the study will be owned by the researcher and University of East London, and the findings will be reported in a doctoral dissertation, with the aim of publication in a peer reviewed publication.

Should the researcher become aware of imminent harm to yourself or others, the research is required to discuss this with their research supervisor after which appropriate action have to be taken in order to prevent harm or risk from occurring.

Location

The research will be carried out in your place of work at a time that suits you. This could be during or after working hours.

Disclaimer

You are not obliged to take part in this study, participation is entirely voluntary. You are free to withdraw from the study up until one month after your interview was conducted. Should you choose to withdraw from the programme within this period of time, your interview and consent form data will be destroyed and will not be used as part of the research. You may withdraw from the study without disadvantage to themselves and without any obligation to give a reason.

Appendix 6: Leaflet summarising the study

Therapists' experiences of the therapeutic alliance with clients with drug problems
Invitation to take part in a research study

My name is Henrike and I am a Trainee Counselling Psychologist at University of East London.

I am conducting a study that attempts to understand how therapists experience the therapeutic alliance with clients who have drug problems.
I am particularly interested in experiences that you think may have influenced the alliance for better or for worse. I am also interested in how you manage the challenges in establishing and maintaining an alliance with clients with drug problems.

Who am I looking for?
I am hoping to interview therapists who have at least 6 months current or past experience of providing therapy to individuals with drug problems. Your clients may have additional alcohol problems, although their primary substance use difficulty must be that of drug use. Unfortunately, therapeutic work with clients with a dual diagnosis or children cannot be included.

What will the study involve?
Participating in this study will involve attending a 1-2-1 interview with me.
The interview will last approximately 60 minutes during which you will be asked some questions about the alliance with your clients. We can meet at your workplace at a time that suits you.

Confidentiality
Confidentiality is fully guaranteed. Your identity and any disclosed identifying details of your clients and workplace will remain anonymous.

Why take part?
By taking part in the study you will have the opportunity to share your specialist knowledge of working with individuals with drug problems. It is hoped that the study findings generated from your knowledge can inform and shape clinical practice and support networks for therapists who work with individuals with drug problems.

I want to take part - What do I do next?
If you would like to take part in the study, please contact me on the contact details below. Alternatively, you can inform the person who gave you this leaflet. If you would like to meet with me to discuss the study before being interviewed, or talk over the telephone, this can easily be arranged. If you have any questions in relation to the study, you can also contact me on the contact details provided below.

Your participation will be greatly appreciated. I look forward to hearing from you.
Thank you.

Henrike Andersson
Counselling Psychologist in Training
Professional Doctorate in Counselling Psychology at University of East London, Stratford Campus, Water Lane, London, E15 4LZ
Phone: 07817516944
E-mail: henrikeandersson@googlemail.com

Appendix 7: Consent form

<div align="center">

<u>UNIVERSITY OF EAST LONDON</u>

Consent to Participate

Therapists' experiences of the therapeutic alliance with clients with drug problems: An interpretative phenomenological analysis

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I have the read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.
I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the research programme has been completed.

I understand that my participation in the research will involve attending a one to one interview with the researcher which will last approximately 60 minutes. I understand that my interview will be audio recorded and transcribed and that small sections of the transcripts will be included in the write up of the project to give examples from a body of data generated by the group of people interviewed as part of this study. I understand that private information will be removed so that your identity cannot be recognised at any point.

I hereby freely and fully consent to participate in the study which has been fully explained to me.

Having given this consent, l understand that I am free to withdraw from the study up until one month after my interview was conducted, without disadvantage to myself and without being obliged to give any reason. I also understand that my participation in the research is entirely voluntary.

Participant's Name (BLOCK CAPITALS) ....

Participant's Signature ....

Investigator's Name (BLOCK CAPITALS) ....

Investigator's Signature ....

Date: ....

Appendix 8: Email informing participants that their identity is known to the Consultant Psychologist

Hi XXXX

I hope you are well.

This is just a quick note to inform you that XXXX has requested to be informed of the names of the therapists within XXXX who agree to take part in my study to keep track of the recruitment progress. Hence, I will provide XXXX with your name and the fact that we have made an appointment to meet. I wanted to mention this to you as it may affect what you feel comfortable about disclosing in your interview. Your confidentiality and anonymity will be protected as your name, workplace and any other identifying details you mention will not feature in the study in any way.

I hope this is okay with you. Do let me know if you wish to discuss it further.

I look forward to seeing you on XXXX

Best Wishes,

Henrike

Appendix 9: Information on support services

<u>Information on Support Services</u>

Therapists' experiences of the therapeutic alliance with clients with drug problems: An interpretative phenomenological analysis

Thank you for participating in the above study.

In case participating in the study has raised difficulties that you would like to receive further support with, I have collated some information on services that you may find helpful.

British Psychological Society (BPS)

Find a Chartered Psychologist: http://www.bps.org.uk/bpslegacy/dcp or call on tel: 0116 254 9568

BACP

Find a BACP registered therapist: http://www.itsgoodtotalk.org.uk/therapists/ or call on tel: 01455 883300

SANEline 08457 67 80 00 (From 6pm -11pm daily)

Relate 0300 100 1234 (Relationship Counselling)

Mind

General contact details: 020 8519 2122 or Infoline: 0300 123 3393

Appendix 10: Extract from reflective diary

Reflective notes made following the identification of the contradictions in the participants' narratives:

It seems the therapists are very keen for me to know that the alliance with their clients is just like the alliance with generic clients. However, their narratives reveal that the alliance is very specific to the client group. Moreover, it seems the therapists are very keen on telling me that the alliance with their clients is not really that difficult. Again, their narratives reveal aspects of therapy that seem very complex and distressing. It is as if the therapists are reluctant to make the alliance specific to drug use and to admit that they struggle to connect with their clients.

What is this need to portray their clients as any other client group? Would they otherwise be the same as those who do not understand their clients, e.g. no better than those who reject their clients? Does it somehow enable them to work with their clients if they tell themselves that the alliance is not really that hard? Could it be that they attempt to avoid coming across as being unable to work with their clients, that they do not wish for the organisation or me to doubt their skills?

How has my own clinical experience and knowledge of forming the alliance with clients who use drugs influenced this observation? Perhaps my experience of struggling to connect with the client group led me to interpret that the therapists struggle? Perhaps the alliance is genuinely not that different and not that challenging compared to that with generic clients? On the other hand, the therapists' contradictions are incredibly evident in their narratives. This suggests that there is a definite clash between what the therapists consciously portray and what they unconsciously experience. In this manner, it seems my own experience of relating to clients who use drugs has aided the data analysis rather than obscured the therapists' experiences. It will be necessary for me to demonstrate the therapists' contradictions explicitly when writing up the results to evidence grounding of their experiences in the data.

	Appendix 12: Example of interview transcript with comments and emerging themes – Melissa	
	Please note: **Transcript has been altered to adjust to page layout, although line numbers provided correspond to original transcript (Appendix 11)**	
	Melissa (274): will even take off their wedding ring before they see a client because they don't want clients to even know they're married, they want them to know nothing about them (Okay), you know, tend to be psychodynamically orientated. Gizmo, come on, please leave her alone, sorry my cat, erm...	
	Interviewer (281): It's okay.	
Self disclosure to let clients know that she understands. What makes this so important for her to do?

Self disclosure - leaves her vulnerable, exposed? 'Crossing over' into.

Therapeutic boundaries seem important, clients can be unboundaried | Melissa (282): I have a good idea, why don't I close the doors and then they'll leave you alone. Erm…but, you know, I don't I don't feel that way (Mm-hm) and so, you know, my clients will be aware, erm, through conversation that I, you know, have a (child) who is (age) and was a teenager so (Mm-hm) when they're talking about their teenage kid I get that too, you know (Okay). Erm, so in other words use of self in that way (Yeah), erm, but this was kind of crossing over into, you know, I want, you know, a part of you. She said something about, you know, "Can I", you know, "can I drive it round the block today?" or | Stretching boundaries of therapy to connect with client

Therapeutic boundaries |

		something (Mm) you know (short laugh), and it's like "No!" (short laugh) (Mm) Erm, and I wasn't clear where she was going with this (Mm). Erm, you hear of clients stalking their former therapist, I mean that hasn't happened (Mm-hm, mm-hm, mm-hm) but it's just…it crosses your mind I guess and and you know I wondered where she was going and it was uncomfortable (Yeah). Mmm.	
	Int. (304):	Mm. And I guess that shaped your relationship?	
Therapist anxiety/wary	Melissa (305):	It made me feel wary for a couple of weeks (Mm), yes (Mm-hm).	
	Int. (307):	Yeah, that's understandable. Any other significant aspects that you can think of in working with with clients who use drugs?	
	Melissa (310):	(Short pause) I think generally that that's about it.	
	Int (311):	Yeah. Any other things that you can think of that how the how the alliances that you form with clients who use drugs might be different from other types of clients that you work with? So you've spoken about the intensity of it…	
	Melissa (316):	Mmm.	
Emotionally charged environment	Int. (317):	…so the emotions are flying around in the room	

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		as soon as you sit down.	
Alliance takes longer to build	Melissa (319):	Mm-hm.	
	Int. (320):	Erm, it takes longer erh to establish an alliance perhaps.	
	Melissa (322):	Mm-hm.	
	Int. (323):	Any other…?	
Fragile alliance	Melissa (324):	Mm-hm. Erm, and (short pause) and at the same time I guess I'd describe it as very fragile (Mm-hm). I'm I'm thinking of another client now (Mm-hm) who, erm, came for obsessive compulsive symptoms, erm, and had been a heroin user, got off heroin and booze, then started using, erm, paracetamol and codeine so his doctor put him on methadone but he was lit this guy had a lot of pressures, he was living in a dry house, couldn't tell them the truth about the methadone (Mm-hm) even though it was medically prescribed (Yeah) and also he was working three days a week and couldn't tell them that either. And he was an example of someone who I think confided this to me pretty readily (Okay), erm, but then regretted it (Okay) and wasn't sure if I could be trusted no matter how much I said to him "Well (Mm) why am I going to tell anybody?" (Mm-hm), erm, "I wouldn't even talk to your GP without your permission" (Yeah), erm, "So I'm certainly not going to	
Clients mistrust therapist, where does mistrust originate from?			Mistrust in the alliance
Attempts at building trust are futile, therapist seems desperate to connect			Struggling to connect

		phone up the house and say 'did you know he's working three days a week?'" (Mm) I said to be honest I'd appreciate it if you could explain their rationale to me because you know the whole…one of the focuses of (service name) services of course is to get people into work (Mm-hm), so, you know, he's doing what we want you to do (Yeah), erm, and yet he's in a situation where he could get canned for that (Yeah). So I said "You know could you explain the rationale to me (Yeah) because I'm not quite clear about why they think that way?" Erm, so…and essentially he was in a very twelve step house (Mm) and that was the thing about it. Erm, but I think he regretted telling me all this (Okay), erm, and erm, he DNAd and the policy of the service is discharge (Mm), DNA, out,	
Stretching boundaries of therapy, would she do this with generic clients?		but I've always managed to sidestep that and I phone people up and I try to, you know, find out what's going on (Mm-hm), find out what's happened, you know. Because I actually did have a client say to me (Mm-hm), erm, I spent the night with my mother, you know, in the hospital and I overslept	Stretching boundaries of therapy to connect
Avoiding conflict by not addressing process, therapist knows client is withholding but chooses not to explore in order to retain in therapy		and it was true (Mm-hm) and, erm, you know, so sometimes something may have happened. Now his explanation was very convoluting and contained a lot of holes but I was still	Attempting to connect

Fragility of alliance Conflict in the alliance		gonna leave it but, you know, with service policy I had to read him the riot act about DNAing and I, you know I just said "You know we've got to discuss this." And the thing is is that when he arrived that day I could see that he was like…he was ready to fight, he was ready to rumble, you know, his whole body language (Mm) sitting in the waiting room was tense (Mm-hm, mm-hm) and, you know, ready to jump and, erm, that's exactly what he did because when I said "Okay", I said "Look, it's fine, it's okay", erm, "I'll accept your version of events" even though I I k I knew they were full of holes but (Yeah) skip it. Erm, but I said "You know I'm obliged to tell you", erm, and he said "You know I don't even like coming here and coming here hasn't done me any good and you know actually I really hate these appointments and they're really annoying me and I'm not going to do any of your god damn homework and I think we really just better call it quits don't you?" and threw his s stuff down and walked out the door. And I was like (Gosh) speechless (Mmm). Erm, so the thing is is that, you know, actually having told me all these things about himself (Mm-hm), erm, lots of things about himself that he was hiding from others	Conflicted alliance
Avoiding conflict			Struggling to connect
Therapist shocked Trust is difficult for clients			Mistrust in the alliance

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		that was creating a lot of pressure on him that was contributing to his obsessive compulsive behaviours (Okay) I felt (Yeah), erm, I think he regretted it and I think that that alliance was actually really fragile (Mm-hm) and so, erm, he regretted it, DNAd because he regretted it (Mm-hm) very probably (Mm-hm). Erm, but then, you know, decided to show up anyway but was expecting, you know, here's where the the continuous overarching schema comes in that (Yeah), you know, is rigid. Erm, (Mm) you know (Mm-hm, mm-hm), "She's gonna yell at me, she's gonna…" and I really didn't yell at him (Mm), I just really nicely (Yeah) tried to find out what had happened (Mm-hm) and I and I "Look, you know the service says" and I…you know I I tried so hard to put it nicely and I played the tape for a supervisor who said "Yeah, you know, you did it nicely, you know, I'm not sure what else you could have said (Mm-hm) if you had to say that." Erm, of course my supervisor pointed out to me that, erm, here's where, you know, services fail. If that was private practice my supervisor would have given him a week or so to cool off and then phoned him up and invited him back to therapy (Okay).	
Impact of schema on alliance			Early experience manifests in the alliance
Therapist questions own skills - Continues to attempt to make sense of losing client from therapy - Needing reassurance from supervisor			Self doubt Use of supervision
Stretching therapeutic boundaries to retain clients in therapy			Stretching therapeutic boundaries to connect

		Whereas in most services (Mm), no, you know?	
	Int (424):	So there's something about the fragility of the alliance which was emphasised…	
	Melissa (426):	Mm.	
	Int. (427):	…by service issues?	

Appendix 13: Example of individual themes table with quotes

Table of superordinate themes and subthemes for Melissa

Superordinate themes with subthemes	Page/Line	Key words
'I get it'		
See human being	P.21 578-583	'You can see that I'm still a human being maybe' (604-605)
Understanding function of use	P.20 537-540	'Self medication hypothesis'
Relapse		
Different relational experience	P.8 151- 161	'..I thought you'd be angry with me'
Therapists' disappointment and anxiety	P.27 741-744	'Disappointed'
	P.42 1209-10	'..lots of angst'
Questioning self	P.41 1163-1190	'..am I doing something wrong?'
Trapped in the system		
Service provision	P.10 211-229	'..but a lot of the time it doesn't get addressed..'
	P.14 355-360	'..DNA, out'
Hopelessness	P. 10 226-229	'..still haven't made a dent'
Navigating the system	P.14 360-368	'Side step'
	P. 11 251-254	'..better to see you and have some level of therapeutic alliance'
	P.7 118-121	'..maybe that's what you have to do that day.'

Resources transcending the alliance		
Supervision	P. P.47 1341-1346	'..I wouldn't be standing'
The conflicted alliance		
Others who do not understand	P. 18 453-461	'..have no idea'
Service provision	P.10 234-247	'..refer upwards to a CMHT, you are joking'
Conflicted clients	P.13 324-357	..he regretted telling me about it..'
	P.15 364-393	'..I don't even like coming here'
Conflicted self		See Contradictions
Avoiding conflict	P.15 364-371	'..I was still going to leave it..'
	P.7 138-144	'..let's see if she tells me.'
Contradictions		
I understand		
- vs struggling to make sense	P.17 435-436	'I'll never know now'
- vs angry and anxious	P.31 877-889	'..you are joking, do you think I'm so stupid?'
- vs questioning self	P.16 409-423	'..I really didn't yell at him'
- vs struggling with clients' ugly side	P.52 1498-1506	'..Most people have redeemable qualities'
Just an added dimension	P.53 1559-1568	'..added dimension of substance misuse
- vs very poignant, specific difficulties		E.g. relapse theme
Secrets in the alliance		
- are not problematic	P.34 968-979	'..maybe that's a good thing'
- are problematic	P.34 978-979	'..isn't a good thing at all'
Making excuses for/protecting client	P.29 814-820	'..it wasn't really deception'
	P.30 833-837	'..so it wasn't really deception'
	P.34 968-978	'..maybe that empowers them

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		in some way...maybe that's a good thing'
	P.43 1226-1234	'..she consistently would show up'
	P.52 1500-1518	'..trying to see the good that's there'
I'm not doing that badly, really, it wasn't my fault	P.39 1135-1139	'..his mother..wasn't a viscous ogre or something..'
	P.43 1226-1234	'..the therapeutic alliance can't have been all that bad.'
	P.26 707-731	'..maybe mom doesn't call him names and maybe she has a good reason to yell'
Struggling to connect	P.8 151-167	',,clearly there was some mismatch between what I thought was a therapeutic alliance..'
Forced alliance	P.39 1124-1134	'..he didn't want to be there so that was an added element of why this was probably never going to be successful.'
Breaking through mistrust and schema	P.43 1252-1257	Because I know it's going to maybe take longer...because you've got to break through that paranoia and very possible assumptions about things..'
Stretching therapeutic boundaries to connect	P.12 283-289	'..my clients will be aware that I have a (child)... so when they're talking about their teenage kid I get that too..'
	P.14 357-363	'..but I've always managed to side step that and I phone people up and I try to, you know, find out what's going on..'

Changing self to connect	P.37 1059-1063	'..and I didn't like him, erm but, you know, I thought well okay, but you know, I think I can overcome this.'
	P.38 1102-1103	'Yeah, I had to find some [empathy] somewhere..'
Being careful not to upset/avoid conflict	P.15 364-374	'Now his explanation was very convoluting and contained a lot of holes, but I was still gonna leave it..'
	P.29 824-829	'..because if I do know, I got to go say something.'

Appendix 14: Master table of superordinate themes and subthemes without quotes

Master table of superordinate themes and subthemes

Superordinate themes	Subthemes
Theme 1 - Trapped in the system	The trapped therapist The trapped client Hopelessness Navigating the system
Theme 2 – Struggling to connect	The unreachable client Taking responsibility to avoid disconnection
Theme 3 – The contradictory therapist	I understand...or do I? It's not that difficult or different...or is it?
Theme 4 - Resources transcending the alliance	Clinical supervision Peer support Use of self

Appendix 15: Master table of superordinate themes and subthemes with quotes

Theme 1: Trapped in the system

Theme 1 - Trapped in the system	Page/line
The trapped therapist	
Melissa: *I mean, all of this [personality issues] is entirely possible to work with but, you know, a lot of the time it doesn't get addressed unless somebody is in inpatient care [...] in shorter term therapy it's very difficult to work with that*	P. 10 212-220
Joe: *I mean there's also policies that you have to comply with that aren't aren't what I what I would do given the free rein that I have in private practice*	P. 9 168-171
Alex: It's a difficult balance [between organisational need and client need]	P. 8 165
The trapped client	
Melissa: *refer upwards to a CMHT, you are joking [...] you know, if you refer anybody to a CMHT they've got to be actively immediately suicidal or frothing at the mouth*	P. 10 238-245
Joe: *their autonomy to a I an extent has been taken away from them and you either attend or they go back to prison*	P. 6 88-91
Alex: *clients were experiencing this as if, erm, they did not really have a choice*	P. 9 189-192
Nadine: *They feel they have to come, but they don't want to come, because of some other service saying, "Well, we can't help unless you can go."*	P. 27 812-815
Hopelessness	
Melissa: *Melissa didn't do that but everybody else will still so you haven't really made a dent in in that part of their view of things*	P. 10 226-229
Joe: *but a drug and alcohol counsellor has got 12 sessions and can't work with... with the trauma*	P. 14 322-325

Alex: *it feels something significant when they're ready for it, rather than for, we have a referral [sighs], they have 8-12 sessions to get, you know, change or even 16 sessions to change if they're lucky*	P. 7 121-127
Navigating the system	
Melissa: *She wants supportive listening [as opposed to CBT] and maybe that's what you have to do that day*	P. 7 120-121
Joe: *So I did it anyway, I paid for it [EMDR course] myself and I did it anyway and that's really helped my practice*	P. 15 355-357
Alex: *Okay, I can still engage in a motivational interviewing intervention to support the people who are ready to make some changes to make those changes*	P. 10 224-228
Nadine: *the moment you pick up on it [ambivalence about therapy] in the first session, you just have to keep revisiting every session as you get them to make that decision [whether to stay in therapy or not]*	P. 28 833-839

Theme 2: Struggling to connect

Theme 2 – Struggling to connect	Page/Line
The unreachable client	
Melissa: *but his mother had sort of hogtied him and brought him along so he didn't want to be there*	P.39 1130-1132
Joe: *an outside force is pushing them to have a relationship with me that they may not even want*	P. 7 118-121
Alex: *when someone comes close to them […] even any notion of closeness means that simply they withdraw further*	P. 29 720-725
Lisa: *and there is a line between the two of you and, erm, and you aren't sitting side-by-side in a way*	P. 8 176-178
Nadine: *Because if the client can't be present, who are you really*	P. 29 879-880

working with?	
Emilia: Erm, it puts pressure on the therapist to come up with different skills or try and engage [...] or make a bigger effort [...] you have to make a decision whether they're in a state where there where there can be interaction [...] you struggle to make the alliance work the best way you can	P. 3 15-25
Melissa: *Because I know it's [development of the alliance] going to maybe take longer [...] because you have to break through that paranoia and very possible assumptions about things*	P.43 1252-1256
Joe: *it [social services involvement] breeds mistrust into the relationship because is the person telling you the truth or are they telling you a load of stuff that is juicy?*	P. 24 603-606
Lisa: *sometimes I think you can pick it up from from a person almost straight away the minute they walk through the door[...] they have a lot of suspicions towards you*	P. 26 714-722
Nadine: *It's, "Okay, you seem okay, you're talking to me respectfully. But it's your job, isn't it? You get paid to do that." That's the attitude they come with*	P. 16 427-430
Emilia: *most clients that I've worked with, erm, somewhere in their developmental stage, the trust has been broken, erm, so erm, it's very hard to really confide or trust anybody else [...] you have to work very hard at, erm, building some trust in order for them to be motivated to change*	P. 32 825-833
Taking responsibility to avoid disconnection	
Melissa: *I was disappointed, yeah, because maybe I wasn't doing so good at it [...] or am I doing something wrong, even, you know, as a therapist*	P.41 1177-1190
Lisa: *you start doubting yourself and you start to think that it's your responsibility to do it [enable client to stop using drugs]*	P. 15 395-397
Emilia: *So in in fact, erm, my internal struggle has nothing to do with how they've seen me [...] And yet you're thinking [sharp intake of*	P. 18 422-436

breath] I I I felt bad for doing what I've done to you, you know. And and maintaining a boundary, erm...so that that's good to to hear afterwards	
Melissa: *the policy of the service is discharge, DNA, out, but I've always managed to side step that and I phone people up and I try to, you know, find out what's going on*	P. 14 359-362
Joe: *That impacts the relationship in that you're chasing the client which you wouldn't do in normal therapy [...] mothering the client*	P. 9 186-191
Lisa: *a lot of the time what we do here if they miss a session we'll call them up and ask if they, you know, if they can attend the next session*	P. 42 1200-1202
Nadine: *I will then change the room [...] because when we're in that room [...] we're at this pace, this distance. And sometimes I lean forward. So we can bring drinks in, so it's more like an intimate chat [...] we're going to have a chat [...] So if I soften it all, including the atmosphere and the environment, it will help them to open up*	P. 34. 1022-1037
Emilia: *somebody who is willing to be there, session after session, whether they turn up or don't turn up, you know, the space is there, makes the phone call to see why they haven't turned up and blah blah blah , you know, and brings them back in*	P. 33 866-872
Melissa: *Now his explanation was very convoluting and contained a lot of holes, but I was still gonna leave it*	P. 15 368-371
Nadine: *So all those sorts of things I take into account, is to what would make them feel unsafe in the early stages of the work. So I have to be really mindful of what room I use and how long for. If I have to use this room, then I do apologise*	P. 35 1063-1068
Emilia: *but you do get the reassurance that you have been, as they said, human. And you've listened to them rather than reject*	P. 19 448-451
Melissa: *and I didn't like him, erm, but you know, I thought, well okay, but you know, I think I can overcome this*	P. 37 1060-1062
Joe: *changing yourself. Changing what you expect to achieve [...]*	P. 33 865-877

how useful is that goal of being clean if they require much longer term work? It's not	
Lisa: *to be less outcome focussed, to be a bit more flexible, erm, and you know, and hold that flexibility in mind because, yeah, things happen and you just can't control them*	P. 41 1182-1186
Nadine: *just don't use certain buzzwords that will make them, you know, feel nervous or whatever. Tone of voice. Body language, the way I sit. Erm, even the rooms we use*	P. 33 990-993
Emilia: *I have a, you know, instinctual repulsion towards somebody who smells badly. So it's about conquering that and again seeing the person rather than the problem*	P. 26 667-672
Alex: *Really I try matching as much as possible*	P. 29 740

Theme 3: The contradictory therapist

Theme 3 – The contradictory therapist	Page/Line
I understand...or do I?	
Melissa: *it's, you know, really seeing that person as an individual and also seeing them as a person [...] you can see that I'm still a human being maybe*	P. 21 579-605
Joe: *drug taking in and of itself is symptomatic, it's not it's not the cause of problems, it's a symptom [of unresolved emotions]*	P. 3 19-21
Lisa: *what I try and do is always attend to the person first and then whatever else comes up [...] by attending to them rather than their drug use it can be quite helpful for them to actually find out who they are*	P. 23 619-638
Nadine: *It's not about where you're coming from, it's not about the labels, it's just about you as a person*	P. 9 211-214
Emilia: *I think if you go past that you still see a human being with with a lot of history of trauma and abuse, PTSD, you know. So I guess, erm, it's going past that facade and and just seeing the real person with real needs and problems and struggles*	P. 21 517-524

Melissa: *a lot of clients have had a lot of experience with therapists, erm, or professionals who, erm, have [....] no understanding of the extreme intensity of emotion [...] that they feel pushed, erh, to go out and use again*	P.18 453-461
Melissa: *because she didn't actually in March feel that she could tell me that she'd relapsed [...] because when she relapses the important people in her life get very, very angry at her*	P. 8 153-161
Lisa: *I think what they experience is quite a lot of irritation and [...] impatience [...] "Why is it taking you so long"*	P. 25 684-687
Lisa: *[Attending to clients' feelings as opposed to drug use] helps, erm, the alliance because, you know, they feel like you actually want to be there for them rather than, erm, maybe be one of those people that [...] will frown upon them*	P. 22 602-607
Nadine: *If you mention anything to do with the NHS the NHS he will run a mile [...] with him, it was a case of finding that one person he could trust, who he can open up to, who was there for him in the main, who cared about the here and now.*	P. 9 194-211
Emilia: *we haven't differentiated and haven't said, "Oh, your drug, or you're you're under drugs influence right now, and get lost, come back another time"*	P. 20 494-498
Melissa: *most of my clients kind of get the impression pretty quickly that I get it*	P. 7 136-137
Melissa: *Erm, I don't know, I'll never know now [why client DNAd]*	P. 17 435-436
Alex: *it feels something significant when they're ready for it [long term therapy]*	P. 7 121-123
Alex: *the cycle of change seems really significant [short term therapy]*	P. 11 230-231
Lisa*: a lot of the time they do actually use drugs because they want to block some of their emotions out*	P. 4 62-64
Lisa: *I think a lot of people do use drugs and alcohol because they that's, erm, that's one way for them to get in touch with their emotions*	P. 36 1022-1024
Nadine: *You've got to do it by yourself, I'm not going to hold your hand for you. You know, no counsellor will hold your hand because that's not going to be helpful for you*	P. 25 721-725
Nadine: *I've got to bring him back down, make him feel safe and secure*	P. 37 1144-1145
Emilia: *that's a differentiation [between highly functioning clients*	P. 22 544-545

and those from a deprived background] that I would not like to make Emilia: *I think people who hide it, erm, have a much more, erm, first of all they can be more resistant*	P. 23 580-582
It's not that difficult or different…or is it?	
Melissa: *acknowledging this added dimension of substance misuse, but the premise that, you know, this is a person just like la the depression client that you saw yesterday* Melissa: *More likely to encounter really, really horrible trauma*	P. 53 1559-1563 P. 5 84-85
Joe: *Is there anything that makes it [the alliance] different? Erm.. I s'pose not, really, err, I think the difference is the organisational context* Joe: *is this where you want the relationship to end because if you carry on using the way you are you are gonna die*	P. 4 49-52 P. 21 515-518
Alex: *Not really. I think there'd have been, other things would apply also with other clients* Alex: *Yes, definitely, the way of administering the drugs*	P. 15 349-350 P. 26 657-658
Emilia: *I guess they can be placed into the category, or or or clients with drug use can be placed into the category of more complex clients* Emilia: *Yeah, so it's harder, but on the same lines, I guess, for anybody else that you see*	P. 12 274-277 P. 14 317-319
Lisa: *what I found in the end was that they do differ a little bit* Lisa: *for a practitioner that's especially that's just starting doing that work it can be a little bit frightening sometimes and can be a little bit sort of, "Oh", you know, "What should I do about now"*	P. 3 25-26 P. 18 487-491
Joe: *it's generally quite easy to to form a an alliance with someone using drugs* Joe: *I think when people lie that hinders but I think people generally lie out of fear*	P. 3 10-12 P. 23 574-576
Alex: *So for me creating the alliance is not a difficulty* Alex: *that makes it really, really hard to form the alliance*	P. 4 26-27 P. 22 538-539
Nadine: *And, you know, when I give that to them, then they'll think about it, then they'll say, "Yeah, you're right"* Nadine: *So for me, yeah…I have to work really hard on the trust*	P. 29 855-857 P. 18 515-517

Theme 4: Resources transcending the alliance

Theme 4 - Resources transcending the alliance	Page/Line
Clinical supervision	
Melissa: *I've had the same counselling psychology clinical supervisor and I tell you what if it wasn't for him I wouldn't be standing*	P. 47 1343-1346
Joe: *Supervision I use a hell of a lot*	P. 31 807
Alex: *Definitely, supervision, a key aspect*	P. 40 1009
Lisa: *and that's when supervision was great because [...] it helped me with kind of realising that no, it's not about me*	P. 45 1301-1310
Nadine: *Oh, if it wasn't for supervision! [laughs]. Oh my lovely supervisor [...] I see them sometimes, and I don't even realise that's how I see them, he brings that to my awareness*	P. 43 1331-1370
Emilia: *So I I I think that's why I needed to see my supervisor, is it just me completely colluding with the client and not realising that, you know, he can actually act on that anger, or or the feelings were real?*	P. 39 1033-1039
Peer support	
Lisa: *peer support has been excellent because [...] a lot of the people that have worked here before me for a number of month or years and they've all had an experience of of that and and they were able to tell me [..] that's how you can approach that*	P. 43 1225-1232
Emilia: *when you come out of the room, and you're in a certain state, it's kind of, like, therapeutic to be with your colleagues [...] talk about how you feel [...] and come back to your own wellbeing*	P. 35 906-914
Use of self	
Melissa: *That must be an awful way to live to have nobody much like you [finding empathy]*	P. 38 1086-1088
Joe: *I think, erm, congruence and immediacy in the therapeutic relationship are key, because, erm, if you feel something, erm, and you share it with the client and it's useful to the client you can move you forwards, but it can also draw you together*	P. 36 933-939

Alex: *I mean sometimes I'm able to conceptualise under the construct of, erm, projective identification, so I may be feeling things they are disowning [...] I'm feeling their anxiety*	P. 38 953-958
Lisa: *they won't say how they feel or they will try and hide it a little bit [...] if you can let yourself sort of feel what [...] is lingering in the room sort of thing then it can give you a lot of clues as to what they're feeling [...] it does help the alliance hugely actually, erm, because it makes it more real*	P. 47 1364-1375
Nadine: *but since working with his mother, erm, I've realised that it empowered her, because it gave her an example of how to deal with his behaviour*	P. 50 1552-1555
Emilia: *So finding a way of saying, "Well, I'm scared sitting here with you" [...] and widening it out to saying, "I wonder if other people out there reject you because they are scared as well?"*	P. 30 769-776